PERSON-CENTERED PLANNING

REVISED PRACTICE GUIDELINE

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I. SUMMARY/BACKGROUND

The Michigan Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a person-centered planning process regardless of age, disability or residential setting. In the past, Medicaid or other regulatory standards have governed the process of plan development. These standards drove the planning process through requirements on the types of assessments to be completed and the professionals to be involved. Person-centered planning departs from this approach in that the individual directs the planning process with a focus on what he/she wants and needs. Professionally trained staff plays 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 Individual Plan of Service, including the identification of possible services and professionals, is based upon the expressed needs and desires of the individual. Health and safety needs are addressed in the Individual Plan of Service with supports listed to accommodate those needs.

The Michigan Department of Community Health (MDCH) has advocated and supported a family approach to service delivery for children and their families. This approach 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. The wants and needs of the child/family are considered in the development of the Individual Plan of Service**.**

Managed care strategies play an important role in planning for, and delivery of, supports, services and/or treatment. Person-centered planning complements these strategies. Both strategies intend to ensure that individuals are provided with the most appropriate services necessary to achieve the desired outcomes. When an individual expresses a choice or preference for a support, service and/or treatment for which an appropriate alternative of lesser cost exists, and compromise fails, a process for dispute resolution and appeal may be needed. This document provides guidelines for addressing disputes.

The literature describes specific methods for person-centered planning, including, but not limited to, individual service design, Personal Futures Planning, MAPS, Essential Lifestyle Planning, Planning Alternative Tomorrows With Hope, etc. This practice guideline does not support one model over another. It does, however, define the values, principals and essential elements of the person-centered planning process.

II. 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 individual.

A. Each individual has strengths, and the ability to express preferences and to make choices.

B. The individual's choices and preferences shall always be honored and considered, if not always granted.

C. Each individual has gifts and contributions to offer to the community, and has the ability to choose how supports, services and/or treatment may help them utilize their gifts and make contributions to community life.

D. Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals and desires.

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

III. PCP PRACTICE GUIDELINES

A. Essential Elements

1. Person-centered planning is a process in which the individual is provided with opportunities to reconvene any or all of the planning processes whenever he/she wants or needs.

2. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate in the planning meeting(s) to assist the individual with his/her dreams, goals and desires.

3. The development of natural supports shall be viewed as an equal responsibility of the CMHSP and the individual. The CMHSP, in partnership with the person, is expected to develop, initiate, strengthen, and maintain community connections and friendships through the person-centered process.

4. The individual is provided with the options of choosing external independent facilitation of his/her meeting(s), unless the individual is receiving short-term outpatient therapy only, medication only, or is incarcerated.

5. Before a person-centered planning meeting is initiated, a pre-planning meeting occurs. In pre-planning the individual chooses:

a. dreams, goals, desires and any topics about which he/she would like to talk
b. topics he/she does not want discussed at the meeting
c. who to invite
d. where and when the meeting will be held
e. who will facilitate
f. who will record

6. All potential support and/or treatment options (array of mental health services including Medicaid-Covered Services and Alternative Services and Mental Health Code-required services) to meet the expressed needs and desires of the individual are identified and discussed with the individual.

   a. Health and safety needs are identified in partnership with the individual. The plan coordinates and integrates services with primary health care.
   b. The individual is provided with the opportunity to develop a crisis plan.
   c. Each Individual Plan of Service must contain the date the service is to begin, the specified scope, duration, intensity and who will provide each authorized service.
   d. Alternative services are discussed.

7. The individual has ongoing opportunities to express his/her needs and desires, preferences**,** and to make choices. This includes:

   a. Accommodations for communication, with choices and options clearly explained, shall be made.
   b. To the extent possible, the individual shall be given the opportunity for experiencing the options available prior to making a choice/decision. This is particularly critical for individuals who have limited life experiences in the community with respect to housing, work and other domains.
   c. Individuals 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.
   d. Service delivery shall concentrate on the child as a member of a family, with the wants and needs of the child and family integral to the plan developed. Parents and family members of minors shall participate in the person-centered planning process unless:

      (1) 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;
      (2) The minor is emancipated; or
      (3) The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process as stated in the Mental Health Code. Justification of the exclusion of parents shall be documented in the clinical record.

8. Individuals are provided with ongoing opportunities to provide feedback on how they feel about the 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 individual's feedback.

9. Each individual is provided with a copy of his/her Individual Plan of Service within 15 business days after their meeting.

B. Illustrations of Individual Needs

Person-centered planning processes begin when the individual makes a request to the Community Mental Health Services Program (CMHSP). The first step is to find out from the individual the reason for his/her request for assistance. During this process, individual needs and valued outcomes are identified rather than requests for a specific type of service. Since person-centered planning is an individualized process, how the CMHSP proceeds will depend upon what the individual requests.

This guideline includes a chart of elements/strategies that can be used by the person representing the CMHSP, depending upon what the individual wants and needs. Three possible situations are:

1. <u>The individual expresses a need that would be considered urgent or emergent</u>.

   When an individual is in an urgent/emergent situation, the goal is to get the individual's crisis situation stabilized. Following stabilization, the individual and CMHSP will explore further needs for assistance and if required, proceed to a more in-depth planning process as outlined below. It is in this type of situation where an individual's opportunity to make choices may be limited.

2. <u>The individual expresses a need or makes a request for a support, service and/or treatment in a single life domain and/or of a short duration</u>.

   A life domain could be any of the following:
   a. Daily activities
   b. Social relationships
   c. Finances
   d. Work
   e. School
   f. Legal and safety
   g. Health
   h. Family relationships, etc.

3. <u>The individual expresses multiple needs that involve multiple life domains for support(s), service(s) or treatment of an extended duration</u>.

The following chart represents the elements/strategies that can be used depending on the kinds of needs expressed by the individual.

ELEMENTS/STRATEGIES	***URGENT/ EMERGENT***	***SHORT DURATION***	***EXTENDED DURATION***
The individual expresses his/her needs and/or desires. Accommodations for communication will be made to maximize his/her ability for expression.	X	X	X
The individual's preferences, choices and abilities are respected.	X	X	X
Potential issues of health and safety are explored and discussed. Supports to address health and safety needs are included in the Individual Plan of Service.	X	X	X
As a result of health or safety concerns or court-ordered treatment, limitations may exist for individual choice. However, opportunities for individuals to express their perceived needs can occur and opportunities to make choices among limited options can be given.	X	X	X
Person-centered planning includes pre-planning activities. These activities result in the determination of whether in-depth treatment or support planning is necessary, and if so, to determine and identify the persons and information that need to be assembled for successful planning to take place.		X	X

ELEMENTS/STRATEGIES	*URGENT/ EMERGENT*	*SHORT DURATION*	*EXTENDED DURATION*
In short-term/outpatient service areas, the individual is provided with information on person-centered planning, including pre-planning at or before the initial visit. Individuals are encouraged to invite persons to the session where the plan is developed.		X	
In collaboration with the CMHSP, the individual identifies strategies and supports, services and/or treatment needed to achieve desired outcomes.		X	X
Exploration of the potential resources for supports and services to be included in the individual's plan are to be considered in this order: The individual. Family, friends, guardian, and significant others. Resources in the neighborhood and community. Publicly-funded supports and services available for all citizens. Publicly-funded supports and services provided under the auspices of the Department of Community Health and Community Mental Health Services Programs.		X	X
Regular opportunities for individuals to provide feedback are available. Information is collected and changes are made in response to the individual's feedback.		X	X

ELEMENTS/STRATEGIES	*URGENT/ EMERGENT*	*SHORT DURATION*	*EXTENDED DURATION*
The individual's support network is explored with that person to determine who can best help him/her plan. The individual and the persons he/she selects together define the individual's desired future, and develop a plan for achieving desired outcomes. For any individual with dementia or other organic impairments, this should include the identification of spouses or other primary care givers who are likely to be involved in treatment or support plan implementation.			X
The process continues during the planning meeting(s) where the individual and others he/she has selected who know him/her well talk about the desired future and outcomes concentrating on the life domains previously identified as needing change.			X

IV. ASSURANCES AND INDICATORS OF PERSON-CENTERED PLANNING IMPLEMENTATION

It is the responsibility of the CMHSP to assure that the Individual Plan of Service is developed utilizing a person-centered planning process. Below are examples of systemic and individual level indicators that would demonstrate that person-centered planning has occurred. The methods of gathering information or evidence may vary, and include the review of administrative documents, clinical policy and guidelines, case record review and interviews/focus groups with individuals and their families.

A. Systemic indicators would include, but not be limited to:

1. The CMHSP has a policy or practice guideline that delineates how person-centered planning will be implemented.

2. Evidence that the CMHSP informs individuals of their right to person-centered planning and associated appeal mechanisms, investigates complaints in this area, and documents outcomes.

3. Evidence that the CMHSP's quality improvement system actively seeks feedback from individuals receiving services, support and/or treatment regarding their satisfaction, providing opportunities to express needs and preferences and the ability to make choices.

4. The CMHSP's staff development plan includes efforts to ensure that staff involved in managing, planning and delivering support and/or treatment services are trained in the philosophy and methods of person-centered planning.

B. Individual indicators could include, but not be limited to:

1. Evidence the individual was provided with information of his/her right to person-centered planning.

2. Evidence that the individual chose whether or not other persons should be involved, and those identified were involved in the planning process and in the implementation of the Individual Plan of Service.

3. Evidence that the individual chose the places and times to meet, convenient to the individual and to the persons he/she wanted present.

4. Evidence that the individual had choice in the selection of treatment or support services and staff.

5. Evidence that the individual's preferences and choices were considered, or a description of the dispute/appeal process and the resulting outcome.

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

V. DISPUTE RESOLUTION/APPEAL MECHANISMS

VI. DEFINITIONS

Case Manager/Supports Coordinator - The staff person who works with the individual to gain access to and coordinate the services, supports and/or treatment that the individual wants or needs.

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 when the individual can reasonably be expected, in the near future, to physically injure himself, herself, or another person; is unable to attend to food, clothing, shelter or basic physical activities that may lead to future harm, or the individual's judgment is impaired leading to the inability to understand the need for treatment resulting in physical harm to self or others.

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

Guardian - A person appointed by the court to exercise specific powers over an individual who is a minor, legally incapacitated, or has developmental disabilities.

Individual Plan of Service - A written Individualized Plan of Service directed by the individual as required by the Mental Health Code. This may be referred to as a treatment plan or a support plan.
Minor - An individual 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 honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Urgent Situation - A situation in which an individual is determined to be at risk of experiencing an emergency situation in the near future if he or she does not receive care, treatment or support services.

VII. LEGAL REFERENCES:

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Refer to the Technical Requirement