COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: September 25, 2024 Person-Centered Planning.P15

RESCINDS: August 23, 2017

CATEGORY: Recipient Rights

SUBJECT: Person-Centered Planning

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS) that all persons receiving mental health services have an Individual Plan of Service (IPOS) developed through a person-centered planning process regardless of age, disability, or residential setting. Each person receiving services will receive integrated treatment to maximize their opportunities for recovering (or establishing) the life they believe is worth living.

PURPOSE: To assure the process used to develop the Individual Plan of Service for each person receiving services is consistent with the requirements of the Mental Health Code and the Home and Community Based Services (HCBS) Final Rule, and to create the foundation for care that is self-directed by the person receiving services, who defines his or her own life goals and designs a unique path towards those goals.

DEFINITIONS:

Individual Plan of Services (IPOS): a written individualized plan of services developed with a person receiving services.

Person-centered planning (PCP): a process for planning and supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that respect the person's preferences, choices, and abilities. The person-centered planning process involves allies (families, friends, and professionals) as the person desires or requires and it may be directed by an Independent Facilitator chosen by the person. Any adult receiving mental health services and supports may choose to have their plan implemented through the process of Self-Determination (see CCMHS's Policy entitled "Self Determination").

PROCEDURE:

I. Values and Principles Underlying Person-Centered Planning

Person-centered planning is a highly individualized process designed to respond to the expressed needs/desires of the person.

- For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach. This approach recognizes the importance of family in the lives of children and that supports and services impact the entire family.

In the case of minor children, the child/family is the focus of planning and family members are integral to success of the planning process.

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

- 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 Mental Health Code;
- The minor is emancipated; or
- 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 as stated in the Code. Justification of the exclusion of parents shall be documented in the clinical record.

  - 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. Persons who have court-appointed legal guardians shall participate in person-centered planning and make decisions that are not delegated to the guardian in the Guardianship Letters of Authority.

  - 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.

  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.

  - 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.

  - 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.

  - Through the person-centered planning process, a person maximizes independence, creates community connections and works towards achieving his or her chosen outcomes.

  - A person's cultural background is recognized and valued in the person-centered planning 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.

II. Essential Elements of Person-Centered Planning

The following characteristics are essential to the successful use of the PCP process with a person and his/her allies.

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 preferences are identified with an optimistic view of the future and plans for a satisfying life. The planning process is used whenever the person wants or needs it, rather than viewed as an annual event.

C. **Outcome-Based.** Outcomes in pursuit of the person's preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.

D. **Information, Support and Accommodations.** The person receives comprehensive and unbiased information on the array of mental health services, community resources, and available providers. 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.** Persons 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 all of the information and resources (e.g., people, agencies) necessary for effective person-centered planning and set the agenda for the process. Each person (except for those who receive short-term outpatient therapy only, medication only, or those who are incarcerated) is entitled to use pre-planning to ensure successful PCP. Pre-planning, is individualized for the person's needs and is used anytime the PCP process is used.

The following topics are addressed through pre-planning with sufficient time to take all necessary/preferred actions (i.e. 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 decide 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 individual may need to meaningfully participate in the meeting (including assistance for people who use behavior as communication);
6. Who will facilitate the meeting; and
7. Who will record what is discussed at the meeting.

G. **Wellness and Well-Being.** Issues of wellness, well-being, health and primary care coordination or integration, and supports 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 so desired by the person, these issues can be addressed outside of the planning 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 per-sonal 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 person-centered planning process. Planning

helps the person identify who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

III. Individual Plan of Service (IPOS)

A. **Preliminary Plan.** A preliminary plan will be developed within seven (7) days of the commencement of services.

B. **Integrated IPOS.** A full IPOS, developed within ninety (90) days of commencement of services, identifies the desired outcomes of the person and utilizes the comprehensive assessment of mental health disorders, substance use disorders, and intellectual/developmental disabilities to identify services and supports to achieve those outcomes. The IPOS is based on medical necessity and the person's readiness to address specific concerns identified in the assessment.

C. **Review of the IPOS.** Once the IPOS has been developed through the PCP process, it shall be kept current and modified when needed (reflecting changes in the intensity of the person's needs, changes in the person's condition or changes in the person's preferences for support). The person or his/her guardian or authorized representative may request a review of the IPOS at any time.

A formal review of the IPOS with the person and his/her guardian or authorized representative using the PCP process shall occur not less than annually.

Persons are provided with ongoing opportunities to provide feedback on how they feel about service, support and/or treatment they are receiving and their progress toward attaining valued outcomes. Information is collected and changes are made in response to the person's feedback.

D. **Documentation Required within the IPOS.** 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. Documentation maintained within the IPOS must include:

1. A description of the person's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports;
2. The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured;
3. The services and supports needed by the person including those available through CCMHS, other publicly or privately funded programs (such as Home Help, Michigan Rehabilitation Services), community resources and natural supports;
4. 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. All settings meet the requirements of the HCBS Final Rule;
5. The amount, scope and duration of medically necessary services and supports authorized by and obtained through the community mental health system;
6. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports;
7. Documentation of any restriction or modification of additional conditions must meet the standards set forth in section F below;
8. The services which the person chooses to obtain through arrangements that support self-determination;

9. The estimated/prospective cost of services and supports authorized by the community mental health system;
10. The roles and responsibilities of the person, the clinician/supports coordinator/case manager, the allies, and providers in implementing the plan;
11. The person or entity responsible for monitoring the plan;
12. 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);
13. The plan for sharing the IPOS with family/friends/ caregivers with the permission of the person;
14. A timeline for review; and
15. Any other documentation required by Section R330.7199 Written Plan of Services of the Michigan Administrative Code.

E. Each person (or his/her court-appointed legal guardian, or authorized representative if one has been designated, or parent in the case of a minor) must be provided a written copy of the IPOS within fifteen (15) business days of the planning meeting date.

F. Any effort to restrict 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 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 PCP 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.

IV. Organizational Standards

The following characteristics are essential for organizations to provide supports and services using a person-centered planning process:

A. **Individual Awareness and Knowledge.** CCMHS provides accessible and easily understood information, support and, when necessary, training to people using services and supports and those who assist them so that they are aware of:

1. Their right to person-centered planning;

2. The essential elements of person-centered planning;
3. The benefits of this approach and the support available to help them succeed (including pre-planning and independent facilitation).
4. This information is provided at first contact and as appropriate during the course of services.

B. **Person-Centered Culture.** CCMHS provides leadership, policy direction and activities for implementing person-centered planning at all levels of the organization. Organizational language, values, allocation of resources and behavior reflect a person-centered orientation.

C. **Conflict of Interest.** CCMHS 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 when a new IPOS is developed or when there is a change to the IPOS.

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. **Quality Management.** Best practices for supporting persons served through PCP are identified and implemented (what is working and what is not working in supporting persons receiving services). Organizational expectations and standards are in place to assure the person receiving services directs the PCP process and ensures that PCP is consistently done well.

G. **Residential.** When an individual resides in a group home, both owned/operated by CCMHS and contractual placements, the current IPOS will be maintained either through the EMR utilized on site or as a standalone paper copy. If a paper copy is maintained, it must be done so in a manner appropriate with HIPAA and confidentiality policies of CCMHs.

The residential site is also required to maintain a record that all staff are trained on the current IPOS prior to working with the individual. This may also be maintained in the EMR or as a standalone paper attestation to training.

V. Dispute Resolution

If a person is not satisfied with his or her Individual Plan of Service, the person, a person authorized to make decisions regarding the IPOS, the guardian of the person receiving services, or the parent of a minor may request a review of the plan. The review of the plan shall be completed within 30 days. 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.

People who have a dispute about the PCP process or the IPOS that results from the process, have grievance, appeals and recipient rights as set forth in detail in the Michigan Mental Health Code, the MDHHS Grievance and Appeal Technical Requirement/ PIHP Grievance System for Medicaid Beneficiaries, and CCMHS policies regarding Grievance and Appeals procedures.

Some of the dispute resolution options are limited to people who have Medicaid and limited in the scope of the grievance (such as denial, reduction, suspension, or termination of services). Other options are available to all persons who receive Michigan mental health services and supports. Clinicians/Supports

Coordinators/ Case Managers and Customer Services staff at CCMHS must be prepared to help people understand and negotiate dispute resolution processes.

CROSS REFERENCES:

MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline

MDHHS Behavioral Health & Developmental Disabilities Administration Person-Centered Planning Policy

Medicaid Managed Specialty Supports and Services 1915 (b)/(c) Waiver Program, Contract Attachment - Person-Centered Planning Policy and Practice Guideline

Medicaid Managed Specialty Supports and Services 1915 (b)/(c) Waiver Program, Contract Attachment – Self-Determination Policy and Practice Guideline

CCMHS Policy – Self-Determination

CCMHS Policy - Advance Directive/Durable Power of Attorney/Plan for Difficult Times/Crisis Plan

CCMHS Policy – Grievance and Appeals Processes – Medicaid & Healthy Michigan (HM)

CCMHS Policy – Grievance and Appeals Processes – Non-Medicaid

CCMHS Clinical Guideline – Independent Facilitation of a Person-Centered Plan