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Policy: It shall be the policy of Southwest Michigan Behavioral Health (SWMBH) and its provider network to adopt the Michigan Department of Health and Human Services (MDHHS) policy and practice guideline on Person-Centered Planning.

Purpose: To establish the standards that define, guide and detail how SWMBH and its provider network comply with the State laws and MDHHS Contractual requirements pertaining to the practice of Person-Centered Planning including the MDHHS Person-Centered Planning Policy and Practice Guideline.

Scope: SWMBH and its provider network involved in Clinical Service provision to client's utilizing Medicaid Funds.

Responsibilities: Please reference the attached document for an overview of responsible parties and their responsibilities in regard to Person Centered Planning.

Definitions: See Definitions List

Standards and Guidelines:

All customers requesting services through SWMBH and its provider network shall have their Individual Plan of Service developed through a person-centered planning process. Each Community Mental Health Service Provider (CMHSP) and its provider network shall establish procedures and provide supplemental information for carrying out the Person-Centered Planning Practice Guidelines.

**Effectiveness Criteria:**

SWMBH clinical quality department will perform Clinical Audits on a yearly basis, utilizing a rotating target population, which will involve analysis of clinical files for Person Centered Plans and Planning Process to ensure that they follow the requirements laid out in the MDHHS policy.

References:

Michigan Mental Health Code (supplemented through Act 152 of 1996: Sec. 712)

Michigan Department of Health and Human Services PIHP Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19 contract: Attachment P 4.4.1.1 Person-Centered Planning Policy and Practice Guideline

Attachments:

Michigan Department of Health and Human Services PIHP Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19 contract: Attachment P 4.4.1.1 Person-Centered Planning Policy and Practice Guideline



**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
PERSON CENTERED PLANNING POLICY
June 5, 2017**

“Person-centered planning” means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities.” MHC 330.1700(g)

I. WHAT IS THE PURPOSE OF THE MICHIGAN MENTAL HEALTH SYSTEM?

The purpose of the community mental health system is to support adults and children with intellectual and developmental disabilities, adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance to live successfully in their communities—achieving community inclusion and participation, independence, and productivity. Person-Centered Planning (PCP) enables individuals to identify and achieve their personal goals. As described below, PCP for minors (family-driven and youth-guided practice) involves the whole family.

PCP is a way for people to plan their lives in their communities, set the goals that they want to achieve, and develop a plan for how to accomplish them. PCP is required by state law [the Michigan Mental Health Code (the Code)] and federal law [the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules] as the way that people receiving services and supports from the community mental health system plan how those supports are going to enable them to achieve their life goals. The process is used to plan the life that the person aspires to have, considering various options—taking the individual's goals, hopes, strengths, and preferences and weaving them into plans for the future. Through PCP, a person is engaged in decision making, problem solving, monitoring progress, and making needed adjustments to goals and supports and services provided in a timely manner. PCP is a process that involves support and input from those people who care about the person doing the planning. The PCP process is used any time an individual's goals, desires, circumstances, choices, or needs change. While PCP is the required planning approach for mental health and I/DD services provided by the CMHSP system, PCP can include planning for other public supports and privately-funded services chosen by the person.

The HCBS Final Rule requires that Medicaid-funded services and supports be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree

of access as individuals not receiving such services and supports. 42 CFR 441.700 et. seq. The HCBS Final Rule also requires that PCP be used to identify and reflect choice of services and supports funded by the mental health system.

Through the PCP process, a person and those he or she has selected to support him or her:

- a. Focus on the person's life goals, interests, desires, choices, strengths and abilities as the foundation for the PCP process.
- b. Identify outcomes based on the person's life goals, interests, strengths, abilities, desires and choices.
- c. Make plans for the person to achieve identified outcomes.
- d. Determine the services and supports the person needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.
- e. After the PCP process, develop an Individual Plan of Services (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

PCP focuses on the person's goals, while still meeting the person's basic needs [the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code]. As appropriate for the person, the PCP process may address Recovery, Self-Determination, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning as described in the relevant MDHHS policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the person to work toward and achieve their personal goals.

For minor children, the concept of PCP is incorporated into a family-driven, youth-guided approach (see the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline). The needs of the child are interwoven with the needs of the family, and therefore supports and services impact the entire family. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the person reaches adulthood, his or her needs and goals become primary.

There are a few circumstances where the involvement of a minor's family may be not appropriate:

- a. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Code.
- b. The minor is emancipated.
- c. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the minor or substantial disruption of the planning process. Justification of the exclusion of parents shall be documented in the clinical record.

II. HOW IS PCP DEFINED IN LAW?

PCP, as defined by the Code, "means a process for planning and supporting the person receiving services that builds upon his or her capacity to engage in activities that promote community life and that honors the person's choices, and abilities. The PCP process involves families, friends, and professionals as the person desires or requires." MHC 330.1700(g).

The Code also requires use of PCP for development of an Individual Plan of Services:

"(1) The responsible mental health agency for each recipient shall ensure that a PCP process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The person in charge of implementing the plan of services shall be designated in the plan." MCL 330.1712.

The HCBS Final Rule does not define PCP, but does require that the process be used to plan for Medicaid-funded services and supports. 42 CFR 441.725. The HCBS Final Rule also sets forth the requirements for using the process. These requirements are included in the PCP Values and Principles and Essential Elements below.

III. WHAT ARE THE VALUES AND PRINCIPLES THAT GUIDE THE PCP PROCESS?

PCP is an individualized process designed to respond to the unique needs and desires of each person. The following values and principles guide the PCP process whenever it is used.

- a. Every person is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the person's ability to make choices.
- b. Every person has strengths, can express preferences, and can make choices. The PCP approach identifies the person's strengths, goals, choices, medical and support needs and desired outcomes. In order to be strength-based, the positive attributes of the person are documented and used as the foundation for building the person's goals and plans for community life as well as strategies or interventions used to support the person's success.
- c. The person's choices and preferences are honored. Choices may include: the family and friends involved in his or her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships and friendships, and transportation. Individual choice must be used to develop goals and to meet the person's needs and preferences for supports and services and how they are provided.
- d. The person's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the person to implement their choices or preferences over time.
- e. Every person contributes to his or her community, and has the right to choose how supports and services enable him or her to meaningfully participate and contribute to his or her community.
- f. Through the PCP process, a person maximizes independence, creates connections and works towards achieving his or her chosen outcomes.
- g. A person's cultural background is recognized and valued in the PCP process. Cultural background may include language, religion, values, beliefs, customs, dietary choices and other things chosen by the person. Linguistic needs, including ASL interpretation, are also recognized, valued and accommodated.

IV. WHAT ARE THE ESSENTIAL ELEMENTS OF THE PERSON-CENTERED PLANNING PROCESS?

The following elements are essential to the successful use of the PCP process with a person and the people invited by the person to participate.

- a. **Person-Directed.** The person directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.
- b. **Person-Centered.** The planning process focuses on the person, not the system or the person's family, guardian, or friends. The person's goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the person's needs or choices, rather than viewed as an annual event.
- c. **Outcome-Based.** The person identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.
- d. **Information, Support and Accommodations.** As needed, the person receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the IPOS. Support and accommodations to assist the person to participate in the process are provided. The person is offered information on the full range of services available in an easy-to-understand format.
- e. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process.
- f. **Pre-Planning.** The purpose of pre-planning is for the person to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Each person must use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all needed actions (e.g. invite desired participants):

1. When and where the meeting will be held.
2. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).

3. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them. (What will be discussed and not discussed).
 4. The specific PCP format or tool chosen by the person to be used for PCP.
 5. What accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).
 6. Who will facilitate the meeting.
 7. Who will take notes about what is discussed at the meeting.
- g. **Wellness and Well-Being.** Issues of wellness, well-being, health and primary care coordination support needed for the person to live the way he or she want to live are discussed and plans to address them are developed. People are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, eating candy or other sweets). If the person chooses, issues of wellness and well-being can be addressed outside of the PCP meeting.
- PCP highlights personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the person's right to assume some degree of personal risk. The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).
- h. **Participation of Allies.** Through the pre-planning process, the person selects allies (friends, family members and others) to support him or her through the PCP process. Pre-planning and planning help the person explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

V. WHAT IS INDEPENDENT FACILITATION?

An Independent Facilitator is a person who facilitates the person-centered planning process in collaboration with the person. In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their person-centered planning process. The terms independent and external mean that the facilitator is independent of or external to the community mental health system. It means that the person has no financial interest in the outcome of the

supports and services outlined in the person-centered plan. Using an independent facilitator is valuable in many different circumstances, not just situations involving disagreement or conflict.

The PIHP/CMHSP must contract with a sufficient number of independent facilitators to ensure availability and choice of independent facilitators to meet their needs. The independent facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, assisting and representing their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The independent facilitator must not have any other role within the PIHP/CMHSP. The role of the independent facilitator is to:

- a. Personally know or get to know the individual who is the focus of the planning, including what he or she likes and dislikes, personal preferences, goals, methods of communication, and who supports and/or is important to the person.
- b. Help the person with all pre-planning activities and assist in inviting participants chosen by the person to the meeting(s).
- c. Assist the person to choose planning tool(s) to use in the PCP process.
- d. Facilitate the PCP meeting(s) or support the individual to facilitate his or her own PCP meeting(s).
- e. Provide needed information and support to ensure that the person directs the process.
- f. Make sure the person is heard and understood.
- g. Keep the focus on the person.
- h. Keep all planning participants on track.
- i. Develop an individual plan of service in partnership with the person that expresses the person's goals, is written in plain language understandable by the person, and provides for services and supports to help the person achieve their goals.

The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called "Treatment Planning" (MPM MH&SAA Chapter, Section 3.25.) If the independent facilitator is paid for the provision of these activities, the PIHP/CMHSP may report the service under the code H0032.

An individual may use anyone he or she chooses to help or assist in the person-centered planning process, including facilitation of the meeting. If the person does not meet

the requirements of an Independent Facilitator, he or she cannot be paid, and responsibility for the Independent Facilitator duties described above falls to the Supports Coordinator/Case Manager. A person may choose to facilitate his or her planning process with the assistance of an Independent Facilitator.

VI. HOW IS PERSON CENTERED PLANNING USED TO WRITE AND CHANGE THE INDIVIDUAL PLAN OF SERVICE?

The Code establishes the right for all people to develop Individual Plans of Services (IPOS) through the PCP process. The PCP process must be used at any time the person wants or needs to use the process, but must be used at least annually to review the IPOS. The agenda for each PCP meeting should be set by the person through the pre- planning process, not by agency or by the fields or categories in a form or an electronic medical record

Assessments may be used to inform the PCP process, but is not a substitute for the process. Functional assessments must be undertaken using a person-centered approach. The functional assessment and the PCP process together should be used as a basis for identifying goals, risks, and needs; authorizing services, utilization management and review. No assessment scale or tool should be utilized to set a dollar figure or budget that limits the person-centered planning process.

While the Code requires that PCP be used to develop an Individual Plan of Services (IPOS) for approved community mental health services and supports, the purpose of the PCP process is for the person to identify life goals and decide what medically necessary services and supports need to be in place for the person to have, work toward or achieve those life goals. The person or representative chooses what services and supports are needed. Depending on the person, community mental health services and supports may play a small or large role in supporting him or her in having the life he or she wants. When a person is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life that he or she desires to have.

People are often at different points in the process of achieving their life goals. The PCP process should be individualized to meet each person's needs of the person for whom planning is done, i.e. meeting a person where he or she is. Some people may be just beginning to define the life they want and initially the PCP process may be lengthy as the person's goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once an IPOS is developed, subsequent use of the PCP process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent to which an IPOS is updated will be determined by the needs and desires of the person. If and when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs of the person as they arise.

An IPOS must be prepared in person-first singular language and be understandable by the person with a minimum of clinical jargon or language. The person must agree to the IPOS in writing. The IPOS must include all of the components described below:

- a. A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.
- b. The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.
- c. The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports.
- d. The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system. The PIHP/CMHSP is responsible for ensuring it meets these requirements of the HCBS Final Rule.
- e. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.
- f. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.
- g. Documentation of any restriction or modification of additional conditions must meet the standards.
- h. The services which the person chooses to obtain through arrangements that support self-determination.
- i. The estimated/prospective cost of services and supports authorized by the community mental health system pursuant to Contract Attachment P.6.3.2.1B.ii.
- j. The roles and responsibilities of the person, the supports coordinator or case manager, the allies, and providers in implementing the IPOS.
- k. The person or entity responsible for monitoring the plan.
- l. The signatures of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).

- m. The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.
- n. A timeline for review.
- o. Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

Once a person has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the person's needs, changes in the person's condition as determined through the PCP process or changes in the personal preferences for support).

The person and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. A person or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the person and his/her guardian or authorized representative, if any, shall occur not less than annually. Reviews will work from the existing IPOS to review progress on goals, assess personal satisfaction and to amend or update the IPOS as circumstances, needs, preferences or goals change or to develop a completely new plan, if the person desires to do so. The review of the IPOS at least annually is done through the PCP process.

The PCP process often results in personal goals that aren't necessarily supported by the CMHSP services and supports. Therefore, the PCP process must not be limited by program specific functional assessments. The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the PCP. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented. Non-paid supports, chosen by the person and agreed to by the unpaid provider, needed to achieve the goals must be documented. With the permission of the person, the IPOS should be discussed with family/friends/caregivers chosen by the person so that they fully understand it and their role(s).

The person must be provided with a written copy of his or her IPOS within 15 business days of conclusion of the PCP process. This timeframe gives the case manager/ supports coordinator a sufficient amount of time to complete the documentation described above.

VII. HOW MUST RESTRICTIONS ON A PERSON'S RIGHTS AND FREEDOMS BE DOCUMENTED IN THE IPOS?

Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS.

The rights and freedoms listed in the HCBS Final Rule are:

- a. A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.
- b. Sleeping or living units lockable by the individual with only appropriate staff having keys.
- c. Individuals sharing units have a choice of roommate in that setting.
- d. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- e. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.
- f. Individuals are able to have visitors of their choosing at any time.

The following requirements must be documented in the IPOS when a specific health or safety need warrants such a restriction:

1. The specific and individualized assessed health or safety need.
2. The positive interventions and supports used prior to any modifications or additions to the IPOS regarding health or safety needs.
3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.
4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.
5. A regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Informed consent of the person to the proposed modification.
8. An assurance that the modification itself will not cause harm to the person.

VIII. WHAT DO PIHPS, CMHSPS AND OTHER ORGANIZATIONS NEED TO DO TO ENSURE SUCCESSFUL USE OF THE PERSON-CENTERED PLANNING PROCESS?

Successful implementation of the PCP Process requires that agency policy, mission/ vision statements, and procedures incorporate PCP standards. A process for monitoring PCP should be implemented by both the PIHPs and CMHSP, along with the monitoring process through the MDHHS site review.

The following elements are essential for organizations responsible implementing the PCP process:

- a. **Person-Centered Culture.** The organization provides leadership, policy direction, and activities for implementing PCP at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.
- b. **Individual Awareness and Knowledge.** The organization provides easily understood information, support and when necessary, training, to people using services and supports, and those who assist them, so that they understand their right to and the benefits of PCP, know the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).
- c. **Conflict of Interest.** The organization ensures that the conflict of interest requirements of the HCBS Final Rule are met and that the person responsible for the PCP process is separate from the eligibility determination, assessment, and service provision responsibilities.
- d. **Training.** All Staff receive competency-based training in PCP so that they have consistent understanding of the process. Staff who are directly involved in IPOS services or supports implementation are provided with specific training.
- e. **Roles and Responsibilities.** As an individualized process, PCP allows each person to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.
- f. **System wide Monitoring.** The Quality Assurance/Quality Management (QA/QM) System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful use of the PCP process. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and

standards are in place to assure that the person directs the PCP process and ensures that PCP is consistently followed.

IX. WHAT DISPUTE RESOLUTION OPTIONS ARE AVAILABLE?

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). When a person is receiving services and no agreement on IPOS can be made through the person-centered planning process during the annual review, services shall continue until a notice of a denial, reduction, suspension, or termination is given in which case the rights and procedures for grievance and appeals take over. Other options are available to all recipients of Michigan mental health services and supports. Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate the dispute resolution processes.

