

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Person-Centered Planning	Chapter: 02 - Customer Services and Recipient Rights	Subject No: 02.03.03
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	Supersedes:	
		Authored By: Kristie Wolbert Additional Reviewers: Director of NSPP & CE, Officer of Recipient Rights and Compliance, Robert Castillo

Purpose:

To establish person-centered planning practice guidelines as the values and principles underlying person-centered planning.

Policy:

As established in the Michigan Mental Health Code, all persons receiving on-going services from Saginaw County Community Mental Health Authority have the right to utilize the Person-Centered Planning (PCP) in the development of the person served Individual Plan of Service (IPOS). The use of this process will be based on the services provided without regard to age, disability, race, color, religion, gender, gender, gender, sexual orientation, gender identity or expression, national origin, legal status, or residential setting.

PCP is 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. PCP is required by state law (the Michigan Mental Health Code (the Code)) and federal law (the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules) as the way that people receiving services and supports from the community mental health system plan how those supports are going to enable them to achieve their life goals. The process is used to plan the life that the person aspires to have, considering various options—taking the individual’s goals, hopes, strengths, and preferences and weaving them into plans for the future. Through PCP, a person is engaged in decision-making, problem solving, monitoring progress, and making needed adjustments to goals and support and services provided in a timely manner. PCP is a process that involves support and input from those people who

care about the person doing the planning. 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.

Application:

All providers, board operated and contracted, of the Saginaw County Community Mental Health Authority network.

Standards:

PCP is an individualized process designed to respond to the unique needs and desires of each person. Through the PCP process, a person and those he or she has selected to support him or her:

1. Focus on the person's life goals, interests, desires, choices, strengths, and abilities as the foundation for the PCP process.
2. Identify outcomes based on the person's life goals, interests, strengths, abilities, desires, and choices.
3. Make plans for the person to achieve identified outcomes.
4. Determine the services and support the person's needs to work toward or achieve outcomes including, but not limited to, services, and supports available through the community mental health system.
5. After the PCP process, develop an Individual Plan of Services (IPOS) that directs the provision of support and services to be provided through the community mental health services program (CMHSP).
6. The plan must be agreed to by RMHA, the recipient, the guardian, or the parent with legal custody of a minor recipient, unless it is part of a court order. Objections must be noted in the plan.
7. The written individual plan of service will have a specific date or date when the plan and any of its sub-components will be formally reviewed for possible modification or revision.
8. If a recipient is not satisfied with their individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review will be completed within 30 days.

9. A recipient will be informed orally and in writing of their clinical status and progress at reasonable intervals established in the individual plan of service in a manner appropriate to their clinical condition.

PCP focuses on the person's goals, while still meeting the person's basic needs [the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code]. As appropriate for the person, the PCP process may address Recovery, Self-Determination, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning as described in the relevant MDHHS policies and initiatives.

PCP focuses on services and support needed (including medically necessary services and supports funded by the CMHSP) for the person to work toward and achieve their personal goals.

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 as well as SCCMHA policy 02.03.03 B Family Centered Practice). The needs of the child are interwoven with the needs of the family, and therefore support and services impact the entire family. As the child ages, services and support should become more youth-guided especially during transition into adulthood. When the person reaches adulthood, his or her needs and goals become primary.

There are a few circumstances where the involvement of a minor's family may not be appropriate:

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 Code.
2. The minor is emancipated.
3. 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. Justification of the exclusion of parents shall be documented in the clinical record.

Every person is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community.

Every person has strengths, can express preferences, and can make choices

The person's choices and preferences are honored. Choices may include: the family and friends involved in his or her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships and friendships, and transportation. Individual choice must be used to develop goals and to meet the person's needs and preferences for support and services and how they are provided.

The person'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 person to implement their choices or preferences over time.

Every person contributes to his or her community, and has the right to choose how support and services enable

Through the PCP process, a person maximizes independence, creates connections, and works towards achieving his or her chosen outcomes.

A person's cultural background is recognized and valued in the PCP process. Cultural backgrounds may include language, religion, values, beliefs, customs, dietary choices, and other things chosen by the person. Linguistic needs, including ASL interpretation, are also recognized, valued, and accommodated.

The following elements are essential to the successful use of the PCP process with a person and the people invited by the person to participate.

1. **Person-Directed.** The person directs the planning process (with the necessary support and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.
2. **Person-Centered.** The planning process focuses on the person, not the system or the person's family, guardian, or friends. The person's goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the person's needs or choices, rather than viewed as an annual event.
3. **Outcome-Based.** The person identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.
4. **Information, Support and Accommodations.** As needed, the person receives complete and unbiased information on services and support available, community resources, and options for providers, which are documented in the IPOS. Support and accommodation to assist the person to participate in the process are provided. The person is offered information on the full range of services available in an easy-to-understand format.
5. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process. See Section II below.
6. **Pre-Planning.** The purpose of pre-planning is for the person to gather the information and resources necessary for effective PCP and set the agenda for the PCP

process. Each person must use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all needed actions (e.g., invite desired participants):

- a. When and where the meeting will be held.
 - b. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).
 - c. 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. (What will be discussed and not discussed).
 - d. The specific PCP format or tool chosen by the person to be used for PCP.
 - e. What accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).
 - f. Who will facilitate the meeting. Including offering an independent facilitator to facilitate the meeting.
 - g. Who will take notes about what is discussed at the meeting.
7. **Wellness and Well-Being.** Issues of wellness, well-being, physical health, and primary care coordination support needed for the person to live the way he or she wants 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 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 person's right to assume some degree of personal risk. The plan must ensure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompasses a range of circumstances (e.g., weather, housing, support staff).
8. **Participation of Allies.** Through the pre-planning process, the person selects allies (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. An individual chosen or required by the person served may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the person served or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

To assure person served involvement in the process, individuals will be asked by their assigned Case Holder to complete the Life Choices Document (see exhibit below) during the pre-planning aspect of the Individual Plan of Service (IPOS).

Persons Served should be offered the ability to create a Crisis Plan, Crisis Stabilization Plan, Psychiatric Advanced Directive, or a Wellness Recovery Action Plan.

The goal of a crisis plan, crisis stabilization plan, psychiatric advanced directive or a wellness recovery action plan is to help the individual and their allies identify signs when the person served is heading for a relapse or needs additional support. This type of planning is to divert crisis intervention or hospitalization or residential treatment and to prevent relapse, by offering additional support to the person served to keep the person in the community.

Discussion with the person served about this type of planning should occur:

- 1) After a hospitalization when the person is healthy enough to discuss or discuss with the person served 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 person served is discussing a less restrictive treatment setting such as step down from an Alternative Treatment Order, or a Court Order.
- 5) After attempting suicide or increase in suicidal thoughts. Please refer to SCCMHA policy 02.03.24 Suicide Prevention

All agency and network staff, at all levels of the organizations (including secretaries, administrators, psychiatrists, janitors, etc.), shall have training in person-centered planning concepts and philosophy within 30 days of hire and annually thereafter.

Additionally, Case Holders will be evaluated at least annually on their knowledge and utilization of the process for their caseloads. This will be part of the annual performance evaluation.

Whenever feasible, the person served should be involved in providing person-centered planning training as co-presenters.

Person-Centered/family planning training should be available and open to persons served, family members and the general public.

To assure 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 person served PCP Process using the PCP Fidelity Checklist 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.

All direct care staff that are tasked with carrying out the individual plan of service, are required to have a copy of the person served IPOS at the provider setting and will be in-serviced by the person that writes the goals for the plan. For instance, if an occupational therapist writes a goal that will be carried out by a community living support staff person or a residential staff person, the occupational therapist is responsible for in-servicing the staff to assure the staff have understanding of the plan as well as can implement the goals as intended by the writer of the goal. A writer of a goal can in-service a home manager/ or lead designated by the organization to in-service staff. The writer of the goal is required to complete an in-service document (see exhibit E). Once the in-service is complete, the document will be scanned into the person served electronic health record (E.H.R.)-senti under IPOSs in-service records. An in-service of the plan should be completed at least annually. The goal writer should also be in-service if there is an extensive change in staffing, or if there are concerns regarding the implementation of the goal. The role of the case manager is to ensure that all staff are in-serviced and that uploads of the in-service documents are in the person served chart.

If new staff are hired after the in-service by the goal writer, it is the responsibility of the home manager or lead designated by the organization to in-service staff and have them sign an in-service log (see exhibit E) and to ensure the in-service log is uploaded.

It is the responsibility of SCCMHA contracted providers to maintain a copy of the person served IPOS and ensure staff are trained prior to service delivery.

Definitions:

Person-Centered Planning: means a process for planning and supporting the individual receiving services that build upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. [MCL 330.1700(g)]

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

Independent Facilitator: A person who attends the pre planning and/planning meeting to discuss the desires of the person served. This person focuses the conversation on the person

served a how their desired goals can be met. SCCMHA has a contract with an agency that provides this service.

References:

The Michigan Mental Health Code

MDHHS Medicaid Provider Manual

MDHHS Person-Centered Planning Policy (June 5, 2017)

MDHHS Person-Centered Planning Policy and Practice Guideline (updated 1/31/2022)

[Policies & Practice Guidelines \(michigan.gov\)](https://www.michigan.gov/policy-guidelines)

SCCMHA Policy & Procedure 02.03.03B Family Centered Practice

SCCMHA Policy & Procedure 02.03.24 Suicide Prevention

Exhibits:

Exhibit A - Chart of Elements/strategies

Exhibit B – Life Choices Documentation Form

Exhibit C – Person Centered Planning Process-Fidelity Checklist

Exhibit D –IPOS Workflow and Activities

Exhibit E – Inservice Documentation Form

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 Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services
Provides leadership through policy that requires staff and network adherence to Person/family Centered Planning policy and practices.	CEO Executive Director of Clinical Services Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services
Assures that training is made available on a regular basis to new staff and contractors as well as person served and family members and that, when possible, person served are involved in providing the training, co-presenters.	CEO Executive Director of Clinical Services Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services SCCMHA Training Unit Supervisor of Customer Services
Case Holder evaluation of utilization of Person-Centered Plan is conducted at least	Clinical Supervisor

annually as part of staff performance evaluation

Assures that all decisions involving a persons served are made utilizing the concepts of person/family centered planning.

Person/family centered planning processes begin when the individual makes a request to the agency. The first step is to find out from the individual the reason for his/her request for assistance. During this process, the individual needs and valued outcomes are identified rather than requests for a specific type of service. Staff can use the attached Chart of Elements/Strategies to determine how to proceed based upon the person's/family's wants and needs.

Before a person/family centered planning meeting is initiated, a pre-planning meeting occurs, and all decisions are documented. In the pre-planning the individual chooses:

“Dreams, goals, desires, and any topics which he/she would like to talk about at the meeting.

“Topics he/she does not want discussed at the meeting.

“Who to invite and who will be responsible for inviting those individuals.

“Where and when the meeting will be held.

“Who will facilitate the meeting? The person served must be given choices including the option for independent facilitation.

“Who will be responsible for recording the meeting?

“Whether the adult individual is interested in participating in self-determination

Before the person/family centered planning meeting is initiated, a Psychosocial Assessment is completed. Annual assessments are completed within 364 days of the last assessment and no more than 45 days prior to the person served planning meeting.

SCCMHA Network

SCCMHA Centralized Access and Intake Staff/Family Guide

Case Holder/Parent/guardian when applicable

Case Holder
Person served

The person/family centered planning meeting is held and directed according to the choices made by the individual/family during the pre-planning meeting.

Person Served
Facilitator
Case Holder
Parent/guardian when applicable
Family members and other invited guests

Each person served shall be given opportunities to express their needs and desired outcomes. Accommodation will be made as necessary to maximize the individual's ability for self-expression. Sensitivity to cultural and linguistic (styles of communication) responsiveness will be practiced.

Person Served
Facilitator
Case Holder
Parent/guardian when applicable
Family members and other invited guests

Each person served is given the opportunity to develop a crisis plan to assist the individual in and those around the person recognize when the person served is regressing in their recovery and assist the person while they are healthy to make decisions about their care when they are feeling unwell or unable to make decisions about their care.

Person Served
Facilitator
Case Holder
Parent/guardian when applicable
Family members and other invited guests
Customer services

During the meeting, the person served is the focal point of conversation. The person served will be addressed directly in the style of communication that they prefer and is understandable by all participants. Simple and clear language will be used to assure understanding of all participants. The person served will be empowered to make decisions regarding his/her care. The professionals involved will act as consultants to the person served rather than primary decisions makers.

Potential support and/or treatment options identified by the consultants/staff to meet the expressed needs/desires of the individual/family will be presented to, discussed with, and approved by the individual/family. All participants should maintain a positive focus on the person served abilities. The individual's choices and preferences about their support and services should always be

Person Served
Facilitator
Case Holder
Parent/guardian when applicable
Family members and other invited guests
Customer services

given primary consideration in planning. Issues and concerns that the individual or others have about the individual's health, welfare and safety should be shared with the individual/family as they make choices. Care will be taken to include access to high quality physical health needs as well as behavioral health. In addition, social services, housing, educational systems, and employment opportunities to facilitate wellness and recovery of the whole person.

Throughout the planning process, the resources and support that are already available to the person served including natural/community supports will be identified. The planning team should consider how these natural supports could be utilized to help the person served/family reach their dreams and desires. If the person served has no natural support, the team will discuss how such support will be developed.

Persons Served are encouraged and supported to reach their highest potential. To the extent possible, the individual shall be given the opportunity to experience the options available prior to making a choice/decision. This is particularly true for individuals who have limited life experiences in the community with respect to housing, work, and other domains.

Person/family centered planning is a dynamic process. Persons Served have the opportunity to reconvene any or all of the planning processes whenever they want or need. Persons Served with dual diagnosis of MI/SUD will have periodic reviews of their PCP completed every 90 days.

Each person served is provided with a copy of their person/family centered plan within 15 business days after the meeting.

Person Served
Facilitator
Case Holder
Parent/guardian when applicable
Family members and other invited guests
Customer services

Person Served
Facilitator
Case Holder
Parent/guardian when applicable
Family members and other invited guests
Customer services

Person Served
Case Holder

Persons Served
Case Holder

People served/families are provided with ongoing opportunities to provide feedback on how they feel about the service, support, and/or treatment he/she receives and his/her progress toward attaining varied outcomes. Information is collected and changes are made in response to the person served/family's feedback.

Case Holder

Once all parties have agreed to all elements of the Person-Centered Plan, the plan will be submitted to the departmental supervisor for review and approval, then forwarded to Care Management for approval of authorization of requested services. The Person-Centered Plan is effective on the date which the required supervisor signs the plan.

Clinical Supervisor, Case Holder, and Care Management

Annually, the Clinical Supervisor will shadow each assigned Case Holder through at least one person served PCP Process using the PCP Fidelity Checklist to train and assess that Case Holder's understanding of the PCP Process. The results of this checklist 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.

Case Holder, Enhanced Health Staff, ABA provider, Community Living Supports Staff, Self Determination Staff, Residential Staff

In-services of the person served plans:

All direct care staff responsible for carrying out the person served IPOS must be in-serviced on the person served goal(s) by the writer of the goal.

Home Manager, lead worker of the organization, Case Holder, Enhanced Health Staff, Persons Served under Self Determination

Will sign an in-service document as proof of in-service.

Will upload the document into the person served E.H.R.

Will ensure all staff have been in-serviced on the person served plan.

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 stabilize the individual's crisis situation. 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.	Should ask at 1 st meeting!	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

Saginaw County Community Mental Health Authority Life Choices Documentation Form

SCCMHA Funded Licensed Residential Setting

Name: _____ Date: _____
Birth Date: _____ Case: _____ Name of home: _____

The Home and Community Final Rule (HCBS) of Medicaid tells SCCMHA to help you to live your life as you would like to live it. This includes assisting you with your choices about where to live, work, and being part of our community. We must treat you just like any person would be treated. The HCBS Final Rule says that we do this through the Person-Centered Planning Process. This form is to help us know about your choices.

You have the right to choose the home you live in from various options. Given the choices available to you at this time, is your current home where you choose to live?	Yes ☐	No ☐
You also have the right to choose your roommate from available options. Given the choices available to you at this time, are you happy with your current roommate?	Yes ☐	No ☐

If at any time you are not happy with the home you live in or your roommate, you can notify your worker: _____, phone: _____ to help you to find out about the choices available.

If you live in a place that you do not own or rent, and have staff present, then please answer these questions:			
The Resident Care Agreement (BCAL-3266) that I (or my guardian) signed, also included a document known as "Summary of Resident Rights: Discharges and Complaints".	Yes ☐	No ☐	Don't know ☐
My bedroom door is lockable from the inside.	Yes ☐	No ☐	
I am able to furnish and decorate my room the way that I want to.	Yes ☐	No ☐	
I set my own schedule (For example: I go to bed when I want to, bathe when I want to, etc.).	Yes ☐	No ☐	
I have access to food at any time.	Yes ☐	No ☐	
I can have visitors whenever I want to.	Yes ☐	No ☐	
I have a place to securely lock up my possessions.	Yes ☐	No ☐	
I receive privacy while doing or receiving personal care.	Yes ☐	No ☐	
*If you answered "no" to any of the above, these should be looked at through the PCP process until resolved.			
I am aware of, and agree to, the following home restriction(s) in place for the safety of fellow residents, that may limit my access to items or activities: (mark all that apply) ☐ No Restrictions			
☐ Restricted visitor timeframe ☐ Laundry Not Accessible ☐ Alarms on doors ☐ Sharp knives locked up			
☐ Quiet Time Hours ☐ Limited access to extra food/snacks ☐ Other restrictions: _____			
Of those restriction(s) checked, I desire access/accommodations to the following, which will be addressed in my individual plan of service: (mark all that apply) ☐ No Restrictions			
☐ Restricted visitor timeframe ☐ Laundry Not Accessible ☐ Alarms on doors ☐ Sharp knives locked up			
☐ Quiet Time Hours ☐ Limited access to extra food/snacks ☐ Other restrictions: _____			

Signature of Person Receiving Services or Legal Representative _____

Date _____

Saginaw County Community Mental Health Authority Life Choices Documentation Form

Non-Residential Settings

Name: _____ Date: _____

Birth Date: _____ Case: _____ Program: _____

The Home and Community Final Rule (HCBS) of Medicaid tells SCCMHA to help you to live your life as you would like to live it. This includes assisting you with your choices about where to live, work, and being part of our community. We must treat you just like any person would be treated. The HCBS Final Rule says that we do this through the Person-Centered Planning Process. This form is to help us know about your choices.

Saginaw County Community Mental Health provides a full range of work and job options including supports to seek employment.

If I want to become employed, I can contact my worker - _____

Phone: _____ to help me find a program to help me find a job.

I am aware about the options available to help me to become part of my community and to develop skills: Supported Employment; Community Ties; Guardian Angels; SVRC, Community Living Supports; Bay Side Lodge; Friends for Recovery; etc.), and chose to attend the program listed above.	Yes ☐	No ☐	Don't know ☐
I am aware that I can make changes at anytime by contacting the worker listed above.	Yes ☐	No ☐	
I am able to choose the hours and days that I attend.	Yes ☐	No ☐	
If I need help with personal care, I receive it in a private place.	Yes ☐	No ☐	
The amount of time I get to go out into the community while I attend this program meets my needs and choices.	Yes ☐	No ☐	
The amount of time I spend with people without disabilities while I attend this program meets my needs and choices.	Yes ☐	No ☐	
My lunch break is scheduled the same as other people working on my job.	Yes ☐	No ☐	
I am OK with the employee benefits I receive.	Yes ☐	No ☐	☐ N/A (I am not an employee)
I am happy with the type of work I do for my employer.	Yes ☐	No ☐	☐ N/A (I am not an employee)

***If you answered "no" to any of the above, these should be looked at through the PCP process until resolved.**

Signature of Person Receiving Services or Legal Representative

Date

EXHIBIT C**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 person served permission), re-viewing written documentation, and through interview or discussion with the person served 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 support are based upon their interests, preferences, strengths, capacities, and dreams.	☐ 2 ☐ 1 ☐ 0	
3. Activities, support, 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, support, and services.	☐ 2 ☐ 1 ☐ 0	
9. A person is viewed as a unique and valued individual, not only as a client or a person of services.	☐ 2 ☐ 1 ☐ 0	
10. Planning meetings is a celebration of the person served	☐ 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, including clear conflict of interest guidelines for all planning participants.	☐ 2 ☐ 1 ☐ 0	

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 bullet 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 people 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 support 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, support, 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 support.**
 - 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 support and services is responsible to personal needs and desires, not the reverse.
 - When funding constraints require support 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. **A person is viewed as a unique and valued individual, not only as a client or a person served of services.**
 - Person-first language is used
 - Refrain from terms like:
 - Non-verbal
 - Low functioning
 - He is a runner, scratcher
 - Non-compliant
 - The "collective we": How are we doing today?
 - Preferred name and gender preferences used
 - Staff understand the background and 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
 - The staff used Motivational Interviewing 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 person served**
 - Discussions were positive, future oriented
 - The person served was encouraged to participate and control the process
 - Consideration was given for person served culture, trauma history, desires, dreams, aspirations
 - Strengths are highlighted - the focus of meetings was on the person served interests and talents while also considering how to actively use these strengths
 - The focus of meetings was on the person served 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 person served time to think and to respond
 - Multiple sources were used to obtain information to obtain a fuller picture of the person served

- 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 are promoted
 - Real opportunities are created
 - Respectfulness prevails
- The approach used was supportive of the person rather than directed by the staff
 - The person served was provided with 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 (60 days prior to IPOS expiration)

1. Case Holder (CH) reviews of information from previous year
 - 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 person served goals
3. CH and person served and (others):
 - a. Complete the Choice Document with the person served
 - b. Determine need or want for Enhanced Health Services (EHS)
 - i. Submit authorization for EHS
 - c. Determine need or want for Community Living Supports
4. CH meets with person served to complete the Pre-Plan form
5. Planning meeting set up (send invites, arrange location, etc.) is completed by parties designated in Pre-Plan
6. CH completes Assessment in Sentri prior to Planning Meeting (annual assessment should be completed within 364 days of the last assessment)
7. CH enters proposed IPOS goals in Sentri prior to Planning Meeting

Planning Meeting

8. At the Planning Meeting, the team
 - a. Reviews the current strengths of the person served from the various communities and SCCMHA provide support, services, and/or programs
 - b. Adds, Reviews and/or revises (if needed) the proposed goals
 - c. 15-day copy "clock" starts from date of planning meeting

Post Planning Meeting

9. CH completes the Planning meeting fields in Sentri (may be done after the planning meeting based on notes)
10. CH Simultaneously submits IPOS for
 - a. Supervisor Review, revision (if required) and approval
 - b. Submit Authorizations in Sentri, revision (if required) and approval
11. CH signs IPOS after Supervisor and authorization approvals
12. CH sends completed IPOS copy to guardian (if applicable), or person served for signature
 - a. CH documents sent in Sentri on IPOS form
 - b. CH documents person served/guardian signature date on IPOS form
 - c. CH assures that the signed Signature Page scanned
13. CH Review IPOS with programs and services
 - a. CH documents any in-service(s) on Sentri on PCP Header

- b. CH assures any in-service by other goal writers is completed and scanned into E.H.R.
 - c. Assures ongoing in-services of any new staff.
- 14. 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

SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

Date: _____

Consumer: _____ ID: _____

Location: _____ Start Time: _____ End Time: _____

IPOS or addendum dated: ____/____/____

[illegible]

☐ Aspect(s) of the IPOS reviewed: _____

Notes or Comments: _____

Trained by (print): _____ Title: _____

Signature: _____ (Credentials/Title)

(if not case holder, who trained the trainer listed) _____

9-9-2020