	Person-Centered Planning		
Chapter:	Board Service and Program Administration	**Policy #**	2-2-6
Section:	Assessment, Service Planning and Documentation	**Revision #**	5

I. PURPOSE: To establish policy and procedures for ensuring that the person-centered planning process is used to develop the Individual Person-Centered Plan of Service (IPOS) for all persons regardless of age, disability or residential setting.

II. APPLICATION: All mental health service providers involved in direct care operated by or contracting with the West Michigan Community Mental Health Governing Body.

III. REQUIRED BY: ACT 258, Public Acts of 1974 – The Michigan Mental Health Code section 330.1712, Michigan Department of Health and Human Services (MDHHS) Contracts; Prepaid Inpatient Health Plan (PIHP) Contract; Centers for Medicare and Medicaid Services, 42 CFR Part 430.

IV. DEFINITIONS:

Advanced Directives: An advanced directive allows the person to have a pre-assigned advocate designated to exercise power regarding his/her mental health treatment decisions and allow the individual to include in their support plan regarding their desires on mental health treatment. This includes executing an application for formal voluntary hospitalization. (This is according to Senate Bill 1464-1472, which amends the Michigan Mental Health Code 2004.)

Clinical Service Planner: A professional staff member of West Michigan Community Mental Health who has the primary responsibility, together with the consumer, for care planning, advocacy, coordination, and monitoring. The CSP, along with the team-based case holder, is responsible for consumer's access to needed health and dental services, financial assistance, housing, employment, education, social services, mental health services, habilitation, employment, preferences and other services and natural supports developed through the person-centered planning process.

Emancipated Minor: A minor child who has filed a petition with the probate court that terminates the parents' right to custody, services, and earnings of the child.

Emergency Situation: Situation when the individual can be reasonably expected, in the near future, to physically injure themselves or another person; unable to provide protection for self or others they are responsible for by not being able to attend to food, clothing, shelter or basic activities that may lead to future harm or, to have impaired judgment leading to the inability to understand the need for care.

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

Guardian: A person appointed by the court to exercise specific powers over an individual who is a minor, legally incapacitated or developmentally disabled.

Home and Community Based Services: Medicaid HCBS Waiver Program allows a State Medicaid Agency to meet the needs of people who prefer to get long term care, services, and supports in their home or community, rather than in an institutional setting. The Program requires that HCB services follow an individualized and person-centered plan of care.

Home and Community Based Services Final Rule: The HCBS Final Rule establishes new federal requirements for different Medicaid authorities that allow States to provide home and community-based long-term services and supports to eligible persons. The rule requires Medicaid Home and Community-Based Services (HCBS) Waiver Programs to ensure that waiver participants have full access to benefits of community living and opportunity to receive services in the most integrated settings.

Individual Plan of Service: The IPOS includes a treatment plan and a support plan, or both. The treatment plan sets measurable goals with the recipient, and the IPOS must identify services, supports, and treatment as desired or required by the patient. The IPOS also includes the expected start date for authorized services, and the amount, scope, and duration of each service. The beneficiary must receive a copy of their IPOS within 14 days.

Minor: An individual under the age of 18 years old.

Older Adult: An individual 60 years of age or older.

Person-Centered Planning (PCP): PCP is 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, needs, strengths, values, and abilities. The person-centered plan is a comprehensive, shared decision-making process that is self-directed whenever possible, including the individual as an active participant as well as families, friends and professionals as the individual desires or requires. The PCP is based on the assessment of the Individual's needs in regard to life domains. The PCP guides the clinician and Individual through the individual's recovery/ care process. The PCP integrates prevention, medical and behavioral health care needs in a collaborative process. The PCP is developed with the individual, and with consent families and other supports, keeping in mind any specific cultural needs as well, such as needs specific to Veterans, older adults, and other specific populations served by the agency.

SUD: Acronym for Substance Use Disorder.

Support Plans: A Support Plan is a living document. This should begin at the beginning of treatment and continue while a person is in treatment. A Support Plan is a very important part of the recovery process. It assists the individual with planning for needs during a crisis. Having a Support Plan assists the person in recognizing symptoms of their illness and can lessen the effects of a mental health emergency. A Support Plan also helps the individual and others around them recognize when the symptoms of the illness are worsening. It provides coping techniques that one can use to lessen the effects of an increase in their symptoms.

Urgent Situation: A time when an individual is determined to be at risk of experiencing an emergency, in the near future, if they do not receive care and/or support services.

Veteran: An individual that has served in the active military, naval or air service.

V. POLICY: It is the policy of West Michigan Community Mental Health that all persons receiving services will have their Individual Plan of Service developed, and service delivered in partnership with WMCMH providers using the person-centered planning approach, and in the case of minors, the child/family will be the focus of service/support planning.

VI. PROCEDURES:

A. The person-centered planning process begins at the first contact with the agency and continues as the person moves into receiving services. The IPOS is based upon the assessed needs and desired changes as identified in the assessment process.

1. At the initial IPOS meeting, and thereafter no less than every 364 days (annually), the Clinical Service Planner and/or case holder shall explain/review the principles of person-centered planning and provide written information on the process. The clinician responsible will document the preliminary planning process in the electronic health record (EHR). On an ongoing basis, and during the course of service planning, the responsible case holder shall assure the following:

   a. The individual seeking services will be given the opportunity/encouraged to express their need or desired outcomes, including:

      - A need for accommodations for communication, if needed, to maximize their ability to express themselves.
      - The identification of outcomes of value to the individual.
      - A statement of the individual's expectations of the service delivery system.

   b. Identification and discussion of potential support/care options to meet the needs of the individual.

   c. The individual is given an ongoing opportunity to express his/her preferences and make choices. In order for this to happen, the responsible case holder shall:
      - Assure choices and options are clearly explained.
      - To the extent practicable, give the individual the opportunity to experience options before having him/her make a decision about a choice. This is particularly critical for those with limited life experience in community work or independent living.
      - Individuals, with court appointed legal guardians, participate in person-centered planning where their preferences, needs, values, strengths and abilities are used in the plan development.
      - The CMHSP, or service provider under contract with the CMHSP, ensures a person served is given a choice of physician and/or mental health professional within the limits of available staff.

- When the person served is a child or adolescent, the person-centered planning process is a family/caregiver, youth guided, and developmentally appropriate approach that addresses home, school, medical concerns, behavioral health, SUD, psychosocial and relationship issues. When the person is an older adult, the person-centered planning process is guided by the individual and supports the intentions of the older adult that addresses mental status, links to community resources, improved ability to live in the community or least restrictive setting possible and other psychosocial or relationship issues.
- When the person served is a Veteran, the person-centered planning process is guided by the individual and supports the expanded principles of VHA recovery of privacy, security and honor, attentive to the Veteran's values and preferences, is evidence-based, and supports the intentions of the Veteran that addresses mental health status, linkages to Veteran-specific community resources, home, medical concerns, behavioral health, SUD, psychosocial and relationship issues.

Parents and significant family members of minors participate in the planning process unless:

- The minor is fourteen years of age, or older, and has requested services without the knowledge of their parent, guardian, or person in loco parentis within the restrictions stated in the Mental Health Code, 330.1707, Rights of Minor or
- The minor is emancipated, or
- The person chosen or required by any recipient may be excluded from participation in the planning process only if inclusion 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 for an individual's exclusion shall be documented in the clinical record.
- The minor is participating in Outpatient SUD Treatment Services and wishes to not inform any parent/guardian of his/her participation in the SUD services. Please note, Substance Treatment regulations have no limit on the number of sessions of SUD treatment a minor can receive without informing parents (i.e., they could begin and complete treatment without ever having to inform parents at all).

d. Individuals are encouraged to provide feedback during review of the plans and at any time they want to express their feelings regarding the service, support, or treatment they are receiving and their progress toward attaining their valued outcomes.

e. An individual (recipient) shall be informed verbally and in writing of his or her clinical status and progress at reasonable intervals established in the individual plan of service in a manner appropriate to his or her clinical condition.

f. In preparation for the PCP process, the Access clinician and/or case holder will engage individuals in pre-planning. Pre-planning encourages the individual(s) to identify whether in-depth treatment or support planning is necessary and if so, to determine and identify the people and information that need to be assembled for successful planning to take place. This will also include designation of time and place for such planning that is convenient and accessible to the individual.

g. The Access clinician and/or case holder, as part of informing the individual regarding the person-centered planning process, will ensure that the individual is aware that they can meet their person-centered planning "team" as often as needed/desired to accomplish desired changes/outcomes.

h. The Access clinician and/or case holder, as part of informing the individual regarding the person-centered planning process, will ensure that the individual is aware that they can choose a PCP independent facilitator who is not an employee of CMH. Please note: This does not apply to individuals enrolled in Mild/Moderate Therapy or Substance Use Disorder services.

i. Person Centered Planning includes the following components:
   (1) Goals that are expressed in the words of the individual
   (2) When necessary, clinical goals that are understandable to the individual.
   (3) Goals that are reflective of the informed choice of the individual.
   (4) Specific service or treatment objectives that are reflective of the individual, service team, age of the individual, developmental status, and culture and ethnicity.
   (5) Service and treatment objectives that reflect the individual's disabilities/disorders and concerns.
   (6) Objectives that are measurable, achievable, time specific, and appropriate to the service/treatment setting.
   (7) Identify specific interventions, modalities, and /or services to be used.
   (8) Frequency of specific interventions, modalities, or services.
   (9) Any needs beyond the scope of CMH
   (10) Referrals to additional internal services (based on psychosocial assessment, this may include trauma informed care, OT, dietary, nursing, or other needed ancillary services).
   (11) Link to community services and resources
   (12) Available supports and care when the individual is discharged from CMH services.

j. In an effort to ensure that the individual is fully informed throughout the person-centered planning process, the Clinical Service Planner and/or case holder will ensure that the individual receives a copy of their IPOS within 15 business days from the IPOS meeting date for review and signature acknowledging informed consent/endorsement. If the individual is not satisfied with his/her IPOS, the individual or his/her guardian or parent of a minor may make a request for informal conflict resolution to the care manager in charge of implementing the plan. The review shall be completed within 10 days and carried out in a manner approved by West Michigan Community Mental Health.

k. Any restriction or limitations of the person's rights shall be justified, time-limited, and clearly documented in the plan of service. Documentation shall be included that describes attempts that have been made to avoid such restrictions as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future.

B. Specific Requirements for Planning for Consumers Participating in Home and Community Based Services Waiver:

1. For consumer participating in Home and Community Based Waiver Services, the person-centered planning process must adhere to the HCBS Final Rules in the following ways:

a. Individuals are provided with the opportunity to invite all staff who support them and are part of the implementation of the plan (including CLS, Skill Building, Supported Employment, and other clinical staff).

b. Individuals are offered meaningful community-based activities that align with their interests no less than twice weekly and these activities/outings are documented and reviewed by the case holder for HCBS compliance.

c. It is ensured that the planning process is in compliance with pertinent conflict-free access and planning implementation requirements and timelines.

d. It is ensured that employment-related goals are included in the IPOS, per consumer preference.

e. It is ensured that providers who are responsible for implementation of the plan are trained on the IPOS prior to implementation/start date of the IPOS.

2. The PCP meeting includes discussion regarding movement toward less restrictive residential living arrangements and exploration of the full array of setting options (including non-disability specific settings). Outcomes of these discussions are documented in the IPOS in this way:

a. In the Initial IPOS:
- list of the setting by name that were explored/discussed/offered.
- efforts by the individual/guardian to choose the setting.
- confirmation that the setting was chosen by the individual.

b. In subsequent IPOS reviews/updates:
- Discussion/confirmation that the individual continues to choose the setting.
- The status of the consumer's skill development that allows movement to a less restrictive setting whenever possible.

c. When modifications or restrictions are imposed upon an individual's rights and freedoms, they are individualized and justified in the IPOS and are to include the following:
   - The identification of the specific and individualized assessed need.
   - The positive interventions and supports used prior to any modification.
   - The less intrusive methods that were tried and did not work, including how and why they did not work.
   - A clear description of the condition that is directly proportionate to the assessed need.
   - The regular collection and review of data to measure the effectiveness of the modification.
   - The established time limits for periodic review to determine if the modification is still necessary or can be terminated; including a fully detailed plan that identifies movement from most restrictive to least restrictive interventions and identification of the services and supports that will be provided to support the development of skill to reduce the need for the modification.
   - The informed consent of the person served; and
   - The assurance that interventions and supports will cause no harm to the person served.

C. **Support Plans**:

A support plan is written with the person and is reviewed and updated on a regular basis as needs change. A support plan assists the person and their supports in recognizing symptoms of their mental illness, potential risk for self-harming behavior and/or substance use disorder and can often lessen the effects of a behavioral health emergency. The support plan helps by proactively identifying what to do in a crisis situation, who to contact and helps define a crisis situation (triggers, warning signs, preferred interventions and advance directives when available). The person should have a copy of this plan so they can use it when needed. A copy of the most recent support plan is located in the EHR. The person may opt out of doing a support plan; however, completing a support plan is encouraged and is revisited whenever the person-centered plan is revised/updated.

D. **Advanced Directive for Mental Health Care**:

Written information is provided to a legally competent adult person with respect to advanced directives at the beginning of services and at least annually. This includes a description of the law, information on the person's right to make decisions concerning their mental health care, including their right to accept or refuse treatment and the right to formulate advance directives. (CR#160). The information provided will reflect any changes in State law as soon as possible, but not later than 90 days after the effective date of the change.

a. If a person has executed an advanced directive, this will be part of the EHR.

b. There will be no discrimination whether or not an advance directive was written.

c. Advanced directives will comply with requirements of state law.

E. **Dispute Resolution/Appeal Mechanisms**: (This section does not apply to individuals in the mild-to-moderate levels of care)

1. If an individual requests inpatient care, or a specific mental health support/service for which an appropriate alternative exists that is of equal or greater effectiveness, and equal or lower cost, the agent representing West Michigan Community Mental Health should:

   a. Identify and discuss the underlying reasons for the request/preference;

   b. Identify and discuss alternatives with the individual;

   c. Negotiate toward a mutually acceptable support, service and/or care;

   d. Provide Adequate Notice indicating the reason why the service was denied; and

   e. If doing the PAS for inpatient, then the PAS document will clearly document alternatives available to the person as well as what the person agreed to.

2. If the preadmission screening unit denies hospitalization, the CSS (Crisis Stabilization Services) or team-based clinician will:

   a. Document, on the appropriate Adequate or Advance Notice Form (CR052), the support/service and/or care that the West Michigan Community Mental Health is offering,

   b. Inform the individual of their right to a second opinion of the inpatient hospitalization denial if the individual is not in agreement with the services offered by WMCMH. Depending on the person's Medicaid status, this would include:

      (1) Non-Medicaid: their right to contact the Customer Service Department for consultation, mediation or intervention in response to their request for a specific mental health support /service;
      (2) Medicaid: their right to request a second opinion as referenced in the Mental Health Code, if requesting inpatient care;
         a. The Executive Director arranges the second opinion to be performed within 3 days; excluding Sunday and holidays.
         b. The Executive Director, in conjunction with the Medical Director, reviews the second opinion if it differs from the opinion of the preadmission screening unit.
         c. The Executive Director's decision to uphold or reject the findings of the second opinion is confirmed in writing to the requestor; the documentation contains the signatures of the Executive Director

and Medical Director or verification that the decision was made in conjunction with the Medical Director.

(3) Their right to the Local Appeals Process and/or their right to a Fair Hearing or MDHHS Level Dispute Resolution Process.

3. If, in the judgment of the responsible clinician, an individual's choice/preference for the inclusion/exclusion of a planning participant, meeting location, or specific provider, poses an issue of health or safety, or exceeds reasonable expectations of resource consumption, the agent should discuss and identify the individual's underlying reason for that specific choice/preference and negotiate toward a mutually acceptable alternative that meets the outcomes intended.

4. If an individual is not satisfied with their IPOS, they are provided the appropriate notice as outlined in the Grievance & Appeals policy, 2-6-5.

5. If the individual believes that the person-centered planning process was not provided as specified in the manner above, it is the responsibility of West Michigan Community Mental Health staff to inform the individual of his/her right to consult with the Recipient Rights Office.

6. When there is a disagreement between an individual and the legal guardian or responsible parent, West Michigan Community Mental Health staff should attempt to mediate between the two parties, in order to provide an outcome that is acceptable to both parties.

F. **Staff Training**

1. Person-Centered Planning Training:

   a. West Michigan Community Mental Health employees and contract providers who coordinate services and/or provide direct care to individuals will receive training within 90 days of hire and at least annually thereafter from the responsible case holder or responsible licensed independent professional (LIP). Proof of the training will be documented in the agent's personnel file.

   b. All staff who work with enrollees of the Habilitation Supports Waiver (HSW), Severe Emotional Disorder (SED) Waiver and Children's Waiver (CWP) must be trained in the individual's current IPOS. This training must be documented and performed by professional staff operating within their scope of practice.

   c. Persons who receive services from West Michigan Community Mental Health receive ongoing education regarding the PCP process throughout their recovery process. In addition, Individuals are provided with written material prior to completion of their person-centered plan (the information is provided via the "Your Rights" and "Person Centered Planning" pamphlets) and a verbal explanation of person-centered planning at the time the initial plan is written. Verbal explanations will occur thereafter, at a minimum, at review/ update of the plan. Written materials are at initial contact and on a periodic basis as needed.

2. Staff at hire participate in Advanced Directive Training. Education to the community and service providers is as needed.

G. **Monitoring and Evaluation**:

1. Clinical documents are routinely reviewed for compliance with person-centered planning as part of the concurrent review by the Clinical Coordinator or related Chief Officer. This process is outlined in the Utilization Management Process. Results of the concurrent review are utilized for individual and program performance improvement activities.

2. On an annual basis, WMCMH provides persons with the opportunity to complete a satisfaction survey. In addition, annually WMCMH administers two satisfaction surveys developed and mandated by the State, programs to be surveyed are also identified by the State. The survey evaluates the person's overall satisfaction with services provided. The data from the MHSIP is reviewed by the QI Steering Committee.

VII. SUPPORTING DOCUMENTS:

Appendix 2-2-6A: Advanced Directive

Please Reference:
Policy 2-6-5: Grievance and Appeal Resolution
Support Plans (see policy 2-2-1)
WMCMH Form #160 Advance Directive Acknowledgement
Intake Paperwork Packets – Initial and Annual CR Form #CD106

VIII. POLICY/PROCEDURES REVIEW:

REV#	APPROVED BY	Policy/Procedure	DATE
			03/2010
			11/2011
			07/2012
			07/2014
			09/2015
			02/2017
			09/2018
			01/2019
2	COC	Procedure	05/2021
3	COC	Procedure	03/2022
3	COC	Annual Review	02/2023
3	COC	Annual Review	02/2024
4	COC	Procedure	06/2024
5	COC	Procedure	3/2025
***Board Approval Date**: 02/16/1999*			

IX. **CHIEF EXECUTIVE OFFICER ENDORSEMENT**:

I have reviewed and approve of policy # 2-2-6 Revision # 5.

CEO: Julia Rupp **Approval Signature: _____**

Appendix 2-2-6A

PSYCHIATRIC ADVANCED DIRECTIVES

Beginning January 3, 2005, a new law went into effect called Psychiatric Advanced Directives. Advanced Directives allow everyone to have the right to make decisions about his or her own health, including the right to choose and/or decline medical and psychiatric treatment. This right cannot be lost later when a person is unable to make a decision for themselves. To be sure your rights are not lost, you can write an "advanced directive" that names another person to direct your treatment when there is a time you cannot direct the treatment and decisions yourself. The advance directive is a way to protect your rights. Here are a few key points to help you understand what an advanced directive is:

- An Advanced Directive is a legal document in which a person can state his or her preference regarding mental health care before a mental health crisis happens.
- You can name a Patient Advocate to make mental health care decisions for you some time in the future if you are not able to make your own decisions.
- An Advanced Directive can be canceled by you at any time.
- An Advanced Directive does not require a specific form or an attorney to fill one out with you.
- It is a great way to be an advocate for yourself.
- You can plan now for a future time when you may be unable to advocate for yourself or make decisions about mental health care. In other words, your choices are made in the present but acted on in the future.
- The right to make health care decisions must be returned to the person as soon as their ability to make such decisions has returned.
- You can choose a person you trust to speak for you. Mental Health workers and professionals must listen to this choice.

Everyone is encouraged to learn more about advanced directives and making decisions about treatment and mental health care.