I. PURPOSE

To establish an appropriate structure for the development of a treatment plan for clients of Barry County Community Mental Health Authority (BCCMHA).

II. GOAL

Each BCCMHA client will be involved with the development and implementation of his or her treatment plan.

III. APPLICATION

The provisions stated in this subject apply to all BCCMHA staff and professional contract provider(s).

IV. POLICY

Every open client of BCCMHA will have an up-to-date treatment plan in their medical record that will be implemented by the assigned service provider and client. The treatment plan is valid for 365 days.

Every treatment plan will occur in accordance with the principles of conflict-free case management. The treatment plan will include specific goals, objectives, interventions, time frames, discharge/level transition criteria, grievance and appeal information, client's hopes, dreams, preferences, requests for authorizations and outcomes of treatment. The treatment plan will include the signature of client/guardian, and signatures of the clinician, the appropriate supervisory staff, the Medical Director, and others involved with the person-centered meeting and treatment process. The treatment plan will outline the amount, scope, and duration of services and supports to be received by the client. The treatment plan will also list client needs as identified via the assessment process which may include, but is not limited to, the following domains: health practices, independent living skills, food, shelter, clothing, health care, employment opportunities where appropriate, educational opportunities where appropriate, legal services and recreation.

The treatment plan will be a comprehensive service plan, developed in partnership with the client, and designated to address the prioritized treatment, service or support needs of the client. A copy of the treatment plan will be provided to the client within 15 business days after the person-centered meeting unless the client declines a copy of their plan. The

provision or refusal of the copy of the plan by the client will be noted in the electronic health record (EHR).

In addition to a copy of the treatment plan, an estimate of the cost of services will be provided to the client. The cost estimate will be provided to the client annually, when significant changes occur to the plan of services, and/or as requested by the client following the person-centered planning process.

The clinician will obtain and document the client's hopes, dreams, preferences, and desired outcomes of treatment and assist the client in developing treatment goals and objectives. Goal and objective development will be based on the principles and processes of person-centered planning. Whenever possible, natural supports will be involved in the development and implementation of the plan of service.

The treatment plan must meet medical necessity criteria and service selecting guidelines as outlined in the Mental Health/Substance Use Disorder Section of the Medicaid Manual, Master Contract(s) with the Michigan Department of Health and Human Services, by Centers of Medicare and Medicaid Services, and be appropriate to the individual's needs.

V. STANDARDS

The stated goals will be derived from the client's expressed dreams, desires, expected outcome of treatment, and contain evidence of the client's and/or guardian's involvement. Goals will be written in terms of obtaining an improved, more satisfactory state for the client, but in all cases is a direct result of the client's own desires for services. These goals will reflect the impact on the client's resources, such as personal strengths, social ties, finances, family situations as identified by the client, and be stated in a positive manner. If the goal cannot be written in this manner, then a written statement will accompany the goal that describes a more positive condition.

The clinician/case manager will help the client create his or her goals in the treatment plan in such a way that the client and clinician/case manager will be able to identify progress in goal areas. Therefore, goals should specify behavioral objectives, be written in measurable language, and state specific observable changes in behaviors, skills, attitudes, or circumstances.

There must be an intervention component for each of the established service goals which will be a description of the methods that are to be implemented by assigned staff to accomplish the stated goals, method of data collection, indicate people responsible for providing the direct service, and how often regular client contacts are to be made. Anticipated referrals to other services, CMH or community, should be included also in the Deferred Treatment Issue Section and copies of related referral documents placed in the medical record. Services

reflected in the Treatment Plan will represent the least restrictive environment possible. This should include not only the client's living situation, but also treatment interventions.

Discharge and/or level of care transition criteria will be outlined in the treatment plan. This will be utilized in assisting clients to monitor their own progress toward discharge or level of care transition, but also communicate what needs to be accomplished before movement to discharge or another level of treatment.

Time frames for each of the developed goals will reflect the needs and desires of the client and document the anticipated completion date.

In order to identify the supports that the client is receiving, goals and/or objectives will address all the program components and services in which the client is involved, when appropriate, (outpatient, psychiatric, case management, intensive outpatient, community based services, AFC, etc.).

The treatment plan is completed in session in conjunction with the client and/or guardian who are part of the treatment process. As evidence of their involvement in developing goals and commitment to the treatment process, the clinician or case manager will obtain the client's and/or guardian's signature.

> **NOTE:** If the client refuses to sign their treatment plan, the clinician or case manager will document the refusal within the treatment plan. If extensive explanation is necessary, the clinician or case manager will utilize a miscellaneous and/or progress note to that effect and identify the date of the corresponding treatment plan.

Addendums to the treatment plan will be made when clients are referred and obtain additional BCCMHA or other community services; (i.e., community based services, case management, intensive outpatient, supported employment, etc.); client request; or as the result of consultation with agency staff or other community agencies. All goals will also be developed with client involvement.

A new treatment plan will be developed at least annually or amended as needed during the course of treatment. Annual review of a new treatment plan is documented through the assessment. If major changes occur prior to the annual date, an updated assessment will be completed to support the treatment plan, and a new treatment plan will be developed and will be denoted as a treatment plan addendum.

The treatment plan will be consistently reviewed and updated on a periodic basis as outlined within the plan of service. This review is documented through a periodic review.

Staff will receive appropriate training in the proper development of a treatment plan and/or treatment plan addendum, including how to develop measurable goals and objectives, and specific action oriented intervention plans.

VI. PROCEDURES

Initial Assessment

The initial assessment is always completed during the intake process. If it is anticipated that the client will require only outpatient therapy services, the clinician will assist the client and/or guardian in developing specific goals to be addressed in therapy. If, at the intake, the clinician believes that case management services will be needed, then a case manager will become involved in the intake process.

Once the assessment has been developed and appropriate signatures have been obtained, the assessment is reviewed by the Single Entry Team for medical necessity in accordance with the Single Entry Team Policy.

The designated staff will be responsible for assuring that all appropriate signatures are obtained. This includes the signature of the clinician, case manager, professionals, medical director, and others involved in the service planning and treatment process.

Annual Assessment

Each client who has been receiving services at BCCMHA through an entire calendar year will receive an annual assessment. This includes a formal review of the treatment plan and completion of a new plan to address goals for the next year.

The clinician or case manager will be responsible for conducting a pre-planning session and holding a person-centered planning meeting. This person-centered planning meeting will include the client and/or guardian, if applicable. The meeting may also include natural supports, representatives from other community services the client is receiving, various professionals involved in implementing the treatment plan, independent facilitators, and any other persons the client would like involved. This meeting will be utilized for developing and/or completing the annual treatment plan before the annual review date. The treatment-planning meeting can be completed up to three months before the annual review date, if appropriate. The annual treatment plan will be developed utilizing person-centered planning principles. Once the treatment plan is completed, it will be reviewed by Utilization Review staff.

To assist with coordination of services and supports for clients in instances where the guardian was unable to attend the person-centered planning meeting, communication regarding the meeting and its outcome will be made by the case holder. Staff will generate a copy of the IPOS through the disclosure log in the EHR as documentation that the individual or guardian received a copy of the plan and a signature was requested, if it was unable to be obtained at the time of the planning meeting. The case holder will ensure that the individual/guardian's signature is obtained on the treatment plan. If review is conducted via mail, a copy of the cover letter requesting the review and signatures will be scanned into the medical record. Clinician/Case manager will encourage and promote the involvement of guardians and other support persons in the treatment planning and implementation of services. Upon the request of the client and obtainment of the proper releases, copies of the treatment plan may be mailed to other individuals who serve as supports for the client. All treatment plans will be housed in the client's medical record.

The case holder will ensure that trainings on the individual Plan of Service are completed with all necessary providers of the services outlined within the plan. Documentation of the trainings will be recorded and scanned into the client file within the EHR.

REFERENCES

Medicaid Manual and Centers for Medicare and Medicaid Services
Medicaid Managed Specialty Services and Supports Contract Attachment
Michigan Mental Health Code Section 712
MDCH/CMHSP Manage Mental Health Supports and Services Contract

QUALITY IMPROVEMENT

This policy/procedure will be evaluated by the Quality Improvement Committee on an annual basis to enhance and improve the quality.

At any time, employees can request in writing, on the form provided, that this policy or items in this policy be reviewed by the Quality Improvement Committee. Employee's written requests can be given to any Quality Improvement Committee member.

When an area for improvement is indicated, the process for improvement as identified in the Quality Improvement Plan will be followed.

APPROVED BY:

Richard Thiemkey Date
Executive Director

Jill Bishop, MA, LLP, QMHP, QMHP, QIDP Date
Clinical Director

Emily Whisner, MA, LLP, QMHP, QIDP, CMHP Date
Chief Clinical Officer