

Person Centered Planning & Delivering Medically Necessary Services

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Community Mental Health
FOR CENTRAL MICHIGAN

What we will cover today...



Value of Clinical Documentation and background of PCP



Define Medically Necessary Services



Person Centered Planning – Roles, development and documentation



Provision of Services within Amount, Scope and Duration




Training on the Individual Plan of Service (IPOS)



How to address service utilization issues

Value of Clinical Documentation:

- Remember: **If it isn't documented, it didn't happen.**
- Accurate and timely documentation is essential for evaluating whether services and treatment plans are effective or if changes are necessary.
- Provides a method of tracking progress over time. Provides evidence of effective, medically necessary treatment.
- Provides a record of services provided and maintains compliance with a number of regulations and mandates.
- But most importantly! Everyone on the team knows their specific role in assisting the consumer. Good documentation is a key part of reaching a consumer's desired outcomes and understanding how you can support an individual.



MDHS
Joint Commission
Md-State Health Network
CMS HPA
Provider Contracts
Code of Federal Regs
Quality/UM

Following the process...



**Psychosocial
Assessment**
(Standard Assessment/
Health Screen, Risk
Level, Trauma screening
and Substance Use)



**Person
Centered
Planning**
(Pre-plan, Planning, Auth's,
IPOS training)



**Monitoring Progress
&
Documenting**
(Progress notes, data collection,
monthly monitoring logs)

Who requires Person Centered Planning (PCP)?

The 1996 revisions to the Mental Health Code require a “person-centered” approach to the planning, selection, and delivery of the supports, services, and/or treatment consumers receive from Community Mental Health Services Programs (CMHSPs) and providers under contract to CMHSPs.

It is the policy of Community Mental Health for Central Michigan (CMHCM) that all individuals will have an individual plan of service developed through a Person Centered Planning process regardless of age, disability or residential setting.

The **Michigan Mental Health Code** (state law), the **Home and Community Based Services (HCBS) Final Rule** (federal law), and the **Medicaid Managed Care Rules** require person-centered planning and establish the right for all persons to plan how those services and supports are going to enable them to achieve their life goals.

While PCP is the required planning approach for mental health and I/DD services provided by the CMHSP system, PCP can include planning for natural, community, other public supports and privately-funded services chosen by the person. In other words, we plan for all supports not just CMH paid supports.

What is Person Centered Planning (PCP)?

The Person-Centered Plan includes a mutually agreed upon set of services and supports that the individual needs to meet their goals and those that CMHCM has agreed to provide (these are the services that have been deemed to be medically necessary for the consumer). All services or supplies that are not medically necessary are not covered by the Medicaid program.

PCP is the process used to develop an Individual Plan of Service (IPOS) with consumers.

PCP is an individualized process designed to meet each person's individual needs and desires as each person is at a different point in the process of achieving their overall goals and reaching their desired life trajectory

“A way for individuals to plan their life in their community, set the goals that they want to achieve, and develop a plan for how to accomplish those goals” –MDHHS

What is Person Centered Planning (PCP)?

PCP is a process of learning how a person wants to live. PCP honors the person's preferences, choices and abilities, while involving family, friends and professionals as the person desires or requires to identify how they can best support the consumer in their long-term and short-term goals. The PCP process is **used at least annually** to review the IPOS and also any time an individual's goals, desires, circumstances, choices, or needs change.

The Person-Centered Planning (PCP) process is not a single meeting. The PCP may include a series of meetings and involve additional informal discussions. It is a process. "Process" means that this is not just one meeting but an **on-going framework** for planning.



Most important, it is a process that is directed by the person who receives the support.

Why is Person Centered Planning Important?

- Through the pre-planning process, the individual may choose supports (friends, family members, etc.) to support them through the PCP process
- Empowers individuals to construct and articulate a vision for the future, consider various paths, engage in decision-making and problem solving, monitor progress, and make needed adjustments in a timely manner.
- Highlights that every person has strengths, can express preferences, and can make choices when given information about their options. Instead of focusing on what a person cannot do, PCP focuses on what they can do.
- Identifies the person's strengths, goals, preferences, health and safety needs, needs for home- and community-based services, and desired outcomes.
- Maximizes independence, creates community connections, and works towards achieving the individual's dreams, goals, and desires.

From Medicaid Provider Manual:

Services are provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code.

Pursuant to state law and in conjunction with the federal Balanced Budget Act of 1997 each beneficiary must be made aware of the **amount, duration, and scope** of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a **copy of their plan of services within 14 calendar days**.

Coordinate with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, school-based services providers, and local MDHHS offices).

Independent Facilitation

What does the Independent Facilitator do?

The independent facilitator serves as a guide during the PCP process, making sure that the consumer's hopes, strengths, interests, and goals are the focus. An independent facilitator helps with the planning activities of the PCP (including the pre-plan where they arrange the time, location, date, and invite attendees to the IPOS meeting) and may also lead the IPOS meeting if the consumer chooses.

Can anyone use an Independent Facilitator?

Yes, all consumers have the right to independent facilitation of their PCP process. We must offer this to all consumers when pre-planning. It is the consumer's choice whether or not to use an independent facilitator

A current list of our contracted independent facilitators can be found on the CMHCM website, in the Provider Choice Listing.



What is a self-direction arrangement?

What is a self-directed arrangement?

Self-determination is a value that promotes consumers having authority over their own lives. A self-directed arrangement is a way of delivering services in a different way; it is not a program. It gives consumers and guardians more control over the use of the Medicaid dollars that are set aside for consumer care.

SD arrangements involve consumers making choices and taking responsibility of their own lives by hiring their own staff and managing their services within a determined budget through the Person Centered Planning process.

Additional SD information can be found on the external website under the Provider tab.

Who can use a self-directed arrangement?

All consumers are offered the opportunity to have services through self-direction

There is no minimum amount of services necessary to qualify for self-direction; all consumers should be afforded the opportunity to participate in SD.

It provides freedom and authority to make choices regarding services and supports both formal and informal. CMHCM supports this right via Michigan's Mental Health Code.

What is Medical Necessity?

Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, 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. Medical necessity of a service shall be documented in the individual plan of services. (Michigan Medicaid Provider Manual)

What does this mean?

Medical necessity is the concept that services must be necessary and appropriate for the evaluation and management of an assessed need or disorder. The care must be considered reasonable when judged against current standards of care.

**We authorize appropriate, medically necessary services
and then provide those services as they are authorized
and written in the individual plan of service.**

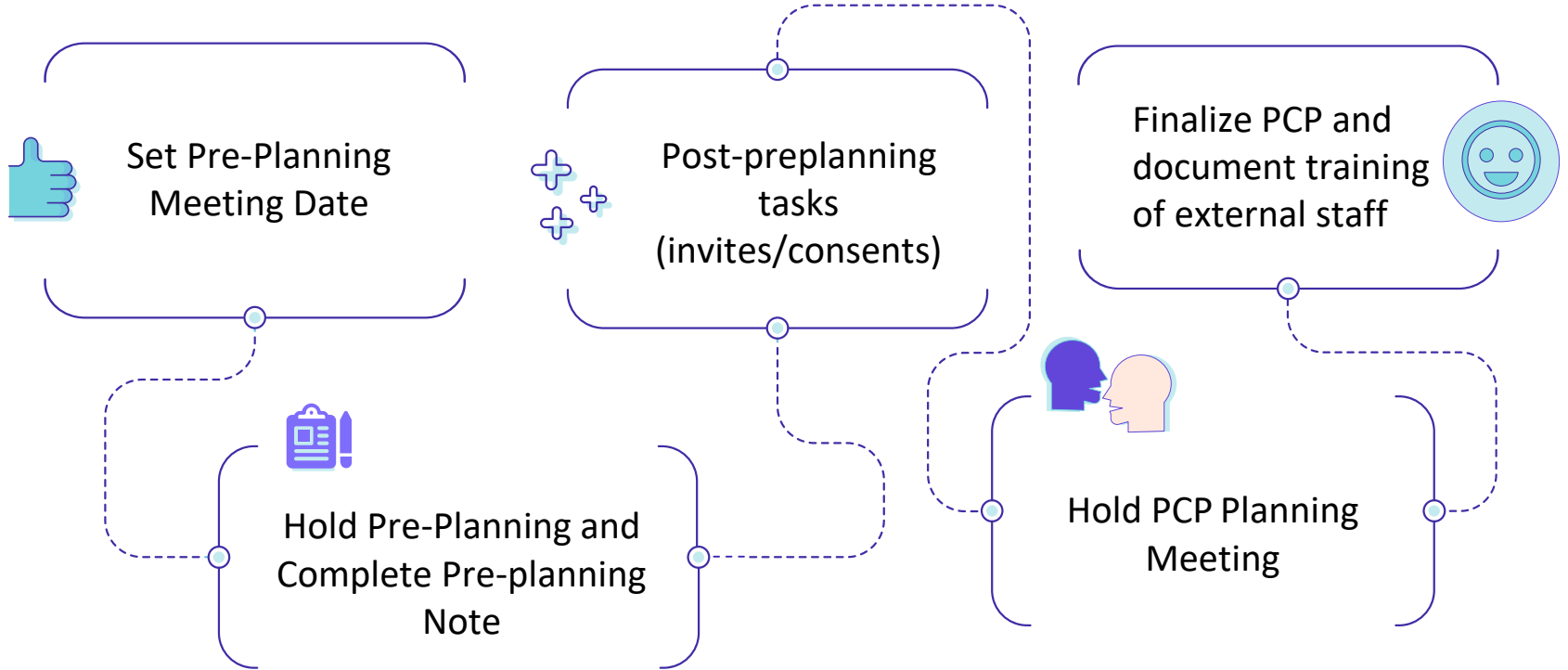
Pre-Planning: Offering Choice to Consumers

- Pre-planning is completed prior to developing the IPOS with a consumer and their identified support people.
- The purpose of pre-planning is to gather information and resources necessary for an effective PCP meeting
- Offer choices of facilitator, note taker and format for PCP meeting; offer self-determination
- Occurs generally 30-45 days prior to expiration of most recent plan/authorizations
- Offered as face-to-face but can be done over the phone/virtually if consumer prefers



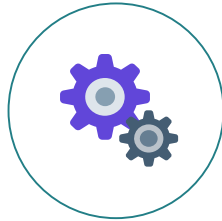
Offer Choices
Gather info and resources
Set the agenda
Invite supports

PRE-PLANNING FOR PCP



Person Centered Goals/Objectives/Interventions

What are the differences between
Goals, Objectives, and Interventions?



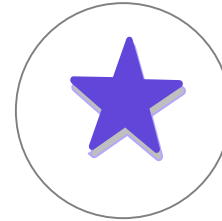
Goals

Overall result or
finish line the
consumer would
like to reach



Objectives

Steps consumer is
going to take to
accomplish the
overall goal
Measurable actions



Interventions

Amount, scope and
duration of supports
and services to
reach goals and
objectives

GOALS:

These are the overall goal statements that a consumer identifies including their desired life trajectory and goals may be long-term or short term

These are always written in the consumer's own words

OBJECTIVES:

Objectives are how the consumer gets to what they want to achieve

The action needs to be on the part of the consumer (not what staff or support staff are going to do for the consumer)

Objectives must be measurable and specific

Some examples of goal statements include:

"I want to stay in my own home."

"I don't know how to cope with what I've been going through. I need to figure out ways of dealing with this stress and stop taking it out on other people."

Some examples of objectives include:

Goal: "I want to go out and do fun things with my friends every week."

Objectives:

-Jane will learn and demonstrate how to pay for her own lunch with verbal assistance from staff over the next three months as reported in CLS progress notes.

-Within one month, Jane will identify three places in the community she can go to meet her friends as reported in CLS progress notes.

INTERVENTIONS:

The intervention section of the plan is where the amount, scope, and duration of services are spelled out along with who is going to provide the support, and in what way they are going to provide it. This is where provider staff will primarily find details about how to specifically support the consumer.

The intervention section of the IPOS should also clearly define specific roles and responsibilities of all supports in a consumers life, these include:

- Natural supports (family and friends)
- Community supports (Church members, MRS, PHCPs, Area Agency on Aging, etc.)
- MDHHS Adult Home Help Services
- CMHCM Services (Internal and External)
- Self-Determination/Choice Voucher Services

Examples of Interventions:

Community Supports:

-Jane receives support from MDHHS for Adult Home Help and is authorized for 18 hours a month for areas of: Personal Hygiene, Bathing, Meal Prep, and Laundry.

-Jane volunteers at the animal shelter twice monthly with a volunteer supervisor who provides assistance and guidance. This is scheduled to continue through the end of the year.

CMHCM and Contracted Supports:

-CLS staff will physically assist Jane in cleaning activities such as cleaning sinks, cleaning the tub/shower, cleaning the refrigerator, cleaning the microwave, cleaning the stove top, cleaning the oven, cleaning the rugs, cleaning the floors, cleaning tables/chairs, cleaning windows/mirrors, changing bed linens, cleaning dishes and utensils, using a washer/dryer, washing folding and putting away clothes, taking out and throwing away trash. Total time 2.5 hours per week until 6/1/20.

GOAL #1

said, "I would like to be independent."

EFFECTIVE DATE	TARGET DATE
3/12/2019	3/11/2020
ACTUAL COMPLETION DATE	DISCONTINUED DATE

STAGE OF CHANGE (OBJECTIVES NEED TO CORRESPOND)

Pre-contemplative
 Contemplative
 Preparation
 Action
 Maintenance
 N/A

INTERVENTION / SUPPORTS

CMHCM will contract with MMI to provide CLS for in the amount of 8 hours per week (2 hours 4 days per week) . Staff will record data daily on progress notes or on data sheets if needed. Case manager will review data at least monthly. MMI Supervisor is responsible for ensuring that all staff working with have reviewed his plan of service and attached data forms. This information will be reported to Case Manager on the Training Record. participated in an Adult Home Help assessment in 2018 and is not eligible for Adult Home Help.

Day 1: (2 hours total)

will work with his CLS staff to come up with ideas for meals to prepare. At least 4 meals per week will be planned. is encouraged to go to the library to print recipes off the internet or check out cookbooks on his own time. There may be meals that do not require a recipe, if that is the case staff should spend time with discussing the steps to make the meal.

Based on the meals identified, staff will assist with making a shopping list. should write down his list himself and staff may assist. In addition to these items, should add things to his list for times when staff are not there to assist. What will he eat, breakfast/lunches? Help check the refrigerator and throw out expired foods. Check cupboards and refrigerator in relation to the list so is not requesting something he already has. Other personal items such as plastic baggies, toilet paper, cleaning supplies should also be added. His father has requested that bring this shopping list with him on Sundays when they take him shopping.

will decide what he will be cooking the following day and take out any meats or frozen items that would need to thaw and place in refrigerator.

Staff may assist with cooking a meal if time allows.

If there is additional time, focus could be spent with on learning food safety and sanitation practices. clean his own kitchen, but verbal guidance may be needed. Staff should not do anything for the himself.

Day 2, 3, and 4 (2 hours per day)

On these days, and CLS staff will work on cooking.

- Step 1: Review Recipe
- Step 2: Gather supplies
- Step 3: Prep items
- Step 4: Cook Food
- Step 5: Portion items for storing
- Step 6: Clean up

Focus on preparing food that require multiple steps and actual cooking rather than just heating som

Goal

Interventions

Objectives

GOAL #1: OBJECTIVE A

Each time CLS is provided, will cook a meal start to finish with no more than one physical assist per meal, 100% of the time, as evidence by progress notes.

EFFECTIVE DATE	TARGET DATE	ACTUAL COMPLETION DATE
3/12/2019	3/11/2020	

GOAL #1: OBJECTIVE B

Once weekly, would like to increase his variety of meals by cooking something new, 100% of the time, as evidence by progress notes.

EFFECTIVE DATE	TARGET DATE	ACTUAL COMPLETION DATE
3/12/2019	3/11/2020	

GOAL #1: OBJECTIVE C

4 or more times per month, will discuss job skills needed for community integrated employment with his job coach or MMI staff, 100% of the time, as evidence by semi-annual review of progress submitted by MMI.

EFFECTIVE DATE	TARGET DATE	ACTUAL COMPLETION DATE
3/12/2019	3/11/2020	

GOAL #1: OBJECTIVE D

will maintain his supported employment with 3 or less employer concerns per month, 100% of the time, as evidence by semi-annual review of progress submitted by MMI.

EFFECTIVE DATE	TARGET DATE	ACTUAL COMPLETION DATE
3/12/2019	3/11/2020	

GOAL #1: OBJECTIVE E

will discuss concerns and questions regarding his services and living arrangements during monthly contact appointments with Case Manager, 100% of the time, as evidence by progress notes.

EFFECTIVE DATE	TARGET DATE	ACTUAL COMPLETION DATE
3/12/2019	3/11/2020	

Monitoring Utilization of Services

- ◀ To determine authorizations we review the current authorization range for each service within the individual plan of service
 - ◀ Authorizations must be in place prior to providing the service
 - ◀ We must provide the minimum amount of services authorized.
 - ◀ Note the authorization effective dates, units authorized, units claimed to date, units available and unit type.

AUTHORIZATIONS						
AUTHORIZATION # 2104A0349082		PROVIDER NAME Isabella - CMHCM CM		AUTHORIZATION EFFECTIVE 05/03/2021 - 05/02/2022		STATUS Approved
Authorized Service(s) Description		Units Authorized	Units Claimed To Date	Units Paid To Date	Units Available	Unit Type
T1017 Targeted Case Management		1-4 Per Month Total: 13-49	4	0	45	15 Minutes
HOW WILL THE SERVICE BE PROVIDED? <input checked="" type="checkbox"/> F-to-F with Consumer only <input checked="" type="checkbox"/> F-to-F with Consumer and others <input type="checkbox"/> F-to-F with others only <input type="checkbox"/> Staff only						
WHERE WILL THE SERVICE BE PROVIDED? <input type="checkbox"/> Consumer's Residence <input type="checkbox"/> Community Setting <input checked="" type="checkbox"/> CMHCM Office <input checked="" type="checkbox"/> Other: covid audio						
RELATED GOALS 1						

AUTHORIZATIONS						
AUTHORIZATION # 2105A0350107		PROVIDER NAME Isabella - CMHCM OPT		AUTHORIZATION EFFECTIVE 05/03/2021 - 05/02/2022		STATUS Approved
Authorized Service(s) Description		Units Authorized	Units Claimed To Date	Units Paid To Date	Units Available	Unit Type
9083X Individual therapy 90832, 90834, 90837		1-2 Per Month Total: 13-25	1	0	24	Encounters
HOW WILL THE SERVICE BE PROVIDED? <input checked="" type="checkbox"/> F-to-F with Consumer only <input type="checkbox"/> F-to-F with Consumer and others <input type="checkbox"/> F-to-F with others only <input type="checkbox"/> Staff only						
WHERE WILL THE SERVICE BE PROVIDED? <input type="checkbox"/> Consumer's Residence <input type="checkbox"/> Community Setting <input checked="" type="checkbox"/> CMHCM Office <input checked="" type="checkbox"/> Other: Covid Audio/Video						
RELATED GOALS 1, 2						

- » If a consumer is not utilizing their services as authorized (but this is due to a shortage in staffing, a nursing home/hospital stay, etc.) this will be documented by the CMH case holder in the chart. If a consumer is utilizing their services less than authorized, the case holder will review to ensure services are still medically necessary at the levels authorized.
- » If a consumer is utilizing more services than authorized a discussion will be held with the consumer and provider (or SD arrangement holder) to bring services back in line with what is authorized as medically necessary.
 - » Once all authorizations have been used, additional authorizations cannot be approved if they are not determined to be medically necessary

Monitoring Utilization of Services Continued

Amount: Is the number of services being requested (the frequency at which these amounts are requested can be: per auth, per day, per month, per quarter, per week, or per year)

Scope: Is the type of service being requested

Duration: Is how long the service is going to last (generally this will go for the full time period of the IPOS but there may be short-term authorizations)

AUTHORIZATION #	PROVIDER NAME	AUTHORIZATION EFFECTIVE	STATUS		
[REDACTED]	Fish Tales Inc	08/10/2021 - 08/21/2021	Approved		
Authorized Service(s) Description	Units Authorized	Units Claimed To Date	Units Paid To Date	Units Available	Unit Type
H0045	1 Per Day Total: 12	0	0	12	Days
HOW WILL THE SERVICE BE PROVIDED?					
<input checked="" type="checkbox"/> F-to-F with Consumer only <input checked="" type="checkbox"/> F-to-F with Consumer and others <input type="checkbox"/> F-to-F with others only <input type="checkbox"/> Staff only					
WHERE WILL THE SERVICE BE PROVIDED?					
<input type="checkbox"/> Consumer's Residence <input checked="" type="checkbox"/> Community Setting <input type="checkbox"/> CMHCM Office <input type="checkbox"/> Other					
RELATED GOALS					
1					

Scope

Amount

Duration

Electronic IPOS Training for Providers

PCP			
Date	County / Affiliate	Status	
06/26/2020	Midland	SIGNED BY: [REDACTED] VERBALLY CONSENTED: Consumer	View Document History View Appointment Print with Original Goals Print with Current Goals Print Signature Page
<div style="display: flex; justify-content: space-between; align-items: center;"> 1 PCP Co 1 10 PCP Training Records 1 Attachment </div>			

PCP			
Date	County / Affiliate	Status	
06/26/2020	Midland	SIGNED BY: [REDACTED] VERBALLY CONSENTED: Consumer	View Document History View Appointment Print with Original Goals Print with Current Goals Print Signature Page
<div style="display: flex; justify-content: space-between; align-items: center;"> 1 PCP Cover Letter PCP Training Records 1 Attachment </div>			
Date	County / Affiliate	Provider Agency	
<div style="display: flex; justify-content: space-between; align-items: center;"> 2 Add PCP Training Record </div>			
03/03/2021	Midland	Arnold Center	View Print Document History
10/22/2020	Midland	Independent Community Living, Inc.	Change View Print
09/16/2020	Midland	Arnold Center	View Print Document History
09/15/2020	Midland	Arnold Center	View Print Document History
09/11/2020	Midland	Arnold Center	View Print Document History
09/10/2020	Midland	Arnold Center	View Print Document History
08/27/2020	Midland	Independent Community Living, Inc.	Change View Print
08/27/2020	Midland	Independent Community Living, Inc.	Change View Print
08/27/2020	Midland	Independent Community Living, Inc.	Change View Print
07/29/2020	Midland	Independent Community Living, Inc.	Change View Print

Electronic IPOS Training for Providers - Continued

PCP Training Record

Date of Training [Use Current Date](#) PCP Effective Date 06/30/2020 Provider Type Contracted Service Direct Service Contracted Service Provider [lookup](#)

The following staff have been trained on the PCP [+ Add Attending Staff](#)

Attending Staff Names

Electronic Signatures

Instructions
When the form/document is completed, type in your password and click 'Sign and Save'. By entering your password you are electronically signing this form/document. Your signature represents your acceptance and approval of the records. Once signed, any future changes must be made via the 'Change Signed Document' option.

Trainer Signature Required By [lookup](#)
181943 Jenelle Lynch LMSW, QMHP, QIDP, C

Enter your password to sign

1. Date of Training

4. Add Staff Trained

2. Choose Contracted Service

3. Lookup Provider Name

5. Sign with Password

Putting it all together - CLS Example

Consumer's goal: "I want to become more independent by improving my housekeeping skills."

Consumer's Objective: James will wash, dry and fold his laundry at least once weekly with three or less verbal prompts as evidenced by CLS progress notes.

Consumer's Interventions: John requires verbal prompts or partial physical assistance to complete most of these steps. CLS staff will provide verbal prompts with sorting laundry, filling laundry machine, selecting the accurate cycle, loading dryer and then folding each piece. If verbal prompts are unsuccessful, staff will provide partial physical assistance to model and teach John the task. Total time 3 hours per week.

Progress notes should describe what assistance was provided in this area and how the consumer participated based on the objectives and specific interventions.

Rather than...

"..he watched TV while I did laundry.." OR "..we went out to the laundromat and to the library.."

CLS notes should say something such as...

"With verbal prompting, John got the laundry soap out. Prompted him first to try sorting clothes, then assisted him in sorting while explaining steps. He placed clothes in washer and I talked him through how to turn the machine to correct cycle.."

Why are Progress Notes Important?

- Every Medicaid covered service requires documentation that indicates a medical necessity for service
- CLS Progress notes help monitor the progress of a consumer, and also track where a consumer is at in their achievement of the goals that they have developed
- Documentation supports open communication between CLS staff and CMHCM staff. Case managers review progress notes regularly to update the Person-Centered Plan as needed and communicate about progress
- CLS goals and objectives are tracked through Progress Notes and this is essential to treatment success and keeps you, the provider, on track too!

Key Words for Progress Note Completion

Achieved	Advocated	Arranged	Assisted	Attended	Built
Checked	Completed	Coordinated	Directed	Explained	Guided
Helped	Increased	Learned	Participated	Prepared	Prompted
Provided	Reminded	Socialized	Supported	Taught	Trained

Recap of today's training!

Person Centered Planning is the process by which we develop an Individual Plan of Service (IPOS) for all consumers. PCP respects a consumer's choice and wishes for the future.

The IPOS is the roadmap to providing direct services to a consumer. Providers may participate in the development of the plan depending on the consumer's wishes.

The IPOS contains goals, objectives and interventions to direct the care providers deliver. The interventions section is usually the primary section that spells out the amount, scope and duration of necessary interventions.

All provider staff must be trained on an IPOS before providing the supports and services authorized. This ensures you know what you are supposed to be doing to support the individual!

Well written progress notes will help you show your efforts and what support you are specifically providing the individual you are working with. This helps our case managers document progress, or lack of progress, so they know what is working and what is not.

References and additional information:

A Guide To Person-Centered Planning - State of Michigan https://www.michigan.gov/documents/mdhhs/pcp_524026_7.pdf

Michigan Medicaid Provider Manual: www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Community Mental Health for Central Michigan Policy # 2.300.015.

Michigan Department of Health and Human Services Behavioral Health and Developmental Disabilities Administration.
PERSON CENTERED PLANNING POLICY. https://www.michigan.gov/documents/mdhhs/Person-Centered_Planning_Policy_P-4-4-1-1_638363_7.pdf

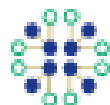
Michigan Developmental Disabilities Institute Wayne State University. Website: www.ddi.wayne.edu



Thanks!

Any questions?

You can find me at jlynch@cmhcm.org or Ext. 1281



Community Mental Health
FOR CENTRAL MICHIGAN