PERSON/FAMILY CENTERED PLANNING OVERVIEW

VBCMH TRAINING – FY25

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Why Person/Family Centered Planning?

- Research has shown that if a person/family is involved in their services, they are more motivated to succeed.
- People/families want more control over their lives in general and this is the case in behavioral/mental health as well.
- It's state law through the Mental Health Code.
- It's federal law through the Home and Community Based Service Final Rule and Medicaid Managed Care rules.
- It's required by the Michigan Department of Health and Human Services (MDHHS).
  - MDHHS has over 40 standards related to person/family centered planning.

What is Person-Centered Planning?

- It's a philosophy. Best practice guidelines have been established with state requirements, but generally person-centered planning is individualized per person.
- It's a process in helping the person think about and obtain what they want to achieve in their life – not just about what program they fit into.
- It's developed and centered around the person and built upon the person's abilities.

    - It is NOT about putting a person in a program – but using creativity and being flexible.
    - It is NOT telling the person what needs to occur but listening to what they think might work.
    - It is NOT about assessing weaknesses or barriers but building on abilities to get past weaknesses or barriers.
    - It does NOT mean the person is entitled to receive anything they want.

What is Person-Centered Planning?

- A process for planning and supporting the individual receiving services that builds upon their capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities.
  - It involves families, friends, and professionals as the individual desires or requires MHC 330.1700(g).
- A PCP process is used to develop a written individual plan of services (IPOS) in partnership with the individual.
- A preliminary plan shall be developed within 7 days of the commencement of services or, if hospitalized for less than 7 days, before discharge or release.
- An IPOS shall establish meaningful and measurable goals and objectives with the individual.
- The IPOS shall address at minimum, as either desired or required by the individual, their need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation.
- The IPOS shall be kept current and shall be amended, as necessary.

Family-Driven/Youth Guided Planning

- "Family" is defined by the individual/guardian (i.e. parents, caregivers, natural supports, etc.).
- Is a process in helping the family think about and obtain what they want as a family unit.
- Is developed and centered around not only the "identified child", but the most important aspect of that child's life – their family.
- Leads to goals and objectives that include the family and not just the "identified child."
- Built upon the family's abilities.
- As child ages, services should become more youth-guided, especially during transition into adulthood.

  - It is NOT about enrolling a family in a program – but using creativity and being flexible.
  - It is NOT telling the family what needs to occur but listening to what they think might work and making recommendations accordingly.
  - It is NOT about assessing weaknesses or barriers but building upon the family's strengths to overcome weaknesses or barriers.
  - It does NOT mean the family is entitled to receive anything they want.

Family-Driven/Youth Guided Planning

- There are a few circumstances where involvement of a minor's family may not be appropriate:
  - 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 Mental Health Code.
  - The minor is emancipated.
  - 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 (Documented in the clinical record).

Differences Between Traditional Processes and Person/Family Centered Planning

Traditional Model

Identify: Deficits
Disorders
Problems

Obtain information about the person through formal Assessment and Standardized Tests

Provide clinical services in specialized treatment centers to resolve identified problems

Assemble professional, interdisciplinary treatment team to make decisions

Person/Family Centered Planning

Focus on: Abilities
Dreams
Aspirations

Invest in knowledge about the person from family, friends, and the individual

Provide individual supports to assist the person in the community and centered around the person and their hopes, wishes, and preferences

Teach the individual, family, and friends to take the lead in making decisions

Values and Principles of Person/Family Centered Planning

Each person/family is unique. Every individual is presumed competent to direct the planning process, achieve their goals and outcomes, and build a meaningful life in the community.

Focus on the person's life goals, interests, desires, choices strengths and abilities as the foundation for the PCP process.

Every individual has strengths, can express preferences, and make choices. The PCP approach identifies and uses the individual's strengths, goals, choices, medical and support needs, and desired outcomes as strategies or interventions to support their success.

The individual's/family's choices and preferences are honored.

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 their choices or preferences over time.

Values and Principles of Person/Family Centered Planning

Individuals contribute to their community and have the right to choose how supports and services enable them to meaningfully participate and contribute to their community.

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

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.

Essential Elements of Person/Family Centered Planning Process

- **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.

- **Person-Centered –** Focus on the individual, not the system or their family, guardian, or friends. Their goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. Occurs as needed, not just an annual event.

- **Outcome-Based -** The individual identifies outcomes based on their life goals, interests, strengths, abilities, desires and choices. The primary clinician assists with making a plan to select medically necessary services and supports needed to align the individual for success in achieving their desired outcomes.

- **Information, Support, and Accommodations –** Individuals receive complete, unbiased information on services and supports available, community resources, and options for providers (documented in the IPOS) in an easy-to-understand format. Accommodations and support to assist them to participate in the process are provided as needed.

Essential Elements of Person/Family Centered Planning Process

- **Independent Facilitation** – Individuals have the information and support to choose an independent facilitator to assist them in the planning process.

- **Pre-Planning** –Required process to gather information and resources necessary for effective PCP and set the agenda for the PCP process. The Pre-Plan includes the following items:
  - NOTE: The Pre-planning meeting should not occur on the same day of the Planning meeting unless the customer determines foregoing as part of the person/family centered planning process (and must be noted in the record).
  - When and where the individual would like the meeting to be held.
  - Who will be invited, including allies, potential conflicts of interest, or disagreements that may arise.
    - Through the pre-planning process, the individual selects allies (friends, family members, and others) to support them through the PCP process. Pre-planning and planning help the individual explore who is currently in their life and what needs to be done to cultivate and strengthen desired relationships.
    - Plan for how to deal with those conflicts/disagreements and determine what will be discussed and not discussed.

Essential Elements of Person/Family Centered Planning Process

- **Pre-Planning Continued**
  - The specific PCP format or tool chosen by the individual to be used for PCP.
  - What accommodations the individual may need to meaningfully participate (including assistance for individuals who use behavior as communication).
  - Who will facilitate the meeting.
  - Who will take notes about what is discussed at the meeting.

- **Wellness and Well-Being** - Issues of wellness, well-being, health, and primary care coordination, support needed for the individual to live the way they want to live are discussed. Plans to address the aforementioned are developed (e.g., healthy diet, exercise, finding a doctor, immunizations).
  - 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).

HCBS Final Rule and IPOS Documentation

- A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.
  - Primary clinicians should be involved in the resident care agreement process annually and a copy should be scanned into the EMR.
- Individuals will have full unfettered access to all common areas of the contracted provider settings they live in and if any modifications are made to the setting it is consistent with HCBS final rule
- Sleeping/living units are lockable by the individual, only appropriate staff have keys.
- Individuals are made aware of the choice of roommate if sharing a unit, discussion is held about where they live and regarding movement toward a lesser restrictive residential living arrangement and that the full array of setting options is explored including non-disability specific settings
  - The primary clinician must document the setting options given by name in the IPOS.

HCBS Final Rule and IPOS Documentation

- Individuals have freedom to furnish and decorate their sleeping/living units, have access to food and can have visitors at any time.
- Individual has support to control their own schedules and activities.
  - The IPOS must include the meaningful community-based activities that align with the individual's interests no less than twice weekly, and that these outings are thoroughly documented and reviewed by the primary VBCMH CM/Clinician for compliance.
    - A run to the store, fast food, and doctor's appointments are not considered a meaningful community activity. Going to the library (if the person wants to do that) or to a museum, fishing or ice skating are all examples of a meaningful community outing.

Person/Family Centered Plan
Reminder Points

- A person/family centered plan must be completed prior to providing services, other than assessment or crisis services.
- The person/family centered plan must be signed within 7 calendar days of the IPOS effective date and a copy offered to the individual/guardian within 15 days of completion of the plan.
- The individual and the guardian (if applicable) must sign and date the IPOS acknowledging their agreement.
- All documentation for services, including the IPOS and assessment, must be signed and dated by the person providing the services.
- Whether the person/family accepts or declines a copy of the plan it must be documented in the Update Copy Given to link in the EMR.

Person/Family Centered Plan **Reminder Points**

- A person/family centered plan must be reviewed in accordance with the frequency listed in the IPOS.
- A person/family centered plan must be amended before changing services or supports.
- Person/family centered planning must indicate that there is a crisis plan in place or evidence that having a crisis plan was offered and declined.
- It is very important to document both the service options discussed with the person/family as well as provider options for the selected services (this is an HCBS Final Rule).
  - In instances where the requested services by the person/guardian are viewed to be harmful, detrimental, unethical, dangerous, ineffective, not medically necessary, or not a provided benefit to the person/family, those services will not be authorized. The assigned service provider will explain why the requested services cannot be provided and both verbal and written information will be provided to the person/guardian regarding Recipient Rights and the Appeals and Grievance process.
- A person/family can request a new IPOS planning meeting at any time.

Further Education and Information

SWMBH provides periodic training on PCP and models to conduct PCP.

MDHHS Person-Centered Planning resources can be found at: *https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/person-centered-planning*