

**CARF
Survey Report
for
Saginaw County
Community Mental
Health Authority**

Organization

Saginaw County Community Mental Health Authority
500 Hancock Street
Saginaw, MI 48602

Organizational Leadership

Sandra M. Lindsey, M.S.W., CSW, Chief Executive Officer

Linda Tilot, M.A., CSW, Director,
Care Management & Quality Systems

Linda Schneider, Director of Clinical Services

Philip Grimaldi, Board Chairman



Three-Year Accreditation

Survey Dates

August 17-19, 2016

Survey Team

Diane Bowen, Administrative Surveyor

Jill G. Bloom, RN, CPRP, Program Surveyor

Jane L. Groh, LISW, Program Surveyor

Programs/Services Surveyed

Assessment and Referral: Mental Health (Adults)

Assessment and Referral: Mental Health (Children and Adolescents)

Case Management/Services Coordination: Mental Health (Adults)

Case Management/Services Coordination: Mental Health (Children and Adolescents)

Community Integration: Integrated: IDD/Mental Health (Adults)

Community Integration: Integrated: IDD/Mental Health (Children and Adolescents)

Crisis Intervention: Mental Health (Adults)

Crisis Intervention: Mental Health (Children and Adolescents)

Health Home: Comprehensive Care (Adults)

Intensive Family-Based Services: Mental Health (Adults)

Intensive Family-Based Services: Mental Health (Children and Adolescents)

Outpatient Treatment: Mental Health (Adults)

Outpatient Treatment: Mental Health (Children and Adolescents)

Previous Survey

June 26-28, 2013

Three-Year Accreditation

Survey Outcome

Three-Year Accreditation

Expiration: September 30, 2019

SURVEY SUMMARY

Saginaw County Community Mental Health Authority has strengths in many areas.

- The leadership shows a commitment to the clinical services it provides. It shows a willingness to engage in evidence-based practices and make changes needed to fully meet the needs of its community.
- Services are provided in settings that are attractive, well maintained, and welcoming. The needs of the individuals served are considered, as evidenced by everything from the water in the lobby to the nursing stations.
- Saginaw County Community Mental Health Authority has a strong vision for improving services and meeting the needs of its community.
- The leadership has made improvements in the structure of its quality management system that will allow for greater efficiency and effectiveness in monitoring and improving outcomes in the future.
- Staff shows a great commitment to collaboration in the provision of services.
- Stakeholders strongly support services and are active in the strategic planning of the organization.
- Organizational staff is open to learning and expanding knowledge of management processes.
- The organization has made significant progress in the development of its performance management system since its previous CARF survey.
- The organization has improved its annual staff performance evaluation form since its previous survey.
- The organization has a strong facilities system that has a unique approach to maintaining a clean environment of care.
- Staff exhibits compassion, understanding, and enthusiasm for the mission and philosophy of the organization and for the provision of its services.
- Consumers interviewed remarked about the degree of caring and individuality demonstrated by the staff in the provision of its services.
- The staff is appreciative of senior management's continuous support and open-door policy that allows for impromptu discussions about concerns and immediate issues in providing services.
- The integration of supervisory staff within the teams strengthens the clinical approach for the persons served.
- The Handbook for First Responders developed by the crisis manager is a well-developed and thoughtful guide for the community. It includes multiple components and provides a clear roadmap for those who need access to emergency procedures.
- The Substance Abuse Mental Health Services Administration (SAMHSA) grant has given Saginaw County Community Mental Health Authority the ability to develop a cutting-edge health home program.
- The health home education is extended to staff members who are encouraged to participate for their own wellness needs.

- The organization has many auxiliary services, such as a pharmacy and a lab that provides a holistic approach to treatment. All consumers benefit from this thoughtful and innovative approach.
- The facility for family treatment is very welcoming and family friendly. The innovative games in the waiting area where one has to find the objects in a tube filled with seeds is an inventive use of simple items to hold a child's attention and foster complex thinking patterns. The children were actively engaged and enjoying themselves!
- The ongoing offering of continuing educational programs and partnership building with local higher education institutions afford the community and organization continued best practice knowledge and expertise, making Saginaw County Community Mental Health Authority a center of excellence for the community.

Saginaw County Community Mental Health Authority should seek improvement in the area(s) identified by the recommendation(s) in the report. Any consultation given does not indicate nonconformance to standards but is offered as a suggestion for further quality improvement.

On balance, Saginaw County Community Mental Health Authority has accomplished a great deal in its pursuit and maintenance of international accreditation. It has demonstrated substantial conformance to the CARF standards. The organization provides unique and quality care in a safe and supportive environment, and persons served and other stakeholders are pleased with services. Referral sources and other stakeholders speak highly of the organization. The organization clearly has a grasp of the intent and value of accreditation, and the leadership demonstrates a commitment to accountability and the accreditation process. The administrative infrastructure overall is strong, and the values of compassion and dedication are apparent among the leadership and direct services members. Leadership is aware of and capable of addressing the areas identified for improvement in this report.

Saginaw County Community Mental Health Authority has earned a Three-Year Accreditation. Leadership and staff members are congratulated on this achievement and are encouraged to address the recommendations noted in this report and to continue to use the CARF standards to improve the quality of its services.

SECTION 1. ASPIRE TO EXCELLENCE®

A. Leadership

Description

CARF-accredited organizations identify leadership that embraces the values of accountability and responsibility to the individual organization's stated mission. The leadership demonstrates corporate social responsibility.

Key Areas Addressed

- Leadership structure
 - Leadership guidance
 - Commitment to diversity
 - Corporate responsibility
 - Corporate compliance
-

Recommendations

A.3.k.

Although the organization annually reviews and updates many of its policies, it is recommended that it conduct an annual review of all policies.

A.6.a.(4)(e)

A.6.a.(4)(f)

It is recommended that the organization's written code of conduct include setting boundaries and witnessing of legal documents.

Consultation

- It is suggested that the organization consider including specific risk and reduction strategies in the compliance plan and update those elements annually.
 - It is suggested that the organization consider becoming an American Psychological Association (APA) training provider to reduce long-term training costs and attract Ph.D. and residency intern positions.
-

C. Strategic Planning

Description

CARF-accredited organizations establish a foundation for success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats.

Key Areas Addressed

- Strategic planning considers stakeholder expectations and environmental impacts
- Written strategic plan sets goals
- Plan is implemented, shared, and kept relevant

Recommendations

There are no recommendations in this area.

D. Input from Persons Served and Other Stakeholders

Description

CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. The standards in this subsection direct the organization's focus to soliciting, collecting, analyzing, and using input from all stakeholders to create services that meet or exceed the expectations of the persons served, the community, and other stakeholders.

Key Areas Addressed

- Ongoing collection of information from a variety of sources
 - Analysis and integration into business practices
 - Leadership response to information collected
-

Recommendations

There are no recommendations in this area.

E. Legal Requirements

Description

CARF-accredited organizations comply with all legal and regulatory requirements.

Key Areas Addressed

- Compliance with all legal/regulatory requirements
-

Recommendations

There are no recommendations in this area.

Consultation

- It is suggested that the organization review HIPAA policies to ensure that it reflects current federal requirements.
-

F. Financial Planning and Management

Description

CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and annual performance objectives. Fiscal practices adhere to established accounting principles and business practices. Fiscal management covers daily operational cost management and incorporates plans for long-term solvency.

Key Areas Addressed

- Budget(s) prepared, shared, and reflective of strategic planning
 - Financial results reported/compared to budgeted performance
 - Organization review
 - Fiscal policies and procedures
 - Review of service billing records and fee structure
 - Financial review/audit
 - Safeguarding funds of persons served
-

Recommendations

There are no recommendations in this area.

G. Risk Management

Description

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their people, property, income, goodwill, and ability to accomplish goals.

Key Areas Addressed

- Identification of loss exposures
 - Development of risk management plan
 - Adequate insurance coverage
-

Recommendations

There are no recommendations in this area.

Consultation

- It is suggested that the organization revise its current risk plan to include probability and severity of risk and measureable methods to manage risk.
-

H. Health and Safety

Description

CARF-accredited organizations maintain healthy, safe, and clean environments that support quality services and minimize risk of harm to persons served, personnel, and other stakeholders.

Key Areas Addressed

- Inspections
 - Emergency procedures
 - Access to emergency first aid
 - Competency of personnel in safety procedures
 - Reporting/reviewing critical incidents
 - Infection control
-

Recommendations

H.7.a.(2)

H.7.b.

Although annual emergency drills are completed related to most emergency situations, it is recommended that annual drills be completed on all emergency situations at all locations and include complete actual or simulated physical evacuation drills.

H.12.h.

It is recommended that the organization have written emergency procedures available in vehicles. It is suggested that the organization consider adding written emergency procedures in the visor area of each vehicle for easy access during an emergency.

I. Human Resources

Description

CARF-accredited organizations demonstrate that they value their human resources. It should be evident that personnel are involved and engaged in the success of the organization and the persons they serve.

Key Areas Addressed

- Adequate staffing
 - Verification of background/credentials
 - Recruitment/retention efforts
 - Personnel skills/characteristics
 - Annual review of job descriptions/performance
 - Policies regarding students/volunteers, if applicable
-

Recommendations

I.6.a.(1)

Although some job descriptions show evidence of being updated or reviewed, it is recommended that the organization consistently review job descriptions on an annual basis.

Consultation

- It is suggested that the organization consider adding the review of job descriptions to the annual staff evaluation to allow the staff member the opportunity to be active in any needed changes.
 - It is suggested that annual performance evaluations for all personnel be completed in a timely manner within the evaluation period. Some evaluations reviewed were completed several months after the evaluation period.
-

J. Technology

Description

CARF-accredited organizations plan for the use of technology to support and advance effective and efficient service and business practices.

Key Areas Addressed

- Written technology and system plan
- Written procedures for the use of information and communication technologies (ICT) in service delivery, if applicable
- Training for personnel, persons served, and others on ICT equipment, if applicable
- Provision of information relevant to the ICT session, if applicable
- Maintenance of ICT equipment in accordance with manufacturer recommendations, if applicable
- Emergency procedures that address unique aspects of service delivery via ICT, if applicable

Recommendations

There are no recommendations in this area.

K. Rights of Persons Served

Description

CARF-accredited organizations protect and promote the rights of all persons served. This commitment guides the delivery of services and ongoing interactions with the persons served.

Key Areas Addressed

- Communication of rights
 - Policies that promote rights
 - Complaint, grievance, and appeals policy
 - Annual review of complaints
-

Recommendations

There are no recommendations in this area.

L. Accessibility

Description

CARF-accredited organizations promote accessibility and the removal of barriers for the persons served and other stakeholders.

Key Areas Addressed

- Written accessibility plan(s)
 - Requests for reasonable accommodations
-

Recommendations

L.2.b.(1) through L.2.c.

It is recommended that the organization consistently review the accessibility plan annually, including progress made in removal of identified barriers needing improvement and areas needing improvement, and update it as necessary.

M. Performance Measurement and Management

Description

CARF-accredited organizations are committed to continually improving their organizations and service delivery to the persons served. Data are collected and analyzed, and information is used to manage and improve service delivery.

Key Areas Addressed

- Information collection, use, and management
 - Setting and measuring performance indicators
-

Recommendations

There are no recommendations in this area.

Consultation

- The organization is encouraged to continue to work toward a standard format for presenting outcomes that will allow staff, persons served, and other stakeholders to more readily understand the information.
-

N. Performance Improvement

Description

The dynamic nature of continuous improvement in a CARF-accredited organization sets it apart from other organizations providing similar services. CARF-accredited organizations share and provide the persons served and other interested stakeholders with ongoing information about their actual performance as a business entity and their ability to achieve optimal outcomes for the persons served through their programs and services.

Key Areas Addressed

- Proactive performance improvement
 - Performance information shared with all stakeholders
-

Recommendations

N.1.b.(2)(a) through N.1.c.(3)

The organization should analyze performance indicators related to service delivery, including effectiveness, efficiency, service access, and the satisfaction and other feedback from the persons served and other stakeholders, and any extenuating or influencing factors. The written analysis should identify areas needing improvement, result in action plans, and outline the changes made to improve performance.

N.2.a.(1) through N.2.d.

It is recommended that the organization use the annual analysis of performance indicators in the review the implementation of the of the mission and core values of the organization, to improve the quality of services, to facilitate organizational decision making process, and to review or update the strategic plan.

N.3.a.(1) through N.3.c.

Once the organization develops an analysis of the performance indicators, it is urged to communicate accurate performance information to persons served, personnel, and other stakeholders according to the needs of the specific group, including the format, content, and timeliness of the information communicated.

SECTION 2. GENERAL PROGRAM STANDARDS

Description

For an organization to achieve quality services, the persons served are active participants in the planning, prioritization, implementation, and ongoing evaluation of the services offered. A commitment to quality and the involvement of the persons served span the entire time that the persons served are involved with the organization. The service planning process is individualized, establishing goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served. The persons served have the opportunity to transition easily through a system of care.

A. Program/Service Structure

Description

A fundamental responsibility of the organization is to provide a comprehensive program structure. The staffing is designed to maximize opportunities for the persons served to obtain and participate in the services provided.

Key Areas Addressed

- Written program plan
- Crisis intervention provided
- Medical consultation
- Services relevant to diversity
- Assistance with advocacy and support groups
- Team composition/duties

- Relevant education
 - Clinical supervision
 - Family participation encouraged
-

Recommendations

A.26.a.

A.26.e.

A.26.h.

It is recommended that documented, ongoing supervision of clinical or direct service personnel address the accuracy of referral skills; issues of ethics, legal aspects of clinical practice, and professional standards, including boundaries; and model fidelity, when implementing evidence-based practices.

Consultation

- Although the organization has policies for supervision, it is suggested that these policies be followed consistently across all the programs.
-

B. Screening and Access to Services

Description

The process of screening and assessment is designed to determine a person's eligibility for services and the organization's ability to provide those services. A person-centered assessment process helps to maximize opportunities for the persons served to gain access to the organization's programs and services. Each person served is actively involved in, and has a significant role in, the assessment process. Assessments are conducted in a manner that identifies the historical and current information of the person served as well as his or her strengths, needs, abilities, and preferences. Assessment data may be gathered through various means, including face-to-face contact, telehealth, or written material, and from various sources, including the person served, his or her family or significant others, or external resources.

Key Areas Addressed

- Screening process described in policies and procedures
- Ineligibility for services
- Admission criteria
- Orientation information provided regarding rights, grievances, services, fees, etc.

- Waiting list
 - Primary and ongoing assessments
 - Reassessments
-

Recommendations

B.9.d.(1)(c)

B.9.d.(1)(d)(iii)

B.9.d.(1)(d)(v)

B.9.d.(1)(d)(viii)

B.9.d.(1)(d)(ix)

B.9.d.(1)(f)(i)

B.9.d.(1)(g)(i) through B.9.d.(1)(g)(iii)

Each person served should receive an orientation that includes ways in which input can be given; behavioral expectations of the person served; discharge criteria; standards of professional conduct related to services; requirements for reporting and/or follow-up for the mandated person served, regardless of his or her discharge outcome; the use of seclusion and restraint; any restrictions the program may place on the person served; events, behaviors, or attitudes and their likely consequences; and the means by which the person served may regain rights or privileges that have been restricted.

B.14.c. through B.14.f.

B.14.i.(2)

B.14.m.

B.14.n.(2)

B.14.n.(4)

B.14.o.(1)(a) through B.14.p.

B.14.s.

B.14.v.

It is recommended that the assessment process include information on the personal strengths, individual needs, abilities and/or interests, and preferences for each person served. It is also recommended that the assessment process gather information about the efficacy of current or previously used medication; the current level of functioning; sexual orientation and gender expression; spiritual beliefs; and history of trauma that was experienced or witnessed, including abuse, neglect, violence, and sexual assault. Other information gathered should include the use of alcohol, tobacco, and/or other drugs; the need for assistive technology in the provision of services; and the psychological and social adjustment to disabilities and/or disorders. It is suggested that the comprehensive assessment contain a prompt to include the identification of the history of trauma to assist clinicians to focus on this area and ensure that they insert the information into the interpretive summary to be used in the development of the treatment plan.

Consultation

- It is suggested that the organization review its timeframes and clarify timelines for record entry. No more than 48 hours to complete required documents, such as progress notes, is suggested.

- The words *client denies* were used frequently in documentation. Trauma-informed principles suggest that a clinician's language set the tone for the treatment episode of the consumer. Using the word *denies* as an answer to questions implies guilt or blame. It is suggested that other descriptive words be used in its place. For example, the question "Does the consumer have a driver's license?" only requires a *yes* or *no*.
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C. Person-Centered Plan

Description

Each person served is actively involved in and has a significant role in the person-centered planning process and determining the direction of his or her plan. The person-centered plan contains goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the person served, as well as identified challenges and potential solutions. The planning process is person directed and person centered. The person-centered plan may also be referred to as an individual service plan, treatment plan, or plan of care. In a family-centered program, the plan may be for the family and identified as a family-centered plan.

Key Areas Addressed

- Development of person-centered plan
 - Co-occurring disabilities/disorders
 - Person-centered plan goals and objectives
 - Designated person coordinates services
-

Recommendations

C.1.c.(1) through C.1.c.(3)

It is recommended that the written person-centered plan be based on the person's strengths, needs, and abilities.

C.2.b.(2)(b)

C.2.b.(5) through C.2.b.(7)

C.2.d.

It is recommended that specific service or treatment objectives be reflective of the person's development; measurable, achievable, and time specific; and identify frequency of specific interventions, modalities, or services.

C.3.b.

C.3.c.

It is recommended that the person-centered plans be reviewed periodically with the person served to maintain relevance and to modify goals, objectives, and interventions, when necessary.

C.5.a.

It is recommended that, when the person served has concurrent disorders or disabilities and/or co-morbidities, the person-centered plan specifically address these conditions in an integrated manner.

C.7.a.(1)(a)**C.7.a.(1)(b)**

Progress notes should document the progress toward achievement of identified objectives and goals.

D. Transition/Discharge

Description

Transition, continuing care, or discharge planning assists the persons served to move from one level of care to another within the organization or to obtain services that are needed but are not available within the organization. The transition process is planned with the active participation of each person served. Transition may include planned discharge, placement on inactive status, movement to a different level of service or intensity of contact, or a reentry program in a criminal justice system.

The transition plan is a document developed with and for the person served and other interested participants to guide the person served in activities following transition/discharge to support the gains made during program participation. It is prepared with the active participation of the person served when he or she moves to another level of care, after-care program, or community-based services. The transition plan is meant to be a plan that the person served uses to identify the support that is needed to prevent a recurrence of symptoms or reduction in functioning. It is expected that the person served receives a copy of the transition plan.

A discharge summary is a clinical document written by the program personnel who are involved in the services provided to the person served and is completed when the person leaves the organization (planned or unplanned). It is a document that is intended for the record of the person served and released, with appropriate authorization, to describe the course of services that the organization provided and the response by the person served.

Just as the assessment is critical to the success of treatment, the transition services are critical for the support of the individual's ongoing recovery or well-being. The organization proactively attempts to connect the persons served with the receiving service provider and contact the persons served after formal transition or discharge to gather needed information related to their post-discharge status. Discharge information is reviewed to determine the effectiveness of its services and whether additional services were needed.

Transition planning may be included as part of the person-centered plan. The transition plan and/or discharge summary may be a combined document or part of the plan for the person served as long as it is clear whether the information relates to transition or pre-discharge planning or identifies the person's discharge or departure from the program.

Key Areas Addressed

- Referral or transition to other services
 - Active participation of persons served
 - Transition planning at earliest point
 - Unplanned discharge referrals
 - Plan addresses strengths, needs, abilities, preferences
 - Follow-up for persons discharged for aggressiveness
-

Recommendations

D.1.b.

D.1.f.

D.1.g.(1)

D.1.g.(2)(a)

It is recommended that the organization implement written procedures for transfer to another level of care, when applicable; follow-up; when transition planning will occur; and where transition planning will be documented.

D.3.a.(1) through D.3.g.(4)

It is recommended that the written transition plan be prepared or updated to ensure a seamless transition when a person served is transferred to another level of care or an aftercare program, or prepares for a planned discharge. The plan should identify the person's current progress in his/her own recovery or move toward well-being and gains achieved during program participation; identify the person's need for support systems or other types of services that will assist in continuing his/her recovery, well-being, or community integration; include information on the continuity of the person's medication(s), when applicable; include referral information, such as contact name, telephone number, locations, hours, and days of services, when applicable; include communication of information on options and resources available if symptoms occur or additional services are needed, when applicable; and include strengths, needs, abilities, and preferences.

D.4.a.(1) through D.4.b.

It is recommended that the transition plan be developed with the input and participation of the person served; the family/legal guardian, when applicable and permitted; a legally authorized representative, when appropriate; team members; the referral source, when appropriate and permitted; and other community services, when appropriate and permitted. It should be given to individuals who participate in the development of the transition plan, when permitted.

D.5.a. through D.5.d.

D.5.f.

It is recommended that, for all persons leaving services, a written discharge summary be prepared to ensure that the person served has documented treatment episodes and results of treatment. The discharge summary should include the date of admission, describe the services provided, identify the

presenting condition, describe the extent to which established goals and objectives were achieved, and identify the status of the person served at last contact. It is suggested that the organization include prompts to ensure completion of documentation.

E. Medication Use

Description

Medication use is the practice of handling, prescribing, dispensing, and/or administering medications to persons served in response to specific symptoms, behaviors, and conditions for which the use of medications is indicated and deemed efficacious. Medication use may include self-administration, or be provided by personnel of the organization or under contract with a licensed individual. Medication use is directed toward maximizing the functioning of the persons served while reducing their specific symptoms and minimizing the impact of side effects.

Medication use includes prescribed or sample medications, and may, when required as part of the treatment regimen, include over-the-counter or alternative medications provided to the person served. Alternative medications can include herbal or mineral supplements, vitamins, homeopathic remedies, hormone therapy, or culturally specific treatments.

Medication control is identified as the process of physically controlling, transporting, storing, and disposing of medications, including those self administered by the person served.

Self-administration for adults is the application of a medication (whether by injection, inhalation, oral ingestion, or any other means) by the person served to his or her body, and may include the organization storing the medication for the person served, or may include staff handing the bottle or blister pack to the person served, instructing or verbally prompting the person served to take the medication, coaching the person served through the steps to ensure proper adherence, and closely observing the person served self-administering the medication.

Self-administration by children or adolescents in a residential setting must be directly supervised by personnel, and standards related to medication use applied.

Dispensing is considered the practice of pharmacy; the process of preparing and delivering a prescribed medication (including samples) that has been packaged or repackaged and labeled by a physician or pharmacist or other qualified professional licensed to dispense (for later oral ingestion, injection, inhalation, or other means of administration).

Prescribing is evaluating, determining what agent is to be used by and giving direction to a person served (or family/legal guardian), in the preparation and administration of a remedy to be used in the treatment of disease. It includes a verbal or written order, by a qualified professional licensed to prescribe, that details what medication should be given to whom, in what formulation and dose, by what route, when, how frequently, and for what length of time.

Key Areas Addressed

- Individual records of medication
 - Physician review
 - Policies and procedures for prescribing, dispensing, and administering medications
 - Training regarding medications
 - Policies and procedures for safe handling of medication
-

Recommendations

E.1.a. through E.1.b.(4)

It is recommended that the organization have a policy that identifies whether or not medications are used in its programs and the process for the persons served to obtain medications needed to promote recovery and/or desired treatment/service outcomes, including whether or not it directly provides medication control, prescribing, dispensing, and administering.

F. Nonviolent Practices

Description

Programs strive to be learning environments and to support persons served in the development of recovery, resiliency, and wellness. Relationships are central to supporting individuals in recovery and wellness. Programs are challenged to establish quality relationships as a foundation to supporting recovery and wellness. Providers need to be mindful of developing cultures that create healing, healthy and safe environments, and include the following:

- Engagement
- Partnership—power with, not over
- Holistic approaches
- Respect
- Hope
- Self-direction

Programs need to recognize that individuals may require supports to fully benefit from their services. Staff is expected to access or provide those supports wanted and needed by the individual. Supports may include environmental supports, verbal prompts, written expectations, clarity of rules and expectations, or praise and encouragement.

Even with supports, there are times when individuals may show signs of fear, anger, or pain, which may lead to aggression or agitation. Staff members are trained to recognize and respond to these signs through de-escalation, changes to the physical environmental, implementation of meaningful

and engaging activities, redirection, active listening, etc. On the rare occasions when these interventions are not successful and there is imminent danger of serious harm, seclusion or restraint may be used to ensure safety. Seclusion and restraint are never considered treatment interventions; they are always considered actions of last resort. The use of seclusion and restraint must always be followed by a full review, as part of the process to eliminate the use of these in the future.

The goal is to eliminate the use of seclusion and restraint in behavioral health, as the use of seclusion or restraint creates potential physical and psychological dangers to the persons subject to the interventions, to the staff members who administer them, or those who witness the practice. Each organization still utilizing seclusion or restraint should have the elimination thereof as an eventual goal.

Restraint is the use of physical force or mechanical means to temporarily limit a person's freedom of movement; chemical restraint is the involuntary emergency administration of medication, in immediate response to a dangerous behavior. Restraints used as an assistive device for persons with physical or medical needs are not considered restraints for purposes of this section. Briefly holding a person served, without undue force, for the purpose of comforting him or her or to prevent self-injurious behavior or injury to self, or holding a person's hand or arm to safely guide him or her from one area to another, is not a restraint. Separating individuals threatening to harm one another, without implementing restraints, is not considered restraint.

Seclusion refers to restriction of the person served to a segregated room with the person's freedom to leave physically restricted. Voluntary time out is not considered seclusion, even though the voluntary time out may occur in response to verbal direction; the person served is considered in seclusion if freedom to leave the segregated room is denied.

Seclusion or restraint by trained and competent personnel is used only when other less restrictive measures have been found to be ineffective to protect the person served or others from injury or serious harm. Peer restraint is not considered an acceptable alternative to restraint by personnel. Seclusion or restraint is not used as a means of coercion, discipline, convenience, or retaliation.

In a correctional setting, the use of seclusion or restraint for purposes of security is not considered seclusion or restraint under these standards. Security doors designed to prevent elopement or wandering are not considered seclusion or restraint. Security measures for forensic purposes, such as the use of handcuffs instituted by law enforcement personnel, are not subject to these standards. When permissible, consideration is made to removal of physical restraints while the person is receiving services in the behavioral healthcare setting.

Key Areas Addressed

- Training and procedures supporting nonviolent practices
- Policies and procedures for use of seclusion and restraint
- Patterns of use reviewed
- Persons trained in use
- Plans for reduction/elimination of use

Recommendations

There are no recommendations in this area.

Consultation

- It is suggested that the nonviolent practices policy be reviewed and reworded to indicate the actual practice of the organization.
-

G. Records of the Persons Served

Description

A complete and accurate record is developed to ensure that all appropriate individuals have access to relevant clinical and other information regarding each person served.

Key Areas Addressed

- Confidentiality
 - Time frames for entries to records
 - Individual record requirements
 - Duplicate records
-

Recommendations

G.2.c.

The individual record should communicate information in a manner that is complete.

G.4.a.

G.4.i.(7)

The individual record should include the date of admission and the transition plan, when applicable.

Consultation

- It is suggested that the organization review its timeframes for documentation and consider using best practice standards models.
-

H. Quality Records Management

Description

The organization has systems and procedures that provide for the ongoing monitoring of the quality, appropriateness, and utilization of the services provided. This is largely accomplished through a systematic review of the records of the persons served. The review assists the organization in improving the quality of services provided to each person served.

Key Areas Addressed

- Quarterly professional review
 - Review current and closed records
 - Items addressed in quarterly review
 - Use of information to improve quality of services
-

Recommendations

H.1.b.(1) through H.1.b.(4)

It is recommended that the program conduct a documented review of the services provided at least quarterly that addresses the quality of service delivery as evidenced by the record of the person served; appropriateness of services; patterns of service utilization; and model fidelity, when an evidence-based practice is identified.

H.2.a.

It is recommended that the review be completed by personnel who are trained and qualified.

H.4.a.(1) through H.4.g.

It is recommended that the records review address whether the persons served were provided with an appropriate orientation and actively involved in making informed choices regarding the services they received; whether confidential information was released according to applicable laws/regulations; and whether the assessments of the persons served were thorough, complete, and timely. The records review process should address whether the goals and service/treatment objectives of the person served were based on the results of the assessments and input of the person served, whether they were revised when indicated, and whether actual services were related to the goals and objectives in the person's plan. It should also address whether the actual services reflect appropriate level of care and reasonable duration and whether the person-centered plan was reviewed and updated in accordance with the organization's policy.

SECTION 3. BEHAVIORAL HEALTH CORE PROGRAM STANDARDS

Description

The standards in this section address the unique characteristics of each type of core program area. Behavioral health programs are organized and designed to provide services for persons who have or who are at risk of having psychiatric disorders, harmful involvement with alcohol or other drugs, or other addictions or who have other behavioral health needs. Through a team approach, and with the active and ongoing participation of the persons served, the overall goal of each program is to improve the quality of life and the functional abilities of the persons served. Each program selected for accreditation demonstrates cultural competency and relevance. Family members and significant others are involved in the programs of the persons served as appropriate and to the extent possible.

MENTAL HEALTH

Core programs in this field category are designed to provide services for persons with or who are at risk for psychiatric disabilities/disorders or have other mental health needs. These programs encompass a wide variety of therapeutic settings and intervention modalities and may provide services to those with behavioral health disabilities or co-occurring disabilities; those with intellectual or developmental disabilities; victims or perpetrators of domestic violence or abuse; persons needing treatment because of eating or sexual disorders; and/or drug, gambling, or internet addictions.

B. Assessment and Referral

Description

Assessment and referral programs provide a variety of activities, including prescreening, screening, psychosocial assessment, determination of need, and referral to appropriate level of care. The provision of information on available resources is not considered a full assessment and referral program. An adequate assessment must be conducted to provide more informed referrals.

Such programs may be separate, freestanding programs, an independent program within a larger organization, or a specifically identified activity within a system of care.

Recommendations

There are no recommendations in this area.

C. Case Management/Services Coordination

Description

Case management/services coordination programs provide goal-oriented and individualized supports focusing on improved self-sufficiency for the persons served through assessment, planning, linkage, advocacy, coordination, and monitoring activities. Successful service coordination results in community opportunities and increased independence for the persons served. Programs may provide occasional supportive counseling and crisis intervention services, when allowed by regulatory or funding authorities.

Case management/services coordination may be provided by an organization as part of its person-centered planning and delivery, by a department or division within the organization that works with individuals who are internal and/or external to the organization, or by an organization with the sole purpose of providing case management/services coordination. Such programs are typically provided by qualified case managers/coordinators or by case management teams.

Recommendations

There are no recommendations in this area.

G. Crisis Programs

Crisis Intervention

Description

Crisis intervention programs offer services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress or in response to acts of domestic violence or abuse/neglect. Crisis intervention services consist of mobile response, walk-in centers, or other means of face-to-face assessments and telephone interventions.

Recommendations

There are no recommendations in this area.

O. Intensive Family-Based Services

Description

These intensive services are provided in a supportive and interactive manner and directed toward maintaining or restoring a positive family relationship. The services are time limited and are initially intensive, based on the needs of the family. The services demonstrate a multisystemic approach to

treatment and have a goal of keeping families together. The services may include wraparound and family preservation programs. The program may also provide services directed toward family restoration when a child has been in an out-of-home placement.

Recommendations

There are no recommendations in this area.

Q. Outpatient Programs

Outpatient Treatment

Description

Outpatient treatment programs provide culturally and linguistically appropriate services that include, but are not limited to, individual, group, and family counseling and education on wellness, recovery, and resiliency. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity. Outpatient programs may address a variety of needs, including, but not limited to, situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, and substance use disorders and other addictive behaviors.

Recommendations

There are no recommendations in this area.

INTEGRATED IDD/MENTAL HEALTH

Core programs in this field category are designed to provide services to persons whose primary diagnoses are intellectual or other developmental disabilities and who are at risk for or exhibiting behavioral disorders or have identified mental health needs. These programs encompass many therapeutic settings and intervention modalities and a commitment to community integration.

E. Community Integration

Description

Community integration is designed to help persons to optimize their personal, social, and vocational competency in order to live successfully in the community. Activities are determined by the needs of the persons served. The persons served are active partners in all aspects of these programs. Therefore, the settings can be informal in order to reduce barriers between staff members and program participants. In addition to services provided in the home or community, this program may include a psychosocial clubhouse, a drop-in center, an activity center, or a day program.

Community integration provides opportunities for the community participation of the persons served. The organization defines the scope of these services based on the identified needs and desires of the persons served. A person may participate in a variety of community life experiences that may include, but are not limited to:

- Leisure or recreational activities.
- Communication activities.
- Spiritual activities.
- Cultural activities.
- Vocational pursuits.
- Development of work attitudes.
- Employment activities.
- Volunteerism.
- Educational and training activities.
- Development of living skills.
- Health and wellness promotion.
- Orientation, mobility, and destination training.
- Access and utilization of public transportation.

Recommendations

There are no recommendations in this area.

COMPREHENSIVE CARE

Core programs in this field category are designed to provide any combination of behavioral health services related to mental illness, addictions or intellectual/developmental disabilities, and management of or coordination with the healthcare needs of the person served. This field category applies only to health home or integrated behavioral health/primary care programs.

L. Health Home

Description

A health home is a healthcare delivery approach that focuses on the whole person and integrates and coordinates primary care, behavioral health, other healthcare, and community and social support services. A health home allows for individual choice and is capable of assessing the various physical and behavioral health needs of persons served. The program demonstrates the capacity to address, either directly or through linkage with or referral to external resources, behavioral health conditions, such as mental illness and substance use disorders, and physical health conditions. Programs may also serve persons who have intellectual or other developmental disabilities and physical health needs or those who are at risk for or exhibiting behavioral disorders. Care is coordinated over time across providers, functions, activities, and sites to maximize the value and effectiveness of services delivered to persons served.

A health home provides comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family/support services, and linkage and referral to community and social support services. Services are designed to support overall health and wellness and:

- Embody a recovery-focused model of care that respects and promotes independence and responsibility.
- Promote healthy lifestyles and provide prevention and education services that focus on wellness and self-care.
- Ensure access to and coordination of care across prevention, primary care (including ensuring that persons served have a primary care physician), and specialty healthcare services.
- Monitor critical health indicators.
- Support individuals in the self-management of chronic health conditions.
- Coordinate/monitor emergency room visits and hospitalizations, including participation in transition/discharge planning and follow-up.

A health home collects, aggregates, and analyzes individual healthcare data across the population of persons served by the program and uses that data and analysis to manage and improve outcomes for the persons served. If the health home is not the actual provider of a particular healthcare service, it remains responsible for supporting and facilitating improved outcomes by providing disease management supports and care coordination with other providers.

Recommendations

There are no recommendations in this area.

Consultation

- The health home program at Saginaw County Community Mental Health Authority could benefit from an integrated electronic record. At present, it uses two systems with no bridge between them, and, as a result, documentation is done twice. An integrated system could improve efficiencies, provide consistent access to data for all staff members, and improve service delivery to the persons served.
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SECTION 4. BEHAVIORAL HEALTH SPECIFIC POPULATION DESIGNATION STANDARDS

C. Children and Adolescents

Description

Programs for children and adolescents consist of an array of behavioral health services designed specifically to address the treatment needs of children and adolescents. Such programs tailor their services to the particular needs and preferences of children and adolescents and are provided in a setting that is both relevant to and comfortable for this population.

Recommendations

C.1.h.

C.1.n.

It is recommended that the organization's assessment for children and adolescents include information about immunization records and prenatal exposure to alcohol, tobacco, or other drugs.

PROGRAMS/SERVICES BY LOCATION

Saginaw County Community Mental Health Authority

500 Hancock Street
Saginaw, MI 48602
US

Assessment and Referral: Mental Health (Adults)
Assessment and Referral: Mental Health (Children and Adolescents)
Case Management/Services Coordination: Mental Health (Adults)
Crisis Intervention: Mental Health (Adults)
Crisis Intervention: Mental Health (Children and Adolescents)
Health Home: Comprehensive Care (Adults)
Outpatient Treatment: Mental Health (Adults)

Albert & Woods Professional Development & Business Center

One Germania Platz
Saginaw, MI 48602
US

Administrative Location Only

Saginaw Child, Family and Youth Services

3875 Bay Road, Suite 7N
Saginaw, MI 48603
US

Case Management/Services Coordination: Mental Health (Children and Adolescents)
Intensive Family-Based Services: Mental Health (Adults)
Intensive Family-Based Services: Mental Health (Children and Adolescents)
Outpatient Treatment: Mental Health (Children and Adolescents)

SCCMHA Services for Persons with Developmental Disabilities

1040 North Towerline Road
Saginaw, MI 48601
US

Community Integration: Integrated: IDD/Mental Health (Adults)
Community Integration: Integrated: IDD/Mental Health (Children and Adolescents)