

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Family Centered Practice	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.03 B
Effective Date: 7/1/07	Date of Review/Revision: 6/18/07, 7/22/08, 5/6/09, 6/30/10, 5/9/12, 5/22/14, 4/7/16, 3/30/17, 3/1/18, 4/3/20, 3/30/21, 10/25/21, 2/28/22, 3/7/23, 3/7/24, 3/18/25, 3/9/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Executive Director of Clinical Services and Programs
	Supersedes:	
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		Authored By: Stacey Farrell Additional Reviewers: Jennifer Stanuszek, LMFT

Purpose:

The purpose of this policy is to define family centered practice and give direction as to how to achieve family centered practice.

Policy:

Saginaw County Community Mental Health Authority (SCCMHA) providers are required to utilize a family centered approach to service delivery and planning process for children and families regardless of age, disability, race, color, religion, gender, sexual orientation, gender identity or expression, national origin, or residential setting.

Application:

The entire SCCMHA network of providers.

Standards:

Family Centered practice is a planning and service delivery process that:

- Recognizes that parents play a unique and essential role in the lives of their minor children and have the greatest influence on the child's health, growth and development.
- Recognizes that enhancing parenting competence and confidence is the best avenue to achieving better outcomes for children.
- Is family specific, individualized by culture, strengths, concerns, and resources of each family.
- Continues to build self-empowerment within parents, children and youth.

- Promotes resiliency by developing interventions that increase abilities and skills in children, youth and families, while reducing risk factors and enhancing protective factors.
- Promotes a child/youth's ability to assume more choice and leadership as he/she matures and develops in preparation for adulthood.

Staff coordinating the planning process will adhere to the following principles when implementing family centered practice:

- Partnerships are developed with parents, children, youth and other caregivers.
- Mutual respect and honesty exist between all partners.
- Planning and services are individualized, family driven and youth guided.
- Family strengths and individual strengths are discovered, acknowledged and built upon.
- Family culture and linguistics (styles of communication) are acknowledged and respected.
- Parenting skill and confidence are strengthened.

The emphasis of family centered practice, as youth become older, is to shift from supporting parents to make decisions for and on behalf of the child, to supporting youth to make his or her own decisions, in the context of their family's values, culture and beliefs.

Providers of services to children and families are required to develop a plan of service utilizing a *family* centered approach—a modification of the essential elements of person-centered planning-- to take into consideration that one is working with a family. The **essential elements of a family centered approach** are:

1. The child, youth and family have an opportunity to reconvene any or all of the planning process whenever he/she/they want or need.
2. The child, youth and family determine who should be involved in the planning meeting.
3. The family is provided with the option of choosing external independent facilitation of their meeting unless they are receiving short term outpatient therapy or a single service.
4. The family will identify the goals, dreams, aspirations and desires for their child and for their family. The child and youth will also have the opportunity to express goals, dreams, aspirations and desires which will be presented to, discussed with and approved by the individual/family.
5. Before a family centered meeting is initiated, a pre-planning meeting with the family occurs. In the pre-planning meeting the child, youth and family chooses:
 - a. Strengths, dreams, goals, aspirations and desires and any topics they want to address or plan for at the meeting
 - b. Topics they do 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 the meeting

6. All potential support and/or treatment options are identified and discussed with the child and family.
7. Health and safety needs are identified in partnership with the child and family.
8. Services are coordinated with primary health care providers and other allied health professionals or systems working with the child.
9. The child, youth and family develop collaborative safety plan which describes what each family member should do during times of stress.
10. The child, youth and family are given ongoing opportunity to express needs, desires and preferences and to make choices.
11. The child, youth and family are provided opportunities to give feedback on the impact of their services, the progress they are making toward outcomes and the plan is modified based on this feedback. Once all parties have agreed to all elements of the Individual Plan of Service (IPOS), the plan will be submitted to the departmental supervisor for approval.
12. The child, youth and family are provided a copy of their Individual Plan of Service within 15 business days of their meeting.

The IPOS should be developed with the family in mind and should be written with minimal professional jargon or language, using the family's own words or in a way that the family may read or comprehend. The IPOS should have person first language.

All persons eligible for services through SCCMHA and SCCMHA contracted network will have an IPOS developed. A family receiving services through the SCCMHA intake process will have a preliminary plan that addresses immediate needs, as well as any crisis needs until the family meets with their assigned case holder and other team members to develop a comprehensive IPOS.

The plan should be developed within 45 days of the assignment to primary team. When a person is in a crisis situation, that situation should be stabilized before the person centered planning process is used to plan the life the family desires to have.

The goal of a collaborative safety plan, is to help the child/youth/family and their allies identify signs when the family is heading for a relapse or needs additional supports. This type of planning is to divert crisis intervention or hospitalization or residential treatment and to prevent relapse.

Discussion with the child/youth/family about this type of planning should occur:

1. Annually, as part of the person centered planning process.
2. After a hospitalization when the child/youth is healthy enough to discuss or discuss with the child/youth's guardian, caregivers etc.
2. After a series of crisis intervention contacts. A series here is defined as three or more.
3. After treatment for SUD in a residential treatment facility.
4. As the child/youth is discussing a lesser restrictive treatment setting such as step down from an Alternative Treatment Order, or a Court Order.

All agency and network staff, at all levels of the organizations (including front desk associates, administrators, psychiatrists, custodial staff, etc.), shall have family-centered practice training within 30 days of hire.

Whenever feasible, child/youth/family members should be involved in providing family-centered planning training as co-trainers.

Person-Centered/family planning training should be available and open to child/youth and family members, as well as the general public.

In order to ensure an understanding of not only the technical process but also the ‘spirit’ and intent of Person-Centered Planning, annually, the Clinical Supervisor will shadow each assigned Case Holder through at least one child/youth’s PCP Process using the PCP Fidelity Checklist (Exhibit C) to train and assess that Case Holder’s understanding of the PCP Process. The results of this tool will be used as part of the annual evaluation and to train areas for skill improvement. Additional shadowing may occur as deemed needed based on the results of the Fidelity Checklist. PCP Fidelity Checklists will be available for review by the SCCMHA Auditing team at the time of annual site reviews.

Definitions:

Child: For purposes of this policy, a child is defined as a minor age birth to 12.

Youth: For purposes of this policy a youth is defined as a minor age 13 to 18.

Family: For purposes of this policy, family is whomever the family defines to be their family.

Case Holder: Case Managers, Supports Coordinators, Therapists, Wrap Coordinators and other staff who provide case management or coordination of care for a consumer

References:

MDHHS Family- Driven and Youth-Guided Policy and Practice Guideline (July 29, 2020).

SCCMHA Policy 02.03.03- Person-Centered Planning

Certified Community Behavioral Health Clinics (CCBHC) Criteria

Exhibits:

Exhibit A - Chart of Elements/strategies

Exhibit B - Person Centered Planning Process-Fidelity Checklist

Exhibit C - IPOS Workflow and Activities

Procedure:

ACTION	RESPONSIBILITY
Provides leadership through policy that requires staff training on Person/Family Centered Planning at all levels of the organization and network.	CEO Executive Director of Clinical Services and Programs

Provides leadership through policy that requires staff and network adherence to Person/Family Centered Planning policy and practices.	Director of Network Services, Public Policy & Continuing Education CEO Executive Director of Clinical Services and Programs Director of Network Services, Public Policy & Continuing Education
Assures that training is made available on a regular basis to new staff and contractors as well as children/youth and family members and that, when possible, children/youth/family members are involved in providing the training.	CEO Executive Director of Clinical Services and Programs Director of Network Services, Public Policy & Continuing Education SCCMHA Continuing Education Supervisor of Customer Services
Ensure that all decisions involving a child, youth and family are made utilizing family centered practices. Schedules a pre-planning meeting in preparation for the family centered planning meeting and ensures that the essential elements of a pre-planning meeting are met. Schedules and coordinates the family centered planning meeting according to the choices made by the family during the pre-planning meeting. Develops the family's plan of service and all of the family outcomes under the name of the identified child. This is with the exception of situations where services to other family members will be provided without the identified child present (medication reviews, respite therapy). In those situations, a single service plan must also be entered for that person. If another family member is going to receive a variety of services and it is expected to be long term a full plan should be developed for them with the outcomes matching those of the first child as it is the family's plan.	SCCMHA Network of providers Case Holder Child/Youth/Family Case Holder Child/Youth/Family Case Holder Child/Youth/Family

Once all parties have agreed to all elements of the Individual Plan of Service, authorizations will be submitted to Care Management for approval.	Case Holder Clinical Supervisor
Provides the family with a copy of their plan of service within 15 business days of the meeting.	Case Holder
Completes periodic reviews	Case Holder
Child/youth/family or staff can request to reconvene any or all of the planning processes whenever desired, wanted or needed.	Case Holder Child/Youth/Family
Provides the family, youth and/or child opportunity to provide feedback regarding how they feel about services and modifies the plan of service based on that feedback.	Case Holder
Provides regular feedback regarding progress toward outcomes.	Case Holder Child/Youth/Family

EXHIBIT A

The following chart of elements/strategies can be used by the person representing the CMHSP, depending upon what the individual wants and needs.

Three possible situations are:

- 1. The individual expresses a need that would be considered urgent or emergent.**

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 this type of situation where an individual's opportunity to make choices may be limited.

- 2. The individual expresses a need or makes a request for support, services and/or treatment in a single life domain and/or of a short duration.**

A life domain could be any of the following:

- ◆ Daily activities
- ◆ Social relationships
- ◆ Finances
- ◆ Work
- ◆ School
- ◆ Legal and Safety
- ◆ Health
- ◆ Family and relationships

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

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

Elements/Strategies	Urgent/ Emergency (< 7 days)	Short Duration (≥ 7 days)	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, to determine if there is a role for other clinicians to provide additional information or opinions.	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 people and information that need to be assembled for successful planning to take place.		X	X
All planning meeting(s) are scheduled at a time and location convenient to the individual and persons the individual chooses to have participate.	<i>Should ask at 1st meeting!</i>	X	X
In collaboration with the RMHA, the individual identifies strategies and supports, services and/or treatment needed to achieve desired outcomes.		X 330.1209a	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 MDCH and CMH Services Programs.		X	X
Regular opportunities for individuals to provide feedback are available.		X	X
The individual's support network is explored with that person to determine who can best help him/her plan. The individual and the people he/she selects together define the individual's desired future, and develop a plan for achieving desired outcomes. For persons 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) at which the individual and, where necessary, 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

EXHIBIT B**PERSON-CENTERED PLANNING PROCESS – Fidelity Checklist**

Staff Member: _____ Review Date: _____

ID: _____

Supervisor: _____

The supervisor will shadow the staff through the PCP process by observation, which include attending meetings (with consumer permission), reviewing written documentation, and through interview or discussion with the consumer and natural supports. The supervisor will then review these findings with the staff and include findings on the annual performance review.

Indicator	Adherence*	Recommendations or Suggestions:
1. The person and people important to him or her are included in lifestyle planning, and have the opportunity to express preferences, exercise control and make informed decisions.	☐ 2 ☐ 1 ☐ 0	
2. The person's routine and supports are based upon his or her interests, preferences, strengths, capacities and dreams.	☐ 2 ☐ 1 ☐ 0	
3. Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect.	☐ 2 ☐ 1 ☐ 0	
4. The person uses, when possible, natural and community supports.	☐ 2 ☐ 1 ☐ 0	
5. The person has meaningful choices, with decisions based on his or her experiences.	☐ 2 ☐ 1 ☐ 0	
6. Planning is collaborative, recurring, and involves an ongoing commitment to the person.	☐ 2 ☐ 1 ☐ 0	
7. The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.	☐ 2 ☐ 1 ☐ 0	
8. The person is satisfied with his or her activities, supports, and services.	☐ 2 ☐ 1 ☐ 0	
9. Person is viewed as an unique and valued individual, not only as a client or a consumer of services.	☐ 2 ☐ 1 ☐ 0	
10. Planning meetings are a celebration of the consumer	☐ 2 ☐ 1 ☐ 0	
11. The Person-Centered Planning process and subsequent documentation belong to the person	☐ 2 ☐ 1 ☐ 0	
12. Strategies were included for solving disagreement within the process,	☐ 2 ☐ 1 ☐ 0	

including clear conflict of interest guidelines for all planning participants.		
Additional Comments or Notes:		

*2 – Displays fidelity to the factors of the indicator; 1 – Displays partial fidelity but needs to improve on various factors, 0 – Did not meet fidelity and needs to improve on all factors

Fidelity Indicators and Factors

Fidelity Indicators are the numbered states that reflect the values of the Person-Centered Planning Process.

Fidelity Factors are the bulleted statements regarding some of the elements or factors that would be shown in the Indicator

- 1. The person and people important to him or her are included in lifestyle planning, and have the opportunity to express preferences, exercise control and make informed decisions.**
 - The person and advocates participated in planning and discussions where decisions are made.
 - A diverse group of people, invited by the person, assisted in planning and decision-making.
- 2. The person's routine and supports are based upon his or her interests, preferences, strengths, capacities and dreams.**
 - The person's dreams, interests, preferences, strengths, and capacities are explicitly acknowledged and consequently their plan drives activities and supports.
 - Supports are individualized and do not rely solely on preexisting models.
 - Supports result in goals and outcomes that are meaningful to the person.
 - Goals are defined by the person with a focus on attaining the life they envision for themselves in the community
- 3. Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect.**
 - The person has friends, and increasing opportunities to form other natural community relationships.
 - The person has a presence in a variety of typical community places. Segregated services and locations are minimized.
 - The person has the opportunity to be a contributing member of the community.
 - The person can access community-based housing and work if desired.
 - The person is an engaged member within their community.
- 4. The person uses, when possible, natural and community supports.**
 - With the person's consent, the support of family members, neighbors and co-workers is encouraged.
 - The person makes use of typical community and generic resources whenever possible.
- 5. The person has meaningful choices, with decisions based on his or her experiences.**
 - The person has opportunities to experience alternatives before making choices.

- The person makes life-defining choices related to home, work and relationships.
 - Opportunities for decision-making are part of the person's everyday routine.
- 6. Planning is collaborative, recurring, and involves an ongoing commitment to the person.**
- Planning activities occur periodically and routinely. Lifestyle decisions are revisited.
 - A group of people who know, value, and are committed to serving the person remain involved.
- 7. The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.**
- Funding of supports and services is responsible to personal needs and desires, not the reverse.
 - When funding constraints require supports to be prioritized or limited, the person or advocates make the decisions.
 - The person has appropriate control over available economic resources.
- 8. The person is satisfied with his or her activities, supports, and services.**
- The person expresses satisfaction with his or her relationships, home, and daily routines.
 - Areas of dissatisfaction result in tangible changes in the person's life situation.
- 9. Person is viewed as a unique and valued individual, not only as a client or a consumer of services.**
- Person-first language is used
 - Refrain from terms like:
 - Non-verbal
 - Low functioning
 - He's a runner, scratcher
 - Non-compliant
 - The "collective we": How are we doing today?
 - Preferred name and gender preferences used
 - Staff understands the background, history of the person
 - Staff are sincere and genuine in interactions with the person.
 - Interactions adhere to the person's preferences and desires such as respecting someone's belongings, personal space wheelchair, privacy, etc..
 - The person's contribution was valued as shown by listening without interrupting, and giving time to respond to a comment or a question.
 - Discussions and documentation are in plain language
 - Motivational Interviewing was used by the staff to obtain a deeper understanding and knowledge of the person and the person's goals, desires, wishes, and dreams
- 10. Planning meetings are a celebration of the consumer**
- Discussions were positive, future oriented
 - Consumer was encouraged to participate and control the process
 - Consideration was given for consumer's culture, trauma history, desires, dreams, aspirations
 - Strengths are highlighted - the focus of meetings were on the consumer's interests, and talents while also considering how to actively use these strengths
 - The focus of meetings were on the consumer's interests, and talents while also considering how to actively use these strengths

- The person was involved in making decisions regarding the meeting, including:
 - Who would attend or not attend
 - Location, date, time of meeting
 - Who would lead, facilitate and/or take notes
 - What was to be discussed and what was not to be discussed
- Staff allowed consumer time to think and to respond
- Multiple sources were used to obtain information to obtain a fuller picture of the consumer
- Choices were offered to the individual regarding the services and supports the individual receives and from whom.

11. The Person-Centered Planning process and subsequent documentation belong to the person

- Plans, schedules, and routines are flexible to the direction of the person
- An environment of choice prevails throughout the process
 - Strength-focused
 - Maximum self-sufficiency and independence is promoted
 - Real opportunities are created
 - Respectfulness prevails
- The approach used was supportive of the person rather than directed by the staff
 - Consumer was provided the necessary information and support to ensure the individual directs the process to the maximum extent possible

12. Strategies were included for solving disagreement within the process, including clear conflict of interest guidelines for all planning participants.

IPOS Workflow and Activities

Pre-planning (45 days prior to IPOS expiration)

1. Case Holder (CH) reviews information from previous year to inform completions of psychosocial assessment
 - a. Chart Review: Periodic Reviews, Progress Notes, Medication Reviews, Incident Reports
 - b. Personal notes or information not in chart
2. CH and person served and (others) complete tools to help develop individual/family goals
3. CH and person served and (others):
 - a. Complete the Choice Document (as applicable) with the person served
 - b. Determine need or want for Enhanced Health Services (EHS)
 - c. Determine need or want for Community Living Supports
 - d. Social Determinants of Health Form is completed
4. CH meets with person served/family to complete the Pre-Plan form and pre-plan tools (typically 1 to 2 weeks before IPOS expiration)
5. Planning meeting set up (send invites, arrange location, etc.) is completed by parties designated in Pre-Plan
6. CH ensures completion of Assessments in Sentri prior to Planning Meeting
 - a. CH ensures that the signed Pre-Plan Signature Page is scanned/signed electronically
 - b. CH ensures that copy of Pre-plan tools(s) is scanned
7. CH obtains signature electronically on IPOS Consents or ensures that it is scanned
8. CH enters proposed IPOS goals in Sentri prior to Planning Meeting

Planning Meeting

9. At the Planning Meeting, the team
 - a. Reviews the current strengths of the consumer from the various community and SCCMHA provide supports, services and/or programs
 - b. Adds, Reviews and/or revises (if needed) the proposed goals and objectives
 - c. 15 day copy to consumer “clock” starts from date of planning meeting

Post Planning Meeting

10. CH completes the Planning meeting fields in Sentri (may be done after the planning meeting based on notes)
11. Simultaneous submits IPOS for
 - a. Supervisor Review, revision (if required) and approval
 - b. Submit Authorizations in Sentri, revision (if required) and approval
12. CH signs IPOS after Supervisor and authorization approvals

13. CH sends completed IPOS copy to guardian (if applicable) or consumer for signature/gains signature electronically
 - a. CH documents date sent in Sentri on IPOS form
 - b. CH assures that the signed IPOS Meeting Signature Page scanned or signed electronically
 - c. CH completes Health Care Coordination Form
14. CH Review IPOS with programs and services
 - a. CH documents any in-services(s) on Sentri on PCP Header
15. CH monitors plan
 - a. Assures that programs and services are being provided per the IPOS
 - b. Monitors progress towards goal achievement as indicated in the IPOS
 - c. Reviews goals per agreed time frames indicated on the IPOS