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| **MONTCALM CARE NETWORK PROCEDURE 611 North State Street, Stanton, MI 48888** | |
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| SUBJECT: Person/Family Centered  Planning (PFCP) | Section: 8119A |
| Effective Date: May 27, 1997 | Revised Date: June 10, 2024 |

Montcalm Care Network has adopted MDHHS contractually defined practice guidelines and any associated interpretive advisories as the basis for our best practice guideline for Person/Family Centered Planning (PFCP).

**PERSON CENTERED PLANNING FOR ADULTS:**

Montcalm Care Network's Person/Family Centered Planning processes will include the following elements:

1. Person-Directed: Individual leads the process and decides when to meet, where and who to invite.
2. Person-Centered: Focused on the individual, not the system or the person’s family, guardian, or supports.
3. Outcome-Based: The person identifies outcomes to achieve in pursuing goals.
4. Information, Support and Accommodations: The person receives complete, unbiased information on services and accommodations to understand information as needed.
5. Independent Facilitation: The person can choose an independent facilitator.
6. Pre-Planning: Each person pre-plans to ensure a successful PCP process.
7. Wellness and Well-being: Issues of wellness, well-being and primary care coordination are discussed to ensure people have the supports to live as they choose with the dignity of risk to make health choice like any other member of the community.
8. Participation of Allies: The person chooses allies (friends, family, and others) to support him/her through the PCP process.

**INDICATORS REFLECTING PERSON-CENTERED PROCESS:**

An Individual Plan of Services (IPOS) will be developed utilizing the PCP process minimally on annual basis (every 365 days) using first person language, understandable to the individual with minimal clinical jargon, and the individual will receive a copy of that plan within 15 business days of completing the PCP process. Written documentation contained in the annual assessment and treatment plan shall reflect the following indications of compliance with Person/Family Centered Processes:

1. A description of individual strengths, abilities, plans, hopes, interests, preferences, and natural supports.
2. The goals and outcomes identified by the person and how progress toward achieving outcomes will be measured.
3. The services and supports needed to work toward or achieve those outcomes through the CMH, other publicly funded programs, community supports, and natural supports.
4. The setting the person chooses to live in and what alternatives were considered. How that setting is integrated into the larger community with opportunities for employment in a competitive setting, engagement in community life, control of personal resources, and the ability to receive services with the same access as persons not in the mental health setting.
5. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the CMH.
6. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.
7. Documentation of any restrictions or modifications of additional conditions.
8. Any services the person is receiving through Self-Determination.
9. The estimate/prospective cost of services and supports authorized by the CMH.
10. The roles and responsibilities of the person, the primary clinician, allies, and providers in implementing the IPOS.
11. The person responsible for monitoring the plan.
12. The signature of the person and/or representative and primary clinician.
13. The plan for sharing the IPOS with natural supports with the individual’s permission.

Documentation in the EHR of who received a copy of the plan.

1. A timeline for review of required notifications.

**TRAINING:**

The Agency staff involved in the Person/Family Centered Process will be provided training related to this process.

Training in the IPOS will be provided to families, foster care home management, direct care staff and other providers as indicated in the plan when a new IPOSis developed and when a change is made.

Informal training of individuals and other participants in the Person/Family Centered Planning process will occur at the Person/Family Centered Planning meetings at least annually and as needed.

The primary clinicianwill facilitate educational updates to those involved in the Person/Family Centered Process, including guardians, person served, home staff, program staff and other interested parties. Information to be shared will include:

1. The philosophy of Person/Family Centered Planning;
2. Rights and responsibilities of the planning process, including communication accommodations, accommodations for preferences of meeting times and place;
3. The QAPIP system will monitor documentation of Person/Family Centered Planning processes in the person served file through Peer and Utilization Review as needed.

**HEALTH AND SAFETY ASSURANCES:**

1. Health and safety screens will be completed minimally on an annual basis. Any identified issues in various community settings (home, work, school, community based social activities, etc.) will be monitored on an ongoing basis by all clinicians involved. Any identified health or safety concerns will be addressed in the IPOS. The plan should minimally include a referral for a physical examination by a qualified medical professional if there are any unmet identified medical concerns identified by the screening.
2. All persons served living in specialized residential settings will receive the following health assessments: annual physical examination completed by a physician, and a nursing assessment annually when medically necessary. Monitoring as indicated on the treatment plan.
3. The primary clinicianis responsible to oversee the coordination, implementation and supports required to insure health and safety of the person served. The primary clinicianis responsible to address safety issues in the annual assessment, individual plan and will monitor these issues at least quarterly.

Persons served choices in their lives will be respected by the treatment team and this MCN. In the case a person served choicesrelated to health and safety are contrary to medical advice or treatment team, the IPOS will highlight personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures to minimize them, while considering the person’s right to assume some degree of personal risk. The plan must assure health and safety. When necessary, an emergency or back-up plan must be documented and encompass a range of circumstances to address the individual health and safety risk.

**HOME and COMMUNITY BASED SERVICES GUIDELINES:**

Any efforts to restrict certain rights and freedom must be justified by a specific and individualized assessed health and safety need.

Rights and Freedoms in Home and Community Based Services (HCBS) for persons residing in specialized foster care.

1. Individuals care must have a lease or residency agreement.
2. Sleeping or living units must be lockable with only appropriate staff having a key.
3. Individuals sharing units must have a choice of roommate.
4. Individuals have a right to furnish and decorate their living unit within lease agreements.
5. Individuals have the right to control their own schedule and access to food.
6. Individuals are able to have visitors of their choosing at any time.

If a restriction to rights is made the IPOS should reflect:

1. The specific and individualized health or safety need.
2. The positive interventions and supports to be used prior to any modification.
3. Previous less intrusive methods that have been tried but were unsuccessful.
4. A description of the modification being proportional to the assessed health or safety need.
5. A regular collection and review of data for effectiveness of the modification.
6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Informed consent from the individual for the modification.
8. An assurance the modification will cause no harm.

**FAMILY CENTERED PLANNING FOR CHILDREN AND YOUTH:**

Family Centered Planning and services encompasses all of the principals, elements, indicators, and assurances of Person Centered Planning for adults with the following additional considerations.

1. For the purpose of this process, a child is defined as a minor up through age twelve (12), a youth is defined as a minor ages 13 through 18.
2. A family self defines who is included in the family and their choices of participants in the Family Centered Planning process.
3. Because child development is at a faster rate than occurs with adults, more frequent review of the plan may be needed or may be required by certain programs.
4. Family Centered Planning and services include the following:
5. The recognition that parents play an essential role in the lives of their children and have the most significant influence on the child's health, growth, development and welfare.
6. The recognition that the enhancement of parental competence is the best avenue for achieving better outcomes for children.
7. The understanding that services and plans must be family-specific, culturally competent and individualized based on the strengths, concerns and resources of the family.
8. The understanding that interventions that build competence and skills promotes self empowerment and resiliency.
9. The understanding that children are best served through the promotion of child/youth choice and leadership consistent with the maturity of the child or youth in preparation for the responsibilities of adulthood.
10. Participants adhere to the following applications of family centered principals:
    1. Partnerships are developed with parents, children and youth.

* Families have unbiased access to the same information that providers have.
* Families are included in all communication about the child.
* Families are counseled about what will work best for their child and their family.
* Families are supported and encouraged to include children in the planning process.
* The partnership with youth is enhanced as they are taught the skills to direct their own treatment outcomes.
* Disagreements between parents and child about who should be involved in the planning process should be negotiated to ensure that the process is as inclusive as possible.
  1. Mutual respect and honesty exist between all partners
* Families are treated as valued customers by every staff they encounter
* Parents receive supportive feedback to help them to be effective; parents are encouraged to do the same for providers.
* Families and providers work together to define responsibilities and roles for carrying out the family-centered plan.
* No decisions are made without consultation of the family.
* Youth are given information to make choices.
  1. Planning and services are individualized
* Each family's plan is unique and includes the services and supports they need and choose as best suited to their family.
* The individualized plan incorporates the child's, youth's and family's strengths and culture.
* The planning process and service is tailored to the child's development. And as children mature, they are expected to make more choices for themselves.
* Family strengths and individual strengths are recognized and built upon.
* Families are told from first contacts that the purpose of mental health services is to build on existing strengths and competencies.
* Help parents to focus most on their child's strengths rather than on their diagnosis or disability.
* Help parents to recognize the strengths of other family members.
  1. Family culture is acknowledged and respected
* Providers actively seek information directly from the family about the family culture.
* Family culture is considered as a major influence impacting the selection of interventions.
* All written materials are available in the native language or preferred mode of communication with the parents, child and youth.
* Language assistance is provided as needed and requested by the family.
* Parenting competence and confidence are strengthened.
* Parents receive supportive feedback regarding their current parenting strategies.
* Parents engage with providers to develop strategies to increase parenting effectiveness.
* The needs of children and youth and family are assessed with families and parenting strategies are individualized based on the strengths, interests and culture of the child, youth and parent.

1. During the pre-meeting process, the family should identify the goals, dreams and desires of the family for their child and family. The child or youth should also have an opportunity to express goals, dreams and desires for themselves and those included in the family discussion in age-appropriate terms. Topics the family/child/youth do not want to discuss are identified in the pre-meeting plan.
2. Parents are informed of independent facilitation options.
3. The plan should include a review of all potential support or treatment options including alternative services and should include the services and supports available through other systems of care including primary healthcare.
4. Health and safety needs are identified and the child or youth and family are provided with an opportunity to develop a crisis and or safety plan to include step-by-step instructions for all family members in the event of a crisis or safety emergency.
5. Parents of minor children are notified of the child's/families appeal and grievance rights.
6. Evidence of progress toward goals/desired outcomes made by the child/youth/family are discussed with the family and documented in progress notes.