ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

BOARD POLICY

Date Issued 03/24

CHAPTER		**CHAPTER**	**SECTION**	**SUBJECT**
Service Delivery		03	001	0005
SECTION	**SUBJECT**			
Treatment	Person-Centered-Planning Process/Individual Plan of Service			
WRITTEN BY	**REVISED BY**		**AUTHORIZED BY**	
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I. APPLICATION:

- ☒ SCCCMHA Board
- ☒ SCCCMHA Provider & Sub-Contractors
- ☒ Direct Operated Programs
- ☒ Community Agency Contractors
- ☒ Residential Programs
- ☒ Specialized Foster Care

II. POLICY STATEMENT:

It shall be the policy of the St. Clair County Community Mental Health Authority (SCCCMHA) Board to align with the PIHP and other regulatory agencies to ensure individuals served by SCCCMHA will have their Individual Plan of Service (IPOS) developed through a person-centered-process regardless of age, disability or residential setting in accordance with the procedures delineated herein. The IPOS shall contain goals and objectives that incorporate the unique needs, strengths, abilities, and preferences of the person served, as well as identified challenges. All individuals served shall be afforded the opportunity to utilize an Independent Facilitator to chair meetings held as part of the Person-Centered-Planning (PCP) process. When minor children and youth are identified as primary individual, this includes the use of a Family-Centered Approach to service planning unless the conditions stated in Standard M below are met.

III. DEFINITIONS:

A. Amount: The number of service units (e.g., 15 minutes = 1 unit, One hour of H2015 = 4 units) identified in and provided through the individual plan of service.

B. Adverse Benefit Determination: A decision that adversely impacts a Medicaid beneficiary or Non-Medicaid individuals' claim for services due to:

1. Denial or limited authorization of a requested service, including the type or level of service requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 42 CFR 438.400(b)(1).
2. Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2).
3. Denial, in whole or in part, of payment for a service. 42 CFR 438.400(b)(3).

4. Failure to make a standard Service Authorization decision and provide notice about the decision with 14 calendar days from the date of receipt of a standard request for service. 42CFR 438.210(d)(2).
5. Failure to make an expedited authorization decision within 72 hours after receipt of a request for expedited Service Authorization. 42 CFR 438.400(b)(4).
6. Failure to provide services within 14 calendar days of the start date agreed upon during the PIHP/Access Screening (10 days for CCBHC referrals) and as authorized by the PIHP/SCCCMHA. 42 CFR 438.210(d)(2).
7. Failure of the PIHP/SCCCMHA to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. 43 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).
8. Failure of the PIHP/SCCCMHA to resolve expedited appeals and provide notice within 72 hours (three working days) from the date of a request for an expedited appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).
9. Failure of the PIHP/SCCCMHA to resolve grievances and provide notice within 90 calendar days of the request. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).
10. For a resident of a rural area with only one MCO, the denial of a beneficiary's request to exercise his or her right to obtain services outside the network. 438.52(b)2(ii).
11. Denial of beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums deductibles, coinsurance, and other beneficiary's financial responsibility. 42 CFR 438.400(b)(7).

C. Certified Community Behavioral Health Clinics (CCBHC) Enrollee: any individual with a MI, SED or SUD diagnosis who seeks a comprehensive range of Behavioral Health Services regardless of the ability to pay, and place of residency.

D. Crisis Intervention: Unscheduled services conducted for purpose of resolving a crisis situation requiring immediate attention. Crisis Intervention services must always pertain to a crisis situation. Crisis Intervention services include crisis response, crisis line, assessment, referral and direct therapy.

E. Crisis Plans (Psychiatric Advance Directives): A set of specific procedures or plan put into the Individual Plan of Service during the person centered planning process that, should the individual choose, will be followed in the event of a psychiatric crisis (a form of advance directive).

F. Crisis Situation: Means a situation in which the individual is experiencing a serious mental illness or intellectual/developmental disability, or child experiencing a serious emotional disturbance, and one of the following applies: (1) The individual can reasonably be expected within the near future to physically injure himself, or another individual, either intentionally or unintentionally. (2) The individual is unable to provide himself food, shelter, clothing, or attend to basic physical activities such as eating, toileting, bathing, etc., and this inability may lead to harm to the individual or to another individual. (3) The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior can reasonably be expected in the near future to result in physical harm to the individual or to another person.

G. Duration: The length of time (e.g. three weeks; six months) it is expected that a service identified in the individual plan of service will be provided.

H. Effective Date of IPOS: This is the date that the PCP Face to Face meeting is held and the plan is written. This date serves as the start date for utilization review purposes as well as for tracking Medicaid and renewal timeframes.

I. Emancipated Minor: The termination of the rights of the parents to the custody, control, services and earnings of a minor, which occurs by operation of law or pursuant to a petition, filed by a minor with the probate court.

J. Emergency Situation: A situation when the individual: (1) Can reasonably be expected in the near future to physically injure himself, herself, or another person. (2) Is unable to attend to food, clothing, shelter or basic physical activities that may lead to future harm. (3) The individual's judgment is impaired leading to the inability to understand the need for treatment resulting in physical harm to self or others.

K. Family Member: A parent, stepparent, spouse, sibling, child, grandparent or an individual upon whom a primary individual is dependent for at least 50 percent of his or her financial support. However, for the purposes of this policy, the individual (and parents for the minor child) can define who is considered family for the person-centered planning process.

L. Guardian: A person appointed by the court to exercise specific powers over an individual who is a minor, legally incapacitated or has and intellectual/developmentally disability.

M. Independent Facilitator: A trained individual, chosen by the individual served, who is not an employee of CMH, PIHP or a Service Provider under contract with the CMH who chairs the Assessment/pre-meeting and PCP Meeting and ensures that all principles of PCP are met and all components addressed.

N. Individual Plan of Service (IPOS): A written plan of service that specifies goal oriented treatment or training and support services, directed by the individual as required by the Mental Health Code. The IPOS identifies the needs and goals of the individual receiving services; and the amount, duration and scope of the services and supports to be provided. For persons receiving mental health services, the individual plan of service must be developed through a person-centered planning process. In case of minors, the child and his family are the focus of service planning, and family members are an integral part of the treatment planning process. This document may be referred to as a treatment plan or a support plan.

O. Medical Necessity: Determination made by a professional practitioner that a specific service is medically (clinically) appropriate, necessary to meet the needs of the service recipient, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care.

P. Minor: An individual under the age of 18 years.

Q. Natural Support: A person who is involved in an individual's life other than just for pay.

R. Person-Centered-Planning: A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community and honor the individual's preferences, choices, and abilities. The person-centered-planning process involves families, friends, and professionals as the individual desires or requires. When minor children and youth are identified as primary individual, this includes the use of a Family Centered Approach to service planning.

S. Primary Case Holder: The staff person who works with the individual to gain access to and coordinate the services, supports and/or treatment which the individual wants or needs. This can include the Case Manager, Clinician, Clinical/Case Manager, Nurse/Casemanager.

T. Scope of Service: The parameters within which the service will be provided. Scope entails the following elements: WHO (e.g. the professional, paraprofessional, aide supervised by a professional); HOW (e.g. face-to-face, telephone, taxi or bus, group or individual); and WHERE (e.g., community setting; office; individual's home). The "scope" of each service provided to each person receiving services must be specified in the individual plan of service.

U. Support Plan: Means a written plan that specifies the personal support services or any other supports that are to be developed with and provided to a recipient of services.

V. Treatment Planning: Planning activities associated with the development and periodic review of the Individual Plan of Service. Treatment planning includes all aspects of the person centered planning process, such as pre-meeting activities, and external facilitation of PCP planning, as well as elements of the Individualized Treatment Planning process. This includes writing goals, objectives, and outcomes, designing strategies to achieve outcomes (i.e. identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending planning meetings per invitation; and documentation.

W. Urgent Situation: A situation in which an individual is determined to be at risk of experiencing an emergency situation in the near future if he or she does not receive care, treatment or support services.

IV. STANDARDS:

Person Center Planning Process

A. Person-Centered Planning is a highly individualized process designed to respond to the expressed needs/desires of the individual. The following statements are values and principles underlying the Person-Center Planning process:

1. Each individual has strengths, and the ability to express preferences and to make choices.
2. The individual's choices and preferences shall always be honored and considered, if not always granted.

3. Each individual has gifts and contributions to offer to the community, and has the ability to choose how supports, services and/or treatment may help them utilize their gifts and make contributions to community life.
4. Person-Centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals, and desires.
5. A person's cultural background shall be recognized and valued in the decision-making process, the delivery of services and supports.

B. Person-Centered Planning Elements/Strategies, Exhibit A. is to be used by the person representing the PIHP/CMH, depending upon what the individual wants and needs.

C. An individual's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services and recreation, as desired or required, will be assessed during the Person-Centered Planning process.

D. Person-Centered Planning is a process in which the individual is provided with opportunities to reconvene any or all of the planning processes whenever he/she wants or needs.

E. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate in the planning meeting(s) to assist the individual with his/her dreams, goals, desires, and recovery.

F. The development of natural supports shall be viewed as an equal responsibility of the PIHP/Community Mental Health Specialty Program (CMHSP) and the individual. The PIHP/CMHSP, in partnership with the individual, is expected to develop, initiate, strengthen, and maintain community connections and friendships through the person-centered planning process.

G. To help the individual reach their goals and become a more active member of the community, supports and services are considered in this order:

1. The individual.
2. Their family, guardian, friends, and significant others.
3. The resources in the neighborhood and community.
4. Public funded supports and services available to all citizens.
5. Public funded supports and services provided under the auspices of the local county CMH.

H. Recipients and their family members shall be treated with dignity and respect. Family members shall be given an opportunity, if the person chooses involvement, to provide information to the Person-Centered Planning team. Family members shall be provided an opportunity to request and receive educational information about the nature of disorders, medications and their side effects, support services in the agency and community (including advocacy and personal support groups), coping strategies.

I. The individual is provided with the options of choosing external independent facilitation of his/her meeting(s), unless the individual is receiving short-term outpatient therapy only, medication only, or is incarcerated. The Independent Facilitator and recipient of services shall be present at all

scheduled meetings where discussion of the individual's IPOS takes place. The Independent Facilitator shall be trained.

J. Recipients shall be given a choice of physician or mental health professional within the limits of available staff within the program. MCL 330.1713.

K. Before a Person-Centered Planning meeting is initiated, a Pre-Planning meeting occurs. (The Pre Planning meeting is not to occur on the same day as the PCP meeting. If both tasks are completed on the same day the Caseholder must document justification in the Pre-Plan.) In Pre-Planning the individual chooses:

1. Dreams, goals, desires, and any topics which he/she would like to talk about.
2. Topics he/she does not want discussed at the meeting.
3. Whom to invite.
4. Where and when the meeting will be held.
5. Who will facilitate this.
6. Who will record.
7. Format or tools chosen to be used for recording.

L. All potential support and/or treatment options (array of mental health services including Medicaid-Covered Services [State Plan and B3] and Mental Health Code-required services) to meet the expressed needs and desires of the individual are identified and discussed with the individual.

1. Health and safety needs are identified in partnership with the individual. The plan coordinates and integrates services with primary health care physician.
2. The individual is provided with the opportunity to develop a crisis plan (psychiatric advance directive(s)).
3. Each Individual Plan of Service must contain the date each service is to begin, the specific scope, duration, intensity, and who will provide each authorized service.
4. Primary Care Provider input into Individual Plan of Service.

M. The individual has ongoing opportunities to express his/her needs, desires, preferences, and to make choices. This includes:

1. Accommodations for communication, with choices and options clearly explained.
2. To the extent possible, the individual shall be given the opportunity for experiencing the options available prior to making a choice/decision. This is particularly critical for individuals who have limited life experiences in the community with respect to housing, work, and other domains.
3. Individuals who have a court appointed legal guardian shall participate in Person-Centered Planning and make decisions that are not delegated to the guardian in the Guardianship Letters of Authority.
4. Service delivery shall concentrate on the child as a member of a family, with the wants and needs of the child and family integral to the plan developed. Parents and family members of minors shall participate in the Person-Centered Planning process unless:

5. 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 Mental Health Code;
6. The minor is emancipated; or,
7. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process as stated in the Mental Health Code. Justification of the exclusion of parent(s) shall be documented in the clinical record.

N. Individuals who are moving from a dependent setting to an independent setting will have all health and safety needs assessed prior to movement. Individuals should have explained to them any risks associated with independent living. Individuals should be provided with any training or assessment of need necessary to assure their independent living situation is safe. It is understood an individual has the right to live where they want.

O. Justification for exclusion of individuals chosen by the recipient to participate in the Person-Centered-Planning process shall be documented in the case record.

Initial Start of Services through the Individual Plan of Service

A. The PIHP Access Center completes a telephone clinical screening to determine eligibility for an Intake assessment for SCCCMHA services. When an individual is found to meet SCCCMHA criteria the screening is electronically transferred to the OASIS electronic health record for review by the SCCCMHA Central Intake Unit (CIU) staff and the SCCCMHA Data Department authorizes the initial (90791) Biopsychosocial Assessment for the CIU.

1. As defined by MDHHS, service commencement shall be the individual's first contact with the SCCCMHA CIU when the outcome of the Biopsychosocial Assessment results in admission to the public mental health system for specialty services or supports.

2. SCCCMHA (or contract agency) shall ensure the Pre-Plan is completed by the individual prior to completion of the IPOS via the Person Centered Planning process.
3. SCCCMHA shall work with the psychiatric inpatient hospital on discharge planning, make all reasonable efforts to see the individual Face to Face within 7 days of discharge and take direction from the hospital's discharge plan. At the point of release from the hospital, an individual may resume treatment under a previous plan of service or an Amendment to the treatment plan may be completed.

B. SCCCMHA (or contract agency) shall develop the comprehensive IPOS as soon as possible, but no longer than <u>thirty-five (35)</u> calendar days from the date of the Biopsychosocial Assessment.

1. The IPOS must be completed and signed by all parties within the 35 day window. Required signatures include individual receiving services, guardian (where applicable), Caseholder and Supervisor. For ACT and CW recipients, MD signature is required. Also, for ACT, all team members' signatures with credentials are required on the IPOS Training Log

2. Should the guardian's signature not be obtained at the time of the IPOS meeting, then documented verbal consent must be obtained from the guardian prior to Plan implementation; and the medical record shall include both the verbal consent and documented efforts made to obtain written approval within the 35 day window. Staff should utilize the Absentee Signature Document to obtain out-of-town guardian signatures and follow-up with guardian to ensure receipt of same. When utilizing the Absentee Signature Document, staff must document in the Enter Delivery Section of the IPOS the date that both the IPOS and Budget were mailed out to individual/guardian. When received, the Absentee Signature Sheet must be scanned into OASIS and attached to the document

3. All authorizations must be obtained at the same time of the development of the IPOS in accordance with CFR requirements, unless previously requested by CIU during the Initial Biopsychosocial Assessment.

4. If there are mitigating reasons in the Person-Centered Planning process that causes the treatment planning process to extend beyond 35 days, then clinical rationale and justification must be documented in the medical record in a Contact Note or a Case Consultation Note. In such rare cases, the 35 day window may be extended.

5. The complete/signed IPOS and budget must be copied and given to the recipient (and guardian) within fifteen (15) business days of the Person-Centered Planning meeting that developed the Plan and the Enter Delivery Information section of the IPOS must be completed, which states the delivery method and the date that the IPOS and Budget was given to the Individual/Guardian.

C. The IPOS shall remain in effect until the IPOS is updated and a new IPOS takes effect. No Plan shall be in effect for more than 365 days from the date of Plan commencement.

1. If there are mitigating reasons in the Person-Centered Planning process that causes the IPOS to extend beyond 365 days, the clinical rationale and justification must be documented in the medical record in a Contact Note or a Case Consultation Note.

2. Any extension of the IPOS shall include documentation of the Supervisor's approval in a Case Consultation Note or a Contact Note.

D. The IPOS must indicate:

1. The start-date the overall IPOS takes effect.

2. The expected start-date each service is to commence.

3. All medically necessary mental health services the recipient chooses (informed choice) to receive.

4. The specialty benefit plan services to be coordinated and integrated with the individual's primary health care physician.

5. The service coordination activities that will occur with other community agencies (including but not limited to, Medicaid Health Plans; family courts; local health departments; school-based service providers; and the county Department of Human Services offices) and primary care provider.

6. The opportunity for the recipient to develop a crisis plan.

7. The plan shall be reviewed, every 90 days or when there are significant changes.

8. The IPOS must also address, as required or desired by the individual, the individual's need for:

   a. Food
   b. Shelter
   c. Clothing
   d. Health care
   e. Employment opportunities
   f. Educational opportunities
   g. Legal services
   h. Transportation and
   i. Recreation.

E. The IPOS shall include the following components:

1. Goals that are:
   a. Expressed in words of the person served
   b. Reflective of the informed choice of the person served or parent/guardian
   c. Appropriate to the person's culture
   d. Appropriate to the person's age
   e. Based upon the person's

      (1) Needs
      (2) Strengths
      (3) Abilities
      (4) Preferences

2. Specific treatment/support Objectives that are:
   a. Reflective of the expectations of:

      (1) The person served
      (2) The treatment team

   b. Reflective of the person's age
   c. Reflective of person's developmental level
   d. Reflective of the person's culture and ethnicity
   e. Responsive to the person's disabilities/disorders or concerns

f. Understandable to the person served
g. Measurable (no longer that 90 days for MI and SUD populations,
h. Achievable
i. Time Specific
j. Indicate frequency of specific treatment interventions
k. Appropriate to the treatment setting
l. Indicate when services are to commence (expected start date)
m. Indicate the amount, duration and scope of each service to be provided
n. Information on, or conditions for, transition to other less-intensive or restrictive services (discharge planning).
o. When applicable, identification of:

(1) Legal Requirements
(2) Legally imposed fees for each service

F. The IPOS shall be developed:

1. With the active participation of the person served (or guardian if the individual cannot actively participate).

2. By using the information from the professional assessments conducted during the Person-Centered/Treatment Planning process.

3. Based upon the needs and desires of the person served and focuses on his/her integration and inclusion into:

a. The local community
b. The family, when appropriate
c. Natural supports systems
d. Primary care provider
e. Other needed services

4. Involving the family of the person served, when applicable or permitted (individual choice).

5. Identifying any needs beyond the scope of the specialty benefits program(s).

6. Specifying the services to be provided by the program.

7. Ensuring all authorized services meet the “medical necessity” and “eligibility” criteria of the PIHP/SCCCMHA Clinical Protocols.

8. Specifying referrals for additional external (non-specialty benefit plan) services.

9. In a manner that is communicated understandable to the individual being served.

10. Specifying the review dates of Periodic Review, no less than every 90 days to review with the person served for continuing relevance, and is modified as necessary.

G. When the person served is one who has been diagnosed with a co-occurring disorder (SUD/MH or MI/DD), the IPOS must specify:

1. Services specifically address co-morbid issues in an integrated manner with the substance abuse system; and,

2. Services are provided by personnel, either within the organization, or by referral, to professionals that are qualified to provide services for persons with co-occurring disabilities/disorders.

H. The IPOS shall be kept current and shall be modified when indicated. Each individual shall be provided with ongoing opportunities to provide feedback on how they feel about the services, supports and/or treatment they are receiving, and their progress toward attaining valued outcomes. Information collected and changes shall be made to the plan in response to the individual's feedback. Each individual shall be informed orally and in writing of his or her clinical status and progress at reasonable intervals established in the individual plan of service in a manner appropriate to his clinical condition. Primary Care provider should be consulted/informed of any changes to the plan.

I. The IPOS will be updated no less frequently than every 90 days via a Periodic Review. This treatment planning evaluation is updated based on any changes in individual's status responses to treatment, or goal achievements which may be triggered during the assessment update. The IPOS can be modified at any time due to significant changes or individual request, however, it must be updated by the treatment team in agreement with and endorsed by the individual/guardian and in consultation with the primary care provider.

J. Any changes or modifications to the IPOS document, due to individual request, or new/changing needs, must be documented by written Amendment by the Primary Caseholder, utilizing the IPOS Amendment Form.

K. The IPOS must indicate the individual(s) in charge of coordinating the plan of services. The designated individual(s) shall assist in IPOS coordination for each person served by:

1. Assuming responsibility for ensuring the implementation of the Individual Plan of Service. This includes providing training to all direct service staff within 5 days of completion of the IPOS, IPOS Amendment or before staff provides services, or coordinating the provision of training by appropriate professional, documenting the training, and ensuring training documentation is part of the case record. Utilization of the IPOS Training Log is required for ACT, HSW and Home-Based Programs to ensure training of all staff providing direct care services to the individual.
2. Ensuring that the person served is oriented to his or her services.
3. Promoting the participation of the person served on an on-going basis in discussions of his or her plan, goals, and status.

4. Identifying and addressing gaps in service provision, and amending the plan accordingly.
5. Sharing information on how to access community resources relevant to his or her needs.
6. Advocating for the person served, when applicable.
7. Communicating information regarding progress of the person served to the appropriate persons and treatment team.
8. Facilitating the transition process, including arrangements for follow-up services.
9. Involving the family or legal guardian, when applicable or permitted.
10. Coordinating services provided outside of the PIHP network.
11. Identifying the process for after-hours contact.
12. Ensuring a viable crisis response plan is in place within the treatment plan.

L. IPOS - Services Authorization: All services/supports authorized in the IPOS must meet the eligibility and medical necessity criteria of the Clinical Protocols, and shall be authorized in accordance with Treatment Authorization Policy 02-001-0015.

1. All Level I services are authorized by the Primary Caseholder at the time of the IPOS development in the Service Authorization Summary ensuring units are within the PIHP Clinical Protocol adherence. Each service activity listed in the IPOS Service Authorization Summary must commence on or after the effective date of the plan and cannot extend outside of the IPOS end date.

2. All Level II services must be authorized by the PIHP and Level I services provided at an intensity that exceeds the Clinical Protocols are considered Level II services. Timeframes for PIHP authorization decisions and notices are:

   a. Standard Authorization Decisions: The PIHP Access Clinician shall provide notice as expeditiously as possible, but may not exceed fourteen (14) days of receipt of request for any Level II service. Authorizations must be obtained prior to plan commencement.
   b. Expedited Authorization Decisions: For cases where the standard decision timeframe could seriously jeopardize the individual's life or health; or ability to attain, maintain, or regain maximum functioning, the PIHP shall make an expedited authorization decision and provide notice to the provider no later than three (3) days after receipt of request for any Level II service.

M. If a recipient is not satisfied with his or her IPOS, he/she may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days. Should the individual not be satisfied with the review results, he/she shall be informed of the grievance and appeal process, including who to contact for assistance in filing a grievance or appeal (refer to SCCCMHA policy Grievance Process 02-001-0040 and Appeals Process and Second Opinion 02-001-0045).

N. The recipient, or an individual chosen or required by the recipient, may only be excluded from participation in the treatment planning process, only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption to the planning process. The recipient may only be removed from that portion of the treatment planning process that is medically contraindicated, and such documentation is noted in the medical record.

O. An open case that is inactive for 60-days shall be closed by the Primary Case Holder. For cases with no activity for 30-60 days, documentation utilizing a Contact Note in the OASIS electronic health record should demonstrate timely outreach and evidence as to why there was no-activity during that time. Some exceptions to the 60-day rule may exist and these exceptions must be well documented and justified.

P. A signature from the psychiatrist/physician approving the information contained in the Individual Plan of Service, Amendment and Periodic Review is required for ACT case records.

Q. Individual Plan of Service shall identify any restrictions or limitations of the recipient's rights and includes documentation describing attempts to avoid such restrictions as well as what action will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future. Consultation with Supervisor regarding potential restrictions could be referred to the Behavior Treatment Plan Review Committee (BTPRC).

V. PROCEDURES:

A. Initial Start of Services

Access Center Staff

1. Completes a telephone clinical screening to determine eligibility to receive an Intake assessment for SCCCMHA services.

Central Intake Unit Staff

2. Completes a Biopsychosocial Assessment and any other necessary assessment tools. Notifies the receiving program that the Biopsychosocial Assessment is completed. These assessments are all available within OASIS.

3. Processes service request to stabilize the individual's crisis situation. (See Exhibit A. Person-Centered-Planning Elements/Strategies.)

4. Refers the eligible person to the most appropriate program (by contacting the Program Supervisor) or Contract Agency designee for an appointment.

5. Informs the individual served of Independent Facilitation Option.

Program Supervisor (Direct Operated or Contract Agency)

6. Reviews the Biopsychosocial Assessment and any other Clinical Assessments completed and assigns to a Primary Caseholder.

B. Person Centered Planning Process / Individual Plan of Service

Primary Caseholder

1. Schedules first appointment/Pre-Planning meeting with the Individual, informs the individual of the Person-Centered- Planning process, and reviews option for Independent Facilitation. If the individual receiving services chooses Independent Facilitation then the staff assists with the process, as noted in procedures C. 1-7 below.

2. Documents during Pre-Planning the individual's request regarding the following items:

   a. Dreams, goals, desires, and any topics which he/she would like to talk about
   b. Topics he/she does not want discussed at the meeting
   c. Whom to invite
   d. Where and when the meeting will be held
   e. Who will facilitate
   f. Who will record
   g. Format or tools chosen to be used for recording Independent Facilitation determination
   h. Primary care input provider

PCP Meeting Participants

3. Discusses the individual's needs/desires and options as agreed upon by the recipient.

Primary Caseholder

4. Informs the individual/family that they have the right to request any identified professional(s) to meet with them separately as a follow-up to the meeting. Schedules as appropriate.

5. Reschedules the meeting if the individual is unable to stay for the entire meeting or cannot attend for clinical reasons (non-attendance should be rare).

6. Documents the individual's choice in selection of treatment and/or supports authorized in the IPOS, which must meet the eligibility and medical necessity criteria of the PIHP's Clinical Protocols.

7. Lists each service activity in the IPOS Service Authorization Summary and identifies services must commence on or after the effective date of the plan, and must end within the 364 days window allowed before a plan must be renewed.

8. Calls Access Center for Treatment Authorization of recommended Level II service/supports units for billing/tracking purposes. (Psychosocial Rehabilitation Only cases require authorization on all cases.)

9. Ensures the IPOS is signed by the individual receiving services (and/or guardian where applicable) and the Primary Caseholder on the effective date of the plan. The individual supervising the plan and other service providers contributing to the plan must also sign the plan.

10. Written consent must be in place for the IPOS within a 35 day window, and prior to the effective date of the plan.

11. Obtains Psychiatrist's or physician's signature within 10 business days of clinical assessment for ACT case records.

12. Provides the completed/signed IPOS and budget to the recipient (and guardian) within fifteen (15) business days of the Person-Centered Planning meeting and completes the Enter Delivery Information section of the IPOS, which states the delivery method and the date that the IPOS and the Budget Report was given to the Individual/Guardian

13. Forwards the finalized Individual Plan of Service to all program site(s) for implementation. (Assessments do not have to be sent to guardians.)

14. Provides or coordinates training to direct care staff on implementation of the Individual Plan of Service including any special needs of the individual; documents the training in writing; and ensures training record is made part of the individual's case record. Training to direct service staff on the IPOS/IPOS Amendment will be provided within 5 days of IPOS completion (Supervisor's signature dates initiates the start of the five days) or before staff provides services. IPOS Training Logs are required for CW, SEDW, HSW and Home-Based Programs and must be attached to the IPOS in the electronic health record.

Supervisor

15. Ensures staff is implementing the Individual Plan of Service, are trained on plan goals and implement plan as designed.

    If review by the supervising professional and/or physician leads to a determination that any services in the plan are not appropriate given the application of medical necessity criteria, the individual receiving services will be given advance notice indicating to them that the services agreed to in the plan are going to be reduced, suspended, or terminated.

Primary Caseholder

16. Ensures a review of the plan no less than every 90 days.

17. Monitors the plan.

C. Independent Facilitator

Primary Caseholder

1. Assists individual receiving services with choosing a facilitator and arranges meeting if facilitator is part of the roster and is trained. If facilitator is not part of the pool, staff meets with the individual and facilitator and arranges facilitator training. [All the steps listed above are not required if the person does not choose to have an Independent Facilitator.]

Independent Facilitator

2. Meets the Individual receiving services Face to Face for a Pre-planning meeting and addresses the following:

   a. Who attends, When and where
   b. Dreams, goals for discussion at PCP meeting
   c. Potential Natural Supports
   d. Specialized services and supports needed
   e. Individuals preferences on providers
   f. Topics which are not "on the table" for the meeting

3. Relays the meeting information to the Primary Caseholder and chairs PCP meeting

Primary Caseholder

4. Arranges for meeting and ensures that persons on individual served list are notified of time and place of meeting.

5. Takes PCP meeting minutes, records choices of individual served, ensures that decisions are consistent with standards and guidelines.

6. Develops plan, obtains review by Independent Facilitator and Individual receiving services.

7. Ensures upon completion of the Individual Plan of Service, each participant signs the Individual Plan of Service with his/her credentials, and date. (Follows steps 10 – 17 above)

VI. REFERENCES:

A. MDHHS and PIHP Contracts

B. Region 10 PIHP: Clinical Practice Guidelines

C. CCBHC Expansion Grant

VII. EXHIBITS:

A. Person-Centered-Planning Elements/Strategies

VIII. REVISION HISTORY:

Dates issued 05/88, 02/92, 12/93, 07/94, 07/96, 06/97, 06/98, 06/00, 03/02, 02/04, 02/06, 04/08, 04/10, 10/11, 01/13, 01/15, 05/16, 05/17, 11/18, 03/19, 01/20, 04/21, 03/22, 04/22, 3/23.

EXHIBIT A

PERSON-CENTERED-PLANNING ELEMENTS/STRATEGIES

Illustrations of Individual Needs

Person-Centered Planning processes begin when the individual makes a request to the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Service Program (CMHSP). The first step is to find out from the individual the reason for his/her request for assistance. During this process, individual needs and valued outcomes are identified rather than requests for a specific type of service. Since Person-Centered-Planning (PCP) is an individualized process, how the PCP proceeds will depend upon what the individual request.

This guideline includes a chart of elements/strategies that can be used by the person representing the PIHP/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 service provider will explore further needs for assistance and if required, proceed to a more in-depth planning process as outlined below. It is in 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 a support, service, and/or treatment in a single life domain and/or of a short duration.

   A life domain could be any of the following:
   a. Daily activities
   b. Social relationships
   c. Finances
   d. Work
   e. School
   f. Legal and safety
   g. Health
   h. Family relationships, etc.

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/ EMERGENT	SHORT DURATION	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. Supports to address health & safety needs are included in the Individual Plan of Service.	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 choice 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 of support planning is necessary, and if so, to determine and identify the persons and information that need to be assembled for successful planning to take place.		X	X
In short-term/outpatient service areas, the individual is provided with information on Person-Centered Planning, including pre-planning at or before the initial visit. Individuals are encouraged to invite persons to the session where the plan is developed.		X	X
In collaboration with the PIHP/CMHSP, the individual identifies strategies and supports, services and/or treatment needed to achieve desired outcomes.		X	X
Exploration of the potential resources for supports and services to be included in the individual's plan and 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 Department of Community Health and Community Mental Health Services Programs.		X	X
Regular opportunities for individuals to provide feedback are available. Information is collected and changes are made in response to the individual's feedback.		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 person he/she selects together define the individual's desired future, and develop a plan for achieving desired outcomes. For any individual with dementia or other organic impairments, this should include the identification of spouses or other primary caregivers who are likely to be involved in treatment or support plan implementation.			X
The process continues during the planning meeting(s) where the individual and 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