Person Centered Planning (PCP)

Home and Community Based Services Final Rule (HCBS)

Self Directed Services (SDS)

Annual and New Hire Training 2025

Clinical Management Team

Person Centered Planning (PCP)

The MDHHS/CMHSP Contract defines PCP as:

A way for people to plan their lives in their communities, set the goals that they want to achieve, and develop a plan for how to accomplish them.

The process used to plan the life that the person aspires to have.

Incorporating the persons goals, hopes, strengths, and preferences.

PCP is the required approach for mental health and I-DD services provided by the CMHSP system

When is the PCP process Used?

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 I/DD services provided by the CMHSP system, PCP can include planning for other public supports and privately-funded services chosen by the person.

PCP for Children and Families

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 person reaches adulthood, his or her needs and goals become primary

PCP and HCBS Overlap

The Home and Community Based Services (HCBS) Final Rule is Federal Law that requires that Medicaid-funded services and supports be delivered in integrated settings and support full access to the greater community.

This includes:

- 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.

The HCBS Final Rule also requires that PCP be used to identify and reflect choice of services and supports funded by the mental health system.

Essential Elements of the PCP Process

Person-Directed	Outcome-Based	Information, Support and Accommodations
The person directs the planning process (with necessary sup-ports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.	The person identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.	As needed, the person 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 person to participate in the process are provided. The person is offered information on the full range of services avail-able in an easy-to-understand format.

Essential Elements of the PCP Process (cont)

Participation of Allies

Through the pre-planning process, the person selects al-lies (friends, family members and others) to support him or her through the PCP 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.

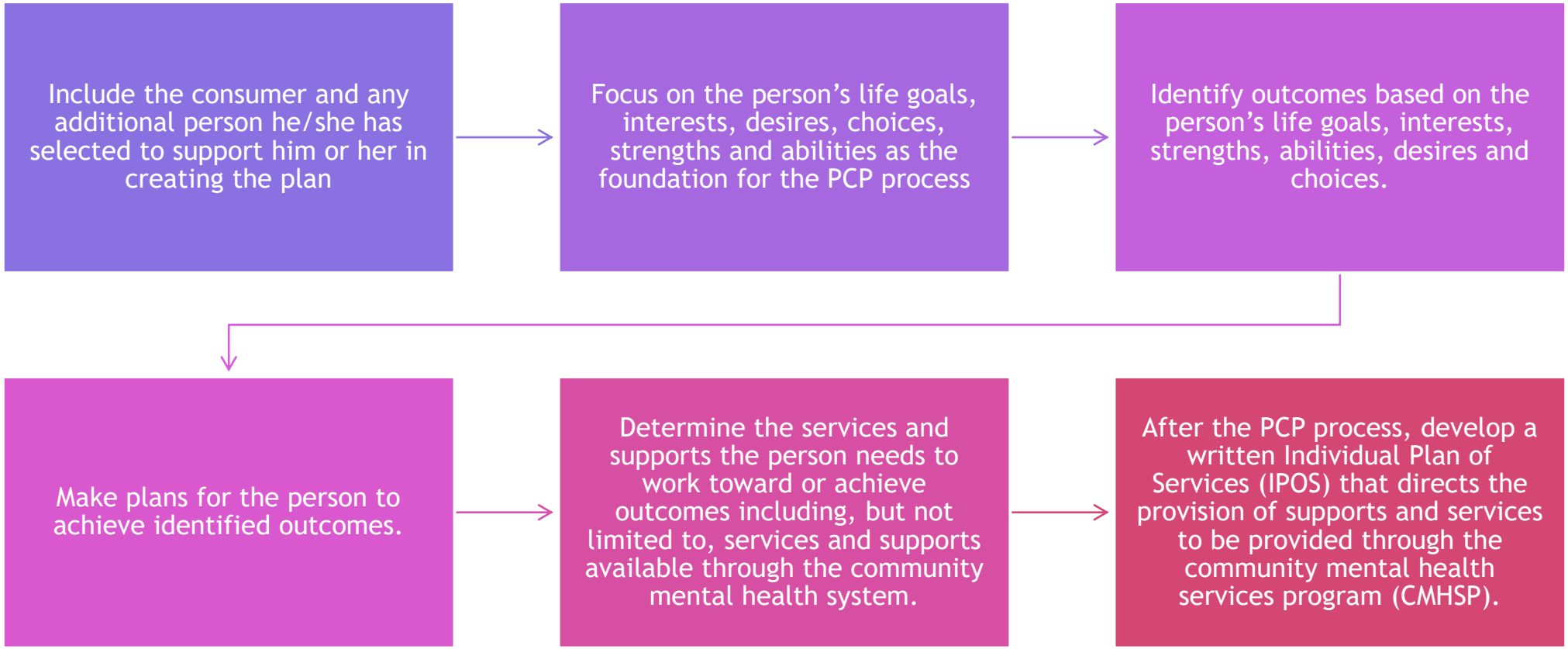
Wellness and Well-Being

Issues of wellness, well-being, health and primary care coordination support needed for the person to live the way he or she want to live are discussed and plans to address them are developed. People 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, eating candy or other sweets). If the person chooses, issues of wellness and well-being can be ad-dressed outside of the PCP meeting.

Personal Responsibility

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 person's right to assume some degree of personal risk. The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).

Expectations of a Successful Person-Centered Plan



Riverwood's Person-Centered Planning (PCP)Process

- Initial or Annual Assessment
- Pre-Planning
- Person-Centered Treatment Planning Meeting
- Progress Notes
- Periodic Reviews
- All documents done in IRIS, or Electronic Health Record (EHR)

The Person-Centered Planning Process Allows Us to Follow "The Golden Thread"

- *"The concept of the Golden Thread is a constant re-evaluation of an individual's needs, goals and progress.*
- *It is the clinician's responsibility to ensure that medical necessity is firmly established and that The Golden Thread is easy to follow within your documentation."*

Initial and Annual Assessments

Riverwood Center

Berrien Mental Health Authority

Annual Assessment

IDENTIFYING INFORMATION				
NAME John L. Doe	DOB 01/01/1984	AGE 35	CASE # 00000011	GENDER Male
ADDRESS 6027 Holly Park Dr., Farmington Hills, MI 48334				
SERVICE H0036 AN Homebased Services		DATE 08/16/2019	TIME 9:02AM - 9:55AM	

ASSESSMENT DATE
08/16/2019

ASSESSMENT TIME
9:02AM

ASSESSMENT TYPE
☒ Annual ☐ Update

CASE #
00000011

DATE OF BIRTH
01/01/1984

DATE OF DEATH

GENDER ASSIGNED AT BIRTH
Male

GENDER IDENTITY
Identifies as Male

SEXUAL ORIENTATION
Heterosexual

FIRST NAME
John

MIDDLE NAME
L

LAST NAME
Doe

ALIASES AND OTHER IDENTIFYING INFORMATION

MEDICAID ID #
002154654564

HOME ADDRESS
6027 Holly Park Dr.
Farmington Hills, MI 48334

PRIMARY PHONE

☑ Do not leave a message

ALTERNATE PHONE

☐ Do not leave a message

COUNTY OF RESIDENCE
Berrien

EMAIL

PRIMARY SPOKEN LANGUAGE
ENGLISH

COMMUNICATION PREFERENCE
Phone

ACCOMODATION NEEDED
☐ Interpreter ☐ Reading Assistance ☐ Sign Language

REFERRAL SOURCE
School (Educational)

Initial and Annual Assessments

- The Initial and Annual Assessment are a tool that is used to gather useful information about the consumer, and to assess progress from the previous year of treatment. Information found includes:
  - Strengths, Needs, Abilities, and Preferences of the consumer
  - Diagnosis with clinical rationale
  - Safety Risks/Barriers
  - Level of Functioning
  - Recommendations for Treatment.

Pre-Planning

1. PCP Pre-Plan: Note

Date

Use Current Date

Meeting Details

What is your preference as to the date and time of your meeting?

Meeting Date

Meeting Time AM

Consumer requests to complete Preplanning and Meeting on the same day

Yes No

Meeting Location

Primary Case Holder lookup clear

1323 Pete Murphy

Parent/Guardian

Information contained on this form was obtained through:

* Select

I would like to use an Independent Facilitator to guide my PCP meeting

Yes No

I would like the following person to facilitate my PCP meeting

I would like the following person to record information for me during my PCP meeting

I am interested in Advance Directives for healthcare and/or mental health

Yes No

I have an interest and would like to discuss Self-Determination Services at my PCP meeting

Yes No

Pre-Planning

The purpose of Pre-Planning is to allow the Consumer and his supports to identify the persons, resources, or accommodations need to plan the treatment and care they desire. Questions in the Pre-Plan Document include:

- **When** and **Where** the meeting will be held.
- **Who** will be invited (including whether the person has allies who can pro-vide desired meaningful support or if actions need to be taken to cultivate such support).
- **What will be discussed and not discussed?** Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and planning for how to deal with them.
- **The PCP format or tool** chosen by the person to be used for PCP (If Desired)
- **What** accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication)?
- **Who** will facilitate the meeting? Is an Independent Facilitator needed?
- **Who** will take notes about what is discussed at the meeting?

Independent Facilitation

- In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their person-centered planning process.
- The terms independent and external mean that the facilitator is independent of or external to the community mental health system or provider agency. It means that the person 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.

Who is considered an Independent Facilitator?

An individual may use anyone he or she chooses to help or assist in the person-centered planning process, including facilitation of the meeting.

If the person does not meet the requirements of an Independent Facilitator, he or she cannot be paid, and responsibility for the Independent Facilitator duties described above falls to the Supports Coordinator/Case Manager.

A person may choose to facilitate his or her planning process with the assistance of an Independent Facilitator.

Role of the Independent Facilitator

The role of the independent facilitator is to:

Personally know or get to know the individual who is the focus of the planning, including what he or she likes and dislikes, personal preferences, goals, methods of communication, and who supports and/or is important to the person.

Help the person with all pre-planning activities and assist in inviting participants chosen by the person to the meeting(s).

Assist the person to choose planning tool(s) to use in the PCP process.

Facilitate the PCP meeting(s) or support the individual to facilitate his or her own PCP meeting(s).

Provide needed information and support to ensure that the person directs the process.

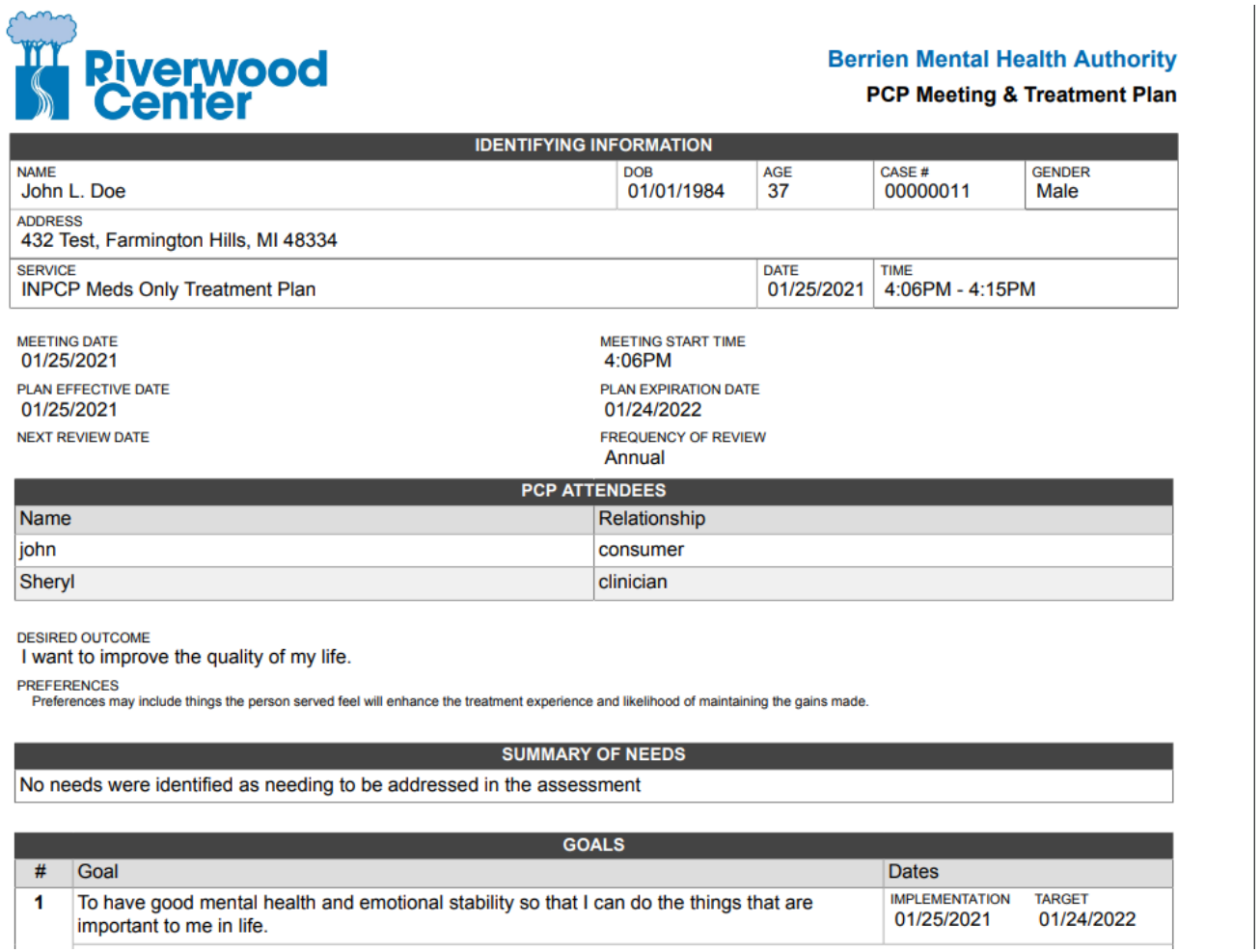
Make sure the person is heard and understood.

Keep the focus on the person.

Keep all planning participants on track.

Develop a person-centered plan in partnership with the person that expresses the person's goals, is written in plain language understandable by the person, and pro-vides for services and supports to help the person achieve their goals.

Person Centered Treatment Plan (PCP) or Individual Plan of Service (IPOS)



Riverwood Center

Berrien Mental Health Authority

PCP Meeting & Treatment Plan

IDENTIFYING INFORMATION				
NAME John L. Doe	DOB 01/01/1984	AGE 37	CASE # 00000011	GENDER Male
ADDRESS 432 Test, Farmington Hills, MI 48334				
SERVICE INPCP Meds Only Treatment Plan		DATE 01/25/2021	TIME 4:06PM - 4:15PM	

MEETING DATE
01/25/2021

MEETING START TIME
4:06PM

PLAN EFFECTIVE DATE
01/25/2021

PLAN EXPIRATION DATE
01/24/2022

NEXT REVIEW DATE

FREQUENCY OF REVIEW
Annual

PCP ATTENDEES	
Name	Relationship
john	consumer
Sheryl	clinician

DESIRED OUTCOME
I want to improve the quality of my life.

PREFERENCES
Preferences may include things the person served feel will enhance the treatment experience and likelihood of maintaining the gains made.

SUMMARY OF NEEDS
No needs were identified as needing to be addressed in the assessment

GOALS			
#	Goal	Dates	
1	To have good mental health and emotional stability so that I can do the things that are important to me in life.	IMPLEMENTATION 01/25/2021	TARGET 01/24/2022

Person Centered Treatment Plan (PCP) or Individual Plan of Service (IPOS)

- Include all those identified in Pre-Plan (the consumer, their family, guardians, service providers, and other community and natural supports) in the discussion and development of the plan.
- Develop Specific, Measurable objectives towards individual goals
- Services not only meet the consumers needs/goals, but also meet medical necessity criteria.
- Set specific and clear discharge criteria that indicate when a consumer would go to the next least restrictive level of care.

Person Centered Treatment Plan (PCP) or Individual Plan of Service (IPOS) Continued

- Create a “treatment roadmap”
- A collaborative process including the consumer and their identified supports.
- Identify criteria for transition/discharge for all services.
- Integrate physical/behavioral health, social determinants and natural supports.
- Most important task and is the foundation for all that is to come in treatment.

Person Centered Treatment Plan (PCP) or Individual Plan of Service (IPOS)

Treatment Plans have 4 distinct sections:

Goals

- Broad statement that identifies outcome of achievement.

Objectives

- Specific and Measurable statement of what, who, and when action will be taken and by whom.

Interventions

- Detailed description of a service and requirements.

Discharge Criteria

- Specific language to identify when how a service will be determined to no longer be needed by a consumer.

Consumers Needing Urgent Intervention

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.

A preliminary plan is simply a general plan of what services are being pursued, what the next step is and what to expect. (It is different than the Pre-Plan). This is typically documented in the Initial Assessment or Hospital Discharge Planning documentation.

Staff Training on the PCP/IPOS

Direct Care staff are required to have training on:

Each individual's plan of services (IPOS/PCP Plan)

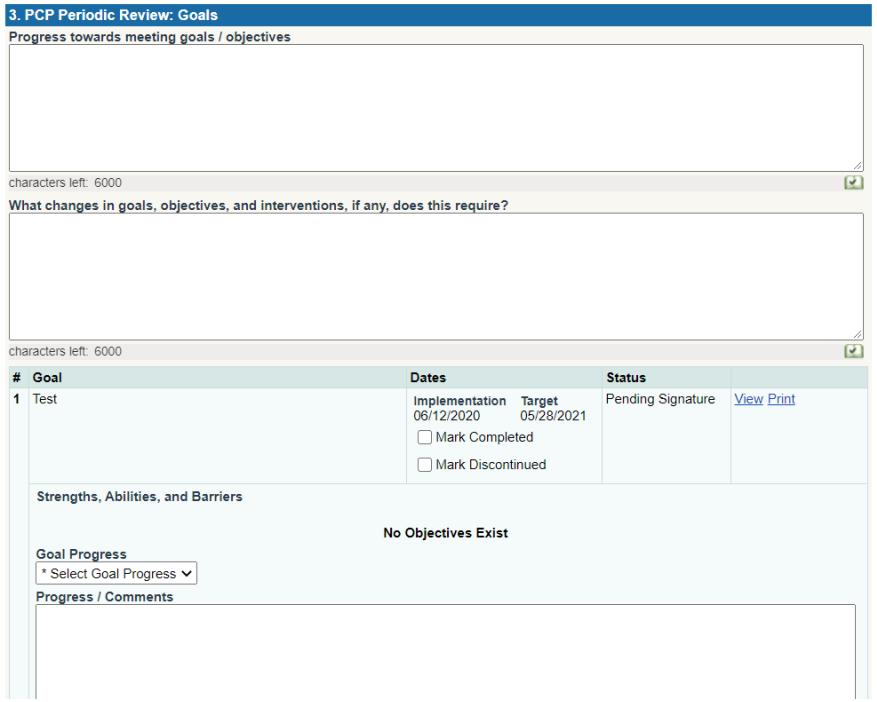
Any/all ancillary plans or recommendations (i.e., Sensory Diet Plans from the OT, Special Dietary Plans, Range of Motion Plans).

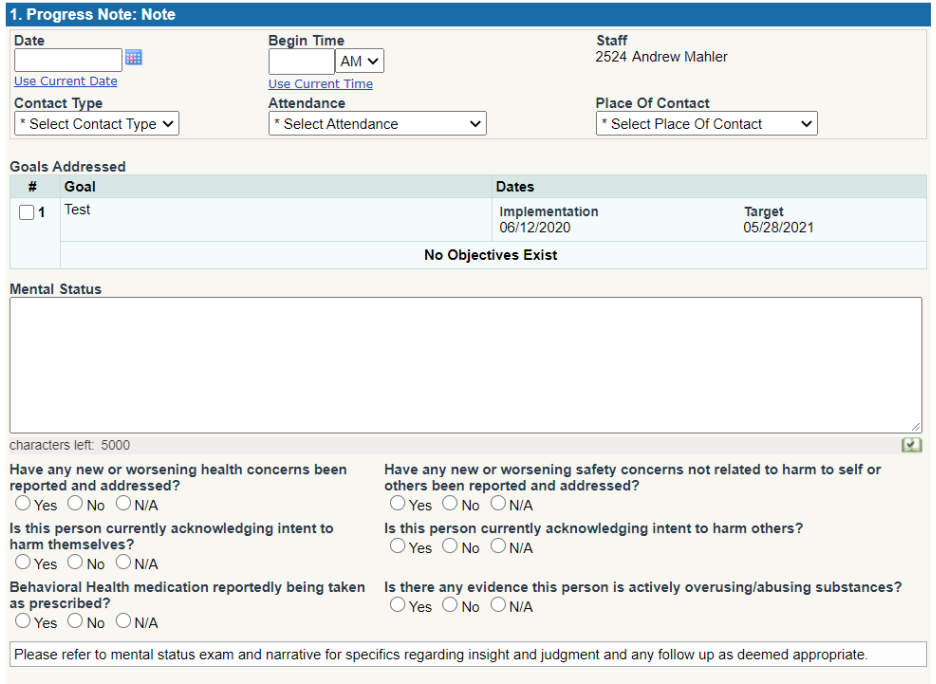
Note/Updated: Staff implementing specialty plans/interventions (i.e., behavior treatment plans, range of motion, sensory diet/activities, non-medical health services, dietary) must be trained by the professional who developed the plan (i.e., Psychologist, OT, RN or Dietitian) or at a minimum by the Manager/Supervisor who received training directly from the professional.

The provider must maintain documentation of the Manager/Supervisor receiving training from the relevant professional in addition to each staff subsequently receiving training.

Documentation of IPOS training must include at a minimum:

- Staff Name
- Date of Training
- Trainer's Name & Title
- Topic of Training (i.e., IPOS for Jane Doe dated 9/30/15)





Periodic Reviews and Progress Notes

Progress Notes

Completed for all consumer contacts from a case manager, and provide evidence of:

- Service delivery
- Consumer participation in treatment and services
- Continued Need for Services
- Goals and Objectives in Treatment Plan are or are not being addressed and why

Periodic Reviews

Periodic Reviews are completed with the consumer to review progress made in the treatment process. The frequency of completion for periodic reviews is dependent upon services received (i.e., every 3 months)

The periodic review document will populate information from the treatment plan. This includes, treatment goals, associated needs, strengths, barriers, objectives and interventions for each separate goal.

Clinicians should review each goal for all services that is identified on the treatment plan. Best practice would include discussion and updates from these services to input into the review document.

PCP: An Ongoing Process

Once a PCP/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 person.

If and when necessary, the IPOS can be completely redeveloped.

The emphasis in using PCP should be on meeting the needs of the person as they arise.

Dispute Resolution

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights.

Self Directed Services (SDS) Definitions

Self-Determination

the right of all individuals to have the power to make decisions for themselves; to have free will. The goals of SD, on an individual basis, are to promote full inclusion in community life, to feel important, and increase belonging while reducing the isolation and segregation of individuals who receive services. SD builds upon choice, autonomy, competence, and relatedness which are building blocks of psychological wellbeing.

Self Direction and Self-Directed Services

an alternative method for obtaining supports and services. It is the act of selecting, directing and managing one's services and supports. Individuals who self-direct their services are able to decide how to spend their CMH services budget with support, as desired.

MDHHS Self-Directed Services Technical Requirement

The Michigan Department of Health and Human Services (MDHHS) provide guidance and direction to Community Mental Health Service Providers on how to allow consumers to decide how services are delivered to them. This guidance can be found at the link below.

https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder50/Folder11/DHHS-2-SD-Policy.pdf?rev=82f1c4f384c743cb8cabdaf774e393ff

Principles of Self-Directed Services

Freedom -Deciding how to live a good life.

Authority - Controlling a targeted amount of dollars.

Support -Organizing resources in a ways that are life enhancing and meaningful.

Responsibility - Using public funds wisely.

Arrangements that support Self Directed Services (SDS)

Riverwood authorizes funding based on the IPOS and delegates to the participant the authority to manage

the individual budget,	choose and manage qualified providers, and	determine service delivery

PIHP/CMHSP provides on-going support and assistance to participants

Benefits of a Self Determined Service Arrangement

Participants have control over their arrangements and resources.

Participants have control over who provides support to them.

Participants can pursue their dreams and goals with the staff they choose.

Participants achieve community participation and inclusion.

Thank You!