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Owner	Alison Gabridge: Manager of Clinical and Practice Improvement
Policy Area	CPI - Clinical Practice Improvement

IPOS Individual Plan of Service / Person Centered Plan

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POLICY

It is the policy of the Detroit Wayne Integrated Health Network (DWIHN) that a comprehensive and integrated array of services/supports which inspires hope and promotes recovery/self-determination, be made available to Wayne County residents and their families. Those individuals with intellectual/developmental disabilities, children with serious emotional disturbances, mental health, substance use and physical health conditions are expected to receive services within a system of care that is welcoming, recovery-oriented and capable of delivering integrated services to meet their needs and preferences. An Individualized Plan of Service (IPOS) developed through the Person-Centered Planning (PCP) process shall be provided to each individual and family being served.

PURPOSE

To provide direction to the Integrated Care Organizations (ICOs) and Network and Out of Network providers in the provision and monitoring of Individual Plans of Service developed through a Person-Centered Process, that meet the requirements of the Michigan Department of Health and Human Services (MDHHS), Michigan Mental Health Code, and DWIHN.

APPLICATION

1. ***The following groups are required to implement and adhere to this policy***: DWIHN Board, DWIHN Staff, Contractual Staff, Clinically Responsible Service Provider (CRSP) and their subcontractors, Specialty Providers, Crisis Services Vendors,
2. ***This policy serves the following populations:*** Adults, Children, Individuals with Intellectual and/or Developmental Disabilities (I/DD), Serious Mental Illness (SMI), Serious Emotional

Disturbance (SED), Substance Use Disorder (SUD), Autism

3. *This policy impacts the following **contracts/service lines**:* MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund

KEY WORDS

1. Adequate Notice of Adverse Benefit Determination for the Uninsured or Under Insured
2. Advance Notice of Adverse Benefit Determination Form Uninsured or Under Insured
3. Alternative Dispute Resolution Process (ADRP)
4. Clinically Responsible Service Provider (CRSP)
5. Home and Community Based Services (HCBS)
6. Independent Facilitation
7. Individual Plan of Services/Treatment Plan (IPOS)
8. Interdisciplinary Treatment Team (ITT)
9. Medicaid Adequate Action Notice
10. Medicaid Advance Action Notice
11. Medicaid Fair Hearing
12. Medical necessity
13. Notice of Denial of Medical Coverage
14. Person Centered Planning (PCP)/Family Centered Planning

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STANDARD

1. The Clinically Responsible Service Provider (CRSP), chosen by the member, will be responsible for facilitating the PCP Process and developing, implementing and coordinating the services identified in the IPOS.
2. Through the PCP process, a person and those he or she has selected to support him or her:
    a. Focus on the person's life goals, interests, desires, choices, strengths and abilities as the foundation for the PCP process.
    b. Identify outcomes based on the person's life goals, interests, strengths, abilities, desires and choices.
    c. Make plans for the person to achieve identified outcomes.
3. PCP is an individualized process designed to respond to the unique needs and desires of each person. The following values and principles guide the PCP process whenever it is used.
    a. Every person is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the person's ability to make choices.
    b. Every person has strengths, can express preferences, and can make choices. The

PCP approach identifies the person's strengths, goals, choices, medical and support needs and desired outcomes. In order to be strength-based, the positive attributes of the person are documented and used as the foundation for building the person's goals and plans for community life as well as strategies or interventions used to support the person's success.

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

d. The person's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the person to implement their choices or preferences over time.

e. Every person contributes to his or her community, and has the right to choose how supports and services enable him or her to meaningfully participate and contribute to his or her community.

4. After the PCP process, an Individual Plan of Service(IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP) is developed and at each request to change services.
5. For each individual there shall be one integrated IPOS, which addresses physical health care needs and relevant co-occurring, mental illness, intellectual/developmental disabilities, serious emotional disturbances, and substance abuse services, even if multiple providers are involved in the provision of services and supports. Case Management/Supports Coordination/ Independent Facilitator/Therapist/Case Holder, etc. staff shall be responsible to support IPOS development and timely implementation.
6. The IPOS shall reflect strength-based assessments, which are culturally relevant and address the health and safety needs for families of children and adolescents with serious emotional disturbances, individuals with both serious mental illness/co-occurring substance abuse disorders, and individuals with developmental disabilities. Identified activities related to the protection of the behavioral and physical health care needs shall be developed in partnership with the individual/guardian and family with the Interdisciplinary Treatment Team.
7. Significant changes in the status of the individual (i.e. psychiatric hospitalization, suicidal attempt, deterioration in physical health status, etc.) shall be assessed as needed within the context of an IPOS process and each request to change services.
8. Within thirty (30) days of commencement of services at outpatient community mental health agency, the members chosen CRSP shall develop the comprehensive IPOS in partnership with the individual/guardian, supports, family and Interdisciplinary Treatment Team.
9. The comprehensive IPOS shall reflect an ongoing partnership with physical health care providers to facilitate integrated health care and effective monitoring of current behavioral and physical health conditions.
10. During the PCP meeting, the full array of supports and services which could assist in meeting

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the needs and goals of the individual are discussed.

11. The parent peer-delivered service occurs as part of the treatment process to better align with family driven, youth guided policy and practice guidelines.
12. All services and supports must be included in the Individual Plan of Services (IPOS). The IPOS must be reviewed, approved and signed by the physician. The case manager, the child and his/her family, friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services.
13. The IPOS shall clearly identify at a minimum the following:
    1. Action oriented goals as identified by the individual;
    2. Objectives that are specific and measurable;
    3. The individuals Stage of Change as applicable for each goal;
        a. The specific stage must be noted for each goal as appropriate (Precontemplation, Contemplation, Preparation/Determination, Action/Willpower, Maintenance, or Relapse)
    4. Interventions that will be utilized that are directly aligned with meeting identified objectives;
    5. The amount of service: number of units (i.e. 15-30 minutes);
    6. The estimated cost of service and supports authorized;
    7. The Crisis Service Vendor of service: parameters within which the services will be provided;
    8. Who will provide the service: (e.g. professional, Case manager, supports coordinator, Assertive Community Treatment team, etc.);
    9. How the service will be rendered: (e.g. face-to-face, telephone, tele-health, group, individual, etc.);
    10. How frequently the service will be provided: (i.e. weekly, monthly, etc.);
    11. Where the service will be rendered: (e.g. community setting, office, home, etc.);
    12. The duration of service: the length of time: (e.g. 3 weeks, 6 months, etc.) it is expected that an identified service will be provided;
    13. All current physical health conditions; and
    14. The specific health care practitioners who are treating any physical health conditions;
    15. Participation of Interdisciplinary Treatment Team. (psychiatrist, psychologist, peer support, nurse, social worker, etc.);
    16. Any assistance: (e.g., referral, coordination, transportation) that the individual needs in accessing health care practitioners.
    17. Must contain a Crisis Plan. If individual declines a crisis plan, document this and any efforts in the individual record.
    18. What needs to be in place for a transition to a less restrictive level of care or for discharge to occur.

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Home and Community Based Services (HCBS):

1. The IPOS must reflect that the setting in which the member resides is chosen by the member. The setting chosen by the member must be integrated in, and support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
   The setting selected by the member must be from among setting options, includingthe option of non-disability-specific settings and an option for a private unit in a residential setting.
2. The setting options must be identified and documented in the IPOS and based on the member's needs, preferences, and, for residential settings, resources available for room and board.
3. Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS. The rights and freedoms listed in the HCBS Final Rule are:
   a. A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.
   b. Sleeping or living units lockable by the individual with only appropriate staff having keys.
   c. Individuals sharing units have a choice of roommate in that setting.
   d. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
      Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.
   e. Individuals are able to have visitors of their choosing at any time.
   f. The setting is physically accessible to the individual.
4. Service plan elements related to modification of the member's rights and freedoms must include the following:
   a. Specific and individualized assessed need.
   b. Positive interventions and supports used prior to any modifications to the person-centered service plan.
   c. Less intrusive methods of meeting the need that have been tried but did not work.
   d. Description of the condition that is directly proportionate to the specific assessed need.
   e. Regular collection and review of data to measure the ongoing effectiveness of the modification.
   f. Time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   g. Informed consent of the member.

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h. Assurance that interventions and supports will cause no harm to the member

Crisis Plan is:

The crisis plan provides direction regarding the care to be provided on his/her behalf during a crisis situation. Refer to DWIHN Crisis Plan policy for the components to consider during a crisis situation.

The Independent Facilitator is:

1. Chosen by the individual/guardian/family and serves as the individual's/guardian/family's guide (and for some individuals, their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences, and concerns are heard and addressed.
2. Does not have any other role within the organization from which the individual/family receives his/her services and supports.
3. Helps with the pre-planning activities and co-leads the PCP meeting(s) with the individual/guardian/family.

The options of an independent facilitator for the PCP who meets the qualifications established by DWIHN shall be provided to each individual/guardian/family. Individuals, guardians and family shall be made aware of the option of independent facilitator services prior to the scheduled planning meeting. Refer to the DWIHN Provider Directory for a list of independent facilitators.

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Pre- Planning Process:

Pre-planning for the PCP meeting involves working with the person served to determine who they would like to have at the meeting, how those people will be invited and by whom, what topics the person would like the meeting to focus on, and what (if any) topics the person does not want discussed at the meeting. Pre-planning for the PCP meeting may take several weeks in order to ensure that the maximum number of friends, allies and others in the person's support network can attend the meeting. It is critical that people served are able to incorporate these supports into their plan as much as possible.

1. The PCP process shall include the active participation of Interdisciplinary Treatment Team., natural supports, family, friends and allies to participate in the PCP process. This process is completed before the IPOS meeting is held, if the individual does not want the PCP meeting to be conducted on the same day as the IPOS meeting.
2. Before the PCP meeting is initiated, a pre-planning meeting is held to to gather all of the information and resources necessary for effective person-centered planning and set the agenda for the process. In the pre-planning meeting the individual/guardian chooses:
    a. Dreams, goals, desires, preferences, strengths and any other topics to be discussed during the PCP meeting;
    b. Topics the individual/guardian does not want discussed during the PCP meeting;
    c. Who to invite and who is responsible for inviting the persons identified (include whether the individual has meaningful support or if actions are needed to cultivate such supports);
    d. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them.

e. Where and when the PCP meeting will take place;
f. Who will facilitate the PCP meeting;
g. Who will record what is discussed in the PCP meeting;
h. What accommodations the individual may need to meaningfully participate in the PCP meeting;
i. The completion of a crisis plan; and the completion of an advance directive.
j. The purpose and advantages of having an advance directive shall be explained to each individual which includes expression of individual preference for doctors, hospitals and medications; expression of other specific wishes or individual choices during a time when he/she is unable to make decisions, and the possibility that a commitment hearing in probate court can be avoided in some circumstances.
k. Individuals shall be informed of the option of receiving peer support services upon enrollment, during the PCP process at the pre-planning meeting and planning meeting, and annually thereafter.

Self-Determination

1. Self-determination (SD) is the right of all people to have the power to make decisions for themselves; to have free will. The goals of SD, on an individual basis, are to promote full inclusion in community life, to have self-worth and increase belonging while reducing the isolation and segregation of people who receive services. Self-determination builds upon choice, autonomy, competence and relatedness which are building blocks of psychological wellbeing.
2. Self-Directing Services- Self-direction is a method for moving away from professionally managed models of supports and services. It is the act of selecting, directing, and managing ones services and supports. Self-directing services is the act of controlling dollars allocated from the member's Individual Plan of Service (IPOS) to select, direct, and manage one's services and supports.

Individual Plan of Service:

1. For individuals to receive peer support, the IPOS shall include one or more of the goals of community inclusion and participation, independence and productivity based upon individual choice and medical necessity criteria.
2. IPOS shall describe the specific peer support services needed to achieve the goals of community inclusion and participation, independence and productivity. These activities shall be provided in partnership with the individual and may include: Vocational assistance; and Housing assistance;
    a. Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS. The rights and freedoms listed in the HCBS Final Rule are:
    b. The following requirements must be documented in the IPOS when a specific health or safety need warrants such a restriction:
        1. The specific and individualized assessed health or safety need.

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2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs.
3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.
4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.
5. A regular collection and review of data to measure the ongoing 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 of the person to the proposed modification.
8. An assurance that the modification itself will not cause harm to the person.

c. Assistance with employment opportunities;
d. Sharing stories of recovery or advocacy;
e. Assisting with entitlements;
f. Assistance with developing wellness plans;
g. Assistance with advance directives;
h. Assistance with learning about alternatives to guardianship;
i. Providing supportive services during a crisis; and
j. Overall assistance in the process of recovery and self-determination.

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Ensure that any modification of the conditions is supported by a specific assessed need and justified in the IPOS. The following requirements must be included in the IPOS when there is any modification:

1. Identify a specific and individualized assessed need.
2. Document the positive interventions and supports used prior to any modifications to the IPOS.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include the informed consent of the member.
8. Include an assurance that interventions and supports will cause no harm to the member.

It is a requirement for the IPOS to be signed by the individual, individual's guardian, designated patient advocate or other qualified legal representative has the authority to sign the IPOS. In cases where foster children are permanent wards of the court, the state worker has the authority to sign. For

children that are temporary court wards, the biological parent, foster parent or the assigned state worker has the authority to sign the plan:

1. Individuals shall be provided with opportunities to provide feedback on how they feel on satisfaction of services including but not limited to a community or residential setting, support and/or treatment they are receiving and their progress toward attaining valued outcomes.
2. Information regarding individual feedback shall be collected monthly at minimum and noted in a progress and/or contact note documenting the encounter with the individual, including changes made in response to the individual's feedback.
3. If the individual/guardian wants to change or is dissatisfied with their chosen CRSP they have the right to request a new CRSP by completing the Clinically Responsible Service Provider (CRSP) Change Form. The CRSP Change Form must be completed by the individual/legal guardian and sent to the DWIHN Access Center who will facilitate the CRSP change. (See CRSP Change Form attached).
4. Each individual shall be provided with a copy of his/her person-centered plan within fifteen (15) business days after the meeting.
5. Informational brochures and reading material that describes the option of independent facilitation and advance directives shall be made available to individuals and families during the intake process.
6. PCP Planning is an ongoing process. The PCP process is completed whenever there is a change in the status of the individual receiving supports, which could impact the amount, scope, or duration of authorized services or at any time it is requested by the individual.
7. Minimally, the PCP process and development of the IPOS is completed annually (within 365 days). A periodic review is completed at least every six months or (180 days) for I/DD and SMI population or when there is a significant life change, i.e (level of care change or hospitialization). A periodic review is completed every 90 days for Assertive Community Treatment (ACT) participants.
8. Minimally, the PCP process and development of the IPOS is completed annually (within 365 days). A periodic review is completed quarterly (180 days) for SED population or when there is a significant life change, i.e (level of care change or hospitalization)
9. For closure of case records, Crisis Service Vendor, and Providers shall develop policies and procedures related to the closure of case records when there has been no contact with an individual for ninety (90) calendar days or more, which includes the following:
    a. Documentation of written and telephone attempts to contact the individual/family to offer services during the ninety (90)-day period.
    b. Notification provided to the individual/family regarding his/her right to local or informal dispute resolution and the recipient rights process at the time of case closure.
    c. Documentation of the provision of an Adequate Action Notice -Medicaid, SMI,SED, IDD, SUD or **Advance Action Notice - Medicaid, SMI, SED, IDD, SUD** to Medicaid enrollees/members, the Notice of Denial of Medical Coverage Form for members/ enrollees in the MI Health Link program or the Adequate Notice of Adverse Benefit Determination for Uninsured or Underinsured Form or Advance Notice of Adverse

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Benefit Determination for Uninsured or Underinsured Form for the Uninsured or Under Insured.

10. In addition to the requirements above, the Autism Spectrum Disorder Applied Behavior Analysis Benefit PCP must:
    a. Service Reviews shall be completed on IPOS services on a semi-annual basis. The date must be within six (6) months from the date of the IPOS or previous addendum or service review.
    b. The Preliminary Plan of Service must include language that the family has choice in service provider selection.
    c. The Preliminary Plan of Service must include language that the family was informed of Abuse, Neglect and Exploitation reporting.
    d. The PCP process must involve written ~~monthly collaboration with~~coordination of care between the Supports Coordinator/Case Manager and the Autism Spectrum Disorder (ASD) ABA Service Provider to ensure the documentation and agreement for services is in-line with the services being provided to the child and family, on no less than a quarterly basis or when deemed necessary.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, risk management program, and Quality Assessment/Performance Improvement Program (QAPIP) Work-plan..

The quality improvement programs of Network Providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

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COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, Direct Contracted Network Providers, and their subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Michigan Mental Health Code Act 258, PA 258 of 1974, as revised. MCL 330.1001 et seq.
    a. MCL 330.1700 (g)
    b. MCL 330.1708
    c. MCL 330.1712
    d. MCL 330.1752
2. Department of Community Health Administrative Rules:
    a. R.330.7135
    b. R.330.7199

c. R.330.7243
d. R.330.1702
e. R.330.1703
f. R. 330.1704
g. R. 330.2814
h. 42 CFR 438.208
i. 42 CFR 441.301
j. 42 CFR 441.530
k. 42 CFR 441.710

3. MDHHS / Advance Directives
4. MDHHS/CMHSP Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs,(in effect, and as as amended)
    a. Attachment P.6.3.1.1: Appeal and Grievance Resolution Processes Technical Requirement
    b. Attachment 6.3.2.1: Grievance and Appeal Technical Requirement
    c. Attachment C.3.3.1

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RELATED POLICIES

1. Choice Voucher System for Children
2. Crisis Plan
3. Customer Service (CS) Enrollee/Member Appeals Policy
4. Denial of Service Policy
5. Utilization Management (UM) Provider Appeals Policy
6. Michigan Department of Health and Human Services Medicaid Fair Hearings for Enrollees/Members
7. Procedures for Behavior Treatment in Community Mental Health Settings
8. Self-Determination Policy
9. Treatment Plan Training Procedure for Direct Support Professional (DSP)/Aide

CLINICAL POLICY

YES

EXTERNAL

Attachments

Adequate Notice of Adverse Benefit Determination for the Uninsured or Under Insured (2023).docx

Adequate Notice of Adverse Benefit Determination Form Medicaid SMI, SED IDD SUD.docx

Advance Notice of Adverse Benefit Determination Form Uninsured or Under Insured (2023).docx

Advance Notice of Benefit Determination Form Medicaid SMI, SED, IDD, SUD (1).docx

CFR-2020-title42-vol4-part441.pdf

DWMHA Crisis Plan Template (8).docx

Elements of an IPOS.pdf

Estimated Cost of Services Template.pdf

Individual Plan of Service Training

MDHHS PCP Policy 6 28 2017.pdf

MDHHS-5617-MAHS_602280_7.dot

Notice of Denial of Medical Coverage Form (MHL).docx

Notice of Hearing Rights-Individual Plan of Service.pdf

Person-Centered_Planning_Practice_Guideline.pdf

TREATMENT PLAN Training Log .docx

Treatment Plan Training Procedure for Direct Support Professional -DSP-Aide.pdf

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Approval Signatures

Step Description	Approver	Date
NCQA Committee	Shana Norfolk: Strategic Planning Administrator	Pending
NCQA Committee	Tania Greason: Quality Administrator	Pending
NCQA Committee	Allison Smith: Project Manager	Pending
NCQA Committee	Maria Stanfield: Director of Strategic Operations	07/2024
Clinical Officer	Marianne Lyons: Director of Adult Initiatives	07/2024

Unit Approval	Alison Gabridge: Manager of Clinical and Practice Improvement	06/2024

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