The Right Door for Hope, Recovery and Wellness

Chapter Title Clinical	Chapter # C		Subject # 320.1
Subject Title Person Centered Planning	Adopted 8/10/01	Last Revised 5/24/2024	Reviewed: 3/15/05; 4/5/10; 1/30/14; 1/9/15; 11/2/15; 12/22/16; 11/22/17; 11/1/18; 12/3/18; 2/27/19; 12/5/19; 7/21/2020; 3/15/21; 9/21/2021; 3/17/22; 3/31/23; 3/28/24; 5/24/2024

Application

This procedure shall apply to the clinical services of The Right Door for Hope, Recovery and Wellness .

1. Summary/Background

The Michigan Mental Health Code establishes the right for all individuals to have their Individual Plan of Service (IPOS) developed through a person-centered planning (PCP) process regardless of age, disability, or residential setting. The IPOS may include a treatment plan, support plan, or both. In the past, Medicaid or other regulatory standards have governed the process of treatment or support plan development. These standards drove the planning process through requirements on the types of assessments to be completed and the professionals to be involved. PCP departs from this approach in that the individual will direct the planning process with a focus on what the individual wants and needs. Professionally trained staff will still play a role in the planning and delivery of treatment and may play a role in the planning and delivery of supports. However, the development of the treatment or support plan, including the identification of possible services and professionals, is based upon the expressed needs and desires of the individual. As part of the planning process, available resources and any legal limitations should be considered.

2. Values and Principles underlying Person-Centered Planning

2.1. PCP is a highly <u>individualized</u> process designed to respond to the expressed needs/desires of the individual:

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2.2. Every individual is presumed competent to direct the planning process, achieve their 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.

2.3. The PCP focuses on the person's goals, while still meeting the person's basic needs for food, clothing, shelter etc.

2.4. Every individual has strengths, can express preferences and can make choices. The person-centered planning approach identifies the person's strengths, goals, choices, medical and support needs and desired outcomes. In order to be strengths 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.

2.5. There is documentation that individual chose the setting in which they live and there is documentation of what alternative living settings were considered by the person.

2.6. The individual's choices and preferences are honored and considered, if not always implemented. Choices may include: the family and friends involved in their 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.

2.7. The person's choices, based on the Medicaid Provider Manual as a medically necessary service, are implemented unless there is a

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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.

2.8. Every individual contributes to their community and has the ability to choose how supports and services enable them to meaningfully participate and contribute.

2.9. Through the PCP process, an individual maximizes independence, creates community connections, and works towards achieving their chosen outcomes.

2.10. An individual's cultural background is recognized and valued in the PCP process. Cultural background may include language, religion, values, beliefs, customs, dietary choices and other things chosen by the person. Linguistic needs, including American Sign Language interpretation, are also recognized, valued and accommodated.

2.11. Potential support and/or treatment options to meet the expressed needs of the person are identified and discussed with the person.

2.12. Screening tools (such as the CAFAS, PECFAS, LOCUS, SIS, etc.) should be used to inform the PCP process; however, these are not a substitute for the PCP process. Assessments and the PCP process must be used together as the basis for identifying goals, risks, and needs, authorizing services, and for utilization review and management. No assessment scale or tool should be utilized to set a dollar figure or budget that limits the PCP process.

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2.13. When a person is in an urgent/emergent situation, the goal is to stabilize the crisis. During the period of crisis, treatment may need to be delivered through a service and/or treatment planning process that differs from the person's original plan of service. Immediately following stabilization, the person and our agency will go back to the PCP process. Appropriate crisis services may begin before a full IPOS is formulated and will address immediate needs.

2.14. Through the PCP process, the individual receives complete and unbiased information on available services and supports, community resources, and options for provider self-determination, which are documented.

3. Essential Elements for Person-Centered Planning

3.1. These elements are essential for Person-Centered Planning (PCP):

3.1.1. 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.

3.1.2. Pre-planning: An individual will complete a pre-plan before the person-centered planning process that does not occur on the same day as the Individual Plan of Service (IPOS) is being created. The purpose of pre-planning is to gather all of the information and resources necessary for effective planning and set the agenda for the process. It is used any time the PCP process is used and includes (except for those individuals who receive short-term outpatient therapy only, medication only, or those who are incarcerated):

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3.1.2.1. When and where the meeting will be held,

3.1.2.2. Who will be invited,

3.1.2.2.1. Participation of Allies – Through the pre-planning process, the person selects allies (friends, family members, and others) to support them through the person-centered planning process. Pre-planning and planning help the person explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

3.1.2.3. What will be discussed and not discussed,

3.1.2.4. What accommodations the individual may need to meaningfully participate in the meeting,

3.1.2.5. Who will facilitate the meeting,

3.1.2.5.1. Independent facilitation: An individual may choose an independent facilitator to assist them in the planning process. The Right Door for Hope, Recovery and Wellness staff should provide assistance, support, and coordination to the individual to assure a positive person-centered planning experience. The Right Door for Hope, Recovery and Wellness staff should assist the external or independent facilitator in receiving adequate training in person centered philosophy and processes to facilitate a planning meeting.

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3.1.2.6. Who will record what is discussed at the meeting.

3.1.2.7. What format or tool will be used.

3.1.2.8. What waiver services are available to the person/family served.

3.2. Person-Centered: The planning process focuses on the individual, not the system or the individual's family, guardian, or friends. The IPOS is developed with active participation of the person served and family/legal guardian of the person served, when applicable and permitted. A consumer may decide to write up their own person-centered plan, however, it is the primary staff person who is responsible to assure the paperwork is completed.

3.2.1. Choices shall be communicated to the individual in a manner that is understandable.

3.2.2. The individual's strengths, needs, abilities, preferences, and goals are identified with an optimistic view of the future and plans for satisfying life.

3.2.3. To the extent possible, the individual shall be given the opportunity for experiencing the services, interventions, or modalities available prior to making a choice/decision.

3.2.4. A legal guardianship does not preclude a person's right to participate in person-centered planning.

3.2.5. For minor children, the concept of PCP is incorporated into a family-driven, youth-guided approach, and to the extent possible, promote

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the minor's relationship to the parent, guardian, or person in loco parentis, and shall not undermine the values that the parent, guardian, or person in loco parentis has sought to instill in the minor recipient. The needs of the child are interwoven with the needs of the family; 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 minor reaches adulthood, their needs and goals become primary. There are a few circumstances where the involvement of a minor's family may be not appropriate. Justification of the exclusion of anyone shall be documented in the clinical record.

3.2.5.1. A minor 14 years of age or older may request and receive mental health services and a mental health professional may provide mental health services, on an outpatient basis, excluding pregnancy termination referral services, inpatient psychiatric hospitalization, and the use of psychotropic drugs without the consent or knowledge of the minor's parent, guardian, or person in loco parentis within the restrictions stated in the Mental Health Code. Except as otherwise provided below, the minor's parent, guardian, or person in loco parentis shall not be informed of the services without the consent of the minor unless the mental health professional treating the minor determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to another individual, and if the minor is notified of the mental health professional's intent to inform the minor's parent, guardian, or person in loco parentis.

3.2.5.2. The minor is emancipated,

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3.2.5.3. The inclusion of the parent(s) or significant family member would constitute a substantial risk of physical or emotional harm to the minor recipient or substantial disruption of the planning process as stated in the Mental Health Code.

3.2.5.4. A minor under the age of 14 presents for issues related to Substance-Use Disorder.

3.2.6. Whenever possible, it is encouraged that primary care physicians/providers are involved in treatment planning and/or linking and referral follow up. This is ultimately up to the consumer. Medication use will be part of the treatment planning process if deemed an appropriate service and agreed upon by person served.

3.2.7. The PCP prevents the provision of unnecessary supports or inappropriate services and supports.

3.2.8. When CLS or Respite services will be a part of the person centered plan, assessment and planning must begin one month prior to the expiration of the current plan.

3.3. Outcomes-Based: The needs and desires of the person served are identified through goals that are expressed in the words of the person served, goals that are reflective of the informed choice of the person served or parent/guardian, and when necessary, clinical goals that are understandable to the person served. Services and supports are identified that enable the individual to achieve his or her goals and desires and any training needed for the providers of those services and supports. Goals are measurable, achievable and time specific.

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3.3.1. Specific service/treatment objectives:

3.3.1.1. Are reflective of the person's age, development, culture and ethnicity.

3.3.1.2. Are responsive to the person's disabilities/disorders or concerns.

3.3.1.3. Are understandable to the person served.

3.3.1.4. Are measurable, achievable and time specific.

3.3.1.5. Are appropriate to the service/treatment setting.

3.3.1.6. Are encouraging and promoting inclusion of consumers in the community. Consumers are encouraged to utilize their natural support systems. Staff shall promote that individuals use community services and participate in community activities.

3.3.2. Specific interventions, modalities, or services are identified in plan as well as their frequency.

3.3.2.1. The estimated/prospective cost of services and supports authorized must be in the plan.

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

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3.3.2.3. The person identified in the role of monitoring is separate from eligibility determination, assessment and service provision responsibilities.

3.3.2.4. The IPOS prevents the provision of unnecessary supports or inappropriate services and supports.

3.4. Wellness and Well-Being: The IPOS is prepared using the information from the assessment process. Concurrent disorders or disabilities and/or co-morbidities are specifically addressed in an integrated manner, if applicable. The IPOS is focused on integration and inclusion of the individual into the community, the family (when appropriate), natural support systems, and other needed services.

Every consumer must have a wellness goal in their IPOS as defined by board outcomes unless the consumer declines.

3.5. Reviewed. Individuals are provided with opportunities to provide feedback on how they feel about the support and/or services they are receiving and their progress toward attaining their goals. The planning process is used whenever the individual wants or needs it. Accommodations for varied communication needs will be made to maximize ability for expression.

3.5.1. The IPOS is reviewed at least every 90 days with the individual (and their guardian if applicable) to reflect current issues, maintain relevance, and modify goals, objectives, and interventions when necessary; and to maintain visitation plans and/or court orders, when applicable.

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3.5.2. Review occurs at least every 90 days to review progress toward goals and objectives and to assess the satisfaction of the individual.

3.6. Information, Support and Accommodations. A provider listing will be given to each individual at time of request for service and whenever requested after the initial request. Support and accommodations to assist the individual in participating in the planning process will be provided.

4. Indicators of Person-Centered Planning implementation

Individual indicators must include but not be limited to:

4.1. Evidence the individual was provided with information of their right to person-centered planning.

4.2. Evidence that the individual chose whether or not other persons should be involved and those identified were given the opportunity to be involved in the planning process/implementation of the IPOS.

4.3. Evidence that the individual chose the facilitator, places and times to meet, convenient to the individual and to the people they wanted present.

4.4. Evidence that the individual was informed of their right of choice in the selection of treatment or support services and staff/providers.

4.5. Evidence that the individual's preferences and choices were honored or a description of the dispute/appeal process including outcome.

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4.6. Evidence of the progress made toward the valued outcomes identified by the individual are reviewed and discussed for the purpose of modifying the strategies and techniques employed to achieve these outcomes.

4.7. Evidence of the specific services and supports to be provided, including the type, amount, scope, duration, frequency and cost.

4.7.1. For Children's Waiver Services, all recipients are required to be seen by the 15th of each month to ensure that services and support are being provided according to the individual plan of service.

4.8. Evidence that once an IPOS is developed, adequate Notice of Benefit Determination authorized will be provided to the person served.

4.9. Evidence that, at the request and consent of the consumer, the IPOS is discussed with family/friends/caregivers chosen by the person served to ensure they are aware of their role(s) within the consumer's IPOS.

4.10. Evidence that the individual has been provided the opportunity to develop a crisis plan.

4.11. Evidence that individuals are provided a copy of their IPOS within 15 business days after the planning meeting.

4.12. Evidence that the IPOS includes signatures of the person and/or representative, primary clinician, and the support broker/agent (if one is involved). This includes minor(s) receiving care without parental consent. See 3.2.5.1

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4.13. Evidence that the IPOS is formally reviewed and updated every six months and that the review includes evidence of the satisfaction of services and/or treatment and progress made towards achieving desired outcomes.

4.14. Evidence that the individual chooses who will participate in the planning process.

4.15. Evidence of the use of pre-planning and request for facilitator forms.

4.16. Evidence that external facilitators of the person-centered planning process have been offered to each individual.

4.17. Inability or unwillingness of the individual (i.e., person, parent of a minor, guardian) to participate in the development of the IPOS shall be documented in the clinical record.

4.18. The Right Door for Hope, Recovery and Wellness will monitor implementation of PCP principles through customer satisfaction surveys. The surveys will be reviewed as part of the quality assurance process.

4.19. For Home and Community Based Services compliance it is documented in the PCP:

4.19.1. the specific person or persons, and/or provider agency or other entity providing services and supports, and

4.19.2. non-paid supports, chosen by the person and agreed to by the unpaid provider.

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4.20. Evidence that the individual has been provided the opportunity to develop a psychiatric advanced directive.

5. Educating Persons Served on the Person-Centered Planning process

5.1. Every person servedwill receive the Mid-State Health Network "Guide to Services" booklet upon completing a financial review and agency orientation process.

5.2. The Right Door for Hope, Recovery and Wellness staff completing the financial review shall go over the "Guide to Services" with the individual and explain the contents.

5.3. If any further explanation is required, The Right Door for Hope, Recovery and Wellness staff person shall direct the individual to the appropriate person/organization for assistance.

5.4. The Right Door for Hope, Recovery and Wellness can provide additional information and support on the process through the primary clinician, customer services or peer support specialists.

6. Dispute Resolution

6.1. Individuals who have a dispute about the person-centered planning process or the IPOS that results from the process have rights to grievance, appeals and/or a recipient rights complaint.

6.1.1. The Right Door for Hope, Recovery and Wellness trains all staff at orientation on consumer grievance and appeals rights and provides trainings at various intervals as determined by agency need.

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6.1.2. The Right Door for Hope, Recovery and Wellness trains all staff in Recipient Rights prior to working with persons served and annually as required by the Mental Health Code.

6.2. Staff and contractors with The Right Door for Hope, Recovery and Wellness should be educated and prepared to help individuals understand and navigate the dispute resolution process(es).

7. Restrictions on a person's rights and freedoms must be documented in the IPOS:

7.1. Rights and Freedoms listed in the HCBS Final Rules are:

7.1.1. A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.

7.1.2. Sleeping or living units lockable by the person with only appropriate staff having keys.

7.1.3. Individuals sharing units have a choice of roommate in that setting.

7.1.4. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.]

7.1.5. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

7.1.6. Individuals are able to have visitors of their choosing at any time.

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

7.2.1. The specific and individualized assessed health or safety need.

7.2.2. The positive interventions and supports used prior to any modifications or additions to the IPOS regarding health or safety needs.

7.2.3. Documentation of less intrusive methods of meeting the needs that has been tried but was not successful.

7.2.4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.

7.2.5. A regular collection and review of data to measure the ongoing effectiveness of the modification.

7.2.6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7.2.7. Informed consent of the person to the proposed modification.

7.2.8. An assurance that the modification itself will not cause harm to the person.

8. Educating Staff on Person Centered Planning process

8.1. All Clinical staff, including contractual staff, shall receive trainings related to person-centered planning annually. New employees shall complete

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person-centered planning training within 90 days of hire, unless they are able to demonstrate person centered planning training within the past year either at the State or at another Community Mental Health Service Provider agency.

8.2. All administrative/non-clinical staff shall receive training related to person-centered planning annually.

8.3. All contracted providers and direct care staff must be trained on the IPOS by the appropriate professional (case manager, behavior specialist, OT/PT/SLP, etc) at the start of care. When changes to the IPOS occur, all appropriate providers must be informed by the appropriate professional within 15 days of the plan being implemented.

8.3.1. Training will be documented utilizing a sign-in sheet, progress note, or other hard copy format to prove compliance.

8.3.2. A physical copy of the IPOS will be available onsite where the place of service is occurring. When an update to the IPOS occurs, new training will occur and a new copy will be made available.

Reference:

MDHHS Contract Policy and Practice on Person-Centered Planning
CARF Standards Manual
Michigan Mental Health Code
Michigan Medicaid Provider Manual

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Kerry Possehn, Chief Executive Officer	Date		