# BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
# POLICIES AND PROCEDURES MANUAL

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| **Section: 5** | **Person Centered Planning** | | |
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## Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) that Client Service Specialists and Clinical Specialists assist recipients through the Person-Centered Planning process.

## Purpose

This policy and procedure was developed to define Client Service Specialists (CSS) and Clinical Specialists (CS).

## Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: All Clinical and Clinical Provider Supervisors
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Primary Care/Outpatient
☐ Policy Only ☒ Policy and Procedure

☐ Other:

## Definitions

Primary Case Holder/Care Coordinator/Case Manager/Supports Coordinator (PCH/CSM/SC:
The staff person who works with the individual to gain access to and coordinate the services, supports and/or treatment that the individual wants or needs. Responsible for the development, coordination, implementation and oversight of the Person Centered Planning (PCP) process and the Individual Plan of Service (IPOS).

## Procedure

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Program Description

BABHA offers Case Management and Services Coordination services to residents of Bay and Arenac Counties. This program provides individuals with the levels of support and supervision they need to be connected to resources in the community and to find services and providers that assist them in achieving their goals. Services are designed to provide comprehensive supports, including supportive counseling, crisis intervention, and a collective and coordinated effort to have all an individual's supports working together. Hours of operation vary. After hours emergency contact is available 24 hours a day, 7 days a week through BABHA's Crisis Intervention services. Admission to the program is by referral from BABHA Access Center.

Targeted Case Management

Targeted Case Management services are available for children with serious emotional disturbance, adults with serious mental illness, persons with developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Targeted case management is a covered service that assists individuals to design and implement strategies for obtaining services and supports that are goal-oriented, individualized and focused on recovery, wellness, skill acquisition, enhanced quality of life, productivity, independence, community inclusion and resiliency. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services, meaningful activities, and natural supports developed through the Person-Centered Planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner, focusing on process and outcomes.

Targeted case management services must be available for children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the Prepaid Inpatient Health Plan (PIHP), and/or are unable to independently access and sustain involvement

with needed services. The location of case management activities are by their choice, usually in the community where the person lives or works, but can be in the office as long as the needs of the persons are met. Individuals must be provided a choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

Core Requirements

Providing a comprehensive orientation to services including system navigation.

Assuring that the Person-Centered Planning process takes place and that it results in the Individual Plan of Service (IPOS) that promotes recovery, wellness, skill acquisition, enhanced quality of life, productivity, independence, community inclusion and resiliency. Planning and/or facilitating planning using person centered principles. This function may be delegated to an independent facilitator chosen by the individual.

- Assuring that the IPOS identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the IPOS, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports. The Targeted Case Manager or qualified staff responsible for monitoring the IPOS and each specialized professional within the scope of their practice will ensure that training in the IPOS is completed for staff/providers responsible for implementing the plan.
  - Oversight of the IPOS implementation and training is determined by the individual's needs identified in the Assessment, not the type of setting, the number of service providers or particular service. For example, individuals living in more structured treatment arrangements with multiple professional staff may only require general oversight by the CSM. Individuals living in less structured settings may require more direct oversight by the CSM to monitor health and safety needs. In these cases, the CSM not only ensures the IPOS is implemented but may have to take additional actions to provide training directly to the individual, family, parents or caregivers.
    Implementation, oversight and monitoring of the IPOS include training the appropriate staff in the IPOS, review of Unusual Incident Reports and Progress Notes, observation of

staff implementing the plan, attending team/staff meetings, providing guidance and clarifying questions on the IPOS.

- Assuring the participation of the beneficiary on an ongoing basis in discussions of his/her plans, goals, and status. The amount scope and duration of services are identified in the plan and documented regularly.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care. The CSM is empowered to monitor the IPOS implementation and training process, including oversight of the training provided by other professional staff without creating any potential individual scope of practice and to coordinate any concerns identified with other professional staff and if necessary supervisory staff.
- Documenting on a monthly basis that individuals are taking behavioral medicines as prescribed and are reporting any potential side effects.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition planning process, including arrangements for follow-up services, linkage to natural supports, and information about available employment and educational opportunities.
- Assisting individuals with crisis planning.
- Identifying the process for after-hours contact.

<u>Staff Qualifications</u>

The primary case coordinator working with adults with serious mental illness must be a Qualified Mental Health Professional (QMHP). If the primary staff works with persons with developmental disabilities they must be a Qualified Intellectual Disability Professional (QIDP). If the case manager has only a bachelor's degree but without the specialized training or experience, they must be supervised by a QIDP or QMHP who does possess the training or experience. Services to a child with serious emotional disturbance must be provided by a QMHP who is also a child mental health professional. A QMHP or QIDP has a minimum of one year

experience working with the population served, to have working knowledge of services and systems relevant to the person's abilities and needs.

Supports Coordination/Support and Service Coordination

Supports Coordination works with adults and children receiving mental health services and in particular individuals on various waiver's to assure all necessary supports and services are provided to enable the individual to achieve community inclusion and participation, productivity, and independence in home and community based settings :

Functions performed by a Supports Coordinator (SC) include assessing the need for support and service coordination, and assurance of the following:

- Supports Coordinator, the individual and others identified by the individual in developing an IPOS using the Person Centered Planning Process.
- Assuring that the IPOS identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Documenting that individuals are receiving behavioral medicines as prescribed and are being monitored for any potential side effects.
- Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
- The SC is empowered to monitor the IPOS implementation and training process, including oversight of the training provided by other professional staff without creating any potential individual scope of practice and to coordinate any concerns identified with other professional staff and if necessary supervisory staff.
- The Supports Coordinator or qualified staff responsible for monitoring the IPOS and each specialized professional within the scope of their practice will ensure that training in the IPOS is completed for staff/providers responsible for implementing the plan.
- Oversight of the IPOS implementation and training is determined by the individual's needs identified in the Assessment, not the type of setting, the number of service providers or particular service. For example, individuals living in more structured treatment arrangements with multiple professional staff may only require general

oversight by the SC. Individuals living in less structured settings may require more direct oversight by the SC to monitor health and safety needs. In these cases, the SC not only ensures the IPOS is implemented but may have to take additional actions to provide training directly to the individual, family, parents or other caregivers.

- Implementation, oversight and monitoring of the IPOS include training the appropriate staff in the IPOS, review of Unusual Incident Reports and Progress Notes, observation of staff implementing the plan, attending team/staff meetings, providing guidance and clarifying questions on the IPOS.
- Assistance with access to entitlements and/or legal representation.
- Linking, coordinating and follow up and advocacy with all supports and services, including Medicaid Health Plan, Medicaid fee for service, or other health care providers.
- Monitoring of Waiver services and other mental health services.
- Planning and/or facilitating planning using person centered principles. This function may be delegated to an independent facilitator chosen by the individual.

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Supports strategies will incorporate the principles of empowerment, community inclusion, self-determination, quality of life, culture of gentleness, recovery, wellness, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with each individual to assure his/her ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports coordination is reported only as a face-to-face contact with the individual; however, the function includes not only the face-to-face contact but also related activities that assure:

- The desires and needs of the individual are determined

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- The supports and services desired and needed by the individual are identified and implemented
- Housing, education and employment issues are addressed
- Social networks and opportunities for relationships and friendships are developed
- Appointments and meetings are scheduled
- Person-Centered Planning is provided and independent facilitation of Person-Centered Planning is made available
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the individual are monitored
- Income/benefits planning and development
- Information is provided to assure the individual is informed about self-determination.
- Activities are documented
- Monitoring of individual budgets (when applicable) for over- or under-utilization of funds are provided
- Plans of supports/services are reviewed at such intervals as are indicated during planning

The supports coordination functions to be performed, and the frequency of face-to-face and other contacts, are specified in the individual's plan. The amount, frequency, and scope of supports coordination contacts and services must take into consideration the health and safety needs of the individual and are documented in the plan and reviewed regularly.

Staff Qualifications:

The primary case coordinator must be a Qualified Intellectual Disability Professional (QIDP) when working with persons with intellectual and developmental disabilities or a Qualified Mental Health Professional (QMHP) when working with adults with serious mental illness. They must also possess a bachelor's degree. If the case manager has only a bachelor's degree but without the specialized training or experience, they must be supervised by a QIDP who does possess the training or experience. A QIDP has a minimum of one year of experience working with the population served, to have knowledge of the services and systems relevant to the person's abilities and needs. Services to a child with serious emotional disturbance must be provided by a QMHP who is also a child mental health professional.

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BABHA Case Management/Support Coordination Philosophy:

1. Each person is unique, and will be treated with dignity and respect
2. We are committed to excellence and ongoing quality improvement
3. We believe in consumer choice and individual services that are focused on recovery, welcoming, person-centered, accessible, effective, and clinically appropriate
4. We are committed to ensuring the availability of programs and services that promote independence and encourage the involvement of family, friends, and community support
5. We are committed to collaboration with other organizations to address community health needs, promote prevention, and increase the understanding of behavioral health.
6. We are committed to promote Person/Family-Centered Planning to assist individuals to live a high quality of life as independently as possible based on their strengths, abilities, and needs

Program Goals

1) To provide better mental health through promotion of recovery and wellness
2) To provide additional community opportunities
3) To provide increased independence for persons served
4) To connect persons served with resources in the community for employment, community living, education, public benefits, and recreational activities
5) To help assure that a person/family is healthy and safe in the community, while honoring their dignity and respect

Service Modalities and Program Objectives

Service Modality:

A single Client Services Specialist (CSS) is chosen/assigned to persons served. An initial, annual, comprehensive assessment is completed to determine the person's life conditions, strengths, needs, abilities, and preferences. A Person-Centered Planning (PCP) process (per BABHA Agency Manual, Policies and Procedures, C04-S05-T01 - Person Centered Planning) results in an Individual Plan of Service (IPOS) which is completed, specifying

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amount, scope, and duration of services with the person. The PCP identifies all services and supports provided by BABHA as well as services and supports outside of the CMHSP system. Services are developed in a variety of settings mainly in the community or home of the individuals. Services can be provided in the office setting when identified in the plan.

Program Objectives:

To assist the person on an individualized basis to access, secure, and maintain services and supports while promoting maximum recovery, independence and quality of life and to assist the person with achieving goals and objectives for recovery and independence as defined by the person in the following areas:

A. Life domains
    1. Housing
    2. Employment
    3. Education
    4. Developing natural supports
    5. Appointments or meetings scheduled
    6. Income benefits
    7. Insurance benefits
    8. Medical care
    9. Psychiatric care
    10. Medication adherence
    11. Crisis planning
    12. Transportation
    13. Other as identified by the person

B. Meaningful daily activities
    1. Meal planning
    2. Budgeting
    3. Personal care
    4. Housekeeping and home maintenance
    5. Community memberships
    6. Volunteering
    7. Other as identified by the person

C. Developing Social Networks
   1. Family
   2. Friends
   3. Acquaintances
   4. Others as identified by the person

Population Identification and Mechanisms

Targeted Populations – Targeted Case Management/Support Coordination

Person resides in Bay or Arenac Counties and has been diagnosed with a severe and persistent mental illness, intellectual and/or developmental disability, severe emotional disturbance, and/or a substance use disorder.

Mechanisms to Address Populations' Needs

Access Center screening and referral process:

1. Referrals for targeted case management or support coordination services are made directly to the program supervisors for case assignment.

2. Intake and assessment process for Outpatient and Case Management services follows BABHA Policy and Procedure, C04-S02-T03.

3. The Person-Centered Planning process is implemented as outlined in BABHA's Agency Manual, Policy and Procedure C04-S05-T01 - Person-Centered Planning and C04-S05-T03 – Case Management/Support Coordination.

4. BABHA's Emergency Services Department provides 24 hour crisis intervention, crisis stabilization, and preadmission screening services for child, adolescent, and adult residents of Bay and Arenac Counties who are experiencing a psychiatric or personal crisis. Trained professional staff are available for telephone and face-to-face contact with persons in crisis on a 24-hour, 7 day a week basis.

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Other Mechanisms in Place to Serve Persons Receiving Case Management and Support Coordination services:

- □ Residential service coordination
- □ Vocational service coordination
- □ Recipient Rights Office
- □ Self-Determination planning
- □ Customer Service Department
- □ Children's Assessment Team
- □ Consumer Operated Programs
- □ Psychological Services

## Attachments

N/A

## Related Forms

N/A

## Related Materials

N/A

## References/Legal Authority

1. Michigan Department of Health and Human Services Medicaid Provider Manual.
2. CARF Section 3 - Behavioral Health Core Program Standards, Case Management – Service Coordination (CM).

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| **SUBMISSION FORM** | | | | |
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| **AUTHOR/ REVIEWER** | **APPROVING BODY/COMMITTEE/ SUPERVISOR** | **APPROVAL /REVIEW DATE** | **ACTION (Deletion, New, No Changes, Replacement or Revision)** | **REASON FOR ACTION - If replacement list policy to be replaced** |
| M. Swank | G. Lesley | 11/11/09 | Revision | Updated P&P to give emphasis to the importance of recovery and wellness |
| M. Swank | CLT | 02/15/10 | Revision | Updated P&P to add assessment of medication adherence and side effects by Client services specialists and supports coordinators during all service contacts. |
| M. Swank | CLT | 03/21/11 | Revision | Updated P&P to change requirement for assessment of medication adherence. Reassessments will be completed at least monthly. |
| M. Swank | M. Swank | 05/20/11 | Revision | Revised P&P statements renaming CSMs and SCs as Client Services Specialists. |
| M. Swank<br>E. Albrecht | PNLT | 08/29/13 | Revision | Added person first language as well as multiple references to recovery, wellness, quality of life, |
| K. Amon | SLT | 06/30/15 | Revision | Change MDCH and typographical error |
| K. Amon | SLT | 8/20/18 | Revision | Triennial Review |
| K. Amon | SLT | 11/27/19 | No changes | Policy and Triennial Review-Early to begin a new Review cycle. |
| K. Amon | SLT/Leadership<br>C. Pinter | 5/12/21<br>6/18/21 | Revisions | Update to comply with Medicaid Provider Manual.<br>Add clarification on the oversight and training of the IPOS |