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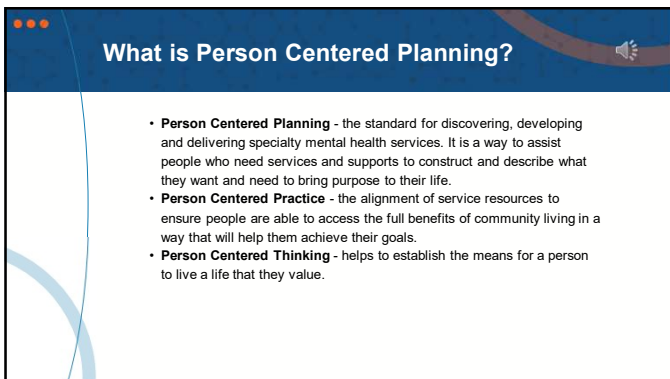
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**What is Person Centered Planning?**

- Discovering, developing and delivering specialty mental health services
- Designed to identify and respond to expressed needs and desires
- Includes pre-planning and all planning activities leading up to the development of the Individual Plan of Service (IPOS)
- Mandated by Michigan's Mental Health Code, the Affordable Care Act and the HCBS Final Rule.
- Self-determination through independence, productivity, and integrated community inclusion.
- Ongoing process that spans the entire time a person receives services

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**Youth Guided/Family Focused Planning Process**

- Family-driven, youth-guided approach.
- Needs of the child are interwoven with the needs of the family.
- Supports and services impact the entire family.
- As the child ages, services and supports become more youth-driven.



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**Youth Guided/Family Focused Planning Process**

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

1. Age 14 years or older and has requested services without the knowledge or consent of a parent, guardian or primary caregiver.
2. The minor is emancipated.
3. Inclusion would constitute a substantial risk of physical or emotional harm to the minor, or substantial disruption of the planning process.

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**Benefits**

- Individuals learn to express themselves, build self-respect, and practice interpersonal skills
- Positive changes in quality of life, abilities, and role within the community
- Builds a vision for their future and determines the steps required to get there
- Results in action plan that reflects the unique interests of the individual and the unique characteristics of the local community

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**Do's of Person Centered Planning**

- Focus on strengths and abilities
- Form unique, individualized plans
- Place authority with individuals and their support people
- Emphasize independence, self-direction and community participation

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**Pre-Planning Process**

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**Steps During the Pre-Planning Meeting**

The Pre-Planning Meeting must be completed in a separate meeting prior to the actual Person Centered Planning meeting.

Pre-planning is integral to creating a meaningful Person Centered Plan (IPOS). The pre-planning process includes:

1. Choosing who to invite
2. Choosing what topics they want to discuss
3. Setting the meeting date and location
4. Selecting a facilitator
5. Determining interest in self-directed services

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**Self-Directed Services**

Persons served may choose self-directed services and hire their own staff to provide services.

- This is a person, not employed by SCCCMH. The person served is the staff person's employer.
- Self-directed staff must meet Medicaid provider eligibility requirements.

If the person served is interested in exploring self-directed services, contact:

Greta Nichols  
gnichols@scccmh.org  
810-363-8481

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**Choosing Who to Invite**

A person's support people includes everyone they would need to assist them in achieving the goals of their plan.

- Family, guardian, friends, advocates, mentors, and other support people
- People the person feels comfortable with, whose opinions they value, who have the ability to guide and support them, and who share a vested interest in the person's future success.
- Service providers

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**Identifying Meeting Topics to Discuss**

Consider the following when planning what topics to discuss during the meeting:

- What topics does the person want to talk about?
- What topics do they not want to discuss during the meeting?
- Are there any topics the person wants to discuss separately from their Person Centered Planning meeting?

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**Setting the Meeting Date & Location**

Consider the following when planning a meeting:

- Where is a comfortable, convenient location?
- What time of day works best?
- What materials will be needed?

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**Choosing a Facilitator**

When choosing a facilitator, choose a trusted individual who has:

- Knowledge of the Person Centered Planning process
- Honors the person's ability to express their preferences, desires, dreams and hopes for the future
- Promotes dignity and respect
- Promotes a shared vision within the team
- Affirms a person's civil and legal rights

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### Role of the Facilitator

Here are some tips on how the facilitator can maintain a positive environment for the meeting:

1. Visualizing process where creative brainstorming can thrive
2. No wrong answers
3. Build on each other's ideas
4. Build trust and do no harm
5. Creativity is encouraged
6. Resolve conflict constructively
7. Communicate clearly
8. Bring the meeting to a close by re-communicating goals and strategies discussed throughout the meeting

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### Independent Facilitator

Persons served may choose an Independent Facilitator to lead their person centered planning meeting.

- This is a person, not employed by SCCCMH and not affiliated with the individual/family
- SCCCMH has a contract with external individuals to provide this service

If the person served is interested in an Independent Facilitator, contact:

**Kristen Thompson**  
 kthompson@scccmh.org  
 810-966-3747

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### How Does the Person Want to be Supported?

- Are you familiar with the person's cultural background?
- Do you know their interests and what is important to them now and in the future?
- How do they best communicate with others?
- What are their abilities and strengths?
- What do they want out of life?
- What are their hopes and fears?
- How do they wish to be supported?
- What areas do they want to be independent in?

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**Pre-Planning Meeting: Summary**

At the end of the Pre-Planning Meeting, verify:

- Date, time and location for the meeting
- Who is to be invited
- Who will contact potential participants
- Who will facilitate
- Who will record
- Topics to discuss or not discuss
- Method - collaborative documentation, notetaking. Be creative in how you elicit and record information!

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**Person Centered Planning Meeting Process**

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**Person Centered Planning (IPOS) Meeting**

The major objectives during the meeting are to:

- Empower the person with choice, independence and community inclusion
- Celebrate the person's strengths and talents
- Listen to the person to discover who they are and what they desire out of life
- Assist the person in the development of a plan that will support their ability to achieve the life they want to lead

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### Informed Decision Making

- Ensuring the individual's needs, goals, preferences and strengths are actively considered and integrated into all decisions
- Encouraging the individual to actively participate and contribute to the planning process
- Providing education about service array

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### Role of the Case Manager

**Assessment** - Assessing functioning and symptoms, independent living ability, etc.

**Advocacy** - Advocating for a second option, for independent living

**Coordination** - Coordination between SUD treatment facility and CMH, with a PCP office, with family

**Monitoring** - Noting progress from a professional viewpoint, observing interactions with peers, etc.

**Linking** - Linking to community resources, physical healthcare, to obtain an ID

**Planning** - Planning for housing, to become one's own guardian, etc.

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### Important Questions to Ask

These are important questions to ask at planning meetings in order to ensure a good person-centered plan:

- What is a person at this life stage typically engaged in?
- What's important to this individual?
- What choice and control do they have to drive their own life?
- What have they tried or never tried?
- What meaningful relationships do they have?
- What are they good at?
- Do they know they are good at something?

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### Medical Necessity

Services and supports included in a person's plan of service must be medically necessary.

- Essential to address a person's behavioral health condition.
- Serves as a standard to determine whether a service is justified based on: clinical needs, evidence-based practices, and the individual's overall health and treatment plan.
- Aligns with evidence-based practices and professional standards for treating the identified condition.
- Necessary for the individual's goals, stabilization or recovery.
- Appropriate to the person's age, developmental level and unique circumstances.

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### The Complete Golden Thread

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### Identifying Goals

What could you accomplish that would help you reach your dreams, and what are some steps you could take to move closer to your dreams?

When writing goals, make sure they are SMART goals (specific, measurable, actionable, realistic and time-limited). Objectives must be specific (3 hours per week, 4 times per week, etc.)

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**Identifying Barriers**

- What barriers or problems could get in the way of the person reaching their goals?
- What can you as the Case Manager do to address the barriers and help the person achieve their goals?
- What can the support team do to address the barriers and help the person achieve their goals?

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**Risk vs. Choice**

- Individuals have the right to live the life they want, even if their family or other support systems don't agree.
- Our job as SCCCMH staff is to advocate for and support each individual as they work to live the life they want.
- Demonstrate through documentation how the person had choice throughout the process.
- It's okay for a person to try something new and fail. Failing forward can be a positive thing!

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**Summarizing the Plan**

- Present a verbal summary of the meeting
- Ask for additions/corrections
- Evaluate the process
- Confirm that the plan seems to be workable
- Review the interventions, including who will meet the need and how the need will be met
- The IPOS is a living document

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## Completing the IPOS in OASIS

The completed IPOS must indicate/include:

- The start date the IPOS takes effect
- The expected start date for each service
- All medically necessary services the individual chooses to receive
- The specialty benefit plan services to be coordinated and integrated with the person's primary care physician.
- The service coordination activities that will occur with other community agencies (Medicaid Health Plans, court systems, health department, etc.)
- The opportunity for the individual to develop a crisis plan.
- The person's need for: food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation and recreation.

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## Medical Necessity

The determination of medically necessary support, service or treatment must be:

- Based on information provided by the person and/or other people who know the person.
- Based on clinical information from health care professionals who have evaluated the person.
- Based on person centered planning.
- Made by appropriately trained professionals with sufficient clinical experience.
- Made within federal and state standards for timeliness.
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the plan of service.

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## Payer Considerations

SCCCMH is the payer of last resort, meaning the Case Manager should be looking for and identifying supports in the following order:

1

**NATURAL SUPPORTS**

Unpaid relationships within a person's everyday life like friends, family, neighbors, etc.

2

**COMMUNITY RESOURCES**

Services and organizations available within the community, including both formal (such as agencies/organizations) and informal (such as clubs, library programs), which may or may not be directly connected to a person's network.

3

**ST. CLAIR COUNTY CMH**

After utilizing natural supports and then community resources that are available to help an individual achieve their goals, SCCCMH will offer supports to meet any medically necessary unmet need.

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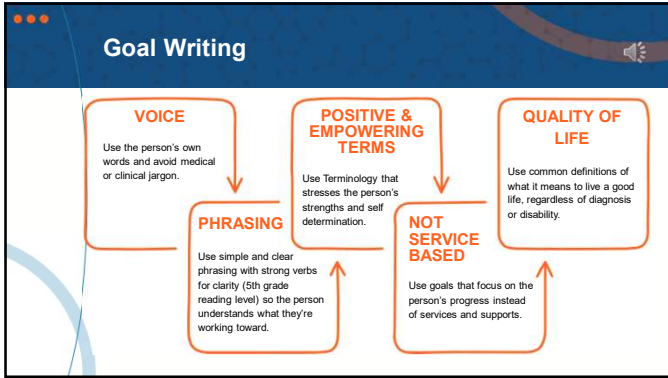
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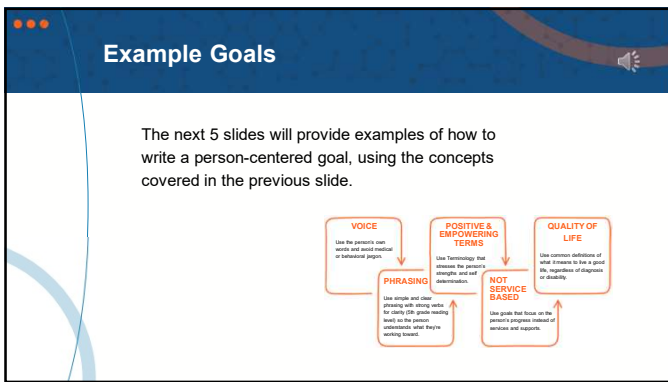
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### Example Goals

**VOICE**  
It's important to involve the person in the goal-setting process.

**YES** I want to do fun things with my friends.

**NO** Patient will participate in community activities.

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**Example Goals**

**POSITIVE & EMPOWERING TERMS**  
 Positive terminology stresses the person's strengths and ability to choose.

**YES** I want to feel good enough to care for my children.

**NO** I don't want to drink anymore.

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**Example Goals**

**QUALITY OF LIFE**  
 Goals should provide a sense of direction, motivation, a clear focus and clear importance.

**YES** I want to have a part-time job.

**NO** I will meet with my psychiatrist.

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**Example Goals**

**PHRASING**  
 The person should clearly understand what they are working toward.

**YES** I want to make my own money.

**NO** Person will demonstrate job readiness by mastering employment skills.

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### Example Goals

**NON SERVICE-BASED**  
Goals are based on the person's hopes, desires and dreams - not compliance or services.

**YES** I want to have friends.

**NO** Person will follow the treatment plan

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### Objectives

**SUBJECT**: The person is the subject of the sentence.

**PHRASING**: Use simple and clear phrasing with strong verbs for clarity (6th grade reading level).

**NOT SERVICE BASED**: Use objectives that promote a person's progress toward life goals instead of focusing on services and supports.

**SPECIFIC**: Use objectives with clear expectations and unambiguous language.

**MEASURABLE**: Use objectives with an observable threshold to allow consensus agreement if it has been completed. Account for the person's desires.

**ACHIEVABLE**: Use objectives that are challenging enough for inspiration, but not so difficult that failure is probable.

**RELEVANT**: Use objectives that are relevant to achieving the goal it is associated with.

**TIMEBOUND**: Use objectives that have a deadline - start and finish date.

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### Example Objectives

The next 8 slides will provide examples of how to write a person-centered objective, using the concepts covered in the previous slide.

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**Example Objectives**

**SUBJECT**  
The person is accomplishing the objective to meet their goal.

**YES** I will attend one job fair in the next two months.

**NO** My case manager will provide me a list of job fairs.

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**Example Objectives**

**PHRASING**  
The person should clearly understand what they are working toward.

**YES** After group, I will list three new ways to respond in crisis.

**NO** The person will demonstrate the acquisition of cognitive behavioral responses.

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**Example Objectives**

**NON SERVICE-BASED**  
Services are not 100% effective for all people or purposes; avoid getting "stuck" with services that don't help them meet goals.

**YES** I will create a daily routine of self-care to follow by December 1st.

**NO** The person will participate in group therapy.

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**Example Objectives**

**SPECIFIC**  
Helps the person avoid distractions and procrastination, resulting in a greater chance of the objective being accomplished.

**YES** I will save 50% of wages each week for housing.

**NO** I will work harder.

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**Example Objectives**

**MEASURABLE**  
Objectives with assured clarity have a greater chance of being accomplished.

**YES** By March 30, I will use 3 new anger management skills and report the results to my therapist.

**NO** I will not get angry and become violent 95% of the time.

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**Example Objectives**

**ACHIEVABLE**  
Supports engagement, and sense of accomplishment and self-efficacy increases for the person as progress is made.

**YES** I will demonstrate at least one assertiveness skill during each group session.

**NO** The person will always demonstrate good choices.

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**Example Objectives**

**RELEVANT**  
Helps the person associate specific, implementable objectives with the significance of the broader goal.

**YES** I will spend less and save more by January 31 as evidenced by my accounts.

**NO** I will learn to bowl.

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**Example Objectives**

**TIMEBOUND**  
Without a time-constraint, there is no sense of urgency, resulting in less motivation.

**YES** By April 15th, I will have all my taxes filed.

**NO** I will look for a job.

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**Amount, Scope, Duration & Frequency**

**AMOUNT** → Number of units to be provided per service  
• 15 minutes, 1 hour, 11 units, etc.

**SCOPE** → **Who** will provide the service, **how** the services will be provided and **where** the service will occur.  
• Case manager, clinician, MHA, etc.  
• Face to Face, in group, individually, etc.  
• In the community, in the office, at home, etc.

**DURATION** → Length it is expected for a service to be provided  
• 6 weeks, 3 months, 1 year, etc.

**FREQUENCY** → How often the service will be provided.  
• Daily, biweekly, monthly, quarterly, etc.

CITATION: P.5.1 & P.1.8.2  
Services and supports are provided as specified in the IPOS including type, amount, scope, duration and frequency.

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**Amount, Scope, Duration & Frequency**

- Be as specific as possible when defining Amount, Scope, Duration, and Frequency (ASFD) for each service.
- Do not use ranges (15-30 minutes, 1-2 times a week, as needed), except when flexibility is allowed (self-determined services).
- The number of units documented in the IPOS should match what is actually being provided.

CITATION: P.5.1 & P.1.B.2  
Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency.

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**Signatures**

**Signatures:**

- Completed and signed within 35 calendar days
- Individual, guardian, caseholder and supervisor
- Verbal consent documentation
- Documentation for rare cases when not completed within 35 days
- Absentee Signatures
- ACT and Community Waiver recipients - additional requirements

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**Sharing the Document**

**Sharing the IPOS with family, friends and caregivers:**

- Provide within 15 calendar days of the meeting date
- Complete Enter Delivery Information section

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**IPOS is a Living Document**

- Modify as needed
- Develop new IPOS every 12 months
- Changes to IPOS as needed and ongoing
- Review every 90 days
- Discuss routinely
- Written copy within 15 business days

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**Person Centered Planning Tools & Resources**

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**Tools & Resources**

- State of Michigan person-centered planning policy, independent facilitation resources, tips for writing goals and objectives, and list of tools/resources is available at:  
<https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/person-centered-planning>

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