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.

Last Revision Date: November 10, 2021

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 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 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.