Southwest Michigan
BEHAVIORAL HEALTH

Section: **Clinical Practices**	Policy Name: **Clinical Practice Guidelines**	Policy Number: **12.18**
Owner: **Director of Clinical Quality**	Reviewed By: **Alena Lacey, MA, LPC**	Total Pages: **3**
Required By: ☒ **BBA** ☐ **MDHHS** ☒ **NCQA** ☒ **Other (please specify):** **PIHP Contract Section** Part II A 4.0 Part II B 32.0-35.0, Attachments 4.4.1.1, 4.7.1, 4.13.1, 7.10.2.1-7.10.4.1	Final Approval By: Alena Lacey	Date Approved: Mar 30, 2023
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):**	Line of Business: ☒ **Medicaid** ☐ **Other (please specify):** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link**	Effective Date: **6/10/20**

Policy:
It shall be the policy of Southwest Michigan Behavioral Health (SWMBH) to review, disseminate, and implement clinical practice guidelines that are consistent with the regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) Specialty Services Contract, National Committee of Quality Assurance (NCQA) accreditation standards, and Medicaid Managed Care rules.

Purpose:
To establish the SWMBH standards and guidelines for the adoption, dissemination, and implementation of clinical protocols and practice guidelines as appropriate throughout the network to effect best practice implementation and uniform benefit in accordance with federal laws and MDHHS Contract requirements.

Scope:
SWMBH, regional Community Mental Health (CMH) organizations, and the provider network system.

Responsibilities:
Southwest Michigan Behavioral Health will adopt clinical practice guidelines and assure that information related to the guidelines is made available to members and providers. Staff of Southwest Michigan Behavioral Health, Community Mental Health Service Providers (CMHSP), and the provider network will assure that decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

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Definitions:

A. Practice Guidelines: Guidelines for providers for specific service, support, or system models of practice that are derived from empirical research and sound theoretical construction.

Standards and Guidelines:

Clinical Protocols and Practice Guidelines will meet the following requirements:

A. Are based upon valid and reliable clinical evidence or a consensus of healthcare professionals in the field.
B. Consider the needs of the SWMBH members,
C. Are adopted in consultation with contracting providers and staff who utilize the protocols and guidelines.
D. Are reviewed and updated periodically as needed, with final approval by the Medical Director and/or Director Clinical Quality.
E. Guidelines are disseminated to all applicable providers through provider orientation/the provider manual and to members upon request. Guidelines are posted on the SWMBH website and are referenced in the provider and member handbooks. Additionally, implementation of new guidelines and/or review of existing guidelines is published in the provider and member newsletters.
F. Any decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

References:

A. MDHHS, through the MDHHS-PIHP Specialty Services and Supports Contract, has mandated practice guidelines for the PIHP and the Medicaid subcontracted provider network. The MDHHS Practice Guidelines are as follows:
    - Inclusion Practice Guideline
    - Housing Practice Guideline
    - Consumerism Practice Guideline
    - Personal Care in Non-Specialized Residential Settings
    - Family-Driven and Youth-Guided Policy and Practice Guideline
    - Employment Works! Policy
    - Person-Centered Planning Practice Guideline

    These practices are mandated by MDHHS and are affixed to the Medicaid Specialty Benefits Contract with the PIHP.

Attachments:

12.18A Clinical Practice Guideline adoption protocol
12.18B Inclusion Practice Guideline
12.18C Housing Practice Guideline
12.18D Consumerism Practice Guideline
12.18E Personal Care in Non-Specialized Residential Settings

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12.18F Family-Driven and Youth-Guided Policy and Practice Guideline
12.18G Employment Works! Policy
12.12H Person-Centered Planning Practice Guideline

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	01/04/2014	N/A: New Template	N/A New Template	
1	01/07/2015		Annual Review	
2	04/20/2016		Annual Review	
3	05/07/2020	Reformatted Policy to new Template; moved from Utilization Management to Clinical Practices; added Scope and Responsibilities as recommended with new format	Annual Review	Brian Walters
4	03/23/23	References and attachments	Annual Review, updated the clinical practice guidelines and added policy attachments	Alena Lacey

12.18 Clinical Practice Guidelines

Final Audit Report 2023-03-30

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Clinical Practice Guidelines Adoption Protocol

- The Regional Clinical Practices Committee (RCP) will review and approve Clinical Practice Guidelines on an annual basis.
- The Clinical Practice Guidelines will align with the standards and guidelines outlined in policy 12.18.
- The Clinical Practice Guidelines will be adopted in consultation with the network providers, who are members of RCP.
- Meeting minutes will document committee review and approval.

MICHIGAN DEPARTMENT OF HEALTH AND Ministration
INCLUSION PRACTICE GUIDELINE

I. SUMMARY

This guideline establishes policy and standards to be incorporated into the design and delivery of all public mental health services. Its purpose is to foster the inclusion and community integration of recipients of mental health service.

II. APPLICATION

a. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).

b. Regional centers for developmental disabilities and community placement agencies operated by the MDHHS.

c. Children's psychiatric hospitals operated by the MDHHS.

d. Special facilities operated by the MDHHS.

e. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) as specified in their contracts with the MDHHS.

III. POLICY

It is the policy of the MDHHS to support inclusion of all recipients of public mental health services.

No matter where individuals live or what they do, all community members are entitled to fully exercise and enjoy the human, constitutional, and civil rights which collectively are held in common. These rights are not conditional or situational. They are constant throughout our lives. Ideally, they are also unaffected if a member receives services or supports from the public mental health system for a day or over a lifetime. In addition, by virtue of an individual's membership in his/her community, he/she is entitled to fully share in all the privileges and resources that the community has to offer.

IV. DEFINITIONS

Community: refers to both society in general and the distinct cities, villages, townships, and neighborhoods where individuals, under a local government structure, come together and establish a common identity, develop shared interests, and share resources.

Inclusion: means recognizing and accepting individuals with mental health needs as valued members of their community.

Integration: means enabling mental health service recipients to become, or continue to be, participants and integral members of their community.

Normalization: means rendering services in an environment and under conditions that are culturally normative. This approach not only maximizes an individual's opportunities to learn, grow, and function within generally accepted patterns of human behavior, but it also serves to mitigate social stigma and foster inclusion.

Self-determination: means the right of a recipient to exercise his/her own free will in deciding to accept or reject, in whole or in part, the services which are being offered. Individuals cannot develop a sense of dignity unless they are afforded the freedom and respect that comes from exercising opportunities for self-determination.

Self-representation: means encouraging recipients, including those who have guardians or employ the services of advocates, to express their own point of view and have input regarding the services that are being planned or provided by the Responsible Mental Health Agency (RMHA).

V. STANDARDS

a. Responsible PIHPs and CMHSPs shall design their programs and services to be congruent with the norms of their community.

   This includes giving first consideration to using a community's established conventional resources before attempting to develop new ones that exclusively or predominantly serve only mental health recipients.

   Some of the resources which can be used to foster inclusion, integration, and acceptance include the use of the community's public transportation services, leisure and recreation facilities, general health care services, employment opportunities (real work for real pay), and traditional housing resources.

b. PIHPs and CMHSPs shall organizationally promote inclusion by establishing internal mechanisms that:

   i. assure all recipients of mental health services will be treated with dignity and respect.

   ii. assure all recipients, including those who have advocates or guardians, have genuine opportunities for consumer choice and self-representation.

   iii. provide for a review of recipient outcomes.

   iv. provide opportunities for representation and membership on planning committees, work groups, and agency service evaluation committees.

   v. invite and encourage recipient participation in sponsored events and activities of their choice.

c. PIHPs and CMHSPs shall establish policies and procedures that support the principle of normalization through delivery of clinical services and supports that:

   i. address the social, chronological, cultural, and ethnic aspects of services and outcomes of treatment.

   ii. help recipients gain social integration skills and become more self-reliant.

   iii. encourage and assist adult recipients to obtain and maintain integrated, remunerative employment in the labor market(s) of their communities, irrespective of their disabilities. Such assistance may include, but is not limited to, helping them develop relationships with co-workers both at work and in non-work situations. It also includes making use of assistive technology to obtain or maintain employment.

   iv. assist adult recipients to obtain/maintain permanent, individual housing integrated in residential neighborhoods.

   v. help families develop and utilize both informal interpersonal and community-based networks of supports and resources.

   vi. provide children with treatment services which preserve, support, and, in some instances, create by means of adoption, a permanent, stable family.

d. PIHPs and CMHSPs shall establish procedures and mechanisms to provide recipients with the information and counsel they need to make informed treatment choices. This includes helping recipients examine and weigh their treatment and support options, financial resources, housing options, education options, and employment options. In some instances, this may also include helping recipients:

   i. learn how to make their own decisions and take responsibility for themself.

   ii. understand his/her social obligations.

VI. REFERENCES AND LEGAL AUTHORITY

MCL 330.116, et seq. MCL 330.1704, et seq.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

HOUSING PRACTICE GUIDELINE

NOTE: Replicated from the Michigan Department of Health and Human Services (MDHHS) Housing Guideline as included in the Public Mental Health Code Manual, Volume III, Section 1708, Subject GL-05, Chapter 07-C, Dated 2/14/95.

I. SUMMARY

This guideline establishes policy and procedure for ensuring that the provision of mental health services and supports are not affected by where individuals choose to live: their own home, the home of another, or in a licensed setting. In those instances when public money helps subsidize an individual's living arrangement, the housing unit selected by the individual shall comply with applicable occupancy standards.

II. APPLICATION

a. Psychiatric hospitals operated by the MDHHS.

b. Special facilities operated by the MDHHS.

c. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) as specified in their contracts with the MDHHS.

III. POLICY

The MDHHS recognizes housing to be a basic need and affirms the right of all individuals of public mental health services to pursue housing options of their choice. Just as individuals living in licensed dependent settings may require many different types of services and supports, individuals living in their own homes or sharing their household with another individual may have similar service needs. RHMAs shall foster the provision of services and supports independent of where the individual resides.

When requested, RHMAs shall educate individuals about the housing options and supports available, and assist individuals in locating habitable, safe, and affordable housing. The process of locating suitable housing shall be directed by the individual's interests, involvement, and informed choice. Independent housing arrangements in which the cost of housing is subsidized by the PIHP and CMHSP are to be secured with a lease or deed in the individual's name.

This guideline is not intended to subvert or prohibit occupancy in or participation with community-based treatment settings, such as an adult foster care home, when needed by an individual recipient.

IV. DEFINITIONS

Affordable: is a condition that exists when an individual's means or the combined household income of several individuals is sufficient to pay for food, basic clothing, healthcare, and personal needs and still have enough left to cover all housing related costs including rent/mortgage, utilities, maintenance, repairs, insurance, and property taxes. In situations where there are insufficient resources to cover both housing costs and basic living costs, individual housing subsidies may be used to bridge the gap when they are available.

Habitable and safe: means those housing standards established in each community that define and require basic conditions for tenant/resident health, security, and safety.

Housing: refers to dwellings that are typical of those sought out and occupied by members of a community. The choices an individual of mental health services makes in meeting his/her housing needs are not to be linked in any way to any specific program or support service needs he/she may have.

Responsible Mental Health Agency (RMHA): means the MDHHS hospital, center, PIHP, or CMHSP responsible for providing and contracting for mental health services and/or arranging and coordinating the provision of other services to meet the individual's needs.

V. STANDARDS

RMHAs shall develop policies and create mechanisms that predominantly consider an individual's choice in selecting where and with whom they live. These policies and mechanisms shall also:

A. Ensure that RMHA-supported housing blends into the community. Supported housing units are to be scattered throughout a building, complex, or the community to achieve community integration when possible. Use of self-contained campuses or otherwise segregated buildings as service sites is not the preferred mode.

B. Promote and support home ownership, individual choice, and autonomy. The number of individuals who live together in RMHA-supported housing shall not exceed the community's norms for comparable living settings.

C. Assure that any housing arranged or subsidized by the RMHA is accessible to the individual and in compliance with applicable state and local standards for occupancy, health, and safety.

D. Be sensitive to the individual's cultural and ethnic preferences and give consideration to them.

E. Encourage and support the individual's self-sufficiency.

F. Provide for ongoing assessment of the individual's housing needs.

G. Assist individuals in coordinating available resources to meet their basic housing needs. RMHAs may consider the use of housing subsidies when individuals have a need for housing that cannot be met by the other resources which are available to them.

VI. REFERENCES AND LEGAL AUTHORITY

MCL 330.1116(j)

VII. EXHIBITS

Federal Housing Subsidy Quality Standards based on 24 CFR § 882.10

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

CONSUMERISM PRACTICE GUIDELINE

I. SUMMARY

This guideline sets policy and standards for consumer inclusion in the service delivery design and delivery process for all public mental health services. This guideline ensures the goals of a consumer-driven system which gives consumers choices and decision-making roles. It is based on the active participation by primary consumers, family members, and advocates in gathering consumer responses to meet these goals.

This participation by consumers, family members, and advocates is the basis of a provider's evaluation. Evaluation also includes how this information guides improvements.

II. APPLICATION

A. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).

B. Centers for individualss with developmental disabilities (DD) and community placement agencies operated by the MDHHS.

C. Children's psychiatric hospitals operated by the MDHHS.

D. Special facilities operated by the MDHHS.

E. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) under contract with the MDHHS.

F. All providers of mental health services who receive public funds, either directly or by contract, grant, or third-party payers including managed care organizations (MCOs) or other reimbursements.

III. POLICY

This guideline supports services that advocate for and promote the needs, interests, and well-being of primary consumers. It is essential that consumers become partners in creating and evaluating these programs and services. Involvement in treatment planning is also essential.

Services need to be consumer-driven and may also be consumer-run. This guideline supports the broadest range of options and choices for consumers in services. It also supports consumer-run programs which empower consumers in decision-making of their own services.

All consumers need opportunities and choices to reach their fullest potential and live independently. They also have the rights to be included and involved in all aspects of society.

Accommodations shall be made available and tailored to the needs of consumers as specified by consumers for their full and active participation as required by this guideline.

IV. DEFINITIONS

Informed Choice: an individual receives information and understands his/her options.

Primary Consumer: an individual who receives services from the MDHHS, the PIHP, or the CMHSP and an individual who has received the equivalent mental health services from the private sector.

Consumerism: active promotion of the interests, service needs, and rights of mental health consumers.

Consumer-Driven: any program or service focused and directed by participation from consumers.

Consumer-Run: any program or service operated and controlled exclusively by consumers.

Family Member: a parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer and any individual upon whom a primary consumer depends for 50 percent or more of his/her financial support.

Minor: an individual under the age of 18 years.

Family Centered Services: services for families with minors which emphasize family needs and desires with goals and outcomes defined. Services are based on families' strengths and competencies with active participation in decision-making roles.

Person-Centered Planning (PCP): the process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life. It honors the individual's preferences, choices, and abilities.

Person-First Language: refers to an individual first before any description of disability.

Recovery: means the process of personal change in developing a life of purpose, hope, and contribution. The emphasis is on abilities and potentials. Recovery includes positive expectations for all consumers. Learning self-responsibility is a major element to recovery.

V. STANDARDS

A. All services shall be designed to include ways to accomplish each of these standards.

1. "Person-First Language" shall be utilized in all publications, formal communications, and daily discussions.

2. Provide informed choices through information about available options.

3. Respond to an individual's ethnic and cultural diversities. This includes the availability of staff and services that reflect the ethnic and cultural makeup of the service area. Interpreters needed in communicating with non-English and limited-English-speaking consumers shall be provided.

4. Promote the efforts and achievements of consumers through special recognition of consumers.

5. Through customer satisfaction surveys and other appropriate individual related methods, gather ideas and responses from consumers concerning their experiences with services.

6. Involve consumers and family members in evaluating the quality and effectiveness of service. Administrative mechanisms used to establish service must also be evaluated. The evaluation is based upon what is important to consumers, as reported in customer satisfaction surveys.

7. Advance the employment of consumers within the mental health system and in the community at all levels of positions including mental health service provision roles.

B. Services, programs, and contracts concerning consumers with mental illness and related disorders shall actively strive to accomplish these goals.

   1. Provide information to reduce the stigma of mental illness that exists within communities, service agencies, and among consumers.

   2. Create environments for all consumers in which the process of "recovery" can occur. This is shown by an expressed awareness of recovery by consumers and staff.

   3. Provide basic information about mental illness, recovery, and wellness to consumers and the public.

C. Services, programs, and contracts concerning individuals with DD shall be based upon these elements.

   1. Provide personal preferences and meaningful choices with consumers in control over the choice of services and supports.

   2. Through educational strategies: promote inclusion, both personal and in the community; strive to relieve disabling circumstances; actively work to prevent occurrence of increased disability; and promote consumers in exercising their abilities to their highest potentials.

3. Provide roles for consumers to make decisions in polices, programs, and services that affect their lives including PCP processes.

D. Services, programs, and contracts concerning minors and their families shall be based upon these elements:

1. Services shall be delivered in a family-centered approach, implementing comprehensive services that address the needs of the minor and his/her family.

2. Services shall be individualized and respectful of the minor and family's choice of services and supports.

3. Roles for families to make decisions in policies, programs, and services that affect their lives and the minor's life.

E. Consumer-run programs shall receive the same consideration as all other providers of mental health services. This includes these considerations:

1. Clear contract performance standards.

2. Fiscal resources to meet performance expectations.

3. A contract liaison individual to address the concerns of either party.

4. Inclusion in provider coordination meetings and planning processes.

5. Access to information and supports to ensure sound business decisions.

F. Current and former consumers, family members, and advocates must be invited to participate in implementing this guideline. Provider organizations must develop collaborative approaches for ensuring continued participation.

Organizations' compliance with this guideline shall be locally evaluated. Foremost, this must involve consumers, family members, and advocates. Providers, professionals, and administrators must be also included. The CMHSP shall provide technical assistance. Evaluation methods shall provide constructive feedback about improving the use of this guideline. This guideline requires that it be part of the organization's Continuous Quality Improvement.

VI. REFERENCES AND LEGAL AUTHORITY

Act 258, Section 116(e), Public Acts of 1974 as amended, being MCL 330.1116, 1704, 1708.

Last revision date: November 10, 2021

PERSONAL CARE IN NON-SPECIALIZED RESIDENTIAL SETTINGS TECHNICAL REQUIREMENT

I. SUMMARY

This guideline establishes operational policy and program and clinical documentation requirements for issuing payments through the Adult Services Automated Payment (ASAP) program (formerly Model Payment Program) for Medicaid beneficiaries under the following circumstances:

- are 18 years of age or older;
- currently receiving services through a Responsible Mental Health Agency (RMHA); and
- need personal care services when placed in a non-specialized residential foster care setting.

II. APPLICATION

A. Prepaid Inpatient Health Plans (PIHPs) as specified in their contracts with the Michigan Department of Health and Human Services (MDHHS).

III. POLICY

Upon placement of an individual into a non-specialized residential foster care setting, the RMHA delegated by the PIHPs or through one of its contracted providers shall ensure that any need for personal care services is identified in their Individual Plan of Service (IPOS) in keeping with Medicaid (MA) standards. In addition, the RMHA shall take the required action(s) to further ensure that payment(s) for personal care services are issued, and all payment problems are resolved.

IV. DEFINITIONS

Client Services Management: a related set of activities which link the recipient to the public mental health system and which staff coordinate to achieve a successful outcome.

Family Member: means a parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer, or an individual upon whom a primary consumer is dependent for at least 50% of his/her financial support.

Individual Plan of Service (IPOS): a written plan which identifies mental health services as defined in MHC 330.1712 amended in 1996.

Medicaid (MA) Designated Case Manager/Supports Coordinator: case manager or supports coordinator must be either a qualified intellectual disability professional (QIDP) as defined in 42 CFR 483.430, or a qualified mental health professional (QMHP) as defined in Michigan's Medicaid Provider Manual.

Non-Specialized Residential Foster Care Setting: a licensed dependent living arrangement which provides room, board, and supervision but does not provide in-home specialized mental health services.

Personal Care Services: services provided in accordance with an IPOS that assist a recipient by hands-on assistance, guiding, directing, or prompting of Activities of Daily Living (ADL) in at least one of the following activities:

A. EATING/FEEDING: Helping with the use of utensils, cup/glass, getting food/drink to mouth, cutting up/manipulating food on plate, swallowing foods and liquids, cleaning face and hands after a meal.
B. TOILETING: helping on/off the toilet, commode, or bedpan; emptying commode, bed pan, or urinal; managing clothing; wiping and cleaning body after toileting; cleaning ostomy and/or catheter tubes/receptacles; and applying diapers and disposable pads. May also include catheter, ostomy, or bowel programs.
C. BATHING: helping with cleaning the body or parts of the body using a tub, shower, or sponge bath; including getting a basin of water, managing faucets, soaping, rinsing, and drying; helping shampoo hair.
D. GROOMING: Maintaining personal hygiene and a neat appearance, including the combing/brushing of hair; brushing/cleaning teeth; shaving; fingernail; and toenail care.
E. DRESSING: Putting on and taking off garments; fastening and unfastening garments/undergarments; assisting with special devices such as back or leg braces, elastic stockings/garments, and artificial limbs or splints.
F. TRANSFERRING: Moving from one sitting or lying position to another; assistance from the bed or wheelchair to the sofa; coming to a standing position; and/or repositioning to prevent skin breakdown.
G. MOBILITY/AMBULATION: Walking or moving around inside the living area; changing locations in a room; assistance with stairs; maneuvering around pets or obstacles including uneven floors.
H. TAKING MEDICATIONS: Taking prescribed and/or over the counter medications.

V. STANDARDS

A. Recipient must be Medicaid active during effective dates of service.

B. Providers of non-specialized residential services must be licensed and meet minimum requirements of the MDHHS as defined and contained therein, Act 218, Public Acts of 1979, as amended, for non-specialized residential settings such as: homes for the aged, adult foster care family home, adult foster care small group home, adult foster care large group home, adult foster care congregate facility, foster family home, foster family group home, and child caring institutions.

C. Personal care services are covered when authorized by the MA designated case manager/supports coordinator based upon face-to-face contact with recipient, and in accordance an IPOS and rendered by a qualified person who is not a member of the individual's family.

D. Supervision of personal care services is required and is provided by the MA designated case manager/supports coordinator who authorized the services. Supervision of personal care services occurs during monthly or quarterly face-to-face visits completed by the MA designated case manager/supports coordinator:

1. Authorization of covered personal care services occurs when the MA designated case manager/supports coordinator has amended the IPOS to indicate the date these services started and what the individual's need for personal care is. The MA designated case manager/supports coordinator will complete the authorization in the ASAP and enter the service start date in the Case Mgr./RN Cert Date section of the ASAP authorization which will trigger the payments to providers.

2. A review of personal care services must occur within a calendar year of the authorization for personal care services based upon a face-to-face contact with recipient to review if the need for personal care is still required. The MA designated case manager/supports coordinator will complete the review and update the IPOS accordingly, in addition to completing a new authorization in the ASAP.

3. It is important that the ASAP authorizations are kept current. If an individual moves out of the AFC, changes providers, ends services with the RMHA, or there is a break in services such as a hospitalization, the MA designated case manager/supports coordinator needs to end the authorization in the ASAP on the effective date.

4. If the individual ends RMHA services, the MA designated case manager/supports coordinator will notify the MDHHS Adult Services Worker (ASW) and coordinate with the AFC provider to transfer the case over to the MDHHS ASW.

5. Retroactive payment requests/authorizations cannot span beyond 365 days of the current date.

6. Temporary Absence Other Than Hospital or nursing home are permissible up to 104 days a year and are permissible without impacting authorizations or payments in situations where the individual is visiting family, away on weekends, or on vacations. Providers will need to record the dates of absences in the facility resident record. The MA designated case manager/supports coordinator will monitor this during face-to-face visits. The MA designated case manager/supports must be made aware

of any absence greater than 8 days a month and the reason for the absences.

7. Recoupment for overpayments needs to occur when a provider is paid for days when an individual is no longer residing in their home or for absences related to hospitalization or nursing home placement. When this occurs, the MA designated case manager/supports coordinator will need to write a Recoupment Letter for Title XIX Payments and include the following:

    - The letter should always be completed on RMHA letterhead.
    - Fax a copy of the completed and signed letter to MDHHS-Overpayments and Collections Unit-ASAP at 517-346-9890.
    - Mail two copies of the letter to the AFC provider.
    - Overpayments that have not been cashed are not considered overpayments, not recoupments. These warrants can be returned to the Department of Treasury:

        Department of Treasury
        Office of Financial Services
        P.O. Box 30788
        Lansing, MI 48909
    - Keep a copy of the letter for the individual's record.
    - One letter is needed for each individual.

E. Provider of service must maintain a service log that documents specific days on which personal care services were delivered consistent with the recipient's IPOS.

F. Compliance with the Personal Care/Adult Services Automated Payment standards of MDHHS, which includes the following:

1. All RMHAs have at least one employee in the role of the lead CMH Liaison in the ASAP. A back-up CMH Liaison is encouraged for each RMHA.
2. CMH Worker roles are assigned to the MA designated case manager/supports coordinator who will be responsible to complete authorizations in the ASAP. CMH Liaisons can also complete the ASAP payment authorizations.
3. CMH Liaisons will approve/deny access of CMH Workers requests in the ASAP and oversee CMH Worker roles in the ASAP.
4. CMH Liaison approval/denial is completed at the State level so open communication with MDHHS and CMH Liaisons is important and critical to the approval/denial of CMH Liaisons.

G. Provider Process:
1. AFC or HFA providers who wish to receive the MA personal care supplement payment must first be licensed with the Michigan

Department of Licensing and Regulatory Affairs (MDLARA), enrolled in the Statewide Integrated Governmental Management Applications system (SIGMA), and enrolled in Bridges.

2. The DHS-2351-X is an internal form and must be completed by an MDHHS worker or approved RMHA. Please make sure to use the most current DHS-2351-X version.
3. For issues related to provider enrollment, please email ProviderSupport@michigan.gov for assistance.

VI. REFERENCES AND LEGAL AUTHORITY

A. Social Security Act, Section 1905(a) (17).
B. 42 CFR 440.170 and 42 CFR 483.430.
C. MHC 330.1712 Individualized Written Plan of Services (amended 1996), MHC 330.1100a Definitions; a to e (amended 2019), MHC 330.1100b Definitions; f to n (to be amended on 03/24/21) and MHC 330.1100c Definitions; p to r (to be amended on 03/24/21)
D. Michigan's Medicaid state provisions for Title XIX of the Social Security Act
E. Michigan Department of Health & Human Services, Adult Services Manual (ASM) Policies; ASM 004, ASM 010, ASM 030, ASM 045, ASM 065, ASM 075 and ASM 121.

Last revision date: 5/20/21

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

FAMILY-DRIVEN AND YOUTH-GUIDED POLICY AND PRACTICE

GUIDELINES

Updated March 2021

A. Summary/Background

The purpose of this guideline is to establish standards for the Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children, youth and their families. For the purposes of this policy "families" are intended to include parents, primary caregivers, foster parents and family members. For the purposes of this policy the term "children" typically refers to the age range up to 12 years old. The term "youth" typically refers to the age range of 13-17 years and "young adult" generally refers to the age range of 18 up to 21 years. This guideline will outline essential elements of family-driven and youth-guided policy and practice at the child, youth and family level, programmatic level, which includes peer delivered services and system level (the community or state level.)

Person-centered planning (PCP) is the method for individuals served by the publically supported community behavioral and mental health system to plan how they will work toward and achieve personally defined outcomes in their own lives. The Michigan Mental Health Code established the right for all individuals to develop individual plans of services (IPOS) through a PCP process regardless of disability or residential setting.

For children, youth and families, the Person-Centered Planning Policy Guideline states: "The Michigan Department of Health and Human Services (MDHHS) has advocated and supported a family-driven and youth-guided approach to service delivery for children, youth and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family, not just the identified child or youth receiving mental health services. In the case of minors, the child, youth and family are the focus of service planning, and family members are integral to a successful planning process. The wants and needs of the child, youth and they/their family are considered in the development of the Individual Plan of Service." As the child or youth matures toward transition age, the focus of the treatment planning, services and supports should be youth/young/adult driven to accommodate the youth as they gain skills towards independence.

As a result of the effort to develop family-driven and youth-guided services, the Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with the Federation of Families for Children's Mental Health, has developed a set of principles (described in section C of this guideline) which serve as the basis for the delivery of family-driven and youth-guided services. These principles comprise the standards which should guide the delivery of services and supports to children, youth and their families and are

essential to the development of an effective system of care. The system of care approach is an organizational philosophy and framework that involves collaboration across agencies, families, children, and youth for the purpose of improving services and access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families.

While agencies are expected to collaborate, they are not intended to be the primary decision-makers on behalf of a child, youth or family. It is important for systems to actively partner ~~with~~ families and support them in leading all decisions about the care of their child or youth. Similarly, as appropriate, based on their age and functioning, youth should be supported to make decisions about their own care. Active family, child and youth participation is also necessary on a broader level with an expectation that they are supported and empowered to be equal partners in system-level governance and planning.

B. Policy

It is the policy of the MDHHS that all publicly-supported community behavioral and mental health agencies and their contact agencies shall implement family-driven and youth-guided practices with children, youth and families. They will support and empower family members, children and youth to be key stakeholders at the program, evaluation and governance levels.

How this policy will be supported:

- The MDHHS staff in partnership with statewide family organizations will work with PIHPs, CMHSPs, and contract agencies to support successful implementation of the family- driven and youth-guided policy and practice requirements.

- The MDHHS will work with other system partners at the state level to ensure PIHPs, CMHSPs, and contract agencies can build an effective system of care.

C. Family-Driven and Youth-Guided Principles

Family-driven and youth-guided principles should be implemented at several different levels: the child, youth and family level, programmatic level which includes peer- delivered services the system level (the community or state level). These principles incorporate all levels and will be detailed under section D: Essential Elements of this guideline.

- Families, children and youth as well as providers and administrators share decision-making and responsibility for outcomes.

- Families, children and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the individualized and potential services and supports for their child or youth and their

family as a whole.

- Children, youth and parents or caregivers have the right to invite an external support and/or advocate to participate as part of their planning and treatment team.
- CMHSPs can partner with family-run organizations engage in peer support activities to reduce isolation, gather, and disseminate accurate information, and strengthen the family voice.
- Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
- PIHP/CMHSPs and contract providers will take the initiative to change policy and practice from provider-driven to family-driven and youth-guided by prioritizing family-driven and youth-guided practices by allocating staff, training, support and resources.
- Community culture shift efforts focus on removing barriers and discrimination created by stigma is supported.
- Communities including public and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate behavioral health disparities and implicit bias.
- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness so that the needs of diverse populations are appropriately addressed with an emphasis on diversity, equity and inclusion.

D. Essential Elements for Family-Driven and Youth-Guided Care

1. "Family-driven" means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children and youth in their community. This includes:
    - Being given the necessary information to make informed decisions regarding the care of their child or youth
    - Choosing culturally and linguistically competent supports, services, and providers will be available,
    - Setting individualized goals and outcomes,
    - Designing, implementing, and evaluating programs by determining effectiveness,
    - Monitoring goals and outcomes, and

- Partnering in funding decisions.

2. "Youth-guided" means that children and youth have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views children and youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).

3. "Family-run organization" means advocacy and support organizations that are led by family members and young adults with lived experience raising children with behavioral health needs including serious emotional disturbance (SED) and/or intellectual and developmental disabilities (I/DD) thus creating a level of expertise. These organizations often provide peer-to-peer support, education, advocacy, and information/referral services to reduce isolation for family members, gather, and disseminate accurate information so families can partner with providers and make informed decisions and strengthen the family voice at the child and family level as well as the systems level.

4. Hiring parents or caregivers and young adults with lived experience to provide peer delivered Medicaid services such as Parent Support Partner, Youth Peer Support and other peer delivered services.

5. Child and Family-Level Action Strategies:

    - Strength and Culture Discovery – Children, youth, and family strengths and culture will be identified and linked to treatment strategies within the plan of service.

    - Cultural Preferences – The IPOS will incorporate the cultural preference unique to each youth and family.

    - Access – Children, youth, and families are provided understandable and meaningful information to make informed choices regarding services and supports and have a voice in determining the services they receive. Services and supports are delivered in the home and community whenever possible.

    - Voice – Children, youth, and families are active partners in the treatment process, their voice is solicited and respected, and their needs/wants are written into the IPOS in language that indicates their ownership.

    - Ownership – The plan reflects the unique strengths, culture, and priorities as identified by the child, youth, and family.

    - Outcome-based – Plans are developed to produce results that the child, youth and family identify. All services, supports, and interventions support outcomes achievement as defined by the child, youth and family.

    - Parent and Caregiver/Youth/Professional Partnerships – Parents or caregivers, children and youth are recognized for having expertise, are active partners in the

treatment process, and share ownership of the outcomes.

- Increase Confidence and Resiliency – The plan will identify specific interventions that maximize the strengths of the child, youth, and family, increase the skills of the youth to live independently and advocate for self, and equip the family with skills to successfully navigate systems and manage the needs of their child, youth and family.
- Participation in Planning Meetings – Children, youth and families determine who participates in the planning meetings.
- Crisis and Safety Planning – Crisis and safety plans should be developed to decrease safety risks, increase competence, skills and confidence of the child, youth and family, and respect the needs/wants of the child, youth and family.

6. Programmatic, including peer-delivered services
   - All services need to reflect family-driven and youth guided practices
   - Parents/primary caregivers who have first-hand experience raising children and youth with behavioral health needs are recruited, trained, and supported in their role as Parent Support Partners. This Medicaid service outlined under the Family Support and Training section of the current Medicaid Provider Manual is a required as part of the service array delivered to parents or caregivers of children with SED and I/DD.
   - Young adults who have lived experience with behavioral health challenges are recruited, trained, and supported in their role as Youth Peer Support Specialists. This Medicaid service outlined under the Peer Delivered section of the current Medicaid Provider Manual is a required as part of the service array delivered to youth and young adults with SED/SMI.
   - CMHSPs or their contract providers can directly hire Parent Support Partners and Youth Peer Support Specialists or contract with a Family Organization.
   - The Statewide Family Organization, Association for Children's Mental Health provides the training, professional development, coaching and technical assistance for Parent Support Partners, Youth Peer Support Specialists and their supervisors.
   - MDHHS will contract with a family run organization to provide and inform the training and technical assistance for peer delivered services for youth and families.

7. System-level Action Strategies:

   - Agencies have policies that ensure that all providers of services to children, youth, and families incorporate parent/caregivers and youth on decision-making groups, CMHSP boards, and committees that support family-driven and youth-guided policy and practice with policies and examples of practice sent to BHDDA upon request.

- Agencies have policies that ensure training, support, and compensation for parents/caregivers and youth who participate in decision-making groups, CMHSP boards, and committees and serve as co-facilitators/trainers.

- Policies are in place within the agency to support employment of youth and parents/caregivers in addition to peer delivered Medicaid service providers.

- Children, youth and parents or caregivers are part of the program and service design, evaluation, and implementation of services and supports.

- Children, youth, and families are sought out to share their experience, expertise and knowledge in presentations, training and education opportunities for other families and youth as well as service providers and administrators.

- Services occur where the children, youth, and family choose and in a way that is aligns with relevant to the family culture.

- All stakeholder groups including CMHSP boards include diverse membership including children, youth and family members who represent the population the agency/community serves.

Employment Works! Policy

MDHHS recognizes that employment is an essential element of quality of life for most people, including individuals with a serious mental illness or a developmental disability; including persons with the most significant disability.

The Michigan Employment First Executive Order No. 2015-15 "recognizes that competitive employment within an integrated setting is the first priority and optimal outcome for persons with disabilities, regardless of level or type of disability; ..." Therefore; in accordance with this Executive Order, it is the policy of MDHHS that:

Each eligible working age individual over 16 years old to correlate with transition planning for the duration of eligibility for these services/supports. All individuals will be afforded the opportunity to pursue individual competitive, integrated employment. MDHHS shall define individual competitive integrated employment using the definition in the Workforce Innovation & Opportunity Act stated below.

Competitive integrated employment:

(i) Is performed on a full-time or part-time basis (including self-employment);

(ii) The individual is compensated at a rate that;

a. Is not less than the higher of the rate specified in the Fair Labor Standards Act of 1938, or the State minimum wage law

b. Is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; and

c. In the case of an individual who is self-employed, yields an income that is comparable to the income received by other individuals who are not individuals with disabilities and who are self-employed in similar occupations or on similar tasks and who have similar training, experience, and skills; and

d. Is eligible for the level of benefits provided to other employees;

(iii) Is at a location that is typically found in the community;

(iv) The employee with a disability interacts for the purpose of performing the duties of the position with other employees within the particular work unit and the entire work site, and, as appropriate to the work performed, other persons (*e.g.,* customers and vendors), who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that employees who are not individuals with disabilities and who are in comparable positions interact with these persons; and

(v) Presents, as appropriate, opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

Furthermore, specifically, individuals with disabilities hired by community rehabilitation programs to perform work under service contracts, either alone or in groups (*e.g.,* landscaping or janitorial crews), whose interaction with persons without disabilities

(other than their supervisors and service providers) is with persons working in or visiting the work locations (and not with employees of the community rehabilitation programs without disabilities in similar positions) would not be performing work in an integrated setting.

Each time a pre-planning meeting is held to prepare for a person's plan of service (at least annually); a person's options for work will be encouraged as noted in Person-Centered Planning and Practice Guideline at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.htmland will be documented during the pre-planning meeting. Competitive employment within an integrated setting will be underscored and encouraged as the first priority and optimal outcome for persons with disabilities, regardless of level or type of disability.

In the case of employment for persons with mental illness, MDHHS has adopted the evidence-based practice of Individual Placement and Support (IPS). The definition for the outcome of competitive employment for this specific population remains; individual jobs that anyone can apply for rather than jobs created specifically for people with disabilities. These jobs pay at least minimum wage or the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled. Further, the jobs do not have artificial time limits imposed by the social service agency.

This proposed policy shall support persons with serious mental illness and developmental disabilities to receive services and supports to achieve and maintain competitive employment. It is imperative that this *Employment Works!* Policy be shared and reinforced as an expectation with staff responsible for employment services and outcomes and with all supports coordinators and case managers.

In order to measure employment outcomes, MDHHS will compare baseline numbers for all individual competitive integrated employment. Additionally, MDHHS will measure facility-based and group employment each year. It is expected that the total percentage of individuals competitively employed in integrated settings will increase individual competitive integrated employment. It is also expected that as individual competitive integrated employment increases, the percentage of individuals in facility-based and group employment will decrease.

Expectations for MDHHS:

- Retain a permanent state-level staff who has responsibility for further developing and directing overall employment policies, messaging, and services for Michigan citizens supported through contracted provider networks. This person will:
    - Encourage progressive use of funding to support services that advance the optimal outcome of individual competitive integrated employment.
    - Strengthen effective working relationships and partnering with Michigan Rehabilitation Services, the Bureau of Services for Blind Persons, and Michigan Department of Education/Office of Special Education, Michigan Developmental Disabilities Council, the Michigan Workforce Development Agency, and other stakeholder organizations.
    - Provide technical assistance to contracted provider networks for program implementation and sustainability and to also provide opportunities for training and development to enhance individual competitive integrated employment.
    - Review existing employment data sources and establish a strategy for collecting and sharing accurate employment outcome data with stakeholders within current technology and resources.
    - Research and advise on emerging employment goals for the contracted provider networks system data and promote prompt commitment to completion of such goals in current contracted provider networks' contracts.

- Encourage and promote the use of best employment practices. (Examples include the evidence based supported employment, customized employment, self-employment, discovery/career exploration, evidence-based Individual Placement & Support model for persons with mental illness etc.)
- Identify contracted provider networks with best employment outcomes, learn from their successes, and highlight these practices.
- Assist PIHPs/CMHSPs in developing expertise in benefits planning.
- Collaborate with existing employment work group(s) as possible.

Expectations for PIHPs/CMHSPs:

- Designate a PIHP/CMHSP staff as liaison to the State-level designee who shall be responsible for local support and implementation of the *Employment Works!* Policy. Designate this liaison to participate in State employment meetings whenever possible (presently held every four (4) months). Designate this liaison to share employment information and strategies with local partners as feasible. This liaison will:
  - Promote progressive use of funding and services to advance the optimal outcome of individual competitive integrated employment.
  - Enhance opportunities and support for contracted provider network consumers through strengthened working relationships and partnering with Michigan Rehabilitation Services, the Bureau of Services for Blind Persons, and local Intermediate School Districts and schools.
  - Work with contracted provider network to provide timely and accurate employment outcome data to MDHHS based on current contractual requirements.
  - Review local employment data and encourage increases annually by establishing a tracking mechanism related to local employment goals. (Examples include the evidence based supported employment, customized employment, self-employment, discovery/career exploration, evidence-based Individual Placement & Support model for persons with mental illness, etc.)
  - Share best employment practices across the contracted provider networks through conferences, webinars, conference calls, newsletters, cross-agency presentations, etc.
  - Work with contracted provider network to designate at least one (preferably two) staff that have successfully completed a BHDDA sponsored benefits planning training (or comparable) that develops needed expertise regarding access to timely and accurate information to address immediate employment interests of persons with disabilities.

Last Revision Date: November 10, 2021

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION

PERSON-CENTERED PLANNING PRACTICE GUIDELINE

"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 honors the individual's preferences, choices, and abilities." **MHC 330.1700(g)**

I. What is the Purpose of the Community Mental Health System?

The purpose of the community mental health system is to support adults and children with intellectual and developmental disabilities (DD), adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance (SED) 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 individuals to plan their life in their community, set the goals that they want to achieve, and develop a plan for how to accomplish those goals. PCP is required by state law, (the Michigan Mental Health Code (MMHC)), and federal law, (the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules), as the way that individuals 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 individual 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, an individual 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 individuals who care about the individual 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 intellectual and DD services provided by the CMHSP system, PCP can include planning for other public supports and privately funded services chosen by the individual.

The Home and Community Based Services (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 community mental health system.

Through the PCP process, an individual and those he/she has selected to support him/her:

a. Focus on the individual's life goals, interests, desires, choices, strengths, and abilities as the foundation for the PCP process.

b. Identify outcomes based on the individual's life goals, interests, strengths, abilities, desires, and choices.

c. Make plans for the individual to achieve identified outcomes.

d. Determine the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, those 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 individual's goals while still meeting his/her basic needs (food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code). As appropriate for the individual, 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 Michigan Department of Health and Human Services (MDHHS) policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the individual to work toward and achieve his/her 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 individual reaches adulthood, his/her needs and goals become primary.

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

a. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, a guardian, or an individual in loco parentis within the restrictions stated in the MMHC.

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 MMHC, "'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. The person-centered planning process involves families, friends, and professionals as the individual desires or requires." MHC 330.1700(g).

The MMHC also requires use of PCP for development of an IPOS:

> "(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 individual 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 that Guide the PCP Process and the Essential Elements of the PCP Process 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 every individual. The following values and principles guide the PCP process whenever it is used.

a. Every individual is presumed competent to direct the planning process, achieve his/her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the individual's ability to make choices.

b. Every individual has strengths, can express preferences, and can make choices. The PCP approach identifies the individual's strengths, goals, choices, medical and support needs, and desired outcomes. In order to be strength-based, the positive attributes of the individual are documented and used as the foundation for building the individual's goals and plans for community life as well as strategies or interventions used to support the individual's success.

c. The individual's choices and preferences are honored. Choices may include the family and friends involved in his/her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships, friendships, and transportation. Individual choice must be used to develop goals and to meet the individual's needs and preferences for supports and services and how they are provided. Therefore, it is important that the individual has the ability to communicate with those involved in the individual's life and care.

d. The individual'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 individual to implement his/her choices or preferences over time.

e. Every individual contributes to his/her community and has the right to choose how supports and services enable him/her to meaningfully participate and contribute to his/her community.

f. Through the PCP process, an individual maximizes independence, creates connections, and works towards achieving his/her chosen outcomes.

g. An individual's cultural background is recognized and valued in the PCP process. Cultural background may include language preference, religion, values, beliefs, customs, dietary choices, and other things chosen by the individual. Linguistic needs, including American Sign Language (ASL) interpretation, text messaging, video phone access, assistive technology and Computer Assisted Realtime Translation (CART), are also recognized, valued, and accommodated.

IV. What are the Essential Elements of the PCP Process?

The following elements are essential to the successful use of the PCP process with an individual and those invited by the individual to participate.

a. **Person-Directed.** The individual 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 individual, not the system or the individual's family, guardian, or friends. The individual'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 individual's needs or choices, rather than viewed as an annual event.

c. **Outcome-Based.** The individual identifies outcomes to achieve in pursuing his/her goals. The way that progress is measured toward achievement of outcomes is identified.

d. **Information, Support, and Accommodations.** As needed, the individual 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 individual to participate in the process are provided. The individual is offered information on the full range of services available in an easy-to-understand format.

e. **Independent Facilitation.** Every individual has the information and support to choose an independent facilitator to assist him/her in the planning process.

f. **Pre-Planning.** The purpose of pre-planning is for the individual to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Every individual must use pre-planning to ensure successful PCP. Pre-planning, individualized for the individual'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 individual has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and plan for how to deal with them as to what will be discussed and not discussed.

3. The specific PCP format or tool chosen by the individual to be used for PCP.

4. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).

5. Who will facilitate the meeting.

6. 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 individual to live the way he/she wants to live are discussed and plans to address them are developed. individuals 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, and eating candy or other sweets). If the individual 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 individual's right to assume some degree of personal risk. The plan must assure the health and safety of the individual. 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 individual selects allies (friends, family members, and others) to support him/her through the PCP process. Pre-planning and planning help the individual explore who is currently in his/her life and what needs to be done to cultivate and strengthen desired relationships.

V. What is Independent Facilitation?

An Independent Facilitator is an individual who facilitates the PCP process in collaboration with the individual. In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their PCP 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 individual 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 and/or the 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/her hopes, interests, desires, preferences, and concerns are heard and addressed. The independent facilitator must not have any other role within the PIHP and/or the 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/she likes and dislikes, personal preferences, goals, methods of communication, and who supports and/or is important to the individual.

b. Help the individual with all pre-planning activities and assist in inviting participants chosen by the individual to the meeting(s).

c. Assist the individual to choose planning tool(s) to use in the PCP process.

d. Facilitate the PCP meeting(s) or support the individual to facilitate his/her own PCP meeting(s).

e. Provide needed information and support to ensure that the individual directs the process.

f. Make sure the individual is heard and understood.

g. Keep the focus on the individual.

h. Keep all planning participants on track.

i. Develop an IPOS in partnership with the individual that expresses the individual's goals, is written in plain language understandable by the individual, and provides for services and supports to help the individual 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 and/or the CMHSP may report the service under the code H0032.

An individual may use anyone he/she chooses to help or assist in the PCP, including facilitation of the meeting. If the individual does not meet the requirements of an Independent Facilitator, he/she cannot be paid, and responsibility for the Independent Facilitator duties described above falls to the Supports Coordinator/Case Manager. An individual may choose to facilitate his/her own planning process with the assistance of an Independent Facilitator.

VI. How is PCP used to Write and Change the IPOS?

The MMHC establishes the right for all individuals to develop an IPOS through the PCP process. The PCP process must be used at any time the individual 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 individual through the pre-planning process, not by the 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 PCP process.

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

individuals are often at different points in the process of achieving his/her life goals. The PCP process should be individualized to meet every individual's needs of the individual for whom planning is done, i.e. meeting an individual where he/she is. Some individuals may be just beginning to define the life he/she wants and initially the PCP process may be lengthy as the individual'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 individual. If and/or when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs of the individual as they arise. An IPOS must be prepared in person-first singular language and be understandable by the individual with a minimum of clinical jargon or language. The individual must agree to the IPOS in writing. The IPOS must include all 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 individual and how progress toward achieving those outcomes will be measured.

c. The services and supports needed by the individual to work toward or achieve his/ her outcomes, including those available through the CMHSP and other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS), community resources, and natural supports.)

d. The setting in which the individual lives was chosen by himself/herself and what alternative living settings were considered by him/her. The chosen setting must be integrated in and support full access to the greater community, including opportunitiesto 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 community mental health system. The PIHP and/or the 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 individual 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 the Technical Requirement for Explanation of Benefits.

j. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and the providers in implementing the IPOS.

k. The individual or entity responsible for monitoring the plan.

l. The signatures of the individual and/or representative, the case manager or the support coordinator, and the support broker/agent (if one is involved).

m. The plan for sharing the IPOS with family, friends, and/or caregivers with the permission of the individual.

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 an individual has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of his/her needs, changes in his/her condition as determined through the PCP process, or changes in his/her personal preferences for support).

The individual and the case manager or the supports coordinator should work on and review the IPOS on a routine basis as part of regular conversations. An individual or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the individual 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 individual 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 are not necessarily supported by the CMHSP services and supports. Therefore, the PCP process must not be limited by program specific functional assessments. The IPOS must describe the services and supports that will be necessary and specify what the HCBS Final Rule is to be provided through various resources, including natural supports, to meet the goals in the PCP. The specific individual or individuals and/or provider agency, or other entity providing services and supports, must be documented. Non-paid supports, chosen by the individual and agreed to by the unpaid provider, needed to achieve the goals, must be documented. With the permission of the individual, the IPOS should be discussed with family, friends, and/or caregivers chosen by the individual so that they fully understand it and their role(s).

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

VII. How Must Restriction on an Individual'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 can 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 individual to the proposed modification.
8. An assurance that the modification itself will not cause harm to the individual.

VIII. What do the PIHPS, the CMHSPS and Other Organizations Need to do to Ensure Successful Use of the PCP 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 the CMHSPs, 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 individuals 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 to, 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 the individual 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 every individual to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; and 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 individual 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 appeals, grievances, and recipient rights as set forth in detail in the Appeal and Grievance Resolution Processes Technical Requirement. As described in this Technical Requirement, 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 an individual is receiving services and no agreement on IPOS can be made through the PCP 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 appeals and grievances take over. Other options are available to all recipients of community mental health services and supports.

Supports Coordinators, Case Managers, and Customer Services at the PIHPs and/or the CMHSPs must be prepared to help people understand and negotiate the dispute resolution processes.