SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

CLINICAL POLICY

NUMBER: BC029

NAME: PERSON-CENTERED and FAMILY-CENTERED PLANNING PROCESS/IPOS DEVELOPMENT

INITIAL APPROVAL DATE:	06/30/1998	BY: Sanilac CMH Board
STAKEHOLDER REVIEW:	09/06/2023	BY: Consumer Advisory Board
(LAST) REVISION DATE:	06/26/2023	BY: Administrative Committee
(LAST) REVIEW DATE:	07/27/2023	BY: Policy Committee
DISCONTINUED DATE:	N/A	REPLACED BY: N/A

I. PURPOSE

To establish a policy that addresses the purpose, principles and guidelines of the Person-Centered and Family-Centered Planning process at Sanilac County Community Mental Health Authority (Sanilac CMH).

II. APPLICATION

Populations: **ALL**
Programs: **Direct - ALL**
Contracted – ALL

III. POLICY

It is the policy of Sanilac CMH that all individuals receiving specialty services and supports regardless of age, disability or residential setting have a plan of service developed through the person-centered planning process that recognizes particular cultural needs as well as other needs as reflected in the results of the needs assessment(s), and includes but is not limited to risk assessment and crisis planning The planning process will be directed by the individual, will focus on their desires and needs, and will incorporate the principles of Recovery, such as hope, choice, and empowerment. Goals and objectives that incorporate the unique needs, strengths, abilities, and preferences of the person served will be included in the plan. When the individual is a minor, the planning process will be family centered and focus on the desires and needs of the family.

As identified by the individual, professionally trained staff will be involved in the planning and delivery of treatment and supports, based on the expressed needs, desires, and choices of the person being served. When services are being delivered to children, Sanilac CMH will use a family approach in the planning process. The child/family will be the focus of service planning. Family members will be an integral part of the planning process and its success. The desires and needs of the child/family will be considered in the planning and evaluation of supports, services and/or treatment.

When an individual expresses a choice or preference for a support, service and/or treatment for which an appropriate alternative of lesser cost exists, and compromise fails, a process for dispute resolution and appeal may be indicated. This policy, together with the Sanilac CMH policy on Grievance and Appeals, will address dispute concerns.

An Individual Plan of Service and/or a Preliminary Plan of Service covering the services to be provided will be completed prior to providing those services. A Preliminary Plan will be completed by Access within 7 days of the first assessment with a new individual. A face-to-face contact needs to be done within 14 days of the initial intake with the IPOS being completed within the first 35 days. For individuals coming out of the hospital there needs to be a face-to-face contact within 7 days. An annual IPOS must be complete within 365 days of the last plan of service. Treatments plans (periodic review) must be updated at least every 90 days for SMI/SED/SUD or 180 days for those with mild/moderate needs. The Individual will be consulted by primary caseholder as to the date, time, and location for their meeting and given adequate time for inviting persons of their choice.

Consents will be presented to the Individual/Legal representative for signature by the primary caseholder at the IPOS meeting or sent in advance to the Individual/Legal representative, prior to the 364th day since last completed. The Approval page of the IPOS will be completed whenever possible by the Individual/Legal representative at the IPOS meeting. If this is not possible, the primary caseholder should pursue and document verbal/witnessed consent via phone as soon as possible and ensure that a copy of the Approval page is mailed to the Individual and/or Legal representative. Primary caseholders will note the date sent and initial the original Approval page to verify that the copy has been sent for signature.

Primary caseholder staff includes the Sanilac CMH Therapist and the Care Manager who has been credentialed and has an electronic signature in the approved software. The primary caseholder will bring the IPOS format to the meeting, as well as any necessary supplies. The primary caseholder assures that the Signature page is passed and signed by all at the meeting. The primary caseholder is responsible to assure that the Adequate Action Notice is provided to the Individual at the IPOS. A copy shall be placed in the chart.

IV. STANDARDS

A. Principals of Person-Centered Planning (PCP) and Family-Centered Planning (FCP)

PCP is a highly individualized process designed to respond to the expressed hopes, dreams, and needs/desires of the individual. When the identified individual is a child, the child/family will be the focus of service planning. Family members will be an integral part of the planning process and its success. The desires and needs of the child/family will be considered in the planning and evaluation of supports, services and/or treatment. Treatment shall be family/caregiver-driven, youth-guided and developmentally appropriate for the treatment of children and adolescents.

1. Issues related to the needs of children that comprehensively address family/caregiver, school, medical, mental health, substance misuse, psychosocial and environmental shall be addressed.

2. Each individual and family system has strengths and the ability to express preferences and to make choices.

3. Individual's and family choices and preferences shall always be considered, if not always granted.

4. Each individual and family has abilities and can contribute to the community. Individuals and families have the right to choose how various supports and services and/or treatment can help them utilize their abilities and make contributions to community life.

5. Independence should be maximized, and community connections created. PCP and FCP should work toward achieving the individual's and families' dreams, goals and desires.

6. Cultural background, specialty populations (i.e., veterans, American Indians, Hispanic) and individual and family differences should be recognized and valued in the decision- making process.

7. The individualized plan is endorsed by the individual, the adult individual's family to the extent that the individual so wishes, or family/caregivers of the youth and children.

8. Veteran's/Active-Duty Military Services: Sanilac CMH clinic or DCO will provide recovery based, behavioral health care to appropriately identified veterans and current active-duty military members who are located further than 50 miles or more from an approved military facility. Treatment recommendations will be based on guidance from the Uniform Mental Health Services Handbook (VHA). DCO or clinic will document in the EMR the military history of all individuals who receive services and their family members. All veterans/active-duty military individuals who are identified for services will work with treatment team to create a treatment plan that is based on their current diagnosis, strengths, personal goals, and desired treatment outcomes. The plan will address reduction/management of symptoms, improving functioning, and prevent relapse or recurrence. Evidence based models will be recommended to ensure the most effective treatment. Based on the wishes of the individual, family members and/or natural supports will be encouraged to participate in the planning and treatment process.

B. Essential Elements

1. A pre-planning meeting will be scheduled at which time the individual, or family system in the case of an individual that is a minor, will determine who will facilitate and who will record his/her meeting. Dreams, goals, desires and topics the person wishes to discuss will be documented, together with those the individual does not want to discuss. The individual's advance wishes related to treatment, as well as crisis management, if any, shall be documented. The person or family system for a minor receiving services will choose where and when the planning meeting will be held, as well as whom to invite. An individual chosen or required by the recipient or family system for a minor 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 recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

2. The primary caseholder will complete the Biopsychosocial assessment and Pre-plan prior to the meeting and offer the Individual or family system for a minor a choice of an Independent Facilitator or Alternate Facilitator. The Pre-plan will identify who the Individual wants to conduct and record the meeting and identify topics the Individual wishes to discuss or not discuss at their meeting.

3. All assessors will complete their evaluations and submit them to the primary caseholder prior to the IPOS meeting. Assessors must include as part of their assessment a review of progress in the previous periodic review period, unless a separate review will be completed for inclusion in the record.

4. The development of natural supports shall be viewed as an equal responsibility of Sanilac CMH and the individual. Participation by individuals such as family, friends and allies are encouraged to assist the individual in reaching his/her dreams, goals and desires. Sanilac CMH, in partnership with the individual, is expected to develop, initiate, strengthen and maintain community connections and friendships through the person-centered process.

5. In order to meet the expressed needs and desires of the person being served, or the family

system for a minor, the complete array of mental health services including Medicaid State Plan, waiver services, and 1115 (i)SPA services will be identified and discussed.

6. During the planning process primary care managers should take into consideration the LOCUS, CAFAS, PECFAS, and other assessment tool scores that are used during the assessment to determine level of care.

7. During the planning process the primary care managers may seek consultation about special emphasis problems, as appropriate, and integrate the results of such consultation in the treatment plan.

8. Health and safety needs are identified in partnership with the individual or family system of a minor. The plan coordinates and integrates services with primary health care.
    a. The individual or family system of a minor is provided with the opportunity to develop a crisis plan and/or psychiatric advance directive[s].
    b. Each Individual Plan of Service must contain the date the service is to begin, the specified amount, scope, duration, and who the provider will be.
    c. Alternative services are discussed, including the integration of prevention, medical, and behavioral health needs and service delivery.
    d. Self Determination (policy BC014) and individual budgets will be discussed at time of plan.

9. Individuals or the family system of a minor will be given ongoing opportunities to express their needs and preferences and to make choices, including:
    a. Accommodations for communication, with choices and options clearly explained.
    b. To the extent possible, the individual or family system of a minor shall be given the opportunity to experience the options available prior to making a choice/decision. This is particularly critical for individuals who have had limited experience in the community with respect to housing, work and other life domains.
    c. Individuals with court-appointed legal guardians shall participate in PCP and make decisions that are not delegated to the guardian in the Guardianship Letters of Authority.

10. The individual or family system of a minor 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.

11. For Individuals that are minors: Service delivery shall concentrate on the child as a member of a family with the desires and needs of the child and family integral to the plan developed. Parents and family members of minors shall participate in the PCP/FCP process unless:
    a. The minor is fourteen 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.
    b. The minor is emancipated.
    c. The inclusion of the parents or significant family members would constitute a substantial risk of physical or emotional harm to the minor or substantial disruption of the PCP/FCP process as stated in the Mental Health Code. Justification of the exclusion of parents shall be documented in the clinical record.

12. Ongoing opportunities are provided to the individual, or family system for a minor, for review on how they feel about the services, supports and treatment they are receiving and their progress toward attaining valued outcomes. Once this information is collected, changes are made to the plan (if needed) in response to the individual's feedback.

13. The plan shall include the needs, strengths, abilities, preferences and goals, expressed in a manner that captures the individual's words or ideas and/ when appropriate, those of the individual's family/caregiver.

14. The primary caseholder will assure that the effective date of the IPOS is noted on the document, and that the Individual and/or guardian receives/is mailed a copy of the IPOS document within 15 business days of the IPOS meeting.

15. Assessors must complete measurable goals and objectives utilizing the agency approved IPOS format for any service areas identified in the planning meeting, as well as completing a progress note/data collection sheet for each objective being implemented at site-based programs and/or residential service sites in an approved agency format. The individual assessor is responsible for distributing any updates, or changes of data sheets to the appropriate technician/program supervisor, caretaker or home, etc.

16. Primary caseholder or individual assessors will complete training on the IPOS and changes to plans for home and program staff and get signatures of training on form #0521 IPOS Acknowledgement, In-service of Plan.

17. The IPOS and services authorizations will be reviewed, signed and authorized by an agency approved physician, clinical supervisor and/or clinical coordinator via their signature on the hardcopy original, or an electronic signature in approved format. Primary caseholder will have access to consult with a Clinical Supervisor and/or clinical coordinator when level of care and services authorizations are in question. Any denial of services or request for services will be done by a clinical supervisor.

18. Primary Caseholder must complete the final IPOS document in approved format and submit for necessary signatures.

19. The primary caseholder will note if the physician or guardian noted any comments or exceptions regarding the IPOS and document response/action as needed in the Individual's clinical chart.

V. REFERENCES

Region 10 Policy Manual: 02-025-0005 Person Centered Planning
Medicaid Provider Manual 3.30 Treatment Planning
Michigan Mental Health Code, 330.1712
Sanilac CMH Policies and Procedures