Saginaw County Community Mental Health Authority (SCCMHA)

Network Services Provider Manual

500 Hancock Street
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Phone: (989) 797-3400

July Update
Fiscal Year 2022

Provider Manual Update - July 2022

Included are the updated policies and procedures since the April 2022 Provider Manual Update

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised	Licensed Residential/Crisis Residential	Enhanced Health Services/Autism (speech, behavioral, ot)	Inpatient	Crisis/CAI/MUTT	Primary Providers (Supports Coordination/Case Management/Primary/ACT/Autism/ Wraparound/Integrated Care)	Community Living Supports/ CLS Per Diem/Respite Services Skill Build/Supported Employment/Clubhouse/Drop-In	Fiscal Intermediaries/Pharmacy/LEP
10	**Tab 1 Introdution to SCCMHA**										
11	N/A	SCCMHA Fact Sheet	Updated statistics for Fiscal Year 2021 and 2022, current staffing and services, and added information abour becoming a CMS Certified Behaviorial Health Clinic (CCBHC) Demonstration site.	7/1/2022	X	X	X	X	X	X	X	X
13	N/A	SCCMHA Network Services Organizational Chart	Auditing Part-time Typist Clerk position vacant.	7/8/2022	X	X	X	X	X	X	X	X
N/A	**Tab 2 Eligibility & Care Management - No Updates**										
N/A	**Tab 3 Services & Protocols - No Updates**										
14	**Tab 4 Service Delivery**										
15	02.03.01	Consumerism	Additions to standards to include information regarding strength-based approach and providing therapeutic, trauma-informed services to all consumers.	3/16/2022	X	X	X	X	X	X	X	X
21	02.03.02	Inclusion	Review Only.	3/3/2022	X	X	X	X	X	X	X	X
25	02.03.03	Person-Centered Planning	Added the following language to standards: Action - Before the person/family centered planning meeting is initiated, a Psychosocial Assessment is completed. Annual assessments are completed within 364 days of the last assessment. Responsibility – Case Holder, Consumer Added the following language to Exhibit D: (annual assessment should be completed within 364 days of the last assessment)	6/28/2022	X	X	X	X	X	X	X	X
49	02.03.03 B	Family-Centered Practice	Small edits to wording in the standards section. No substantive changes made. Updated name of Training Unit to Continuing Education in Procedure section.	2/28/2022	X	X	X	X	X	X	X	
63	02.03.04	Self Determination	Small edits to wording in the standards section. No substantive changes made.	3/31/2022	X	X	X	X	X	X	X	X

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised								
77	02.03.05	Recovery	Enhanced the Purpose and the Policy statements (e.g., strengths-based, resiliency-oriented language). Added Social Determinants of Health (SDOH) to Definitions section. Added Healthy People 2030 to the Reference section. Added Whole-Person Care policy in the Reference Section and removed reference to the Health Home policy. Added Standard C: Recovery support services shall include peer support as well as assistance with addressing the social determinants of health (see definition below) and 1. SCCMHA providers shall work to remove barriers and address health disparities. Added definition of resilience.	5/10/2022	X	X	X	X	X	X	X	
88	02.03.07	Employment of Consumers	Minor grammatical changes to standards section. Procedures section updated to reflect correct title for Director of Services for Persons with Mental Illness.	3/24/2022	X	X	X	X	X	X	X	
96	02.03.08	Welcoming	Enhanced policy statement to include resiliency building. Added new Standard A: SCCMHA shall provide safe, functional, clean, and welcoming in-person and virtual environments (telehealth services) for consumers and staff that are conducive to the scope of services provided. Added remote (telehealth) to Standard B as well as to the section on Programs/Agencies. Added telehealth and resiliency focus to Exhibit A.	4/12/2022	X	X	X	X	X	X	X	X
103	02.03.09.09	System of Care (SOC)	Removed the procedure section as it is no longer relevant. Left the policy intact as it is foundational for children/youth with deep-end needs. Added "developmentally appropriate" language and removed references to Saginaw County (per CCBHC standards). Added Reference D. SCCMHA Policy 02.03.09.09 – Wraparound	5/10/2022	X	X	X	X	X	X	X	X

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised								
110	02.03.09.12	Mobile Response and Stabilization Services (MRSS)	Added populations to Application and Policy area: SUD or COD and I/DD. Policy area updated to reflect service availability: individuals experiencing a crisis, including non-Saginaw, non-SCCMHA, non-active cases. Changes to staffing requirements within standards section. Wording changes throughout standards section. Updated name of MRSS Adult Brochure in Exhibits. Added MRSS Child/Youth/Family Brochure to Exhibits.	3/28/2022				X				
126	02.03.12	Alternatives to Guardianship	Minor changes to wording in various sections. No substantive changes made.	5/10/2022	X	X	X	X	X	X	X	
148	02.03.17	Outcome Tool for Adults (ANSA)	Review Only.	3/14/2022		X		X	X			
157	02.03.18	PECFAS & CAFAS	Added CPP as eligible EBP in standards section. No substantive changes made.	2/28/2022		X		X	X			
185	02.03.21	Autism Spectrum Disorder (ASD) Program	Information regarding Primary Care Physician referral requirement added to standards section. Minor formatting changes throughout standards section. Added "MDHHS Medicaid Autism Spectrum Disorder Screening, Evaluation and Treatment Recommendation Best Practice Guidelines" as reference.	3/3/2022		X	X	X	X	X	X	
195	02.03.24	Suicide Prevention	Rewrote the Policy section to include updated information including data and statistics. Revised Standard B to update it, tie it to the revised Policy section, and to point to the ASQ (in addition to the C-SSRS). Updated language in Standards section from MUTT to MRSS Added ASQ to Standard E. 1). Updated reference to MRSS Policy. Removed reference to Health Home Policy and replaced it with Whole-Person Care Policy. Updated/revised the Reference section.	5/10/2022	X	X	X	X	X	X	X	

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised								
207	02.03.25	Wellness	Significant expansion of the Policy statement to be more inclusive and capture CCBHC standards. Added reference to Whole-Person Care policy. Added language to Standard C to emphasize the relationship between general health and mental health. Removed reference to SCCMHA Policy 10.01.02 – Health Home Services which no longer exists.	5/10/2022	X	X	X	X	X	X	X	
212	02.03.41	SOGI Safe	Added affirming language to the Policy section. Added a definition of "Questioning".	5/10/2022	X	X	X	X	X	X	X	
220	03.01.03	Consumer Choice & Service Management	Review Only.	3/16/2022	X	X	X	X	X	X	X	X
229	03.01.04	Jail Detention & Diversion	Added Jail Diversion Practice Guidelines (P.7.10.3.10) to References.	4/20/2022	X	X	X	X	X	X	X	
235	03.02.02	Academic and Vocational Continuity	Review Only.	3/22/2022	X	X	X	X	X	X	X	
237	03.02.03	Monitoring & Reassessment	Review Only.	3/17/2022	X	X	X	X	X	X	X	
248	03.02.05	Plans of Service and Support	Updated review timeframe for annual IPOS to every 3 months from every 6 months.	3/22/2022	X	X	X	X	X	X	X	X
259	03.02.07	Residential Services	Review Only.	3/21/2022	X	X	X	X	X	X	X	
N/A	03.02.08	Behavioral Interventions	Archived.	Archived	X	X	X	X	X	X	X	
306	03.02.09	Behavior Treatment Plan Review Committee (BTPRC)	The entire policy has revised, rewritten, edited and reformatted. Added Standard A. 8.c.: Consumers and their parents and/or guardians shall have the right to refuse a proposed behavior treatment plan, including positive supports and interventions. Those who choose to do so will be requested to sign a Decline of Behavior Treatment Plan form (Exhibit C). Added Standard A. 8.d.: Consumers who are currently receiving services under an Alternative Order for Treatment (AOT) shall be required to adhere to their interdisciplinary treatment team's recommended BTP, including positive supports and interventions. Added Standard A.9.b.: Consumers and their parents and/or guardians shall have the right to refuse a proposed plan for behavior modifying medications. If this occurs, SCCMHA shall have the right to appeal the matter to a court of appropriate jurisdiction for adjudication. *Continued on next page...*	5/10/2022	X	X	X	X	X	X	X	

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised								
			Added Standard A.10.c.: Consumers who are currently receiving services under an Alternative Order for Treatment (AOT) shall be required to adhere to their interdisciplinary treatment team's recommended BTP that includes medication(s). Added Standard B.: SCCMHA will adhere to the standards and guidelines of the MDHHS Technical Requirement for Behavior Treatment Plans as delineated in SCCMHA Policy 03.02.27 – Behavior Treatment Plans (BTPs). Added Standard E.3.e.: It is expected that the author of the plan will present the initial BTP and prepared quarterly review reports of BTPs. If the author of the plan is unable to present quarterly reviews, the author may appoint a proxy to represent in their place. Changes to Reference section. Added Exhibit C. Decline of Behavior Treatment Plan Form.									
324	03.02.10	Clinical Risk Committee	Added review of security alerts to policy section. Removed language indicating consumer over age 18 needs approval from Clinical Risk Committee to receive services from MRSS. Updated Exhibit A to include the updated copy of the Clinical Risk Committee Referral Form.	3/3/2022	X	X	X	X	X	X	X	X
328	03.02.11	Child Diagnostic and Treatment Training Requirements	Minor edits. No substantive changes made.	3/3/2022				X	X			
336	03.02.12	Peer Delivered and Operated Service	Review Only.	3/14/2022	X	X	X	X	X	X	X	
338	03.02.13	Transition/Discharge Services	Review Only.	3/3/2022	X	X	X	X	X	X	X	
342	03.02.15	Safe Transportation of Children and Teens	Review Only.	3/3/2022	X	X		X	X	X	X	X
346	03.02.16	Discharges for Assaultive or Aggressive Behavior	Review Only.	4/27/2022	X	X	X	X	X	X	X	
349	03.02.18	Respite Services	Review Only.	3/3/2022	X	X	X	X	X	X	X	
363	03.02.21	Structured Daytime Activity Programming	Review Only.	3/16/2022	X	X			X			
379	03.02.26	Consumer Transition Planning	Review Only.	4/27/2022	X	X	X	X	X	X	X	
384	03.02.27	Behavior Treatment Plans (BTPs)	New policy name; replaces Behavioral Plans. The entire policy has been rewritten, revamped, expanded and reformatted so that it now adheres to MDHHS and other requirements. Several Exhibits and References have been added.	5/10/2022	X	X	X	X	X	X	X	

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised								
418	03.02.31	Services for Members of the Armed Forces, Veterans and their Families	Revised Policy section to include continued unmet need for help for the transition to civilian life. Added Standard D. SCCMHA shall, resources permitting, provide an on-site Veteran and Military Family Program Navigator as a component of the continuum of care for veteran and military member consumers. Added Standard Q. SCCMHA shall establish and maintain a Memorandum of Understanding (MOU) with the Aleda A. Lutz VA Medical Center.	5/10/2022	X	X	X	X	X	X	X	
423	03.02.33	Genoa HealthCare- MED DROP™ Program for Children	Review Only.	3/16/2022					X	X		
453	03.02.34	Services for American Indians	Expanded Policy statement: The purpose of this policy is to ensure the provision of and/or coordination of services to American Indians is person/family-centered, trauma-informed, recovery-oriented, developmentally and phase-of-life appropriate, culturally and linguistically sensitive and promotes consumer engagement and shared decision-making using evidence-based practices and treatments to maximize the potential for beneficial outcomes. Deleted reference to Saginaw County as a place of residence required for services (due to CCBHC standards). Revised the Policy Section using CCBHC language. Minor revisions to the Application section. Added Whole-Person Care policy to the References Section. Updated and revised the Reference section.	5/10/2022	X	X	X	X	X	X	X	
457	03.02.35	Serving LGBTQ+ Consumers	Revised the Policy statement to include affirming language. Added shared decision-making to Standard C. Added a definition of Questioning and amended definitions including “In The Closet”, Sexual Minorities, and Transsexual. Added Standard L: SCCMHA providers shall avoid inadvertently outing LGBTQ+ consumers to others, including the families of youth being served. Revised and updated the References section.	5/10/2022	X	X	X	X	X	X	X	

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised								
468	03.02.39	Psychiatric Hospitalization of consumers with Intellectual and Developmental Disabilities and Children with Autism	Added information about requesting an interdisciplinary treatment team meeting to the Standards and Procedures section.	4/27/2022	X			X	X			
474	03.02.40	Serious Emotional Disturbance Waiver (SEDW) program Overview	Review Only.	4/29/2022				X	X			
477	03.02.41	SEDW Entry Criteria	Updated Procedures to reflect transfer to Wraparound for internal referrals and Care Management assignment to Wraparound for intake referrals	4/29/2022				X	X			
482	03.02.42	SEDW Exit Criteria	Review Only.	4/29/2022				X	X			
486	03.02.47	Children's Home and Community – Based Waiver Program (CWP) Overview	New Policy.	5/10/2022		X			X			
489	03.02.47.01	Children's Home and Community – Based Waiver Program (CWP) Eligibility and Enrollment	New Policy.	5/10/2022		X			X			
496	04.01.04	Trauma Screening, Assessment, and Treatment Services	Major changes to policy as follows: Added language throughout policy to include (parent/guardian), as applicable, when discussing consumer. Added language throughout policy to reflect trauma assessments will be completed as "agreed upon by consumer/parent/guardian." Update Standards section with the following: • Added language reflecting how to complete Trauma Screening review during OTM. • Added language indicating requested Trauma Assessment will be included as a goal within the IPOS. • Added language indicating Trauma Assessment results being documented within therapist assessment or IPOS. • Added language stating IPOS goal(s) will be added which address treatment option(s) for trauma. • Removed language regarding email notification requirements for Care Management for Eligibility Determination and remainder of this process.	2/28/2022		X		X	X			
522	**Tab 5 Regulatory Management/HIPAA Compliance**											
523	08.04.01	Consumer Records	Review Only.	4/29/2022	X	X	X	X	X	X	X	
537	08.04.09	Ownership & Retention of Hard Copy Consumer Records	Review Only.	4/29/2022	X	X	X	X	X	X	X	X
N/A	**Tab 6 Recipient Rights - Customer Service - Appeals & Grievance - No Updates**											

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised								
546	**Tab 7 Claims Processing**											
547	05.02.06	Financial Liability	Review Only.	1/10/2022	X	X	X	X	X	X	X	X
N/A	09.02.01.01.05	Injectables Billing/Claims for Contract Providers	Archived.	Archived	X				X			
551	09.10.01.01	Contracted Network Provider Claims Submission	Renumbered from 09.02.01.01	5/16/2022	X	X	X	X	X	X	X	X
555	09.10.01.01.01	Electronic Claims Submission by Provider	Renumbered from 09.02.01.01.01	5/16/2022	X	X	X	X	X	X	X	X
572	09.10.01.01.05	UB04 (CMS-1450) Uniform Billing Instructions	Renumbered from 09.02.01.01.10.08	5/16/2022			X					
577	09.10.01.01.06	Provider Registration and Maintenance for Access to Sentri	Renumbered from 09.02.01.01.14	5/16/2022	X	X	X	X	X	X	X	
585	09.10.01.01.08	Provider Submission of Start and Stop Times on Claims	Renumbered from 09.02.01.01.16	5/16/2022	X	X	X	X	X	X	X	
588	09.10.01.01.11	Electronic Claims Submission by Provider-Step by Step Instructions	Renumbered from 09.02.01.01.30	5/16/2022	X	X	X	X	X	X	X	
604	09.10.01.02.07	Contracted Network Provider Claims Workflow	Renumbered from 09.02.01.05.01	5/16/2022	X	X	X	X	X	X	X	X
609	**Tab 8 Network Services**											
610	01.03.05	SCCMHA ListServer	Grammatical changes in standards and exhibit sections. No substantive changes made.	4/28/2022	X	X	X	X	X	X	X	X
618	08.04.08	Agency Forms	Review Only.	4/29/2022	X	X	X	X	X	X	X	X
N/A	**Booklets and Brochures - No Changes**											

Tab 1

Introduction to SCCMHA

SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

FACT SHEET

- SCCMHA is a local, independent, governmental unit serving Saginaw County, a Community Mental Health Services Program (CMHSP) and has been a mental health authority under contract with the Michigan Department of Community Health, since October 1, 1997.
- In Fiscal Year 2021, SCCMHA served 7,648 persons in Saginaw County.
- The Michigan Mental Health Code defines service populations, including persons with developmental disabilities, adults with serious mental illness and children with severe emotional impairments. SCCMHA is also responsible for persons with substance use disorders.
- Since January 2014, SCCMHA is part of the regional 21 county PIHP, Mid-State Health Network (MSHN), one of 10 such PIHPs in Michigan providing specialty mental health and substance use disorder services.
- Funding includes: prepaid, capitated Medicaid and Health Michigan, and MI Child funds to cover medically necessary services for eligible enrollees; State General Fund revenue to cover uninsured persons eligible for services and state hospital services including forensic services; categorical state funds for special populations; HUD and MSHDA funds that support low income housing subsidy; various special project grants, including federal block grants; and local match funds from the County of Saginaw.
- SCCMHA became a CMS Certified Behavioral Health Clinic (CCBHC) Demonstration site in the State of Michigan in 2022. The CCBHC demonstration aims to improve the behavioral health for all Michiganders by increasing access to high-quality care, integrating behavioral health with physical health care, promoting the use of evidence based practices, and establishing standardization and consistency with a set criterion for all certified clinics to follow. The demonstration requires and emphasizes accessible 24/7/365 crisis response services, along with other critical elements including: strong financial and quality metric reporting accountability; formal coordination with primary and other care settings to provide intensive care management and transitions; linkage to social services, criminal justice/law enforcement, and educational systems. CCBHCs are designed to provide comprehensive mental health and substance use disorder services to persons in need, regardless of their ability to pay, including those who are underserved, have low incomes, are on Medicaid, insured or uninsured, and are active-duty military or veterans. CCBHC services are available to any person in need, including but not limited to those with serious mental illness, serious emotional disturbance, long-term chronic addiction, mild or moderate mental illness, and substance use disorders. A pre-existing diagnosis is not required, as CCBHCs are required to provide timely assessment and diagnostic services.
- Services are provided to persons through an individualized person-centered or family-centered planning process, with guiding principles of recovery, consumer choice and voice, and trauma informed care. SCCMHA provides services and supports through a variety of community programs and evidence-based practices.
- SCCMHA operates some services directly and also contracts with service providers to ensure a comprehensive service array required by state and regional contracts to meet local needs.
- SCCMHA is governed by a 12-member Board of Directors who are appointed by the Saginaw County Board of Commissioners.
- SCCMHA must meet all obligations of the Michigan Specialty Supports and Services Program agreed upon by the federal government, including services to consumers, and administrative, policy and regulatory management.
- The annual budget for SCCMHA for fiscal year 2022 is approximately $95+ million dollars.

- SCCMHA employs over 288 staff members and contracts with over 150 different organizations, programs or individuals.

- The vision statement of SCCMHA is: *A belief in potential, A right to dream, An opportunity to achieve* – core corporate values include: consumer potential, excellence, accountability, respect, integrity, public stewardship, collaboration, customer service philosophy and effective communication.

- Key services provided or purchased include: 24/7 crisis screening, psychiatry, nursing and a variety of clinical treatment and ancillary health services; case management and supports coordination; specialized residential; community living supports and skill build services; supported employment; and housing services with targeted low income rent subsidies.

- SCCMHA is headquartered at 500 Hancock Street, Saginaw, Michigan 48602; telephone is 989-797-3400 and website address is www.sccmha.org.

July 2022

Saginaw County Community Mental Health Authority

Network Services Organizational Structure

Rev. 7/8/2022

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Tab 4

Service Delivery

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:
Consumerism</td><td>Chapter: 02 -
Customer Services and Recipient Rights</td><td>Subject No: 02.03.01</td></tr>
<tr><td rowspan="2">Effective Date:
January 22, 2003</td><td>Date of Review/Revision:
2/11/03, 6/12/07, 5/6/09, 6/23/10, 6/12/12, 5/22/14, 4/7/16, 3/1/18, 3/7/19, 2/28/20, 3/11/21, 3/16/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Kristie Wolbert

Additional Reviewers:
Clinical Directors
Program Coding/Compliance Specialist
HRC Supervisor</td></tr>
<tr><td>Supercedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to set standards for consumer inclusion in the service delivery, design, and delivery process for all mental health services. This policy ensures the goals of a consumer-driven system which gives consumers choices and decision-making roles. This consumer-driven system is based on the active participation by primary consumers (hereafter to include both youth/young adults, families, and adults), family members and advocates in gathering consumer responses to meet these goals.

Application:
The entire network of SCCMHA service providers.

Policy:
It is the policy of SCCMHA that provided services must advocate for and promote the needs, interests, and well-being of primary consumers. It is essential that consumers (including youth) become partners in creating and evaluating treatment planning, programs, and services.

It is the policy of SCCMHA that provided services be consumer-driven/family-driven/youth-guided and may also be consumer-run (i.e., Youth Breaking Boundaries, Clubhouse, etc.). This policy supports the broadest range of options and choices for consumers in services. It also supports consumer-run programs which empower consumers in the decision-making of their own services.

It is the policy of SCCMHA that all consumers will be provided opportunities and choices to reach their fullest potential and live independently. They also have the right to be included and involved in all aspects of society, particularly their own communities.

It is the Policy of SCCMHA to support the belief that every consumer, child or adult, deserves the opportunity to live a fulfilling life, including those with behavior challenges, and that SCCMHA is committed to the success of each person or family served.

Accommodations shall be made available and tailored to the needs of consumers, as specified by consumers, for their full and active participation as required by this guideline. These accommodations will include respect for unique background, culture, and communication styles.

Standards:

1. All services shall be designed to include ways to accomplish each of these standards:
   a) Engage with individuals in a culturally and linguistically (styles of communication) responsive manner. This includes the availability of staff and services that reflect the racial, ethnic, and cultural makeup of the service area.
   b) Interpreters needed in communicating with non-English and limited-English-speaking persons shall be provided, including different styles of communication (especially for individuals with physical, hearing, or visual needs), to ensure linguistic responsiveness.
   c) Ensure that individuals/families are fully engaged in driving decisions for developing, implementing, monitoring, and evaluating their own plans, including incorporation of individual choice and preferences. Engage individuals/families in researching options and incorporating their choice and preferences.
   d) Promote the efforts and achievements of consumers through special recognition of consumers.
   e) Through customer satisfaction surveys and other appropriate consumer related methods, gather ideas and responses from consumers concerning their experiences with services.
   f) “Person-First Language" shall be utilized in all publications, formal communications, and daily discussion.
   g) Consumers and family members will be involved in evaluating the quality and effectiveness of services and the administrative mechanisms used to establish services. The evaluation is based upon what is important to consumers, as reported in customer satisfaction surveys.
   h) Advance the employment of consumers within the mental health system and in the community at all levels of positions, including mental health service provision roles.
   i) Provide therapeutic, trauma-informed services to all consumers that are served, recognizing that not all consumers may disclose they have experienced trauma, in or outside of the mental health system.

2. Services, programs, and contracts concerning persons with mental illness and related challenges shall actively strive to accomplish these goals:
   a) Elimination of stigma regarding mental illness that exists within the public communities, service agencies, and among consumers, through education about mental illness, recovery, resiliency, and wellness.
   b) Provide a strength-based approach when working with consumers, recognizing that every consumer has strengths that contribute to their resiliency.
   c) Create environments for all consumers in which the process of recovery and the promotion of resiliency can occur. This is shown by an expressed awareness of recovery by consumers and staff.
   d) Provide basic information about mental illness, recovery, and wellness to consumers and the public.

3. Services, programs, and contracts concerning persons with developmental disabilities shall actively strive to accomplish these goals:
   a) Provide personal preferences and meaningful choices with consumers in control of the choice of services and supports.
   b) Through educational strategies: promote inclusion, both personal and in the community; strive to relieve disabling circumstances: actively work to prevent occurrence of increased disability; and promote individuals in exercising their abilities to their highest potentials.
   c) Provide a role for consumers to make decisions in polices, programs, and services that affect their lives including person-centered planning processes.

4. Services, programs, and contracts concerning minors (hereafter referred to as youth/young adults) and their families shall actively strive to accomplish these goals:
   a) Services shall be delivered in a family-centered/driven approach, implementing comprehensive services that address the needs of the youth/young adults and his/her family.
   b) Services shall be individualized, family-driven, and youth guided with respect for the youth/young adults and family's choice of services and supports.
   c) Services shall be responsive to youth/young adults and family’s culture and styles of communication.
   d) Roles for families and youth/young adults to make decisions in policies, programs and services that affect their lives and their youth’s life, utilizing a “youth guided” approach.

5. Consumer-run programs shall receive the same consideration as all other providers of mental health services. This includes these considerations:
   a) Clear contract performance standards.
   b) Fiscal resources to meet performance expectations.
   c) A contract liaison person to address the concerns of either party.
   d) Inclusion in provider coordination meetings and planning processes.
   e) Access to information and supports to ensure sound business decisions.

PROVIDER compliance with this guideline shall be evaluated. Foremost, this must involve consumers, family members, and advocates. Providers, professionals, and administrators must be also included. The AUTHORITY shall provide technical assistance. Evaluation methods shall provide constructive feedback about improving the use of this policy.

Definitions:
"Informed Choice" means that an individual receives information and understands his or her options.

"Primary Consumer" means an individual who receives services from a Community Mental Health Service Program. It also means a person who has received the equivalent mental health services from the private sector. This includes both adults and youth/young adults.

"Consumerism" means active promotion of the interests, service needs, and rights of mental health consumers.

"Consumer-Driven" means any program or service focused and directed by participation from consumers.

"Consumer-Run" refers to any program or service operated and controlled exclusively by consumers.

"Family Member" means a parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer. It is also any individual upon whom a primary consumer depends for 50 percent or more of his or her financial support.

"Minor" means an individual under the age of 18 years. In this document, the word youth is used for this purpose as well.

"Family Centered Services" means services for families with minors which emphasize family needs and desires with goals and outcomes defined. Services are based on the families' strengths and competencies with active participation in decision-making roles.

“Family Driven” families will be included in treatment planning discussions and decisions that are about them.

"Person-Centered Planning" means the process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life. It honors the individual's preferences, choices, and abilities, with focus on consumers goals, dream and desires.

"Person-First Language" refers to a person first before any description of disability.

"Recovery" means the process of personal change in developing a life of purpose, hope, and contribution. The emphasis is on abilities and potentials. Recovery includes positive expectations for all consumers. Learning self-responsibility is a major element to recovery.

“Resiliency” is a developed characteristic that allows positive adaptation with the context of significant adversity.

“Youth Guided” youth will be engaged in treatment planning, discussions and decisions that are about them to the extent that is developmentally appropriate.

References:
Act 258, Section 116(e), Public Acts of 1974 as amended, being MCL 330 1116 1704, 1708.

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Establishes policy requiring consumer inclusion in the service delivery, design and delivery process for all mental health services.	CEO Executive Director of Clinical Services
Establishes a Citizens’ Advisory Committee which is active in assisting with the development and review of customer satisfaction surveys.	CEO
Appoints consumers to the quality committees.	CEO Quality Governance Board
Provides services that advocate and promotes the needs, interests and well being of primary consumers.	All SCCMHA Service Providers
Provides accommodations for consumers based on the expressed needs of the consumer.	All SCCMHA Service Providers
Gathers ideas and responses from consumers concerning their experiences with services and makes changes based on these findings.	All SCCMHA Service Providers
Involves consumers and family members in evaluating the quality and effectiveness of services and makes changes based on these findings.	All SCCMHA Service Providers

Evaluates compliance with this policy and provides constructive feedback to providers on how to improve upon their compliance with this policy.	Director of Network Services Network Services Auditing Staff

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Inclusion</td><td>Chapter: 02 - Customer Services and Recipient Rights</td><td>Subject No: 02.03.02</td></tr>
<tr><td rowspan="2">Effective Date:
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Sandra M. Lindsey, CEO

Responsible Director:
Director of Services for Persons with Intellectual and Developmental Disabilities

Authored By:
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Additional Reviewers:
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Amanda Elliott</td></tr>
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<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
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Purpose:
The purpose of this policy is to foster the inclusion and community integration of all Saginaw County Community Mental Health Authority consumers.

Application:
The entire Saginaw County Community Mental Health Authority network of providers.

Policy:
No matter where people live or what they do, all community members are entitled to fully exercise and enjoy the human, constitutional and civil rights which collectively are held common. These rights are not conditional or situational. These rights are constant throughout our lives. These constitutional and civil rights are unaffected by the fact that a citizen receives services or supports from the public mental health system. By virtue of an individual's membership in his or her community, he or she is entitled to fully share in the privileges and resources that the community has to offer. Saginaw County Community Mental Health Authority supports the inclusion and community integration of all consumers of service.

Standards:

I. The Saginaw County Community Mental Health Authority network of providers will design programs and services to be congruent with the norms of their community. This requires giving first consideration to using a

community's established conventional resources before attempting to develop new ones that exclusively or predominantly serve only mental health consumers. Some of the resources, which can be used to foster inclusion, integration and acceptance include:

- Securing entitlements including SSI, SSD, Medicaid, and food stamps
- Use of the community's public transportation system
- Leisure and recreation facilities
- General health care services
- Employment opportunities (real work for real pay)
- Traditional housing resources
- Generic resources for low-income persons in the community including clothes closets, food pantries, etc.
- Access to faith-based resources and support
- Access to educational resources and opportunities

II. The Saginaw County Community Mental Health network of service providers shall organizationally promote inclusion by establishing internal mechanisms that:

- Assure all consumers of mental health services are treated with dignity and respect.
- Assure all consumers, including those who have guardians or advocates, have opportunities for consumer choice and self-representation.
- Provide for a review of consumer outcomes.
- Provide opportunities for consumer representation and membership on planning committees, workgroups and agency evaluation committees.
- Invite and encourage consumer participation in sponsored events and activities of their choice.
- Provide and assist with research and resources for community inclusion

III. The Saginaw County Community Mental Health network of service providers shall establish policies and procedures that support the principles of normalization, or "a life like everyone else", through delivery of clinical services and supports that:

- Address the social, chronological, cultural, linguistic, and ethnic aspects of services and outcomes of treatment.
- Help consumers gain social integration and assertive communication skills to become more self reliant in all life environments for daily living (i.e., purchasing/returns at stores, banking, grocery, doctor's appointments).
- Encourage and assist consumers, as applicable, to obtain and maintain integrated, competitive employment in the community labor market(s), irrespective of one's disability. Assistance may include, but is not limited to, helping the consumer to develop relationships with co-

workers both at work and in non-work situations. This includes making use of assistive technology to obtain or maintain employment.
- Assist adult consumers to obtain/maintain permanent individual housing integrated in residential neighborhoods.
- Help families develop and utilize both informal interpersonal and community-based networks of supports and resources.
- Provide children with treatment services in a community-based manner which promotes permanency.

IV. The Saginaw County Community Mental Health network of service providers shall establish procedures and mechanisms to provide consumers with the information and counsel they need to make informed treatment choices. This includes helping consumers examine treatment and support options, financial resources, housing options, education, and employment options. In some instances, this may include helping a consumer to:
    - Learn how to make and assertively communicate one's own decisions
    - Learn to take responsibility for decisions made
    - Understand his/her obligations as well as rights.

Definitions:
Community: Refers to both society in general as well as the distinct cities, villages, townships, and neighborhoods where people, under a local government structure, come together and establish community identity, develop shared interests and shared resources.

Inclusion*:* Means recognizing and accepting people with mental health needs as valued members of their community.

Integration: Means enabling mental health consumers to become or continue to be participants and integral members of their community.

Normalization*:* Means rendering services in an environment and under conditions that are culturally normative. This approach not only maximizes the individual's opportunities to learn, grow and function within general accepted patterns of human behavior but it also serves to mitigate social stigma and foster inclusion.

Self-representation*:* Means encouraging consumers, including those who have guardians, to employ the services of advocates to express their own point of view and to have input regarding the services that are being planned or provided by the Provider.

References:
Michigan Department of Health and Human Services (MDHHS) Inclusion Best Practice Guideline

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Provides leadership through procedures and practices which foster inclusion and community integration of consumers of mental health services.	CEO Executive Director of Clinical Services Network Providers
Designs programs and services to be congruent with the norms of the community.	The entire SCCMHA network of providers Families/youth/consumers
Establish internal mechanisms that organizationally promote community inclusion for all consumers.	The entire SCCMHA network of providers
Develop or adopt policies and procedures that support the principles of normalization.	The entire SCCMHA network of providers
Provide and foster opportunities for consumer representation on planning committees, work groups and agency service evaluation committees.	The entire SCCMHA network of providers
Establishes procedures and mechanisms to provide consumers the information and accommodations needed to make informed choices.	The entire SCCMHA network of providers

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<tr><td>Subject:
Person-Centered Planning</td><td>Chapter: 02 -
Customer Services and Recipient Rights</td><td>Subject No: 02.03.03</td></tr>
<tr><td rowspan="2">Effective Date:
December 1, 2002</td><td>Date of Review/Revision:
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Sandra M. Lindsey, CEO

Responsible Director:
Director of Network Services, Public Policy & Continuing Education

Authored By:
Kristie Wolbert

Additional Reviewers:</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To establish person-centered planning practice guidelines as the values and principles underlying person-centered planning.

Policy:
As established in the Michigan Mental Health Code, all consumers receiving on-going services from Saginaw County Community Mental Health Authority have the right to utilize the Person-Centered Planning (PCP) in the development of the consumer's Individual Plan of Service (IPOS). The use of this process will be based on the services provided without regard to the age, disability, race, color, religion, gender, sexual orientation, gender identity or expression, national origin, legal status, or residential setting.

PCP is a way for people to plan their lives in their communities, set the goals that they want to achieve, and develop a plan for how to accomplish them. PCP is required by state law (the Michigan Mental Health Code (the Code)) and federal law (the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules) as the way that people receiving services and supports from the community mental health system plan how those supports are going to enable them to achieve their life goals. The process is used to plan the life that the person aspires to have, considering various options—taking the individual's goals, hopes, strengths, and preferences and weaving them into plans for the future. Through PCP, a person is engaged in decision-making, problem solving, monitoring progress, and making needed adjustments to goals and supports and services provided in a timely manner. PCP is a process that involves support and input from those people who care about the person doing the planning. The PCP process is used any time an individual's goals, desires, circumstances, choices, or needs change. While PCP is the required planning approach for mental health and I/DD services provided by the CMHSP system,

PCP can include planning for other public supports and privately-funded services chosen by the person.

Application:
All providers, board operated and contracted, of the Saginaw County Community Mental Health Authority network.

Standards:
PCP is an individualized process designed to respond to the unique needs and desires of each person. Through the PCP process, a person and those he or she has selected to support him or her:

1. Focus on the person's life goals, interests, desires, choices, strengths and abilities as the foundation for the PCP process.

2. Identify outcomes based on the person's life goals, interests, strengths, abilities, desires and choices.

3. Make plans for the person to achieve identified outcomes.

4. Determine the services and supports the person needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.

5. After the PCP process, develop an Individual Plan of Services (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

PCP focuses on the person's goals, while still meeting the person's basic needs [the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code]. As appropriate for the person, the PCP process may address Recovery, Self-Determination, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning as described in the relevant MDHHS policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the person to work toward and achieve their personal goals.

For minor children, the concept of PCP is incorporated into a family-driven, youth-guided approach (see the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline). The needs of the child are interwoven with the needs of the family, and therefore supports and services impact the entire family. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the person reaches adulthood, his or her needs and goals become primary.

There are a few circumstances where the involvement of a minor's family may be not appropriate:

1. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Code.
2. The minor is emancipated.
3. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the minor or substantial disruption of the planning process. Justification of the exclusion of parents shall be documented in the clinical record.

Every person is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community.

Every person has strengths, can express preferences, and can make choices

The person's choices and preferences are honored. Choices may include: the family and friends involved in his or her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships and friendships, and transportation. Individual choice must be used to develop goals and to meet the person's needs and preferences for supports and services and how they are provided.

The person's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the person to implement their choices or preferences over time.

Every person contributes to his or her community, and has the right to choose how supports and services enable

Through the PCP process, a person maximizes independence, creates connections, and works towards achieving his or her chosen outcomes.

A person's cultural background is recognized and valued in the PCP process. Cultural background may include language, religion, values, beliefs, customs, dietary choices and other things chosen by the person. Linguistic needs, including ASL interpretation, are also recognized, valued and accommodated.

The following elements are essential to the successful use of the PCP process with a person and the people invited by the person to participate.

1. **Person-Directed.** The person directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

2. **Person-Centered.** The planning process focuses on the person, not the system or the person's family, guardian, or friends. The person's goals, interests,

desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the person's needs or choices, rather than viewed as an annual event.

3. **Outcome-Based.** The person identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.

4. **Information, Support and Accommodations.** As needed, the person receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the IPOS. Support and accommodations to assist the person to participate in the process are provided. The person is offered information on the full range of services avail-able in an easy-to-understand format.

5. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process. See Section II below.

6. **Pre-Planning**. The purpose of pre-planning is for the person to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Each person must use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

   The following items are addressed through pre-planning with sufficient time to take all needed actions (e.g. invite desired participants):

   a. When and where the meeting will be held.

   b. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).

   c. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them. (What will be discussed and not discussed.

   d. The specific PCP format or tool chosen by the person to be used for PCP.

   e. What accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).

f. Who will facilitate the meeting.

g. Who will take notes about what is discussed at the meeting.

7. **Wellness and Well-Being**. Issues of wellness, well-being, physical health and primary care coordination support needed for the person to live the way he or she want to live are discussed and plans to address them are developed. People are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, eating candy or other sweets). If the person chooses, issues of wellness and well-being can be addressed outside of the PCP meeting.
   PCP highlights personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the person's right to assume some degree of personal risk. The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).

8. **Participation of Allies**. Through the pre-planning process, the person selects allies (friends, family members and others) to support him or her through the PCP process. Pre-planning and planning help the person explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

To assure consumer involvement in the process, consumers will be asked by their assigned Case Holder to complete the Choice Document (see exhibit below) during the pre-planning aspect of the Individual Plan of Service.

Consumers should be offered the ability to create a Crisis Plan, Psychiatric Advanced Directive, or a Wellness Recovery Action Plan.

The goal of a crisis plan, psychiatric advanced directive or a wellness recovery action plan it to help the consumer and their allies identify signs when the consumer is heading for a relapse or needs additional supports. This type of planning is to divert crisis intervention or hospitalization or residential treatment and to prevent relapse.

Discussion with the consumer about this type of planning should occur:

1) After a hospitalization when the consumer is healthy enough to discuss or discuss with the consumer guardian, caregivers etc.
2) After a series of crisis intervention contacts. A series here is defined as three or more.
3) After treatment for SUD in a residential treatment facility.
4) As the consumer is discussing a lesser restrictive treatment setting such as step down from an Alternative Treatment Order, or a Court Order.

All agency and network staff, at all levels of the organizations (including secretaries, administrators, psychiatrists, janitors, etc.), shall have training in person-centered planning concepts and philosophy within 30 days of hire and annually thereafter.

Additionally, Case Holders will be evaluated at least annually on their knowledge and utilization of the process for their caseloads. This will be part of the annual performance evaluation.

The SCCMHA Customer Service Staff will complete a survey of a sampling of consumers who have recently had their Person-Centered Planning Pre-Planning Meeting. The sampling will include at least 50 consumers per month and will include every member of the SCCMHA Provider Network.

- The results of the surveys will be collected and shared with the Quality Governance Committee on a quarterly basis.

Whenever feasible, consumers should be involved in providing person-centered planning training as co-presenters.

Person-Centered/family planning training should be available and open to consumers, family members and the general public.

To assure an understanding of not only the technical process but also the 'spirit' and intent of Person-Centered Planning, annually, the Clinical Supervisor will shadow each assigned Case Holder through at least one consumer's PCP Process using the PCP Fidelity Checklist to train and assess that Case Holder's understanding of the PCP Process. The results of this tool will be used as part of the annual evaluation and to train areas for skill improvement. Additional shadowing may occur as deemed needed based on the results of the Fidelity Checklist.

Definitions:
Person-Centered Planning: means a process for planning and sup-porting the individual receiving services that build upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. [MCL 330.1700(g)]

Case Holder: Case Managers, Supports Coordinators, Therapists, Wrap Coordinators and other staff who provide case management or coordination of care for a consumer

References:
The Michigan Mental Health Code
MDHHS Person-Centered Planning Policy (June 5, 2017)
MDHHS Person-Centered Planning Policy and Practice Guideline (3/15/2011)

Exhibits:
Exhibit A - Chart of Elements/strategies
Exhibit B – Choice Document

Exhibit C – Person Centered Planning Process-Fidelity Checklist
Exhibit D –IPOS Workflow and Activities

Procedure:

ACTION	RESPONSIBILITY
Provides leadership through policy that requires staff training on Person/family Centered Planning at all levels of the organization and network.	CEO Executive Director of Clinical Services Director of Network Services, Public Policy & Continuing Education
Provides leadership through policy that requires staff and network adherence to Person/family Centered Planning policy and practices.	CEO Executive Director of Clinical Services Director of Network Services, Public Policy & Continuing Education
Assures that training is made available on a regular basis to new staff and contractors as well as consumers and family members and that, when possible, consumers are involved in providing the training, co-presenters.	CEO Executive Director of Clinical Services Director of Network Services, Public Policy & Continuing Education SCCMHA Training Unit Supervisor of Customer Services
Case Holder evaluation of utilization of Person-Centered Plan is conducted at least annually as part of staff performance evaluation	Clinical Supervisor
Assures that all decisions involving a consumer are made utilizing the concepts of person/family centered planning.	SCCMHA Network
Person/family centered planning processes begin when the individual makes a request to the agency. The first step is to find out from the individual the reason for his/her request for assistance. During this process the individual needs and valued outcomes are identified rather than requests for a specific type of service. The attached Chart of Elements/Strategies can be used by staff to determine how to proceed based upon the person's/family's wants and needs.	SCCMHA Centralized Access and Intake Staff/Family Guide
Before a person/family centered planning meeting is initiated, a pre-planning	Case Holder/Parent/guardian when applicable

meeting occurs and all decisions are documented. In the pre-planning the individual chooses: ♦ Dreams, goals, desires and any topics which he/she would like to talk about at the meeting. ♦ Topics he/she does not want discussed at the meeting. ♦ Who to invite and who will be responsible for inviting those individuals. ♦ Where and when the meeting will be held. ♦ Who will facilitate the meeting? The consumer must be given choices including the option for independent facilitation. ♦ Who will be responsible for recording the meeting? ♦ Whether the adult consumer is interested in participating in self-determination	
Before the person/family centered planning meeting is initiated, a Psychosocial Assessment is completed. Annual assessments are completed within 364 days of the last assessment.	Case Holder Consumer
The person/family centered planning meeting is held and directed according to the choices made by the individual/family during the pre-planning meeting.	Consumer Facilitator Case Holder Parent/guardian when applicable Family members and other invited guests
Each consumer shall be given opportunities to express his/her needs and desired outcomes. Accommodations will be made as necessary to maximize the individual's ability for self-expression. Sensitivity to cultural and linguistic (styles of communication) responsiveness will be practiced.	Consumer Facilitator Case Holder Parent/guardian when applicable Family members and other invited guests
Each consumer is given the opportunity to develop a crisis plan to assist the individual	Consumer Facilitator

in and those around the person recognize when the consumer is regressing in their recovery and assist the person while they are healthy to make decisions about their care when they are feeling unwell or unable to make decisions about their care. During the meeting, the consumer is the focal point of conversation. The consumer will be addressed directly in the style of communication that they prefer and is understandable by all participants. Simple and clear language will be used to assure understanding of all participants. The consumer will be empowered to make decisions regarding his/her care. The professionals involved will act as consultants to the consumer rather than primary decisions makers.	Case Holder Parent/guardian when applicable Family members and other invited guests Customer services
Potential support and/or treatment options identified by the consultants/staff to meet the expressed needs/desires of the individual/family will be presented to, discussed with and approved by the individual/family. All participants should maintain a positive focus on the consumer's abilities. The consumer's choices and preferences about his/her supports and services should always be given primary consideration in planning. Issues and concerns that the individual or others have about the consumer's health, welfare and safety should be shared with the consumer/family as he/she makes choices. Care will be taken to include access to high quality physical health needs as well as behavioral health. In addition, social services, housing, educational systems, and employment opportunities to facilitate wellness and recovery of the whole person.	Consumer Facilitator Case Holder Parent/guardian when applicable Family members and other invited guests Customer services
Throughout the planning process, the resources and supports that are already available to the consumer including natural/community supports will be	Consumer Facilitator Case Holder Parent/guardian when applicable

identified. The planning team should consider how these natural supports could be utilized to help the consumer/family reach his/her dreams and desires. If the consumer has no natural supports, the team will discuss how such supports will be developed.	Family members and other invited guests Customer services
Consumers are encouraged and supported to reach their highest potential. To the extent possible, the individual shall be given the opportunity for experiencing the options available prior to making a choice/decision. This is particularly true for individuals who have limited life experiences in the community with respect to housing, work and other domains.	Consumer Facilitator Case Holder Parent/guardian when applicable Family members and other invited guests Customer services
Person/family centered planning is a dynamic process. Consumers have the opportunity to reconvene any or all of the planning processes whenever he/she wants or needs. Consumers with dual diagnosis of MI/SUD will have periodic reviews of their PCP completed every 120 days.	Consumer Case Holder
Consumers/families are provided with ongoing opportunities to provide feedback on how he/she feels about the service, support and/or treatment he/she receives and his/her progress toward attaining varied outcomes. Information is collected and changes are made in response to the consumer's/family's feedback.	Consumer Case Holder
Once all parties have agreed to all elements of the Person-Centered Plan, the plan will be submitted to the departmental supervisor for approval, as well as Care Management for approval of authorization of requested services. The Person-Centered Plan is effective on the date which the required supervisor signs the plan.	Case Holder Clinical Supervisor Care Management

Each consumer is provided with a copy of his/her person/family centered plan within 15 business days after the meeting.	Case Holder
The SCCMHA Customer Service Staff will complete a survey of a sampling of consumers who have recently had their Person Centered Planning Pre-Planning Meeting. The sampling will include at least 50 consumers per month and will include every member of the SCCMHA Provider Network. ➢ The results of the surveys will be collected and shared with the Quality Governance Committee on a quarterly basis.	SCCMHA Customer Service Staff
Annually, the Clinical Supervisor will shadow each assigned Case Holder through at least one consumer's PCP Process using the PCP Fidelity Checklist to train and assess that Case Holder's understanding of the PCP Process. The results of this checklist will be used as part of the annual evaluation and to train areas for skill improvement. Additional shadowing may occur as deemed needed based on the results of the Fidelity Checklist.	Clinical Supervisor Case Holder

EXHIBIT A

The following chart of elements/strategies can be used by the person representing the CMHSP, depending upon what the individual wants and needs.

Three possible situations are:

1. **<u>The individual expresses a need that would be considered urgent or emergent.</u>**

   When an individual is in an urgent/emergent situation, the goal is to get the individual's crisis situation stabilized. Following stabilization, the individual and CMHSP will explore further needs for assistance and if required, proceed to a more in-depth planning process as outline below. It is this type of situation where and individual's opportunity to make choices may be limited.

2. **<u>The individual expresses a need or makes a request for support, services and/or treatment in a single life domain and/or of a short duration.</u>**

   A life domain could be any of the following:
   - ♦ Daily activities
   - ♦ Social relationships
   - ♦ Finances
   - ♦ Work
   - ♦ School
   - ♦ Legal and Safety
   - ♦ Health
   - ♦ Family and relationships

3. **<u>The individual expresses multiple needs that involve multiple life domains for support(s), service(s) or treatment of an extended duration.</u>**

The following chart represents the elements/strategies that can be used depending on the kinds of needs expressed by the individual.

Elements/Strategies	Urgent/ Emergency (< 7 days)	Short Duration (≥ 7 days)	Extended Duration
The individual expresses his/her needs and/or desires. Accommodations for communication will be made to maximize his/her ability for expression.	X	X	X
The individual's preferences, choices and abilities are respected.	X	X	X
Potential issues of health and safety are explored and discussed, to determine if there is a role for other clinicians to provide additional information or opinions.	X	X	X
As a result of health or safety concerns or court-ordered treatment, limitations may exist for individual choice. However, opportunities for individuals to express their perceived needs can occur and opportunities to make choices among limited options can be given.	X	X	X
Person-centered planning includes pre-planning activities. These activities result in the determination of whether in-depth treatment or support planning is necessary and if so, to determine and identify the people and information that need to be assembled for successful planning to take place.		X	X
All planning meeting(s) are scheduled at a time and location convenient to the individual and persons the individual chooses to have participate.	***Should ask at 1st meeting!***	X	X
In collaboration with the RMHA, the individual identifies strategies and supports, services and/or treatment needed to achieve desired outcomes.		X 330.1209a	X
Exploration of the potential resources for supports and services to be included in the individual's plan are to be considered in this order: - The individual. - Family, friends, guardian, and significant others. - Resources in the neighborhood and community. - Publicly-funded supports and services available for all citizens. - Publicly-funded supports and services provided under the auspices of the MDCH and CMH Services Programs.		X	X
Regular opportunities for individuals to provide feedback are available.		X	X
The individual's support network is explored with that person to determine who can best help him/her plan. The individual and the people he/she selects together define the individual's desired future, and develop a plan for achieving desired outcomes. For persons with dementia or other organic impairments, this should include the identification of spouses or other primary care givers who are likely to be involved in treatment or support plan implementation.			X
The process continues during the planning meeting(s) at which the individual and, where necessary, others he/she has selected who know him/her well talk about the desired future and outcomes concentrating on the life domains previously identified as needing change.			X

EXHIBIT B

SCCMHA Funded Licensed Residential Setting

Name: _____ Date:_____

The Home and Community Final Rule (HCBS) of Medicaid tells SCCMHA to help you to live your life as you would like to live it. This includes assisting you with your choices about where to live, work, and being part of our community. We must treat you just like any person would be treated. The HCBS Final Rule says that we do this through the Person-Centered Planning Process. This form is to help us know about your choices.

Birth Date: _____ Case: _____ Name of home: _____

You have the right to choose the home you live in from various options. **Given the choices available to you at this time, is your current home where you choose to live?**	Yes ☐	No ☐
You also have the right to choose your roommate from available options. **Given the choices available to you at this time, are you happy with your current roommate?**	Yes ☐	No ☐

If at any time you are not happy with the home you live in or your roommate, you can notify your worker: _____ , phone: _____ to help you to find out about the choices available.

If you live in a place that you do not own or rent, and have staff present, then please answer these questions:			
The Resident Care Agreement (BCAL-3266) that I (or my guardian) signed, also included a document known as "Summary of Resident Rights: Discharges and Complaints".	Yes ☐	No ☐	Don't know ☐
My bedroom door is lockable from the inside.	Yes ☐	No ☐	
I am able to furnish and decorate my room the way that I want to.	Yes ☐	No ☐	
I set my own schedule (For example: I go to bed when I want to, bathe when I want to, etc.).	Yes ☐	No ☐	
I have access to food at any time.	Yes ☐	No ☐	
I can have visitors whenever I want to.	Yes ☐	No ☐	
I have a place to securely lock up my possessions.	Yes ☐	No ☐	

I receive privacy while doing or receiving personal care.	Yes ☐	No ☐	

***If you answered "no" to any of the above, these should be looked at through the PCP process until resolved.**

_____

Signature of Person Receiving Services or Legal Representative
Date

Non-Residential Settings

Name: _____ Date: _____

Birth Date: _____ Case: _____ Program: _____

The Home and Community Final Rule (HCBS) of Medicaid tells SCCMHA to help you to live your life as you would like to live it. This includes assisting you with your choices about where to live, work, and being part of our community. We must treat you just like any person would be treated. The HCBS Final Rule says that we do this through the Person-Centered Planning Process. This form is to help us know about your choices.

Saginaw County Community Mental Health provides a full range of work and job options including supports to seek employment.

If I want to become employed, I can contact my worker - _____ Phone:_____ to help me find a program to help me find a job.

I am aware about the options available to help me to become part of my community and to develop skills: Supported Employment; Community Ties; Guardian Angels; SVRC, Community Living Supports; Bay Side Lodge; Friends for Recovery; etc.), and chose to attend the program listed above.	Yes ☐	No ☐	Don't know ☐
I am aware that I can make changes at any time by contacting the worker listed above.	Yes ☐	No ☐	
I am able to choose the hours and days that I attend.	Yes ☐	No ☐	
If I need help with personal care, I receive it in a private place.	Yes ☐	No ☐	
The amount of time I get to go out into the community while I attend this program meets my needs and choices.	Yes ☐	No ☐	
The amount of time I spend with people without disabilities while I attend this program meets my needs and choices.	Yes ☐	No ☐	
My lunch break is scheduled the same as other people working on my job.	Yes ☐	No ☐	
I am OK with the employee benefits I receive.	Yes ☐	No ☐	☐N/A (I am not an employee)
I am happy with the type of work I do for my employer.	Yes ☐	No ☐	☐N/A

			(I am not an employee)

***If you answered "no" to any of the above, these should be looked at through the PCP process until resolved.**

_____

_____

Signature of Person Receiving Services or Legal Representative
Date

EXHIBIT C

PERSON-CENTERED PLANNING PROCESS – Fidelity Checklist

Staff Member:_____ Review Date:_____ ID:_____ Supervisor:_____

The supervisor will shadow the staff through the PCP process by observation, which include attending meetings (with consumer permission), reviewing written documentation, and through interview or discussion with the consumer and natural supports. The supervisor will then review these findings with the staff and include findings on the annual performance review.

Indicator	Adherence*	Recommendations or Suggestions:
1. The person and people important to him or her are included in lifestyle planning, and have the opportunity to express preferences, exercise control and make informed decisions.	☐2 ☐1 ☐0	
2. The person's routine and supports are based upon his or her interests, preferences, strengths, capacities and dreams.	☐2 ☐1 ☐0	
3. Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect.	☐2 ☐1 ☐0	
4. The person uses, when possible, natural and community supports.	☐2 ☐1 ☐0	
5. The person has meaningful choices, with decisions based on his or her experiences.	☐2 ☐1 ☐0	
6. Planning is collaborative, recurring, and involves an ongoing commitment to the person.	☐2 ☐1 ☐0	
7. The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.	☐2 ☐1 ☐0	
8. The person is satisfied with his or her activities, supports, and services.	☐2 ☐1 ☐0	
9. Person is viewed as an unique and valued individual, not only as a client or a consumer of services.	☐2 ☐1 ☐0	
10. Planning meetings are a celebration of the consumer	☐2 ☐1 ☐0	
11. The Person-Centered Planning process and subsequent documentation belong to the person	☐2 ☐1 ☐0	
12. Strategies were included for solving disagreement within the process, including clear conflict of interest guidelines for all planning participants.	☐2 ☐1 ☐0	

Additional Comments or Notes:

*2 – Displays fidelity to the factors of the indicator; 1 – Displays partial fidelity but needs to improve on various factors, 0 – Did not meet fidelity and needs to improve on all factors

Fidelity Indicators and Factors

Fidelity Indictors are the numbered states that reflect the values of the Person-Centered Planning Process.
Fidelity Factors are the bulleted statements regarding some of the elements or factors that would be shown in the Indicator

1. **The person and people important to him or her are included in lifestyle planning, and have the opportunity to express preferences, exercise control and make informed decisions.**
   - The person and advocates participated in planning and discussions where decisions are made.
   - A diverse group of people, invited by the person, assisted in planning and decision-making.

2. **The person's routine and supports are based upon his or her interests, preferences, strengths, capacities and dreams.**
   - The person's dreams, interests, preferences, strengths, and capacities are explicitly acknowledged and consequently their plan drives activities and supports.
   - Supports are individualized and do not rely solely on preexisting models.
   - Supports result in goals and outcomes that are meaningful to the person.
   - Goals are defined by the person with a focus on attaining the life they envision for themselves in the community

3. **Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect.**
   - The person has friends, and increasing opportunities to form other natural community relationships.
   - The person has a presence in a variety of typical community places. Segregated services and locations are minimized.
   - The person has the opportunity to be a contributing member of the community.
   - The person can access community-based housing and work if desired.
   - The person is an engaged member within their community.

4. **The person uses, when possible, natural and community supports.**
   - With the person's consent, the support of family members, neighbors and co-workers is encouraged.
   - The person makes use of typical community and generic resources whenever possible.

5. **The person has meaningful choices, with decisions based on his or her experiences.**
   - The person has opportunities to experience alternatives before making choices.
   - The person makes life-defining choices related to home, work and relationships.
   - Opportunities for decision-making are part of the person's everyday routine.

6. **Planning is collaborative, recurring, and involves an ongoing commitment to the person.**
   - Planning activities occur periodically and routinely. Lifestyle decisions are revisited.

- A group of people who know, value, and are committed to serving the person remain involved.

7. **The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints**.
   - Funding of supports and services is responsible to personal needs and desires, not the reverse.
   - When funding constraints require supports to be prioritized or limited, the person or advocates make the decisions.
   - The person has appropriate control over available economic resources.

8. **The person is satisfied with his or her activities, supports, and services.**
   - The person expresses satisfaction with his or her relationships, home, and daily routines.
   - Areas of dissatisfaction result in tangible changes in the person's life situation.

9. **Person is viewed as a unique and valued individual, not only as a client or a consumer of services.**

   - Person-first language is used
     - Refrain from terms like:
       - Non-verbal
       - Low functioning
       - He's a runner, scratcher
       - Non-compliant
       - The "collective we": How are we doing today?
   - Preferred name and gender preferences used
   - Staff understands the background, history of the person
   - Staff are sincere and genuine in interactions with the person.
   - Interactions adhere to the person's preferences and desires such as respecting someone's belongings, personal space wheelchair, privacy, etc..
   - The person's contribution was valued as shown by listening without interrupting, and giving time to respond to a comment or a question.
   - Discussions and documentation are in plain language
   - Motivational Interviewing was used by the staff to obtain a deeper understanding and knowledge of the person and the person's goals, desires, wishes, and dreams

10. **Planning meetings are a celebration of the consumer**
    - Discussions were positive, future oriented
    - Consumer was encouraged to participate and control the process
    - Consideration was given for consumer's culture, trauma history, desires, dreams, aspirations
    - Strengths are highlighted - the focus of meetings were on the consumer's interests, and talents while also considering how to actively use these strengths
    - The focus of meetings were on the consumer's interests, and talents while also considering how to actively use these strengths
    - The person was involved in making decisions regarding the meeting, including:
      - Who would attend or not attend
      - Location, date, time of meeting
      - Who would lead, facilitate and/or take notes
      - What was to be discussed and what was not to be discussed
    - Staff allowed consumer time to think and to respond
    - Multiple sources were used to obtain information to obtain a fuller picture of the consumer

- Choices were offered to the individual regarding the services and supports the individual receives and from whom.

11. The Person-Centered Planning process and subsequent documentation belong to the person

- Plans, schedules, and routines are flexible to the direction of the person
- An environment of choice prevails throughout the process
    - Strength-focused
    - Maximum self-sufficiency and independence is promoted
    - Real opportunities are created
    - Respectfulness prevails
- The approach used was supportive of the person rather than directed by the staff
    - Consumer was provided the necessary information and support to ensure the individual directs the process to the maximum extent possible

12. Strategies were included for solving disagreement within the process, including clear conflict of interest guidelines for all planning participants.

EXHIBIT D

IPOS Workflow and Activities

Pre-planning (60 days prior to IPOS expiration)

1. Case Holder (CH) reviews of information from previous year
    a. Chart Review: Periodic Reviews, Progress Notes, Medication Reviews, Incident Reports
    b. Personal notes or information not in chart
2. CH and consumer and (others) complete tools to help develop consumer goals
3. CH and consumer and (others):
    a. Complete the Choice Document with the consumer
    b. Determine need or want for Enhanced Health Services (EHS)
        i. Submit authorization for EHS
    c. Determine need or want for Community Living Supports
4. CH meets with consumer to complete the Pre-Plan form
5. Planning meeting set up (send invites, arrange location, etc.) is completed by parties designated in Pre-Plan
6. CH completes Assessment in Sentri prior to Planning Meeting (annual assessment should be completed within 364 days of the last assessment)
7. CH enters proposed IPOS goals in Sentri prior to Planning Meeting

Planning Meeting

8. At the Planning Meeting, the team
    a. Reviews the current strengths of the consumer from the various community and SCCMHA provide supports, services and/or programs
    b. Adds, Reviews and/or revises (if needed) the proposed goals
    c. 15 day copy "clock" starts from date of planning meeting

Post Planning Meeting

9. CH completes the Planning meeting fields in Sentri (may be done after the planning meeting based on notes)
10. CH Simultaneously submits IPOS for
    a. Supervisor Review, revision (if required) and approval
    b. Submit Authorizations in Sentri, revision (if required) and approval
11. CH signs IPOS after Supervisor and authorization approvals
12. CH sends completed IPOS copy to guardian (if applicable) or consumer for signature
    a. CH documents date sent in Sentri on IPOS form
    b. CH documents consumer/guardian signature date on IPOS form
    c. CH assures that the signed Signature Page scanned
13. CH Review IPOS with programs and services
    a. CH documents any in-service(s) on Sentri on PCP Header
14. CH monitors plan

a. Assures that programs and services are being provided per the IPOS
b. Monitors progress towards goal achievement as indicated in the IPOS
c. Reviews goals per agreed time frames indicated on the IPOS

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject:
Family Centered Practice</td><td>Chapter: 02 -Customer Services & Recipient Rights</td><td>Subject No: 02.03.03 B</td></tr>
<tr><td rowspan="2">Effective Date:
7/1/07</td><td>Date of Review/Revision:
6/18/07, 7/22/08, 5/6/09, 6/30/10, 5/9/12, 5/22/14, 4/7/16,3/30/17, 3/1/18, 4/3/20, 3/30/21, 10/25/21, 2/28/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Stacey Farrell

Additional Reviewers:
Jennifer Stanuszek</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to define family centered practice and give direction as to how to achieve family centered practice.

Policy:
Saginaw County Community Mental Health Authority (SCCMHA) providers are required to utilize a family centered approach to service delivery and planning process for children and families regardless of age, disability, race, color, religion, gender, sexual orientation, gender identity or expression, national origin, or residential setting.

Application:
The entire SCCMHA network of providers.

Standards:
Family Centered practice is a planning and service delivery process that:

- Recognizes that parents play a unique and essential role in the lives of their minor children and have the greatest influence on the child's health, growth and development.
- Recognizes that enhancing parenting competence and confidence is the best avenue to achieving better outcomes for children.
- Is family specific, individualized by culture, strengths, concerns, and resources of each family.
- Continues to build self-empowerment within parents, children and youth.
- Promotes resiliency by developing interventions that increase abilities and skills in children, youth and families, while reducing risk factors and enhancing protective factors.

- Promotes a child/youth's ability to assume more choice and leadership as he/she matures and develops in preparation for adulthood.

Staff coordinating the planning process will adhere to the following principles when implementing family centered practice:

- Partnerships are developed with parents, children, youth and other caregivers.
- Mutual respect and honesty exist between all partners.
- Planning and services are individualized, family driven and youth guided.
- Family strengths and individual strengths are discovered, acknowledged and built upon.
- Family culture and linguistics (styles of communication) are acknowledged and respected.
- Parenting skill and confidence are strengthened.

The emphasis of family centered practice is to shift over the child's life from supporting parents to make decisions for and on behalf of the child to supporting youth to make his or her own decisions, in the context of their family's values, culture and beliefs.

Providers of services to children and families are required to develop a plan of service utilizing a *family* centered approach—a modification of the essential elements of person-centered planning-- to take into consideration that one is working with a family. These **essential elements of a family centered approach** are:

1. The child, youth and family have an opportunity to reconvene any or all of the planning process whenever he/she, they want or need.
2. The child, youth and family determine who should be involved in the planning meeting.
3. The family is provided with the option of choosing external independent facilitation of their meeting unless they are receiving short term outpatient therapy or a single service.
4. The family will identify the goals, dreams, aspirations and desires for their child and for their family. The child and youth will also have the opportunity to express goals, dreams, aspirations and desires which will be presented to, discussed with and approved by the individual/family.
5. Before a family centered meeting is initiated, a pre-planning meeting with the family occurs. In the pre-planning meeting the child, youth and family chooses:
    a. Strengths, dreams, goals, aspirations and desires and any topics they want to address or plan for at the meeting
    b. Topics they do not want discussed at the meeting
    c. Who to invite
    d. Where and when the meeting will be held
    e. Who will facilitate
    f. Who will record the meeting
6. All potential support and/or treatment options are identified and discussed with the child and family.

7. Health and safety needs are identified in partnership with the child and family. Services are coordinated with primary health care providers and other allied health professionals or systems working with the child.
8. The child, youth and family are provided an opportunity to develop crisis and safety plans which describes what each family member should do during a crisis.
9. The child, youth and family are given ongoing opportunity to express needs, desires and preferences and to make choices.
10. The child, youth and family are provided opportunities to give feedback on the impact of their services, the progress they are making toward outcomes and the plan is modified based on this feedback. Once all parties have agreed to all elements of the Individual Plan of Service, the plan will be submitted to the departmental supervisor for approval. The Individual Plan of Service (IPOS) is effective on the date which the required supervisor signs the plan.
11. The child, youth and family are provided a copy of their Individual Plan of Service within 15 business days of their meeting.

The IPOS should be developed with the family in mind and should be written with minimal professional jargon or language, using the family's own words or in a way that the family mat read or comprehend. The IPOS should have person first language.

All persons eligible for services through SCCMHA and SCCMHA contracted network will have an IPOS developed. A family receiving services through the SCCMHA intake process will have a preliminary plan that addresses any crisis needs as well as any needs as the family meets with their assigned case holder and other team members to develop a comprehensive IPOS.

The plan should be developed within 45 days of the assignment to a case holder. When a person is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life the family desires to have.

The goal of a crisis plan, is to help the consumer/ family and their allies identify signs when the consumer is heading for a relapse or needs additional supports. This type of planning is to divert crisis intervention or hospitalization or residential treatment and to prevent relapse.

Discussion with the consumer/family about this type of planning should occur:

1. After a hospitalization when the consumer is healthy enough to discuss or discuss with the consumer guardian, caregivers etc.
2. After a series of crisis intervention contacts. A series here is defined as three or more.
3. After treatment for SUD in a residential treatment facility.
4. As the consumer is discussing a lesser restrictive treatment setting such as step down from an Alternative Treatment Order, or a Court Order.

All agency and network staff, at all levels of the organizations (including front desk associates , administrators, psychiatrists, custodial staff , etc.), shall have family-centered practice training within 30 days of hire.

Whenever feasible, consumers should be involved in providing family-centered planning training as co-trainers.

Person-Centered/family planning training should be available and open to consumers, family members and the general public.

In order to ensure an understanding of not only the technical process but also the 'spirit' and intent of Person-Centered Planning, annually, the Clinical Supervisor will shadow each assigned Case Holder through at least one consumer's PCP Process using the PCP Fidelity Checklist (Exhibit C) to train and assess that Case Holder's understanding of the PCP Process. The results of this tool will be used as part of the annual evaluation and to train areas for skill improvement. Additional shadowing may occur as deemed needed based on the results of the Fidelity Checklist. PCP Fidelity Checklists will be available for review by the SCCMHA Auditing team at the time of annual site reviews.

Definitions:
Child: For purposes of this policy, a child is defined as a minor age birth to 12.

Youth: For purposes of this policy a youth is defined as a minor age 13 to 18.

Family: For purposes of this policy, family is whomever the family defines to be their family.

Case Holder: Case Managers, Supports Coordinators, Therapists, Wrap Coordinators and other staff who provide case management or coordination of care for a consumer

References:
MDHHS Family- Driven and Youth-Guided Policy and Practice Guideline (July 29, 2020).
SCCMHA Policy 02.03.03- Person-Centered Planning
Certified Community Behavioral Health Clinics (CCBHC) Criteria

Exhibits:
Exhibit A - Chart of Elements/strategies
Exhibit B - Person Centered Planning Process-Fidelity Checklist
Exhibit C - IPOS Workflow and Activities

Procedure:

ACTION	RESPONSIBILITY
Provides leadership through policy that requires staff training on Person/Family Centered Planning at all levels of the organization and network.	CEO Executive Director of Clinical Services Director of Network Services, Public Policy & Continuing Education
Provides leadership through policy that requires staff and network adherence to	CEO Executive Director of Clinical Services

Person/Family Centered Planning policy and practices.	Director of Network Services, Public Policy & Continuing Education
Assures that training is made available on a regular basis to new staff and contractors as well as consumers and family members and that, when possible, consumers are involved in providing the training.	CEO Executive Director of Clinical Services Director of Network Services, Public Policy & Continuing Education SCCMHA Continuing Education Supervisor of Customer Services
Assures that all decisions involving a child, youth and family are made utilizing family centered practices.	SCCMHA Network of providers
Schedules a pre-planning meeting in preparation for the family centered planning meeting and assures that the essential elements of a pre-planning meeting are met.	Case Holder Consumer/Youth/Families
Schedules and coordinates the family centered planning meeting according to the choices made by the family during the pre-planning meeting.	Case Holder Consumer/Youth/Families
Develops the family's plan of service and all of the family outcomes under the name of the identified child. This is with the exception of situations where services to other family members will be provided without the identified child present (medication reviews, respite therapy). In those situations, a single service plan must also be entered for that person. If another family member is going to receive a variety of services and it is expected to be long term a full plan should be developed for them with the outcomes matching those of the first child as it is the family's plan.	Case Holder Consumer/Youth/Families
Once all parties have agreed to all elements of the Individual Plan of Service, authorizations will be submitted to Care Management for approval.	Case Holder Clinical Supervisor

Provides the family with a copy of their plan of service within 15 business days of the meeting.	Case Holder
Completes periodic reviews along with updating of CAFAS/PECFAS/DECA assessments.	Case Holder
Consumer/youth/family or staff can request to reconvene any or all of the planning processes whenever desired, wanted or needed.	Case Holder Consumer/youth/family
Provides the family, youth and/or child opportunity to provide feedback regarding how they feel about services and modifies the plan of service based on that feedback.	Case Holder
Provides regular feedback regarding progress toward outcomes.	Case Holder Consumer/youth/family

EXHIBIT A

The following chart of elements/strategies can be used by the person representing the CMHSP, depending upon what the individual wants and needs.

Three possible situations are:

1. **<u>The individual expresses a need that would be considered urgent or emergent.</u>**

   When an individual is in an urgent/emergent situation, the goal is to get the individual's crisis situation stabilized. Following stabilization, the individual and CMHSP will explore further needs for assistance and if required, proceed to a more in-depth planning process as outline below. It is this type of situation where and individual's opportunity to make choices may be limited.

2. **<u>The individual expresses a need or makes a request for support, services and/or treatment in a single life domain and/or of a short duration.</u>**

   A life domain could be any of the following:
   - ♦ Daily activities
   - ♦ Social relationships
   - ♦ Finances
   - ♦ Work
   - ♦ School
   - ♦ Legal and Safety
   - ♦ Health
   - ♦ Family and relationships

3. **<u>The individual expresses multiple needs that involve multiple life domains for support(s), service(s) or treatment of an extended duration.</u>**

The following chart represents the elements/strategies that can be used depending on the kinds of needs expressed by the individual.

Elements/Strategies	Urgent/ Emergency (< 7 days)	Short Duration (≥ 7 days)	Extended Duration
The individual expresses his/her needs and/or desires. Accommodations for communication will be made to maximize his/her ability for expression.	X	X	X
The individual's preferences, choices and abilities are respected.	X	X	X
Potential issues of health and safety are explored and discussed, to determine if there is a role for other clinicians to provide additional information or opinions.	X	X	X
As a result of health or safety concerns or court-ordered treatment, limitations may exist for individual choice. However, opportunities for individuals to express their perceived needs can occur and opportunities to make choices among limited options can be given.	X	X	X
Person-centered planning includes pre-planning activities. These activities result in the determination of whether in-depth treatment or support planning is necessary and if so, to determine and identify the people and information that need to be assembled for successful planning to take place.		X	X
All planning meeting(s) are scheduled at a time and location convenient to the individual and persons the individual chooses to have participate.	***Should ask at 1st meeting!***	X	X
In collaboration with the RMHA, the individual identifies strategies and supports, services and/or treatment needed to achieve desired outcomes.		X 330.1209a	X
Exploration of the potential resources for supports and services to be included in the individual's plan are to be considered in this order: - The individual. - Family, friends, guardian, and significant others. - Resources in the neighborhood and community. - Publicly-funded supports and services available for all citizens. - Publicly-funded supports and services provided under the auspices of the MDCH and CMH Services Programs.		X	X
Regular opportunities for individuals to provide feedback are available.		X	X
The individual's support network is explored with that person to determine who can best help him/her plan. The individual and the people he/she selects together define the individual's desired future, and develop a plan for achieving desired outcomes. For persons with dementia or other organic impairments, this should include the identification of spouses or other primary care givers who are likely to be involved in treatment or support plan implementation.			X
The process continues during the planning meeting(s) at which the individual and, where necessary, others he/she has selected who know him/her well talk about the desired future and outcomes concentrating on the life domains previously identified as needing change.			X

EXHIBIT B **PERSON-CENTERED PLANNING PROCESS – Fidelity Checklist**

Staff Member:_____ Review Date:_____

ID:_____

Supervisor:_____

The supervisor will shadow the staff through the PCP process by observation, which include attending meetings (with consumer permission), reviewing written documentation, and through interview or discussion with the consumer and natural supports. The supervisor will then review these findings with the staff and include findings on the annual performance review.

Indicator	Adherence*	Recommendations or Suggestions:
1. The person and people important to him or her are included in lifestyle planning, and have the opportunity to express preferences, exercise control and make informed decisions.	☐2 ☐1 ☐0	
2. The person's routine and supports are based upon his or her interests, preferences, strengths, capacities and dreams.	☐2 ☐1 ☐0	
3. Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect.	☐2 ☐1 ☐0	
4. The person uses, when possible, natural and community supports.	☐2 ☐1 ☐0	
5. The person has meaningful choices, with decisions based on his or her experiences.	☐2 ☐1 ☐0	
6. Planning is collaborative, recurring, and involves an ongoing commitment to the person.	☐2 ☐1 ☐0	
7. The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.	☐2 ☐1 ☐0	
8. The person is satisfied with his or her activities, supports, and services.	☐2 ☐1 ☐0	
9. Person is viewed as an unique and valued individual, not only as a client or a consumer of services.	☐2 ☐1 ☐0	
10. Planning meetings are a celebration of the consumer	☐2 ☐1 ☐0	
11. The Person-Centered Planning process and subsequent documentation belong to the person	☐2 ☐1 ☐0	
12. Strategies were included for solving disagreement within the process,	☐2 ☐1 ☐0	

including clear conflict of interest guidelines for all planning participants.		
Additional Comments or Notes:		

*2 – Displays fidelity to the factors of the indicator; 1 – Displays partial fidelity but needs to improve on various factors, 0 – Did not meet fidelity and needs to improve on all factors

Fidelity Indicators and Factors

Fidelity Indictors are the numbered states that reflect the values of the Person-Centered Planning Process.
Fidelity Factors are the bulleted statements regarding some of the elements or factors that would be shown in the Indicator

1. **The person and people important to him or her are included in lifestyle planning, and have the opportunity to express preferences, exercise control and make informed decisions.**
   - The person and advocates participated in planning and discussions where decisions are made.
   - A diverse group of people, invited by the person, assisted in planning and decision-making.

2. **The person's routine and supports are based upon his or her interests, preferences, strengths, capacities and dreams.**
   - The person's dreams, interests, preferences, strengths, and capacities are explicitly acknowledged and consequently their plan drives activities and supports.
   - Supports are individualized and do not rely solely on preexisting models.
   - Supports result in goals and outcomes that are meaningful to the person.
   - Goals are defined by the person with a focus on attaining the life they envision for themselves in the community

3. **Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect.**
   - The person has friends, and increasing opportunities to form other natural community relationships.
   - The person has a presence in a variety of typical community places. Segregated services and locations are minimized.
   - The person has the opportunity to be a contributing member of the community.
   - The person can access community-based housing and work if desired.
   - The person is an engaged member within their community.

4. **The person uses, when possible, natural and community supports.**
   - With the person's consent, the support of family members, neighbors and co-workers is encouraged.
   - The person makes use of typical community and generic resources whenever possible.

5. **The person has meaningful choices, with decisions based on his or her experiences.**
   - The person has opportunities to experience alternatives before making choices.

- The person makes life-defining choices related to home, work and relationships.
- Opportunities for decision-making are part of the person's everyday routine.

6. **Planning is collaborative, recurring, and involves an ongoing commitment to the person.**
   - Planning activities occur periodically and routinely. Lifestyle decisions are revisited.
   - A group of people who know, value, and are committed to serving the person remain involved.

7. **The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints**.
   - Funding of supports and services is responsible to personal needs and desires, not the reverse.
   - When funding constraints require supports to be prioritized or limited, the person or advocates make the decisions.
   - The person has appropriate control over available economic resources.

8. **The person is satisfied with his or her activities, supports, and services.**
   - The person expresses satisfaction with his or her relationships, home, and daily routines.
   - Areas of dissatisfaction result in tangible changes in the person's life situation.

9. **Person is viewed as a unique and valued individual, not only as a client or a consumer of services.**

   - Person-first language is used
     - Refrain from terms like:
       - Non-verbal
       - Low functioning
       - He's a runner, scratcher
       - Non-compliant
       - The "collective we": How are we doing today?
   - Preferred name and gender preferences used
   - Staff understands the background, history of the person
   - Staff are sincere and genuine in interactions with the person.
   - Interactions adhere to the person's preferences and desires such as respecting someone's belongings, personal space wheelchair, privacy, etc..
   - The person's contribution was valued as shown by listening without interrupting, and giving time to respond to a comment or a question.
   - Discussions and documentation are in plain language
   - Motivational Interviewing was used by the staff to obtain a deeper understanding and knowledge of the person and the person's goals, desires, wishes, and dreams

10. **Planning meetings are a celebration of the consumer**
    - Discussions were positive, future oriented
    - Consumer was encouraged to participate and control the process
    - Consideration was given for consumer's culture, trauma history, desires, dreams, aspirations
    - Strengths are highlighted - the focus of meetings were on the consumer's interests, and talents while also considering how to actively use these strengths
    - The focus of meetings were on the consumer's interests, and talents while also considering how to actively use these strengths

- The person was involved in making decisions regarding the meeting, including:
    - Who would attend or not attend
    - Location, date, time of meeting
    - Who would lead, facilitate and/or take notes
    - What was to be discussed and what was not to be discussed
- Staff allowed consumer time to think and to respond
- Multiple sources were used to obtain information to obtain a fuller picture of the consumer
- Choices were offered to the individual regarding the services and supports the individual receives and from whom.

11. The Person-Centered Planning process and subsequent documentation belong to the person

- Plans, schedules, and routines are flexible to the direction of the person
- An environment of choice prevails throughout the process
    - Strength-focused
    - Maximum self-sufficiency and independence is promoted
    - Real opportunities are created
    - Respectfulness prevails
- The approach used was supportive of the person rather than directed by the staff
    - Consumer was provided the necessary information and support to ensure the individual directs the process to the maximum extent possible

12. Strategies were included for solving disagreement within the process, including clear conflict of interest guidelines for all planning participants.

EXHIBIT C

IPOS Workflow and Activities

Pre-planning (60 days prior to IPOS expiration)

1. Case Holder (CH) reviews of information from previous year
    a. Chart Review: Periodic Reviews, Progress Notes, Medication Reviews, Incident Reports
    b. Personal notes or information not in chart
2. CH and consumer and (others) complete tools to help develop consumer goals
3. CH and consumer and (others):
    a. Complete the Choice Document with the consumer
    b. Determine need or want for Enhanced Health Services (EHS)
        i. Submit authorization for EHS
    c. Determine need or want for Community Living Supports
4. CH meets with consumer to complete the Pre-Plan form
5. Planning meeting set up (send invites, arrange location, etc.) is completed by parties designated in Pre-Plan
6. CH completes Assessment in Sentri prior to Planning Meeting
7. CH enters proposed IPOS goals in Sentri prior to Planning Meeting

Planning Meeting

8. At the Planning Meeting, the team
    a. Reviews the current strengths of the consumer from the various community and SCCMHA provide supports, services and/or programs
    b. Adds, Reviews and/or revises (if needed) the proposed goals
    c. 15 day copy "clock" starts from date of planning meeting

Post Planning Meeting

9. CH completes the Planning meeting fields in Sentri (may be done after the planning meeting based on notes)
10. CH Simultaneously submits IPOS for
    a. Supervisor Review, revision (if required) and approval
    b. Submit Authorizations in Sentri, revision (if required) and approval
11. CH signs IPOS after Supervisor and authorization approvals
12. CH sends completed IPOS copy to guardian (if applicable) or consumer for signature
    a. CH documents date sent in Sentri on IPOS form
    b. CH documents consumer/guardian signature date on IPOS form
    c. CH assures that the signed Signature Page scanned
13. CH Review IPOS with programs and services
    a. CH documents any in-service(s) on Sentri on PCP Header

14. CH monitors plan
    a. Assures that programs and services are being provided per the IPOS
    b. Monitors progress towards goal achievement as indicated in the IPOS
    c. Reviews goals per agreed time frames indicated on the IPOS

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:
Self Determination</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.04</td></tr>
<tr><td rowspan="2">Effective Date:
June 1, 2002</td><td>Date of Review/Revision:
5/21/02, 10/10/02 6/12/07, 5/11/09, 6/17/10, 11/4/11, 5/16/13, 1/29/14, 5/22/14, 5/5/16, 3/24/17, 3/1/18, 2/21/19, 3/4/21, 3/31,22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Charlotte Fondren

Additional Reviewers:
Self-Determination Committee, Self-Determination staff and supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY</td></tr>
</table>

Purpose:

The purpose of this policy is to establish the expectation that all individuals receiving mental health services are encouraged to live a self-directed life. Self -determination (SD) provides a route for individuals to engage in activities that accompany a meaningful life, promoting deep community connections, the opportunity for real work, ways to contribute to one's community, and to participate in personally-valued experiences.

Application:

This policy applies to both the SCCMHA board operated programs and the provider network.

Policy:

It shall be the policy of Saginaw County Community Mental Health Authority (SCCMHA) to assist individuals with disabilities to live a self-directed life. SCCMHA shall make available methods and tools that provide opportunities for the individual to control and direct their services and support plans. This process should be directed by the individual and aimed at defining and securing the needed supports that are necessary for them to obtain their needs, wishes and dreams. This includes the availability of financial management services (FMS) for those individuals who choose to self-direct their own budgets. Every person receiving mental health services should be asked about their level of interest in self-directing their services at their pre-planning meeting and any time thereafter. Self-direction with an adult (18 years of age and up) is through a Self-Determination Arrangement and self-direction with a child (under 18 years of age) is through a Choice Voucher Arrangement

Standards:

- Participation in self-determination shall be a voluntary option on the part of the individual.

- Individuals with a disability who receive services from SCCMHA or the provider network have a right to live a self-determined life. SCCMHA is committed to making available a variety of tools to help individuals to live the life of their choosing, utilizing the person-centered planning process.

- Individuals who are eligible for Community Mental Health (CMH) services and desire alternative but eligible services or providers (that are not part of the community mental health provider panel), may access these services through the use of an FMS using the purchase of service model.
    - This involves:
        - The preparation of an individual budget
        - Identification of appropriate natural and formal support services approved by the community mental health agency
        - And an agreement with a financial management service provider (FMS) to assist with the hiring of supports, record keeping, and bill paying.
    - For example, an individual receiving SCCMHA services wishes to hire a private therapist or an independent case manager/supports coordinator from outside of the existing provider network. This would have to be approved by the budget committee to ensure services provided meet all of the requirements determined in the Medicaid Provider Manual. An independent case manager/supports coordinator would have to have all of the credentials needed to provide services, i.e. licensure if required, be of good standing with the law, at least 18 years of age, etc. (More can be found in a document called "Michigan Provider Qualifications Per Medicaid and HCPC/CPT code."

- The FMS will receive and account for funds provided by the community mental health agency, or otherwise provided on behalf of the individuals. They will maintain complete and current financial records and supporting documentation verifying expenditures in accordance with generally accepted accounting principles, and as mandated by Medicaid. The FMS will also be responsible for assisting the individual with items such as, but not limited to, payment of bills, the hiring or contracting and payment of support staff and, with the applications and record keeping that are necessary to serve as an employer in the State of Michigan and the United States.

The individual may choose to contract with an agency that provides staff (Purchase of Service Model) or they may directly hire an individual (Direct Employment Model). When signing an employment agreement with a direct hire or agency, the individual will be the employer of record for support staff hired to provide services. The employer of record will identify the required qualifications of the support staff and the service providers who will

assist the individual. The FMS will assist the individual with the application and record keeping that is necessary to serve as an employer. The FMS will also assist with assuring that the staff are paid, and do not work hours beyond what is authorized.

- The individual, along with their designated support staff, will assure that each provider of services and supports meets provider requirements identified by SCCMHA, and agrees to secure or have secured appropriate background checks on any potential providers.

- Service providers must meet basic qualifications including but not limited to:
  - At least 18 years of age
  - Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports.
  - Able to communicate expressively and receptively in order to follow individual plan of service (IPOS) requirements and individual beneficiary specific emergency procedures, and report on activities performed
  - In good standing with the law (i.e. not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien). Refer to section 1 of Legal Guide-Exclusions under 42 U.S. Code 1320a-7
  - Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the Prepaid Inpatient Health Plan (PIHP) to demonstrate competence in basic first aid procedures.
  - Be trained in recipient rights.
  - Has received training in the beneficiary's IPOS.
  - Willing to complete additional trainings as identified by the employer of record, specific to unique needs of the employer.
  - The type of service being offered may determine other provider qualifications.

- The individual may also choose to make an agreement with an agency that is in-network with the CMHSP. (Agency Supported Self-Direction Model) In this model of self-direction, an FMS is not utilized. The individual serves as a 'managing employer', but does not have full employer authority. The 'Agency' serves as employer of record and it responsible for the administrative aspects of employment as determined by the individual (i.e. determining pay rate, benefits, paying payroll, taxes, worker's comp, etc.). Workers in this model are employees of the Agency but are managed by the individual and are referred to as 'workers', in relation to the individual.

- The SD team participates in the development of the initiative, providing ongoing input and oversight of activities. This team consists of a variety of individuals from the community who are advocates of self-determination and may include:
  - Primary consumers
  - Secondary consumers (including family members)

- SCCMHA finance staff
- SCCMHA self-determination coordinators
- SCCMHA Director of Clinical Services
- SCCMHA Director of Care Management and Quality Systems
- SCCMHA CEO as ex-officio.

♦ Each individual's budget will be based upon their goals and dreams. During the person-centered planning process, an individualized budget will be developed for the upcoming year, utilizing a zero-based budget approach. The budget will include all-natural support contributions, as well as, community resources such as an application for Home Help or Expanded Home Help Services through the Michigan Department of Health and Human Services (MDHHS).

♦ The Budget Review Committee will be made up of community partner(s) and agency staff relevant to the decision.,

♦ A Budget Review Committee will review and make recommendations regarding individual budgets, as submitted by the self-determination coordinator. If further clarification is needed the Budget Review Committee will give its recommendations in writing to the SD coordinator who will discuss with the employer of record within seven business days after the budget proposal, which occurs as needed.

♦ If an individualized budget is not approved by the Budget Review Committee, then the employer of record may directly appeal that decision through the SCCMHA appeals process.

♦ The Budget Review Committee will annually review all budgets to ensure that there is an appropriate use of public funds, that Medicaid dollars are being spent following the Self-Determination agreement, and in conjunction with what is identified in the IPOS.

♦ All the supports provided must meet the determination criteria identified in the Medicaid Services Administration, Medicaid Manual the section on Mental Health and Substance Abuse Services and the Department of Community Health Master Contract. All new SD arrangements for those served with an intellectual or developmental disability will require that a Support Intensity Scale (SIS) be completed. SIS scores will not indicate a pre-determined level of support but will help to inform the budget development process.

♦ It is the responsibility of the individual, guardian, representative payee, support coordinator/case manager, representative, self-determination coordinator, community mental health fiscal department, natural supports and the FMS, to assure that the public funds allocated for services are spent responsibly and according to the approved budget. The FMS and the individual/guardian are responsible for providing the documentation necessary for verification of the

funding received, as well as spending. In the case of durable medical equipment and environmental modifications, the SCCMHA process will be followed.

- Either party –SCCMHA or the individual – may terminate a self-determination agreement, and therefore the self-determination arrangement. Prior to terminating and unless it is not feasible, SCCMHA shall inform the individual of the issues that have led to considering termination and provide an opportunity for problem resolution. Typically, this shall be conducted using the person-centered planning process, and if necessary, the local process for dispute resolution may be utilized to address and resolve these issues. Termination of a self-determination agreement shall not, by itself, change the individual's plan of service, nor eliminate the obligation of SCCMHA to assure services and supports required in the plan.

Definitions:

Advocate: a person who supports and/or stands up for another person or a cause that they believe in.

Budget Review Committee: A committee established to review and make recommendations regarding individualized budgets. The committee reviews all budgets to assure that funding is utilized for covered services and that medical necessity/determination criteria is met.

Community Partner: An individual who chooses to assist with a specific cause. These individuals may be from local organizations, private organizations, or concerned citizens in general who wish to collaborate in an effort to assist SCCMHA with furthering the self-determination initiative.

CMHSP—Community Mental Health Service Provider – i.e. Saginaw County Community Mental Health Authority

Determination Criteria: The determination of a medically necessary support, service, or treatment must be: based on information provided by the beneficiary, their family and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and for beneficiaries with mental illness or intellectual/developmental disabilities, based on person centered planning, and for beneficiaries with substance disorders, individualized treatment planning; and made by appropriate trained mental health, intellectual/developmental disabilities, or substance abuse professionals with sufficient clinical experience; and made within federal and state standards for timeliness; and sufficient in amount, scope and duration of the service/s to reasonable achieve its/their purpose. This is documented in the IPOS.

Financial Management Service provider: FMS is an independent legal entity (organization or individual) that acts as a fiscal agent of the PIHP/CMHSP for the purpose of assuring fiduciary accountability for the funds comprising an individual budget. The FMS shall

perform its duties as specified in a contract with a PIHP/CMHSP or its designated sub-contractor. The purpose of the FMS is to receive funds making up an individual budget, and make payments as authorized by the individual to providers and other parties to whom an individual using the individual budget may be obligated. The FMS may also provide a variety of supportive services that assist the individual in selecting, employing and directing individual and agency providers. Examples of entities that might serve in the role of FMS include; bookkeeping or accounting firms and local Arc or other advocacy organizations.

Individual: For the purpose of this policy, "individual" means an individual receiving direct specialty mental health services and supports. The individual may select a representative to enter into the self-determination agreement and for other agreements that may be necessary for the individual to participate in arrangements that support self-determination. The individual may have a legal guardian. The role of the guardian in self-determination shall be consistent with the guardianship arrangement established by the court. Where an individual has been deemed to require a legal guardian, there is an extra obligation on the part of the PIHP/CMHSP and those close to the individual to assure that it is the individual's preferences and dreams that drive the use of self-determination arrangements, and that the best interests of the individual are primary.

Individual Budget: An individual budget is a fixed allocation of public mental health resources denoted in dollar terms. These resources are agreed upon as the necessary cost of specialty mental health services and supports needed to accomplish an individual's IPOS. The individual served uses the funding authorized to acquire, purchase, and pay for specialty mental health services and supports in his or her IPOS.

IPOS: Individual plan of service – the individual's plan of service and/or supports, as developed using the person-centered planning process.

PIHP: Prepaid Inpatient Health Plan - is a managed care entity that provides Medicaid-funded mental health specialty services and supports in an area of the state.

Primary consumer: An individual who has received or is receiving services from the department or a community mental health services program or services from the private sector equivalent to those offered by the department or a community mental health services program (Definition from the Michigan Mental Health Code).

Qualified Provider: A qualified provider is an individual worker, a specialty practitioner, professional, agency or vendor that is a provider of specialty mental health services or supports that can demonstrate compliance with the requirements contained in the contract between the Michigan Department of Health and Human Services and the PIHP/CMHSP, including applicable requirements that accompany specific funding sources, such as Medicaid. Where additional requirements are to apply, they should be derived directly from the person-centered planning process and should be specified in the IPOS or result from a process developed locally to assure the health and well-being of individuals, conducted with the full input and involvement of local individuals and advocates.

Choice Voucher Arrangements: Choice Voucher is the name for self-directed services for people under the age of 18. This is because children cannot independently direct their services until adulthood.

Self-Direction: Self-direction is a method for moving away from professionally managed models of supports and services. It is the act of selecting, directing, and managing one's service and supports. People who self-direct their services are able to decide how to spend their CMH services budget with support, as desired.

Self-Determination: Self-determination (SD) is the right of all people to have the power to make decisions for themselves; to have free will. The goals of SD, on an individual basis, are to promote full inclusion in community life, to have self-worth and increase belonging while reducing the isolation and segregation of people who receive services. Self-determination builds upon choice, autonomy, competence, and relatedness which are building blocks of psychological wellbeing. Within Michigan's public mental health system, self-determination involves accomplishing system change to assure that services and supports for individuals are not only person-centered, but person-defined and person-controlled. Self-determination is based on five principles. These principles are:

FREEDOM: The ability for individuals, with assistance from significant others (e.g., chosen family and/or friends), to plan a life based on acquiring necessary supports in desirable ways, rather than purchasing a program. This includes the freedom to choose where and with whom on lives, who and how to connect to one's community, the opportunity to contribute in one's own ways, and the development of a personal lifestyle.

AUTHORITY: The assurance for a person with a disability to control a certain sum of dollars in order to purchase these supports, with the backing of their significant others, as needed. It is the authority to control resources.

SUPPORT: The arranging of resources and personnel, both formal and informal, to assist the person in living his/her desired life in the community, rich in community associations and contributions. It is the support to develop a life dream and reach toward that dream.

RESPONSIBILITY: The acceptance of a valued role by the person in the community through employment, affiliations, spiritual development, and caring for others, as well as accountability for spending public dollars in ways that are life enhancing. This includes the responsibility to use public funds efficiently and to contribute to the community through the expression of responsible citizenship.

CONFIRMATION: The important leadership role that individuals with disabilities and their families must play in a newly re-designed system and support for the self-advocacy movement.

Self-Determined Life: A life chosen and lead by the individual.

Secondary consumer: Generally, a family member or other blood relative of a primary consumer. Other relationships would be considered on a case by case basis.

Supports Intensity Scale (SIS): SIS measures the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. SIS was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals

Zero-Based Budgeting: A comprehensive budgeting process that systematically considers the priorities and alternatives for current and proposed activities in relation to organizational (or individual) goals and objectives. Annual justification of programs and activities is required in order to rethink priorities within the agreed upon objectives. Zero-based budgeting requires that one reevaluate all activities at the start of the budgeting process to make decisions about which ones to continue, eliminate, or fund at a different level.

References:

- Michigan Department of Health and Human Services Person-Centered Planning Policy
- Michigan Department of Health and Human Services and Substance Abuse: Interpretive and Consultative Advisory Person-Centered Planning and the Role of Health and/or Safety Considerations.
- Michigan Department of Health and Human Services
  Behavioral Health and Disabilities Administration Self-Determination Practice and Fiscal Intermediary Guideline July 29,2020
- Consumer Choice and Service Management Policy
- Michigan workforce background check program-Legal Guide Section 1- 42U.S. Code 1320a-7 May 2007.
- Michigan Department of Health and Human Services Self-Direction Technical Requirement Implementation Guide Version 2.0 October 2020
- Michigan Department of Health and Human Services Medicaid Provider Manual. January 1, 2021

Exhibits:

Exhibit A: Workflow for Self Determination
Exhibit B: Workflow for Self Determination Narrative
Exhibit C: Characteristics of a Self Determination Coordinator
Exhibit D: Self- Determination Time Sheet

Procedure:

ACTION	RESPONSBILITY
Assigned Administrator responsible for oversight of Self-Determination initiative.	CEO

Convenes a self-determination team. Approves the self-determination policy based on the recommendations of the Self-Determination Team.	
Provides leadership for the development of the initiative. Assigns the responsibilities of the self-determination coordinator.	Director of Clinical Services
Serves as assigned administrator for self-determination and actively participates on the Self-Determination Budget Review Committee. Assigns a care management staff to the Budget Review Committee for self - determination to review and make recommendations on proposed self - determination budgets. The individual or guardian is given information on the SCCMHA appeals process.	Director of Care Management and Quality Systems
Participates in the development of the self-determination initiative. Provides ongoing input and oversight of self-determination activities. Reviews the self-determination policy on a regular basis and makes changes, as needed. Meets at least quarterly.	Self-determination team (Consumers, secondary consumers, community partners, advocates, self-determination coordinator, SCCMHA administrative staff, and fiscal staff)
Co-leads the self-determination team. Coordinates and provides staff training for case holders as well as network providers. Attends person-centered planning meetings, as invited, for persons expressing an interest in self-direction to manage their own budget. Tracks the number of individuals that are managing their own budgets. Monitors individual/family satisfaction. Assures adherence to the Consumer Choice and Services Management Policy. Maintains a central record of self-determination services. Has the authority to approve any budget revisions that do not exceed $500.00 without approval of the budget committee.	Self-Determination Coordinator
Expresses a desire to live a self-determined life by participating in self-direction. Accepts the responsibility to live life as independently as	Individual

possible. Agrees to participate in the person-centered planning process. Develops a budget as part of their IPOS based on identified needs, wants, hopes, and dreams. Agrees to explore natural supports and other community resources as part of the planning process. Agrees to participate in the SIS assessment. Agrees to use resources wisely and to contribute back to the community in a meaningful way. Agrees to live within the agreed upon budget.	
Reviews and makes recommendations for all self-determination budgets via email/Sentri II or meeting face-to-face as needed. Provide ongoing input when approached regarding a new self- determination budget or a revision to an existing budget.	Budget Review Committee

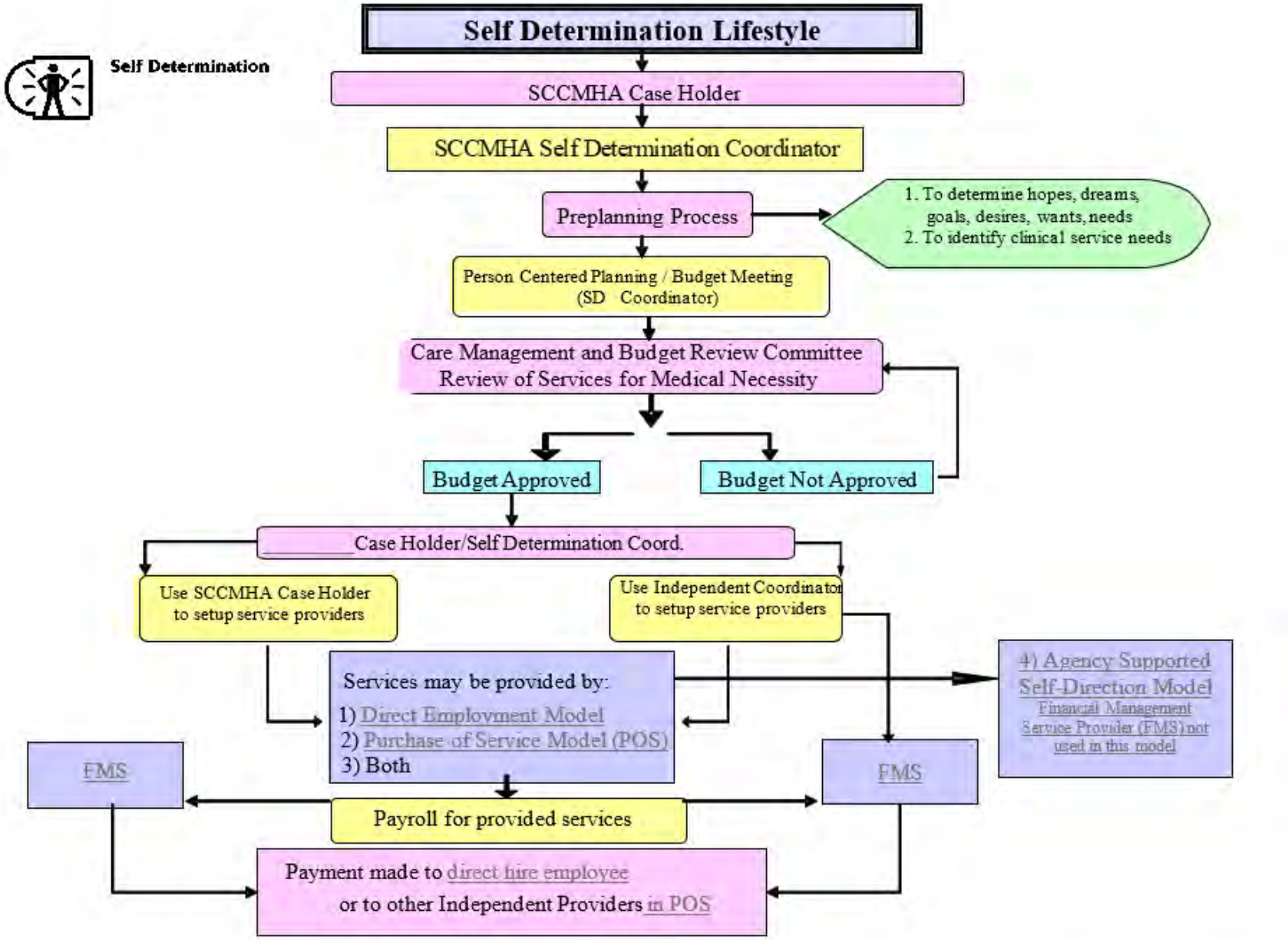
Self Determination
Self Determination Lifestyle
SCCMHA Case Holder
SCCMHA Self Determination Coordinator
Preplanning Process
1. To determine hopes, dreams, goals, desires, wants, needs
2. To identify clinical service needs
Person Centered Planning / Budget Meeting (SD Coordinator)
Care Management and Budget Review Committee Review of Services for Medical Necessity
Budget Approved
Budget Not Approved
Case Holder/Self Determination Coord.
Use SCCMHA Case Holder to setup service providers
Use Independent Coordinator to setup service providers
Services may be provided by:
1) Direct Employment Model
2) Purchase of Service Model (POS)
3) Both
4) Agency Supported Self-Direction Model
Financial Management Service Provider (FMS) not used in this model
FMS
FMS
Payroll for provided services
Payment made to direct hire employee
or to other Independent Providers in POS
Document created: 12/3/02

Exhibit B

Workflow for Self Determination

- Individual desires information pertaining to self- determination.
- SD coordinator is contacted by case holder, guardian, individual, or any interested party.
- SD coordinator sets up an initial meeting to explain the basics of self-determination; what it is, what is involved, what is a financial management service provider (FMS), etc.
- If individual (or guardian) wishes to have self -determination as their lifestyle, the Case holder needs to reflect this in the IPOS, with very specific information pertaining to hiring staff, housing preferences, employment choices, etc.
- SD coordinator sets up a budget meeting with all interested parties who support the individual in their quest toward independence. Attendees could include, but are not limited too; individual/guardian, caregivers, friends, any and all family, church friends, physicians, social workers, FMS, etc.
- Once a budget has been determined, the SD coordinator must have the budget approved by the SD budget committee, which includes but not limited to care management specialist for the individual case being reviewed and care management supervisor. This committee assures that the services requested meet medical necessity criteria.
- Once the SD budget is approved, then the SD coordinator contacts the contracts department for development of the SD agreement for appropriate signatures. If the budget is not approved, then the SD coordinator goes back to the individual and their support team for revisions or appeal.
- SD coordinator schedules a "kick off meeting" for all of the paperwork to be completed and discuss all the roles and responsibilities of the employer and their employees in an SD arrangement. (SD contract, financial papers for the FMS, 42CFR agreement for each staff providing services, self- determination training guide is presented to the individual/guardian, background check information is discussed, etc.)
- The individual chooses to receive case management/support coordination services (case holder) through an SCCMHA employee/contract provider of SCCMHA or forms a contract with an independent case holder. The provider must have a minimum of a BSW and be approved by SCCMHA as qualified and credentialed.
- Case holder authorizes services under the financial management service provider.
- Care management approves the authorization, which will be reflective in the Sentri II system. If it is not approved, then the case holder may be asked to provide additional information.
- The FMS dispenses the dollars as outlined in the individualized budget and sends monthly reports to the SD coordinator and to the individual/guardian. It is the responsibility of the individual/guardian to review these statements each month for accuracy. The SD coordinator will also review on a monthly basis.

Exhibit C

Characteristics for a Self -Determination Coordinator

- Solid knowledge base of housing available in Saginaw County, (homes, apartments, condominiums, availability, interest rates, etc.)
- Partnership and collaboration with community leaders to develop natural supports, i.e. local churches, schools, etc.)
- Job development skills
- Skilled in contract development
- Financial experience for budget development and service allocation
- Solid knowledge base of Medicaid Chapter III
- Partnership and collaboration with Occupational Therapists, Speech Therapist, Recreational Therapists, Psychologists, Registered Dieticians, Family Physicians, Psychiatrists, etc. to offer choice to individuals choosing self determination
- Clinical background to assist individuals with all disabilities and their families on their path towards independence
- Conference Planning and in-service (training) development
- Participates in the development / maintenance of program policies and procedures related to service delivery
- Participates in Continuous Quality Improvement
- Establishes program goals, priorities, objectives to encourage consistency of service outcomes to all adult, SCCMHA individuals
- Advocates for all individuals with disabilities and appropriate organizations (i.e. Department of Health and Human Services, ARC, Disability Network of Mid-Michigan, etc.), other health care agencies (i.e. primary physician, etc.), natural support systems (i.e. family members, community organizations, etc.).
- Strong leadership, organizational, and administration skills

Exhibit D

Self-Determination Time Sheet

Consumer Name:

Provider/Staff Name: **Month & Year:**

Day:							
Date:							
Service Code:							
Time in :							
Time out :							
Time in :							
Time out :							
Personal Care (Guide and Direct only)							
Meal Preparation							
Laundry							
Routine, Seasonal & Heavy Household care and maintenance							
Eating							
Bathing							
Dressing							
Personal Hygiene							
Medication Administration/Monitoring							
Shopping for food and other necessities of daily living							
Community Living Supports							
Money Management							
Non Medical Care (not requiring a nurse or physician intervention)							
Socialization and Relationship building/Supervision							
Transportation (excludes to and from medical appointments)							
Participation in regular community activities and recreation opportunities							
Attendance at medical appointments							
Acquiring or procuring goods, other than those listed under shopping and non medical services							
Total Hours:							
Progress Note Completed (Staff Initial box daily)							
SD Staff Signature							
Consumer/Guardian/Representative							

Service Code

H2015 U7 Community Living Support 15 min

H2015 U7UN: Shared (2 consumers) CLS 15 min

T1005 U7 Respite 15 minute

H0045 U7 Respite Overnight Per Day

TR: Training (Online, In-Class, Other)

Note: Please be sure that the progress note you have written also matches this time sheet, including dates, times , codes. If they do not match you risk having future funds deducted from your check.

Revised 10-1-20

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Recovery</td><td>Chapter: 02 - Customer Services and Recipient Rights</td><td>Subject No: 02.03.05</td></tr>
<tr><td rowspan="2">Effective Date:
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Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Barbara Glassheim

Additional Reviewers:
None</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to inculcate an overarching philosophy of recovery, delineate a framework for the provision of strengths-based recovery and resilience focused services and supports, and to provide a structure for the provision of opportunities that support and foster consumer recovery.

Policy:
All services and supports for consumers and their families shall be provided within the context of a true collaborative partnership that instills hope and a belief that consumers can recover. SCCMHA shall assist each consumer in learning to effectively approach each day's challenges, acquire skills to live independently, and contribute to society in meaningful ways. This includes addressing all of the determinants of health (social and medical).

Application:
This policy applies to all SCCMHA-funded providers of mental health and substance use disorder prevention, treatment, and recovery services.

Standards:
A. SCCMHA shall adhere to the fundamental components of recovery set forth by the Substance Abuse and Mental Health Services Administration (SAMHSA) in December 2011, which are follows:
   1. Four major dimensions that support a life in recovery:
      a. **Health:** overcoming or managing one's disease(s) or symptoms – or example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem – and for

everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.

b. **Home:** a stable and safe place to live.

c. **Purpose:** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.

d. **Community:** relationships and social networks that provide support, friendship, love, and hope.

2. Ten Guiding Principles of Recovery:

a. **Recovery emerges from hope:** The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

b. **Recovery is person-driven:** Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

c. **Recovery occurs via many pathways:** Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds – including trauma experiences – that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

d. **Recovery is holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment,

education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.

e. **Recovery is supported by peers and allies:** Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

f. **Recovery is supported through relationship and social networks:** An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

g. **Recovery is culturally-based and influenced:** Culture and cultural background in all of its diverse representations – including values, traditions, and beliefs – are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, and competent, as well as personalized to meet each individual's unique needs.

h. **Recovery is supported by addressing trauma:** The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical

and emotional) and trust, as well as promote choice, empowerment, and collaboration.

i. **Recovery involves individual, family, and community strengths and responsibility:** Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

j. **Recovery is based on respect:** Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

3. SCCMHA shall include the following additional components of recovery when working with veterans:
   a. Privacy
   b. Security
   c. Honor
   d. Support for VA patient rights
4. SCCMHA shall adhere to the 16 Guiding Principles of a Recovery Oriented System of Care (ROSC) for persons with substance use disorders:
   a. Adequately and flexibly financed
   b. Inclusion of the voices and experiences of recovering individuals, youths, families, and community members
   c. Integrated strength-based services;
   d. Services that promote health and wellness will take place within the community
   e. Outcomes driven
   f. Family and significant others involvement
   g. System-wide education and training
   h. Individualized and comprehensive services across all ages
   i. Commitment to peer support and recovery support services
   j. Responsive to cultural factors and personal belief systems
   k. Partnership-consultant relationship
   l. Ongoing monitoring and outreach
   m. Research-based

n. Continuity of care
o. Strength-based
p. Promote community health and address environmental determinants to health

5. Service providers will work with consumers to help them develop recovery plans that:
   a. Enable each consumer to identify goals for achieving wellness
   b. Specify what each consumer can do to reach those goals
   c. Include daily activities as well as longer term goals
   d. Track any changes in a consumer's mental health problem
   e. Identify triggers or other stressful events that can make a consumer feel worse, and help the consumer learn how to manage them
   f. Foster consumer self-care
   g. Are family-driven and youth-guided

B. Support for recovery shall include ensuring that comorbid general health conditions are addressed in a whole-person manner.
   1. Providers shall offer self-management support to activate consumers to self-manage their care, collaborate with providers, and to maintain their health.
   2. Case Holders shall ensure coordination of care among all practitioners and programs serving consumers, including medical services to address comorbid general health conditions.
      a. Services, supports and coordination shall be provided within the context of an interdisciplinary team approach to care.
      b. Providers shall address the social determinants of health as well as ensure that the medical determinants of health are addressed.

C. Recovery support services shall include peer support as well as assistance with addressing the social determinants of health (see definition below).
   1. SCCMHA providers shall work to remove barriers and address health disparities.

Definitions:

Care Coordination: The Agency for Healthcare Research and Quality (2014) defines care coordination as *involving deliberately organizing [consumer] care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the [consumer's] needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the [consumer]*.

Health Coaching: The use of evidence-based skillful conversation, clinical interventions and strategies to actively and safely engage consumers in health behavior change. Health coaches focus on helping consumers who may have chronic conditions or those at moderate to high risk for chronic conditions take charge of their lives.

Michigan's ROSC Definition: Michigan's recovery oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities. (Adopted by the ROSC Transformation Steering Committee, 2010)

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA, 2011) According to the National Consensus Statement on Mental Health Recovery, "*Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."*

Recovery Coaching is a peer-based service that is provided by persons who are in recovery and, as a result, have gained knowledge on how to attain and sustain recovery. Also known as peer mentoring, recovery coaching entails the provision of strengths-based support to individuals with addictive disorders and those who are in recovery from alcohol, other drugs, codependency, or other addictive behaviors. It focuses on achieving goals that are of importance to the individual and is a type of partnership in which the person in or seeking recovery self-directs their own recovery while the coach provides expertise in supporting successful change.

Recovery Community: Persons having a history of alcohol and drug problems who are in or seeking recovery, including those currently in treatment; as well as family members, significant others, and other supporters and allies (SAMHSA, 2009).

Recovery Support Services (RSS): These are non-clinical services that assist individuals and families to recover from alcohol or drug problems and include social support, linkages to and coordination among service providers, and a full-range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. RSS may be provided in conjunction with treatment, or as separate and distinct services, to individuals and families who desire and need them. Professionals, faith-based and community-based groups, and other RSS providers are key components of ROSC (SAMHSA, 2009).

Resilience: An individual's ability to cope with change and adversity. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges but also to be better prepared for the next stressful situation. (SAMHSA 4/4/2022)

Social Determinants of Health (SDOH): Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. (CDC). Social determinants of health as the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. They state social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. (WHO)

Five key areas are identified in Healthy People 2030:

1. Healthcare Access and Quality: The connection between people's access to and understanding of health services and their own health. This domain includes key issues such as access to healthcare, access to primary care, health insurance coverage, and health literacy.
2. Education Access and Quality: The connection of education to health and well-being. This domain includes key issues such as graduating from high school, enrollment in higher education, educational attainment in general, language and literacy, and early childhood education and development.

3. Social and Community Context: The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and wellbeing. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, and incarceration.
4. Economic Stability: The connection between the financial resources people have – income, cost of living, and socioeconomic status – and their health. This area includes key issues such as poverty, employment, food security, and housing stability.
5. Neighborhood and Built Environment: The connection between where a person lives – housing, neighborhood, and environment – and their health and wellbeing. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and neighborhood crime and violence.

Whole-Person/Integrated Care: A comprehensive and coordinated person-centered system of care that allows healthcare professionals (i.e., behavioral health, primary care, and specialty providers) to simultaneously consider all of a consumer's health conditions, resulting in the systematic coordination of physical and behavioral healthcare. Such integrated healthcare services that are delivered in a whole-person approach produce beneficial outcomes for people with multiple and complex healthcare conditions.

References:

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B. Center for Substance Abuse Treatment. (2010). *Recovery-Oriented Systems of Care (ROSC) Resource Guide.* SAMHSA. Rockville, MD. [On-line]. Available: http://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf.

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D. Copeland, M. (Undated). *Recovering Your Mental Health—A Self-Help Guide.* United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Rockville, Md. [On-line]. Available: http://store.samhsa.gov/shin/content//SMA-3504/SMA-3504.pdf.

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G. Michigan DCHODCP Treatment Technical Advisory No. 07: *Peer Recovery/Recovery Support Services.* [On-line]. Available: http://www.michigan.gov/documents/mdch/TA-T-07_Peer_Recovery-Recovery_Support_230852_7.pdf.
H. Office of Disease Prevention and Health Promotion. *Healthy People 2030*: https://health.gov/healthypeople
I. SAMHSA's Recovery and Recovery Support Initiative: https://www.samhsa.gov/find-help/recovery
J. SCCMHA Policy 02.03.08 – Welcoming
K. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
L. SCCMHA Policy 02.03.09.10 – Substance Use Disorder Services
M. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
N. SCCMHA Policy 02.03.19 – Peer Support Services
O. SCCMHA Policy 02.03.25 – Wellness
P. SCCMHA Policy 03.02.01 – Health Care Integration
Q. SCCMHA Policy 03.02.31 – Services for Members of the Armed Forces Veterans & their Families
R. SCCMHA Policy 03.02.46 – Whole-Person Care
S. United States Public Health Service Office of the Surgeon General. (1999). *Mental Health: A report of the Surgeon General.* Department of Health and Human Services, E.S. Public Health Service. Rockville, MD. [On-Line]. Available: http://www.surgeongeneral.gov/library/mentalhealth/home.html.
T. Veteran's Health Administration. (September 11, 2008, Amended November 16, 2015). *Uniform Mental Health Services in VA Medical Centers and Clinics*. [On-line]. Available: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762.

Exhibits:

A. SAMHSA's Four Dimensions of the Recovery Process
B. SAMHSA's 10 Guiding Principles of Recovery
C. Recovery Oriented System of Care (ROSC)

Exhibit A

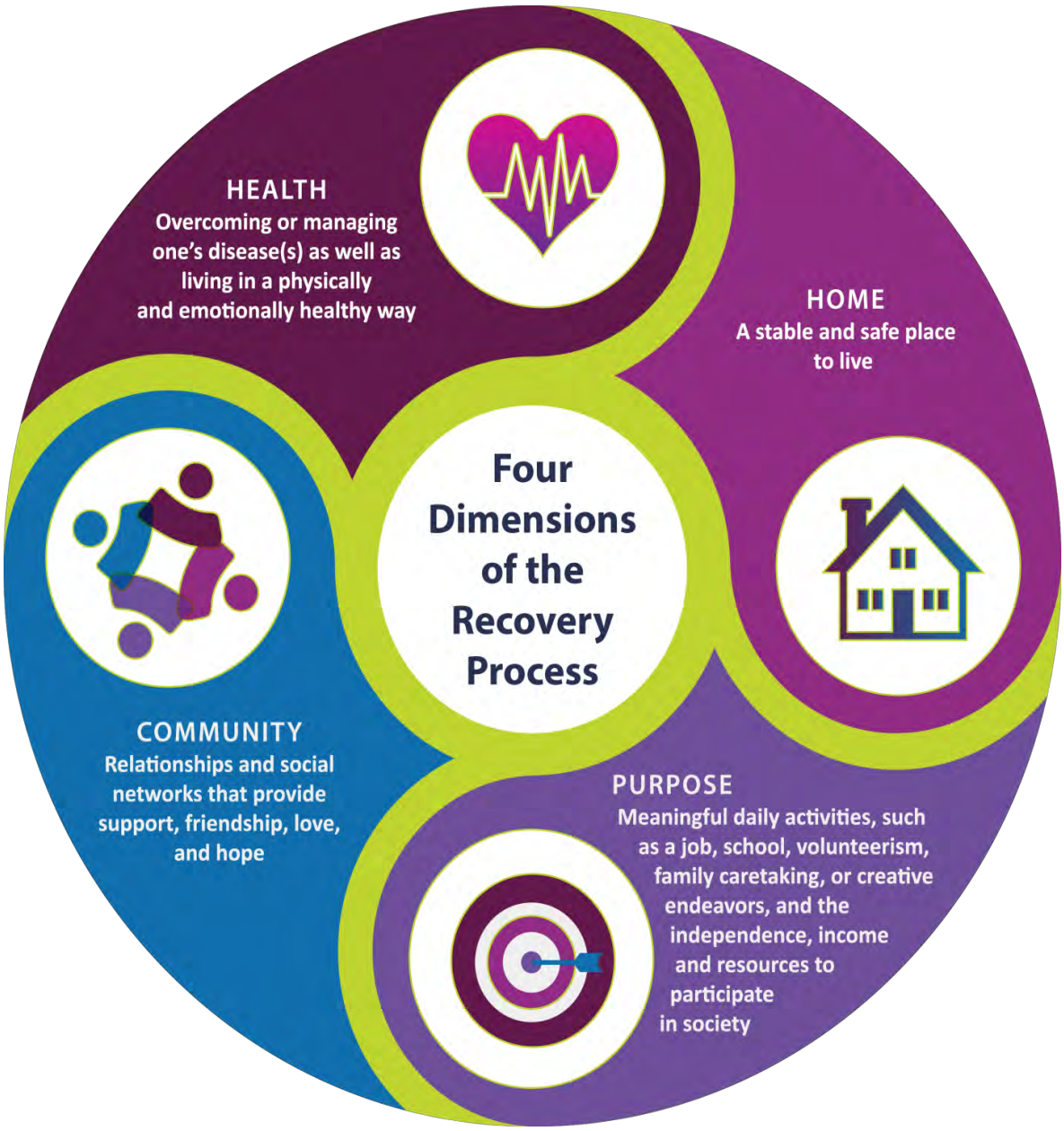

HEALTH
Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
HOME
A stable and safe place to live
Four Dimensions of the Recovery Process
COMMUNITY
Relationships and social networks that provide support, friendship, love, and hope
PURPOSE
Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society

Exhibit B

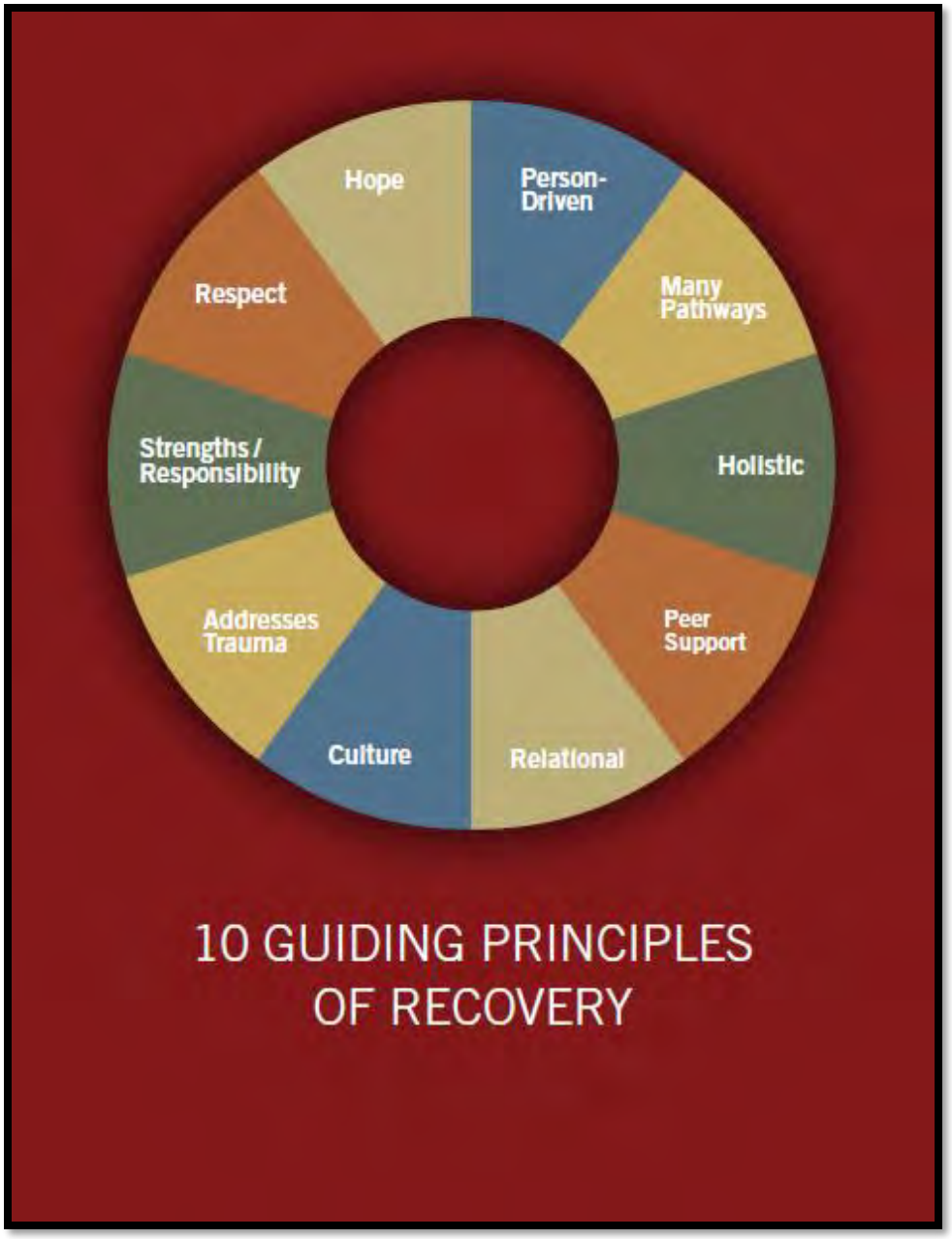
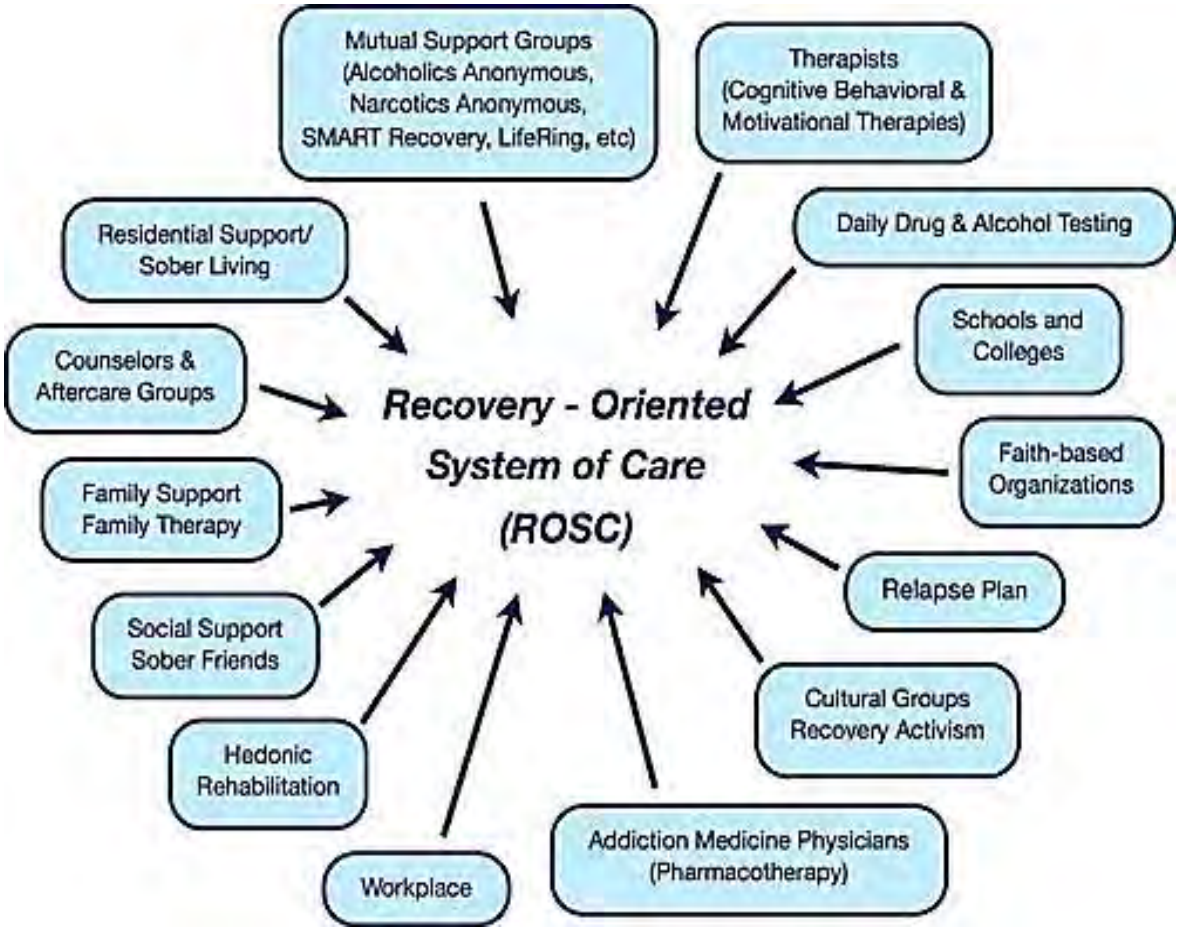

Hope
Person-Driven
Respect
Many Pathways
Strengths / Responsibility
Holistic
Addresses Trauma
Peer Support
Culture
Relational
10 GUIDING PRINCIPLES OF RECOVERY

Exhibit C


Mutual Support Groups (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, LifeRing, etc)
Therapists (Cognitive Behavioral & Motivational Therapies)
Residential Support/ Sober Living
Daily Drug & Alcohol Testing
Schools and Colleges
Counselors & Aftercare Groups
Recovery - Oriented System of Care (ROSC)
Faith-based Organizations
Family Support Family Therapy
Relapse Plan
Social Support Sober Friends
Cultural Groups Recovery Activism
Hedonic Rehabilitation
Addiction Medicine Physicians (Pharmacotherapy)
Workplace

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Employment of Consumers</td><td>Chapter: 02 - Customer Services and Recipient Rights</td><td>Subject No: 02.03.07</td></tr>
<tr><td rowspan="2">Effective Date:
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Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Rollin Archangeli

Additional Reviewers:
Rollin Archangeli, John Burages</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:

1. To ensure that persons served by the SCCMHA network have opportunities, supports and services which promote sustained, competitive, community employment whenever a consumer's capabilities make community employment feasible at any level.
2. To assist SCCMHA to become a leader among Community Mental Health Service Program (CMHSP) in Michigan in the area of consumer employment.

Application:

This policy applies to all components of the SCCMHA organization, including all business operations and all members of the SCCMHA provider network, contracted or board operated. SCCMHA will work with the Michigan Rehabilitation Services (MDHHS-VR; Labor and Economic Opportunity - Michigan Rehabilitation Services) in efforts to improve the employment opportunities for persons served as funds allow and local needs indicate. SCCMHA is required to report on the employment of consumers to the Michigan Department of Health and Human Services (MDHHS).

Policy:

It is the policy of SCCMHA that systematic efforts will be made to advance the employment of individuals served in competitive, community settings. SCCMHA will engage in evidence-based best practices that promote community-based, real competitive employment for consumers. It is the belief of SCCMHA that the opportunity for meaningful community activity or engagement is a basic right of all individuals and an essential part of the recovery process. It is further the belief of SCCMHA that the employment of consumers or persons with disabilities will assist to fulfill the dreams and desires of many individuals as well as assist consumers to be fully involved and integrated in their communities. Promotion of consumer employment will also assist the SCCMHA

organization and network to improve services and supports. To be credible and most effective, SCCMHA will include meaningful, paid involvement of individuals in the development, delivery and evaluation of services and supports provided by the SCCMHA system. Employment services and supports of the SCCMHA network will recognize the individual needs, goals and functioning of each person.

Standards:

A. SCCMHA will ensure that staff and contractors are informed and reminded of the importance of the systemic goal regarding the employment of consumers.
B. SCCMHA will continually seek to ensure that employment needs, wants and goals of consumers served are fully explored and re-evaluated over time throughout the Person-Centered Planning process.
C. SCCMHA will focus on the alleviation of both internal and external barriers that impact the sustained and successful employment experiences of consumers.
D. SCCMHA will appoint a service level coordinator of consumer employment opportunities.
E. SCCMHA will continually monitor, redirect and procure new funds as available to assist consumers in employment readiness development.
F. SCCMHA funding and service priorities and philosophy will emphasize competitive employment options for consumers whenever feasible.
G. SCCMHA will require provider and organizational reporting on the employment of persons with disabilities throughout the system.
H. SCCMHA will serve as an example to the network through the direct employment of persons with mental illness and intellectual and developmental disabilities, as well as substance use disorders.
I. Consumers employed by SCCMHA or SCCMHA provider network members of SCCMHA system will be subject to all normal human resource administration requirements and expectations, including routine job descriptions, benefits, and performance evaluations.
J. Consumer specific positions may be developed for certain functions, such as customer service, to ensure consumer leadership and input for SCCMHA operations in beneficiary areas.
K. SCCMHA will promote employment of consumers through a variety of methods and means, including direct and contract employees or contractors, full or part-time positions, as well as promotion of consumer employment within the SCCMHA service area and greater business community.
L. SCCMHA will reimburse primary consumers for their involvement on SCCMHA administrative committees and boards. Consumer assistance with transportation to support their involvement in these policy venues will also be made available as needed or requested.
M. SCCMHA will ensure that follow-along services relative to employment maintenance are provided by case management/supports coordination or job coach/specialists or other means to assist in job retention and satisfaction.
N. SCCMHA will sponsor an ongoing employment work group, whose members will consist of both consumers, community members and employers, as well as staff; the role of the employment work group will be continuous oversight of SCCMHA

administrative and service level employment goals, activities, and outcomes, as well as employment initiative development and barrier identification and problem-solving.

O. SCCMHA recognizes that for some persons, employment success may not be feasible in the competitive market. In addition to SCCMHA provided supported employment supports, other options or other community or vocational alternatives in these situations will be pursued according to individual person-centered plans.
P. SCCMHA recognizes that for all persons, employment success may often include trial and error, and must often allow for the individual's right to try and fail, and to learn from these efforts.
Q. SCCMHA will coordinate effective use of resources and cooperatively address consumer needs with the consumers' team.
R. SCCMHA will continue to maintain an organizational goal of increasing the number of individuals with disabilities who are competitively employed; particularly those persons served by the SCCMHA network,.
S. SCCMHA will support, whenever possible, the promotion of consumer-run businesses and micro-enterprises.
T. Vocational supports for individuals will be coordinated with educational and other community resources whenever appropriate.
U. SCCMHA will develop and operate an array of employment services based on the evidence-based practice model for IPS (Individual Placement & Support) employment. Fidelity to the model will be monitored and maintained.
V. SCCMHA will disseminate information on employment opportunities that might benefit consumers, including network peer roles.

Definitions:

Competitive Employment: Employment occurring as a single, individual job placement (excludes group and enclave settings at deviated wages) in a community-based setting with compensation at or above minimum wage. In addition, this would be employment that is available to all eligible citizens, regardless of ability.

Supportive/Integrated Employment Services: The provision of initial and ongoing support services to assist persons to obtain and maintain paid employment. Examples of these services are job development, job placement, job coaching, and long-term follow-along services required to maintain employment.

Skill Building Assistance: Activities that assist an individual to achieve economic self-sufficiency and/or to engage in meaningful activities such as school, work and/or volunteering. The services provide knowledge and specialized skill development and/or support.

References:

Internal:	SCCMHA Person-Centered Planning Policy
	SCCMHA Supported Employment Services Policy 02.03.09.03
External:	SAMHSA's Implementation Resource Kit
	Federal Rehabilitation Act of 1973

Exhibits:

Exhibit A – SCCMHA Supported Employment Service Flow Chart

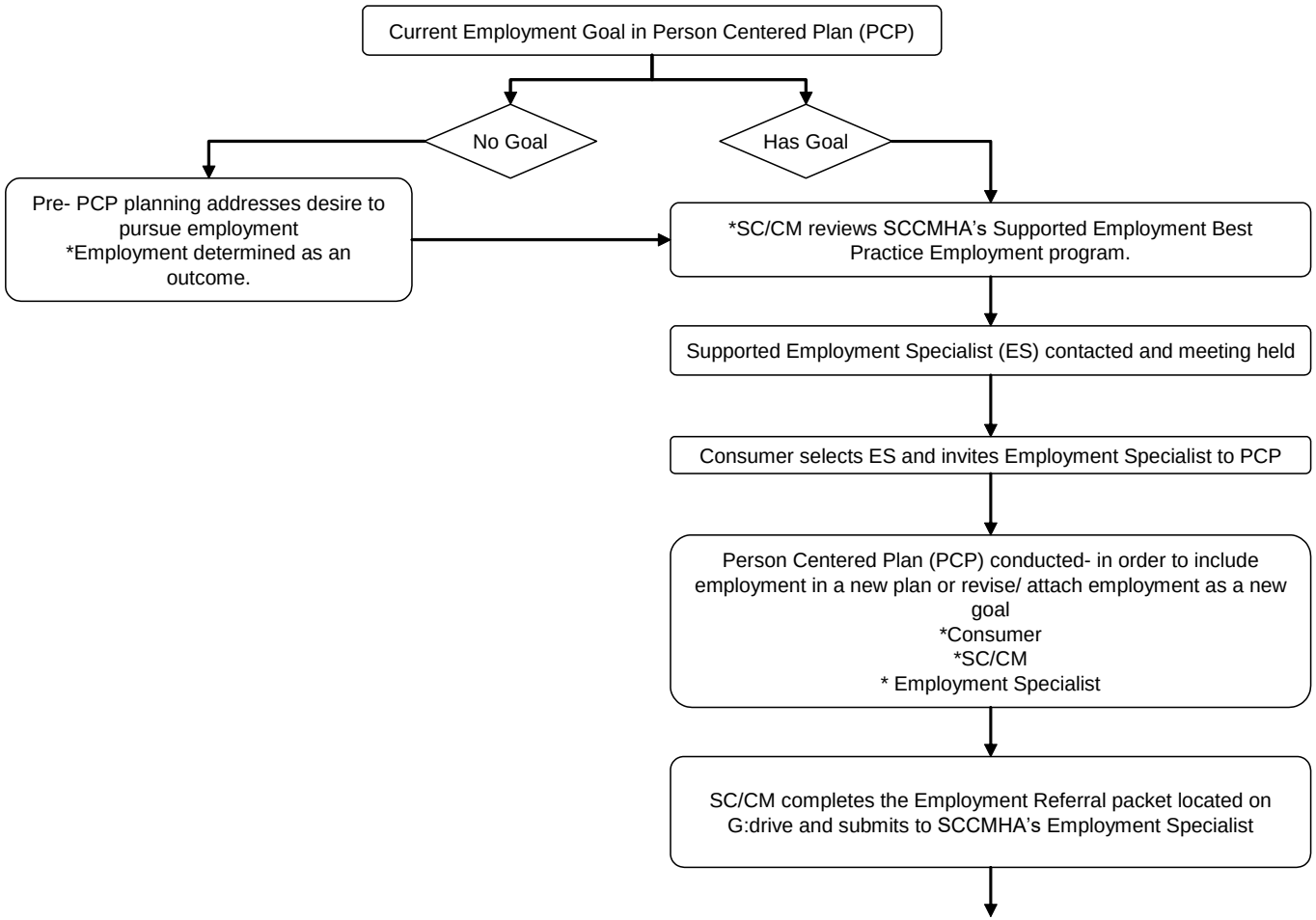
Procedure:

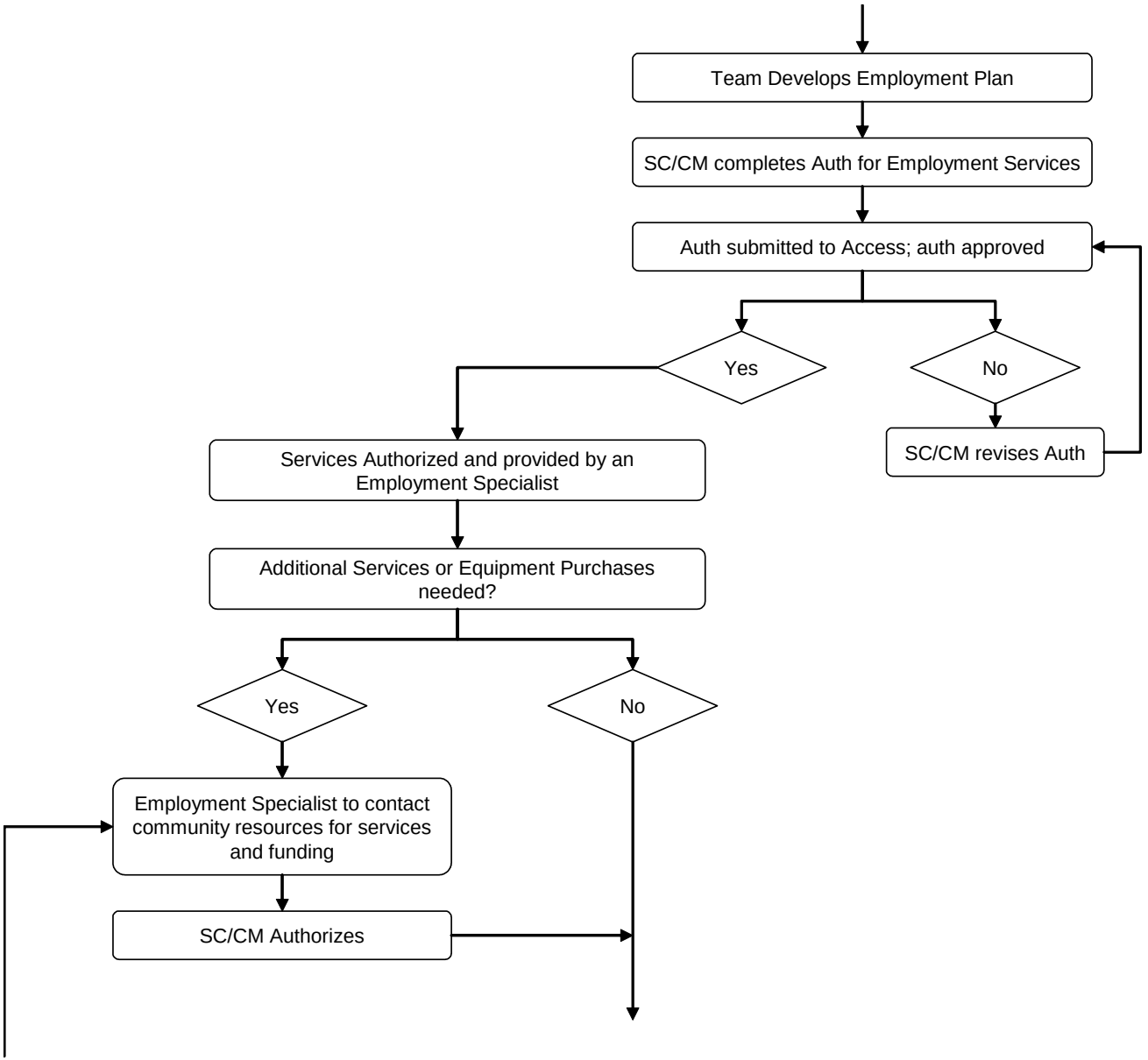
ACTION	RESPONSIBILITY
Approves employment related policies and funding plans, and reports to SCCMHA Board on system outcomes and initiatives regarding consumer employment.	CEO
Ensure that consumer leadership committees and groups are given the opportunity for policy direction and outcome review regarding the employment of consumers in the SCCMHA system.	CEO, Director of Clinical Services & Programs and Supervisor of Recipient Rights/Customer Services
Serves as lead SCCMHA Administrator for consumer employment related matters. Appoints Employment Coordinator to chair SCCMHA's SE Best Practice Team. Employment Oversees system Person-Centered Planning process to include employment as primary area. Oversees training throughout the system on the employment of consumers, including changes in employment resources or requirements.	Director of Clinical Services & Programs, Employment Coordinator and/or Supported Employment Supervisor
Chairs the SE Best Practice Team. Coordinates service delivery with staff, providers and other needed resources.	Director of Network Services, Public Policy & Continuing Education
Disseminates employment policy through the network; assures provider reporting on employment efforts. Serves as administrative liaison to MRS and others on employment related grants and contracts.	
Advises and reports on budgets and expenditure tracking, including grants, relative to employment of consumers.	Director of Finance
Directs outcome reporting processes that include employment status of persons served. Ensures consumer employment is addressed in access, care management & quality areas. Oversees encounter and	Director of Services for Persons with Mental Illness

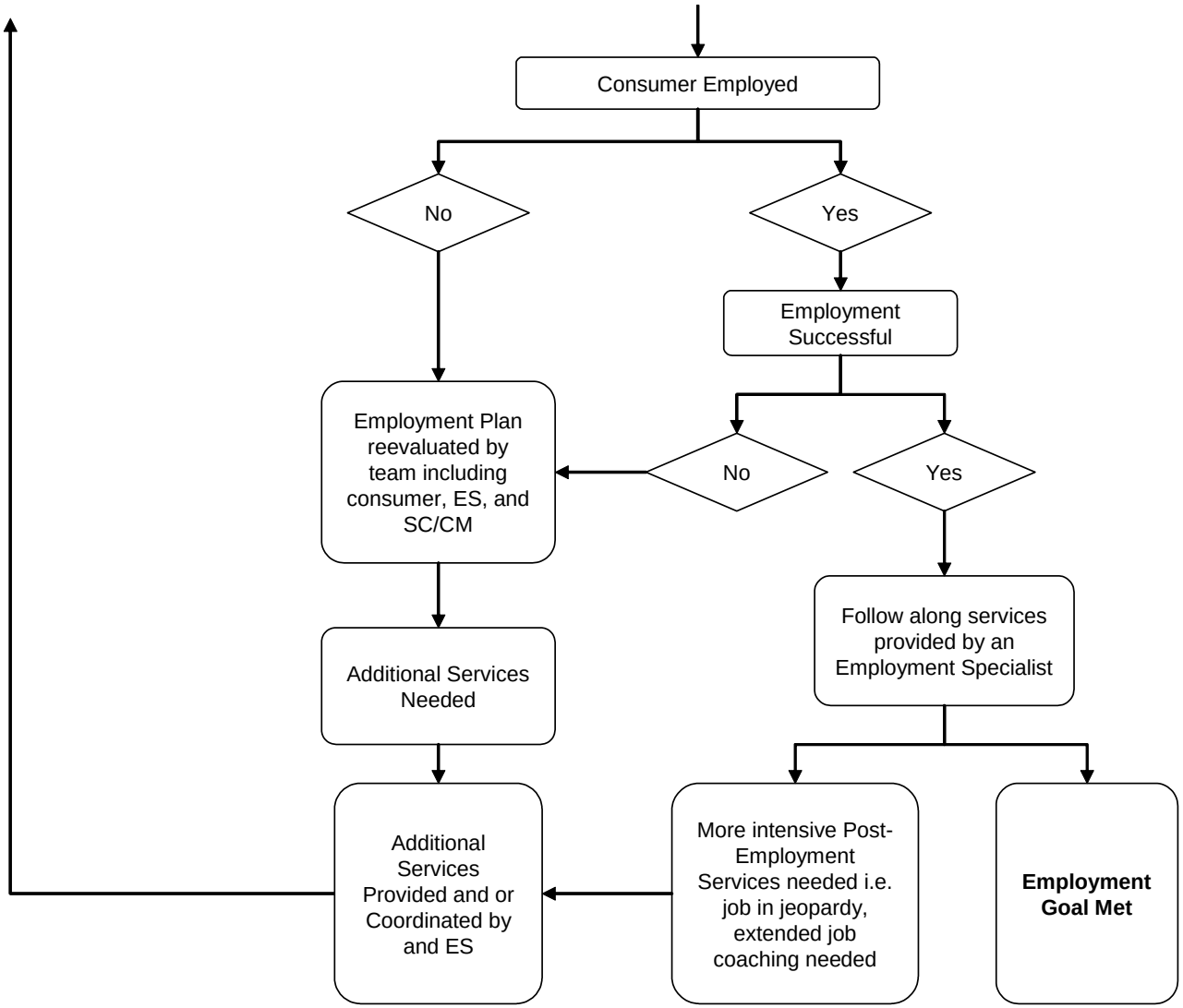
performance indicator data collection for consumer employment.	
Include consumer employment outcomes and preferences in Person-Centered Planning processes. Refer consumers to SCCMHA's SE Best practice Program or other employment related resources. Encourage and provide feedback on individual consumer employment readiness plans.	Case Managers & Supports Coordinators
Provide consumer-related employment services per SCCMHA, provider or direct consumer referral. Coordinate and write, when necessary, individualized work plan (IWP) with consumer, case manager/supports coordinator, MRS, employer and/or other consumer requested representatives. Work with consumer to implement IWP, which could include job development, job placement, job coaching, or other employment related services. Will monitor and Provide feedback to consumers, SC/CM and other team members on job progress, including barrier identification and problem-solving assistance in areas that may jeopardize employment. Provide data reporting as required by SCCMHA and participate in SCCMHA employment services planning.	Case Managers & Supports Coordinators SCCMHA Employment Specialist

Exhibit A

SCCMHA Supported Employment Service Flow Chart




Team Develops Employment Plan
SC/CM completes Auth for Employment Services
Auth submitted to Access; auth approved
Yes
No
SC/CM revises Auth
Services Authorized and provided by an Employment Specialist
Additional Services or Equipment Purchases needed?
Yes
No
Employment Specialist to contact community resources for services and funding
SC/CM Authorizes


Consumer Employed
No
Yes
Employment Successful
Employment Plan reevaluated by team including consumer, ES, and SC/CM
No
Yes
Additional Services Needed
Follow along services provided by an Employment Specialist
Additional Services Provided and or Coordinated by and ES
More intensive Post-Employment Services needed i.e. job in jeopardy, extended job coaching needed
Employment Goal Met

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Welcoming</td><td>Chapter: 02 - Customer Services and Recipient Rights</td><td>Subject No: 02.03.08</td></tr>
<tr><td rowspan="2">Effective Date:
7/1/07</td><td>Date of Review/Revision:
5/18/09, 4/2/12, 5/6/14, 4/5/16, 6/13/17, 4/10/18, 4/9/19, 7/29/20, 4/13/21, 5/10/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Barbara Glassheim

Additional Reviewers:</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to set forth expectations and standards of a welcoming philosophy wherein individuals and their family members engage in meaningful, non-judgmental interactions with staff within a consumer-centered, trauma-informed, recovery/resiliency building-oriented system of services and supports.

Policy:
SCCMHA recognizes that a welcoming philosophy is based on the core belief of dignity and respect for all people. Therefore, SCCMHA and its provider network shall create empathic, inclusive and welcoming relationships within all programs and incorporate welcoming into cultural and organizational structures and practices irrespective of service eligibility.

Application:
This policy applies to the entire SCCMHA network of direct operated and contracted service providers.
Welcoming applies to all clients/customers including individuals seeking services and their families, the public seeking services; other providers seeking access for their clients; agency staff; and the local community.

Standards:
A. SCCMHA shall provide safe, functional, clean, and welcoming in-person and virtual environments (telehealth services) for consumers and staff that are conducive to the scope of services provided.
B. All persons seeking, or currently receiving services from SCCMHA providers shall experience face-to-face, telephone, and remote (telehealth) assistance provided in a warm, welcoming manner.
C. Irrespective of an individual's presenting problem(s), SCCMHA shall:

1. Convey the message that it is okay to ask for help.
2. Indicate that the person has come to the right place.
3. Let the individual know that if SCCMHA cannot help them, SCCMHA will ensure that the individual is connected to a place(s) that can be of assistance.
4. Convey understanding of what the person seeking services is experiencing and that assistance is going to be provided.
5. Convey positive regard and empathy for each individual and their situation.
6. Indicate that no matter what problem(s) the person is facing, SCCMHA is going to work with the person on them.
7. Help each individual feel that there is hope.
8. Convey acceptance that, for individuals with complex problems, non-adherence to one or more treatment recommendations can be typical.
9. Convey hope through empathizing with the reality of despair, encouragement for asking for help, and acknowledging small step successes.
10. Enable timely access to treatment, services, and supports.

D. All clinical contacts shall be welcoming, empathic, hopeful, culturally sensitive, and consumer-centered in order to engage individuals who may be unwilling to accept or participate in recommended services, or who do not fit into available program models.

E. Welcoming shall be recognized and operationalized as the first step in engagement, by emphasizing welcoming attitudes and messaging at routine and emergency access points. This includes recognizing that addressing co-occurring issues or disorders concurrently results in the most successful and desirable outcomes.

1. All SCCMHA providers shall include specific welcoming language for people with co-occurring disorders as part of their admissions policies and in recognition of the need to treat co-occurring disorders simultaneously in order to optimize the potential for successful and desirable treatment outcomes.

F. Staff shall demonstrate a belief in the possibility of recovery, a willingness to start where the consumer/family is at, and provide services accordingly, including harm reduction approaches.

G. Consumers shall be engaged in a culturally sensitive manner that conveys empathy and hope and that actively reaches out to the consumer/family.

H. All individuals and families self-identifying as in need of services shall be welcomed; a “no wrong door” approach to all service requests shall be maintained.

1. No individual requesting services shall be turned away based on eligibility/exclusion criteria; every door is the right door for screening and gaining access to the most appropriate services irrespective of whether that person/family will be provided with continuing services in a SCCMHA-funded setting.

I. Program materials (e.g., consumer and staff orientation information, website, brochures, posters and newsletters) shall incorporate principles of welcoming including being visibly accessible, culturally and linguistically relevant, and consumer-friendly.

J. An orientation to welcoming skills shall be provided to all staff.

K. All SCCMHA providers shall have a welcoming policy and procedure that includes how staff are oriented and trained in the warm, welcoming approach and how this shall be utilized for performance improvement.

L. All SCCMHA providers shall have clinician competencies as a written part of human resource policies that require welcoming attitudes, accepting values, and skills in conveying empathy and hope to consumers, and that these competencies need to be demonstrated in practice and by formal assessment.

Definitions:

Welcoming is an accepting attitude and understanding of how people present for treatment that also reflects a capacity on the part of the provider to address the client's needs in a manner that accepts and fosters a service and treatment relationship. Welcoming is considered a best practice for programs that serve persons with co-occurring mental health and substance use disorders. Welcoming consists of the following:

Reception areas:

- Places of welcome that give newcomers first impressions of the whole organization
- Greeting in a manner that conveys the person matters to the people who are in charge of the facility/program
- Communicating that people are properly cared about and confidentiality is respected
- A culturally competent invitation to receive services, including assistance for individuals whose first language is not English.
- A clean and cared for environment
- Up-to-date and commonly read materials (e.g., magazines and newspapers) in waiting areas, as well as information on various mental health disorders and recovery-oriented treatments
- Group meetings clearly posted
- Tasteful décor
- Posters and artwork promote hope and recovery
- Receptionists greet all with warmth, respect, and dignity
- A welcome sign
- Waiting areas include consideration for family members or others accompanying the individual seeking services

Facilities:

- Clean and cared for
- Furniture that is clean, of good quality, comfortable, and ergonomically correct
- Treatment areas that afford privacy and confidentiality
- Barrier-free accommodations
- Smoking areas designated away from the entrance

Staff members:

- Listen to consumers
- Offer consumers helpful suggestions
- Help consumers with decision-making in an empowering manner
- Offer explanations

- Provide assistance
- Function as advocates for consumers regardless of whether they are in agreement with consumers' perspectives
- Support hope and belief in the unlimited potential of consumers
- Provide prompt and on-time services
- Offer choices to consumers

Programs/Agencies:

- Hours of operation meet the needs of the population(s) being served
- The service location is considered with regard to public transportation and accessibility, including access to telehealth

References:

A. Michigan Department of Community Health, Office of Drug Control Policy Treatment Technical Advisory # 05 (October 1, 2016) – Welcoming: https://www.michigan.gov/documents/mdch/TA_Treatment_05_Welcoming_175207_7.pdf
B. SCCMHA Policy 02.03.03 – Person-Centered Planning
C. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
D. SCCMHA Policy 02.03.09.01 – Dual Diagnosis Treatment Capacity
E. SCCMHA Policy 02.03.05 – Recovery
F. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
G. SCCMHA Policy 02.01.10 – Therapeutic Environment
H. SCCMHA Policy 02.01.01.02 – Cultural Competence
I. SCCMHA Policy 02.01.05 – Consumer Orientation
J. SCCMHA Policy 02.01.02 – Customer Services
K. SCCMHA Policy 03.02.31 – Services for Members of the Armed Forces, Veterans & their Families
L. SCCMHA Policy 03.02.34 – Services for American Indians
M. SCCMHA Policy 03.02.35 – Serving LGBTQ+ Consumers

Exhibits:

A. Consumer-Centered, Trauma-Informed, Welcoming Tips and Reminders (Dawn Heje, 9.29.16)

Exhibit A

Consumer-Centered, Trauma-Informed, Welcoming Tips and Reminders

It is the policy and the expectation that anyone seeking or receiving services from SCCMHA or its network will experience face-to-face, telephone, video (telehealth) assistance that is provided in a warm, welcoming, non-judgmental, consumer-centered, trauma-informed, recovery/resiliency building manner. We will always keep in mind that the person we are talking to is someone's cherished husband or wife, brother or sister, mother or father, child or best friend. It is our job to give the person and their loved ones hope for recovery.

Do	Don't
• During face-to-face contacts sit beside or at a right angle to the person whenever possible.	• Sit across from the person with a desk or table between you.
• Ask the person if it would be okay to take notes while you talk. Take notes in a way that the person can see what you are writing. Transfer the notes into the EMR after the face-to-face contact. • If you must enter directly into the EHR when you are with the person, acknowledge the limited eye contact and let them know what you typing as you type.	• Type into a computer as you talk with the person. If you are entering information into the EMR you are not fully engaged with the person. • Sit or stand with your back to the person at any time.
• Use non-verbal and para-verbal communication to let the person know you are listening and that you care. The way you listen, look, move and react is going to tell the person how well you are listening. Examples include eye contact as appropriate for the person's culture; nodding; "um-hmm", leaning in toward the person, facial expression.	• Look at your watch or phone, enter information into the EMR while the person is talking, fidget, stare out the window, doodle or use facial expressions that convey anything but care, concern or respect. • Use sarcasm or an angry tone of voice.
• Truly listen. If you are planning what you're going to say next, daydreaming, or thinking about something else, you are probably going to miss nonverbal cues and other subtleties in the conversation. Stay focused on the person and the conversation in order to fully understand what's going on.	• Interrupt, daydream, plan your response, focus on your notes, check your phone, or show signs of impatience or disinterest. • Finish the person's sentence.
• Convey verbally and non-verbally that no matter what the person is facing, there is hope and acknowledge the big step the person took by asking for help. • Each contact should offer explanations and clarifications, and resources and support,	• Turn away a person based on eligibility or exclusion criteria. Remember that every door is the right door for screening and gaining access to the most appropriate services.

especially if the outcome is not quite what was requested.	
• Make the person the most important part of the interview. Gathering information is more than getting answers to all of the questions on the intake screen.	• Make the questionnaire or medical record the focus of the interview.
• Make the person feel safe and in control by offering the choice of where they would like to sit, offer water, having a box of tissues close by, showing where restrooms are in a gender-neutral way, letting the person know they can take a break at any time, and letting the person know they have the right to not respond to any question.	• Ignore the person's basic needs. • Force them to ask where restrooms are located. • Insist the person answer questions.
• Listen without judgement, artfully ask questions for clarification, provide accurate information, offer assistance, and support the person in their recovery journey by starting in the place they are at to ensure that the person will come back for services.	• Offer advice, assume you know what is best for the person, or judge the person's decisions or situation.
• Remember that asking people to reveal personal information can be re-traumatizing, embarrassing, or frightening. Fully explain about confidentiality before starting every contact. • Acknowledge that some questions can be difficult to answer and that the person is doing a great job with a difficult task.	• Hand the person confidentiality material to read and expect they fully understand about confidentiality. • Neglect the person's signs of discomfort or embarrassment.
• Keep in mind that if a person becomes upset during the interview, it is not recommended to probe for more information. The clinician should stop, take care of the person's needs and help the person regain a sense of safety.	• Ignore signs of distress. • Continue with the interview while the person is crying or showing other signs of emotional distress. • Neglect to offer follow-up services before the person leaves.
• Be extra sensitive to questions about gender identity, sexual orientation, sexual activity, military experience, homelessness or near homelessness, family situation, abuse and trauma, and suicidality.	• While any question could trigger re-traumatization, don't forget that some questions are more likely to bring to mind painful memories, shame or guilt.
• Look for signs of distress or agitation at the end of the session and help the person regain control over their feelings. Once the clinician is sure the person is okay, end with a warm sendoff or warm handoff.	• End the interview or session with the person distressed or disassociated. • Neglect to spend a few minutes engaging with the person before gently handing

• Each contact should summarize key information and confirm next steps or follow up plans if applicable.	them off to another person or walking them to the front door. • Neglect to let the person know what a genuine pleasure it was to meet with them.

For more information:

http://www.samhsa.gov/behavioral-health-equity/lgbt/curricula

National Sexual Violence Resource Center: http://www.nsvrc.org

http://www.mentalhealth.va.gov/msthome.asp

http://homeless.samhsa.gov/channel/trauma-29.aspx

Zero Suicide: http://zerosuicide.sprc.org/

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: System of Care (SOC)</td><td>Chapter: 02 - Customer Services and Recipient Rights</td><td>Subject No: 02.03.09.09</td></tr>
<tr><td rowspan="2">Effective Date:
5/1/08</td><td>Date of Review/Revision:
6/10/09, 6/10/10, 4/4/12, 5/6/14, 4/19/16, 6/13/17, 4/10/18, 4/9/19, 7/29/20, 4/13/21, 5/10/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Barbara Glassheim

Additional Reviewers:
None</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:

A. The purpose of this policy is to delineate a framework for fostering the development and maintenance of a System of Care (SOC) for children and families with a serious emotional/behavioral disturbance who require services and supports from multiple child-serving organizations and public sector service delivery systems, and that enables children to be cared for in their homes, schools, and communities. SOC goals include:

1. Helping children and families develop the skills needed to manage their lives in their homes and communities.
2. Promoting parent–professional–community partnerships in the design, implementation and evaluation of the system of care.
3. Ensuring cultural competence in the delivery of services.
4. Expanding the amount and quality of services and supports available from all child-serving agencies and matching them to each individual child.
5. Providing ongoing training/education for families, advocates, and professionals.
6. Using quality improvement activities to help make decisions.
7. Expanding community-based systems of services and supports.
8. Providing state-of-the-art, effective clinical services and supports.

Policy:

Children with serious emotional disturbances and their families often need a range of comprehensive, individualized, coordinated services and supports. All key partners must come together to plan for and deliver these services, with families as full partners in the process. To this end, SCCMHA shall promote and help maintain a child-focused and family-centered system of community-based, trauma-informed, resiliency-focused,

developmentally appropriate care for children with a serious emotional disturbance and their families.

Application:
This policy applies to all providers of mental health treatment and related supports to children, adolescents, and families operating under the auspices of the Saginaw County Community Mental Health Authority.

Standards:
A. Children with severe emotional disturbances often experience a variety of problems that require solutions from an array of professionals and services.
B. Serving children who have severe emotional disturbances and multiple service system needs requires substantial assistance from the community.
C. The following core values of a system of care shall be adhered to:
    1. Child and family-centered. The needs of the child and family shall dictate the types and mix of services and supports provided; services are adapted to the child and family rather than expecting the child and family to conform to preexisting service and support configurations.
    2. Individualized. A unique service plan shall be developed for each child and family which assesses their strengths and needs, prioritizes their needs in each life domain, and is responsive to the family's cultural, racial, and ethnic identity.
    3. Community-based. Services shall be provided within or close to the child's home community in the least restrictive setting feasible, and coordinated and delivered via connections between providers.
    4. Oversight by a multi-agency advisory team. A multi-agency advisory team shall provide oversight for a system of care. The team shall be comprised of representatives from families and partner agencies who engage in planning and decision-making. The team will monitor the development and maintenance of interagency collaborations, seek to improve the overall effectiveness of the partnerships and help to maintain open communication and decision-making across all stakeholders.
D. The following guiding principles of a system of care shall be adhered to:
    1. Service coordination or case management
    2. Prevention and early identification and intervention
    3. Smooth transitions among agencies, providers, and to the adult service system (where indicated)
    4. Human rights protection and advocacy
    5. Nondiscrimination in access to services
    6. A comprehensive array of services
    7. Individualized service planning
    8. Services in the least restrictive environment
    9. Family participation in all aspects of planning, service delivery, and evaluation
    10. Integrated services with coordinated planning across child-serving systems
    11. Promotion of the use of best practices across all systems; evidence-based clinical interventions which are integral to an effective system of care.

Definitions:

Blended Funds: Funds that come from various sources that are merged and used interchangeably.

Braided Funding: Funding that uses monies from different sources but accounts for the different sources separately.

Cultural Competence: Help that is sensitive and responsive to cultural differences. Caregivers are aware of the impact of culture and possess skills to help provide services that respond appropriately to a person's unique cultural differences, including race and ethnicity, national origin, religion, age, gender, sexual orientation, or physical disability. They also adapt their skills to fit a family's values and customs.

System of Care (SOC): A method of addressing children's mental health needs that is based on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. An SOC is developed around the principles of child-centeredness, family-driven, strength-based, cultural competence, and interagency collaboration. It is comprised of a wide range of mental health and related services and supports working together to provide care. It is designed to help children with serious emotional disturbances and their families obtain the services and supports they need in or near their homes and communities. In systems of care, local public and private organizations work in teams to implement a set of services unique to each child in accordance with their physical, emotional, social, educational, and family needs that focus on the strengths of the child and the family.

References:

A. Glassheim, B. (2006). *A Guide to Evidence-Based Practices for Children, Adolescents and their Families*. SCCMHA: https://www.sccmha.org/userfiles/filemanager/287/

B. Hernandez, M., Worthington, J., Davis, C.S. (2005). *Measuring the Fidelity of Service Planning and Delivery to System of Care Principles: The System of Care Practice Review (SOCPR).* (Making children's mental health services successful series, 223-1). University of South Florida, The Louis de la Parte Florida Mental Health Institute. Tampa FL. [On-line]. Available: http://cfs.fmhi.usf.edu/tread/PDFs/SOCPR_Monograph%20FINAL-3-5-05.pdf.

C. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)

D. SCCMHA Policy 02.03.09.09 – Wraparound

E. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

F. Stroul, B. (2002). A Framework For System Reform In Children's Mental Health. *Issue Brief*. National Technical Assistance Center For Children's Mental Health, Georgetown University, Child Development Center. Washington, DC. [On-line]. Available: http://gucchd.georgetown.edu/files/products_publications/SOCbrief.pdf.

G. Stroul, B. & Friedman, R. (1986). *A System of Care for Children and Youth with Severe Emotional Disturbances*. Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. Washington, DC.

H. Worthington, J., Davis, C., Hernandez, M., Pinto, A., Vergon, K. (2005). *System of Care Practice Review: Review Team Member Training Manual* (rev. ed.) University of South Florida, The Louis de la Parte Florida Mental Health Institute. Tampa, FL. [On-line]. Available:

http://cfs.fmhi.usf.edu/tread/PDFs/SOCPR%20Training%20Manual.pdf.

Exhibits:

A. System of Care Framework
B. System of Care Practice Review (SOCPR) domains and subdomains

Procedure:

None

Exhibit A

System of Care Framework

The range of services that may be included in a system of care:

- Case management (service coordination)
- Community-based in-patient psychiatric care
- Counseling (individual, group, and youth)
- Crisis residential care
- Crisis outreach teams
- Day treatment
- Education/special education services
- Family support
- Health services
- Independent living supports
- Intensive family-based counseling (in the home)
- Legal services
- Protection and advocacy
- Psychiatric consultation
- Recreation therapy
- Residential treatment
- Respite care
- Self-help or support groups
- Small therapeutic group care
- Therapeutic foster care
- Transportation
- Tutoring
- Vocational counseling

Exhibit B

SYSTEM OF CARE PRACTICE REVIEW (SOCPR)

DOMAIN 1	Child-Centered and Family-Focused: The needs of the child and family dictate the types and mix of services provided.

SUBDOMAINS

INDIVIDUALIZATION	Individualization refers to the development of a unique service plan for each child and family in which their needs are assessed and prioritized in each life domain. Strengths are also identified and included as part of the plan.
FULL PARTICIPATION	Developing an individualized service plan is possible with full participation of the child, family, providers, and significant others. Additionally, the child and family participate in setting their own treatment goals, and plan for the evaluation of interventions to reach those goals.
CASE MANAGEMENT	Case management is intended to ensure the child and family receive the services they need in a coordinated manner, that the type and intensity of services are appropriate, and that services are driven by the family's changing needs over time.

DOMAIN 2	Community-Based: Services are provided within or close to the child's home community, in the least restrictive setting possible, and are coordinated and delivered through linkages between public and private providers.

SUBDOMAINS

EARLY INTERVENTION	Early identification and intervention for the child with emotional disturbances enhance the likelihood of positive outcomes by reversing maladaptive behaviors and preventing problems from reaching serious proportions. This refers to both providing services before problems escalate, in the case of the older child, and designing services for the younger child.
ACCESS TO SERVICES	Each child and family has access to comprehensive services across physical, emotional, social, and educational domains. These services are flexible enough to allow the child and family to integrate them into their daily routines.
MINIMAL RESTRICTIVENESS	Systems serve the child in as normal an environment as possible. Interventions provide the needed services in the least intrusive manner to allow the family to continue day-to-day routines as much as possible.
INTEGRATION AND COORDINATION	Coordination among providers, continuity of services, and movement within the components of the system are of central importance for each child and family with multiple needs.

DOMAIN 3	Culturally Competent: Services are attuned to the cultural, racial, and ethnic background and identity of the child and family.

SUBDOMAINS

AWARENESS	Culturally competent service systems and providers are aware of the impact of their own culture and the culture of each family being served. They accept cultural differences and understand

	the dynamics at play when persons from different cultural backgrounds come into contact with each other. They recognize how cultural context uniquely relates to service delivery for each child and family.
AGENCY CULTURE	The child and family are assisted in understanding the agency's culture, in terms of how the system operates, its rules and regulations, and what is expected of them.
SENSITIVITY AND RESPONSIVENESS	Cultural Competence includes the ability to adapt services to the cultural context of each child and family.
INFORMAL SUPPORTS	Cultural Competence is reflected in the inclusion of the family's informal or natural sources of support in formal service planning and delivery. Each service provider becomes knowledgeable about the natural resources that may be used on behalf of the child and family and are able to access them.

DOMAIN 4 Impact: The SOC philosophy implies that the implementation of SOC principles at the practice level produce positive outcomes for child and family receiving services.

SUBDOMAINS

IMPROVEMENT	Services that have had a positive impact on the child and family have enabled the child and family to improve their situation.
APPROPRIATENESS OF SERVICES	Services that have had a positive impact on the child and family have provided appropriate services that have met the needs of the child and family.

<table>
<tr><th colspan="3">Policy and Procedure Manual
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<tr><td>Subject: Mobile Response and Stabilization Services (MRSS)</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.12</td></tr>
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7/7/21, 2/28/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Farrah Wojcik, MRSS Site Program Supervisor
Carey Moffett, MRSS Supervisor
Marky Baukus, EBP Coordinator

Additional Reviewers:
EBP workgroup</td></tr>
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<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:

A. To provide SCCMHA employees and network providers with comprehensive information regarding SCCMHA mobile crisis response model, Mobile Response and Stabilization Services.
B. To reflect the expansion of service array and populations served by Mobile Response and Stabilization Services (formerly known as Mobile Urgent Treatment Team).
C. To identify the purpose and processes of SCCMHA Mobile Response and Stabilization Services.

Application:

1. SCCMHA
2. Provider Network Members
3. SCCMHA Divisions serving children, adults with mental illnesses, substance use disorders or co-occurring disorders, and persons with intellectual or developmental disabilities

Policy:

SCCMHA shall endeavor to provide services and supports in the least restrictive setting possible. Services and supports shall be strengths-based, consumer-driven, community-based, trauma-informed, and culturally and linguistically competent. In addition, care planning shall be individualized, collaborative, and flexible based on consumer need.

SCCMHA shall provide telephonic (warm line and triage), virtual (video conferencing), and mobile (on-site, in-person) crisis intervention for children, adolescents, families, and adults with mental illness, substance use disorders or co-occurring disorders, and/or intellectual or developmental disabilities. The primary goals for crisis intervention shall be: to de-escalate crisis situations; to provide opportunities for immediate stabilization while maintaining the least restrictive setting/level of care; to prevent out-of-home placements when clinically appropriate (i.e., inpatient psychiatric hospitalization, residential services, or incarceration/detention); to limit emergency room utilization, unnecessary involvement of emergency personnel, and unnecessary pre-admission screening while maintaining the safety of the consumer, his/her/their family, and the community.

Standards:

A. SCCMHA MRSS services shall be made available, as resources permit, to individuals who are experiencing a crisis.
    1. Referrals will be accepted from any SCCMHA-funded providers/programs, law enforcement agencies, schools, juvenile court/probation department, other community agencies, Saginaw DHHS, SCCMHA Clinical Risk Committees, families, and consumers through an established referral procedure.
    2. MRSS services are not limited to open, active SCCMHA consumers.
    3. For callers who are not residents of Saginaw County, telephonic and virtual crisis intervention will be provided. For in-person assistance, MRSS will facilitate in the referral to the appropriate local resources.
B. The team responding to the crisis will be comprised of the following:
    1. Primary team member: the lead clinician will be identified as a "Stabilization Therapist" and will have a master's degree and licensing in the mental health field (i.e., LMSW, LLMSW, LC, LLC, LMFT)
    2. Secondary team member: the supporting staff may be a Stabilization Therapist as well, or may also be a Client Services Manager (Child, Family, and Youth Services; Community Support Services), Supports Coordinator, Wraparound Coordinator, Peer Support Partner/Parent Support Partner, and/or Juvenile Probation Officer.
        i. A minimum of a bachelor's degree or lived experience and registration as a Qualified Mental Health Professional (QMHP) shall be required for secondary MRSS personnel.
    3. Mobile Response and Stabilization Services shall be supervised by a master's prepared clinician.
    4. The Daytime MRSS Team shall consist of, at minimum, four Stabilization Therapist staff.

5. The Evening MRSS Team shall include staff from: Child, Family, and Youth Services (including Infant Mental Health), Wraparound, Autism, Supports Coordination, Community Support Services, Central Access and Intake, Housing Resource Center, and juvenile probation.
    i. A roster of at least 15 MRSS staff shall be maintained at all times.
    ii. The Evening Team shall consist of, at minimum, two staff for the duration of the shift.
6. The Overnight MRSS Team (3rd shift) shall consist of, at minimum, two Stabilization Therapist staff and two secondary team members who will operate in a rotation for daily coverage of at least two team members per shift

C. Hours of operation:
    1. Telephone, virtual, and community-based intervention shall be made available 24 hours per day, 7 days per week, 365 days per year.
        i. Community-based services are provided by a minimum of two team members working in tandem on-site at a crisis situation.
        ii. Requests for on-site crisis interventions shall be completed within two hours of the request being received by the team.
        iii. MRSS staff shall triage incoming calls and assess for safety prior to completing on-site crisis interventions.
D. Daily team huddles and regular shift reports shall be held to discuss cases.
E. The MRSS Site Program Supervisor shall conduct monthly staff meetings to discuss operations.
F. Documentation of MRSS Contacts will be completed in the Sentri II electronic health record.
    1. MRSS staff shall enter an emergency note for each telehealth or in-person contact.
        i. This documentation shall be completed by the end of the team's shift.
        ii. The note shall include the names of the MRSS personnel involved in any intervention, summarize what transpired during the contact, describe any interventions or coaching that were implemented during the episode of care, and detail the disposition (short-term plan of safety/follow-up) of the contact.
        iii. The staff designated as the primary MRSS staff will be responsible for the documentation of the emergency note; secondary staff will complete non-billable supporting documentation as needed
        iv. All documentation will include a copy sent to the consumer's current case holder.
G. MRSS staff shall conduct a safety assessment to determine the danger a consumer poses to themselves or others, and to determine the services and supports necessary for resolving the crisis and preventing placement in higher, more restrictive levels of care.
H. Intervention shall focus on coaching and support to help consumers and their families self-regulate when homeostasis (optimal functioning) is disrupted, providing educational resources for consumers and providers, modifying the

physical environment, connecting consumers to community resources, providing solution-focused counseling for consumers and families in crisis, and providing consultation and support for providers.

1. MRSS staff will assist the consumer/family in developing a safety plan to facilitate de-escalation with a focus on safety.
2. MRSS shall provide support to the consumer/family as well as community information and resources to assist them until they have follow-up contact with their primary case holder/treatment team.
3. MRSS staff may provide follow-up to the consumer/family via call-backs, telephonic coaching, and wellness checks.
4. MRSS may also serve as a liaison between a consumer and available community resources.
5. Proactive, or wellness, contacts shall be an integral component of MRSS and shall be provided to support consumer/family strengths and to prevent escalation of a crisis due to a known life stressor.
    i. Life stressors may include: ongoing family conflict, eviction, Children's Protective Services (CPS) or Adult Protective Services (APS) involvement/risk for removal, emerging psychiatric symptoms that are not florid, domestic violence, existence of trauma and possible Post-Traumatic Stress Disorder (PTSD), and other causative conditions (e.g., poverty, high crime, dearth of natural supports, etc.).
    ii. Proactive contacts may also be completed following the consumer's discharge from an inpatient admission/step-down from a higher level of care.
    iii. Proactive contacts are determined each shift by the MRSS Supervisor, MRSS Site Program Supervisor, and identified mobile response team members who shall compile a list of High-Risk consumers as referred to MRSS by SCCMHA staff, as well as other staff, agencies, or programs that collaborate with MRSS.
6. If a consumer/family requests a pre-admission screening for inpatient hospitalization and all efforts made by MRSS to provide stabilization and diversion in the community have been unsuccessful, MRSS will notify Crisis Intervention Services of the consumer/family's impending arrival to Hancock/Covenant Emergency Department and assist the consumer/family in identifying the safest, least restrictive mode of transportation.

I. Mobile Response and Stabilization Services shall work in close collaboration with the consumer's primary treatment team, SCCMHA Central Access and Intake Services (CAI), and SCCMHA Crisis Intervention Services (CIS).
    1. MRSS will provide a disposition to the consumer's case holder following the consumer's contact with MRSS to ensure coordination of services between Mobile Response's acute crisis intervention and the clinicians who provide ongoing services.
    2. MRSS Supervisor/Site Program Supervisor will participate in Clinical Risk Committee (Adult and Child) to assist in completing clinically

appropriate referral of a consumer to MRSS for proactive and/or crisis contacts.

3. MRSS staff will collaborate with staff from CAI to CIS to complete contact with identified consumers following initial screening or diversion after pre-admission screening, as guided by consumer preference and clinical need.
4. MRSS staff will assist CAI with after-hours requests for services by scheduling a screening for eligibility and/or an intake assessment when appropriate.

J. Mobile Response and Stabilization Services include the following time-limited stabilization services (regular business hours only):
   1. Access and Stabilization for Children (ASC)
   2. Stabilization services for adult consumers

Definitions:

Crisis:

A situation in which an individual's behaviors places them at risk of harming themselves or others and/or when a parent/caretaker is unable to resolve the situation with the skills and resources available to them.

MRSS intervention is warranted when a crisis significantly interferes with the ability to function and is severe enough to place the consumer at risk for placement disruption or treatment in higher levels of care. The clinical threshold for crisis may include emotional dysregulation; interpersonal conflict; physically or verbally aggressive behaviors; suicide attempts/suicidal ideation/non-suicidal self-injury; risk of harm to self or others; drug and alcohol overdose or abuse; or disruptive symptoms related to mood and anxiety disorders (e.g., panic, hopelessness, anger, depression). It may also present as an overt change in functioning or be prompted by traumatic life events (Shannahan & Fields). Crises may be psychiatric, behavioral, or situational in nature.

Crisis Interventions:

Unscheduled activities conducted for the purpose of resolving a crisis requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy (Michigan Medicaid Provider Manual).

Crisis Plan (Safety Plan):

An individualized plan that is designed to address behaviors and help prepare for a crisis. The plan may contain the following elements: mental health diagnosis, medical history, list of consumer's strengths and interests; trigger behaviors or antecedents; strategies and treatments that have previously been effective; actions that may escalate the problematic behavior as well as what helps calm the consumer or reduces symptoms; current medication(s) as well as those that have been previously ineffective; interventions/treatments being used as well as those shown to be ineffective in the past, those that should be avoided and treatment preferences; members of the consumer's natural support system; safety concerns (e.g., limiting access to weapons, over-the-counter [OTC] and prescription medications); safety plan for other family members; and resources (e.g., community agencies, advocacy organizations, support groups).

Mobile Crisis Response and Stabilization Services (MRSS):

A cost-effective alternative to the use of EDs (emergency departments) and inpatient treatment, MRSS provides mobile, on-site and rapid intervention for youth experiencing a behavioral health crisis, allowing for: immediate de-escalation of the situation in the least restrictive setting possible; prevention of the condition from worsening; and the timely stabilization of the crisis. The mobile crisis component of MRSS is designed to provide time-limited, on-demand crisis intervention services in any setting in which a behavioral health crisis is occurring. Depending on the needs of the child, the stabilization component may include a temporary, out-of-home crisis resolution in a safe environment.

A growing body of evidence points to MRSS as a cost-effective method for: improving behavioral health outcomes; deterring ED and inpatient admissions; reducing out-of-home placements; reducing lengths of stay and the cost of inpatient hospitalizations; and improving access to behavioral health services. In addition, families often report greater satisfaction with MRSS when compared to the ED (Shannahan & Fields). Because of the efficacy of this mobile crisis response model with youth and families, MRSS has expanded services to any individual experiencing a mental health crisis.

References:

A. Michigan Medicaid Provider Manual: http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.
B. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
C. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
D. SCCMHA Policy 02.03.24 – Suicide Prevention
E. Shannahan, R., Fields, S. (May 2016). *Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization Services*. National Technical Assistance Network for Children's Behavioral Health. Washington, DC
F. Substance Abuse and Mental Health Services Administration. (2014). *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.* HHS Publication No. (SMA)-14-4848. Substance Abuse and Mental Health Services Administration. Rockville, MD

Exhibits:

A. Mobile Response and Stabilization Services Referral Form
B. MRSS Child/Youth/Family Brochure
C. MRSS Adult Brochure
D. MRSS Flyer

Procedure:

ACTION	RESPONSIBILITY
Compile and amend a daily High-Risk List (HRL) of consumers requiring proactive contacts and manage incoming referrals to the list.	Stabilization Therapist (identified primary clinician, all shifts) MRSS Supervisor, MRSS Site Program Supervisor

Contact the identified consumer and/or parent/guardian as indicated by the HRL for proactive contact and/or coaching to reinforce current coping skills and alternatives to hospitalization or incarceration	Identified team members on-call (primary clinician, secondary staff)
Coordinate/communicate with secondary team members on each shift	Stabilization Therapist (identified primary clinician, all shifts)
Complete phone screening and safety check prior to completing in-person contacts	Stabilization Therapist (identified primary clinician, all shifts) Secondary staff member (all shifts), non-billable supportive documentation
Conduct an in-person, face-to-face follow-up visit with assigned colleague upon the request of a consumer, parent/guardian, or other relevant community referral.	Stabilization Therapist (identified primary clinician, all shifts) Secondary staff member (all shifts), non-billable supportive documentation
Document the event in the SCCMHA electronic health record with an emergency note that includes: the names of Stabilization Therapist and secondary staff member as well as a brief narrative detailing the content of the visit, intervention, the family's response to the intervention and the plan for follow-up with the consumer's assigned treatment team.	Stabilization Therapist (identified primary clinician, all shifts), billable contact Secondary staff member (all shifts), non-billable supportive documentation
Communicate and coordinate Diversion/Crisis Plans with the next team members covering the next shift	Stabilization Therapist (identified primary clinician, all shifts)
Provide feedback to the treating therapist each day to inform interventions provided in a manner that reinforces alternatives to seeking hospitalization with the consumer and family.	Stabilization Therapist (identified primary clinician, all shifts)
Conduct monthly staff meetings	MRSS Site Program Supervisor

Attend Adult and Child Clinical Risk Committee meetings to provide consultation and support to primary case holders who identify consumers at-risk of requiring a more intensive level of care.	MRSS Supervisor MRSS Site Program Supervisor

Exhibit A

Rev10.21.FW

Mobile Response and Stabilization Services
Proactive Contact Referral Form

The following information is required for all High-Risk List (HRL) referrals to the Mobile Response and Stabilization Services (MRSS) team unless requested directly from a consumer or family.

1. Consumer Name:
2. SENTRI ID:
3. Case holder name and agency/department:

4. Person completing referral to MRSS (if not case holder):

5. Parent or guardian name and relationship to consumer, if applicable:

6. Please indicate if the consumer requires accommodations for communication with the team (e.g., interpretive services, text-based communication, etc.):

7. Phone number:

8. Home address:

9. Contact type:
   - ☐Proactive phone call
   - ☐Proactive home visit **The team will call in advance of the visit to arrange a time to visit, unless otherwise specified.*

10. Frequency of contact (e.g., one-time, daily, every other day, weekly, etc.):

11. Reason for referral:
    - ☐Suicidality/severe depressive symptoms
    - ☐Interpersonal conflict/risk or history of physical aggression toward others
    - ☐Emotional dysregulation
    - ☐Noncompliance with directives from parent/guardian
    - ☐Acute need for services
    - ☐Other:
12. Additional information (please expand upon the reason for the referral you chose above with specific circumstances):

13. What should the Mobile Response team's priority or goal for contact with this consumer be?

14. Is there a completed crisis support plan in the consumer's chart for the team to reference?
    - ☐Yes--- Last updated on: _____
    - ☐No---- *If the consumer needs repeated mobile response or crisis intervention, a crisis support plan should be established prior to referral.*

15. Please indicate if there are any safety concerns of which the team should be aware if responding in-person:

16. If the consumer has a trauma history, please indicate any known trauma triggers/reminders for the team:

17. The consumer has been provided information about Mobile Response and has consented to proactive contact from the team.
    - ☐Yes---- Completed on:
    - ☐No---- *Mobile Response is a person-centered service and does not complete unexpected or unwanted contacts with consumers. The team can assist case holders in introducing consumers to the service if desired.*

Please send your completed referral from to the distribution list *"Mobile Response Referral"* in the Sentri II email system. A team member will respond confirming your request was added to the HRL for contact. For questions on if a consumer/situation warrants a referral to the HRL, please contact Carey Moffett (daytime) or Farrah Wojcik (after-hours) directly.

Considerations in completing a referral (please also ensure that the consumer/family you're referring is aware of this information):

On crisis contact with minors:

- Mobile Response cannot see children if they are home alone. A parent/caregiver must be present during the home visit.
- If there is a request to call/visit and the adult does not have legal authority of the child (grand parent, aunt, uncle, foster parents), a release of information is required for the team to contact them.

General guidelines:

- Mobile Response can only travel within Saginaw County. At times, urgent response may take up to two hours to complete, per Michigan Medicaid Manual guidelines. If the consumer is at risk of imminent serious physical harm to self/others, the family will be advised to contact emergency services.
- A consumer can be on the HRL for up to 7 days at a time. After 7 days, the case will be reviewed with the case holder to determine if additional time on the HRL is needed. Mobile Response cannot be the primary provider of clinical services.

Exhibit B

What is MRSS?

Originally named the Mobile Urgent Treatment Team, MRSS, or Mobile Response, was initially created to help youth experiencing a mental health crisis. Now, MRSS has expanded to include all Medicaid-eligible residents of Saginaw County. The team can provide assistance by phone or by meeting face-to-face with you and/or your child at a location in the community or at your home.

What is a crisis?

A crisis is any situation which escalates beyond an individual's ability to resolve it independently, often to the point that the individual or their loved ones feel that additional help is needed to keep the individual and the community safe. Mobile Response will provide support and assistance to crises as defined by you or your child.

We're here to help!

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Main Facility
500 Hancock, Saginaw, Michigan 48602

Phone
(989) 797-3400
Toll Free 1-800-258-8678
Michigan Relay 711 or 1-800-649-3777

24-Hour Mental Health Emergency Services
(989) 792-9732
Toll Free: 1-800-233-0022

www.sccmha.org

For questions about Mobile Response and Stabilization Services, please contact:

(989) 272-0275

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Mobile Response and Stabilization Services (MRSS)

A team created to help children, youth, and families in crisis.

Your wellbeing is our primary concern.

When should I call?

Anytime you or your child has a serious behavioral or emotional problem that causes you to feel that you need help. The team is available daily from 8AM until 10PM, including holidays.

Call (989) 272-0275

for

Mobile Response and Stabilization Services

What should I do if it's an emergency situation?

Sometimes, there are situations where someone is in immediate danger. At these times, you should call local law enforcement or emergency services. MRSS can provide support to first responders in deciding whether or not to transport the individual to the Mental Health Crisis Department for further evaluation.

What can I expect when I call?

The Mobile Response team will interview you to determine what the problems are and how serious they have become. If the problem suggests that your child needs to be placed outside of the home for safety reasons, MRSS staff will assist with the referral process. However, if there are any other forms of treatment possible, MRSS will talk with you about those options.

What other ideas might MRSS discuss with me?

There are a number of solutions in the community, including placement with another family member, outpatient counseling or therapy, referral for in-home or other intensive individual or family therapy and referrals to other agencies.

What is MRSS trying to do for people who call?

The Mobile Response team will attempt to resolve the crisis as quickly and as effectively as possible. They will attempt to prevent out-of-home placement, while ensuring the safety of your loved ones.

Exhibit C

What is MRSS?

Formerly known as the Mobile Urgent Treatment Team, Mobile Response, or MRSS, was initially created to help youth experiencing a mental health crisis. Now, MRSS has expanded to include all Medicaid-eligible residents of Saginaw County. The team can provide assistance by phone or by meeting face-to-face with you at a location in the community or at your home.

What is a crisis?

In general, a crisis is any situation which escalates beyond an individual's ability to resolve it independently, often to the point that the individual or their loved ones feel that additional help is needed to keep the individual and the community safe. The goal of MRSS is to assist someone with whatever experience that person has defined as a crisis, rather than making that determination for them.

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Mobile Response and
Stabilization Services

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There are a number of solutions in the community, including placement with another family member or support person, outpatient therapy, referral for in-home or other intensive individual therapy, and referrals to other agencies.

What is MRSS trying to do for people who call?

The Mobile Response team will attempt to resolve the crisis as quickly and as effectively as possible. They will attempt to prevent out-of-home placement, while ensuring the safety of you and your loved ones.

Exhibit D

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Mobile Response

and Stabilization Services (MRSS)

(989) 272-0275

The Mobile Response team, or MRSS, is a team of professionals trained to support youth, families, and adults through a mental health crisis. MRSS can provide phone or virtual support or respond in-person to a home, school, or other community setting within Saginaw County. This service is available to Saginaw County residents who are eligible for Medicaid.

CURRENT HOURS OF OPERATION

8AM-10PM Daily

24-Hour Mental Health Emergency Services

(989) 792-9732

Toll Free: 1-800-233-0022

500 Hancock St
Saginaw, MI 48602

www.sccmha.org
www.facebook.com/sccmha

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Alternatives to Guardianship</td><td>Chapter: 02 - Customer Services & Recipient Rights</td><td>Subject No: 02.03.12</td></tr>
<tr><td rowspan="2">Effective Date:
5/1/08</td><td>Date of Review/Revision:
6/10/09, 6/10/10, 4/4/12, 5/8/14, 8/6/14, 10/29/14, 5/4/15, 6/13/17, 4/10/18, 12/11/18, 4/9/19, 8/14/20, 4/13/21, 5/10/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Barbara Glassheim

Additional Reviewers:
Director of Customer Services & Recipient Rights</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
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Purpose:

This document sets forth SCCMHA's policy regarding alternative methods to handle decision-making that assist adults with a serious mental illness, substance use disorder, intellectual/developmental disability, and their advocates. It is designed to provide guidance, encourage best practice, and promote the rights of persons served by SCCMHA as well as ensure that individuals have access to alternatives to guardianship including, but not limited to those delineated below in Standard F.

Policy:

Independence, respect, and equality are values important to all people and, as such, help define the concepts of autonomy (i.e., independence and freedom) and self-determination (i.e., a person's right to make decisions for him or herself).

SCCMHA believes that adults should be empowered to make their own decisions but recognizes that consumers may require support that can include restrictions on autonomous decision-making in instances of clearly demonstrable risks to health and safety. SCCMHA shall always seek to balance the preservation of safety with the dignity of risk.

The least restrictive alternative should always be considered before taking away a person's civil and legal rights to make decisions for him or herself. The least restrictive alternative is an option that allows a person to maintain as much autonomy and self-determination as possible while providing only the level of protection and supervision necessary.

Consumers for whom decision-making autonomy has been restricted shall be provided with opportunities to acquire the skills and abilities needed for autonomous decision-making as well as those deemed essential to maintaining health and safety.

Application:
This policy applies to all SCCMHA-funded providers of services and supports to adults with mental illness, a substance use disorder, and/or intellectual/developmental disability.

Standards:

A. All SCCMHA-funded providers shall endeavor to preserve the basic human, civil rights and freedom of all persons served.

B. Alternatives to guardianship shall always be pursued prior to considering guardianship for consumers.
   1. These options shall be reviewed with consumers and their supporters.

C. The alternative to guardianship identified for each individual shall be deemed as the most effective relative to the person's situation in terms of empowerment and legal enforceability.
   1. Alternatives to full guardianship that offer the greatest autonomy and are the least intrusive/restrictive shall be given priority consideration.
   2. Any restrictions placed upon the consumer's right to autonomous decision-making shall be as narrow as feasible and shall be based on demonstrable health and safety issues.
      a). Said restrictions shall be reviewed on a regular basis to ensure that they continue to be necessary and are effective.
         1). Reviews and continued justification of any restrictions placed upon the consumer's autonomy shall be documented in the consumer's PCP.
      b). A consumer whose decision-making autonomy has been reduced or eliminated shall be offered interventions that are designed to help them gain the necessary skills and abilities to eliminate or decrease the restrictions placed upon them for their health and safety.

D. Guardianship issues and alternatives to guardianship shall, as indicated and warranted, be incorporated into the person-centered planning process and documented in the consumer's person-centered plan of service and shall include:
   1. The identification of a specific and individualized assessed need.
   2. Documentation of positive interventions and supports used prior to any revisions to the person-centered service plan that will result in a curtailment of the consumer's decision-making autonomy.
   3. Documentation of less intrusive methods of addressing the identified need that have been tried but found to be ineffective.
   4. A clear description of the condition that is directly proportionate to the specific assessed need.
   5. Systematic collection and review of data on an ongoing basis to measure the effectiveness of the modification.
   6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   7. The informed consent of the individual.
   8. An assurance that interventions and supports will not cause harm to the consumer.

E. The consumer's clinical record shall clearly indicate any surrogate decision-maker and the extent of that surrogate's authority.

1. This will be recorded in the applicable Demographic section of the electronic record (Sentri).
2. A legible and legal document providing proof, such as the court guardianship papers, power of attorney, etc. must be scanned into the electronic record (Sentri).

F. SCCMHA providers need to be familiar with alternatives to guardianship and actively advocate for alternatives including the following options:

1. A natural support system consisting of a network of committed family members, friends, and circles of support that are fully aware of a person's strengths, wishes, and character traits can assure that decisions are not made in a void or by paid service providers. In addition, a support system can distribute tasks and supports in a shared fashion so that no single person bears full responsibility. Consideration should be given for a release of information to allow family and other supporters access to medical records and receive routine invitations to participate in person-centered planning meetings.
2. The provision of community assistance for support and observation including, but not limited to:
    a. Postal service checks for piled up mail
    b. Unpaid utility bills and meter reader observation
    c. Telephone reassurance programs
    d. Home visitors and pets on wheels
    e. Meals on wheels
    f. Food and prescription medication delivery
    g. Home sharing/roommate
    h. Personal assistance/home health care
    i. Service animals
3. The provision of assistance with finances for people who have difficulty managing their funds. Including the following options:
    a. A representative payee designated by the Social Security Administration, the Veteran's Administration, and other government agencies to receive monthly benefit checks on behalf of a beneficiary when the beneficiary is determined incapable of managing the funds themselves.
    b. A bill payer who assists an individual in organizing monthly income and expenditures, writes checks for the person's signature, and assists the client with paperwork related to bill paying. **Bill** payer programs serve individuals with limited incomes who are still in charge of their own financial affairs but need some help organizing their bills and checkbook.
    c. Banking arrangements and dual signature accounts can be used as alternatives to conservatorships. A person can often retain control of their own affairs with the help of automatic deposits and withdrawals for bills or banking by mail or phone. Another method often used is the establishment of a joint bank account in which a trusted friend or family member's name is added to an account.

Caution is recommended because both persons on the account have ownership of the account. A limited bank account that requires a co-signor to access funds, write checks, or transact business is another banking option.

d. A joint property arrangement in which two or more people share ownership of real estate or bank accounts is a common form of property management. Joint property arrangements, particularly joint bank accounts, generally are easy and inexpensive to establish and no court supervision is necessary. On the other hand, joint property arrangements are inherently risky because of the control they allow the co-owner over money or property and these arrangements may be less flexible once control over the property is given to the co-owner.

4. Families can set up Special Needs Trusts (SNTs) that adhere to Social Security, SSI (Supplemental Security Income), and Medicaid rules to ensure their family member with a disability has available resources after parents or other caretakers are no longer available. Funds in Special Needs Trusts are not counted as part of an individual's income (unlike funds in traditional savings accounts) and thus provide a safeguard for benefits such as Medicaid and Social Security. People with disabilities can also set up trusts on their own behalf.

   a. An OBRA 93 trust is used to shelter the assets of a person with a mental illness or intellectual/developmental disability while protecting their eligibility for Medicaid. Such assets are typically in the form of accounts created for the person prior to reaching the age of majority or unexpected distributions such as inheritances, gifts from relatives, or personal injury settlements. OBRA 93 trust provisions must require that the income and principal be unavailable to provide support to the beneficiary. These trusts must also specifically authorize that the state of Michigan will receive all amounts remaining in the trust upon the death of recipient up to an amount equal to the total medical expenditures paid on their behalf, including benefits received prior to the creation of the trust. An exception allows for the assets retained by the trust subsequent to the death of the beneficiary by a trustee that is a nonprofit organization which may then use retained assets for the benefits of others with disabilities.

   b. An amenities trust is designed to supplement means-tested entitlement benefits[1] (e.g., SSI, SSDI, and Medicaid) that are essential to securing personal assistance and medical treatment. Amenities trusts provide a resource for purchasing amenities to enhance the person's quality of life without hindering their access to essential public benefits. They can also be used to purchase a

[1] Any outright inheritance or distribution received by an individual with an intellectual/developmental disability or mental illness can interfere with the flow of their mean-tested benefits such as SSI or Medicaid.

residence[2] for the beneficiary and ensure the beneficiary's needs are monitored subsequent to parents' deaths. An Amenities trust is typically a subtrust to a family or credit shelter trust funded upon the death of the grantor and grantor's spouse. A fiduciary is required to manage the assets throughout the beneficiary's lifetime. The grantors (typically parents) determine the disposition of any remaining trust assets subsequent to the death of the beneficiary.

c. A "solely for the benefit of" trust is created solely for the benefit of a person who is disabled under federal law and is in the amenities trust format. The transfer of assets to the trust (typically by a parent) is used to qualify the parent for Medicaid without disqualifying the person with an intellectual/developmental disability or mental illness from also receiving Medicaid. Thus, the assets are transferred to the trust and removed from the parent's countable assets which are not a divestment subject to the look-back period with respect to the parent's Medicaid application. A parent who is moving toward long-term care and may need to qualify for Medicaid can create a trust that is solely for the benefit of his/her child with an intellectual/development disability or mental illness and can fund the trust during the parent's lifetime. The parent thus becomes immediately eligible for medical assistance and the beneficiary of the trust does not have to count the trust assets or income generated by the trust. This type of trust can be effective in estate planning when the parent's estate is at risk for depletion due to their medical and long-term care needs.

5. **ABLE (Achieving a Better Life Experience) accounts** are tax-advantaged savings accounts that enable eligible individuals with disabilities to save money in a tax-exempt account that may be used for qualified disability expenses while still maintaining their eligibility for federal public benefits. Contributions to ABLE accounts are made on an after-tax basis and earnings grow tax-deferred and are tax-free if used for qualified disability expenses. Contributions may be made by any person (the account beneficiary, an employer, family and friends) and may or may not be tax deductible depending on the specifics of the state ABLE law. Funds in the account may be used for many different types of expenses (e.g., education, housing, transportation, employment training and support, assistive technology, personal support services, health care expenses, financial management and administrative services, daily living expenses and other expenses to enhance the beneficiary's quality of life). The beneficiary is the owner of the account, but legal guardianship and powers of attorney will

[2] If the beneficiary pays rent to the trust and the rent payment constitutes a reasonable share of the expenses for maintaining the home, the provision that the trust not be used for shelter is satisfied. The amenities trust can purchase the home in the beneficiary's name if their income is sufficient to pay for basic utilities and property taxes. If the beneficiary opts to include roommates, they can share the expenses associated with home maintenance.

permit others to control ABLE funds in the event that the beneficiary is unwilling or unable to manage the account.

6. **Power of Attorney** allows an individual to designate a person to discuss and make decisions regarding medical decisions, living situations, confidentiality issues and other areas. The power of attorney allows the individual to give that power and they can take it away if they become dissatisfied with the decisions being made. There are general powers of attorney that convey a broad range of authority and limited powers of attorney that convey power over specific activities.
    a. A General Power of Attorney authorizes the attorney-in-fact to act on the person's behalf in all personal affairs and financial transactions. The authorization ceases upon death. Unless the document is a durable power of attorney, it terminates upon disability or incapacity.
    b. A Limited Power of Attorney authorizes the attorney-in-fact to act on the person's behalf only in matters specifically designated in the written document. The authorization ceases upon death. Unless the document is a durable power of attorney, it terminates upon disability or incapacity.
    c. Durable and Standby Powers of Attorney continue to be effective even in the event of disability or incapacity. Furthermore, a durable power of attorney can be made effective upon occurrence of a certain date or event such as a diagnosis by a physician of disability or incapacity. Because the effective date is delayed, this type of durable power of attorney is referred to as a standby power of attorney. Financial and medical Powers of Attorney can be made durable.
    d. A Medical (Durable) Power of Attorney or Durable Power of Attorney for Health Care appoints an agent to provide informed consent to surgery, medical treatment, personal care, and other medical or health related matters. A Medical Durable Power of Attorney covers a broader spectrum of medical procedures than a Living Will can. This type of power of attorney allows an individual to choose someone as their agent (i.e., someone who acts on their behalf) to make health care decisions whenever the individual cannot, due to unconsciousness or loss of ability to think and reason. This agent is required to make health care decisions according to directions provided by the principal. If the principal's wishes are not clearly understood and defined, then the agent must make decisions based on what he or she believes to be in the principal's best interests. The durable power of attorney for health care only comes into play when the principal's doctor has determined that the principal is unable to make health care decisions for him or herself, even when the situation is temporary.
        1) A Protective Medical Decisions Document (PMDD) is a durable power of attorney for health care that gives a person

named (the agent) to make health care decisions the authority to act on another person's behalf. The PMDD does not give the agent authority to approve the direct and intentional ending of life; it specifically prohibits euthanasia and assisted suicide.

e. A Financial (Durable) Power of Attorney appoints an agent to make financial decisions and/or handle financial transactions for an individual.

7. A conservator is appropriated by the court and is responsible for making decisions about the financial affairs of the ward. The ward's financial affairs include assets (e.g., stocks, bonds, bank accounts, cash and real estate) for which the conservator has assumed responsibility. Generally, the conservator controls all of the ward's income and property, takes care of paying bills, and handles other financial matters. The conservator's duties are to first, take possession of all the real and personal property of the ward. The conservator should immediately establish a bank account on which the conservator has signature authority. All of the ward's income, including Social Security, investment income and other sources should go into this account so the conservator can control it and render appropriate accounting when it is required.

   It is also the conservator's duty to preserve and protect the ward's property. At all times the conservator should exercise the same diligence that he/she would practice handling his/her own financial affairs. The conservator should invest prudently, keep records, and return the assets at the termination of the conservatorship. The conservator must be careful not to mix his/her property with the ward's property.

   A conservator's powers are divided into two distinct categories: those powers that can be exercised without prior court approval, and those powers that can be exercised only with the court's prior approval. Powers that the conservator can exercise without prior court approval include: collecting principal and income from any source; suing or defending claims in favor of, or against, the ward; selling or transferring perishable personal property; voting for the ward at corporate meetings; and receiving additional property from any source. The powers that the conservator can exercise only with the court's prior approval include: making payments to or for the benefit of the ward, including payments for nursing homes, medical expenses; investing the ward's funds; executing leases on behalf of the ward; applying any part of the ward's income or property for the support of anyone else; settling a legal claim; selling any property of the ward's; canceling contracts entered into by the ward that are no longer beneficial to the ward; and making gifts.

   a. A limited conservatorship gives only those specific powers that are set out in the court order; the ward can still make decisions in all other matters. By law, the court must attempt to give the conservator the fewest powers necessary to meet the needs of the ward. In contrast, a general or full conservatorship gives the conservator the authority to make all but a few decisions on behalf of the ward.

b. A standby conservatorship can be appropriate for a person who may currently be able to handle his/her affairs but anticipates a time when he/she may not be able. A person of sound mind can establish a standby conservatorship to plan for any infirmities without giving up present control over the property. A verified petition must be executed for the voluntary appointment of a conservator to establish a standby conservatorship. The petition must contain the express condition that the petition be acted upon by the court only upon the occurrence of a specified event, or the existence of a described condition of mental or physical health of the petitioner. The occurrence of the event, or the existence of such condition, must be established in the manner directed by the petition. The petitioner can revoke the petition before the appointment if the petitioner is of sound mind.

8. An Advance Directive names a proxy and provides guidance about a person's wishes and is essentially a combination of a health care power of attorney (or health care proxy) and a living will. Advance directives are oral or written instructions an adult gives to health care providers, family and loved ones while able to communicate. The reason for giving advance directives is to ensure a person's wishes regarding their health care are followed in case the person is no longer able to communicate with providers. Advance directives should be executed while the principal (person entering into an advance directive) is competent. The principal must be able to understand who he or she is appointing to make health care decisions and should choose an agent who is trusted. There are two types of advance directives: the durable power of attorney for health care and the living will.
9. A living will, also called a directive or declaration, is a document, signed while an individual is competent, that instructs doctors to withdraw or withhold artificial life support if the individual becomes medically terminal. Living wills only apply to artificial life sustaining procedures. It should be noted that because the attending physician may be a total stranger who is completely unfamiliar with the consumer's values and wishes, terms in the document may be interpreted by the physician in a manner that was not intended by the signer. In addition, family members and others who are familiar with the signer's values and wishes have no legal standing to interpret the meaning of the directive.

Definitions:

ABLE Act: The Stephen Beck Jr. Achieving a Better Life Experience (ABLE) Act (PL 113-295) added Section 529A to the federal tax code to enable eligible individuals with disabilities to save money in a tax-exempt account that may be used for qualified disability expenses while still keeping their eligibility for federal public benefits.

ABLE Account: A tax-advantaged savings account that qualified individuals with disabilities may open as a result of the passage of the ABLE Act of 2014 and subsequent enactment of state ABLE laws. Individuals with disabilities can only have $2,000 in assets at any given time in order to remain eligible for many federal means-tested benefits

programs which provide much-needed supports, such as Supplemental Security Income (SSI). Under ABLE, eligible individuals and families may establish ABLE savings accounts that will not affect their eligibility for SSI (up to $100,000), Medicaid and other public benefits. ABLE accounts provide a mechanism to essentially increase this $2,000 asset limitation so that individuals with disabilities and their families can save money for their future and to improve their quality of life.

An individual must meet two requirements to be eligible for an ABLE account: an age requirement and a severity of disability determination. The onset of symptoms of the person's disability must have occurred before age 26. Additionally, the disabled individual must have "marked and severe functional limitations" (essentially, a Social Security definition of disability). An individual whose disability occurred prior to age 26 and is already receiving SSI and/or SSDI is automatically eligible to establish an ABLE account. Those who are not recipients of SSI and/or SSDI but still meet the age of onset disability requirement will be eligible to open an ABLE account upon obtaining a disability certification from their physician.

The total annual contributions by all participating individuals, including the beneficiary, family and friends, is $14,000 (the federal gift tax exclusion). The total limit of contributions that could be made to an ABLE account over time is tied to the individual state's maximum amount for regular 529 accounts (typically around $350,000). The first $100,000 in ABLE accounts will be exempted from the SSI $2,000 individual resource limit. After $100,000, the beneficiary's SSI will be suspended (but not terminated), though Medicaid benefits will continue regardless of ABLE funds.

Amenity: An amenity is anything that is not food or shelter and does not involve a direct distribution of cash to a Medicaid recipient. For purposes of SSI, amenities trusts cannot pay for basic support including rent, utilities (gas, water, sewer, electricity, and garbage removal), mortgage payments, property taxes, and property insurance.

Allowable amenities include:

- acupuncture/acupressure
- advocacy
- appliances (TV, VCR, stereo, microwave, stove, refrigerator, washer/dryer)
- bottled water
- bus pass/public transportation fees
- clothing
- clubs and club dues (record clubs, book clubs, health clubs, service clubs)
- computer (hardware, software, programs, Internet service)
- courses or classes (academic or recreational)
- curtains, blinds, drapes
- dry cleaning and laundry services
- elective surgery
- fitness equipment
- furniture, home furnishings
- gasoline for automobile
- haircuts/salon services
- house cleaning/maid services
- insurance (automobile and/or possessions)
- linens and towels
- massage
- musical instruments (including lessons)
- nonfood grocery items (laundry soap, bleach, fabric softener, deodorant, dish soap, hand and body soap, personal hygiene products, paper towels, napkins, Kleenex, toilet paper, any household cleaning products)
- over-the-counter medications (including vitamins or herbs)
- personal assistance
- pet, pet supplies
- physician specialists

- private counseling
- repair services (appliance, automobile, bicycle, household)
- retail store charge accounts (gift stores, craft stores, hardware stores, pet stores)
- sporting goods/equipment
- taxi cab scrip
- telephone, internet, cable or satellite television
- tickets to concerts or events (for beneficiary and accompanying companion)
- transportation (automobile, motorcycle, bicycle, moped)
- vacation (including paying for a companion to accompany the beneficiary)

Guardian: A person who is responsible for someone legally unable to care for him/herself and manage his/her affairs and has been given decision making authority pursuant to testamentary or court appointment. A guardian is appointed by the court to make decisions about the ward's needs or affairs other than financial matters. These may include decisions regarding medical treatment, where the ward lives, and arrangements for services such as meals, personal care, training, and education. A guardian's duties and powers are divided into two distinct categories: those powers and duties that can be exercised without prior court approval, and those powers and duties that can be exercised only with the court's prior approval. Powers that a guardian can exercise without prior court approval include: providing for the care, comfort and maintenance of the ward, including appropriate training and education intended to maximize the ward's potential; taking reasonable care of the ward's clothing, furniture, vehicle and other personal effects; assisting the ward in developing maximum self-reliance and independence; ensuring that the ward receives necessary emergency medical services and routine medical care; ensuring that the ward receives professional care, counseling, treatment and services as needed; plus any other powers and duties that the court may specify. The powers the guardian can exercise only with the court's prior approval include: changing the ward's permanent residence if the proposed residence is more restrictive than the current residence; arranging the provision of major elective surgery or any non-emergency major medical procedure; and consenting to the withholding or withdrawal of life-sustaining procedures.

A **general guardian** is someone charged with the care of both the ward and his property. This includes room and board, personal maintenance, financial needs, medical care, and other legal responsibilities pertaining to handling the ward's estate, property, and assets responsibly. A **personal guardian** or **guardian of the person** has the power only to make all personal decisions, including where the ward will live.

A **full (plenary) guardian** possesses all the legal duties and powers enumerated in law. A person with a full guardian has some or all of their rights taken away and given to another person including the right to choose their own clothes, leisure activities, friends, and food.

A **limited guardian** possesses fewer than all other legal duties and powers of a full guardian and whose rights, powers, and duties have been specifically enumerated by the court. A limited guardianship gives the guardian only those specific powers that are set out in the court order; in all other matters the ward can still make decisions for him or herself. The court must, by law, only give the guardian the powers necessary for the guardian to meet the needs of the ward. By contrast, a general or full guardianship gives the guardian the authority to make all decisions on behalf of the ward, except those that require prior court approval.

A person may currently be able to handle their affairs but anticipates a time when he/she may not be able to do so. To pre-determine who will serve as guardian, if in the future a guardianship becomes necessary, a person of sound mind can establish a **standby guardianship**. The standby guardianship takes effect only upon the occurrence of an event specified in the document (petition). With a standby guardianship, a person can retain control over his/her personal affairs until the event specified occurs. To establish a standby guardianship, a verified petition must be executed for the voluntary appointment of a guardian. The petition must contain the express condition that the petition be acted upon by the court only upon the occurrence of an event specified or the existence of a described condition of mental or physical health of the petitioner. The occurrence of the event or the existence of such conditions shall be established in the manner directed by the petition. The petitioner can revoke the petition before the need for appointment if the petitioner is of sound mind.

A guardian is usually selected in accordance with the following prioritized list:

1. A member of the individual's natural support system (e.g., spouse, adult child, parent, sibling relative or friend)
2. A representative of a recognized advocacy organization (e.g., United Cerebral Palsy Association of Michigan, National Association for the Mentally Ill Michigan Chapter, the ARC, Disability Rights Michigan).

It should be noted that Michigan law provides that guardianship over individuals with intellectual/developmental disabilities be considered as a last resort (MCL 330.1602). In addition, guardianship does not confer power of compulsion, only of persuasion. Guardianship is not appropriate in order simply to require a person to take medication nor does it authorize a person to be treated without their consent. Moreover, unless a guardian with the person 24/7, guardianship cannot prevent abuse or exploitation; guardianship cannot prevent bad things from happening.

Health Care Proxy: An agent who makes health care decisions for a person lacking the capacity to make such decisions for him/herself.

Incapacitated Person: Any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication or other cause (except minority) to the extent that s/he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his/her person or which cause has so impaired the person's judgment that he/she is incapable of realizing and making a rational decision with respect to his/her need for treatment.

Living Will: A legal document directing the principal's doctor to withhold or withdraw certain treatments (life-sustaining procedures) that could prolong the dying process. It is used to express wishes for medical decisions about withholding or withdrawing of life-sustaining treatment wherein the person lacks capacity to make decision. This advance directive becomes effective only at the point when, in the written opinion of the doctor (and confirmed by one other doctor), the principal is expected to die soon and is unable to make health decisions for him or herself (because he/she is unconscious or unable to think and reason) or because of permanent unconsciousness (irreversible coma or persistent vegetative state). A living will is often used in conjunction with health care proxy.

Power of Attorney: A written document by which one person (the principal) gives to another person (attorney-in-fact) the authority to act on the first person's behalf in one or more matters. The person giving legal authority must be competent to grant a power of

attorney and only a trusted individual should be chosen to act as the attorney-in-fact. A power of attorney for financial matters grants authority to the attorney-in-fact to transact business on the person's behalf. The power of attorney can grant the attorney-in-fact one or all of the following:

- Open, maintain or close bank accounts or brokerage accounts
- Access to safe deposit boxes and their contents
- Make financial investments
- Borrow money, mortgage property, or renew or extend debts
- Prepare and file federal and state income tax returns
- Vote at corporate meetings
- Sell, convey, lease or maintain real estate
- Purchase insurance for the principal's benefit
- Initiate, defend, prosecute, or settle any lawsuit
- Start or carry on business
- Employ professional and business assistances of all kinds, including lawyers, accountants, real estate agents, etc.
- Apply for benefits and participate in governmental programs
- Transfer to a trustee any and all property
- Disclaim part or all of an inheritance

Representative Payee: A person appointed to take care of another person's money. Government benefits may be paid to a representative payee. The person appointed as the Representative Payee will pay for the other person's living expenses. The Social Security Administration and the Veterans Administration (if applicable) must be contacted to have a representative payee appointed for someone.

Trust: A legal relationship in which one person (a trustee) holds real or personal property (e.g., money, real estate, stocks, bonds, collections, business interests, personal possessions, and other tangible assets) for the benefit of another person (the beneficiary). Trusts that can be changed or terminated at any time by the grantor are **revocable**. Trusts that cannot be changed or terminated before the time specified in the trust itself are **irrevocable**. The trustee holds legal title to the property transferred to the trust and has a legal duty to use the property as provided in the trust agreement as permitted by law. The beneficiary retains equitable title (i.e., the right to benefit from the property as specified in the trust). Trusts can be useful planning tools for incapacity because they can be established and controlled by a competent person and later continue in operation under a successor trustee if the person establishing the trust becomes unable to manage his/her affairs. One person often establishes a trust for the benefit of another. This type of trust involves at least three people: the grantor/trustor (the person who creates the trust); the trustee (the person or financial institution who holds and manages the property for the benefit of the grantor and others); and the beneficiary or beneficiaries (the person(s) who receives the benefits from the trust).

Exhibits:

A. Guardianship Referral Form
B. Authorization for Payment to Guardianship Services
C. Guardianship Questionnaire Electronic Form

References:

A. Centers for Medicare & Medicaid Services (CMS) Home and Community Based Services (HCBS) Final Rule (CMS 2249-F/2296-F): https://www.michigan.gov/documents/mdch/Final_Rule_474879_7.pdf
B. MDHHS BHDDA HCBS Guardianship FAQs: https://www.michigan.gov/documents/mdhhs/MDHHS_BHDDA_HCBS_GUARDIANSHIP_FAQ_6.25.18_634277_7.pdf
C. Medcaid.gov Home & Community Based Services Final Regulation: https://www.medicaid.gov/medicaid/hcbs/guidance/hcbs-final-regulation/index.html
D. Michigan Medicaid Provider Manual: Home and Community Based Services Chapter
E. Michigan Mental Health Code, Chapter 6 (*Guardianship for the Developmentally Disabled)*: https://www.legislature.mi.gov/(S(es1wxoil2rubqjnavtoe3pjd))/documents/mcl/pdf/mcl-258-1974-6.pdf
F. SCCMHA Policy 02.03.03 – Person-Centered Planning
G. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

Procedure:

ACTION	RESPONSIBILITY
1. Incorporates discussion of guardianship issues and alternatives into the person-centered planning process, as indicated/needed, and documents that process in the consumer's person-centered plan of service and ongoing reviews in accordance with Standards C and D of this policy.	1. Case Holder
2. Establishes a guardianship request review committee to review requests for guardianships	2. Executive Director of Clinical Services
3. Submits the guardianship referral form to the Administrative Coordinator for the Customer Service/Recipient Rights Office	3. Case Holder
4. Adds the form to the guardianship review committee's monthly meeting agenda.	4. Administrative Coordinator for the Customer Service/Recipient Rights Office
5. Meets with the Case Holder, reviews relevant information, and decides whether or not SCCMHA agrees that the Case Holder should pursue a guardianship and whether or not to	5. SCCMHA Guardianship Committee

	request authorization for a court-required psychological evaluation.	
6.	If approved, completes the Guardianship Questionnaire form and sends to Braun Kendrick Law Offices for pursuit of guardianship	6. Case Holder
7.	Sends a copy of the signed Guardianship Referral form to Medical Records for scanning into the Clinical Record.	7. Administrative Coordinator for the Customer Service/Recipient Rights
8.	Works with family/advocate/supporter to establish an alternative to guardianship if the committee determines the Case Holder should not pursue guardianship.	8. SCCMHA Guardianship Committee and Case Holder
9.	Completes the Authorization for Payment form and sends it to Guardianship Services when there is a vacancy in the list kept by Guardianship Services.	9. Director of Customer Service/Recipient Rights

Exhibit A

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Guardianship Referral Form

Please review Alternatives to Guardianship Policy # 02.03.12 before making the referral to the Guardianship Committee

Case Manager/Support Coordinator to complete form and send to the Customer Service/Recipient Rights Administrative Coordinator for inclusion on the next scheduled Guardianship Committee Meeting.

Date of Referral:			
Consumer Name:		Consumer Case #:	
Case Holder:			
Provider/Team:			
Reason for Referral:			
Referral Approved by Supervisor:	Name/Signature		Date

Information Below to be completed by Guardianship Committee

Date of Guardianship Committee Meeting:	
Request for SCCMHA Support of Guardianship Accepted:	☐
Request for SCCMHA Support of Guardianship Declined:	☐
Reason for Decision OR other Recommendations:	

SCCMHA Guardianship Chair – Kristie Wolbert **Date**

Scan: Legal

Exhibit B

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Authorization for Payment to Guardianship Services

Guardianship Committee to complete this form for every person approved for Guardianship or Payee Services through contract with SCCMHA.

Consumer Name: _____ **Consumer Case #:** _____

Case Holder: _____

Provider/Team: _____

Reason for Authorization: _____

_____

Service to be Provided: ☐ **Guardianship** ☐ **Payee**

Date of Guardianship/Payee Authorization: _____

_____ _____

SCCMHA Guardianship Chair – Kristie Wolbert **Date**

Exhibit C

GUARDIANSHIP QUESTIONNAIRE

Kosta D. Povich, Esq.
Braun Kendrick Finkbeiner P.L.C.
4301 Fashion Square Blvd.
Saginaw, Michigan 48603
Phone: (989) 399-0620
Fax: (989) 799-4666
E-mail Address: kospov@braunkendrick.com

If you are asking the Court to appoint a guardian, then you are the *petitioner*. The person who requires a guardian is the *proposed ward*. The person/entity that you want to have the Court appoint as guardian is the *proposed guardian*. The information contained in this Questionnaire will be used to draft a Petition seeking the appointment of the *proposed guardian*.

NOTE: A Report must accompany the Petition that is submitted to the Court for the appointment of a guardian. The Report is to be completed by a licensed medical professional and cannot be more than a year old. Please also note that we will be required to submit information regarding the medications that the proposed ward is receiving. The type of Petition and Report that is submitted to the Court will depend on what type of guardianship is sought. The Court has standard forms that are used for the Petition and the Report.

*After you have completed this Questionnaire, please ***fax*** it to my attention at the number above. Please do not hesitate to call me at the number above regarding any questions or concerns. I look forward to working with you on this matter. Thank you.

****

GUARDIANSHIP COMMITTEE ONLY

A guardian is needed to assist the proposed ward with the following responsibilities and duties:

Proposed ward's name: _____

☐ medical treatment
☐ program and placement decisions
☐ other: _____
☐ living arrangements
☐ financial matters

Guardianship Committee is Requesting:

☐ plenary (full) guardian of the ☐ individual ☐ estate

☐ partial guardian of the ☐ individual
☐ estate with the following powers: _____

****

****

PETITIONER INFORMATION:

Name of the petitioner: _____

Petitioner's interest/relationship to the proposed ward: _____

☐ Address: _____

City: _____ State: _____Zip Code: _____

Telephone number: _____ Cell phone number:_____

Email: _____ Fax: _____

****

PROPOSED GUARDIAN INFORMATION IF NOT GUARDIANSHIP SERVICES OF SAGINAW COUNTY, INC.:

Full name of proposed guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____ Cell phone number:_____

Email: _____

****

PROPOSED WARD INFORMATION:

Proposed ward's name: _____

Address where proposed ward is currently living: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____ Cell phone number:_____

County proposed ward is a resident of: _____

Date of birth: _____

Social security number: _____ Race: _____

☐ Male ☐ Female

If applicable, citizen of foreign country: _____

Does the proposed ward have:

A guardian: ☐ Yes ☐ No

A Conservator: ☐ Yes ☐ No

A General Durable Power of Attorney: ☐ Yes ☐ No

A Durable Medical Power of Attorney: ☐ Yes ☐ No

A representative payee for social security benefits: ☐ Yes ☐ No

*If you answered "Yes" to any of the above, please provide additional information/ documentation of same.

****

The proposed ward has a severe, chronic condition that meets the following:

☐ self-care ☐ receptive and expressive language ☐ learning ☐ mobility

☐ self-direction ☐ capacity for independent living ☐ economic self-sufficiency

****

Specific nature and extent of proposed ward's disability is:

_____

****

The proposed ward lacks sufficient understanding or capacity to make or communicate informed decisions due to: (mark all that apply)

☐ mental illness ☐ mental deficiency ☐ physical illness/disability
☐ chronic intoxication ☐ chronic drug use

Facts about the proposed ward's recent condition or conduct that is believed to warrant the need for a guardian and/or conservator:

_____

Estimated value of proposed ward's estate and income:

Real Estate: $ _____ Yearly Income: $ _____

Personal Property: $ _____ Source of Yearly Income: _____

Does the proposed ward receive, or is he/she entitled to receive any income, financial assistance or other payment of money? If so, provide yearly amount.

Social Security: Yes _____ No _____ Unknown _____

SSI: Yes _____ No _____ Unknown _____

MDHS: Yes _____ No _____ Unknown _____

Pension: Yes _____ No _____ Unknown _____

Veterans benefits: Yes _____ No _____ Unknown _____

If yes, provide claimant number: _____

Annuity Payments: Yes _____ No _____ Unknown _____

Dividends: Yes _____ No _____ Unknown _____

****

If an action within the jurisdiction of the family division of circuit court involving the family or family members of the proposed ward has been previously filed provide the following:

County: _____ Judge: _____

Case Number: _____ ☐ remains ☐ is no longer pending.

****

Name of proposed ward's spouse: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

****

All children of the proposed ward: (attach extra sheet if necessary)

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

****

Name of proposed ward's father, if living: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

Name of proposed ward's mother, if living: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

****

Please provide information regarding any other relatives of the proposed ward: (attach extra sheet if necessary)

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

****

Who currently has the care and custody of the proposed ward?

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____

****

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Outcome Tool for Adults (ANSA)</td><td>Chapter: 02.03 – Philosophy of Care</td><td>Subject No: 02.03.17</td></tr>
<tr><td rowspan="2">Effective Date:
9/27/13</td><td>Date of Review/Revision:
5/4/16, 3/28/17, 5/18/18, 4/9/19, 4/7/20, 3/29/21, 3/14/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Heidi Wale Knizacky

Additional Reviewers:
Clinical Directors
Sara Anani, John Burages</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
In order to assure recovery and effective services, the use of an evidenced-based and standardized tool, the Adult Strengths and Needs Assessment (ANSA), will be used as the required clinical outcome tool for adults. The ANSA documents both needs and strengths in functioning.

Policy:
It is the policy of the Saginaw County Community Mental Health Authority that an evidenced-based, standardized tool will be used in the provision of services to promote recovery and meeting the clinical needs of each individual served by the agency.

Application:
This policy applies to the SCCMHA Network of providers who serve adult consumers with an SMI (Severe Mental Illness) diagnosis.

Standards:

A. Permission for Use:
The ANSA is a copyrighted tool that is available for free use by permission of the John Praed Foundation. In April 2012, SCCMHA obtained written permission to use the ANSA within specified limits and requirements. (See Exhibit A)

B. A belief in the concept of recovery is integral to the items represented and language inherent to the ANSA.

C. The ANSA is used to:
   1. help determine the appropriate match of services to needs for an individual,
   2. create a common language for communicating strengths and needs between treatment team members and other providers,

3. identify treatment and training needs for program planning,
4. provide accountability to funding sources, the community, auditors, and stakeholders,
5. aid in evaluating the effectiveness of SCCMHA Evidence Based Practice (EBP) programs,
6. help clinicians identify treatment interventions of best fit and measure progress,
7. aid in keeping track of all relevant facets of an individual's circumstances - including monitoring of safety issues,
8. strengthen ongoing and transparent dialogue between each clinician and consumer to aid the therapeutic relationship and promote recovery, and
9. provide a mechanism for all members of the treatment team, especially the consumer themselves, to visually see and celebrate improvements in functioning.

D. Completion schedule:
   a. The ANSA must be completed for all adult consumers with SMI receiving SCCMHA services
      i. during the initial Person-Centered Planning process and prior to the completion of the Individual Plan of Service,
      ii. every six months during service enrollment, and
      iii. at exit from services.
   b. The ANSA profile should reflect the needs addressed within the service plan. On the occasion that a consumer's circumstances or life functioning alters greatly, or very different information is presented to the clinician from what was previously known, another ANSA assessment outside of the initial and every six months schedule should be completed by the case holder, or therapist providing treatment, to assist with therapeutic rapport and treatment planning.

E. Staff responsible:
   1. The ANSA is to be scored only by a "reliable rater" (one who has been trained in the use of the ANSA). Any case holder who has not achieved 'reliable rater' status will collaborate with a staff member who has achieved this status in order to assure the ANSA is properly completed.
   2. The assigned case holder will assure that the assessment results are recorded in Sentri.

F. Training requirements:
   a. All ANSAs must only be completed by individuals who are reliable raters in good standing with SCCMHA. To become a reliable rater an individual will attend a full-day training program, complete a test vignette, and obtain a score of ".70" or higher.
      i. All prospective ANSA raters will receive a user account allowing access to online training resources under the SCCMHA jurisdiction. Accounts will be set up for individual users during the initial reliability training session. The current web address for this program is https://www.schoox.com/login.php. The training

account provides users with item scoring instructions and a downloadable copy of the ANSA manual.

ii. Reliability examinations, both initial and annual renewals, are to be completed via the online user account.

iii. Individual accounts must pay an annual subscription fee. SCCMHA will purchase vouchers and the ANSA Coordinator will distribute to network raters annually to maintain their account access.

b. Raters must renew reliability status annually by both 1) attending a booster training and 2) independently completing a reliability exam by rating a test vignette and obtaining a score within acceptable limits.

i. The booster training format will be announced and scheduled by fiscal year.

ii. Reliability exams must be completed within 30 days of the rater's annual renewal date. Failure to pass the reliability exam within 90 days of the annual renewal date may result in removal of access to ANSA within Sentri.

c. Additional trainings or activities may be required to address individual, program, or agency needs.

G. Distribution of ANSA information:

a. Since the ANSA is intended to facilitate helpful communication between clinicians and consumers, each time an ANSA is completed, the consumer should be presented with their profile report and invited to review with a service professional who is knowledgeable about the assessment and involved in their treatment planning.

b. The information represented by the ANSA should be referenced during treatment planning conversations.

c. ANSA profiles should be referenced during staff supervision and team consultation.

d. The results from the ANSA are to be integrated into the development of the outcomes, goals, and objectives for each consumer as part of the Person-Centered Planning process.

e. Having a current ANSA will be a requirement in order to attain authorization for services.

f. The ANSA Coordinator will provide regular aggregate reports, quarterly at minimum, by collaborating with clinical supervisors to determine areas of focus for clinical needs, outcomes, and data integrity.

g. Supervisors will review aggregate ANSA reports for their teams to aid in identifying supervisory, training, and other resource needs.

h. Supervisors will review data integrity reports to ensure staff enter ANSA assessments into the SENTRI II system within the required timeframes.

Definitions:

Rater – Case Manager, therapist, or supervisor who is authorized to complete an ANSA assessment by meeting minimum ANSA training and testing requirements and proof of their credential is approved by the SCCMHA ANSA Coordinator.

ANSA – Adult Needs and Strengths Assessment

IPOS – Individual Plan of Service
SMI – Serious Mental Illness

References:
SCCMHA Recovery Policy 02.03.05

Exhibits:
A. Praed SCCMHA letter, April 2012

Procedure:

ACTION	RESPONSIBILITY
A group of individuals will be designated as an ANSA leadership team, one member of which will serve as the ANSA Coordinator.	The SCCMHA Outcomes Management Group or members of the SCCMHA Management Team
The ANSA leadership team will be comprised (at least in part) of reliable raters who have satisfactorily participated in additional trainer training sanctioned by the Praed Foundation. The ANSA leadership team will develop local training materials, conduct trainings for SCCMHA staff and contractual providers, and monitor and respond to the needs of ANSA raters working with SCCMHA consumers. Members of the team may or may not determine to become an official ANSA Trainer as recognized by the Praed Foundation. The ANSA leadership team will also coordinate with SCCMHA's EMR provider to design and maintain electronic data collection of the ANSA.	ANSA leadership team
Service staff who have demonstrated and maintained ANSA reliability status will be granted Sentri access to rate ANSA within individual consumer records. Staff who have not maintained their reliability credential will have rating access removed.	SCCMHA Information Technology Department
The ANSA Coordinator will coordinate efforts of the ANSA leadership team. The Coordinator will maintain a list of raters in	ANSA Coordinator

good standing and share this list with the SCCMHA Information Technology department to ensure raters have electronic access to complete an ANSA. The Coordinator shall collect current research and practice use of the ANSA and draw from this information to design and create meaningful reports for all stakeholders of SCCMHA ANSA data on a quarterly basis or as requested by stakeholder groups.	
The results from the ANSA are integrated into the outcomes, goals, and objectives for the consumer as part of the Person-Centered Planning process.	Case Holder
Semi-annually, an ANSA is completed to reflect the current needs and strengths of the consumer. An ANSA should also be completed if a consumer experiences a significant change in functioning that results in a need to change their IPOS. Prior to or while completing an ANSA, the consumer should be interviewed and collateral sources of information referenced to insure accurate and reliable rating. Completed ANSA's must be entered into Sentri and electronically signed. The results will be integrated, as applicable, into the consumer's plan of service through the Periodic Review.	Case Holder
An "Exit" ANSA will be completed to reflect a consumer's needs and strengths upon termination of services. This should be done as part of a collaborative process with the consumer for planned termination of services. If the termination was unplanned (e.g. for prolonged "no shows" to appointments), whenever possible an ANSA should be completed and dated to reflect that last known status of the consumer when engaged in services. In the circumstance that no opportunity has presented to obtain complete information regarding the consumer since their last	Case Holder

completed ANSA, the consumer's case should be closed without entering an Exit ANSA.	
ANSA profiles are consulted during chart reviews, case consultations, and staff meetings to review progress and identify needs and concerns to be addressed in service planning.	Program Supervisors

Exhibit A

April 9, 2012

To Whom It May Concern:

The Praed Foundation (Foundation) recognizes the complexity of the Saginaw County Community Mental Health Authority behavioral health care system and supports the work of SCCMHA and its contracted behavioral health providers to improve behavioral health services, including the use of improved assessment tools. The Foundation is working with SCCMHA to develop assessment tools tailored for the use of SCCMHA and its contracted behavioral health providers.

The Foundation is issuing this letter to certify that it is granting permission to Saginaw County Community Mental Health Authority (SCCMHA), its agents, contracted behavioral health providers, and business associates to use the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA) tools as modified for SCCMHA.

The Foundation recognizes that additional modifications to the CANS and ANSA assessment tools may be necessary. The Foundation should be consulted regarding substantive modifications to the assessment, including adding or removing items or language from the Needs Assessments forms and manuals. Changes limited to altering formatting, item/domain order, or to correct typographical or grammatical errors may be implemented without seeking prior approval.

Appropriate training received from a certified trainer or Training Entity is a necessary component for successful use of the SCCMHA Needs Assessments. To ensure that proper training is attained, completion of a certification program is required for all SCCMHA Needs Assessments users. The Foundation authorizes SCCMHA to determine whether the Needs Assessments users must seek recertification and the frequency of any recertification.

SCCMHA or its contracted behavioral health providers may choose to develop capacity to be designated as training entities. In this capacity SCCMHA or its contracted behavioral health providers could develop and certify both users and trainers of the SCCMHA Needs Assessments. Certification of SCCMHA or its contracted behavioral health providers as Training Entities requires that SCCMHA or its contracted behavioral health providers work with the Praed Foundation on meeting the following requirements:

- Develop and maintain at least one certified trainer who works as a trainer for a minimum of one year training on the CANS and ANSA; and
- During the one year training period, works with the Praed Foundation to learn how to provide trainer training and certification; and
- Does at least one joint trainer program with a Praed Foundation designated trainer of trainers.

In order to maintain its status as a training entity, SCCMHA or its contracted behavioral health provider will need to maintain at least one qualified trainer of trainers in its employ.

Subject to SCCMHA receiving certification as a Training Entity by the Foundation and if SCCMHA chooses to develop its own training program, the Foundation authorizes SCCMHA to perpetually, irrevocably, without licensing costs, and royalty-free, establish, develop, administer, and maintain a training program which will focus on services provided to consumers in Saginaw, Michigan for staff at SCCMHA, its contractors, and business associates.Any licensing or royalty fee is also perpetually waived if SCCMHA directly provides training to end users, however the following also applies.

At SCCMHA' discretion, SCCMHA may contract with another party, including the Foundation, for any or all training-related activities. Should SCCMHA exercise its contracting option and the Foundation is selected as a contractor, the Foundation reserves the right to charge SCCMHA training fees for any contracted service requested of the Foundation as listed in Attachment A to this letter.

For any contract between SCCMHA and a third party that already pays the Foundation a licensing or royalty fee associated with CANS or ANSA training services, the Foundation does not, nor is the third party is expected to, waive those fees for services provided to SCCMHA when those fees are normally incorporated into its service charges, such as those associated with providing web-based training.

The Foundation also authorizes SCCMHA and/or its agents, contractors, business associates, to perpetually, irrevocably, without licensing costs, and royalty-free:

- Develop, distribute, and utilize any computer software (including, but not limited to, Electronic Health Record (EHR) system(s), stand-alone application(s), component code, system documentation, data tables, table structures, and file structures), templates, electronic or paper materials and documents, associated business rules, training guides and examinations, and other materials or resources that may be used to operationalize, utilize, implement, support, address, or incorporate the SCCMHA Needs Assessments into clinical operations and health care delivery;

- Incorporate and utilize the SCCMHA Needs Assessments as a component of a(n) EHR(s) and/or other Health Information Technology (HIT) application or system(s);
- Use and distribute the SCCMHA Needs Assessments in paper and/or electronic form;
- Grant unlimited access and usage for all appropriately trained and certified users to the SCCMHA Needs Assessments in electronic and/or paper form; and
- Deliver technical support to trained users and potential users relating to the SCCMHA Needs Assessments.

Thank you and good luck with your use of the CANS and ANSA to help improve care to the citizens of Saginaw, Michigan.

Sincerely,

John S. Lyons, Ph.D.
President

[

Praed Foundation
550 N Kingsbury, Suite 101 Chicago IL 60654
www.praedfoundation

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Preschool and Early Childhood Functional Assessment Scale (PECFAS) & Child and Adolescent Functional Assessment Scale (CAFAS)</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.18</td></tr>
<tr><td rowspan="2">Effective Date:
June 4, 2014</td><td>Date of Review/Revision:
5/6/16, 3/30/17, 4/10/18, 4/8/19, 3/29/20, 3/4/21, 2/28/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Heidi Wale Knizacky

Additional Reviewers:
Jennifer Stanuszek, Clinical Directors</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
In order to determine care needs and changes in functioning, the Preschool and Early Childhood Assessment Scale (PECFAS®) and Child and Adolescent Assessment Scale (CAFAS®) will be utilized with all Seriously Emotionally Disturbed (SED) children and youth within the designated age ranges. The PECFAS® and CAFAS® measures have established acceptable reliability and validity for assessing functioning of children and youth in a variety of both natural and care environments.

Application:
This policy applies to all clinicians, Wraparound workers, case managers and the SCCMHA CAI (Centralized Access and Intake) staff who serve all SED (Seriously Emotionally Disturbed) child and youth consumers ages of 4 years and above, supervisors of these staff, and the Care Management and Utilization team.

Policy:
It is the policy of the Saginaw County Community Mental Health Authority that an evidenced-based, standardized tool will be used in the provision of services to promote recovery and meeting the clinical needs of each individual served by the agency.

Standards:
A. Permission for Use:

1. The PECFAS and CAFAS are copyrighted tools that are available for use by purchase through Functional Assessment Systems (FAS) of Multi-Health SystemsInc.(MHS). http://www.mhs.com/product.aspx?gr=cli&prod=cafas&id=overview
2. The Michigan Department of Health and Human Services (MDHHS) requires the use of the tools per MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY18 ATTACHMENT C4.7.2. MDHHS currently pays the FAS Outcomes annual licensing fee for web-based use at web address https://app.fasoutcomes.com/. (Exhibit A - Michigan Department of Health and Human Services CAFAS and PECFAS Guidance to PIHPs and MHSPs March 2018)

B. Purposes of PECFAS/CAFAS use:
1. determine eligibility and assist with determining the appropriate match of services to needs for an individual,
2. create a common language for communicating needs between treatment team members and other providers,
3. help clinicians identify treatment interventions of best fit and measure progress,
4. aid in keeping track of all relevant facets of an individual's circumstances - including monitoring of safety issues,
5. strengthen ongoing and transparent dialogue between each clinician and consumer to aid the therapeutic relationship and promote recovery,
6. provide a mechanism for all members of the treatment team, especially the child and their family themselves, to visually see and celebrate improvements in functioning,
7. identify treatment and training needs for program planning,
8. comply with MDHHS Provider requirements,
9. provide accountability to funding sources, the community, auditors, and stakeholders, and
10. aid in evaluating the effectiveness of SCCMHA Evidence Based Practice (EBP) programs.

C. Eligibility determinations:
1. Amongst other dimensions, such as a supporting diagnosis, criteria for determining when a child 7 through 17 years is considered to have a serious emotional disturbance (SED) includes "Functional impairment that substantially interferes with or limits the minor's role or results in impaired functioning in family, school, or community activities." (MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY 19: Attachment C4.7.2) This functional impairment is determined by:
    a. A total score of 50 (using the eight subscale scores on the Child and Adolescent Functional Assessment Scale (CAFAS), or
    b. Two 20s on any of the first eight subscales of the CAFAS, or
    c. One 30 on any subscale of the CAFAS, except for substance abuse only.
2. According to the 2020 Michigan Medicaid Provider Manual (Behavioral Health and Intellectual and Developmental Disability Supports and Services p.55), for purposes of qualification for home-based services, children/adolescents age 7

to 17 may be considered markedly or severely functionally impaired if the minor has:

a. An elevated subscale score (20 or greater) on at least two elements of the Child/Adolescent Section of the CAFAS; or
b. An elevated subscale score (20 or greater) on one element of the CAFAS Child/Adolescent Section, combined with an elevated subscale score (20 or greater) on at least one CAFAS element involving Caregiver/Care-giving Resources; or
c. A total impairment score of 80 or more on the CAFAS Child/Adolescent Section.

3. Functional impairment qualifications for the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SED-W) are: (2019 Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services, Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix, pB2)
   a. CAFAS® score of 90 or greater for children age 7 to 12; OR
   b. CAFAS® score of 120 or greater for children age 13 to 18; OR
   c. For children age 3 to 7, elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others; AND

   Be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, the child can remain on the waiver up to their 21st birthday.
4. If, based on evidence-based clinical judgment, the child is believed to be in significant need of SCCMHA-funded SED services despite a non-qualifying CAFAS score, the rating clinician should: 1) still submit the CAFAS completed in accordance to rules of reliable scoring; and 2) type an explanation of clinical need for services in the rater comments section of the CAFAS. This information will be reviewed and considered by the Utilization and Care Management department.

D. Age and diagnostic applications:
1. A PECFAS must be completed for all children with 1) a primary services eligibility designation of SED and 2) who are age 4, 5 or 6 years old.
2. A CAFAS must be completed for all children and youth with 1) a primary services eligibility designation of SED and 2) who are ages 7 and above.
3. PECFAS/CAFAS should not be completed for children and youth who are primarily eligible for services through Intellectual/Developmental Disabilities (I/DD) determination. On the occasion that a consumer has both SED and I/DD diagnoses, the PECFAS/CAFAS should only be completed if SED is the consumer's primary service eligibility determination.
   a. Youth who initially present to SCCMHA requesting Autism Benefit qualification for services may be initially considered SED until the required assessment process for Autism Benefit eligibility is complete. These youth will receive an initial PECFAS or CAFAS assessment as part of their intake assessment with the Central Access and Intake

Department. The FAS Program designation for these youth at intake should be CAI-ASD; youth who qualify for the Autism Benefit need to be marked Inactive in the FAS software upon beginning of services in the Autism program or, upon determination of ineligibility, Transferred within the FAS software to the designated SED youth program.

b. If a youth is receiving both SED and I/DD services, their eligibility is considered primary I/DD if the youth is assigned Supports Coordination services. These youth should not receive a PECFAS/CAFAS.

c. If the youth meets criteria for a non-developmental behavioral health diagnosis and CAI staff are unable to reasonably predict primary I/DD over SED eligibility, a PECFAS/CAFAS assessment should be completed.

4. Children and youth often receive services within the context of being a family member which poses unique considerations regarding who the recipients of treatment are. Service providers must determine if an individual is the intended direct beneficiary of services (as determined by a Person-Centered Plan) with expectations of improved emotional and behavioral functioning. Individuals who meet this criteria must receive ongoing standardized assessment as required by age and eligibility classification.

E. Assessing caregivers:

1. Up to three caregiving environments/residences may be rated for each youth during each assessment period:
    a. Primary Family
    b. Non-Custodial Family or Parent Not Living in Youth's Home
    c. Surrogate Caregiver
2. At minimum, ratings must be provided for a Primary Family caregiver for each PECFAS/CAFAS youth assessment completed. Non-Custodial and Surrogate Caregiver ratings should be completed as relevant.
3. The Primary Family designation should reflect:
    a. The youth's parent figure that has primary custody of the youth (even if rights are temporarily suspended), and
    b. The actions of the parent figure and that caregiver's household environment, such as activities of live-in partners, and
    c. The same caregiver throughout the entire episode of care for a youth unless that caregiver's rights are terminated during the episode of care.

F. Assessment timeframes:

1. A PECFAS/CAFAS must be completed for all eligible youth at intake, every three months while receiving services, and at exit from services.
2. The time period rated is the last three months of functioning prior to the assessment. Exceptions to this rule are:
    a. If a recent significant event is related to why a youth is seeking treatment but the event occurred prior to the three-month assessment window, the window should be extended to include the episode. Example: If a youth committed a seriously aggressive act four months prior and subsequent incarceration or foster care placement changes interfered with presenting for intake assessment for more

than 90 days, the assessment period would be extended back to the time of the aggressive act.

b. Time periods assessed should not overlap. If a youth is exiting from services less than 90 days after the previous CAFAS assessment, the Exit CAFAS should only reflect the previously unrated expanse of time.

3. The case holder must complete a "Revised Initial" PECFAS/CAFAS if:
   a. significantly different information about the youth's functioning is presented to the service provider (information that would change the PECFAS/CAFAS score or the consumer's diagnosis), and
   b. the information is obtained after the Initial PECFAS/CAFAS was completed, and
   c. this new information was also true at the time of intake, and
   d. the information is revealed within six weeks of completion of the Initial PECFAS/CAFAS.
4. Having a current PECFAS/CAFAS will be a requirement in order to attain authorization for services.
5. An Exit PECFAS/CAFAS must be completed for youth who terminate services. The assessment must accurately reflect functioning at the time of termination. If no new information is known about the youth since the last PECFAS/CAFAS was completed (e.g. the youth stopped attending treatment sessions), the assessment designation of the most recent assessment may be changed to "Exit" or, in the instance that considerable time has passed or some services were provided after the date of the last assessment but not enough information is known about the youth to complete the assessment, the case may be designated "Inactive" in the FAS software without completing the required Exit assessment.

G. All PECFAS/CAFAS must only be completed by individuals who are reliable raters in good standing with SCCMHA.
   1. The CAFAS Coordinator will complete and maintain both PECFAS and CAFAS trainer requirements as established by MDHHS.
   2. Case holders who have not achieved 'reliable rater' status will collaborate with a staff member who has achieved this status in order to assure the PECFAS/CAFAS is properly completed. The case holder will serve as an information source and the reliable rater will rate the PECFAS/CAFAS.
   3. To become a reliable rater an individual will attend an SCCMHA provided or sanctioned 12-hour training program for each instrument, complete a set of test vignettes, and obtain an algorithm of passing scores for each subscale.
      i. Child Diagnostic credits will be provided for participation in these trainings
   4. Individual coaching and re-test opportunities will be made available for individuals who do not obtain a score above the minimum threshold on their first attempt and whose job position requires them to be a reliable rater.
   5. Raters who have been trained in other locations may apply for SCCMHA reliable rater status by furnishing their training information (including

trainer's name and contact information, training date and location, and the completed reliability grid) to the CAFAS Coordinator. Reliable rater status will be granted upon verification that the rater:

i. Was trained by a qualified trainer, and
ii. The training followed an accepted curriculum, and
iii. The rater successfully completed all reliability vignettes, and
iv. The training took place within the previous two years.

6. An individual may apply to the CAFAS Coordinator for permission to complete a self-training course set forth in the PECFAS/CAFAS self-training manuals instead of attending the in-person reliability training. Individuals who receive this permission will submit their completed test vignettes to the CAFAS Coordinator for review. An individual may qualify for this option if:
    i. The individual works for an SCCMHA contract provider agency, and
    ii. Rating the PECFAS/CAFAS is required to fulfill their job duties, and
    iii. They work less than 10 hours per week for the provider agency.
7. All raters will be provided a copy of the PECFAS/CAFAS Manual during their initial training as a new rater. Raters should preserve and maintain access to this manual for future reference.
8. Raters must renew reliability status every two years by attending a SCCMHA provided or sanctioned Booster training for each instrument and passing the requirements of the course.
    i. Raters who do not renew reliability status within a 6-month grace period of the two-year requirement will be revoked of reliable rater status and lose access to completing an assessment in the FAS software.
    ii. Child Diagnostic credits will be provided for participation in these trainings
9. Additional trainings or activities may be required to address individual, program, or agency needs.

H. Information sources:

1. To reliably rate the PECFAS/CAFAS, raters must obtain all relevant information about current functioning covered by each subscale domain. (Exhibit B – Basic Information Necessary to Rate PECFAS® and CAFAS®)
2. Information gathered from all credible information sources should be referenced when rating. Information sources typically include (but are not limited to): clinical interview, child report, caregiver report, teacher report, academic records, medical records, and clinician observation.

I. Information sharing:

1. It is the consumer's (and caregiver's) right to be apprised of their treatment and assessment information. Furthermore, sharing information helps strengthen treatment collaborations between professional staff and families. The rater should volunteer to share and explain individual CAFAS scores

with the consumer (or their caregiver). The consumer and/or their caregiver(s) will have the choice to discuss the information represented by the scores.

2. The information represented by the PECFAS/CAFAS should be referenced during treatment planning conversations.
3. PECFAS/CAFAS profiles should be referenced during staff supervision and team consultation.
4. The results from the PECFAS/CAFAS are to be integrated into the development of the outcomes, goals, and objectives for each IPOS as part of the Person-Centered Planning process.
5. Supervisors should regularly review PECFAS/CAFAS profiles to determine specialized care and treatment needs based on high risk behaviors, needs for changes in level of care, and to develop protocols and interventions for consumers who are apparently not responding to treatment. Detailed reports with this information can be generated and viewed through the Supervisor Dashboard application within the Functional Assessment Systems software.
6. Aggregate reports for PECFAS and CAFAS must be completed by fiscal year and submitted to MDHHS by 5 PM on November 30th. (MDHHS web site at www.michigan.gov/MDHHS per MDHHS/CMHSP Managed Specialty Supports and Services Contract: FY16ATTACHMENT C6.5.1.1. Exhibit C – MI_-_Generating_Aggregate_Reports_366780_7_441795_7 Generating CAFAS® and PECFAS® Aggregate Reports.)
7. All youth that DHS Incentive Payments (DHIP) were provided for at any time during a fiscal year must be labeled by fiscal year within the FAS software and an annual report must be generated and submitted to MDHHS. See the documents DHIP Labeling Instructions (Exhibit D) and Annual DHIP Outcomes Reporting: CAFAS® and PECFAS® Exporting and Reporting Guide for labeling and reporting instructions.
8. Customized program reports will be provided to administrators and supervisors quarterly at minimum. Reports will be designed to support data integrity processes, determine program strengths, identify program needs, and provide annual comparisons to state benchmarks.

J. Determining episodes of care:

1. A record is started in the FAS system for a youth consumer when they first present for SCCMHA services. The FAS Primary Client ID is the same as the consumer's Sentri identification number.
    i. Each individual youth should have only ONE client record in the FAS system and each client record can hold multiple service episodes. If a consumer has previously received SCCMHA services, the record is located through the Search Clients menu option, selecting "Show: Both" under the Client Search Criteria, and searching by Primary Client ID (i.e. Sentri identification number). If no existing record is located through the Primary Client ID search criteria, then the record should be located by Last Name, using the first two letters of the consumer's last name (or previous last name

if they have been adopted or otherwise had a name change) and by choosing "Show: Both" under the Client Search Criteria.

ii. The returning consumer's status is designated "Active" on the Demographics tab under the "Edit Client Details" menu option.

2. If the youth consumer is receiving services for the first time:
    i. A PECFAS or CAFAS assessment will be completed and designated "Initial Assessment." This will automatically begin a First Episode of treatment within the FAS software.
    ii. After completing the Initial Assessment, the CAI department will designate the consumer record "Inactive" in the FAS software.
    iii. When the case holder contacts the UM department for authorization of services, the UM department will designate the consumer's FAS record "Active" and transfer the record within the software to the appropriate department.
    iv. The case holder will continue the First Episode by designating the next assessment either "Revised Initial" or "3 Months" as appropriate.
    v. Each time the record manger requests authorizations for service, the UM staff will verify the PECFAS/CAFAS assessments are up to date.
    vi. When the consumer terminates services, the case holder will 1) complete an "Exit" assessment and, 2) designate the consumer record "Inactive" in the FAS software.
    vii. If the consumer returns for services within 90 days under the same treatment plan, the FAS record can be returned to "Active" and the "Exit" assessment label can be changed to reflect the time-period of treatment (e.g. "6 Months"). Assessments can resume within the First Episode, each labeled progressively reflecting time since the intake.
3. If the youth consumer is returning for services after a gap in services of more than 90 days:
    i. The client record status must be set to "Active." If the record was not previously inactivated, the record must be set to "Inactive" and then "Active" again.
    ii. A new "Initial Assessment" must be completed. This will begin a new episode of care in the record (e.g. "Second Episode"). Changes in functioning will be measured against this new baseline.
4. If the consumer experiences a significant change in life circumstances and functioning with the result of beginning an entirely new IPOS with wholly different goals and objectives, follow the process outlined in Step 3 above to begin a new Episode within the software.
5. If the consumer was receiving PECFAS assessments throughout a course of treatment and that consumer turns seven years old while continuing treatment: (Exhibit E - What to do when Your Client Leaves PECFAS)

i. Modify the Assessment Setup Info for the last PECFAS completed by selecting "No Subsequent Assessment Due" under the Next Assessment Date.
ii. Continue assessments every three months with CAFAS.
iii. Designate the Assessment Setup Info: Administration label for the first CAFAS completed as a continuation of the completed PECFAS Administration labels. (For example, if the youth received an Initial, 3 Month, and 6 Month PECFAS and then the youth turned 7 years old, the next assessment would be a 9 Month CAFAS.)
iv. Indicate the youth's episode is assessed across the two different measures by selecting the drop-down client label "Aged from PECFAS to CAFAS" (located within the Client Labels tab under the Edit Client Details menu).

6. Assessment period labels are detailed in three month increments from Initial through 96 Months. If a youth consumer is enrolled in a single, continuous Episode for more than 8 years, the "Special Circumstances" label should be chosen for remaining assessments.

K. Special client labels:
1. Provision of specific Evidence-Based Practice (EBP) treatments must be tracked with beginning and ending dates under the Client EBTs tab under Edit Client.
i. Specific labeling instructions exist regarding youth who are receiving PMTO, PTC/PTC-R, CPP, or TFCBT interventions (Attachment A)
2. Youth consumers who turn 7 years old while in the midst of treatment will have both PECFAS and CAFAS assessments during the same care episode. These youth must be assigned the "Aged from PECFAS to CAFAS" label under the Client Labels tab within the Edit Client menu.
3. Youth consumers who are referred from or involved with the juvenile justice system (JJ) while receiving SCCMHA services must be assigned the "JJ Involved" label under the Client Labels tab under the Edit Client menu.
4. Youth consumers who are SED-W recipients must be assigned the appropriate SED-W label under the Client Labels tab under the Edit Client menu.
5. Youth consumers that DHIP funding has been provided for must be identified by fiscal year code under the Caregivers tab in Client Information. (See Exhibit D – DHIP Labeling Instructions.)

L. To objectively measure clinical improvement, the following benchmarks are considered valid indicators of change:
1. A decrease in total PECFAS/CAFAS score by 20 or more points;
2. A profile with no Severe (score = 30) level of impairment in subscales and where one or more Severe impairments were present on Initial Administration;
3. A total CAFAS score of 40 or below and where total score was 50 or higher on Initial Administration;
4. A drop in CAFAS "Tier Type" (see Exhibit F);

5. A subscale score decrease to 10 (Mild) or 0 (Minimal or No Impairment) in School, Home, and/or Behavior Toward Others for a youth who previously met criteria for Pervasive Behavioral Impairment (PBI).

M. Staff who are not required to rate the CAFAS as part of their job duties, but do provide direct services to children and youth who are SED eligible, must be familiar with the CAFAS in order to effectively communicate with all individuals involved in planning and executing service plans (including family members).
   1. The Michigan Department of Health and Human Services (MDHHS) stipulates as a Medicaid provider qualification that assessments of/services to children ages 7-17 with SED must be provided by a Child Mental Health Professional (CMHP) trained in CAFAS. As of January 1, 2019, this requirement applies to use of any of the following Medicaid Service HCPCS Codes: 90887, 96105, 96110, 96112, 96113, 96127, H0036, T1017, 90832, 90834, 90837, 90785, 90853, 90785, H2021, H2022.
   2. In accordance with this requirement, all individuals employed within the SCCMHA Network as Child Mental Health Professionals must complete training to become familiar with the CAFAS. This training requirement can be fulfilled by participation in CAFAS Reliability (rater) training. However, a supervisor and their managing director may determine that a non-Case Holder CMHP staff position will not rate the CAFAS and deem the position eligible to complete a training for non-raters.
   3. Non-rater CAFAS training is offered in two formats: 1) an interactive workshop which introduces the concepts of assessing functioning in children and reviews uses of CAFAS across the SCCMHA network, OR 2) an independent self-study training which introduces CAFAS subscales and scoring guidelines.
   4. Participation in either format must be pre-approved by the direct supervisor and advance approval submitted to the SCCMHA Training Department by emailing registrations@sccmha.org.

Abbreviations:

CAFAS – Child and Adolescent Functional Assessment Scale®
CAI - Centralized Access and Intake Department
CMHSP – Community Mental Health Services Provider
DHIP – Department of Human Services Incentive Payments
EBP – Evidence-Based Practice
FAS – Functional Assessment Systems
I/DD – Intellectual/Developmental Disability
IPOS – Individual Plan of Service
JJ – Juvenile Justice
MDHHS – Michigan Department of Community Health
MHS – Multi-Health Systems
MHSP – Mental Health Services Program
PBI – Pervasive Behavioral Impairment
PECFAS – Preschool and Early Childhood Functional Assessment Scale®
PIHP - Prepaid Inpatient Health Plan
SED – Serious Emotional Disturbance

SED-W – Children's Serious Emotional Disturbance Home and Community-Based Services Waiver
UM – Utilization and Care Management Department

Definitions:

- CAFAS – Child and Adolescent Functional Assessment Scale®: Assessment tool completed by clinician to determine functional impairments of school-aged children across eight domains. Rating generates specific subscale score profiles and Total Score. Caregiving environments specific to youth are also assessed.
- CAFAS Tiers: Tool to assist in clinical conceptualization of CAFAS scores and aid in targeting treatment needs of most critical functional impairments.
- Functional Assessment Systems (FAS): Corporate owner of PECFAS/CAFAS, PECFAS/CAFAS software, and PECFAS/CAFAS training materials.
- Initial Assessment – First PECFAS/CAFAS assessment completed at the beginning of an episode of care. Initial Assessments measure a youth's baseline functioning just as services are beginning. Changes during treatment are measured against this baseline.
- PECFAS – Preschool and Early Childhood Assessment Scale®: Assessment tool completed by clinician to determine functional impairments of preschool-aged children across seven domains. Rating generates specific subscale score profiles and Total Score. Caregiving environments specific to youth are also assessed.
- Rater – Case manager, therapist, intake worker or supervisor who is authorized to complete PECFAS/CAFAS assessment by meeting minimum training and testing requirements and proof of their credential is approved by the SCCMHA CAFAS Coordinator.
- Revised Initial Assessment – Completed when new information is presented about a youth consumer shortly after services begin. A Revised Initial Assessment replaces the Initial Assessment as the treatment baseline and changes in functioning are measured against this marker.

References:

Child and Adolescent Functional Assessment Scale (CAFAS®). Hodges, K.
Preschool and Early Childhood Functional Assessment Scale (PECFAS®). Hodges, K.
SCCMHA Recovery Policy 02.03.05
MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY18 ATTACHMENT C4.7.2
Michigan Medicaid Provider Manual
Annual DHIP Outcomes Reporting: CAFAS® and PECFAS® Exporting and Reporting Guide

Exhibits:

Exhibit A - Michigan Department of Health and Human Services CAFAS and PECFAS Guidance to PIHPs and MHSPs March 2018
Exhibit B – Basic Information Necessary to Rate PECFAS® and CAFAS®
Exhibit C – MI_-_Generating_Aggregate_Reports_366780_7_441795_7 Generating CAFAS® and PECFAS® Aggregate Reports
Exhibit D - DHIP Labeling Instructions

Exhibit E – What to do when Your Client Leaves PECFAS
Exhibit F – CAFAS Tier Types

Procedure:

ACTION	RESPONSIBILITY
A member of the IT Department will be designated as the local FAS Super IT Administrator. The Super IT Administrator will provide assistance and technical support to SCCMHA provider users and make changes and updates to the FAS software user interface.	Super IT Administrator
The CAFAS Coordinator will maintain credentials to be a PECFAS/CAFAS trainer, provide trainings as needed for all SCCMHA staff and providers, maintain tracking records of reliable raters, and assign rater access to the FAS software.	CAFAS Coordinator
Reliability training for new raters will be offered on a quarterly basis (or as needed) for PECFAS and CAFAS. Booster trainings will be offered at least semiannually. Training for non-raters will be offered annually, or as needed. Other trainings will be scheduled as needed.	Continuing Education Supervisor and CAFAS Coordinator
PECFAS/CAFAS raters will establish reliable rater status by participating in training and passing examination. Status must be renewed every two years through booster training participation and examination.	Clinicians, Wraparound workers, case managers and CAI staff who serve SED youth ages 4 through 17
PECFAS/CAFAS ratings will be completed for all SED youth ages 4 through 17 at intake, every three months throughout service provision, and at exit from services. Raters will gather sufficient information to reliably rate the PECFAS/CAFAS at required assessment times.	Clinicians, Wraparound workers, case managers and CAI staff who serve SED youth ages 4 through 17
Consumer records will be transferred within the FAS software to the department providing services to the youth. Current PECFAS/CAFAS ratings will be reviewed	Utilization and Care Management staff

as a requirement for authorization of services.	
PECFAS/CAFAS profiles and scores will be reviewed with consumers and caregivers. Identified needs will be discussed and reviewed during the PCP process.	Clinicians, Wraparound workers, case managers, CAI staff
PECFAS/CAFAS information will be utilized during supervision and team consultation to note risk behaviors and help determine treatment progress and needs.	Clinicians, Wraparound workers, case managers, CAI staff, children's service provider supervisors
PECFAS/CAFAS information will be utilized to help determine program strengths and needs.	CAFAS Coordinator, SCCMHA administrative staff, children's service provider supervisors
Report creation using PECFAS/CAFAS data as requested by program supervisors, SCCMHA Directors, or the SCCMHA CEO to assist in efforts to improve quality of services provided to minor children and their families, including efforts to coordinate care throughout the community.	CAFAS Coordinator
PECFAS/CAFAS profiles will be referenced to determine treatment eligibility	Utilization and Care Management staff
All special labels for youth, with the exception of DHIP fiscal year codes, will be entered into the FAS consumer record at time of occurrence.	Clinicians, Wraparound workers, case managers, CAI staff
DHP fiscal year codes will be entered annually into the FAS consumer record.	CAFAS Coordinator
MDHHS reporting requirements will be upheld.	CAFAS Coordinator
Customized program reports will be created and shared at monthly Child Case Management Supervisors meetings.	CAFAS Coordinator
Technical assistance available to all stakeholders related to rating assessments and interpreting reports.	CAFAS Coordinator

Technical assistance with utilizing FAS software.	CAFAS Coordinator and Super IT Administrator

Exhibit A

Michigan Department of Health and Human Services
Child and Adolescent Functional Assessment Scale (CAFAS) and
Preschool and Early Childhood Functional Assessment Scale (PECFAS)

Guidance to PIHPs and CMHSPs
March 2018

To ensure that CMHSPs and PIHPs provide for the administration of the PECFAS and CAFAS to children served in the behavioral health system, this guidance is provided to clarify requirements for the administration of the tools, the training requirements, and the MDHHS support for the administration and training in the tools.

Issue	CAFAS	PECFAS
Contract Requirements	In the MDHHS contract with the PIHPs/CMHSPs, the CAFAS is a required assessment tool for all children with **Serious Emotional Disturbance (SED)** in the CMHSP system, ages 7 through 17 years and/or as long as they are receiving children's services. The CAFAS is to be completed at intake, quarterly thereafter and at exit from CMHSP for children in this age range receiving behavioral health services. The CAFAS is used as part of the determination of functional impairment that substantially interferes with or limits the minor's role or results in impaired functioning in family, school, or community activities.	In the MDHHS contract with the PIHPs/CMHSPs, the PECFAS is a required assessment tool for all children with **Serious Emotional Disturbance (SED)** in the CMHSP system ages 4 through 6 years. The PECFAS is to be completed at intake, quarterly thereafter and at exit from CMHSP for children in this age range receiving behavioral health services. The PECFAS is used as part of the determination of functional impairment that substantially interferes with or limits the minor's role or results in impaired functioning in the family, childcare/school or community activities.
	Submission of CAFAS and PECFAS data to MDHHS on an annual basis is a contract requirement (6.5.1.1).	
Using CAFAS/PECFAS to assess functioning as part of eligibility and level of care determination	The CAFAS is used as part of the determination of functional impairment **of the child with SED**** to document that their mental health condition substantially interferes with or limits the minor's role or results in impaired functioning in family, school, or community activities. This is defined as: • A total score of 50 (using the eight subscale scores on the CAFAS, or	The PECFAS is used as part of the determination of functional impairment **of the child with SED**** to document that their mental health condition substantially interferes with or limits the minor's role or results in impaired functioning in the family, childcare/school or community activities. Specific scores have not been identified for use as part of the

Issue	CAFAS	PECFAS
	• Two 20s on any of the first eight subscales of the CAFAS, or • One 30 on any subscale of the CAFAS, except for substance abuse only. The CAFAS • is used as a criteria to consider in determining the intensity of services needed, as an outcome measure (pre and post), as an aid to actively manage cases during a course of treatment, and for agency tracking and quality improvement. • measures eight subscales; School, Home, Community, Behavior Towards Others, Moods/Emotions, Self-Harmful Behavior, Substance Use and Thinking/ Communication. The CAFAS also includes Caregiver Resources Scale which is not included in the total score.*	determination of functional impairment at this time. The PECFAS: • is used as a criteria to consider in determining the intensity of services needed, as an outcome measure (pre and post), as an aid to actively manage cases during a course of treatment, and for agency tracking and quality improvement. • measures seven subscales; School/Daycare, Home, Community, Behavior Towards Others, Moods/Emotions, Self-Harmful Behavior and Thinking/ Communication. The PECFAS also includes Caregiver Resources Scale which is not included in the total score.* For young children, ages 3-4, that are involved in the SED Waiver and Wraparound, the PECFAS is required.
	***** A comprehensive psychosocial assessment identifies the parent, family and caregiver's strengths and needs which informs the treatment plan. Utilization of the Caregiver Resources Scale is encouraged to assist clinicians in identification of issues for planning purposes, but is not required nor scores reported to the Department.	
	** Information on Eligibility Criteria for children with serious emotional disturbance is outlined in the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY18- P.4.7.4 Technical Requirement for SED Children and MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY18- C 4.7.2 Technical Requirement for SED Children	
	Please Note: ***Do not use the CAFAS and PECFAS to assess children with I/DD*** *and do not use the online PECFAS/CAFAS system to enter data on these children.*	

Issue	CAFAS	PECFAS
Using the LOCUS and CAFAS for youth, ages 18-21	For young adults ages 18 to 21, new or currently receiving PIHP/CMHSP services, the LOCUS is required for adults with Serious Mental Illness (effective October 1, 2016); the CAFAS is optional but recommended. For youth, ages 18-21, that are involved in the SED Waiver and Wraparound, the CAFAS is required.	
Transitioning from PECFAS to CAFAS	When transitioning from the PECFAS to the CAFAS during a treatment episode because the child will be continuing to receive services past the age of 7, it is recommended that an exit PECFAS and an initial CAFAS be completed as close as possible to the child's seventh birthday. If both an initial and exit score is not entered for either or both tools (as applicable) for a particular child, data is not captured for that child in state aggregate reports. *Contrary to SCCMHA policy: Standard J5 and accompany Exhibit E - What to do when Your Client Leaves PECFAS	
Evidence Based Practice Labeling (EBPs)	Pre-post labels are to be identified for EBPs at the administration closest to the implementation of the EBP, including: • *Parent Management Training-Oregon (PMTO), Parenting Through Change (PTC) and Parenting Through Change Reunification (PTC)* All non-certified and certified PMTO/PTC/PTC-R clinicians must label the CAFAS and PECFAS pre- and post-intervention for all children/youth receiving PMTO (individual) or PTC/PTC-R (group). Caregiver Wish list is recommended but not required. • *Trauma Focused Cognitive Behavioral Therapy (TFCBT) and Trauma Assessment* All clinical supervisors and clinicians providing trauma assessment and TFCBT (during the Learning Collaborative/training, after completion of the training) are to use the TFCBT label on the web-based application. Please note: *Children/youth receiving the DHHS Incentive Payment (DHIP) are labeled by the designated person after payment.*	
PIHP/CMHSP Responsibilities	PIHPs/CMHSPs are expected to establish and/or maintain access to CAFAS and PECFAS trainers (employ them or contract with trainers) to ensure that their children's staff have access to CAFAS and PECFAS Rater Trainings and Rater Boosters. All CAFAS and PECFAS training and booster records for raters and trainers must be maintained by the CMHSP/PIHP.	

Issue	CAFAS	PECFAS
Training Requirements	**Initial Rater Reliability for CAFAS and for PECFAS** Rater reliability training is required for all child mental health professionals providing assessment and treatment to children/youth beginning at four years of age. CAFAS or PECFAS raters must attend rater reliability training and pass the reliability test in order to become a reliable rater of CAFAS and/or PECFAS. The Multi-Health Systems online CAFAS training may be used to enhance face-to-face training but is not a substitute for face-to-face rater training. **Booster for Raters** Raters must maintain their reliability every two years by completing a booster training for CAFAS and/or PECFAS.	
	CAFAS or PECFAS Train the Trainers and Boosters for Trainers MDHHS and MHS have an agreement that allows Michigan to continue to train trainers and raters in both tools. All training materials for the CAFAS and PECFAS are to display the following language, on every slide: *Copyright ©2006. Multi-Health Systems Inc. All rights reserved. Not to be translated or reproduced in whole or in part, stored in a retrieval system, or transmitted in any form or by any means, photocopying, mechanical, electronic, recording or otherwise, without prior permission in writing from Multi-Health Systems Inc. Applications for written permission should be directed in writing to Multi-Health Systems Inc. at 3770 Victoria Park Avenue, Toronto, Ontario M2H 3M6, Canada.* In order to be considered a **trainer of either/both the CAFAS and/or PECFAS**; a person must have attended the two-day rater training for the tool, plus the two-day training of trainers for the tool. Trainers are then required to attend a trainer booster every two years.	
Multi-Health Systems, Inc. (MHS)	The Functional Assessment Systems (FAS) website is owned and maintained by MHS (www.fasoutcomes.com). Manuals and other materials are available for purchase via the MHS website, www.mhs.com.	
MDHHS Support	**Licensing Fee** MDHHS pays the licensing fee for the use of the web-based PECFAS and CAFAS (and Caregiver Wish List) for Michigan's CMHSPs and their provider agencies through a contract with Multi-Health Systems Inc. (MHS). Additional "basic web services" may be purchased by sites but "fully integrated web services" are not an available to Michigan sites because it prevents data from being included in the statewide aggregate data.	
	Training MDHHS will continue to provide CAFAS and PECFAS Train the Trainer trainings and CAFAS and PECFAS Trainer Boosters through the Michigan Association of Community Mental Health Boards (MACMHB). Please go to the MACMHB's website for training details and registration, www.macmhb.org	

Issue	CAFAS	PECFAS
Questions	Kim Batsche-McKenzie, LMSW Manager of Services to Children with SED, Division of Mental Health Services to Children and Families, MDHHS T: (517) 241-5765 E: Batsche-mckenziek@michigan.gov	Mary Ludtke Consultant, Division of Mental Health Services to Children and Families, MDHHS T: (517) 241-5769 E: Ludtkem@michigan.gov

Exhibit B

Basic Information Necessary To Rate PECFAS® and CAFAS®

School/Daycare/Work

- Does the youth's learning/performance (e.g. grades/reports) match intellectual abilities?
- Has the youth been disciplined for behavior in this environment?
- Has the youth been aggressive in this environment?
- Does the youth receive accommodations or assistance for behavior in this environment?

Home

- Is the youth compliant with rules and expectations?
- Do the youth's behaviors place an excessive burden on caregiver(s)?
- Does the youth damage the home or furnishings?
- Does the youth hurt or threaten others within their residence?
- Has the youth run away?

Community

- Has the youth committed any unlawful acts?
- Is the youth on probation?
- Does the youth choose to associate with other youths known to engage in delinquent acts?
- Has the youth played with fire?
- Based on the youth's behaviors, is there concern about the youth being sexually inappropriate around or sexually aggressive toward vulnerable youth?

Behavior Toward Others

- Does the youth behave in a way that interferes with their ability to develop healthy natural supports?
- Has the youth committed an act of aggression during the rating period?
- Does the youth express anger inappropriately/excessively?

Moods/Emotions

- Related to depression/anxiety/trauma has the youth experienced problems with:
    - Social interest
    - Academic performance
    - Sleeping
    - Appetite
    - Ability to concentrate
    - Enjoyment of pleasurable activities
    - Energy level
    - Somatic complaints (e.g. stomachaches, headaches)
    - Self-esteem

    - Ability to self-soothe
- Is youth depressed and wants to die?
- Is the youth restricted or unusual in their ability to display typical emotions that are obviously correlated to and proportionate to environmental events?

Self-Harmful Behavior

- Has the youth deliberately harmed, or attempted to harm, his/her own body?
- Does the youth talk about, or admit thinking about, suicide or a desire to be dead?

Substance Use

- Has the youth consumed alcohol or other substances?
- Do caregivers suspect that the youth is using substances?
- Does the youth choose to socialize with known substance users?

Thinking

- Is the youth's ability to utilize rational (e.g. age appropriate cause and effect problem-solving) thought processes compromised?
- Can the youth organize their thoughts into clear, effective and relevant communication?
- Does the youth experience sensory events that are not real?
- Is the youth oriented in all spheres (e.g. knows who they are, where they are, when it is)?
- Does the youth become excessively preoccupied with topics that are harmful or that otherwise interfere with healthy development?

Caregiver Resources: Material Needs

- Are all of the youth's needs for food, clothing, shelter, medical care, and neighborhood safety consistently met?

Caregiver Resources: Family/Social Support

- Do caregivers demonstrate unconditional positive regard to youth?
- Does the household provide structure and support for academic, social and developmental achievement?
- Are the youth's activities consistently monitored?
- Do caregivers provide consistent, appropriate, and relevant discipline?
- Does abuse, neglect or domestic violence occur in the home?
- Do caregivers model good problem-solving communication?
- Is the youth provided adequate nurturing relative to needs/diagnosis?

Exhibit C

Generating CAFAS® and PECFAS® Aggregate Reports

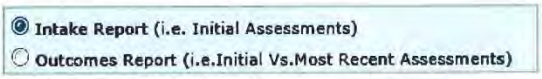
NOTE: Only persons with the role of Business Administrators are able to view Aggregate Reports. See left navigation bar to begin the process. If you do not have this access, then contact your IT department or your CAFAS lead at your site.

This guide will walk you through the process to generate three different kinds of Aggregate Reports:

- Report 1: An Aggregate Report of Initial Assessments for Active and Inactive Cases
- Report 2: An Aggregate Report of Outcomes for Inactivate (Closed) Cases
- Report 3: An Aggregate Report of Outcomes for Active and Inactive Cases

Generating an Aggregate Report is a very straightforward task. Simply specify your criteria and choose to generate the report. We'll go over each option here to make sure you understand every selection fully.

1. *Choose a report type*
   Click the radio button to specify whether you want an Intake Report of only Initial assessments or an Outcomes Report that compares clients' most recent assessments with their Initial assessment.



   For Report 1, choose "Intake Report"
   For Reports 2 and 3, choose "Outcomes Report"

2. *Select a date range*
   Type in the start and end dates you would like to use, or click the calendar icon to use the calendar tool to pick a date from the calendar.
   If you are doing an Intake Report, then any Initial assessments found in the time period that meets the other criteria will be included in the report. If you are doing an Outcomes Report, any *non*-Initial assessment found in the time period that meets the other criteria will be included and compared to the Initial assessment even if the Initial assessment is not in the specified time frame.

   Note: You cannot export data over more than a one year period. You may specify any time frame that you have data for, but the difference between the two dates cannot be more than one year.

   For Reports 1, 2, and 3, choose the dates for the fiscal year for which you want the reports run.

3. *Select a Client Status*
   Click a radio button to indicate the Case Status of clients you would like to see included in the report (**Active**, **Inactive** or **Both**). This allows you to report on active cases, closed cases, or both.

For Reports 1 and 3, choose "Both"
For Report 2, choose "Inactive"

4. *Select the Service Areas/Programs*
   Check or uncheck boxes to indicate the Service Areas and Programs to include on the report. The Aggregate Report will be limited to only cases in the selected Service Areas and Programs.

For Reports 1, 2, and 3, check "All" and ensure that every check box is checked

5. Click **Generate Report**. A printable PDF report will appear in a separate window.
   Note: You must have pop-up blockers disabled for the PDF to appear, or you must choose to allow https://app.fasoutcomes.com as an allowed site. If the PDF is blocked, a bar will appear at the top of your internet browser with suggested actions that will allow you to open the PDF.

6. You now have the report based on the specified criteria in a convenient PDF format. This PDF can be easily saved and e-mailed or printed.

7. **REPEAT THIS PROCESS FOR BOTH THE CAFAS® AND THE PECFAS® TO GENERATE A TOTAL OF 6 REPORTS (3 CAFAS® and 3 PECFAS®.)**

8. Email the PDF files to Jennifer Stentoumis at MDCH at stentoumisj@michigan.gov

If you want examples of the state aggregate reports, contact Jennifer Stentoumis at the Michigan Department of Community Health at stentoumisj@michigan.gov or 517-335-6258.

Exhibit D

DHIP Labeling Instructions

Overview:

Each CMH must identify within the Functional Assessment Systems (FAS) software (i.e. CAFAS® and PECFAS®) all youth for whom they received Department of Human Services Incentive Payments (DHIP) within a fiscal year.

Specification:

Enter the DHIP identifier for every youth between the ages of 4 and 17 and for whom the CMH received DHIP for at any time (and for any duration) during the fiscal year.

Procedure:

1. Log into the FAS software (https://app.fasoutcomes.com/) and locate the client for whom DHIP was provided. Clients can be located through the user's "My Clients" menu option or searched for through the "Search Clients" menu option.
2. Choose "Edit Client Details."
3. On the Edit Client page, choose the second tab ("Caregivers").
4. On the Caregivers page, select the "Add New Caregiver" link on the right side of the page.
5. Enter the following information in the Add Caregiver form:

   First Name: **FY13**

   Last Name: **DHIP**

   Caregiver ID: **DHIPFY13**

   Relationship: **Other**

   Description if Other: **DHIPFY13**

6. Select "Save."

Comments on using the Caregiver variable for tracking:

- This method allows for simply adding a new "Caregiver" each year that DHIP is provided for the youth. Previously collected information remains intact.
- The directive in Step 5 above shows information EXACTLY as it should be entered for a youth that DHIP was provided for during any time during Fiscal Year 12/13 (October 1, 2012 through September 30, 2013). For youth who are granted DHIP at any time between October 1, 2013 and September 30, 2014, a new "Caregiver" must be entered with "First Name" **FY14** and "Caregiver ID" and "Description if Other" both **DHIPFY14**, with the remaining two labels entered as shown above and without variation. This pattern will continue into FY15, and beyond if applicable.
- Many Caregivers may be added for a single youth without disrupting or eliminating existing information.
- A list of all DHIP labeled clients may be viewed by selecting "Search by Caregiver" from the navigation menu and entering the Caregiver ID (e.g. DHIPFY13). ***Hint:*** *Viewing this list will allow CMH supervisors or QI personnel to verify that all DHIP youth were correctly identified and labeled.*

Exhibit E

What to do when Your Client Leaves PECFAS

Four-, Five- and Six-year-olds can leave PECFAS ratings behind through three different types of events:

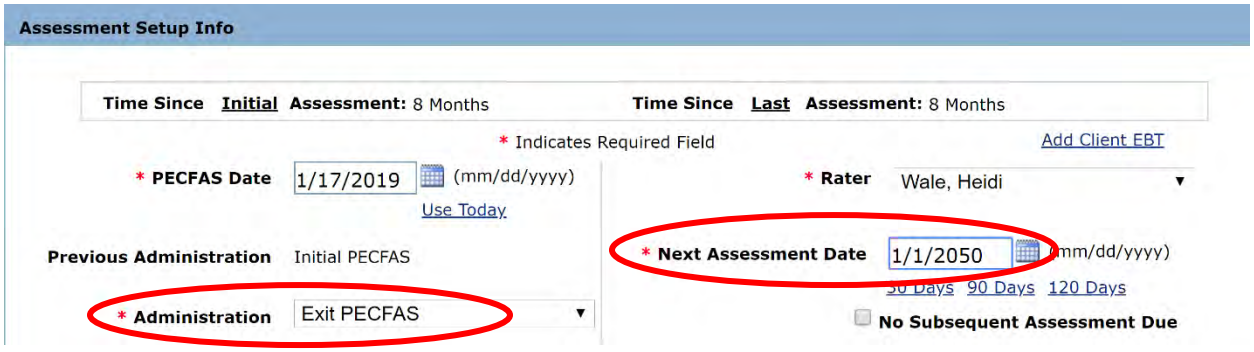
1. They have a planned exit from services
2. They drop out of services
3. They turn SEVEN years old

Each of these events requires some notations within the FAS software system.

Planned Exit From Services

1. Complete an Exit PECFAS.

In the Next Assessment Date field put **January 1, 2050**. *Why? Because this works around a glitch in the program; if the youth returns to services when they are older, they won't show up as having missing PECFAS assessments.*



2. Inactivate the Client's Record in the FAS System.

Under Demographics within the Edit Client option, click "Inactivate" and Save.

Client Drops Out of Services

1. Complete an Exit PECFAS

If the client received services for several weeks past their last PECFAS assessment:

1. Complete an Exit PECFAS and date it for the last time you received information (e.g. through seeing the youth, talking to the parents, talking to school personnel) about the youth's functioning.
2. Complete all steps under "Planned Exit From Services."

OR 1. Modify Setup Info

IF the last time the client received services was within a couple of weeks of the last time a PECFAS assessment was completed AND the last PECFAS assessment was not the Initial assessment:

1. Open (Review) the last PECFAS assessment
2. Select Modify PECFAS Setup Info
3. Change the Administration to Exit PECFAS
4. Change the Next Assessment Date to January 1, 2050 *(see note under Planned Exit instructions)*

2. Inactivate the Client's Record in the FAS System.

Regardless of if the client had an Exit PECFAS or not (e.g. the client only had an Intake PECFAS), the case file must be Inactivated within the FAS system. Under the Edit Client option, click "Inactivate" *(see image under Planned Exit instructions).*

Active Client Turns Seven

1. Complete a CAFAS

On the next assessment due date, complete a CAFAS. Continue the Administration labeling from the PECFAS assessments (e.g. 9 Months). *In other words, do NOT label the first CAFAS "Initial CAFAS" unless the assessment is a baseline measure of the youth's functioning when services begin.*

2. Modify Last PECFAS

1. Open (Review) the last PECFAS assessment
2. Select Modify PECFAS Setup Info *(see image under Drop Out of Services instructions)*
3. Change the Next Assessment Date to January 1, 2050 *(see note under Planned Exit instructions)*

3. Add Label

Under Client Labels within the Edit Client option, select the “Aged from PECFAS to CAFAS” label and Save.

Exhibit F

CAFAS Tiers ® (CAFAS Types Hierarchy)

Thinking (30 or 20 on Thinking subscale)

Maladaptive Substance Use (30 or 20 on Substance Use subscale)

Self-Harmful Potential (30 or 20 on Self-Harmful or 30 on Moods/Emotions subscales)

Delinquency (30 or 20 on Community subscale)

Behavior Problems with Moderate Mood (30 or 20 on School, Home OR BTO subscales & 20 on Moods/Emotions subscales)

Behavior Problems without Mood (30 or 20 on School, Home OR BTO subscales)

Moderate Mood* (20 on Mood/Emotions subscale)

Mild Behavior and/or Mood* (10 on any subscale)

**Types combined in some reporting as "Adjustment/Prevention Client Type"*

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Autism Spectrum Disorder (ASD) Program</td><td>Chapter: 02 – Customer Service & Recipient Rights</td><td>Subject No: 02.03.21</td></tr>
<tr><td rowspan="2">Effective Date:
3/10/15</td><td>Date of Review/Revision:
5/6/16, 8/10/16, 6/13/17, 4/10/18, 3/31/20, 3/23/21, 3/3/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Heather Beson

Additional Reviewers:
Clinical Directors
Amanda Elliott</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to specify requirements for the implementation of the Medicaid and MIChild Autism Spectrum Disorder (ASD) benefit.

Application:
This policy applies to children with ASD served by SCCMHA.

Policy:
SCCMHA shall provide services and supports to children with ASD and their families in accordance with evidence-based practice standards and the MIChild and Medicaid ASD benefit.

Standards:
A. SCCMHA shall provide early identification and intervention for individuals under the age of twenty-one (21) with a diagnosis of ASD based upon a medical diagnosis of Autistic Disorder *and* who have the developmental capacity to clinically participate in the available interventions covered by the Medicaid/MIChild ASD benefit.
B. The Primary Care Physician (PCP) for the individual seeking the ASD benefit will submit to family or SCCMHA a referral for ASD evaluation. This referral would include information about the presenting signs and symptoms of ASD, screening tool completed by the PCP and ruling out any other possible contributing factors to the presenting symptoms.
C. SCCMHA shall offer other services to children who do not meet criteria for ASD services in accordance with SCCMHA's eligibility standards.

D. The M-Chat (Modified Checklist for Autism in Toddlers) for children ages 1.5 through 2.5 or SCQ (Social Communication Questionnaire) for children ages 2.6 or higher shall be administered prior to conducting an eligibility determination.

If the child fails more than three items total or two critical items on the M-Chat or above 15 on the SCQ, and meets additional medical necessity criteria, he/she will be referred for an Eligibility Determination.

E. A needs-based eligibility determination shall be provided in accordance with the following standards:

The following battery is expected to be completed (Adaptive/developmental assessment should be completed *PRIOR to* the ADOS-2)

• **Clinical interview**, including thorough assessment of developmental symptom history (medical, behavioral, and social history [ADI-R or clinical equivalent])

• **Developmental evaluation** (Mullen Scales of Early Learning, Bayley Scales of Infant Development- Third Edition) **unless testing has already been conducted to give an estimate of the child's developmental skill levels, including expressive language, receptive language, and nonverbal skills*

• **Adaptive skills** (Vineland-3 or similar measure)

• **Observational assessment of social behaviors (**ADOS-2 & informal)

F. A formal review of the IPOS shall take place no less than annually with the child and family. Every three months, the IPOS is to be reviewed to ensure satisfaction and progress towards goals. A Child and Adolescent Needs and Strengths profile is to completed every three months upon entry to services.

While receiving the benefit, one of the behavioral outcome measurement tools, such as the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) or Assessment of Basic Language and Learning Skills revised (ABBLLS-R), shall be administered every 6 months

G. SCCMHA shall provide a team approach to treating ASD.

1. All providers of ABA services shall meet credentialing standards as identified in the EPSDT benefit and Michigan Medicaid Manual in order to perform their function.
   a. It is the requirement of SCCMHA that Behavior Consultants submit proof of credentials to the SCCMHA Provider Network Auditing Supervisor for verification prior to serving consumers. Credentials must be verified prior to services being billed.
2. The team shall be comprised of the following members who have received approved training in ASD:
   a. Autism Program Supervisor who oversees the ASD program and team.
   b. Board Certified Behavior Analyst (BCBA and/or BCBA Practicum Student being provided supervision by a fully credentialed BCBA)or Qualified Behavior Health Practitioner (QBHP) who:

- Develops and implements treatment program

- Reviews and monitors data and makes programmatic changes based on the data
- Provides skill development training and supervision of Behavioral Technicians
- Administers one of the behavioral outcome measurement tools. Board-Certified Assistant Behavior Analyst (BCaBA) who works under supervision of the Board Certified Behavior Analyst and may provide direct implementation of the treatment plan as well as gather data and make program adjustments under the direction of the BCBA.

d. Behavioral Technicians who work under the supervision of the BCBA to provide the technical assistance and implementation of the treatment plan.

e. Qualified Licensed Practitioner who provides psychological testing, psychological evaluations, and therapy, administers the ADOS and the developmental family history, and recommends the intensity of the ABA service and other service recommendations.

f. Autism Program Supports Coordinator who provides planning and/or facilitates planning using person-centered principles and develops the Individual Plan of Service. Links, coordinates, and follows up with all medically necessary supports and services. Monitors the ABA service and other mental health services the child receives.

3. Ancillary services including, but not limited to:
   a. Psychotherapy to address issues such as anxiety, disruptive behavior, coping with stress and bullying, social skills, and others
   b. Occupational therapy to improve independent functioning and to teach basic skills (e.g., dressing, bathing, etc.)
   c. Physical therapy using exercise and other measures (e.g., heat) to help children with ASD control body movements
   d. Speech and language therapy to help children with ASD gain the ability to speak or to initiate language development
   e. Pharmacotherapy services to treat associated behaviors and mental health disorders such as anxiety, attention deficit hyperactivity disorder (ADHD), and depression

H. Children and adults who age out of the ASD benefit (i.e., reach the age of 21) or are found no longer eligible upon re-evaluation shall be transferred to general Supports Coordination services or other appropriate team as determined by Care Management and shall be ineligible for ABA but shall be eligible for Speech and Language, Occupational Therapy, Respite, and other needed services. At times it is medically necessary to have individuals continue to receive services through the Autism department.

I. All Telepractice services must be prior authorized by the Michigan Department of Health and Human Services (MDHHS) unless noted otherwise by MDHHS.
   1. Telepractice must be obtained through real-time interaction between the child's physical location and the provider's physical location.
   2. It is the expectation of providers, facilitators, and staff involved in Telepractice are trained in the use of equipment and software prior to servicing consumers.

3. Qualified providers of behavioral health services are able to arrange Telepractice services for the purposes of teaching the caregivers to provide individualized interventions to their child and engage in behavioral health clinical observation and direction. The provider is only able to monitor one child/family at a time.
4. The administration of Telepractice services are subject to the same provision of services provided to a consumer in person.
5. Providers must ensure the privacy of the child and secure any information shared via telemedicine.
6. The technology must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards (i.e. HIPPA rules).
7. The consumer site may be located within a center, clinic, at the consumer's home, or any other established site deemed appropriate by the provider.
8. The room must be free of distractions that would interfere with the Telepractice sessions.
9. Providers interested in utilizing Telepractice must notify immediately the primary Supports Coordinator and Autism Program Supervisor.

J. Applied Behavior Analysis is available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD based on recommendation from the qualified professional.
    1. Hours of intervention are determined by the treatment team based on recommendations from the qualified professional, ABA provider, Supports Coordinator, and caregiver.
    2. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in the school or other settings, or to be provided when the child would typically be in school but for the caregiver's choice to homeschool their child (please see School and ABA Procedure for more information).

Definitions:

Antecedent Package: Interventions that entail the modification of situational events that typically precede the occurrence of a target behavior (e.g., cueing and prompting/prompt fading procedures, noncontingent reinforcement).

Applied Behavior Analysis (ABA): ABA is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior (Baer, Wolf, & Risley, 1968). ABA incorporates evidence-based strategies and techniques that are targeted to increasing ADL (activities of daily living) skills as well as communication, higher cognitive functions, interpersonal interaction, learning readiness, motor skills, play, and self-regulation in order to increase developmentally-appropriate skills to facilitate independence and community integration. ABA services are provided in the office, home or community settings. There are two levels of intensity within ABA services: Focused and Comprehensive.

Autism: A neurodevelopmental disorder that is characterized by impaired social interactions, impairments in verbal and nonverbal communication, repetitive behaviors,

and/or severely limited activities and interests. Autism can be viewed as a continuum or spectrum, known as ASD, and includes Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDDNOS). While the disorders on the spectrum vary in presentation and severity manifestations of core symptoms are present in all of them.

Autism Diagnostic Observation Schedule-2 (ADOS-2): An instrument for diagnosing and assessing autism. The protocol consists of a series of structured and semi-structured tasks that involve social interaction between the examiner and the subject. The examiner observes and identifies segments of the subject's behavior and assigns these to predetermined observational categories. Categorized observations are subsequently combined to produce quantitative scores for analysis. Research-determined cut-offs identify the potential diagnosis of autism or related autism spectrum disorders, allowing a standardized assessment of autistic symptoms

Autism Spectrum Disorder (ASD): A group of developmental disabilities defined by significant impairments in social interaction, communication, and the presence of unusual behaviors and interests. ASDs include Autism, Asperger Syndrome and Pervasive Developmental Disorder – Not Otherwise Specified.

Behavioral Health Treatment (BHT): Services that are designed to prevent the progression of ASD, prolong life, and promote physical and mental health, and competencies. BHT services include a variety of evidence-based behavioral interventions including:

- The systematic gathering of information regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis)
- Environmental adaptations that are designed to promote positive behaviors and learning and reduce negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports, stimulus fading)
- The application of reinforcement in order to alter behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction)
- The systematic application of teaching techniques that are designed to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation)
- Teaching parents/guardians/caretakers to deliver individualized interventions that will be of benefit to the child (i.e., parent/guardian/caretaker implemented/mediated intervention)
- The utilization of typically developing peers (who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups, peer social interaction training)
- The application of technology to alter behaviors and teach skills (e.g., video modeling, tablet-based learning software)

Behavioral Package: Interventions that are designed to reduce problem behaviors and teach functional alternative behaviors or skills through the application of basic principles of behavior change (e.g., chaining, reinforcement, functional communication training and discrete trial training).

Discrete Trial Training (DTT): A specific method of teaching used to maximize learning. It is a method within the science of Applied Behavior Analysis that involves providing numerous discrete opportunities to practice a skill. The discrete trial sequence involves a stimulus or instruction, a behavior and the consequence for that behavior (such as reinforcement). It is a teaching technique or process used to develop many skills, including cognitive, communication, play, social and self-help skills.

Joint Attention Intervention: Interventions that entail building the foundational skills involved in regulating the behaviors of others. Joint attention often involves teaching a child to respond to the nonverbal social bids of others or to initiate joint attention interactions (e.g., pointing to objects, showing items/activities to another person and following eye gaze).

Modeling: Interventions that rely on an adult or peer providing a demonstration of the target behavior in order to elicit an imitation of the target behavior by the consumer. Modeling is often combined with other strategies such as prompting and reinforcement. Modeling can be live (in vivo) modeling or provided via recording (i.e., video).

Naturalistic Teaching Strategies: Interventions that entail using primarily child-directed interactions to teach functional skills in the natural environment. These interventions often involve the provision of a stimulating environment, modeling how to play, and encouraging conversation, providing choice and direct/natural reinforcers, and rewarding reasonable attempts.

Peer Training Package: Interventions that teach children without disabilities (such as peers or siblings) strategies for facilitating play and social interactions with children who have ASD. These interventions may include components of other treatment packages (e.g. self-management for peers, prompting, reinforcement, etc.).

Pivotal Response Treatment: Interventions that focus on targeting pivotal behavioral areas including motivation to engage in social communication, self-initiation, self-management, and responsiveness to multiple cues, with the development of these areas having the goal of very widespread and fluently integrated collateral improvements.

Schedules: Interventions that involve the presentation of a task list that communicates a series of activities or steps required to complete a specific activity. Schedules are often supplemented by other interventions such as reinforcement and can take several forms including written words, pictures or photographs, or work stations.

Self-management: Interventions that involve promoting independence by teaching consumers to regulate their behavior by recording the occurrence/non-occurrence of the target behavior and securing reinforcement for doing so. Initial skills development may involve other strategies and may include the task of setting one's own goals. In addition, reinforcement is a component of this intervention with the consumer independently seeking and/or delivering reinforcers. Examples include the use of checklists (using checks, smiley/frowning faces), wrist counters, visual prompts and tokens.

Story-based Intervention Package: Treatments that entail a written description of the situations under which specific behaviors are expected to occur. Stories may be supplemented with additional components (e.g. prompting, reinforcement, discussion, etc.) Social Stories are the most well-known story-based interventions**.**

Telepractice: The use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telepractice services are provided to consumers through hardwire or internet connection.

References:

A. Baer, D., Wolf, M., Risley, T. (1968). Some Current Dimensions of Applied Behavior Analysis. *Journal of Applied Behavior Analysis 1:* 91-97. [On-line]. Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1310980/pdf/jaba00083-0089.pdf.

B. Michigan Department of Health and Human Services. (April 1, 2017). Michigan Medicaid Provider Manual. Michigan Department of Community Health. Lansing, MI. [On-line]. Available: http://www.mdch.state.mi.us/dch-medicaid/manuals/medicaidprovidermanual.pdf.

C. Michigan Department of Health and Human Services. (January 1, 2016). *Coverage of Autism Services for Children Under 21 Years of Age.* Medicaid Bulletin. MSA 15-59. MDHHS. Lansing, MI. [On-line]. Available: http://www.michigan.gov/documents/mdhhs/1543-EPSDT-P_507415_7.pdf.

D. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)

E. Weitlauf, A., McPheeters, M., Peters, B., et al. (August 2014). *Therapies for Children With Autism Spectrum Disorder: Behavioral Interventions Update. Comparative Effectiveness Review No. 137.* Agency for Healthcare Research and Quality. Rockville, MD. [On-line]. Available: http://dlr.sd.gov/autism/documents/cer_behavioral_interventions_2014.pdf.

F. Mid-State Health Network (MHSN) Policy, Autism Benefit Compliance Monitoring Procedure

G. MSHN Policy, Autism Benefit Re-Evaluation Eligibility

H. MSHN Policy, Autism Spectrum Disorder Benefit

I. Michigan Medicaid Provider Manual

J. MSA 15-59

K. SCCMHA Policy and Procedure Manual, Eligibility Determination and Re-Evaluation

L. SCCMHA Policy and Procedure Manual, Support Coordinator Responsibilities

M. SCCMHA Policy and Procedure Manual, School and ABA

N. SCCMHA Policy and Procedure Manual, Discharge Planning

O. SCCMHA Policy and Procedure Manual, Expectations Regarding Treatment Planning

P. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EBPs)

Q. ASD Grid-Age Ranges and CPT Codes 12-14-20

R. MDHHS Medicaid Autism Spectrum Disorder Screening, Evaluation and Treatment Recommendation Best Practice Guidelines

Exhibits:

Exhibit A - Staff Qualifications

Procedure:

None

Exhibit A

Qualified Provider	Education and Training Requirements	License/Certification	Services Provided
Board Certified Behavior Analyst-Doctoral (BCBA-D)	Minimum of a doctoral degree from an accredited institution conferred in a degree program in which the candidate completed a course sequence approved by the Behavior Analyst Certification Board (BACB).	Current certification as a BCBA-D through the Behavior Analyst Certification Board (BACB). Must be licensed by the State of Michigan.	Behavioral assessment Behavioral intervention Behavioral observation and direction
Board Certified Behavior Analyst (BCBA)	Minimum of a master's degree from an accredited institution conferred in a degree program in which the candidate completed a course sequence approved by the Behavior Analyst Certification Board (BACB).	Current certification as a BCBA through the Behavior Analyst Certification Board (BACB). Must be licensed by the State of Michigan.	Behavioral assessment Behavioral intervention Behavioral observation and direction
Board Certified Assistant Behavior Analyst (BCaBA)	Minimum of a bachelor's degree from an accredited institution conferred in a degree program in which the candidate completed a course sequence approved by the Behavior Analyst Certification Board (BACB). Works under the supervision of the BCBA/BCBA-D.	Current certification as a BCaBA through the Behavior Analyst Certification Board (BACB). Must be licensed by the State of Michigan.	Behavioral assessment Behavioral intervention Behavioral observation and direction
Licensed Psychologist (LP) *(Must be certified as a BCBA by 09/30/20)*	A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Minimum doctoral degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas: 1. Ethical considerations. 2. Definitions & characteristics and principles, processes & concepts of behavior. 3. Behavioral assessment and selecting interventions outcomes and strategies. 4. Experimental evaluation of interventions. 5. Measurement of behavior and developing and interpreting behavioral data. 6. Behavioral change procedures and systems supports. Works in consultation with the BCBA/BCBA-D to discuss the caseload, progress, and treatment of the child with ASD.	Doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements.	Behavioral assessment Behavioral intervention Behavioral observation and direction

Exhibit A

Qualified Provider	Education and Training Requirements	License/Certification	Services Provided
Limited Licensed Psychologist (LLP) *(Must be certified as a BCBA by 09/30/20)*	A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Minimum of a master's or doctoral degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas: 1. Ethical considerations. 2. Definitions & characteristics and principles, processes & concepts of behavior. 3. Behavioral assessment and selecting interventions outcomes and strategies. 4. Experimental evaluation of interventions. 5. Measurement of behavior and developing and interpreting behavioral data. 6. Behavioral change procedures and systems supports. Works in consultation with the BCBA/BCBA-D to discuss the progress and treatment of the child with ASD.	Doctoral or master's level psychologist licensed by the State of Michigan. Must complete all coursework and Experience requirements.	Behavioral assessment Behavioral intervention Behavioral observation and direction
Qualified Behavioral Health Professional (QBHP) *(Must be certified as a BCBA by 09/30/20)*	Must meet at least one of the following state requirements: Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Minimum of a master's degree in a mental health-related field from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. May hold a master's degree in a Behavior Analyst Certification Board (BACB) approved degree category from an accredited institution Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas: 1. Ethical considerations. 2. Definitions & characteristics and principles, processes & concepts of behavior.	A license or certification is not required, but is optional.	Behavioral assessment Behavioral intervention Behavioral observation and direction

Exhibit A

Qualified Provider	Education and Training Requirements	License/Certification	Services Provided
	3. Behavioral assessment and selecting interventions outcomes and strategies. 4. Experimental evaluation of interventions. 5. Measurement of behavior and developing and interpreting behavioral data. 6. Behavioral change procedures and systems supports. Works under the supervision of the BCBA/BCBA-D.		
Behavior Technician (BT) *(Formerly ABA Aide)*	Will receive 40 hours of training in accordance with the Behavior Analyst Certification Board (BACB) Registered Behavior Technician (RBT) Task List as conducted by a professional experienced in BHT services (BCBA, BCaBA, LP, LLP, and/or QBHP), but is not required to register as an RBT with the BACB upon completion in order to furnish services. Must be at least 18 years of age Must be able to practice universal precautions to protect against the transmission of communicable disease Must be able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedure, and to report on activities performed Must be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien) Must be able to perform and be certified in basic first aid procedures Must be trained in the IPOS/behavioral plan of care utilizing the person-centered planning process. Works under the supervision of the qualified provider who is able to perform behavioral observation and direction (i.e. BCBA, BCBA-D, BCaBA, LP, LLP or QBHP) and who provides oversight of the behavioral plan of care, with minimally one hour of clinical observation and direction for every 10 hours of direct treatment.	No license or certification is required.	Behavioral intervention

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Suicide Prevention</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.24</td></tr>
<tr><td rowspan="2">Effective Date:
8/1/16</td><td>Date of Review/Revision:
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Sandra M. Lindsey, CEO</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td><td>Responsible Director:
Executive Director of Clinical Services

Authored By:
Barbara Glassheim

Additional Reviewers:</td></tr>
</table>

Purpose:

The purpose of this policy is to delineate a framework for addressing suicidality and preventing suicide from occurring.

Policy:

Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities. According to the CDC, suicide is a leading cause of death in the United States. In 2020, almost forty six thousand (45,979) Americans died from suicide. This amounts to about one death every eleven (11) minutes. In 2020, suicide was among the top nine (9) leading causes of death for people ages ten (10) to sixty four (64). Suicide was the second leading cause of death for people ages ten (10) to fourteen (14) and twenty five (25) to thirty four (34).

Groups with the highest rates were non-Hispanic American Indian/Alaska Native and non-Hispanic White populations. Other Americans with higher than average rates of suicide are veterans, people who live in rural areas, and workers in certain industries and occupations like mining and construction. Young people who identify as lesbian, gay, or bisexual have higher rates of suicidal ideation and behavior than their peers who identify as heterosexual.

SCCMHA is committed to preventing suicide and dedicating resources to support education and training as well as functioning as a catalyst to energize and mobilize key stakeholders to promote community awareness and support interventions that are targeted to eliminating suicidality. SCCMHA shall promote an integrated, multi-tiered approach to suicide prevention in a comprehensive and collaborative manner in order to increase protective factors and mitigate risk factors (see Exhibit A) at both the community and individual consumer levels.

Application:
The policy applies to the entire SCCMHA service delivery system and is considered to be a foundational element of the system.

Standards:

A. SCCMHA shall adopt a "zero suicides" goal for all populations served.

B. SCCMHA shall screen all consumers for suicide risk, with particular attention to the high risk groups enumerated in the Policy section above using standardized, validated screening instruments (ASQ, C-SSRS).
   1. Each consumer served shall be assessed for risk including danger to self, danger to others, danger to property, access to firearms and other health and safety issues and the results shall be documented in the electronic health record (EHR) as part of the psychosocial assessment.
      a. Suicide risk factors that shall be taken into consideration include ideation as well as planned action.
      b. Screening for suicide risk shall include standard questions in the SCCMHA electronic health record, as well as the ANSA (Adult Needs and Strengths Assessment), CAFAS (Child and Adolescent Functional Scale), MAYSI-2 (Massachusetts Youth Screening Instrument), and screening instrument used for the SCCMHA Health Home & Wellness Center (i.e., the NOMs Client-Level Measures).

C. Individuals who are served by SCCMHA shall be educated about crisis management services and Psychiatric Advance Directives (crisis plans) and how to access crisis services, including suicide or crisis hotlines and warm lines, at the time of the initial evaluation in accordance with the appropriate methods, language(s), and literacy levels of consumers.
   1. The SCCMHA *Customer Services Handbook* (which describes how to access crisis management services, advance directives and psychiatric advance directives) shall be distributed to all consumers during the initial meeting.
   2. Psychiatric Advance Directives shall be documented in the consumer's electronic health record.

D. Crisis planning shall be offered to consumers and shall be deemed a formal component of the Person Centered Plan.
   1. The consumer's acceptance of crisis planning, or lack thereof, shall be documented in the EHR.
   2. Safety plans shall be developed for at-risk consumers and documented in the electronic health record.

E. SCCMHA shall conduct and/or sponsor trainings for mental health and substance use disorder treatment providers on the recognition, assessment, and management of at-risk behavior as well as the delivery of effective clinical care for individuals who are at risk for suicide.
   1. Staff shall receive initial and annual training on suicide prevention.
      a. Mandatory initial and annual training requirements shall include suicide risk and assessment knowledge and roles of families and peers**.**

1). All SCCMHA staff and network providers who have contact with recipients of services shall be required to receive suicide prevention and suicide response training which shall include the Columbia-Suicide Severity Rating Scale (C-SSRS) and ASQ.

b. SCCMHA shall promote the use of evidence-based suicide prevention and intervention practices.

F. SCCMHA shall promote public awareness and resources to improve recognition of the signs and symptoms of mental disorders and risks for suicide and where to get help.

1. SCCMHA shall promote and support community-wide efforts to reduce access to lethal means and methods of suicide.
2. SCCMHA shall promote and support responsible media reporting of mental illness and suicide in order to reduce prejudice and stigma as well as prevent contagion.
3. SCCMHA shall maintain authorship and make available the *Saginaw County First Responder's Guide for Behavioral Interventions* which is a written instruction tool for all local collaborating partners in dealing with any type of behavioral health crisis response, including the role of law enforcement in responding to a psychiatric crisis.
   a. This document shall provide guidance and define all local collaborating partners' roles with SCCMHA, including the SCCMHA provider network, in urgent psychiatric and substance use disorder responses in the community.
      NOTE: The *Saginaw County First Responders Guide for Behavioral Interventions* has been signed by all sixteen law enforcement jurisdictions in the county and by the Sheriff representing the County Jail, and is actively used and referred to by officers in their collaborations with SCCMHA to meet urgent needs.
4. SCCMHA shall publish a suicide hotline on its website.
5. SCCMHA shall disseminate information to the community on suicide risk and prevention.
6. The SCCMHA website shall describe available mental health crisis services and how to access them.
7. The SCCMHA website shall offer a resource section on suicide awareness and prevention including links to the Saginaw County Suicide Awareness and Prevention Service and other prevention resources including the Trevor Project for LGBTQ youth and the National Suicide Prevention Hot Line.
8. SCCMHA shall participate in the Michigan Association for Suicide Prevention, a statewide organization devoted to providing resources to a broad-based audience, as well as any local or regional suicide prevention or awareness initiatives.
9. SCCMHA shall support and promulgate its nationally recognized, award-winning anti-stigma campaign in an effort to reduce prejudice about mental disorders and suicide in an effort to enhance help-seeking behaviors.

10. SCCMHA shall offer Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMFA) to the community free of charge in order to promote improved knowledge and awareness and expand the capacity of the community to identify persons who are at-risk and increase referrals for treatment.

G. SCCMHA shall provide county-wide crisis intervention services.
   1. SCCMHA shall provide 24/7 crisis services for adults and youth including suicide prevention and response, a mobile crisis team response (Mobile Response and Stabilization Services, or MRSS), emergency crisis intervention service and crisis stabilization and post intervention services.
   2. SCCMHA's Crisis Intervention Services (CIS) unit shall maintain a key responsibility to respond appropriately to any and all suicide related crises and emergencies.

H. SCCMHA shall continue to promote trauma-informed policies and practices in order to ensure that consumers are treated with respect and in a manner that promotes healing and recovery.
   1. Resources shall be made available to offer social support, resiliency training, problem-solving skills, and other protective factors to consumers and their families and/or support network.
   2. SCCMHA shall offer and/or link survivors with postvention services.

I. SCCMHA shall ensure that systems are in place to evaluate the effectiveness and efficiency of the interventions provided (quality Improvement).
   1. The SCCMHA Critical Incident Review Committee (CIRC) shall review all incidences of consumer death by suicide and reported suicide attempts.
   2. Each attempt and successful suicide shall represent an opportunity for the system and provider to evaluate care delivered and to consider opportunities for improvement.
      a. A root cause analysis of suicide attempts and deaths shall be conducted when recommended by the CIRC.
      b. Findings shall be used to continuously improve the quality of services and supports provided to consumers.

Definitions:

Postvention: Activities following a suicide to help alleviate the suffering and emotional distress of the survivors, and prevent additional trauma and contagion; response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

Prevention: A strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors; activities implemented prior to the onset of an adverse health outcome (e.g., dying by suicide) and designed to reduce the potential that the adverse health outcome will take place.

Protective Factors: Attributes, characteristics, or environmental exposures that reduce the likelihood of suicidal behaviors; conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during difficult times that make suicidal behaviors less likely to occur. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment. For example, connectedness to others, including family members, teachers, coworkers,

community organizations, and social institutions help increase an individual's sense of belonging, foster a sense of personal worth, and provide access to sources of support help to protect against suicide.

Resilience: Capacities within a person that promote positive outcomes (e.g., mental health and well-being) and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors: Personal or environmental characteristics that increase the likelihood that an individual will think about suicide or engage in suicidal behaviors. Risk factors may encompass biological, psychological, and/or social factors in the individual, family, and environment. For example, mental and/or a substance use disorders can greatly increase the risk for suicidal behaviors. Suicide risk tends to be highest when someone has several risk factors at the same time.

Root Cause Analysis (RCA): A step-by-step method that leads to the discovery of a fault's first or root cause using a systematic approach to identify the progression of actions and consequences that led to an undesired event. Within the context of suicide prevention, an RCA investigation entails tracing the cause and effect path from a suicide attempt or death back to the root cause.

Safety Plan: A written list of warning signs, coping responses, and support sources that an individual can avail themselves of in order to avert or manage a suicide crisis.

Screening: A procedure in which a standardized tool, instrument, or protocol is used to identify individuals who may be at risk for suicide.

Suicide: Death caused by self-directed injurious behavior with intent to die as a result of the behavior.

Suicide Attempt: A non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicidal Behavior: A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide as well as preparatory behavior such as buying a gun, hoarding pills, writing a suicide note, etc.

Suicide Contagion: Suicide risk associated with the knowledge of another person's suicidal behavior, either firsthand or through the media. Suicides that may be at least partially caused by contagion are sometimes called "copycat suicides." Contagion can contribute to a suicide cluster. Community and media education is vitally important to reduce this risk.

Suicidal Ideation: Thoughts or fantasies about engaging in suicide-related behavior.

Warning Signs: Behaviors and symptoms that may indicate that a person is at immediate or serious risk for suicide or a suicide attempt.

References:

A. Michigan Suicide Prevention Coalition. (2005). Suicide Prevention Plan for Michigan: http://www.sprc.org/sites/default/files/Michigan_Suicide_Prevention_Plan_2005_135849_7.pdf

B. Michigan Association for Suicide Prevention. (2012). *Suicide Prevention Plan for Michigan Evaluation:* https://www.michigan.gov/documents/mdch/State_Suicide_Prevention_Plan_Evaluation_409439_7.pdf

C. Saginaw County's First Responders Guide for Behavioral Health Interventions: https://www.sccmha.org/userfiles/filemanager/12403/.
D. SCCMHA Policy 02.03.09.12– Mobile Response and Stabilization Services (MRSS)
E. SCCMHA Policy 02.03.09.17 – Mental Health First Aid (MHFA)
F. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
G. SCCMHA Policy 03.02.31 – Services for Members of the Armed Forces, Veterans and their Families
H. SCCMHA 03.02.34 – Services for American Indians
I. SCCMHA Policy 03.02.35 – Serving LGBTQ+ Consumers
J. SCCMHA Policy 03.02.46 – Whole-Person Care

Exhibits:

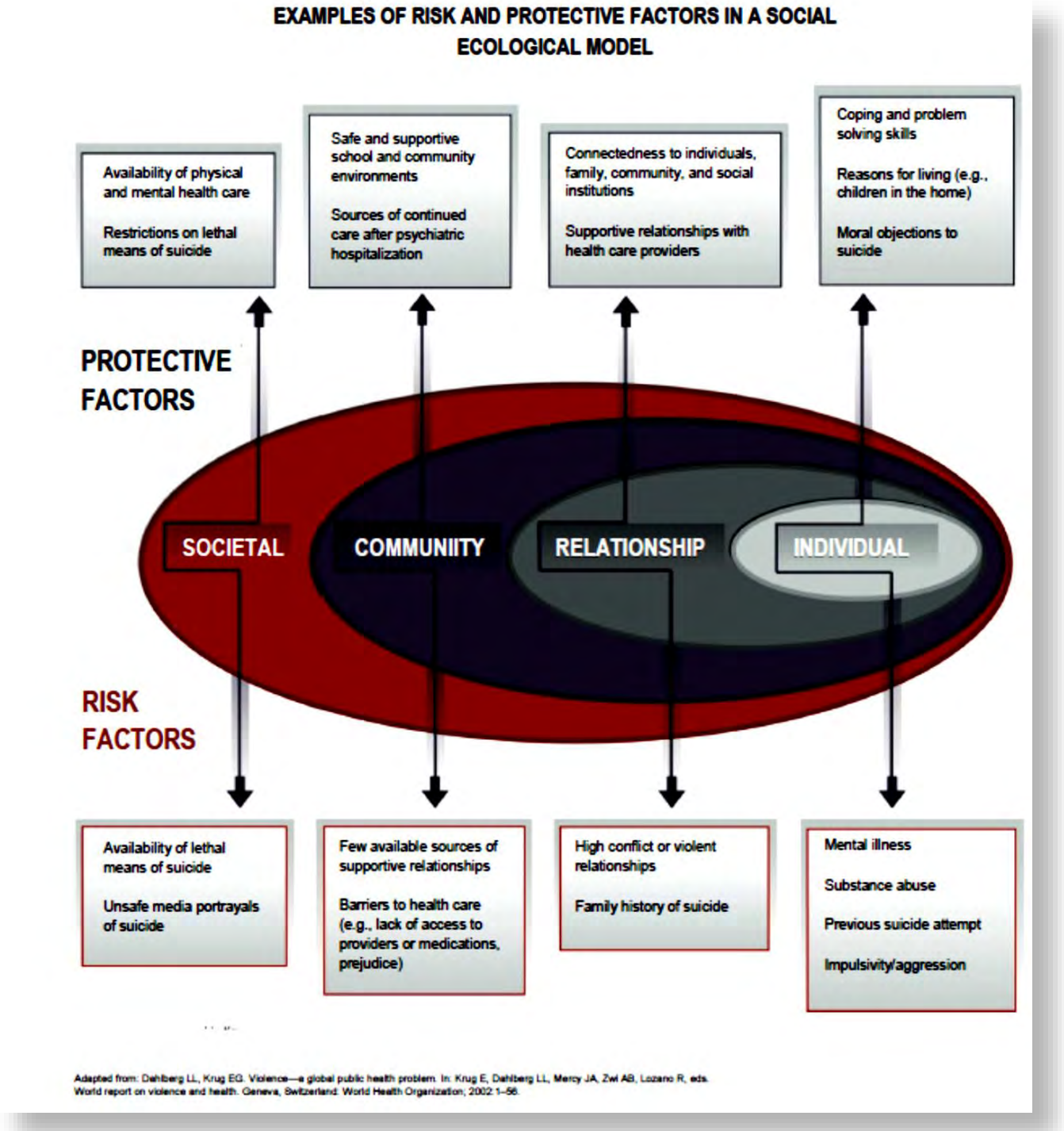
A. Social Ecological Model of Risk and Protective Factors
B. ASQ
C. Columbia-Suicide Severity Rating Scale (C-SSRS)
D. Columbia-Suicide Severity Rating Scale (C-SSRS) – for Individuals with Cognitive Impairment

Procedure:

ACTION	RESPONSIBILITY
Conducts suicide risk screening using the questions in SCCMHA EHR, ASQ for children, and Columbia Suicide Rating Scale for adults and individuals with I/DD during the initial assessment in addition to taking relevant measures in the ANSA or CAFAS into consideration.	CAI/CIS/Case Holder
If the consumer screens positive for suicide risk (i.e., a danger to self, others, or property as documented in SENTRI), conducts an assessment using a standardized tool that has been validated for the population served (e.g., children, adults). Works with at-risk consumers (and families as appropriate) to develop a safety plan.	Assigned master's prepared mental health clinician
If unable to develop a safety plan, immediately refer the consumer to CIS for a suicide assessment	CAI/CIS/Case Holder/Master's level clinician
Conducts an assessment. Scans the assessment into the consumer's electronic health record.	CIS

Works with the consumer and family (as appropriate) as well as the treatment team to ensure the safety plan is incorporated into the person-centered pan and adhered to. Documents the safety plan in the SCCMHA EHR. Conducts routine, ongoing screening of consumers with a history of suicide risk as well as consumers who are currently at risk using the SCCMHA EHR, ANSA, and CAFAS in accordance with planned periodic reviews of the person-centered plan. Screens consumers at high risk during each encounter. Adjusts the frequency of subsequent, ongoing screening in accordance with identified risk. Seeks consultation with supervisor and/or clinical leadership for all consumers with identified risk.	Case Holder
Provides consultation and guidance to staff.	Clinical supervisory staff/leadership

Exhibit A



(HHS, 2012)

Exhibit B

NIMH TOOLKIT

Suicide Risk Screening Tool

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 6/13/2017

Exhibit C

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

	Past Month		Lifetime (Worst Point)	
Ask questions that are bolded and underlined.	**YES**	**NO**	**YES**	**NO**
Ask Questions 1 and 2				
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*				
2) *Have you actually had any thoughts of killing yourself?*				
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.				
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"				
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"				
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*				

How long ago did the Worst Point Ideation occur? _____

	YES	NO
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

Exhibit D

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you ever wish you weren't alive anymore?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?*** ***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
INTENSITY OF IDEATION		
The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). ***Lifetime - Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation*** ***Recent - Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** ***Write response***_____ (1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 Months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you ever hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	Yes ☐ No ☐ Total # of Attempts _____	Yes ☐ No ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐ No ☐	Yes ☐ No ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	Yes ☐ No ☐	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____	Yes ☐ No ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____	Yes ☐ No ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	Yes ☐ No ☐ Total # of preparatory acts _____	Yes ☐ No ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Wellness	**Chapter**: 02.03. – Philosophy of Care	**Subject No**: 02.03.25
Effective Date: 6/13/17	**Date of Review/Revision**: 4/10/18, 4/9/19,7/29/20, 4/13/21, 5/10/22 **Supersedes**:	**Approved By**: Sandra Lindsey, CEO
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Executive Director of Clinical Services **Authored By**: Barbara Glassheim **Additional Reviewers**:

Purpose:

The purpose of this policy is to delineate a framework for the adoption and support of a culture of well-being for consumers and staff so that services and supports are provided in a person/family-centered, trauma-informed, recovery/resiliency-oriented, developmentally and phase-of-life appropriate, culturally and linguistically sensitive manner that promotes consumer engagement and shared decision-making and employs evidence-based practices and treatments to maximize the potential for beneficial outcomes.

Policy:

A. SCCMHA recognizes that individuals with a mental illness experience a life span that is 25 years shorter than members of the general population (with an average age of death of 53 years). Moreover those who have a co-occurring substance use disorder are at even greater risk for premature death. This disparity in life expectancy has been found to be primarily due to increased morbidity and mortality from treatable medical conditions that are caused by modifiable risk factors including smoking, obesity, and substance abuse, as well as preventable medical conditions such as diabetes and cardiovascular, respiratory, or infectious diseases (including HIV). In addition, people with mental health problems often live in poverty and experience social isolation, stigma, and trauma, which can lead to higher levels of stress and/or reduce access to quality primary care services that can help prevent and manage health conditions.

B. SCCMHA recognizes that persons with substance use disorders (SUDs) also often experience comorbid mental health conditions including anxiety disorders, posttraumatic stress disorder (PTSD), attention-deficit hyperactivity disorder (ADHD), as well as physical health conditions, including chronic pain,https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/references cancer, and heart disease. In addition, suicide is the leading cause of death among people with SUDs and co-occurring mental illness and SUDs increases the risk even further. (SAMHSA)

C. SCCMHA also recognizes the growing disparity in health status and life expectancy between individuals with intellectual/developmental disabilities (I/DD) and the general population. Individuals with I/DD have been found to be in poorer overall health and have a higher incidence of obesity (as well as the secondary conditions that often accompany obesity including hypertension, hypercholesterolemia, and diabetes), coronary heart disease, and pulmonary problems.

D. SCCMHA further recognizes that chronic diseases (e.g., depression and hypertension) can lead to a decline in the overall health of employees and that a healthy lifestyle can lead to a significant reduction in the risk of developing chronic diseases and premature disability and death.

E. SCCMHA-funded providers shall support physical health prevention, wellness checks, routine tests or screenings recommended by physicians, and other health and wellness promotion activities for consumers and staff members.

F. SCCMHA shall adopt the Wellness Initiative developed by the Substance Abuse and Mental Health Service (SAMHSA) which encourages the incorporation of the Eight Dimensions of Wellness into the lives of consumers as well as staff:

1. **Emotional:** Coping effectively with life and creating satisfying relationships
2. **Environmental:** Good health by occupying pleasant, stimulating environments that support well-being
3. **Financial:** Satisfaction with current and future financial situations
4. **Intellectual:** Recognizing creative abilities and finding ways to expand knowledge and skills
5. **Occupational:** Personal satisfaction and enrichment from one's work
6. **Physical:** Recognizing the need for physical activity, healthy foods and sleep
7. **Social:** Developing a sense of connection, belonging, and a well-developed support system
8. **Spiritual:** Expanding our sense of purpose and meaning in life

Application:

This policy applies to all SCCMHA employees, consumers, visitors, volunteers, and contractors.

Standards:

A. SCCMHA shall support the well-being of consumers and staff through a whole-person approach that encompasses the integration of mental health and physical health which allows for holistic approaches to disease prevention and health promotion.

B. SCCMHA shall promote a culture of well-being among consumers as well as staff and support the adoption of a healthy lifestyle.

1. SCCMHA shall promote the use of myStrength™ which is available to consumers and staff free of charge.
2. SCCMHA shall use its Better Together We Can campaign to promote health and well-being among consumers, providers and staff through SCCMHA-sponsored events, activities, classes and presentations.

a. To encourage participation in SCCMHA's culture of well-being and adopt a healthy lifestyle, full and part-time SCCMHA employees shall earn Better Together (BT) hours based on employment status in accordance with SCCMHA human resource policy.

C. SCCMHA shall promote mental health recovery by supporting improved general health and vice versa.

D. Consumers shall be encouraged to stop or reduce high-risk behaviors as well as engage in healthy activities, including, but not limited to:
   1. Eating a healthy diet
   2. Getting physical exercise
   3. Effective stress management, including, but not limited to:
      a. Gaining an understanding of triggers and how to mitigate or avoid them
      b. Learning to use mindfulness as a technique to manage stress
   4. Recommended health screenings (e.g., A1c level, blood pressure, body mass index, cholesterol levels)
   5. Maintaining oral health and accessing preventive oral health services
   6. Screening for depression and suicidality
   7. Participating in programs that target tobacco cessation
   8. Avoiding substance misuse and abuse
   9. Developing a natural support system
   10. Engaging in meaningful activities

Definitions:

Health: A resource that allows people to realize their aspirations, satisfy their needs and to cope with the environment in order to live a long, productive, and fruitful life. Health is more than the absence of disease. (Centers for Disease Control and Prevention [CDC])

myStrength™: An on-line, self-help mental health wellness portal that offers evidence-based resources for individuals experiencing mild or moderate depression and anxiety. It includes personalized eLearning programs, interactive coping tools, resources, daily inspiration to enhance motivation, weekly action plans and step-by-step learning modules to provide ways to improve mental health and overall well-being on a daily basis. (https://www.mystrength.com/)

Well-being: While there is a lack of consensus around a single definition of well-being, it is generally agreed that, at minimum, well-being includes the presence of positive emotions and moods (e.g., contentment, happiness), the absence of negative emotions (e.g., depression, anxiety), satisfaction with life, fulfillment and positive functioning. Aspects of well-being include: physical well-being; economic well-being, social well-being; development and activity; emotional well-being; psychological well-being; life satisfaction; domain specific satisfaction; and engaging activities and work.

Wellness: A conscious, deliberate process that requires an individual to become aware of and make choices for a more satisfying lifestyle. It is the process of creating and adapting patterns of behavior that lead to improved health in the wellness dimensions (physical, spiritual, social, intellectual, emotional/mental, occupational, environmental, and financial).

Wellness is self-defined because each person has individual needs and preferences, and the balance of activity, social contact, and sleep varies from person to person.

Wellness Lifestyle: A self-defined balance of health habits such as adequate sleep and rest, productivity, exercise, participation in meaningful activity, nutrition, productivity, social contact, and supportive relationships.

Whole-Person/Integrated Care: A comprehensive and coordinated person-centered system of care that allows healthcare professionals (i.e., behavioral health, primary care, and specialty providers) to simultaneously consider all of a consumer's health conditions, resulting in the systematic coordination of physical and behavioral healthcare. Such integrated healthcare services that are delivered in a whole-person approach produce beneficial outcomes for people with multiple and complex healthcare conditions.

References:

A. Better Together We Can: https://www.sccmha.org/healthcare-partnerships/better-together-we-can/
B. Glassheim, B. (March 2022). *A Guide to Evidence-Based Wellness Practices.* SCCMHA: https://www.sccmha.org/userfiles/filemanager/1058/
C. myStrength™: https://www.sccmha.org/healthcare-partnerships/mystrength.html
D. SCCMHA Consumer Health Education Council Workgroup Charter
E. SCCMHA Employee Handbook Policy Number 528 – Better Together Bank
F. SCCMHA Employee Wellness Committee Workgroup Charter
G. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
H. SCCMHA Policy 03.02.46 – Whole-Person Care
I. SCCMHA Policy – Learning About Healthy Living Tobacco and You (LAHL)
J. SCCMHA Policy – Whole Health Action Management (WHAM)

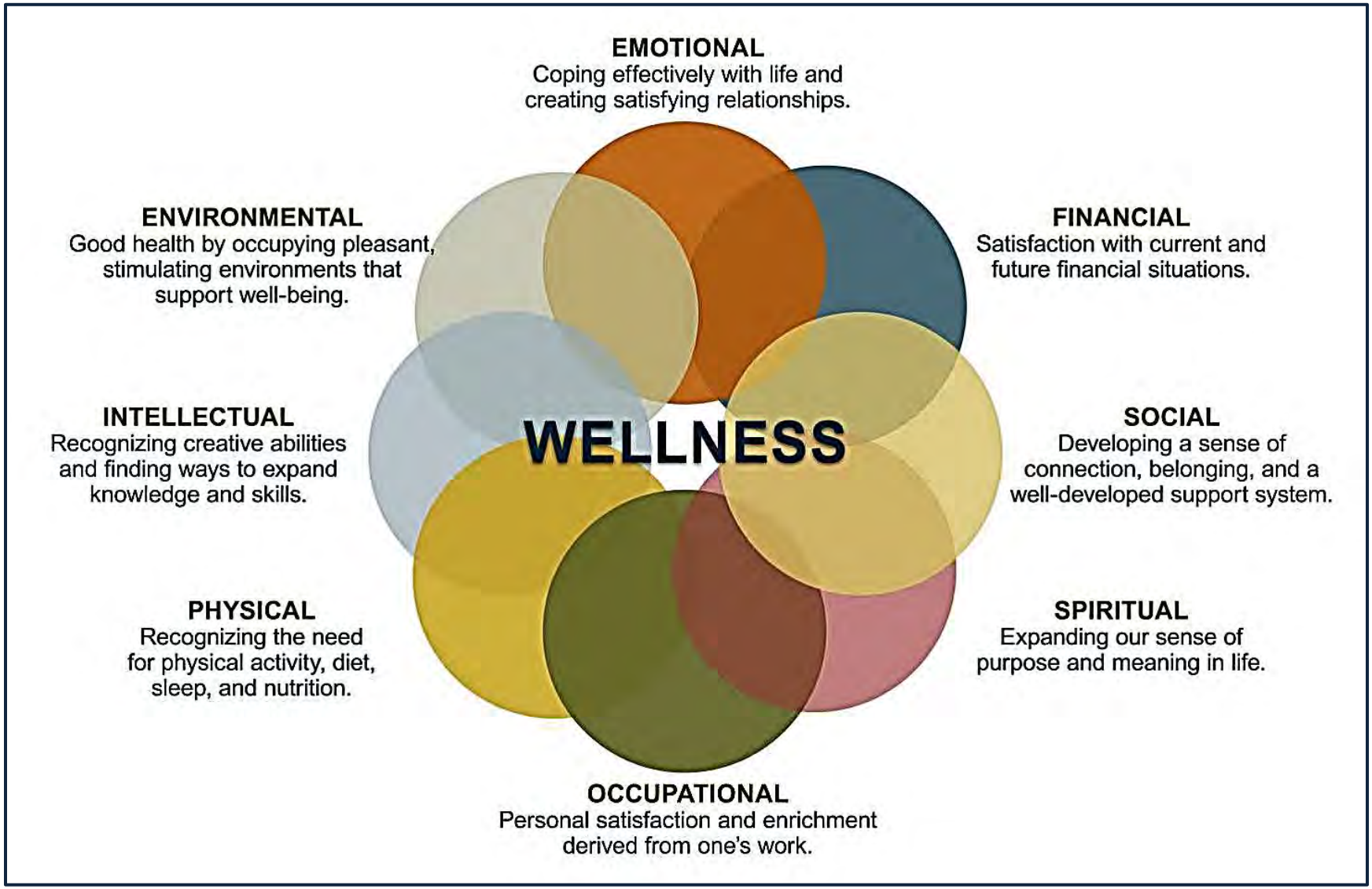
Exhibits:

A. SAMHSA's Eight Dimensions of Wellness

Procedure:

None

Exhibit A: The Eight Dimensions of Wellness (SAMHSA)



Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: SOGI Safe	**Chapter**: 02 - Customer Services and Recipient Rights	**Subject No**: 02.03.41
Effective Date: 4/10/18	**Date of Review/Revision**: 4/9/19, 8/21/20, 5/10/21, 4/12/22, 5/10/22	**Approved By**: Sandra M. Lindsey, CEO
	Supersedes:	
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Executive Director of Clinical Services **Authored By:** Barbara Glassheim, Heidi Wale Knizacky **Additional Reviewers**:

Purpose:
The purpose of this policy is to apply specific staff development training that is designed to promote a safe, supportive and welcoming environment for LGBTQ+ consumers as well as to enhance the competency and effectiveness of providers who serve LGBTQ+ consumers and their families.

Application:
This policy applies to SCCMHA-funded providers.

Policy:
SCCMHA recognizes that LGBTQ+ people face many health disparities and experience stigma and discrimination in health care settings as well as discrimination in employment, housing, and public accommodations. SCCMHA also recognizes that LGBTQ+ consumers have higher rates of histories of trauma (including abuse and neglect), depressive symptomatology, PTSD (posttraumatic stress disorder), suicidality, and SUDs (substance use disorders) than their counterparts in the general population.

In addition, SCCMHA recognizes that LGBTQ youth are more likely than their counterparts in the general population to experience family rejection, victimization (including bullying, teasing, harassment, and physical assault), employment and housing instability, and have higher rates of juvenile justice involvement.

In an effort to maximize the potential for recovery and resiliency through the provision of affirming services and supports to LGBTQ+ consumers, SCCMHA shall, resources permitting, offer a Sexual Orientation and Gender Identity (SOGI) Safe Study group to providers.

Standards:
A. SCCMHA shall endeavor to increase its provider network's understanding of the unique needs of LGBTQ+ individuals in order to be able to effectively assess and

provide and/or coordinate appropriate, supportive services within a safe environment for LGBTQ+ consumers and their family members by providing relevant training, including a SOGI Safe Study Group.

B. The SCCMHA SOGI Safe Study Group shall endeavor to inculcate the following principles and standards in order to increase the number of providers that can effectively and skillfully offer an authentically safe, non-judgmental and affirmative space for LGBTQ+ consumers and their families:

1. Use gender neutral language (e.g., significant other) until informed by the consumer of another preference.
2. Understand and appreciate the fact that people may use a range of pronouns, including "she/her/hers", "he/him/his", and "they/them/their".
3. Avoid disrespectful language, including terminology that is considered outdated (e.g., homosexual, transvestite, etc.).
4. Ask, rather than assume terms, labels, and experiences.
5. Avoid assuming gender or sexual orientation; a person's gender or sexual orientation cannot be assumed based on how they look or sound.
6. Understand and appreciate the fact that gender identity and sexual orientation labels are personally relevant, and that these labels may change, especially for individuals who are gender fluid, working through the Coming Out process, or Questioning.
7. Appreciate and understand the ways a consumer's sexual orientation and gender identity can be relevant to the provision of mental health services and supports.
8. Understand and appreciate the challenges families can face in accepting a child who is LGBTQ-identified.
9. Demonstrate cultural awareness of multiple social identities and the intersectionality of race, ethnicity, religion and other cultural factors (e.g., socioeconomic status).
10. Understand how past and present trauma may impact the lives of LGBTQ+ people and ways to avoid re-traumatization as well as mitigate the adverse effects of trauma.
11. Differentiate between effective, appropriate evidence-based treatments and those that are ineffective and/or harmful to LGBTQ+ consumers.

Definitions:

Coming Out: The process that LGBTQ+ people go through as they work to accept their sexual orientation or gender identity and share that identity openly with other people. Coming out is a process of understanding, accepting, and valuing one's sexual orientation/identity that typically occurs in stages and is nonlinear. Moreover, a person may come out multiple times to different people and groups throughout a lifetime. Every time an LGBTQ+ person meets someone new (e.g., friends, co-workers, healthcare and other professionals, etc.), they have to decide if, when, and how to come out. Finally, it should be noted that coming out can have benefits and risks and is not always by choice; some people are outed by others.

LGBTQ+: An acronym for Lesbian, Gay, Bisexual, Trans, Queer/Questioning, and others. It refers to a population of people united by having gender identities or sexual orientations that differ from the heterosexual and cisgender (i.e., individuals whose gender identity

matches the sex that they were assigned at birth or those who perform a gender role society considers appropriate for one's sex) majority. It is used as a catchall term to represent the entire spectrum of diversity in sexual orientation and gender identity.

Questioning: The process of exploring, learning, or experimenting with one's gender, sexual orientation, romantic orientation, or another part of one's identity. Questioning can happen at any age, and can take anywhere from days to years. Questioning is normal for anyone, irrespective of whether they persons turns out to actually be LGBTQ+ or not. Questioning can describe the process of exploring one's identity as well as an individual who is in the process of questioning.

SOGI: Sexual Orientation and Gender Identity is an all-inclusive term; sexual orientation describes people that an individual is sexually or romantically attracted to as compared to their own gender; gender identity is any individual's own internal awareness of their gender (often "male" or "female," but gender is not solely a binary construct). Sexual orientation and/or gender identity may change during an individual's lifetime.

SOGI Safe: The provision of a safe and welcoming space and the creation of a supportive and inclusive climate that encourages the success of all individuals irrespective of sex, gender identity, or sexual orientation.

References:

A. Applied Research Consultants (APPRECOTS) / Sexual Orientation Gender Identity (SOGI) Youth Issues: http://www.apprecots.com/sogi/
B. It's Pronounced Metrosexual: http://itspronouncedmetrosexual.com/
C. National LGBT Health Education Center: https://www.lgbthealtheducation.org/
D. SCCMHA Policy 02.01.01.02 – Cultural Competence
E. SCCMHA Policy 02.03.08 – Welcoming
F. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
G. SCCMHA Policy 03.02.35 – Serving LGBTQ+ Consumers

Exhibits:

A. SCCMHA SOGI Safe Study Group Pre-Test
B. The Genderbread Person v3.3
C. What Does it Mean to be SOGI Safe?

Procedure:

ACTION	RESPONSIBILITY
Arrange accommodations for the SCCMHA SOGI Safe Study Group in conjunctions with the facilitator(s)	SCCMHA CE Unit
Promote the group to recruit participants	SCCMHA CE Unit/Agency Leaders
Complete the SCCMHA SOGI Safe Study Group Pre-Test	SOGI Safe Study Group Participants
Convene the SCCMHA SOGI Safe Study Group	SOGI Safe Study Group Facilitator(s)
Complete the SCCMHA SOGI Safe Study Group Post-Test	SOGI Safe Study Group Participants
Evaluate the effectiveness of the SOGI Safe Study Group	SOGI Safe Study Group Facilitator(s)

Exhibit A

SCCMHA SOGI Safe Study Group

Pre-Test

*Name: Job Title:

**This questionnaire is being used to establish a baseline from which the outcomes of this study group will be measured. Your name is requested so individual changes can be measured by differences in Post-Test scores at the end of this program. All reporting will only show aggregate results and absolutely no individual responses will be shared with anyone outside of the APPRECOTS team.*

Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory

Frank R. Dillon and Roger L. Worthington

Instructions: Below is a list of activities regarding counseling/psychotherapy. Indicate your confidence in your current ability to perform each activity by marking the appropriate answer below each question ranging from Not at all Confident to Extremely Confident. Please answer each item based on how you feel now, not on your anticipated (or previous) ability. I am interested in your actual judgments, so please be honest in your responses.

	How confident am I in my ability to … ?	**Not at all Confident**					**Extremely Confident**
1	Directly apply sexual orientation/identity development theory in my clinical interventions with lesbian, gay, and bisexual (LGB) clients.	1	2	3	4	5	6
2	Directly apply my knowledge of the coming out process with LGB clients.	1	2	3	4	5	6
3	Identify specific mental health issues associated with the coming out process.	1	2	3	4	5	6
4	Understand the socially constructed nature of categories and identities such as lesbian, bisexual, gay, and heterosexual.	1	2	3	4	5	6
5	Explain the impact of gender role socialization on a client's sexual orientation/identity development.	1	2	3	4	5	6
6	Apply existing American Psychological Association guidelines regarding LGB-affirmative counseling practices.	1	2	3	4	5	6
7	Use current research findings about LGB clients' critical issues in the counseling process.	1	2	3	4	5	6
8	Assist LGB clients to develop effective strategies to deal with heterosexism and homophobia.	1	2	3	4	5	6
9	Evaluate counseling theories for appropriateness in working with an LGB client's presenting concerns.	1	2	3	4	5	6

10	Help a client identify sources of internalized homophobia and/or biphobia.	1	2	3	4	5	6
11	Select affirmative counseling techniques and interventions when working with LGB clients.	1	2	3	4	5	6
12	Assist the development of coping strategies to help same-sex couples who experience different stages in their individual coming out processes.	1	2	3	4	5	6
13	Facilitate an LGB-affirmative counseling/support group.	1	2	3	4	5	6
14	Recognize when my own potential heterosexist biases may suggest the need to refer an LGB client to an LGB-affirmative counselor.	1	2	3	4	5	6
15	Examine my own sexual orientation/identity development process.	1	2	3	4	5	6
16	Identify the specific areas in which I may need continuing education and supervision regarding LGB issues.	1	2	3	4	5	6
17	Identify my own feelings about my own sexual orientation and how it may influence a client.	1	2	3	4	5	6
18	Recognize my real feelings versus idealized feelings in an effort to be more genuine and empathic with LGB clients.	1	2	3	4	5	6
19	Provide a list of LGB-affirmative community resources, support groups, and social networks to a client.	1	2	3	4	5	6
20	Refer an LGB client to affirmative social services in cases of estrangement from their families of origin.	1	2	3	4	5	6
21	Refer LGB clients to LGB-affirmative legal and social supports.	1	2	3	4	5	6
22	Provide a client with city, state, federal, and institutional ordinances and laws concerning civil rights of LGB individuals.	1	2	3	4	5	6
23	Help a same-sex couple access local LGB-affirmative resources and support.	1	2	3	4	5	6
24	Refer an elderly LGB client to LGB-affirmative living accommodations and other social services.	1	2	3	4	5	6
25	Refer an LGB client with religious concerns to an LGB-affirmative clergy member.	1	2	3	4	5	6
26	Integrate clinical data (e.g. mental status exam, intake assessments, presenting concern) of an LGB client.	1	2	3	4	5	6
27	Complete an assessment for a potentially abusive same-sex relationship in an LGB-affirmative manner.	1	2	3	4	5	6

28	Assess for post-traumatic stress felt by LGB victims of hate crimes based on their sexual orientations/identities.	1	2	3	4	5	6
29	Assess the role of alcohol and drugs on LGB clients' social, interpersonal, and intrapersonal functioning.	1	2	3	4	5	6
30	Establish an atmosphere of mutual trust and affirmation when working with LGB clients.	1	2	3	4	5	6
31	Normalize an LGB client's feelings during different points of the coming out process.	1	2	3	4	5	6
32	Establish a safe space for LGB couples to explore parenting.	1	2	3	4	5	6

Additional Items:

Support parents/family members as they come to terms with their LGBTQ+ youth's identity.	1	2	3	4	5	6
Have the same (or higher) level of confidence in working with Transgender youth as I do with working with LGB youth.	1	2	3	4	5	6
Refer a transgender client for appropriate and affirmative medical consultation and care.	1	2	3	4	5	6

What is your own individual growth objective for participating in the SCCMHA SOGI Safe Study Group?

How will you know you have achieved this objective?

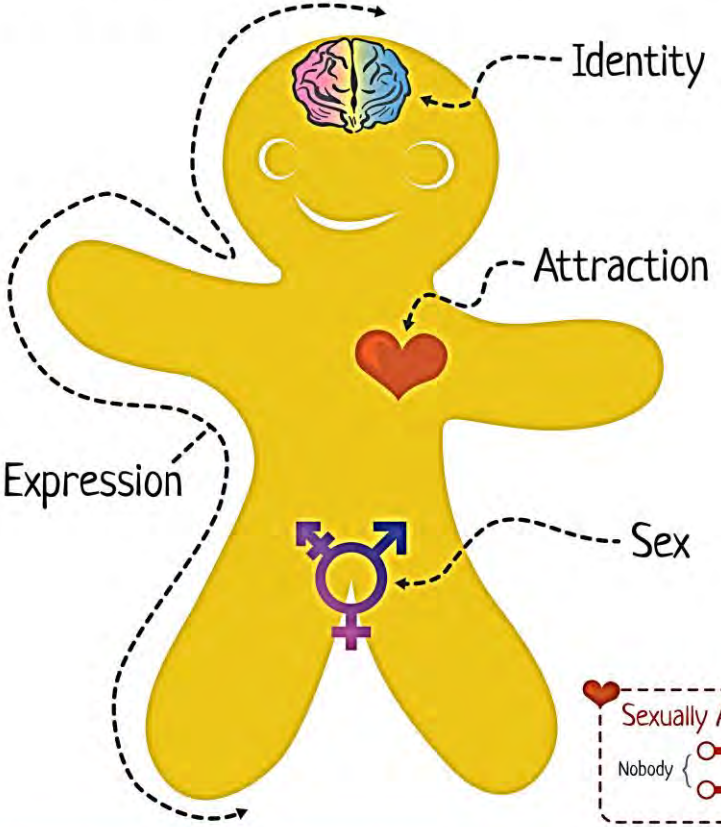
What support do you hope to receive from the group leaders and other group members to help you achieve your objective?

Exhibit B

The Genderbread Person v3.3

by it's pronounced METROsexual .com

Gender is one of those things everyone thinks they understand, but most people don't. Like *Inception*. Gender isn't binary. It's not either/or. In many cases it's both/and. A bit of this, a dash of that. This tasty little guide is meant to be an appetizer for gender understanding. It's okay if you're hungry for more. In fact, that's the idea.



Plot a point on both continua in each category to represent your identity; combine all ingredients to form your Genderbread

4 (of infinite) possible plot and label combos

Gender Identity

⊘ Indicates a lack of what's on the right.

Woman-ness

Man-ness

"woman" "man" "two-spirit" "genderqueer"

How you, in your head, define your gender, based on how much you align (or don't align) with what you understand to be the options for gender.

Gender Expression

Feminine

Masculine

"butch" "femme" "androgynous" "gender neutral"

The ways you present gender, through your actions, dress, and demeanor, and how those presentations are interpreted based on gender norms.

Biological Sex

Female-ness

Male-ness

"male" "female" "intersex" "MtF Female"

The physical sex characteristics you're born with and develop, including genitalia, body shape, voice pitch, body hair, hormones, chromosomes, etc.

Sexually Attracted to

Nobody { (Women/Females/Femininity) (Men/Males/Masculinity)

Romantically Attracted to

Nobody { (Women/Females/Femininity) (Men/Males/Masculinity)

In each grouping, circle all that apply to you and plot a point, depicting the aspects of gender toward which you experience attraction.

For a bigger bite, read more at http://bit.ly/genderbread

Exhibit C

What Does it Mean to be SOGI Safe?

You can tell that a professional is SOGI Safe if they:

Don't:

- Assume clients are straight and/or cisgender.
- Gender stereotype clients or clients' interests.
- Assume that being LGBTQ+ is caused by trauma.
- Assume that knowing a client's sexual orientation and gender identity isn't relevant to providing treatment.
- Assume that a client's sexual orientation and gender identity is ALWAYS relevant to their treatment.
- Impose judgment on families who are struggling to accept their LGBTQ+ loved one.
- Ignore clients' intersectionality of race, religion, or other cultural backdrops.
- Assume LGBTQ+ clients will volunteer the fact that they're LGBTQ+ if no one asks.

Do:

- Use gender-neutral language, such as "significant other," until told otherwise.
- Demonstrate a working knowledge of the Coming Out process and the decisions each individual faces related to personal congruence and choosing to share or not share information with others.
- Recognize forms of trauma and microaggressions that are unique to LGBTQ+ individuals.
- Understand that when youth are raised in affirming environments, risk of trauma can be mitigated.
- Cite APA guidelines and research on the inefficacy of anti-gay conversion therapy.
- Ask (rather than assume) terms, labels, and experiences.
- Understand that gender identity and sexual orientation labels are personally relevant, and that individuals, especially those who are gender fluid, working through the Coming Out process, or Questioning, may change their labels.
- Offer an authentically safe, non-judgmental space for clients and clients' families.

Perhaps most of all, SOGI Safe professionals will continue to bring their intense awareness and willingness to learn into their work with LGBTQ+ clients, and will actively pursue further professional competency as more knowledge becomes available.

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Consumer Choice and Service Management</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.01.03</td></tr>
<tr><td rowspan="2">Effective Date:
August 1, 2002</td><td>Date of Review/Revision:
2/11/02, 8/14/02, 7/19/06, 6/12/07, 6/22/09, 7/15/10, 6/7/12, 5/27/14, 4/7/16, 3/8/17, 11/1/17, 3/1/18, 3/7/19, 3/5/20, 3/11/21, 3/16/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Director of Services for Persons with Intellectual and Developmental Disabilities

Authored By:
Jennifer Rieck-Martin, Julie Bitterman

Additional Reviewers:
CAC, Thomas Peck, Amanda Elliott, Charlotte Fondren</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To define standards, policy and procedures for consumer choice and related service selection, service coordination and care management.

Application:
Entire SCCMHA Network and Direct Operated Program

Policy:
The consumers of mental health services provided by Saginaw County Community Mental Health Authority (SCCMHA) will be given choice in the type of mental health service they receive, and, to the maximum extent possible, choice of provider. SCCMHA will ensure consumers have complete information regarding the mental health services available to them, as well as resources available in their communities. Consumers will be supported in creating and maintaining their service plans through the availability of peer support specialists, support coordination and case management, and independent facilitation of person-centered planning activities. SCCMHA has a self-determination model that will support consumers who so desire to assume greater responsibility for managing their lives. SCCMHA will offer a reasonable choice of providers equitably and consistently across the service area. Throughout the course of offering choice of provider, increased consumer control over decision making and service management offered to consumers, emphasis will be placed on increasing consumer employment, independent living, use of natural supports, and maintenance of health and safety. Specific attention will be given to settings where

consumers live and work, in order to assure specific rights, freedoms and choices as required by this policy and state and federal requirements.

Standards:

- SCCMHA will establish provider panels for services wherever feasible and economically reasonable to offer more choice and flexibility to consumers.
- Efforts will be made to maximize variety in choice of provider throughout the geographic area served by SCCMHA.
- Consumers will be given a choice regarding how much assistance they receive and who will assist them with coordinating their care.
- Case management and support coordination staff employed by provider network agencies, including SCCMHA, will be given the freedom to freely advise consumers regarding the array of mental health services available and how to access them.
- Case management and support coordination staff will be equipped to advise consumers regarding other services and supports available to them from other community organizations and groups.
- Consumers will be offered the choice of an independent facilitator for planning activities.
- SCCMHA will connect consumers to advocacy organizations and/or other primary/secondary consumers to assist with accessing and understanding mental health services that are available.
- SCCMHA will make available a self-determination model that allows consumers to assume greater control of their mental health services.
- SCCMHA will ensure all staff and providers assisting consumers with understanding services available, selecting providers, and planning or managing their mental health services, will focus on maximizing the consumer's involvement and access to employment opportunities, increasing opportunities for independent living, optimizing health and safety, and increasing use of natural supports.
- Residential settings cannot have written or unwritten house rules or imposed visiting hours for residents.
- <u>Restrictions on consumer choices and freedoms can only be imposed if clearly specified based upon evident health and safety concerns; modifications to HCBS requirements as noted below must be supported by specific assessed need and justified in the person-centered service plan.</u>
- All settings must be fully accessible.
- Settings serving consumers should involve consumers in the hiring process
- Consumers will be provided information about how to express concerns or complaints.
- Consumers will be offered **<u>choices</u>** in the following specific areas at minimum by all applicable providers:
  - Choice of settings and roommates in residential settings, as well as the option to seek to obtain a private bedroom and/or information on how to obtain new housing.
  - Opportunity to provide input or express preferences for staff who assist them.
  - Choice of what personal clothing or attire to wear on a daily basis.
  - Choice to decorate or furnish their private spaces as desired.

- Consumers will be afforded **privacy** in the following areas at minimum by all applicable providers:
  - The ability to close and lock bedroom and bathroom doors for privacy in residential settings.
  - The assurance that staff will ask before entering private spaces such as bedrooms and bathrooms.
  - The ability to have privacy in shared bedroom settings as desired.
  - The ability to store and secure personal belongings as desired.
  - The assurance that staff will discuss consumer personal matters, when necessary, in private in all settings.
  - The assurance that personal care assistance as needed from others will be provided in a private place and when available per the consumers choice of staff.
- Consumers will be assured **freedoms** in the following areas at minimum by all applicable providers:
  - The ability to have freedom of movement access without barriers to all common areas and spaces in residential settings with or without support as needed at any time, including kitchen, dining, bathroom and laundry areas, with access to appliances.
  - The ability to have access to comfortable seating areas at any time.
  - The ability to have access to food at any time in residential settings.
  - The opportunity to choose what food they wish to eat.
  - The opportunity to choose to eat alone or with others.
  - The ability to control their own schedule including bed times, bath times, etc. in residential settings.
  - The ability to arrange and control their personal schedule of daily appointments and activities.
  - The ability to have access to personal funds at any time and to use personal funds based on their own choice.
  - The ability to come and go from and inside and outside of residential settings as desired including access to transportation.
  - The opportunity to interact with others in the community not receiving services at least once per week based on their own choice.
  - The ability to have family, friends or visitors without restrictions on hours or times, with space in the home to meet with visitors privately.
  - The ability to have work schedules, lunch or break times and benefits as available to others without disabilities.
  - The ability to access a communication device to communicate with people they wish to contact or who wish to contact them.

Definitions:
None

References:
- MDHHS Person Centered Planning Practice Guideline
- MDHHS Consumerism Practice Guideline

- SCCMHA Self-Determination Policy
- SCCMHA Suitable Services
- CMS/MDHHS Home and Community Based Waiver Rule requirements

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Guiding Principles for Consumer Choice and Service Management	
1. Any written materials provided to consumers to educate them about choices will be adapted to accommodate consumer special needs by offering versions on tape, in Spanish, and in large print.	1. Director of the Customer Services/Recipient Rights Office; Directors of Clinical Services and Director of Auditing & Continuing Education
2. All SCCMHA staff and contractors involved in assisting and supporting consumers in making choices, selecting providers and planning or managing their care, will emphasize through their communications with the consumer, the following values: a. consumer employment and generation of income; b. greater freedom and independence; c. normalization of residential living situations; d. development and use of natural supports; e. community integration; f. fostering of recovery and prevention of relapse; g. keeping children at home with their families; and h. maintenance of health and safety, including proactive planning for potential emergent needs.	2. Director of the Customer Services/Recipient Rights Office; Directors of Clinical Services, Director of Auditing & Continuing Education, Director of Care Management and Quality Systems, Medical Director and all staff under their supervision
3. Staff will ensure consumers are provided with information regarding the support services available from	3. Director of the Customer Services/Recipient Rights Office; Directors of Clinical Services and

SCCMHA and the larger community to help them achieve these goals. These values will be employed as guiding principles for staff and contract efforts in guiding consumer decision making and service planning.	Director of Auditing & Continuing Education, Director of Care Management and Quality Systems
Choice of Provider	
1. In adherence with SCCMHA Procurement Procedures and contracting practices, provider panels will be created and maintained for case management services, skill building services, support coordination services, respite care, health services, and community living support staffing and residential services. As service demand changes or the availability of qualified providers increase or decreases, new panels will be created or deleted, expanded or reduced. Network Services staff will monitor the service delivery system for consistent availability of service choice for consumers across the service area, particularly in the areas of case management and support coordination.	1. Contracts & Properties Manager, Director of Auditing & Continuing Education
2. At the point of intake or at the commencement of any service new to the consumer, the consumer will be informed of the providers available for a chosen service. Informational materials from each provider will be provided to the consumer upon request.	2. Director of Clinical Services, Director of Care Management and Quality Systems, Access Staff, All SCCMHA Board Operated and Contract Agency "intake" staff
3. At the point of intake, consumers will be given a choice of case manager/support coordinator. At a minimum they will be offered a choice of the staff person who will work with them, and where a panel has been established, a choice of provider agency.	3. Director of Clinical Services, Director of Auditing & Continuing Education, Access and Intake Staff

4. Consumers will be assisted with making changes in their chosen case manager/support coordinator, when their relationship with that staff person is no longer functional and/or the consumer requests a change. If a consumer is changing case managers/support coordinators at a frequency that appears to be detrimental to their mental health or their achievement of their desired outcomes, case management/support coordination supervisory staff will try to educate the consumer regarding the potential negative impact of frequent change. If necessary, the situation will be referred to the Clinical Risk Committee.	4. Primary Record Holder Supervisory Staff
Independence and Flexibility of Case Management/Supports Coordination Functions	
1. Case managers and support coordinators will ensure the consumer's desire for assistance with management of their care is discussed during the Person Centered Planning Process and documented in the meeting summary. The frequency of contact and the areas in which they desire assistance will be noted in each consumer's service plan.	1. Primary Record Holder
2. Case management and support coordination staff will focus their activities on those aspects of care coordination that serve to increase consumer independence in decision making and community integration, including but not limited to linking to community resources and public benefits, developing and maintaining networks of natural support, education regarding mental health diagnosis and prognosis, identifying and selecting needed services and supports, advance planning to address current and future	2. Primary Record Holders & Primary Record Holder Supervisory Staff

health and safety concerns, coordinating mental health services with primary health care, and monitoring the effectiveness of services in achieving the consumer's desired life outcomes.	
3. Case management and support coordination staff employed by provider network agencies, including SCCMHA, will be trained regarding the full array of services available as defined in the Master Contract between SCCMHA and the MDHHS, as well as the choices of provider that are available. Case management and support coordination providers will establish and keep up-to-date a resource manual for staff use that includes information about community resources available and relevant to consumers of mental health services.	3. Primary Record Holder Supervisory Staff
4. All access intake, case management and support coordination staff, particularly intake staff, will be trained regarding their responsibility to advocate for independence in decision making by consumers, as well as their responsibility to not steer consumers toward certain providers, nor to pressure consumers into making provider choices when hesitant, in a crisis situation or ill-informed.	4. Access, Primary Record Holder Supervisory Staff
5. SCCMHA will create and maintain agreements with consumer advocacy organizations and/or will employ primary/secondary consumers to be available upon request to assist consumers with the service access and provider selection process. Advocates will also assist consumers with understanding what mental health services are available, how to access services, how to advocate for	5. Family Services Unit, Primary Record Holder, Supervisory Staff; Director of Customer Services and Recipient Rights; Contract & Properties Manager

themselves, and what to do if they disagree with service decisions made by SCCMHA.	
6. Consumers will be informed that advocacy organizations or peer advocates are available to them during the access process and will be assisted with securing the support of an advocate or peer if desired.	6. Supervisor of Customer Services, Access Staff, Primary Record Holders
Independent Meeting Facilitator	
1. SCCMHA will make available a panel of qualified meeting facilitators. Facilitators will be trained in their role and responsibilities; person centered planning principles, meeting facilitation techniques, planning meeting documentation requirements, futures planning methods, recipient rights requirements and the Medicaid service array. Independent facilitators must be trained in facilitation in order to be paid for the service.	1. Directors of Clinical Services and Director of Auditing & Continuing Education
2. At the onset of planning activities consumers will be asked if they desire to have a facilitator who is independent of the SCCMHA provider network, and if so, they will be allowed to select a facilitator from the panel. The consumer will be asked to sign a release of information to permit SCCMHA to engage the services of the facilitator on the consumer's behalf. Assistance to the consumer in selecting an independent facilitator can be obtained by calling Customer Services, as well. Case management and support coordination staff will document in the meeting summary if the consumer declined to have an independent meeting facilitator.	2. Primary Record Holder, Director of Customer Services/ Recipient Rights

3. SCCMHA provider network staff will be trained in the purpose and role of independent meeting facilitators.	3. Director of Auditing & Continuing Education, Director of Clinical Services
Self Determination	
1. SCCMHA has a separate but related policy defining the implementation of a self-determination model that defines how consumers may increase their control of their mental health services within a set budget, including taking responsibility for planning and paying for services, selecting and/or employing service staff, moving resources between service categories to address their changing service needs and monitoring the effectiveness of services received in helping them achieving their goals.	1. SCCMHA Chief Executive Officer or Designee

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Jail and Detention Diversion</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.01.04</td></tr>
<tr><td rowspan="2">Effective Date:
8/6/01</td><td>Date of Review/Revision:
6/12/07, 6/30/09, 8/31/09, 4/7/16, 3/28/17, 3/1/18, 3/12/19, 4/7/20, 4/6/21, 4/20/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Steve Gonzalez

Additional Reviewers:
John Burages, Natividad Gonzalez</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this Jail and Detention Diversion Procedure is to ensure that adults and youth with mental illness, substance abuse, emotional disturbance, trauma, and developmental disabilities who are at risk of incarceration due to infractions of the law precipitated by behaviors and conditions related to their disability are diverted from incarceration into appropriate mental health services and supports.

Policy:
It is the policy of Saginaw County Community Mental Health Authority that: The individual be provided the Person-Centered Planning Process during jail diversion services. The individual will be provided an assessment of the risk factors that consumer may increase the likelihood of re-incarceration. Jail Diversion services will provide.
evidence-based practices that will increase the consumer's opportunities to participate in their Recovery and Wellness plan.

SCCMHA will commit and ensure that all Case Record Holders, Therapists and Family Intervention Specialists will acquire competency interventions in knowledge of the steps of arrest and incarceration and the points of opportunity for diversion. All clinicians be familiar with collaboration between law enforcement agencies, local courts, and Saginaw County Community Mental Health Authority to implement best practices in order to reduce jail or prison recidivism through Jail Diversion Services and Saginaw Mental Health Court. That cross-training efforts with law enforcement and criminal justice shall also ensure that all law enforcement officers will be knowledgeable of how to access mental health crisis and assessment services for persons detained or in protective custody.

Application:
This policy creates a system of jail and detention diversion which is to be implemented by SCCMHA Program Directors, Supervisors, Case Record Holders, Therapists, Family Intervention Specialists, and free-standing contractual service providers.

Standards:

- Law enforcement personnel in Saginaw County will know how to access mental health crisis assessment services for eligible SCCMHA consumers and will be periodically surveyed on their satisfaction with services.
- The Saginaw County Jail administrators will be able to access mental health consultation on the classification of inmates and assistance with post booking diversion through the SCCMHA Community Support Services (CSS) Forensic Team and will be periodically surveyed regarding the jail satisfaction regarding SCCMHA consumers and potential applicants for mental health and co-occurring disordered person with substance use treatment needs.
- Registered consumers of services and their natural supports will be informed on the availability of assistance from SCCMHA to intervene with the prosecutor and criminal courts when they have been arrested and/or incarcerated. The Jail Diversion will interface with Saginaw County Judicial Courts and Saginaw County Jail medical department.
- SCCMHA Case Record Holders, Therapists and Family Intervention Specialists will show competency in the assessment and interventions required to anticipate risk and respond with pre-booking and post-booking diversion interventions through Jail Diversion Services. Jail Diversion Specialist shall be available for consultation of incarcerated consumers and assistance with transitional planning if appropriate for the consumer.
- SCCMHA will provide consultation through the Jail Diversion Specialist on active consumers of the agency to the Saginaw County Jail Medical Department with screening of inmates for mental health needs and substance abuse needs. That the Jail Diversion Specialist will be the lead clinician to provide this consultation if clinically appropriate.

Definitions:
Arrest: When a person has been detained by law enforcement to answer to a criminal or civil charge.
Arraignment: Means the stage in the court process where the person is formally charged and enters a plea of guilty or not guilty.
Booking: Means the stage in the law enforcement custody process following arrest and when the individual is clerically processed for formal admission to jail.
Classification of Inmates: The process of identification of inmates for assignment to jail levels of security with special review for persons at risk of self harm or medical need who should be assigned to special observation or placement other than the general population.
Protective Custody: When a person is held under force of law for his or her own protection and when because of mental illness there is concern that the person may harm themselves or others.

References:
Michigan Mental Health Code: Public Act 258 of the Public Acts of 1974 as amended, Section 207, 426, and 427
MDCH Master Contract: Jail Diversion Best Practice Guideline: Attachment 3.11.5
Jail Diversion Practice Guidelines (P.7.10.3.10)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
1. Pursuant to the priorities established by the Board of Directors, the Management Team will review needs assessment and performance tracking related to jail diversion and will ensure available resources and supportive policy to address contractual requirements for jail and detention diversion.	1. SCCMHA Executive Director of Clinical Services and Management Team
2. The CSS Forensic Team Supervisor will serve as the jail diversion coordinator for adults and the Family Services Unit Supervisor will serve as detention diversion coordinator for children and adolescents. Each supervisor of SCCMHA (children, adolescents, and adult consumers) is responsible for needs assessment, training, service coordination and monitoring of diversion activities.	2. Community Support Services Forensic Supervisor – CSS Team 2, Crisis Intervention Service Supervisor, and Family Services Supervisor
3. The Jail Diversion Coordinators will not less than annually survey local law enforcement services regarding their understanding of the community benefit of diversion of persons with mental illness, emotional disturbance and developmental disabilities from jail and detention and will assesses their need for training in this regard. The Jail Diversion Therapist will document contact with various law enforcement agencies of Saginaw County.	3. Executive Director of Clinical Services and Director of Network Services Public Policy and Continuing Education, and Director of Services for Persons with Mental Illness
4. As a result of this survey the Diversion Coordinators will provide or coordinate training for law enforcement personnel. This training may be in a variety of formats including briefings or bulletins. Training shall	4. Forensic Team Supervisor CSS Team 2 and Crisis Intervention Services Supervisor for adults and Family Services Supervisor

include information on how to identify persons with mental illness, emotional disturbance, and developmental disabilities and how to access emergency assessment for persons in protective custody or under arrest.	for youths.
5. The Executive Director of Clinical Services, Director of Care Management and Quality Systems, the Director of Network Service, Policy and Continuing Education and, the Clinical Director and the Jail Diversion Coordinators for adults and youth will coordinate training for all SCCMHA board operated and network contractual clinicians regarding: • Assessment of persons at risk of incarceration including persons with a history of arrest, substance abuse, violence or threatening, homelessness or other problematic public behavior. • Safety Planning to avert future contacts with law enforcement. • Diversion Planning and Intervention	5. Service Management Team, Training Supervisor, Forensic Team Supervisor CSS 2, Crisis Intervention Service Supervisor, Family Services Supervisor
6. The Jail Diversion Therapist will provide pre-booking diversion through assessments of persons brought to CIS by law enforcement. Whether the person is in protective custody or accompanied voluntarily by police officers, the CIS staff will complete an assessment of the client's mental status, risk for harm to self or others, and immediate need for supports and services.	6. Jail Diversion Therapist, Crisis Intervention Specialists and Primary Case Record Holder
7. If the consumer is found appropriate for pre-booking diversion, the Jail Diversion Therapist and/or the Primary Care Staff shall prepare a diversion plan for the police officer's consideration. The plan may include hospitalization, crisis residential or crisis stabilization services or represent a modification of existing supports and services to address the crisis and concerns related to community safety.	7. Forensic Team CSS 2, Case Record Holder, Therapist, Family Intervention Specialist, Crisis Intervention Therapist.
8. All jail and detention diversion plans shall	8. Case Record Holder,

specify persons responsible for monitoring and reporting to the police department, prosecutor, probation officer, judge or other officer of the court if required.	Therapist, Family Intervention Specialist, Crisis Intervention Therapist Jail Diversion Specialist
9. If an adult inmate not currently receiving services from SCCMHA is identified during classification as a person suspected of mental illness or developmental disability, the jail mental health therapist shall provide an assessment and if appropriate proceed with the initiation of services including post booking diversion interventions.	9. Consumer, Case Record Holder, Therapist or Family Intervention Specialist.
10. If a registered adult consumer is arrested and booked without pre-booking screening or diversion, the Case Manager shall inform the Jail Diversion Therapist as soon as possible of the need for post booking diversion assessment and inmate services. If the jail diversion therapist becomes aware of a mental health consumer through inmate classification the jail therapist shall initiate contact with the primary care staff and facilitate post booking diversion and/or inmate services. Consumer will provide the opportunity to utilize Motivational Interviewing and forensic evidence-based practice to increase the recovery and wellness in returning to the community. Jail Diversion Specialist and Case Record Holder will refer to the Health Care Integration Nurse when chronic or acute medical conditions exist for the consumer.	10. Executive Director of Clinical Services, Director of Services for Persons with Mental Illness, Forensic Team Supervisor, Jail Diversion Therapist and SCCMHA Clinical Risk Committee.
11. All arrests of active Medicaid Waiver consumers will be reviewed by the Clinical Risk Committee to examine the level of care and the sufficiency of the Person-Centered Plan.	11. Clinical Risk Committee
12. SCCMHA shall make available to Family Division of the Circuit Court mental health consultation and post booking diversion and intervention services and shall encourage collaboration and improvements in the system of care for children and adolescents with	12. Directors of Children Services and Family Services Supervisors

serious emotional disturbance.	
13. If a registered child or adolescent consumer is arrested and booked, the Family Intervention Specialist or Therapist shall approach the relevant officer of Family Division of Circuit with a request for consideration of mental health consultation and possible diversion. Or if a child or adolescent who is booked and confined in the Detention Center is identified on the Massachusetts Assessment of Youth Symptom Inventory (MAYSI) or by staff observation as having mental health issues or needs, the SCCMHA Juvenile Justice program shall be contacted to assess the child for diversion or in detention service needs.	13. Director of Children Services, and Family Services Supervisors, Transition Age Youth (TAY) Supervisor and Family Service Unit Specialist, Therapist
14. Adult Pre-booking and Post-booking activity shall be documented in the Sentri Information System and reports and analysis of that activity shall be reviewed in the SCCMHA Quality Program.	14. Executive Director of Clinical Services, Director of Services for Persons with Mental Illness, Director of Quality Management, Forensic team supervisor, Jail Diversion Therapist, and SCCMHA Clinical Risk Committee.

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Academic and Vocational Continuity</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.02</td></tr>
<tr><td rowspan="2">Effective Date:
August 12, 2004</td><td>Date of Review/Revision:
8/12/04, 6/12/07, 8/12/08, 5/21/10, 5/10/12, 5/23/14, 4/7/16, 3/30/17, 3/1/18, 3/7/19, 3/28/20, 3/31/21, 3/22/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Tom Peck

Additional Reviewers:
Wardene B. Talley
Kelley Feltman</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this academic and vocational continuity policy is to ensure that adults and children with mental illness, emotional disturbance, and developmental disabilities who are at risk of disruption of their academic and/or vocational activities are provided with opportunities to maintain continuity of those activities as deemed clinically appropriate.

Application:
SCCMHA Direct Operated Program and Network Providers

Policy:
It is the policy of Saginaw County Community Mental Health Authority that consumers at risk of disruption of ongoing academic and vocational activities will have an opportunity to continue those activities as they move through a continuum of care supported by their person-centered plan or plan for emergent service. SCCMHA ensures that all Case holders, Therapists, Family Intervention Specialists, Wraparound Coordinators, Parent Support Partners and Infant Mental Health Specialists will facilitate the continuity of these activities whenever possible.

Standards:
When a consumer experiences an inpatient hospitalization, residential placement, or other more restrictive service, they will be provided with advocacy and other assistance to assure that there is as little disruption as possible in their educational or vocational activities.

Definitions:
Category III
Program requirements: Care Coordination

General Requirements of Care Coordination

References:
III A1.
Based upon a person and family-centered plan of care aligned with the requirements of Section 240(a) of the ACA and aligned with state regulations and consistent with best practices, the CCBHC must coordinate care across the spectrum of health services, including access to high quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing , educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. Note: See criteria 4.K relating to care and coordination requirements for veterans.

SCCMHA Consumer Choice and Service Management Policy (03.01.03.02)
Michigan Mental Health Code
SCCMHA and MDCH contract

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Assures that all staff with primary record holder responsibility has access to policy, training, and resources to assist them in the facilitation of academic and vocational continuity.	CEO Director of Clinical Services Director of Network Services CCBHC
Assures that when possible, contractual arrangements and memoranda of understanding with local agencies address academic and vocational continuity.	CEO Director of Clinical Services Director of Network Services Contract Manager
Educates staff with primary record holder responsibility regarding the methods of advocating for educational and vocational continuity.	Director of Clinical Services All Clinical Supervisors
Advocates for educational and vocational continuity.	Case Holders, Therapists, Family Intervention Specialists, Infant Mental Health Specialists, Parent Support Partners, Family Guides and Contractual Providers of services to SCCMHA consumers

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Monitoring and Reassessment	**Chapter**: 03 - Continuum of Care	**Subject No**: 03.02.03
Effective Date: June 22, 2007	**Date of Review/Revision**: 5/6/09, 6/30/10, 6/15/12, 1/8/13, 2/10/14, 4/7/16, 3/30/17, 3/1/18, 8/6/18, 4/2/19, 4/8/20, 3/29/21, 3/17/22 **Supersedes**:	**Approved By**: Sandra M. Lindsey, CEO **Responsible Director:** Director of Services for Persons with Intellectual and Developmental Disabilities **Authored By:** John Burages **Additional Reviewers**: Clinical Directors, Charlotte Fondren
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		

Purpose:
To establish the service expectation that all consumers will receive ongoing monitoring and reassessment. This monitoring is essential to assure that all consumers receive the maximum benefit of clinical opportunities to gain access to best practices or Evidence Based Practices enhancing the potential for the consumer's recovery, empowerment, and resiliency.

Application:
Saginaw County Community Mental Health Authority network of service providers

Policy:
The development of a plan of services utilizing a person-centered process should not be viewed as an annual event but rather a starting point. The plan that is developed must be monitored throughout the year and modified as needs and/or desires change or if it is determined to be ineffective in supporting the person to meet their desired outcomes. In addition, at times the needs of the consumer substantially change such as in the situation of a serious physical health development or admission to an inpatient psychiatric unit. In these situations, the person's needs should be reassessed, and the plan modified to address the change in situation.

Standards:

- A core function of case holder/s and/or home-based services is monitoring. This monitoring function includes monitoring that the individual plan of service/s (IPOS) is effective, monitoring that the services that were promised in the plan of

service are in fact being provided and are provided at the scope, duration and amount that was described in the (IPOS) individual plan of service and monitoring that the consumer is satisfied with the services that they are receiving and that the services are meeting their needs. The assessment or monitoring should always consider the consumer's strengths, abilities, needs and preferences. The case holder should elicit the support of natural supports in the consumer's recovery and that assessments be clinically documented in an interpretative manner and identifying stages of change and readiness to change according to consumer's motivation.

- The entire plan of service should be reviewed with the consumer at intervals determined during the planning meeting and indicated in the individual plan of service. The case holder should seek the involvement of interested parties involved in the recovery process and when conflict is present that an independent facilitator is recommended to the consumer as one possibility of conflict resolution.
- Monitoring of the consumer must occur in a variety of settings including home, school, community, work, and/or Skill Nursing Facility (SNF) depending on the activities of the individual consumer.
- Persons residing in specialized residential settings must receive **monthly** monitoring of the home setting to assure that the services being purchased in the residential setting are being provided at the scope, duration and amount described in the (IPOS) and that they are effective to meet the consumer's needs. Part of this monitoring should also be to determine if the services continue to be needed or if the consumer could be served in a less restrictive environment.
- Consumers placed in a SNF will continue to be monitored by case holder and in most cases should have a goal to be discharged from SNF to resume living out in the community and not in a SNF unless long-term care has been deemed necessary.
- It is the goal of SCCMHA that all consumers receive their services in Saginaw County unless the reason they are in another county is their personal choice because of the other counties' proximity to other family members. Therefore, in situations when a consumer is placed in another county, their individual plan of service must address their ultimate return to Saginaw County with expected time frames. Except for the situations where the consumer moved to another county because of personal choice, monitoring by the case holder should continue to be provided by SCCMHA with **monthly** monitoring as described in this policy and a plan for their ultimate return to Saginaw County.
    - SCCMHA currently has several consumers that are placed outside of Saginaw County where case holder services are authorized to another agency. These consumers must also have an individual plan of service written by SCCMHA case holder to address the consumer ultimate return to Saginaw County with expected time frames. This individual plan of service will be referred to as a Single Service Plan. Case Holder services should continue to be provided by SCCMHA with quarterly monitoring and a plan for their ultimate return to Saginaw County. The SCCMHA case holder will develop a detailed IPOS with goals, objectives, and

rationale for the consumer to reside out of county. This IPOS will be used by the residential provider to assist with providing appropriate care and by the record holder of the contracted agency to assist with goal attainment. It is the expectation that the SCCMHA case holder will be responsible for obtaining all required paperwork including but not limited to a release of information, any health care coordination, Psychosocial Assessment and detailed individual plan of service including scope, duration and amount of services pertaining to the consumer's goal attainment. The record holder of the contracted agency will be identified as the Primary Record Holder in the electronic health record, Sentri. In Sentri, a Single Service plan will be used to indicate that the SCCMHA Case Holder will monitor the placement if the contracted agency develops the IPOS.

  - A copy of the consumer's IPOS from that agency will be attached to the Single Service Plan

- SCCMHA currently has several COFR (County of Financial Responsibility) agreements where the case holder services are provided by the other county. These consumers' individual plan of service are monitored through the Care Management Unit and their services authorized according to their plan. Part of the monitoring function of Care Management will be to determine if it continues to be necessary/desired for the person to receive services out of county SCCMHA or the network provider will develop a Single Service Plan for the consumers return to Saginaw County. When it appears that the person may be ready for a return to Saginaw County the other county will be notified, and the case holder responsibility will be transferred back to a Saginaw provider. The Saginaw County provider will then be expected to work with the consumer to assist with their return to Saginaw County and initiate continued services. The Saginaw provider will monitor the out of county placement a minimum of monthly as they would any other specialized residential setting.
  - In Sentri, a Single Service Plan will be used as a placeholder and a copy of the out county IPOS will be attached
- At times consumers needs change substantially and their IPOS must be modified to address these changes. Examples would include a person whose health needs have drastically changed, a person who lived in a family home and their primary care giver dies, a person whose mental health condition declined to the point of requiring inpatient psychiatric hospitalization, a person who has been excluded from their day time activity (club house, Community Ties, , school, etc.) due to symptoms/behaviors or a person whose needs can no longer be met in their current residential setting and they must be moved to a more restrictive setting. When these situations occur, it is expected that the consumers needs be reassessed by members of the current team working with them and/or by other disciplines (psychiatry, nursing, dietary, behavioral, etc.) that may be necessary to address the situation. It is also expected that the IPOS will be modified at this point to address the change of needs and incorporate the recommendations of the new assessment.

Definitions:
None

References:
PIHP Review Protocols
SCCMHA Person Centered Planning Policy
CARF general program standards
Policy # 03.02.05 – Plans of Service and Supports

Exhibits:
Exhibit A - Monitoring Checklist for Primary Workers, Rev. 2-10-14
Exhibit B - Independent Living Checklist, Rev. 2-10-14
Exhibit C – SCCMHA Life Choices Documentation Form
(SCCMHA Funded Licensed Residential Setting)

Procedure:

ACTION	RESPONSIBILITY
Identifies consumer's needs through initial assessment with input from the consumer and makes recommendations about the steps to recovery and referral to appropriate clinical services.	Central Access Intake Clinical Staff
Orientation meeting with program supervisor or lead clinician regarding clinical services.	Supervisor or designated staff
Identifies their desired outcomes through the person-centered planning process.	Consumers
Assesses the consumers to determine the supports/services necessary to support the consumer to achieve their identified outcome.	Case Holder
Monitors the implementations of the individual plan of service (IPOS) to determine if the services promised are being provided at the promised duration and amount and that they are effective to help the consumer achieve their identified outcome.	Case Holder
Monitors the services provided to assure that the consumer is satisfied with the services.	Case Holder
Monitors the specialized residential setting monthly to assure that the purchased services are being provided at the duration and amount required and that the intensity of service continues to be needed.	Case Holder
Monitors COFR arrangements to assure that need to purchase services out of county continues to exist.	Care Management Staff
Reassess the consumers' needs when substantial changes in need occur and modifies the plan of service accordingly.	Case Holder

Monitors staff adherence to this policy	Supervisory level staff SCCMHA auditing staff Care Management staff

Exhibit A

Monitoring Checklist for Primary Workers
(Case Holders)

Consumer Name:_____ **Consumer ID #:**_____

Monitor Monthly

Medication Logs

Y ☐ N ☐ Have all new psychiatrist prescribed medications been started on the medication log?
Y ☐ N ☐ Are there any blanks on the medication log?
Y ☐ N ☐ Are there explanations on the back of the medication log with regard to any blanks found on the front of the log?
Y ☐ N ☐ Are there written incident reports on file in the home for medication related incidents (i.e. medication missing from the home)?
Y ☐ N ☐ Have you initialed the medication log as proof of your visit and review?

Personal Care (PC) & Community Living Support (CLS) Services Logs

Y ☐ N ☐ Is the PC & CLS Log filled out appropriately- based on consumer needs that are outlined in the consumer's annual assessment?
Y ☐ N ☐ Have you initialed the PC & CLS Services Log as proof of your visit and review?

Consumer Progress Notes

Y ☐ N ☐ Are there progress note items that are out of the ordinary?
Y ☐ N ☐ Are there progress note items that require the completion of an incident report?
Y ☐ N ☐ Are there written incident reports in the home for any items that must be reported to recipient rights?
Y ☐ N ☐ Are there any Enhanced Health Service (EHS) issues noted in the progress notes (i.e. physical therapy, occupational therapy, diet/nutrition, nursing)
Y ☐ N ☐ Are there any trends or recurrent behaviors found in the consumer's progress notes that require a change in the consumer's plan of service?
Y ☐ N ☐ Are the causes for these trends/recurrent behaviors able to be determined?
Y ☐ N ☐ Should referral to the Behavior Specialist be made?
Y ☐ N ☐ Are there any trends that could be related to a need for additional equipment or other physical plant modifications?
Y ☐ N ☐ Are there any concerns or changes in the consumers medical condition that might require

a change to their plan of service?
Y ☐ N ☐ Have you initialed consumer progress notes as proof of your visit and review?

Other

Y ☐ N ☐ Has the consumer had any medical appointments since the last visit by the primary worker?
Y ☐ N ☐ Are consumers paying for meals that should be provided as part of Room and Board (i.e. breakfast, lunch, dinner)?
Y ☐ N ☐ Are there written incident reports for any reportable incidents that were mentioned in staff communication logs?
Y ☐ N ☐ Have you initialed and dated ALL reports that you reviewed during this visit?

Monitor Quarterly

Home Name:

Physical Plant

Y ☐ N ☐ Is the consumer's living area free of health and safety hazards?
Y ☐ N ☐ Is the consumer's bedroom furnished with a mattress cover, sheets & bed spread and furniture that is in good repair?
Y ☐ N ☐ Are bathrooms furnished with soap and towels?
Y ☐ N ☐ Is the kitchen area free of health and safety hazards?

Dietary

Y ☐ N ☐ When asked, does the consumer's report regarding their last two meals match the posted menu for the home?
Y ☐ N ☐ Does the home have adequate groceries to prepare the menu items for the next two days?
Y ☐ N ☐ Are there fresh vegetables available in the home?
Y ☐ N ☐ Do consumers have access to fresh fruits and vegetables if they want?
Y ☐ N ☐ Do consumers have access to snacks purchased with their own money?

Medication

Y ☐ N ☐ Is the medication cupboard locked?
Y ☐ N ☐ Are allergies listed on the consumer's medication log?
Y ☐ N ☐ Were you at the home during a medication passing time?
If you were in the home during a medication passing time, please complete the following questions:
Y ☐ N ☐ Did you observe staff passing medications?
Y ☐ N ☐ Are medications pre setup in cups to be given at a later time?

Y ☐ N ☐ Did staff sign for medications prior to actually giving the consumer the medication?

Resident Fund Sheets

Y ☐ N ☐ Are consumers paying for basic personal care items, toothpaste, toilet tissue, deodorant, etc. with their own money?
Y ☐ N ☐ Does the consumer's money match the resident's fund sheet?
Y ☐ N ☐ Are there receipts to accompany any items purchased by the consumer?
Y ☐ N ☐ Are consumers signing for funds given directly to him/her?
Y ☐ N ☐ Is the consumer reporting he or she does not get funds?

Other Comments:

_____

_____

_____

_____

_____

_____

_____ _____

Name of primary worker who is completing the monitoring of monitoring **Date**

Exhibit B

INDEPENDENT LIVING CHECKLIST

A Guide to Evaluating Independent Living Skills – A Life Like Everyone Else

Name:_____ **ID:**_____

I-does Independently, **R**-does with Reminders, **S**-does with Supports

I. Home Environment

Item	I	R	S
Displays safety in using electrical, heating, plumbing			
Use of thermostat to control home temperature			
Use & safety of small kitchen appliances			
Use & safety of garbage disposal			
Safely handle hot pots, pans, oven ware			
Safely handle hot foods & water			
Stove burner - turn on			
Stove burner – knows difference between temps			
Stove burner – knows safety concerns			
Oven - turn on			
Oven – use of temperature control			
Microwave – can use			
Dishwasher – determine item dishwasher safe			
Dishwasher – proper/safe loading: knives			
Dishwasher – proper/safe loading: upper rack			
Dishwasher – proper/safe loading: light plastic items			
Dishwasher – proper/safe loading: bottom rack			
Dishwasher – operation: proper detergent			
Dishwasher – operation: control panel			
Food Storage – what needs to be refrigerated			
Food Storage – what needs to go in freezer			
Food Storage – what goes in cupboards			
Food Storage – what to do with leftovers			
What to do if an appliance is not working			
Ability to reach & operate appliances, outlets, switches, faucets, etc.			
Washer – sort clothing			
Washer – load clothing			
Washer – use detergent/fabric softener			
Washer – operate the control panel			
Washer – knows not to reach in while operating			
Dryer – load dryer (include cleaning lint filter)			
Dryer – operate the control panel			
How & when to clean: sinks & tub			
How & when to clean: toilet			
How & when to clean: refrigerator			
How & when to clean: microwave			
How & when to clean: oven			
How & when to clean: stove top			
How & when to clean: rugs			
How & when to clean: vinyl floor			
How & when to clean: tables & chairs			
How & when to clean: windows & mirrors			
How & when to clean: dishes			
Proper use & storage of cleaning products			
Has system for telling time or scheduling days			
Correctly adjusts water temperature for bath/shower			
Use door key			

Item	I	R	S
Lock/Unlock door			
Knows how to identify & respond to people at door			
Carries ID, health insurance information, house key			
Knows not to leave with strangers			
Knows how to be safe with sharp objects			
Can safely use stairs			
Demonstrates safe smoking practices (if applicable)			
Can use a flashlight when needed			
Can identify & maneuver on slippery surfaces			
Can safely dispose of broken glass			

II. Responding to Emergencies

Item	I	R	S
Can identify an emergency situation			
Can identify emergency phone numbers			
Can dial emergency phone numbers			
Can discuss an emergency on the phone			
Can identify & properly store poisons			
Understands the purpose of a smoke detector			
Knows how to inspect & maintain smoke detector			
Knows how to operate a fire extinguisher			
Knows when to use a fire extinguisher			
Knows what to do in case of a fire			
Knows what to do in case of a tornado			
Knows who to call in case of medical emergency			
Knows what to report medications & allergies in case of medical emergency			
Knows what to do if security of home is threatened			
Knows what to do in case of mental health emergency			
Knows who to call if utilities/phone are not working			
Knows when to leave home if utilities not working			

III. Community

Item	I	R	S
Use of Public Telephone			
Use of Public Transportation			
Knows own address & phone number			
Knows address/phone for person to call for help			
Ask for help if lost			
Follows basic traffic rules, safety when in car,			

walking, bike riding			
Knows what to do if approached by a stranger			
Knows how & who to ask for help if accosted			
Knows how to respond to a physical assault			
Knows basic knowledge of money, value, purchasing			
Knows effects of, & laws about, alcohol on driving			

IV. Personal Hygiene & Health

Item	I	R	S
Knows how & when to brush teeth			
Knows how & when to: take bath/shower			
Knows how & when to: wash hair			
Item	**I**	**R**	**S**
Knows how & when to: change clothes			
Knows how & when to: wash clothes			
Knows how & when to: wash linens			
Knows how & when to: comb/brush hair			
Knows how & when to: clip nails			
Knows how & when to: use deodorant			
Knows how & when to: use lotions/sun screen			
Knows how & when to: schedule doctor appointments			
Knows how & when to: schedule dental appointments			
Knows how & when to: schedule mental health appointments			
Taking medications and perform treatments as prescribed			
Ordering medications and treatments			
Responds to minor health concerns with first aid			
Differentiates between minor health concerns and those requiring medical attention			
Knows the need for rest and how much rest is needed			
Knows how to use tissues (i.e. Kleenex)			
Knows how to protect from disease			
Knows how to protect from unwanted pregnancy			
Understands balanced diet			
Can create a healthy meal			
Can use a cookbook			
Can make a shopping list			
Knows health effects of alcohol and tobacco			

V. Friends and Support Staff

Item	I	R	S
Knows & understands need to do background checks & seek references for potential staff			
Knows right to be treated with dignity & respect, and without physical or emotional harm			
Knows what is private and about privacy			
Knows how and who to contact in case of abuse or exploitation (financial, physical, emotional)			

VI. Equipment and Furnishings

Item	I	R	S
Has basic furniture: bed, table, chairs, couch, lamp(s), curtains/blinds			
Has appliances: stove, refrigerator, washer and dryer			
Appliances and heating system are in working order			
Toilet, sinks, tub/shower in working order with comfortable temperature & proper drainage			
Electrical outlets have wall plates			
Kitchen and bathroom outlets are GFI			
Neighborhood is safe			
Home exterior and interior clean and/or repaired			
Home has adequate lighting – inside and outside			
Adequate ventilation – windows open with screens			
Home is barrier free and accessible			

VII. Social Connections

Item	I	R	S
Family supports decision of independent living			
Family concerned about person living independently			
Network of natural supports in the community			
Person participates in leisure & recreational activities			

VII. Recommendations

Any items that are marked other than independent should be assessed for training or additional/different supports to increase independence. List these below and how training will be provided or why it will not.

Exhibit C

Saginaw County Community Mental Health Authority Life Choices Documentation Form

SCCMHA Funded Licensed Residential Setting

Name: _____ Date: _____

Birth Date: _____ Case: _____ Name of home: _____

The Home and Community Final Rule (HCBS) of Medicaid tells SCCMHA to help you to live your life as you would like to live it. This includes assisting you with your choices about where to live, work, and being part of our community. We must treat you just like any person would be treated. The HCBS Final Rule says that we do this through the Person-Centered Planning Process. This form is to help us know about your choices.		
You have the right to choose the home you live in from various options. **Given the choices available to you at this time, is your current home where you choose to live?**	Yes ☐	No ☐
You also have the right to choose your roommate from available options. **Given the choices available to you at this time, are you happy with your current roommate?**	Yes ☐	No ☐

If at any time you are not happy with the home you live in or your roommate, you can notify your worker: _____ , phone: _____ to help you to find out about the choices available.

If you live in a place that you do not own or rent, and have staff present, then please answer these questions:			
The Resident Care Agreement (BCAL-3266) that I (or my guardian) signed, also included a document known as "Summary of Resident Rights: Discharges and Complaints".	Yes ☐	No ☐	Don't know ☐
My bedroom door is lockable from the inside.	Yes ☐	No ☐	
I am able to furnish and decorate my room the way that I want to.	Yes ☐	No ☐	
I set my own schedule (For example: I go to bed when I want to, bathe when I want to, etc.).	Yes ☐	No ☐	
I have access to food at any time.	Yes ☐	No ☐	
I can have visitors whenever I want to.	Yes ☐	No ☐	
I have a place to securely lock up my possessions.	Yes ☐	No ☐	
I receive privacy while doing or receiving personal care.	Yes ☐	No ☐	
I am aware that there is the following home restriction(s) that may limit my access to items or activities: (mark all that apply) ☐ **No Restrictions** ☐Restricted visitor timeframe ☐Laundry Not Accessible ☐Alarms on doors ☐Sharp knives locked up ☐Quiet Time Hours ☐Limited access to extra food/snacks ☐Other restrictions:_____			

***If you answered "no" to any of the above, these should be looked at through the PCP process until resolved.**

_____ _____

Signature of Person Receiving Services or Legal Representative Date

HCBW Choice Document Rev: 12/26/2019 Scan as an attachment to Sentri Pre-planning Form

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Plans of Service and Supports</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.05</td></tr>
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Sandra M. Lindsey, CEO

Responsible Director:
Director of Services for Persons with Intellectual and Developmental Disabilities

Authored By:
Thomas Peck

Additional Reviewers:
PCP Workgroup, Management Team, Charlotte Fondren, Amanda Elliott
Kelley Feltman</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
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Purpose:
To establish a procedure for Service and Support Planning utilizing a person-centered planning approach.

Application:
The entire SCCMHA network of providers

Policy:
A person-centered planning process will be used to develop an Individual Plan of Service (IPOS) in partnership with the consumer. The IPOS directs the provision of supports and services to be provided by Saginaw County Community Mental Health Authority (SCCMHA) to the consumer during the course of treatment and recovery.

Standards:
A preliminary plan will be developed within 7 days of the commencement of services.

Within 45 days from the designated primary program orientation meeting, or, if no orientation, from the first meeting with the assigned primary case holder, an Individual Plan of Service (IPOS) will be completed and implemented using a Person-Centered Planning process (PCP).

Planning must include needs, strengths, abilities, preferences, choices, and goals, expressed in a manner capturing the consumer's words or ideas and, when appropriate, those of the family/caregiver.

The IPOS is a living document, intended to be changed as the consumer's desires and needs change, and may be modified as needed with the consent of the consumer through the periodic review of the plan. If there is a life-changing event, such as moving from one level of care to another (examples: moving into a more restrictive/protective residence, enrollment into a program, on-set of a medical impairment) then a new IPOS meeting will need to be convened for re-creation of the IPOS in relation to this life-changing event.

At least annually, the entire plan will be reviewed with the consumer's team. The annual review process will start sixty (60) days prior to 365 days from the last IPOS team meeting. This review will include completion of a Pre-Planning Meeting, use of PCP Planning Tool(s), Life Choice document (if needed), updating the Psycho-Social Assessment, referral or updating of Enhanced Health or other referred services and other actions needed to develop a meaningful Individual Plan of Service.

The IPOS must be prepared in person-first singular language and be understandable by the consumer with a minimum of clinical jargon or language and without the use of acronyms

The consumer must be involved in the development of the IPOS to the best of their ability. The IPOS should be revised when a consumer requests a change, when a consumer goal changes, when significant progress or regression occurs, or within 364 days from the previous IPOS, whichever is soonest.

The IPOS includes a treatment plan and a support plan. The plan must be comprehensive, addressing all service areas that are identified at the IPOS Meeting or during pre-planning.

The Support Plan will be those services or activities to be provided to the consumer based on the consumer's level of care, safety, needs or desires.

The IPOS will document the services and supports, community resources, and provider options that are available to the consumer.

The IPOS will have meaningful and measurable goals based on the desires and choices of the consumer with the purpose of aiding in recovery or promoting resilience. These goals will be written using the consumer's own words.

Goals related to enhanced health services, nursing, therapy etc., do not need to be specifically stated in an objective rather those services specific assessments should be referenced in the specific objective related to that goal.

Clinical goals do not have to be included in the IPOS if they are related to a consumer goal, but the service plan containing these goals must be attached to the IPOS. Clinical

goals must be written in a manner so are to be understood by the consumer, consumer's guardian (if applicable) and to those implementing any parts of the plan.

The IPOS must include all the components described below:(from the Michigan Department of Health and Human Services Person-Centered Planning Policy, June 5, 2017)

1. A description of the individual's strengths, abilities, plans, hopes, interests, preferences, and natural supports.

2. The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.

3. The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports.

4. The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system. The PIHP/CMHSP is responsible for ensuring it meets these requirements of the HCBS Final Rule.

5. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

6. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.

7. Documentation of any restriction or modification of additional conditions must meet the standards set forth in section IV below.

8. The services which the person chooses to obtain through arrangements that support self-determination.

9. The estimated/prospective cost of services and supports authorized by the community mental health system pursuant to Contract Attachment P.6.3.2.1B. ii.

10. The roles and responsibilities of the person, the supports coordinator or case manager, the allies, and providers in implementing the IPOS.

11. The person or entity responsible for monitoring the plan.

12. The signatures of the person and/or representative, his or her case manager or support coordinator,

13. The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.

14. A timeline for review.

15. Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

The development of the IPOS, including the identification of possible services and professionals, is based upon the expressed needs and desires of the individual. Where appropriate, consultation is sought about special emphasis problems, including for treatment planning purposes (e.g., trauma, eating disorders). The plan must integrate the results of such consultation into treatment planning. (See Exhibit A for guidelines to adding services during the PCP Process)

Health and safety needs are addressed in the IPOS with supports indicated to accommodate wants and needs as expressed by the consumer. When a health and safety concern is present that puts a consumer at risk for harm, the consumer must be made aware of the risk to assure that an informed decision has been made by the consumer regarding how to address that risk.

- Health and Safety needs can be indicated in one of two areas – the Support Plan section of the IPOS or within a consumer goal when that need is related to that goal. Any restrictions or limitations indicated in the plan must adhere to SCCMHA policies and any related rules and regulations.

The IPOS shall address, as either desired or required by the consumer, the consumer's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation.

The IPOS should be kept current and should be reviewed for modification as indicated in the plan.

- The implementation date of the plan will occur as designated by the team.
- The consumer will receive a copy of the plan within 15 days from the IPOS meeting. This will require that the IPOS be entered into the electronic record within five (5) working days from the Planning Meeting.
- The plan will be submitted simultaneously for approval to Care Management for medical necessity and the assigned Primary Program Supervisor for clinical efficacy. Both will work directly with the Case Holder to revise the plan as needed to meet both medical necessity and clinical efficacy expeditiously within that 15-day window
- The consumer/guardian may designate when a review or reviews of the plan occur during the next calendar year. This review will be with the consumer and entail the entire plan and status of services.

- A clinical review of the plan by the case holder will occur at a minimum, three months after of the implementation date of the plan. This review will entail determining the status of the consumer goals and services. Additional clinical reviews may occur as needed or warranted.

If a consumer is not satisfied with his/her individual plan of services, the consumer or the person authorized by the consumer to make decisions regarding the individual plan of services, the guardian of the consumer, or the parent of a minor may make a request for review to the designated individual in charge of implementing the plan. The review should be completed within 30 days.

An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the consumer or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

Consumers should be provided with ongoing opportunity to provide feedback on how they feel about service, support and/or treatment they are receiving and their progress toward attaining valued outcomes. Information is collected and changes are made in response to the individual's feedback.

Any staff or individual who will be implementing the plan will be in-serviced by the Case Holder or other team member prior to the implementation of the plan. Documentation of training will be in the IPOS In-Service Records section of the IPOS Header and have attached any supporting documentation from the training.

Standards for Use of the Single Service Plan

The Single Service Plan (SSP) is to be used when the following circumstances occur:

1. At the onset of intake. The SSP will be used as the preliminary plan.

2. When a consumer is receiving only a single service from SCCMHA such as Psychiatric Medication Review, Therapy, or Respite, and when case management or support coordination services are not being provided by SCCMHA or a contracted agency.

3. When SCCMHA is only monitoring the services of a contracted entity that is providing services, including case management or support coordination, for a consumer who is not living in Saginaw County.

4. Other circumstances as approved or indicated by the Executive Director of Clinical Services.

The Single Service Plan cannot be used in place of the Plan of Service when SCCMHA is providing a full array of services to consumers who live in Saginaw County.

When used, the Single Service Plan requires a clinical review of the plan and need for services at least six (6) months from implementation.

The Single Service Plan cannot exceed one year in duration. If the circumstances continue, a new Single Service Plan is required.

When the Single Service Plan is used in #3 above, a copy of the Individual Plan of Service and any reviews of that IPOS must be attached to the SSP in the electronic record.

Definitions:

Consumer - An individual directly receiving service from Saginaw County Community Mental Health Authority or its network of providers.

Person-centered planning - Means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends and professionals as the individual desires or requires.

Support Plan - Means a written plan that specifies the personal support services or any other supports that are developed with and provided for a consumer.

Treatment Plan - Means a written plan that specifies the goal-oriented treatment or training services that are to be developed with and provided for a consumer.

References:

Michigan's Mental Health Code (Act 258 of the Public Acts of 1974 as amended)
SCCMHA Person Centered Planning policy
MDHHS PERSON-CENTERED PLANNING POLICY (June 5, 2017)
PIHP Site Review Protocols
Treatment Team, Treatment Planning and Care Coordination 11 D1. (Page 64)
Commission on Accreditation of Rehabilitation Facilities section 2.C

Exhibits:

Exhibit A – Protective Restrictions and Devices

Procedure:

ACTION	RESPONSIBILITY
Establishes procedure for services and support planning utilizing a person-centered planning approach.	CEO Director of Clinical Services,
Within 45 days from the designated primary program orientation meeting, or, if no orientation, from the first meeting with the assigned primary case holder, an Individual Plan of Service (IPOS) will be completed and implemented using a Person-Centered Planning Process	Case Holder
At least sixty (60) days prior to one year from the	Case Holder

previous IPOS meeting, the planning process will begin by scheduling at least one pre-planning meeting with the consumer. At the pre-planning meeting(s) the consumer identifies: • Dreams, goals, desires, and any topic which he or she would like to talk about. • Topics he/she does not want talked about at the planning meeting. • Who to invite to the planning meeting and who will send out the invitations. • Where and when the planning meeting will be held. • Who will facilitate. • Who will record. • If the consumer would like to participate in self-determination. • What assessments for service(s) might be necessary in preparation for the planning meeting as based on the needs and expressed desires/outcomes of the consumer.	
The SCCMHA Customer Service Staff will complete a survey of a sampling of consumers who have recently had their Person-Centered Planning Pre-Planning Meeting. The sampling will include at least 50 consumers per month and will include every member of the SCCMHA Provider Network. • The results of the surveys will be collected and shared with the Quality Governance Committee on a quarterly basis.	SCCMHA Customer Service Staff
As part of the planning process, prior to the planning meeting, the following will occur: • If desired by the consumer, coordinates with the Independent Facilitator • Reviews the entire consumer's record including the previous IPOS and Reviews, progress notes, Medication Reviews, assessments and screenings, Incident Reports, etc. • Verifies the reported medical and health conditions of the consumer through coordination with the Integrated Health Nurse (using ICOP-Zenith, Care Connect 360, or other health data base) or through direct contact with the Primary Care Physician • Requests an evaluation or assessment or status from any services the consumer is receiving or may need (as determined in the pre-planning process).	Case Holder and/or Facilitator

• Completes an updated Psycho-social Assessment • Prepares the IPOS by entering the dreams, desires, and goals.	
Meets for the person-centered planning meeting at the date and place requested by the consumer, documenting who attended the meeting. • Assures that the consumer is the focal point of the planning process and that all participants look at and communicate with the consumer during the planning process. • Identifies and discusses the consumer's desired outcomes, including any health and safety needs. • Determines what natural supports are available to assist the consumer in achieving their desired outcomes. • If no natural supports exist, develops a plan for developing natural supports if the consumer desires • Identifies what services and supports will be provided to assist the consumer in achieving their desired outcomes. • Determines the scope, amount, and duration of each service that is to be provided. • Determines how often the plan should be reviewed.	Case Holder or Facilitator
A service and support plan is written based on what was agreed to at the person-centered planning meeting. • The service and support plan should include measurable goals and objectives. • Clearly identifies in the plan the person in charge of implementing the plan.	Case Holder or Facilitator
Once all parties have agreed to all elements of the Individual Plan of Service, the following time frame will occur for implementation: • Within five (5) business days from the Planning Meeting, the Case Holder will write the plan in Sentri and submit the plan to their Supervisor for clinical review and request authorization from Care Management at the same time	Case Holder
• Within three (3) business days from the request for authorization, the Care Management Specialist (CMS) will review for necessity and approve	Care Management Specialist

authorization. In the event there is a concern over Medical Necessity being shown in the IPOS, the Case Holder will work with the Care Management Specialist to resolve that concern within five (5) business days.	Case Holder
• Within three (3) business days from plan submission, the Supervisor will review and approve the plan. In the event there is a clinical concern, the Supervisor and Case Holder will resolve the concern within five (5) business days.	Supervisor
• Within 15 business days from the planning meeting, the Case Holder will sign the plan and provide a copy to the consumer and the guardian as well as schedule any needed in-services regarding the plan.	Case Holder
• The Case Holder will also obtain, either at the planning meeting or afterwards, a consent signature from the consumer or guardian either electronically in Sentri or on the designated form.	Case Holder
Any staff or individual who will be implementing the plan will be in-serviced by the Case Holder or other team member prior to the implementation of the plan, and this must be documented in the Sentri IPOS In-Service document section.	Case Holder
Reviews the plan within 30 days of the consumer expressing dissatisfaction with the plan.	Case Holder
Reviews the service and support plan at intervals agreed to at the planning meeting and discusses the consumer's progress toward attaining identified outcomes.	Case Holder
Completes a Clinical Review at a minimum of three (3) months from the implementation date of the Individual Plan of Service.	Case Holder
Provides ongoing opportunities for the consumer to provide feedback on how they feel about services, support and or treatment they are receiving and makes changes based upon the feedback received.	Case Holder

Exhibit A

Protective Restrictions and Devices Protocol

Protective Restrictions or Devices are those interventions used to help protect a consumer from the consequences of a chronic harmful behavior. These may be specific equipment such as Mitts or Helmets or restrictions on activities such as a fluid or eating restriction. There are two types of circumstances that may warrant use of Protective Restrictions or Devices:

Volitional Harmful Behavior

The first, volitional harmful behavior, is a harmful behavior that the consumer does based on a set of environmental conditions or events. The behavior is typically voluntary and the consumer may exhibit some control or the harmful behavior only occurs when a specific set of precursors happen such as being denied a desired object, another person is in their space, experiencing anger toward another person, etc. Health reasons have been ruled out as the cause of volitional harmful behaviors.

In the case of volitional harmful behaviors, the uses of protective restrictions or devices must be pre-approved by the Saginaw County Community Mental Health Authority Behavior Treatment Committee (SCCMHA BTC). When in response to volitional harmful behavior, use of protective restrictions or devices should be short-term or until the behavior is ameliorated by a behavior intervention plan (use of the restriction or device is not sufficient enough intervention for the behavior). Approval for use of protective restrictions or devices in response to volitional harmful behaviors will require a Behavior Treatment Plan be presented for review, approved, and monitored by the SCCMHA BTC.

Harmful Health Conditions

The second type of harmful behaviors are a result of a health condition such as polydipsia, epilepsy, Alzheimer's disease, diabetes, urinary tract infection, brain damage, etc. and the behavior is typically involuntary or uncontrollable. The use of Protective Restrictions and Devices as a safety accommodation for a harmful health condition do not require BTC review or approval but **do require an order from a physician**. The use of the approach must be documented in the consumer's Individual Plan of Service (IPOS) with the following requirements:

1. The medical or health reason for the limitation must be clearly indicated in both the Physician Order for the restriction or device and the Individual Plan of Service. This usually will typically be indicated in the Health and Safety section of the plan.
2. Fluid or food limitation requires a second opinion unless the consumer has a documented history of a condition or incidents that indicate the restriction such a peg tube or occurrences of aspiration, occasions of falling, etc. A restriction cannot be solely based on just a diagnosis unless the restriction is part of the usual treatment modality for that condition. The documentation must include a rationale that warrants the restriction.
3. The Physician Order must:

a. Clearly give the parameters of the restriction such as 64oz per day, pureed items, every 8 hours, etc.

b. Detail actions to be taken as a medical and safety response if the consumer does not adhere to the order.

c. Make clear which medical provider is responsible for monitoring the health status of the consumer as it relates to the order.

d. Identify frequency of monitoring, including specified tests or screenings to be administered at a set interval to assess the benefit/effect of this intervention.

e. Be dated, time limited, and expire within a maximum of one-year.

4. If the restriction order is written by a psychiatric provider, the provider must first consult with the consumer's primary care provider to determine risks and benefits of maintaining the order and document this consultation in the consumer record.

5. The IPOS must detail:
    a. How to deal with any anticipated safety or medical protocols of the behavior. This includes any signs/symptoms that would indicate the need for an evaluation by a medical professional or any other medical protocols indicated by the physician.

    b. How to respond to any harmful behaviors that occur as a result of implementing the use of the device or the restriction.

    c. How positive behavior support steps will assist the consumer with adherence to prescribed limitations and promote increased health behaviors.

    d. Identify frequency of monitoring, including specified tests or screenings to be administered at a set interval to assess the benefit/effect of this intervention.

    e. Be dated, time limited, and expire within a maximum of one-year.

6. If the restriction order is written by a psychiatric provider, there must be documentation of consultation with the consumer's primary care provider to determine risks and benefits of maintaining the order.

7. The IPOS must detail:
    a. How to deal with any anticipated safety or medical protocols of the behavior. This includes any signs/symptoms that would indicate the need for an evaluation by a medical professional or any other medical protocols indicated by the physician.

    b. How to respond to any harmful behaviors that occur as a result of implementing the use of the device or the restriction.

    c. How positive behavior support steps will assist the consumer with adherence to prescribed limitations and promote increased health behaviors.

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Continuum of Care</td><td>Subject No: 03.02.07</td></tr>
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Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services.

Authored By:
Kristie Wolbert

Reviewed By:
Allison Kalmes-Hadd, Management Team, Jennifer Stanuszek, Charlotte Fondren</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
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Purpose:
To identify and clarify residential options available for SCCMHA Consumers

Policy:
SCCMHA providers of service are in a position, on a regular basis, to assist consumers/guardians with decisions about the most appropriate residential option for the consumer. Though there are many options available, those decisions should be based on some guiding principles.

The guiding principles for helping a consumer/guardian make decisions about the most appropriate residential option should include:

The residential option chosen should be based upon the consumer's choice.

It should be the least restrictive setting to meet the consumer's needs.

The consumer's health and safety needs must be able to be met within the residential option chosen.

It should allow the consumer to be integrated into his/her home community when at all possible.

The setting must be safe and habitable.

The setting chosen must afford the consumer a rich quality of life.

The opportunity to use a fiscal intermediary in order to guide over a directed budget, using the principals of self determination. (See SCCMHA policy 02.03.04 Self Determination)

SCCMHA believes that all consumers, regardless of their living situation, have the right to live in a quality environment. SCCMHA monitors quality of residential settings in a variety of ways including through SCCMHA's auditing and contracts and properties management units and through Quality of Life visits. (The monitoring form used for these visits "Quality of Life Home Visit Report" is included as an exhibit to this policy Exhibit H). SCCMHA has a Residential Watch Committee that discusses residential situations that may have some potential risk. See SCCMHA procedure 09.04.03.07, Residential Provider Watch Program.

Application:
The Network of SCCMHA Providers.

Standards:

- A three-day supply of fresh, perishable foods is available in contracted homes. Examples may include but are not limited to: Eggs, milk, cheese, fruit, vegetables, bread.
- Provider will post menus that follow the Choose My Plate guidelines, including fruits and vegetables offered each meal and proper portions of fruits, vegetables, grains, protein, and dairy. Please refer to www.choosemyplate.gov for more information regarding healthy meal choices. (See SCCMHA Policy 03.02.07C Residential Service - Exhibits to AFC, Licensed Residential, and CLS – Exhibit F)
- Provider will promote health and wellness in the form of exercise at least weekly, though preferably daily, such as walking, exercise videos, interactive video games, etc.
- Provider will ensure proper maintenance is occurring at the residential facility as documented by the completion of preventative maintenance logs at least quarterly.
- Provider should be completing documentation of monthly water, refrigerator, and freezer temperatures. This can be done directly on the preventative maintenance log or on a separate log created by the Provider.
- Provider will ensure all consumers are being treated with dignity and respect, to which they are entitled (See SCCMHA Policy 02.02.28 Recipient Rights – Dignity and Respect)

Definitions:
Adult Foster Care (AFC):
Adult Foster Care homes are homes operated by provider corporations or by individuals and licensed by Michigan Department of Consumer and Industry Services Division of

Adult Foster Care Licensing (CIS) to provide room, board and supervision to persons in need of such services. An AFC home is independent and does not operate under the auspices of a mental health agency, although they may contract with a mental health agency to receive funds to provide specialized personal care, medical monitoring, and behavioral services. Foster care homes may provide placements for consumers not associated with an agency, although many users of adult foster care services are consumers of the Michigan Department of Health & Human Services (MDHHS) or Community Mental Health (CMH). Foster care homes are located throughout the community and may or may not be part of the family home of the provider. The home may be staffed by the provider family or the provider may hire staff to assist. The level of staffing varies but often consists of non-awake overnight coverage and one staff to assist with high consumer demand hours such as mornings, late afternoons, and evenings. The number of beds in each home varies and is regulated by the local CIS Licensing. Personal care and assistance with activities of daily living are provided as part of routine care. Each person pays the provider directly for room and board, generally through SSI/SSA benefits. The rate of SSI payment can be domiciliary only or include personal care. Each consumer is allowed to keep a standard amount of his/her SSI/SSA per month for personal items; the AFC provider must keep a current Resident Funds form on consumer's personal money where the consumer plan indicates the need for assistance with money management by AFC staff.

Considerations: Potential participants/consumers must be in need of supervision. Generally they should have low to medium behavioral, medical, personal care, domiciliary or other needs, although the level of need a home can address differs. Some home operators are more experienced and/or have specialized training, which lends to serving individuals with significant behavioral and medical concerns.

SCCMHA publishes a Residential Directory that lists the providers located in Saginaw County and some basic information about the home and the license for the home. This Directory is located on the SCCMHA website under *Community Resources.* This resource is meant to be used by the consumer and those assisting the consumer in choosing an AFC that will meet the consumer wants and needs. (www.sccmha.org)

Adult Foster Care (AFC) with Model Payments now known as (ASAP) Adult Services Authorized Payments

Under this type of care all of the same requirements pertain as with Adult Foster Care (AFC) but the consumer may need some additional assistance with bathing, dressing, or other area that requires more assistance than just reminders to the consumer. Under this level of care the provider may ask for Model Payments or ASAP for a consumer. This type of funding is a set amount per month. The amount is set by the State of Michigan and paid by the State of Michigan. The case manager or support coordinator has to do a monthly visit to the facility to assure staff are providing the additional care needed. The case manager has to initial the paperwork as proof of review and that the provider is giving the care that was prescribed by the case manager or support coordinator. Usually the Case Manager or Support Coordinator will initial above the date they visit. The Case Manager or Support Coordinator must initial minimally the consumer Personal Care and

Community Living Support Log form. They may also need to initial the medication sheets and the consumer resident funds if the consumer needs assistance in both of these areas. The provider has to submit monthly paperwork to the State of Michigan to receive payment for services rendered. The provider can bill electronically or by telephone. Questions about this process can be directed to SCCMHA's Care Management Department.

Specialized Residential Settings:
Some adult foster care homes are licensed to provide adult foster care and at the same time are certified by the state to provide specialized residential services. This certification allows the provider to receive contract funds from community mental health to provide specialized mental health services.

There are two types of Specialized Residential Settings:
One type are adult foster care homes that accept a mixture of consumers, some of which are funded through a contract from community mental health and some that are not. Such homes may have one or several consumers either funded and/or served by SCCMHA. Staff working in the home are required to have completed specialized group home training. The contract rate paid for each consumer is designated in the provider contract; based on the specialized mental health needs of the consumer and the amount of staffing necessary to meet those needs. The home is expected to follow the treatment plan developed through the person centered planning process. These homes are usually owned by the provider. These homes may or may not have awake staff 24 hours a day. However, for homes with contracts inside Saginaw County, the contract requires 24 hour awake staff.

The second type are homes in which CMH contracts exclusively for all the beds in the home and pays a set daily per diem based on a contracted amount of full time equivalent staff or FTE's being utilized to meet the needs of consumers. SCCMHA owns these homes and contracts with a company to provide staffing and general maintenance of the homes. These homes generally provide 24 hour awake supervision. Staff working in the home are required to have completed specialized group home training. The home is expected to follow the treatment plan developed through the person centered planning process.

Considerations for specialized residential settings: The needs of the consumer must go beyond the typical needs of the person served in a general adult foster care home. The home must have an adequate amount of trained staff to safely meet the needs of the consumer as outlined in their plan of service. Persons placed into specialized residential settings typically have increased personal care needs or exhibit behavioral symptoms that require regular intervention.

Enhanced Housing Needs
These are for services outside the realm of Specialized Residential funds which are used for the following purposes:

Temporary Lodging is payment for room and board amount - paid from the General Fund or other non-Medicaid funds. Community resources must first be exhausted and documented in the clinical record prior to authorization for payment.

Housing Assistance is payment for shelter costs such as room and board. Community resources must first be exhausted and documented in the clinical record prior to authorization for payment.

Enhanced Staffing is additional staffing hours exceeding a contracted amount, and is subject to the following conditions:

- Is provided to avoid hospitalization
- Is provided to address medical or behavioral conditions that threaten placement or safety of the consumer, staff or community. The plan must be as specific as feasible in order to identify the need for Enhanced Staffing; including times, locations, and conditions for the service to be provided.
- Unless noted in the plan as "On-going", enhanced staffing will only be authorized for brief periods. Long term enhanced staffing may be figured into the overall contract rate for the home.
- Must be for the minimum needed number of hours per day. Sleeping hours, day program hours, home leave of absence (LOA) hours must be factored in determining the hours requested.

A request for Adaptive Equipment is to provide supplies, equipment, or assistive devices, which will assist the consumer to remain living within a community setting as defined and described in the Michigan Medicaid Provider Manual. (See SCCMHA Policy 03.02.07C Residential Service - Exhibits to AFC, Licensed Residential, and CLS, for applicable form)

A request for Environmental Modification is to be used for payment to modify, repair, or enhance the residential environment as defined and described in the Michigan Medicaid Provider Manual. (See SCCMHA Policy 03.02.07C Residential Service - Exhibits to AFC, Licensed Residential, and CLS for applicable form)

Leave of Absence (LOA): (Exhibit J)

LOA occurs when the resident leaves a specialized residential setting for an overnight absence that absolves the provider from the responsibility of providing services for the duration of the consumer's absence. This would be circumstances such as: a planned vacation, family visit, hospitalization, incarceration, etc.

The provider remains responsible for the provision of service in circumstances such as elopement, working, day program, in the neighborhood, going to the store or movie, etc. even though the consumer is not in the facility or under the direct supervision of the provider

For reimbursement and payment purposes, SCCMHA considers the start of the billable day as 12:00 AM midnight. A provider must be responsible for services to a consumer at

the start of that day in order to bill for that day. Under this provision, if a consumer leaves on a leave of absence (LOA), the provider would not be paid for the day the resident leaves but would be paid on the day the resident returns. In other words, the provider will be paid for date of admission but not date of discharge.

References:

MDHHS Medicaid Provider Manual: Mental Health/ Substance Abuse Section
SCCMHA Procedure 09.04.04.03- Personal Care and Community Living Supports Service Log Documentation- Rev. 7-15-06
SCCMHA Procedure 09.04.01.04 Quality of Life Visits
SCCMHA Procedure 09.04.03.07 Residential Provider Watch Program
SCCMHA Policy 03.02.17 Medication Management in Licensed Residential Settings
SCCMHA Policy 05.06.08 Management of Consumer Funds.
SCCMHA Policy 02.03.04 Self Determination
SCCMHA Policy 02.02.28 Recipient Rights – Dignity and Respect
SCCMHA Policy 03.02.07C Residential Service - Exhibits to AFC, Licensed Residential, and CLS

Exhibits:

Exhibit A: Adult Foster Care Home Requirements Summary form State of Michigan Licensing Rules
Exhibit B: Consumer Checklist- Individual AFC Placement Checklist
Exhibit C: Summary of Resident Rights for AFC Group Homes (R400.15304)
Exhibit D: Guidelines for Specialized Residential Services
Attachment 1: Staff Schedule
Attachment 2: Sample Emergency Food List
Attachment 3: Sample Emergency Food Menus
Attachment 4: Quarterly Preventative Maintenance Checklist
Attachment 5: Personal Care and Community Living Supports Service Log
Attachment 6: Health Visit Record
Attachment 7: Consumer Inventory List
Attachment 8: Sample Activity Calendar
Exhibit E: Licensed Specialized Residential Provider Guidelines for Personal Care and Community Living Supports
Exhibit F: Samples of Assessment Plan for AFC Residents
Exhibit G: SCCMHA/Quality of Life Home Visit Report
Exhibit H: Checklist for moving consumers into Licensed Residential Facilities
Exhibit I: Leave of Absence Form
Exhibit J: 911 Guidelines

Procedure:

ACTION	RESPONSIBILITY
Makes a variety of residential options available to consumers of mental health services.	Saginaw County Community Mental Health Authority

Participates in a person centered planning process to discuss the consumer's needs and desires particularly as it relates to residential options.	Consumer, guardian, case holder, others as identified by the consumer/guardian.
Reviews the residential option desired to determine if it can meet the needs of the consumer with special attention to the health and safety needs of the consumer.	Consumer, guardian, case holder, and others as identified by the consumer/guardian.
Develops a plan of service which addresses the specific needs of the consumer, including amount, scope and duration. The plan should also address each need identified in the licensed residential authorization, or DCH 3803. Keeping in mind the least restrictive setting.	Consumer, guardian, case holder, and others as identified by the consumer/guardian.
Follows the Specialized Residential Process and Workflow (See SCCMHA Policy 03.02.07c Residential Service - Exhibits to AFC, Licensed Residential and CLS for assistance with this process) for placement into Specialized Residential settings. Also see Checklist for Moving consumers into Licensed Residential Settings (See Exhibit I).	Case Holder Clinical Supervisor Care Management Specialist Residential Provider
Referral to the Residential Placement Committee for any possible out of county placements or moves from a less restrictive setting into a more restrictive setting. A review of the persons file will occur, and a decision will be made in 7-10 business days.	Case Holder/Chair of the Residential Placement Committee
Assist with the procurement of needed Equipment or Environmental Modification Utilizing the "Request for Additional Funds Form" only after all outside resources have been exhausted. (See SCCMHA Policy 03.02.07c Residential Service - Exhibits to AFC, Licensed Residential, and CLS for applicable form)	Case Holder

Monitors the consumer in the residential option at intervals agreed to in the resident's plan of service. Monthly home visits are recommended by SCCMHA to assure that the needs of the consumer are being met in the residential setting and that the consumer is satisfied with the services provided. If the individual is in specialized residential, a monthly visit is required at minimum.	Case Holder and guardian when one is appointed.
Follows the Guidelines for Specialized Residential Service Providers as written in Exhibit E and the Guidelines For Personal Care and Community Living Supports as written in Exhibit F.	Residential Provider
Attends residential facility staff meetings as needed to provide in-services on consumer plans, help resolve issues, clarify concerns, etc.	Case Holder

Exhibit A

ADULT FOSTER CARE HOME REQUIREMENTS SUMMARY FROM STATE OF MICHIGAN

LICENSING RULES

This is a summary of the State of Michigan requirements that licensed AFC home providers are expected to meet.

- Provide personal care, protection and housing and food for residents.
- Treat residents with respect, courtesy, dignity and fairness.
- Maintain all licensing requirements of the State of Michigan.
- Provide nutritious meals and post menus.
- Staff is trained and competent, including knowledge of persons to be served.
- Meet physical, emotional and intellectual needs of each resident.
- Able to handle emergency situations appropriately.
- Assure welfare of the residents, including safety, privacy and protection from moral, social and financial exploitation.
- Sufficient staffing to meet the needs of residents.
- Maintain appropriate and current home and resident records.
- Maintain records of resident funds and valuables.
- Maintain home policies, including admission and discharge.
- Provide house rules to residents.
- Promote resident interactions that encourage cooperation, self-esteem, self-direction, independence and normalization.
- Provide opportunities for positive social skill development, contact with relatives and friends, community-based recreational activities, privacy and leisure time and religious education/attendance of choice.
- Provide personal care and community living skill development as specified in each person's written plan.
- Explain rights to each resident.
- Provide behavioral interventions that are positive and relevant with unacceptable behavior addressed in written plans.
- Protect residents from mistreatment, restraint, punishment, confinement, mental or emotional cruelty or withholding of food, water, clothing, rest or toilet.
- Pay attention to resident health care needs, including medication and special diets.
- Report to resident representatives/responsible agencies of serious situations or events.
- Reasonable provision for varied leisure/recreational equipment/activities.
- Safe and healthy facility environment, including temperature, space and egress.
- Complete background checks of staff before hiring.
- Provide opportunity and instructions for personal hygiene when appropriate.

Exhibit B

Consumer CHECKLIST

INDIVIDUAL AFC PLACEMENT CHECKLIST

Home Name:_____

Visit Date: _____

SCCMHA suggests that you obtain a copy of the house rules for any general AFC home and a copy of the rental agreement from the provider and consider the list of state requirements included in this directory when you consider your choices in selecting an adult foster care provider. Below is a list of questions for potential residents/consumers and/or their family members to ask or find out about when visiting potential living situations. You may want to rate how important each item is to you. Not all items on the list are a top priority to everyone. In order to make the right decision, you or your family member may wish to identify the five most important items to you in considering a home setting. This may help to narrow your choices. Extra forms are available at the SCCMHA customer services office.

FOOD

- ❑ I like to have fresh fruits and vegetables available to me.
- ❑ I like to be able to help prepare meals and have access to the kitchen when I want.
- ❑ I like to be able to cook meals.
- ❑ I like to be able to have choices in the meals I eat each day.
- ❑ I like to be able to have certain foods to eat: ethnic, religious or just favorite foods.

COMMUNITY ACTIVITIES

- ❑ I like to go shopping for personal things and would like to continue this activity. (How often?)
- ❑ If the provider is not able to take me to activities; I would like to have access to bus transportation.
- ❑ How close is the bus stop?
- ❑ What locations does the bus route take from the bus stop closest to the home?
- ❑ I prefer to go on low-cost activities.
- ❑ I prefer to go to the movies.
- ❑ I like to go to the library.
- ❑ The cost of transportation may be extra.
- ❑ I like to attend church services each week.
- ❑ I like to go out to get my hair done.
- ❑ I like to have a say in the types of activities I participate in.
- ❑ I like to participate in activities in the community each week.

GENERAL ITEMS

- ❑ I prefer to live with other males only.
- ❑ I prefer to live with only other females.
- ❑ I like to live in the same house with both males and females.
- ❑ I use a wheelchair to get around and need a ramp.
- ❑ I have ambulation problems that cause me not to be able to use stairs.
- ❑ I have a breathing machine that will require extra care and electricity to use.
- ❑ I have special medical needs that will require extra care by the provider/caregivers.
- ❑ I like to have the owner or provider of the home live in the same home I will be moving into.
- ❑ I prefer to smoke indoors.
- ❑ I like to be able to smoke when I want. I do not like to be limited in the number of cigarettes or

the times I may be able to have a cigarette.

- ❑ I prefer to have access to staff in the middle of the night if needed.
- ❑ I need to have awake staff at night due to my medical condition.
- ❑ I like to be able to go to bed when I want.
- ❑ I want to have a say in the time I wake up.
- ❑ I want to have a say in the time I come in at night from visiting my friends/family.
- ❑ I like to be able to participate in household chores, laundry, dishes, etc.
- ❑ I prefer to have my own room (there may be an extra cost for a private room).
- ❑ I like to know there are staff available during the day if I need help.
- ❑ I would like to be able to bring my pet with me to my new living arrangement.
- ❑ I like to be able to plug in several electronic pieces of equipment (more than five).
- ❑ I like to have family and friends come to see me at my house.
- ❑ I like to visit with family and friends privately where there are not interruptions and others cannot hear the conversations.
- ❑ I prefer to do my own laundry.
- ❑ I like to have my clothes laundered at least weekly.
- ❑ I like to be able to come and go from the home as I please.

Comments: _____

Exhibit C

SUMMARY OF RESIDENT RIGHTS FOR AFC GROUP HOMES (R400.15304) RESIDENTS HAVE THE FOLLOWING RIGHTS:

- To be free from discrimination on the basis of race, religion, color, national origin, sex, age, handicap, marital status or source of payment in the provision of services and care.

- To exercise his or her constitutional rights, including the right to vote, the right to practice the religion of his or her choice, the right to freedom of movement and the right of freedom of association.

- To refuse participation in religious practices.

- To write, send and receive uncensored and unopened mail at his or her own expense.

- To have reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A provider may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.

- To voice grievances and present recommendations pertaining to the policies, services and house rules of the home without fear of retaliation.

- To associate and have private communications and consultations with his or her physician, attorney or any other person of his or her choice.

- To participate in the activities of social, religious and community groups at his or her own discretion.

- To use the services of advocacy agencies and to attend other community services of his or her choice.

- To have reasonable access to and use of his or her personal clothing and belongings.

- To have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose work hours make it necessary to meet with the resident outside the usual visiting hours.

- To employ the services of a physician, psychiatrist or dentist of his or her choice for obtaining medical, psychiatric or dental services.

- To refuse treatment and services, including the taking of medication, and to be made aware of the consequences of that refusal.

- To request and receive assistance from the responsible agency in relocating to another living situation.

- To be treated with consideration and respect, with due recognitions of personal dignity, individuality and the need for privacy.

- To have access to his or her room at his or her own discretion.

- To confidentiality of records as stated in section 12(3) of the act.

- The provider will respect and safeguard the resident's rights specified in sub rule (1) of this rule, which states: Upon a resident's admission to the home, a licensee shall inform the resident or the resident's designated representative of, explain to the resident or the resident's designated representative and provide to the resident or the resident's designated representative a copy of all the above resident rights.

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Exhibit D

Guidelines for Specialized Residential Service Providers

Revised: 1/5/07; 12/2014

All providers offering Specialized Residential Services under the auspices of Saginaw County Community Mental Health Authority (SCCMHA) must comply with the following regulations:

- The Michigan Department of Consumer and Industry Services Division of Adult Foster Care Licensing (CIS) (Licensing information can be found at www.michigan.gov/mdhhs)
- The Michigan Department of Health and Human Services Certification Requirements for a Specialized Program; and
- The Michigan Mental Health Code, including Chapter 7, Recipient Rights.

Copies of these rules may be secured from the relevant regulatory body or from SCCMHA, upon request. In addition, provider compliance with the guidelines outlined in this document is required by Saginaw County Community Mental Health Authority.

Licensure:
The provider shall maintain any licenses, certification, accreditation, and authorizations for its services, personnel and facilities, as mandated by law and funding sources. If any such license, certification, accreditation, or authorization is ever suspended, revoked, or expires and is not renewed, the provider shall immediately notify, in writing, SCCMHA's Contract and Properties Manager.

Benefits/Entitlements:
The residential provider is expected to assist all eligible consumers who reside in the home with applying for any food stamps/Bridge Card, reimbursements/entitlements, i.e., SSI, Veterans Benefits, Insurance(s), Medicare, and Medicaid, etc., for which they may be eligible. In addition, the provider agrees to facilitate proper billing of the Qualified Health Plan for medical care received by each consumer by:

- **assuring that** medical providers are aware of consumer insurance, Medicare and Medicaid coverage and any other relevant coverage or benefits which the consumer holds;
- securing medical care for the consumer only through medical providers who are enrolled in the consumer's Health Plan or to whom the consumer's primary physician provides a referral; and by
- securing proper approval from the Health Plan prior to initiating medical care in those instances where it is the responsibility of the consumer to secure prior authorization as opposed to the medical provider.

If the provider fails to adhere to these requirements for medical services covered by the consumer's Qualified Health Plan and the Health Plan denies payment, and/or if the provider fails to secure prior written authorization from SCCMHA for coverage of the cost of services which are needed but are not covered by the Qualified Health Plan, the SCCMHA reserves the right to hold the provider financially responsible for costs incurred to the SCCMHA and/or the consumer for the unauthorized medical care.

Residential providers are required to assist SCCMHA with assuring that all benefits are exhausted before SCCMHA funds being utilized for care and services to the consumer. In addition, residential providers will assist SCCMHA in maximizing consumer use of natural community resources, such as church, human service agency and/or family assistance, in order to avoid unnecessary depletion of consumer resources.

Model Payments, *now known as (ASAP) Adult Services Authorized Payments* may not be requested or paid to the provider for services rendered to any consumer for the same time period the residential provider is receiving reimbursement from SCCMHA under a contractual agreement for specialized residential services. SSI or other funds received by the provider for provision of room and board to a consumer will be reimbursed to the consumer if the consumer is discharged or leaves the home for any reason before the end of the month for which the room and board was paid. The amount reimbursed to the consumer by the provider will be pro-rated by day.

Authorization of Services:
All providers must have authorization through the consumers case manager/support coordinator in order to be paid for services under SCCMHA specialized residential funding. All authorizations for services must be supported by the consumer plan and based on the consumer need for this level of residential services. Every request for authorization will be reviewed by SCCMHA Care Management staff for medical necessity. If the necessity for the service is not noted SCCMHA Care Management will request additional information from the case manager / support coordinator. If it appears given the information that the consumer could be served under a different level of service care management will request that the case manager/ support coordinator pursue an alternative to meet the consumer needs. Once a provider is authorized, a letter will be sent to the provider with an authorization number which the provider will use to bill services to SCCMHA.

Authorizations for specialized residential services are usually time limited and case managers/ support coordinators will be asked to justify the continued need for the service in this care setting.

As part of the authorization process the case manager /support coordinator will be required to fill out the appropriate Sentri form titled "Licensed Residential Authorization Form, DCH 3803, which has a five column rating system. (See SCCMHA Policy 03.02.07C Residential Service - Exhibits to AFC, Licensed Residential, CLS, and SIP for assistance with this process)

Home Administration:
Residential providers must have a designated home manager or lead staff who is responsible for the administration of the home and is available to SCCMHA and home staff twenty-four hours a day, seven days a week. Residential providers must supply SCCMHA and home staff with a 24-hour contact number where emergencies can be reported.

Reporting Emergency Situations:
SCCMHA case holders and/or the SCCMHA Contract and Properties Manager should be contacted in the event that there is an emergency situation at the home (i.e. fire, need for evacuation). The SCCMHA Crisis line (989) 792-9732 or 1-800-233-0022 can be used to communicate emergency situations after regular business hours.

SCCMHA case holders should also be contacted as soon as possible whenever a consumer requires emergency medical treatment. This should include any important medical or health changes that have occurred. If consumer attends a day program, Provider should also be in contact with day program staff to relay any information regarding special care, including written instructions as needed. If consumer is receiving nursing services, Provider should also inform consumer's nurse regarding the emergency treatment and any medical or health changes that may have occurred.

If medical treatment is sought and found to be related to a communicable disease that is reportable to SCCMHA based on the SCCMHA Infection Control Policy, this should be reported to Cheryl Carlevato, SCCMHA Infection Control RN by phone.

Staffing:
The provider must maintain staffing at the levels required to provide the residential service for which the provider was contracted and as defined in each consumer's plan of service. (For example, if a home provides care for an individual who has an elopement risk, then that home should never have less than two staff on each shift.) Consumers are to be group supervised, (i.e., staff are typically in visual contact with consumers, but at a minimum within hearing range) at all times, unless otherwise specified in the consumer's plan of service. The provider is required to provide overnight staffing at a level which meets consumer needs and assures consumer safety, and complies with requirements related to foster care licensure and provider contract. *(Please see sample "Staff Schedule" Attachment 1)* In some cases, consumers may require specialized 1:1 staffing to best ensure their safety. This requires approval by the case holder, residential placement committee. This will then need to go to contracts department with a date the home can have staff on board to provide the additional staffing. Provider should note that individualized 1:1 staffing in licensed settings is considered restrictive and must have plans and ways to reduce this restriction written in the consumer plan.

Providers are not authorized to provide staffing beyond normal visitation and support to the consumer while they are in the hospital. In extenuating circumstances, limited staffing during hospital hours may be granted, however such requests **must be pre-approved**. Hospitals will provide staff for consumers in their rooms to assist if the consumer is a fall risk or is exhibiting challenging behaviors. However there are circumstances when consumers are not able to communicate their wants and needs, unable to eat by themselves, or exhibit extreme behavior challenges related to being in an unfamiliar setting and may need a staff that is familiar with the consumer to assist in the hospital. The need for these services should be spelled out in the plan if it is known from prior hospitalizations that this is a concern. If this is not known prior, an authorization can be obtained through the case holder. A request for authorization to provide 1:1 staffing should indicate specific times services will be provided (i.e. meal times, medication administration times, etc.) based on the consumer's needs for this service. When requesting these services, the role of staff providing the 1:1 services should be detailed as to what assistance will

be provided to the consumer while in the hospital. Provider should be aware that 1:1 staffing outside the home is not transferrable between facilities without Care Management approval. This means that if a consumer has 1:1 staffing in the home, consumer's Case Holder will need to seek approval from Care Management for the specialized staffing to continue when they are moved to a hospital setting. The same rule applies if a consumer is transferred from one hospital setting to another; if 1:1 staffing is provided in the first hospital and still needed in the second setting, Care Management will need to approve the transfer, prior to 1:1 staffing occurring at the new facility. Provider should also note that 1:1 staffing outside of the home will not be authorized for consumers if they are admitted to a nursing home setting.

Training:
Provider direct care and home management staff are required to successfully complete the Michigan Department of Community Health approved direct care staff training curriculum. Staff are required to complete the following trainings before being able to work alone in the home:

1) Introduction to Residential Services
2) Person Centered Planning (annual renewal)
3) Recipient Rights (annual renewal)
4) Working with People I
5) Working with People II
6) Nutrition and Food Safety
7) Environmental Emergencies/ Fire Safety
8) Physical Intervention
9) CPR (every two year renewal)
10) First Aid (every two year renewal
11) Basic Health
12) Basic Medications (medication renewal every three years)
13) Blood borne Pathogens/ Infection Control (annual renewal)

Providers must also require all home staff to participate in training as required by SCCMHA and clinician contractors in order to safely and correctly implement each consumer's plan of service, to the extent funded by the provider's contract with SCCMHA. Other SCCMHA required trainings, not mentioned above, include the following:

14) Limited English Proficiency (LEP)
15) Ethics of Touch
16) Cultural Diversity
17) HIPAA Privacy (annual renewal)
18) HIPAA Security (annual renewal)
19) Advance Directives (home managers only)
20) Home Manager Training
21) Trauma Training
22) Intro to Evidence Based Practices

The provider will ensure staff are thoroughly and regularly educated on recipient rights related regulations, emergency preparedness and emergency evacuation procedures and any other training required annually such as person-centered planning, CPR and blood-borne pathogens and infection control.

The provider will not permit untrained staff to provide care to consumers without appropriate on-site supervision by trained personnel. Physical intervention should not be performed by untrained staff unless an emergency situation calls for such action. The administration of medications as specified in a physician order may not be performed by untrained staff. Only staff certified in medication management are allowed to pass medications in the home. Home staff must first complete the approved group home training curriculum and then be certified by the home manager/ lead staff of the home. Home managers/ lead staff must be certified in medication management by SCCMHA nurses. See SCCMHA policy 03.02.17 Medication Management in Licensed Residential Settings for more details.

SCCMHA staff and contracted staff (case mangers, support coordinators, OT's, Psychologists, nurses, etc.) will provide training, at a minimum, to the home manager/lead staff on the implementation of a consumer's plan of service whenever a new or revised plan of service is developed. The provider will notify SCCMHA to request re-in-service of a consumer's plan of service when substantial changes in staffing have occurred. The provider's home management staff are required to review all consumer plans of service with new staff before they are allowed to work directly with consumers.

Direct in-service by qualified individuals is required before any provider staff implement high risk procedures, including but not limited to: physical intervention; transfers, range of motion or other physical manipulation of individuals with chronic contractures or dislocations; injections; management of feeding tubes; therapeutic positioning; and suctioning. The consumer plan of service will specify those procedures which require in-service by qualified personnel and who will perform the in-service.

Providers are to fully comply with SCCMHA Policy 05.06.03- Competency Requirements for the SCCMHA Provider Network, located in the SCCMHA Network Services Provider Manual.

Access and Reporting:
The provider shall provide consumer data and statistical information as required by SCCMHA or its funding sources at such times and in such manner as requested. Authorized representatives of SCCMHA shall have access to the physical plant, consumers, staff, consumers records and records related to maintenance of the physical plant upon request, for monitoring and treatment purposes.

Quality Improvement/Program Evaluation:
The provider agrees to participate in quality improvement activities and to assist SCCMHA in reviewing and evaluating services at intervals to be determined by SCCMHA. *(Please see sample "Provider Quality Improvement Plan" in SCCMHA Policy 03.02.07C Residential Service - Exhibits to AFC, Licensed Residential, CLS, and SIP)*

Incident Reporting:
The provider agrees to immediately report via Incident Report any of the following situations (per SCCMHA policy 02.02.10- Recipient Rights - Reporting Unusual or Unexpected Incidents):

1) Unusual or unexpected incidents that occur in the lives of a consumer of mental health services that occur while under the services of SCCMHA and the Provider Network will be reported to the SCCMHA ORR within 24 hours. This includes Community Living Services being provided in an independent living setting.

2) Incident Reports for Licensed Residential Settings will be completed using a form approved by DHHS Licensing; the BCAL-4607 form is included with this policy as an exhibit of an approved form. Incidents for other programs, such as Skill Building and outpatient settings can be completed on the DCH 0044 form, also included as an exhibit to this policy.

3) The use of approved physical intervention will be documented on an Incident Report.

4) In addition to the Incident Report for a physical intervention, the form called "BMC Incident Report Attachment" (shown as an exhibit to this policy) will be completed and submitted with the Incident Report. The first page is to be completed by the staff filling out the Incident Report and the second page is to be completed by the supervisor or designee.

5) Incident Reports are Peer Review documents and are not subject to FOIA requests. Copies of Incident Reports are not given out to anyone including the guardian without a court order signed by a judge.

6) Incidents involving a death or significant physical or psychological injury or serious rights complaint should be immediately reported by phone to the SCCMHA ORR.

7) Incident Report forms will be filled out completely. This includes full first names and last names of all staff and consumers, including any witnesses to the incident. No initials should be used unless it involves a consumer from a different county where confidentiality will be an issue.

8) Incident Report forms not filled out completely will be returned to the program supervisor with the requirement of that supervisor documenting the appropriate missing information and returning it to ORR within 24 hours of the form being sent back to the supervisor.

9) The indication of the Potential Sentinel Event in sentri (Procedure # 2 below) is used only as a process to notify the Chair of the Sentinel Event Review Committee. The final documentation related to the Sentinel Event will be kept in the minutes of the Sentinel Event Review Committee.

Definitions:

Physical Intervention: An approved technique (as trained by the SCCMHA Continuing Education Unit) used to physically assist someone in preventing danger to themselves or someone else.

Restrictive or Intrusive Intervention: A technique described in a Behavior Management Treatment Plan to help to teach someone to reduce negative behaviors. These techniques may only be used when included in a Behavior Management Treatment Plan, written by a Behavioral Psychologist.

Examples:

- **Response Cost:** Someone being asked to apologize to another person after they have done something to them, such as steal an item from them.

- **Over Correction/Positive Practice:** An action intended to exaggerate a point, such as cleaning up a spill and being asked to clean the same area again even though the spill is already taken care of.

Unusual or unexpected incident: An occurrence that disrupts or adversely affects the course of treatment or care of a consumer that is not expected. Such occurrences shall include but are not limited to:

1) Death (any death of a consumer of SCCMHA services, including a death occurring in a private residence);
2) Any injury of a consumer, explained or unexplained;
3) Unusual medical problem;
4) Trip to the emergency room, express medical services, medical or psychiatric admission to a hospital or treatment facility (this should generate a call to the SCCMHA ORR);
5) Environmental emergencies or incidents;
6) Problem behaviors, if not addressed in a Plan of Service;
7) Suspected abuse or neglect of a consumer;
8) Inappropriate sexual acts;
9) Suspected sexual abuse;
10) Medication errors;
11) Medication refusals;
12) Suspected criminal offenses involving consumers;
13) Every use of physical intervention (see # 5 in the Standards Section above);
14) Any significant event in the community involving a consumer;
15) Arrests;
16) Convictions;
17) A traffic accident involving consumers.

In addition to reporting these issues on an Incident Report form, the provider is required to contact the Office of Recipient Rights, Case Holder, and the assigned Nurse if applicable for serious incidents. In the event SCCMHA is closed, the provider shall utilize SCCMHA's 24-hour crisis service for such reports. Written reports must be received by the SCCMHA Office of Recipient Rights within 48 hours. There is a drop box available 24 hours per day for providers to drop off Incident Reports outside the main doors of the 500 Hancock building.

The provider agrees to review all incidents on a periodic basis to look for and act upon trends.

Emergency Preparedness:
SCCMHA suggests that providers maintain a minimum of two days of backup food onsite for emergency purposes *(see attached "Sample Emergency Food List" Attachment 2)*. The stored food will be consistent with consumer diet orders including the special needs for persons with diabetes, hypertension etc.. Provider is also required to maintain a current agreement for Interim and Overnight Emergency Shelter with an established hotel or motel in the community. There should be documentation on official hotel or motel letterhead of this agreement available in the home at all times. The Emergency Shelter agreement does not require regular renewal, however, Provider should be able to show documented proof, updated annually, that the hotel or motel is currently in business and accepting patrons.

When applicable, Provider will be expected to have a contingency plan made available for each of the following: volunteers and/or pets. The plan(s) should provide detail which discusses the

steps Provider will take to ensure consumer safety in the home when volunteer persons and/or pets will be in the home.

Provider to have a vehicle breakdown and accident procedure for staff to follow in case of an emergency. Because staff are sometimes distracted when either of these circumstances occur, the provider should have a step by step procedure to follow along with pertinent telephone numbers to contact in case either of these circumstances should arise.

Providers will also maintain an infection control kit, first aid kit and emergency kit. The kit contents listed below meet both SCCMHA and Michigan Department of Health and Human Services (MDHHS) requirements.

Infection Control Kit

The following will also meet OSHA recommendations:

- Disposable shoe covers
- Disposable gown
- Disposable apron
- Disposable mouth/nose cover
- Antiseptic cleansing wipes
- Germicidal wipes
- Spill Kit (including the following)
  - Scooper
  - Sealable scoop bag
  - Gloves
  - Eye shields
  - Body fluid pick up guard
  - Absorbent packs
  - Bio-hazard bags
  - Disposable clean-up towels
  - Germicidal floor wipes
  - Biohazard identification sticker

First Aid Kit

Staff who work in a licensed facility are required to take CPR and First Aid training. It is mandatory that a First Aid/CPR booklet be given to each participant. Included in that booklet is a list of what should be included in a first aid kit. Items include:

- Disposable gloves
- Antiseptic towelettes
- Safety Goggles
- Red biohazard bags
- Breathing barrier
- Assorted sized adhesive bandages
- Triangular bandages
- Elastic bandages
- Non stick wound dressing
- Roller gauze
- Sterile gauze pads
- Adhesive tape
- Scissors
- Cold pack
- Sterile eye pads
- Eye wash
- Antibacterial ointment
- First aid booklet

Emergency Kits

Should be stored in a water proof case, in a convenient area, so it is readily available for use. Someone should be assigned to check and restock the supplies regularly. An emergency kit is a bag of supplies – usually a duffle style bag preferably with wheels for easy transport– that is located near the main exit used for fire escape/drills. An emergency kit should also be kept in each vehicle used for transportation. Items that should be included in an emergency bag include:

- List of emergency phone numbers (Home Manager, Case Mgr./ Supports Coordinator, guardians, contracts coordinator, recipient rights, licensing, power company etc.)
- Consumer profiles
- List of medications for each person

- Slippers or disposable foot covers for each recipient
- Emergency type blankets for each person (the small camp style emergency blankets that appear like shiny foil)
- Rain coats
- Disposable briefs
- Gloves
- Small first aid kit
- Wet wipes
- Flashlight and extra batteries
- Weather Radio and extra batteries
- Batteries
- Extra keys for the house and vehicles
- Pen/pencil and small note pad
- Bottled water (with date on it)
- Snack food or small reinforcements (individually wrapped crackers or cookies)
- Other Critical Medical Supplies (such as insulin or battery operated feeding pumps)

Evacuation Difficulty Index (EDI) Scores:
All specialized residential providers are required to complete EDI scores as part of their licensing certification with the Michigan Department of Health and Human Services (MDHHS). These scores determine the ability of staff and consumers to evacuate the home in case of emergency. Scores should be completed annually at minimum. Scores need to be completed within 30 days of any consumer moving into or out of a home. All EDI scoring forms can be printed from the "Licensing" section of the MDHHS website located at: www.michigan.gov/mdhhs/.

Physical Plant:
Consumers will be encouraged to maintain their own personal living quarters. SCCMHA encourages consumers to participate in day to day housekeeping chores per their plan of service. Providers are encouraged to document their home's cleaning schedule and inspect their home's physical plant structure and appearance on a quarterly basis using the "SCCMHA Sample Preventive Maintenance Checklist" *(Please see Attachment 4)*. Such physical plant inspections including checks for health & safety hazards should be routinely documented and signed off by appropriate home staff or landlord. Any client specific needs such environmental modifications or physical plant repair to ensure the safety of the resident(s) should be requested on the "Durable Medical Equipment/ Environmental Modification Request for Additional Funds" form *(Please see SCCMHA Policy 03.02.07C Residential Service - Exhibits to AFC, Licensed Residential, CLS, and SIP for applicable form)*. The Durable Medical Equipment/ Environmental Modification Request for Additional Funds should be signed off by the provider and submitted to the consumer case holder. Providers are responsible for all routine maintenance repairs as well as any cost/repair/damage to the physical structure and contents of their home and surroundings caused by negligence on the part of its employees. The SCCMHA auditing and contract departments may request copies of such routine physical plant inspections at any time to ensure quality standards as it relates to the health and safety of SCCMHA residential referrals.
All caustic chemicals and cleaning supplies shall be stored in a locked location to prevent any potential mishaps.

Admissions/Discharges:
The provider shall have the right to reject a request from the SCCMHA for placement of consumer(s) or to terminate an existing placement, providing such action occurs in consultation with the consumer(s), SCCMHA, and with the consumer's legal representative where applicable. Provider must give SCCMHA & the consumer/ guardian 30-day written notice of any consumer placement terminations.

In situations where SCCMHA is contracting all beds in the home, SCCMHA reserves the right to select consumers for placement in the home. Providers will be given opportunity to visit candidates for placement in the home and may request, in writing, SCCMHA reconsider a proposed candidate if the provider believes the home does not have the capacity to meet the needs of the consumer. However, SCCMHA reserves the right to re-evaluate providers who reject consumers without good reason or lack the capability or flexibility to meet the residential service needs of those consumers SCCMHA is obligated to serve under the Michigan Mental Health Code and the terms of SCCMHA's master contract with the Michigan Department of Health and Human Services.

Leave of Absence (LOA):
The provider will ensure consumer(s) have all needed medications, treatments and personal items necessary for proper care during any periods of absence from the home. The provider will inform the individual taking a consumer on a leave of absence of any health and safety precautions in the consumer's plan of service. For consumers with guardians, the provider will obtain prior authorization from the guardian before allowing any individual, other than the guardian, to remove the consumer from the residence for day or overnight visits. An Application for Leave of Absence should be kept on file in the home. Restrictions on leaves of absence can only be made if an acute risk of physical or mental harm to the consumer and/or community has been identified, the restriction is included in the consumer's plan of service and the restriction has been approved by the SCCMHA Behavior Management Committee. (*Please see attached "Application for Leave of Absence" Exhibit J)*

The provider remains responsible for the provision of service in circumstances such as elopement, working, at day program, in the neighborhood, going to the store or movie, etc. even though the consumer is not in the facility or under the direct supervision of the provider

For reimbursement and payment purposes, SCCMHA considers the start of the billable day as 12:00 AM midnight. A provider must be responsible for services to a consumer at the start of that day in order to bill for that day. Under this provision, if a consumer leaves on an LOA, the provider would not be paid for the day the resident leaves but would be paid on the day the resident returns. In other words, the provider will be paid for the date of admission but not for the date of discharge.

Plan of Service/Records:
The provider agrees to deliver services to each consumer accepted for care in accordance with the consumer's approved plan of service and to make a good faith effort to achieve the goals and objectives contained within the plan. The plan of service will outline the clinical services to be provided to each consumer. The provider will ensure that all caregivers are updated routinely of any changes in a consumer's plan. If the plan is unclear, the provider will request clarification immediately from the consumer's Case Holder. Consumer plans of service are to be implemented within 24 hours of receipt by the provider. If the provider is unable to implement a plan of service for any reason, they will notify the SCCMHA Case Holder immediately. Please note that all providers have access to consumer plans, for which they are authorized, on SCCMHA electronic medical record called Sentri.

The provider agrees to complete daily documentation on each shift reflecting consumer participation in his/her plan of service. The "SCCMHA Licensed Residential Personal Care &

Community Living Supports Service Log" will be completed for all SCCMHA consumers served under this contract. *(Please see Attachment 5 "Specialized Licensed Residential Personal Care & Community Living Supports Service Log").*

A daily medication administration/treatment record will be maintained for those SCCMHA consumers requiring medications and treatment. This record is included by the pharmacy when the pharmacy dispenses prescriptions.

Food Acceptance Logs will be maintained when recommended by the dietician, nurse or Case Holder.

Other documentation will be maintained as requested by the SCCMHA Case Holder or Clinicians.

Copies of each consumer's plan of service, assessments, monitoring reports, and relevant medical records shall be retained in the provider's facility. The original or main case record for the consumer will be maintained at the office of the consumer's primary provider.

Medical Appointments:
Providers will monitor the health status of consumers and will ensure that scheduled medical and clinical appointments are made in a timely manner, that the consumer attends the appointments and that resulting reports, prescriptions, evaluations and other documentation are secured by attending staff and implemented promptly and appropriately. The provider will notify the case holder and assigned SCCMHA nurse (if applicable), of reports, medications, treatments, and any additional medical services ordered by the consumer's primary physician or other medical provider. Providers will implement and maintain a log documenting physician appointments, results and recommendations. *(Please see the attached sample of a "Health Visit Record", Attachment 6.)*

The provider will insure that SCCMHA consumers have healthcare appraisals completed as required by Adult Foster Care Licensing Rules and as funded by Medicaid. The appraisal is to include a review of current symptoms, an evaluation of bodily systems, vision and hearing screenings as appropriate and routine lab work, as well as TB screening and an update of immunizations as recommended by the primary care physician. Psychiatric, Speech, Physical Therapy, Occupational Therapy, Psychological, Nursing and Dietary evaluations will be secured for the consumer by SCCMHA as needed and desired by consumer. If a consumer is on medications prescribed by a psychiatrist, regular Medication Reviews by the prescribing psychiatrist will be scheduled by the provider, unless otherwise specified in the consumer's plan of service.

Do Not Resuscitate Orders:
Providers must comply with current opinions as issued by the Michigan Attorney General's Office regarding the implementation or non-implementation of valid Do-Not-Resuscitate Orders pursuant to the Michigan Do-Not-Resuscitate Procedure Act for SCCMHA consumers. Please reference SCCMHA Policy 03.02.14-Advanced Directives for more information on this topic.

Personal Care:
Providers shall provide consumers with a basic supply of personal care items such as shampoo, toothpaste and deodorant as required by licensing. Consumer items will want to be individually

labeled in case they are left in the bathroom, staff will know to whom items belong. Providers will also monitor and maintain any personal care equipment required by consumers. If equipment is in disrepair, the provider will immediately assist the consumer with securing repair or purchasing a replacement. Providers will make every effort to ensure consumers maintain a neat appearance and receive the assistance needed to complete personal care on a daily basis.

Nutrition & Dietary:
Providers will follow and utilize SCCMHA's Guidelines for Dietary Services (located in the SCCMHA Network Services Provider Manual). Provider is also expected to follow the My Plate food guidelines which discusses how much of fruits, vegetables, grains, protein, and dairy should be consumed on a daily basis to ensure a healthy diet. Provider is encouraged to explore the My Plate website at www.choosemyplate.gov for tips to healthy eating and living. It is recommended that a routine cleaning schedule be maintained to ensure cleanliness. Foods are to be monitored for expiration dates and disposed of properly. Wherever possible, provider staff will participate in family style meals with consumers. Providers must pay close attention to altered consistency diets or modified diets; in addition, due to the large number of consumers with swallowing difficulties, SCCMHA discourages the serving of choking trigger foods such as hotdogs, grapes and peanut butter. (Note: Only physicians can order a modified diet or reduced calorie diet.)

Adaptive Equipment:
The provider will ensure all durable medical equipment or assistive devices purchased or rented for the consumer as ordered by the consumer's physician and identified in the consumer's plan of service are readily available and used as prescribed. Providers will also ensure proper maintenance of any adaptive equipment, including immediate repair and making arrangements for loaner equipment for critical items such as wheelchairs. Providers will ensure that consumers with special needs such as incontinence, or other healthcare or behavioral concerns are provided with a regular supply of clean linen and bedding in accord with their needs. Client specific needs for adaptive equipment should be requested on the "Durable Medical Equipment/ Environmental Modification Request for Additional Funds" form. *(Please see SCCMHA Policy 03.02.07 Residential Services for this form)* This form should be signed off by the provider and submitted to the consumer's case holder.

Personal Possessions and Funds:
Providers will maintain an inventory list of all consumer's personal items (i.e. TVs, radios) to ensure safekeeping. Provider to update personal possessions inventory at least annually and preferably as items are bought or brought for consumer into the facility. Providers will ensure consumer clothing is kept in good repair and replaced, as needed. Providers will ensure SCCMHA consumers choose their own clothing and have proper clothing for a variety of activities, occasions and seasons and appropriate for their size, age, and gender. *(Please see attached sample "Consumer Inventory List", Attachment 7)* Providers will maintain consumer funds according to SCCMHA policy 05.06.08 Management of Consumer Funds.

Individuality/Lifestyle:
Consumers will be able to maintain their own personal lifestyles while respecting other consumers in the home. Consumers will be allowed to personalize their living quarters within reason. Providers will encourage and support consumers to participate in independent decision making as able regarding activities of daily living and in any other life decisions, and to pursue

as vital and valued roles in the community as they are able to maintain. Providers are to promote the growth, individuality, development and independence of consumers.

Activities/Recreation:
The provider will offer consumers frequent opportunities for home and community activities and recreation. Providers will allow consumers to choose their own activities, within any limitations defined in the consumer's plan of service, and where the consumer has not expressed a preference, the provider will plan activities that are age appropriate so as to maintain the dignity of each consumer, and should be as meaningful to the consumer as possible. Activities will be community integrated and offer the consumer the opportunity to interact with other individuals in the community who are not part of the mental health service system. Providers should document such activities to demonstrate compliance to the standard. *(Please see attached sample "Provider Activity Calendar" Attachment 8)*

Transportation:
Providers will provide consumers with appropriate transportation to SCCMHA services, medical appointments and community activities. The provider will have continuous and adequate access to a vehicle(s) for use to evacuate consumers from the residence in case of an emergency. The provider will provide barrier free transportation as required for consumers who utilize a wheelchair or have other significant ambulation deficits.

SCCMHA will provide transportation to and from SCCMHA skill building services as appropriate given consumer needs and the availability of public transportation or natural supports.

Providers will ensure transportation is given to consumers if the need for emergency medical treatment arises. If consumer is attending a day program and a medical emergency occurs, staff currently responsible for the consumer will be required to ensure consumer is given transportation to the medical facility. This may or may not involve the responsible staff transporting the individual. If a consumer requires transportation to a medical facility while at program, consumer's home staff should be notified immediately. If at all possible, home staff should meet the consumer to provide transportation to the medical facility as necessary. If time does not allow for home staff to transport consumer, it is expected that a staff from the home will meet the consumer at the medical facility as soon as possible to ensure the treating health professional receives any necessary health information. It is the expectation of SCCMHA that daytime program sites and residential home staff will work together when an injury or illness occurs that requires transportation to and supervision of a consumer while at a medical facility.

Services:
SCCMHA agrees to provide additional mental health services as defined in the plan of service as appropriate for the consumer, given their needs and available community resources. SCCMHA will assign a Case Holder for each consumer in the home to help coordinate their care.

Attachments to this Guideline:
1. Staff Schedule
2. Sample Emergency Food List
3. Sample Emergency Food Menus
4. Quarterly Preventative Maintenance Checklist

5. Personal Care and Community Living Supports Service Log
6. Health Visit Record
7. Consumer Inventory List
8. Sample Activity Calendar

Staff Schedule

Attachment 1

Home Name: _____

Home Address: _____

Month: _____ Year: _____

Staff Name	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total Hours
Date:																

Total Hours_____ Two Week Total Hours_____

Number of Home Manager Administrative Hours: _____

Attachment 2

SAMPLE EMERGENCY FOOD LIST
(2 Day Supply)

1 Lg. Jar	APPLESAUCE
2 Cans	APRICOTS
2 Cans	FRUIT (any variety)
1 Box	DRIED FRUIT (raisins, prunes)
2 Cans	FRUIT COCKTAIL
2 Cans	MANDRIAN ORANGES
3 Cans	PEACHES
3 Cans	PEARS
3 Cans	PINEAPPLE TIDBITS
1 Can	APPLE JUICE
2 Cans	GRAPE JUICE
2 Cans	GRAPEFRUIT JUICE
1 Can	FRUIT JUICE
3 Cans	ORANGE JUICE
3 Cans	PRUNE JUICE
1 Can	TOMATO JUICE
2 Cans	BEETS
2 Cans	CARROTS
4 Cans	CORN
4 Cans	GREEN BEANS
4 Cans	PEAS
3 Cans	BEEF STEW
4 Cans	CANNED MEAT
3 Cans	CHICKEN NOODLE SOUP
4 Cans	TUNA FISH
1 Jar	PEANUT BUTTER
1 Jar	JELLY OR JAM
6 Cans	EVAPORATED MILK
1 Box	CEREAL
1 Box	COOKIES
2 Boxes	CRACKERS
1 Box	GRAHAM CRACKERS
1 Box	VANILLA WAFERS
2 Jars	CHEESE SPREAD
2 Cans	PUDDING
4 Cans	SOUP (beef, tomato)
1 Jar	DECAF COFFEE
1 Box	CARNATION INSTANT BREAKFAST
4 Gallons	WATER

SAMPLE EMERGENCY FOOD MENUS

Day 1

Breakfast:

1 ½ cups	Cold cereal with ½ cup chopped canned fruit
1 cup	Milk-diluted (dilute 1 can of milk with 1 can of bottled water)
1 cup	Orange Juice (canned)
6	Crackers
as desired	Jelly/Jam
optional	Instant decaf coffee

Lunch:

12	Crackers
1 cup	Soup
½ cup	Carrots (canned)
½ cup	Pears (canned)
¾ cup	Prune Juice

Supper:

1 ½ cups	Beef Stew (canned)
½ cup	Apricots (canned)
1 cup	Milk (diluted-see note in recipe above)
1 cup	Green beans

H.S. Snack:

2	Cookies
1 cup	Milk (diluted)

Day 2

Breakfast:

1 ½ cups	Cold cereal with 1 Tbsp. dried fruit, chopped
1 cup	Milk (diluted)
1 cup	Grapefruit Juice (canned)
6	Crackers
2 Tbsp.	Peanut Butter

Lunch:

12	Crackers
½ cup	Tuna fish
½ cup	Tomato Juice
½ cup	Pudding with 3 vanilla wafers
1 cup	Peaches (canned)

Supper:

1 ½ cups	Chicken noodle Soup (canned)
½ cup	Fruit cocktail (canned)
1 cup	Milk (diluted)
1 cup	Corn (canned)

H.S. Snack:

4	Graham crackers with 2 Tbsp. peanut butter
¾ cup	Apple juice (canned)

Attachment 3

SAGINAW COUNTY MENTAL HEALTH AUTHORITY
QUARTERLY PREVENTATIVE MAINTENANCE CHECKLIST

DESCRIPTION OF MAINTENANCE	1	2	3	4	5	6	7	8	9	10	11	12
Clean Clothes Dryer Lint Filter Each Usage: Service washer & dryer (if necessary)												
Check Refrigerator & Freezer Temperature: door seals & vacuum condenser, cooling units on both												
Check function of all appliance operations												
Check furniture for repair needs												
Clean drapes as needed												
Clean oven, stove hood, and exhaust filter/inspect range elements and burners, clean drip pans												
Clean refrigerator & freezer drip pan												
Check Garbage Disposal guards to assure they are in place												
Check dishwasher function, filter & seals												
Check toilet water supply & functions												
Check grouting and ceramic tiles												
Check caulking around showers, tubs & sinks												
Check water systems for leaks												
Check air pressure in holding tank												
Replace furnace air filters during months of use												
Check gutters and downspouts blockage												
Seasonally mow, prune, shovel snow as needed												
Check interior walls integrity, paint, etc.												
Inspect all floor coverings												
Check integrity of doors & cupboards, hardware and jams, etc.												
Inspect fire extinquishers & detectors (service as needed)												
Check, repair or install storms/screens												
Inspect residence for pest infestations												
Inspect basement or crawl space for damage												
Check all floor drains and clean as needed												
Check septic system and pump out if needed												
Inspect all exterior & interior lighting & electrical outlets												
Check attic for hazards or water leaks												
Service water heater, elements, burner, etc.												
Inspect well controls and motor												
Inspect chimney & vents												
Lubricate & adjust garage doors												
Check garage area for cleanliness												
Check outside of home & grounds for wear & tear such as cracks in cement, etc.												
Have furnace & air conditioner checked by qualified professional Annually												

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Specialized Licensed Residential
Personal Care & Community Living Supports Service Log

R = Refusal
LOA = Leave of Absence
/ = In Hospital
E = Elopement
O = Other

Name: **Case Number:**

Home: **Month & Year:**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Personal Care																															
Transferring																															
Ambulation/Mobility																															
Eating																															
Toileting																															
Bathing																															
Dressing																															
Grooming																															
Taking Medication																															
Special Food Prep, Laundry, Housekeeping																															
Community Living Supports																															
Meal Preparation																															
Shopping for food & other necessities of daily living																															
Money Management																															
Non-medical care (not requiring nurse or physical intervention)																															
Socialization & relationship building																															
Transportation (to/from community activities excluding medical appts.)																															
Participation in regular community activities & recreation opportunities (e.g. attending classes, movies, concerts, & events in the park; volunteering, voting)																															
Attendance at medical appointments																															
Acquiring or procuring goods, other than those listed under shopping & non medical services																															

Instructions: Please verify with staff initials per shift (1st & 2nd) of staff completing duties. Services provided based on consumer's assessment & PCP.

revised KSL 6/4/08; JW

Staff Signature	Initials		Staff Signature	Initials

Date	Narrative Section (to be used if box on other side of form contains anything except staff initials or if additional services were or were not provided per assessment).

Provider/Home Manager Signature:_____ **Date of Review & Approval:**_____

revised KSL 6/4/08; JW 7/2010

Attachment 6

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Health Visit Record

Client Name:		Case #:	Home Name:	
Date of Service	Service Provider	Reason for Visit	Report Reference*	Initials

*MSS – Medical Support Service Section
*NSGQ – Nursing Quarterly; Medical Support Services Section
*LAB – Lab & Specials Reports Section
*SPCL – Special Clinic Report Section
*IMZ – Immunization Record Section
*PE – Physicals Section
*DENT – Dental Record Section
*IR – Incident Report; Behavior & Emergency Treatment Section

CMW 10/23/98

Attachment 7

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Consumer Inventory List

Consumer Name:		**Case #:**		
Provider Name:				
Inventory Item	**Quantity**	**Staff/ Supervisor Initials**	**Date Added to Inventory**	**Date Disposed Of**

Staff Signature:_____ **Date:**_____

Consumer/Guardian Signature:_____ **Date:**_____

Attachment 8

PROVIDER ACTIVITY CALENDAR

January 2005

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
						1 GROUP WALK at SAGINAW TOWNSHIP REC CTR
2	3	4 CURRENT EVENTS NIGHT	5	6	7 MOVIE & POPCORN NIGHT	8 Swimming at the YMCA
9 BAKING NIGHT	10	11 DANCE NIGHT	12	13	14 DOLLAR BILL STORE	15
16	17	18 CURRENT EVENTS NIGHT	19	20 LIBRARY	21	22 SHRINE CIRCUS
23 SNOW FESTIVAL-FRANKENMUTH	24	25	26 DISCUSSION ABOUT HEALTHY FOOD CHOICES	27	28 DOLLAR BILL STORE	29
30 SUPER BOWL SUNDAY	31					

ksl 1/18/05 JJK 7/2/14

Exhibit E

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Licensed Specialized Residential Provider Guidelines For Personal Care and Community Living Supports

Revised 6/29/09 tp

This guideline outlines requirements for all specialized residential providers regarding the provision of personal care and community living supports (CLS) services to consumers receiving SCCMHA funded specialized residential services.

Personal Care

Personal Care Services are those services that are provided in accordance with an individualized plan of service that assist a person by hands-on assistance, guiding, directing, or prompting personal activities of daily living in at least one of the following activities:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food).
- **Eating and Feeding**: The process of getting food by any means from a receptacle (plate, cup, glass) into the body. This item describes the process of eating after food is placed in front of an individual.
- **Toileting:** The process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleansing self after elimination and adjusting clothing.
- **Bathing:** The process of washing the body or body parts, including getting to or obtaining the bath water and/or equipment, whether this is in bed, shower, or tub.
- **Grooming:** The activities associated with maintaining personal hygiene and keeping one's appearance neat, including care of teeth, hair, nails, skin, etc.
- **Dressing:** The process of putting on, fastening and taking off all items of clothing, braces and artificial limbs that are worn daily by the individual, including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual.
- **Transferring:** The process of moving horizontally and/or vertically between the bed, chair, wheelchair and/or stretcher.
- **Ambulation:** The process of moving about on foot or by means of a device with wheels.
- **Assistance With Self-Administered Medication:** The process of assisting the person with medications that are ordinarily self-administered, when ordered by the person's physician.

Community Living Supports (CLS)

Community Living Supports services are used to increase or maintain personal self sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. Community Living Supports services include the following:

Assisting, reminding, observing, guiding and/or training in the following activities:

- **Meal Preparation**
- **Laundry**
- **Routine, seasonal, and heavy household care and maintenance**
- **Activities of daily living** (e.g., bathing eating dressing, personal hygiene)
- **Shopping for food and other necessities of daily living**

Staff assistance, support and/or training with activities such as:

- **Money Management**
- **Non-medical Care** (not requiring nurse or physician intervention)
- **Socialization and Relationship Building**
- **Transportation from the beneficiary's residence to community activities, among community activities, and form the community activities back to the beneficiary's residence** (transportation to and form medical appointments is excluded)
- **Participation in regular community activities and recreation opportunities** (e.g. attending classes, movies, concerts and events in a park; volunteering; voting)
- **Attendance at Medical Appointments**
- **Acquiring or procuring goods, other than those listed under shopping, and non-medical services**

Reminding, observing and/or monitoring of:

- **Medication Administration**

The need of each consumer for personal care and community living supports services must be assessed by Saginaw County Community Mental Health Authority and the prospective residential provider upon placement of the consumer in a residential setting.

SCCMHA case holders will document the assessment of personal care and community living supports needs by completing the Licensed Residential Authorization page in Sentri.(Within this See SCCMHA Policy 03.02.07C Residential Service - Exhibits to AFC, Licensed Residential, CLS, and SIP for assistance with this task)

The residential provider will document their assessment of the consumer's personal care & community living supports needs by completing the "Assessment Plan for AFC Residents" form in accordance with the Michigan Department of Health and Human Services (MDHHS) Adult Foster Care Licensing regulations (please see attached sample Exhibit M). This form can also be printed from the MDHHS website at www.michigan.gov/mdhhs.

The personal care and community living supports needs identified in the assessment that require intervention will be addressed in the SCCMHA plan of service.

Providers must document provision of personal care and community living supports assistance on the SCCMHA form titled, "Specialized Licensed Specialized Residential, Personal Care and Community Living Supports Service Log" (please see Attachment 5 form Within Exhibit E). This documentation must take place on a daily basis.

The continuing need for personal care and community living supports services must be re-assessed at least annually and the consumer plan of service revised accordingly.

ASSESSMENT PLAN FOR AFC RESIDENTS

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

Exhibit F

INSTRUCTIONS:

1. A written assessment plan is required. The licensee is responsible for assuring that a written assessment plan is completed.
2. This form has been approved by the Department of Licensing and Regulatory Affairs and contains the information required by administrative rule and Section 3 (9) of.1979 P.A. 218.
3. This form is to be completed by the licensee and resident, or the resident's designated representative. The responsible agency, if any, may assist in this process.
4. Use additional sheets if necessary and **PRINT CLEARLY.**

Name of Resident	Name of Designated Representative (if applicable)	Date of Birth	Sex
			☐ M ☐ F

I. SOCIAL/BEHAVIORAL ASSESSMENT PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Yes	No	IF NO, Describe Needs and How They Will Be Met
A. Moves Independently in Community	☐	☐	
B. Communicates Needs	☐	☐	
C. Understands Verbal Communication	☐	☐	
D. Alert to Surroundings	☐	☐	
E. Reads and Writes	☐	☐	
F. Tells Time	☐	☐	
G. Manages Money	☐	☐	
H. Follows Instructions	☐	☐	
I. Controls Aggressive Behavior	☐	☐	
J. Controls Sexual Behavior	☐	☐	
K. Gets Along With Others	☐	☐	
L. Exhibits Self Injurious Behavior	☐	☐	
M. Participants in Social Activities	☐	☐	
N. Smokes	☐	☐	
O. Appropriately Uses Alcohol/Drugs	☐	☐	

See Page 4 for Non-discrimination and ADA statement

Continued on Next Page

II. SELF CARE SKILL ASSESSMENT **PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Needs Help		IF YES, Describe Needs and How The Will Be Met
	Yes	No	
A. Eating/Feeding	☐	☐	
B. Toileting	☐	☐	
C. Bathing	☐	☐	
D. Grooming (hair care, teeth, nails, etc.)	☐	☐	
E. Dressing	☐	☐	
F. Personal Hygiene	☐	☐	
G. Walking/Mobility	☐	☐	
H. Stair climbing	☐	☐	
I. Use of Prosthesis (Dentures, Artificial limbs, etc.)	☐	☐	
J. Use of Assistive Devices (explain)	☐	☐	
K. Other (explain)	☐	☐	

III. HEALTH CARE ASSESSMENT **PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Yes	No	IF YES, Describe Needs and How They Will Be Met
A. Taking medication	☐	☐	
B. Special Diets	☐	☐	
C. Physical Limitations	☐	☐	
D. Special Equipment Used (Wheel chair, Walker, Cane, etc.)	☐	☐	
E. Other Difficulties (Vision, Weight, Allergies, etc.)	☐	☐	
F. Susceptible to Hypothermia or Hyperthermia	☐	☐	

Continued on Next Page

IV. SOCIAL AND PROGRAM ACTIVITIES PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Yes	No	Explain How These Activities Will Be Provided or Encouraged
A. Participates in Religious Practice	☐	☐	
B. Participates in Household Chores	☐	☐	
C. Adult Activity Program	☐	☐	
D. Senior Center	☐	☐	
E. Workshop or job	☐	☐	
F. School	☐	☐	
G. Hobbies/Special Interest	☐	☐	
H. Recreation	☐	☐	
I. Physical Exercise	☐	☐	
J. Family/Friends (Please Address Any Applicable Visitation Prohibitions and/or Other Considerations)	☐	☐	
K. Other (explain)	☐	☐	

V. MEDICAL INFORMATION

Name of Primary Physician/Clinic		Telephone Number ( )
Primary Physician's Complete Address (Street Number and Name)	City	State / Zip Code

V. MEDICATIONS TAKEN AT TIME OF ASSESSMENT

Name of Medication	Who Prescribed	Dosage

Continued on Next Page

Exhibit G

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Quality of Life Home Visit Report

Date of Visit: _____ Time of Visit: _____ QOL Auditor Name(s):_____

Group Home Name:_____ Address:_____
Service Provider:_____ Number of Staff Present: _____
Names of Staff on Duty: _____
Number of Residents Living at this home: ___ Men ___ Women _____
Name of Resident Interviewed: _____ Staff Assisting Interview:_____

Resident Feedback

1. What were the residents doing when you arrived?

2. How does the resident interviewed make meaningful choices in his/her life (large and small)?

3. How does the resident decide when to go to bed and get up?

4. Does the consumer that your talking to have at least one activity of his/her choice outside the home per week? Examples of the activity? If no what would they like to do?

5. Are there residents that stay home during the day (do not attend a skill build program, supported employment program or clubhouse)? What things do they do when they stay home all day? Do they go anywhere?

6. Does the resident connect with friends and relatives outside of the group home setting? If so, what kind of activities do they do?

7. Does the individual participate in activities with other group home residents? List examples.

8. Does the individual like where he/she lives? What are likes & dislikes of the group home setting?

9. Does the home do any type of exercise? What types?

10. How often does the home eat fast food or got out to a restaurant a week?_____

11. How does the individual gain access to his/her money?

12. What were the staff doing when you arrived?

Volunteer Feedback

13. Is the menu posted, and did it match the account of what consumers ate? ☐ Yes ☐ No

14. Are there grocery items to match menu for the next two days? ☐ Yes ☐ No

15. Is there fresh milk (not powdered) in the refrigerator? ☐ Yes ☐ No

16. Are there fresh fruits and vegetables available? ☐ Yes ☐ No

17. Are there sheets, mattress pads, pillows, and blankets on the beds? ☐ Yes ☐ No

18. Are there soap and towels available in the bathroom? ☐ Yes ☐ No

19. Is the medication cupboard locked? ☐ Yes ☐ No

20. Is there a communication book for staff, and is it up to date? ☐ Yes ☐ No

21. Is the living area free from health and safety hazards? ☐ Yes ☐ No

22. Is the kitchen area free of health and safety risks? ☐ Yes ☐ No

23. Is the residence a *"home"*? ☐ Yes ☐ No

24. What is the "mix" of consumers in the home?

Are there any additional comments or issues that need to be addressed?

Quality of Life Auditor Signature

Distribution: 1 Copy SCCMHA, 1 Copy Owner/Administrator
2/07, revised JRM 2012

Exhibit H

Checklist for moving consumers into Licensed Residential Facilities

It is the philosophy of SCCMHA to encourage consumers to reside in the least restrictive and most supportive setting AFC placement is the most restrictive type of setting offered and should be a last resort after considering or attempting other options such as CLS support for independent living and SIP.

The following checklist is to assist in assuring that the necessary steps are completed for placement into an AFC Home, Specialized or General. **Prior to any move, the Case Worker should consult with their Supervisor.**

PRIOR TO MOVE-IN, the Case Worker should:

- ☐ Obtain approval for the move from individual with authority to approve the move (consumer, guardian, court order, Supervisor, etc.) NOTE: Any out-of-county moves require the approval of the Director of Clinical Services.
- ☐ Determine level of staffing needed by the consumer and review potential placements based on the level of staffing required.
- ☐ Review list(s) of potential homes, contacting home and discussing needs regarding placement. You cannot provide specific or identifiable information to the home at this point.
- ☐ Determine appropriateness of placement including, if needed, touring home, reviewing Incident Reports regarding home, other potential concerns with home
- ☐ Obtain signed *Release of Information* to provide information, and discuss consumer needs with the potential home. These documents should be pertinent to the placement and must include:
  - ☐ Person-Centered Plan (PCP)
  - ☐ Annual Assessment
  - ☐ Other documents that would be a factor in determining placement.
- ☐ Discusses these placement factors with the home (the consumer and/or guardian if applicable)
  - ☐ Accommodations the consumer may require, including work, family, program.
  - ☐ Staffing and equipment needs for personal care and health and safety issues
  - ☐ Home rules and regulations
  - ☐ Additional charges the home assesses on the consumer for services (such as transportation, shopping for items, etc.)
  - ☐ If this is a Specialized Residential placement, determine if temporary intensive staffing will be required to assist with transition and request prior to consumer move-in.
- ☐ Discuss the placement with consumer/guardian.
- ☐ Have consumer and/or guardian tour the new home and met new provider and staff.
- ☐ Determine approval of move by home and consumer or guardian.
- ☐ Discuss with the home any special transitioning accommodations for the move such as: visits to the home to get comfortable with the environment, overnight stays prior to move, visits by staff to the previous setting.
- ☐ Set move-in date
- ☐ Notify current residence if required (may need 30 day notice if under contract with SCCMHA)
- ☐ If attending a work or day program or clubhouse, directly contact to notify of change of address and ridership. (Community Ties will also require a *Change of Ridership* form completed).
- ☐ Update Annual Assessment if significant changes such as needing more care, more restrictive environment, etc
- ☐ **If this is a new Specialized Residential Placement**:
  - ☐ Enter a Residential Budget in Sentri
  - ☐ Start the Person-Centered Planning process within seven (7) days of move-in:
- ☐ **If moving from one Specialized Residential setting to another**
  - ☐ Update the PCP using a Periodic Review. Include
  - ☐ Changes in needs
  - ☐ Requirements for the home to provide to the consumer
  - ☐ Terminate the Residential Budget for the previous home
  - ☐ Enter a Residential Budget for the new placement
- ☐ **If moving from more restrictive setting to a lesser restrictive setting,** start the Person-Centered Planning process within seven (7) days of move-in.
- ☐ Inform home of appointments, current pharmacy, physician.
- ☐ Request provider to prepare any forms Case Worker will need to sign. These are listed below.
- ☐ A form BCAL 3947 Physical/Health Care Appraisal-available from Michigan Department of Human Services (DHS)-is required within 90 days **prior** to move. If this is an emergency placement then the provider has 30 days after placement to get a Physical/Health Care Appraisal completed by the Primary Care Physician or Nurse. (Emergency placement is defined in the *DHS Licensing Rule Books*)

Checklist for moving consumers into Licensed Residential Facilities

ON DATE OF MOVE: Case Worker:

- ☐ Provide home with additional documents, including
  - ☐ Guardianship Papers (if applicable)
  - ☐ Medications dosages and times
  - ☐ Medical information to new provider
  - ☐ PCP indicating home's responsibilities and services to provide
  - ☐ Crisis Plan
  - ☐ Personal Care/Community Living Supports information
- ☐ Provide home with the list of scheduled medical appointments. These appointments should include: eye, hearing, dental, neurology, psychiatrist, therapy and primary care physician etc. as they pertain.
- ☐ For MPS, end date the old placement and start the new placement.
- ☐ Assure consumer mail will be forwarded to new placement.
- ☐ Provide information for the home to complete the AFC assessment plan (BCAL 3265), and sign as the agency designee.
- ☐ Provide information for the home to complete the Resident Care Agreement (BCAL 3266) with guardian or consumer.
- ☐ Send DHS 3471 to:

1. Social Security Administration
   611 East Genesee
   Saginaw, MI 48607
2. Michigan Department of Human Services
   P.O. Box 5070
   411 E. Genesee, Saginaw, MI 48605

Review with home the items and frequency that the Case Worker will be monitoring the home using the **Licensed Residential Setting Checklist & Worksheet** and other areas including:

- ☐ Checking for health and safety concerns
- ☐ Reviewing the physical condition of the home
- ☐ Asking consumer about meals
- ☐ Checking menu items to see if it matches posted menu
  - ☐ Checking availability, expiration, status, freshness, of groceries (two days menu)
  - ☐ Checking consumers access to fresh fruits/vegetables and snacks
  - ☐ Checking Medication Logs for accuracy: new medications started, Rx matches from last doctor appointment, allergy information present, signatures current,
  - ☐ Observing the security of medication storage, dispensing of medications (including preparation, safety and documentation).
  - ☐ Reviewing Resident Fund Sheets to match current money consumer has with items on fund sheet and reviewing receipts, how funds are dispersed to consumer, and if consumer verifies getting funds.
  - ☐ Checking additional costs or charges to consumer. Home is not allowed to charge for meals that are part of Room and Board (i.e. breakfast, lunch, dinner), certain transportation or shopping, basic personal care items, toothpaste, toilet tissue, deodorant, laundry detergent, etc.
- ☐ Reviewing communication logs including assuring incident reports written as necessary
- ☐ Reviewing progress notes
  - ☐ Checking incident reports that were written.
- ☐ Reviewing with home trends that indicate a need to change PCP
- ☐ Reviewing recurrent behavioral concerns including: possible causes for behaviors and need for referral for Behavior services.
- ☐ Reviewing other trends or new needs for equipment or other physical environment modifications
- ☐ Reviewing results of any recent medical appointments for concerns or changes in consumer medical condition that might require change in PCP.
- ☐ Reviewing for any Enhanced Health Issues
- ☐ Initialing & dating reviewed reports

ON DATE OF MOVE: Home

- ☐ Must have Physical/Health Care Appraisal (BCAL 3947) completed no more than 90 days prior to move.
- ☐ Make sure copies of Person Centered Plan, Adequate Action Notice, Consent forms, Crisis Plan, Guardianship Papers, Personal Care/Community Living Supports information
- ☐ Complete the Resident Care Agreement and AFC Assessment Plan is complete.
- ☐ Complete the Resident ID Record (BCAL 3483) which is required by FIA/licensing regulations.
- ☐ Review Recipient Rights and House Rules with consumer.
- ☐ Start and sign Resident Funds Part I and Part II (BCAL 2318 & BCAL 2319)
- ☐ Create Weight Record form (BCAL 3485)
- ☐ If applicable, create Seizure Log

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Exhibit I

Leave of Absence Form

The purpose of this form is document absences from the residential facilities as a way for the homes to plan staffing, to be able to locate a consumer if the need arises during an absence and to assure medications are available for a consumer while on leave.

Name of Consumer:_____ Case #:_____
Facility: _____ Date of Departure: _____
Type of leave: Partial Day ☐ Expected time of return: _____
Overnight or longer ☐ Expected Date of return: _____
Expected Time of return: _____
Person accompanying consumer while on leave:
Name: _____ Relationship: _____
Address: _____ Telephone: _____
Cell phone: _____

If consumer has a guardian, has guardian given consent for this consumer to go on leave with the person identified above:

Yes ☐ No ☐

It is important that medications are given as prescribed.

I understand (recognize) that the accompanying medication(s) are not packaged in child resistant containers and I will take appropriate precautions to keep them out of reach of small children.

Release of Consumer

Are medications being sent with consumer?
Yes ☐ No ☐
(If yes list below)

Name of medication/strength	Amount Sent

Employee releasing medication(s):
Signature:_____
Title:_____
Date:_____ Time:_____

Return of Consumer

Amount of Medications Returned (if any)

_____
_____
_____
_____
_____

Inspection/Comment on return:

Employee receiving any medication(s):
Signature:_____
Title:_____
Date:_____ Time:_____

I have had the opportunity to ask questions about administering the medications: Yes ☐ No ☐

Signature of person accompanying _____ on leave. _____
(Signature) (Date)

CMW 10/1/98; revised KSL 7/30/05; revised JJK 6/2010

SCCMHA 911 Guidelines

SCCMHA understands that there may be situations when 911 must be called in a home setting. Even with the best efforts of SCCMHA and home staff, not all situations can be anticipated. A good example of this is if a weapon is identified, or if there is eminent and reasonable belief that someone will be seriously harmed. If staff or visitors are exhibiting suspected criminal behavior - regardless of whether there is an immediate threat to consumer safety - would also be an example to call 911. Another obvious situation is if there is an intruder in the home or eminent threat outside the home. An additional example of course is always when the home is in need of immediate medical response. (police vs. ambulance or fire) SCCMHA will not second guess or penalize homes for contacting 911, if in their best situational judgment, such intervention is needed to prevent serious harm.

However, SCCMHA as well as MDCH do emphasis prevention and planning as an effective tool in managing consumer behavior and ensuring the safety and welfare of all in the home, consumers and staff. It is expected that staff will have a basic knowledge of protocols to follow when an escalating incident occurs. SCCMHA recommends that home staff discuss possible or even probable scenarios or situations and make plans for how such would be managed in advance of any situation. Such planning also serves to help staff stay calm in situations as they understand what the plan is to be and can execute such as discussed prior to the actual situation. Staff are less likely to act in any inappropriate manner if they have a plan at their ready availability. Staff should be familiar with specific consumer behavior plans and be ready to respond proactively, with emphasis on prevention of behavior escalation whenever possible. In some circumstances it might be advisable to practice the preferred response or several possible responses, including distracting techniques when appropriate. Calling 911 to simply prevent or even halt minor property destruction is not recommended by SCCMHA. Again, if there is a history of such potential behavior, preventative steps should be taken to protect consumers and staff whenever possible, which will also result in property protection.

It is also the expectation of SCCMHA that if 911 must be contacted for a situation, a debriefing will occur to plan for a second similar occurrence, with an emphasis on prevention of a similar occurrence where ever possible. For consumers where it might be anticipated that a behavior might occur, either a crisis plan developed with a consumer and/or a behavioral treatment plan should be pursued. Giving consumer's ownership of how staff can assist them to prevent situations where feasible is highly recommended, although it is recognized that this may not always be feasible with all persons, but this should always be the preferred goal. Emphasis on the development of positive relationships and interactions with consumers, at the times when a negative behavior is not present, is also recommended. Prevention assists consumers to avoid being in a situation or getting to the point where they feel their only resort is to act out or face negative consequences, including 911 calls and/or police at the setting. Under no circumstances should be calling 911 be used as a routine or periodic threat or consequence of any kind for consumer behavior.

Along with physical management techniques, to be used as a last resort, redirection, de-escalation and other calming techniques should be used, even if 911 is being contacted simultaneously. One plan could involve the ability to dispatch extra staff if the distance is reasonable. If a consumer is known to tend to react to a trigger, then all appropriate methods should be used to prevent or avoid that trigger likely to induce a reaction. If certain times or situations are a trigger, scheduling an extra staff member to help start a pattern of behavior prevention might be appropriate.

All behavior is a result of some intent or reaction, and getting to the source of the cause when feasible can assist in developing avoidance, prevention, and management methods, helping consumers as well as staff to avoid potential 911 and/or other higher risk situations.

March 2012

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Behavior Treatment Plan Review Committee (BTPRC)</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.09</td></tr>
<tr><td rowspan="2">Effective Date: 1/31/03</td><td>Date of Review/Revision: 2/11/03, 9/9/03, 6/15/09, 5/24/10, 8/18/10, 3/21/12, 3/22/13, 6/18/13, 5/28/14, 12/1/15, 4/7/16, 3/16/17, 3/1/18,11/7/18, 2/28/19, 7/16/19, 3/3/20, 3/30/21, 9/27/21, 5/10/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Director of Services for Individuals with I/DD

Authored By: Char Fondren, Barb Glassheim

Additional Reviewers:
SCCMHA Behavior Treatment Plan Review Committee</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to establish standards and guidelines for the SCCMHA Behavior Treatment Plan Review Committee (BTPRC) which is charged with reviewing, approving or disapproving, and monitoring Behavior Treatment Plans (BTPs) that propose to incorporate intrusive or restrictive techniques or psychotropic medication for purposes of behavior control.

Application:
This policy applies to the entire SCCMHA Provider Network.

Policy:
The SCCMHA BTPRC shall be responsible for assuring that interventions for individuals who exhibit seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of harm, comply with all relevant state and federal rules and regulations as well as to the standards enumerated below in this policy.

Standards:
A. SCCMHA will establish and support the functioning of an effective Behavior Treatment Plan Review Committee.
   1. The BTRPC is a specially constituted committee appointed by the SCCMHA CEO whose purpose is to review and approve or disapprove any BTPs that propose to use restrictive or intrusive interventions with individuals served by SCCMHA who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk for physical harm.

2. The SCCMHA BTPRC shall:
    a. Review plans and behavioral data to assure that an intervention is necessary, the least restrictive effective intervention, and that the rights of the individual are protected.
    b. Disapprove any BTP that proposes to use aversive techniques, physical management, or seclusion or restraint within a setting where these techniques are prohibited by law or regulation.
    c. Determine whether a causal analysis (i.e., a Functional Behavioral Assessment [FBA]) of the target behavior has been performed, positive reinforcers have been identified, behavioral supports and interventions have been adequately pursued, and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
    d. Expeditiously review and approve or disapprove, considering current peer-reviewed literature and/or practice guidelines, all BTPs proposing to utilize intrusive or restrictive techniques, and all requests to use a physical management technique not approved in accordance with this policy.
    e. Meet on a regular basis to review submitted plans that require committee action.
        1). For each approved plan, the committee shall set and document a date to re-examine the continuing need for the approved technique(s).
    f. Arrange for evaluation of the BTPRC's effectiveness by stakeholders, including individuals who experienced approved plans, as well as family members and advocates.
    g. Track and report BTP activity to the SCCMHA Quality Improvement Committee.
    h. Maintain minutes of all meetings held.
        1). Meeting minutes shall clearly delineate the actions of the committee.
3. The SCCMHA BTPRC shall be comprised of a minimum of three (3) members.
    a. At least one (1) member must be a board certified behavior analyst or licensed behavior analyst, and/or a full or limited licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, of the Michigan Medicaid Provider Manual, Behavioral Health and Intellectual Disabilities Chapter, who has completed the required training as specified in the Manual.
    b. At least one (1) member must be a licensed physician/psychiatrist as defined in the Michigan Mental Health Code at MCL 33.1100c (10).
    c. At least one (1) member must be a clinical representative with expertise in working with individuals with mental illness and/or intellectual/developmental disabilities.
    d. In accordance with MDHHS requirements, a Recipient Rights Officer/Advisor shall serve on an ex-officio basis as a non-voting

member of the committee to provide consultation and technical assistance to the committee and Committee Chair.

e. At the discretion of the BTRPC, and with the consent of the of the individual whose treatment plan is being reviewed, ad hoc participation by other non-voting attendees, such as an advocate or Certified Peer Support Specialist shall be allowed.

4. The SCCMHA BTRPC shall meet as often as needed to conduct its business in a timely and efficient fashion.
5. The presence of two (2) of the required voting members shall constitute a quorum.
6. Any member who has prepared a BTP for review by the BTRPC will recuse himself/herself from the final decision-making.
7. Proposed plans, data and reports for BTPRC review must be received by the BTPRC Chairperson/designee at least five (5) working days prior to the next scheduled meeting.
    a. Behavior Treatment Plans submitted for review must include:
        1). Request to Use Intrusive/Restrictive Intervention(s) in a Behavior Treatment Plan from (i.e., SCCMHA form BTC 001 found in Exhibit B).
        2). Identified target behaviors (included as part of the proposed plan).
        3). Results of assessments performed to rule out relevant physical, medical, and environmental causes of the challenging behavior.
        4). A functional behavior assessment including strengths and deficits and a hypothesis of need(s) being met by performance of the behavior with evidence to support the hypothesis.
        5). Baseline data of the target behaviors and the method of data collection.
        6). Measurable behavioral goals and objectives with specified timeframes for the achievement of each.
        7). Evidence that the plan was developed as part of the person-centered planning process utilizing input from the individual, guardian, parent of a minor child or designated patient advocate.
        8). Evidence of the kinds of behavioral supports or interventions, including their amount, scope, duration and intensity, that have been attempted to ameliorate the behavior and that have proven to be unsuccessful prior to consideration of any intrusive or restrictive interventions.
        9). Proactive positive behavior adaptive/replacement strategies including skill building .
        10). Reactive/responsive positive behavior replacement strategies.

11). Intrusive/restrictive intervention(s) that stipulate specific and limited applications in the formal plan.
12). Known risks of the proposed intrusive/restrictive interventions.
13). Methods for monitoring and reducing intrusive/restrictive interventions.
14). Results of inquiries regarding any medical, psychological, or other factors that might put the individual subjected to intrusive or restrictive techniques at risk of death, injury, or trauma.
15). Peer reviewed literature or practice guidelines that support any proposed restrictive or intrusive interventions.
16). References to literature, and where the proposed intervention has limited or no support in the literature, why the plan is the best option available.
17). A plan for implementation, documentation, staff training and evaluation.

8. Once a BTP has been approved by the BTRPC, written special consent of the plan shall be obtained from the individual, their legal guardian, parent with legal custody of a minor child, or designated patient advocate prior to implementation of plan.
   a. Once written special consent has been obtained, it shall become part of the person's written Individual Plan of Service (IPOS).
   b. The individual, legal guardian, parent with legal custody of a minor child or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-initiated, as well as the right to revisit the BTP. (MCL 330.172 [2]).
   c. Consumers and their parents and/or guardians shall have the right to decline a proposed behavior treatment plan, including positive supports and interventions.
      1). Those who choose to do so will be requested to sign a Decline of Behavior Treatment Plan form (Exhibit C).
   d. Consumers who are currently receiving services under an Alternative Order for Treatment (AOT) shall be required to adhere to their interdisciplinary treatment team's recommended BTP, including positive supports and interventions.
9. Psychotropic medications shall be prescribed for symptoms of mental illness and should not be used for control of behaviors without careful consideration.
   NOTE: If behaviors are severe and place the individual or others at significant risk, psychotropic medications may be helpful.
   a. If medications are used for behavior modification, and medications are an integral part of a consumer's plan, the plan should be created by the person-centered interdisciplinary treatment team to assure the least restrictive treatment, and ultimately, the reduction and/or

elimination of medications utilized for the purpose of behavior control.

b. Consumers and their parents and/or guardians shall have the right to decline a proposed plan that includes medication(s) used for behavior modification.

1). If this occurs, SCCMHA shall have the right to appeal the matter to a court of appropriate jurisdiction for adjudication.

c. Consumers who are currently receiving services under an Alternative Order for Treatment (AOT) shall be required to adhere to their interdisciplinary treatment team's recommended BTP that includes medication(s).

B. SCCMHA will adhere to the standards and guidelines of the MDHHS Technical Requirement for Behavior Treatment Plans as delineated in SCCMHA Policy 03.02.27 – Behavior Treatment Plans (BTPs).

C. Positive Behavior Supports (PBS) shall be deemed the first-line intervention to address consumer behaviors that impede community integration, are socially inappropriate, seriously aggressive, self-injurious, or put the individual or others at risk of harm.

D. SCCMHA shall bar the use of interventions in BTPs that are aversive, entail the use of physical management techniques, include police assistance, restraints, or seclusion, or as otherwise defined in and prohibited by the MDHHS Technical Requirement for Behavior Treatment Plans with the exception of circumstances enumerated below in Standard E.

1. Individuals receiving SCCMHA services have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
2. Physical management and police assistance may only be used as emergency interventions.

E. SCCMHA shall allow the use of intrusive or restrictive interventions for short-term urgent circumstances.

1. Such interventions must incorporate positive support elements to reduce or eliminate the behavior.
2. An intrusive or restrictive intervention cannot be used as a standalone or sole intervention for the harmful behavior.
3. Behavior treatment interventions for unprecedented and unpredicted crises or emergency occurrences of seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of harm will be the least restrictive and least intrusive needed to prevent imminent harm.
4. If an expedited review by the BTPRC of a proposed BTP is requested in an emergent situation, the committee will review and approve or deny the request within forty eight (48) hours.

a. Expedited plan reviews may be requested, when, based on data presented by professional (psychologist, psychotherapist, RN, supports coordinator, case manager) staff members of the interdisciplinary treatment team, the plan requires immediate implementation.

b. The BTPRC Chair may receive, review, and approve such plans on behalf of the committee.

c. The SCCMHA Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan.

1). Upon approval, the plan may be implemented.

2). All plans approved in this manner must be subject to full review at the next regular meeting of the BTPRC.

NOTE: The most frequently occurring example of the need for expedited review of a proposed plan in emergent situations occurs as a result of Michigan AFC licensing rule R400.14309 – Crisis Intervention, which states: "Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been insufficient time to develop a specialized intervention plan to reduce the behavior causing the crisis. If the [individual] requires the repeated or prolonged use of crisis intervention procedures, the licensee must contact the [individual's] designated representative and the responsible agency…to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan."

2. Physical management will only be used on an emergency basis when the situation places the individual or others at imminent risk of physical harm and will be documented per agency requirements.

NOTE: Utilization of physical management or requests law enforcement intervention may be evidence of treatment/supports failure.

a. Should physical management use occur more than three (3) times within a thirty (30) day period, the individual's written individual plan of service must be revisited through the person-centered planning process and modified accordingly.

NOTE: The MDHHS Technical Requirements for Behavior Treatment Plan Review Committees prohibits emergency interventions as a component or step in any behavior plan. The plan may note, however, that should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individuals or others, approved emergency interventions may be implemented.

3. Plans with intrusive or restrictive techniques require a quarterly review at a minimum.

a. The committee may require BTPs that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review.

b. If the Case Holder is not present at the BTPRC meeting and/or quarterly review, the BTPRC Chair/designee will notify the Case Holder of the results of the regular meeting and/or quarterly meeting – i.e., whether the committee approved the plan, approved the plan with revision(s), or the committee denied the use of the intervention.
c. The BTPRC may make recommendations to address the concerns.
d. The Case Holder will be responsible for notifying the plan author (if not in attendance at the meeting) of the results and coordinate with the Case Holder on further requirements.
e. It is expected that the author of the plan will present the initial BTP and prepared quarterly review reports of BTPs.
    1). If Author is unable to present quarterly reviews, the author of the plan may appoint a proxy to represent in their place.

4. The BTPRC will track and report data on a quarterly basis to Mid-State Health Network on the use of all physical management, involvement of law enforcement, or PRN medication for behavior, and the use of intrusive and restrictive techniques by each individual receiving the intervention as well as:
    a. Dates and numbers of interventions used.
    b. The settings (e.g., group home, day program) where behaviors and interventions occur.
    c. Observations about any events, settings, or factors that may have triggered the behavior.
    d. Behaviors that initiated the techniques.
    e. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
    f. Description of behavioral supports used.
    g. Behaviors that resulted in termination of the interventions.
    h. Length of time of each intervention.
    i. Review and modification or development, if needed, of the individual's BTP.
    j. Staff development and training and supervisory guidance and coaching to reduce the use of these interventions.
        1). Retrospective reviews of cases in which such interventions have been used shall be conducted as part of continuous quality assurance in an effort to determine whether effective alternatives could be used.
5. In a non-emergent situation, the SCCMHA BTPRC will not approve BTPs that propose:
    a. To use physical management and/or involvement of law enforcement
    b. Aversive techniques
    c. Seclusion or restraint in a setting where prohibited
6. Non-physical intervention is required to be used prior to implementing physical management.

F. SCCMHA may require the approval of its BTPRC for SCCMHA consumers with BTPs that include intrusive or restrictive interventions provided in inpatient settings that lack a behavior treatment plan review committee.

Definitions:

Anatomical Support: Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a consumer's physical functioning.

Applied Behavior Analysis (ABA): The practice of applying the psychological principles of learning theory in a systematic way to modify behavior. The practice is used most extensively in special education and the treatment of autism spectrum disorder (ASD), but also in healthcare, animal training, and even business.

Aversive Techniques: Techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant and may often generate physically painful responses into the average person or would have a specific unpleasant effect on a particular person) to achieve the management, or control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist, or other noxious substance to consequate target behavior or to accomplish a negative association with a target behavior and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques. Otherwise, use of aversive techniques is prohibited.

NOTE: SCCMHA prohibits the use of aversive interventions; no SCCMHA staff member (employee) or contracted provider staff member may use aversive interventions.

Behavior Assessment/Functional Analysis: A precise description of a consumer's behavior, its context, and its consequences, with the intent of better understanding the behavior and those factors influencing it. A behavior assessment/functional analysis must occur prior to the establishment of a Behavior Treatment Plan. The behavior assessment/functional analysis addresses the following issues associated with identified target behaviors: environmental and contextual factors (antecedent, behavior, and consequence) and the consumer's skill and/or performance deficits. Additionally, the target behavior(s) is identified and the frequency, duration, and/or intensity of the target behavior(s) is assessed.

Behavior Management: The exercise of strategies for the control or treatment of problem behavior to achieve therapeutic objectives using a variety of recognized techniques. Techniques are based on general behavior theory, verbal directions, physical guidance, physical management, and medications.

NOTE: It is the policy of SCCMHA to employ behavior modification treatment techniques rather than behavior management techniques when the technique used is not needed to assure safety.

Behavior Modification: The systematic application of principles of general behavior theory to the development of adaptive and/or elimination of problem behavior consistent with therapeutic objectives. Interventions used for behavior modification include but are not limited to applied analysis of behavior, schedules of reinforcement, token systems,

cognitive therapy, self-control therapy, social skills training, modeling, shaping, fading, generalization, relaxation training, systematic desensitization, stimulus control, positive practice and contingency management. refers to the systematic.

Behavior Treatment Plan Review Committee (BTPRC): A specially constituted committee whose primary function is to oversee the proposed use of any intrusive and restrictive techniques that might be considered for usage as a last resort with consumers.

Behavior Treatment Plan (BTP): Treatment methods encapsulated in a plan written for the purpose of changing targeted behavior through specific behavior modification methods. Behavior treatment is the intervention used with target behavior(s) to achieve therapeutic objectives using a variety of recognized techniques. The terms "Behavior Treatment Program" and "Behavior Treatment Plan" are used interchangeably. All BTPs are individualized and are based on the results of a behavior assessment. Prior to implementation, as appropriate, individuals and/or their family/guardian are educated about, and must agree to participate in, behavior treatment. Those participants will then take part in identifying antecedents to, and consequences of, the target behavior(s) and must agree to the target behavior(s) and treatment interventions before the BTP can be put into effect. Behavior treatment plans must be developed through the Person-Centered Planning process and be approved by the individual, or his/her guardian on his/her behalf if one has been appointed, or the parent with legal custody of a minor. Behavior treatment interventions identify, teach, and support the acquisition and reinforcement of identified adaptive/replacement behaviors. Behaviors being treated are assessed to determine that appropriate behavior is exhibited.

NOTE: In conjunction with affiliate data collection and reporting activities, SCCMHA reviews and monitors the use of behavior treatment interventions to monitor and improve treatment efficacy.

Bodily Function: The usual action of any region or organ of the body.

Consent: A written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.

Emergency Interventions: There are only two (2) emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and a request for law enforcement intervention.

Emotional Harm: Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.

Functional Behavioral Assessment (FBA): An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a particular behavior and guide the development of an effective and efficient behavior treatment plan. The focus of an FBA is to identify social, affective, environmental, and trauma based factors or events that initiate, sustain, or end a target behavior. A physical examination must be conducted by a licensed physician (MD or DO) to identify biological or medical factors related to the target behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the target behavior itself so that a new behavior or skill will be

developed to provide the same function or meet the identified need. Functional assessments should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.

Imminent Risk: An event/action that is about to occur that will likely result in the serious physical harm to oneself or others.

Intrusive Techniques: Techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition.

NOTE: Use of intrusive techniques as defined here requires the review and approval of the SCCMHA BTPRC.

Medical and Dental Procedures Restraints: The use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint can only be used as specified in the individual written plan of service for medical or dental procedures.

Non-physical Interventions: Strategies that promote a culture of gentleness and teach staff to help an individual calm before a situation escalates. Use of these techniques is required prior to implementing physical intervention. Different techniques will be used depending on the situation, but staff should be consistent in their actions. These techniques include proactive options, communication skills, confrontation avoidance, and de-escalation. They should be used regularly and naturally during interactions with individuals who display challenging behaviors.

Peer Reviewed Literature: Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researcher and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

Person-Centered Planning (PCP): A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by continued direct physical contact to prevent the individual from seriously harming himself, herself, or others.

Note: Physical management can *only* be used on an emergency basis when the situation places an individual or others at imminent risk of serious physical harm.

Positive Behavior Support (PBS): A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious, or other targeted behaviors that place the individual or others at risk of physical

harm by conducting a functional assessment, and teaching new skills, and making changes in a person's environment. PBS combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction. Positive behavior supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

Positive Support: A person-centered process that considers the function of the recurring behavior of concern and develops supports to promote positive social interactions, support for communication, support for meaningful activity, provision of predictable and consistent environments, support to establish and maintain relationships with family and friends, provision of choice, encouragement of more independent functioning, support for personal healthcare, an acceptable physical environment, mindful and skilled carers, effective management and staff support, and effective organizational context. (Adapted from McGill, 2015)

Practice or Treatment Guidelines: Treatment or intervention recommendations published by professional organizations such as the American Psychiatric Association (APA), or the federal government.

Proactive Strategies in a Culture of Gentleness: Strategies within a positive behavior support plan used to prevent seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of physical harm from occurring or for reducing their frequency, intensity, or duration. Supporting individuals in a culture of gentleness is an ongoing process that requires patience and consistency. As such, no precise strategy can be applied to all situations. Some examples of proactive strategies include unconditional valuing, precursor behaviors, redirection, stimulus control, and validating feelings.

Prone Immobilization: Extended physical restraint of an individual in a face down (prone) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position for the purpose of control.

Protective Device: A device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of a behavior. A protective device that is incorporated in a written individual plan of services is not considered a restraint (as defined below).

Psychotropic Drug: Any medication administered for the treatment or amelioration of disorders of thought, mood or behavior.

Reactive Strategies in a Culture of Gentleness: Strategies within a positive behavior support plan used to respond when individuals begin to feel unsafe, insecure, anxious, or frustrated. Some examples of reactive strategies include reducing demanding interactions, increasing warm interactions, redirection, giving space, and blocking.

Recipient Rights: A person who receives services from the PIHP (pre-paid inpatient health plan) region, or an agency or provider under contract with the PIHP region, has the same rights, benefits, and privileges as a person who is not receiving mental health services, including rights guaranteed by the Michigan Mental Health Code (MMHC), except when divested or limited by: a court, statute or rule, and/or voluntary agreement of the recipient or person legally empowered to consent on behalf of the recipient.

Recurring Behavior of Concern: When a consumer repeats a behavior, or a set of behaviors, that are culturally abnormal and of such an intensity, frequency, or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or the

behavior is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities (Adapted from Emerson, 1995).

Request for Law Enforcement Intervention: Calling 9-1-1 and requesting law enforcement assistance because of an individual exhibiting a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance only when; caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

Restraint: The use of a physical device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.

Restrictive Techniques: Techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques include limiting or prohibiting communication with others when that communication when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual.

NOTE: Use of restrictive techniques require the review and approval of the BTPRC.

Seclusion: The temporary placement of an individual in a room, alone, where egress is prevented by any means. Seclusion is prohibited except in a hospital or unit operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

Serious Physical Harm: Physical damage suffered by a consumer that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

Special Consent: Obtaining the written consent of the consumer, their legal guardian, the parent with legal custody of a minor child, or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the recipient, guardian, or parent of a minor recipient may only occur when the recipient has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Michigan Mental Health Code.

Support Plan: A written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.

Target Behavior(s): A behavior or behaviors that are the focus of treatment in a behavior treatment plan.

Targeted Case Manager (CSM)/Supports Coordinator (SC): The designated staff person whose primary function is to plan, coordinate, link, and monitor the delivery of

services and supports which are identified in the individual's approved behavior treatment plan.

Therapeutic De-escalation: An intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the recipient is placed in an area or room, accompanied by staff who shall therapeutically engage the consumer in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

Time Out: A voluntary response to the therapeutic suggestion to a consumer to remove himself or herself from a stressful situation to prevent a potentially hazardous outcome.

Treatment Plan: A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, which are to be developed with and provided for a consumer.

Unreasonable Force: Physical management or force that is applied by an employee, volunteer, or agent of a provider to a consumer in one or more of the following circumstances: (1) There is no imminent risk of serious or non-serious physical harm to the recipient, staff, or others. (2) The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency. (3) The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service. (4) The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.

References:

A. 1997 federal Balanced Budget Act at 42 CFR 438.100
B. Michigan Department of Health and Human Services (MDHHS) Service Standards and Requirements for Behavior Treatment Plan Review Committees: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900-552435--,00.html
C. Michigan Administrative Code Part 3 Section R 400.14309 – Crisis Intervention:
D. Michigan Medicaid Provider Manual
E. Michigan Mental Health Code, Public Act 258 of 1974
F. Mid-State Health Network Behavior Treatment Plans Policy revised 1/12/21: https://midstatehealthnetwork.org/application/files/6216/1063/4850/Quality_Behavior_Treatment_Plans.pdf
G. SCCMHA Policy 03.02.27 – Behavior Treatment Plans (BTPs)

Exhibits:

A. SCCMHA Behavior Treatment Plan Review Committee Membership Roster
B. Request to Use Intrusive/Restrictive Intervention(s) in a Behavior Treatment Plan (SCCMHA form BTC 001)
C. Decline of Decline of Behavior Treatment Plan Form

Procedure:

ACTION	RESPONSIBILITY
1. Appoints members to the Behavior Treatment Plan Review Committee (BTPRC) including designating the	1. CEO or Designee

Committee Chair.	
2. Provides regular information to staff regarding the roles of the BTPRC and staff responsibilities.	2. BTPRC Committee
3. Requests the BTPRC review for approval Behavior Treatment behavior plans that propose to use restrictive or intrusive interventions.	3. Case Holder and/or Author of Plan
4. Assures plans are reviewed and action taken regarding approval in a timely manner.	4. BTPRC Chair
5. Assures Guardian approval for Plans approved by the BTPRC.	5. Case Holder
6. Assures minutes of the BTPRC are completed according to policy and relevant portions are entered into the consumer's electronic health record.	6. BTPRC Chair or Designee
7. Assures required data and information is properly processed as required by the MDHHS Technical Requirement or other authorities.	7. BTPRC Chair or Designee

Exhibit A

SCCMHA Behavior Treatment Plan Review Committee Members

Title	Name	Term Expires
*Chair	Charlotte Fondren, LMSW	December 31, 2022
*Psychiatrist	Dr. Ali Ibrahim, Medical Director	December 31, 2022
*Psychologist	Heidi Wale Knizacky, MS, LLP	December 31, 2022
*Recipient Rights	Tim Ninemire (or designee), Recipient Rights Director	Ex officio
Member	Jenipher Swanson, Supervisor of Autism Services	December 31, 2022

* MDHHS *Standards for Behavior Treatment Plan Review Committees* requirement

Exhibit B

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Request to use Intrusive/Restrictive Intervention(s) in a Behavior Treatment Plan (BTP)

Saginaw County Community Mental Health Authority Behavior Treatment Committee (BTC)

☐ ***Expedited Review*** *(check if needed within 24 – 48 hours)*

Consumer Name: Click or tap here to enter text.

Consumer ID #: Click or tap here to enter text.

Plan Author: Click or tap here to enter text.

Date: Click or tap to enter a date.

Residential Living Arrangement:	☐ Specialized Residential Home (AFC, children's therapeutic group home) ☐ General Residential Home (licensed foster care facility not certified to provide specialized program) ☐ Private residence with CLS and/or AHH staff support ☐ Private residence without CLS and/or AHH staff support ☐ Foster home/Foster care (minor child) ☐ Other (Please specify: Click or tap here to enter text.) ☐ **Check if currently in a crisis residential or psychiatric unit placement, jail or other correctional placement, or state hospital**

Reoccurring Behavior(s) of Concern (list all): Click or tap here to enter text.

Reason for BTC Review:

☐ New Behavior Treatment Plan
☐ Amended Behavior Treatment Plan
☐ Positive Support Plan (no intrusive/restrictive interventions)

☐ Quarterly Review of approved Behavior Treatment Plan:
☐ Regression ☐ No Change ☐ Progress

Date existing plan was originally approved: Click or tap to enter a date.

☐ ABA plan that contains restrictive/intrusive interventions
☐ New HCBS health and safety modification request (Ensure the Assessment/IPOS/physician script or OT/PT eval support the request)
☐ Review of existing HCBS health and safety modification (includes medical devices)

Date modification was originally approved: Click or tap to enter a date.

☐ Review due to medications prescribed

Date of last prescriber report form (must be done at least annually): Click or tap to enter a date.

Is the individual currently receiving evidence-based treatment: ☐ Yes ☐ No
If yes, specify which evidence-based treatment below:

☐ PMTO ☐ DBT ☐ TF-CBT ☐ Family Therapy ☐ ABA Therapy ☐ BSFT

☐ Other (describe): Click or tap here to enter text.

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Request to use Intrusive/Restrictive Intervention(s) in a Behavior Treatment Plan (BTP)

Saginaw County Community Mental Health Authority Behavior Treatment Committee (BTC)

Briefly summarize current treatment the individual is receiving (services received, level of engagement, attendance, etc.):
Click or tap here to enter text.

Intrusive Intervention(s) in the BTP? ☐ **Yes** ☐ **No**
If yes, check all that apply from below:

☐ 1:1 Supervision	☐ Line of Sight	☐ Arm's Reach	☐ Physical Prompt
☐ ABA 2:1	☐ Restore Environment	☐ Overcorrection	☐ Medications
☐ Protective Device	☐ Anatomical/Physical Support Rx MD/PT/OT	☐ Special Clothing	

☐ **Other (describe):** Click or tap here to enter text.

Restrictive Intervention(s) in the BTP? ☐ **Yes** ☐ **No**
If yes, check all that apply from below:

Freedom of Movement
☐ Limit Access to Activity, Environment ☐ Therapeutic De-Escalation (required relaxation)
☐ **Other (describe):** Click or tap here to enter text.

Property Rights
☐ Restrict Access to Property ☐ Restrict Access to Money ☐ Search & Seizure
☐ Restitution/Response Cost ☐ Planned Inquiry (i.e. request to see purchases made)

Entertainment
☐ Restrict Access to Viewing, Listening, etc.

Communication Rights
☐ Limit Access to Phone ☐ Limit Access to Visits ☐ Limit Access to Mail ☐ Limit Access to Other Persons
☐ **Other (describe):** Click or tap here to enter text.

Notes/Comments: Click or tap here to enter text.

Exhibit C

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Decline of Behavior Treatment Plan

Consumer Name: Click or tap here to enter text.

Case Number: Click or tap here to enter text.

I, Click or tap here to enter text., on behalf of Click or tap here to enter text., have been contacted regarding the implementation of a behavior treatment plan due to reoccurring behavior(s) of concern. I have been advised of the potential benefits and risks of implementing a behavior treatment plan. A behavior treatment plan, including positive behavior supports and interventions, and possibly the administration of behavior modifying medications, has been discussed in detail and I have had all my questions and concerns answered. I understand the benefits and risks of a behavior treatment plan and do not agree to the implementation of a behavior treatment plan. Therefore, by my signature below, I elect to decline a behavior treatment plan.

_____ _____

Signature of consumer, legal guardian or parent of minor Date

_____ _____

Signature of legal guardian or parent of minor (if applicable) Date

_____ _____

Signature of Witness Date

3/15/2022

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Clinical Risk Committee</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.10</td></tr>
<tr><td rowspan="2">Effective Date:
10/24/96</td><td>Date of Review/Revision:
1/24/05, 6/8/07, 5/6/09, 5/21/10, 6/15/12, 1/9/13, 4/7/16, 4/7/17, 3/1/18, 3/7/19, 4/7/20, 3/16/21, 3/3/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
John Burages

Additional Reviewers:
Kristie Wolbert, John Burages</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
Through an inter-disciplinary committee, Saginaw County Community Mental Health Authority will monitor and consult on consumer and agency clinical issues related to the safe and appropriate treatment of consumers, specifically where risk of psychiatric hospitalization is involved.

Policy:
A Clinical Risk Committee has been established with the following mission:

1. To monitor clinical issues related to the safety and appropriate treatment of consumers served by this agency.
2. To address and recommend treatment approaches for consumer's whose conditions are at high risk, complicated, or unusual.
3. To review cases brought forth with concerns regarding diagnosis and treatment.
4. To review arrest of individuals on waivers or residing in specialized AFC.
5. To review state hospital census.
6. To review hospital recidivism.
7. To review security alerts.
8. The committee may also review and recommend modifications to agency policy and/or practices that negatively affect the treatment of consumers and/or the safety of consumers, staff and/or visitors.

Application:
The entire SCCMHA network of providers.

Standards:

1. The Clinical Risk Committee will meet at least monthly.

2. Membership on the committee will be as indicated by the Director of Services for Persons with Mental Illness and will be Supervisors or specialists from various providers or services. The list will be maintained by the Director of Services for Persons with Mental Illness.
3. Minutes will be taken for each meeting.
4. Recommendations will be documented in the electronic medical record.
5. The preferred process for Referral to Clinical Risk is:
    a. The Record Holder is notified or becomes aware of an assigned consumer's concern or attempts to address the concern have been unsuccessful.
    b. The Record Holder seeks assistance from his/her Supervisor and implement attempts to address the concern.
    c. If the concern continues, the Supervisor refers to Clinical Risk directly to the Director of Services for Persons with Mental Illness or Administrative Assistant
    d. Referrals may be made by other entities if the concern is imminent or has not been resolved through the Record Holder and Supervisor.
6. All requests should include the reason for the referral to the committee.
7. The Record Holder and Supervisor, or other representative, must attend the Clinical Risk Committee Meeting designated for that case.

Definitions:
High Risk Case: A case can be considered "high risk" for a variety of reasons. The person may present a high risk to themselves as in the case of a person making repeated suicide attempts or threats or the person may exhibit behaviors that put them at high risk (substance abuse, homelessness). The person may be high risk to others as in persons making homicidal threats and/or gestures. The person may be high risk to the community as in persons with pedophile behaviors. Finally, the person may be considered high risk to the agency either for similar issues as those listed above or for financial reasons such as the repeated use of inpatient hospitalization.

Complicated Case: A case may be referred to as complicated for a variety of reasons as well. The case may prove to be difficult to diagnose, a history of instability, or barriers to the development of an appropriate and/or effective treatment plan.

Unusual Case: Again, a case can be considered unusual for any number of reasons. The person may present with a diagnosis that is seldom seen and the agency may have minimal experience with. Factors affecting the case may be unusual or typical treatments may be ineffective with the case.

References:
CARF Standards Manual

Exhibits:
Exhibit A: Clinical Risk Referral Form

Procedure:

ACTION	RESPONSIBILITY
Chairs the Clinical Risk Committee	Director of Services for Persons with Mental Illness or assigns designated chairperson.
The Record Holder is notified or becomes aware of an assigned consumer's concern or attempts to address the concern have been unsuccessful.	Record Holder
The Record Holder seeks assistance from his/her Supervisor and implement attempts to address the concern.	Record Holder Supervisor
If the concern continues, the Supervisor refers to Clinical Risk directly to the Director of Services for Persons with Mental Illness or Administrative Assistant	Record Holder Supervisor
Referrals may be made by other entities if the concern is imminent or has not been resolved through the Primary Case Holder and Supervisor.	Professional Staff Treating psychiatrist Supervisor Executive Director of Clinical Services
Establishes an agenda for the committee based on level of risk that a referral may pose.	Director of Services for Persons with Mental Illness or assigned chairperson or Administrative Assistant
Meets on a monthly basis to review cases that are considered to be high risk, complicated, and/or unusual.	Clinical Risk Committee
Attends the committee to present a referred case.	Referring person (and/or) Case Holder Supervisor
Makes recommendations which are documented and forwarded to the primary record holder for follow through and inclusion in the clinical record.	Clinical Risk Committee
Reports back to the committee regarding effectiveness of recommendations, when requested.	Referring person (and/or) Record Holder Supervisor

Exhibit A

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Clinical Risk Committee Referral

Date:_____

This form serves as a referral to the Clinical Risk Committee which is an inter-disciplinary committee to monitor and consult on consumer and agency clinical issues related to the safe and appropriate treatment of consumers, specifically where risk of psychiatric hospitalization is involved.
All referrals must first be discussed and approved by your Supervisor.
Upon completion, send via Sentri Message to John Burages and Allison Kaimes-Hadd.

Consumer Name: _____ **Case #:**_____

Referred by:_____ **Program:** _____

Please print responses below.
Reason for the referral:

Describe the "risk" behaviors and history (be specific):

Explain attempts to address the behavior and outcomes:

State what assistance is needed from Clinical Risk:

Staff Signature: _____ **Date:**_____

Supervisor Signature: _____ **Date:**_____

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Child Diagnostic and Treatment Training Requirements</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.11</td></tr>
<tr><td rowspan="2">Effective Date:
June 30, 2003</td><td>Date of Review/Revision:
6/30/03, 7/21/16, 3/30/17, 3/1/18, 2/26/19, 3/9/20, 6/1/20, 3/5/21, 3/3/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Carey Moffett LMSW

Additional Reviewers:
Erin M. Nostrandt, Clinical Directors, Brooke Maylee</td></tr>
<tr><td>Supersedes:
09.06.00.03 – Child Diagnostic and Treatment Unit Training Requirements</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to set standards for training for staff working with children who have a Severe Emotional Disturbance (SED)

Application:
This policy applies to all Saginaw County Community Mental Health Authority (SCCMHA) board operated programs. The SCCMHA Outpatient Provider Network is required to follow this policy or have their own policy that is submitted and approved by SCCMHA.

Policy:
It is the policy of SCCMHA that all staff who are assigned as Case Holders or staff who have credentials and are providing mental health treatment services to children with SED will acquire at least twenty-four hours of age specific training per calendar year.

Standards:
Any staff who provide mental health care or are Case Holders of children with SED will maintain and improve the clinical skills for working with children and families by documenting at least twenty-four hours of age-specific training per calendar year.

Supervisor(s) will seek reasonable opportunities for staff to be able to obtain twenty-four hours of age-specific training per calendar year.

Master prepared staff who diagnose children shall receive training before performing initial screenings for child mental health services.
Each unit or agency that offers treatment to children with SED will provide opportunities for trainings, either in-house or outsourced, at least monthly for staff.

Staff who meet the credentialing criteria may lead discussion or provide training to staff.

All training provided will be documented with the Continuing Education Department of Saginaw County Community Mental Health Authority within the staff Training History in Sentri II.

The credentials of all trainers and discussants will be approved by the Supervisor of the Continuing Education Department of SCCMHA to ensure that the credentials of the trainer/discussant are current and consistent with the standards of this policy.

Staff can acquire Child Diagnostic credits in 4 methods:

- Internal SCCMHA Professional Continuing Education Trainings
- External Trainings
- Online Trainings
- Case Consultation
    - Up to 12 Child Diagnostic credits per year can be earned through case consultation. This must be documented on the appropriate form, see Exhibit B

Continuing Education Unit Staff will run Child Diagnostic reports via Sentri II training database and will send quarterly Child Diagnostic reports to the respective

Definitions:
None

References:
Michigan Mental Health Code, specifically Chapter 4A
Michigan Department of Community Health, Mental Health and Substance Abuse Services, Administrative Code, specifically Subpart 6
MDHHS Indicators (2017): SEDW-CLS E.1.5, E.3.4-6
MDHHS Indicators (2017): HSW 14.5.A and 2.4
Form 2016 1 WIP-HSW SED CWP 1915 (c) Waivers Final Site Review Protocol
03.17.16 –Q.1.3

Exhibits:
Exhibit A: Documentation of Child Diagnostic Credits: General
Exhibit B: Documentation of Child Diagnostic Credits Received at Case Consultation
Exhibit C: Standard Email Template for distributing Child Diagnostic Reports

Procedure:

ACTION	RESPONSIBILITY

Responsible for assuring compliance with this policy.	Chief Executive Officer, Executive Director of Clinical Services
Responsible for assuring appropriate credentials of trainers/discussants.	Supervisor of Continuing Education Unit or Agency Supervisor
Responsible for assuring that trainings are made available to staff	Supervisor of Continuing Education Unit or Agency Supervisor
Responsible for assuring that documentation is appropriate	Supervisor of Continuing Education Unit or Agency Supervisor
Responsible for assuring that they have twenty-four hours of age-specific training per calendar year • Individual Training Completions: Staff are encouraged to send the SCCMHA Continuing education a completion notice (certificate) by printing & scanning via email to registrations@sccmha.org in order for the credits to be added to their training record • Departmental Trainings: Department supervisor is encouraged to submit the completed form (Exhibit A: Documentation of Child Diagnostic Credits: General) to the Continuing Education Department • Case Consultations: Department supervisor is to submit the completed form (Exhibit B: Documentation of Child Diagnostic Credits Received at Case Consultation) to the CE Department registrations@sccmha.org , while maintaining a copy for their records.	Case Holder or staff providing mental health treatment to children with SED

How Child Diagnostic Credits are awarded. • If the training title reflects education of family, child, adolescent, infant, toddler, teen, parent, etc., Staff will receive 100% Child diagnostic credit based on the course training hour. • If any of the above is not identified in the title, staff will need to send additional information about the education/training which identifies education of family, child, adolescent, infant, toddler, teen, parent, etc. to determine # of Child Diagnostic credits awarded	Continuing Education Staff
The Report process steps: 1. Sentri II 2. Training Management Report 3. Print Transcript 4. Select green 'lookup' after provider 5. In the 'name' field type in as much as you know about the provider (Ex: SCCMHA Autism, SCCMHA Mobile Response and Stabilization Services, WGC Children, SPS Children) 6. Choose 'Search' 7. Choose 'select' in blue to the right of the provider you need a. If department search is SCCMHA in-house, always be sure to choose 'Direct Program as identified in the 'Org Type/Panel Type' Column b. If the department search is a contracted provider you will need to select 'Contracted Service Provider.	Continuing Education Assistant or Designated Continuing Education Unit Staff

8. Start Date = the start of the previous quarter (example Jan 1 "Year") > End date = Reporting Date 9. Generate PDF File 10. Refer to your Sentri II Mail (white envelope next to HELP at top of Sentri page) to Open the report 11. Save As (go to this folder in G-Drive): *G:\Network Services\Training\Reports\Child Diagnostic Reports* 12. Find (or create) the file for the correct quarter 13. Title should be saved as: "Department Supervisor last name (or contracted program name) Child Dx __ Quarter [Year]". Once all transcripts' reports are run, they are emailed to the respective SCCMHA supervisor or contracted provider contact.	

Exhibit A

Documenting Child Diagnostic Credits

Title of Education/Training/In-Service:
Name of agency/professional providing education:
Date:
Length of Education (15 minutes, 30 minutes, 45 minutes, 1 hour, etc.):

Saginaw County Community Mental Health Authority

Continuing Education

Staff in attendance

Printed Staff Name	Staff Signature

Child Diagnostic credits will be assigned when appropriately documented trainings are submitted to the Continuing Education department.

Printed Supervisor Name	Supervisor Signature

PLEASE ATTACH ANY EDUATION INFORMATION YOU HAVE, SUCH AS A FLYER

Exhibit B

Documenting Child Diagnostic Credits Received at Case Consultation

Title of Education/Training/In-Service:
Name of agency/professional providing education:
Date:
Length of Education (15 minutes, 30 minutes, 45 minutes, 1 hour, etc.):

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Continuing Education

Staff in attendance

Printed Staff Name	Staff Signature

Up to a maximum of 12 Child Diagnostic credits will be assigned when appropriately documented Case Consultations are submitted to the Continuing Education department.

Printed Supervisor Name	Supervisor Signature

Exhibit C

Hello –

Please see attached Child Diagnostic Report for Jan – March "Year". All trainings with Child Diagnostic credits are identified with the # of credits within the title of the training. These credits will need to be manually counted as the database does not have a current method of auto calculating these credits.

This reporting method is still being developed. If you see any errors or have any questions please contact me.

Thank you,

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Peer Delivered and Operated Service</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.12</td></tr>
<tr><td rowspan="2">Effective Date:
6/15/05</td><td>Date of Review/Revision:
3/25/05, 6/8/07, 6/22/09, 7/1/10, 3/14/12, 5/23/14, 4/7/14, 4/7/16, 4/7/17, 3/1/18, 3/21/19, 4/8/20, 3/29/21, 3/14/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
John Burages

Additional Reviewers:
Clinical Directors, Sara Anani, John Burages</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To establish policy and standards for the provision of peer delivered and operated services.

Policy:
Saginaw County Community Mental Health Authority supports and encourages the use and development of peer delivered and operated services.

Application:
Network of SCCMHA Providers

Standards:
A comprehensive diagnostic and treatment planning evaluation is required for all SCCMHA and Provider Network consumers the extent of the evaluation will depend on the individual consumer and on existing state, federal, or applicable accreditation schedule. As part of the certification, states will establish the requirements for these evaluations. Factors considered should include: assessment of need for other services required by the statue (i.e., peer and family/caregiver support services). Peer delivered and operated programs provide individuals with opportunities to learn and share coping skills and strategies.

They help consumers to move into more active assistance and leadership roles and away from passive patient roles and identities.

They help to build self-esteem and self-confidence.

The services must support the identified goals of community inclusion and participation, independence and/or productivity.

In order to be a billable service, the individual plan of service must identify goals and how the presence of a peer, supports these goals.

Definitions:
Peer delivered and operated services: Billable service activities intended to improve outcomes for individuals through the support of a peer.
Peers: Individuals who have a unique background and skill level from their experience in utilizing services and supports to achieve their personal goals of community membership, independence and productivity. Peers have a special ability to gain trust and respect of other individuals based on shared experience and perspectives with disabilities, and with planning and negotiating human service systems.

References:
Michigan Medicaid Provider Manual Section 17: Additional Mental Health Services (B3s)
SCCMHA Policy: 02.03.11 Peer Support Specialists

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Establishes policy supporting and encouraging the development of peer delivered and operated services.	CEO, Executive Director of Clinical Services
Pursues grants and other additional assistance to aid in the support and development of peer delivered and operated services.	Executive Director of Clinical Services, other providers, consumers, or other interested parties.
Monitors program sites for compliance with standards.	Network Services
Considerations for Peer Delivered and Operated Services are initiated and can be Family Advocates explored at Intake. Additionally, some services specifically involve Peers to support service, community link and resource referrals.	Family Guide/Parent Support Partners Family Advocates

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:
Transition/Discharge Services</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.13</td></tr>
<tr><td rowspan="2">Effective Date:
7/1/07</td><td>Date of Review/Revision:
6/22/07, 5/7/09, 7/1/10
6/15/12, 5/23/14, 4/7/16,
1/25/17, 3/1/18, 3/16/20,
3/29/21, 3/3/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Sara Anani

Additional Reviewers:
Clinical Directors, Sara Anani, John Burages, Brooke Maylee</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To establish the practice of transition, continuing care, and discharge planning for consumers. To assist in the movement from one level of care to another within SCCMHA, or to obtain other needed services in order to promote consumer recovery and no longer requiring SCCMHA services.

Policy:
It is the policy of SCCMHA that services be focused toward the attainment of a level of functioning, habilitation, and recovery so that SCCMHA services are no longer needed.

It is the policy of SCCMHA that upon transitioning to other programs within the SCCMHA network, or consumers being discharged from the organization, that they receive assistance to assure that all needed services are in place to promote ongoing recovery.

Application:
Saginaw County Community Mental Health Authority and its network of service providers

Standards:
Transition and discharge planning begins upon intake into services and is an on-going theme throughout the duration of a consumer's active status with SCCMHA. Transition and discharge planning are critical for the support of the individual's ongoing recovery, resiliency and well-being.

Transition may include planned discharge or movement to a different provider within the SCCMHA network, through either natural changes in level of care or through consumer/family request.

The Transition Plan indicates what the consumer's life would be upon recovery or attaining habilitation. This plan will be a key consideration in the development of goals, program participation and services while an active SCCMHA consumer. The Transition Plan will be documented on the consumer's Psychosocial Assessment and Individual Plan of Service.

Planning for transition from and to any services will include early and active involvement by the consumer and the family. Additional resources and other community agencies that will be serving the consumer will be included.

Considerations for transitioning from or to a service include:

- The consumer's perception of progress with recovery goals, their preferences and dreams and desires.
- Aspects of the consumer's personality and reaction to change, including reducing any trauma or re-traumatization that could occur from the change that would need to be addressed.
- Identification of skills, needs, and gains achieved.
- Progress toward meeting the consumer's personal goals and recovery.
- Supports that will be needed both during and after the transition.

The Discharge Plan is a clinical document that includes information about the person's goals, services and reason for discharge. This document must be prepared when the person leaves services for any reason. Post discharge efforts will be made to contact consumers and/or their respective family/caregivers to gather any updated information.

For persons leaving services, the written discharge summary must include:

- The date of admission and the date of cessation of services
- The presenting condition(s) that mitigated services
- The extent to which outcomes were achieved
- The services provided
- The reasons for discharge
- The person's need for support systems or other types of services that will assist in continuing their recovery or well being
- Recommendations for services or supports
- Information on medications when applicable
- Identification of the person's current functioning defined by an interpretative summary:
    - Progress toward their own recovery or move toward well being
    - Gains achieved during treatment
    - Strengths, needs, abilities and preferences

Consumer discharge information will be reviewed to evaluate the effectiveness of services.

Definitions:
Consumer –An individual, youth, or adult, who is enrolled to receive services from SCCMHA directly or through a contracted service provider. This term may also include the family of the consumer as applicable.

Transition- For purposes of this document, transition may include a planned discharge, a status of inactive participation, change in level of service in terms of scope, duration and intensity, or re-entry into a forensic/criminal justice entity.

Service delivery process: The procedures and requirements for the providing of services.

Discharge: The cessation of service provision by SCCMHA.

Community agencies: These are services offered or provided that are not contracted with or funded through SCCMHA.

Referral sources: An entity that requests or refers the individual for services.

External programs/services: Private sector providers determined to be a certified deliverer of outpatient psychiatric/behavioral services and substance use treatment.

References:
CARF general program standards
SCCMHA Recovery Policy #02.03.05

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Initiates transition/discharge planning at the earliest point in service. Screening through Central Access Intake and Care Management Services to determine eligibility and referral to appropriate clinical service or evidence based practice.	*Centralized Access and Intake clinician assigned designated program or supervisor providing orientation. *Case /Record Holder *Treatment teams if consumer is assigned to an evidence based practice or best practice services to assist with recovery.

Orientation meeting with program supervisor for the purpose of welcoming and engaging consumers to begin the process of Person Centered Planning and eventual transition planning to the least restrictive setting. The orientation meeting will introduce the consumer to the treatment team.	Treatment Team/Supervisor Consumer/Family
Completes the transition/discharge screens in the electronic health record for persons transitioning to another provider or being discharged from SCCMHA.	Case /Record Holder in collaboration with the consumer, family members when applicable and referral sources
Makes follow up contact after transition/discharge to assure that needed services are in place	Case /Record Holder
Makes follow up contact after transition plan to determine from post-discharge status the effectiveness of services received or if additional services are needed when possible.	Administrators – Quality Assurance staff Supervisors Case/Record Holder
Reviews and signs the discharge plan	Supervisors Consumer/Family
Reviews discharge data such as the ANSA and LOCUS scores to assess the validation or indicate the challenges to the recovery process for the consumer and evaluate the effectiveness of clinical services provided to the consumer.	SCCMHA quality program

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Safe Transportation of Children and Teens</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.15</td></tr>
<tr><td rowspan="2">Effective Date:
1/5/07</td><td>Date of Review/Revision:
1/5/07, 6/8/07, 4/13/09, 9/14/09, 10/22/12, 4/7/16, 3/30/17, 3/1/18, 3/20/19, 3/27/20, 3/5/21, 3/3/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Director of Children’s Services

Authored By:
Carey Moffett

Additional Reviewers:
Clinical Directors, Brooke Maylee</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To establish policy for the safe transportation of children and teens while being transported by employees or contractors of SCCMHA.

Application:
All employees, volunteer, or contractors of SCCMHA and/or persons driving vehicles owned by SCCMHA.

Policy:
It is the policy of SCCMHA that all children and teens being transported by an employee or contractor of SCCMHA and/or in a SCCMHA vehicle will be transported meeting at least the minimal standards of the Michigan Child Passenger Protection Law.

Standards:

- Per the State of Michigan Children younger than age 4 need to ride in a car seat in the rear seat if the vehicle has a rear seat. If all available rear seats are occupied by children under 4, then a child under 4 may ride in a car seat in the front seat. A child in a rear-facing car seat may only ride in the front seat if the airbag is turned off.

- Children must be properly buckled in a car seat or booster seat until they are 8 years old or 4-feet-9-inches tall. Children must ride in a seat until they reach the age requirement or the height requirement, whichever comes first.

- Children being transported under the auspices of SCCMHA by employees, volunteers or contractors or using an SCCMHA vehicle will be properly secured in the vehicle during the operation of that vehicle following the rules and laws of the State of Michigan.
- It is the expectation of SCCMHA that children under the age of 12 be transported in the back seat of a vehicle when possible. It is required if the vehicle in use is equipped with a passenger side air bag.
- All passengers must wear a safety belt or use a safe transportation device.
- Children must be in an approved safe transportation device and must not be transported on another passenger's lap or buckled with another passenger into one safety belt.
- The vehicle operator will assure all teenage or adult passengers have properly secured their safety belt, snug and low across the hips prior to starting the vehicle.
- The vehicle operator must assure that safe transportation devices are properly installed according to the manufacturer's instruction as found in the owner's manual.
- The vehicle operator must assure that the safe transportation device used to transport children is an approved device.
- **Proper use of Safe Transportation Devices for Children:**
    - **Rear-facing Babies & Toddlers**
        - Keep infants in a rear-facing car seat in the back seat for as long as possible - up to the height or weight limit of the car seat. The "12 months and 20 lbs" rule often cited is the bare minimum to turn a child forward-facing. Rear-facing children are safest during transportation.
        - A child too large for an infant seat but under two (2) years of age or under 30-40 pounds (depending on the seat manufacturer's standard) should use a rear-facing convertible seat until reaching the weight/height limit allowed by the manufacturer or over age 2.
        - A rear-facing car seat should be semi-reclined so that the baby's head stays in contact with the seat and does not flop forward. This is important to keep the baby's airway open.
        - The shoulder straps should be through the slots at or below the child's shoulders.
        - Never put a rear-facing car seat in front of an active frontal airbag.
    - **Forward-facing Children**
        - When a child has outgrown the car seat's rear-facing weight or height limit, turn the child around to be forward-facing. The car seat should be in the upright position.
        - The shoulder straps should be through the slots at or above the child's shoulders.
        - Keep the child in a car seat with a full harness until they reach the weight or height limit of that seat (usually 40 lbs or 40 inches).
    - **Booster Age Children**
        - When a child outgrows the car seat, a booster seat must be used.

        - Always use the vehicle lap & shoulder belt with a booster seat, NEVER a lap belt only.
    - **For All Seats**
        - If your car seat has a harness, be sure the chest clip is at armpit level on your child.
        - Be sure the harness is snug on your child's shoulders, with NO slack.
        - Use the seat belt or LATCH system to lock the car seat into the car, but NOT both.
        - The car seat should not move more than one inch from side to side, or front to back. Grab the car seat at the seat belt or LATCH path to test for tightness.
        - Every car seat has an expiration date. Do not use an expired seat.
        - Never buy a used car seat if you do not know its full history.
        - Never use a car seat that has been in a crash.
        - Children should not wear bulky clothing under harness straps.
        - Do not use products that did not come with your car seat (in or with the seat).
        - Add-on toys can injure your child in a crash.
- SCCMHA staff will encourage families to follow the above standards.

Definitions:
None

References:
Safe Kids Michigan http://michigansafekids.org/car-seat-safety-info.htm
Michigan Secretary of State (www.Michigan.gov/sos)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
All units/agencies working with children will assure that the vehicles used to transport children are equipped with approved and properly installed safe transportation device(s), as required by law based on age of the child.	Supervisors
Any person using an Agency vehicle, or transporting a child under the auspices of SCCMHA, will assure that a safe transportation device is properly installed and functioning prior to transportation.	SCCMHA Staff and volunteers

All supervisors of staff working with children and teens will assure that any person transporting a child under the auspices of SCCMHA know the requirements of this policy and responsibilities when transporting children and teens.	Supervisors
When transporting a child in a vehicle as part of an SCCMHA activity or service, a child safe transportation device will be utilized as required by law and based on the age of the child.	SCCMHA Staff and volunteers

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Discharges for Assaultive, Aggressive, or Other Types of Disruptive Behavior</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.16</td></tr>
<tr><td rowspan="2">Effective Date:
6/1/08</td><td>Date of Review/Revision:
5/7/09, 7/8/10, 6/8/12, 5/27/14, 4/8/16, 3/17/17, 3/1/18, 2/25/19, 3/31/20, 3/29/21, 4/27/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Director of Services for Persons with Intellectual and Developmental Disabilities

Authored By:
Jennifer-Rieck-Martin

Additional Reviewers:
Clinical Directors, John Burages</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To establish the expectation that consumers will not be permanently discharged from services as a result of assaultive, aggressive, or other types of disruptive behavior.

Application:
SCCMHA Network of Providers

Policy:
Saginaw County Community Mental Health Authority (SCCMHA) serves persons with developmental disabilities, serious emotional disturbance, and/or severe mental illnesses (hereinafter referred to as "consumers"). Upon occasion, and due to a variety of factors, consumers may engage in assaultive, aggressive, or other types of disruptive behavior, and it is the policy of SCCMHA that doing so is insufficient reason for the termination of eligibility or permanent discharge from services.

Standards:
Persons deemed eligible for services are entitled to receive services regardless of the symptoms that they present. This applies to all services or programs that are under contract with SCCMHA or that SCCMHA is providing funding for the consumer to reside, participate, or attend that program, so long as the consumer meets the eligibility criteria for that service or program. These programs include but aren't limited to:

residential settings, day activity, applied behavior analysis, skill building, employment skill and work skill training, psycho-social, and transportation.

Careful planning may be required for persons who have a history of engaging in assaultive, aggressive, or other types of disruptive behavior when services are being provided to assure the protection of the individual and others and to assure the efficacy of the service or program being provided. This planning may include security alerts, behavior planning, environmental modification or other actions, but may not include permanent denial of those services, so long as the consumer meets the eligibility criteria for those services.
When a consumer engages in assaultive, aggressive, or other types of disruptive behavior at a service or program, immediate emergency steps may need to be taken to protect all individuals – consumer, other consumers, individuals in proximity, and staff - from harm. These steps can include program suspension, emergency physical intervention, and/or police intervention. Incident Reports must be filed for a behavior that results in emergency interventions.

When a consumer is suspended from a program or service, the suspension cannot exceed thirty (30) days unless approved by the SCCMHA Director(s) of Clinical Services or designee.

The purpose of the suspension is not punitive. It is to allow time to develop a plan to address the actions or needs required for the consumer to return to the service or program.

This plan will include an indication of how best to respond to that behavior and to assure the safety and efficacy of the service or program. This plan may include: utilizing one-on-one staffing; evaluation for hospitalization; temporary movement to crisis residential, etc. In most situations, the expectation is that the person will return to that service or program once the revised plan is in effect. Permanent exclusion from a program will not be an acceptable aspect of that plan.

When a consumer is temporarily suspended for assaultive, aggressive, or other types of disruptive behavior, a team meeting must be held within 5 working days to develop this plan.

Definitions:
Assaultive: A threat or attempt to inflict offensive physical contact or bodily harm on a person (as by lifting a fist in a threatening manner) that puts the person in immediate danger of or in apprehension of such harm or contact.

Aggressive: A forceful action or procedure (as an unprovoked attack) especially when intended to dominate or master.

Disruptive: An action by a consumer that does not fit within the definition for "Assaultive" or "Aggressive" that interrupt the normal routine and involves either the potential for harm to self or others or could initiate such action by self or others. These

behaviors include: threat or actual acts of destruction to items or property of self or others; actions that disturb the peace and routine such as inciting others to cause harm, instigation of others to engage in harmful behavior such as teasing, gossiping, yelling, screaming, name-calling, stealing or taking items, etc.; elopement from assigned locations; frequent calling ambulance, fire, or police; and public nudity.

References:
CARF Standard 2.D.1
CARF Standard 2.F.1.b

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Establishes the expectation that consumers will not be permanently discharged from any SCCMHA service for assaultive, aggressive, or other types of disruptive behavior.	CEO, Executive Director of Clinical Services
When a temporary suspension from an SCCMHA provided program occurs, case holder convenes a planning team meeting within 5 days to address the reason for the suspension and to assure that the consumer is not suspended for more than 30 days unless approved by the SCCMHA Director(s) of Clinical Services or designee.	Program Supervisor Case Holder or Director of SCCMHA provided program Behavioral Specialist Others as needed or required.

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Respite Services</td><td>Chapter: 03 – Continuum of Care</td><td>Subject No: 03.02.18</td></tr>
<tr><td rowspan="2">Effective Date:
1/1/06</td><td>Date of Review/Revision:
5/14/09, 6/8/12, 6/4/14, 3/30/17, 3/1/18, 3/20/19, 3/4/20, 4/22/20, 3/29/21, 3/3/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Director of Services for Persons with Intellectual and Developmental Disabilities

Authored By:
Erin Nostrandt

Additional Reviewers:
Matt Briggs, Carey Moffett, Amanda Elliott, Charlotte Fondren</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:

1. To ensure that appropriate respite services are available and accessible to all families in need of temporary relief from the care giving duties of those consumers with severe emotional disturbance and/or developmental disabilities.
2. To promote the principle that families and consumers with special needs merit supportive services to help protect the integrity of the family, prevent unnecessary, long term out-of-home placements, and that the least restrictive level of care is provided.

Application:

This policy applies to all components of the SCCMHA organization, including all business operations and all members of the SCCMHA provider network, contracted or board operated. SCCMHA will work closely with community partners in an effort to improve the type and availability of respite services for persons served.

Policy:

It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) that systemic efforts are made to support the respite needs of unpaid caregivers and families of consumers with disabilities. SCCMHA will implement a respite program which focuses on the needs of the unpaid caregiver and family. It is the belief of SCCMHA that respite services will provide needed support and relief for full-time unpaid caregivers, preventing possible abuse, neglect, and family discord due to the extreme stressors associated with caring for persons with disabilities. SCCMHA realizes that respite is a

proven prevention method for high-risk families and can be a significant support to our caregivers. It is further the intention of SCCMHA to create alliances with other community organizations that have a stake in family stability, enriching the availability and usefulness of the respite program.

Standards:

A. SCCMHA will ensure that staff and contractors are informed and reminded of the importance of the systemic goals regarding the access and provision of respite services.
B. SCCMHA will continually seek to ensure that respite needs, wants and goals of consumers and families served are fully explored and re-evaluated over time throughout the Person-Centered Planning process, considering all variables regarding behavioral and physical needs of the consumer inside and outside the home environment and at the least on an annual basis.
C. SCCMHA respite services will include planned hourly respite (in-home and community), planned out-of-home respite, crisis respite and camps.
D. SCCMHA will focus on the creation of community alliances that help to sustain and expand the funding and service availability of respite services across all consumer populations.
E. SCCMHA will seek creative and unique partnerships with area businesses and organizations that can mutually benefit from consumer patronage via respite outings and events.
F. SCCMHA will appoint service level coordinators of both camps and standard respite in the two major service populations – severe emotional disturbances and developmental disabilities.
G. SCCMHA will continually monitor, redirect, and procure new funds as available to assist families with additional respite services.
H. SCCMHA funding and service priorities and philosophy will emphasize least restrictive respite options to ensure family unity.
I. SCCMHA will require provider and organizational reporting on the usage of respite throughout the system.
J. SCCMHA will promote recruitment of external contracted agency-based respite providers (i.e., hourly staffing agencies) and facility-based respite opportunities within the SCCMHA service area and throughout the county.
K. SCCMHA will reimburse primary consumers and families for their involvement on SCCMHA administrative committees and boards for the purpose of revision and redesign of the respite service structure. Consumer assistance with transportation to support their involvement in these policy venues will also be made available as needed or requested.
L. SCCMHA will ensure that staff and providers are fully informed of respite policies, procedures, access, assessment, and service availability.
M. SCCMHA will sponsor an ongoing respite work group as needed, whose members will consist primarily of staff and contracted agencies. The role of the respite work group will be continuous oversight of SCCMHA administrative and service level respite goals and activities, as well as respite development and barrier identification and problem-solving.

N. SCCMHA recognizes that for all families, the level of respite service need changes and may need to be re-evaluated more frequently than annually, with families' levels of need increasing or decreasing according to various external supports available at any given time.
O. SCCMHA will coordinate effective use of resources and cooperatively address consumer respite needs with various community partners.
P. SCCMHA will continue to maintain an organizational goal of implementing a need-based respite service structure that falls within the current availability while consistently expanding the network of available services.
Q. SCCMHA will require respite service to be provided only by a contracted respite provider.

Definitions:

Respite: A temporary relief for [unpaid] caregivers and families (parents, grandparents, guardians) who are caring for people with disabilities or other special needs such as chronic or terminal illnesses.

Planned Hourly Respite: This type of respite is traditionally known as In-Home respite. While respite often does occur within the consumer's home, we have expanded this service to also include group and community activities, where a respite worker can take a consumer out of their home, into the community for such events as seeing a movie, dining at McDonalds, or visiting the local zoo.

Planned Out-of-Home Respite: This type of respite service is defined as a temporary out-of-home placement for a period of 1 to 14 days. A planned placement is a voluntary placement devoid of any court ordered intervention, which is scheduled with a minimum of 2-weeks notice. Traditionally, this type of overnight respite has occurred within a facility (group home or other), licensed foster home, medical center, or other similar type of setting. In addition, there have been rare occasions where a respite worker has stayed in the home with the consumer while the rest of the family takes a vacation.

Crisis Out-Of-Home Respite: This type of respite service is considered an emergency out-of-home placement and determined a crisis by the attending clinician or therapist. This type of respite service does not require advance notice but should be utilized in only the most extreme family situations. A crisis out-of-home placement would be subject to availability within a less restrictive environment; otherwise, a facility-based setting would be used.

Camps: Licensed traditional and non-traditional camps, including day camps and overnight camps well trained in various disabilities.

Contract Respite Provider: An organization that holds an active contract for respite services with SCCMHA. All respite services must be provided by a SCCMHA contracted provider.

Respite Worker: Individual employed by contract agency.

References:

Internal:

SCCMHA Policy- 02.02.06 Person-Centered Planning
SCCMHA "Respite Program and Service Guide- Staff Reference Guide"
SCCMHA "Family/ Caregiver Respite Program Guide"
SCCMHA "What You Need to Know About Me- A Child/Adolescent Guide For Families and Caregivers"

External:

Michigan Department of Community Health (MDCH) Medicaid Manual
National ARCH Respite, 2005
Connecticut Lifespan Respite Coalition, Inc., 2004
Detroit-Wayne County Community Mental Health, 1997

Exhibits:

Exhibit A - SCCMHA "Guidelines for Respite Care Providers"

Procedure:

ACTION	RESPONSIBILITY
Approves respite related policies and funding plans, and reports to SCCMHA Board on system outcomes and initiatives regarding respite services.	CEO
Ensure that consumer leadership committees and groups are given the opportunity for policy direction and service usage review regarding the respite services for consumers in the SCCMHA system.	CEO, Director of Clinical Services & Programs and Supervisor of Recipient Rights/Customer Services
Serves as lead SCCMHA Administrator for respite related matters. Appoints service level coordinators in both major population groups: severe emotional disturbance and developmental disabilities. Oversees system Person-Centered Planning process to include respite as a service area. Oversees training throughout the system on respite service availability, including changes in respite resources and/or requirements.	Director of Clinical Services & Programs
Participates on Respite Work Group. Coordinates service delivery with staff, providers, and families.	Respite Service Level Coordinators – Three Respite Coordinators in the Camp Program.
Disseminates respite policy through the network; assures provider reporting on respite services.	Director of Network Services & Public Policy, Contract

Maintains panel of respite provider organizations to meet consumer services and supports needs. Serves as administrative liaison to community partners and others on respite related grants and contracts.	Coordinator, Director of Clinical Services & Programs
Advises and reports on budgets and expenditure tracking, including grants, relative to respite services.	Director of Finance
Directs outcome reporting processes that include respite success data for persons served. Ensures respite is addressed in access, care management & quality areas. Oversees encounter and performance indicator data collection for respite success.	Director of Care Management & Quality Systems
Include respite service needs in Person-Centered Planning processes; ensure consumer choice in providers of respite services and supports.	Case Managers & Supports Coordinators
Provide family-focused respite services per SCCMHA referral. Work with consumer, case managers/support coordinators, and family to coordinate respite service implementation. Provide feedback to families and SCCMHA staff on family needs and consumer behavior during respite service provision. Record specific services delivered as required by the family and SCCMHA. Participate in SCCMHA services planning if requested by consumer/family.	SCCMHA Providers of Respite Services

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Exhibit A

Guidelines for Respite Care Providers

Revised August 2020 by kb

Service Description

Respite is a support offered for families with dependents who have serious emotional disturbance and/or developmental disabilities by Saginaw County Community Mental Health Authority (SCCMHA). Respite Services are provided to families who are primary, unpaid caregivers for a son, daughter, or ward (adult or child) who has a serious emotional disturbance or significant developmental disability. Respite care services are offered as a Medicaid benefit through the MDHHS Service Guidelines. This includes children participating in the MDHHS Children's Waiver program. The term "children" refers to people age 18 or younger. The term "adult" refers to people over the age of 18. Most participants have a relatively high level of need and require specialized respite services. Hourly Respite (in-home and community-based) is provided either in the consumer's home or in the community with an individual respite provider administering services on an hourly basis. Out-of-Home Respite is provided on a very short-term basis, typically over a weekend. Crisis Out-Of-Home Respite is considered an emergency out-of-home placement and determined a crisis by the attending clinician or therapist. This type of respite service does not require advance notice but should be utilized in only the most extreme family situations. Camps are available through the respite program and are coordinated through the local YMCA and other like camping organizations, with a mix of both day camps (daytime only) and overnight camps. Group Respite is provided in a "group" setting (i.e. more than one child per respite worker). This can occur most frequently when there are multiple consumers receiving respite care in one home.

The Michigan Department of Michigan Department of Health and Human Services (MDHHS) and/or SCCMHA authorizes specific numbers of hours of respite that can be used by the consumer and family in a given month. Funding is provided by the Michigan Department of Community Health and/or SCCMHA.

Services are provided by SCCMHA through provider agency contracts and/or a respite staffing agency in unlicensed settings or licensed facilities. The respite provider receives specialized training regarding providing care to people with disabilities, and through direct contact with the consumer and their family, becomes educated regarding the consumer's unique needs. Respite services are not intended to provide active skill training; however, a respite provider must still be able to meet the special needs of the consumer, including being able to assist with:

1) Eating, bathing, dressing, grooming, personal hygiene, and bathroom needs;
2) Ambulation/mobility, positioning and transfers;
3) Assistance with medications and/or treatments, such as oral feedings, limited respiratory treatment and skin care (where under contract requirements);

4) Assistance with communication;
5) Assistance with behavioral challenges; and
6) Assistance with medications.

The respite care provider is expected to provide the care necessary for the consumer to maintain a safe and healthy daily routine. Behavioral and medical interventions that have been outlined in the consumer's Individual Plan of Service are continued by the respite provider, to protect the consumer as well as others in the home. In some cases, respite is provided by Licensed Practical Nurses (LPN) or Registered Nurses (RN) due to the level of medical intervention that is required.

The family ensures that the provider has adequate clothing, personal care items, medications and treatments, adaptive equipment and money as needed for the consumer. The provider must have the means to contact the consumer's parent or guardian in case of emergency. Parents and guardians will give the provider written permission to access emergency medical care as needed and administer medications according to contractual guidelines.

If the consumer will be assisted by the provider with handling money or taking medications, the consumer or their parent/guardian, and the provider must agree in advance how the money handling will be documented and determine how medications need to be administered. Medications and treatments, including prescriptions and over-the-counter products, cannot be administered by respite care providers and/or agencies funded by SCCMHA unless the medications are in the original, pharmacy labeled containers, with written instructions by the consumer's physician.

Prior to starting services, the respite provider must be in-serviced by the consumer and/or their parent/guardian regarding the consumer's unique needs, including those activities of daily living the consumer is capable of performing themselves and those with which s/he requires assistance, and any medications or treatments required. The SCCMHA Staff Member (Supports Coordinator/Case manager) will provide all necessary documentation to inform the respite care provider of the consumer's needs, such as the consumer's Plan of Service, including the consumer's health and safety needs, medical conditions, and any behavioral interventions to be provided. SCCMHA will ensure the provider has access to a copy of the consumer's Plan of Service for reference. In addition, the respite provider agrees to read each consumer's Plan of Service prior to providing such respite services.

Consumer Choice

A person-centered approach is used for the planning and implementation of Respite services. Following person-centered planning principles means that the consumer is primary in day-to-day decision making, within the boundaries of health and safety, reasonableness, and cost effectiveness. For those under age 18, the family is primary in determining daily activities. Daily activities would include choice of meals, leisure activities, daily schedule, personal care preferences, and so on.

It is critical that family members and providers encourage independence. Providers must be careful to avoid projecting their preferences onto the consumer. The only circumstances in which a consumer choice should be overridden are situations where a guardian or parent has the legal authority to decide, or where there is an immediate risk to health and safety. Also, consumer choice does not mean the consumer may excuse themselves from performing activities which they are capable of performing or doing.

Service Authorization

A consumer's need for Respite is determined at a consumer person- centered planning meeting. Subsequent to the meeting, the SCCMHA Staff Member prepares a request for services, including the number of hours/units of respite needed. If the request is denied, a written explanation is provided and the consumer's parent/guardian has the right to file an appeal of the decision following Medicaid Appeal Criteria. In the case of the Children's Waiver, some requests may require the approval of the Michigan Department of Health and Human Services
The respite care provider's will be notified via Sentri of authorization of services.
Providers and consumers are not allowed to schedule respite hours that exceed the stated authorization. Hours that exceed the authorization will not be reimbursed by SCCMHA. SCCMHA staff will verify respite care provider billings against authorizations prior to processing of provider claims. All authorizations and services rendered are subject to audit by SCCMHA and MDCH.

Respite Care Provider Panel and Consumer Provider Selection

SCCMHA has established a panel of Respite Care Providers, through provider agency contracts and/or a respite staffing agency that can give consumers a choice of respite care providers. Agencies employ individuals who have been screened for criminal history, have completed the core direct care staff training, and have been interviewed to be an employee for the agency. New providers will be considered for employment by the staffing agency at the request of a consumer or by self-referral. Other adults living in the provider's home are not eligible to provide paid respite care to consumers, including guardians.

When Respite Care Services have been authorized, SCCMHA staff will consult with the consumer, his/her family and SCCMHA Staff and provider agency/ respite staffing agency, to select a provider from the available respite workers. Provider selection should be based upon consumer needs and provider capability. Respite hours are scheduled directly by the family with the selected respite care agency. Neither the consumer nor the provider can schedule respite care hours in excess of those authorized by SCCMHA.

The family and the consumer may choose any provider from the available staffing agency respite workers. However, if a family is making frequent changes, SCCMHA and the

staffing agency reserves the right to counsel a family regarding the potential risk to the consumer, especially if the provider changes appear unrelated to the consumer's needs.

SCCMHA and the staffing agency will make every effort to include an adequate number of respite workers to offer an array of choices that can be reasonably expected to meet the majority of consumer's needs. Consumers who have utilized and rejected all of the providers are considered to have exhausted their service options, unless they are understood to have a unique or highly specialized need that SCCMHA agrees the current provider cannot meet. In those cases, SCCMHA will work with the family to try to identify alternate providers.

Providers may refuse to serve a consumer and/or request that their services to an individual consumer be terminated if they feel they cannot meet the consumer's needs. The provider will give adequate advance notice of the termination to the consumer and to SCCMHA. Provider's who refuse to serve or terminate consumers deemed appropriate for this service by SCCMHA, and/or if the reason given by the provider is not deemed acceptable by SCCMHA, the provider contract may be terminated by SCCMHA. A consumer may request to receive a provider's services, and once services have been initiated, the consumer may request termination of the provider's services. Providers are not guaranteed a minimum or maximum amount of utilization of the provider's services by consumers unless authorized (SCCMHA reserves the right to modify/term authorizations with 30-day notice).

Provider Qualifications

The contract provider staff must meet the following requirements:

- ☒ They must have the capacity to provide the personal care, medical interventions, and/or behavioral interventions required by the consumer. They must have references who can describe their experience with the target population, if requested by SCCMHA or the family.

- ☒ They must be willing to participate in customer satisfaction surveys, physical plant reviews (if services provided in provider home) and unannounced home visits (consumer or provider) by SCCMHA staff to monitor health and safety issues, as well as overall service quality.

- ☒ The contract agency will carry no less than one million dollars in professional liability insurance to cover the respite worker who is assisting with the provision of respite care services. The respite worker will meet all the requirements that the contract agency deems necessary for in-home respite care (i.e., maintain a valid homeowners or renters insurance policy if providing services in his/her own home).

☒ Each respite worker that will be transporting a consumer will carry adequate auto insurance. Proof of all insurance will be provided to contract agency per their written contract with SCCMHA.

☒ The provider/respite worker must complete incident reports to document injuries, possible abuse, neglect, or significant incident(s) involving the provider and the consumer (forms are available through the SCCMHA Recipient Rights Office). Copies of incident reports must be forwarded to the SCCMHA Recipients Rights Office within forty-eight (48) hours of an occurrence and the Support Coordinator/Case Manager informed as soon as possible.

☒ Providers/respite workers will maintain ready access to items needed to provide care to the consumer in the case of an emergency, including a first aid kit, flashlight, battery operated radio, and any medical or food supplies needed, such as diabetic supplies and diapers.

☒ Respite workers must have an up-to-date TB test with acceptable results.

☒ The contracted organization respite workers, whether employed by said organization or other arrangement, must submit to and pass a criminal and drivers license background check.

☒ Respite workers must not have any substantiated Abuse Class II or III Recipient Rights violations under the Michigan Mental Health Code within the past year. Individuals with an Abuse Class I substantiated rights violation at any point in time will not be accepted for participation on the provider panel. The provider will sign a release of information as necessary for review of SCCMHA recipient rights claims.

☒ Respite workers must be trained in the following, at a minimum:

- Advance Directives
- Basic Medications
- Blood Borne Pathogens & Infection Control
- CPR
- Cultural Diversity
- Environmental Emergencies/ Fire Safety
- Ethics of Touch
- First Aid
- HIPAA Privacy
- HIPAA Security
- Limited English Proficiency
- Nutrition and Food Safety
- Person-Centered Planning
- Physical Intervention (if outlined in Plan of Service)
- Recipient Rights

- Working With People I
- Working With People II

☒ Respite workers must have a basic understanding of safe food handling practices, methods to use to avoid confrontations with consumers, and awareness of the need to maintain professional boundaries with consumers.

☒ Respite workers must have a good understanding of the consumer plan and the services the provider will need to perform to help or assist the consumer when providing care.

Contract Respite Provider must agree to immediately report any serious injuries, hospitalizations, deaths, unauthorized leaves of absence and/or allegations of abuse/neglect of consumers to the SCCMHA Support Coordinator/case manager and to the SCCMHA Recipient Rights Office. They must agree to comply with regulations regarding recipient rights as outlined in the contract with SCCMHA, including rules regarding confidentiality.

The provider must complete incident reports to document any of the above or any significant incident(s) involving the provider and the consumer (forms are available through the SCCMHA Recipient Rights Office). Copies of incident reports must be forwarded to the SCCMHA Recipients Rights Office within forty-eight (48) hours of an occurrence and the Support Coordinator informed as soon as possible.

Certification and accreditation are not required for overnight respite; however, providers who hold a Children's Foster Care License and/or an Adult Foster Care License (for participants over age 18) are preferred.

The provider must be available, within reason, to provide respite care services on demand. Providers must be available on weekends, holidays, and summer vacation periods to meet consumer needs for respite care. Providers who repeatedly cancel scheduled respite care services or refuse to accept consumers may have their contract terminated.

When the respite worker provides care in their own home or alternative location (any alternative locations pre-approved by the family before service occurs), that person's home or alternative location must meet the following standards:

☒ Be clean, and safe from obvious hazards, such as: unsanitary conditions; fire hazards; rodents; high crime areas; exposure to adverse weather; and dangerous machinery, equipment and/or chemicals.

☒ Equipment and supplies which are used for normal household activities are acceptable assuming normal safety precautions are taken and consumers are closely supervised if they will be handling the material;

- ☒ Not be in violation of any health and safety precautions defined in the consumer's support and service plan, such as exposing a consumer with allergies to identified allergens, not providing barrier free access for a consumer who uses a wheelchair and/or exposing the consumer to situations which would be considered by the general community as morally or socially inappropriate;

- ☒ Have enough space to provide the consumer with a private area for sleeping and personal care, and their own bed;

- ☒ The home must have telephone service and a reliable mode of transportation;

- ☒ The home must have identified fire exits and a written fire evacuation plan;

- ☒ The home must have all toxic materials, sharps, firearms, and any other items commonly recognized as weapons under lock and key; and

- ☒ The home must have the capacity to provide three meals per day which are nutritious and well balanced and meet the dietary requirements of the consumer.

- ☒ The home must meet the standards set forth by the contract respite provider agency.

Provider Documentation

The provider will prepare a HCFA1500 Claim Form reflecting the number of units (in minute increments) of respite care service provided each day of the month to a given consumer. Claims will be submitted to the SCCMHA Claims Department for processing. HCFA1500 Claim Forms must be submitted to SCCMHA within the timeframes specified in the provider contract. The information on the Claims Form must adhere to the requirements listed in Section 9 "Claims Processing" of this SCCMHA Service Provider Manual.

The provider must be able to prove services were provided by keeping a log or documentation of what services, activities, etc., were done during respite care service. This information is needed as proof documentation for event verification of billing submitted to SCCMHA. We need to see progress notes, medication logs, behavior data sheets, or treatment data sheets as acceptable proof documents. The progress notes should match the services explained in the consumer plan and should be dated to indicate the date of services provided. If the services in the plan do not match the services you put in your notes, Medicaid states it is not a Medicaid covered service. Therefore, the money will need to be paid back. If the plan does not specify what duties you are to perform for the consumer you should contact the Case Manager or Support Coordinator for the consumer to discuss this issue and make sure your duties are clearly spelled out in the plan.

The provider will keep on file, in confidential storage, any documents s/he have received regarding the care to be provided to the consumer, including authorization received from the family or guardian for access to emergency medical care and copies of Plans of Service.

Quality Assurance

The process of accepting providers for the panel will include a site visit by SCCMHA staff, including a review of the physical plant and the provider's compliance with the requirements outlined in this guideline. After services are initiated, the consumer will be asked to complete satisfaction surveys on a bi-annual basis to ensure the respite care services provided are meeting his/her needs.

The following defines minimum expectations for provider performance:

1) Consumers are satisfied with the Provider's service delivery as measured in SCCMHA issued consumer satisfaction surveys.
2) Services are delivered in accord with SCCMHA Guidelines for Respite Care Providers and the consumer's Plan of Service, as generated by the SCCMHA, as well as within the limitations specified in the MDHHS Children's Waiver Implementation Instructions.
3) Provider claims for payment are submitted to SCCMHA within 90 days of service.
4) The Provider has not exceeded the authorized respite care units for individual consumers served as authorized by SCCMHA and has delivered services at the agreed upon hourly rates.

Conservation of Respite Care Services

Participants are expected to request and utilize respite care services only as needed. Respite is a short-term service, and the consumer and his/her parents or guardian maintain primary responsibility for the consumer's care. Additional care needs that extend beyond the purpose of respite should be evaluated and alternate services should be sought (i.e., CLS services). Each consumer is encouraged to apply for any Home Help services available to them through the Department of Health and Human Services. Amounts of Home Help benefits received by the consumer will be considered when requests for authorization of Respite Care Services are processed. Providers who provide the SCCMHA funded respite care and MDHHS funded chore services for the consumer, will be given the MDHHS funds directly by the consumer, and will not bill SCCMHA for services already reimbursed through MDHHS Home Help funds.

Termination of Services

Changes in consumer eligibility status, violation of the Respite Care Services guidelines specified in this document, changes in the level of need for assistance and/or discontinuation of SCCMHA funding or authorizations may result in discontinuation of Respite Care Services. Families whose services must be terminated will be notified in advance in writing and given an opportunity to appeal the decision. Similarly, providers may be removed from the provider panel for poor performance or non-compliance with these respite service guidelines.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Structured Daytime Activity Programming	**Chapter**: 03 – Continuum of Care	**Subject No**: 03.02.21
Effective Date: 10/20/17	**Date of Review/Revision**: 2/25/19, 2/26/20, 3/11/21, 3/16/22	**Approved By**: Sandra M. Lindsey, CEO
	Supersedes:	
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Executive Director of Clinical Services **Authored By:** Jennifer Rieck-Martin and Julie Bitterman **Additional Reviewers**: Clinical Directors

Purpose:
The purpose of this policy is to formalize the process for Structured Daytime Activity Programming (SDAP). Structured Daytime Activity Programming is a type of programming to allow consumers to interact more with their community versus a center-based activity program.

Policy:
It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) that all consumers should be involved in activities that are meaningful to the consumer. For some consumers this means an alternative to the formal center-based activity program. Consumers may choose instead to develop skills within the consumer's community with the home staff in a structured daytime activity program.

Application:
SCCMHA Residential Providers, Case Holders, and Occupational Therapists

Standards:
- Consumers are allowed an alternative to community-based activity programming services.
- Consumers can attend a community-based activity program as well as structured daytime activity programming.
- The Structured Daytime Activity Programming will be provided by the AFC Home under contract with SCCMHA.

- Structured Daytime Activity Programming will be incorporated into the contract and each consumer will have a special set up in Sentri in order for case holders to request an authorization for this service.
- Structured Daytime Activity programming will be approved by the SCCMHA Clinical Director prior to the contract set up.
- An Occupational Therapist will evaluate and make recommendations for activities for the Structured Daytime Activity Programming based on a Structured Daytime Activity interest survey *(Exhibit A*). This evaluation will include how many hours *(not a range)* of community activities per day and number of days per week the structured daytime programming activities will occur based on consumer interest and consumer tolerance due to medical and/or physical limitations.
- During this process the Occupational Therapist can recommend other activities that are of interest to the consumer that can be provided in the home. These activities will be a part of the home staffing hours included in the contracted AFC per diem paid to the home/provider corporation. These activities will not be included in Structured Daytime Activities.
- Structured Daytime Activity Programming will be included in the Individual Plan of Service (IPOS).
- The number of hours of Structured Daytime Activity Programming with consumer specific start date will be sent to the SCCMHA Contract Department. (*Exhibit B)*
- Structured Daytime Activity Programming will be included in the Specialized Residential AFC Provider's contract with SCCMHA.
- Contract set up will include up to $40.00 per consumer per week to assist in payment of activities for consumers and if staff are unable to get in free then these dollars will help pay for staff. Please note that some events will allow for a consumer and the caregiver, and providers should attempt to obtain free caregiver tickets whenever possible. If a provider goes over the $40.00 one week then provider should adjust the next week activities to accommodate.
- Contract will include $25.00 for transportation expense.
- The documentation must include a start time of the activity and end time of the activity
- The contract rate will include cost of staffing and activities Provider will keep a separate schedule for Structured Daytime Activities. This calendar should reflect the same changes the provider would make to their regular schedule to accommodate any changes. The staff documenting SDAP activities should be consistent with the schedule. Daily progress notes should refer to SDAP on the date the SDAP occurred as verification of services provided.
- Occupational Therapist will evaluate the consumer interests to build a program that is meaningful to the consumer. (*Exhibit C)*
- The Contracted AFC home will have a structured daytime activity calendar posted for the consumer(s) noting each activity the consumer will participate in and when. (*Exhibit D)* This activity calendar will be separate from the community outings that are required as part of the Licensed Residential AFC Contract with SCCMHA and any other programming required by contract with SCCMHA which is four activities per month outside the home.

- The Contracted AFC home will use the attached data sheets (*Exhibit E)* for tracking activities. This data sheet will include both those that were participated in and those that the consumer chose not to participate in and why.
- Case Holders and Occupational Therapists will assure that the number of Structured Daytime Activity hours is noted in the consumer plan with specific activities noted and the frequency and duration. *Note activities should be at least 45 minutes in duration unless team and Clinical Director approval has been obtained to complete less than 45 minutes of SDAP services.*
- Occupational Therapists and Case Holders will monitor that the programming is occurring happening and that consumers are not limited to only the community inclusion activities that are part of the structured day time activity programming as each provider contract does include the need for-4 community outings per month as part of the contract with SCCMHA.
- Occupational Therapists and Case holder will adjust the programming as needed to account for consumer changing needs.
- Residential provider will keep a calendar of activities separate from their activities that are part of their Residential contract with SCCMHA.
- Residential provider will pay for any meal that is part of the consumer room and board fee paid by consumer SSI/SSDI.
- Residential provider will assure appropriate documentation is kept as audit proof of services rendered.
- Residential Provider, Case Holder, and Occupational Therapist will notify contracts if consumer is hospitalized, or is in an extended care facility or the consumer is unable to attend SDAP for more than a week.
- Residential Provider shall ensure service delivery once the contract is in place without interruption. Occupational Therapists will submit Daytime Activity in Residential Setting: noted hours per consumer no later than August of each year so that consumer needs can be updated every year in the provider contract. (*Exhibit B)*

Definitions:

Structured Daytime Activity Programming- is programming that has been designed with an Occupational Therapist to fit the needs of the consumer that are community-based activities. These activities are different than the outings that should be offered as part of the Specialized Residential contract with SCCMHA.

** Please note in order to be considered an appropriate Structured Daytime Activity

a. Must be a reasonable duration. Longer than 45 minutes.
b. The consumer needs to be actively involved or engaged in 50% of the activity. So if going to the store the consumer must be involved in picking out the items, making choices, paying for items if appropriate, etc.
c. Shopping trip cannot be part of the homes regular shopping i.e. Grocery shopping, filling up vehicle, picking up prescriptions from the pharmacy.
d. Activities should be meaningful to the consumer. Staff and home business related activities are not acceptable.
e. Only one food focused outing per week.

References:
None

Exhibits:

A. Structured Daytime Activity Interest Checklist
B. Structured Daytime Activity Programming: Noted hours per consumer
C. Structured Daytime Activity Programming Post Activity Satisfaction Indicator
D. Structured Daytime Activity Calendar -Sample
E. Structured Daytime Activity Programming- Planner & Log
F. Structured Daytime Activity Programming Sample Planner
G. Structured Daytime Activity Programming Sample Log

Procedure:

ACTION	RESPONSIBILITY
Discuss the option of alternative to center-based activity programming with the Consumer	Case Holder
Discuss consumer desire to have Structured Daytime Activity Programming as an alternative to center-based activity with Clinical Director. This discussion may also be taken to the Residential Watch Committee Meeting for discussion.	Case Holder/Case Holder Supervisor/Clinical Director
Discuss consumer's desire and approval by Clinical Director with Occupational Therapist.	Case Holder
Completes a structured daytime activity interest checklist. *(Exhibit A)*	Occupational Therapist
Devise a schedule and a budget for Structured Daytime Activity Programming and submits to Health Supervisor who will obtain Clinical Director Approval and then forward to Contracts Manager. (*Exhibit B*)	Occupational Therapist/Enhanced Health Supervisor
Add Structured Daytime Activity Programming to consumer plan with number of hours and number of days a week the consumer will be engaged in Structured Daytime Activity Programming.	Case Holder
Revise the Specialized Residential Home Contract to include Structured Daytime Activity Programming.	Contracts Department
Submit Authorization for consumer to Care Management by using the Contract Setup.	Case Holder
Approve Authorization for Structured Daytime Activity Programming.	Care Management

In-service Structured Daytime Activity Programming to the Residential staff.	Occupational Therapist
Create a schedule for Structured Daytime Activity Programming that is separate from the residential Hours schedule. Adjust SDAP schedule as you would home schedule.	Residential Provider
Create a Structured Daytime Activity Programming Calendar that is separate from the required four outings per month per new home and community-based waiver rules and SCCMHA Policy.	Residential Provider
Follow and document the Structured Daytime Activity Programming as outlined by the Occupational Therapist. All documentation has to have a start and end time	Residential Provider
Review home and Structured Daytime Activity Programming schedules at least monthly.	Residential Provider
Review data weekly to assure staff document correctly moving to monthly as appropriate. 1. Will monitor consumer participation to the plan and will notify case holder and Contracts and Properties Manager of any changes needed to the plan and the contract. 2. If consumer needs one to one staffing for Structured Daytime Activities that it is clear who the assigned staff for the consumer is through schedule and documentation.	SCCMHA Contracts and Properties Manager Occupational Therapist
Auditing department will audit any new program on a quarterly basis. To assure all involved are clear on the expectations of this program.	SCCMHA Auditing Unit
Review data monthly to assure staff document correctly. Things to watch for are: 1. Monthly Calendar of Structured Daytime Activities is separate from the activities that should be offered under specialized residential contract. *Per policy and SCCMHA contract the clients must have 4 outings a month as a residential Provider through SCCMHA. The SDAP outings must be beyond these outings.* 2. Things not considered as Structured Daytime Activities as noted above**. 3. Outing appropriateness 4. Start and end times of activities are being recorded.	Case Holder

5. If consumer needs one to one staffing for Structured Daytime Activities that it is clear who the assigned staff for the consumer is through schedule and documentation. 6. Will notify Occupational Therapist and Contracts and Properties Manager if the number of outings the consumer participates in or the frequency changes so that the contract can be adjusted. 7. Will assure that outings include receipts and will monitor for the $40.00 (or amount agreed upon in the provider contract) activity allowance that is noted in the contract.	
Submit data sheets weekly to the Occupational Therapist moving to monthly as appropriate and as noted by the Occupational Therapist.	Residential Provider
Review staff schedules to assure appropriate amount of staffing is noted on the schedules based on hours specified in the contract.	Contract and Properties Management Unit
Submit annually in August Exhibit B to Contracts Department. This is to assure that any updates in consumer Structured Daytime Activities are noted in the contract every year. Things that might change are the amount of weekly activity budget. Number of hours per outing and number of days per week for outings.	Occupational Therapists
Review Structured Daytime Activity Programming as part of the annual audit process and more frequently when necessary.	SCCMHA Auditing Unit

Exhibit A

STRUCTURED DAYTIME ACTIVITY INTEREST CHECKLIST

Consumer Name: _____

Consumer ID number: _____

Date: _____

Signature of person completing inventory: _____

Activity	What has been your level of interest? In the past ten years			Do you currently participate in this activity?		Would you like to pursue this in the future?	
	Strong	Some	No	Yes	No	Yes	No
Social/Entertainment							
Playing cards							
Church activities							
Holiday activities							
Movies							
Speeches/lectures							
Visiting							
Parties							
Television							
Concerts							
Musuem/parks							
Senior Center							
Eating out/go for coffee							
Politics							
Clubs/Lodge							
Scouting							
Attending plays							
Dating							
Barbecues							
Home							
Shopping							
Home decorating							
Home repairs							
Housecleaning							
Cooking/baking							
Laundry/ironing							
Child care							
Car repair							
Sports/Exercise							
Walking							
Dancing							
Golf							
Football							
Swimming							

STRUCTURED DAYTIME ACTIVITY INTEREST CHECKLIST

Activity	Continued What has been your level of interest? In the past ten years			Do you currently participate in this activity?		Would you like to pursue this in the future?	
	Strong	Some	No	Yes	No	Yes	No
Bowling							
Wrestling							
Cycling							
Tennis							
Basketball							
Camping							
Fishing							
Auto racing							
Hunting							
Special Olympics							
Scouting							
Hobbies							
Gardening/yard work							
Sewing/needlepoint							
Puzzles							
Checkers/chess							
Reading							
Traveling							
Model Building							
Pottery							
Bingo							
Table games							
Handicrafts							
Hairstyling							
Woodworking							
Fashion							
Collecting							
Leather work							
Photography							
Painting/drawing							
Recycling							
Library							
Singing							
Diving							
History							
Science							
Foreign languages							
Listen to radio/music							
Writing							
Pets/livestock							
Dancing							
Bird watching							

STRUCTURED DAYTIME ACTIVITY INTEREST CHECKLIST

Please name 3 things the individual likes: _____

_____

_____

Name 3 things the individual doesn't like: _____

_____

_____

_____

Time of day when at his/her best (most awake with energy): _____

_____

_____

_____

Number of hours of activity tolerated per day: _____

Number of hours of activity tolerated per week: _____

Exhibit B

Structured Daytime Activity Programming: Noted hours per consumer.

This form is used to indicate the number of hours the consumer(s) will be participating in Structured Day Time Activity Programming in lieu of participation in a Center Based Activity Program. Once completed please submit to SCCMHA Contracts Department.

Home Name: _____

Occupational Therapist Assigned: _____

Consumer Initials	Community Activities # of hours and number of days per week	Notes	Total Hours per week
Sample	2 hours/day, 3 days/week Monday-Friday = 10 hours/ week	Requires 1:1 staffing out in the community	

Total hours per week needed in contract: _____

Weekly Activity Budget needed per consumer on Structured Daytime Activity Programming (include activity as well as gas allowance): _____

Please note SCCMHA will pay $40.00 per consumer per week. Anything outside this parameter needs to be approved through SCCMHA Residential Watch Committee.

Outlined Community Activities list per individual need to be monitored weekly by Occupational Therapist						
Consumer Initials	**Sample**					
Community Activity ideas	Park, children's zoo, mall walk, dollar store, lunch outing, painterly pottery, Frankenmuth walk, loons game, bay city museum, fair, Concert, bike ride, Dow Gardens.					
	Sample					
In home activity ideas	Puzzles, Playing board games, Uno, Going for a walk around the block,					

Exhibit C

STRUCTURED DAYTIME ACTIVITY PROGRAMMMING

Post-Activity Satisfaction Indicator

Consumer Name: _____ Consumer ID number: _____

Date of Activity: _____

Activity: _____

Start Time of Activity: _____ End Time of Activity : _____

Location of Activity: _____

Staff person assisting with Activity: _____

RESPONSE INDICATOR:

VERBAL: **Circle Appropriate Indicator**

Did the individual like the activity? **Yes** **No**

What did the individual like best about the activity? _____

_____

What did the individual like least about the activity? _____

_____

What type of activity is being refused, if any: _____

BEHAVIORAL:

The individual:

-was engaged in the activity	**Yes**	**No**
-smiled during the activity	**Yes**	**No**
-demonstrated resistance to any element of this activity	**Yes**	**No**

Explain: _____

_____

STAFF OBSERVATION:

Rate the individual's level of enjoyment of this activity using the scale below. Please circle the appropriate response.

Rating Scale:
1 – Dislike
2 – Neutral
3 - Like

Exhibit D

STRUCTURED DAYTIME PROGRAMMING ACTIVITY CALENDAR

Consumer Name: _____

January 2016

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
						1 GROUP WALK at SAGINAW TOWNSHIP REC CTR
2	3	4 Baking cookies	5	6	7 MOVIE & POPCORN NIGHT	8 Swimming at the YMCA
9 BAKING NIGHT	10	11 Painting	12	13	14 DOLLAR BILL STORE	15
16	17	18 CURRENT EVENTS NIGHT	19	20 LIBRARY	21	22 SHRINE CIRCUS
23 SNOW FESTIVAL-FRANKENMUTH	24	25	26 DISCUSSION ABOUT HEALTHY FOOD CHOICES	27	28 DOLLAR BILL STORE	29
30 SUPER BOWL SUNDAY	31					

ksl 1/18/05 JJK 7/2/14

Exhibit E

Structured Daytime Activity Programming - Planner & Log

Consumer: **Case#:**

Provider: **Month & Year:**

Activity Expectations:

Date	Planned Activity	Refused	Start Time	Stop Time	Staff Signature	Consumer Repsonse 1-Dislike 2-Neutral 3-Like
		☐ Y ☐ N				
Narrative:						
		☐ Y ☐ N				
Narrative:						
		☐ Y ☐ N				
Narrative:						
		☐ Y ☐ N				
Narrative:						
		☐ Y ☐ N				
Narrative:						

HM Review: OT Review: CM Review:

The **Structured Daytime Activity Programming (SDAP) Planner & Log** is intended to be a stand alone document that satisfies the requirements of several allied parties, including: Providers, Home Managers, Case Holders, and Occupational Therapists. This form is intended to be used for scheduling and planning SDAP, along with recording actual SDAP activities as they occur. A breakdown of each section of the form is included below, and users of this form are reminded to reference the Structured Daytime Activity Programming policy for additional clarification.

ACTIVITY EXPECTATIONS: This language should be taken directly from the Consumer's plan of service, specifically stating the number of activities to be scheduled per day or week, and the maximum allowed length of time for each activity. Consumer plans of service should indicate which Consumers require one-to-one SDAP, and which Consumers are able to receive SDAP by one staff supervising two or more Consumers at the same time, and this information should also be included in this area.

DATE: Before each month begins, Home Managers should fill in the dates of anticipated activities, making sure to not include weekend dates. SDAP services cannot be performed on Saturdays and Sundays, as activities scheduled on these days should be covered under regular Residential Community Living Support services.

PLANNED ACTIVITY: Activities should be planned in advance based on recommendations from the Consumer's plan of service, along with feedback generated from the SDAP Interest Checklist completed by the OT. Home Managers need to consider that activities should be planned for at least 45 minute blocks of time, and should occur outside the Specialized Residential setting.

REFUSED: After offering the planned SDAP to the Consumer, staff need to record whether the activity was refused (Y), or occurred as planned and was not refused (N).

NARRATIVE: This should include a progress note on the SDAP activity, including specifics about where the activity took place, what the consumer did during the outing, how SDAP funds were used, etc. If the Consumer refused the activity (Y), notes should be made in the Narrative box as to why, and an alternate activity should occur and be recorded in the Narrative section.

START TIME/STOP TIME: The start and stop time of services must be recorded, using am or pm as appropriate, and reflect the SDAP lasted for at least 45 minutes.

STAFF SIGNATURE: The staff who carried out the SDAP must sign for service delivery. It is implied that staff providing SDAP are Direct Care Workers (DCW), and as such do not need to include a title with their signature. Any staff who is not a DCW, like a Home Manager or Assistant Home Managers, should include their title with their signature.

CONSUMER RESPONSE: This area is for rating Consumer satisfaction with the SDAP they participated in. Feedback given, like repeated 2 or 1 ratings for similar activities, should be used to direct future planning efforts and ensure planning focuses on Consumer preferences.

HM/OT/CM/SC REVIEW: To ensure SDAP services occur as outlined in Consumer plans, appropriate parties should be reviewing and signing the SDAP Planner & Logs. Information gathered on the logs, like continued refusals of one activity, activities cut short due to low Consumer stamina, not offering activities identified in the SDAP Interest Checklist, etc. should be used to generate discussion and improvement of each Consumers SDAP goal within their plan of service.

Exhibit F

Structured Daytime Activity Programming - Planner & Log

Consumer: BOB BARKER **Case#:** 0101010101

Provider: ABC HOME **Month & Year:** OCT-2017

Activity Expectations: 2 days/wk, 2hrs/activity – must be 1:1

Date	Planned Activity	Refused	Start Time	Stop Time	Staff Signature	Consumer Repsonse 1-Dislike 2-Neutral 3-Like
10/10	BOWLING	☐ Y ☐ N				
Narrative:						
10/12	PUTT PUTT GOLF	☐ Y ☐ N				
Narrative:						
10/17	SWIMMING	☐ Y ☐ N				
Narrative:						
10/19	UBTCATM	☐ Y ☐ N				
Narrative:						
10/24	MOVIE	☐ Y ☐ N				
Narrative:						
10/26	BOWLING	☐ Y ☐ N				
Narrative:						
10/31	TRUNK OR TREAT	☐ Y ☐ N				
Narrative:						

HM Review: OT Review: CM Review:

Exhibit G

Structured Daytime Activity Programming - Planner & Log

Consumer: BOB BAKER **Case#:** 0101010101

Provider: ABC HOME **Month & Year:** OCT-2017

Activity Expectations: 2 days/wk, 2hrs/activity – must be 1:1

Date	Planned Activity	Refused	Start Time	Stop Time	Staff Signature	Consumer Repsonse 1-Dislike 2-Neutral 3-Like
10/10	BOWLING	☐ Y ☒ N	9:00 AM	11:00 AM	Amy Keen	3
Narrative: BOB LOVED GOING EARLY WHEN THERE WERE NO CROWDS. WENT TO STARDUST - PAID $11.50 FOR TWO GAMES, SHOE RENTAL, AND A POP.						
10/12	PUTT PUTT GOLF	☐ Y ☒ N	10AM	11:30 am	Sue Smith	2
Narrative: Took Bob to Kokomos in Saginaw. He had fun at first, but got hot as the morning went on. We spent $13 on golf, and then $5 in the arcade so he could cool down inside.						
10/17	SWIMMING	☒ Y ☐ N	8:30 am	10:30 am	Sue Smith	3
Narrative: Refused swimming after two offers. Bob went to the arcade at the mall instead. It was empty because we went early, and he loved not having to wait for games. Spent $10 on tokens						
10/19	LIBRARY	☐ Y ☐ N				
Narrative:						
10/24	MOVIE	☐ Y ☐ N				
Narrative:						
10/26	BOWLING	☐ Y ☐ N				
Narrative:						
10/31	TRUNK OR TREAT	☐ Y ☐ N				
Narrative:						

HM Review: **OT Review:** **CM Review:**

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject:
Consumer Transition Planning</td><td>Chapter: 03 – Continuum of Care</td><td>Subject No: 03.02.26</td></tr>
<tr><td rowspan="2">Effective Date:
1/23/13</td><td>Date of Review/Revision:
4/2/14, 5/19/14, 4/7/16, 3/22/17, 3/1/18, 4/2/19, 3/5/20, 3/11/21, 4/27/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Steve Gonzalez

Additional Reviewers:
Residential Watch Committee, Program Coding/Compliance Specialist, Wardene B. Talley</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to assure that Transition Planning for consumers moving from one residential setting or situation occurs as part of the Person-Centered Planning process and to better prepare for changes in consumer living arrangements and support systems, whether this transition is voluntary or involuntary.

Application:
This policy applies to all SCCMHA-funded providers of mental health and substance abuse services.

Policy:
It is the policy of Saginaw County Community Mental Health Authority that the primary goal of Transition Planning is to obtain a residential setting that best compliments the needs, desires, and goals of the consumer, rather than placement to fill an available opening.

It is the policy of Saginaw County Community Mental Health Authority that Transition Planning begins at the onset of services as part of the Person-Centered Planning process and continues as part of that process through the duration of consumer services with Saginaw County Community Mental Health Authority.

It is the policy of Saginaw County Community Mental Health Authority that, when at all possible, a detailed Transition Plan will be developed prior to any residential move. This plan should include, as is feasible, the following elements:

1. Use of the person-centered planning process to involve the consumer and his/her allies in determining the consumer's desires and preferences regarding where to live, work, and be involved in meaningful activities.
2. Consider the consumer's method of communication in order to ensure he/she has the opportunity to express choice and control and so that caregivers providing service in that setting can communicate with the consumer.
3. Focus on building relationships based on trust, respect, and caring between the consumer and caregivers.
4. Establish a daily structure in the residence and include the consumer in this planning step. Minimizing change in daily structure adds a level of comfort to the consumer and can help prevent behavior escalation.
5. Prior to moving into the new residence, the consumer should be presented with two or three opportunities to visit the new home in order to become familiar with the home, housemates, and caregivers. It is helpful to have at least one of the same experienced caregivers at every visit to help the consumer build a relationship. The caregivers should also visit the consumer in his/her current setting prior to placement.
    a. On the occasion where a visit to the home by the consumer is not feasible, then the consumer's family and assigned case holder should visit the home and the new care givers/staff, as is feasible, should visit the consumer in his/her current residence.
6. Develop strategies to orient the consumer to his/her new home in order to prepare him/her for the move. Examples include providing pictures of the home, caregivers, and housemates, having a scrapbook of activities that will take place in the home, involving the consumer in choosing decorations for his or her bedroom, etc.
7. Provide consistent experienced and well-trained caregiver, especially during the first few weeks after the move.
8. Assure the CMHSP and the provider is accessible and supportive of home caregiver, including on-site visits to the home.
9. Schedule regular meetings with the CMHSP, provider, and caregivers after the consumer moves into the home to troubleshoot, plan for the future, and further train caregivers. It is recommended to meet with the home staff biweekly for the first two months to provide support, catch problems early and reinforce training.

Standards:
Saginaw County Community Mental Health Authority will provide assistance, as needed, or requested, in consumer residential transitions.

Saginaw County Community Mental Health Authority recognizes that residential transition can be stressful times for consumers and needs to respond to those events with adequate and appropriate services and recognition for the consumer's needs, desires, and preferences. This includes consideration of the following:

- Physical location: If he/she likes quiet areas, walking in the woods, and gardening, perhaps a rural or suburban location would be preferred. If he/she likes walking in the neighborhood, interacting with lots of people and community activities, perhaps a place in town and on the bus route would be best.

- Physical plant: Some people may need the home to be accessible, and some people may prefer their own room. While sometimes related to sensory issues, many individuals are sensitive to lighting, activity, and noise levels. They may also be sensitive to visual clutter.

- Group homes: If the person is excitable, he/she will likely need a calm, quiet atmosphere. Some people will need lots of varied activities, while others may prefer quiet activities and early bedtimes. An individual who is passive and vulnerable needs protection from someone who is more intrusive or emotionally fragile.

- Staffing: Some individuals more positively react to caregivers who are his/her own age and gender. It is also important to make sure the right caregivers are in place for the individual with the necessary training and expertise needed to support him/her well.

Transition Planning will include direct input from the consumer, guardian, family members, community members, providers, and others to assure transition planning meets the needs, desires, and preferences, as feasible, of the consumer.

Definitions:
Transition Planning is the process of obtaining a complimentary match for the consumer with the place he/she will live, the people who will live with him/her, and the people who will support him/her.

References:
Michigan Department of Health and Human Services Administration Person-Centered Planning Policy and Practice Guideline 3/15/2011

CARF Standards: 2.A.3.b; 2.A.24.h; 2.B.8.d.(1). d.(iv); 2.C.2.e.(3); 2.D

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Assures that Transition Planning is part of the Person-Centered Planning process at the on-set of services	Case Holder

In the event that a consumer requires a move from one residential setting to another, a detailed transition plan will be developed following the policy and standards indicated in the policy: 1. Use of the person-centered planning process to involve the consumer and his/her allies in determining the consumer's desires and preferences regarding where to live, work, and be involved in meaningful activities. 2. Consider the consumer's method of communication in order to ensure he/she has the opportunity to express choice and control and so that caregiver providing service in that setting can communicate with the consumer. 3. Focus on building relationships based on trust, respect, and caring between the consumer and caregivers. 4. Establish a daily structure in the residence and include the consumer in this planning step. Minimizing change in daily structure adds a level of comfort to the consumer and can help prevent behavior escalation. 5. Prior to moving into the new residence, the consumer should be presented with two or three opportunities to visit the new home in order to become familiar with the home, housemates, and caregivers. It is helpful to have at least one of the same experienced caregivers at every visit to help the consumer build a relationship. The caregiver should also visit the consumer in his/her current setting prior to placement. a. On the occasion where a visit to the home by the consumer is not feasible,	Case Holder

then the consumer's family and assigned case holder should visit the home and the new caregivers. In turn, caregivers, as is feasible, should visit the consumer in his/her current residential setting. 6. Develop strategies to orient the consumer to his/her new home in order to prepare him/her for the move. Examples include providing pictures of the home, caregivers, and housemates, sharing a scrapbook of activities that will take place in the home, involving the consumer in choosing decorations for his or her bedroom, etc. 7. Provide consistent experienced and well-trained caregivers, especially during the first few weeks after the move. 8. Assure the CMHSP and the provider is accessible and supportive of home staff, including on-site visits to the home. 9. Schedule regular meetings with the CMHSP, provider, and home caregivers after the consumer moves into the home to troubleshoot, plan for the future, and further train caregivers. It is recommended to meet with the home caregivers biweekly for the first two months to provide support, catch problems early and reinforce training	

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Behavior Treatment Plans (BTPs)	**Chapter**: 03 – Continuum of Care	**Subject No**: 03.02.27
Effective Date: 5/16/14	**Date of Review/Revision**: 1/21/16, 4/7/16, 3/17/17, 3/1/18, 3/7/19, 3/2/20, 3/30/21, 5/10/22	**Approved By**: Sandra M. Lindsey, CEO
	Supersedes: Behavioral Plans	**Responsible Director:** Director of Services for Persons with I/DD
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Authored By:** Barb Glassheim, Char Fondren **Additional Reviewers**: SCCMHA Behavior Treatment Plan Review Committee

Purpose:
The purpose of this policy is to set forth requirements for the development and implementation of behavior treatment plans (BTPs) in accordance with current standards of care as promulgated by Mid-State Health Network PIHP, MDHHS, as well as applicable state and federal statutes.

Application:
This policy applies to all supports and services delivered to consumers under the auspices of SCCMHA.

Policy:
All SCCMHA-funded providers shall adhere to a culture of gentleness and the provision of positive supports, the promotion of dignity and respect, and the provision of a safe and therapeutic environment for all consumers. Ensuring the availability of necessary supports, services and resources for consumers and their families fosters the development of safe environments for staff and consumers and minimizes the use of restrictive and/or intrusive behavior management interventions and thus the potential for traumatizing or re-traumatizing consumers. Positive supports and Culture of Gentleness approaches shall be first-line interventions for shaping behaviors.

Standards:
A. The person-centered planning (PCP) process, used to develop an individualized plan of service (IPOS), will, when warranted, identify the need for a behavior treatment plan (BTP).
    1. Assessments shall be conducted during this process to rule out potential physical, medical, or environmental causes of deleterious behavior as well

as the identification of previous unsuccessful attempts to alter the target behavior using positive behavioral supports and interventions.

2. The Case Holder and/or BTP author/provider, whenever possible, shall collect behavioral baseline data for a period of at least one (1) month.

   NOTE: If baseline data is not presented to the Behavior Treatment Plan Review Committee (BTPRC) with the request for a BTP, the BTPRC may require this to be gathered before moving forward.

3. BTPs shall be approved by the consumer, or his/her guardian on his/her behalf if a guardian has been appointed, or the parent with legal custody of a minor.
4. A functional behavior assessment (FBA) shall be conducted to rule out physical, medical, or environmental causes of the target behavior(s).
5. BTPs must be accompanied by evidence of the types of positive behavior supports or interventions that have been attempted but proven unsuccessful in reducing/eliminating the target behavior(s) *prior* to initiating restrictive or intrusive techniques, which are *always* considered a last resort.
   a. BTPs that include such interventions must be approved by the SCCMHA BTPRC.
6. BTPs shall not include physical management in non-emergent situations, aversive techniques, or the use of seclusion or restraint in a setting in which these are prohibited by law.

B. The primary goal of all behavior treatment interventions and/or treatment plans shall be to maximize opportunities for growth and development of the consumer, incorporating positive and proactive strategies.

   NOTE: Positive support tends to be most successful when programs are developed around an individual consumer's needs and demonstrated abilities.

   1. Procedures in Exhibit A (Behavior Modification Procedures that do not Require a Behavior Treatment Plan or Authorization by SCCMHA Administration or the SCCMHA BTPRC) are preferred; these can be used by staff without prior authorization by SCCMHA administrative staff or the BTPRC.

C. SCCMHA provider staffing ratios and training must be adequate to support the effective implementation of a BTP.

D. BTPs shall be formulated, implemented, and monitored in accordance with SCCMHA policies, as well as those of MSHN and MDHHS, and federal guidelines, regulations, and laws.
   1. BTPs shall be formulated in a manner that utilize the least restrictive/intrusive methodologies and behavior modification techniques as possible using a hierarchy of least to most restrictive.
      a. In all cases, the rights and privileges of consumers shall be safeguarded, including the right to safe and effective treatment.

E. BTPs shall be developed to address a consumer's Recurring Behavior(s) of Concern (RBCs), the primary aims of which shall be to increase and promote healthy (i.e., adaptive and prosocial) behaviors.

F. Emergency Interventions (see definition below) are prohibited from being part of any plan to address consumer behavior.

1. Emergency interventions may only be used as a last resort when there is imminent serious risk (i.e., an event/action that is about to occur is highly likely to result in potential harm to self or others).
    a. If all other less restrictive measures have failed, staff should implement the least restrictive techniques necessary in accordance with SCCMHA's approved physical intervention policy to maintain safety and avoid injury (per Reference C).
2. Emergency procedures may never be employed as punishment, for the convenience of staff, or as a substitute for therapeutic programming.
3. Any use of physical interventions must be documented on an "Incident Report Form" (DCH-0044 (W) 05/08) and provide evidence that there was no alternative available for preventing physical harm to the recipient, to others, or for preventing the imminent destruction of property. (See Reference K, SCCMHA Policy 04.01.02 – Incident Reporting and Review.)
    a. The completed Incident Report form shall be submitted to the SCCMHA Recipient Rights Office within one (1) business day.
4. If a consumer repeatedly requires the use of emergency physical intervention, the consumer's interdisciplinary treatment team must meet to address the use of emergency procedures, evaluate the BTP or the need for such a plan, and request a review by the Behavior Treatment Plan Review Committee (BTPRC). (See Exhibit H, Request For Use of Restrictive or Intrusive Interventions in a BTP.)
5. BTPs sent to the BTPRC shall be accompanied by:
    a. The results of assessments performed to rule out relevant physical, medical, and environmental causes of the target behavior on the Case Holder Recurring Behavior of Concern Checklist form (Exhibit I).
    b. A functional behavior assessment that includes strengths and challenges.
    c. Results of inquiries about any medical, psychological, or other factors that might subject the individual to intrusive or restrictive techniques that are known to have a high risk of death, injury, or trauma.
    d. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration, that have been attempted to ameliorate the behavior and that have proven unsuccessful.
    e. Evidence of continued efforts to find other options.
    f. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention (i.e., evidence-based treatments or practices).
    g. References to relevant literature.

1). Interventions with limited or no support in the literature should include a rationale for why the plan is the best option available.

h. A plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

G. The following techniques (see Definitions section below) for the control or management of consumer behavior are expressly prohibited:

1. Mechanical or material devices designed to restrict the movement of a consumer (with the exception of inpatient hospital settings).
2. Seclusion/isolation (with exception of inpatient hospital settings).
3. Denial of a basic need such as a nutritional diet, drinking water, or essential, safe, and appropriate clothing
4. Aversive procedures or techniques.
5. Fear-eliciting procedures.
6. Mechanical restraints.
7. Prone immobilization.
8. Any behavior modification or treatment modification that is implemented by another consumer.
   a. While, consumers are not permitted to implement another consumer's behavior plan, positive interaction with peers that may inadvertently be construed as positive reinforcement is considered appropriate.
9. Experimental medications.
10. Corporal punishment.

H. Behavior treatment plans must never be:

1. Used as punishment tool
2. Developed for the convenience for staff
3. Used as a substitute for other more clinically appropriate and effective interventions

I. While the goal of behavior treatment interventions is to maximize opportunities for promoting the growth and development of the consumer, there are times when the consumer's behavior presents a serious risk to the consumer or other persons or otherwise interfere with the learning process and thereby impede that growth and development and thus warrant the use of more restrictive or intrusive techniques or interventions. Under such conditions, these procedures may not only be necessary, but represent the only viable way to make available the consumer's right to habilitation. If positive approaches have been attempted and have not been successful in sufficiently promoting desirable behaviors, restrictive techniques may be considered to be a reasonable therapeutic approach.

1. A formal treatment plan is necessary for restrictive and/or intrusive procedures.
   a. Each BTP shall identify the target behavior, treatment objectives, proposed interventions.
   b. Each BTP must include special written consent, particularly if it proposes the use of restrictive or intrusive interventions. (See Exhibit C)

1). Consent must be provided in writing by the individual, their legal guardian, the parent with legal custody of minor child, or designated patient advocate, and supervising clinician.

2. In all cases, a hierarchy of least to most restrictive techniques will be followed. (See Exhibit B)
3. BTPs that propose the use of restrictive or intrusive techniques must be reviewed and approved SCCMHA BTPRC *prior* to implementation.
4. Plans must include ongoing tracking of target behavior(s) for frequency of occurrence.

J. The author/provider of the plan shall be responsible for preparing data on the frequency on behavior(s) targeted into a summary format/report and presenting this to the BTPRC which reviews cases on quarterly basis at minimum..

K. BTPs shall be individualized and tailored to each consumer's needs and circumstances.

L. BTPs must be documented in the consumer's electronic health record:

4. A BTP shall be part of the IPOS, but shall require special consent of individual and/or guardian. (See Exhibit C)
5. All planned interventions shall be outlined in in the consumer's BTP.
6. Implementation of a BTP shall be documented in progress notes in the consumer's electronic health record in a timely manner.
7. The effectiveness of a BTP shall be reviewed on periodic basis of no less than every ninety (90) days, in accordance with SCCMHA policy, and documented in the consumer's electronic health record.

M. After BTPRC approval of the BTP, the author and/or provider of the BTP will facilitate staff training regarding assigned responsibilities for implementing the BTP. the behavior treatment plan.

1. The author/provider will submit a training log to SCCMHA after conducting staff training.

N. During scheduled home visits, the Case Holder and BTP author will routinely collect and review the data being tracked in the home and monitor the behaviors and interventions.

1. This data review will take place on at least a monthly basis.
2. Any data sheets remaining in the homes will be sent to the Case Holder and BTP author; a copy shall be retained in the home.

O. A formal written BTP is necessary when medications are used for behavior control and/or for the purpose of behavior management.

1. Whenever behavior-modifying medications are employed by an SCCMHA physician/psychiatrist to eliminate maladaptive or target behaviors, the consumer's electronic health record shall include documentation of the fact that less restrictive procedures of modifying or replacing the behaviors have been demonstrated to be ineffective.
2. Medications shall not be used as:
    a. Punishment.
    b. For the convenience of staff.
    c. As a substitute for therapeutic programming.

d. In quantities that interfere with an individual's developmental program.

3. The need for a referral for behavior-modifying medications shall be a decision made by the consumer's interdisciplinary treatment/care and support team.
4. A behavior-modifying medication which offers the most effective treatment for the maladaptive or problem behaviors exhibited by the consumer shall be selected.
5. When possible, only one (1) behavior-modifying medication should be prescribed for a consumer at any given time for behavior control.
    a. When two (2) or more behavior-modifying medications are prescribed for behavior control, the prescribing physician shall document the justification as well as the rationale for the concomitant use of two (2) or more medications in the consumer's electronic health record.
6. If medications are used for behavior modification and medications are an integral part of a consumer's plan, the plan should be created by the person-centered interdisciplinary treatment team to assure the least restrictive treatment, and ultimately the reduction and/or elimination of medications, being utilized.
    a. A plan for titrating and eliminating the medications shall be documented as part of the plan.
7. A psychiatric evaluation shall be conducted whenever a psychiatrist is prescribing psychotropic medications to control behavior.
8. Dosage levels shall not ordinarily exceed those specified in one of the following: manufacturer's recommendations (package insert), Physician's Desk Reference (PDR), American Society of Health-System Pharmacists (ASHP) Formulary Service, AMA Drug Evaluation, or GenRX.
    a. The medical rationale shall be documented in the consumer's electronic health record if dosage levels prescribed are higher than the maximum recommended dose.
9. The medication regimen must be individually determined by considering the consumer's need, age, sex, weight, physical condition, comorbid illnesses and/or general health conditions, other medications and any previous adverse reaction to medication.
10. The consumer, parent of a minor child, or empowered guardian shall be advised of the medication's known side effects orally and in writing and shall be instructed to report the occurrence of possible side effects to the prescribing physician or nurse.
11. The effects of the medication on the consumer's behavior and on the target symptoms shall be recorded in the consumer's electronic health record.
    a. When the consumer's behavior or target symptom has stabilized and there is a need for long-term maintenance medication, the physician shall document the clinical rationale for that need in a progress note.
12. A consumer's medication change shall be accompanied by a doctor's note by the prescribing physician documenting the rationale for the change.

13. The concurrent use of multiple psychotropic drugs within the same class is discouraged.
14. SCCMHA discourages the long-term use of anticholinergic agents when used concurrently with antipsychotic agents.
    a. The physician/psychiatrist shall document the justification/rationale for use of an anticholinergic agent in the consumer's electronic health record.
    b. Extrapyramidal symptoms (EPS) may be treated with an anticholinergic agent.
        1). The consumer shall be gradually weaned from the anticholinergic agent until it is discontinued.
        2). The anticholinergic agent shall not be reinstated unless the consumer again exhibits EPS.
15. The AIMS (Abnormal Involuntary Movement Scale) shall be administered to consumers who are prescribed medications that have the potential to produce or to contribute to Tardive Dyskinesia.
    a. The AIMS shall be administered by a physician or registered nurse (RN) at the time the psychotropic medication is initiated and at least quarterly thereafter, for the duration of the prescription of the medication.
        1). The results shall be documented in the consumer's electronic health record.
16. When a physician prescribes an antipsychotic agent for a consumer for longer than three (3) months, the physician shall weigh the benefits of continued use of the antipsychotic agent against the risks of its long-term use, and shall document the basis of the decision, either to continue or discontinue the anti-psychotic medication in the consumer's electronic health record.

P. Any use of psychotropic medications for behavior control purposes that may result in limitations of the consumer's rights must be reviewed and approved by the BTPRC.
1. Any limitation must be justified, time-limited, and clearly documented in the consumer's IPOS.
    a. Documentation must describe attempts that have been made to avoid limitations, as well as what actions will be taken to as part of the plan to ameliorate or eliminate the need for the limitations in the future (per Reference C).
2. PRN medications shall be used as a last resort to manage deleterious behaviors.
    a. BTPs shall be considered first-line interventions for harmful behaviors.
    b. PRN medications shall not be used to control or ameliorate potentially harmful behaviors in the absence of a valid psychiatric diagnosis and without a review by the SCCMHA BTPRC.

c. PRN medications administered in response to harmful behavior(s) that are unrelated to a psychiatric condition shall be considered emergency interventions.

d. PRN medications shall never be used as a means of punishment, for the convenience of staff, or as a substitute for other appropriate treatment.

3. Intensity Scale for PRN Medication:

8. Before administering PRN medication for behavior, proactive strategies delineated in a BTP or Positive Support Plan should be implemented and documented on ABC data sheets. (See Exhibits D and E for examples.)

9. A Behavior Intensity Scale (Exhibit F) can be implemented to help staff use proactive strategies for target behavior(s) and to identify the function of the behavior(s).

10. The impact of PRN medications shall be tracked to ascertain their effectiveness. (See Exhibit G)

Q. Intrusive and/or Restrictive Techniques used for Behavioral Modification in Plans:

1. The BTPRC must review and approve or disapprove any plans that propose to use restrictions or intrusive interventions.

NOTE: According to MDHHS, intensive supervision may fall under the category of Intrusive/Restrictive techniques if it intrudes upon the consumer's personal space by being less than arm's length or results in restricting a consumer's access to physical or environmental areas that would be accessible if the supervision was not present

2. If one-one-one (1:1) or two-on-one (2:1) staffing is requested and approved by BTPRC, the role of the 1:1 and/or 2:1 must be clearly defined in the IPOS and the BTP.

a. The 1:1 staff should be aware of precursors or warning signs which may include, for example, pacing, making noises which sounds like heavy breathing which can lead to yelling or screaming (that becomes increasing louder).

R. Review of Proposed Behavioral Treatment Plans:

1. BTPs in emergency situations:

a. Behavior treatment interventions for unprecedented and unpredicted crises or emergency occurrences of seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of harm will be the least restrictive and least intrusive needed to prevent imminent harm.

NOTE: The most frequently-occurring example of the need for expedited review of a proposed plan in emergent situations occurs as a result of AFC licensing rule R400.14309 Crisis Intervention, which states: "Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been

insufficient time to develop a specialized intervention plan to reduce the behavior causing the crisis. If the individual requires the repeated or prolonged use of crisis intervention procedures, the licensee must contact the individual's designated representative and the responsible agency to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan."

b. If expedited review of a proposed BTP is requested in an emergent situation, the BTPRC will review and approve or deny the proposed plan within forty eight (48) hours.

c. Expedited plan reviews may be requested, when, based on data presented by the professional staff (psychologist, RN, supports coordinator, therapist, case manager), the plan requires immediate implementation.

1). The BTPRC Chair may receive, review, and approve such plans on behalf of the BTPRC.

a) The BTPRC Chair will consult with the BTPRC psychologist to arrange for immediate review.

b). The Recipient Rights Officer will be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan.

d. Upon approval, the plan may be implemented.

1). All plans approved in this manner must be reviewed in full at the next scheduled BTC meeting.

2. Initial review of a proposed BTP:

a. The author of the plan will submit a full assessment based on the consumer's entire electronic health recording including historical information.

1). The assessment will include, but not be limited to, the following:

a). Results of assessments performed to rule out physical, medical, and environmental causes of the problem behavior.

b). Any medical, psychological or other issues which might place the consumer at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.

c). Evidence of the kinds of less intrusive and positive behavioral supports or interventions, including their amount, scope, and duration that have been attempted and proved to be unsuccessful.

d). Evidence of continued efforts to find other options.

e). Peer-reviewed literature or practice guidelines that support the proposed intervention or, if there is a lack

of evidence in the literature to support the intervention, an explanation of why the intervention is the best option available.

f). A plan for monitoring and staff training to assure consistent implementation and documentation of the intervention.

3. Approval and Implementation of a proposed BTP (see Exhibit J):
   a. The Behavioral Evaluation (Functional Behavioral Assessment) and BTP must be approved by the BTPRC prior to implementation.
   b. Re-evaluation will be completed at minimum during quarterly (90-day) reviews to determine if there are changes needed to the annual BTP and prior to any addenda or changes to the existing plan.
   c. Addenda to the BTP must be approved by the BTPRC *prior* to implementation *if* additional restrictive or intrusive techniques are proposed.
      1). BTP addenda without additional restrictive or intrusive techniques must be forwarded to the BTPRC for review but can be implemented as soon as signed consent is received from the individual/guardian.
   d. The BTPRC shall not approve any plans that have not been developed with an analysis of the causes of the behavior or a determination regarding positive behavioral supports and interventions have been adequately pursued and proven unsuccessful.
4. Quarterly reviews of BTPs (see Exhibit K):
   a. All cases will be reviewed at least quarterly.
      1). The BTPRC may conduct reviews on a more frequent basis often as needed.
   b. The BTPRC discussion, rationale, recommendations, next scheduled review, and decisions will be documented in the committee's meeting minutes.
   c. The attendance of BTPRC members will be taken electronically upon review of each case.
      1). In the event that a committee member is unable to attend the review meeting, they (or their designee) will have up to forty eight (48) hours to review the notes and mark their decision of for, against or abstain in the minutes and sign the document.

Definitions:

Anatomical Support: Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a consumer's physical functioning.

Applied Behavior Analysis (ABA): The practice of applying the psychological principles of learning theory in a systematic way to modify behavior. The practice is used most extensively in special education and the treatment of autism spectrum disorder (ASD), but also in healthcare, animal training, and even business. ABA is widely recognized as the

only scientifically valid therapy available for treating behavioral issues associated with ASD (autism spectrum disorder).

Aversive Techniques: Techniques that require the deliberate infliction of unpleasant/aversive stimuli (i.e., those that would be unpleasant and may often generate physically painful responses in to the average person or would have a specific unpleasant effect on a particular person) to achieve the management or control of a target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist, or other noxious substance to consequate[1] target behavior or to accomplish a negative association with a target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. Aversive techniques that consist of clinical methods and practices established in peer reviewed literature and prescribed in a behavior treatment plan that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques. Otherwise, use of aversive techniques is prohibited.

NOTE: SCCMHA prohibits the use of aversive interventions by any staff member (employee) or contracted provider staff member.

Behavior Assessment/Functional Analysis: A precise description of a consumer's behavior, its context and its consequences, with the intent of better understanding the behavior and those factors influencing it. A behavior assessment/functional analysis must occur prior to the establishment of a Behavior Treatment Plan. The behavior assessment/functional analysis addresses the following issues associated with identified target behaviors: environmental and contextual factors (antecedent, behavior, and consequence), and the consumer's skill and/or performance deficits. Additionally, the target behavior(s) is identified and the frequency, duration, and/or intensity of the target behavior(s) is assessed.

Behavior Management: The exercise of strategies for the control or treatment of problem behavior to achieve therapeutic objectives using a variety of recognized techniques which are based on general behavior theory, verbal directions, physical guidance, physical management, and medications.

NOTE: It is the policy of SCCMHA to employ behavior modification treatment techniques rather than behavior management techniques when the technique used is not needed to assure safety.

Behavior Modification: The systematic application of principles of general behavior theory to the development of adaptive and/or elimination of problem behavior consistent with therapeutic objectives. Interventions used for behavior modification include, but are not limited to, applied analysis of behavior, schedules of reinforcement, token systems, cognitive therapy, self-control therapy, social skills training, modeling, shaping, fading, generalization, relaxation training, systematic desensitization, stimulus control, positive practice, and contingency management.

Behavior Treatment Plan (BTP): Treatment methods encapsulated in a plan written for the purpose of changing targeted behavior through specific behavior modification methods.

Behavior treatment is the intervention used with target behavior(s) to achieve therapeutic

[1] According to the American Psychological Association this is a verb that means to establish a consequence to a behavior. If the behavior becomes more probable, consequation is said to have resulted in reinforcement. If the behavior becomes less probable, consequation has resulted in punishment.

objectives using a variety of recognized techniques. The terms "Behavior Treatment Program" and "Behavior Treatment Plan" are used interchangeably. All BTPs are individualized and are based on the results of a behavior assessment. Prior to implementation, as appropriate, individuals and/or their families/guardians are educated about, and must agree to participate in, behavior treatment. Those participants will then take part in identifying antecedents to, and consequences of, the target behavior(s) and must agree to the target behavior(s) and treatment interventions before the BTP can be put into effect. BTPs must be developed through the person-centered planning process and be approved by the individual, or his/her guardian on his/her behalf if one has been appointed, or the parent with legal custody of a minor. Behavior treatment interventions identify, teach, and support the acquisition and reinforcement of identified adaptive/replacement behaviors. Behaviors being treated are assessed to determine that appropriate behavior is exhibited.

NOTE: In conjunction with affiliate data collection and reporting activities, SCCMHA reviews and monitors the use of behavior treatment interventions in order to assess and improve treatment efficacy.

Behavior Treatment Plan Review Committee (BTPRC): A specially constituted committee whose primary function is to oversee the proposed use of any intrusive and restrictive techniques that might be considered as a last resort to be used on consumers.

Bodily Function: The usual action of any region or organ of the body.

Consent: A written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.

Emergency Interventions: There are only two (2) emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and a request for law enforcement intervention.

Emotional Harm: Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.

Expedited Review: A review and approval or denial of a proposed BTP by the BTRPC within a short time, such as forty eight (48) hours.

Functional Behavior Assessment (FBA): An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a particular behavior and guide the development of an effective and efficient behavior treatment plan. The focus of an FBA is to identify social, affective, environmental, and trauma-informed factors or events that initiate, sustain, or end a target behavior. A physical examination must be conducted by a licensed physician (MD or DO) to identify biological or medical factors related to the target behavior. This assessment provides insight into the function of a behavior, rather than just focusing on the target behavior itself, so that a new behavior or skill will be developed to provide the same function or meet the identified need. The FBA should integrate medical conclusions and recommendations. Functional assessments should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.

Imminent Risk: An event/action that is about to occur that will likely result in the serious physical harm to oneself or others.

Intensive Supervision (One-On-One or Two-On-One Enhanced Staffing): The use of additional staffing, either in number of staff or duration of their presence, that is contingent on a target behavior as identified in a BTP, where the additional supervision intrudes upon the consumer's personal space by being less than arm's length or results in restricting consumer access to physical or environmental areas that would be accessible if the supervision were not present.

Intrusive Techniques: Techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug used to manage or control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition.

NOTE: Use of intrusive techniques as defined here requires the review and approval of the SCCMHA BTPRC Committee.

Medical and Dental Procedures Restraints: The use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint can only be used as specified in the individual written plan of service for medical or dental procedures.

Non-physical Interventions: Strategies that promote a culture of gentleness and teach staff to help an individual calm before a situation escalates. Use of these techniques is required prior to implementing physical intervention. Different techniques will be used depending on the situation, but staff should be consistent in their actions. These techniques include proactive options, communication skills, confrontation avoidance, and de-escalation. They should be used regularly and naturally during interactions with individuals who display challenging behaviors.

Peer-Reviewed Literature: Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

Person-Centered Planning (PCP): A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by continued direct physical contact to prevent the individual from seriously harming himself, herself, or others.

Note: Physical management shall only be used on an emergency basis when the situation places an individual or others at imminent risk of serious physical harm.

Positive Behavior Support (PBS): A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious, or other targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, teaching new skills, and making changes in a person's environment. PBS combines valued outcomes, behavioral and biomedical science, and validated procedures as well as systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction. PBS is most effective when implemented across all environments, such as home, school, work, and in the community.

Positive Support: A person-centered process that considers the function of the recurring behavior of concern and develops supports to promote positive social interactions; support for communication; support for meaningful activity; provision of predictable and consistent environments; support to establish and maintain relationships with family and friends; provision of choice; encouragement of more independent functioning; support for personal healthcare; an acceptable physical environment; mindful and skilled carers; effective management and staff support; and effective organizational context. (Adapted from McGill, 2015)

Practice or Treatment Guidelines: Treatment or intervention recommendations published by professional organizations such as the American Psychiatric Association (APA), or the federal government.

Proactive Strategies in a Culture of Gentleness: Strategies within a PBS plan used to prevent seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of physical harm from occurring or for reducing their frequency, intensity, or duration. Supporting individuals in a culture of gentleness is an ongoing process that requires patience and consistency. As such, no precise strategy can be applied to all situations. Some examples of proactive strategies include unconditional valuing, precursor behaviors, redirection, stimulus control, and validating feelings.

Prone Immobilization: Extended physical restraint of an individual in a face down (prone) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position for the purpose of control.

NOTE: SCCMHA PROHIBITS PRONE IMMOBILIZATION UNDER ANY CIRCUMSTANCES.

Protective Device: A device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of a behavior. A protective device that is incorporated in written individual plan of service is not considered to be a restraint (as defined below).

Psychotropic Drug: Any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior.

Reactive Strategies in a Culture of Gentleness: Strategies within a PBS plan used to respond when individuals begin to feel unsafe, insecure, anxious, or frustrated. Some examples of reactive strategies include reducing demanding interactions, increasing warm interactions, redirection, giving space, and blocking.

Recipient Rights: A person who receives services from the PIHP (pre-paid inpatient health plan) region, or an agency or provider under contract with the PIHP region, has the same rights, benefits, and privileges as a person who is not receiving mental health services, including rights guaranteed by the Michigan Mental Health Code (MMHC), except when

divested or limited by a court, statute or rule, and/or voluntary agreement of the recipient or person legally empowered to consent on behalf of the recipient.

Recurring Behavior of Concern: When a consumer repeats a behavior, or a set of behaviors, that are culturally abnormal and of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or the behavior is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities (Adapted from Emerson, 1995).

Request for Law Enforcement Intervention: Calling emergency services (9-1-1) and requesting law enforcement assistance with an individual exhibiting a seriously aggressive, self-injurious or other behavior that places that individual or others at risk of physical harm. Law enforcement should be called for assistance only when caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection; safe implementation of physical management is impractical; and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

Restraint: The use of a physical device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.

Restrictive Techniques: Techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques include: limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the BTPRC.

Seclusion: The temporary placement of an individual in a room, alone, where egress is prevented by any means. Seclusion is prohibited except in a hospital or unit operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

Serious Physical Harm: Physical damage suffered by a consumer that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

Special Consent: The written consent of the consumer, their legal guardian, the parent with legal custody of a minor child, or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the recipient, guardian, or parent of a minor recipient may only occur when the recipient has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Michigan Mental Health Code.

Support Plan: A written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.

Target Behavior(s): A behavior or behaviors that are the focus of treatment in a BTP.

Targeted Case Manager (CSM)/Supports Coordinator (SC): The designated staff person whose primary function is to plan, coordinate, link, and monitor the delivery of services and supports identified in the individual's approved BTP.

Therapeutic De-escalation: An intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the recipient is placed in an area or room, accompanied by staff who shall therapeutically engage the consumer in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

Timeout: A voluntary response to the therapeutic suggestion to a consumer to remove himself or herself from a stressful situation to prevent a potentially hazardous outcome.

Treatment Plan: A written plan that specifies goal-oriented treatment or training services, including rehabilitation or habilitation services, which are developed in partnership with and provided for a consumer.

Unreasonable Force: Physical management or force that is applied by an employee, volunteer, or agent of a provider to a consumer under one or more of the following circumstances: (1) There is no imminent risk of serious or non-serious physical harm to the recipient, staff, or others. (2) The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency. (3) The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service. (4) The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.

References:

A. 1997 federal Balanced Budget Act at 42 CFR 438.100
B. Mid-State Health Network Behavior Treatment Plans Policy revised 1/12/21: https://midstatehealthnetwork.org/application/files/6216/1063/4850/Quality_Behavior_Treatment_Plans.pdf
C. MDHHS Behavior Treatment Plans Review Committee FAQs: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900-552435--,00.html
D. MDHHS Behavior Treatment Plans Technical Requirement: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900-552435--,00.html
E. Michigan Medicaid Provider Manual
F. Michigan Mental Health Code, Public Act 258 of 1974
G. SCCMHA Policy 02.02.14 – Restraint and Seclusion
H. SCCMHA Policy 03.02.09 – Behavior Treatment Plan Review Committee (BTPRC)
I. SCCMHA Policy 03.02.20 – Medication Review
J. SCCMHA Policy 03.02.30 – Use of PRN Psychotropic Medications in Mental Health Settings
K. SCCMHA Policy 04.01.02 – Incident Reporting and Review

Exhibits:

A. Behavior Modification Procedures that do not Require a Behavior Treatment Plan or Authorization by SCCMHA Administration or the SCCMHA BTPRC

B. Behavior Modification – Intrusive and Restrictive Procedures
C. Behavior Treatment Plan Special Informed Consent
D. ABC Data Sheet Example
E. Intensity ABC Data Sheet Example
F. ABC Data Analysis Sheet Example
G. Example PRN Medication Tracking Tool
H. Request For Use of Restrictive or Intrusive Interventions in a BTP
I. Case Holder Recurring Behavior of Concern Checklist form
J. BTC Review form
K. Behavior Intervention Plan (BIP) Quarterly Review form

Exhibit A

Behavior Modification Procedures that do not Require a Behavior Treatment Plan or Authorization by SCCMHA Administration or the SCCMHA BTPRC	
Behavior Chains	A sequence of stimuli and responses that end with terminal behavior, such as forward chaining, backward chaining, and total task chaining. • Forward Chaining is a procedure where the behavioral sequence is broken into small steps and a person is trained in a series of steps from the initial step in the sequence to the final step. • Backward Chaining is a procedure where the behavioral sequence is broken into small steps and a person is trained in a series of steps from the final step in the sequence to the initial step. • Total Task Chaining is a procedure where the behavioral sequence is broken into small steps and a person is trained in all steps simultaneously.
Differential Reinforcement	The delivery of reinforcement after an appropriate behavior, and/or incompatible behavior other than the target behavior, is displayed, resulting in the decrease of the target behavior. **Differential Reinforcement of Other Behavior(s) (DRO)** - is a procedure where any behavior other than the target behavior is reinforced on a periodic schedule **Differential Reinforcement of Alternative Behavior(s) (DRA)** - is a procedure where an alternative or competing behavior to the target behavior is reinforced on a periodic schedule **Differential Reinforcement of Incompatible Behavior(s) (DRI)** - is a procedure where a behavior that cannot be emitted at the same time as the target behavior is reinforced on a periodic schedule **Differential Reinforcement of Low Rates of Behavior(s) (DRL)** -is a procedure where the infrequent occurrence (rate) of a target behavior is reinforced **Differential Reinforcement of High Rates of Behavior(s) (DRH)** - is a procedure where the frequent occurrence (rate) of a target behavior is reinforced
Extinction	Is the systematic elimination of potential reinforcement following a particular behavior. This is often accomplished by staff pretending that a behavior did not occur by ignoring it.
Fading	The gradual change of stimulus control. Fading is used to foster independence by eliminating control that prompts have had over a person's behavior.
Instructional Control	The delivery of information about the incorrectness/inappropriateness of a person's behavior. Such instructions may be affected through manual guidance of the person. Such instructions may be affected through manual guidance of the person through the correct response, a prompt, or verbal statement such as "yes" or "no", "correct" or "wrong". Instructional control is not considered restrictive.
Interruption	Is the use of a verbal cue to break in upon an action, e.g. "Please, Stop! You may not spit on the floor."

Low Stimulation	Is a consumer's voluntary response to the therapeutic suggestion to remove himself/herself from a stressful situation to prevent a potentially hazardous or undesirable outcome.
Non-contingent Reinforcement	Is the delivery of a reinforcer that is not dependent upon the occurrence or non-occurrence of a target behavior.
Positive Practice	A procedure in which a person behaving inappropriately, is requested to and voluntarily complies with, repeated practice of desirable behavior following the occurrence of an inappropriate behavior. For example, the person is required to practice asking for help instead of throwing work materials.
Positive Reinforcement	The presentation of a stimulus or occurrence of an event, contingent upon a specific response, that results in an increase of the frequency of occurrence of the response.
Prompting	An additional discriminative stimulus that is presented in order to cue the person to perform a specified behavior. Prompts may be verbal, gestural, or involve physical guidance. a. Verbal prompts are defined as oral sounds or sign language signs presented to a person to cue performance of a specific task b. Gestural prompts are defined as pointing, hand movements, or other body movements presented to a person to cue performance of a specific task c. Physical prompts are defined as non-restrictive physical contacts with a person, using no significant physical pressure, to cue performance of a specific task
Redirection	Is an initial verbal prompt, which may be paired with a physical prompt that guides the individual to the appropriate activity.
Reinforced Practiced	A procedure whereby a person is afforded many opportunities to practice and receive reinforcement for practicing a behavior in his/her repertoire to ensure the behavior is learned.
Shaping	The process of differentially reinforcing successive approximations (small steps) toward the desired level of behavior until the behavioral sequence is fully achieved.
Stimulus Change	Is the altering of stimuli to create a situation so different from that which previously existed that the ongoing behavior is temporarily suppressed.
Other Voluntary Techniques	The following commonly accepted practices, while not an exhaustive list, are also included to illustrate additional procedures which do not require administrator, consumer, guardian, or other approving authority to use: • Anger Management Techniques/Calming Strategies/Self-Control Activities & Exercises • Social Skills Training • Social Stories • Picture Activity Schedules • Structured Social/Activity Involvement • Daily Positive Interaction Time (with parent or staff member) • Daily/Weekly Outings or Other Rewards (beyond what is specified in the consumer's PCP) • Problem Solving Discussions • Structured Relaxation Training

	• Suggested Relaxation • Teach/Train Positive Activity with Property (for individuals who exhibit property damage) • Nighttime Bed Checks for Enuresis/Encopresis (Toileting Schedule) • Behavioral Contracting/Contingency Contracting • Visual Demonstration of Personal Space (arm's length away) • Compliance Training • Sensory Stimulation – utilizing an alternative stimulus for the purpose of redirection (e.g., a client who engages in finger-flicking is given object to hold/wear of certain texture, color, size) • Structured Alone Time • Daily Journaling • Encourage Incompatible Behavior As Targeted Behavior Occurs
Restoration/ Restitution/Simple Correction:	Requiring a person to return an environment to its former or original state or to return an item that has been removed.

Exhibit B

Behavior Modification – Intrusive and Restrictive Procedures **The BTPRC must review and authorize (in writing) these procedures *before* they may be used. These require written legal consent by the consumer or the consumer's guardian. There must be a BTP developed through the PCP process and it must be approved by the individual, or his/her guardian (if one has been appointed), or the parent with legal custody of a minor.**	
Alarms	Alarms installed for treatment of a particular individual.
Intensive Supervision	Arm's length, direct line of sight supervision and one-on-one supervision and two-on-one supervision.
Medications Prescribed for Behavioral Control	The use of psychotropic medication for the purpose of decreasing a specific inappropriate behavior or sequence of behaviors. This procedure does not include the use of psychotropic medication for the reduction of psychiatric symptoms such as, anxiety, hallucinations, or inappropriate affect.
Negative Practice	A procedure in which a person, behaving inappropriately, is required to repeatedly practice the inappropriate behavior in order to reduce that behavior.
Positive Practice	A procedure requiring a person to repeatedly practice a desirable behavior following the occurrence of an inappropriate behavior. For example, the person is required to practice asking for help instead of throwing work materials.
Removal of Personal Property	The removal of personal property where property could be deemed to be harmful to self or others.
Response cost	The response-contingent removal of a positive reinforcer. A previously earned reinforcer or access to personal property may be removed.
Restitution/ Overcorrection	The teaching of a person to assume responsibility for the disruption of an environment caused by his/her maladaptive behavior by requiring the person to restore the environment to a condition as good as or better than that which existed prior to the person's display of the maladaptive behavior.
Restricting Access to or Use of Personal Property	Limiting free access to an individual's personal property. Examples include: clothing, cigarettes, lighters, items that can be of harm to self or others.
Satiation	Refers to the reduction in effectiveness of a reinforcer after an excessive amount of it has been presented. This procedure may apply when unlimited amounts of a reinforcer, that has maintained an unacceptable response, is presented non-contingently in order to reduce targeted behavior(s).
Search and Seizure	A procedure that involves searching a person or a person's belongings for a particular item. This procedure is part of a Behavior Treatment Plan designed to: increase adaptive, appropriate behavior, to decrease maladaptive behavior, and/or to promote safety. All searches must comply with the Michigan Mental Health Code.

Therapeutic De-escalation	An intervention, the implementation of which is incorporated in the individual written plan of service, wherein the recipient is placed in an area or room, accompanied by staff who shall therapeutically engage the recipient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.
Token Economy with a Response Cost	The systematic arrangement within a person's environment whereby the person receives tokens contingent upon the occurrence of specified appropriate behaviors, with response cost contingencies. The tokens serve as a generalized conditioned reinforcer for appropriate behaviors and may be exchanged for a variety of privileges. A token economy without a response cost is not considered a restrictive intervention.
Other Techniques	These additional restrictive and/or intrusive procedures also require BTPRC review and approval when included as part of a formal Behavioral Treatment Plan: • Removal of Inedible Item from Hand/Mouth Area (pica behaviors) • Contingent Apology • Planned Ignore Strategy/Selective Inattention • Non-Exclusionary Required Relaxation • Non-Exclusionary Time-Out Procedure • Meal Interruption of sixty (60) Seconds or More • Stimulus Change • Loss of Privileges • Request to Turn Over Stolen Items

Exhibit C

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Behavior Treatment Plan Special Informed Consent

Consumer Name: Click or tap here to enter text. **Case Number:** Click or tap here to enter text.

I, Click or tap here to enter text., **on behalf of** Click or tap here to enter text., **have been provided a copy of the behavior treatment plan dated** Click or tap to enter a date. **This plan was presented to the SCCMHA Behavior Treatment Review Committee (BTRC) for approval. I have reviewed the behavior treatment plan and have had all questions and concerns answered. I understand the program and agree with its implementation as approved by the BTRC. Furthermore, I understand the risks or potential risks that have been considered to be associated with this program.**

Brief Summary Description of the Program: The behavior treatment plan is outlined with proactive strategies, reactive strategies, basic redirection and systemic reinforcement to address the identified behaviors of concern. The following are outlined as intrusions/restrictions within the behavior treatment plan:

1:1 Staffing: The role of 1:1 is to ensure safety of the consumer and those who may be present when an unsafe behavior occurs. The 1:1 staff should be aware of the precursors or warning signs which may be apparent prior to an unsafe behavior. The 1:1 staff should be prepared to have activities nearby for redirection and/or meeting needs being communicated by the behavior.

PRN and/or Medication for Behavior: At times the experience of anxiety or agitation requires PRN medication to prevent or cease unsafe behavior. PRN medication shall be administered per doctor's written order. Prescribing doctor will monitor medication(s) for optimum functioning, being prescribed to address specific diagnoses consistent with DSM 5 and will address titration of medication.

Restricted Access: Access to items and/or spaces may temporarily be restricted when recent behaviors indicate a high potential for safety risk with unlimited and unsupervised access.

Risks or Potential Risks: Risks related to the intrusive/restrictive plan include that as intrusions/restrictions are implemented and structure/expectations increase the frequency, intensity, and duration of the behaviors of concern may initially increase due to a typical behavior change phenomenon known as an "extinction burst" and/or agitation related to the above noted intrusions/restrictions in the behavior treatment plan.

I understand that this consent for behavior treatment plan implementation, as stated above, may be revoked by me at any time. If I choose to revoke this authorization, I may do so verbally or in writing. Without express revocation, this consent expires one year from the date of signature or sooner, as specified.

_____ _____

Signature of consumer, legal guardian or parent of minor Date

_____ _____

Signature of legal guardian or parent of minor (if applicable) Date

_____ _____

Signature of Witness Date

☐ Check if revocation of this consent has been made, verbally or in writing. Date: _____

2/1/2022

Exhibit D

ABC (Antecedent, Behavior, Consequence) Chart Form Consumer Name: _____ Month: _____

Date/Time	Antecedent	Behavior	Consequence
Date/Time when occurred	What happened right before the behavior that may have triggered the behavior	What the behavior looked like	What happened after the behavior or because of the behavior

Exhibit E

ABC (Antecedent, Behavior, Consequence) Chart Form

Date/Time	Antecedent	Behavior	Consequence	Intensity
Date/Time when occurred	What happened right before the behavior that may have triggered the behavior	What the behavior looked like	What happened after the behavior or because of the behavior	Rate on a scale of 1-5 Circle the level of intensity
				1 2 3 4 5
				1 2 3 4 5
				1 2 3 4 5
				1 2 3 4 5
				1 2 3 4 5
				1 2 3 4 5
				1 2 3 4 5
				1 2 3 4 5
				1 2 3 4 5
				1 2 3 4 5

Intensity scale: 1 – exclusively vocal maladaptive behavior (one or two yells and done) 2 – vocal maladaptive behavior (tone of yelling has changed and continues) 3 – vocal maladaptive behavior (tone and length has changed, continuous) and attempt of physical aggression (kick the walls, hit the TV) 4 - vocal maladaptive behavior (tone and length has changed, continuous) and attempt of physical aggression (kick the walls, hit the TV), stomping through the house

5 - vocal maladaptive behavior (tone and length has changed, continuous) and attempt of physical aggression (kick the walls, hit the TV), stomping through the house and physical aggression towards staff (hit or pull-on staff)

Exhibit F

ABC Data Analysis Consumer Name: Month: _____

Antecedent *What was happening before the behavior occurred?*	Behavior *What does the behavior of interest look like?*	Consequence *What happened after the behavior was presented?*
Date: _____ **Time:** _____ **Describe:**	☐hit others ☐pinch others ☐hit self in chest ☐spit at others ☐bite self ☐Other: _____ ☐Other: _____	**Describe:**

Antecedent *What was happening before the behavior occurred?*	Behavior *What does the behavior of interest look like?*	Consequence *What happened after the behavior was presented?*
Date: _____ **Time:** _____ **Describe:**	☐hit others ☐pinch hair ☐hit self in chest ☐spit at others ☐bite self ☐Other: _____ ☐Other: _____	**Describe:**

Exhibit G

Tracking Behavior(s) Consumer Name: _____

Month/Day After administrating of Ativan how long before behavior occurs, 20 minutes, half hour, hour, two hours, etc, before giving PRN

Date	Ativan 8am	Ativan 12pm	Ativan 4 pm	Ativan 8 pm	PRN Ativan

Exhibit H

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Request to use Intrusive/Restrictive Intervention(s) in a Behavior Treatment Plan (BTP)

Saginaw County Community Mental Health Authority Behavior Treatment Committee (BTC)

☐ ***Expedited Review*** ***(check if needed within 24 – 48 hours)***

Consumer Name: Click or tap here to enter text.

Consumer ID #: Click or tap here to enter text.

Plan Author: Click or tap here to enter text.

Date: Click or tap to enter a date.

Residential Living Arrangement:	☐ Specialized Residential Home (AFC, children's therapeutic group home) ☐ General Residential Home (licensed foster care facility not certified to provide specialized program) ☐ Private residence with CLS and/or AHH staff support ☐ Private residence without CLS and/or AHH staff support ☐ Foster home/Foster care (minor child) ☐ Other (Please specify: Click or tap here to enter text.) ☐ **Check if currently in a crisis residential or psychiatric unit placement, jail or other correctional placement, or state hospital**

Reoccurring Behavior(s) of Concern (list all): Click or tap here to enter text.

Reason for BTC Review:

☐ New Behavior Treatment Plan
☐ Amended Behavior Treatment Plan
☐ Positive Support Plan (no intrusive/restrictive interventions)

☐ Quarterly Review of approved Behavior Treatment Plan:
☐ Regression ☐ No Change ☐ Progress

Date existing plan was originally approved: Click or tap to enter a date.

☐ ABA plan that contains restrictive/intrusive interventions
☐ New HCBS health and safety modification request (Ensure the Assessment/IPOS/physician script or OT/PT eval support the request)
☐ Review of existing HCBS health and safety modification (includes medical devices)

Date modification was originally approved: Click or tap to enter a date.

☐ Review due to medications prescribed

Date of last prescriber report form (must be done at least annually): Click or tap to enter a date.

Is the individual currently receiving evidence-based treatment: ☐ Yes ☐ No
If yes, specify which evidence-based treatment below:

☐ PMTO ☐ DBT ☐ TF-CBT ☐ Family Therapy ☐ ABA Therapy ☐ BSFT

☐ Other (describe): Click or tap here to enter text.

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Request to use Intrusive/Restrictive Intervention(s) in a Behavior Treatment Plan (BTP)

Saginaw County Community Mental Health Authority Behavior Treatment Committee (BTC)

Briefly summarize current treatment the individual is receiving (services received, level of engagement, attendance, etc.):
Click or tap here to enter text.

Intrusive Intervention(s) in the BTP? ☐ **Yes** ☐ **No**

If yes, check all that apply from below:

☐ 1:1 Supervision	☐ Line of Sight	☐ Arm's Reach	☐ Physical Prompt
☐ ABA 2:1	☐ Restore Environment	☐ Overcorrection	☐ Medications
☐ Protective Device	☐ Anatomical/Physical Support Rx MD/PT/OT	☐ Special Clothing	

☐ Other (describe): Click or tap here to enter text.

Restrictive Intervention(s) in the BTP? ☐ **Yes** ☐ **No**

If yes, check all that apply from below:

Freedom of Movement

☐ Limit Access to Activity, Environment ☐ Therapeutic De-Escalation (required relaxation)

☐ Other (describe): Click or tap here to enter text.

Property Rights

☐ Restrict Access to Property ☐ Restrict Access to Money ☐ Search & Seizure

☐ Restitution/Response Cost ☐ Planned Inquiry (i.e. request to see purchases made)

Entertainment

☐ Restrict Access to Viewing, Listening, etc.

Communication Rights

☐ Limit Access to Phone ☐ Limit Access to Visits ☐ Limit Access to Mail ☐ Limit Access to Other Persons

☐ Other (describe): Click or tap here to enter text.

Notes/Comments: Click or tap here to enter text.

Exhibit I

Saginaw County Community Mental Health Authority

Reoccurring Behavior(s) of Concern Checklist

To be completed by: Case Holder

Consumer Name: Click or tap here to enter text. **Consumer ID #:** Click or tap here to enter text. **Case Holder:** Click or tap here to enter text.

****Must complete this form before completing a Referral Form for Psychological Services due to behavior(s), medication(s), health & safety and/or change in mental status****
What is the reoccurring behavior(s) of concern? (Brief explanation with examples) Click or tap here to enter text.
When did the behavior(s) of concern first occur? Click or tap to enter a date.
Have any of the following changes occurred with the consumer? *(Check all that apply & include a brief explanation.)* ☐ Change in environment – Click or tap here to enter text. ☐ Change in medication – Click or tap here to enter text. ☐ Change in health – Click or tap here to enter text. ☐ Other – Click or tap here to enter text.
List all prior intervention(s) that have been used to address the reoccurring behavior(s) of concern: Click or tap here to enter text.
Is there a possible trauma explanation(s) for the behavior? ☐ Yes ☐ No If yes, briefly explain: Click or tap here to enter text. Is there a Positive Trauma Screen? ☐ Yes ☐ No
Implement ABC chart(s) for the reoccurring behavior(s) of concern ***Schedule an Interdisciplinary Team Meeting (Form: SCS 002) to assist with answering the rest of this checklist***
Date of last appointment with Primary Care Physician: Click or tap to enter a date. *Schedule an appointment for Primary Care Physician to rule out medical if last appointment preceded the onset of the behavior(s) of concern.
• Were any specific health issues identified that may contribute to the behavior(s)? ☐ Yes ☐ No
• Date labs were last completed: Click or tap to enter a date.
Is SCCMHA Nursing Services involved? ☐ Yes ☐ No
• Has medical been ruled out? ☐ Yes ☐ No

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Reoccurring Behavior(s) of Concern Checklist

To be completed by: Case Holder

Are OT services involved? ☐Yes ☐ No
• Has sensory has been ruled out? ☐ Yes ☐ No
• Have environmental causes been ruled out? ☐ Yes ☐ No
Are PT services involved? ☐ Yes ☐ No
• Have exercises and/or equipment helped with regaining or improving physical ability? ☐ Yes ☐ No
• Has PT improved and/or enhanced body mechanics? ☐ Yes ☐ No
Are dietary services involved? ☐ Yes ☐ No
• Has a modification of diet been ruled out? ☐ Yes ☐ No
Are speech services involved? ☐ Yes ☐ No
• Has speech therapy resulted in an improvement in expressive and receptive language skills? ☐ Yes ☐ No
• Has a swallowing disorder been ruled out? ☐ Yes ☐ No
• Has a communication barrier been ruled out? ☐ Yes ☐ No
***If all the above has been ruled out, submit a Referral Form for Psychological Services (Form: SCS 001). Include the following with the referral:** • **this Reoccurring Behavior(s) of Concern Checklist** • **at least 1-month of ABC chart(s)** • **Interdisciplinary Team Meeting notes**

Additional Notes/Comments: Click or tap here to enter text.

Exhibit J

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Behavior Treatment Committee (BTC)

Review Form

Consumer Name: _____ BTC Meeting Date: _____

Consumer ID #: _____ Date of Plan: _____

☐ Intrusions/Restrictions Approved: _____

_____

Review Frequency: ☐ Quarterly ☐ Monthly ☐ Other: _____

- **Prior to implementation**, BTC must receive a copy of the signed Special Consent Form and Staff Training/In-Service Log(s). **Due Date:** _____

☐ Intrusions/Restrictions Denied: _____

_____

Revisions required & **Due Date**: _____

_____

_____

_____

- Note: The use of intrusive/restrictive techniques without a fully approved, formal plan is a Recipient Rights violation.

☐ Nothing intrusive/restrictive – No formal plan required

☐ Discharged from BTC Review

- Note: Requests for BTC review in the future based on the addition of intrusive/restrictive measures, health & safety modification, or due to medications prescribed are expected to be requested by the treatment team.

Form: BTC 005 Revised 3/23/2022

Exhibit K

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Behavior Intervention Plan (BIP)
Quarterly Review

Saginaw County Community Mental Health Authority Behavior Treatment Committee (BTC)

Consumer Name	
Consumer ID #	
Date of Birth	
Evaluator/Author *(name & credentials)*	
Agency	
Date	

Target/Problem Behavior(s):

Please include the operational definition, hypothesized function, and end goal for each behavior.

For example:

- *Aggression: defined as any instance of throwing objects, hitting, kicking, biting, hair pulling, or scratching during the time of the observation.*
- *Function: Examiner reviewed ABC data, observed the learner in the clinic setting and spoke to relevant care providers. It is this examiner's hypothesis that this behavior serves an escape/avoid function.*
- *Goal: John will reduce his aggression from a baseline average of 7 times per day to zero times per day for 60 consecutive days.*

Intrusive and/or Restrictive Measure(s) currently in place:

What is the plan to reduce (or titrate) the intrusive/restrictive measure(s)?

When will the intrusive/restrictive measure(s) be faded?

Proactive Strategies:

Reactive Strategies:

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Behavior Intervention Plan (BIP) Quarterly Review

Saginaw County Community Mental Health Authority Behavior Treatment Committee (BTC)

Baseline & Current Data:

<Add graphs here – include baseline data & current/updated data>

Has there been progress, no change or regression?

Include a brief summary.

If there has been a change, what has changed?

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Services for Members of the Armed Forces, Veterans and their Families</td><td>Chapter: 03 – Continuum of Care</td><td>Subject No: 03.02.31</td></tr>
<tr><td rowspan="2">Effective Date: 5/5/16</td><td>Date of Review/Revision: 9/7/16, 6/13/17, 4/10/18, 4/9/19, 7/29/20, 4/13/21, 5/10/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Barbara Glassheim

Additional Reviewers:
SCCMHA Veteran and Military Family Navigator</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:

The purpose of this policy is to specify services and supports that may be provided to members of the armed forces, veterans and their families who meet SCCMHA's eligibility criteria.

Policy:

Mental health problems are common among veterans, particularly those who have been exposed to combat. Exposure to combat has been found to be a risk factor for posttraumatic stress disorder (PTSD) and depression. Service members have been identified as an "at risk" population. As such, they face increased risk for substance use disorders; suicide; diminished physical health and increased mortality; diminished employment and productivity; homelessness; and family problems including marital distress, parenting issues and adverse child outcomes.

Adjustment to civilian life following military service includes coping with the loss of the support and regimentation of military life, challenges with reestablishing relationships with family and friends, accessing needed services and benefits and finding, and maintaining gainful employment. Historically, the United States military has not provided adequate transition training and supports for military members and veterans who are returning home. While the military and Department of Veterans Affairs have begun to address the challenges of transitioning military members, the need to provide supports and resources for returning service members continues at the federal, state, and local levels.

In recognition of these challenges and the unmet mental health needs of many veterans, SCCMHA shall provide mental health and substance use disorder treatment

services to eligible members of the armed forces, veterans, and their families in accordance with standards set forth by SAMHSA for Certified Community Behavioral Health Clinics **(**CCBHCs). Such services shall include: crisis services; screening, assessment and diagnosis; person-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care.

Application:
This policy applies to all SCCMHA-funded services for veterans with mental illnesses, substance use disorders and co-occurring disorders.

Standards:
A. SCCMHA-funded providers shall, as resources permit, receive cultural competency training that includes understanding military culture.
B. All persons seeking services shall be screened for military service (or family member's service in case of children).
C. Consumers' military status shall be documented in the clinical record.
D. SCCMHA shall, resources permitting, provide an on-site Veteran and Military Family Program Navigator as a component of the continuum of care for veteran and military member consumers.
E. SCCMHA providers shall coordinate care for members of the armed forces and veterans with Department of Veterans Affairs' facilities and providers as appropriate.
F. Consumers currently serving in the military (i.e., active military personnel) shall be offered assistance in accordance with the following standards:
    1. Active-Duty Service Members (ADSMs) must use their servicing Military Treatment Facility (MTF).
        a. SCCMHA providers shall contact the consumer's MTF Primary Care Manager (PCM) regarding referrals outside the MTF[1].
G. SCCMHA shall serve veterans who decline or are ineligible for Veterans Health Administration (VHA) services in accordance with the minimum clinical mental health guidelines promulgated by the VHA and who meet SCCMHA eligibility criteria.
H. Services for consumers/veterans with co-occurring disorders (e.g., substance use and psychiatric disorders or more than one psychiatric disorder) and/or comorbid medical conditions shall be provided in an integrated manner in accordance with SCCMHA policy.

[1] ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and use the network PCM, or select any other authorized TRICARE provider as the PCM. In addition, PCMs make referrals to specialists for care they cannot provide and work with the VHA's regional managed care support contractor for referrals/authorizations. Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE-authorized provider, network or non-network. Veterans: Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services.

I. Every consumer who is a veteran shall be assigned a principal behavioral health provider, typically a case manager or therapist who shall be identified in the veteran's/consumer's record and to the consumer.
    1. The principal behavioral health provider shall ensure that services are coordinated and contact with maintained with consumers/veterans receiving services from more than one behavioral health provider and who are involved in more than one program.
        a. The principal (or primary) provider shall ensure that a psychiatrist or other qualified independent prescriber reviews and reconciles the consumer/veteran's psychiatric medications on a regular basis.

J. The consumer's/veteran's treatment plan shall incorporate input from the consumer/veteran and, when appropriate, the family with the consumer's/veteran's consent when the consumer/veteran has adequate decision-making capacity or with the consumer's/veteran's surrogate decision-maker's (e.g., legal guardian's) consent when the consumer/veteran lacks such capacity.
    1. Implementation of the treatment plan, including progress and care delivered, outcomes achieved and goals attained shall be monitored and documented in the clinical record.
    2. The treatment plan shall be periodically reviewed with the consumer/veteran and revised when indicated.

K. The primary therapist or behavioral health provider shall communicate with the consumer/veteran (and their natural support system when appropriate and with the consumer's/veteran's consent) about the treatment plan and any problems or concerns expressed by the consumer/veteran regarding their care.

L. All veterans/consumers shall be offered crisis planning services and the opportunity to designate a surrogate decision-maker in the event of incapacity.
    1. Consumer/veterans are offered the opportunity to prepare Advance Directives in accordance with SCCMHA policy and VHA Handbook 1004.1.

M. The treatment plan shall be person-centered and reflect the consumer/veteran's goals and preferences for care.

N. The consumer/veteran shall verbally consent to their treatment plan and sign it in accordance with SCCMHA policy and VHA Handbook 1004.1.
    1. Consumers/veterans whose capacity for decision-making is of concern shall be referred for a formal assessment and the results of that evaluation shall be documented in the record.
        a. An authorized surrogate decision-maker shall be identified for a veteran/consumer who is deemed to lack such capacity and the authorized surrogate's consent to treatment on behalf of the consumer/veteran is documented per VHA Handbook 1004.1.

O. Veterans shall be offered evidence-based practices that are available to consumers of SCCMHA with psychiatric and substance use disorders (e.g., Seeking Safety, Motivational Interviewing, Family Psychoeducation, Supported Employment, smoking cessation, CBT for relapse prevention, CBT for depression and anxiety

disorders, and pharmacotherapies[2] including Medication Assisted Treatment [MAT], etc.).

1. SCCMHA shall make every effort refer veterans in need of specialized approaches (e.g., gender-specific treatment for MST/Military Sexual Trauma) to providers with relevant training and expertise.

P. Services and supports for veterans shall be recovery-oriented, person-centered, trauma-informed evidence-based and provided in a manner consistent with relevant SCCMHA policies and the VHA Handbook 1160.01.

Q. SCCMHA shall establish and maintain a Memorandum of Understanding (MOU) with the Aleda A. Lutz VA Medical Center.

R. SCCMHA shall work with assigned liaison(s) from the local VA to coordinate services for veterans including participating in community events designated for veterans and their families (e.g., Stand Downs for veterans who are homeless and Community Homeless Assessment Local Education and Networking Groups [CHALENG] meetings).

Definitions:

Mental Health Treatment Coordinator (MHTC): A veteran's primary contact for all specialty mental health services. MHTCs coordinate mental health treatment plans for veterans.

TRICARE: The Department of Defense's (DoD) health care benefits program which serves all of members of the uniformed services and their families.

Veteran: Any person who served for any length of time in any **military service branch**.

References:

A. Substance Abuse and Mental Health Services Administration. (Undated). Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics: http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

B. Substance Abuse and Mental Health Services Administration. (2012). Behavioral Health Issues Among Afghanistan and Iraq U.S. War Veterans. *In Brief*, Volume 7, Issue 1: http://store.samhsa.gov/shin/content/SMA12-4670/SMA12-4670.pdf

C. SCCMHA Policy 03.02.14 – Advance Directives

D. SCCMHA Policy 02.01.01.02 – Cultural Competence

E. SCCMHA Policy 10.01.02 – Health Home Services

F. SCCMHA Policy 02.03.03 – Person-Centered Planning

G. SCCMHA Policy 02.03.05 – Recovery

H. SCCMHA Policy 02.03.09.01 – Dual Diagnosis Treatment Capacity

I. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

J. SCCMHA Policy 02.03.08 – Welcoming

K. Department of Veterans Affairs. (August 14, 2009). *Informed Consent for Clinical Treatments and Procedures. VHA Handbook 1004*: http://www1.va.gov/vhapublications/viewpublication.asp?pub_ID=2055.

[2] Veterans diagnosed with schizophrenia or schizoaffective disorders with severe residual suffering, symptoms, or impairments must be offered clozapine after two trials of other antipsychotic medications.

L. Department of Veterans Affairs. (September 11, 2008, revised November 16, 2015). *Uniform Mental Health Services in VA Medical Centers And Clinics. VHA Handbook 1160.01*: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762.

Exhibits:
None

Procedure:
None

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Genoa HealthCare- MED DROP™ Program for Children</td><td>Chapter: 03 – Continuum of Care</td><td>Subject No: 03.02.33</td></tr>
<tr><td>Effective Date:
5/26/16</td><td>Date of Review/Revision:
2/16/21, 3/16/22
Supersedes:</td><td rowspan="2">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Allison Kalmes, Monique Taylor-Whitson, Diane Cranston (Genoa)

Reviewed By:
Management Team, Erin Nostrandt</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to discuss the uses, benefits, and requirements for the MED DROP™ Program for Children offered by Genoa Healthcare located Saginaw County.

The aim of the Med Drop Program for Children offered by Genoa Healthcare is to provide consumers between the ages of seven (7) and seventeen (17), who have a history of medication non-adherence, a service to assist in the transition from receiving daily assistance from the medication drop program, to taking their medication independently.

Application:
This policy shall apply to all consumers of the SCCMHA network between the ages of seven (7) and seventeen (17).

Policy:
The MED DROP™ Program for Children offered by Genoa Healthcare Saginaw County is meant to provide consumers from the ages of seven (7) through age seventeen (17), who have been diagnosed with a serious emotional disturbance, with a history of medication non-adherence and currently receiving psychiatric services from a SCCMHA prescriber, a service to assist with increasing medication adherence. The main goal of this program is for consumers and/or parents/guardians to ensure medications are being taken properly without the regular assistance of staff.

Prior to any consumer receiving MED DROP ™ services the consumer must have an assessment by clinical staff to assure this service meets medical necessity and must be included in the consumer person centered planning process and agree to the service as part of the consumer plan. The primary case holder will need to request an authorization as part of this process for care management review for medical necessity. Once the services have been approved the case holder and the MED DROP™ Coordinator will begin the coordination of services.

For consumers to achieve the goal of taking medications as prescribed; the MED DROP™ program will partner with consumer and parents/guardians and provide education about the medications being prescribed. This education includes teaching the names of the medications, purposes of the medications, how and when to take the medications, the side effects of the medications, and environmental factors (certain foods, over exposure to sun) to avoid when taking the medications.

The goal is also achieved by the MED DROP ™ Treatment Team (consumer, MED DROP™ Staff, MED DROP™ Coordinator, Case Holder, Treating Prescriber and Guardian) through helping the consumer and/or parents/guardians to identify and implement organizational strategies to take medications as prescribed on a consistent basis.

The MED DROP™ program consists of four (4) components:

1) Program Orientation Session conducted by the MED DROP™ Coordinator.
2) Medication delivery (medication drop) provided by the MED DROP™ staff.
3) Medication and organizational strategy education provided by the MED DROP™ staff.
4) Care coordination provided by the MED DROP™ staff.

The medication delivery (MED DROP™) component consists of the MED DROP ™ staff dropping medications to a consumer at an agreed upon time and location. MED DROP™ staff will drop medications at the frequency determined by the MED DROP™ Treatment Team and approved by the Treating Prescriber, but no more than two times per day. A medication delivery schedule will be determined by the MED DROP™ Program Coordinator and consumer/parent/guardian unless a court order specifies a frequency and duration. With the approval of the prescribed dosages, which are to be taken three (3) or more times a day will be left with a parent/guardian/authorized adult either at consumer's home or at the consumer's school. Medication drop times are typically from 8am to 8pm, 365 days per year. MED DROP™ staff are to deliver the medication to the parent/guardian/authorized adult and observe this individual give the medications to the consumer for self-administration. MED DROP™ staff will then ask how the consumer is feeling, if the consumer is experiencing any side effects, and if the consumer/parent/guardian/authorized adult has any medication concerns. The MED DROP staff will also observe and note if there are any changes in the consumer's speech, physical appearance, or mood. At this time, the MED DROP™ staff will provide medication education and discuss organizational strategies that the consumer/parent/guardian/authorized adult can use; MED DROP™ staff will also remove

medications from the home that are outdated or no longer being used by the consumer. Daily medication deliveries will be documented by MED DROP™ staff in the Sentri II electronic system detailing this information.

Standards:

- The MED DROP ™ Program shall be used to assist consumers with the transition from daily medication deliveries to taking their medication independently.
- The option to participate in the MED DROP™ Program for Children will be based upon the consumer/parents/guardian's acceptance to do so, unless otherwise ordered by the court.
- The use of the MED DROP™ Program for Children should be considered the least restrictive means of ensuring medication adherence for consumers participating in the program.
- Only consumers meeting the requirements as noted below will be eligible to receive services through the MED DROP™ Program for Children. Individuals who may be applicable for this program include consumers who are between the ages of seven (7) and seventeen (17), with a diagnosis of serious emotional disturbance, who have a history of medication non-adherence and currently receiving psychiatric services from an SCCMHA prescriber, and at least one (1) of the following is occurring:
    - child is not taking his/her medications (ex: refusing, hoarding, hiding, cheeking meds, etc.),
    - child is exiting a residential setting,
    - child is exiting a psychiatric or physical health care setting,
    - parent(s)/guardian(s) are forgetting to give the medications as prescribed to the child,
    - parent(s)/guardian(s) are having challenges that make it difficult to ensure their child receives his/her medications as prescribed,
    - DHHS has stipulated that the child must receive his/her medication as prescribed, and/or
    - Family Court has stipulated that the child must receive his/her medication as prescribed.
- To receive services through the MED DROP™ Program for Children, the Primary Case Holder would:
    - initiate a discussion regarding the service with the consumer/parent/guardian, and if all terms are agreed upon by the consumer/parent/guardian then,
    - the MED DROP Referral form (Exhibit B) would be completed by the Primary Case Holder, and
    - the Case Holder would address the service in the Individual Plan of Service by developing a MED DROP™ goal with the consumer/parent/guardian,
    - and an authorization would be submitted for approval accompanied by the MED DROP™ Referral form (Exhibit B) as support for medical necessity.
    - a current CAFAS must also be completed if the last one completed was over 90 days old.

- Once the requested service authorization is approved by Care Management, then coordination to link services to the consumer/family/guardian will be initiated by the MED DROP™ Program Coordinator who will contact the Primary Case Holder within one business day of receiving a current authorization for services.
    - The MED DROP™ Program Coordinator will connect with the Primary Case Holder.
    - Case Holder gather dates/times of when the Program Orientation can be completed with the family.
    - Case holder contacts the family and determines what works best with them.
    - Case holder seeks to ensure they can attend this Orientation Meeting.
    - The Case holder then informs the MED DROP™ Program Coordinator of the selected date/time identified by the family.
    - The Case Holder ensures/remind the consumer/family of the coordinated Orientation Session.
- MED DROP™ Program Orientation Session, which will include the following:
    - Explanation of the program,
    - Completion of program consents, medication reconciliation activities, and Medication Adherence Questionnaire (Exhibit C), which is the consumer's and parent/guardian's self-report of the consumer's/parent's/guardian's medication adherence strengthening and risk factors.
    - Coordinate with Case Holder any changes necessary to consumer Individual Plan of Service (IPOS) goal, objectives, and interventions for the MED DROP™ Program.
    - Initial education of consumer's medications, and
    - A decision on when medication deliveries will begin.
- To participate in the program, consumer's parent/guardian must agree to utilize Genoa Healthcare for all prescribed behavioral health medication and physical healthcare medication, if applicable. This is to assure good coordination and monitor for any medication interactions.
- For consumers participating in the MED DROP™ Program, the MED DROP™ Program Coordinator, with input from the MED DROP™ staff, will complete the MED DROP™ Monthly Treatment Review document (Exhibit D) and upload into consumers Sentri record. This completed document is forwarded to the Treating Prescriber and Primary Case Holder. This document represents a monthly progress report on the consumer's progress in the MED DROP™ Program. The document contains the following information:
    - number of months the consumer has been in the program.
    - number of days the consumer was in a psychiatric hospital, medical hospital, or crisis home during the month.
    - consumer's adherence rate for the month and how this compares to the prior month.
    - consumer/parent/guardian's medication adherence strengthening and risk factors.

    - consumer/parent/guardian's medication knowledge and the organizational strategies that the consumer/parent/guardian is implementing to remember to take his/her medications.
    - consumer's progress on his/her MED DROP™ Treatment Goal.
    - consumer's readiness to take his/her medications independently or readiness to decrease the frequency of his/her MED DROP™ contacts.
- A consumer may remain in the program for an extended period, depending on his/her progress. This will be determined by adherence in the program which is defined as:
    - Full adherence – consumer taking his/her medications 80% or more of the available days while in the program.
    - Partial Adherence – consumer taking his/her medications 60% to 79% of the available days while in the program.
    - Non-Adherence – consumer taking his/her medications 59% or less of the available days while in the program.
- A consumer will be discharged from the program based upon progress and readiness to take medications independently, and/or as prescribed.

Definitions:

Child Adolescent Functioning Assessment Scales (CAFAS): Assessment tool completed by clinician to determine functional impairments of school-aged children across eight domains. Rating generates specific subscale score profiles and Total Score. Caregiving environments specific to youth are also assessed.

References:

SCCMHA Policy 03.02.32 Genoa Medication Drop Service Program for Adults
SCCMHA Policy 02.03.18 Preschool and Early Childhood Assessment Scale (PECFAS) & Child and Adolescent Functional Assessment Scale (CAFAS)

Exhibits:

Exhibit A: Genoa – MED DROP™ Program for Children Overview
Exhibit B: Genoa – MED DROP™ Program for Children Referral Form
Exhibit C: Genoa – MED DROP™ Program for Children Medication Adherence Questionnaire
Exhibit D: Genoa – MED DROP™ Program for Children Monthly Treatment Team Review Form
Exhibit E: Genoa- MED DROP™ Assessment of Clients Medication Assistance Need- CHILD

Procedure:

ACTION	RESPONSIBILITY
Determine the least restrictive means of ensuring medication compliance for children having trouble taking their medications as prescribed. Additionally, the consumer's parent/guardian agrees to	Primary Case Holder

utilize MED DROP™ Services for Children for all prescribed behavioral and physical healthcare medications if applicable, and the consumer is believed to be eligible based on the standards (see above).	
Complete the MED DROP™ Program referral form (Exhibit B) for consumers who meet the outlined eligibility requirements.	Primary Case Holder
Update consumer's individual plan of service to reflect consumer's participation in the MED DROP™ Program for Children, including the benefits and desired outcome from utilizing the program services (see Exhibit A for details).	Primary Case Holder
Request authorization from Care Management for MED DROP™ Program for Children and attach the completed MED DROP™ Program referral form as support for medical necessity.	Primary Case Holder
Review request for Authorization for MED DROP™ Program for Children, including the MD DROP™ Referral form and the IPOS to determine if authorization is approved or denied within the standard timeframe.	Care Management
Care Management will ensure the completed MED DROP™ Referral form accompanies the authorization to the MED DROP™ Program Coordinator when the service is approved to initiate services.	Care Management MED DROP™ Program Coordinator
Coordination is initiated by the MED DROP™ Program Coordinator with the Primary Case Holder within one business day of the initial referral and authorization being approved and submitted to MED DROP™ Program Coordinator. Communication between the MED DROP Program Coordinator and the Case Holder	MED DROP™ Program Coordinator Primary Case Holder

is centered on coordinating a Program Orientation Session appointment with the consumer, parent/guardian, case holder and MED DROP™ Program Coordinator.	
Attend the Program Orientation Session (Exhibit A) with consumer/parent/guardian who are starting the MED DROP™ Program. The Program Orientation Session is facilitated by the MED DROP™ Program Coordinator.	Primary Case Holder MED DROP™ Program Staff
The Program Orientation Session will include the following: explanation of the program; completion of program consents, a Medication Adherence Questionnaire, and medication reconciliation activities; development of family centered goal, objectives, and interventions for the MED DROP™ Program; initial education of consumer's medications, and a decision on what day medication deliveries will begin.	MED DROP™ Program Staff
A Copy of the completed MED DROP™ Treatment Plan should be forwarded to the case holder within 14 calendar days of the Program Orientation Session.	MED DROP™ Program Coordinator (with input from MED DROP™ Staff)
Complete daily documentation in Sentri II system for all medication delivery services that occur. This requires completing the MED DROP™ Progress Note in Sentri II and includes the success of the medication drop, consumer's orientation, mood, Suicidal Ideations/Homicidal Ideations/Psychosis Risk Factors, any health and safety concerns, and the provision of education; as well as any concerns that the consumer/parent/guardian shares with the MED DROP™ staff.	MED DROP™ Program Staff
Complete Monthly Treatment Review form (Exhibit D) available under chart documents in the Sentri II system for all consumers participating in the MED DROP™ Program for Children. Form	MED DROP™ Program Coordinator

should be completed with input from MED DROP™ Program staff and then forwarded to the consumer's case holder and treating prescriber. This form contains the consumer's medication adherence rate and readiness to take his/her medications independently or readiness to decrease the frequency of his/her medication drops.	
Monitor adherence to the MED DROP™ Program at least monthly, and document monitoring activities by creating a Progress Note in the Sentri II system and reporting on the consumers progress or barriers and any necessary actions to support the consumers success.	Primary Case Holder
Attend Medication Reviews for consumers of the MED DROP™ Program for Children whenever possible. Attendance should be documented on the MED DROP™ Treatment Team Review Form and forwarded to consumer's primary case holder.	Primary Case Holder MED DROP™ Program Staff

Exhibit A

FY2020 Attachment A
MED DROP™ PROGRAM
PROGRAM OVERVIEW for Children

Program Philosophy:

The Med Drop Program for Children is a Community Living Services (CLS) based intervention that focuses on improving medication adherence through the observation related to a child's self-administration of his/her medication[1]. The Med Drop Program for Children is designed to assist parents/guardians (and child when appropriate) in identifying and implementing strategies and skills to ensure their child take his/her behavioral health medications as prescribed. If the parents/guardians choose, the child's physical health care medications can also be included in the program. This service is expected to improve the child's overall mental health and daily functioning by improving the symptoms treated by his/her medications.

Target Population:

This program is designed for children who are not taking their medications in the prescribed manner. The medication non-adherence may be attributed to child factors such as refusal, hoarding or hiding the medications; or parent/guardian factors such as forgetting to give the medications to the child, or having his/her own difficulties that are impeding his/her ability to provide the child with the medication as prescribed.

This non-adherence often results in more clinical symptoms for the child and the possibility of a more restrictive level of care, and a lesser quality of life.

Eligibility:

The following children are eligible for this service:

Children diagnosed with a serious emotional disturbance between the ages of 7 and 17 who reside in Saginaw County, currently receive psychiatric services from a Saginaw County Community Mental Health Authority (SCCMHA) network prescriber; are not taking their medications as prescribed, have eligible Child Adolescent Functional Assessment Scales (CAFAS) item numbers, and one (1) of the following are applicable:

●Child is not taking his/her medications (ex: refusing, hoarding, hiding, cheeking meds, etc)
●Child is exiting a residential setting
●Child is exiting a psychiatric or physical health care setting
●Parent(s)/Guardian(s) are forgetting to give the medications as prescribed to the child
●Parent(s)/Guardian(s) are having challenges that make it difficult to ensure their child receives his/her medication as prescribed
●DHS has stipulated that the child must receive his/her medication as prescribed
●Family Court has stipulated that the child must receive his/her medication as prescribed

In order to participate in this program, the parent/guardian must agree to utilize Genoa Healthcare for all of his/her child's behavioral health medications. If physical health care medications are included in the program, the parent/guardian must agree to use Genoa Healthcare for his/her child's physical health medications. Discussion of the program, its requirements, and the parent/guardian and child's agreement with participation, should occur in the context of a family centered planning meeting process that involves minimally the child/family's primary clinician.

Program Description:

The goal of the Med Drop Program for Children is to increase the parents/guardians' skills so that they can become independent in assisting/ensuring that the child takes his/her medications as prescribed and improves the quality of life for the child and his/her family. To assist the parents/guardians in becoming independent in managing the child's medications, the program includes educating the parents/guardians (and child when appropriate) on the names of the medications, how and when to take the medications, the purpose of the medications, the side effects of the medications and possible interactions with other medications, or foods to avoid when taking the medications. The program also assists the parents/guardians (and child when appropriate) by helping them to identify and implement organizational strategies to ensure the child takes his/her medications as prescribed. These strategies might include specialized packaging- Dispill, using a medication box, setting alarms, etc.

It is the program's intent to move a child from receiving daily medication drops to taking his/her medications independently (with the consistent support/assistance of the parents/guardians) within 18 months. However, it is recognized that some children/parents/guardians may need to be in the program longer than 18 months. The recommendation for the length of time a child participates in the program will be made during the course of a family centered planning process, taking into account recommendations by the Medication Drop Services (MDS) Treatment Team which includes the treating prescriber, case manager/supports coordinator, MDS Staff, and MDS Coordinator. In order for this to be accomplished, the MDS Coordinator works in a coordinated manner with the case manager/supports coordinator and/or treating prescriber. This care coordination includes the MDS Staff, MDS Coordinator, and case manager/supports coordinator working together to identify reasons for the child's medication non-adherence and communicating this information to the treating prescriber, especially if it has to do with side effects from the prescribed medications.

How quickly the parents/guardians/child move from Point A (daily med drop services) to Point B (independence- parents/guardians ensuring child is taking medications as prescribed) is based upon the parents/guardians/child's engagement in the med drop service and other psychiatric/behavioral services, the child's clinical stability and day to day functioning, AND the parents/guardians ability to ensure the child takes his/her medications as prescribed.

The Med Drop Program consists of 4 components: Program Orientation Session, Medication Drop (Delivery) Service, Medication Education, and Care Coordination (Treatment Planning) Services.

Program Orientation Component:

If the child is determined to be eligible for the program, after the MDS Coordinator has the discussion with child's case manager/supports coordinator, the case manager/supports coordinator will contact the parents/guardians to schedule the Program Orientation Session. The case manager/supports coordinator is required to present when the MDS Coordinator conducts the Program Orientation Session. In most instances, the Program Orientation Session will occur in the

parents/guardians/child's home, but it can occur at the CMH building, at the Genoa Healthcare Pharmacy or at an identified location in the community.

At the program orientation session, the MDS Coordinator will explain the program, complete the program consents including the "Authorized Adult" form, complete the Medication Adherence Questionnaire (MAQ), review the Assessment of the Child's Medication Assistance Needs, review current demographic information, discuss the child's drop frequency, days and times of the drop and drop start date. The MDS Coordinator will also perform medication reconciliation activities, and if necessary, contact the Med Drop Pharm Tech from the field for medication reconciliation assistance. The MDS Coordinator will collaborate with the parents/guardians/child on the development of a treatment goal, objectives, and interventions for the Med Drop Program which will be forwarded to the case manager/supports coordinator for inclusion in the family centered plan. The MDS Coordinator will bill this session as an H0031- Assessment.

During the program orientation session, the MDS Coordinator will offer the parent/guardian education materials. When appropriate, the child will also be offered these materials. These materials include medication information sheets; information materials for the parent/guardian that are specifically designed for parents/guardians whose children are taking psychiatric medications; information sheets for questions to ask the child's psychiatrist, and a booklet on mental health medications.

Medication Drop (Delivery) Service Component

"Dropped" medications are prescribed by the child's Network Provider's Treating Prescriber. If the parents/guardians chose, the child's physical health medications can also be included in the Med Drop. These medications are prescribed by the child's Primary Care Provider or Specialty Care Provider.

The MDS Staff provides the medication drop (delivery) service component. This component consists of dropping behavioral health medications, and physical health medications if included in the program, to the child's residence/location in the designated service area at the regularly scheduled time. This time is based upon the child's address and where the address is placed on the route. There is an AM route that typically starts at 8 AM and a PM route that typically starts at 5:00 PM. The routes run 365 days a year. These home/community based drops can occur up to twice a day. If the child is prescribed medications that are to be taken three (3) or more times a day, the MDS Staff will leave dosages with the parents/guardians and the Treating Prescriber/Case Manager/Supports Coordinator is notified.

If the child is in school and medications are to be taken during school hours, medications will be delivered weekly to the school and administered per the school's policy.

The child's drop frequency is determined by the child's progress, parents/guardians' choice, treating prescriber, case manager/supports coordinator and MDS Coordinator's input. Ultimately, the child's Treating Prescriber approves the drop frequency. Most children will begin the Med Drop Program at one drop a day; however, a child can begin the program at a lower frequency such as 1 drop per week. It is expected that the child "steps down" to lower drop frequencies depends upon the parents/guardians/child's engagement in the med drop service and other psychiatric/behavioral services, the child's clinical stability and day to day functioning, AND the parents/guardians ability to ensure the child takes his/her medications as prescribed. The Treating Prescriber Must approve "step downs." In turn, the MDS Coordinator coordinates "step down" dates with the MDS Staff.

At the time of the scheduled drop, the child and parent/guardian or “authorized adult” in lieu of the parent/guardian must be present. An “authorized adult” is defined as an adult identified and authorized by the parent/guardian, with the approval of the case manager/supports coordinator, to hand the medication to the child if the parent/guardian has an extenuating circumstance whereby he/she can not be present at the scheduled delivery time.

If the child/”Authorized Adult” is not present for the scheduled drop, depending upon the route schedule, the MDS Staff may make a second attempt on that day, but it is not required. If the child/ “Authorized Adult” is not present for a scheduled drop, the child is considered “unavailable” for that day and the MDS Staff will indicate this on the MDS Progress Note. If the child is “unavailable” or “refuses” all dosages on a given day, the child is considered “non-adherent” for that day.

If a child is “non-adherent” two (2) consecutive days, the MDS Coordinator will notify the treating prescriber and case manager/supports coordinator. This notification is important because missing two (2) consecutive days may impact the child’s clinical response to his or her medication. The treating prescriber and case manager/treating prescriber will decide the action to take to address the child’s non adherence.

If the child is not going to be available for a scheduled drop, the parents/guardians are expected to contact the MDS Staff to arrange for a Leave of Absence (LOA). A LOA is a situation where the parents/guardians request that the child’s medications be dropped at a prior drop because the child is not going to be available at the schedule drop time. Examples of LOA situations are the child has a doctor appointment, is going on vacation, or is going to be visiting family/friends outside of the designated drop area. It is expected that many parents/guardians will ask for LOAs during the Holiday Seasons. Case Managers/Supports Coordinators can approve LOAs without the Treating Prescriber’s approval.

The MDS Staff will do their best to arrive at the scheduled drop time; however, based upon other clients’ needs, this is not always possible. If the MDS Staff is going to be more than 30 minutes late for the scheduled drop, the MDS Staff will contact the parents/guardians.

During the drop, The MDS Staff will observe the parent/guardian/”authorized adult” giving the medication to the child and the child self-administering the medication, ask how the child is feeling, ask about any side effects, and observe the child’s physical appearance, behavior and speech. The MDS Staff will also observe the parent/guardian/”authorized adult’s” physical appearance, behavior and speech.

If the child’s and/or parent/guardian’s physical appearance, behavior or speech is unusual for him/her, or the child/parent/guardian expresses concerns/issues, the MDS Staff shall do the following:

- Contact the MDS Coordinator or MDS Pharm Tech, who is turn will attempt to reach the child’s case manager/supports coordinator

- If after business hours, the MDS Staff will contact the CMH’s Crisis Center
- Depending upon the nature and urgency of the situation, the MDS Staff will contact 911

If the situation is severe/urgent, the MDS Staff MUST speak to a “live person” regarding the situation.

If the child reports experiencing any side effects to the medications, the MDS Staff will note this on the MDS Progress Note, forward the note to the MDS Coordinator, who will discuss the concern with the Genoa Pharmacist and/or forward the note to the Treating Prescriber. The Genoa Pharmacist will decide on the next steps which may include contacting the client's Primary Care Provider or Treating Prescriber.

The MDS Staff complete the following documentation:

- Medication Administration Record (MAR) on a daily basis
  The MAR is completed by the MDS Staff and submitted to the MDS Coordinator on a monthly basis for billing verification.

- MDS Progress Note on a daily basis
  The MDS Progress Notes are completed by the MDS Staff within one (1) business day of the drop. These are completed in the CMH's Electronic Health Record (EHR). Non-routine progress notes are immediately forwarded to the MDS Coordinator for follow up.

- Chart/Contact Note, as needed
  The Chart/Contact Note is completed by the MDS Coordinator for any contact with the parents/guardians outside of the medication drop; contact with members of the MDS Treatment Team; and to record significant information such as admission/discharge to an out of home setting and discharge from the program. This Note is completed in the CMH's EHR.

- Medication Adherence Questionnaire every 6 months
  The MDS Coordinator completes this document initially at the Program Orientation Session. The MDS Program Staff complete this with the child/parent every 6 months.

- MDS Monthly Review Form every 4 to 6 weeks
  The MDS Coordinator completes this document with input from the MDS Staff. The completed document is forwarded to the client's case manager/supports coordinator and treating prescriber.

Education Component

During the drop, the MDS Staff will regularly review with the parent/guardian (and if appropriate, the child) the name of the medications, the medications' physical appearance and purpose, how and when to take the medications, side effects, and environmental precautions to be taken regarding the medications such as in the area of food or exposure to sunlight. If requested by parents/guardians/child, medication information sheets are available. Also available to the parents/guardians/child are information sheets with questions to ask the Treating Prescriber, a booklet on mental health medications in general, and materials that are specifically designed for parents/guardians whose child is taking psychiatric medications.

Care Coordination/Treating Planning Services Component

Genoa's MDS Coordinator will work collaboratively with the child's case manager/supports coordinator to address parents/guardians/child's concerns that arise during the drop visits. In general, if the expressed concern focuses on medication issues, the MDS Coordinator will follow up. If the

expressed concern focuses on non-medication issues, the case manager/supports coordinator will follow up.

The MDS Coordinator will complete and forward the Monthly Review Form to the child's case manager/supports coordinator and treating prescriber. The Monthly Review Form is completed with input from the MDS Coordinator and MDS Staff that are interacting with the child and parents/guardians; as well as, information that is provided by the case manager/other treatment team members over the course of the reporting month. The Monthly Review Form identifies the child's medication adherence rate, identifies the child's medication adherence strength and risk factors, summarizes the parents/guardians and child's progress including using the chosen organizational strategy effectively, and contains recommendations regarding the frequency of the medication drops.

Also as part of care coordination, the MDS Coordinator will participate in the child's treatment planning. Treatment Planning consists of the MDS Coordinator, parents/guardians, child, and any other members of the treatment team (such as Treating Prescriber) that the parents/guardians/child wishes to have present, including the case manager/supports coordinator, when developing the goal, objectives and interventions for the MDS Program during the program orientation session. Within 14 calendar days of the program orientation session, the MDS Program goal, objectives and interventions are forwarded to the case manager/supports coordinator for inclusion in the child's family centered plan.

The MDS Program Goal will be reviewed at the ongoing MDS Treatment Team planning sessions, which will typically occur at the time of the child's medication review appointment. If the MDS Coordinator participates in the Treatment Team planning session, the MDS Coordinator will complete the MDS Treatment Team Review Form (the same form as the MDS Monthly Review Form) which summarizes the child's progress, medication adherence strength and risk factors for the child, and recommendations regarding the frequency of the medication drops. If the case manager/supports coordinator does not attend the MDS Treatment Team planning session (Med Review). When applicable, the MDS Coordinator will also share the recommendations from the MDS Treatment Team planning session (Med Review) with the MDS Staff.

Outcome Measurements:

Individual Outcomes:

1. Medication Adherence

Adherence is defined as the child ingests ALL prescribed dosages of his/her medications on an "available day". An "available day" is defined as the child is in the community and in the MDS designated service area.

Monthly Adherence is defined as the following:

- Full Adherence is defined as the child taking his/her medications 80% or more of the available days in a month.

- Partial Adherence is defined as the child taking his/her medications 60-79% of the available days in a month

- Non-Adherence is defined as the child taking his/her medications 59% or less of the available days in a month,

Program Adherence is defined as the following:

- Full Adherence is defined as the child taking his/her medications 80% or more of the available days while in the program.

- Partial Adherence is defined as the child taking his/her medications 60% to 79% of the available days while in the program.

- Non-Adherence is defined as the child taking his/her medications 59% or less of the available days while in the program.

80% of the children who participate in the program shall attain Full Adherence while in the program.

2. Reduction in Psychiatric Inpatient Admissions

70% reduction in psychiatric inpatient hospital admissions by children who have a history of psychiatric inpatient hospital usage as measured by a comparison of psychiatric inpatient hospital admissions in the 12 months prior to program admission to psychiatric inpatient hospital admissions while in the program. The 12 months prior data will be obtained from the CMH's EHR.

70% reduction in psychiatric inpatient hospital days used by children who have a history of psychiatric inpatient hospital usage as measured by a comparison of inpatient hospital days used in the 12 months prior to program admission to days used while in the program. The 12 months prior data will be obtained from the CMH's EHR.

3. Reduction in Out of Home Respite Admissions

75% reduction in out of home respite admissions by children who have a history of out of home respite usage as measured by a comparison of out of home respite admissions in the 12 months prior to program admission to out of home respite admissions while in the program. The 12 months prior data will be obtained from the CMH's EHR.

75% reduction in out of home respite days used by children who have a history of out of home respite usage as measured by a comparison of out of home respite days used in the 12 months prior to program admission to days used while in the program. The 12 months prior data will be obtained from the CMH's EHR.

Other Individual Data Measures:

1. Indicators related to Medication Adherence Strengthening and Risk Factors

An increase in medication adherence strengthening factors self- reported by the parents/guardians/child as measured by their first completion of the Medication Adherence Questionnaire (MAQ) compared to their second/last completion of the Medication Adherence Questionnaire. The child MUST have at least 2 completed MAQs to be included in "second/last" data set.

A decrease in medication adherence risk factors self-reported by the parents/guardians/child as measured by their first completion of the Medication Adherence Questionnaire compared to their second/last completion of the Medication Adherence Questionnaire. The child MUST have at least 2 completed MAQs to be included in the "second/last" data set.

The number of children who discharge from the program that are able to independently adhere to their medication regimen without assistance or with assistance.

2. Indicators related to Medical Admissions

The number of children who self-report a history of medical hospital usage shall reduce their medical hospital usage while in the program. This also includes the parents/guardians report relative to the children's medical hospitalizations.

A decrease in the number of medical hospital admissions by children who self- report a history of medical hospital admissions as measured by a comparison of medical hospital admissions in the 12 months prior to program admission to medical hospital admissions while in the program. The 12 months prior data represents children's self –report at the time of the Program Orientation Session.

A decrease in the number of medical hospital days used by children who have a history of medical hospital days as measured by a comparison of the medical hospital days used in the 12 months prior to program admission to days used while in the program. The 12 months prior data represents children's self-report at the time of the Program Orientation Session.

3. Indicators related to Juvenile Detention/Youth Home Admissions

The number of children who self-report a history of juvenile detention/youth home usage shall reduce their juvenile detention/youth home usage while in the program. This also includes the parents/guardians report relative to the children's medical hospitalizations.

A decrease in the number of juvenile detention/youth home admissions by children who have a history of juvenile detention/youth home admissions as measured by a comparison of juvenile detention/youth home admissions in the 12 months prior to program admission to juvenile detention/youth home admissions while in the program. The 12 months prior data represents child's self-report at the time of the Program Orientation Session.

A decrease in the number of juvenile detention/youth home used by children who have a history of juvenile detention/youth home days as measured by a comparison of days in juvenile detention/youth home in the 12 months prior to program admission to days in juvenile detention/youth home while in the program. The 12 months prior data represents child's self-report at the time of the Program Orientation Session.

System Outcomes:

A reduction in psychiatric hospital admissions as measured by a comparison of the number of psychiatric hospital admissions for the Med Drop children in the 12 months prior to program admission to admissions while in the program. The 12 months prior data will be obtained from the CMH's EHR.

A reduction in psychiatric hospital days as measured by a comparison of the number of psychiatric hospital days used for the Med Drop children in the 12 months prior to program admission compared to psychiatric hospital days used while in the program. The 12 months prior data will be obtained from the CMH's EHR.

A reduction in out of home respite admissions as measured by a comparison of the number of out of home respite admissions for the Med Drop children in the 12 months prior to program admission to admissions while in the program. The 12 months prior data will be obtained from the CMH's EHR.

A reduction in out of home respite days as measured by a comparison of the number of out of home respite days used for the Med Drop children in the 12 months prior to program admission compared to out of home respite days used while in the program. The 12 months prior data will be obtained from the CMH's EHR.

The Med Drop Program Manager will complete a quarterly program evaluation report. The reporting dates are January 30th, April 30th, July 30th and October 30th. The Med Drop Program Manager will complete an annual program outcome report. This reporting date is October 30th. In order for the MDS Coordinator to complete these reports in a timely manner, the 12 month prior data for psychiatric inpatient hospital admissions, psychiatric inpatient days usage, out of home respite admissions, and out of home respite days usage needs to be obtainable from the CMH's EHR.

Referral Process:

Children will be identified for this program by the CMH/CMH's Provider Network staff. The referring staff member, in most cases this person is the case manager/supports coordinator, will complete the Program Referral Form and concurrently submit the initial authorization for 90 days of medication drop services. This authorization will consist of submission for one (1) assessment session-H0031, three (3) Treatment Planning Sessions-H0032, and 90 days of medication drop services (H2015)

Eligibility Determination and Program Acceptance:

The MDS Coordinator receives the referral and checks the CMH's EHR to see that the initial authorization has been approved. When these two (2) items are in place, within two (2) business days, the MDS Coordinator contacts the individual's case manager/supports coordinator to complete the Assessment of Client's Medication Assistance Need. The Assessment of Client's Medication Assistance Need assists in determining the child's appropriateness for the Med Drop Program as well as the child's initial drop frequency. At the end of this conversation, the MDS Coordinator and case manager/supports coordinator identify a date and time for the Program Orientation Session. It is the case manager/supports coordinator's responsibility to contact the referred child's parents/guardians and schedule the Program Orientation Session.

Authorizations

The CMH will generate an initial authorization for 90 days of medication drop services-H2015, one (1) assessment- H0031 and three (3) treatment planning sessions-H0032.

At the end of each authorization period, one (1) of the following is expected to have occurred:

1. The parents/guardians are able to independently ensure that the child takes his or her medications as prescribed. The parent/guardian no longer needs the MDS Staff to

coach him/her on how to organize the medications and the child is ingesting his/her medications when prompted/observed by parent/guardian. The parent/guardian and child are ready for the program to end. As the child is preparing for discharge, the parents/guardians can choose to have Genoa Pharmacy continue to dispense the medications in Dispill. If the parent/guardian chooses this option, Genoa Pharmacy will continue to contact the child's providers for medication refills and prepare the child's medication on a monthly basis for pick up or to be mailed.

2. The parent/guardian/child has made progress and can continue to benefit from the Med Drop Program. In some cases, the child may be ready to have his/her drop frequency reduced. For this reason, the Med Drop Program is expected to continue per the recommendation of the MDS Treatment Team and a continued authorization request will be submitted by the child's case manager/supports coordinator.

3. The parent/guardian/child has made no progress and the MDS Treatment Team makes a recommendation regarding a different level of care outside of the Med Drop Program. Within the context of the family centered planning process, this recommendation is discussed with the parent/guardian and child. If the parent/guardian/child agrees, the case manager/supports coordinator will facilitate a referral to the recommended level of care.

The MDS Coordinator will collaborate with the case manager/supports coordinator to submit ongoing authorization requests in 90 day increments.

When the child exits the program, the MDS Coordinator will complete a discharge note in the CMH's EHR. This note will be forwarded to the case manager/supports coordinator and treating prescriber.

Reimbursement:

Service Description	**Code**	**Unit**
Community Living Supports (CLS)	H2015	Per 15 minute face to face
Treatment Planning	H0032	Per Encounter
Assessment by Non-Professional	H0031	Per Encounter

The MDS program will use the following codes: H0031- 1 Assessment per year; H0032- 1 per quarter; and H2015- drop days/units based upon child's clinical needs. The codes are only reimbursable if the child is present. In addition, to bill the H0032, another member of the child's Treatment Team (treating prescriber, case manager/supports coordinator, nursing staff, etc) must be present.

Staff Qualifications:

The Med Drop Program administration consists of the Genoa Healthcare Pharmacist, who supervises the Med Drop Pharm Tech; Med Drop Program Manager- LMSW who ensures the Med Drop Program Services are implemented as described; and a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who works with the Med Drop Services (MDS) Staff and ensures the medications are properly stored, accounted for and dropped as prescribed.

The MDS Staff will possess the following minimum qualifications:

- At least 18 years old
- High School Diploma or GED equivalent
- At least 1 year of experience working with children with behavioral challenges or mental illness, preferred.
- Must have reliable transportation
- Able to practice prevention techniques to reduce transmission of any communicable disease
- Able to follow/implement the client's Medication Drop Services (MDS) Treatment Goal, Objectives and Interventions.
- Able to perform basic first aid and emergency procedures
- Be in good standing with the law (not a fugitive from justice, a convicted felon, or an illegal alien)
- Be trained in Recipient Rights
- Be able to use good judgment/follow procedures in addressing client concerns/issues
- Demonstrate the ability to work independently and as a part of a coordinated team.
- Excellent interpersonal, verbal and written communication, time management and organizational skills

Quality Assurance:

Genoa's Med Drop Program Manager will conduct an annual internal and external review of the Med Drop Program utilizing the MDS Program Review forms.

MDS Program Contact Information:

CMH/Funding Source	Genoa Healthcare
TBD	Diane Cranston MDS Program Manager 517-945-3863 dcranston@genoahealthcare.com

References:

[1]MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual & Developmental Disability Supports and Services p. 133 January 1, 2020.

Exhibit B

MED DROP™ Program- Children
Program Referral Form

Date: _____

Child's Information:

Name: _____ DOB: _____ SS #: _____

_____

Address (Street, City, State, and Zip): _____

Insurance Type (Ex: Medicaid, Medicare, Commercial, and Uninsured): _____

_____

Parent/Guardian's Name: _____ Relationship to Child: _____

Phone Number(s): H: _____ C: _____

School Information:

Name and Address of Child's School: _____

Child's Grade: _____ What time does the Child leave for school in AM? _____

_____

Does the Child receive Special Education Services? ☐No ☐Yes* *Explain _____

_____

Parent Information:

Is CPS Involved with the family? ☐No ☐Yes* * Explain _____

_____

Is the Child a Temporary Court Ward (TCW)? ☐No ☐Yes * * Explain _____

_____

Is the Child a Permanent Court Ward (PCW)? ☐No ☐Yes* * Explain _____

_____

Does parent/guardian have Full Legal Custody or Joint Legal Custody of Child? _____

_____

If the parents have Joint Legal Custody, are both parents in agreement, and willing to participate in the MDS Program? ☐Yes ☐No* *Explain _____

_____

Has the MDS Program been explained to the Child and Parent/Guardian? ☐Yes ☐No

Does the Parent/Guardian know that the MDS Coordinator will be contacting him/her to schedule a Program Orientation/Intake? ☐No ☐ Yes* *Is the Parent/Guardian expecting a call within a certain time frame from the MDS Coordinator? ☐No ☐ Yes* * Identify the time frame that was given to the Parent/Guardian: _____ Are the Child and Parent/Guardian willing to actively participate in the MDS Program? ☐Yes ☐No

Medication Information:

List the child's current behavioral health medications and current name and address of pharmacy:

_____

_____

If applicable, does the Parent/Guardian want to include the child's physical health medications in the MDS Program? ☐ No ☐ Yes* *List the medications and current name and address of pharmacy:

_____

Can the MDS Staff safely deliver daily medications to the Child's Address? ☐Yes ☐No* If No, is the Child
and Parent/Guardian willing to meet the MDS at a different location (indicate address)? _____

_____

Additional Comments regarding Child's Address: _____

_____

SCCMHA Information:
Primary Clinician's Name: _____
Phone Number: W: _____ C: _____
Treating Prescriber Name: _____
Phone Number: W: _____ C: _____
The Child and Parent/Guardian are receiving the following SCCMHA Services: _____

_____

Eligibility Criteria:

Age: Child is between the ages of 7 and 17. ☐Yes ☐No* *Child is not eligible for program
CAFAS Score: Date of Most Recent CAFAS Administration _____ The date MUST be within 90 days of the date of the referral. If the date is not within 90 days of the referral date, the CAFAS MUST be administered prior to making the referral to the MDS Program.
Enter CAFAS Subscale Data:

	School/ Work	Home	Community	Behavior Toward Others	Moods/ Emotions	Self-Harmful Behavior	Substance Use	Thinking
Impairment Score								
Item Numbers (list all applicable items)								

Child and/or Parent(s)/Guardian(s) meets: (Check all that apply):

☐ Child is not taking medications (ex: refusing, hoarding, hiding, cheeking meds etc.)

☐ Child is exiting a residential setting, including out of home respite, juvenile detention or youth home

☐ Child is exiting a psychiatric or physical health care setting

☐ Parent(s)/Guardian(s) are forgetting to give the medications to the child

☐ Parent(s)/Guardian(s) are having challenges organizing the child's medications

☐ Parent(s)/Guardian(s) are having their own challenges that make it difficult to ensure their child receives

his/her medication as prescribed

☐ DHS has stipulated that the child must receive his/her medication as prescribed

☐ Family Court has stipulated that the child must receive his/her medication as prescribed

☐ Other: (Explain): _____

_____ _____

Referring SCCMHA Staff Member Signature Date

Referring SCCMHA Staff Member's Phone Number and Email Address if not included above:

******The Initial Authorization for the MDS Program MUST be attached to this Referral Form*****

Forward completed Referral Form and Initial Authorization to: Sarah Charbonneau-Whyte Med Drop Coordinator through the Sentri E-Mail System, or fax to 989-793-3133. If you have questions, feel free to contact Sarah at 989- 574-7727.

Exhibit C

MED DROP™ Program- Children
Medication Adherence Questionnaire

Child's Name: _____ DOB: _____

Parent/Guardian's Name: _____

Questionnaire Completion Date: _____Person Completing Questionnaire: _____

Your MDS Staff Member and MDS Coordinator would like to work with you and your parent/guardian in a way that best addresses your thoughts, attitudes and actions regarding taking your mental health medications. For this reason, I want to ask you and your parent/guardian some questions to get a sense of what you and your parent/guardian think about you taking psychiatric medications.

Questions to Child:

1. Why do you have to take medications? If the child says "I don't know", ask him/her "What has your Doctor or Parent told you are the reasons why you have take the medication"?

2. Do you think the reasons that you just said about having to take your medications are True for you[1]?

3. Do you know the names of your medications and what they are for?

4. Do you like your doctor[1]?

5. Do you like your therapist? If the child looks puzzled, ask "Do you like the person that comes to your house to work with you and your family?

6. Are the medications making you feel different in a bad way?

7. Are your medications helping you to feel or act better[1]?

8. Do you forget to take your medications?

9. Do you sleep well[1]?

10. Does your Best Friend know that you are taking meds? Does anyone else know that you are taking meds? How do you feel about people knowing that you are taking meds[2]?

11. Is this a true statement for you " I am only taking medications because my parents are making me[2]."

12. Do you drink alcohol? Do you use marijuana? Do you use other drugs[2]?

13. What concerns/worries do you have about taking medications?

Questions to Parents:

1. What is your child's psychiatric diagnosis? Do you believe this is true for your child[1]?

2. What are your child's current mental health medications and what symptoms are they prescribed for?

3. Has your child taken mental health medications in the past? Do you remember their names? How did the mental health medications work*/not work for him/her[1]?

4. Do you like your child's Psychiatrist/NP/PA[1]?

5. Is your child reporting or complaining of side effects to the medications?

6. Do your child's side effects bother him/her as he/she goes about his/her daily activities[2]?

7. Are your parents/family members/friends supportive in you giving psychiatric medications to your child[1]?

8. Is this a true statement for you “I do not want anyone to know that I am giving psychiatric medications to my child because they would judge me, criticize me, think less of me as a parent” [2]?

9. Do you think your child’s symptoms/behaviors are improving with the use of the medications[1]?

10. Do you forget to give your child his/her medications? If so, how many days per week do you forget?

11. Does your child sleep well[1]?

12. Is this a True Statement: “My child is only taking his/her medications because I am making him/her do it. He/She really does not want to take psychiatric medications.”[2]?

13. Does your child drink alcohol? Does your child use marijuana? Does your child use other drugs[2]?

14. What are your top 3 concerns regarding your child’s medications?

Yes[1]=Strength No[1]= Risk No[2]= Strength Yes[2]= Risk Total = 15

Exhibit D

MED DROP™ Program- Children
Monthly Review / MDS Treatment Team Review (circle applicable review)

Child's Name: _____DOB: _____Review Date: _____

Start Time: _____End Time: _____ Current Service Level:_____

Individuals participating in Review: _____

Reporting Month (indicate the number of months in the program)**:** _____
# of Days in Psych Hospital: __ # of Days in Medic Hospital: __ # of Days in Respite: ___ # of Days in Yth Home: ___

Adherence Rate:
In the past month, the child has attained the following adherence rate: (__increase __decrease ___same as before)

- ☐ Full Adherence - taking medications as prescribed 80% or more days in the month. Rate:_____
- ☐ Partial Adherence - taking medications as prescribed 60-79% days in the month. Rate:_____
- ☐ Non-Adherence - taking medications as prescribed 59% or less days in the month. Rate:_____

Medication Adherence Factors:
The following <u>Medication Adherence Strengthening Factors are present</u>: (circle/check all that apply):

- ☐ Child believes that he/she has a serious emotional disturbance/mental illness
- ☐ Parent/Guardian believes that the child has a serious emotional disturbance/mental illness
- ☐ Child accepts that he/she has a serious emotional disturbance/mental illness
- ☐ Parent/Guardian accepts that the child has a serious emotional disturbance/mental illness
- ☐ Child believes his/her symptoms/behaviors will/are improving with the medications
- ☐ Parent/Guardian believes the child's symptoms/behaviors will/are improving with the medications
- ☐ Child likes his/her doctor, Wraparound Facilitator or Primary Clinician
- ☐ Parent/Guardian likes the child's Prescriber, Wraparound Facilitator or Primary Clinician
- ☐ Parent/Guardian believes the benefits outweigh the risks for his/her child taking medications
- ☐ Child feels better when taking medications
- ☐ Parent/Guardian believes the child's overall functioning is improving
- ☐ Child is bothered by/concerned about the medication's side effects
- ☐ Parent/Guardian is bothered by/concerned about the medication's side effects
- ☐ Child's friends are supportive in him/her taking mental health medications
- ☐ Parent/Guardian's family members/friends are supportive in him/her giving medication to the child.

The following <u>Medication Non-Adherence Risk Factors are present</u>: (circle/check all that apply):

- ☐ Parent/Guardian does not believe or accept that the child has a serious emotional disturbance or mental illness
- ☐ Parent/Guardian does not like the child's Prescriber, Wraparound Facilitator or Primary Clinician

- ☐ Child reports the medications are not working/symptoms are not improving
- ☐ Parent/Guardian reports the medications are not working/symptoms are not improving
- ☐ Child is not able to tolerate the side effects
- ☐ Parent/Guardian is concerned about side effects
- ☐ Child's friends do not support him/her taking mental health medications
- ☐ Parent/Guardian's family members or friends do not support him/her giving psychiatric meds to child
- ☐ Stigma- child is ashamed to take medications, feels judged by others for taking medications
- ☐ Stigma- parent/guardian is ashamed, feels judged by others that his/her child is taking meds
- ☐ Family Court or DHS has stipulated that the parent/guardian must participate in the MDS Program
- ☐ Child is only taking medications because the parent/guardian/Family Court/DHS is making him/her
- ☐ Child has tried medications in past and reported they have not worked
- ☐ Parent/Guardian does not have transportation to pick up medications
- ☐ Parent/Guardian does not have money to pay for medications
- ☐ Parent/Guardian forgets to give the medications to the child

Medication Knowledge Areas: (check all that apply)

The Parent/Guardian can state the following:

- ☐ The names of the child's medications
- ☐ The purpose of the child's medications
- ☐ How and when the child is to take the medications
- ☐ Side Effects of the medications
- ☐ Environmental Factors (food, etc.) to avoid when taking the medications

Organizational Strategies:

The Parent/Guardian (child if appropriate) is:
☐ Working on this ☐ Not working on this ☐ Completed

MDS Treatment Goals:

The Parent/Guardian (child if appropriate) is:
☐ Working on this ☐ Not working on this ☐ Completed

Readiness for Taking Medications Independently:
The Parent/Guardian is ready to decrease the frequency of the medication drops

☐ Yes ☐ No Provide Rationale: _____

_____

_____

_____

Exhibit E

MED DROP™ Program
Assessment of Client's Medication Assistance Need

Client's Name: _____

Date Completed: _____ **Name of Person Completing: _____**

This is to be completed with Referral Source/Case Manager prior to Program Orientation Session. This is to be referenced during the Program Orientation Session.

1. What is the Referral Source's goal for the child who he/she is referring to the Med Drop Program?

   a. Does the person expect the child to come into the program for a short period of time 3-6 months and then be able to successfully complete the program? If so, why?

   b. Does the person think the child will be in the program for a long period of time? If so, why?

2. Review the following "Need Factors" with the Referral Source & Child/Guardians/Parents:

   a. Does the child have a co-occurring disorder?

   Does the child have a history of abusing/misusing prescription medications?

   Can medications be left in the child's possession?

   b. Is the child at risk for going into an out of home placement?

Does the child already have In Home CLS services?

c. Is the child experiencing active clinical symptoms?

Are the symptoms due to the treating prescribing adjusting medications to find a medication regimen that works? Or, is this the child's clinical baseline?

d. Does the child have chronic medical conditions that are of concern?

e. How many medications is the child taking including psychiatric and physical health?

f. Can the child/parents/guardians read and write?

g. Does the child/parents/guardians have cognitive/learning challenges including an Intellectual Developmental Disorder?

h. Does the parents/guardians have physical challenges to managing medications? Inability to open DISPILL or bottles? Vision/Blindness Problems? Hearing/Deafness Problems? Physical Health Concerns? Extreme Shaking Hands, etc.?

i. Does the client/parents/guardians have memory issues that are Not related to a cognitive/learning challenge or Intellectual Developmental Disorder?

3. Is someone helping the parents/guardians/child with the child's medications now?

   What is the level of help? Is it specific phone calls at a certain time? Is it having possession of the meds? Is it taking the medicine out of the bottle and giving to the child? Or is it intermittently asking the child if he/she is taking her medications with no further oversight?

   Does the parent/guardian have regular "scheduled" help with medications. If so, how many days of the week?

4. Based upon all of the above, what drop frequency is the Referral Source recommending for the child? Does the Treating Prescriber support his/her recommended frequency?

<table>
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<tr><td>Subject: Services for American Indians</td><td>Chapter: 03 – Continuum of Care</td><td>Subject No: 03.02.34</td></tr>
<tr><td rowspan="2">Effective Date:
5/5/16</td><td>Date of Review/Revision:
6/13/17, 4/10/18, 4/9/19, 7/29/20, 5/10/22</td><td rowspan="2">Approved By:
Sandra M. Lindsey, CEO</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td><td>Responsible Director:
Executive Director of Clinical Services

Authored By:
Barbara Glassheim

Additional Reviewers:</td></tr>
</table>

Purpose:

The purpose of this policy is to ensure the provision of and/or coordination of services to American Indians is person/family-centered, trauma-informed, recovery-oriented, developmentally and phase-of-life appropriate, culturally and linguistically sensitive and promotes consumer engagement and shared decision-making using evidence-based practices and treatments to maximize the potential for beneficial outcomes.

Policy:

SCCMHA shall provide holistic, person/family-centered, trauma-informed, developmentally and phase of life appropriate care which recognizes the particular cultural and linguistic needs of the consumer and addresses health disparities..

Services for American Indian consumers may be provided either directly or via agreement with tribal providers. In some instances, services may be provided conjointly by SCCMHA and tribal providers.

Application:

This policy applies to the delivery of all services and supports funded by SCCMHA for persons with a mental illness, substance use disorder, intellectual/developmental disability as well as children and youth with a severe emotional disturbance.

Standards:

A. SCCMHA shall address the five nationally accepted core elements of cultural competence in serving members of any distinct cultural group, including American Indians:
   1. Awareness, acceptance and valuing of cultural differences
   2. Awareness of one's own culture and values
   3. Understanding the range of dynamics that result from the interaction between people of different cultures

4. Developing cultural knowledge of the particular community served or to access cultural brokers who may have that knowledge
5. Ability to adapt individual interventions, programs, and policies to fit the cultural context of the individual, family, or community

B. SCCMHA shall offer cultural competency training to providers in order to help them understand and appreciate American Indian culture.

C. SCCMHA shall offer choice of providers to eligible members of the Saginaw Chippewa Indian Tribe residing in Saginaw County who request mental health services.
   1. SCCMHA shall serve American Indians who request and meet criteria for services.
      a. SCCMHA shall engage and coordinate care with the Saginaw Chippewa Indian Tribe Behavioral Health Program when serving members of the tribe.

D. SCCMHA shall work with the Saginaw Chippewa Indian Tribe Behavioral Health Program to assist in the provision of services to tribal members who are SCCMHA consumers and to help inform the provision of culturally appropriate services to those consumers including traditional approaches to care.
   a. Every effort shall be made to ensure services and supports are compatible with the Tribe's traditional healing practices and commitment to restoring the balance of the mind, body, and spirit and address mental health issues specific to Tribes including, but not limited to, historical trauma, relocation, grief and loss, foster placement, physical, sexual, emotional, spiritual abuse, reactive attachment disorder, and trauma.

E. SCCMHA shall develop and implement an agreement to coordinate care and/or fund services on an out-of-network basis for persons deemed eligible for SCCMHA services who are tribal members and seek services at the Saginaw Chippewa Indian Tribe Behavioral Health Program.
   1. SCCMHA shall authorize medically necessary services provided to eligible Medicaid and Healthy Michigan Plan beneficiaries who are eligible to receive services from the Saginaw Chippewa Indian Tribe Behavioral Health Program in accordance with established medical necessity criteria.
   2. SCCMHA shall provide crisis screening and intervention, including authorization for inpatient psychiatric hospitalization services, for tribal members when needed.
   3. SCCMHA case holders shall coordinate care for consumers who are serviced by both SCCMHA and the Saginaw Chippewa Indian Tribe Behavioral Health Program.
   4. Reimbursement rates to the Chippewa Indian Tribe Behavioral Health Program shall be in alignment with SCCMHA network rates for like services.

Definitions:

Culture: The beliefs, customs, social norms, and material traits of a racial, religious, or social group. It affects the group members' viewpoints: how they act; how they think; and how they see themselves in relation to the rest of the world. Culture is also defined as a

particular society that has its own beliefs, ways of life, art, etc. or a way of thinking, behaving, or working that exists in a place or organization (such as a business).

Culture is transmitted through language, symbols, and rituals. Cultural differences can be manifested in help-seeking behaviors, language and communication styles, symptom patterns and expressions, nontraditional healing practices, and the role and desirability of an intervention or treatment.

Cultural Customs: A particular group or individual's preferred way of meeting their basic human needs and conducting daily activities as passed on through generations. Customs are influenced by: ethnicity, origin, language, religious/spiritual beliefs, socioeconomic status, gender, sexual orientation, age, marital status, ancestry, history, gender identity, geography, etc. American Indian cultural customs are expressed via material culture such as food, dress, dance, ceremony, drumming, song, stories, symbols, and other visible manifestations.

Cultural Competence: Recognition of the importance of the cultures, skills, knowledge, and policies needed to deliver effective treatments. Cultural competence is demonstrated through respecting and valuing differences among consumers, assuming responsibility to address these differences, and an appraising the effectiveness of an organization's ability to address cultural differences.

Cultural Identity: The character or feeling of belonging to a group that is part of a person's self-conception and self-perception and is related to nationality, ethnicity, religion, social class, generation, locality or any kind of social group that has its own distinct culture. An individual's own personal and family history determines their cultural identity and practices, which may change throughout the lifespan as they are exposed to different experiences.

Ethnicity: A population or group having a common cultural heritage that is distinguished by customs, characteristics, language, and common history.

Diversity: Differences in geographic location (rural, urban), sexual orientation, age, religion or spiritual practice, socioeconomic status, and physical and mental capacity.

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D. SCCMHA Policy 02.01.01.02 – Cultural Competence

E. SCCMHA Policy 02.03.05 – Recovery

F. SCCMHA Policy 02.03.08 – Welcoming

G. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
H. SCCMHA Policy 03.02.46 – Whole-Person Care
I. Substance Abuse and Mental Health Services Administration (SAMHSA). (September 2010). *American Indian and Alaska Native Culture Card: A Guide to Build Cultural Awareness.* SAMHSA. Rockville, MD. [On-line]. Available: https://store.samhsa.gov/sites/default/files/d7/priv/sma08-4354.pdf.

Exhibits:
None

Procedure:
None

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Serving LGBTQ+ Consumers	**Chapter**: 03 – Continuum of Care	**Subject No**: 03.02.35
Effective Date: 5/5/16	**Date of Review/Revision**: 6/13/17, 4/10/18, 4/9/19, 8/21/20, 4/8/21, 5/10/22 **Supersedes**:	**Approved By**: Sandra M. Lindsey, CEO
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Executive Director of Clinical Services **Authored By:** Barbara Glassheim, Heidi Wale Knizacky **Additional Reviewers**:

Purpose:

The purpose of this policy is to provide basic information regarding LGBTQ+ culture and terminology as well as to ensure that consumers with mental illnesses, substance use disorders, severe emotional disturbances and intellectual/development disabilities who are lesbian, gay, bisexual, transgender, questioning, intersex, pansexual, two-spirit, and other types of sexual orientation or gender identity minority (LGBTQ+) are provided with high-quality, culturally competent services and supports.

Policy:

SCCMHA shall provide gender/identity affirming, person/family-centered, trauma-informed, developmentally and phase of life appropriate, recovery-oriented, and culturally and linguistically sensitive services to consumers who identify as LGBTQ+ in a manner that promotes consumer engagement and shared decision-making.

Background:

LGBTQ+ people who have mental health needs face significant challenges in receiving quality mental health care. Prejudice and discrimination against LGBTQ+ people has been well-documented and widely acknowledged. The physical and behavioral health of LGBTQ+ consumers can be affected by prejudice, discrimination, phobia and other negative behaviors and attitudes exhibited by the public at large. Physical and behavioral health challenges can be compounded when these negative behaviors and attitudes are perpetuated by providers responsible for representing and implementing behavioral health care programs.

People who do not fit into conventional heterosexual and gender roles have been pathologized for much of the history of psychiatry. Homosexuality was considered a mental illness until the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and a psychiatric illness in the International Statistical Classification of Diseases, Ninth Edition (ICD-9). LGBTQ+ people seeking mental health care continue to

encounter mental health providers who consider their sexual orientation and/or gender identity a delusion or a symptom that will "go away" when their mental illness is resolved. As of 2020, Gender Dysphoria (DSM-5) remains a current diagnosis provided for treatment of individuals who are experiencing both incongruence between their assigned and expressed gender and significant distress related to this incongruence. Disagreement remains among some mental health providers regarding the application of this diagnosis and the implication that it may label transgender individuals as "mentally ill". However, mental health licensing bodies, such as the American Psychological Association, the National Association of Social Workers, and the American Counseling Association, have formal statements that recognize both sexual orientation and gender identity as normal, healthy spectrums, and proclaim expectations that their members are culturally competent in serving LGBTQ+ individuals. Homophobic attitudes among mental health services providers and heterosexist mental health programs create barriers to recovery and undermine the effectiveness of treatment and support services.

Within the LGBTQ+ population, several sub-groups are at higher risk for behavioral health concerns. LGBTQ+ individuals of any age who are in the process of coming out to themselves, their families and their communities are at especially high risk for suicide, drug and alcohol abuse, depression and physical abuse. LGBTQ+ youth are at much greater risk for suicide attempts, physical victimization and substance abuse. Individuals in rural communities may also be at higher risk due to increased visibility, ripple effects of rejection, isolation and the absence of affirmative behavioral health resources. LGBTQ+ parents and other family members, elders, immigrants, and people with HIV/AIDS and other physical disabilities face uniquely complex sets of challenges.

While LGBTQ+ people are identified as such by their sexual, affectional or social preferences, transgender people identify as transgender based on their own sense of their own gender. Transgender and intersex people are often the target of harassment and assault and may be especially impacted by societal and internalized transphobia, violence, discrimination, family problems, isolation, lack of educational and job opportunities, lack of access to health care, and low self-esteem. Many transgender people have had negative experiences with providers of health care, and they may be distrustful of providers.

LGBTQ+ people of color and LGBTQ+ women face the compounded life challenges of discrimination and disempowerment based on perceived race and gender, mixed in with their own LGBTQ+ identity and presentation. These challenges are further complicated among people with low incomes who comprise much of the consumer population served by the public mental health system.

In many cases, even the self-identification of an LGBTQ+ person as lesbian, gay, bisexual, or transgender is challenged or denied by the mental health care providers who are entrusted to support the person, in the name of "repairing" or "converting" the person to a "normal" condition.

Despite some recent advances in understanding and acceptance, LGBTQ+ individuals remain subject to the traumas of negative stereotyping, rejection, marginalization, and discrimination, all of which impede help-seeking behaviors. Due to homophobia and discrimination against LGBTQ+ individuals, some may find it difficult or uncomfortable to access treatment services. Substance abuse treatment programs are often not equipped to meet the needs of this population. Heterosexual and cisgender treatment staff members may be uninformed about LGBTQ+ issues, may be insensitive to

or antagonistic toward LGBTQ+ clients, or may falsely believe that sexual orientation or gender identity causes substance abuse or can be changed by therapy. These beliefs by providers become barriers to treating the LGBTQ+ client.

However, while social prejudice and discrimination create stress that increases risk for some LGBTQ+ individuals and groups, this population has also demonstrated significant resiliency and resourcefulness. The LGBTQ+ community has struggled, and in many cases succeeded, in responding to these needs over time by providing community members with affirmative resources and counseling from mental health and substance-related care tailored to the needs of LGBTQ+ people.

Application:

This policy applies to all SCCMHA-funded services and supports provided to persons with mental illnesses, substance use disorders, intellectual/developmental disabilities and children with severe emotional disturbances.

Standards:

A. SCCMHA values diversity and inclusiveness including, but not limited, to race, ethnicity, age, religion, gender, sexual orientation, and disability among others, and shall provide services and supports in a manner that is sensitive to the concerns of diverse consumers including those who are LGBTQ+.
   1. SCCMHA shall create a safe and welcoming atmosphere safe for LGBTQ+ people.
   2. SCCMHA-funded providers shall display the appropriate cultural awareness, knowledge and skill to create a welcoming environment for behavioral health consumers of every sexual orientation, gender identity and gender expression.

B. SCCMHA shall use inclusive language in policies and practice including:
   1. Using gender-neutral terms such as partner, spouse, loved one, child, and caregiver to avoid heteronormative and gender binary language, which can be discriminatory.
   2. Avoiding the use of words such as lifestyle, sex-change, and homosexual, as these may be offensive and inappropriate.
   3. Asking individuals to identify their own pronouns, preferred name, and preferred identity terms and adhering to these terms when talking to and about the individual and adding documentation to their medical record.

C. SCCMHA shall provide culturally competent, trauma-informed, integrated treatment and recovery support services that are grounded in a strengths-based, shared decision-making approach to LGBTQ+ people.

D. SCCMHA shall deliver services and supports that are LGBTQ+-welcoming and respectful by:
   1. Not assuming anyone is straight or cisgender.
   2. Not assuming an individual will disclose their sexual orientation or gender identity if not asked.
   3. Not viewing an individual’s sexual orientation or gender identity as a behavioral target or symptom in need of treatment intervention.
   4. Avoiding influencing or implying a pre-determined outcome when working with individuals who are questioning their sexual orientation or gender identity.

5. Recognizing that, while being LGBTQ+ does not imply need for treatment, individuals who are LGBTQ+ are at increased risk for experiences of trauma and minority stress and a thorough assessment should be completed to identify all needs.
6. Recognizing and supporting the function of self-actualizing behaviors of LGBTQ+ individuals and avoiding labels and diagnoses – such as Oppositional Defiant Disorder – that place the burden of change on the individual when the conflict is, in fact, due to inappropriate family or societal response.

E. LGBTQ+-affirmative values shall be reflected in in employee training, supervision, and evaluation.

F. SCCMHA shall include topics regarding LGBTQ+ cultures and communities during cultural awareness and competency trainings.
1. SCCMHA shall provide staff education regarding the LGBTQ+ population.
2. Training will encourage culturally affirmative environments of care for LGBTQ+ consumers and family members.

G. SCCMHA shall promote LGBTQ+ tolerance in the community and speak out against discrimination and intolerance.
1. SCCMHA shall forge relationships with LGBTQ+ groups and resources by attending their events, meeting to discuss common interests, supporting their efforts, and sharing resources.
2. SCCMHA shall endeavor to help address stigma and microaggressions, including those associated with LGBTQ+ people, and to foster a deeper sense of heritage and community.

H. SCCMHA recognizes the dangers of conversion or "reparative" therapy for LGBTQ+ people and does not provide or support it; SCCMHA supports only those therapies that affirm the identities of LGBTQ+ people and respect their right to self-determination.

I. SCCMHA policies, regulations, training materials and contracts shall reflect protection from discrimination based on sexual orientation, gender identity and gender expression.

J. Consumers, families, providers and staff shall be encouraged to report violations of SCCMHA's policies of non-discrimination and anti-conversion therapy.

K. SCCMHA shall ensure that all practices consider LGBTQ+ needs.
1. SCCMHA shall ensure that all family services are available for domestic partners and significant others of LGBTQ+ consumers.

L. SCCMHA providers shall avoid inadvertently outing LGBTQ+ consumers to others, including to the families of youth being served.

Definitions:

Note: *Language changes, especially around topics such as LGBTQ+ issues that have a history of oppression which leads to covert communication. As conversations, and therefore language, becomes more inclusive, more accurate terms are identified and use of terms evolves. Checking updated sources and – especially – asking preferences of individuals whose language will be used with and about is advised.*

Agender: A person who does not identify with a specific gender.

Ally: A person who identifies as heterosexual and cisgender but is connected to or a part of the LGBTQ+ community and is an advocate of rights for LGBTQ+ people.
Androgyne/Androgynous: A person who presents themselves in a gender-neutral manner or who combines outward characteristics that are typically thought of as masculine or feminine. Androgynous people may identify as male, female, a third gender, or no gender.
Asexual: An individual who does not identify with any sexual orientation because they do not experience sexual attraction; a person who does not feel sexual attraction or a desire to engage in sexual behavior with either men or women.
Bigender: A person who has two genders; exhibiting cultural and/or physical characteristics of male and female roles.
Biphobia: Irrational fear and dislike of bisexual people.
Bisexual: An individual who is attracted to people of both genders or of either gender. This term may be used to describe self-identity, behavior, or both. It may be used to describe a person's past, present, or potential range of romantic and/or sexual attraction. Bisexual people may be monogamous, non-monogamous, or celibate, and may never have had sexual relations with men, with women, or with anyone at all.

Some bisexually identified people indicate that gender is irrelevant to their attraction or choice of romantic partners while others indicate that gender is quite salient and they are attracted to men and to women for different reasons or at different times. (Bisexual does not mean that the person is necessarily involved with both men and women at the same time.)
Bisexuality: The capacity to be romantically and/or sexually attracted to individuals of more than one sex.
Cisgender: An individual who identifies with the gender assigned to them at birth; someone who is not transgender.
Closeted (or "being in the closet"): Lack of disclosure or actively hiding or disguising, one's sexual orientation or gender identity. Like "coming out," it may be situational and/or change over time; a given person may be "closeted" at work, but quite "out" socially.
Coming Out (or "coming out of the closet" or being "out"): The individual process by which a person recognizes, accepts, and shares with others one's sexual and/or gender identity. This is a non-linear process; an individual may be "out" in some situations or to certain people but not to others. The process of coming out to oneself and to others is unique for every individual.
Conversion Therapy or Reparative Therapy: Clinical treatment with the purpose of changing a person's sexual orientation. This type of treatment assumes that any sexual or affectional preferences other than heterosexual are pathological.
Cross Dresser: A person of any gender and any sexual orientation who wears clothing that is not usually associated with his/her socially assigned gender roles.
Culture: The beliefs, customs, social norms, and material traits of a racial, religious, or social group. It affects the group members' viewpoints: how they act; how they think; and how they see themselves in relation to the rest of the world. Culture is also defined as a particular society that has its own beliefs, ways of life, art, etc. or a way of thinking, behaving, or working that exists in a place or organization (such as a business). Culture is transmitted through language, symbols, and rituals. Cultural differences can be manifested in help-seeking behaviors, language and communication styles, symptom patterns and

expressions, nontraditional healing practices, and the role and desirability of an intervention or treatment.

Ethnicity: A population or group having a common cultural heritage that is distinguished by customs, characteristics, language, and common history.

Diversity: Differences in geographic location (rural, urban), sexual orientation, age, religion or spiritual practice, socioeconomic status, and physical and mental capacity.

F to M: A female to male transgender or transsexual person (i.e., a person who transitioned or is transitioning from living as a girl/woman to living as a man).

Family of choice: Supportive friendship networks that function as family, often due to rejection or lack of disclosure to the biological family. Persons an individual sees as significant in his or her life. It may include none, all, or some members of his or her family of origin as well as include individuals such as significant others or partners, friends, coworkers, etc.

Family of Origin: Birth or biological family or any family system instrumental or significant in an individual's early development.

Gay: A person who is attracted to people of the same gender. It is primarily used in reference to men (gay men) but may also be used as an inclusive term to encompass both men and women. Gay may also be used as an adjective to denote same-sex sexual orientation. Someone who identifies as gay may have sex with someone of the same sex, the opposite sex, or may not have sex.

Gender: A person's biological, personal, social and /or legal status as male or female. However, the term "sex" may be defined as the biological, and "gender" as the personal, social, or legal. Thus, a person could have male (biological) sex but live full time as and think of herself as a woman.

Gender Binary: The assertion that there are only two genders, male and female and that a person can only be either exclusively male or female.

Gender Expression: Characteristics in appearance, personality, and behavior, culturally defined as masculine or feminine – i.e., the manner in which an individual outwardly expresses their gender identity.

Gender Fluid (or genderfluid): An individual who does not identify as having a fixed gender.

Gender Identity: An individual's inner sense of self as male, female, somewhere in between, or something else altogether. Most people develop a gender identity that corresponds to their biological sex, but some do not. Gender Identity may or may not be consistent with biological, social or legal gender. For example, a person may be born with a penis – and therefore assigned as male at birth - but have a female gender identity.

Genderism: The belief that there are, and should be, only two genders, and that one's gender, or most aspects of it, are inevitably tied to one's sex assigned at birth.

Gender Neutral: Facilities that any individual can use regardless of gender (e.g. gender-neutral bathrooms); can also be used as a synonym for androgynous, or someone who does not identify with a particular gender.

Gender Non-Conforming (GNC): A person who does not subscribe to gender expression or roles imposed by society.

Genderqueer: A person who identifies as living outside the traditional gender construct of male body and gender, and female body and gender; someone who resists male or female labels.

Gender Roles: Female or male roles created by society and culture that often proscribe narrow sets of behavior for both men and women (and disregard transgender people).
Gender Variant: Individuals who self-identify as not conforming to the conventions of male and female behavior (e.g., those who are transgender).
Heterocentric or Heterosexist: The presumption that everyone is heterosexual, or that heterosexuality is better or more normal than other orientations.
Heteronormative/ Heteronormativity: The general practice in our culture of assuming that heterosexuality and traditional gender identities are the norm.
Heterosexism: The value and belief attitude that heterosexuality is the only valid or acceptable or natural sexual orientation and that it is inherently healthier or superior to other types of sexuality. Heterosexism "can affect LGBTQ+ people by causing internalized homophobia, shame, and a negative self-concept.
Heterosexual ("straight"): A person who is attracted to people of the opposite gender – i.e., – a woman who identifies as being attracted to men, or a man who identifies as being attracted to women. Some heterosexual people are attracted to people of the same sex but have sexual relations only with the opposite sex. Others who consider themselves heterosexual may have sexual relations with men and women, and still others may not have sex.
Heterosexual Privilege: A term describing the benefits derived automatically from being heterosexual or perceived as heterosexual, which are denied to people of other sexual orientations.
Homophobia: The fear or hatred of LGBTQ+ people or what they do and often used as a justification for discrimination. Homophobia in the hands of the dominant or more powerful in society results in heterosexism**.**
Homosexual: A historical term for a person who is attracted to people of the same gender. Some homosexual people are attracted to people of the opposite sex but have sex only with the same sex. Others who consider themselves homosexual may have sex with men and women, and still others may not have sexual relations. (This term may be considered outdated and negative due to its historical use as a clinical term when being gay or lesbian was considered de facto a mental illness.)
Internalized Homophobia: The experience of shame, aversion or self-hatred internalized by LGBTQ+ people in reaction to society's homophobia and discrimination due to their acceptance and belief of the negative messages of the dominant group regarding LGBTQ+ people.
Intersex: refers to people born with sex chromosomes, external genitalia, and/or internal reproductive systems that are not typical for either male or female, but instead are mixed, blended, or indeterminate. Intersex people may be of any sexual orientation and any gender identity. (The historical term "hermaphrodite" is now considered offensive by many because of the inaccurate implication that the person can self-reproduce.) Intersex conditions are caused by any number of prenatal genetic or hormonal anomalies, including those listed below. Individual with these conditions are sometimes at higher risk for other medical conditions, for example, osteoporosis.

> **Adrenal Hyperplasia** is the most prevalent cause of intersexuality among chromosomally XX people with a frequency of about 1 in 20,000 births, and is caused by an anomaly of adrenal function causing the synthesis and excretion an androgen precursor, initiating virilization (development of male secondary sex

characteristics) of a XX person in-utero. Because the virilization originates metabolically, masculinizing effects continue after birth.

Androgen Insensitivity Syndrome (AIS) is a genetic condition occurring in approximately 1 in 20,000 individuals. In an individual with complete AIS, the body's cells are unable to respond to androgen. Some individuals have partial androgen insensitivity. Partial androgen insensitivity typically results in ambiguous genitalia.

Progestin Induced Virilization is caused by prenatal exposure to outside androgens, most commonly Progestin, a drug that was administered to prevent miscarriage in the 50's and 60's. It is converted to an androgen (a virilizing hormone which causes the development of male secondary sex characteristics) by the prenatal XX person's metabolism.

Klinefelter Syndrome (KS) is the set of symptoms that result from two or more X chromosomes in males rather than the typical inheritance of a single X chromosome from the mother and a single Y chromosome from the mother. Men with KS, which is also known as 47, XXY or XX, inherit an extra X chromosome from either father or mother; their karyotype is 47 XXY. KS is quite common, occurring in 1/500 to 1/1,000 male births.

"In The Closet": A lesbian, gay, bisexual, transgender or intersex person who chooses not to disclose his or her sex, sexual orientation or gender identity to friends, family, co-workers or society. There are varying degrees of being "in the closet." For example, a person can be "out" in his or her social life, but "in the closet" at work or with family. Also known as **on the "Down-low"** or **"D/L."**

Lesbian: A woman who identifies primarily as being attracted relationally and sexually to other women.

LGBT: An abbreviation for Lesbian, Gay, Bisexual, and Transgender. Used as an inclusive shorthand to refer to all of the currently identified sexual minorities. It is common to also see GLBT, LesBiGay, LGBTQ, LGBTQ+, GLBTI, GLBTQI, or LGBTA. The "Q" is added to include individuals who are *questioning* their sexual orientation/identity, the "I" is added to include *intersex* people, and the "A" is added to include *allies*. In recent years, usage of this acronym has evolved in widening circles to *LGBTQ+2-S,* where *Q* represents *queer* or *questioning*; *I* represent *intersex*; and *2-S* refers to the Native American term that means *two spirits*.

LGBTQ+: A widely-accepted identifier which explicitly and affirmatively includes people who identify as lesbian, gay, bisexual, transgender, questioning and intersex, and is intended to communicate inclusiveness as well as within-group differences.

M to F: A "male to female" transgender or transsexual person. That is, someone who transitioned or is transitioning from living as a boy/man to living as a woman.

Men who have sex with men (MSM): Refers to sexual behaviors only, independent of the person's sexual orientation, romantic orientation, and/or identity.

Minority Stress: The chronic stress experienced by LGBTQ+ individuals related to stigmatization, marginalization, and lack of institutional and social supports within a predominantly heterosexual society. The negative effects of homophobia, transphobia, discrimination and violence on LGBTQ+ people results in negative mental health outcomes.

Pansexual: A person who does not consider the gender label of others as a criterion for determining sexual or romantic attraction.

Queer: An umbrella term used by some LGBTQ+ people to refer to themselves and to reflect an ongoing attitude of non-restriction toward sexual orientation, gender identity and/or one's gender expression. This is sometimes a preferred label for people who feel that other sexuality/gender labels are not appropriate. Although the term is used by some heterosexist individuals as a derogatory term for LGBTQ+ individuals, some members of the LGBTQ+ community use it positively to refer to themselves or their community.

Questioning: A person who is unsure about their sexual orientation and/or gender identity, or who chooses at a given time to hold off in defining their sexual orientation and/or gender identity.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Same Gender Loving: A term most often used in communities of color to describe people with same sex attractions in order to avoid the negative connotations of the terms gay, homosexual, bisexual or lesbian.

Sex: A biological construct that is based primarily on physical attributes such as chromosomes, external and internal genital and reproductive anatomy and hormones.

Sexual Behavior: Physical sexual activities a person engages in (which can be different from their sexual orientation).

Sexual Minorities: An encompassing term which includes lesbian, gay, bisexual, and pansexual people, however they may identify themselves.

Sexual Orientation: The term used to describe the gender to whom a person is attracted. People who are attracted to members of the opposite gender are heterosexual, or straight. People who are attracted to people of the same gender are homosexual, or gay. Gay women are often called lesbians. People who are attracted to both genders are bisexuals. Sexual orientation is distinct from sexual behavior – i.e., an individual's sexual behavior may not match their orientation (e.g. celibacy, experimentation, or prostitution).

SOGIE: An acronym for sexual orientation, gender identity and gender expression. Everyone has a sexual orientation, gender identity and gender expression.

Straight: A man who is attracted to women or a woman who is attracted to men.

Transgender: When a person's biological or assigned gender does not coincide with their personal inner sense of gender identity, the person may identify as transgender. Transgender persons live at least some of their lives as members of the opposite gender; those who seek gender reassignment surgery form a subgroup. Some transgender people undergo surgeries or take hormones to alter the sex characteristics of their bodies, and others do not. Transgender people may consider themselves to be gay, lesbian, bisexual, transsexual, heterosexual, or none of these. They may identify explicitly with being male or female, a man or a woman, or they may not identify with any of these.

> **Transgender Man:** A person who was assigned female sex at birth, but identifies as and is living as a man. Similar terms include: "trans man," "trans boy," "transgender boy" and "affirmed male." Some transgender people object to the use of "FTM" or "F2M," abbreviations for "female-to-male."
>
> **Transgender Woman:** A person who was assigned a male sex at birth, but identifies as and is living as a woman. Similar terms include: "trans woman," "trans

girl" and "affirmed female." Some transgender people object to the use of "MTF" or "M2F," abbreviations for "male-to-female."

Transition: A process by which transgender people align their anatomy (medical transition) or gender expression (social transition) with their gender identity. Often individuals and medical services will instead use the terms gender affirmation or gender confirmation. Terms such as "sex change" or "sex change operation" should not be used.

Transphobia: The irrational fear and hatred or non-acceptance of people whose gender identity or gender expression differs from the gender they were assigned at birth.

Transsexual: Individual with biological characteristics of one sex who identifies himself or herself as the opposite gender. In other words, a person whose gender identity is not consistent with their biological gender. Some may seek or want to make their body more gender congruence with their internal gender identity through surgery and/or hormonal treatment, although many do not. Transsexuals may be heterosexual, bisexual or homosexual in their orientation. The term is also used to refer to a person who undergoes gender confirmation surgery, changing physical characteristics from female to male or male to female. Because many transgender people do not undergo surgery and/or hormone treatment, the term is now used as a more inclusive description of trans-people regardless of physical sex characteristics.

Two spirit (2-S): Adopted in 1990 at the third annual spiritual gathering of GLBT Natives, the term derives from the northern Algonquin word *niizh manitoag*, meaning *two spirit*, and refers to the inclusion of both feminine and masculine components in one individual.

Women who have sex with women (WSW): Refers to sexual behaviors only, regardless of the individual's sexual orientation, romantic orientation, and/or identity.

References:

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F. SCCMHA Policy 02.03.05 – Recovery

G. SCCMHA Policy 02.03.08 – Welcoming

H. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

I. SCCMHA Policy 02.03.41 – SOGI Safe
J. Substance Abuse and Mental Health Services Administration. (2012). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.* SAMHSA. Rockville, MD.: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/sma12-4104.pdf.
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Exhibits:
None

Procedure:
None

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Psychiatric Hospitalization of Consumers with Intellectual and Developmental Disabilities and Children with Autism	**Chapter**: 03 – Continuum of Care-Integrated Service System	**Subject No**: 03.02.39
Effective Date: 10/1/2019	**Date of Review/Revision**: 6/1/20, 3/19/21, 4/27/22 **Supersedes**:	**Approved By**: Sandra M. Lindsey, CEO
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Executive Director of Clinical Services **Authored By**: Director of Network Services, Public Policy and Continuing Education & Director of Services for Persons with Intellectual and Developmental Disabilities **Additional Reviewers**: Residential Watch Committee, Supervisor of Crisis Services, Autism Program Supervisor

Purpose:
The purpose of this policy is to provide guidance to those staff that work with consumers who are diagnosed with Intellectual and Developmental Disabilities (I/DD). The ultimate goal is to reduce the need for consumers to be psychiatrically hospitalized.

Application:
This policy applies to all staff working with persons with Intellectual and Developmental Disabilities including Residential Providers.

Policy:
It is the policy of SCCMHA to provide services to all individuals in the least restrictive setting. Since hospitalization is considered the most restrictive setting our goal is to keep consumers out of the hospital whenever possible by providing alternative interventions to address concerns that might lead to the need for psychiatric hospitalization. SCCMHA

would like to reduce the occurrences of caregivers/Residential Staff taking consumers to the emergency room in order to address consumer maladaptive behaviors.

Standards:

1. Consumers with functional behavior concerns will have an assessment and a plan to address these functional behavior concerns.
2. When changes in behavior occur, it will be important to bring it to the case holders' attention.
3. Case holders that note a change in behavior will need to complete a functional behavior assessment by:
    a. Identifying the Problem Behavior
    b. Observation and Interview of consumer, family, and/or caregivers/ Residential Staff
    c. Collect data regarding the behavior using the appropriate data tracking form
    d. Analyzing information and formulating a hypothesis
    e. Develop a Positive Support Pan or request a formal behavior plan through a psychologist.

    ****NOTE:** A Positive Support Plan cannot contain restriction of movement, choice or access. If it is believed, that restrictions are necessary they must be based upon health and safety needs and will require a behavioral treatment plan.

4. Case holders should evaluate if the change in behavior could be due to other factors, such as a change in environment, change in interpersonal/caregivers/ Residential Staff, change in health status, change in medications?
    a. Questions to ask caregivers/family/Residential Staff to determine potential causes for behavior can include but are not limited to the following:
        i. Interpersonal/caregivers/staff change:
            1. Has there been a change in the consumer environment?
            2. Has there been a change in caregiver or care giver routine?
        ii. Health Status change:
            1. When was the last time the consumer saw his/her primary care physician or nurse practitioner?
            2. What was s/he seen for when they went to the primary care physician or nurse practitioner?
            3. Has there been a change in medications, physical health care medications, over the counter medications, or prescriptions by the psychiatrist in the past 30 days?
            4. Have you noted consumer pulling on ears?
            5. When was the last time the consumer saw a dentist?
            6. Increase in symptoms for a known health concern?
            7. Has there been any indication the consumer could be experiencing a new health concern?

8. Could the consumer potentially have a Urinary Tract Infection? Is the person prone to these types of infections or other infections?
9. When was the last time the consumer had a bowel movement?

iii. Environmental change:

1. Has there been a change in consumer routine?

5. If the change in behavior is believed to be due to medications: The Case Holder should request an immediate appointment with a psychiatrist, nurse, or nurse practitioner to perform a medication review.
6. Consider other interventions that might help alleviate the need for psychiatric hospitalization such as:
    a. 1:1 staffing
    b. Discussion with behavior champions about possible intervention
    c. Referral to Children's Clinical Risk and/or Clinical Risk Committee
    d. Engage Mobile Response and Stabilization Services to assist with de-escalation of a situation or assist staff with an immediate intervention.
    e. Additional discussion with caregivers/residential staff to obtain more detailed input about functional behavior.
    f. Request an interdisciplinary meeting with all treatment team members involved to discuss possible interventions or implement possible positive proactive techniques
7. If a consumer does present in the emergency room due to behavioral concerns/issues that staff are unable to address in the home, be aware that consumers that have a history of functional behavior challenges will not be accepted into a psychiatric unit especially if the behavior presented is typical of the consumer.
8. Situations that would warrant the need for a consumer with an I/DD diagnosis to be psychiatrically hospitalized can include the following:
    a. Consumer is not stable on current medication regime. This could be due to a medication change or the psychiatrist not finding the best medication regime for the consumer currently.
    b. Consumer is a threat to him/herself
    c. Consumer is a threat to others beyond the normal functional behaviors displayed; i.e. If consumer is known to have aggression toward other consumers and has a plan in place this would **not** warrant a need for hospitalization unless the usual behavior has escalated or changed.
    d. Psychiatric status of the consumer has changed (meaning new symptoms or behavior is being displayed that is not typical).
9. If a consumer requires psychiatric hospitalization or is taken to the emergency to be evaluated by Crisis Intervention Services for hospitalization the following will occur:
    a. Crisis Intervention Services staff will review the consumer file.
    b. Crisis Intervention Services staff will notify the supervisor of the team to discuss consumer.

c. If the Supervisor is unable to answer questions the Supervisor or Crisis Intervention Services staff may contact the case holder to determine the following:
    i. Is the behavior noted typical of the consumer?
    ii. If not, what is the typical behavior?
    iii. What has been tried to alleviate the behavior prior to this visit to Crisis?
    iv. Are there medications that have been tried in the past that did not work for the consumer?
    v. Would additional staffing in the home help to alleviate the possibility of the need for psychiatric hospitalization?
    vi. Would the Residential home have the ability to increase staffing?
    vii. Would a change in medications by the psychiatrist or other professional with the ability to complete a medication review, help to alleviate the need for psychiatric hospitalization?
    viii. If Crisis Intervention Services staff are uncertain if psychiatric hospitalization is necessary the consumer's psychiatrist or the Medical Director can be consulted.

Please note: Residential Settings in the community are unable to accept consumers who require restraints. If a consumer requires physical restraints in the hospital or emergency room it would be best practice to have the case holder involved to provide information for how to engage the consumer, provide resources and avoid trauma triggers, also including the psychiatrist/nurse practitioner who has been working with the consumer to provide consultation in regards to possible medication changes or other recommended options for the consumer.

If the case holder is new or less familiar with the consumer, they can serve as the liaison to others in the consumer's life who know them well and can advise of strategies that have worked in the past and/or strategies to be avoided.

Definitions:

Functional Behavior- an action that is used to obtain a positive or negative attention/result. The attention can come from peers or adults. Negative behavior can sometimes be just as reinforcing as positive behavior for some individuals. Behavior can also be used to gain access to a tangible item.

Consumer Treatment Team- all the individuals involved in the consumer life, this can include natural supports, residential staff, care givers, nurse, psychiatrist, occupational therapist, speech therapist, physical therapist, dietitian, behavior specialist, case holder.

Residential Staff- those persons that are paid to care for a consumer in their home, AFC, or CLS staffed living situation.

Case Holder- the person noted in Sentri 2 as the case holder and also coordinates services for the consumer.

Behavior Champions- staff that have a particular interest in consumer behavior and how it influences how consumers interact with others and their environment. Each team has a

behavior champion assigned and the behavior champions meet regularly to discuss difficult cases.

Clinical Risk Management Committee (Adults and Children)- a group of staff with varied backgrounds and knowledge that comes together for the purpose of problem solving and assisting consumers with continued placement in their community.

References:

Michigan Mental Health Code Chapter 5http://www.legislature.mi.gov/(S(52rtq3x5nvnms1out3fv1uaa))/mileg.aspx?page=GetObject&objectname=mcl-Act-258-of-1974
SCCMHA Policy 03.02.27 Behavioral Plans
SCCMHA Policy 03.02.09 Behavior Treatment Committee
SCCMHA Policy 02.03.14 Trauma-Informed Services and Supports
SCCMHA Policy 03.02.08 Behavioral Interventions

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1. Develops an Individual Plan of Service (IPOS) through the person- centered planning process that address the wants and needs of the consumer so that they can live their best life, which may include remaining in the community in the least restrictive setting. Continuously evaluates for changes in functional behavior through monitoring and periodic reviews.	1. Consumer Treatment Team and Case Holder
2. Consults with behavior champions as needed.	2. Case Holder
3. Interdisciplinary meeting is requested to discuss consumer needs	3. Any member of treatment team
4. Consults with Clinical Risk Committee (Children and Adult) as needed.	4. Case Holder
5. Notifies Case Holder about changes in consumer behavior.	5. Residential Staff
6. Addresses functional behavior challenges/concerns in consumer's IPOS.	6. Case Holder
7. In-services residential staff and other person's involved in consumers life that may experience functional behavior challenges of the consumer; on the consumer plan including any	7. Case Holder

positive supports plan or behavior treatment plan.	
8. Crisis Intervention Services staff to contact supervisor to discuss case and develop an appropriate plan of action.	8. Crisis Intervention Services Staff, Unit Supervisor and Case Holder
9. Works with Residential staff to understand requirements of psychiatric inpatient hospitalizations as it relates to each individual consumer.	9. Case Holder
10. Works with Crisis Intervention Services Staff as needed to assure that consumer receives appropriate monitoring and care when brought to Crisis Unit or Emergency Care Center.	10. Unit Supervisor and Case Holder

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Serious Emotional Disturbance Waiver Program (SEDW) - Children	**Chapter**: 03-Continuum of Care	**Subject No**: 03.02.40
Effective Date: 6/22/2020	**Date of Review/Revision**: 4/9/21, 7/16/21, 4/29/22 **Supersedes**:	**Approved By**: Sandra M. Lindsey, CEO
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Erin Nostrandt, Director of Children's Services **Authored By**: Stacy Farrell, MSW **Additional Reviewers**: Hannah Rousseau, LMSW

Purpose:
This policy sets forth the overview for SCCMHA's Serious Emotional Disturbance Waiver (SEDW) Program for Children.

The Michigan Department of Health and Human Services (MDHHS) received approval from the Centers for Medicare and Medicaid Services (CMS) for the Children's Home and Community-Based Services Waiver for Children with Serious Emotional Disturbance (SEDW), which began in October 2005.

Application:
Wraparound Services

Policy:
The SEDW program enables Medicaid to fund necessary home and community-based services for children with serious emotional disturbance who meet the criteria for admission to the state inpatient psychiatric hospital (Hawthorn Center) and are at risk of hospitalization without waiver services. The CMHSP is responsible for assessment of potential waiver candidates by SEDW Specialist. CMHSP SEDW Specialist will participate in required SEDW Child Welfare technical assistance meetings and trainings. The Children's SEDW provides services that are enhancements or additions to Medicaid State Plan coverage for children through age 21 with SED. The MDHHS operates the SEDW through contracts with the CMHSP and PIHP.

Standards:
None

Definitions:
None

References:
MSHN Waiver for Children with Severe Emotional Disturbance (SEDW)
Michigan Medicaid Provider Manual

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Child is assessed to ensure eligibility criteria is met and accepted into Wraparound Program. All SEDW cases MUST participate in Wraparound.	CAI Intake Specialist, Case holder, Care Management
Family is assessed for children with serious emotional disturbance who meet the criteria for admission to the state inpatient psychiatric hospital (Hawthorn Center) and are at risk of hospitalization without waiver services.	SED Waiver DHHS Access Specialist
Consumers who are placed out of the community (detention, hospital, run away, residential etc.) 90 days or more the SEDW recipient's service status must switch to inactive in the WSA. • A child can remain enrolled in the SEDW up to 90 days max with an inactive service status. • If the child returns to the community within 45 days of the inactive date the SED Waiver DHHS Access Specialist is to switch the consumer's services status back to active. • If the child does not return within 45 days, the SED Waiver DHHS Access Specialist must contact MDHHS and provide a status update. • If the update does not include a solid plan to return to the community within the *next* 45 days, the SED	

Waiver DHHS Access Specialist must send notice of appeal and terminate.	
The Children's SEDW provides services that are enhancements or additions to Medicaid State Plan coverage for children through age 21 with SED as written in Wraparound Plan of Service.	SED Waiver DHHS Access Specialist and Wraparound Care Coordinator
CMHSP SEDW Specialist will participate in required SEDW Child Welfare technical assistance meetings and trainings.	SED Waiver DHHS Access Specialist

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Serious Emotional Disturbance Waiver (SEDW) Program-Entry Criteria</td><td>Chapter: 03-Continuum of Care</td><td>Subject No: 03.02.41</td></tr>
<tr><td rowspan="2">Effective Date: 6/22/2020</td><td>Date of Review/Revision: 4/9/21, 7/16/21, 4/29/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Erin Nostrandt, Director of Children’s Services

Authored By: Stacy Farrell, MSW

Additional Reviewers:
Hannah Rousseau, LMSW</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
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Purpose:
This policy sets forth the guidelines and expectations for SCCMHA administration of the Serious Emotional Disturbance Waiver (SEDW) program.

Application:
All Children who receive SEDW program benefits must participate in Wraparound Services. Children/youth and families served in Wraparound shall meet two or more of the following criteria:

- Children/youth who are involved in multiple child/youth serving systems.
- Children/youth who are at risk of out-of-home placements or are currently in out-of-home placement.
- Children/youth who have received other mental health services with minimal improvement in functioning.
- The risk factors exceed capacity for traditional community-based options.
- Numerous providers are working with multiple children/youth in a family and the identified outcomes are not being met.

Policy:
SCCMHA shall administer the SEDW program in accordance with the Prepaid Inpatient Health Plan (PIHP) contract and the Medicaid Provider Manual.

Standards:
Eligibility Criteria for SEDW Program-

SEDW beneficiaries must be enrolled through the Michigan Department of Health and Human Services (MDHHS) enrollment process by the Prepaid Inpatient Health Plan (PIHP) designee. The enrollment process must include verification that the beneficiary meets the following (all must apply):

A. Meet the current MDHHS contract criteria for the state psychiatric hospital (Hawthorn Center) and be at risk of hospitalization.
B. CAFAS®/PECFAS score of 90 or greater for children age 12 or younger; or if age 3-7 PECFAS elevated sub scores in at least one of the following areas-self-harmful behaviors, moods/emotion, thinking/communication or behavior towards others, AND
C. Be under the age of 18 when approved for the Waiver,
D. CAFAS® score of 120 or greater for children age 13 to 18;
E. Be under the age of 21;
F. Express willingness and capacity to actively engage in the Wraparound Program,
G. Reside with his/her birth or adoptive parents(s), or

-In the home of a relative who is the child's legal guardian, or
-In foster care or therapeutic foster care, with a permanency plan to return home.

H. Be financially eligible for Medicaid when viewed as a family of one (i.e., when parental income and assets are waived);
I. Need waiver services in order to remain in the community
J. SEDW beneficiaries must receive at least one SEDW service per month to maintain eligibility.
    - Special attention should be noted if the consumer is placed out of the community (detention, hospital, run away, residential etc.) 90 days or more to ensure the consumer's Waiver Application Status (WSA) is accurately reported, and the consumer/family are properly served.
        - The consumer must be made *inactive* on the date the child is placed out of the community in the WSA.
            - SEDW recipient's service status must switch to inactive whenever a child is placed out of the community (detention, hospital, run away, residential etc.)
            - A child can remain enrolled in the SEDW up to 90 days max with an *inactive* service status.
            - If the child returns to the community within 45 days of the inactive date the SED Waiver DHHS Access Specialist is to switch the consumer's services status back to active.
            - If the child does not return within 45 days the SED Waiver DHHS Access Specialist lead must contact MDHHS and provide a status update.
            - If the update does not include a solid plan to return to the community within the *next* 45 days the SED Waiver DHHS Access Specialist must send notice of appeal and terminate.

K. The beneficiary's services and supports must be specified in the individual's plan of services developed through the person-centered planning process that must be specific to:

1. Medical necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
2. Amount: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
3. Scope: The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.
4. Duration: The parameters within which the service will be provided, including Who (e.g., professional, paraprofessional, aide supervised by a professional); How (e.g., face-to-face, telephone, taxi or bus, group or individual); and Where (e.g., community setting, office, beneficiary's home).

Definitions:
CAFAS: Child and Adolescent Functional Assessment Scale
IPOS: Individual Plan of Service
MDHHS: Michigan Department of Health and Human Services
PECFAS: Preschool and Early Childhood Functional Assessment Scale
PIHP: Pre-Paid Inpatient Health Plan
SEDW: Waiver for Children with Serious Emotional Disturbances

References: Hawthorne State Hospital Intake Criteria Michigan Medicaid Manual
MDHHS Children with Serious Emotional Disturbance (SEDW) (https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_80988-427532--,00.html
MDHHS Criteria for Inpatient Admission to the State Hospital- https://www.michigan.gov/documents/mdhhs/Hawthorn_Center_General_Information_654205_7.pdf

Exhibits:
None

Procedures:

ACTION	RESPONSIBILITY
Meet the current MDHHS contract criteria for the state psychiatric hospital (Hawthorn Center) and be at risk of hospitalization.	SED Waiver DHHS Access Specialist

CAFAS®/PECFAS score of 90 or greater for children aged 12 or younger; or if age 3-7 PECFAS elevated sub scores in at least one of the following areas-self- harmful behaviors, moods/emotion, thinking/communication or behavior towards others, AND Be under the age of 18 when approved for the Waiver, CAFAS® score of 120 or greater for children aged 13 to 18. Be under the age of 21. Express willingness and capacity to actively engage in the Wraparound Program, Reside with his/her birth or adoptive parents(s), or -In the home of a relative who is the child's legal guardian, or -In foster care or therapeutic foster care, with a permanency plan to return home. Be financially eligible for Medicaid when viewed as a family of one (i.e., when parental income and assets are waived). Need waiver services to remain in the community.	
SEDW beneficiaries must receive at least one SEDW service per month to maintain eligibility. The beneficiary's services and supports must be specified in the individual's plan of services developed through the person-centered planning process that must be specific to: <u>Medical necessity</u>: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology, and functional	SED Waiver DHHS Access Specialist and Wraparound Care Coordinator and Community Team

impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services. Amount: The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided. Scope: The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided. Duration: The parameters within which the service will be provided, including Who (e.g., professional, paraprofessional, aide supervised by a professional); How (e.g., face-to-face, telephone, taxi or bus, group or individual); and Where (e.g., community setting, office, beneficiary's home).	
For internal referrals: Level of Care Change form is completed and sent to Care Management, who approves transfer to Wraparound Department.	Case holder Care Management Specialist
For intake referrals: CAI intake worker will assess for eligibility during intake appointment, and coordinate with Care Management for assignment to Wraparound Department.	CAI intake worker Care Management

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Serious Emotional Disturbance Waiver (SEDW) Program -Exit Criteria	**Chapter**: 03-Continuum of Care	**Subject No**: 03.02.42
Effective Date: 6/22/2020	**Date of Review/Revision**: 4/8/21, 7/16/21, 4/29/22 **Supersedes**:	**Approved By**: Sandra M. Lindsey, CEO
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Erin Nostrandt, Director of Children's Services **Authored By**: Stacy Farrell, MSW **Additional Reviewers**: Hannah Rousseau, LMSW

Purpose:
This policy sets forth the guidelines and expectations for SCCMHA administration of the exit criteria of the Serious Emotional Disturbance Waiver (SEDW) Program.

Application:
SCCMHA SEDW program exit criteria may occur for clinical, developmental, and/or administrative circumstances.

Policy:
SCCMHA shall administer the exit criteria from the SEDW program in accordance to the Medicaid Provider Manual.

Standards:
Clinical Exit Criteria:
A consumer and family receiving services through the Serious Emotional Disturbance Waiver may exit the program for any one of the following:

1. The functional impairments identified within CAFAS and PECFAS have been significantly ameliorated.
2. The consumer is effectively engaged in appropriate and preferred educational programming and/or employment as expressed by the family, consumer and Wraparound team.
3. Family and consumer indicated that established treatment goals have been achieved. The family and consumer demonstrate the capacity to adjust and function within the home and community setting.

Developmental Exit Criteria:

1. The consumer has exceeded the age limits of the program. The consumer can remain within the SEDW program up until his/her 21st birthday.

Administrative Exit Criteria:

1. At time of annual recertification, CAFAS® score of 80 or less for children aged 7 to 12; or CAFAS® score of 110 or less for children age 13 to 18; or for children age 3 to 7: the following PECFAS® subscale scores are will be scored as a 0, reflecting no impairment- self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others.
2. The consumer and/or family have demonstrated or expressed an inability or an unwillingness to participate in SEDW program services including Wraparound.
3. The consumer and family no longer receive other services in the within the SCCMHA network.
4. The consumer and family no longer reside in Saginaw County. If the family and consumer relocate to a county within Michigan, assistance will be provided to transfer the SEDW responsibilities to the new county.
5. The consumer is placed out of the community (detention, hospital, run away, residential etc.) 90 days or more.
    - *__NOTE__: *Inactive Status* and the Waiver Status Application (WSA): The consumer must be made *inactive* on the date the child is placed out of the community in the WSA.
        - SEDW recipient's service status must switch to inactive whenever a child is placed out of the community (detention, hospital, run away, residential etc.)
        - A child can remain enrolled in the SEDW up to 90 days max with an inactive service status.
        - If the child returns to the community within 45 days of the inactive date the SED Waiver DHHS Access Specialist is to switch the consumer's services status back to active.
        - If the child does not return within 45 days the SED Waiver DHHS Access Specialist must contact MDHHS and provide a status update.
        - If the update does not include a solid plan to return to the community within the *next* 45 days the SED Waiver DHHS Access Specialist must send notice of appeal and terminate.
6. At the time of recertification, the consumer no longer meets current MDHHS criteria for the State psychiatric hospital for children, as defined in the Michigan Medicaid Provider Manual.

7. The consumer no longer meets the eligibility requirements for the program. Since these exit criteria are clinically appropriate, whenever possible the decision to exit services will be mutually decided upon by the family or consumer and the treatment team.

Definitions:
None

References:
MSHN Waiver for Children with Severe Emotional Disturbance (SEDW)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Wraparound Plan is reviewed for Transition and/or Graduation Summary and identified as a Developmental, Administrative, or Clinical Exit.	Wraparound Care Coordinator and Wraparound Supervisor
Clinical Exit: CAFAS/PECFAS is completed to reflect that the scores no longer meet Wraparound eligibility, and no further assessment is required. Developmental Exit: A consumer aging out of the program (21st birthday) is referred to an appropriate service provider for ongoing treatment.	Wraparound Care Coordinator
Administrative Exit: CAFAS/PECFAS When a child's CAFAS® score is 80 or less for children aged 7 to 12; or CAFAS® score of 110 or less for children aged 13 to 18; or for children aged 3 to 7: the following PECFAS® subscale scores will be scored as a 0, reflecting no impairment- self-harmful behaviors, moods/emotions, thinking/communicating or behavior towards others. The case will be referred to another service provider or the case will be closed per family request.	Wraparound Care Coordinator

Administrative Exit: Other • The consumer and/or family have demonstrated or expressed an inability or an unwillingness to participate in SEDW program services including Wraparound. In this case, an Adverse Benefits Determination letter is sent to family. • The consumer and family no longer receive other services in the within the SCCMHA network. In this case, an Adverse Benefits Determination letter is sent to the family. • The consumer and family no longer reside in Saginaw County. If the family and consumer relocate to a county within Michigan, assistance will be provided to transfer the SEDW responsibilities to the new county. • The consumer is placed out of the community (detention, hospital, run away, residential etc.) 90 days or more. In this instance, the case is suspended or terminated, and an Adverse Benefit Determination letter is sent to the family. • At the time of recertification, the consumer no longer meets current MDHHS criteria for the State psychiatric hospital for children, as defined in the Michigan Medicaid Provider Manual. In this case appropriate referrals are made, and Adverse Benefit Determination letter is sent.	Wraparound Care Coordinator or SED Waiver DHHS Access Specialist

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Children's Home and Community – Based Waiver Program (CWP) Overview	**Chapter**: 03-Continuum of Care	**Subject No**: 03.02.47
Effective Date: 5/10/2022	**Date of Review/Revision**: **Supersedes**:	**Approved By**: Sandra M. Lindsey, CEO
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Charlotte Fondren, Director of Director of Services for Persons with IDD **Authored By**: Kristie Wolbert, LMSW **Additional Reviewers**:

Purpose:
This policy sets forth the overview for SCCMHA's Children's Home and Community – Based Waiver Program (CWP).

The Children's Home and Community – Based Waiver Program (CWP) is administered and monitored by the Michigan Department of Health and Human Services (MDHHS) and funded with State and Federal Medicaid dollars.

Application:
Support Coordination Services and the Autism Program

Policy:
The Children's Home and Community – Based Waiver Program (CWP) enables Medicaid to fund necessary home and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parents or with a relative who has been named legal guardian, regardless of their parent's income.

Saginaw County Community Mental Health Authority (SCCMHA) is responsible for assessment of potential waiver candidates. SCCMHA is also responsible for referring potential waiver candidates by completing the CWP "pre-screen" form and sending it to MDHHS to determine priority rating.

SCCMHA is responsible for completing the CWP application and is responsible for the coordination of the child's waiver services. All services and supports must be included in the Individual Plan of Services (IPOS).

Standards:
None

Definitions:
CWP: Children's Home and Community-Based Services Waiver Program
MDHHS: Michigan Department of Health and Human Services
PIHP: Prepaid Inpatient Health Plan
ICF/IID: Intermediate Care Facility for Individuals with Intellectual Disabilities – 42 CFR 435.1009 – an institution (or distinct part of an institution) that (a) is primarily for the diagnosis, treatment, or rehabilitation of people with developmental disabilities or persons with related conditions; and (b) provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.
Developmental Disability: means either of the following:
1. If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements:
    a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments
    b. Is manifested before the individual is 22 years old
    c. Is likely to continue indefinitely
    d. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
        i. Self-care
        ii. Receptive and expressive language
        iii. Learning
        iv. Mobility
        v. Self-direction
        vi. Capacity for independent living
        vii. Economic self-sufficiency
    e. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
2. If applied to a minor, birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (1) if services are not provided.

References:
MSHN Children's Home and Community – Based Waiver Program (CWP) Policy
Michigan Medicaid Provider Manual

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Child is assessed to ensure eligibility criteria is met.	CAI Intake Specialist, Children's Waiver Specialist and Care Management
Family is assessed for children with developmental disabilities, who would otherwise be at risk of out-of-home placement into and an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Individuals are enrolled based upon eligibility criteria: 1. The child must meet criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and be at risk of an ICF/IID out-of-home placement. 2. Has a developmental disability as defined in federal law. 3. Resides with birth or adoptive parents, a relative with legal guardianship, or in specialized foster care (with a permanency plan to return home within 30 days). 4. Under the age of 18. 5. Medicaid eligible when viewed as a family of one.	Children's Waiver Specialist
The Children's CWP provides services that are enhancements or additions to Medicaid State Plan coverage for children through age 18 with developmental disabilities as written in the Individual Plan of Services.	Support Coordinator

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Children's Home and Community – Based Waiver Program (CWP) Eligibility and Enrollment	**Chapter**: 03-Continuum of Care	**Subject No**: 03.02.47.01
Effective Date 5/10/2022	**Date of Review/Revision**: **Supersedes**:	**Approved By**: Sandra M. Lindsey, CEO
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Charlotte Fondren, Director of Director of Services for Persons with IDD **Authored By**: Kristie Wolbert, LMSW **Additional Reviewers**:

Purpose:
This policy sets forth the eligibility and enrollment for Saginaw County Community Mental Health Authority's (SCCMHA) Children's Home and Community Based Waiver Program (CWP). The Children's Home and Community Based Waiver Services Program (CWP) allows for enhancements or additions to regular Medicaid coverage to children up to age 18 who are eligible for the CWP. Enrollment and provision of the CWP services will comply with the Michigan Department of Health & Human Services and Michigan Medicaid Provider Manual standards

The Children's Home and Community Based Waiver Program (CWP) is administered and monitored by the Michigan Department of Health and Human Services (MDHHS) and funded with State and Federal Medicaid dollars.

Application:
Support Coordination Services and the Autism Program

Policy:
The Children's Home and Community – Based Waiver Program (CWP) enables Medicaid to fund necessary home and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parents or with a relative who has been named legal guardian, regardless of their parent's income.

Saginaw County Community Mental Health Authority (SCCMHA) is responsible for assessment of potential waiver candidates. SCCMHA is also responsible for referring

potential waiver candidates by completing the CWP "pre-screen" form and sending it to MDHHS to determine priority rating.

SCCMHA is responsible for completing the CWP application and is responsible for the coordination of the child's waiver services. All services and supports must be included in the Individual Plan of Services (IPOS).

Standards:

Eligibility Requirements

The child must qualify for specialty mental health services. This is determined through the intake process which includes an Eligibility Screen and Initial Assessment; the SCCMHA Central Access and Intake (CAI) Department will refer to Support Coordination Services for an intake with the Children's Waiver Specialist. The Children's Waiver Specialist will determine that the child meets criteria for Children's Home and Community Based Waiver Services Program (CWP) after completing a full biopsychosocial assessment.

1. The child must have an intellectual/developmental disability (as defined in Michigan state law), is less than 18 years of age, and in need of habilitation services.
2. The child resides with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child, regardless of their parent's income.
3. The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).
4. The child is at risk of being placed in an ICF/IID facility due to the intensity of the child's care and the lack of needed support, or the child currently resides at the ICF/IID facility, but with appropriate community support, could return home.
5. The child's intellectual or functional limitations indicate that he would be eligible for health, habilitative, and active treatment services provided at the ICF/IID level of care. Habilitative services are designed to assist individuals with acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in a home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the child to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

The CWP Specialist determines if the child is eligible for the CWP and will complete the enrollment process for the CWP, following the WSA – CWP Training Manual.

Enrollment Process

1. Potential waiver candidate has a completed CWP "pre-screen" form with information entered in the WSA. MDHHS determines priority rating.
2. Information in the CWP “pre-screen” is updated as changes occur or every 6 months along with information on private insurance.
3. When the child is invited to apply for enrollment, the following must be completed within 30 days of the invitation to apply:
    a. Certification form completed and uploaded to the Document tab in the WSA.
    b. Add/Update Parent/Guardian demographics in the WSA.
    c. Medical Examination Form (DHS-49) details entered in the WSA.
    d. Submit to Mid-State Health Network (MSHN) and then MDHHS for approval. Final approval and effective date will be issued by MDHHS.
4. MDHHS Central Office will mail a Medicaid application with specific instructions for the family to follow. The Medicaid application must be completed and returned.
5. Case Holder completes assessment and Category of Care Narrative.
6. The child and his/her family, friends are willing to work cooperatively to identify the child’s needs and will identify all services and supports in the Individual Plan of Services (IPOS).
7. The IPOS is reviewed and approved. CWP Specialist enters service plan details in the WSA.
8. CWP Specialist enters the child’s Medicaid ID in the WSA.
9. To meet ICF/IID level of care – services should be provided on an almost daily level.
10. Individual must meet or be below Medicaid income and asset limits when viewed as a family of one (parent(s) income is waived).

Acceptance for Children’s Waiver Services is dependent on approval by Michigan Department Health and Human Services, which has limited slots available.

Annual Recertification

There is an annual recertification that is required for the CWP.

- Annually, at the time of the Person-Centered Plan, complete the Psychosocial Assessment and Behavioral Category of Care Assessment and update the Choice Voucher Budget (if applicable).
- IPOS information is entered in the “Service” tab in the WSA.
- Annual CWP Certification form and Performance on Areas of Major Life Activity form must be completed within 365 days. These documents along with the IPOS is uploaded to the WSA by CMHCM CWP Specialist and submitted to MSHN and MDHHS for review and approval.
- The Medical Form (DHS-49) must be done annually. The date is based on the date of the child’s last physical.

Disenrollment

The child will be disenrolled from the CWP when:

- The child turns 18
- The child no longer resides in the community with biological/adoptive parents or with relatives who have been named legal guardian.
- The child in specialized foster care does not return home within six months of inception of waiver services.
- The child no longer meets criteria for ICF/IID facility.
- Parent(s) or guardian(s) withdraw consent for participation in Children's Waiver Services Program.
- Income no longer meets Medicaid income and asset limits when viewed as a family of one (parent(s) income is waived).

Definitions:

CWP: Children's Home and Community-Based Services Waiver Program
MDHHS: Michigan Department of Health and Human Services
PIHP: Prepaid Inpatient Health Plan
ICF/IID: Intermediate Care Facility for Individuals with Intellectual Disabilities – 42 CFR 435.1009 – an institution (or distinct part of an institution) that (a) is primarily for the diagnosis, treatment, or rehabilitation of people with developmental disabilities or persons with related conditions; and (b) provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.
Developmental Disability: means either of the following:
1. If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements:
    a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments
    b. Is manifested before the individual is 22 years old
    c. Is likely to continue indefinitely
    d. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
        i. Self-care
        ii. Receptive and expressive language
        iii. Learning
        iv. Mobility
        v. Self-direction
        vi. Capacity for independent living
        vii. Economic self-sufficiency
    e. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
2. If applied to a minor, birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (1) if services are not provided.

References:

MSHN Children's Home and Community – Based Waiver Program (CWP) Policy

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Child is assessed to ensure eligibility criteria is met.	CAI Intake Specialist, Children's Waiver Specialist and Care Management
Family is assessed for children with developmental disabilities, who would otherwise be at risk of out-of-home placement into and an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).	Children's Waiver Specialist
Individuals are enrolled based upon eligibility criteria: 1. The child must meet criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and be at risk of an ICF/IID out-of-home placement. 2. Has a developmental disability as defined in federal law. 3. Resides with birth or adoptive parents, a relative with legal guardianship, or in specialized foster care (with a permanency plan to return home within 30 days). 4. Under the age of 18. 5. Medicaid eligible when viewed as a family of one.	Children's Waiver Specialist
Enrollment: Potential waiver candidate has a completed CWP "pre-screen" form with information entered in the WSA. MDHHS determines priority rating.	Children's Waiver Specialist

While waiting for approval information in the CWP "pre-screen" is updated as changes occur or every 6 months along with information on private insurance.	Children's Waiver Specialist
When the child is invited to apply for enrollment, the following must be completed within 30 days of the invitation to apply: • Certification form completed and uploaded to the Document tab in the WSA. • Add/Update Parent/Guardian demographics in the WSA. • Medical Examination Form (DHS-49) details entered in the WSA. • Submit to Mid-State Health Network (MSHN) and then MDHHS for approval. Final approval and effective date will be issued by MDHHS.	Children's Waiver Specialist
Medicaid application mailed to the family with specific instructions to follow.	MDHHS Central Office
The Medicaid application must be completed and returned.	Children's Waiver Specialist, Case Holder and Parent/Guardian
Complete assessment and Category of Care Narrative.	Case Holder
Individual Plan of Services (IPOS) to identify the child's needs and will identify all services and supports is completed with the child, family, friends and any supports as requested by family.	Case Holder
Service plan details and Medicaid ID are entered in the WSA.	Care Management
The Children's CWP provides services that are enhancements or additions to Medicaid State Plan coverage for children through age 18 with developmental disabilities as written in the Individual Plan of Services.	Case Holder

Annual Recertification: Annual recertification that is required for the CWP.	Case Holder
At the time of the Person-Centered Plan, complete the Psychosocial Assessment and Behavioral Category of Care Assessment and update the Choice Voucher Budget (if applicable).	Case Holder
IPOS information is entered in the "Service" tab in the WSA.	Care Management
Disenrollment: The child will be disenrolled from the CWP when: • The child turns 18 • The child no longer resides in the community with biological/adoptive parents or with relatives who have been named legal guardian. • The child in specialized foster care does not return home within six months of inception of waiver services. • The child no longer meets criteria for ICF/IID facility. • Parent(s) or guardian(s) withdraw consent for participation in Children's Waiver Services Program. • Income no longer meets Medicaid income and asset limits when viewed as a family of one (parent(s) income is waived).	Case Holder/Care Management

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Trauma Screening, Assessment, and Treatment Services</td><td>Chapter: 04 – Improving Organizational Performance</td><td>Subject No: 04.01.04</td></tr>
<tr><td>Effective Date:
06/01/2020</td><td>Date of Review/Revision:
3/31/21, 2/28/22
Supersedes:</td><td rowspan="2">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Kristie Wolbert,
Executive Director of Clinical Services

Authored By:
Erin M. Nostrandt

Additional Reviewers:
Trauma-Informed Workgroup
Jennifer Stanuszek</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to ensure that SCCMHA screens for trauma (and related symptomology) within each population during the initial intake, as well as during other points in time as clinically appropriate. Based on results of the preliminary screening further trauma assessments will be administered. It is further the intent of SCCMHA that all consumers (parents/guardians) identified as presenting with trauma symptomatology upon screening, will be provided a summary of screener results, as well as recommended treatment service options. This discussion will allow and support the consumer (parent/guardian) to engage in thoughtful decisions regarding their treatment.

Policy:
It is the policy that SCCMHA will screen all consumers during the initial intake, as well as during other points in time as clinically appropriate, using a culturally competent, standardized, and validated screening tool that is appropriate for each population. Additionally, it is the policy that SCCMHA will administer trauma specific assessments that are culturally competent, standardized, and validated for each population when clinically indicated and agreed upon by consumer/parent/guardian.

Application:
This policy applies to SCCMHA-funded providers of services and supports to children, adolescents and their families/caregivers and adults.

Standards:

A. SCCMHA and its network providers will conduct routine trauma screenings during the intake process and other points of treatment/services as clinically indicated.
B. SCCMHA and its network providers will administer trauma assessments when initial screening results indicate further assessment is needed and consumer/families agree to further assessment.
C. SCCMHA and its network providers will discuss the results of trauma screenings and assessments with consumers in an effort to illicit thoughtful discussions and decisions that support the treatment of trauma.
D. SCCMHA and its network providers will use evidence-based trauma specific services for each population in sufficient capacity to meet the need and will ensure that all services are delivered in a trauma informed environment.
E. SCCMHA and its network providers support SAMHSA's Trauma Informed Approach: Key Assumptions and Principles (02.03.14- Trauma-Informed Services and Supports)
F. SCCMHA and its network providers shall create and maintain a trauma-informed system of care for children and their families (02.03.14 - Trauma Informed Services and Supports).

Definitions:

None

References:

SAMHSA's Trauma Informed Approach: Key Assumptions and Principles (02.03.14- Trauma-Informed Services and Supports)

Exhibits:

A. CTAC (Children's Trauma Assessment Center) Trauma Screening Checklist: Identifying Children at Risk; Ages 0-5
B. CTAC (Children's Trauma Assessment Center) Trauma Screening Checklist: Identifying Children at Risk; Ages 6-18
C. CTAC (Children's Trauma Assessment Center) Trauma Screening Checklist; Adult Trauma Screen- Self Report
D. Clinicians- Administered PTSD Scale for DSM-5 (CAPS-5) Past Month Version
E. Life Events Checklist for DSM-5 (LEC-5) Interview Version
F. UCLA PTSD Assessment DSM-5
G. Young Child PTSD Checklist (YCPC) 1-6 years

Procedure:

ACTION	RESPONSIBILITY

Intake Specialist will conduct a trauma screen specific to the consumers age (0-5 years, 6-18 years, adult) during the initial intake assessment, and document the results of the screening within the consumers Sentri record (Section 7; under-*Observation and Reported Information*).	Intake Specialist
Following approval for service eligibility by Care Management the Trauma Screen will be reviewed by the receiving team's Supervisor to determine and identify potential areas of concern that would suggest further assessment. The receiving team's Supervisor (or designee) is responsible to ensure the following: • A review and discussion of the completed trauma screen during the Orientation Team Meeting (OTM). *The results of the trauma screening are expected to be reviewed with the consumer to assist with making an informed decision regarding treatment. By providing information on how trauma exposure may be related to presenting symptoms (behavioral presentation), and how further assessment is recommended (if clinically indicated) as it can improve appropriate treatment matching, decrease symptom severity, and potentially increase the consumers overall functioning. • The Supervisor (or designee) completing the OTM will specify in the consumer's OTM progress note if a recommendation for *further trauma assessment* is to be completed based on the results of the screening and the discussion with the consumer/parent/guardian. If an assessment is clinically appropriate and declined by the consumer/parent/guardian this is to be documented in the OTM	Supervisor/designee

progress note clearly explaining the reason for declining further assessment.	
• If further trauma assessment is indicated in the OTM progress note the receiving case holder is responsible to initiate coordination of a Trauma Assessment to be completed by a masters level clinician. This will be done through IPOS process by including trauma assessment within an IPOS goal. If the consumer is to receive therapy services, or the case holder is a therapist, the trauma assessment should be completed by the assigned therapist.	Case Holder Case Holder/Masters Level Clinician
• Upon completion of the Trauma Assessment, results will be reviewed with consumer/parent/guardian, including discussion of appropriate treatment options (i.e. psychotherapy or group) to improve functioning. Trauma Assessment results and subsequent discussion will be documented in therapist assessment and/or IPOS.	Case Holder
• Score sheet of Trauma Assessment will be submitted for scanning into consumer electronic health record. (See Exhibits for the corresponding Trauma Assessment Tool specific to age of the consumer).	Case Holder
• If consumer/parent/guardian agrees to treatment options (i.e. psychotherapy or group) to address trauma, this service intervention will be included in an IPOS goal. o If a trauma screening is conducted during the course of a treatment episode and results indicate that further assessment is needed, the case holder is	Case Holder

	expected to follow the above steps.	

Exhibit A

SOUTHWEST MICHIGAN Children's Trauma Assessment Center

NCTSN The National Child Traumatic Stress Network

Trauma Informed System Initiative

Ages 0–5

CTAC Trauma Screening Checklist: Identifying Children at Risk

Please check each area where the item is known *or suspected*. The screen can help determine whether a comprehensive assessment may be helpful in understanding the child's functioning and needs.
Note: Endorsing exposure items does not necessarily mean substantiation of the child's experience; it is for screening purposes only.

1. **Are you aware of or do you suspect the child has experienced any of the following:**

_____ Physical abuse
_____ Neglectful home environment
_____ Emotional abuse
_____ Exposure to domestic violence
_____ Exposure to other chronic violence
_____ Sexual abuse or exposure
_____ Parental substance abuse
_____ Impaired parenting (mental illness)
_____ Exposure to drug activity *aside from parental use*
_____ Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
_____ Lengthy or multiple separations from parent
_____ Placement outside of the home (foster care, kinship care, residential)
_____ Loss of significant people, places etc.
_____ Frequent/multiple moves; homelessness
_____ Other _____

Even if no areas are checked above, but multiple concerns are present below, further assessment may still be indicated, as there is a strong relationship between the following areas and trauma exposure.

2. **Does the child show any of these behaviors:**

_____ Aggression towards self; self-harm
_____ Excessive aggression or violence towards others
_____ Explosive behavior (Going from 0-100 instantly)
_____ Hyperactivity, distractibility, inattention
_____ Excessively shy
_____ Oppositional and/or defiant behavior
_____ Sexual behaviors not typical for age
_____ Difficulty with sleeping, eating, or toileting
_____ Social/developmental delays in comparison to peers
_____ Repetitive violent and/or sexual play (or maltreatment themes)
_____ Unpredictable/sudden changes in behavior (i.e., attention, play)
_____ Other _____

3. **Does the child exhibit any of the following emotions or moods:**

_____ Excessive mood swings
_____ Frequent, intense anger
_____ Chronic sadness, doesn't seem to enjoy any activities, depressed mood
_____ Flat affect, very withdrawn, seems emotionally numb or "zoned out"
_____ Other _____

4. **Does the child have any of the following relational/attachment difficulties:**

_____ Lack of eye contact, or avoids eye contact
_____ Sad or empty eyed appearance
_____ Overly friend with strangers (lack of appropriate stranger anxiety)
_____ Vacillation between clinginess and disengagement and/or aggression
_____ Doesn't reciprocate when hugged, smiled at, spoken to
_____ Doesn't seek comfort when hurt or frightened; shakes it off, or doesn't seem to feel it
_____ Has difficulty in preschool or daycare
_____ Other _____

Child's Name or Identifier: _____ **Age:** _____ **Sex:** _____

County/Site: _____ **Race:** _____ **Date:** _____

Henry, Black-Pond, & Richardson (2010), rev: 3/16 Western Michigan University
Southwest Michigan Children's Trauma Assessment Center (CTAC)

Exhibit B

SOUTHWEST MICHIGAN Children's Trauma Assessment Center

NCTSN The National Child Traumatic Stress Network

Trauma Informed System Initiative

Ages 6–18

CTAC Trauma Screening Checklist: Identifying Children at Risk

Please check each area where the item is known *or suspected*. The screen can help determine whether a comprehensive assessment may be helpful in understanding the child's functioning and needs.
Note: Endorsing exposure items does not necessarily mean substantiation of the child's experience; it is for screening purposes only.

1. **Are you aware of or do you suspect the child has experienced any of the following:**
   - _____ Physical abuse
   - _____ Neglectful home environment
   - _____ Emotional abuse
   - _____ Exposure to domestic violence
   - _____ Exposure to other chronic violence
   - _____ Sexual abuse or exposure
   - _____ Parental substance abuse
   - _____ Impaired parenting (mental illness)
   - _____ Exposure to drug activity *aside from parental use*
   - _____ Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
   - _____ Lengthy or multiple separations from parent
   - _____ Placement outside of the home (foster care, kinship care, residential)
   - _____ Loss of significant people, places etc.
   - _____ Frequent/multiple moves; homelessness
   - _____ Other _____

Even if no areas are checked above, but multiple concerns are present below, further assessment may still be indicated, as there is a strong relationship between the following areas and trauma exposure.

2. **Does the child show any of these behaviors:**
   - _____ Aggression towards self; self-harm
   - _____ Excessive aggression or violence towards others
   - _____ Explosive behavior (Going from 0-100 instantly)
   - _____ Hyperactivity, distractibility, inattention
   - _____ Excessively shy
   - _____ Oppositional and/or defiant behavior
   - _____ Sexual behaviors not typical for age
   - _____ Difficulty with sleeping, eating, or toileting
   - _____ Social/developmental delays in comparison to peers
   - _____ Other _____

3. **Does the child exhibit any of the following emotions or moods:**
   - _____ Excessive mood swings
   - _____ Frequent, intense anger
   - _____ Chronic sadness, doesn't seem to enjoy any activities, depressed mood
   - _____ Flat affect, very withdrawn, seems emotionally numb or "zoned out"
   - _____ Other _____

4. **Does the child have any of the following problems in school:**
   - _____ Low or failing grades
   - _____ Attention and/or memory problems
   - _____ Sudden change in performance
   - _____ Difficulty with authority/frequent behavior referrals
   - _____ Other _____

5. **Does the child have any relational/attachment difficulties?**
   - _____ Lack of eye contact, or avoids eye contact
   - _____ Lack of appropriate boundaries in relationships
   - _____ Does not seek adult help when hurt or frightened

Child's Name or Identifier: _____ **Age:** _____ **Sex:** _____

County/Site: _____ **Race:** _____ **Date:** _____

Henry, Black-Pond, & Richardson (2010), rev: 3/16 Western Michigan University
Southwest Michigan Children's Trauma Assessment Center (CTAC)

Exhibit C

SOUTHWEST MICHIGAN Children's Trauma Assessment Center

Adult Trauma Screen-Self Report

Please check each area where the item is known *or suspected*. The screen can help determine whether a more comprehensive assessment may be helpful in understanding your functioning and needs.
Note: Endorsing exposure items does not necessarily mean others agree, or that these events were proven to have happened; it is for screening purposes only.

1. **Have you, or have you been told (by someone you trust) that you experienced the following *as a child (under the age of 18):***

_____ Physical abuse
_____ Neglectful home environment
_____ Emotional abuse
_____ Exposure to domestic violence
_____ Exposure to other chronic violence
_____ Sexual abuse or exposure to adult sexuality.
_____ Parent substance abuse
_____ Impaired parenting (i.e. mental illness)
_____ Exposure to drug activity *aside from parent's own use*
_____ Refugee camps, war zones, trafficking *(including forced prostitution)*
_____ Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
_____ Lengthy or multiple separations from primary attachments – parent, other caregivers, siblings or close friends
_____ Placement outside of the home (foster care, kinship care, residential)
_____ Loss of significant people, places etc.
_____ Frequent/multiple moves; homelessness
_____ International adoption, immigration,
_____ Other _____

2. **Have you experienced any of the following *as an adult (over the age of 18):***

_____ Domestic violence/assault (DV)
_____ Physical abuse/assault *other than DV*
_____ Emotional abuse by partner
_____ Trafficking and/or prostitution
_____ Sexual assault (not included above)
_____ Refugee camps, war zones
_____ Incarceration/institutionalization
_____ Military trauma
_____ Loss of significant people, places etc.
_____ Frequent/multiple moves; homelessness
_____ Other _____

3. **Do you or have others told you that you show any of these behaviors:**

_____ Empty, Flat, dismissive – as if you 'don't care'; minimize seriousness of problems/actions
_____ Persistent distrust of others; suspicious
_____ Inappropriate/extreme sexual behavior: overly sexual or avoidant of sexual relationships
_____ Cocky, seem to "know it all"
_____ Current substance abuse, or history of chronic substance abuse
_____ Live with or/spend significant time with others who abuse substances
_____ Unpredictable, explosive responses to events
_____ Excessively controlling
_____ Repeatedly victimized or taken advantage of
_____ Frequent lying, denying things known to be true
_____ Misreads and/or don't seem to understand social cues and/or anticipate negative responses or outcomes
_____ Mixes up appointments, needs information repeated or explained, frequently forgetful
_____ Shares too much private information; gives unnecessary details
_____ Difficulty coping with change
_____ Sleep problems
_____ Impulsive, rash behaviors and decisions
_____ Other _____

Black-Pond, C., Richardson, M., Adult Trauma Screen. Western Michigan University Children's Trauma Assessment Center (CTAC) – Draft 6/29/15

Exhibit D

Clinicians- Administered PTSD Scale for DSM-5 (CAPS-5) Past Month Version can be found at
https://www.ptsd.va.gov/professional/assessment/documents/CAPS_5_Past_Month.pdf

Exhibit E

Life Events Checklist for DSM-5 (LEC-5) Interview Version can be found at
https://www.ptsd.va.gov/professional/assessment/documents/LEC-5_Interview.pdf

UCLA PTSD REACTION INDEX FOR CHLDREN/ADOLESCENTS - DSM-5©

Child/Adolescent Name: _____ ID #_____ Age: _____ Sex: □ Girl □ Boy
Grade in School _____ School: _____ Teacher: _____ City/State _____
Interviewer Name/I.D. _____ Date (*month, day, year*) ____/____/____ (Session #_____)

TRAUMA/LOSS HISTORY SCREENING QUESTIONS: Use the questions in the screening form provided below to ask about history of different types of trauma and loss. Place a check mark in the box on the left for each type of trauma /loss experience that has occurred. In interviewing the child/adolescent, you may ask: ***Sometimes people have scary or violent things that happen to them where someone could have been or was badly hurt or killed. I'm going to ask you some questions about whether any of these kinds of things have happened to you so that you can tell me if they did.*** [For those children/adolescents able to complete the form on their own, you may instruct them to place a check mark in the box on the left of the screening form to indicate that the trauma/loss has happened to them.] In either case, follow up on those items endorsed using the **TRAUMA/LOSS DETAILS** form provided in the next section.

TRAUMA/LOSS HISTORY SCREENING QUESTIONS

- □ **Serious Accidental Injury**: Have you ever been in a bad accident (like a serious car, bus, train or bicycle accident or a bad fall) where you or someone else was or could have been badly hurt or killed? Have you ever seen a bad accident where someone was badly hurt or killed?
- □ **Illness/Medical Trauma**: Have you ever been so sick that you and your parents (or people taking care of you) were scared that you might die? Did you have a medical treatment that was very scary or painful? Did you ever see someone you really care about get so sick that you were scared they might die?
- □ **Community Violence**: Did you ever see a bad fight or shooting in your neighborhood, like between gangs? Were you afraid of getting badly hurt or killed? Have you seen someone mugged, robbed, stabbed or killed in your neighborhood?
- □ **Domestic Violence**: Have you ever seen adults you live with get in a bad fight with each other, where someone got punched, kicked or hit with something? Have adults you live with threatened to hurt each other? Have you ever seen an adult you live with forced to do something sexual by another adult you live with?
- □ **School Violence/Emergency**: Were you ever at school when something really scary happened, like a shooting, a stabbing, a fire, where you or someone else got badly beaten up or someone attempted or committed suicide?
- □ **Physical Assault**: Have you ever been badly physically hurt (punched, kicked, stabbed) by someone outside of your family or who was not taking care of you? Have you ever been badly hurt by someone outside your family, like someone in your neighborhood, a boy or girl friend or a stranger?
- □ **Disaster**: Have you ever been in a natural disaster, like a hurricane, tornado, earthquake, flood or wildfire where you were hurt or could have been hurt or killed? Have you been in a natural disaster where you saw someone badly hurt or killed? Have you been in a place where there was a chemical spill or explosion?
- □ **Sexual Abuse**: Did someone who was taking care of you ever force you to do something sexual? Did someone taking care of you ever make you watch something sexual?
- □ **Physical Abuse**: Have you ever been badly hurt (punched, kicked, stabbed, shaken) by someone who is in your family (like a parent, brother or sister) or someone who was taking care of you? Have you seen another child in your family being badly physically hurt by a parent, caregiver or legal guardian?
- □ **Neglect**: Has there ever been a time when someone who should have been taking care of you didn't, like they didn't take you to a doctor when you were really sick, they left you alone for too long, didn't make sure you were going to school or didn't do their best to keep you healthy or safe?
- □ **Psychological Maltreatment/Emotional Abuse**: Did anyone in your family ever keep telling you that you are no good, keep yelling at you or keep threatening to or send you away?

Exhibit F

- ☐ **Impaired Caregiver**: Was there ever a time when someone who was supposed to take care of you couldn't, like they were too sick, they were so sad they stayed in bed or they had a drinking or drug problem?
- ☐ **Sexual Assault/Rape**: Did someone outside your family ever force you to do something sexual? Did you ever see someone else being forced to do something sexual?
- ☐ **Kidnapping/Abduction**: Have you ever been stolen or kidnapped (taken somewhere against your will) by someone without the permission of your parent or legal guardian?
- ☐ **Terrorism**: Were you ever there when a terrorist attack happened, like a bombing, chemical attack or where people were taken hostage?
- ☐ **Bereavement**: Has someone you really cared about ever died?
- ☐ **Separation**: Were you ever separated for a long time from someone you depend on, like a parent went to jail or was hospitalized, or you were placed in foster care?
- ☐ **War/Political Violence**: Have you lived in a country where a war or armed conflict was happening (like soldiers or groups were fighting with weapons)? Did you see people who had been badly hurt or killed in a war or where soldiers were fighting?
- ☐ **Forced Displacement**: Have you ever been forced to move out of your house due to war, armed conflict or disaster, like having to move to a trailer or refugee camp?
- ☐ **Trafficking/Sexual Exploitation**: Have you ever done sexual things for money, food, clothes, shelter, or protection? Were you ever sold to someone to work for them? Have you been forced into having sex (prostitution) or doing sexual things, like being in sexual pictures (pornography)?
- ☐ **Bullying**: Has someone your age or a student at your school ever bullied you, like kept calling you dirty names, making sexual comments, threatening to beat you up or spreading mean rumors around school or online?
- ☐ **Attempted Suicide**: Have you ever tried to kill yourself?
- ☐ **Witnessed Suicide**: Have you ever seen someone after he/she committed suicide?

TRAUMA/LOSS DETAILS: For each experience endorsed on the Trauma/Loss History Screening Questions form, place a check mark to indicate whether the specified trauma details were present, whether the child/adolescent was a *victim*, *witness* or *learned about** the trauma, and the age(s) over which the trauma occurred. (Both of these forms may be updated over the course of treatment as additional information about trauma history is revealed or as additional traumas occur.) **Learned about* **only** refers to indirect exposure in learning aversive details of violent personal assault, homicide, suicide, serious accident, or serious injury to a close relative or friend. It does **not** include learning about death due to natural causes.

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Serious Accidental Injury	☐ Motor Vehicle ☐ Fall ☐ Dog Bite ☐ Hospitalized ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Illness/Medical Trauma	☐ Self ☐ Family ☐ Friend ☐ Type _____ _____ _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

UCLA PTSD REACTION INDEX FOR CHILDREN/ADOLESCENTS - DSM-5©

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Community Violence	☐ Robbery ☐ Mugging ☐ Killed ☐ Gang-Related ☐ High Crime Community ☐ Drug Traffic ☐ Other _____ _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Domestic Violence	☐ Witnessed bad fight ☐ Threatened harm ☐ Witnessed sexual assault ☐ Weapon Used ☐ Serious Injury ☐ Report Filed	☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
School Violence/Emergency	☐ Shooting ☐ Stabbing ☐ Fire ☐ Suicide ☐ Bomb threat ☐ Assault ☐ Other _____ _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Physical Assault	☐ Punched ☐ Kicked ☐ Stabbed ☐ Shaken ☐ Weapon Used ☐ Reported to CPS (if a minor) ☐ Reported to police ☐ Other _____ _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Disaster	☐ Earthquake ☐ Fire ☐ Flood ☐ Hurricane ☐ Tornado ☐ Chemical spill ☐ Explosion Other _____ ☐ Lost Home ☐ Injured	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

UCLA PTSD REACTION INDEX FOR CHILDREN/ADOLESCENTS - DSM-5©

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Sexual Abuse	☐ Forced sexual behavior ☐ Watch something sexual ☐ Penetration occurred ☐ CPS report filed ☐ Investigation conducted ☐ Charges filed ☐ Conviction ☐ Perpetrator removed from home	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Physical Abuse	☐ Badly physically hurt ☐ Punched ☐ Kicked ☐ Stabbed ☐ Shaken ☐ Weapon Used ☐ Reported to CPS ☐ Reported to police	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Neglect	☐ Medical (did not take to Dr.) ☐ Left alone/unsupervised ☐ School ☐ Failure to promote health ☐ Failure to promote safety ☐ Other _____ ☐ Reported to CPS ☐ Child removed from home ☐ Caregiver removed from home	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Psychological Maltreatment/ Emotional Abuse	☐ Berating/humiliating ☐ Threatened abandonment ☐ Excessive punishment ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Impaired Caregiver	**Impairment Due to:** ☐ Medical illness ☐ Mental health problem ☐ Alcohol use/abuse/addiction ☐ Drug use/abuse/addiction **Affected Caregiver:** ☐ Mother ☐ Father ☐ Other relative ☐ Other (non-related) adult ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Sexual Assault/Rape	**Perpetrator**: ☐ Relative ☐ Boy or girl friend ☐ Position of trust (teacher, coach, minister) ☐ Acquaintance (neighbor etc) ☐ Stranger **Trauma Details:** ☐ Weapon used ☐ Drug used/suspected ☐ Penetration occurred ☐ Date/Acquaintance rape ☐ Reported to police ☐ Investigation conducted ☐ Charges filed ☐ Conviction ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Kidnapping/ Abduction	**Perpetrator**: ☐ Relative ☐ Position of trust (teacher, coach, clergy, etc.) ☐ Acquaintance (neighbor etc) ☐ Stranger ☐ Other _____	☐ Victim ☐ Witnessed ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Terrorism	☐ Shooting ☐ Suicide bombing ☐ Bombing (package, vehicle) ☐ Chemical agent ☐ Biological agent ☐ Radiological agent ☐ Hostages taken ☐ Other _____	☐ Victim ☐ Witnessed ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Bereavement	**Deceased:** ☐ Parent ☐ Sibling ☐ Other Relative ☐ Friend ☐ Other _____ **Cause of Death:** ☐ Drug overdose ☐ Natural Causes (illness, age) ☐ Accident (car, drowning) ☐ Natural disaster ☐ Homicide ☐ Suicide ☐ Other _____	☐ Witnessed ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Separation	**Cause of Separation:** ☐ Parents separated ☐ Parents divorced ☐ Parent hospitalized ☐ Parent deported ☐ Parent/sibling incarcerated ☐ Child placed in foster care ☐ As refugee, separated from relatives/close friends in country of origin ☐ Other _____ _____		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
War/Political Violence	☐ Lived in war-torn region ☐ Saw wounded people ☐ Saw dead bodies ☐ Home damaged/destroyed ☐ Internally displaced ☐ War refugee ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Forced Displacement	**Cause of Displacement:** ☐ War/political violence ☐ Disaster ☐ Other _____ **Site of Displacement:** ☐ Trailer ☐ Refugee camp ☐ Relocation center ☐ Other _____		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Trafficking/Sexual Exploitation	☐ Sex for money, food, clothes ☐ Pornography ☐ Sold into prostitution ☐ Sold into slave labor (unpaid servant or worker) ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Bullying	☐ Verbal insults ☐ Threats of physical harm ☐ Sexual comments ☐ Rumors at school/internet ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Attempted Suicide	**Method:** ☐ Drug ☐ Hanging ☐ Drowning ☐ Firearm ☐ Other _____	☐ Victim ☐ Witness ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Trauma Type	Trauma Details	Role in Event	Age(s) Experienced 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Witnessed Suicide	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other relative ☐ Close friend ☐ Acquaintance/schoolmate ☐ Stranger ☐ Other _____	☐ Witnessed suicide ☐ Witnessed body/scene ☐ Learned about	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

If only one trauma/loss type is endorsed above, write in the trauma/loss type in this blank: _____.
If more than one trauma/loss type is endorsed, have the child/adolescent choose the trauma/loss experience that BOTHERS THEM THE MOST NOW and identify that trauma/loss type in this blank: _____.

Clinician: Provide a brief description of the trauma/loss type that is most bothersome now:

_____
_____
_____
_____
_____
_____
_____

POSTTRAUMATIC STRESS SYMPTOMS

Here is a list of problems people can have after bad things happen. Please think about the bad thing that happened to you that bothers you the most now. For each problem **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how many days the problem happened to you **in the past month,** even if the bad thing happened a long time ago. Use the **Frequency Rating Sheet** to help you decide how many days the problem happened **in the past month.**

HOW MUCH OF THE TIME DURING THE PAST MONTH…		None	Little	Some	Much	Most
1_{E3}	I am on the lookout for danger or things that I am afraid of (like looking over my shoulder even when nothing is there).	0	1	2	3	4
2_{D2}	I have thoughts like "I am bad."		1	2	3	4
3_{C2}	I try to stay away from people, places, or things that remind me about what happened.	0	1	2	3	4
4_{E1}	I get upset easily or get into arguments or physical fights.	0	1	2	3	4
5_{B3}	I feel like I am back at the time when the bad thing happened, like it's happening all over again.	0	1	2	3	4
6_{D4}	I feel like what happened was sickening or gross.	0	1	2	3	4
7_{D5}	I don't feel like doing things with my family or friends or other things that I liked to do.	0	1	2	3	4
8_{E5}	I have trouble concentrating or paying attention.	0	1	2	3	4
9_{D2}	I have thoughts like, "The world is really dangerous."	0	1	2	3	4
10_{B2}	I have bad dreams about what happened, or other bad dreams.	0	1	2	3	4
11_{B4}	When something reminds me of what happened I get very upset, afraid, or sad.	0	1	2	3	4
12_{D7}	I have trouble feeling happiness or love.	0	1	2	3	4
13_{C1}	I try not to think about or have feelings about what happened.	0	1	2	3	4
14_{B5}	When something reminds me of what happened, I have strong feelings in my body like my heart beats fast, my head aches or my stomach aches.	0	1	2	3	4
15_{D3}	I am mad with someone for making the bad thing happen, not doing more to stop it, or to help after.	0	1	2	3	4
16_{D2}	I have thoughts like "I will never be able to trust other people."	0	1	2	3	4
17_{D6}	I feel alone even when I am around other people.	0	1	2	3	4
18_{B1}	I have upsetting thoughts, pictures or sounds of what happened come into my mind when I don't want them to.	0	1	2	3	4
19_{D3}	I think that part of what happened was my fault.	0	1	2	3	4
20_{E2}	I hurt myself on purpose.	0	1	2	3	4
21_{E6}	I have trouble going to sleep, wake up often, or have trouble getting back to sleep.	0	1	2	3	4
22_{D4}	I feel ashamed or guilty about some part of what happened.	0	1	2	3	4
23_{D1}	I have trouble remembering important parts of what happened.	0	1	2	3	4
24_{E4}	I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
25_{D4}	I feel afraid or scared.	0	1	2	3	4
26_{E2}	I do risky or unsafe things that could really hurt me or someone else.	0	1	2	3	4

27_{D4}	I want to get back at someone for what happened.	0	1	2	3	4
With Dissociative Symptoms (Dissociative Subtype)						
28_{A1}	I feel like I am seeing myself or what I am doing from outside my body (like watching myself in a movie).	0	1	2	3	4
29_{A1}	I feel not connected to my body, like I'm not really there inside.	0	1	2	3	4
30_{A2}	I feel like things around me look strange, different, or like I am in a fog.	0	1	2	3	4
31_{A2}	I feel like things around me are not real, like I am in a dream.	0	1	2	3	4

Clinician: Check whether the reactions (thoughts and feelings) above appear to cause clinically significant ***distress*** *or* ***functional impairment***.

☐ **Clinically Significant Distress:** (check if youth endorses #1 below)
☐ Yes ☐ No 1. Do these reactions (thoughts and feelings) bother or upset you a lot?

☐ **Clinically Significant Functional Impairment**: (check if functional impairment at home, at school, in peer relationships, in developmental progression)

☐ **Home**: (check if youth endorses #1, #2 or #3 below)
☐ Yes ☐ No 1. Do these reactions (thoughts and feelings) make it harder for you to get along with people at home?
☐ Yes ☐ No 2. Do these reactions (thoughts and feelings) get you into trouble at home?
☐ Yes ☐ No 3. Do these reactions (thoughts and feelings) cause some other problem at home?
Describe: _____

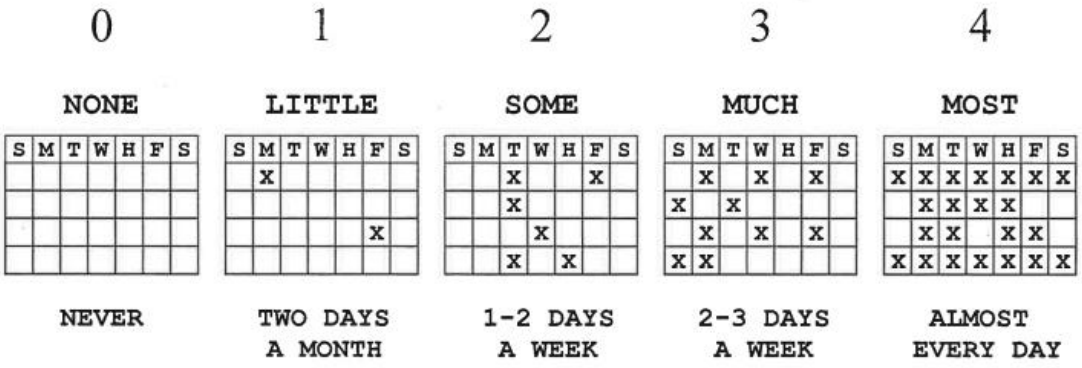
☐ **School**: (check if youth endorses #1 *or* #2 below)
☐ Yes ☐ No 1. Do these reactions (thoughts and feelings) make it harder for you to do well in school?
☐ Yes ☐ No 2. Do these reactions (thoughts and feelings) cause other problems at school?
Describe: _____

☐ **Peer Relationships**: (check if youth endorses #1 below)
☐ Yes ☐ No 1. Do these reactions (thoughts and feelings) make it harder for you to get along with your friends or make new friends?
Describe: _____

☐ **Developmental Progression**: (check if youth endorses #1 below)
☐ Yes ☐ No 1. Do these reactions (thoughts and feelings) make it harder for you to do important things that other kids your age are doing?
☐ Yes ☐ N0 2. Other (describe) _____
_____

FREQUENCY RATING SHEET

HOW MANY DAYS DURING THE PAST MONTH
DID THE PROBLEM HAPPEN?



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SCORE SHEET

Subject ID#_____ **Age**____ **Sex (circle): M F Date:** _____ **Subject Name:** _____

For Items 2, 9, and 16: indicate highest score only for DSM-5 Symptom D2; for Items 15 and19: indicate highest score only for DSM-5 Symptom D3; for Items 6, 22, 25, and 27: indicate highest score only for DSM-5 Symptom D4; for Items 20 and 26: indicate highest score only for DSM-5 Symptom E2. Category B Total: Sum scores for symptoms B1-B5; Category C Total: Sum scores for symptoms C1 **and** *C2; Category D Total: Sum scores for symptoms D1-D7; Category E Total: Sum scores for symptoms E1-E6; PTSD-RI Total Scale Score: Sum Category B, C, D, and E.*

Item #	DSM-5 Symptom	Score *(0-4)*
18	B1	
10	B2	
5	B3	
11	B4	
14	B5	
SYMPTOM CATEGORY B SUMMATIVE SCORE:		____
13	C1	
3	C2	
SYMPTOM CATEGORY C SUMMATIVE SCORE:		____

Item #	DSM-5 Symptom	Score *(0-4)*
23	D1	
2*	D2	
9*	D2	____
16*	D2	
15*	D3	
19*	D3	____
6*	D4	
22*	D4	
25*	D4	____
27*	D4	
7	D5	
17	D6	
12	D7	
SYMPTOM CATEGORY D SUMMATIVE SCORE:		____

Item #	DSM-5 Symptom	Score *(0-4)*
4	E1	
20*	E2	
26*	E2	____
1	E3	
24	E4	
8	E5	
21	E6	
SYMPTOM CATEGORY E SUMMATIVE SCORE		____

Dissociative Symptoms

28. A1 ____
29. A1 ____
(*Indicate highest score for A1*) ___

30. A2 ____
31. A2 ____
(*Indicate highest score for A2*) ___

PTSD-RI TOTAL SCALE SCORE

_____

DSM-5 PTSD DIAGNOSIS

B:	One or more Category B symptoms present:	☐
C:	One or more Category C symptoms present:	☐
D:	Two or more Category D symptoms present:	☐
E:	Two or more Category E symptoms present:	☐
F:	Symptom duration greater than one month:	☐
G:	Symptoms cause clinically significant *distress* or *impairment*:	☐
Specify Dissociative Subtype:		
	One or more dissociative symptoms present:	☐

Estimating Whether DSM-5 PTSD Category B, C, D, and E Symptom Criteria are Met

If symptom score is 3 or 4, then score symptom as "present." For question #4, #10, and #26; use a rating of 2 or more for symptom presence. Then determine whether one or more B symptoms are present; whether one or more C symptoms are present; whether two or more D symptoms are present; and whether two or more E symptoms are present. If one or more Dissociative Symptoms are present, then assign Dissociative Subtype.

Exhibit G

YOUNG CHILD PTSD CHECKLIST (YCPC)

1-6 years. Updated 5/23/14.

Name _____ ID _____ Date _____

TRAUMATIC EVENTS

TO COUNT AN EVENT, YOUR CHILD MUST HAVE FELT ONE OF THESE:
(1) FELT LIKE HE/SHE MIGHT DIE, OR
(2) HE/SHE HAD A SERIOUS INJURY OR FELT LIKE HE/SHE MIGHT GET A SERIOUS INJURY, OR
(3) HE/SHE SAW (1) OR (2) HAPPEN TO ANOTHER PERSON, OR SAW SOMEONE DIE.

	Circle 0 if this did not happen to your child.	Circle 1 if this did happen to your child.	Write your child's age when this happened to him/her the first time.	Write your child's age when this happened to him/her the last time.	Write how many times this happened to your child. If it happened lots of times, please make your best guess.
1. Accident or crash with automobile, plane or boat.	0	1			
2. Attacked by an animal.	0	1			
3. Man-made disasters (fires, war, etc.).	0	1			
4. Natural disasters (hurricane, tornado, flood).	0	1			
5. Hospitalization or invasive medical procedures.	0	1			
6. Physical abuse.	0	1			
7. Sexual abuse, sexual assault, or rape.	0	1			
8. Accidental burning.	0	1			
9. Near drowning.	0	1			
10. Witnessed another person being beaten, raped, threatened with serious harm, shot at seriously wounded, or killed.	0	1			
11. Kidnapped.	0	1			
12. Other:	0	1			

13. If more than one event happened to your child: write the number of the event that you think caused the most distress to him/her:	

IF THERE WERE NO TRAUMATIC EVENTS ENDORSED ABOVE, STOP HERE.
OTHERWISE, PLEASE CONTINUE ON NEXT PAGE.....

1

YCPC

Below is a list of symptoms that children can have after life-threatening events.
When you think of ALL the life-threatening traumatic events from the first page, circle the number below (0-4) that best describes how often the symptom has bothered you in the LAST 2 WEEKS.

0	1	2	3	4
Not at all	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/ almost always	Everyday

14. Does your child have intrusive memories of the trauma? Does s/he bring it up on his/her own?	0	1	2	3	4
15. Does your child re-enact the trauma in play with dolls or toys? This would be scenes that look just like the trauma. Or does s/he act it out by him/herself or with other kids?	0	1	2	3	4
16. Is your child having more nightmares since the trauma(s) occurred?	0	1	2	3	4
17. Did night terrors start or get worse after the trauma(s)? Night terrors are different from nightmares: in night terrors a child usually screams in their sleep, they don't wake up, and they don't remember it the next day.	0	1	2	3	4
18. Does your child act like the traumatic event is happening to him/her again, even when it isn't? This is where a child is acting like they are back in the traumatic event and aren't in touch with reality. This is a pretty obvious thing when it happens.	0	1	2	3	4
19. Since the trauma(s) has s/he had episodes when s/he seems to freeze? You may have tried to snap him/her out of it but s/he was unresponsive.	0	1	2	3	4
20. Does s/he get upset when exposed to reminders of the event(s)?	0	1	2	3	4

For example, a child who was in a car wreck might be nervous while riding in a car now.
Or, a child who was in a hurricane might be nervous when it is raining.
Or, a child who saw domestic violence might be nervous when other people argue.
Or, a girl who was sexually abused might be nervous when someone touches her.

21. Does your child get physically distressed when exposed to reminders? Like heart racing, shaking hands, sweaty, short of breath, or sick to his/her stomach?"	0	1	2	3	4

Think of the same type of examples as in #20.

22. Does your child show persistent negative emotions (fear, guilt, sadness, shame, confusion) that are <u>not</u> triggered by exposure to reminders of the event as in #20?	0	1	2	3	4

PLEASE CONTINUE ON NEXT PAGE…..

0	1	2	3	4
Not at all	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/ almost always	Everyday

23. Does your child try to avoid people or conversations that might remind him/her of the trauma(s)? For example, if other people talk about what happened, does s/he walk away or change the topic?	0	1	2	3	4
24. Does your child try to avoid things or places that remind him/her of the trauma(s)? For example, a child who was in a car wreck might try to avoid getting into a car. Or, a child who was in a flood might tell you not to drive over a bridge. Or, a child who saw domestic violence might be nervous to go in the house where it occurred. Or, a girl who was sexually abused might be nervous about going to bed because that's where she was abused before.	0	1	2	3	4
25. Has s/he lost interest in doing things that s/he used to like to do since the trauma(s)?	0	1	2	3	4
26. Since the trauma(s) has your child become more distant and withdrawn from family members, relatives, or friends?	0	1	2	3	4
27. Since the trauma(s), does your child show a restricted range of positive emotions on his/her face compared to before?	0	1	2	3	4
28. Has your child become more irritable, or had outbursts of anger, or developed extreme temper tantrums since the trauma(s)?	0	1	2	3	4
29. Has s/he been more "on the alert" for bad things to happen? For example, does s/he look around for danger?	0	1	2	3	4
30. Does your child startle more easily than before the trauma(s)? For example, if there's a loud noise or someone sneaks up behind him/her, does s/he jump or seem startled?	0	1	2	3	4
31. Has your child had more trouble concentrating since the trauma(s)?	0	1	2	3	4
32. Has s/he had a hard time falling asleep or staying asleep since the trauma(s)?	0	1	2	3	4
33. Has your child become more physically aggressive since the trauma(s)? Like hitting, kicking, biting, or breaking things.	0	1	2	3	4
34. Has s/he become more clingy to you since the trauma(s)?	0	1	2	3	4

PLEASE CONTINUE ON NEXT PAGE…..

0	1	2	3	4
Not at all	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/ almost always	Everyday

35. Since the trauma(s), has your child lost previously acquired skills? For example, lost toilet training? Or, lost language skills? Or, lost motor skills working snaps, buttons, or zippers?	0	1	2	3	4
36. Since the trauma(s), has your child developed any new fears about things that don't seem related to the trauma(s)? What about going to the bathroom alone? Or, being afraid of the dark?	0	1	2	3	4

FUNCTIONAL IMPAIRMENT

Do the symptoms that you endorsed above get in the way of your child's ability to function in the following areas?

0	1	2	3	4
Hardly ever/ none	Some of the time	About half the days	More than half the days	Everyday

37. Do (symptoms) substantially "get in the way" of how s/he gets along with you, interfere in your relationship, or make you feel upset or annoyed?	0	1	2	3	4
38. Do these (symptoms) "get in the way" of how s/he gets along with brothers or sisters, and make them feel upset or annoyed?	0	1	2	3	4
39. Do these (symptoms) "get in the way" with the teacher or the class more than average?	0	1	2	3	4
40. Do (symptoms) "get in the way" of how s/he gets along with friends at all – at daycare, school, or in your neighborhood?	0	1	2	3	4
41. Do (symptoms) make it harder for you to take him/her out in public than it would be with an average child?" Is it harder to go out with your child to places like the grocery store? Or to a restaurant?	0	1	2	3	4
42. Do you think that these behaviors cause your child to feel upset?	0	1	2	3	4

version 12/9/13

SCORING

The Traumatic Events page (items 1-13) is important to include before administering the symptom portion because it is important to know all of the traumatic events one has experienced that may be linked to symptoms. This page provides a systematic menu to facilitate recall of all events.

Symptoms are scored for totality of events in contrast to many other checklists that rate for only one event.

Items 14-36 are PTSD symptom items. Sum the scores from items 14-36. The suggested cutoff is based on a "probable diagnosis" of PTSD, which is a score of 26 or more for items 14-36. When youth have scores lower than 26 they can still have symptoms and functional impairment that would benefit from treatment.

(Items 37-42 are functional impairment items. These can summed for an impairment score but are not used for the PTSD symptoms score.)

	Items	Probable Diagnosis Cutoff
PTSD Symptoms	14-36	≥ 26
Functional impairment	37-42	≥ 4

Tab 5

Regulatory Management/ HIPAA Compliance

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:
Consumer Records</td><td>Chapter: 08 -
Management of Information</td><td>Subject No: 08.04.01</td></tr>
<tr><td rowspan="2">Effective Date:
12/18/02</td><td>Date of Review/Revision:
9/19/02, 7/13/07, 8/1/07, 5/28/08, 8/20/08, 3/17/09, 5/21/10, 5/17/12, 6/2/14, 5/6/16, 3/8/17, 3/1/18, 3/2/20, 3/11/21, 4/29/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Allison Kalmes-Hadd, Rich Garpiel

Additional Reviewers:
Clinical Directors</td></tr>
<tr><td>Supersedes: 6.07.00.00 and 6.07.01.00</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to ensure uniformity for the establishment, organization, storage, maintenance, and quality of Consumer Records. This policy will ensure that the clinical record adheres to professional standards and meets applicable regulatory standards of governmental and third-party organizations.

Application:
This policy shall apply to all Primary Providers of SCCMHA.

Policy:
All Consumer records will be maintained in a secure and confidential manner, as required by law, rules, regulation, practices or policy.

Information in the Consumer Record will be maintained in a fashion that assures it is:

a. Organized
b. Clear
c. Complete
d. Current
e. Legible

The Electronic Record (Sentri) is the primary record for documentation and storing information regarding consumer treatment and services at Saginaw County Community Mental Health Authority, and will be maintained in a manner applicable to the laws, rules, regulation and policies for electronic media.

Consumer information is primarily maintained in Sentri data fields. Paper documents will be scanned into Sentri in a timely manner. It shall be the responsibility of the Case Holder to assure that information submitted or stored in the consumer record meet the standards of this policy.

Paper documents that were not scanned into Sentri during the conversion to an electronic record are maintained as archival documents, stored in alphabetical order in a secured area.

Standards:
The designated Case Holder is responsible for assuring the accuracy, completeness, and efficacy of the information in the Record.

Sentri will be the primary storage place for treatment and other consumer information. This will be maintained in Sentri either through direct entry or the scanning of hard copy documents.

Printed documents created from Sentri will not be scanned into Sentri unless needed for documenting consumer/guardian approval, or for proof of delivery.

Hard copy documents are to be be submitted to records immediately upon cessation of the need for that document to remain in a working file, but no more than five (5) days from that cessation. Examples of cessation of need or use include: receipt of a signature on a document; receipt of additional parts of a document; or completion of the use of information from a document.

Documents will be scanned into Sentri within five (5) working days after submission to records.

Documents to be scanned should meet the **Consumer Record Document Guidelines** for submission and scanning.

Working Files: each Case Holder may maintain a working file for reference purposes. These documents may include Peer Review Documents, Psycho-therapy Notes, miscellaneous communications, copies of documents, etc. Working File information is to be maintained in a locked setting. This locked setting must be accessible by the Case Holder, program supervisor, or other administrative personnel.

Accurate data and information entry is the responsibility of the staff who enters the information and must meet the standards or requirements of the SCCMHA core values, legal, rule, regulatory, accrediation and as established by the profession of the person entering the documentation.

It is the responsibility of the Case Holder to assure that any proof document supporting a consumer's status are found in the record. Examples of proof documents include

- Legal– Guardianship orders, Power of Attorney
- Medical - Do Not Recessitate, physician orders

- Financial – Payee order
- Others as needed

All Consumer Record entries of service delivery must be completed within time frames designated by department standards but not more than five (5) working days.

Consumer record entries will use and maintain acceptable grammatic structure and language that is understood in lay terms. If on a paper document, will be legible.

Some additional standards when entering documentation:

- Documentation should be strength-based and respectful, reflecting the core values of the agency

- The use of acronymns is allowed only when the full title is first indicated and the acronymn indicated in parenthesis. For example: Saginaw County Community Mental Health Authority (SCCMHA)

- When noting persons other than the consumer in the documentation, the person should be identified by role - such as parent, therapist, friend, housemate, etc. – when first indicated.

- If another consumer is involved in the documentation, this person should not be identified as a consumer nor that person's consumer number be indicated.

- When noting self actions, use first person pronoun – I, my – or title – Case Holder, Therapist.

Consumer record entries may follow a specified format as determined necessary by the program supervisor.

Errors in documentation can be corrected using the Change function found on the list page of most Sentri documents.

Deletion of Sentri documents should only be for the following reasons:

- The Sentri document was started but will not be completed by that staff member. There will be a link to Delete this document.
- The Sentri document is an error such as:
    - a duplicate Sentri document
    - is in the wrong record
    - is the wrong type of Sentri document for that service
    - is a blank document started by a staff who no longer has access to Sentri
- Deletion of unsigned Sentri documents may be done only by the staff entering that document.
- Deletion of signed Sentri documents must be done using the Delete Request function on the list page. Those Sentri documents that do not have the Delete

Request function and meet the category for deletion can be requested using the Sentri Message to the Clinical Records Coordinator.

- The Clinical Records Coordinator will regularly review the Document Deletion Request Queue in Sentri and either Approve or Deny the request.
    - Denials will be done if the request does not meet the criteria for denial
        - A Denial will be documented on the Denial form in Sentri
    - Approvals will remove the document from view in the consumer record but is maintained in the Queue
    - Some requests may be delayed due to needing further or additional action such as removal of a billing or BH-TEDS deletion.

The Records Department will maintain a description of Documentation Types. This list will be updated at least annually or as needed.

The Records Department will maintain a list of documents that are regularly submitted with a corresponding Documentation Type or that should not be entered into Sentri. This list will be updated at least annually or as needed.

Definitions:

Archive file refers to any form of Consumer record that is designed to maintain any purged or inactive case information.

Chart is a physical file for paper or otherwise hard-copy documents for each consumer or family, or a video medium, such as tape or CD, that has been produced in the provision of clinical service to the consumer or family.

Record is the storage of information regarding the medical, historical, mental health, financial, and other information for the purpose of providing services, planning, documentation, communication, proof for reimbursement, state reporting, and is a legal document in criminal or civil legal proceedings.

SENTRI is the acronym for the electronic consumer record.

Case Holder refers to the designated case worker of a consumer.

References:
Michigan Mental Health Code Act 258 of 1974
MDCH contract, including attachments and reference documents
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Exhibits:
Exhibit A - Guidelines for Storage of Information in the Consumer Record
Exhibit B - Quality Protocol for Scanning
Exhibit C - Document Type Descriptions

Procedure:

ACTIONS	RESPONSIBLE
Provides leadership through procedures and practices for uniform and secure Consumer record establishment, organization, maintenance, and retention.	CEO Executive Director of Clinical Services Clinical Records Coordinator
Ensures that all Consumer records adhere to professional standards and meet applicable regulatory standards of governmental and third-party organizations.	Executive Director of Clinical Services Clinical Records Coordinator Primary Provider Supervisor
Ensures that information in Sentri is current, complete, and accurate to the standards indicated in this policy	Case Holder and any staff entering information into a record
Ensures that any proof documents relating to consumer status, such as guardianship, is scanned into the record	Case Holder
Submits to Records all hard-copy documents for scanning in a timely manner and in compliance with the **Consumer Record Document Guidelines**	Staff submitting documents

Exhibit A – Consumer Record Document Guidelines

Overview
SCCMHA uses an electronic health record titled **Sentri**. The full use of electronic means for storage of documents and recording of services was instituted in 2007. All paper documents received after that date have been digitized and saved in Sentri, either in general scanning or as an attachment to a Sentri document.

According to the American Health Information Management Association, these are the functions of the record:

- Storage of information to provide a continuity of care
- Providing information useful for planning, documentation of treatment and services, and communication.
- Providing proof for reimbursement and for state reporting - a factor in determining agency funding.
- Is used as part of criminal or civil legal proceedings.

Various laws and regulations also impact the record such as HIPAA, the Mental Health Code, Michigan Medicaid Provider Manual standards, etc. whose goal is to assure both record integrity and usefulness.

To assure this integrity and usefulness, only documents and information that meets the functions and regulations need to be retained in the record.

Unneeded documents include:

- Psychotherapy Notes are those notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
- Working or personal files such as notes, drafts, document copies of blank documents, copies of submitted applications, copies of documents already in the record, to-do lists, and reminders
- Peer Review documents such as Incident Reports, Audits, Rounds minutes, Clinical Risk minutes, etc.
- Transitory Correspondence written communications of short term interest which have no documentary value or would have no value in the event of litigation. This could include fax cover sheets, fax transmittal sheet, letters of transmittal, internal requests for information, internal referrals for service,

invitations to work-related events, and meeting notifications. These actions can typically be documented on a Progress Note without having to have the actual document in the record. Here are some examples:

- the copy of a Medicaid application would not be scanned, rather kept in a Working File until benefits are attained or denied, but the acceptance/denial letter could be scanned.
- the fax cover and transmittal for a prescription to a pharmacy would be scanned as legal proof that a medication was ordered, but the fax and cover transmittal requesting information would not be scanned, rather kept in a Working file and discarded when the information is recieved.
- Copies of emails regarding requests for services should be summarized and noted in a progress note but not scanned into the record.
- Communications from out-of-agency sources whould be scanned as well as documented on a Progress Note.
- A utility shut-off notice would not be scanned but saved in a Working File until payment secured, then discarded.

Considerations for Submitting Documents for Placement into Sentri

The primary consideration is to maintain the integrity and function of the record. Neither the chart nor Sentri is a place to retain an item just to retain it – documents should be retained because they are either required or necessary. Submission of documents for the Record need to be done in a purposeful and thoughtful manner. The information that goes into the record is permanent and not easily removed, therefore the information should meet the purposes of the record as well as policy and regulation.

The record is not to be used for the purpose of defaming, embarrassing, impugning or otherwise harming another person. It is not the place to put old, no-longer-needed documents. It is not the place to put in a document merely because one is not sure what to do with that document.

In light of this, when submitting a document for the record, consider the following points:

- ✓ Does the document have usefulness in recording treatment, planning, or support - does the information on the document meet the purposes of the record?
- ✓ Have I already captured the important information from this document elsewhere in a Progress Note, Assessment, or other text field and is this necessary to have a copy?
- ✓ Does this contain information that should NOT be in the record such as: designating others as a consumer; unrelated information; false, inflammatory, libelous, or derogatory remarks or categorizations; or other irrelevant information?

- ✓ Should the information on this document be part of the permanent, legal record?
- ✓ Do you want this attached to Sentri document or into general scanning?
    - o If a Sentri document, please indicate what document
    - o If general scanning, please indicate what Document Type if this is an atypcial document
- ✓ The document should fall within these guidelines as compiled from AHIMA, HIPAA, SCCMHA policies, and best practice:
    - Information entered or submitted in the record must meet agency policies
    - All documents need to include the consumer name and case number and be dated.
    - SCCMHA Documents are required to have the consumer name and case number on every page, and to include the name of the staff authenticating the document.
    - Non-SCCMHA Documents should have some form of authentication by the author (minimally the name of the author of the document) or staff submitting the document
    - Documents should be submitted in a timely fashion - NOTE: it is both unethical and illegal to pre-date or back-date documentation relating to treatment, billing or legal proof.
    - Documents in a bundle will be maintained based on the top document. Record staff will not separate bundles for scanning/filing.
    - Bundled documents should be paper clipped or clamped and not stapled to facilitate scanning.
    - Fax cover sheets and receipts should be bundled to the bottom of document(s).
    - Only copies of Sentri documents that contain a consumer/guardian signature should be submitted for filing or scanning.
    - Duplicates of documents already in the chart or in Sentri should not be submitted.
    - Policy 08.04.08 – Agency Forms requires:
        - o The use of only the most recent version of an SCCMHA form. These are found in the Agency or Clinical Forms on the G:Drive.
        - o New SCCMHA forms are required to be approved by the Clinical Director (per policy 08.04.08 Agency Forms). These should also be submitted to Records for determination of scan category and/or Chart tab. The use of unevaluated forms could result in rejection or delay of placement into the record.

- Documents submitted to the record are considered permanent documents. Removal of documents from the Chart should only be done by Records staff in accordance with procedures and policy.
- Staff hand-written documents should be legible.
- Brochures, flyers, etc should be submitted only as an attachment to another document.
- Documents should not be submitted if the information is already in Sentri or if an Sentri document (unless a consumer signature is required).
- Staff may need to "create" a Sentri page, such as the Release of Information, for scanning in of a document.

Return of Documents

Documents that do not appear to meet the above guidelines will be reviewed by the Records department.

If a document is returned to the submitting staff or Case Manager (if the submitting staff cannot be determined), then a note of explanation will be attached, and other action requested, such as creating a Release in Sentri, adding a date, designating a category, etc.

Typically, the return form will go directly to the staff in order to expedite resolution. Staff should contact their supervisor or the Clinical Records Coordinator with questions regarding the return, and not engage in a discussion regarding the document with Records clerks.

Exhibit B - Quality Protocol for Scanning and Uploading 2021

SCANNED DOCUMENTS

1. Scanning needs to be done in a moderate, thoughtful and steady manner. Hurrying to scan in documents leads to errors and mistakes. It is better to be a little behind in scanning than to do scanning quickly.
2. Review the document for applicability for scanning
    a. The only printed documents with the Sentri II logo that are scanned are those requiring a signature. Return if the required signature is not present
    b. Scan fax cover sheets in the back of the document
    c. Contact the submitting person if the document appears incomplete
    d. Review if meets the Do Not Scan list
3. Preparing the document for scanning.
    a. Review the darkness of the printing or background to determine possible problems.
    b. Remove staples, clips or other objects that could jam the machine.
    c. Separate sheets to check if they are stuck together
    d. Count the number of sheets.
    e. Check to assure that there is consumer name or number or other identifier
    f. Check the list of documents to ascertain the scan category
4. Scanning
    a. Make sure that the consumer name and number on Sentri match the document
    b. Make sure that the proper category is highlighted in the drop-down list
    c. Enter the title of the document and/or identifying information in the Attachment Comments field
        i. Avoid using initials or shortened names – such as use Psychiatric Evaluation not “PE”
        ii. Include identifiers such as the name and form number, agency and form name, etc.
    d. Check to assure that the document(s) are properly aligned in the scanner feeder
    e. Watch the scanner as the papers run through to check for stuck sheets
    f. Count the number of sheets and compare with the count shown on the scan
    g. Check the scanned image for clarity of the words, positioning, alignment, and proper page order

h. If it is not clear and proper, do not save and rescan. If it is clear, save the scan.

5. Post-scanning
    a. Place the paper document into the shredding container or shred if you have an approved shredder.

UPLOADING DOCUMENTS

1. Uploading documents need to be done in a moderate, thoughtful and steady manner. There is no 'review' function for an uploaded document
2. Check the document before uploading and be sure to verify the document name and file folder location
3. Uploading
    a. Make sure that the consumer name and number on Sentri match the document
    b. Make sure that the proper category is indicated in the drop-down list
    c. Enter the title of the document and/or identifying information in the Notes text field
        i. Please avoid using initials or shortened names. For example: A Psychiatric Evaluation should be entered with that title not "PE"
        ii. Use as much identifying information as possible such as the name and form number, agency and form name, etc.

ERRORS

1. Errors in naming or category can be corrected by using the 'Change' link on the List Page
2. Errors such as the wrong record require the scan to be deleted.
    a. If it is a wrong record, print out or download the document and scan or upload into the correct record
    b. Using the "Change' link, select the **Documentation Type** as "AA-Delete"
    c. There is no need to send notification or a message to the Records Department as there is a report run regularly to remove documents entered in error.

Exhibit C: Document Type Descriptions

Type	Description	Examples
AA-Delete	Indicating Scan/Upload has been entered in error and needs removal	
Admissions & History	Documents collected during the admissions process that provide historical information on a consumer. Also, may contain documents from the Archive Files	Documents completed prior to SENTRI
Appeal	Forms from the Appeal Process	Appeal Forms filed or rulings Previous paper appeal documents completed prior to SENTRI Correspondence regarding appeals
Appeal: Notice of Image	For use by Care Management only	Care Management Department Use
Appeal: Supporting Document	For use by Care Management only	Care Management Department Use
Assessments	Any assessment or evaluation not indicated in other categories	Intake / assessment documents completed prior to SENTRI Tools used such as CAFAS, OQ 45, Psych testing etc. Specialized assessment documents (OT, PT, S&L etc.) completed prior to SENTRI
Authorizations	Authorizations for services from other providers	
Autism	For use by the Autism Program to house documents	Autism Documents
Behavior Management	Documents related to Behavior Management	Behavior Management documents completed prior to SENTRI Behavior Management Review Behavior Plan Behavior Management Assessment
CCD	Not Used	
CEHR Resource	Not Used	
COFR Documents	COFR Documents for out-of-county placements where case management/services provided by that county	Previous COFR documents completed prior to n-set of SENTRI COFR Correspondence, Assessment, TX notes, Plan
Consents – Treatment/Services	Consents not housed elsewhere	Consent / revocation for treatment Other consents Consent / revocation for emergency medical care Consent / revocation for medication
Consult/Referral/Application	Documents that are referrals for services	Consults
Consumer Signatures	Auto loaded from bar code	

Contract	For use by Contracts Dept only	
Contract Amendment	For use by Contracts Dept only	
Correspondence	Any letters / correspondence not applicable to other categories	Any letters / correspondence not applicable to other categories
Crisis / Safety Plan	Plans regarding crisis intervention or consumer safety not found in other categories or SENTRI documents	Previous crisis / safety plan documents prior to SENTRI Current non- SENTRI crisis / safety plans
Direct Mail Attachment	Not for Use by Clinical Services	
Employment Services	For use by Employment Services	Previous employment documents prior to SENTRI Disability for work documents MRS / MI Works / Other outside referral documents Competitive employment documents
Entitlement and Benefits	Document Entitlements & Benefits efforts	Applications for Benefits SSI / SSD applications SSSD / SSI information / determination CHORE Determination or Application
Family Support Subsidy	For use by Family Support Subsidy	FSS Documents
Healthcare Integration & Other M	Documents relating to physical health care	Medical evaluations Letters to / from healthcare providers Health Reviews Other healthcare related information
HELP Resources	Do Not Use	
Hospital Records	Documents from Hospitals such as discharges	Records form psychiatric admissions from local facilities
Housing	Housing Department Use	Housing Department Use
Imported EDI 820 File	Do Not Use	
Imported EDI 834 File	Do Not Use	
Insurance Policies	Documents related to Insurance	Insurance cards Medicaid Deductible documents
IR Attachment	Do Not Use	
Labs	Lab & Test Orders and Results	Lab & Test Orders and Results
Legal Documents	Documents relating to court or legal actions. NOTE: Protective Services complaints should not be scanned into the consumer record	ATO / Deferral / Petition / Cert Other court or legal document Guardianship

		Other court related documents
MCG Episode Summary	Crisis MCG Episode Document	
Medication Consent Scan	For Medication Consent attachment	
Model Payment	Model Payment requests and information	3803/2355
NGRI	For use by NGRI (no longer used)	NGRI Program Document
OBRA	For use by OBRA	Forms used prior to SENTRI Letters of determination
ORR Attachment	Do Not Use	
Other	Miscellaneous documents not found elsewhere	Miscellaneous documents not found elsewhere
Payer Authorization	For use by Finance only	
Person Centered Plans	Documents from or related to the Individual Plan of Service should be attached to the IPOS	Signed signature sheets Forms used prior to SENTRI
Prescriptions for Services	Prescriptions for medication or services	Clinical services (OT, PT..)
Progress Notes	Progress Notes from other sources not captured elsewhere	Forms used prior to SENTRI Progress notes not entered SENTRI
Proof of Insurance Attachment	For use by Finance only	
Psych Evals / Med reviews	Documents for Psychiatric Evaluations	Forms used prior to SENTRI
Self Determination	Documents related to the Self-Determination	FI information / agreements & related documents Budget & Vouchers
SIS Assessment	Copy of SIS Assessment	
State Facility	Documents from a State Facility	Any information sent to and from a state facility
Task Log	Task Logs	
Test	Testing of scans/uploads	
Treatment Guides & Protocols	Documents relating to treatment approaches	
Waiver Documents	Documents relating to the obtaining or continuation for Waivers for services	Hab waiver information Certificates of eligibility
Wrap Around	For use by Wrap Around	Wrap Documents

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Ownership and Retention of Hard Copy Consumer Records	**Chapter**: 08 – Management of Information	**Subject No**: 08.04.09
Effective Date: 2/11/15	**Date of Review/Revision**: 3/8/17, 3/1/18, 8/6/18, 4/6/20, 2/24/21, 4/29/22	**Approved By**: Sandra M. Lindsey, CEO
	Supersedes:	
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Executive Director of Clinical Services **Authored By**: Richard Garpiel, Jennifer Keilitz **Additional Reviewers**: Allison Kalmes-Hadd, Clinical Directors

Purpose:
The purpose of this policy is to clarify the ownership and retention of hard copy documents as part of consumer records.

Policy:
It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) that the ownership, maintenance, and retention of hard copy documents rests with the agency, programs, individual or provider (herein after called an entity) contracted or funded by SCCMHA who is holding those document(s) at the time of creation or receipt of said document(s).

It is the policy of Saginaw County Community Mental Health Authority that ownership, maintenance, and retention of electronic records rests with SCCMHA.

Application:
The entire SCCMHA Network of service providers.

Standards:
Electronic or digitalized documents will be retained indefinitely, either within the electronic health record or in other standardized digital storage media.

Documents will not be purged or removed from the electronic health record unless placed in the record in error.

Hard copy documents will be maintained by an entity in a safe and secure manner that assures the integrity of the document and the confidentiality of the consumer and in accordance with the contract between SCCMHA and the Mid-State Health Network, 42CFR 438.230 and/or State of Michigan General Schedules for Local Government #7 and State of Michigan General Schedules for Local Government #20, as applicable.

Documents will be maintained, removed, or retained in accordance with the contract between SCCMHA and the Mid-State Health Network, 42CFR 438.230 or
in accordance with the most current and applicable version of the State of Michigan General Schedules for Local Government #7 and State of Michigan General Schedules for Local Government #20 by the entity who is holding or maintaining that record. The standard which retains the document the longest will be used.

If an agency or provider ceases to contract with SCCMHA, these documents must be maintained by the same provision as above.

If an agency or provider ceases existence, then the entity will destroy such records per SCCMHA policy and in compliance to State and Federal regulations, unless SCCMHA requests that the possession of these records be transferred to SCCMHA.

Destruction of hard copy documents will be done according to the requirements of the contract with Mid-State Health Network or other State and Federal laws as applicable.

Definitions:

Entity: any agency, individual, program, or service that receives funding or reimbursement from Saginaw County Community Mental Health Authority to provide services to a consumer or consumers of Saginaw County Community Mental Health Authority

Digitalized – a printed document converted to an electronic document

References:

State of Michigan General Schedules for Local Government#7
State of Michigan General Schedules for Local Government#20
08.04.01 Consumer Records
SCCMHA Record Retention and Disposal Schedule
42 CFR 438.230
Mid-State Health Network Contract

Exhibits:

Exhibit A: In a Nutshell - HITECH and FACTA Compliant Document Destruction
Exhibit B: General Schedule #20

Procedure:

ACTION	RESPONSIBILITY
Maintains hard-copy documents relating to the consumer file in a safe and secure manner following State and Federal requirements	Each SCCMHA entity

Exhibit A

- In a Nutshell -

HITECH & FACTA Compliant Document Destruction

From the SCCMHA Office of Regulatory Compliance

HITECH – The *Health Information Technology for Economic and Clinical Health* (HITECH) Act is a part of the *American Recovery and Reinvestment Act* (ARRA) of 2009. Portions of HITECH are effective Feb 17, 2010. HITECH imposes new security breach notification requirements, extends HIPAA's privacy and security requirements directly to business associates, provides for expanded criminal penalties and higher monetary penalties for violations, and provides guidance for securing Protected Health Information (PHI). (For additional information related to HITECH see ***HITECH in a Nutshell***.)

FACTA – The *Fair and Accurate Credit Transactions Act of 2003* (FACTA) was adopted to minimize the risk of identity theft and consumer fraud. Any person who maintains or otherwise possesses consumer or employee information for a business purpose is required to properly dispose of the information. An effective and secure method of disposing of information in a written form – is by **properly** shredding.

- **IMPORTANT**: The release of Individually Identifiable Information (verbally, in writing or transmitted – including voice mail and answering machine messages) without the consumer's consent is prohibited and considered a **breach of privacy**.
- **Potential Penalty:** You may be liable for a fine up to $250,000 and 1 - 10 years imprisonment!
- **What to do? RELEASE NOTHING** (even verbally) without a proper release. Shred documents, properly, as soon as permitted!
- Proper destruction of documents containing Protected Health Information (PHI) is just as important as protecting the documents while they exist!!

General Rule: Consumer information must be properly secured, stored, and when necessary, properly destroyed. Destruction of paper records should be accomplished through shredding, burning, pulping or pulverizing so that the PHI is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed.

Standard: *Unsecured PHI* means PHI that is **not** rendered unusable, unreadable, or indecipherable to unauthorized persons. While HITECH provides extensive guidance for the encryption of PHI on **electronic media**, *HITECH & FACTA Compliant Document Destruction* will discuss the destruction of **paper records**.

- A Primer on Shredding Documents -

- Identity theft is BIG business.
- The Supreme Court, in 1998, ruled that Americans do not have a right to privacy when it comes to their trash. While the *Economic Espionage Act of 1996* makes it a federal offence to steal trade information, companies that fail to take "reasonable steps" to protect their information, are not protected.

- Dumpster diving, while unsavory, is generally not an illegal activity. Thieves go after employee information, payroll records, customer information, and medical record information.
- The Better Business Bureau indicates that 80% of identity thefts come from paper records that have not been properly secured.
- Documents which contain names, Social Security numbers, dates of birth, account balances, or information which HIPAA defines as Protected Health Information, should be properly shredded when no longer needed.

- ***What standard should be used for the destruction of documents?*** HIPAA requires that a document containing PHI be rendered *essentially unreadable, indecipherable, and otherwise cannot be reconstructed*. HIPAA does not specify the standard by which the document is to be shredded; only that reasonable precautions be taken in destroying sensitive and confidential information. The Department of Defense however, has created a standard which many commercial shredders follow – shredding documents to between 7/16 and 1/32 of an inch. When the documents are shredded in a "cross-cut" manner, they are rendered impossible to re-assemble.

- On-site shredding machines Not all Shredders are Created Equal -

- A paper shredder is a mechanical device used to cut paper into '*chad*', typically either in **strips** or **fine particles.**
- The ***Deutshe Industrial Norm*** (DIN) for paper shredders range from DIN 1 (lowest security) to DIN 5 (high security). (Level 6 is an unofficial designation used primarily by the military.) The larger the scrap of paper after the paper goes through the shredder, the lower the security number.
- ***Strip Shredder*** – A strip-shredder cuts a sheet of paper into spaghetti-like strips which are easier to re-assemble (with a little glue and a lot of patience) – providing a lower level of security. The long thin strips vary in width from ¼ -inch to 1/8-inch strips. These shredders are usually **DIN Level 1** and **Level 2**, and are not advised for confidential documents.

This is the approximate size of the strips produced by a strip shredder

- ***Cross-cut Shredder*** – The cross-cut shredder offers more security (from **DIN Level 3** up to **DIN Level 6**), and the resulting waste is less bulky than that produced by the strip-shredder. Cross cut shredders cut documents into tiny pieces (resembling confetti). Level 6 shredders reduce paper to 1/32-inch by 5/32-inch (1mm x 4-5mm) particles or smaller. Cross-cut shredders result in less bulky waste, resulting in cost savings.
- **Be sure your paper shredder is a security level 3 or higher to keep your sensitive information safe.**

HIPAA-Compliant Mobile Shredding Services

- Mobile shredding services bring mobile shredders to the location of the paper on a regular basis and shred the documents which have been stored in a locked container. Receipts are provided which document the proper disposal of the documents.

Exhibit B:

Note: only those sections which would be retained in a Consumer Record from General Schedule #20 are shown:

Responsible Department	Item Number	Series Title	Retention Period	H, E, H/E
Clinical Services	20.0031	Family Support Subsidy Records	FY Plus 7 Years	
CEO	20.0058	Consumer Case Records - Adults - Identifying And Summary Data	Active Plus 20 Years	
CEO	20.0059	Consumer Case Records - Audits - Medical Data	Active Plus 10 Years	
CEO	20.0060	Consumer Case Records - Adults - Non-medical Data	Creation Plus 7 Years	
CEO	20.0061	Consumer Case Records - Children - Medical Data	Active Plus 10 Years	
CEO	20.0062	Consumer Case Records - Children - Non-medical Data	Active Plus 7 Years	

SCCMHA Record Retention and Disposal Schedule

Number	HAL Series Title	Retention Period	
Department	Policy Reference		

20.0031 **Family Support Subsidy Records** **Creation plus 7 years** **C.S.**

The Michigan Legislature passed the Family Support Subsidy Act in 1983. The Family Support Subsidy Program provides financial assistance to families who care for their children with severe disabilities at home. The Department of Community Health and the CMHSPs administer and implement the Act. These records are maintained to document family support subsidy assistance for children 18 years of age or younger. The records will include the application, the child's birth certificate, a copy of the family's most recently filed Michigan Income Tax Return (MI 1040), written proof from the local or intermediate school district that certifies that the child is eligible, and the child's Social Security number.

20.0058 **Consumer Case Records** **Active plus 20 years** **CEO**

Adults – Identifying and Summary Date

This information is found in the consumer case record and will document the basic identification information for a consumer including the final face sheet, final discharge summary, and diagnosis. The records will be retained until the last date of service (ACTIVE) plus 20 years.

20.0059 **Consumer Case Records** **Active plus 10 years** **CEO**

08.04.01

Adults – Medical Data

This information is found in the consumer case record and will document adult consumers who are receiving services and/or support from the CMHSP, a contracted provider of the CMHSP, or a vendor under valid contract with the CMHSP. The case records will contain clinical/medical information including consents, releases, treatment plans, financial status updates, reports, plans and strategies, evaluations, assessments, testing, consumer contact sheets, health and history reviews, progress notes, charge slips, PES, medication reviews, psychological evaluations, medication order sheets, bridge scripts, medication consent forms, labs, Aims test, health provider correspondence, discharges, transfers, third party information, self-determination agreements, etc. Records may be in hard copy or electronic format and will be retained until the last date of services (ACTIVE) plus 10 years.

Note: If documents are purged from this file, they must be retained until the last date of service (ACTIVE) plus 10 years.

20.0060 **Consumer Case Records** **Creation plus 7 years** **CEO**

08.04.01

Adults – Non-medical data

Non-medical and non-psychological treatment/case management information including correspondence and copies of information from other agencies shall be retained for 7 years.

20.0061 **Consumer Case Records** **Active plus 10 years** **CEO**

08.04.01

Children – Medical Data

These records will document consumers under the age of majority who are receiving services and/or support from the CMHSP, a contracted provider of the CMHSP, or a vendor under valid contract with the CMHSP. The case records may contain face sheets, consents, releases, treatment plans, financial status updates, reports, plans, strategies, evaluations, assessments, testing, consumer contact sheets, health and history reviews, progress notes, charge slips, PES, medication reviews, psychological evaluations, medication order sheets, bridge scripts, medication consent forms, lab, Aims test, health provider correspondence, discharges, transfers, third party information, etc. Records may be in hard copy or electronic format and will be retained until the client is 6 years past the age of majority and last date of service (ACTIVE) plus 10 years.

20.0062 **Consumer Case Records** **Active plus 7 years** **CEO**

08.04.01

Children – Non-medical Data

Non-medical and non-psychological treatment/case management information including correspondence and copies of information from other agencies shall be retained for a period not less than 7 years after the consumer reaches the age of majority (ACTIVE).

Definition of Retention Codes

The retention codes that appear on the SCCMHA Record Retention and Disposal Schedule are used to establish how long records are retained by SCCMHA before they are destroyed (or transferred to the State Archives for permanent retention).

Active

An active code is usually assigned to records that are case or project related. The records are retained "until the case or project is closed." This code can also be applied to records where a subjective decision is needed to determine when the records become inactive, as with a subject file. The record is retained "until it is determined to be inactive." The retention period is applied when the ACTIVE condition has been met. For instance, a case file might be retained until the case is closed (ACTIVE) plus five years.

Creation

A creation code is assigned to records when a definitive retention period can be assigned. The retention period is usually based on a calendar year and where there are no conditions that must be met. For instance, correspondence has a two-year retention period. The retention period begins from the date the correspondence is created or received.

Expiration

An expiration code is typically assigned to contracts, grants or other types of agreements that must be retained until an expiration date or other legal condition has been met. For instance, contracts may be held until contract expiration (EXPIRATION) plus six years.

Fiscal Year

A fiscal year code is similar to a CREATION code. The code is assigned to records when a definitive retention period can be assigned, however the retention is based on a fiscal year rather than a calendar year. This retention code is usually assigned to accounting records and their supporting documentation.

SUPERSEDED

A superseded code is typically assigned to records that are updated or revised at various times during the records lifetime. Examples would include policies or procedures. As a policy is updated and the old version is replaced or superseded, only the current version is needed.

EVENT

Event codes are assigned to records when a retention period is based on a future action or condition. We use this code when we know that a future action or condition will be met, but we do not know exactly when it will happen. For instance, deeds are retained to document the ownership of land by the State of

Michigan. If and when the State of Michigan divests itself of that land, a retention period can be applied to the records. The records will be retained until the State of Michigan sells the land (EVENT).

IMMEDIATE DISPOSAL

Immediate Disposal is a retention code that is used when an agency requires an authorization to destroy obsolete records upon the approval of their Records Retention and Disposal Schedule. Once the Retention Schedule is approved the agency has the legal authority to destroy the obsolete records.

PERMANENT

These records are not authorized for destruction at any point in time and will be retained in the custody of the creating agency.

Tab 7

Claims Processing

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:
Financial Liability for Mental Health Services</td><td>Chapter: 05 - Organizational Management</td><td>Subject No: 05.02.06</td></tr>
<tr><td rowspan="2">Effective Date:
October 1, 2002</td><td>Date of Review/Revision:
9/30/02, 6/1/07, 6/2/14, 8/3/16, 7/31/17, 5/2/18, 2/12/19, 1/1/20, 12/31/20, 1/10/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Chief Financial Officer

Authored By:
Laura Argyle

Additional Reviewers:
None</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
In order to ensure that when an consumer is covered, in part or in whole, under any type of insurance coverage, private or public, for services provided directly or by contract with SCCMHA, the benefits from that insurance coverage(s) is considered to be available to pay the consumer's financial liability, in addition to the consumers's calculated ability to pay, notwithstanding that the insurance contract was entered into by a person other than the consumer or that the insurance coverage was paid for by a person other than the consumer. Additionally, the insurance coverage is considered available to pay for the consumer's financial liability for services provided by SCCMHA or its contracted providers in the amount and to the same extent that coverage would be available to cover the cost of services if the consumer had received the services from a health care provider other than SCCMHA or it's contracted providers.

Application:
All the following functions within the SCCMHA Provider Network, but not limited to:

- Customer Service Department
- Finance Department
- Care Management Department
- Network Services Department
- Network Services Providers
- All SCCMHA staff

Policy:

It is the policy of SCCMHA to properly bill all responsible parties who are financially liable for the cost of services provided to an consumer either directly or by contract with SCCMHA, and to coordinate the benefits related to the services received.

Standards:
When a responsible party is financially liable for the cost of services provided to the consumer directly by or by contract with SCCMHA:

1. SCCMHA shall charge responsible parties for that portion of the financial liability that is not met by insurance coverage. The amount of the charge shall be the least of the following:
    a. Ability to pay (ATP) determined rules and guidelines of the Mental Health Code
    b. Cost of Services as defined in Section 800 of the Mental Health Code.
    c. The amount of coinsurance and deductible in accordance with the terms of participation with a payer or payer group.

2. SCCMHA shall waive payment of that part of a charge determined to exceed financial liability, and shall not impose charges in excess of ability to pay.

3. If the consumer is single, insurance coverage and ATP shall first be determined for the consumer. If the consumer is an unmarried minor and the consumer's insurance coverage and ATP are less than the cost of the services, insurance coverage and the ATP shall be determined for the parents. If the consumer is married, insurance coverage and ATP shall be determined jointly for the consumer and the spouse.

4. The total combined financial liability of the responsible parties shall not exceed the cost of the services.

5. A consumer shall not be denied properly approved and eligible services because of the inability of responsible parties to pay for the services.

6. If a responsible party willfully fails to apply to have insurance benefits that cover the cost of services provided to the consumer, the responsible party's ATP shall be determined to include the amount of insurance benefits that would be available. If the amount of insurance benefits is not known, the responsible party's ATP shall be determined to be the full cost of services.

7. Willful failure to provide the relevant financial information by a responsible party may result in a determination of ATP up to the full cost of services received by an consumer.

8. Consumers who receive services will receive a determination of the responsible parties' insurance coverage and ATP as soon as practical after the start of services.

9. No determination of ATP made by SCCMHA shall impose an undue financial burden for the consumer or the consumer's family members.

10. SCCMHA shall annually determine the insurance coverage and ATP of each consumer who continues to receive services and of each additional responsible party, if applicable.

11. A responsible party may request SCCMHA to make a new determination of ATP, if they believe it does not appropriately reflect their ATP. The responsible party has a right to contest an ATP, by means of an administrative hearing.

12. In no instance shall the request for a redetermination of ATP result in an amount greater than the original determination.

Definitions:

Ability to Pay (ATP) - the ability of a responsible party to pay for the cost of services, as determined under sections 818 and 819 of the Mental Health Code

Coordination of Benefits (COB) – The coordination of billing priority when an consumer is covered, in part or in whole, under any type of insurance coverage, private or public, for services provided directly or by contract with SCCMHA.

Cost of Services – The total operating and capital costs incurred by SCCMHA with respect to, or on behalf of, an consumer. Cost of services does not include the costs of research programs or expenses unrelated to the provision of mental health services. Section 800 of the Mental Health Code

Consumer – The minor or adult who receives services from SCCMHA or one of its contracted providers.

Insurance Benefits – Payments made in accordance with insurance coverage for the cost of health care services provided to an consumer.

Insurance Coverage – Any policy, plan, program, or fund established or maintained for the purpose of providing for its participants or their dependents medical, surgical, or hospital benefits. Insurance coverage includes, but is not limited to, Medicaid or Medicare; policies, plans, programs, or funds maintained by nonprofit hospital services and medical care corporations, health maintenance organizations, and prudent purchaser organizations, and commercial, union, association, self-funded and administrative service policies, plans, program and funds.

Responsible Party – The person financially liable for services furnished, which includes the consumer and, as applicable, the consumer's spouse and parent or parents of minor.

References:

Michigan Mental Health Code – Act 258 of 1974, Chapter #8 , Section – 330-1800 - 330.1844
SCCMHA Procedure 09.02.03.01 Ability to Pay Determination Process
SCCMHA Procedure 09.02.03.02 Consumer Finance Information Sheet - Instructions for Completion of Form
SCCMHA Procedure 09.02.08.04.01 Self Pay Billing Procedure

Exhibits:
None

Procedures:

	ACTIONS	RESPONSIBLE
1.	A financial billing system is set up and maintained to ensure that timely billing of services can be achieved.	Chief Executive Officer
2.	Ensure that responsible parties who are financially liable for cost of services are properly billed for services.	Chief Financial Officer Finance Department Billing Staff
3.	When an consumer is covered, in part or in whole, under any type of insurance coverage, private or public, for services provided directly by or by contract with SCCMHA, the benefits from that insurance(s) become a significant part of the coordination of benefits for service.	Chief Financial Officer Finance Department Billing Staff
4.	A determination of the responsible parties and consumer's ability to pay (ATP) is completed as soon as practical after the start of services.	Clinical Supervisors Primary Case Holder Finance Department Entitlement & Billing Staff
5.	Annual re-determinations of abililty to pay is completed.	Primary Case Holder Finance Department Entitlement & Billing Staff
6.	Re-determination of ATP will be completed when requests are received from responsible parties.	Primary Case Holder Finance Department Entitlement & Billing Staff
7.	Communication to responsible party that they have a right to administrative hearing to contest an ability to pay determination.	Customer Service Department

<table>
<tr><th colspan="3">Finance Department Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:
Contracted Network Provider Claims Submission</td><td>Chapter: 09.02.01 - Claims</td><td>Subject No: 09.10.01.01</td></tr>
<tr><td colspan="3">  </td></tr>
<tr><td rowspan="2">Effective Date:
September 14, 2000</td><td>Date of Review/Revision:
3/18/02, 10/1/02, 4/1/03, 10/1/03, 10/1/06, 2/7/07, 7/1/10, 9/1/10, 11/10/11, 6/15/12, 6/2/14, 5/4/16, 7/21/17, 6/20/18, 6/14/19, 1/27/20, 3/31/20</td><td rowspan="2">Approved By:
Laura Argyle, Chief Financial / Chief Operating Officer

Authored By:
Sue McCrea, Admin Account Supervisor

Reviewed By:
Claims Processors: Pauline Najera, Carrie Davis</td></tr>
<tr><td>Supersedes:</td></tr>
</table>

Purpose:
In order to ensure accurate and timely payment of claims, the following specific claims related guidelines have been issued.

Application:
SCCMHA Claims Processors
SCCMHA Administrative Accounting Supervisors
SCCMHA Chief Financial Officer
SCCMHA Contracted Network Service Providers

Policy:
None

Standards:
None

Definitions:
Clean Claim: A clean claim is defined as having all claims criteria accurately supplied and free of all error messages.

References:
SCCMHA Financial Liability for Mental Health Services Policy - 05.02.06
Professional 1500 (CMS-1500) Uniform Billing Form - 09.02.01.01.10.05
Professional 1500 (CMS-1500) Uniform Billing Form Instructions - 09.02.01.01.10.06
UB04 (CMS-1450) Uniform Billing Form - 09.02.01.01.10.07
UB04 (CMS-1450) Uniform Billing Form Instructions - 09.02.01.01.10.08
Sentri Claims Adjudication Reason Codes - 09.02.01.01.01
Non Panel– Non Contract Provider Claims Submission Procedures - 09.02.01.01.02
Sentri Claims Processing and Reimbursement Procedures - 09.02.01.02.20

Exhibits:
None

Procedure:
- Claims Submission:

The provider shall submit to SCCMHA claims for payment of authorized covered services. There are three types of submission:

1. Claims prepared on either a form CMS-1500 for Professional Charges or UB04 (CMS-1450) for Institutional charges for Inpatient Stays as described in the Service Provider Manual and mailed to SCCMHA.
2. Online data entered directly in to the SCCMHA software "Sentri". Login must be obtained by SCCMHA IS Department individually to each billing clerk as described in the Service Provider Manual.
3. Electronic data transmission approved thru SCCMHA 837 file, but only after a SCCMHA trading partner agreement has been signed.

The provider shall submit clean claims within ninety (90) calendar days of service or within thirty (30) calendar days of receipt of remittance advice from payors precedent to SCCMHA, not to exceed a year from date of service.

To prevent delay in processing of claims, all paper claims should be mailed to:

SCCMHA
Attn: Claims Processing Department
500 Hancock
Saginaw, MI 48602

Claims may also be dropped off at the Customer Services window at 500 Hancock, addressed to the attention of Claims Processing.

- Claims Criteria:

All claims must be submitted in a HIPAA 837 compliant format, with all critical information provided without errors in order to be considered a clean claim.

The letter(s) of authorization distributed by SCCMHA will provide current claims information. Every claim must contain this authorization number in order to be considered a clean claim. **Claim Processers do not create authorization numbers**.

- Claims Processing:

The Provider must adjudicate the claim batch and review for errors. The errors should be corrected and the claim batch should be re-adjudicated by the Provider prior to the submission. This above statement also applies to electronic 837 files.

The Claims Processors will assist the Provider but will not make corrections for the Provider. Claims with errors remaining after submission will be returned or denied.

Please refer to Procedure 09.02.01.01.01 Sentri Claims Adjudication Reason Codes. It outlines the various error messages received from Sentri.

If there is a payor precedent to SCCMHA, the Provider must enter the COB information on the line item and provide proof of COB information to the Claims Processer. COB information can be submitted via Sentri Email, fax 989-799-3918 or US Mail.

SCCMHA will make timely payments to all providers for covered services provided under a signed contract. Paper claims received at SCCMHA will be date stamped when received. Claims received thru Sentri will have a submission date. Clean claims will be paid within 30 days of receipt.

This standard may vary for services rendered under a sub-contract in which other timeliness standards have been specified and agreed to by both parties.

- Claims Payment:

SCCMHA's contract requires providers are to bill SCCMHA their actual cost of providing the service rendered. Claims will be paid based on the rate established in the signed contract with the provider. If a contract does not exist, it will be at the discretion of SCCMHA to determine if claims will be paid based on the previous contract or hold the claims until there is an agreeable and signed contract.

Additionally, SCCMHA shall deny payment of any claim submitted by the provider when at least one of the following criteria is met:

- When there are no payors precedent to SCCMHA and the claim is not submitted within ninety (90) calendar days of service
- When there are payors precedent to SCCMHA and:
    a. The claim is not submitted to SCCMHA within thirty (30) calendar days of receipt of remittance advice from those payers, or

b. The claim is not submitted to the SCCMHA within a year of the date of service

False Claims: If a claim submitted by the provider is paid by SCCMHA, but is subsequently determined to be a false claim (i.e., improper or unsubstantiated), SCCMHA is entitled to recover its costs by deducting the amount of the false claim from the provider's future claims or requiring reimbursement by the provider. In addition to the amount of the false claim, SCCMHA costs may include, but are not limited to, associated administrative costs and expenses. SCCMHA also reserves the right to seek any other remedies available at law and/or in equity.

ACTION	RESPONSIBILITY
1. Mail paper claims in UB4 or 1500 format. to SCCMHA	Network Services Provider
2. If submitting electronically, either by 837 file or direct data entry into Sentri. Provider to Run and Review the Adjudication Report in Step #2 on Sentri	Network Services Provider
3. If submitting electronically, Provider is to correct any errors prior to submission of Claims to SCCMHA	Network Service Provider
4. Provider to Submit Clean Claims to SCCMHA via either US mail system or electronically this also includes the COB information required if CMH is not primary Payor.	Network Services Provider
5. SCCMHA will Adjudicate Claims	Claims Processors
6. SCCMHA Claims Processors will Assist Providers with Resolving Errors. It is the Providers Responsibility to submit Clean Claims	Claims Processors
7. SCCMHA Claims Processors will return Batches if Claims are not Clean	Claims Processors
8. Print and Analyze Reports	Claims Processors

Finance Department Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Electronic Claims Submission by Provider	**Chapter:** 09.02.01 - Claims	**Subject No:** 09.10.01.01.01
		
Effective Date: 10/1/06	**Date of Review/Revision:** 3/28/07, 6/24/10, 11/18/11, 6/15/12, 6/2/14, 5/13/16, 6/20/18, 6/14/19, 1/27/20 **Supersedes:** 09.02.01.01.30	**Approved By:** Laura Argyle, Chief Financial / Chief Operating Officer **Authored By** Sue McCrea, Admin Accounting Supervisor **Reviewed By:** Claims Processors: Pauline Najera, Carrie Davis

Purpose:
To provide instruction to network providers on claims entry and submission using the Sentri claims processing software.

Application:
SCCMHA Claims Processors
SCCMHA Administrative Accounting Supervisors
SCCMHA Chief Financial Officer
SCCMHA Provider Network

Policy:
None

Standards:
None

Definitions:

Adjudication- Reported process that shows whether the claim has errors. The report should be run prior to submission of claims to SCCMHA. Final adjudication is performed by the SCCMHA Claims Processors.

Approval- recommend for payment.

Approved Claims- Approved claims in this procedure refers to the claims that have been entered and approved by the provider to be submitted to SCCMHA for payment. Claim entry and provider approval is achieved by completing Steps 1& 2 on the Sentri claims processing menu.

Authorization- The document allowing the provider to render and bill for services. This is obtained thru SCCMHA Care Management Dept.

Claim Form- UB04 (CMS 1450) or HCFA 1500 (CMS 1500).

Claims Processing/Management - Sentri view that allows access to claims submission functions.

CMHSP- Community Mental Health Service Program. Saginaw County Community Mental Health Authority is one of Michigan's CMHSPs.

Entered Claims- Entered claims in this procedure refers to the claims that have completed Step 1 of the Sentri claims processing menu.

Reconsider- Process where a claim line is backed out by SCCMHA Claim Processors. This places a credit on the Provider's account.

SCCMHA- Saginaw County Community Mental Health Authority

SCCMHA Sentri software- The claims processing system and software used by SCCMHA for payment of claims.

837 File – HIPAA compliant electronic file submission

References:
SCCMHA Provider Registration/SCCMHA Sentri System Training – 09.02.01.01.14
SCCMHA Sentri Claims Submission & Reimbursement Procedures– 09.02.01.02.20
SCCMHA Sentri Claims Adjudication Reason Codes – 09.02.01.01.01

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
1. Enter claims into Sentri System	Provider

2. Adjudicate the batch and review for errors. Make corrections and re-adjudicate	Provider
3. Send Batch(es) to CMHSP (or SCCMHA)	Provider
4. Final Adjudication for Submitted Approved Claims from Provider	SCCMHA Claims Processor(s)
5. Print checks	SCCMHA Accounts Payable Clerk
6. Print & analyze reports, remittance advice and explanation of benefits	Claims Processors/Provider/ Provider's Supervisor
7. Mail checks	SCCMHA Claims Processor(s)

- Provider claims are either entered directly into the Sentri system or through a HIPAA 837 compliant format.

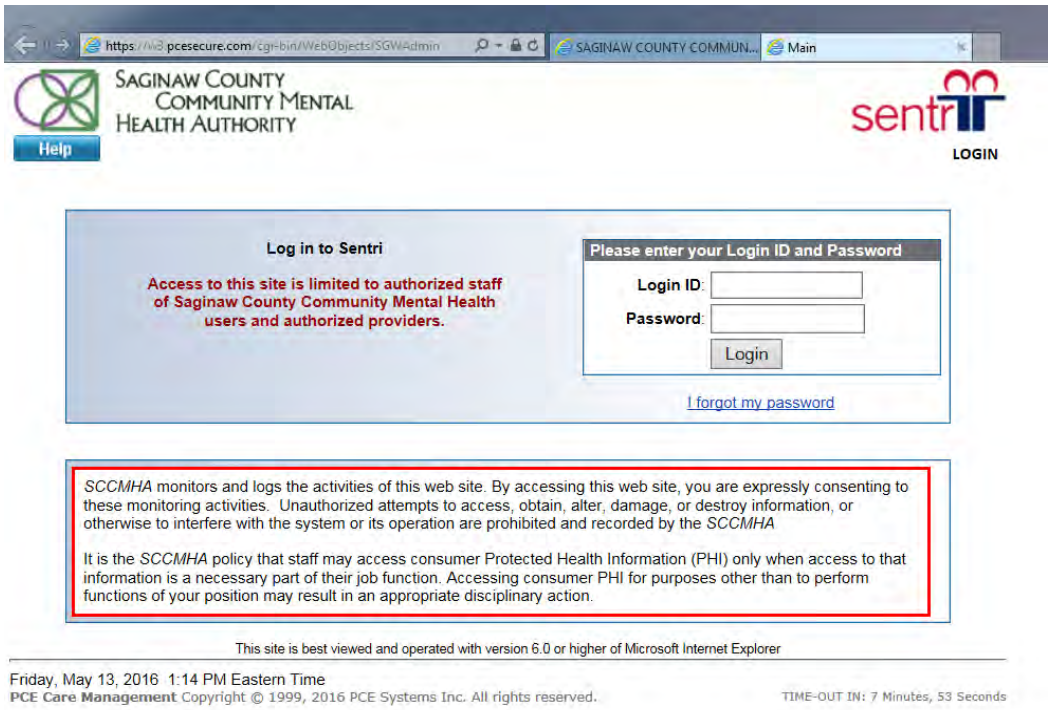
- The provider must contact the SCCMHA IS Department Help Desk via email Hdesk@sccmha.org to make arrangements for electronic access. Please reference procedure 09.02.01.01.14- SCCMHA Provider Registration/SCCMHA Sentri System Training for additional information.

- Call the Claims Processing Department to set up training, if wanted at (989) 797-3516 Carrie Davis or (989) 498-4205 Pauline Najera.

- After obtaining the Log In, and Password, the provider can log into https://w3.pcesecure.com/cgi-bin/WebObjects/SGWAdmin

- Login's should not be shared and should be kept secure. SCCMHA staff, service programs and network providers will abide by current HIPAA requirements to protect the privacy and security of the health information of persons who are service recipients of SCCMHA. SCCMHA is a "Covered Entity" as defined by HIPAA and HIPAA compliance is an employment and contractual obligation for all of the members of the SCCMHA workforce.

Snapshot of Sentri Login Screen:

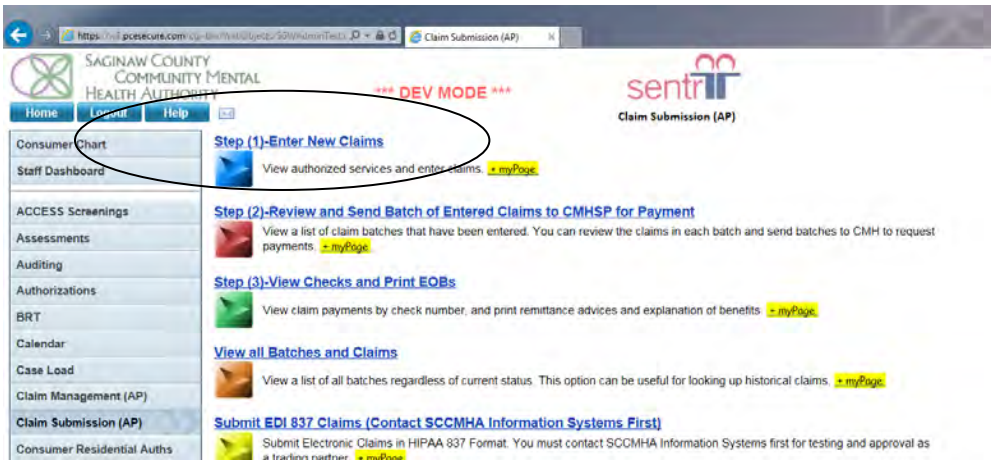


CLAIMS PROCESSING IN SENTRI

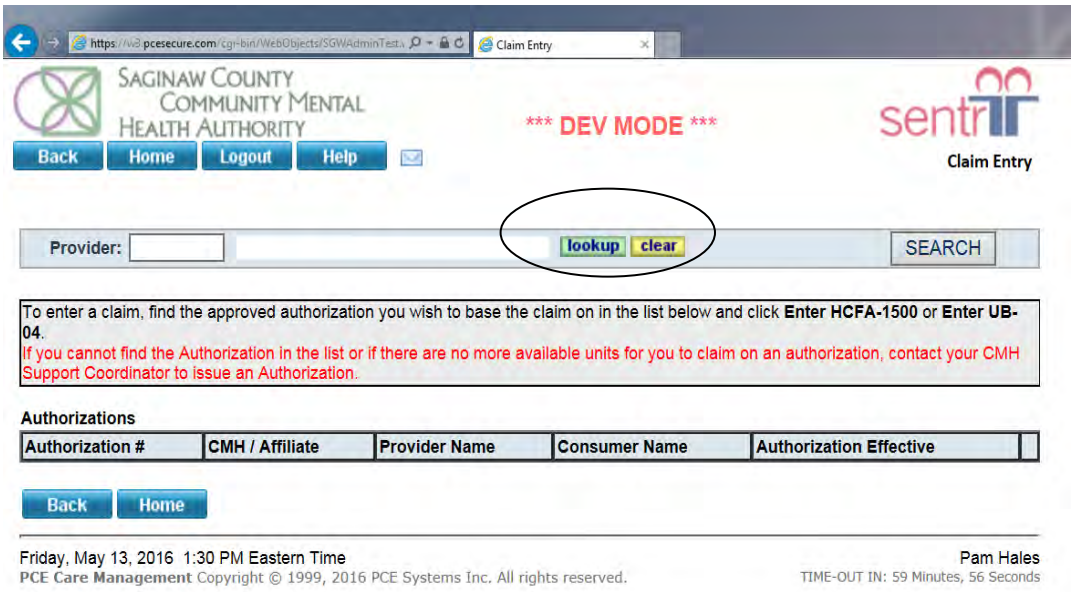
After logging into Sentri, click on **"Claim Submission"** button on the left side of the screen.

STEP 1

A) Click "Step (1) - Enter New Claims"

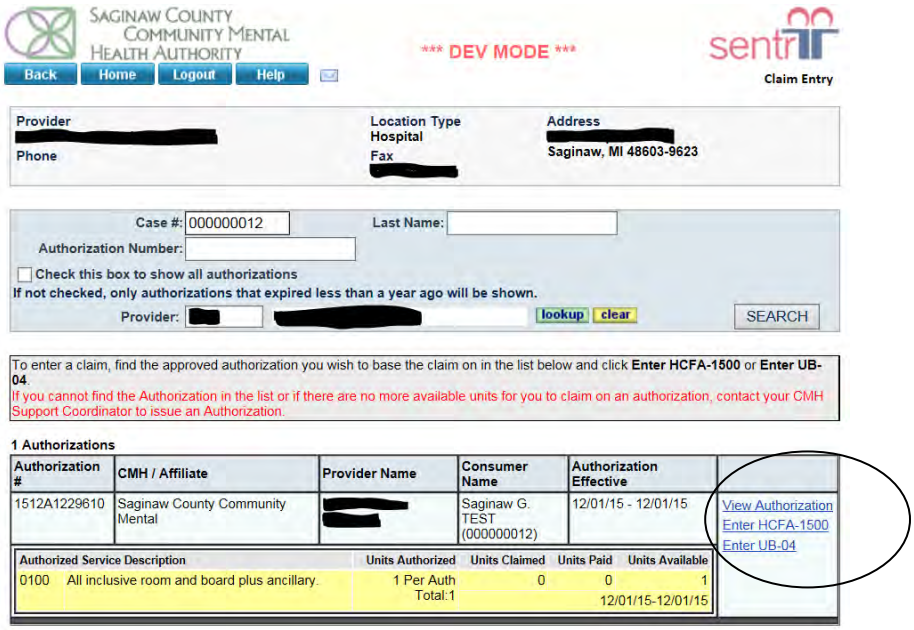


B) Click "Lookup" and type in Provider name.



C) Enter either the consumers "Case#" or "Last Name" and click the "Check this box to show all authorizations". Then click "**Search".**

D) Authorizations will appear for the consumer in newest to oldest order. Note: There may be more than one page of authorizations to view. Find the authorization that matches the provider, date range and code that you are preparing to bill for. Use the blue links circled below to proceed to the correct billing form (the HCFA-1500 or the UB-04); there is also a link to "View Authorization" that will allow you to see more detail regarding the authorization.



If you are unable to locate an authorization; you will **not** be able to continue entering claims for this consumer. Please contact the consumer's Case Manager or Supports Coordinator to have an authorization requested, or to check the status of the authorization.

TIP Be Proactive - Make your inquiries via secure email so they are documented. Set up some kind of tracking be sure to follow up on the same email thread.

Reminder you only have 90 days from the Date of Service or 30 days from the date of receipt of remittance advice from Payers precedent to SCCMHA, not to exceed a year from date of service to submit a clean claim to SCCMHA.

Reminder September 30th is SCCMHA's year end. Dead line then becomes December 31st for clean claims for September dates of service.

Create your own internal set of procedures:

- What does the Billing Clerk do when they can't enter a claim because the Authorization is missing or needs correction?
- How are you going to track this claim to make sure it gets submitted?
- How long should the Billing Clerk wait before the next level of your internal Management gets involved?
- What is causing the missing Authorization? Is the problem chronic?
- Do you need a formal Correction Action Request system?

Don't wait to reconcile SCCMHA's check against your internal system to find out the claim was never submitted.

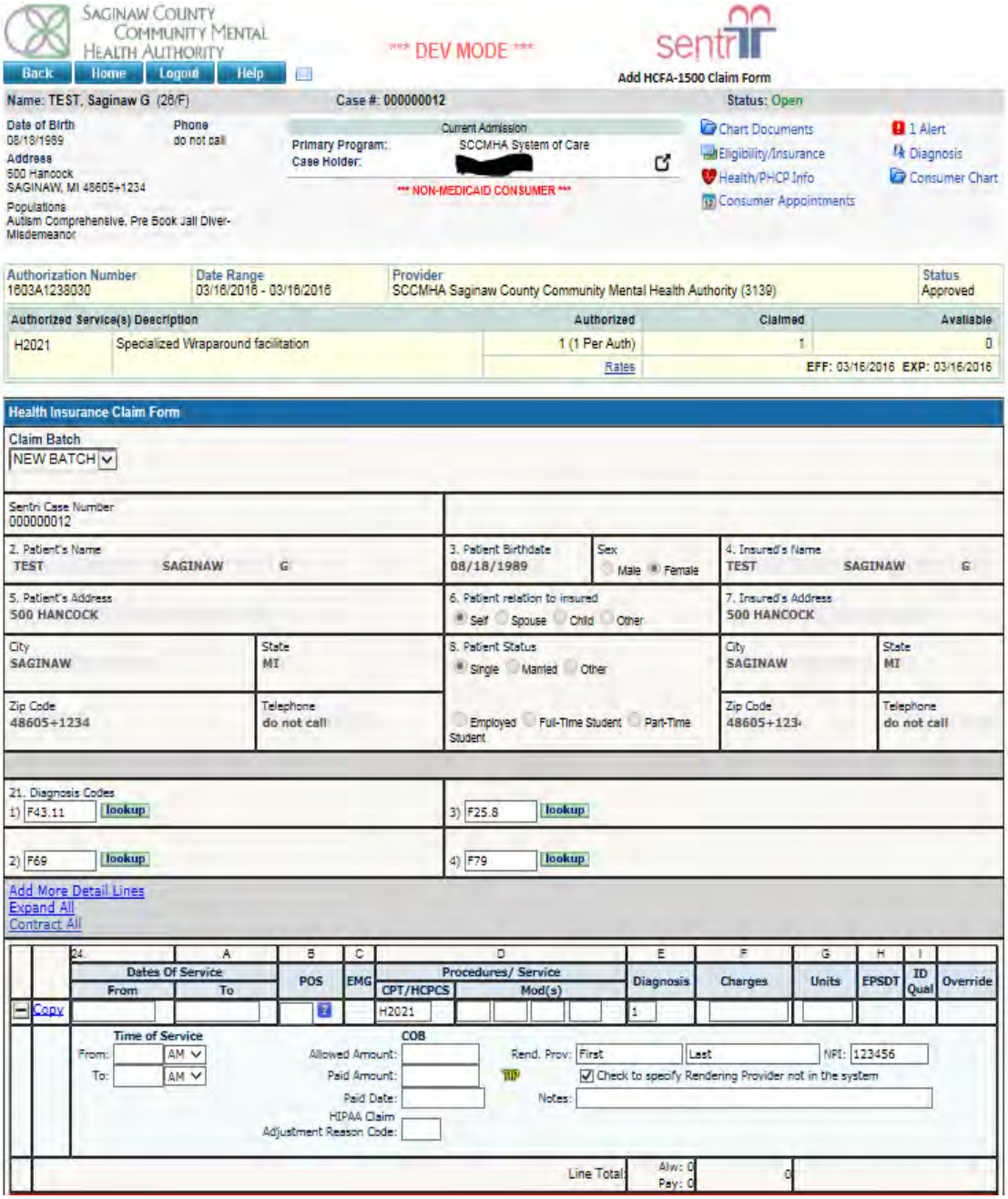
SCCMHA Claims Processors do not have authority or access to create or change Authorizations.

Timely claim submission will help your organizations cash flow.

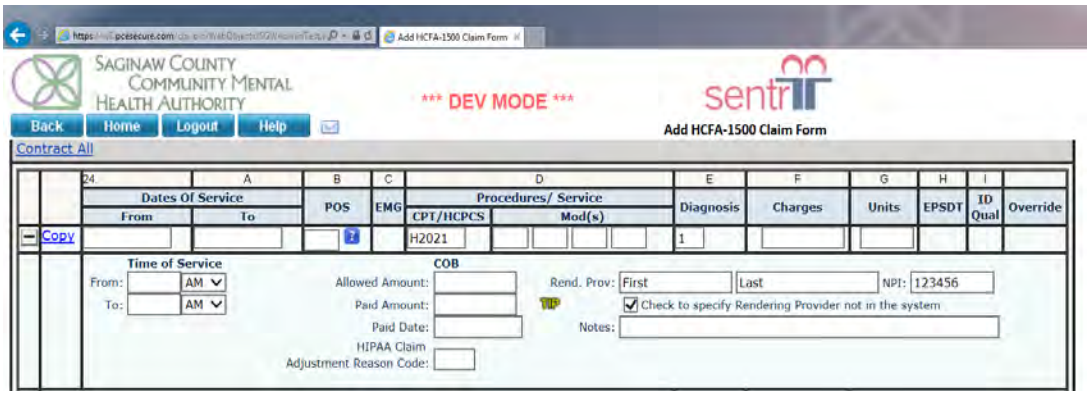
SCCMHA is required to submit various reports to their PHIP and State of MI throughout the year regarding funding requirement forecasts. We need timely claim submission to allow us to provide accurate figures to submit. This has a direct effect on the funds that are made available to SCCMHA from the State of MI.

E) Enter claim information into the electronic form. A number of the fields will automatically populate with consumer data that is housed in Sentri. Other fields will need to be manually entered.

Sample: HCFA-1500 Form



Box #24 of the HCFA contains a number of fields that require manual entry such as: Dates of Service, POS (Place of Service), CPT/HCPCS (procedure code), Mod(s) (Modifiers), Charges, Units, COB (Coordination of Benefits), NPI number, and Time of Service fields.



24 A. Dates of Service
The dates you enter must fall in between the dates on the Authorization or the line will error out. Are you using the correct Authorization?

24 B. POS Place of Service
Sentri has a menu item to obtain current list. Below is a sample list

Place of Service

Search for:

Ok to use only

Search

26 Records

◂PREVIOUS 1 2 3 NEXT▸

		Ok To Use?	
01-Pharmacy	01	Yes	
02-Telehealth	02	Yes	
03-School	03	Yes	
04-Homeless Shelter	04	Yes	
09-CCI / Jail / Prison	09	Yes	
11-Office	11	Yes	
12-Home	12	Yes	
13-Assisted Living Facility	13	Yes	
14-Group Home (AFC)	14	Yes	
15-Mobile Unit	15	Yes	

◂PREVIOUS 1 2 3 NEXT▸

24 C. EMG – is left blank.

24 D. Procedures/Service
CPT/HCPCS and Modifiers must be on the Authorization. If you get an error message refer back to the Authorization. Are you using the correct Authorization number?

24 E. Diagnosis Code

24 F. Charges
Providers are to bill SCCMHA their actual costs. Claims will be paid based on the rate established in the signed contract with the provider.

24 G. Units

See PIHP/CMHSP ENCOUNTER REPORTING HCPCS and REVENUE CODES for rules on Units of measure.

PIHP/CMHSP ENCOUNTER REPORTING
HCPCS and REVENUE CODES

GENERAL RULES FOR REPORTING

1a. Rounding rules for HCPCS reporting:

"Up to 15 Minutes"	15 Minutes	30 Minutes	45 Minutes	60 Minutes
1-15 = 1 unit	1-14 minutes= 0*	0-29 minutes = 0*	0-44 minutes = 0*	1-59 minutes = 0*
16-30 = 2 units	15-29 = 1 unit	30-59 = 1 unit	45-89 = 1 unit	60-119 = 1 unit
31-45 = 3 units	30-44 = 2 units	60-89 = 2 units	90-134 = 2 units	120-179 = 2 units
46-60 = 4 units	45-59 = 3 units		135-179 = 3 units	180-239 = 3 units
61-75 = 5 units	60-74 = 4 units			240-299 = 4 units
76-90 = 6 units	75-89 = 5 units			300-359 = 5 units
91-105 = 7 units	90-104 = 6 units			360-419 = 6 units
106-120 = 8 units	105-119 = 7 units			420-479 = 7 units
	120-134 = 8 units			480-539 = 8 units

* Do not report if units equal zero.

1b. Rounding rules for CPT reporting of 15-minute codes:

Units	Time
0	0-7 minutes
1	8-22 minutes
2	23-37 minutes
3	38-52 minutes
4	53-67 minutes

1. Select the service (see CPT code descriptions).
2. Report a timed service based on face-to-face time on each date of service.
3. The CPT rule states that a unit of time is attained when the mid-point is passed.

If you get an error "Units Exhausted", check the Authorization screen in Sentri. There might be another Authorization. You may have to request more units.

Notes on Time of Service fields

- "Time of Service" fields are found in box #24 of the HCFA-1500 form located in Sentri.
- These fields are displayed by clicking the **"+"** sign on the left-hand side of the form, next to the blue "Copy" link.
- Time of Service fields may be required depending on the CPT code. **The start/stop time must equal the units. The claim will error out if they don't match.**

Notes on Coordination of Benefit fields

- Claims with COB information need to be entered into a separate batch.
- "Coordination of Benefit" line specific fields are found in box #24 of the HCFA-1500 form located in Sentri.
- These fields are displayed by clicking the **"+"** sign on the left hand side of the form, next to the blue "Copy" link.
- The "Coordination of Benefit" line specific fields include the following:
  - **"Allowed Amount"** (REQUIRED field)
  - **"Paid Amount"** (REQUIRED field)
  - **"Paid Date"** (REQUIRED field)
  - **"HIPAA Claim Adjustment Reason Code"** (REQUIRED field)
  - **"Notes"**– this text box can be used by the provider to document/communicate any specific notes regarding the specific claim line.
  - The Provider is required to submit the paper copy of the EOB for all payors prior to SCCMHA. The EOB can be faxed to 989-799-3918, emailed to Claim Processors thru Sentri messaging or US mailed. Please note the batch number on the EOB paperwork.

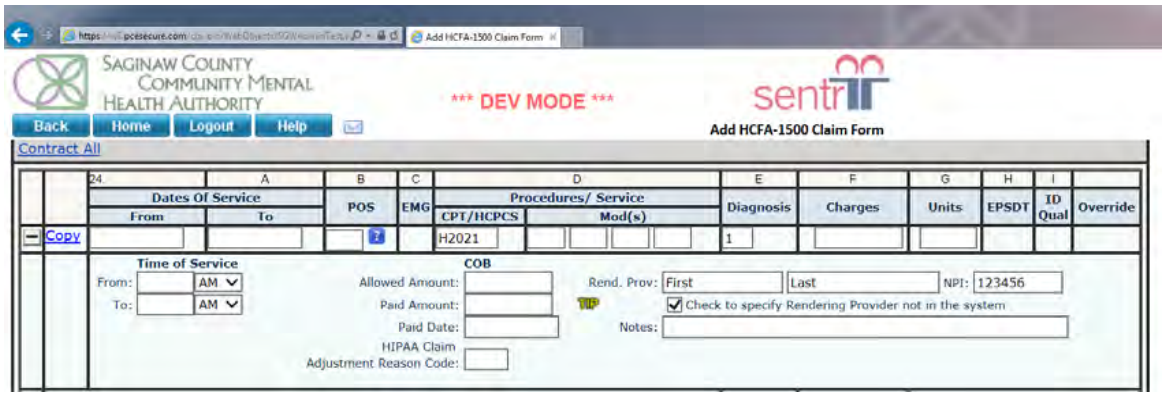
TIP Notes on "Copy" feature

A claim line can be copied by clicking the blue "**Copy**" link on the left hand side of the Sentri HCFA-1500 form. After clicking **"Copy"**, a calendar will appear that will allow you to designate the days of the month where you'd like the current claim line copied.

Notes on NPI (National Provider Identifier) if applicable. New requirements were loaded into Sentri effective 10-1-19.

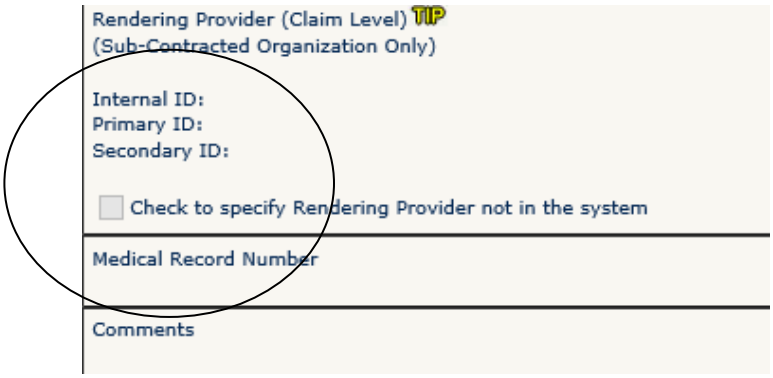
- "**Rendering Provider**" and "**NPI**" line specific fields are found in box #24 of the HCFA-1500 form located in Sentri.

- These fields are displayed by clicking the **"+"** sign on the left hand side of the form, next to the blue "Copy" link.
- Click the box next to: **"Check to specify Rendering Provider not in the system"**
- Then fill in the following fields
- "**Rend. Prov**" – Rendering Provider
- "**NPI**" –National Provider Identifier



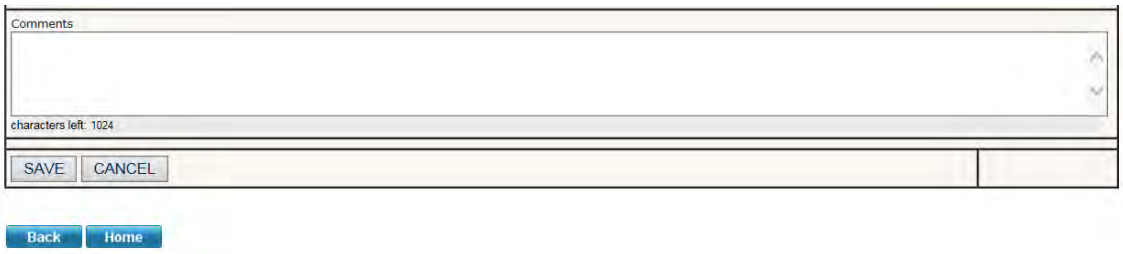
TIP How to add a new Rendering Provider to Sentri
Send an email to Monique Taylor-Whitson at mtaylor-whitson@sccmha.org. She is Provider Network Auditing Supervisor. Your email should state the name of the Billing Provider, the full proper name and NPI # of the new rendering provider you wish to add to Sentri.

Box #31 – If a consumer is a COFR or has a SED Waiver, this Rendering Provider Box must also be filled out.



E) Enter any notes related to the claim in the "Comment" field at the bottom of the form.

F) When the form is complete, click "**Save**" the bottom of the claim.



Sentri will assign a batch number. Keep track of your batch numbers in some kind of log.

Always remember to SAVE the claim!

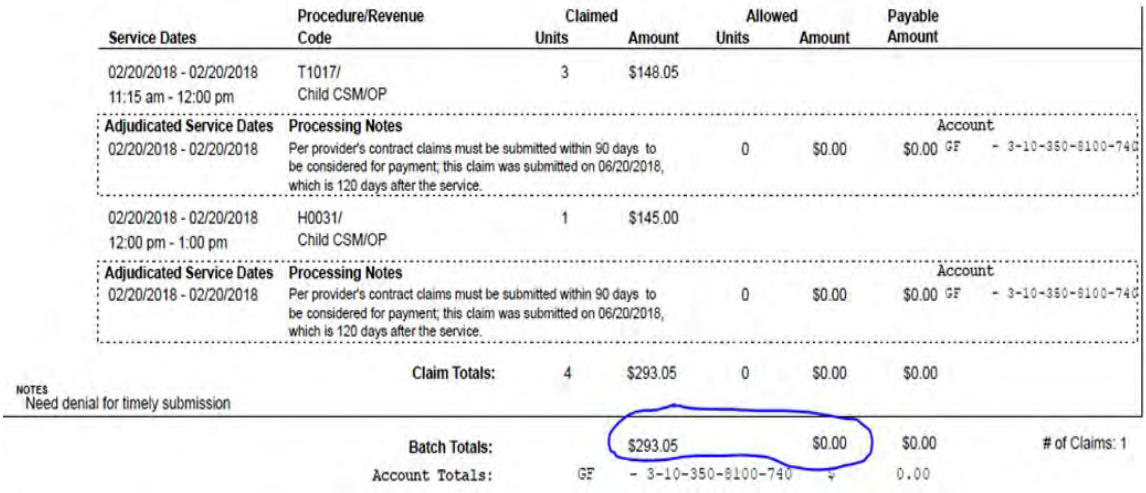
STEP 2

After all claims have been entered, return to the "Claims Management" home page and click **"Step (2) – Review and Send Batch of Entered Claims to CMHSP for Payment"**.

Run and review the Adjudication Report and look for errors. You can review these on the screen. Smaller batches are sometimes more manageable than 100 page claims.

Correct the errors and re-adjudicate the batch. Run and review the Adjudication Report again until all the errors are corrected and you have a "clean claim".

Review the bottom of the batch check to see if the numbers at the bottom match.



Service Dates	Procedure/Revenue Code	Claimed Units	Claimed Amount	Allowed Units	Allowed Amount	Payable Amount	
02/20/2018 - 02/20/2018 11:15 am - 12:00 pm	T1017/ Child CSM/OP	3	$148.05				
Adjudicated Service Dates: 02/20/2018 - 02/20/2018	Processing Notes: Per provider's contract claims must be submitted within 90 days to be considered for payment; this claim was submitted on 06/20/2018, which is 120 days after the service.			0	$0.00	$0.00	Account: GF - 3-10-350-8100-740
02/20/2018 - 02/20/2018 12:00 pm - 1:00 pm	H0031/ Child CSM/OP	1	$145.00				
Adjudicated Service Dates: 02/20/2018 - 02/20/2018	Processing Notes: Per provider's contract claims must be submitted within 90 days to be considered for payment; this claim was submitted on 06/20/2018, which is 120 days after the service.			0	$0.00	$0.00	Account: GF - 3-10-350-8100-740
	Claim Totals:	4	$293.05	0	$0.00	$0.00	

NOTES
Need denial for timely submission

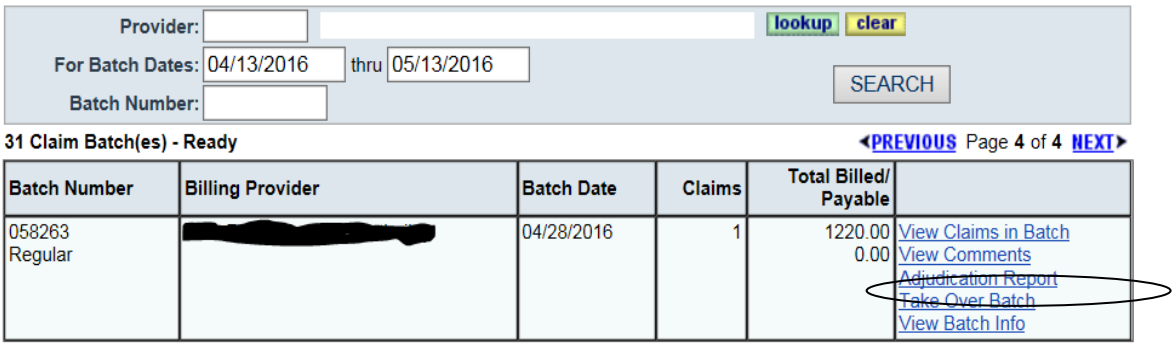
Batch Totals:	$293.05	$0.00	$0.00	# of Claims: 1	
Account Totals:	GF - 3-10-350-8100-740	0	0.00		

In the above sample the Batch Total Claimed Amount is $ 293.05. The amount in the Allowed Amount column is Zero. This means SCCMHA is not paying this line item.

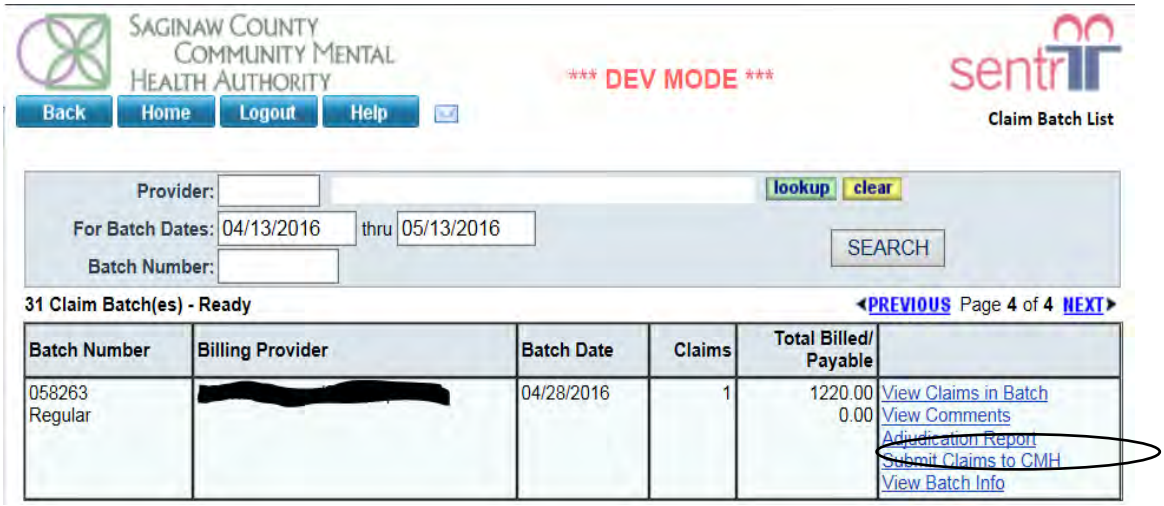
Reference Procedure 09.02.01.01.01 Sentri Claims adjudication Reason

Do not wait until you are missing a payment to reconcile your claims. Reconcile them before you do the next step.

Click the blue link that says, "**Take Over Batch**"



Then click the blue link that says, "**Submit Claims to CMH**"



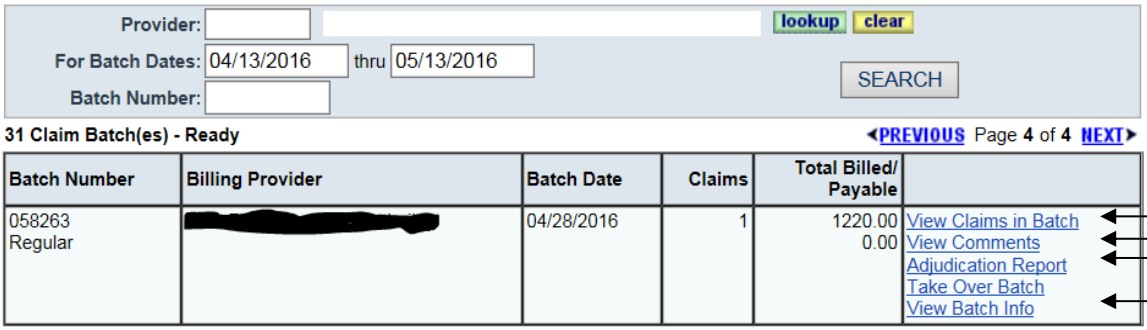
<u>Important: This step is necessary for claims to be sent to SCCMHA for processing. Failure to complete this step will result no claim payment and/or possible claim denial.</u>

When the batch is submitted to SCCMHA it is date stamped by Sentri. SCCMHA Claim Processors will review each batch. They may return a batch to you for correction.

SCCMHA Claim Processors will assist you with error messages. **Claim Processors cannot make corrections to your claims**. Claim Processors cannot override error messages. They must obtain approval from the Admin Accounting Supervisor.

Please review your email timely and make the necessary changes. If you re-submit the claim again without making the changes, the claim may be denied.

OTHER INFORMATION obtained through the "Step (2)-Review and Send Batch of Entered Claims to CMHSP for Payment" screen



The "Step (2)- Review and Send Batch of Entered Claims to CMHSP for Payment" screen will allow you to access the following links:

a) "View claims in Batch" will allow you to:

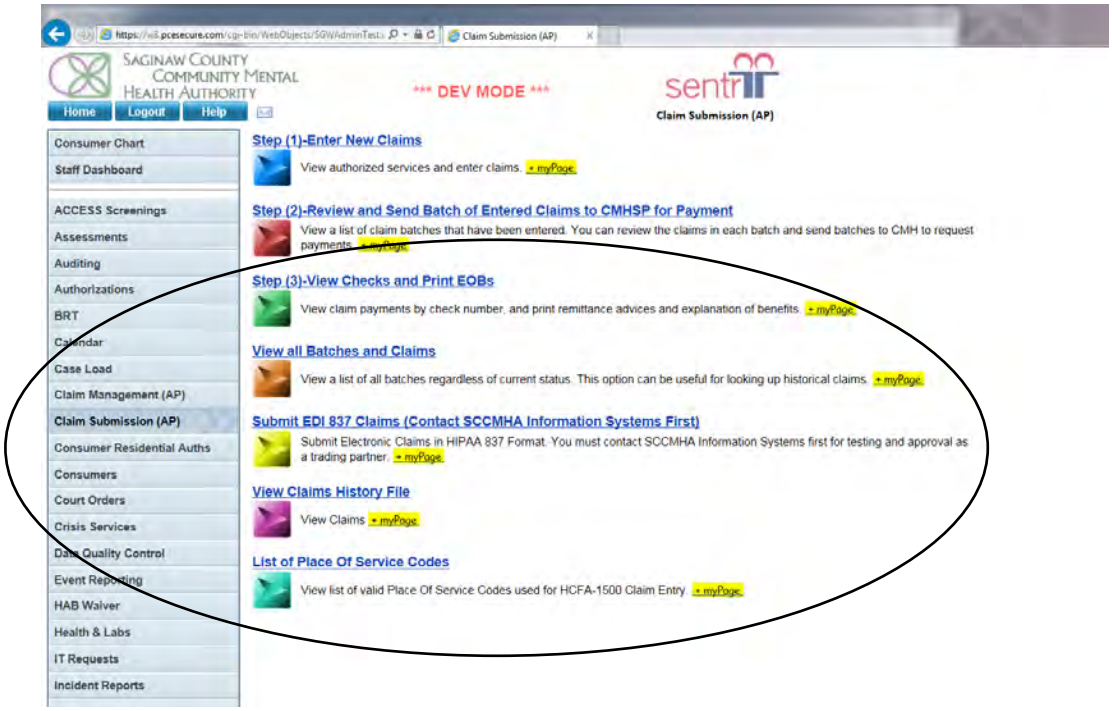
- View a claim
- Change a claim
- Delete a claim

b) "**View Comments**" allows a provider to view any comments typed into the comment field located at the bottom of the claim entry form.

c) "**Adjudication Report**" allows you the ability to review the claims entered in the batch through a "*Batch Edit Report",* click on the "Adjudication Report" link and then click on the icon at the top of the screen to view/print the report.

d) **"View Batch Info"** gives a summary of batch information

OTHER INFORMATION obtained through "Claims Submission" Home Page



a) "**Step (3)- View Checks and print EOBs"** by entering the desired check number and clicking "Search".

b) "**View all Batches and Claims"** allows providers to status their claim batches.

c) "**Submit EDI 837 Claims (Contact SCCMHA information Systems First)**" is used by providers who upload their claims using an 837 file.

d) "**View Claims History File**" allows provider to view paid claims.

e) "**List of Place of Service Codes**" contains Place of Service reference list.

RECONSIDER A CLAIM

The process of reconsidering a claim zeros out the line item on a claim that is in error. It will process as a credit on the Billing Providers Account.

If you have errors that need to be corrected after the batch is processed. A request to reconsider a claim must be made in writing via Sentri Message system to the Claim Processer that has your account.

Please provide the claim number, the Consumers Name, Sentri ID#, Date of Service, reason for the request for reconsider and dollar amounts.

The claim will be reconsidered by a SCCMHA Claims Processor. The Claims Processor will notify you when complete. If applicable you can re-enter the proper billing. Reference the Batch number and the Claim number of the 1st claim.

SCCMHA Event Verification – Audit results from SCCMHA Provider Network Audit Department.

If errors are found during an audit, you will receive a letter from SCCMHA Audit Department. **Do not send us a check.**

The below Claims Processor assigned to you will Reconsider the Claims to Zero. This will put a credit on your account and will be subtracted from the next check. The letter may state that you can re-bill the claim fixing whatever is wrong. It is important that the claim is zeroed out first. Otherwise you may get a duplicate service error. Contact your Claims Processor to help resolve the re-bill.

SCCMHA Claims Department Contact Information:

Pauline Najera
Claims Processor
(989) 498-4205
pnajera@sccmha.org (please use the Sentri email link)

Carrie Davis
Claims Processor
(989) 797-3516
cdavis@sccmha.org (please use the Sentri email link)

Sue McCrea
Accounting Supervisor of Claims/AP
(989) 797-3597
smccrea@sccmha.org (please use the Sentri email link)

Finance Department Procedure Manual Saginaw County Community Mental Health Authority		
Subject: UB 04 (CMS-1450) Uniform Billing Form Instructions	**Chapter:** 09.02.01 - Claims	**Subject No:** 09.10.01.01.05
		
Effective Date: October 1, 2006	**Date of Review/Revision:** 10/1/06, 5/23/07, 7/1/10, 11/10/11, 6/15/12, 6/2/14, 4/27/16, 5/1/17, 6/20/18, 6/14/19, 2/27/20 **Supersedes:**	**Approved By:** Laura Argyle, Chief Financial / Chief Operating Officer **Authored By:** Sue McCrea, Admin Accounting Supervisor **Reviewed By:** Claims Processors

Purpose:
In order to insure accurate and timely payment of claims, the following specific claims related guidelines have been issued.

Application:
SCCMHA Claims Processors
SCCMHA Administrative Accounting Supervisors
SCCMHA Director of Finance
SCCMHA Provider Network and Non-Contract Providers

Policy:
None

Standards:
None

Definitions:
None

References:
SCCMHA Cash Management Policy- Subject No. 05.02.03
SCCMHA Financial Liability for Mental Health Services Policy- Subject No. 05.02.06
UB04 (CMS-1450 form) Uniform Billing Form- Subject No. 09.02.01.01.10.07

Exhibits:
Exhibit A - Example of UB 04 (CMS 1450) Claim Form

Procedure:

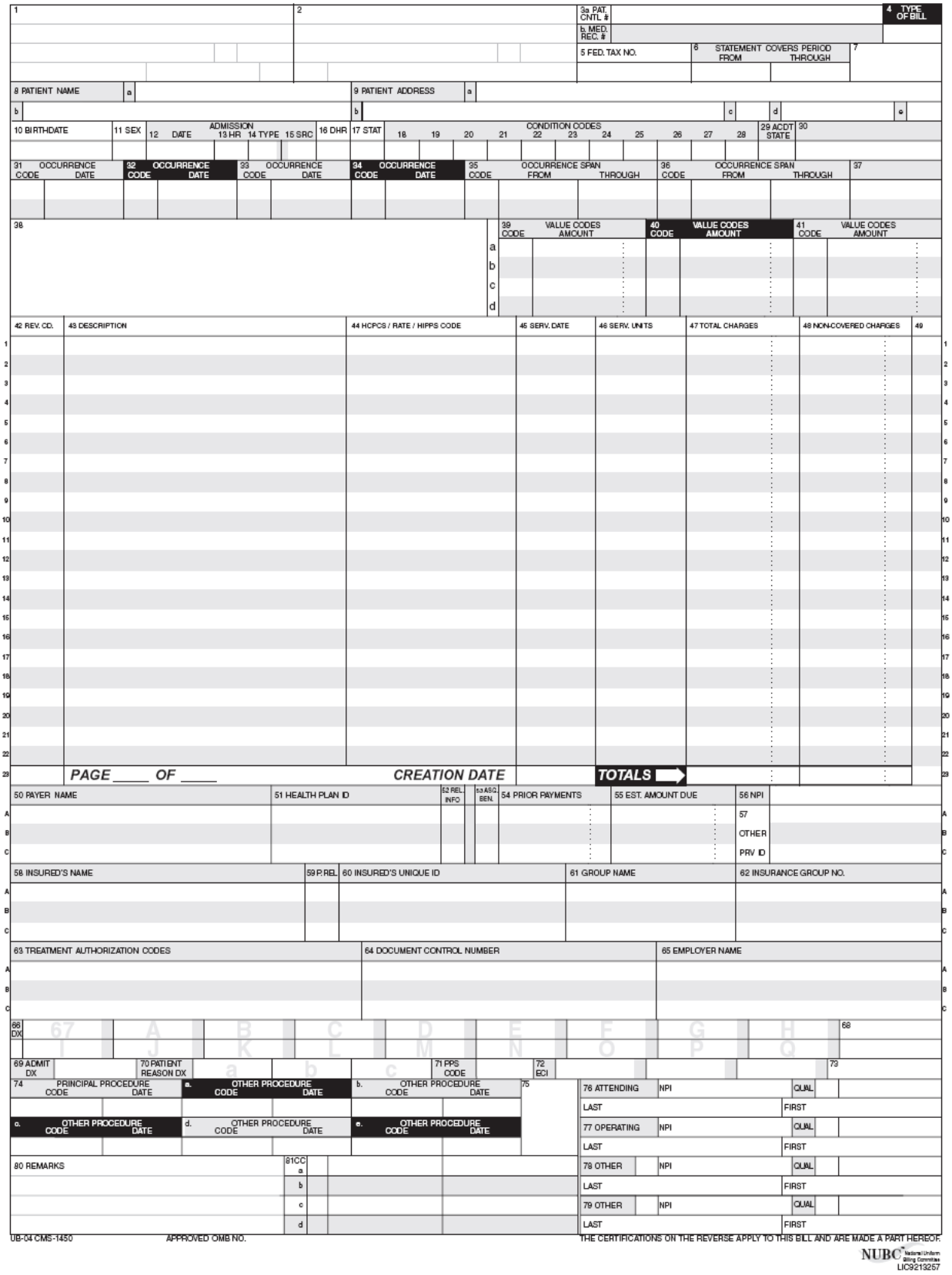
ACTION	RESPONSIBILITY
1. Enter claims for submission to SCCMHA Sentri or Fill out UB04 Paper Claim for SCCMHA	Network Services Provider
2. If submitting electronically, Provider to Run and Review the Adjudication Report in Step #2 on Sentri	Network Services Provider
3. If submitting electronically, Provider is to correct any errors prior to submission of Claims to SCCMHA	Network Service Provider
4. Provider to Submit Clean Claims to SCCMHA via either US mail system or electronically	Network Services Provider
5. SCCMHA will Adjudicate Claims	Claims Processors
6. SCCMHA Claims Processors will Assist Providers with Resolving Errors. It is the Providers Responsibility to submit Clean Claims	Claims Processors
7. SCCMHA Claims Processors will return Batches if Claims are not Clean	Claims Processors
8. Print and Analyze Reports	Claims Processors

UB 04 or CMS -1450

- Box 1 Provider Name
  Provider Street Address
  Provider City, State, Zip
- Box 2 Pay-to Name
  Pay-to Address
  Pay-to City, State, Zip
- Box 3a Patient Control Number
- Box 3b Medical Record Number
- Box 4 Type of Bill
- Box 5 Federal Tax Number
- Box 6 Statement Covers Period-From/Through
- Box 7 Unlabeled
- Box 8 Patient Name-ID
- Box 9 Patient Address-Street
  Patient Address-City
  Patient Address-State
  Patient Address-Zip
  Patient Address-County Code
- Box 10 Patient Birth date
- Box 11 Patient Sex
- Box 12 Admission Date
- Box 13 Admission Hour
- Box 14 Type of Admission/Visit
- Box 15 Source of Admission
- Box 16 Discharge Hour
- Box 17 Patient Discharge Status
- Box 18-28 Condition Codes
- Box 29 Accident Status
- Box 30 Unlabeled
- Box 31-34 Occurrence Code Date
- Box 35-36 Occurrence Span Code
  From/Through
- Box 37 Unlabeled
- Box 38 Responsible Party Name/Address
- Box 39-41 Value Code-Code
  Value Code-Amount
- Box 42 Revenue Code
- Box 43 Revenue Code Description
- Box 44 HCPCS/Rate/HIPPS/Rate Codes
- Box 45 Service/Creation Date

- Box 46 Units of Service
- Box 47 Total Charges
- Box 48 Non-Covered Charges
- Box 49 Unlabeled
- Box 50 Payer Name-Primary
  Payer Name-Secondary
  Payer Name-Tertiary
- Box 51 Health Plan-ID
- Box 52 Release of Information
- Box 53 Assignment of Benefits
- Box 54 Prior Payments
- Box 55 Estimated Due Amount
- Box 56 National Provider Identifier (NPI)
- Box 57 Other Provider ID-Primary, Secondary, Tertiary
- Box 58 Insured's Name-Primary, Secondary, Tertiary
- Box 59 Patient's Relationship-Primary, Secondary, Tertiary
- Box 60 Insured's Unique ID-Primary
- Box 61 Insurance Group Name-Primary, Secondary, Tertiary
- Box 62 Insurance Group Number-Primary, Secondary, Tertiary
- Box 63 Treatment Authorization Code-Primary, Secondary, Tertiary
- Box 64 Document Control Number
- Box 65 Employer Name-Primary, Secondary, Tertiary
- Box 66 Diagnosis Version Qualifier
- Box 67 Principal Diagnosis
- Box 67 AQOther Diagnosis
- Box 68 Unlabeled
- Box 69 Admitting Diagnosis Code
- Box 70 Patient Reason for Visit
- Box 71 PPS Code
- Box 72 External Cause of Injury Code (E-code)
- Box 73 Unlabeled
- Box 74 Principal Procedure Code/Date
- Box 74 AE Other Procedure Code
- Box 75 Unlabeled
- Box 76 Attending-NPI/Qual/ID
  Attending-Last/First Name
- Box 77 Operating-NPI/Qual/ID
  Operating-Last/First Name
- Box 78-79 Other ID-NPI/Qual/ID
  Other ID-Last/First Name
- Box 80 Remarks
- Box 81 Code-Qual/Code/Value

Exhibit A


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 ADMISSION DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81CC
UB-04 CMS-1450
APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC
LIC9213257

Finance Department Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Provider Registration and Maintenance for Access to Sentri	**Chapter:** 09.02.01 - Claims	**Subject No:** 09.10.01.01.06
		
Effective Date: October 1, 2006	**Date of Review/Revision:** 4/26/07, 5/5/10, 11/11/11, 6/15/12, 6/2/14, 4/27/16, 6/20/18, 6/14/19, 3/31/20 **Supersedes:**	**Approved By:** Laura Argyle, Chief Financial Officer/ Operating Officer **Authored By:** Sue McCrea, Admin Accounting Supervisor **Reviewed By:** Claims Processors: Pauline Najera, Carrie Davis, SCCMHA Helpdesk

Purpose:
To instruct SCCMHA Providers on how to initially enroll in SCCMHA's Sentri claims processing software and make changes to users.

Application:
SCCMHA Service Providers
SCCMHA Claims Processors
SCCMHA IS Help Desk
SCCMHA Administrative Accounting Supervisors
SCCMHA Chief Financial / Chief Operating Officer

Policy:
None

Standards:
None

Definitions:
SCCMHA Sentri Electronic Medical Records System- The software claims processing system used by SCCMHA for payment of claims.

https://www.sccmha.org/about-us/sentri-add-remove-staff-form.html
- Link to register for Sentri access and request Sentri claims training.

SCCMHA IS Help Desk –
Provides technical assistance for computer/software related issues and is responsible for creating Sentri sign ons.

SCCMHA Claims Department Staff – The staff and supervisor responsible for processing Provider claims for payment. The Claims Department Staff also provides Sentri training to Service Provider Sentri users.

References:
SCCMHA Claims Procedures – Subject 09.02.01
Activation, Change, and Deactivation of Staff User Accounts - 09.07.01.29
Tracking of Credentials for Staff Electronic Signatures - 09.04.03.09

Exhibits:
Exhibit 1 – SCCMHA Home Page
Exhibit 2 – Business Partnerships Page
Exhibit 3 – Sentri Add Staff Form
Exhibit 4 – Sentri Login Page

Standards:
As an agency, it is important for all to understand how staff accounts are created and closed so we can manage data flow of consumer information. All board operated and contracted providers are expected to follow this procedure to ensure consumer information is kept confidential.

Contracted providers will have background checks, Sanction checks, Codes for billing, provider fee, Federal ID, Medicare ID, and Provider NPI, etc. prior to any access to Sentri claims processing.

Procedure:
To initiate the setup of a SCCMHA Sentri sign-on, Provider should access the SCCMHA website and complete the following request
https://www.sccmha.org/about-us/sentri-add-remove-staff-form.html or contact SCCMHA's IS Department Help Desk via the email address HDesk@sccmha.org. for assistance

ACTION	RESPONSIBILITY
1. Complete electronic form to request Sentri access for claim entry.	SCCMHA Service Provider

2. Establish User Names & Passwords for SCCMHA Service Providers who are requesting Sentri Access after credentialing has been confirmed by Network Auditing Supervisor.	SCCMHA IS Department
3. Provide Sentri claims system training.	SCCMHA Claims Department

Exhibit #1: SCCMHA Homepage

When accessing the SCCMHA website you will reach the screen shown in Exhibit #1 below.

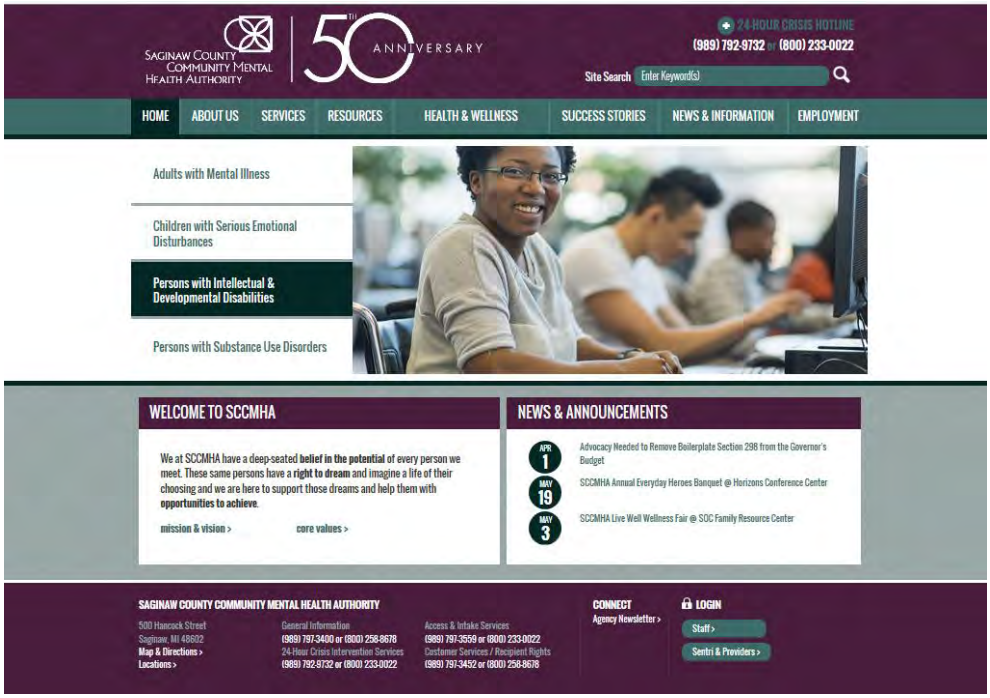


Exhibit #2: Business Partnerships page

From the SCCMHA home screen, click on "About Us" and "Business Partnerships" to access the "Business Partnerships" screen shown in Exhibit #2 below.

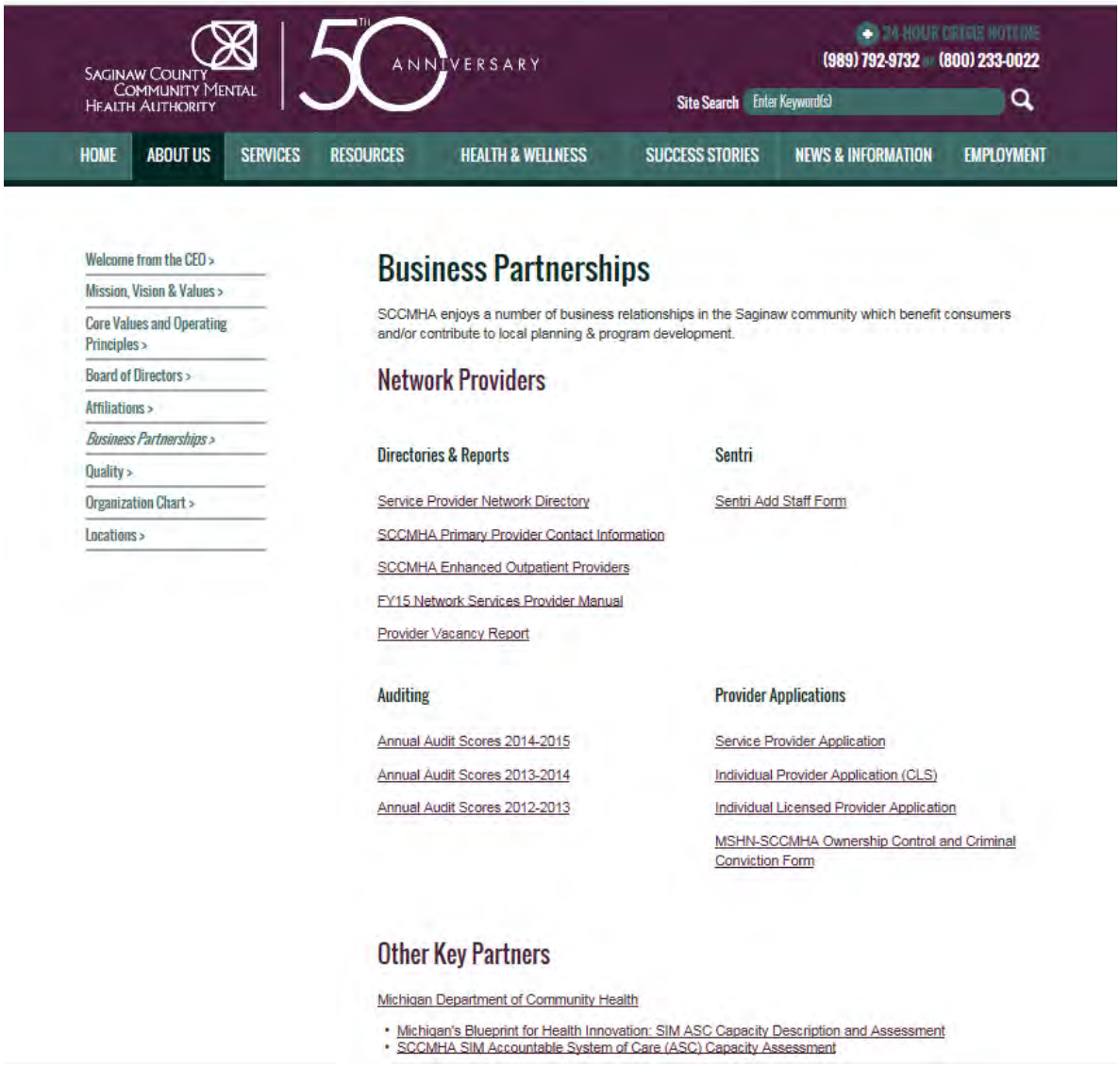
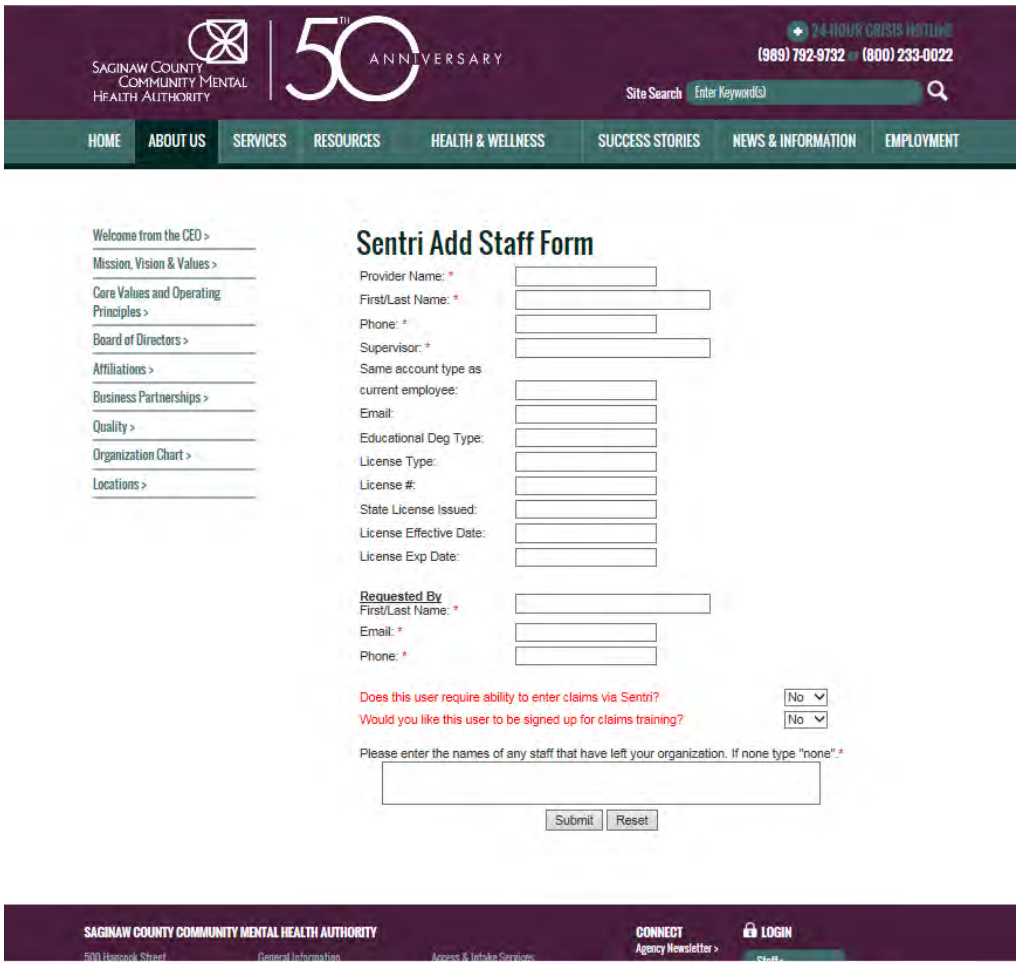


Exhibit #3: Sentri Add Staff Form

Once on the "Business Partnerships" page, find the "Sentri" heading and click on the link called, "Sentri Add Staff Form". This link will take you to the web-based form shown in Exhibit #3 below.



Answer "Yes" to the following two questions on the "Sentri Add Staff" form to request Sentri claims access and to request training on the Sentri claims system.

Does this user require ability to enter claims via Sentri? Yes

Would you like this user to be signed up for claims training? Yes

After providing all of the information for provider staff setup, as requested on the "Sentri Add Staff" form, select "Submit" to forward this information to the SCCMHA IS Help Desk

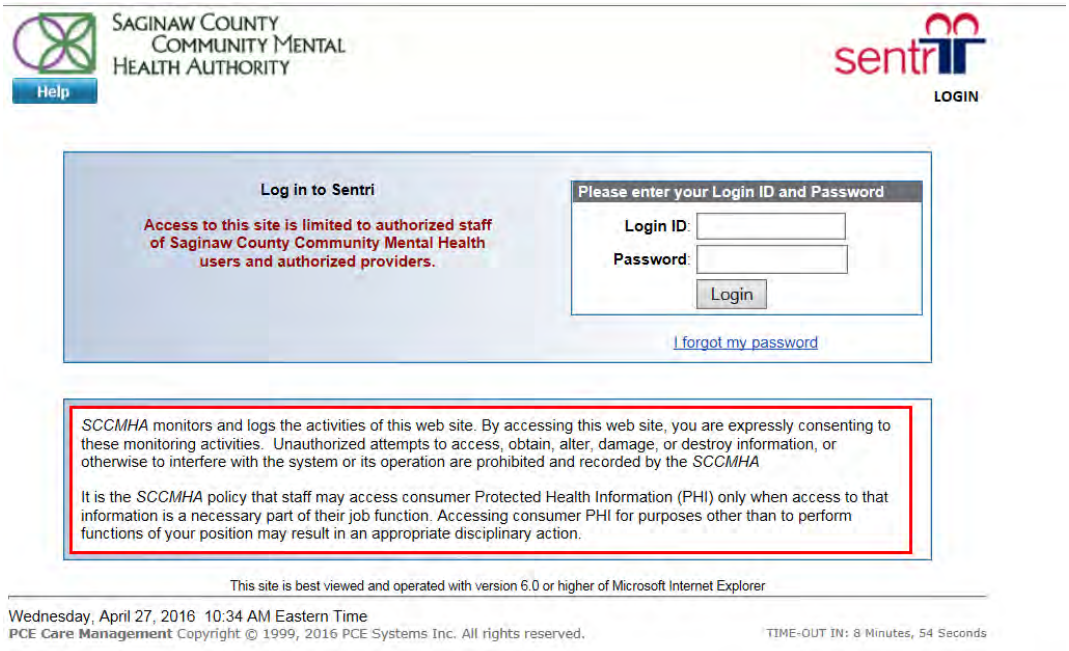
SCCMHA IS Help Desk will forward the information for new users to the Network Auditing Supervisor who will verify credentials and approve the creation of the sign on.

The SCCMHA IS Department Help Desk will contact you by email (as provided in the "Sentri Add Staff" form), to finalize the initial setup. Each individual using the Sentri system should be setup with a separate secure sign-on.

Once Sentri User Names and Passwords have been established by the SCCMHA IS Help Desk, enrolled users will be able to access Sentri by clicking on the "Sentri & Providers" button at the bottom right of the SCCMHA home page (See Exhibit #1).

Exhibit #4: Sentri Login page

The Sentri login-in screen will appear as shown in Exhibit #4 below.



To access Sentri, enter “User Name” & “Password” and click “Login”.

Finance Department Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Provider Submission of Start and Stop Times on Claims	**Chapter:** 09.02.01 - Claims	**Subject No:** 09.10.01.01.08
		
Effective Date: October 1, 2009	**Date of Review/Revision:** 6/2/14, 5/4/16, 6/20/18, 6/14/19, 1/27/20 **Supersedes:**	**Approved By:** Laura Argyle, Chief Financial / Chief Operating Officer **Authored By:** Sue McCrea, Admin Accounting Supervisor **Reviewed By:** Claims Processors: Pauline Najera, Carrie Davis

Purpose:
To provide instruction and clarify procedures for submission of start and stop times on provider claims.

Application:
SCCMHA Network Providers
SCCMHA Claims Processors
SCCMHA IS Help Desk
SCCMHA Administrative Accounting Supervisors
SCCMHA Chief Financial /Chief Operating Officer

Policy:
None

Standards:
None

Definitions:
SCCMHA Sentri software- The claims processing system and software used by SCCMHA for payment of claims.

SCCMHA Network Services/Contracts Department- Department authorized to allow providers to perform services for SCCMHA consumers.

References:
SCCMHA Contracted Network Provider Claims Submission Procedure - 09.02.01.01

Exhibits:
None

Procedure:

INSTRUCTIONS FOR ADDING TIMES TO A HCFA 1500 FORM

Log into Sentri through the SCCMHA website at www.sccmha.org and click on "Claims Submission"

Click, "Step (1)-Enter New Claims":
A) Enter your 4 digit Provider Code

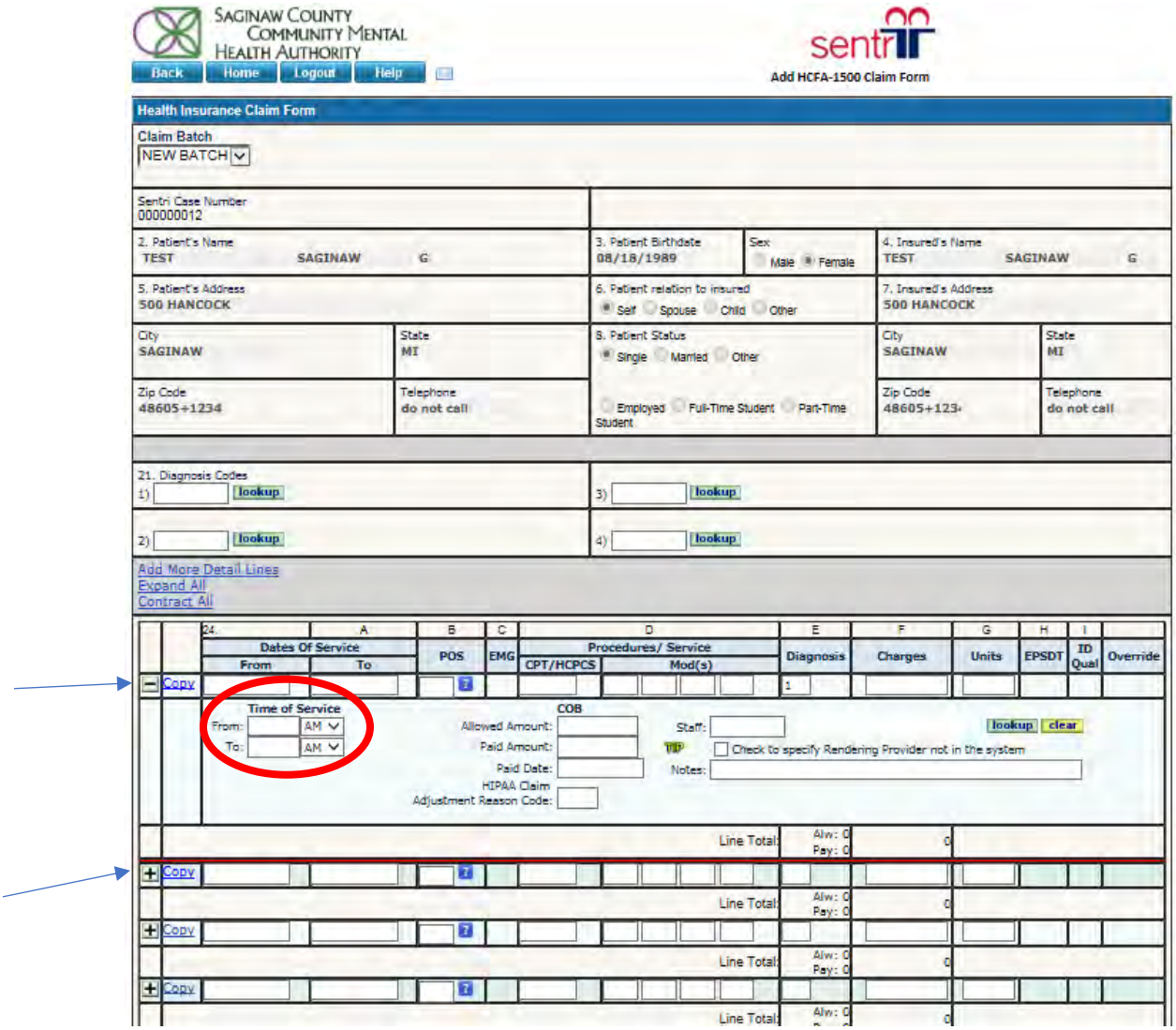
B) Enter the Consumer number or search by name. Select appropriate authorization

C) Enter dates of service, point of service (POS), procedure code & modifier (if necessary), diagnosis, charges, and units.

a. After completing all the information for a line of service, select the ⊞ box to the left of that line. This will expand the line in order to add times of service for that date.
b. Times of Service are necessary, in order for a claim to process. **Times of Service must match the units entered. An error message will appear if they don't match.**
c. When adding the "From" & "To" times of service, note the AM/PM. AM is the default, so make sure that you pick the correct time of day.

D) After entering the times for a specific date of service, you may hit the ⊟ button, in order to close that field and proceed to the next date of service.

E) When finished adding dates of service and times of service, you must **SAVE** at the bottom of the form and go on to add other claims or proceed to the next step.



For Providers sending batches through an 837 file

After uploading the 837 file onto your computer, it will be necessary for you to manually go into Step (1) and follow the complete instructions above.

If you have any questions, please feel free to call Claims Processors Pauline @ (989)-498-4205 or Carrie @ (989) 797-3516

Finance Department Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Electronic Claims Submission by Provider	**Chapter:** 09 - Department Procedures	**Subject No:** 09.10.01.01.11
		
Effective Date: 10/1/06	**Date of Review/Revision:** 3/28/07, 6/24/10, 11/18/11, 6/15/12, 6/2/14, 5/13/16, 6/20/18, 6/14/19 **Supersedes:**	**Approved By:** Laura Argyle, Director of Finance **Authored By** Sue McCrea **Reviewed By:** Mary Hart, Pauline Najera, Carrie Davis

Purpose:
To provide instruction to network providers on claims entry and submission using the Sentri claims processing software.

Application:
SCCMHA Claims Processors
SCCMHA Administrative Accounting Supervisors
SCCMHA Chief Financial Officer
SCCMHA Provider Network

Standards:
None

Definitions:
Adjudication- Reported process that shows whether the claim has errors. The report should be run prior to submission of claims to SCCMHA. Final adjudication is performed by the SCCMHA Claims Processors.

Approval- recommend for payment.

Approved Claims- Approved claims in this procedure refers to the claims that have been entered and approved by the provider to be submitted to SCCMHA for payment. Claim entry and provider approval is achieved by completing Steps 1& 2 on the Sentri claims processing menu.

Authorization- The document allowing the provider to render and bill for services.

Claim Form- UB04 (CMS 1450) or HCFA 1500 (CMS 1500).

Claims Processing/Management - Sentri view that allows access to claims submission functions.

CMHSP- Community Mental Health Service Program. Saginaw County Community Mental Health Authority is one of Michigan's CMHSPs.

Entered Claims- Entered claims in this procedure refers to the claims that have completed Step 1 of the Sentri claims processing menu.

Reconsider- Process where a claim line is backed out by SCCMHA Claim Processors. This places a credit on the Provider's account.

SCCMHA- Saginaw County Community Mental Health Authority

SCCMHA Sentri software- The claims processing system and software used by SCCMHA for payment of claims.

837 File – HIPAA compliant electronic file submission

References:
SCCMHA Cash Management Policy – Subject No. 05.02.03
SCCMHA Provider Registration/SCCMHA Sentri System Training – Subject No. 09.02.01.01.14
SCCMHA Sentri Claims Submission & Reimbursement Procedures– Subject No. 09.02.01.02.20
SCCMHA Sentri Claims Adjudication Reason Codes – Subject No. 09.02.01.01.01

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
1. Enter claims	Provider
2. Adjudicate the batch and review for errors. Make corrections and re-adjudicate	Provider and/or Provider's Supervisor

3. Send Batch(es) to CMHSP (or SCCMHA)	Provider/ Provider's Supervisor
4. Final Adjudication for Submitted Approved Claims from Provider	SCCMHA Claims Processor(s)
5. Print checks	SCCMHA Accounts Payable Clerk
6. Print & analyze reports, remittance advice and explanation of benefits	Claims Processors/Provider/ Provider's Supervisor
7. Mail checks	SCCMHA Claims Processor(s)

- Provider claims are either entered directly into the Sentri system or through a HIPAA 837 compliant format.

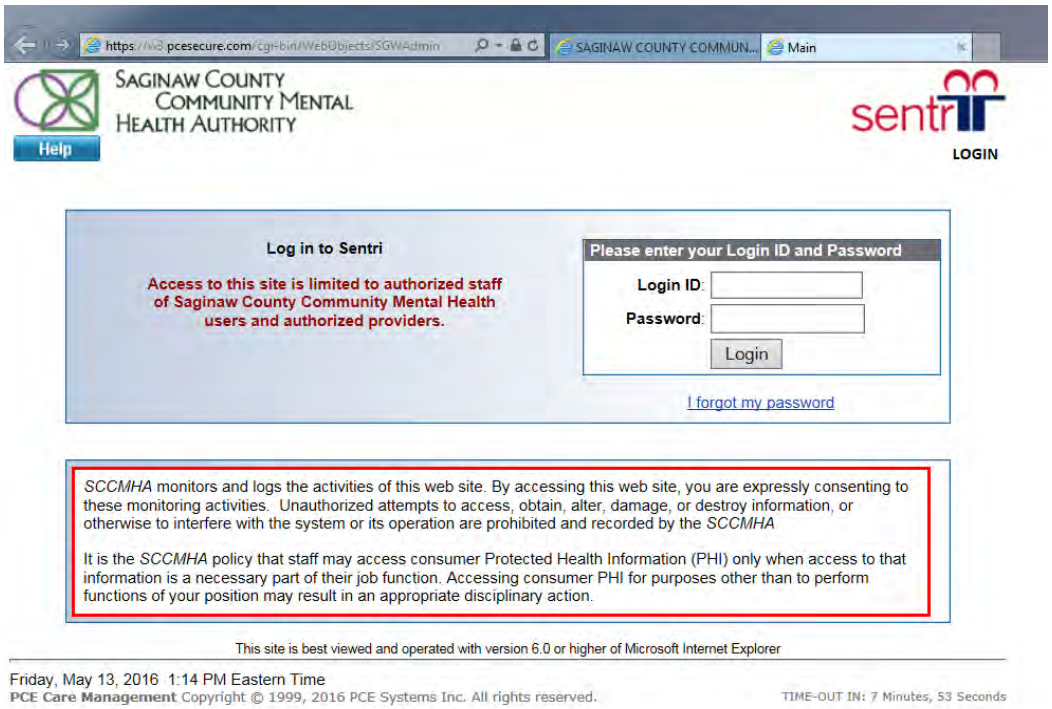
- The provider must contact the SCCMHA IS Department Help Desk at (989) 797-3577 to make arrangements for electronic access. Please reference procedure 09.02.01.01.14- SCCMHA Provider Registration/SCCMHA Sentri System Training for additional information.

- Call the Claims Processing Department to set up training, if wanted at (989) 797-3516 Carrie Davis or (989) 498-4205 Pauline Najera.

- After obtaining the Log In, and Password, the provider can log into https://w3.pcesecure.com/cgi-bin/WebObjects/SGWAdmin

- Login's should not be shared and should be kept secure. SCCMHA staff, service programs and network providers will abide by current HIPAA requirements to protect the privacy and security of the health information of persons who are service recipients of SCCMHA. SCCMHA is a "Covered Entity" as defined by HIPAA and HIPAA compliance is an employment and contractual obligation for all of the members of the SCCMHA workforce.

Snapshot of Sentri Login Screen:

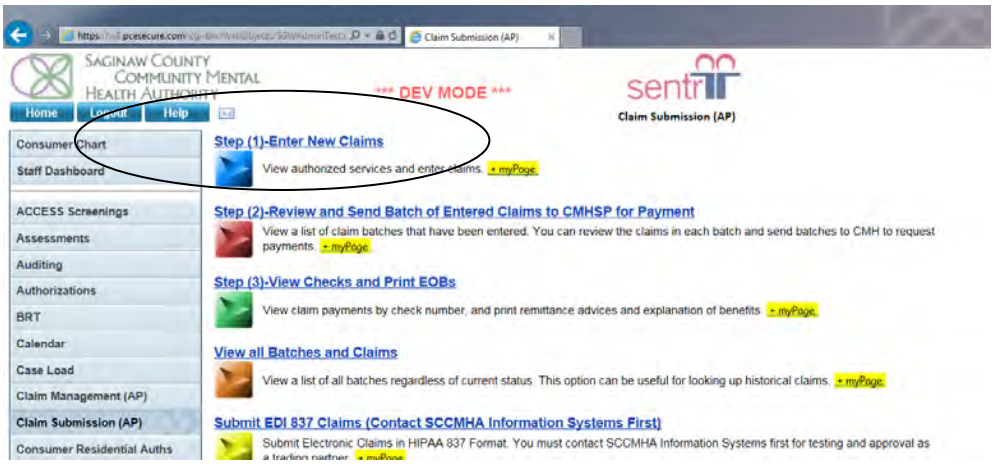


CLAIMS PROCESSING IN SENTRI

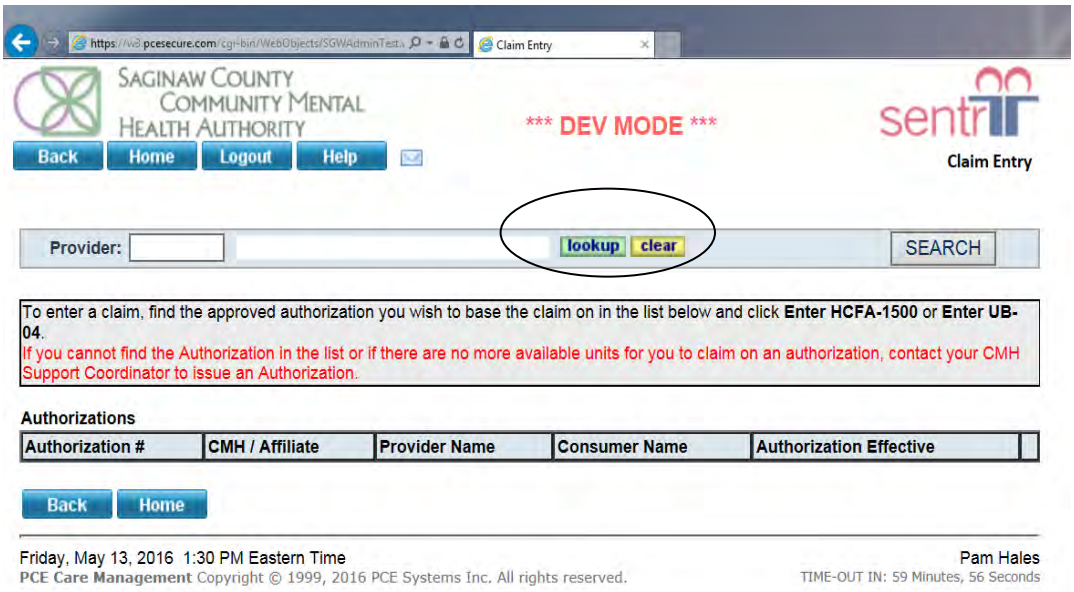
After logging into Sentri, click on **"Claim Processing"** button on the left side of the screen.

STEP 1

A) Click "Step (1) - Enter New Claims"

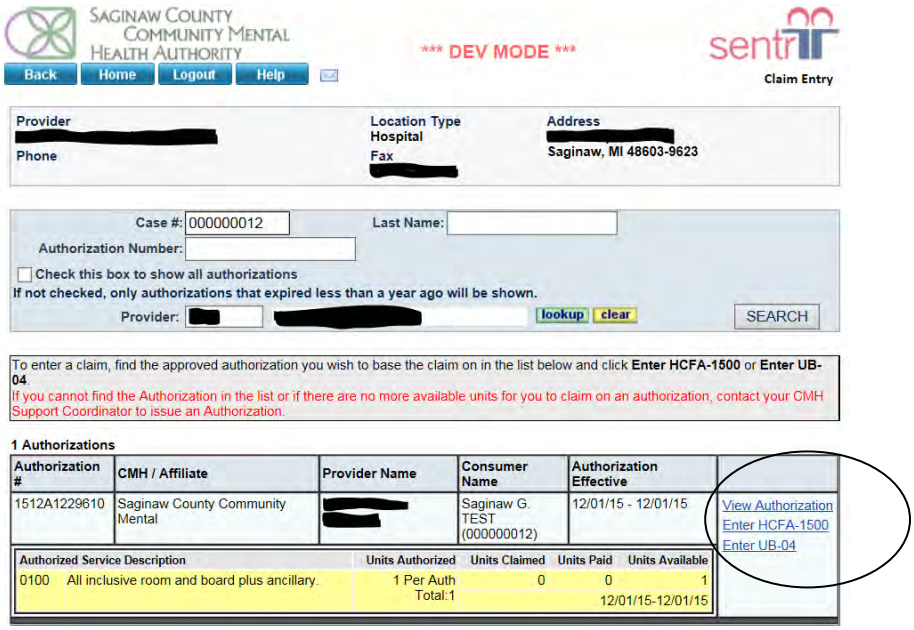


B) Click "Lookup" and type in Provider name.



C) Enter either the consumers "Case#" or "Last Name" and click the "Check this box to show all authorizations". Then click "**Search".**

D) Authorizations will appear for the consumer in newest to oldest order. Note: There may be more than one page of authorizations to view. Find the authorization that matches the provider, date range and code that you are preparing to bill for. Use the blue links circled below to proceed to the correct billing form (the HCFA-1500 or the UB-04); there is also a link to "View Authorization" that will allow you to see more detail regarding the authorization.



If you are unable to locate an authorization; you will **not** be able to continue entering claims for this consumer. Please contact the consumer's Case Manager or Supports Coordinator to have an authorization requested, or to check the status of the authorization.

TIP Be Proactive - Make your inquiries via secure email so they are documented. Set up some kind of tracking be sure to follow up on the same email thread.

Reminder you only have 90 days from the Date of Service or 30 days from the date of receipt of remittance advice from Payers precedent to SCCMHA, not to exceed a year from date of service to submit a clean claim to SCCMHA.

Reminder September 30th is SCCMHA's year end. Dead line then becomes December 31st for clean claims for September dates of service.

Create your own internal set of procedures:

- What does the Billing Clerk do when they can't enter a claim because the Authorization is missing or needs correction?
- How are you going to track this claim to make sure it gets submitted?
- How long should the Billing Clerk wait before the next level of your internal Management gets involved?
- What is causing the missing Authorization? Is the problem chronic?
- Do you need a formal Correction Action Request system?

Don't wait to reconcile SCCMHA's check against your internal system to find out the claim was never submitted.

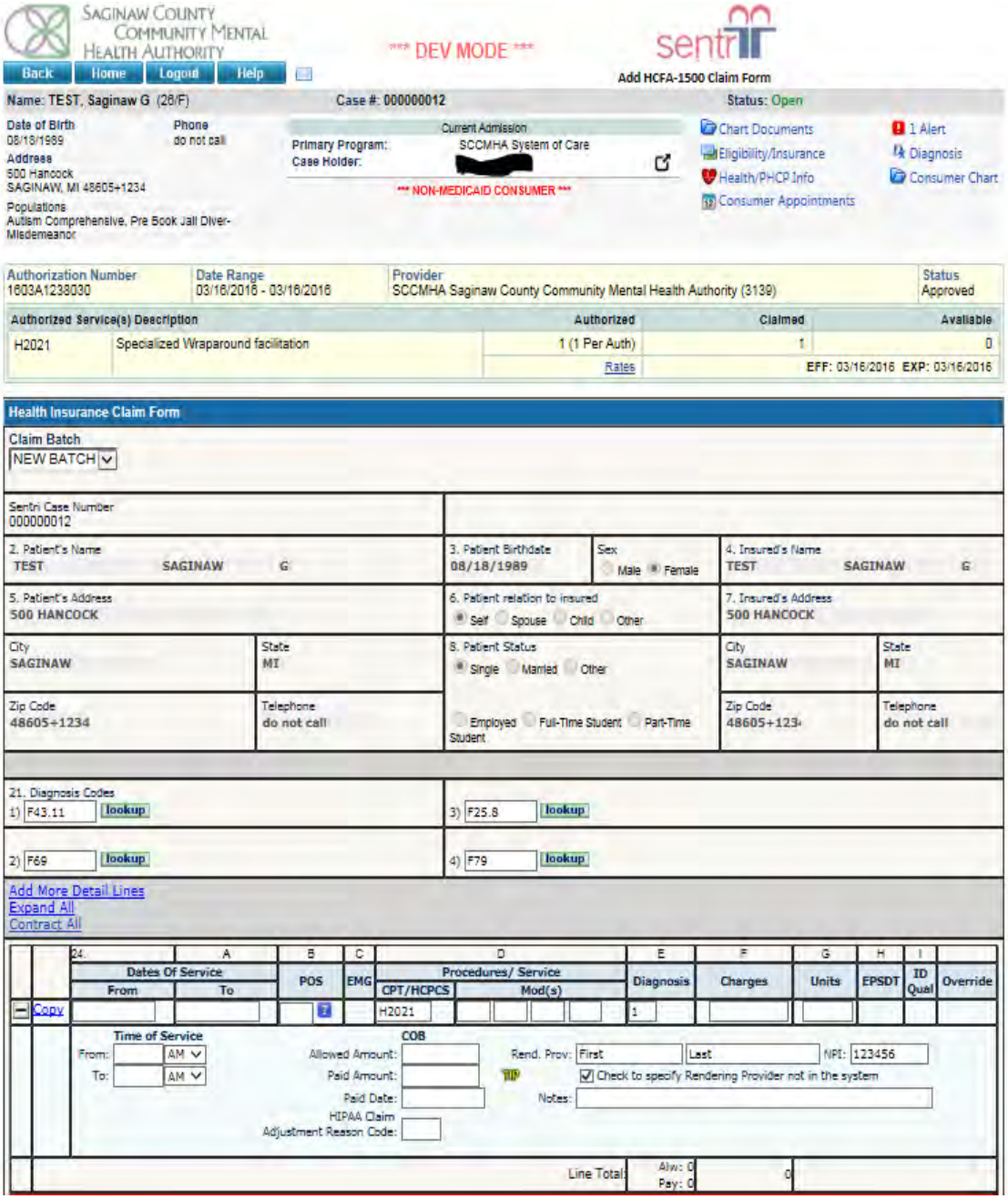
SCCMHA Claims Processors do not have authority or access to create or change Authorizations.

Timely claim submission will help your organizations cash flow.

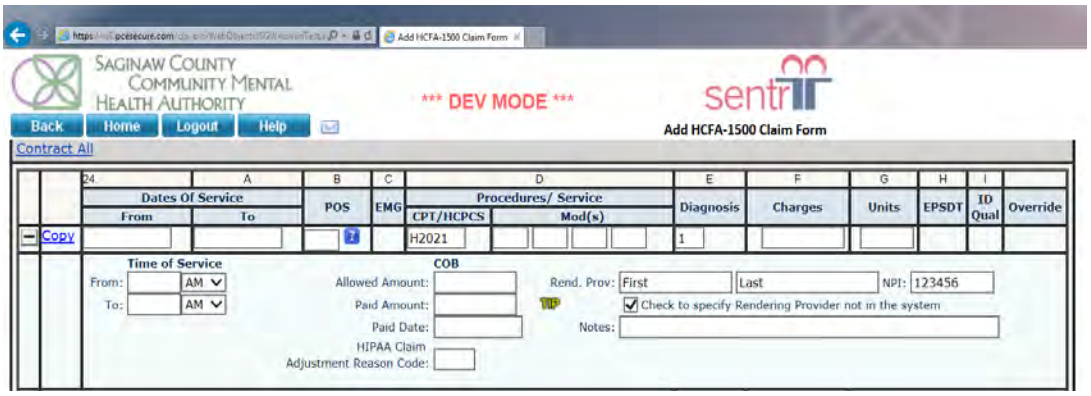
SCCMHA is required to submit various reports to their PHIP and State of MI throughout the year regarding funding requirement forecasts. We need timely claim submission to allow us to provide accurate figures to submit. This has a direct effect on the funds that are made available to SCCMHA from the State of MI.

E) Enter claim information into the electronic form. A number of the fields will automatically populate with consumer data that is housed in Sentri. Other fields will need to be manually entered.

Sample: HCFA-1500 Form



Box #24 of the HCFA contains a number of fields that require manual entry such as: Dates of Service, POS (Place of Service), CPT/HCPCS (procedure code), Mod(s) (Modifiers), Charges, Units, COB (Coordination of Benefits), NPI number, and Time of Service fields.



24 A. Dates of Service
The dates you enter must fall in between the dates on the Authorization or the line will error out. Are you using the correct Authorization?

24 B. POS Place of Service
Sentri has a menu item see page 11of this procedure to obtain current list. Below is a sample list

Place of Service

Search for:

Ok to use only

Search

26 Records

PREVIOUS 1 2 3 NEXT

		Ok To Use?
01-Pharmacy	01	Yes
02-Telehealth	02	Yes
03-School	03	Yes
04-Homeless Shelter	04	Yes
09-CCI / Jail / Prison	09	Yes
11-Office	11	Yes
12-Home	12	Yes
13-Assisted Living Facility	13	Yes
14-Group Home (AFC)	14	Yes
15-Mobile Unit	15	Yes

PREVIOUS 1 2 3 NEXT

24 C. EMG – is left blank.

24 D. Procedures/Service
CPT/HCPCS and Modifiers must be on the Authorization. If you get an error message refer back to the Authorization. Are you using the correct Authorization number?

24 E. Diagnosis Code

24 F. Charges

Providers are to bill SCCMHA their actual costs. Claims will be paid based on the rate established in the signed contract with the provider.

24 G. Units
See PIHP/CMHSP ENCOUNTER REPORTING HCPCS and REVENUE CODES for rules on Units of measure.

PIHP/CMHSP ENCOUNTER REPORTING
HCPCS and REVENUE CODES

GENERAL RULES FOR REPORTING

1. Rounding rules for unit reporting:

- "Up to 15 minutes"
  - 1-15=1 unit
  - 16-30=2 units
  - 31-45=3 units
  - 46-60=4 units
  - 61-75=5 units
  - 76-90=6 units
  - 91-105=7 units
  - 106-120=8 units
- 15 minutes
  - 1-14 minutes=0*
  - 15-29=1 unit
  - 30-44=2 units
  - 45-59=3 units
  - 60-74=4 units
  - 75-89=5 units
  - 90-104=6 units
  - 105-119=7 units
  - 120=134=8 units
- 30 minutes
  - 0-29 minutes=0*
  - 30-59 minutes=1 unit
  - 60-89 minutes=2 units
- 45 minutes
  - 0-44 minutes=0*
  - 45-89=1 unit
  - 90-134=2 units
  - 135-179=3 units
- 60 minutes
  - 1-59 min=0*
  - 60-119 min=1 unit
  - 120-179 min=2 units
  - 180-239 min=3 units
  - 240-299 min=4 units
  - 300-359 min=5 units
  - 360-419 min=6 units
  - 420-479 min=7 units
  - 480-539 min=8 units

*Do not report if units = 0

If you get an error "Units Exhausted", check the Authorization screen in Sentri. There might be another Authorization. You may have to request more units.

Notes on Time of Service fields

- "Time of Service" fields are found in box #24 of the HCFA-1500 form located in Sentri.
- These fields are displayed by clicking the **"+"** sign on the left hand side of the form, next to the blue "Copy" link.
- Time of Service fields are REQUIRED (*effective 8/2009*) for all providers, with the exception of Adult Foster Care providers (who have a daily rate) and Inpatient providers

Notes on Coordination of Benefit fields

- "Coordination of Benefit" line specific fields are found in box #24 of the HCFA-1500 form located in Sentri.
- These fields are displayed by clicking the **"+"** sign on the left hand side of the form, next to the blue "Copy" link.
- The "Coordination of Benefit" line specific fields include the following:
  - **"Allowed Amount"** (REQUIRED field)
  - **"Paid Amount"** (REQUIRED field)

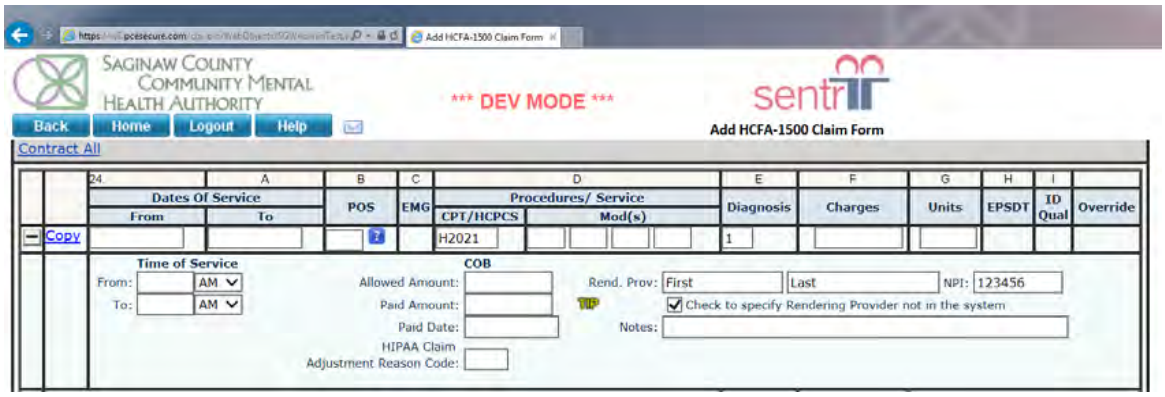
- **"Paid Date"** (REQUIRED field)
- **"HIPAA Claim Adjustment Reason Code"** (REQUIRED field)
- **"Notes"**– this text box can be used by the provider to document/communicate any specific notes regarding the specific claim line.

TIP Notes on "Copy" feature

A claim line can be copied by clicking the blue "**Copy**" link on the left hand side of the Sentri HCFA-1500 form. After clicking **"Copy"**, a calendar will appear that will allow you to designate the days of the month where you'd like the current claim line copied.

Notes on NPI (National Provider Identifier) if applicable

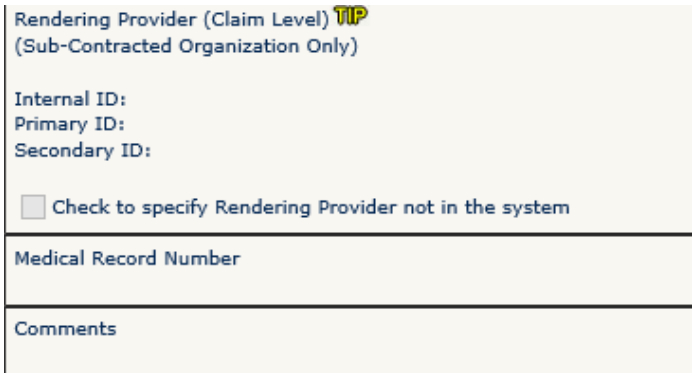
- "**Rendering Provider**" and "**NPI**" line specific fields are found in box #24 of the HCFA-1500 form located in Sentri.
- These fields are displayed by clicking the **"+"** sign on the left hand side of the form, next to the blue "Copy" link.
- Click the box next to: **"Check to specify Rendering Provider not in the system"**
- Then fill in the following fields
- "**Rend. Prov**" – Rendering Provider
- "**NPI**" –National Provider Identifier



TIP How to add a new Rendering Provider to Sentri

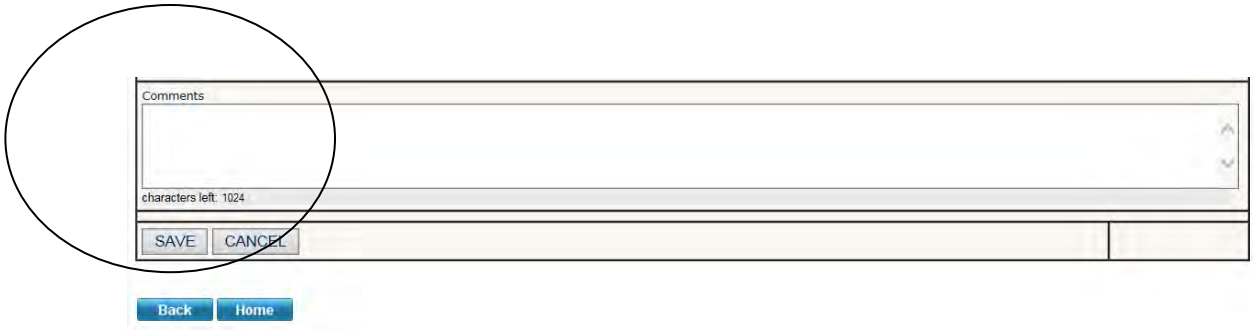
Send an email to Monique Taylor-Whitson at mtaylor-whitson@sccmha.org. She is Provider Network Auditing Supervisor. Your email should state the name of the Billing Provider, the full proper name and NPI # of the new rendering provider you wish to add to Sentri.

Box #31 – If a consumer is a COFR or has a SED Waiver, this Rendering Provider Box must also be filled out.



E) Enter any notes related to the claim in the "Comment" field at the bottom of the form.

F) When the form is complete, click "**Save"** the bottom of the claim.



Sentri will assign a batch number. Keep track of your batch numbers in some kind of log.

Always remember to SAVE the claim!

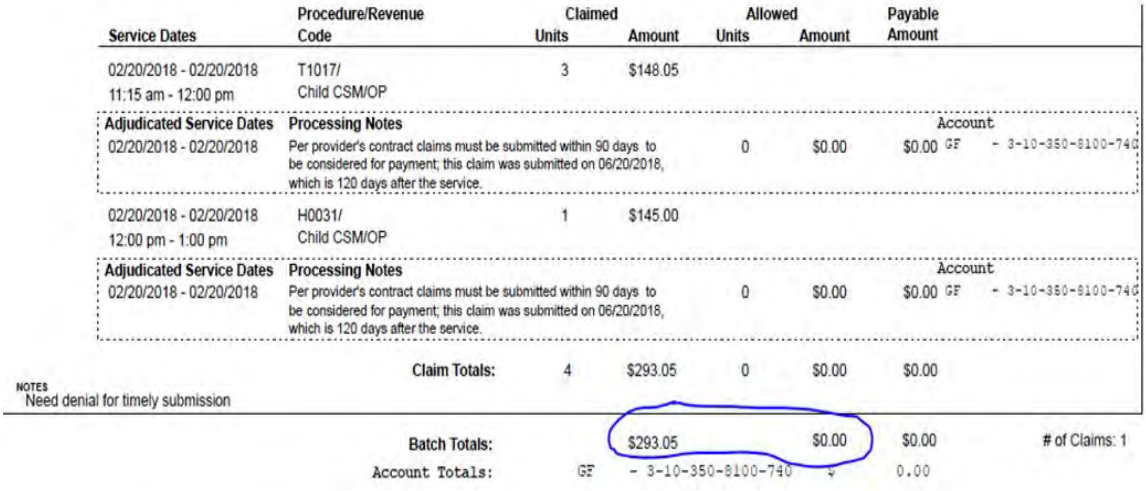
STEP 2

After all claims have been entered, return to the "Claims Management" home page and click **"Step (2) – Review and Send Batch of Entered Claims to CMHSP for Payment"**.

Run and review the Adjudication Report and look for errors. You can review these on the screen. Smaller batches are sometimes more manageable than 100 page claims.

Correct the errors and re-adjudicate the batch. Run and review the Adjudication Report again until all the errors are corrected and you have a "clean claim".

Review the bottom of the batch check to see if the numbers at the bottom match.



Service Dates	Procedure/Revenue Code	Claimed Units	Claimed Amount	Allowed Units	Allowed Amount	Payable Amount	
02/20/2018 - 02/20/2018 11:15 am - 12:00 pm	T1017/ Child CSM/OP	3	$148.05				
Adjudicated Service Dates: 02/20/2018 - 02/20/2018	Processing Notes: Per provider's contract claims must be submitted within 90 days to be considered for payment; this claim was submitted on 06/20/2018, which is 120 days after the service.			0	$0.00	$0.00	Account: GF - 3-10-350-8100-740
02/20/2018 - 02/20/2018 12:00 pm - 1:00 pm	H0031/ Child CSM/OP	1	$145.00				
Adjudicated Service Dates: 02/20/2018 - 02/20/2018	Processing Notes: Per provider's contract claims must be submitted within 90 days to be considered for payment; this claim was submitted on 06/20/2018, which is 120 days after the service.			0	$0.00	$0.00	Account: GF - 3-10-350-8100-740
	Claim Totals:	4	$293.05	0	$0.00	$0.00	

NOTES
Need denial for timely submission

Batch Totals: $293.05 $0.00 $0.00 # of Claims: 1

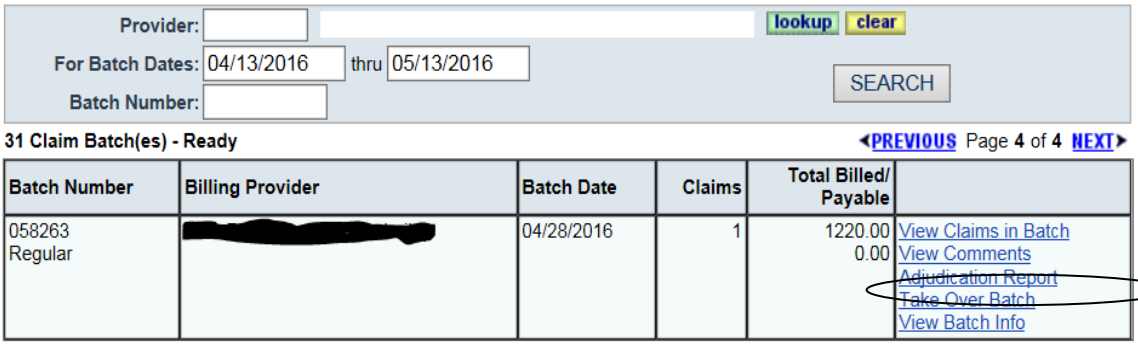
Account Totals: GF - 3-10-350-8100-740 0.00

In the above sample the Batch Total Claimed Amount is $ 293.05. The amount in the Allowed Amount column is Zero. This means SCCMHA is not paying this line item.

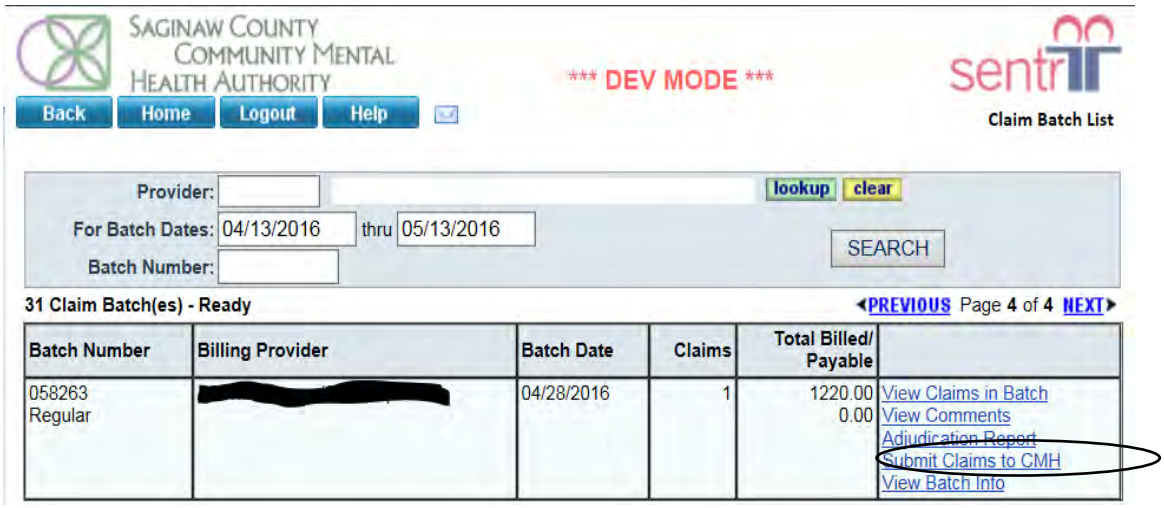
Reference Procedure 09.02.01.01.01 Sentri Claims adjudication Reason

Do not wait until you are missing a payment to reconcile your claims. Reconcile them before you do the next step.

Click the blue link that says, "**Take Over Batch**"



Then click the blue link that says, "**Submit Claims to CMH**"



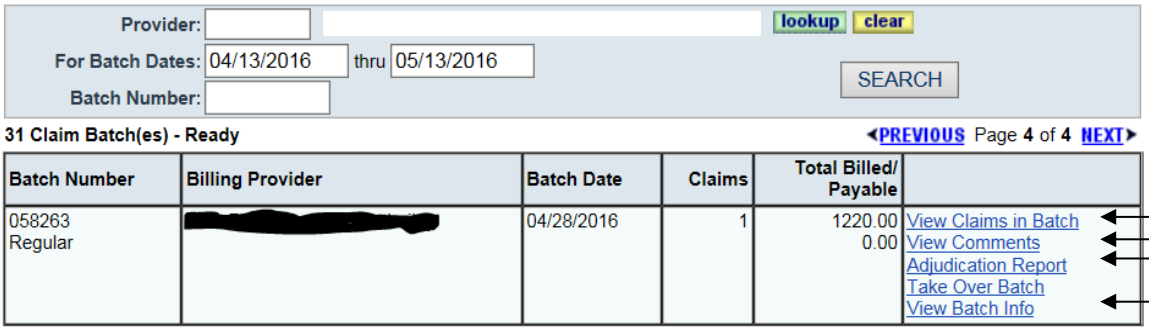
Important: This step is necessary for claims to be sent to SCCMHA for processing. Failure to complete this step will result no claim payment and/or possible claim denial.

When the batch is submitted to SCCMHA it is date stamped by Sentri. SCCMHA Claim Processors will review each batch. They may return a batch to you for correction.

SCCMHA Claim Processors will assist you with error messages. **Claim Processors cannot make corrections to your claims**. Claim Processors cannot override error messages. They must obtain approval from the Admin Accounting Supervisor.

Please review your email timely and make the necessary changes. If you re-submit the claim again without making the changes, the claim may be denied.

OTHER INFORMATION obtained through the "Step (2)-Review and Send Batch of Entered Claims to CMHSP for Payment" screen



The "Step (2)- Review and Send Batch of Entered Claims to CMHSP for Payment" screen will allow you to access the following links:

a) "<u>View claims in Batch</u>" will allow you to:

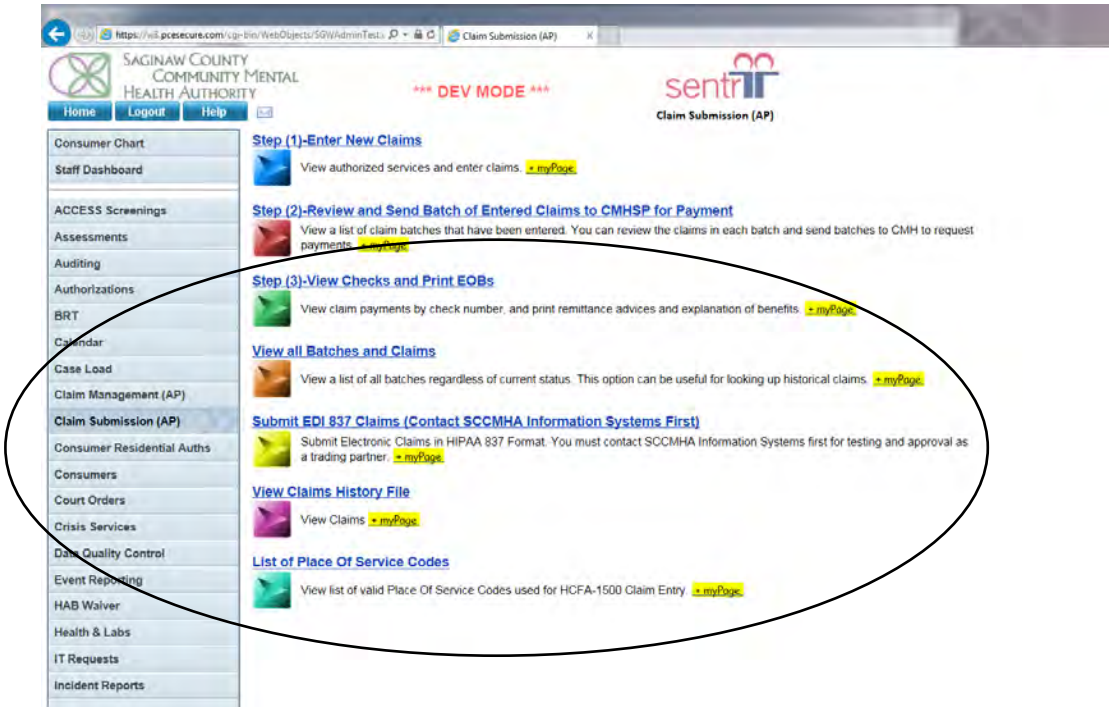
- View a claim
- Change a claim
- Delete a claim

b) "**<u>View Comments</u>**" allows a provider to view any comments typed into the comment field located at the bottom of the claim entry form.

c) "**<u>Adjudication Report</u>**" allows you the ability to review the claims entered in the batch through a "*Batch Edit Report",* click on the "Adjudication Report" link and then click on the icon at the top of the screen to view/print the report.

d) **"<u>View Batch Info</u>"** gives a summary of batch information

OTHER INFORMATION obtained through "Claims Submission" Home Page



a) "**<u>Step (3)- View Checks and print EOBs</u>"** by entering the desired check number and clicking "Search".

b) "**<u>View all Batches and Claims</u>"** allows providers to status their claim batches.

c) "**Submit EDI 837 Claims (Contact SCCMHA information Systems First)**" is used by providers who upload their claims using an 837 file.

d) "**View Claims History File**" allows provider to view paid claims.

e) "**List of Place of Service Codes**" contains Place of Service reference list.

RECONSIDER A CLAIM

The process of reconsidering a claim zeros out the line item on a claim that is in error. It will process as a credit on the Billing Providers Account.

If you have errors that need to be corrected after the batch is processed. A request to reconsider a claim must be made in writing via Sentri Message system to the Claim Processer that has your account.

Please provide the claim number, the Consumers Name, Sentri ID#, Date of Service, reason for the request for reconsider and dollar amounts.

The claim will be reconsider by a SCCMHA Claims Processor. The Claims Processor will notify you when complete. If applicable you can re-enter the proper billing. Reference the Batch number and the Claim number of the 1st claim.

SCCMHA Claims Department Contact Information:

Pauline Najera
Claims Processor
(989) 498-4205
pnajera@sccmha.org (please use the Sentri email link)

Carrie Davis
Claims Processor
(989) 797-3516
cdavis@sccmha.org (please use the Sentri email link)

Sue McCrea
Accounting Supervisor of Claims/AP
(989) 797-3597
smccrea@sccmha.org (please use the Sentri email link)

Finance Department Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Contracted Network Provider Claims Workflow	**Chapter:** 09.02.01 - Claims	**Subject No:** 09.10.01.02.07
		
Effective Date: October 1, 2006	**Date of Review/Revision:** 2/14/07, 7/1/10, 6/2/14, 5/13/16, 6/20/18, 6/14/19, 1/28/20 **Supersedes:**	**Approved By:** Laura Argyle, Chief Financial / Chief Operating Officer **Authored By:** Sue McCrea, Admin Accounting Supervisor **Reviewed By:** Claims Processors

Purpose:
In order to show the workflow for provider claims, the following procedure is used to document the process.

Application:
SCCMHA Claims Processors, Accounts Payable Clerk
SCCMHA Administrative Accounting Supervisors
SCCMHA Chief Financial / Chief Operating Officer
SCCMHA Provider Manual

Policy:
None

Standards:
None

Definitions:
Sentri – SCCMHA's electronic medical record and claims payment software

Adjudicate- Step #2 in Sentri. Sentri runs edits against the data entered and will produce error messages if the data needs correcting. This step needs to be done before Submission to SCCMHA to make sure you are submitting a clean claim.

EOB- Explanation of benefits, the documentation showing the allowed amounts, and the amounts that will be paid for the code/code(s) billed to Saginaw County Community Mental Health Authority.

Remittance – Detail summary of claims paid with each check

References:
SCCMHA Cash Management Policy Subject No. 05.02.03
SCCMHA Contracted Network Provider Claims Submission Procedures Subject No. 09.02.01.01
SCCMHA Contracted Network Provider Claims Workflow Subject No. 09.02.01.05.02
SCCMHA Sentri Claims Processing and Reimbursement Procedure Subject No. 09.02.01.02.20

Exhibits:
Exhibit A - Claims Work Flow

Procedure:
There are 3 methods to enter claims: Paper Claims mailed, Data Entry Directly into Sentri and Submission of an 837 Electronic File.

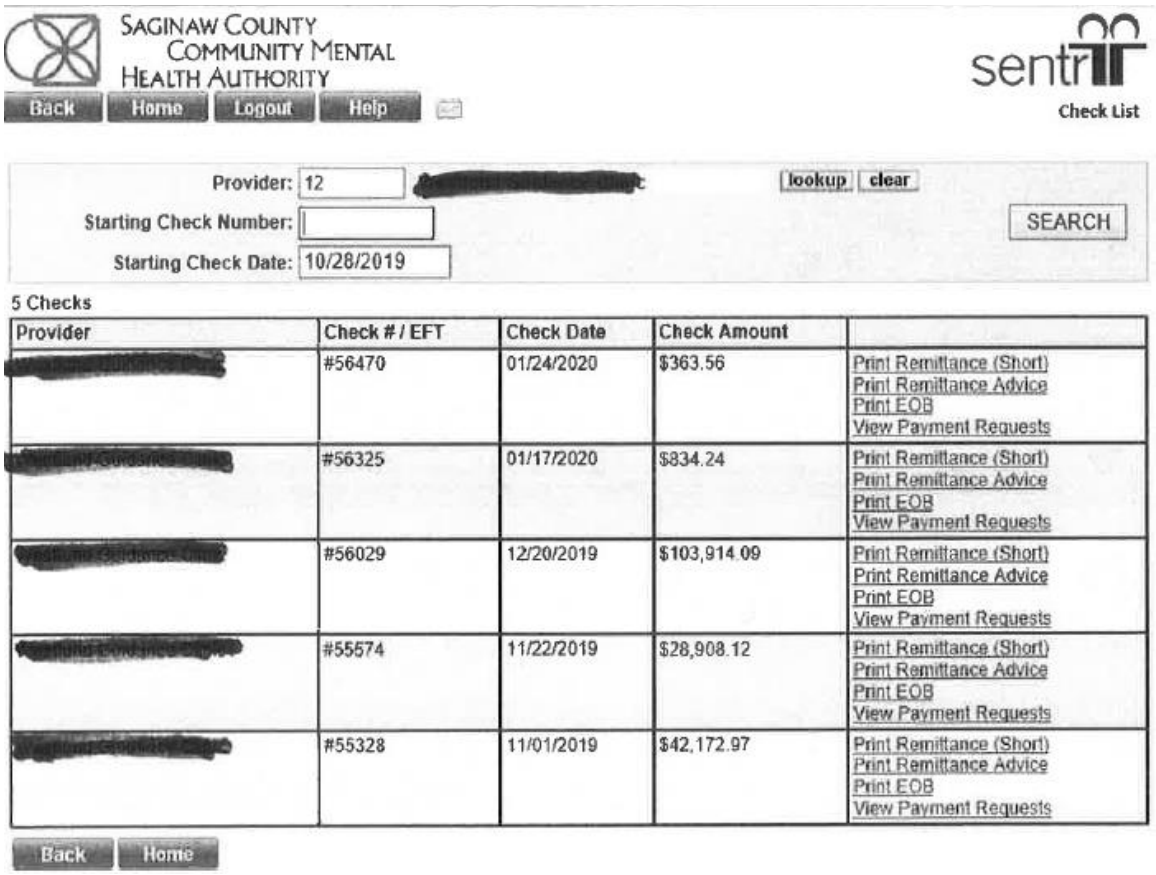
All paper claims, must be mailed to the corporate address listed in Procedure 09.02.01.01. Upon receipt of the claims from Customer Service, claims are date stamped. The Claims Processors enter the paper claims into Sentri. Paper claims that cannot be processed are returned to Provider by mail for correction.

Claims submitted via Data Entry Directly in to Sentri and 837 Electronic File should be adjudicated by the Provider before the Submission Step #2 to SCCMHA, errors should be corrected before the Submission Step.

All claims are adjudicated after Submission by Claims Processors, checked for errors. If errors are found the whole batch may be returned to the Provider for correction. Batches that are clean claims when adjudicated by the Claims Processors continue to the next step.

The Claim Processor prints a Check Request and forwards to the CFO for Signature. After being processed through the Great Plains Accounting software; Weekly the Staff Accountant creates a payment batch by due date checks are printed. The Claims Processors verify the checks before mailing checks to the provider with the full check stub and the explanation of benefits.

The Providers can go into Sentri and obtain the Explanation of Benefits and Remittance Advise using Step #3 on the main screen. Put in your Provider number and select a Starting Check Date. In the example below, we selected an Oct date. The screen shows all checks issued after 10-28-19



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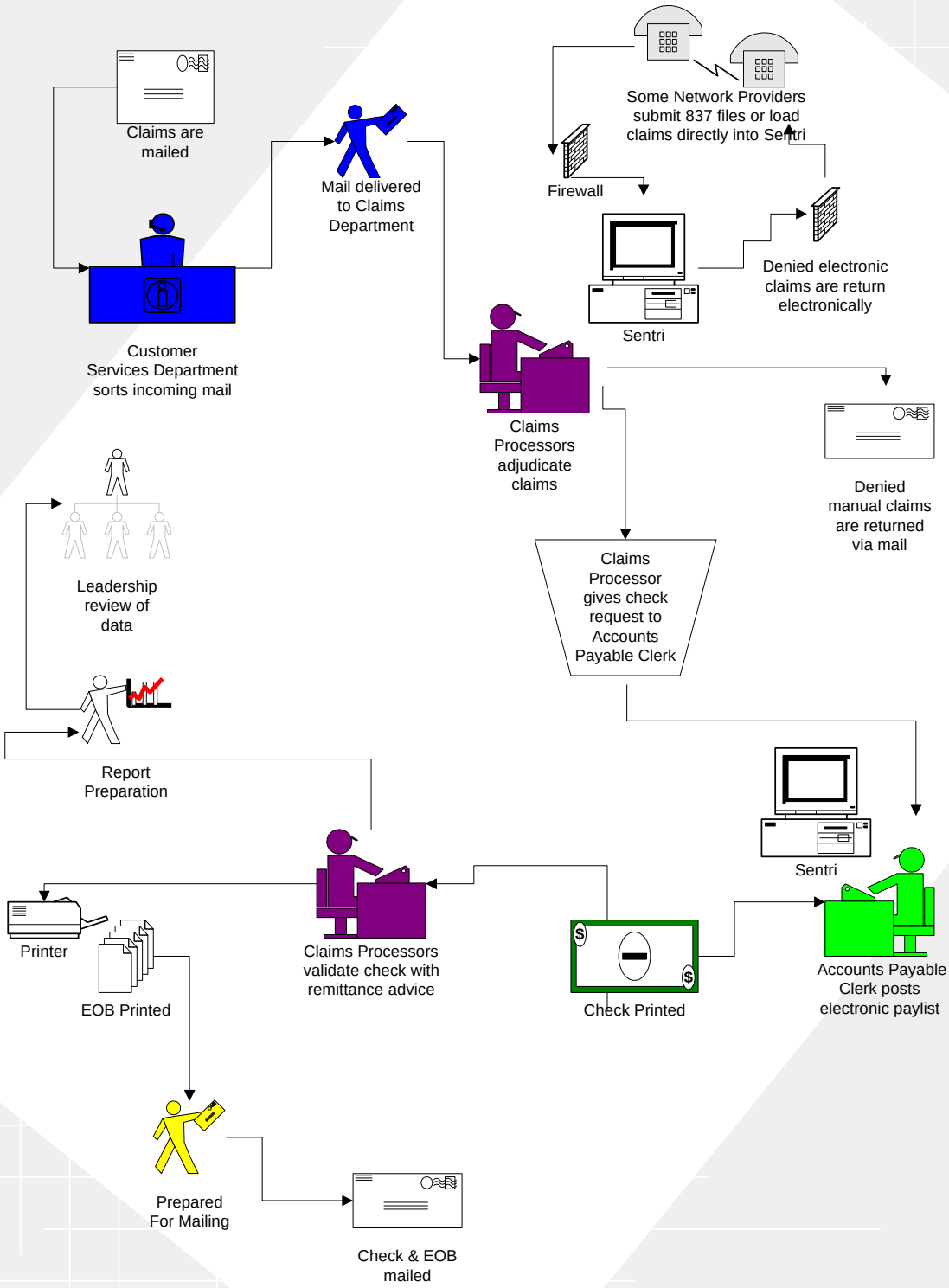
ACTION	RESPONSIBILITY
1. Upon receipt of the paper claims from Customer Service, claims are date stamped.	Claims Processors
2. Paper claims are keyed into Sentri and Adjudicated. Unclean claims are returned via mail to Providers., Claims that have been Submitted by Providers are Adjudicated. Batches with errors are returned electronically to the Provider for corrections of errors and re-submission	Claims Processors Provider's Billers
3. Clean Claims are adjudicated through the Sentri	Provider's Billers Claims Processor
4. Check requests are printed and forwarded to the CFO for approval. Staff Accountant pulls a payment	Claims Processor, CFO Staff Accountant

batch weekly by due date. Accounts Payable Clerk prints the check.	Accounts Payable Clerk
5. Upon receipt of the check request back from Accounts Payable Clerk, it is verified for correct amounts and totals. .	Claims Processor
6. Checks are validated and Explanations of Benefit and/or Remittance Advice are printed, copies are attached to claims for filing.	Claims Processor
7. Checks are mailed to the Provider. Explanation of Benefits are available in Sentri for Provider to Print.	Claims Processor
8. Claims processors respond to Providers request to resolve check issues	Claims Processor
9. Provider training regarding billing, corrections, rebilling etc.	Claims Processor

Exhibit A


Claims are mailed
Mail delivered to Claims Department
Some Network Providers submit 837 files or load claims directly into Sentri
Firewall
Sentri
Denied electronic claims are return electronically
Customer Services Department sorts incoming mail
Claims Processors adjudicate claims
Denied manual claims are returned via mail
Leadership review of data
Claims Processor gives check request to Accounts Payable Clerk
Report Preparation
Sentri
Printer
EOB Printed
Claims Processors validate check with remittance advice
Check Printed
Accounts Payable Clerk posts electronic paylist
Prepared For Mailing
Check & EOB mailed

Tab 8

Network Services

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject:
SCCMHA ListServer</td><td>Chapter: 01 - Leadership</td><td>Subject No: 01.03.05</td></tr>
<tr><td rowspan="2">Effective Date:
March 2, 2020</td><td>Date of Review/Revision:
3/22/21, 4/28/22</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Allison Kalmes-Hadd

Additional Reviewers:
Jennifer Keilitz, Clinical Directors</td></tr>
<tr><td>Supersedes:
09.06.00.11 – CMHC ListServe</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of the SCCMHA ListServer (Here after called ListServer) is to communicate through a monitored e-mail ListServer any important, relevant, and timely communication, resources, needs, events, and/or other such information as is relevant to the benefit of the consumers or staff of SCCMHA and the Network of Providers.

Application:
The entire SCCMHA network.

Policy:
It is the policy of Saginaw County Community Mental Health Authority for communication to all SCCMHA and SCCMHA network case holders, secondary case holders, therapists, peers, clinical supervisors, and others, as appropriate or needed, to be able to communicate with each other as a group about job function-related resources and tips quickly and conveniently utilizing existing email. Users can ask for resources as well as share resources. This list will enable them to more efficiently assist the individuals we serve and can support users with their day-to-day job functions.

Standards:
The following standards apply to the use of the ListServer:

- The ListServer is for SCCMHA and network job function-related use only.
- Users are to exercise professional judgment in your comments.

- Each user is to extend the same professional courtesies in ListServer communication as in non-electronic exchanges.

- Users are to clearly and concisely state the topic in the subject line. This will allow for better responses and to assist in archive searches.

- If a need or item is targeted for a small group or individual, then the use of the ListServer is inappropriate. Messages sent should be relevant, beneficial or informational for the users, or is seeking assistance across the network. For example: “I need a resource for a new bed for a consumer” would be appropriate for the entire group, while “Can someone share the Power Point from the last staff meeting?” would be appropriate for a specific group of individuals.

- Messages in response such as "thanks for the information" or "me, too" should be sent to the individual poster, not to the entire list. This can be done by using the ‘Forward’ function as the “Reply” function will go to all users.

- Do not include any Protected Health Information in posts or responses. This is a violation of confidentiality policies, regulations and laws.

- Users are to use caution when posting for the ListServer as once a message is shared, there is no recall function. The ListServer is moderated for compliance to these standards, but each user is responsible for the content of their posts. The user and agency may be liable for the content of messages.

- All defamatory, abusive, profane, threatening, offensive, or illegal information is strictly prohibited from postings.

- Users may not use the ListServer for advertising or soliciting for business ventures, organizational campaigns, political, or religious purposes without prior approval from the ListServer administration. These may be indicated in a posting as a resource.

- Users must not send on the ListServer any personal communications such as chain e-mail letters, spam, letter bombs, or otherwise use the ListServer in such a way as to cause interference with SCCMHA and network business operations or put SCCMHA at risk.

- Users are not to challenge or attack others through ListServer posts. Any discussion about a posting must be intended to stimulate conversation and to share resources and information.

- Users must not use religious, political, ideological, controversial, inflammatory, or other phrases, messages, or graphics within a posting that might promote a particular cause or belief without prior approval from the ListServer administration.

- Users cannot opt out of receiving e-mails from the ListServer, but are not required to save or reply to posts.
- In order to assure that messages sent through the ListServer meet standards, posted messages will be held for moderator review and approval before being posted on the ListServe. Some staff may be pre-approved to send without moderation upon approval of a Director or ListServe Administrator.

Definitions:
Mailman's interfaces - The system that operates CMSC ListServe is called "mailman" Mailman has two different interfaces for the list subscriber: the web interface and the email interface.

- Most discussion list subscribers use the email interface, since this includes the email address you use to send mail to all the subscribers of that list.
- Use the web interface for changing options, since the web interface provides instructions as you go.

Some common terms with this system:

- A "post" typically denotes a message sent to a mailing list. (Think of posting a message on a bulletin board.)
- People who are part of an electronic mailing list are usually called the list's "members" or "subscribers."
- "List administrator" is the person in charge of maintaining the CMSC ListServe mailing list
- This list also has people in charge of reading posts and deciding if they are appropriate. These people are called list moderators.

The web interface
The web interface of Mailman makes it easy for subscribers and administrators to see which options are available, and what these options do.
The mailing list is accessible by a number of web pages:

- List information (list info) page: http://cmsclistserve.org/mailman/listinfo/comments
    - The list info page is the starting point for the subscriber interface. As one would assume from the name it's given, it contains information about the CMSC ListServe "comments" list. Usually all the other subscriber pages can be accessed from this point, so you really only need to know this one address.
- Member options page, found at http://cmsclistserve.org/mailman/options/comments/, **after "comments/" you must put your email address to connect to your specific options page, for example: http://cmsclistserve.org/mailman/options/comments/jdoe@sccmha.org**
    - This page can also be accessed by going to the list info page and entering your email address into the box beside the button marked "Unsubscribe or Edit Options" (this is near the bottom of the page). The member options page allows you to log in/out and change your list settings, as well as get a copy of your password mailed to you. Unsubscribe requests will not be

approved unless an individual is no longer working at SCCMHA or a provider in a capacity that would benefit from this list.
    - To log in to your member options page: If you are not already logged in, there will be a box near the top for you to enter your password. Enter your password in the box and press the button.
    - Once you are logged in, you will be able to view and change all your list settings.
- List Archives: http://cmsclistserve.org/mailman/private/comments/
    - The list archive pages have copies of the posts sent to the mailing list, usually grouped by month. In each monthly group, the posts are usually indexed by author, date, thread, and subject.

The email interface

- To post a message to all the list members, send email to comments@cmsclistserve.org
    - If you wish to reply only to the sender and not to the entire list, then do not include the above email in the message and only that of the original sender. Please note that if you choose this option, your reply will not be included in the discussion thread.
    - If you want to reply to a reply that is part of the discussion and keep it in the thread, be sure that you choose the "reply all" option.
- comments-owner@cmsclistserve.org – This address reaches the list owner and list moderators directly. This is the address you use if you need to contact the person or people in charge.
- comments-bounces@cmsclistserve.org – This address receives bounces from members whose addresses have become either temporarily or permanently inactive. The bounces address a mail robot that processes bounces and automatically disables or removes members as configured in the bounce processing settings. Any bounce messages that are either unrecognized, or do not seem to contain member addresses, are forwarded to the list administrators. You likely will have no need to use this address unless you are a moderator or administrator.

References:

SCCMHA E-Mail Policy; Most of the information in this procedure has been adapted from this document: http://www.list.org/mailman-member.pdf

Exhibits:

Exhibit A – Frequently Asked Questions (FAQs)

Procedure:

ACTION	RESPONSIBILITY

1. To post a message to all of the list members, send email to comments@cmsclistserve.org	1. List user/member

Exhibit A

FAQs

1. I need to talk to a human!

You can always reach the person or people in charge of a list by using the list administrator email address. The list administrators can help you figure out how to do something or change your settings if you are unable to change them yourself for some reason. Contact comments-owner@cmsclistserve.org.

2. Passwords

Your password was either set by you or generated by Mailman when you subscribed. You probably got a copy of it in a welcome message sent when you joined the list, and you may also receive a reminder of it every month. It is used to verify your identity to Mailman so that only the holder of the password (you!) and the administrators can view and change your settings.

Warning: Do NOT use a valuable password for Mailman, since it can be sent in plain text to you.

3. How do I change my password?

From the web interface:

1. Log in to your member options page.
2. Look for the password changing boxes on the right-hand side of the page and enter your new password in the appropriate boxes, then press the button marked ”Change My Password.”

4. How do I get my password?

If you’ve forgotten your password and haven’t saved the welcome message or any reminder messages, you can always get a reminder through the web interface:

1. Go to the list information page for the list from which you wish to get your password http://cmsclistserve.org/mailman/listinfo/comments
2. Look for the section marked "comments subscribers” (this section is usually found near the bottom of the page).
3. There should be a button marked "Unsubscribe or Edit Options”. Enter your email address in the box beside this button and press the button.
4. You should be brought to a new page which has a "Password Reminder” section. Press the "Remind” button to have your password emailed to you.

If you do not receive the password reminder email after doing this, make sure that you typed your email address correctly and that the address you used is, indeed, actually subscribed to that list. For security reasons, Mailman generates the same member options page regardless of whether the address entered is subscribed or not. This means that people cannot use this part of the web interface to find out if someone is subscribed to the list, but it also means that it’s hard to tell if you just made a typo.

5. How can I avoid getting duplicate messages? (Duplicates option)

Mailman can’t completely stop you from getting duplicate messages, but it can help. One common reason people get multiple copies of a mail is that the sender has used a "group

reply" function to send mail to both the list and some number of individuals. If you want to avoid getting these messages, Mailman can be set to check and see if you are in the To: or CC: lines of the message. If your address appears there, then Mailman can be told not to deliver another copy to you.
To turn this on or off using the web interface:
1. Log in to your member options page.
2. Scroll down to the bottom of the page to the section marked "Avoid duplicate copies of messages?" and change the value accordingly.

6. How do I stop or start getting copies of my own posts? (myposts option)

By default in Mailman, you get a copy of every post you send to the list. Some people like this since it lets them know when the post has gone through and means they have a copy of their own words with the rest of a discussion, but others don't want to bother downloading copies of their own posts.
Note: This option has no effect if you are receiving digests.
To set this using the web interface:
1. Log in to your member options page.
2. Look for the section marked "Receive your own posts to the list?" Set it to "Yes" to receive copies of your own posts, and "No" to avoid receiving them.

7. No one has sent any mail to the list(s) you're on for a little while.

To check if this is the case, try visiting the archives of the list (assuming that the list has archives). If the list has no archives, you may have to ask another subscriber.

Note: Generally, it is considered impolite to send test messages to the entire list. If you feel a need to test that the list is working and for some reason you cannot simply compose a regular message to the list, it is less disruptive to send a help message to the list request address comments-owner@cmsclistserve.org to see if that works.

8. How can I start or stop getting the list posts grouped into one big email? (Digest option)

Groups of posts are called "digests" in Mailman. Your account will be set to default to the "digest" setting. Rather than get messages one at a time, you can get messages grouped together. On a moderately busy list, this typically means you get one email per day, although it may be more or less frequent depending upon the list.
To turn digest mode on or off using the web interface,
1. Log in to your member options page.
2. Look for the section marked "Set Digest Mode".
3. Set it to "On" to receive messages bundled together in digests.
4. Set it to "Off" to receive posts separately.

9. What are MIME and Plain Text Digests? How do I change which one I get? (Digest option)

- MIME is short for Multipurpose Internet Mail Extensions. It is used to send things by email that is not necessarily simple plain text. (For example, MIME would be used if you were sending a picture of an event to someone.)
- A MIME digest has each message as an attachment inside the message, along with a summary table of contents.

- A plain text digest is a simpler form of digest, which should be readable even in mail readers which don't support MIME. The messages are simply put one after the other into one large text message.
- Most modern mail programs do support MIME, so you only need to choose plain text digests if you are having trouble reading the MIME ones.

Note: This option has no effect if you are not receiving mail bunched as digests.

To set your digest type using the web interface:
1. Log in to your member options page.
2. Look for the section marked "Get MIME or Plain Text Digests?".
3. Set it to "MIME" to receive digests in MIME format, or "Plain text" to receive digests in plain text format.

This can also be changed for multiple lists at the same time if you are subscribed to more than one list on the same domain.

10. How do I view the list archives?

They can be viewed by going to a web page address.
http://cmsclistserve.org/mailman/private/comments

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Agency Forms	**Chapter**: 08 - Management of Information	**Subject No**: 08.04.08
Effective Date: 6/11/07	**Date of Review/Revision**: 3/8/17, 3/1/18, 2/25/19, 3/30/20, 3/11/21, 4/29/22	**Approved By**: Sandra M. Lindsey, CEO
	Supersedes:	
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Executive Director of Clinical Services **Authored By:** Allison Kalmes-Hadd **Additional Reviewers**: Clinical Directors, Jennifer Keilitz, Colleen Sproul

Purpose:
The purpose of this Policy is to regulate the creation, approval, and implementation of generated documents and forms used by the Agency.

Application:
All SCCMHA staff and personnel.

Policy:
It is the policy of Saginaw County Community Mental Health Authority that forms created for use by SCCMHA will adhere to the standards set forth in this policy.

Standards:
Staff will only use the most current and approved SCCMHA forms.

All documents created by staff in the conduct of regular business must use the most current, approved formats. These include any document or form that contains any indication that it has been created by SCCMHA. This would include use of the Agency logo, departmental logo, "Saginaw County Community Mental Health Authority", "SCCMHA", "CMH", "Saginaw County Mental Health" or any other initials, acronym or language that could be construed as having been generated by the agency or personnel.

A form must be approved for use by the Director of the department where the form will be used. If use will be by more than one department, then the form must be approved for use from each Director of each affected department.

Forms must have a date in the lower margin of the form. When an update to a form occurs, then this date will be updated as well. Staff will use only the most recent version of a form as indicated in the lower margin of the form. Previous blank versions of the form, either electronic or paper, is to be removed from personal drives.

Forms that will be scanned into Sentri (the electronic record) will include the Document Type in the lower margin to indicate where in the Scanned Documents section it may be found.

Forms must be maintained in an electronic version and stored either in a designated folder on the agency G: Drive or designated section of the agency website or both, as there is a transitioning from use of the G: Drive to the website for the primary location of forms.

Copies of forms may be maintained by staff on their personal drives (H) but it is contingent upon that staff to assure use of the most recent version of the form.

Any hard-copy versions of forms will be maintained as directed by each Department Director. Electronic versions of hard-copy forms will be stored on the G: Drive in the Agency Forms folder or a sub-folder of Agency Forms or on the website in a designated location. Maintenance of this folder on the G: Drive will be coordinated by the Executive Director of Clinical Services or designee.

When applicable, a form that is related to a policy or procedure should be attached as an Exhibit to that policy or procedure.

Forms created by SCCMHA Departments for use by secondary service providers will adhere to these standards for creation and review.

Forms created by individual staff for their personal use, such as for a tickler file, monitoring, coordinating care, etc. should not be entered into the consumer record without prior approval by the Department Director.

Forms that will be uploaded or scanned into the consumer record (Sentri) must include the following:

- Name and/or Sentri ID number
- Date of the document – either date signed, or date indicated on the form
- The title to be used for the Notes section of the scanned document if different from the title of the document
- The **Document Type** from the list in Sentri
- The name of the staff submitting the document

Definitions:
Forms are standardized templates used for documenting, recording or conducting agency business or affairs.

E-forms are those forms that can be stored, modified and/or shared in an electronic manner.

Hard-copy versions are those forms that are printed forms that do not allow for modification of format.

G: Drive is the agency electronic document storage area accessible to staff with access to the agency computer system. Access to certain folders may be limited to designated personnel.

References:
None

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Approves forms to be utilized	Department Directors
Placement of approved electronic hard-copy documents within the Agency Forms on the G: Drive	Clinical Director Administrative Assistant
Organization of the Clinical Forms on G: Drive in Agency Forms folder	Clinical Director Administrative Assistant
Other Departments may maintain folders for electronic documents in Agency Forms and these will be monitored by the Director of that Department or a designee	Department Director
Staff will use only the most recent version of a form as indicated in the lower margin of the form. Previous blank versions of the form, either electronic or paper, is to be removed from personal drives.	Staff