Title: Person Centered Planning Process and Individual Plan of Service (IPOS) Procedure

Prepared By: Clinical Director

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Purpose:

To define the guidelines and requirements to be used when developing a person/family centered plan of service in accordance with established state and federal regulations (reference Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program).

Scope:

This procedure applies to all employees (including full-time and part-time employees), contract clinical providers, volunteers, students, and/or interns of Huron Behavioral Health (HBH) and all consumers served by HBH.

Information:

1. The Michigan Mental Health Code requires that every consumer receives a written Individual Plan of Service (IPOS) within seven (7) days from the "commencement of service" (330.1712) (see also "Definitions" section for clarification). HBH makes every effort to schedule the first appointment after the intake assessment within seven (7) days. However, the Michigan Department of Health and Human Services (MDHHS) allows up to fourteen (14) calendar days for the first follow-up appointment.

2. In accordance with the MDHHS contractual requirements and "Person-Centered Planning Practice Guideline", the consumer will be given options in the person-centered planning process. An "Optional PCP Tool Brochure" (90-769) is provided to the consumer during the pre-planning process. Some person-centered planning options may include (but may not be limited to):
   - McGill Action Planning System (MAPS)
   - Essential Lifestyle Planning (ELP)
   - Planning Alternative Tomorrows with Hope (PATH)
   - Personal Futures Planning (PFP)
   - Other suitable tools requested by the consumer
     Note – If the consumer declines the option of using one of the available tools, the worker will note this on the Pre-Plan form in the EMR system.

3. If the consumer is interested in utilizing any of the optional person-centered planning tools, the primary worker will coordinate with the Independent Facilitator to see that this occurs (see also "Independent Facilitation Procedure" QI.2.15).

4. The "Person-Centered Planning Policy Practice Guideline" also requires the IPOS must be delivered to the consumer within fifteen (15) business days of their IPOS meeting.

5. The IPOS is to be developed and written with the fullest possible participation of the consumer and their family and/or legal guardian, as appropriate. Individuals chosen by the consumer to participate in their IPOS planning process will only be excluded from the process if that individual would constitute a substantial risk of physical or emotional harm to the consumer or substantial disruption of the planning process. If this occurs, it must be noted in the consumer's case record. By definition, the person-centered planning process is directed by the consumer, and their parent and/or guardian. The consumer must sign his/her IPOS. If the consumer has a guardian, the guardian will also sign the IPOS (see also "Personal Representative/Guardian Policy" ORI.1.15).

6. HBH will assist the consumer and his/her advocates to design services which are based on medical necessity and are the least restrictive/intrusive services available to meet the needs of the individual.

7. Some consumers served by HBH do not have a range of life experiences to be able to make fully informed decisions. Because of this, it is essential for HBH staff to:
   a. Assist the consumer to gain the experience and skills needed to make informed decisions

b. Explain (in ways that the consumer and their natural supports can clearly understand):
   - The available options/service alternatives
   - The benefits, consequences, and risk factors, including back-up plans and strategies
   - The ways HBH can (and cannot) support the achievement of their desired outcomes

8. The IPOS is the foundation for all treatment activities and becomes the prescription for services. Therefore, treatment cannot be effectively or efficaciously provided until mutually agreed upon goals and service needs are defined. The Individual Plan of Service consists of many aspects, which include, but may not be limited to:
   - Identifying medically necessary services (Scope, Duration, Frequency, Intensity)
   - Identifying any co-occurring treatment needs
   - Defining goals, objectives, methodology, and the timeframes for completing them
   - Developing social inclusion activities and community involvement
   - Assisting with meaningful and competitive employment opportunities
   - Identifying the consumer's natural supports/family relationships and informal social networks
   - Identifying and addressing the consumer's health and safety concerns
   - Identifying the consumer's strengths and skills
   - Identifying the consumer's cultural and ethnic issues
   - Identifying any assistive technology/LEP (Limited English Proficiency) needs
   - Identifying any unmet service and supports needs
   - Assessing the consumer's need for food, shelter, clothing healthcare, employment, education, legal services, transportation, and recreation
   - Defining the review frequency (Periodic Reviews)

9. Huron Behavioral Health views the IPOS as the individual's treatment plan. When the HBH physician is involved in the consumer's treatment, the HBH physician will also sign the IPOS. Additionally, using the Electronic Medical Record (EMR) system, the IPOS must specify all services (with the exception of those not requiring an authorization such as Emergency Services, Inpatient Hospitalization, Initial Assessment, etc.). Each service that requires an authorization must show how and by whom they are to be provided, as well as the amount, scope, frequency, and expected duration of each service to be provided and their desired outcomes.

10. Clinical Assessments should be used to inform the person-centered planning process, but is not a substitute for the process. Functional assessments must be done using a person-centered approach. The functional assessment and the person-centered planning process together should be used as the basis for identifying goals, risks, and needs. The IPOS must also incorporate recommendations from the assessment, pre-plan, safety checklists, and initial health screens. As applicable, these must be completed prior to the IPOS meeting so that the recommendations are incorporated into the IPOS as goals, objectives, and team assignments, etc,

11. It is the policy of HBH to have only one (1) active IPOS for each consumer served. If additional services are added or changed after an IPOS is developed, a new IPOS or an addendum may be used to convey the additions/changes to the plan (see section "H" below).

12. The person-centered planning process also reflects when a behavior treatment plan needs to be developed as part of the treatment plan (see also "Behavior Treatment Plan Policy" BM.1.01).

13. Family-centered and youth-guided planning, supports, and services are provided for minor children.

14. Consumers are provided with ongoing opportunities to express their needs, desires, preferences, and meaningful choices.

15. If desired, staff will assist consumers with Intellectual/Developmental Disabilities (I/DD) to receive support and education regarding sexuality and relationships that have been tailored to their assessed needs, capacity, and

learning style, including sexual health and development, family planning, and prevention of STDs, HIV/AIDS and sexual abuse and exploitation including giving and receiving sexual consent.

16. Individuals are provided with ongoing opportunities to provide feedback relative to the services, supports, and treatment they are receiving from HBH (e.g., during periodic reviews, through the program-specific consumer satisfaction survey process, etc.).

17. In accordance with regional/affiliation agreement and standardized practices, if a guardian cannot attend the consumer's IPOS meeting and is not available to sign the IPOS, it is understood that "implied consent" has been granted to the consumer to sign/approve the IPOS (see "Definitions" section).

18. Any persons providing direct care services in conjunction with a planned service (as directed in the individuals' IPOS) will receive IPOS-specific training regarding the individual's needs must sign a "IPOS-Specific Training and Agreement Form for Personal Care Staff" (90-004) to indicate they understand and will abide by the individual's plan of service. Additionally, contract providers are required to maintain a current copy of the consumer's IPOS at the provider's setting and ensure staff is trained in the IPOS prior to service delivery.

19. In accordance with the Medicaid Provider Manual, staff who provide direct care to consumers in conjunction with a planned service as directed in the consumer's Individual Plan of Service (IPOS), must receive IPOS-specific training regarding the consumer's needs. This includes consumers who are receiving services in the following programs:

    - Home and Community Based Services (HCBS)
    - Children's Waiver Program (CWP)
    - Waiver for Children with Serious Emotional Disturbance (SEDW)
    - Habilitation Supports Waiver (HSW)

    This training is typically provided by the CSM/SC to assure that staff is competent to implement the IPOS prior to providing services to the consumer. IPOS training must be completed at the time of a new IPOS, with the annual IPOS, when there is an addendum to the IPOS, or whenever there is a new direct care provider, or when there is a behavior treatment plan. Evidence of IPOS-specific training must be documented on the "IPOS-Specific Training and Agreement Form for Personal Care Staff" (90-004) and must identify:

    - Who was trained
    - Content of the training
    - Who the trainer was (including title)
    - When (specific date) the training was provided
    - A legible signature of the staff who received the training

Procedure:

A. Person-Centered Planning Process and IPOS Requirements:

1. Before services can be provided by HBH, an IPOS must be completed (except for Emergency Services (ES)/crisis interventions and Initial Assessments).

2. The Michigan Mental Code requires that every consumer be given person-centered pre-planning (see "IPOS Pre-Planning Procedure" QI.2.34).

3. An IPOS must be started well enough in advance of the current IPOS's so that services are continuous and uninterrupted. Workers are expected to begin the person-centered planning process at the third Periodic Review to assure adequate time to conduct the new person-centered planning process without any lapse in the IPOS and services).

4. An IPOS can be written for up to one (1) year but cannot exceed a one (1) year period.

5. An IPOS must list every service that is to be provided (except for emergency services, inpatient hospitalization, and initial assessments).
6. An IPOS must be addended or re-written if the consumer's treatment needs change.
7. If HBH is billing/invoicing for a service, it must be:
   - Medically necessary
   - Stated in the IPOS *(Note: Exceptions include Emergency Services and Initial Assessments)*
   - Provided to the individual at the frequency, scope, & duration stated in the IPOS
   - Accurately documented in the consumer's case record
8. Services defined in the IPOS must be medically necessary and must be stated in terms that align with the service terminology utilized in the Medicaid Provider Manual. All services to be provided (including all ancillary services must be included in the services section of the IPOS. Decisions to deny or authorize service in amount, scope, duration that is less than requested are made by a health care professional with the appropriate clinical expertise in treating the individual's condition. In addition to defining the services in the IPOS, the worker must include the unit cost for services to provide a "Cost of Service Report" as part of the written plan of service.
9. Services must be defined in the IPOS with amount, scope, and duration (see guidelines in the table below):

Service	Amount	Scope	Duration	Level of Need/ Medical Necessity
Medication Reviews	1-3 Times	Quarterly	1 year	per Psychiatrist direction
Outpatient Therapy	2-4 sessions	Monthly	6-12 months	Locus Level 1 or 2 (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the IPOS)
Group Therapy	1 time	Weekly	Length of Group Therapy	Locus Level 1 or 2 (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the IPOS)
Case Management	1-2 times	Monthly	1 year	Locus Level 1 or 2 (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the IPOS)
Intensive Case Management	1 time	Weekly	1 year	Locus Level 3 or higher (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the IPOS)
Home Based/Children's Case Management	4 hours	Weekly	6-12 months	MichiCANS "Need" scores must be addressed in the IPOS (complete Initially, annually, and at end of services)
Assertive Community Treatment (ACT)	2-5 times	Weekly	1 year	Locus Level of 4 or higher (complete Initially, when the Level of Care changes, quarterly, at the end of services, at the time of the IPOS)
Skill Building Assistance	11-22 units	Weekly	1 year	IPOS and Assessment of Need (90-573)
Supported Employment	22-66 units	Weekly	1 year	IPOS and Assessment of Need (90-573)
Respite Care	As determined by Respite Rating Scale (90-547)			Respite Needs Assessment Form (90-547)
Community Living Supports	8-60 units	Weekly	1 year	Person-Centered Planning and Assessment of Need
Specialized Residential	Daily rate after assessed rating (10-008)			Specialized Residential Rating Scale Form (10-008)

10. It may be determined during the person-centered planning process that an individual meets the medical necessity criteria for occupational therapy (OT) and/or physical therapy (PT) services and these services will be included in the IPOS. If it is determined after the person-centered planning process that OT and/or PT services are medically necessary, the IPOS will be addended. (Note per Medicaid guidelines, these services must be prescribed by a physician.) If the consumer is receiving nursing services, the Registered Nurse (RN) will contact the physician's office and request an order for the OT and/or PT service(s). If a consumer is not under a program nursing service, the primary worker will obtain an order from the primary care provider. A copy of the order is to be retained in the consumer's case record.

11. Services provided to the consumer must be in accordance with the frequency, scope, and duration agreed upon in the IPOS. If the consumer is being under-served (e.g., receiving fewer services than the defined frequency in the plan) or over-served (e.g., receiving more frequent services than defined in the plan), the IPOS must be addended (see section H below). If under-served, the consumer must also be given Adverse Benefit Determination Notice in accordance with the HBH "Appeals and Grievance Procedure" (RR.2.36) as this is a reduction in services from what was agreed upon in the plan. Additionally, the IPOS provides the consumer with available conflict resolution options and information.

12. Any services listed in the IPOS must have supporting goals, objectives, and/or team assignments to evidence the need for the service being provided by HBH.
    - Whenever primary services are prescribed in the IPOS, the worker must develop supporting goals and/or objectives (primary services include services such as targeted case management, home-based, assertive community treatment, medication clinic services, outpatient therapy, etc.).
    - Whenever ancillary services are prescribed in the IPOS, the worker must develop supporting goals, objectives, and/or team member assignments in the IPOS (ancillary services include services such as skill building, supported employment, community living supports, respite, peer support specialist services, etc.).

13. Services are not to be provided to the consumer unless there is a current IPOS or Addendum to the plan (except for emergency services, inpatient hospitalization, and initial assessments). While it is the primary worker's responsibility to have a valid/current IPOS in place for each consumer served, all HBH programs are required to continuously monitor to assure that there is a current/valid plan and to be continually monitoring for a lapsed plan. Staff is to immediately notify their supervisor and the primary worker when the IPOS has lapsed and there is not a current plan in the EMR system.

14. Program supervisors must continuously monitor the status of the Individual Plans of Service for the consumers being served in their program to assure that they are not violating Medicaid Provider Manual guidelines.

15. If service delivery cannot occur in accordance with the consumer's Individual Plan of Service for circumstances that are beyond the worker and/or consumer's control (for example the consumer has been hospitalized, jailed, or has traveled out of state, etc.), the following guidelines shall be used by staff:

    a. If a consumer is hospitalized, in jail, or out-of-area for one (1) month or less, it is not necessary to addend the IPOS or generate an Adverse Benefit Determination Notice, since the situation is short-term/temporary. However, the worker must document the situation in progress notes explaining why planned routine visits were not conducted.

    b. If the length of time in the hospital, jail, or out-of-area exceeds one (1) month in duration, the consumer should be sent an Adverse Benefit Determination Notice identifying the suspension of services in accordance with the "Appeals and Grievance Procedure" (RR.2.36) and the IPOS should be addended in accordance with section "H" below.

       If the above steps are not met, it also creates a Recipient Rights violation which requires staff to formalize a Recipient Rights Complaint and the HBH Recipient Rights Officer to conduct a formal rights investigation.

c. If a consumer has not been active or engaged in treatment for more than one (1) month, and an Adverse Benefit Determination Notice has been sent with no response from the consumer, the worker will generate an administrative addendum to close out authorizations, goals, and objective in the EMR system. Since the addendum is administrative in nature, the addendum does not need to be sent to the consumer/guardian, but is an EMR systems record only.

16. HBH staff who do not comply with the requirements for the person-centered planning process requirements are subject to disciplinary action in accordance with the HBH Employee Handbook (PPM.00).

B. IPOS for New Consumers in a Stable State:

1. The Primary Worker is responsible for completing the IPOS Pre-Plan and the Individual Plan of Service with the consumer.

2. In accordance with the Michigan Mental Health Code, HBH strives to complete an IPOS for every consumer served within seven (7) days of the commencement of services. Note: For the purpose of this procedure, "commencement of services" will be defined as the Initial Intake Assessment for all Programs except OBRA. For the OBRA program, "commencement of services" shall be the date that HBH receives the signed consent form after the MDHHS letter of determination has approved eligibility for mental health services). However, since the consumer determines their preference for when the IPOS meeting will be held, this may not always be feasible. In these situations, a progress note shall document the consumer's reason for the delay in completing the Individual Plan of Service (note: staff reasons for delaying an IPOS are not allowable). In all cases, an IPOS must be completed within thirty (30) days of the start of services, unless the consumer is clinically incapable or in an unstable state and cannot participate in the person-centered planning process. In these cases, the exception will be clearly documented by the worker in progress notes as to why the plan could not be completed.

3. In accordance with MDHHS guidelines, the IPOS must be delivered to the consumer within fifteen (15) business days of the IPOS meeting (see "Definition" section below), along with the Fair Hearing Information (for Medicaid and Non-Medicaid consumers).

C. Individual Plans of Service for New Consumers in an Acute Psychotic State:

1. At the first visit, the Primary Worker will complete an Initial/Intake Assessment utilizing the Clinical Assessment Form in EMR.

2. While in an acute psychotic state, documentation will be generated for the case record that identifies the short-term treatment activities and services provided. This may be accomplished through progress notes, evaluations, assessments, etc., which will also include the reasons that the IPOS is being delayed.

3. In these cases, an "Initial Assessment & Plan Form" (90-164) should be completed which serves as a temporary treatment plan until the consumer is stable and can develop his/her IPOS. As soon as the consumer is stable and is capable of participating in a IPOS meeting, a Pre-Plan and IPOS will be developed.

D. Individual Plans of Service for Current Consumers / On-going Services:

1. The Primary Worker is responsible for completing and maintaining a current Individual Plan of Service at all times. There can be no lapses in IPOS and no delinquent IPOS.

2. The IPOS must be updated at least annually (or more often if there are significant changes in status, goals, or needs, or if the consumer requests a new plan).

3. Well in advance of the expiration of the IPOS (typically at the third periodic review), the primary worker will complete a pre-plan with the consumer and schedule an IPOS meeting date, such that the current IPOS does not expire before a new one is completed.

4. The IPOS must be completed by the primary worker and forwarded to the Unit Manager within seven (7) calendar days of the IPOS meeting.

5. The IPOS must be given to the consumer within fifteen (15) business days (see "Definition" section below) of the IPOS meeting.

E. Person-Centered Planning Requirements for Transfers and Referrals to Other HBH Services:

1. When a consumer is receiving multiple services, the more intensive service will be responsible for developing the IPOS. Levels of intensity are shown in examples below, ranked from most intensive to least intensive:

MOST Intensive	Assertive Community Treatment (ACT) / Home-Base Services
↓	Intensive Case Management (ICSM)
	Case Management (CSM)
LEAST Intensive	Out-Patient Therapy (OP)
	Dr. Services only/Medication Clinic only

2. If a consumer is transferred to an additional service or from one service to another, the following guidelines will be used to determine what is needed for a treatment plan:
   - **For an Added Service** that is LESS intensive than the initial service (for example adding Outpatient Therapy when the consumer is already receiving ACT services), an addendum will be completed to supplement the IPOS. The addendum will identify the services, goals, team assignments that are being added/changed. New goal(s) can be addended into the IPOS which was completed by the more intensive service provider (in this case, ACT).
   - **For an Added Service** that is MORE intensive than the initial service (for example adding CSM services when the consumer is already receiving Out-Patient Therapy), a full IPOS will be developed by the more intensive service program which then replaces any previous IPOS.
   - **For a Transfer of Services:** (e.g., closing out one service and replacing it with another service) If the consumer is transferred from one service to another, a new IPOS must be developed within thirty (30) days of the transfer. For example, when a consumer is transferred from Case Management to ACT, a new IPOS must be done; an addendum is not acceptable.

F. Consumer Refusal to Participate in the Person-Centered Planning process:

1. On rare occasion, a consumer may refuse to participate in the Person-Centered Planning process. If the treatment team determines that the consumer needs to continue treatment regardless of their willingness to develop an individual plan of service, the treatment team will develop a treatment plan including clinical treatment goals based upon their knowledge of the individual's needs and desired outcomes. The goals will be monitored through progress notes. After the treatment plan is developed, the plan will be presented to the consumer for signature. If the consumer refuses to sign the plan, the primary worker will write "Refused to Sign" on the consumer's signature line. A copy of the plan will be given to the consumer within fifteen (15) business days of signing.

2. The primary worker must continue to encourage the consumer to develop an IPOS, and, as soon as he/she is willing to participate in an IPOS meeting, a pre-plan and IPOS is to be developed with the consumer's input. The worker's efforts to encourage the development of an IPOS and the consumer's responses must be clearly documented in progress notes.

G. IPOS Addendums:

1. An addendum may be written to supplement/modify an IPOS in certain situations:
   - The consumer's goals have changed or new goals have been added
   - A Behavior Treatment Plan is needed to address behavioral issues
   - Team Assignments have changed or been added
   - Additional services have been added which require additional or revised goals

- Health and/or safety concerns have been identified

2. When an addendum is needed, the worker will generate the addendum in the EMR system and document the reason for the addendum. The primary worker will obtain the necessary support information and appropriate signatures. When a supplemental addendum is developed it remains active until the next full IPOS is completed.

3. IPOS Addendums are considered a supplement to the IPOS and therefore must follow the same guidelines as defined contractually and by the Michigan Mental Health Code in that addendums must be delivered to the consumer within fifteen (15) business days of the completion of the addendum.

Definitions/Acronyms:

Definitions:

"Given to the consumer within Fifteen (15) Business Days" – In conjunction with the regional/affiliate board practices, HBH has adopted the practice of counting the business days from the time the IPOS is given to the consumer. A copy of the IPOS may be given with the consumer and worker signatures only. (If changes are made to the IPOS during the supervisor and/or clinical director sign-off, an updated copy must be given to the consumer reflecting the changes made). If the consumer has a guardian, counting the days can begin from the date the IPOS is mailed to the guardian. The IPOS may be mailed with signatures of the consumer, worker, supervisor, and clinical director. The IPOS need not be held for Guardian and Psychiatrist signatures before counting the days.

"Commencement of Services" – For the purpose of this procedure, start of services will be the point of the Initial Intake Assessment.

"Implied Consent" – refers to the understanding given between the guardian and worker when the guardian has been invited to the IPOS meeting, but cannot/does not attend and the consumer signs their own IPOS which is considered a valid IPOS for the purposes of providing the IPOS to the consumer within the required fifteen (15) business days.

Acronyms:

AIDS - Acquired Immune Deficiency Syndrome
ACT – Assertive Community Treatment
CLS – Community Living Supports
COA – Council on Accreditation
CSM – Case Management
CWP - Children's Waiver Program
ELP – Essential Lifestyle Planning
EMR – Electronic Medical Record
HBH – Huron Behavioral Health
HCBS - Home and Community Based Services
HIV - Human Immunodeficiency Virus
HSW - Habilitation Supports Waiver
ICSM – Intensive Case Management
I/DD – Intellectual/Developmental Disability
IPOS – Individual Plan of Service
LEP – Limited English Proficiency
MAPS – McGill Action Planning
MDHHS – Michigan Department of Health and Human Services
MichiCANS – Michigan Child and Adolescent Needs and Strengths
OBRA – Omnibus Budget Reconciliation Act
OP – Out-Patient
OT – Occupational Therapy
PATH – Planning Alternative Tomorrows with Hope
PFP – Personal Futures Planning
PT – Physical Therapy

SEDW - Waiver for Children with Serious Emotional Disturbance
STD – Sexually Transmitted Disease

Forms:

10-008 Specialized Residential Rating Scale
90-004 IPOS-Specific Training and Agreement Form for Personal Care Staff
90-164 Initial Assessment & Plan Form
90-547 Self-Determination Respite Needs Assessment Form
90-573 Supported Employment and CLS Assessment of Need Form
90-769 Optional PCP Tool Brochure
Clinical Assessment (in EMR)
Individual Plan of Service (IPOS) (in EMR)
MichiCANS Assessment Tool
Pre-Plan Form (in EMR)
IPOS Addendum (in EMR)

Records:

Records of IPOS are retained in the consumers' case record in accordance with the HBH Record Retention and Storage Policy (QI.1.23).

Reference(s) and/or Legal Authority

COA standards
MDHHS Person-Centered Planning Best Practice Guidelines @ http://www.michigan.gov/mdhhs/
Michigan Mental Health Code MCL 330.1700(g) and MCL 330.1712
Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program
BM.1.01 Behavior Treatment Plan Policy
ORI.1.15 Personal Representative/Guardian Policy
QI.1.05 Person-Centered Planning Policy
QI.2.15 Independent Facilitation Procedure
QI.2.34 Pre-Planning Requirements for Person Centered Planning Procedure
QI.1.23 HBH Record Retention and Storage Policy

Change History:

Change Letter	Date of Change(s)	Changes
AA	01/19/21	Changed "PCP" and "Person-Centered Plan" to "Individual Plan of Service" and "IPOS" (41 places), changed "Advance Notice" to "Adverse Benefit Determination Notice" (4 places), made numerous minor wording/grammatical changes/corrections throughout procedure without changing sentence content.
BB	04/07/21	In "Information" section added #13 & #17, in "Acronyms" section added "AIDS", "CWP", "HCBS", "STD", "HIV", "I/DD", "LEP", CWP", "SEDW", in "Change History" section removed change records A through Z. See Controlled Documentation Manager for historical changes and/or previous versions of this procedure.
CC	10/08/22	In "Information" section added #2 & #3, in "Acronyms" section added "ELP", "PFP' "PATH", & "MAPS" and removed "PCP", "Forms" section added 90-769, in "References" section added QI.2.15 ("Independent Facilitation Procedure") to better comply with MDHHS "Person-Centered Planning Practice Guidelines", also made several minor wording/grammatical changes/corrections throughout procedure without changing sentence content.
DD	05/13/24	In "Information" section #18 added "Additionally, contract providers are required to maintain a current copy of the consumer's IPOS at the provider's setting and ensure staff is trained in the IPOS prior to service delivery."
EE	08/22/25	In Information" section #5 added 2nd & 3rd sentences, and 12th bullet in #8, in "Procedure" section A.5 & A.13 added "inpatient hospitalization, in A.9 changed "CAFAS" & "PECFAS" to "MichiCANS" and removed "Supports Coordination", in E.1 removed "Supports Coordination", removed "G", ("IPOS Flowchart"), in "Acronyms" section added "MichiCANS" and removed "SC", "CAFAS" & "PECFAS", made several minor wording/grammatical changes/corrections throughout procedure without changing sentence content.
FF	09/06/26	In "Procedure" section A.9 (table – row labeled "Home Based/Children's Case Management") changed MichiCANS from "complete initially, quarterly, at end of services" to "complete initially, annually, and at end of services", in "Forms" section added "MichiCANS Assessment Tool".