COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	*Policy and Procedure* *Person Centered Planning Policy*
Department: Clinical Performance Team **Author:**	**Local Policy Number (if used)**
Regional Operations Committee Approval Date **6/10/2020**	**Implementation Date** **8/10/2020**

I. PURPOSE

Establish the service and treatment philosophy of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) is based on the values and principles of the person-centered planning process, establish standards and applications for person-centered planning, and ensure compliance with the requirements governing service delivery established by regulatory and/or funding bodies.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
2003		Original document
2005	1.0	
2011	2.0	
2014	3.0	Revised to reflect the new regional entity.
2015	4.0	Revised to reflect the Quality Improvement Council's (QIC) quality improvement plan.
2018	4.0	Revised to reflect the Quality Improvement Council's (QIC) quality improvement plan.
2018	5.0	Regional Review of Policy.
2020	6.0	Revisions in receiving the estimated annual cost of services re: HSAG EQR review

III. APPLICATION

This policy applies to all staff, students, volunteers and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY

It is the policy of the CMHPSM that all eligible persons are informed of their right to engage in Person Centered Planning at any time. All individuals who receive services shall have a plan outlining the individual outcomes to be achieved through various means of

support and or services. The process by which a plan is developed shall be done in a way that is person centered as outlined in the standards of this policy.

V. DEFINITIONS

Assessment: The process for obtaining clinically relevant information about each individual seeking behavioral health care, treatment, or services. The information is used to match an individual's need with the appropriate setting, service/program, and intervention. The systematic collection and review of data specific to an individual served. Data from assessments is used in the development of the Individual Plan of Service (IPOS).

Client Services Manager/Supports Coordinator: A designated individual responsible for assisting the individual in accessing needed supports and services. Activities include needs assessment, pre-planning, planning, coordinating, monitoring and evaluating the effectiveness of needed supports and services.

Community Mental Health Partnership of Southeast Michigan: The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program: A program operated under Chapter 2 of the Michigan Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Emancipated Minor: The termination of the rights of the parents to the custody, control, services and earnings of a minor which occurs by operation of law or pursuant to a petition filed by a minor with the Probate Court.

Emergency situation: A situation where the individual can reasonably be expected within the near future to physically injure himself, herself, or another person; or is unable to attend to the need for food, clothing, shelter or basic physical activities, and this inability may lead in the near future to harm to the person or to another person; or, the individual's judgment is impaired, leading to the inability to understand the need for treatment or support which can be expected to result in physical harm to self or others. The sudden disruption of the person's system of supports may constitute an emergency if s/he is unable meet basic needs and maintain health and safety in the absence of these supports.

Family-Centered Planning Process: An approach that recognizes the importance of the family and the fact that supports, and services impact the entire family. Therefore, in the case of minors, the child/family is the focus of service planning, and family members are integral to the planning process and its success.

Family member: A parent, stepparent, spouse, significant other, sibling, child, or grandparent of a primary recipient, or an individual upon whom a primary recipient is dependent for at least 50 percent of his or her financial support.

Legal Representative: Legal Representative - A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Individual Plan of Services (IPOS): A written individualized plan of supports and services directed by the individual as required by the Mental Health Code. This plan may include both support and treatment elements.

Interim IPOS: A time-limited plan, not to exceed 90 days (best practice within 30 days), that needs to be completed in because an annual re-assessment and/or annual IPOS has not been completed, order to prevent any gaps of the continuation of services that remain medically necessary until an annual re-assessment and/or annual IPOS can be completed.

Minor: A person under the age of 18 years.

Person-Centered Planning: 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 honor the individual's preference, choices, and abilities. The person-centered planning process involves family, friends and professionals as the individual desires or requires. The process is directed by the person and focuses on his or her desires, dreams, strengths and needs for support.

Reassessment: Ongoing data collection which begins at initial assessment, comparing the most recent data with the data collected at earlier assessments. Consumer may be reassessed for many reasons. These include: evaluation of his or her response to care, treatment or services; response to a significant change in status and/or diagnosis or conditions; request from the consumer and/or the consumer's representative for a change in the supports and services authorized in the most current IPOS; as required to satisfy regulatory requirements (i.e. for eligibility determination for a Children's Waiver, or Habilitation Support Wavier (HSW); as required for the determination of ongoing eligibility for supports and services based on a managed care authorization period. In addition, a reassessment of need shall occur during a routine periodic review or annual review prior to the revision of an existing IPOS.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, developmental disabilities, and substance use disorder needs.

Specialty Assessments: Assessments and evaluations resulting from referrals following an initial biopsychosocial assessment, a reassessment, or as authorized in an IPOS. Included are psychiatric evaluations, nursing assessments, occupational therapy assessments, physical therapy assessments, speech and language assessments, behavior treatment assessments, nutrition assessments, and psychological testing. Autism related screens and assessments also are considered Specialty Assessments.

Significant Change: A Significant Change occurs when a consumer experiences a change in functioning or circumstances potentially impacting service needs. The assessment update will focus on the consumer's current need and may result in change to the Individual Plan of Service (IPOS) that may add new outcomes, amend existing authorizations for services or supports, or add authorizations for new supports or services. A Significant Change may be the result of a positive change so that the consumer needs less service or less restrictive care, such as mainstreaming to primary care as a medical home. Or, consumer may be at risk of, or experiencing, a decrease in functional ability or a loss of supports necessary to maintain functioning. A Significant Change in functioning may result from an acute illness or injury or as a result of a chronic condition. Additionally, environmental change may lead to the need for substantial modifications in service delivery.

Examples of Significant Change that would initiate a reassessment include:

- A sentinel event
- Change in level of care, treatment, or service need. For example, transition to a less independent service (more restrictive service) or transition to a more independent service (less restrictive service)
- Legal status change (involvement with the law enforcement/court action, being charged with a crime or the victim of a crime, or guardianship awarded or modified)
- Significant health, nutrition, safety change or hospitalization (new diagnosis medical diagnosis, nutritional issues including significant weight loss/gain or new mobility issues).
- Loss of parent, significant other or caretaker that effects treatment
- Introduction of protective devices (including a helmet, gait belts, door/bell alarms, or bed rails)
- Introduction of a behavior plan that includes restrictive or intrusive techniques and/or introduction of medication when prescribed solely for the purpose of behavior control not resultant of a documented diagnosis of a psychotic, mood or anxiety disorder
- Introduction of new medical equipment
- When a consumer has a major change in presenting conditions or disabilities
- When a consumer reaches the age of majority
- If a consumer experiences abuse/neglect or other major trauma
- If a new diagnosis is given.

VII. STANDARDS

A. All persons must have a current Individual Plan of Services (IPOS). An IPOS must be reviewed and completed annually. A completed IPOS means the IPOS goals and objectives are written and agreed upon, the plan is signed by all parties (including the consumer/legal guardian) and the authorization is completed.

B. Consumers who are enrolled in a C waiver program (Habilitation Waiver, Children's Waiver, Children's SED Waiver) cannot have an IPOS that exceeds 365 days. Ideally all consumers served by the CMHSP/CMHPSM would have a new plan at least annually.

C. For those consumers not enrolled in a waiver, if a new IPOS cannot begin by the expiration date of the current IPOS, and the continuation of services needs to be ensured, an extension of the current IPOS and current authorization must be completed and submitted for supervisory/UM approval. The reasons for the need of such an extension need to be clearly documented in the consumer record. Depending on the reasons, such an extension would be conducted as an engagement plan or interim plan. The start date of the Interim Plan of Service will be the day after the current IPOS expires, and such an extension cannot exceed more than 90 days.

D. Each individual has the ability to express preferences and to make choices with appropriate supports. The capacity for growth and choice shall be recognized in all persons. Individual choices and preferences shall always be honored, if not always granted.

E. The individual's perceptions, expressions, thoughts, and experiences are the most valid avenue of relatedness.

F. Only the person him/herself can develop his/her potential. Person centered services and supports create a climate and context for that development.

G. Planning shall be based upon individual strengths and abilities and shall presume competence and assume readiness.

H. A person's cultural background shall be recognized and valued in the decision-making process.

I. Planning shall promote the provision of services to children within the context of their family and to adults in the home of their choice.

J. Supports and services are provided with the goal of promoting meaningful connections through relationship, work, recreation and community involvement.

K. Services shall promote growth, maximum independence, and interdependence within the context of natural support systems, and community membership and recognition.

L. Community inclusion and participation include choice and control over living arrangements, relationship building, opportunities to contribute and be productive, and leisure and recreation.

M. Community accountability for services includes addressing health and safety concerns, assuring fairness, equity and privacy and assuring quality

N. Professional services shall be made available to individuals as part of a full array of supports and services and provided based upon individual interest, preference and need. Professional services are offered in the context of providing resources and opportunities and will facilitate a climate of safety for growth.

O. Persons with legal guardians will be included in person centered planning. Wherever possible, guardians shall be educated regarding the values and principles of person centered planning and encouraged to offer the person served maximum input and control over choices and decisions.

P. Parents and significant family member of minors shall participate in the planning process unless:
    1. The minor is fourteen years of age or older and has requested services without the knowledge or consent of parent, guardian, or person in loco parentis within the restriction of the Mental Health Code.
    2. The minor is emancipated.
    3. The inclusion of the parents(s) or significant family members would constitute a substantial risk of physical or emotional harm to the person or substantial disruption of the planning process as defined in the Mental Health Code. Justification of exclusion shall be documented in the clinical record.

Q. Persons with emergent or urgent needs, including those which present an imminent danger to self or others, or a health and safety risk, shall receive those immediate services needed to assure the person's well being and stabilization of the situation. To the extent possible, person centered values and principles will be honored in the provision of emergency services, although the complete Person-Centered Process may not be feasible. Limitations of choice and rights will be only those sufficient and necessary to assure the health and safety of the person and others. Following stabilization of the situation,

should the person continue in services, the person shall be invited to participate in Person Centered Planning.

R. An Individual Plan of Service for persons receiving Intensive Crisis stabilization and/or Crisis Residential Services must be developed within 48 hours. The use of interim plans does not apply in these situations.

S. 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.

T. Persons expressing a need or making a request for a single support or service, or short-term services, will be offered services based upon the principles in this policy, assuring maximum choice, control and individualization of services. Persons will be invited to participate in Person Centered Planning, if desired. This may include future planning for children or adults living with family members, particularly when it is anticipated that additional supports will be needed over time.

U. Requests for Interim Plans: In case where an interim plan needs to be completed in order to continue medically necessary services until an annual re-assessment and/or annual IPOS can be completed, the following shall apply:
   a. The reason for the interim plan is clearly stated in the plan. Examples include engagement issues with the consumer, or the need to reschedule a re-assessment/IPOS meeting.
   b. Interim plans need to have a goal, outcomes, and the amount scope and duration of the services provided.
   c. The interim IPOS goals shall state what goal(s) will be accomplished specifically for that interim period of time, and what services will be needed to accomplish that goal. Examples include:
      - Assisting the consumer to re-engage with their CMH clinical team (loss of contact).
      - Interventions staff need to provide or ways they would assist with overcoming barriers to care for the consumer.
      - Goals specific to the consumer they would continue to work on during the interim (such as abilities they are learning through the using of CLS/skill building services that would continue the interim, or their care needing to be maintained in their living setting).

V. All persons expressing complex needs which involve multiple life domains and supports, services or treatment of an extended duration will receive supports and services through the Person-Centered Planning Process.

W. For consumers receiving only substance use disorder treatment services, a recovery plan will be developed using Person Centered Planning principles.

X. Needs Assessment and Pre-Planning
   1. Before a person-centered planning meeting is initiated, an assessment of needs and a pre-planning meeting occurs. The needs assessment can occur on the same day or on a separate day of the pre-planning meeting. The pre-planning meeting cannot occur on the same day of the person-centered planning meeting. Ideally, a pre-planning meeting will occur 30 days prior to the planning meeting so that persons have sufficient time to consider their outcomes and invite those they may wish to attend their planning meeting. Persons are not required to have a 30-day time frame but will be given the choice in the amount of time they need between their pre-planning and planning meetings.

2. The person is offered the opportunity to express needs, desires and preferences. Any needed accommodations for communication are provided. Pre-planning begins with the person's initial contact with the local CMHSP. Information gathering activities include eliciting information about the person's needs for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation and recreation, as defined by the Mental Health Code.
3. The needs assessment and planning process shall acknowledge that the person and those closest to him/her know the individual best. Information may be gathered from family, friends, co-workers, teachers and current service providers with the permission of the person.
4. Potential issues of health and safety are explored and discussed to determine if there is a role for other professionals to provide additional information, opinions or recommendations for supports and services. Such services are arranged for and provided based upon needs assessment and pre-planning activities.
5. Persons will be offered an opportunity to develop a crisis prevention plan.
6. As a result of health or safety concerns, or court ordered treatment, limitations may exist for individual choice. Within the context of any such limitations the individual will be offered the maximum input and control over decisions.
7. If the individual currently has a legal representative, the level of and/or the appropriateness of the legal restriction such as an Alternative Treatment Order (ATO), shall be reviewed considering the expressed desire for independence. As a result, the IPOS may include steps and activities for the consumer to pursue that could lead to a lessening or removal of the legal restriction.
8. Valued outcomes are identified from the perspective of the individual.
9. Potential sources of services and support, including natural, generic, and specialized supports are explored fully with the person. Initial expectations of the service delivery system are identified. Satisfaction with any current services and supports is explored.
10. Persons are assisted in exploring their support network to identify who they would like involved in the person-centered planning process and are offered support and assistance in inviting those persons to participate. Persons are also offered the opportunity to identify which professionals or support providers they would like to participate in their planning meeting. Persons will be educated on and offered peer support services where applicable.
11. Within the context of support for communication needs, and education regarding potential options, the person is given ongoing opportunities to express preferences and make meaningful choices. Choice making shall include adequate information regarding options available. Opportunities for exploration, dialogue and experimentation shall be provided. The service system shall provide education, supports and skill development when needed to support the person's development of the ability to make meaningful choices. The knowledge of those closest to the person regarding the person's preferences shall also be honored and acknowledged.
12. The person is offered the opportunity to identify what information will be shared and discussed during the planning meeting in the presence of all participants and what information should be discussed privately.
13. The person is also offered the opportunity to select a facilitator who will facilitate the meeting on his/her behalf. Ideally, this will be the person him/herself, an advocate, or a person trained specifically for the task. The option of an external independent facilitator will be included in these choices.
14. Persons are offered the opportunity for self-determination arrangements as an alternative in arranging their supports and services.

Y. Planning

1. Planning occurs at a time and place convenient and comfortable to the person and others who have been invited to participate in the process. Ground rules are established to ensure that the person is the focal point, that the process is not "professionalized" and that the meeting is conducted in the manner the person chooses.
2. The person, and those he or she has selected, explore the desired future and valued outcomes, and determine what resources and supports are needed to support those outcomes. The focus is on strengths, abilities and building on the capacities of the person.
3. The person's preferences, choices and abilities are honored in the planning process. The role of professionals is to consult and make recommendations and contributions based upon their expertise and their knowledge of the person. The person retains the right and responsibility to make decisions, and to determine who will be a part of his/her decision-making process.
4. The person's dreams, desires and preferences are captured in short-term and long-term outcomes which are consistent with the person's values.
5. Exploration of resources and the building of a support plan are to be considered in this order:
    a. The person
    b. Family, friends, guardian, and significant others
    c. Resources in the neighborhood and community
    d. Publicly funded supports and services available to all persons
    e. Publicly funded supports and services available through the CMHSP/CMHPSM

    The development of natural supports (family, friends, and community) shall be an equal responsibility of the CMHSP and the person.
6. A written individualized plan of supports and services shall be developed which includes those supports to be provided by natural supports, generic community supports, and the CMHSP service system. Specialized supports augment enriches and do not necessarily supplant those provided by an existing network of natural and community supports. The plan is specific as to the supports to be provided and who/how those supports will be delivered.
7. The plan or accompanying documentation will specify the rationale for deferring, not addressing or not providing any of the supports and services identified as needed or desired.
8. The plan will specify the CSM/Supports Coordination activities to be provided and the planned frequency.

Z. Service Provision and Follow-Up
1. Those implementing a new or changed IPOS, must be in-serviced within 30 days of the effective date. Documentation must occur within 1 business day of the training. The CMHSP and CMHPSM will provide ongoing monitoring to ensure this training occurs.
2. Supports and Services are provided as identified in the person's plan and delivered by the providers of the individual's choice wherever possible. Depending upon the preferences of the person and/or family, the CSM/Supports Coordinator will arrange for and coordinate the provision of supports identified.
3. Supports and Services remain focused on the person and his/her needs, rather than on program elements or slots.
4. The IPOS shall include an authorization for the amount, scope, duration, and frequency of the supports and services to be provided.
5. The IPOS process shall also include providing the consumer/legal representative the estimated annual cost of each covered support and service he or she is re-

ceiving in the IPOS. Providing the annual cost of services will be included in the review and signing of the IPOS process with the consumer/legal representative. This estimated annual cost can be in the form of the consumer budget report in the electronic health record, printed out and included in the IPOS documents.

6. Each individual shall be provided a copy of her/his IPOS no later than 15 business days following the completion of the IPOS. This copy shall include the amount, scope, duration, and frequency of the supports and services that were authorized for the individual.
7. Persons are provided with opportunities to provide ongoing feedback regarding their individual supports and services. These mechanisms include both informal feedback through persons providing or monitoring supports, formal satisfaction and outcome measurement processes, and problem resolution/complaint processes.
8. Planning is an ongoing process. Consumers may experience significant changes in functioning or circumstances potentially impacting service needs. The assessment update will focus on the consumer's current need and may result in change to the Individual Plan of Service (IPOS) Services are tailored or adjusted over time based on changes in needs or preferences. The plan shall be updated and amended as frequently as needed. The person will be provided the opportunity for a person-centered planning meeting no less than annually.
9. The IPOS identifies the frequency that it will formally be reviewed for effectiveness and reviews of the plan are completed at those intervals.
10. The CSM/Supports Coordinator reviews the IPOS and monitors the provision of supports and services at a frequency identified in the planning process to assure implementation and to assess the effectiveness of supports in achieving the outcomes identified.

AA. Dispute Resolution/Appeal Mechanisms

1. If a person is not satisfied with his or her IPOS, the person, their guardian, or their legal representative may request a review of the IPOS to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.
2. Persons have the right to access the local CMH grievance, appeals, rights or problem resolutions processes if they believe that:
    a. They have not received the opportunity for person centered planning
    b. They believe they have been inappropriately denied a requested service or provided with less services than they requested
    c. They disagree with limitations that have been placed on choice or preference for health and safety reasons

VIII. EXHIBITS

EXHIBIT A: Process for Person-Centered Planning
EXHIBIT B: Engagement Examples
EXHIBIT C: Person-Centered Process Outcomes Statement Guidelines; Values and Rationale
EXHIBIT D: Outcome Improvement Exercise

IX. REFERENCES

Michigan Mental Health Code, Public Act 258 of 1974, as amended - 330.1409(1-7), 330.1700(g), 330.1707(1-5), 330.1712(1-3)
Department of Community Health Person- Centered Planning Guideline –Attachment P.3.4.1.1 to the MDCH/CMHSP Managed Mental Health Supports and Services Contract

Michigan Renewed Habilitation Supports Waiver, Section 7: Person Centered Process, April 1996
MDHHS Application for Renewal of the 1915(b) Specialty Supports and Services Managed Care Waiver.
MDHHS Policy and Practice Guideline, Attachment P.3.4.4 to the MDHHS/CMHSP Managed Mental Health Supports and Services Contract
CMHPSM Assessment and Reassessment Policy
CMHPSM Diagnosis and Clinical Formulation Policy
CMHPSM Timeliness of Service Provision and Documentation Policy
CMHPSM Self-Determination Policy