# Saginaw County Community Mental Health Authority (SCCMHA)

# Network Services Provider Manual

500 Hancock Street
Saginaw, MI 48602
Phone: (989) 797-3400

*July Update*
Fiscal Year 2024

# Provider Manual Update - July 2024

## Included are the updated policies and procedures since the FY24 January 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N/A | **Tab 1 Introdution to SCCMHA - No Updates** | | | | | | | | | | | |
| 15 | **Tab 2 Eligibility & Care Management** | | | | | | | | | | | |
| 16 | 02.03.19 | LOCUS | Removed Crisis from procedure and training expectations. Updated policy to "persons served". Removed LOCUS as part of pre-screening. | 6/12/2024 | X | X | X | X | X | X | X | X |
| 25 | 05.04.05 | Organizational Research | Removed definitions to be put in new policy 08.05.00.01- Compliance Definitions and updated reference for waiver programs. | 7/9/2024 | X | X | X | X | X | X | X | X |
| 28 | 09.03.01.05 | Courtesy Authorization Initiation | Review only. | 6/10/2024 | X | X | X | X | X | X | X | X |
| 35 | 09.06.00.13 | Case Transfer | Completely updated standards. Added definitions for General and Specialized Residential Adult Foster Care. | 5/10/2024 | | | | X | X | | | |
| N/A | **Tab 3 Services & Protocols - No Updates** | | | | | | | | | | | |
| 60 | **Tab 4 Service Delivery** | | | | | | | | | | | |
| 61 | 02.03.01 | Consumerism | Review only. | 3/12/2024 | X | X | X | X | X | X | X | X |
| 67 | 02.03.02 | Inclusion | Review only. | 3/5/2024 | X | X | X | X | X | X | X | X |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 71 | 02.03.03 | Person Centered Planning | Changed Consumer to Persons Served or Individual.<br>Changed he/she to they and his/her to their in keeping with DEI and SOGI<br>Added: 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 as well as SCCMHA policy 02.03.03B Family Centered Practice).<br>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.<br>Added reference of SCCMHA Suicide Prevention policy 02.03.24.<br>Added reference to CCBHC Handbook.<br>Deleted: 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.<br>The results of the surveys will be collected and shared with the Quality Governance Committee on a quarterly basis.<br>Added language about independent facilitation as well as definition of Independent facilitator.<br>Changed routing of persons served plan from Care Management to supervisor.<br>Added information about in-services per HCBS and also external providers keeping copies of consumer plans available for staff at the site.<br>Added Exhibit E. | 4/30/2024 | X | X | X | X | X | X | X | X |
| 95 | 02.03.03 B | Family Centered Practice | Wording changes and adding electronic signature as option for IPOS. | 3/7/2024 | X | X | X | X | X | X | X | |
| 109 | 02.03.05 | Recovery | Removed Reference P. | 4/5/2024 | X | X | X | X | X | X | X | |
| 120 | 02.03.07 | Employment of Consumers | Wording changes. | 4/4/2024 | X | X | X | X | X | X | X | |
| 126 | 02.03.08 | Welcoming | No changes. | 4/5/2024 | X | X | X | X | X | X | X | X |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 133 | 02.03.09 | Evidence-Based Practices (EBPs) | Small grammar edits, added point under standard D regarding keeping a supervision log, updated job titles under Standard E and removed SUD Coordinator. Added “other members…” to this standard. Update privileging policy number. | 1/31/2024 | X | X | X | X | X | X | X | |
| 153 | 02.03.09.01.01 | Practice Guidelines | Corrected reference policy number for Trauma-Informed Services policy. | 1/31/2024 | X | X | X | X | X | X | X | |
| 158 | 02.03.09.02 | Assertive Community Treatment (ACT) | Small grammar edits, updated link. | 1/31/2024 | | X | X | X | X | X | X | |
| 168 | 02.03.09.05 | Family Psychoeducation (FPE) | Updated where to find reference K. | 1/31/2024 | | X | X | X | X | | | |
| 188 | 02.03.09.09 | System of Care (SOC) | Updated policy to include conceptual revisions to SOC found in the current literature. These include:<br>Coordination between primary health care and specialty mental health services.<br>Incorporating mental health promotion, prevention, screening, early identification, and early intervention services.<br>Core services that shall be made available to eligible children, youth and families as needed and resources permit:<br>1.Mobile Crisis Response and Stabilization Services (MRSS) shall be provided to children and youth who are experiencing mental health emergencies and their families in order to defuse and stabilize crises, maintain children and youth in their current living arrangements, prevent hospitalization, prevent disruption of child welfare placements, and improve functioning.<br>2.Intensive care coordination using Wraparound as an approach to providing individualized care for children, youth, and young adults with complex mental health needs and their families.<br>3.Intensive in-home mental health treatment services | 4/5/2024 | X | X | X | X | X | X | X | X |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | provided to improve child, youth, and family functioning and to prevent the need for out-of-home placement, inpatient hospitalization, or residential treatment that includes individual and family therapy, skills training, behavioral interventions, crisis response, and care coordination.<br>4.Parent and youth peer support provided by individuals who have personal "lived" experience with mental health conditions and navigating service systems, either as a consumer or as a family member or caregiver.<br>5.Respite care to provide parents and other primary caregivers with planned or emergency short-term care for their child, enabling children and youth with mental health needs to remain in a safe and supportive environment, usually in their own homes.<br>6.Flex funds using financing mechanisms covered by Medicaid and other sources.<br>7.Trauma-specific treatments and trauma-informed systems to address traumatic experiences with particular attention to the impact of adverse childhood experience on later mental health needs.<br>8.The provision of evidence-based services as well as specific evidence-informed and promising practices to ensure treatment effectiveness.<br>9.Telehealth services including videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communication particularly to provide care to underserved populations and thus increase access to behavioral health care services.<br>Updated the definition of SOC.<br>Added Reference J which substantially updates SOC principles and practices. | | | | | | | | | |
| 196 | 02.03.09.12 | MRSS | Adding language regarding 24/7 hours and 3rd shift staffing. | 4/2/2024 | | | | X | | | | |
| 204 | 02.03.09.13 | Trauma Recovery & Empowerment (TREM) | Updated reference link. | 1/31/2024 | | X | | X | X | | | |
| 209 | 02.03.09.16 | Cognitive Behavior Therapy (CBT) | Review only. | 1/31/2024 | | X | X | X | X | | | |
| 216 | 02.03.09.17 | Mental Health First Aid (MHFA) | Updated training link and exhibit. | 6/11/2024 | X | X | | X | X | X | X | X |
| 223 | 02.03.09.18 | Child-Parent Psychotherapy (CPP) | Simplified/reduced exhibits to one. Added an additional reference. | 1/31/2024 | | | | X | X | | | |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 230 | 02.03.09.19 | Infant Mental Health- Home Visiting (IMH-HV) | New policy. | 4/10/2024 | | | | X | X | | | |
| 235 | 02.03.09.20 | Parent-Child Interaction Therapy (PCIT) | New policy. | 4/10/2024 | | | | X | X | | | |
| 245 | 02.03.09.22 | Picture Exchange Communication System (PECS) | Review only. | 1/31/2024 | X | X | | X | X | X | X | |
| 248 | 02.03.09.24 | Permanent Supportive Housing (PSH) | Updated reference links. | 1/31/2024 | | X | X | X | X | X | | |
| 260 | 02.03.09.25 | Seeking Safety | Review only. | 1/31/2024 | | | | | X | | | |
| 266 | 02.03.09.27 | Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) | Updated reference link. | 1/31/2024 | | | | X | X | | | |
| 276 | 02.03.09.28 | Whole Health Action Management (WHAM) | Review only. | 1/31/2024 | | X | | X | X | | X | |
| 281 | 02.03.09.40 | SBIRT-YSBIRT | Language use updates, update to Standard I. Updated link. Updates to responsibility section. | 1/23/2024 | X | | | X | X | | | |
| 298 | 02.03.09.42 | Mindfulness | Updated reference link. | 1/31/2024 | | | | | X | | | |
| 301 | 02.03.09.43 | Problem-Solving Skills Therapy (PSST) | Review only. | 1/31/2024 | | | | | X | | | |
| 318 | 02.03.12 | Alternatives to Guardianship | No changes. | 4/5/2024 | X | X | X | X | X | X | X | |
| 340 | 02.03.17 | Outcome Tool for Adults (ANSA) | Review only. | 3/11/2024 | | X | | X | X | | | |
| 349 | 02.03.18 | PECFAS & CAFAS | Review only. | 3/7/2024 | | X | | X | X | | | |
| 376 | 02.03.21 | Autism Spectrum Disorder (ASD) Program | Wording changes. | 3/15/2024 | | X | X | X | X | X | X | |
| 386 | 02.03.23 | Care Coordination | Changed the word consumer to person served language.<br>Summarized the purpose and policy statements.<br>Added a standard about using EBPs and one about addressing SDoHs due to SAMHSA standards.<br>Added standard about Team-based approach, due to NatCon standards.<br>Added MDHHS, CCBHC, BHH, NatCon to references. | 5/8/2024 | X | X | X | X | X | X | X | |
| 391 | 02.03.24 | Suicide Prevention | Policy updated to include Zero Suicide EBP. | 4/9/2024 | X | X | X | X | X | X | X | |
| 404 | 02.03.25 | Wellness | Updated Reference section: removed obsolete reference (A) and added reference to the SCCMHA Wellness Incentive Program (G).<br>Replaced previous Exhibit (Eight Dimensions of Wellness) with the more up-to-date SAMHSA Wellness Wheel. | 4/5/2024 | X | X | X | X | X | X | X | |
| 409 | 02.03.41 | SOGI Safe | Corrected the definition of “coming out”.<br>Updated the Reference section: removed website (A) which no longer exists and added C as the replacement. | 4/5/2024 | X | X | X | X | X | X | X | |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 418 | 03.01.03 | Consumer Choice & Service Management | Review only. | 3/5/2024 | X | X | X | X | X | X | X | X |
| 427 | 03.01.04 | Jail Detention & Diversion | Review only. | 3/7/2024 | X | X | X | X | X | X | X | |
| 433 | 03.02.02 | Academic and Vocational Continuity | Review only. | 3/7/2024 | X | X | X | X | X | X | X | |
| 435 | 03.02.03 | Monitoring & Reassessment | Review only. | 3/15/2024 | X | X | X | X | X | X | X | |
| 446 | 03.02.05 | Plans of Service and Support | Review only. | 3/7/2024 | X | X | X | X | X | X | X | X |
| 457 | 03.02.07 | Residential Services | Review only. | 3/7/2024 | X | X | X | X | X | X | X | |
| 486 | 03.02.09 | Behavior Treatment Plan Review Committee (BTPRC) | Updated exhibits. | 4/8/2024 | X | X | X | X | X | X | X | |
| 503 | 03.02.10 | Clinical Risk Committee | Review only. | 3/7/2024 | X | X | X | X | X | X | X | X |
| 508 | 03.02.11 | Child Diagnostic and Treatment Training Requirements | Review only. | 3/12/2024 | | | | X | X | | | |
| 517 | 03.02.12 | Peer Delivered and Operated Service | Review only. | 3/11/2024 | X | X | X | X | X | X | X | |
| 519 | 03.02.13 | Transition/Discharge Services | Review only. | 3/11/2024 | X | X | X | X | X | X | X | |
| 523 | 03.02.14 | Advance Directives | Updated phone number for Customer Service<br>Updated usage and grammar errors. | 7/9/2024 | X | X | X | X | X | X | X | |
| 532 | 03.02.15 | Safe Transportation of Children and Teens | Review only. | 4/4/2024 | X | X | | X | X | X | X | X |
| 536 | 03.02.16 | Discharges for Assaultive or Aggressive Behavior | Review only. | 3/7/2024 | X | X | X | X | X | X | X | |
| 539 | 03.02.18 | Respite Services | Review only. | 4/1/2024 | X | X | X | X | X | X | X | |
| 553 | 03.02.21 | Structured Daytime Activity Programming | Review only. | 3/5/2024 | X | X | | | X | | | |
| 569 | 03.02.26 | Consumer Transition Planning | Review only. | 4/4/2024 | X | X | X | X | X | X | X | |
| 574 | 03.02.27 | Behavior Treatment Plans (BTPs) | Added: Quarterly reviews shall include:<br>1). A completed Request to use Intrusive/Restrictive Intervention(s) in a Behavior Treatment Plan (BTP) form.<br>2). Baseline data and data for the last three (3) months.<br>3). A progress summary encompassing the last three (3) months.<br>Updated Exhibit C with new form (Special Informed Consent).<br>Updated Exhibit H (Request to use Intrusive/Restrictive Interventions in a BTP).<br>Updated Exhibit I (Recurring Behavior(s) of Concern Checklist).<br>Removed Exhibit K (Behavior Intervention Plan (BIP) Quarterly Review form) because it is no longer in use. | 4/5/2024 | X | X | X | X | X | X | X | |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 605 | 03.02.30 | Use of PRN Psychotropic Medication in Mental Health Settings | Changed word consumer to person served language.<br>Updated the title to add the meaning of PRN (Pro Re Nata).<br>Moved standards from the policy statement to the standards section.<br>Added standard that a PE, informed consent, and medical necessity are required.<br>Removed standard that references use of PRN medications given as emergency intervention when not related to the individuals Dx.<br>Removed redundant standards that are addressed in other policies (general medication standards).<br>Clarified language related to the standard that describes documentation of symptoms and changed to use DSM language.<br>Removed the instructions from the standards that describe what staff should do when a medication is administered for behavioral reasons because we don't administer medications for behavioral reasons.<br>Almost all definitions were removed because they were not used in the document or were not specific to the document. | 5/8/2024 | | | X | | X | | | |
| 614 | 03.02.31 | Services for Members of the Armed Forces, Veterans and their Families | Review only. | 4/4/2024 | X | X | X | X | X | X | X | |
| 619 | 03.02.33 | Genoa HealthCare- MED DROP™ Program for Children | Exhibit updates from Genoa. | 3/12/2024 | | | | | X | X | | |
| 642 | 03.02.34 | Services for American Indians | Review only. | 4/5/2024 | X | X | X | X | X | X | X | |
| 646 | 03.02.35 | Serving LGBTQIA+ Consumers | Added definition of LGBTQIA2S+.<br>Entirely revised the definition of gender.<br>Rewrote/revised the definition of genderism.<br>Revised the definition of "in the closet".<br>Enhanced definition of "M to F".<br>Rewrote the definition of sexual minorities.<br>Removed examples from "sexual orientation" because all of the terms are defined elsewhere in the policy.<br>Enhanced the definitions of transgender, trans man and trans women. | 4/5/2024 | X | X | X | X | X | X | X | |
| 658 | 03.02.39 | Psychiatric Hospitalization of consumers with Intellectual and Developmental Disabilities and Children with Autism | Added language regarding Health and Safety Regulation form and how/when it should be completed.<br>Added Health and Safety Regulation form. | 4/4/2024 | X | | | X | X | | | |
| 665 | 03.02.40 | Serious Emotional Disturbance Waiver (SEDW) Program Overview | Review only. | 3/11/2024 | | | | X | X | | | |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 668 | 03.02.41 | Serious Emotional Disturbance Waiver (SEDW) Entry Criteria | Review only. | 3/11/2024 | | | | X | X | | | |
| 673 | 03.02.42 | Serious Emotional Disturbance Waiver (SEDW) Exit Criteria | Review only. | 3/11/2024 | | | | X | X | | | |
| 677 | 03.02.45 | Interdisciplinary Treatment Teams | Review only. | 4/5/2024 | X | X | X | X | X | X | X | X |
| 682 | 03.02.46 | Whole-Person Care | Policy statement updates:<br>Archived the history and background information to make the policy more usable to staff. With updates to the CCBHC handbook, some of it is outdated.<br>Added the CCBHC handbook as a reference.<br>Added BHH handbook as a reference.<br>Removed standards from policy statement to reduce redundancy.<br>Standards updates:<br>The only standard that was removed was the personal health review because we are no longer using that document. All elements of that document are incorporated into other documents.<br>Removed outdated flowchart.<br>Removed NOMs. Added new SDOH assessment tool.<br>Health literacy information was updated to reflect the Health Literacy policy that was recently updated. The health literacy policy was added as a reference.<br>Changed MA to Care Coordinator<br>Outdated exhibits removed. | 5/8/2024 | | X | | | X | | | |
| 706 | 03.02.47 | Children's Waiver Overview | Review only. | 3/11/2024 | | X | | | X | | | |
| 709 | 03.02.47.01 | Children's Waiver Enrollment and Eligibility | Update language referring to waiver eligibility and enrollment as provided by Community Liaison. | 3/11/2024 | | X | | | X | | | |
| 716 | 03.02.48 | Older Adult Services | New policy. | 6/1/2024 | | | | X | X | | | |
| 721 | 03.02.49.01 | Care Transitions | Changed word consumer to person served language.<br>Removed bullet points from under the policy statement and replaced them with a policy statement.<br>Moved action items to procedures section. | 5/9/2024 | X | X | X | X | X | | | |
| 731 | 04.01.04 | Trauma Screening, Assessment, and Treatment Services | Review only. | 3/7/2024 | | X | | X | X | | | |
| 758 | 09.03.01.04 | Level of Care Reviews | Review only. | 6/10/2024 | X | X | X | X | X | X | X | |
| 772 | **Tab 5 Regulatory Management/HIPAA Compliance** | | | | | | | | | | | |
| 773 | 05.07.01 | Compliance & Ethics Program – Corporate Compliance Plan (CCP) | Changed consumers to persons served. | 7/9/2024 | X | X | X | X | X | X | X | |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 776 | 05.07.03 | Deficit Reduction Act Compliance (False Claims) | Removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | X |
| 780 | 05.07.05 | Reporting of Medicaid Fraud, Waste & Abuse | Added "Waste" to subject name and throughout document, changed consumers to persons served. | 7/9/2024 | X | X | X | X | X | X | X | X |
| 784 | 08.04.01 | Consumer Records | Review only. | 4/5/2024 | X | X | X | X | X | X | X | |
| 798 | 08.04.09 | Ownership & Retention of Hard Copy Consumer Records | Review only. | 4/5/2024 | X | X | X | X | X | X | X | X |
| 807 | 08.05.00.01 | Compliance Definitions | New policy. | 7/9/2024 | X | X | X | X | X | X | X | |
| 818 | 08.05.03.01 | HIPAA Privacy Set: The Right to Request Privacy Protection for PHI – Requesting Restrictions on Uses and Disclosures | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 822 | 08.05.03.02 | HIPAA Privacy Set: The Right to Request Privacy Protection for PHI – Confidential Communications for PHI | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 826 | 08.05.04.01 | The Individual's Right to Access PHI – Granting Access to Inspect & Obtain a Copy | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 832 | 08.05.04.02 | The Individual's Right to Access PHI – Denying Access to Inspect & Obtain a Copy | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 837 | 08.05.04.03 | The Individual's Right to Access PHI – Reviewing a Denial to Access | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 840 | 08.05.04.04 | The Individual's Right to Access PHI – Extending Time to Access | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 843 | 08.05.05.01 | The Right of Individuals to Amend PHI – Accepting Requests for Amendment to PHI | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 847 | 08.05.05.02 | The Right of Individuals to Amend PHI – Denying Requests for Amendment to PHI | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 851 | 08.05.06.01 | Scope of U&D – Identifying When Routine Health Information become PHI – Inclusive of 42 CFR Part 2 | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 853 | 08.05.06.02 | Scope of U&D – Creating De-identified information | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 857 | 08.05.06.03 | Scope of U&D – Creation of Uses of a Limited Data Set | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 861 | 08.05.07.01 | Disclosing & requesting only the Minimum amount of PHI | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 865 | 08.05.09.01 | Consent – Obtaining a Consent for Use or Disclosure of PHI | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 870 | 08.05.09.02 | Authorizations – Conditioning Services on the Provision of an Authorization | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 873 | 08.05.09.03 | Authorizations – Individual Revocation of an Authorization to Disclose PHI | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 875 | 08.05.09.04 | Consent – Prohibiting the Use of an Invalid Consent to Disclose PHI | Removed definitions to add to compliance definitions policy. | 7/9/2024 | X | X | X | X | X | X | X | |
| 877 | 08.05.09.05 | Consent – Authorization for the Use or Disclosure of Psychotherapy Notes | Removed definitions to add to compliance definitions policy. | 7/9/2024 | X | X | X | X | X | X | X | |
| 881 | 08.05.10.01 | U&D – Disclosure of PHI to Person's Involved in an Individual's Care | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 885 | 08.05.11.01 | Consent Agree or Object – Disclosing PHI as Required by Law | Review only. | 7/9/2024 | X | X | X | X | X | X | X | X |
| 889 | 08.05.11.02 | Authorization, Agree or Object – Disclosing PHI for Public Health Release | Removed definitions to add to compliance definitions policy. | 7/9/2024 | X | X | X | X | X | X | X | |
| 893 | 08.05.11.03 | AAO – Disclosing PHI about Victims of Abuse, Neglect, or Domestic Violence | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 896 | 08.05.11.04 | Consent, Agree or Object – Disclosing PHI involving child abuse or neglect | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 899 | 08.05.11.05 | Consent, Agree or Object – Disclosing PHI for Health Oversight Release | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 902 | 08.05.11.06 | Consent, Agree or Object – Disclosing PHI Required by Legislative Subpoena | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 905 | 08.05.11.07 | AAO – Disclosing Non-Privileged PHI for Judicial and Administrative Release | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | X |
| 909 | 08.05.11.08 | AAO – Disclosing Privileged PHI for Judicial and Administrative Release | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 912 | 08.05.11.09 | Consent, Agree or Object – Disclosing PHI for Law Enforcement Release | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | X |
| 918 | 08.05.11.10 | Consent, Agreement or Object – Disclosing PHI About Decedents | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 921 | 08.05.11.11 | AAO – Disclosing PHI to Avert Serious Threat to Health & Safety | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 925 | 08.05.11.12 | AAO – Disclosing PHI for Specialized Government Functions | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | |
| 929 | 08.05.11.13 | Consent, Agree or Object – Disclosing PHI for Worker's Compensation | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | X |
| 932 | 08.05.15.01 | Marketing – Using and Disclosing PHI for Marketing | Changed consumer to person served, updated grammar errors, removed definitions to be put in new policy 08.05.00.01- Compliance Definitions. | 7/9/2024 | X | X | X | X | X | X | X | X |
| N/A | **Tab 6** | **Recipient Rights - Customer Service - Appeals & Grievance - No Updates** | | | | | | | | | | |
| N/A | **Tab 7** | **Claims Processing - No Updates** | | | | | | | | | | |
| 935 | **Tab 8** | **Network Services** | | | | | | | | | | |
| 936 | 01.03.03 | Media-Communications Request for Agency Information | Updated person served language.<br>Added: The Office of the CEO must approve the development of any new or special program or logo/graphic including any updates to current brochures, flyers, pamphlets, publications or SCCMHA website.<br>Public inquiries and requests for information concerning the following should be directed to:<br>8. Professional Speakers to Media or by invitation to community, state or national events.<br>"Persons Served" will replace the term "consumer" beginning in Quarter 4 / 2024 as requested by SAMHSA in FY 2023 CCBHC Certification standards in effect in 2025.<br>SCCMHA has a standard logo accompanied by the organizations name in a specific font and color. Black & White versions are also available.<br>Request for speakers from SCCMHA must be made to and approved by the CEO or their designee. | 7/9/2024 | X | X | X | X | X | X | X | X |
| 954 | 01.03.05 | SCCMHA ListServer | Review only. | 4/6/2024 | X | X | X | X | X | X | X | X |

| Page | Policy Number | Policy/Procedure Name | What Was Added / Updated | Date Revised | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 962 | 05.06.06 | SCCMHA Continuing Education Program | Changed consumer to person served. Added DCO to the language with network providers. | 5/9/2024 | X | X | | X | X | X | X | X |
| 968 | 08.04.08 | Agency Forms | Review only. | 4/5/2024 | X | X | X | X | X | X | X | X |
| 971 | 09.04.01.01 | Auditing | Added CCBHC language and Person Served definition. Updated Pre-Audit procedure. | 5/23/2024 | X | X | X | X | X | X | X | X |
| N/A | **Booklets and Brochures - No Updates** | | | | | | | | | | | |

# Tab 2

# Eligibility & Care Management

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: LOCUS</td><td>Chapter: 02 - Customer Services & Recipient Rights</td><td>Subject No: 02.03.19</td></tr>
<tr><td rowspan="2">Effective Date:<br>4/1/10</td><td>Date of Review/Revision:<br>5/8/12, 6/1/13, 6/10/13, 3/14/17, 5/8/18, 9/10/19, 12/2/20, 10/21/22, 4/26/23, 8/1/23, 6/12/24</td><td rowspan="3">Approved By:<br>Sandra Lindsey, Chief Executive Officer<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Mary Baukus<br><br>Additional Reviewers:<br>Jennifer Keilitz, Holli McGeshick</td></tr>
<tr><td>Supersedes: 03.01.01.01</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
To provide SCCMHA with a standardized assessment for use with Adults with Mental Illness in the review of eligibility and continuing stay decisions and to comply with MDHHS requirement for initial and annual LOCUS assessment with reporting of composite scores in the BH-TEDS data set.

**Policy:**
SCCMHA will implement the Level of Care Utilization System for Psychiatric and Addiction Services Adult Version 2010 (LOCUS) to measure the level of functioning for adults with mental illness. The LOCUS scores will be used in addition to a clinical review of the presenting needs as rationale for admission to services and to levels of care. SCCMHA will apply the LOCUS scores as descriptive of the resource intensity required by the person served rather than prescriptive of services or a service setting. This is consistent with the Beneficiary Eligibility criteria set forth in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Chapter section 1.6, which describes a need for access to "specialty mental health services and supports."

**Application:**
The LOCUS will be used by SCCMHA for utilization management activities for services for adults with mental illness. The LOCUS will be scored initially as a part of the intake assessment, quarterly, and upon discharge.

**Standards:**

1. The LOCUS consists of seven subscales with a maximum composite score of 35. The LOCUS recommends six levels of care with a level of care placement algorithm which adjusts for acuity and risk. SCCMHA defines levels of care according to Exhibit one to this policy.

**Definitions:**

Basic Services (Score range up to 9): Basic services are those services that should be available to all members of the community. They are designed to prevent the onset of illness or to limit the magnitude of morbidity associated with already established disease processes. These services may be developed for individual or community application and are generally conducted in a variety of community settings. These services will be available to all members of the community with a special focus on children.

Level One: Recovery Maintenance and Health Management: This level of care provides treatment to consumers who are living either independently or with minimal support in the community and who have achieved significant recovery from past episodes of illness. Treatment and service needs do not require supervision or frequent contact. Score range 10-13.

Level Two: Low Intensity CMH/Community Based Services: This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Score Range 14-16.

Level Three: High Intensity Community Based Services: This level of care provides treatment to consumers who need intensive support and treatment, but who are living either independently or with minimal supports in the community. Services needs do not require daily supervision, but treatment needs require contact several times per week. Score Range 17-19.

Level Four: Medically Monitored Non-Residential Services: This level of care refers to services provided to consumers capable of living in the community in supportive or independent settings, but whose treatment needs require intensive management by a multi-disciplinary treatment team. Score Range 20-22.

Level Five: Medically Monitored Residential Services: This level of care refers to residential treatment provided in community setting. This level of care has traditionally provided in a non-hospital, freestanding residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included in this level. Score Range 23-27.

Level Six: Medically Managed Residential Services: This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital setting, but could in some cases, be provided in freestanding non-hospital settings. Score Range 28-35.

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 shall be documented in the individual plan of services.

**References:**
1) Medicaid Provider Manual
2) SCCMHA Policy Eligibility Criteria 03.01.01
3) LOCUS Manual, Adult Version 2010

**Exhibits:**
A: SCCMHA LOCUS Eligibility and Resource Intensity Matrix
B. LOCUS Training Expectations 2024

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. MDHHS shall purchase the license to use the LOCUS from Deerfield Behavioral Health Systems as implemented through PCE in the Sentri, electronic medical record. | 1. Network Services and Information Systems Depts. |
| 2. Staff complete the required Deerfield online training and submit proof to the Continuing Education Department. | 2. Clinical staff who complete LOCUS |
| 3. The SCCMHA Continuing Education Department will schedule advanced LOCUS training quarterly or as needed. | 3. Continuing Education Dept. |
| 4. Information about opportunities for refresher trainings through Community Mental Health Association of Michigan will be shared as they are available. | 4. Continuing Education Dept. |
| 5. The LOCUS will be reviewed by a Care Management Specialist for initial and ongoing eligibility determination. The LOCUS score is never used as a sole determinant of eligibility or continuing stay; it is considered in the context of diagnosis, assessment and person served needs as described by the consumer. | 5. Central Access & Intake Specialist, Care Management Specialist |

| | |
|---|---|
| 6. Clinicians who score the LOCUS, such as Central Access and Intake Specialists or Case Holders, may also override the LOCUS, based on clinical judgement and well-documented clinical rationale. Overrides should be rare. | 6. Clinical staff who complete LOCUS. |
| 7. The Care Management specialist may override the LOCUS disposition if the presenting consumer's needs indicate that a different level of resource intensity is required. | 7. Care Management Department |
| 8. The Care Management Specialist will also request a LOCUS when a level of care change is requested, or at the occurrence of a continuing stay review in targeted Utilization Management projects. | 8. Care Management Specialist and Care Management Conference. |
| 9. Crisis staff do not need to complete a LOCUS if an MCG is being performed in the Crisis setting. The MCG will determine the level of care in these situations and should be used for both inpatient and Crisis Residential placements. | 9. Crisis Staff |
| 10. Case Holders will update LOCUS every 90 days. | 10. Case Holders |
| 11. A new LOCUS will also be completed for a new episode of care. For example, upon discharge from the hospital. | 11. Case Holders |
| 12. If a person served requests a Medicaid fair hearing for appeal or grievance or Local Dispute Resolution regarding a level of care decision; SCCMHA representative will present the LOCUS score and other supporting documentation to the consumer, Appeals Coordinator, and/or administrative law judge. | 12. Manager of Utilization Care Authorizations. |

Exhibit A

| SAGINAW COUNTY MENTAL HEALTH AUTHORITY LOCUS ELIGIBILITY AND RESOURCE INTENSITY MATRIX | | | | |
|---|---|---|---|---|
| **LOCUS LEVEL OF CARE** | **SCORE RANGE** | **DESCRIPTION** | **ENTRANCE AUTHORIZATION** | **EXIT AUTHORIZATION** |
| **Basic** | **0-9** | **Prevention and Health Maintenance** | | |
| **SCCMHA Service Level** | | **Entry level through CCBHC only. Refer to appropriate treatment team and authorize services accordingly or offer choice of community partner** | **Eligible through CCBHC only** | |
| **Level One** | **10-13** | **Recovery Maintenance and Health Management** | | |
| **SCCMHA Service Level** | | **Entry level to CCBHC only. Refer to appropriate treatment team and authorize services accordingly or offer choice of community partner** | **Eligible through CCBHC only** | |
| **Level Two** | **14-16** | **Low Intensity CMH/Community Based Services** | | |
| **SCCMHA Service Level** | | **Eligible for entry to CCBHC, refer to appropriate treatment team, if available and authorize services accordingly. Or offer choice of community partner** | **Eligible through CCBHC to Enter Outpatient Level of Care** | **Medicaid discharge from care after one year with a score of less than 14.** |
| **Level Three** | **17-19** | **High Intensity Community Based Services** | | |
| **SCCMHA Service Level** | | **Eligible for entry to Medicaid PIHP Targeted Case Management, proceed with Person Centered Planning and authorize services accordingly, this level of care does not include specialized residential services.** | **Eligible to enter Targeted Case Management Level** | **Medicaid discharge from care after one year with a score of less than 14.** |
| **Level Four** | **20-22** | **Medically Monitored Non-Residential** | | |
| **SCCMHA Service Level** | | **Eligible for Medicaid PIHP benefit, proceed with Person Centered Planning and authorize services accordingly, authorized services may include general foster care, SIP or CLS in own home, or ACT, but not specialized residential care** | **Eligible to enter Intensive Targeted Case Management or ACT Level** | **General Fund discharge if not Medicaid eligible within 90 days of notice** |
| **Level Five** | **23-27** | **Medically Monitored Residential** | | |
| **SCCMHA Service Level** | | **Eligible for Medicaid PIHP benefit, proceed with Person Centered Planning and authorize services accordingly, authorized services may include residential services up to and including specialized residential care. Or admission to Crisis Residential at this score or with a lower score and single score of 4 in risk of harm, functional status, or co-morbidity.** | **Level required for General Fund entry** | |
| **Level Six** | **28 or higher** | **Medically Managed Residential** | | |
| **SCCMHA Service Level** | | **Admission to Inpatient at this score or with a lower score and single score of 5 in risk of harm, functional status, or co-morbidity.** | **Entry to Inpatient** | |

Exhibit B

# LOCUS Training Expectations

**Who is expected to be trained in LOCUS?**
All SCCMHA Network staff Case holders who work with adult consumers with Mental Illness, Mobile Response and Stabilization Services Workers, and Central Access and Intake Specialists.
What are the minimum requirements to be considered fully trained in LOCUS?

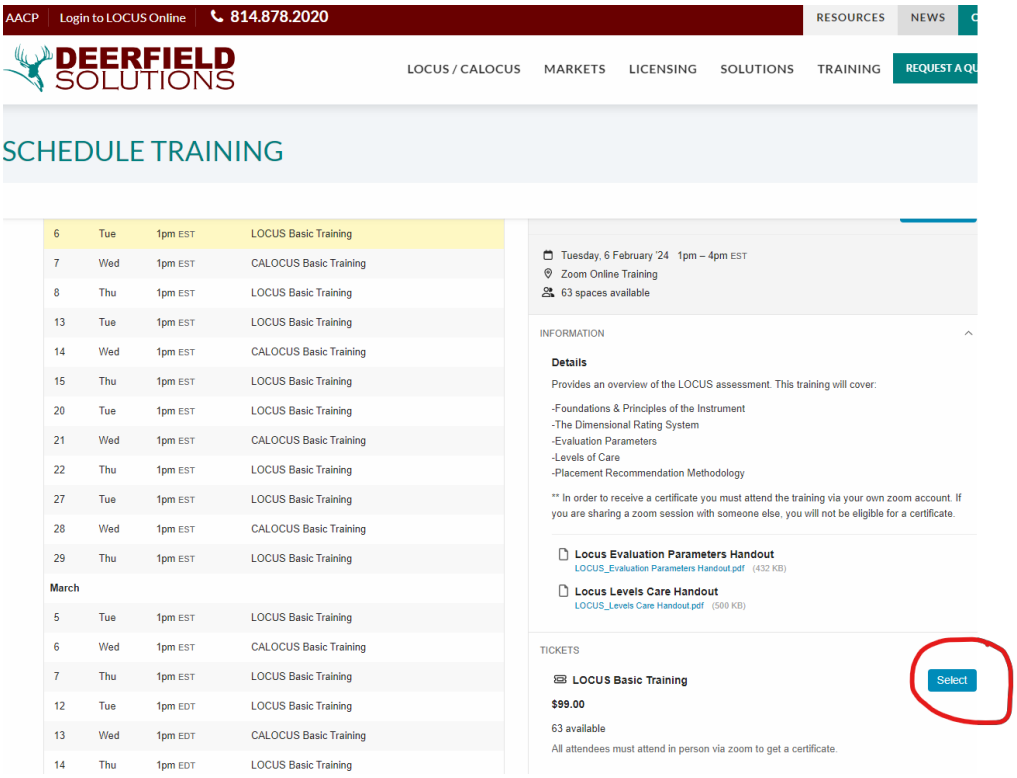
1. Complete online Deerfield LOCUS training: Within the first 30 days of employment.
2. LOCUS 201: After completing Deerfield training and within the first 90 days of employment.
3. LOCUS refresher training: At least one training course annually.

**How do I access the Deerfield LOCUS training?**

**Instructions for scheduling LOCUS Step 1 training**.

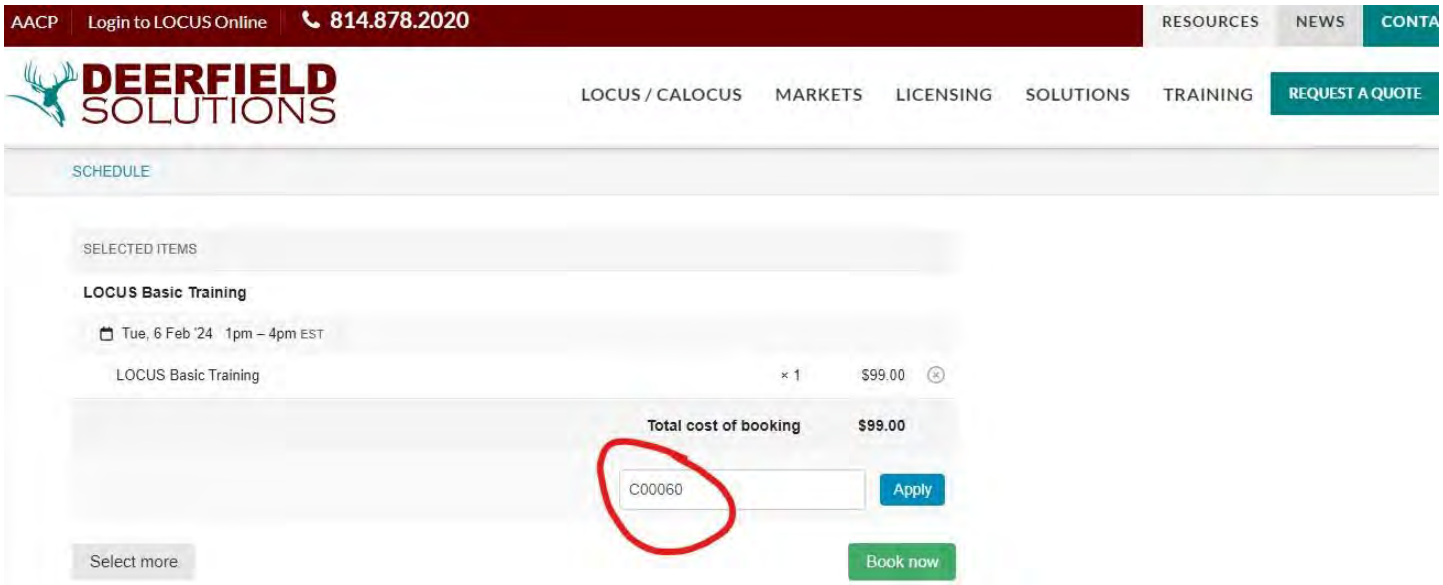
***Please review all steps carefully***:

1. Website: Schedule Training | Deerfield Solutions
2. Choose a **LOCUS Basic Training** date (website states this is for INDIVIDUAL training ONLY, not for groups )
3. Then choose blue Select button on the bottom right

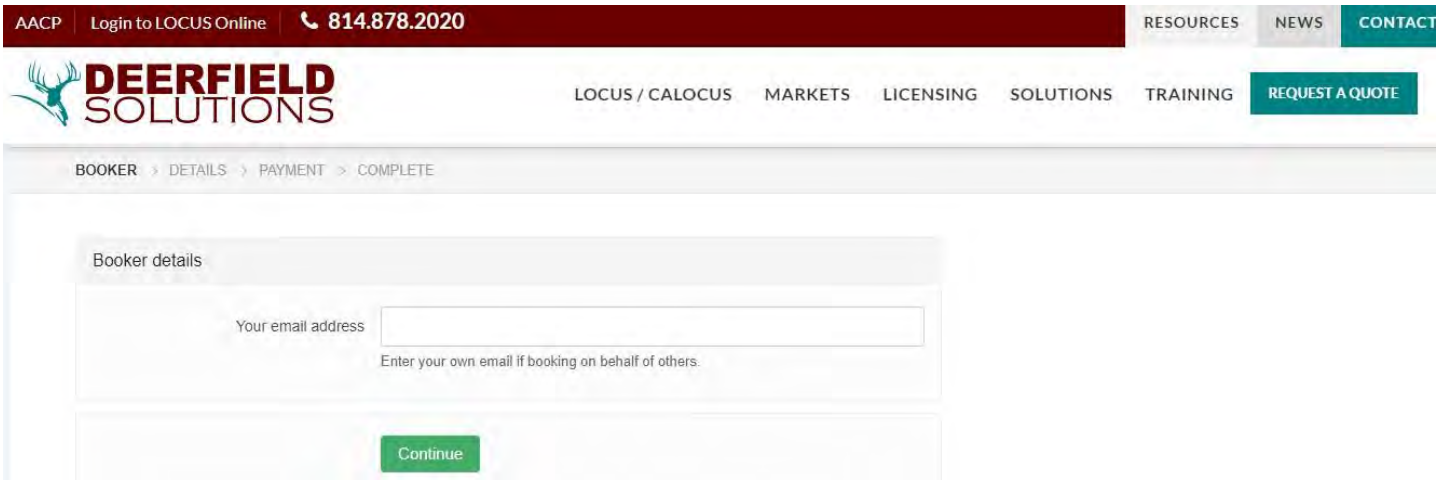


The above will change your selection to “1”.

4. Choose “View Selections” once that is done.4. You should see a screen like the below, enter code: **C00060** then choose the blue *APPLY* button

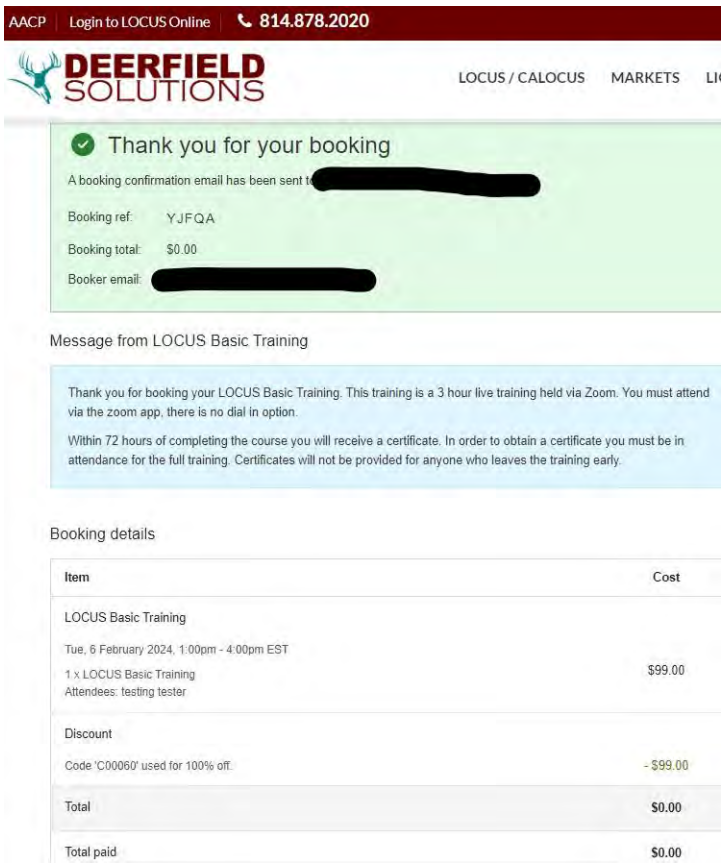



5. You should see a change to $0 fee. Choose the green *Book Now* button

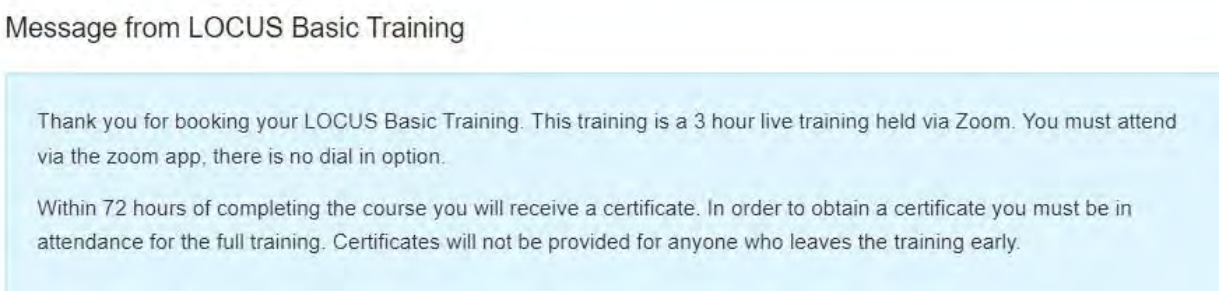



6. Enter your email address (even if booking on behalf of someone, enter your email address.

7. You should receive a confirmation such as the below




8. PLEASE READ the blue box within your confirmation, this is a 3-hour LIVE training held through Zoom.




****BE SURE you test *Zoom app at least 24 hours prior* to ensure the app is loaded (or can be loaded – check with IS department, if necessary, at least 24 hours BEFORE the training starts)**

9. Directions to attend and the Zoom link will be emailed to you – please pay attention to this information and follow all directives.

10. Please email or fax the certificate of completion to the Continuing Education Department:
registrations@sccmha.org or 989-498-4219

**What is LOCUS 201 and how do I complete it?**
LOCUS 201 is an advanced LOCUS course that allows the participants to go more in-depth into areas of challenge when it comes to scoring the LOCUS instrument. This training is offered internally through SCCMHA. This course provides multiple examples of challenging scenarios and provides opportunities to learn how to score them as part of the learning process. This course builds upon the foundational knowledge from online learning through Deerfield and takes it to the next level, with competency measured through a course examination where full vignettes are scored by the learner independently. People who take this course should gain the knowledge to use the LOCUS instrument accurately and reliably.

Look for email announcements of LOCUS 201 availability sent from the training department. With your supervisor's permission, contact registrations@sccmha.org to sign up. The Deerfield training must be completed prior to completing the LOCUS 201 training. *However, if you took a LOCUS training before the Deerfield training was available, you are encouraged to take LOCUS 201 as a refresher. You are not required to also take the Deerfield training, unless otherwise instructed by your supervisor.*

**How do I complete annual LOCUS training?**
These are external training opportunities offered quarterly through CMHAM. You can find these opportunities at the Community Mental Health Association website: Conferences & Training • CMHAM - Community Mental Health Association of Michigan. The CMHAM training resource link is posted on the Continuing Education tab > Training Resources section of the SCCMHA intranet for quick access.
With your supervisor's permission, for outside of SCCMHA trainings, use the Conference Training Request Form and contact registrations@sccmha.org to register. You may also go to the Community Mental Health Association website and check their offerings directly: Conferences & Training • CMHAM - Community Mental Health Association of Michigan, and then follow the steps listed previously to register. Network providers: please follow your external training procedures.

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:<br>Organizational Research</td><td>Chapter: 05 -<br>Organizational Management</td><td>Subject No: 05.04.05</td></tr>
<tr><td rowspan="2">Effective Date:<br>July 1, 2018</td><td>Date of Review/Revision:<br>9/10/19, 6/7/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer & Chief Quality & Compliance Officer.<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:<br>Research and Evaluation System policy and procedure 06.08.00.00 dated 08.22.08</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
To protect the rights and well-being of human subjects of research conducted by Saginaw County Community Mental Health Authority (SCCMHA) and/or its provider network and to ensure compliance with the Protection of Human Subjects Act, 45 CFR, Part 46 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

This Policy is also intended to assist SCCMHA in its compliance with Mid-State Health Network's policy related to this topic.

**Application:**
This Policy applies to all SCCMHA Staff and Provider Network.

**Policy:**
Prior to initiation of formal research by SCCMHA and/or its provider network SCCMHA will submit Institutional Review Board (IRB) application material for all research involving human subjects that is conducted in programs sponsored by the Michigan Department of Health and Human Services (MDHHS) or in programs that receive funding from or through the State of Michigan. The application and approval material will be submitted to the MDHHS's IRB for review and approval or for acceptance of the review by another IRB. All such research must be approved by a federally assured IRB, but the MDHHS's IRB can only accept the review and approval of another institution's IRB under

a formally approved interdepartmental agreement. The manner of the review will be agreed upon between the MDHHS's IRB Chairperson and the Contractor's IRB Chairperson or Executive Officer(s).

All research and related projects shall be conducted in such a manner as to ensure the rights, benefits, and privileges guaranteed by law.

All research involving SCCMHA consumers must be reviewed and approved by SCCMHA or an SCCMHA Contractor Research Review Committee before involvement of SCCMHA subjects in the project. Externally funded projects involving the use of SCCMHA consumers are to be approved by an SCCMHA Research Review Board. SCCMHA acknowledges that grant application time frames may require submission prior to SCCMHA review; however, approval by the SCCMHA research review board is required prior to acceptance and implementation of the grant award.

The Research Review Board shall include minimally:

1. A senior officer of SCCMHA or its contractors
2. A senior clinician with expertise with the identified population
3. A recipient rights officer
4. A medical director for medically related research

The Research Review Board is responsible for reviewing proposed research projects involving human subjects before submission to the MDHHS's IRB for approval of the research project to ensure that:

1. The rights and welfare of the subjects are protected.
2. Written informed consent is obtained from each subject using appropriate methods.
3. The risks and potential benefits are disclosed to participating subjects; and
4. Review completed (IRB) application material

SCCMHA may request additional expertise when necessary for adequate review by the Research Review Board.

The Quality Governance Council serving as the SCCMHA research review board shall maintain a written record of all research proposals and publication submissions and report at least annually to the SCCMHA CEO.

**Standards:**
None

**Definitions:**
Please see *SCCMHA Policy 08.05.00.01- Compliance Definitions Policy* for the following terms.

- HIPAA
- Human Subject
- IRB

- MSHN
- MDHHS
- Provider Network
- Research Review Board
- Research

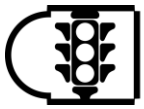
**References:**

- 45 CFR Part 46: Human Subjects Research
- The Medicaid Managed Specialty Supports and Services Concurrent 1915(i)/(c), 1115 Waiver Program(s), the 1115 Healthy Michigan Plan and Substance Use Disorder Community Grant
- Programs Agreement FY 24 contract

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1) Receive and process requests for research project review. | Officer of Recipient Rights and Compliance |
| 2) Quality Governance Council serves as the IRB for review of project requests. | Quality and Medical Records Supervisor |
| 3) All research projects approved by the Quality Governance Council will be submitted to Mid-State Health Network and/or MDHHS for IRB interdepartmental agreement. | Quality and Medical Records Supervisor |
| 4) The Quality Governance Council will monitor project progress, review any request for amendments in protocol and receive final reports. | Quality Governance Council |
| 5) The Primary Investigator (researcher) will obtain permission to publish results from the Quality Governance Council. | Primary Investigator |

<table>
<tr><td colspan="3">Care Management Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Courtesy Authorization Initiation</td><td>Chapter: 09.03- Care Management Services - Department Procedures</td><td>Subject No: 09.03.01.05</td></tr>
<tr><td colspan="3">  Care Management</td></tr>
<tr><td rowspan="2">Effective Date:<br>10/1/09</td><td>Date of Review/Revision:<br>8/12/10, 10/29/09, 5/19/16, 7/19/17, 6/28/18, 10/10/19, 8/1/22, 6/10/24</td><td rowspan="2">Approved By:<br>Chief of Network Business Operations<br><br>Authored By:<br>Director of Utilization Care Authorizations<br><br>Reviewed By:<br>Care Management Specialists</td></tr>
<tr><td>Supersedes:</td></tr>
</table>

**Purpose:**
The purpose of this procedure is to establish the protocol and steps required for initiating a Courtesy Authorization from Care Management. SCCMHA recognizes that the contractual prior authorization requirement for providers can be a barrier to meeting the needs of person served in day to day course of care. This is especially true with a case holder centralized model of prior authorization. SCCMHA desires to help providers in good standing and in good faith meet the needs of person served as they present for care; acknowledging that there are many circumstances in which an authorization might not be in place at that point of service. The purpose of a Courtesy Authorization is to prevent abrupt termination or point of service refusal of essential person served services due to lack of authorization. Our goal is to ensure compliance and manage risk in a business environment that prioritizes consumer care and values provider relations.

**Policy:**
SCCMHA's Care Management Department will eliminate the need for providers to communicate with case holders in unplanned point of service situations and enable them to expedite the authorization procedure for a brief period of time in accordance with Care Management Services guidelines regarding authorizations. The assumption is that the authorization being requested is already in the person served's care plan and that it has expired, or there are insufficient units available or that the service needed is consistent with the care plan but the authorized service codes did not anticipate the exact service. Alternately, a Courtesy Auth might be requested or issued prior to the Person-

Centered Plan for the purpose of access and engagement with new person served. Continuing authorizations will be dependent on the case holder submitting the necessary documentation and continued authorization request.

**Application:**
All SCCMHA Internal & External Network Providers.

**Standards:**
1. Courtesy Authorizations will be issued the ***same day*** as requested.

2. Courtesy Authorization will not exceed ***thirty days forward***, during which time the Case Holder and the Provider shall work together to ensure that the required documents are in place to request a full authorization.

3. A Courtesy Authorization request may be retro-active not more than ***90 days*** in addition to the 30 days forward from date of request.

**Definitions:**
Authorization: Authorization is the approval of services and the process of determining service necessity and the level of care based on scope, amount, and duration. Authorization is typically a computerized function which is closely involved in processing the service provider's claims. The authorization is issued to the service provider with a unique number to which claims are processed.

Case Record Holder: The assigned worker to a particular person served. Includes home based clinician and those employed in internal & external primary teams.

Care Management Services: An integrated system of managing capitated funds for covered services to a defined population including the policies, protocols and tools established by the Authority governing the provision of services to eligible persons.

CMS: Care Management Specialist within the Care Management Department

Days: All reference to Days in this procedure, mean calendar days.

Courtesy Authorization: An authorization issued at the request of a provider to cover a period of time no longer than 120 days, during which a record holder and their supervisor will update the required medical necessity documentation. The courtesy auth is issued to ensure that services are not interrupted. This procedure also allows SCCMHA to hold providers to a billing standard of 90 days from date of service; the absence of a current authorization is no longer an accepted reason for non-timely billing. Appeals submitted due to no authorization will be denied.

Medical Necessity: Describes those services necessary for screening and assessing the presence of a mental illness, and/or required to identify and evaluate a mental illness that is inferred or suspected; and/or intended to treat, ameliorate, diminish or stabilize the

symptoms of mental illness, including impairment of functioning; and/or designed to provide rehabilitation or habilitation for the recipient to attain or maintain an adequate level of functioning. The determination of a medically necessary service must be based upon a person-centered planning process.

Provider: Either internal or external contracted primary and secondary providers are referenced in the use of this term for this policy.

RFA: Request for Authorization

Utilization Management: This dimension of Care Management is the array of strategies employed to ensure the right amount and mix of services. Utilization Management includes: pre-admission screening, pre-authorization, authorization, claims review, concurrent review, and retrospective review.

**References:**

- Care Management Conference Procedure, 09.03.01.06
- Care Management Services Policy, 05.04.01
- NSPP Provider Appeal and Dispute Resolution Policy, 05.07.04

**Exhibits:**
Exhibit A: Courtesy Authorization Q & A
Exhibit B: Bridging Documentation Format

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. The provider is to contact Care Management the same day or next business day via email at Broadcast (Courtesy Auth Request), encrypted email or the Care Management voice mail box (989-797-3500, ext. 3101-do not dial 9 as instructed) or through Sentri messaging to the Care Management Courtesy Authorization requesting a Courtesy Authorization for a 30-calendar day time frame and not more than 90 days retroactive. If this is not completed, no RFA will be approved. In addition, if a provider fails to contact Care Management and continues to provide service for the person served, a sanction will be issued by the Director of Network Services and Public Policy. | 1. Provider, Director of Network Services and Public Policy |

| | |
|---|---|
| 2. After the CMS has received a Courtesy Auth request from a provider, the record holder, their direct supervisor, and the requester will be notified via e-mail that the Courtesy Authorization has begun and the record holder has 30 calendar days to complete the necessary documentation in order for the provider to continue servicing the consumer. The Subject on the e-mail should always be COURTESY AUTHORIZATION, exactly as written. | 2. Care Management Specialist, Provider, Record Holder, Supervisor, |

**Exhibit A**

## Courtesy Authorization FAQ

**Q: Why was the Courtesy Authorization procedure initiated?**

**A:** Many times, services need to be provided without an authorization on short notice for unforeseen circumstances, or due to oversite. This procedure prevents service interruption for the person served, protects the integrity of the authorization process, and preserves provider relations.

**Q: Who can request a Courtesy Authorization?**

**A:** Any provider or representative of the provider such as a billing clerk, the Courtesy Auth is not limited to case holders.

**Q: How often can providers request a Courtesy Authorizations?**

**A:** Providers can request Courtesy Authorizations as many times as necessary.

**Q: If I receive a Courtesy Authorization, isn't that a bad thing? Will I get written up?**

**A:** The fact that a Courtesy Auth was provided is notification to the Case Holder of an unmet need for a consumer, it should be an alert to review the adequacy of the plan and to check on the compliance with required time frames. The supervisor is copied to be sure that they are aware of possible concerns for staff and persons served under their supervision. It is up to your supervisor and the director to determine whether it is an individual performance issue or a procedural issue.

**Q: What will happen if I don't complete the necessary paperwork on time?**

**A:**

- External providers will not be able to bill SCCMHA for their services.
- Internal primary staff that provide a service without an authorization will be unable to sign their SAL, resulting in the service not counting towards productivity expectations and not being able to encounter report that service to the State.

**Q: What if I am a provider performing a service without an authorization?**

**A:** The first step is to contact the Care Management Department ASAP in order to obtain a Courtesy Authorization. You will do that by calling the Care Management voice mail number. To dial directly call 989-797-3500, and then 63101 (do not dial 9 as instructed by the recording), email request to Broadcast (Courtesy Auth Request), or Sentri messaging to Care Management's Courtesy Authorizations. You may also call Customer Service at 989-797-3400 and request to be transferred to the Care Management voice mail box, extension 3101.

**Q: What if I am a provider and the 90 day/30-day Courtesy Authorization has lapsed and I still don't have an approved authorization?**

**A:** Contact the Care Management Department and they will facilitate an authorization before the end of the next business day.

**Q: What is the time frame? How long can I provide the service without an authorization?**

**A:** You can request a Courtesy Authorization for 30 days ahead or 90 days retroactively.

**Q: When is a Courtesy Authorization not appropriate?**

**A:**

- Inpatient hospitalizations

**Q: What about authorizations, including residential budgets that are pending?**

**A:** If you have entered a request for authorization and the Care Management Specialist pended it, it is because something hadn't been completed that needs to be in order to get that approved. It is up to you to get what is needed done in order to get the authorization approved *before* the date of the service; otherwise, a Courtesy Authorization would need to be requested.

**Exhibit B**

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

## *Bridging Documentation Format*

*What is Bridging Documentation?* Bridging documentation is written to close gaps between lapses in services of authorizations, while documenting medical necessity for the continuation of services to be provided.

*When is Bridging Documentation Needed?* Bridging documentation is needed when there is a lapse in authorization for a provided service with no documented explanation in place.

When is a Bridging document excluded? Bridging documentation related to initial ASD Determination for primary payor commercially insured persons served will not be accepted by SCCMHA: primary commercial payor must complete its own ASD assessment/determination and forward to SCCMHA Autism department's assigned care management specialist for coordination of benefits SCCMHA/Medicaid determination as payor of last resort.

*Who is responsible for Bridging Documentation?* The Case Holder's immediate SUPERVISOR is responsible for completing the Bridging Documentation.

*How is the procedure completed?*

Step 1: Supervisor *MUST* complete the bridging document in the form of a chart note in Sentri.

Step 2: Chart Note must be labeled "Bridging Documentation".

Step 3: Chart Note includes the following information

a) Date of coverage for retro authorization
b) Reason for delay
c) Continuous medical necessity as evidence by; RN, Psychiatry, peer ETC… (Why are services needed?)
d) Continuous provision of services…e.g. did CSM keep monthly contact? If Not why?
e) What is the plan of correction if any needed?

Effective 02/08/2010
Date Revised 6/10/24

| Clinical Services Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Case Transfer | **Chapter**: 09.06.00 - Clinical Services | **Subject No**: 09.06.00.13 |
| **Clinical Services** | | |
| **Effective Date**:<br>1/1/2015 | **Date of Review/Revision**:<br>1/1/15, 5/2/16, 3/17/17, 3/1/18, 3/21/19, 2/10/20, 3/17/21, 10/24/22, 5/10/24<br>**Supersedes**: | **Approved By**:<br>Kristie Wolbert, Executive Director of Clinical Services<br><br>**Authored By:**<br>Executive Director of Clinical Services<br><br>**Reviewed By**:<br>Clinical Directors, Director of NSPP & CE |

**Purpose:**
To assure continuity of care when a case is transferred from one staff to another and to set standards to assure that all the informational and document requirements for the transferring and receiving of cases are completed.

**Application:**
All SCCMHA contracted and board operated clinical staff

**Policy:**
It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) that the transfer of persons receiving services cases from one case holder to another shall occur in a manner that is trauma informed and results in minimal distress for the person.

**Standards:**
The transfer of cases between units or providers is through Care Management.

The transfer of cases between staff within a unit or provider will be done through the Supervisor.

When a transfer of a case occurs, the primary concern is the impact of the transfer on the person receiving services, with the person receiving services well-being of utmost priority.

The transfer of cases will be done in a trauma-informed manner with the goal of causing minimal distress for the person receiving services.

The transfer of cases will be done in a professional, collaborative, and cooperative manner by all staff involved.

When a case is being transferred between units or providers, the transfer will include a discussion between the supervisors of those teams. The supervisor transferring the case will initiate the transfer by completing a "Level of Care Change" form and submitting it to the teams assigned Care Management Specialist.

A person receiving services will continually be assigned a staff to contact during the transfer process.

It is the responsibility of the transferring staff to have all necessary information and documents current and complete prior to the transfer, and when feasible, to communicate with the receiving staff any additional pertinent information regarding the case. This includes the minimum quality data set and ability to pay assessment. Please see Member Enrollment, Transfer/Discharge, Quality Data and Case Service Status policy number 05.04.02.

In situations where a staff member leaves an organization, the supervisor will work to update any missing documentation prior to transferring to another organization.

It is the responsibility of the receiving staff person to review the case and understand the care that has been provided to the person as soon as possible. The review should include the following:

1) Current psychosocial assessment.
2) Current therapy assessment if applicable.
3) Current individual plan of service (IPOS)
4) Assure all releases of information and consents are in the Sentri electronic health record.
5) Last several months of progress notes and chart notes.
6) Last three medication reviews if applicable.
7) Assure any follow up has occurred as noted in any of the above documents.

Once the case has been transferred it is important to meet with the person receiving services and review the IPOS and get to know the person within 10 days of the transfer. This is important to build a rapport with the person as well as to understand the strengths and needs of the person receiving services.

When a person receiving services is transferring to a higher level of care, the case holder is required to complete a new psychosocial assessment, and IPOS. These circumstances could include the following:

1) From case management to Assertive Community Treatment or ACT services.
2) From a home setting to a general Adult Foster Care (AFC) setting.

3) From a general AFC setting to a specialized AFC setting.

When a person receiving services moves to a lower level of care, the case holder is required to complete a new psychosocial assessment and IPOS that reflects the needs and desires of the person receiving services. A few examples of when this might occur are:

1) Person receiving services moves from AFC to their own apartment or in with family.
2) Person moves from ACT to case management.
3) Person moves from Specialized AFC to general AFC.
4) Person moves from case management to outpatient therapy.
5) Person moves from Wraparound to case management.

**Definitions:**

Case Transfer: The transfer of person receiving care from one case holder to another.

Case Holder: This is a term that refers to the primary record holder or the person assigned to the care of the case in Sentri. This can be a case manager, supports coordinator, or therapist - whoever is assigned as the primary staff person to oversee the person receiving services care and coordination.

Supervisor: This is a term that refers to the Supervisor or the person that oversees the Case Holder.

Initial Assessment: the assessment located in sentri used to determine eligibility and probable services that a new person receiving services will require.

Annual Psychosocial Assessment: the assessment located in sentri based off the Initial Assessment and used as part of the process for developing the Individual Plan of Service as part of the Person-Centered Planning.

Therapy Assessment: the assessment located in sentri used as part of the determination of the course of treatment for a person served receiving individual or group therapy.

Transferring Case Holder: The team where the Case Holder for the person receiving services is handing over the person receiving services care and coordination to another Case Holder.

Receiving Case Holder: The team where the Case Holder will take over monitoring and care and coordination for the person receiving services.

Same Level of Service Transfer: Refers to the circumstance where a person receiving services is moving from a Case Holder by one team of providers to another team of providers with out the need for increased or decreased level of care. *Examples are Community Support Services to Community Support Services, Community Support Services to TTI case management, TTI case management to Saginaw Psychological Services Inc., Support Coordination Services to Disability Network.*

Different Level of Service Transfer: Refers to the circumstance where a person receiving services is moving from one level of service to another level of service. *Examples are Family Services Unit Home Based to Family Services Unit Case Management, Community Support Services to Assertive Community Treatment, Family Services Unit to Community Support Services, Family Services Unit to Wraparound Services, Wraparound Services to Westlund or Family Services Unit, Family Services Unit to Autism, Family Services Unit to Westlund, Caro Regional Center or Forensic Center to Community Residential Treatment.*

General Adult Foster Care (AFC)- is typically a home licensed by the state of Michigan as an adult foster care home to provide shelter, three meals a day, and assure medications are given to persons receiving services. The homes may have people referred from the Department of Health and Human Services or from SCCMHA and network providers.

Specialized Residential Adult Foster Care (AFC)- is typically a home licensed by the state of Michigan as an adult foster care home to provide shelter, three meals a day, and assure medications are given to persons receiving services. These homes also have a certification by the State of Michigan to provide specialized care and have a contract with a Community Mental Health Specialty Program (CMHSP). This specialized contract pays for the additional staffing required to provide the extra care that is required for the people receiving services. These AFC homes must abide by HCBS rules in order to pay the providers. These homes are required to have 24-hour awake staff and at least two staff on shift unless otherwise noted in the contract with the CMHSP. Please refer to SCCMHA Policy on Residential Services 03.02.07 and related policies 03.02.07.01-03.02.07.11 for more information about requirements.

**References:**
SCCMHA Policy on Transition/Discharge Services 03.02.13
SCCMHA Procedure on Care Management Procedure on Continuing Stay Reviews 09.03.01.04
SCCMHA Policy on Member Enrollment, Transfer/Discharge, Quality Data and Case Service Status 05.04.02
SCCMHA Policy on Residential Services 03.02.07

**Exhibits:**
Exhibit A - Intake Process
Exhibit B - Intake Steps Chart
Exhibit C - Case Transfer Checklist
Exhibit D - Care Management Specialist Disposition form
Exhibit E - SCCMHA Care Management Continuing Stay Review/Level of Care Review
Exhibit F – Level of Care Change Form – Adult Version
Exhibit G– Level of Care Change Form – Child Version

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|

| | |
|---|---|
| **Case transfer from Central Access and Intake (CAI):** | |
| a. Will complete Intake Assessment to determine Eligibility for SCCMHA services. | CAI Specialist |
| b. Will complete checklist of forms and have them scanned into Sentri. | CAI Specialist |
| c. Will assign to a team in Sentri for orientation. | Care Management Specialist |
| d. Will review *Case Transfer Checklist attached*, to make sure all documents are in the person receiving services file. | Receiving Case Holder |
| e. Care management Specialist will provide authorization for orientation. | Care Management Specialist |
| f. Will schedule orientation in Case Holder Supervisor; Sentri scheduler. | CAI Specialist |
| g. Will give proper status in Sentri scheduler of orientation appointment met. | Receiving Case Holder<br>Supervisor/designated staff |
| h. Will transfer case to Case Holder within five (5) working days. | Receiving Case Holder Supervisor |
| i. Will schedule face to face meeting with person receiving services within five (5) working days of assignment. | Receiving Case Holder |
| j. Will complete an Annual Psychosocial Assessment) of strengths and needs and record in Sentri within 45 days. This assessment should also include the necessity for any additional services identified within the 45 days' timeframe. *If person receiving services is also receiving therapy from the record holder then a Therapy Assessment is needed in addition to the updated psychosocial assessment.* | Receiving Case Holder |
| k. Initiates Person-Centered Planning process including completing a Pre-Plan to set the planning meeting with person receiving services and/or family. | Receiving Case Holder |

| | |
|---|---|
| l. Will obtain any items missing at first visit with person receiving services/family. *See Case Transfer Checklist attached*. | Receiving Case Holder |
| m. The receiving Case Holder will add any needed authorization for assessments of needed services and supports. | Receiving Case Holder |
| **Case Transfer with Same Level of Service:** | |
| ***Transferring*** Case Holder: | |
| a. Will discuss with person receiving services the need for the person to be transferred to new Case Holder and document in the person receiving services electronic medical record (Sentri). | Transferring Case Holder |
| b. Will assure all mandatory documents are in the person receiving services file. *See Case Transfer Checklist attached.* | Transferring Case Holder/Supervisor |
| c. Will complete update psychosocial assessment and update person receiving services /family plan if plan and psychosocial assessment does not contain current information about the person receiving services /family or/is 326 days old or older. | Transferring Case Holder/Supervisor |
| *d.* Completes the Care Management continuing stay or level of care form to request transfer. *Refer to Continuing Stay procedure 09.03.01.04.* | Transferring Case Holder |
| e. Review request and documents in sentri the disposition of review. | Care Management Specialist |
| f. Assures all mandatory documents are in the person receiving services file. *See Case Transfer Checklist attached.* | Transferring Case Holder |
| *g.* Discusses with receiving team supervisor the need to transfer the person receiving services to a new | Transferring Case Holder<br>Supervisor |

| | |
|---|---|
| team. | |
| *h.* Notifies both receiving and transferring Case Holder and both Supervisors of the decision via Care Management disposition form. *Refer to Continuing Stay procedure 09.03.01.04.* | Care Management Specialist |
| i. Care Management Specialist sets the time and day of orientation in the supervisor Sentri scheduler and enters authorization for orientation. Notifies transferring supervisor of orientation appointment. | Care Management Specialist |
| j. Transferring Case Holder notifies person receiving services of orientation for new case manager. ***Please note: Transferring Case Holder maintains case until orientation appointment has been met.*** | Transferring Case Holder |
| k. Will give proper status in sentri scheduler of orientation appointment met. | Receiving Case Holder Supervisor |
| l. Transfers the person receiving services case in Sentri to appropriate team and Case Holder once orientation appointment has been met and notifies the transferring team and Case Holder of transfer. | Care Management Specialist |
| m. Will transfer case to Case Holder within five (5) working days. | Receiving Case Holder Supervisor |
| n. Will assure receiving Case Holder is aware of any upcoming appointments or other relevant information needed by receiving case holder. | Transferring Case Holder |
| o. Reviews consumer information including those items noted in policy section of this document. Will assure the assessment and plan, are not older than 326 days prior to official transfer of case in Sentri. | Care Management Specialist |
| p. Will make sure all progress notes are up to date from transferring case | Transferring Case Holder, |

| | |
|---|---|
| manager. | |
| q. Will make sure appropriate authorization(s) is/are in place for receiving Case Holder for residential, CLS, Respite, MiAIMS/Adult Community Placement, Occupational Therapy, Physical Therapy, Speech Therapy, Psychologist, Psychiatrist, Supported Employment, Clubhouse, Drop-In Center, Medication Drop, etc. services. | Transferring Case Holder Supervisor and Care Management Specialist |
| r. Will notify Case Holder Supervisor of Case Holder receiving the person receiving services case. | Transferring Case Holder Care Management Specialist |
| ***Receiving Case Holder:*** | |
| a. Completes the orientation, gives proper status of orientation in sentri scheduler, and notifies care management specialist of met orientation appointment. | Receiving Case Holder Supervisor |
| b. Assigns Case Holder within five (5) working days of the receipt of notice of transfer. | Receiving Case Holder Supervisor |
| c. Will assure all mandatory documents are in person receiving services file. Including health care coordination notifying primary care physician of change in service and new case holder. *See Case Transfer Checklist attached.* | Receiving Case Holder |
| d. Will meet with person receiving services within ten (10) working days of assignment. | Receiving Case Holder |
| e. Will obtain new notice of privacy practices if needed (different agency from transferring case holder). | Receiving Case Holder |
| f. Will review psychosocial assessment and person receiving services/family plan. | Receiving Case Holder |
| g. Will review plan with person receiving services/family to assure plan is relevant and still what | Receiving Case Holder |

| | |
|---|---|
| person receiving services wants in the plan. | |
| h. Will assure that goals and objectives noted in plan are still relevant for the person receiving services/family. If not, new psychosocial assessment and plan should be developed. | Receiving Case Holder |
| i. Will submit authorization request for any additional services or supports noted during contacts. | Receiving Case Holder |
| **Case Transfer to Different Level of Service:** | |
| ***Transferring*** Case Holder: | |
| a. Will discuss with person receiving services the transfer of the care and coordination to a new Case Holder and document in person receiving services chart (sentri). | Transferring Case Holder |
| b. Will assure all mandatory documents are in the person receiving services file (sentri). *See Case Transfer Checklist attached.* | Transferring Case Holder |
| c. Will complete SCCMHA Care Management Continuing Stay Review/Level of Care Review form (*see attached*) | Transferring Case Holder |
| d. Will complete updated psychosocial assessment and update plan if plan and psychosocial assessment do not contain current information about the person receiving services/family or are 326 days old or older. | Transferring Case Holder |
| e. Discusses with receiving team supervisor the need to transfer the person receiving services to a new team. | Transferring Case Holder Supervisor |
| f. Will complete and adequate notice for appeal. | Transferring Case Holder |
| g. Will assure all progress notes are up to date. | Transferring Case Holder |
| h. Will assure all authorizations and consents are in place prior to | Transferring Case Holder |

| | |
|---|---|
| transfer. Assure authorizations will not expire in the next 15 days. | |
| i. Assures all mandatory documents are in the person receiving services file. *See Case Transfer Checklist attached.* | Transferring Case Holder Supervisor |
| j. Discusses with receiving team supervisor the need to transfer the person receiving services to a new team. | Care Management Specialist |
| k. Notifies both receiving and transferring Case Holder of the decision via Care Management disposition form. *Refer to Continuing Stay procedure 09.03.01.04.* | Care Management Specialist |
| l. Care Management Specialist sets the time and day of orientation in the supervisor sentri scheduler and enters authorization for orientation. Notifies transferring team of orientation appointment. | Care Management Specialist |
| m. Transferring Case Holder notifies person receiving services of orientation for new case manager. ***Please note: Transferring Case Holder maintains case until orientation appointment has been met.*** | Transferring Case Holder |
| n. Receiving Case Holder Supervisor will give proper status in sentri scheduler of orientation appointment met. | Receiving Case Holder Supervisor |
| o. Transfers the person receiving services case in sentri to appropriate team and Case Holder once orientation appointment has been met and notifies the transferring team and Case Holder of transfer. | Care Management Specialist |
| p. Will transfer case to Case Holder within five (5) working days. | Receiving Case Holder Supervisor |
| q. Will assure receiving Case Holder is aware of any upcoming appointments or other relevant information needed by receiving case holder. | Transferring Case Holder |

| | |
|---|---|
| r. Care Management Specialist will assure the assessment and plan, are not older than 326 days prior to official transfer of case in sentri. | Care Management Specialist |
| s. Will make sure all progress notes are up to date from transferring case holder. | Transferring Case Holder and Transferring Case Holder Supervisor |
| t. Will make sure appropriate authorization(s) is/are in place for receiving Case Holder for residential, CLS, Respite, Model Payments (ASAP), Occupational Therapy, Physical Therapy, Speech Therapy, Psychologist, Psychiatrist, Supported Employment, Clubhouse, Drop-In Center, Medication Drop, etc. services. | Transferring Case Holder |
| u. Will notify receiving Case Holder Supervisor of Case Holder receiving the person receiving services case. | Care Management Specialist |
| ***Receiving Case Holder:*** | |
| a. Completes the orientation and notifies care management specialist of met orientation appointment. | Receiving Case Holder Supervisor |
| b. Assigns Case Holder within five (5) working days of the receipt of notice of transfer. | Receiving Case Holder Supervisor |
| c. Make sure all mandatory information is in the person receiving services chart in sentri. *See Case Transfer Checklist attached.* | Receiving Case Holder |
| d. Will meet with person receiving services within ten (10) working days of assignment. | Receiving Case Holder |
| e. Will obtain any new releases of information including health care coordination notifying primary care physician of change in service and new case holder. | Receiving Case Holder |
| f. Will obtain new notices of privacy notices (if different agency from transferring case holder.) | Receiving Case Holder |
| g. Will have a 30-day authorization to | Care Management Specialist & |

| | | |
|---|---|---|
| | complete new assessment and plan as level of care has changed. If Case Holder has need of additional time to complete, please document reason for delay in person receiving services electronic medical record and have Supervisor complete Bridging Document, then contact Care Management Specialist to discuss the circumstances. *If person receiving services is also receiving therapy from the record holder, then a Therapy Assessment is needed in addition to the updated assessment.* | Receiving Case Holder |
| h. | Will request authorization for services and supports needed as part of new person receiving services plan. | Receiving Case Holder |
| i. | Will complete an adequate notice for appeal. | Receiving Case Holder |
| j. | Will give/send copy of updated plan to person receiving services/family. | Receiving Case Holder |
| k. | Will note date plan given/sent to person receiving services/family in sentri. | Receiving Case Holder |
| l. | Will monitor services and supports noted in the plan including additional services such as residential, CLS, Respite, MiAIMS for Adult Community Placement payments, Occupational Therapy, Physical Therapy, Speech Therapy, Psychologist, Psychiatrist, etc. | Receiving Case Holder/Supervisor |
| m. | Will make changes to person receiving services plan as necessary. | Receiving Case Holder |

Exhibit A

**INTAKE PROCESS**

| **Step** (in order) | **Staff** | **Time Standard** | **Actions/Description/Note** |
|---|---|---|---|
| Access Screening Contact /Intake Eligibility | CAI Intake Specialist | Point of service | • Potential Consumer calls/walks in for assistance<br>  ○ Coordinates with CIS for Access Call Back<br>• Creates Eligibility Screening (signs using code H0002)<br>• Determines if meets intake eligibility<br>  ○ If no, do linking<br>  ○ If yes:<br>• Creates Admission with CAI as Team<br>• Makes Intake Appointment<br>• Determines any proof document needs and requests consumer to bring to Appointment<br>  ○ MI Consumer requests code H0031<br>  ○ DD Consumer requests code 90887<br>• Letter sent, to Consumer Re: expectations<br>• Documents actions on Progress Note |
| Intake Appointment | CAI Intake Specialist | 2 days from Access Screening Contact /Intake Eligibility | • Places name as "Case Holder" on Admission form<br>• Creates Initial Intake assessment (date is start for Timeliness Standards)<br>  ○ Marks Eligibility field as "Pending"<br>  ○ Does not sign document<br>• Obtains any needed proof documents<br>  ○ Documents delays daily on Progress Note<br>• Completes items on the Initial Orientation form<br>• Sends notification to Care Management for Eligibility Determination<br>• Documents action in a Progress Note (non-billable) |
| Eligibility Determination | Care Management Specialist | 1 day from Notification | • Coordinates with CAI Intake Specialist to make a determination for Eligibility and Medical Necessity<br>• Notifies CAI worker of eligibility determination<br>  ○ If ineligible, notifies CAI worker to do linking<br>  ▪ Sends Adequate Notice<br>  ○ If eligible, notifies CAI regarding the Team<br>  ○ Changes Team name on Admission from CAI to assigned Team<br>• Documents actions on Progress Note (non-billable)<br>• Creates Authorization for initial services (T1016/T1017) |
| Completion of Initial Intake Assessment | CAI Intake Specialist | 1 day from Notification | • Completes Preliminary Plan fields on Initial Intake<br>• Coordinates with Consumer and Team Supervisor's Sentri Calendar to set Orientation appointment date<br>  ○ Email notification to Team Supervisor<br>• Adds to Intake Assessment, Orientation appointment (14 days from Intake Assessment)<br>  ○ Documents reason of deviation from 14 days on both Progress Note and Intake Assessment<br>• Signs Initial Intake with Code H0031<br>• Documents actions on Progress Note (non-billable) |
| Orientation Appointment | Team Supervisor or designee | 5 days from Completion of Initial Intake Assessment | • Documents on Scheduler and on Progress Note any changes in appointment date<br>• Meets consumer<br>• Completes items on the Team Orientation Form<br>• Introduces new Case Holder<br>• Changes Admission Form Case Manager field to assigned Case Holder<br>  ○ Sets meeting date for Pre-plan or initiates Pre-plan<br>• Documents actions on Face/Face Progress Note using code T1016/T1017<br>• Request Authorization for services based on the Preliminary Plan to expire 60 days from Orientation Appointment<br>  ○ Requests Authorization for additional needed services (not indicated in the Preliminary Plan)<br>  ○ Documents in a Progress Note |
| Pre-planning | Assigned Case Holder | 5 days from Orientation Appointment | • Meets with consumer<br>• Does Annual Assessment update from Intake Assessment<br>• Starts Pre-planning<br>• Documents in Face/Face Progress Note using apropos code |

Exhibit B

## INTAKE STEPS CHART

| Deadline | **Point of service** → | **2 days** → | **1 day** → | **1 day** → | **5 days** |
|---|---|---|---|---|---|
| Step | Access Screening Contact /Intake Eligibility | Intake Appointment | Eligibility Determination | Completion of Initial Intake Assessment | Orientation Appointment |
| Who | CAI Intake Specialist | CAI Intake Specialist | Care Management Specialist | CAI Intake Specialist | Team Supervisor or designee |
| Does What | • Takes potential Consumer calls/walk ins for assistance<br>  ○ Coordinates with CIS for Access Call Back<br>• Determines if meets intake eligibility<br>  ○ If no, completes linking<br>  ○ If yes<br>• Creates Admission with CAI as Team<br>• Schedules Intake Appointment<br>• Determines any proof document needs and requests consumer to bring to Appointment<br>  ○ CM generates code H0031<br>• Letter sent, to Consumer Re: expectations<br>• Documents actions in Chart Note | • Places name as "Case Manager" on Admission form<br>• Creates Initial Intake assessment (date is start for Timeliness Standards)<br>  ○ Marks Eligibility field as "Pending"<br>  ○ Does not sign document<br>• Obtains any needed proof documents<br>  ○ Documents delays daily in chart Note<br>• Completes items on the Initial Orientation form<br>  ○ DD Consumers may need a second appointment made to discuss/review findings.<br>• Sends notification to Care Management for Eligibility Determination<br>• Documents actions in chart note | • Coordinates with CAI Intake Specialist to make a determination for Eligibility and Medical Necessity<br>• Notifies CAI worker of eligibility determination<br>  ○ If ineligible, notifies CAI worker to do linking<br>  ▪ Sends Adequate Notice<br>  ○ If eligible, notifies CAI regarding the Team<br>  ○ Changes Team name on Admission from CAI to assigned Team<br>• CM generates code S9445 if eligible for service<br>• Documents actions on Progress Note<br>• Creates Authorization for initial services (T1017 or T1016) | • Completes Preliminary Plan fields on Initial Intake<br>• Coordinates with Consumer and Team Supervisor's Sentri Calendar to set Orientation appointment date<br>  ○ Email notification to Team Supervisor<br>• Adds to Intake Assessment, Orientation appointment (14 days from Intake Assessment)<br>  ○ Documents reason of deviation from 14 days on both Chart Note and Intake Assessment<br>• Signs Initial Intake with Code H0031<br>• Documents actions in Chart Note<br>• | • Documents on Scheduler and on Progress Note any changes in appointment date<br>• Meets consumer<br>• Completes items on the Team Orientation Form<br>• Introduces new Case Worker<br>• Changes Admission Form Case Manager field to assigned Case Worker<br>  ○ Sets meeting date for Pre-plan or initiates Pre-plan<br>• Documents actions on Face/Face Progress Note using code T1016/1017<br>• Request Authorization for services based on the Preliminary Plan to expire 60 days from Orientation Appointment<br>  ○ Requests Authorization for additional needed services (not indicated in the Preliminary Plan)<br>• Documents actions on Progress Note |
| Forms Screen | Eligibility Screening<br>Admission<br>Sentri Scheduler<br>Chart Note | Admission Form<br>Initial Intake<br>Initial Orientation Form<br>Email<br>Chart Note | Admission Form<br>Adequate Notice<br>Email<br>Progress Note | Initial Intake<br>Sentri Scheduler<br>Email<br>Authorization<br>Chart Note | Sentri Scheduler<br>Admission<br>Progress Note<br>Team Orientation Form<br>Progress Note |
| **Tracking** | **Chart Note** | **Initial Intake**<br>**Chart Note** | **Progress Note** | **Initial Intake**<br>**Chart Note** | **Progress Note** |

03-27-12 revised 11-26-13; KW 5-2-16

Exhibit C

# Case Transfer Checklist

**From Central Access and Intake (CAI):**

*Case Manager to do the following:*

☐ What Authorizations are in place?

☐ Proof of Notice of Privacy for your agency (i.e. SCCMHA, TTI, Westlund, Disability Network, Saginaw Psychological, Case Management of Michigan) in the file?

☐ Consent to Treatment form signed?

☐ Consumer notified of recipient rights and given brochure?

☐ Does person need to sign the Consent for Substance Abuse and receive the recipient rights booklet for Substance abuse treatment (any person receiving COD, IDDT, or Co-occurring Services)?

☐ Ability to Pay information is current in Sentri?

☐ Release of information to consumer primary care physician?

☐ Release of information for others as applicable: Payee, family other than guardian, other doctors or specialists, school, DHHS, Social Security Administration, etc.

☐ Health Care coordination notice sent to primary care physician noting services to be provided to consumer, notice of the primary record holder, psychiatrist if one is assigned, and any medications that are prescribed by psychiatrist.

☐ Assure all demographic fields are completed.

- Primary care physician (should match releases of information to primary care and should match health care coordination notice).
- Residential Living Arrangement
- Consumer people are filled in including guardian, payee, and other emergency contacts.
- Health Conditions are accurate

☐ If guardian involved a copy of guardianship papers are in the consumer file?

☐ Complete consumer psychosocial assessment of strengths and needs to determine services and reason for continuing treatment/services.

☐ Complete pre planning meeting and enter into Sentri.

☐ Complete planning meeting and enter into Sentri.

☐ Plan should address scope of services for all internal services, community resources, and any assistance the natural supports will give to assist the consumer.

☐ Make sure consumer receives or has copy of the following and these are explained to the consumer/family:

- Recipient Rights Booklet
- Recipient Rights Booklet for Substance Abuse *if* receiving services for Substance Use as well as Mental Health Services (any person receiving COD, IDDT, or Co-occurring Services)
- Copy of Independent Facilitation Brochure
- Copy of Appeals and Grievance Brochure

☐ Obtain signature on the consumer plan after development. Be sure appropriate boxes are checked on the form including consent to treatment.

☐ Send copy of signed signature page to Medical Records, or other staff that scan information into consumer electronic medical record; to scan into consumer electronic medical record.

☐ Enter date plan given/sent to consumer.

☐ All outstanding documentation will be completed prior to transfer, including Progress Notes, Case Notes, and scanned documents

# Case Transfer Checklist

☐ If psychiatrist prescribes medications make sure consumer has signed medication consent for each medication and this is scanned into Sentri.
☐ Make sure if medications are initiated by the psychiatrist or changed, a new health care coordination notice is sent to the consumer primary care physician.

**Same Level of Service:**
*Case Manager to check the following:*

☐ Notify consumer/family of new primary case holder and new primary case holder contact information including supervisor name and contact information if unable to contact case worker.
☐ What Authorizations are in place?
☐ Make sure consumer receives copy of your agency (i.e. SCCMHA, TTI, Westlund, Disability Network, Saginaw Psychological, Case Management of Michigan, SVRC, New Hope) privacy practices. Notice of Privacy Practices.
☐ Does person need to sign the Consent for Substance Abuse and receive the recipient rights booklet for Substance abuse treatment? (any person receiving COD, IDDT, or Co-occurring Treatment)
☐ Ability to Pay information is current in Sentri?
☐ Release of information to consumer primary care physician?
☐ Release of information for others as applicable: Payee, family other than guardian, other doctors or specialists, school, DHHS, Social Security Administration, etc.
☐ Health Care coordination notice sent to primary care physician noting services to be provided to consumer and notice of the primary record holder, psychiatrist if one is assigned, and any medications that are prescribed by psychiatrist.
☐ Assure all demographic fields are completed.

- Primary care physician (should match releases of information to primary care and should match health care coordination notice.
- Health Care Conditions are correct and have not changed
- Residential Living Arrangement
- Consumer people are filled in including guardian, payee, and other emergency contacts.
- Correct team and primary case holder identified in the consumer chart?

☐ If guardian involved a copy of guardianship papers are in the consumer file?
☐ Date of next appointments such as with psychiatrist?
☐ Review consumer assessment of strengths and needs update if needed.
☐ Does consumer/family have current plan? If not develop.
☐ Is there a signature of the consumer/family on the consumer plan?
☐ Review plan with consumer/family to assure plan is reflective of consumer/family wants and needs.
☐ Develop new plan if goals/outcomes are different than the plan states.
☐ Make sure consumer receives copy of the following if they would like a new copy and these are explained to the consumer/family:

- Recipient Rights Booklet

- Recipient Rights Booklet for Substance Abuse *if* receiving services for Substance Use as well as Mental Health Services (any person receiving COD, IDDT, or Co-occurring Treatment)
- Copy of Independent Facilitation Brochure
- Copy of Appeals and Grievance Brochure

☐ Obtain signature on the consumer plan after development. Be sure appropriate boxes are checked on the form including consent to treatment.
☐ Send copy of signed signature page to Medical Records, or other staff that scan information into consumer electronic medical record, to scan into consumer electronic medical record.
☐ Enter date plan given/sent to consumer into sentri
☐ All outstanding documentation will be completed prior to transfer, including Progress Notes, Case Notes, and scanned documents
☐ If psychiatrist prescribes medications make sure consumer has signed medication consent for each medication and this is scanned into Sentri.
☐ Make sure if medications are initiated by the psychiatrist or changed, a new health care coordination notice is sent to the consumer primary care physician.

**Different Level of Service Transfer:**
*Case Manager to check the following:*

☐ Discuss with consumer/family the need to transfer to different level of service and why.
☐ What Authorizations are in place?
☐ Make sure consumer receives copy of your agency (i.e. SCCMHA, TTI, Westlund, Disability Network, Saginaw Psychological, Case Management of Michigan, SVRC, New Hope) privacy practices. Notice of Privacy Practices.
☐ Does person need to sign the Consent for Substance Abuse and receive the recipient rights booklet for Substance abuse treatment? (anyone receiving COD, IDDT, or Co-occurring services)
☐ Ability to Pay information is current in Sentri?
☐ Release of information to consumer primary care physician?
☐ Release of information for others as applicable: Payee, family other than guardian, other doctors or specialists, school, DHHS, Social Security Administration, etc.
☐ Health Care coordination notice sent to primary care physician noting services to be provided to consumer and notice of the primary record holder, psychiatrist if one is assigned, and any medications that are prescribed by psychiatrist.
☐ Assure all demographic fields are completed.

- Primary care physician (should match releases of information to primary care and should match health care coordination notice).
- Health Care Conditions are current and reflect consumer current conditions
- Residential Living Arrangement
- Consumer people are filled in including guardian, payee, and other emergency contacts.
- Correct team and primary case holder identified in the consumer chart in sentri?

☐ If guardian involved a copy of guardianship papers are in the consumer file in sentri?
☐ Date of next appointments such as with psychiatrist?

# Case Transfer Checklist

☐ Complete new consumer psychosocial assessment as needs are probably different if consumer is changing level of service.
☐ Complete new plan of service to reflect the needed changes in services by consumer/family.
☐ Plan should address scope of services for all internal services, community resources, and any assistance the natural supports will give to assist the consumer.
☐ Make sure consumer receives copy of the following and these are explained to the consumer/family:

- Recipient Rights Booklet
- Recipient Rights Booklet for Substance Abuse if receiving services for Substance Use as well as Mental Health Services (anyone receiving COD, IDDT, and Co-occurring services)
- Copy of Independent Facilitation Brochure
- Copy of Appeals and Grievance Brochure

☐ Obtain signature on the consumer plan after development.
☐ Send copy of signed signature page to Medical Records, or other staff that scan information into consumer electronic medical record; to scan into consumer electronic medical record (sentri).
☐ Update Sentri with date plan was sent to consumer/guardian.
☐ Provide services and at the frequency noted in the plan and assure team members via monitoring are completing services at the frequency noted in the plan.
☐ Update goals as needed.
☐ All outstanding documentation will be completed prior to transfer, including Progress Notes, Case Notes, and scanned documents
☐ If psychiatrist prescribes medications make sure consumer has signed medication consent for each medication and this is scanned into Sentri.
☐ Make sure if medications are initiated by the psychiatrist or changed, a new health care coordination notice is sent to the consumer primary care physician.

**FOR ALL TYPES OF TRANSFERS**
☐ All outstanding documentation will be completed prior to transfer, including Progress Notes, Case Notes, and scanned documents

Exhibit D

**Care Management**

## Care Management Specialist Disposition

**Consumers Name:** **Case Managers Name:**

**Consumers Sentri ID:** **Supervisors Name:**

**Medical Necessity (please check one):**

☐ Medical Necessity Criteria Met
Comments:

| Diagnosis | |
|---|---|
| | |

Medications:
Utilizations history

☐ Medical Necessity Criteria Not Met
Specify Reason:

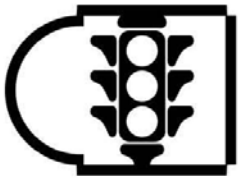
☐ Medical Necessity Criteria Met, but Service Array Modification Requested
Specify Change Requested and Reason:

**Actions Taken/Date:**

_____ _____
Care Management Specialist Date

_____ _____
Care Management Supervisor Date

Exhibit E



**Care Management**

# SCCMHA Care Management Continuing Stay Review

| | |
|---|---|
| **Consumer Name:** | **Sentri ID:** |
| **Case Manager Name/Team:** | **Supervisor:** |
| **Current PCP Date:** | |

Information required will be used the SCCMHA Care Management Department to determine if a consumer currently enrolled in services continues to meet the required medical necessity criteria for continuing authorization of services.

Please complete this form electronically, print, sign, and forward to the Care Management Specialist assigned to your team. Complete as thoroughly as possible.

| PROVIDER REPORT (To be completed by the Case Manager) | CARE MANAGEMENT REVIEW (To be completed by Care Management Specialist) |
|---|---|
| **I. Diagnosis**<br><br>Date of Diagnosis:<br>Diagnosis Given By:<br><br>Axis I:<br><br>Axis II:<br><br>Axis III:<br><br>Axis IV:<br><br>Axis V:<br><br>LOCUS Co-morbidity Score ( ) | Is this diagnosis current and valid and is it a service eligible diagnosis according to Service Selection Guidelines?<br><br>☐ Yes<br><br>☐ No |
| **II. Severity of Illness**<br><br>**Psychiatric Signs/Symptoms:**<br><br>LOCUS Dangerousness/Risk Score ( ) | Does the provider describe a severity of illness/functional impairments requiring access to the SCCMHA specialty array of supports and services?<br><br>☐ Yes |

| | |
|---|---|
| **Functional Impairments**<br>List all functional impairments currently presenting:<br><br>LOCUS Functional Status Score (  ) | ☐ No |
| **III. Medications**<br><br>Please list consumers current medications: | Do the medications listed support medical necessity based on the diagnosis?<br><br>☐ Yes<br><br>☐ No |
| **IV. Intensity of Services**<br><br>Start date of this episode of care:<br><br>List services used in the last 12 months, including those provided by the primary care physician:<br><br>List hospitalizations in the last 12 months:<br><br>LOCUS Treatment and Recovery Score (  )<br><br>LOCUS Attitude and Engagement Score (  ) | Has this consumer's utilization of services shown a need for access to the SCCMHA specialty array of supports and services?<br><br>☐ Yes<br><br>☐ No<br><br>Has this consumer shown progress in treatment resulting in improvement in signs/symptoms/level of functioning as a result of services provided?<br><br>☐ Yes<br><br>☐ No |
| **V. Proposed Continued Services**<br><br>Specify services requested for authorizations:<br><br>Anticipated discharge date:<br><br>Notes/Additional Comments: | Do the proposed continued services demonstrate that the consumer needs access to the SCCMHA array of specialty supports and services?<br><br>☐ Yes<br><br>☐ No |

Exhibit F

Level of Care Change Form – Adult Version

## SCCMHA Level of Care Change for Adults

| | |
|---|---|
| Consumer Name: | Sentri ID: |
| CSM/SC Name/Team: | Supervisor: |
| Date: | Current PCP Date: |

**Diagnosis Review**

| Diagnosis Import from Sentri | Supported in Record |
|---|---|
| Axis I | |
| Axis II | |
| Axis III | |
| Axis IV | |
| Axis V | |

**General Information**

Review Purpose

☐ Initial ☐ Ongoing ☐ Discharge ☐ Acute Crisis

Did you discuss this change with consumer/parent/guardian: Yes ☐ No ☐

Supported in record (progress note/periodic review date):

1. Risk of Harm within last year & history of attempts, ideations, and self-harm behaviors.

**Supported in record (progress note/periodic review date):**

2. Current level of function to include psychiatric symptoms and medications used.

**Supported in record (progress note/periodic review date):**

3. Medical risk

**Supported in record (progress note/periodic review date):**

4. Substance abuse risk

**Supported in record (progress note/periodic review date):**

5. Treatment and Recovery History

**Supported in record (progress note/periodic review date):**

| 6. Benefits: adherence/non-adherence to current services. |
|---|
| **Supported in record (progress note/periodic review date):** |

| **Utilization Summary** | |
|---|---|
| Services over the last six months | |
| Entitlement Status | Hospital Episodes: Date/Number of Days |
| | |
| Reason for level of care change. | |

| **Recommendations** |
|---|
| Next Step in Recovery Plan |
| Disposition:<br>☐ Transfer to<br>☐ MI ☐ DD<br>☐ Increase Level of Care to<br>☐ Case Management ☐ ACT<br>☐ Maintain Level of Care; transfer to _____<br>☐ Reduce Level of Care to<br>☐ Therapy only ☐ Case Management<br>☐ Prepare for Discharge to<br>☐ Outside Provider* ☐ Primary Care<br>*agencies that accept consumer's Qualified Health Plan |
| Discharge Recommendations |
| |

CSM/SC Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Exhibit G

Level of Care Change Form – Child Version

## SCCMHA Level of Care Change for Children

| | |
|---|---|
| Consumer Name: | Sentri ID: |
| CSM/SC Name: | Supervisor: |
| Date: | Current PCP Date: |

**Diagnosis Review**

| Diagnosis Import from Sentri | Supported in Record |
|---|---|
| Axis I | |
| Axis II | |
| Axis III | |
| Axis IV | |
| Axis V | |

**General Information**

Review Purpose
☐ Initial ☐ Ongoing ☐ Discharge ☐ Acute Crisis
Did you discuss this change with consumer/parent/guardian: ☐ Yes ☐ No
Supported in record (progress note/periodic review date):

CAFAS/PECFAS Total

| | | |
|---|---|---|
| 1. Schoolwork | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 2. Home | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 3. Community | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 4. Behavior towards others | CAFASPECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 5. Moods and emotions | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 6. Self-harm behavior | CAFASPECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |

| 7. Substance Abuse | CAFAS/PECFAS Score | |
|---|---|---|
| **Supported in record (progress note/periodic review date):** | | |
| 8. Thinking; symptoms and medications | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 9. Adherence/non-adherence to current service (child and parent). | | |
| **Supported in record (progress note/periodic review date):** | | |
| **DECA: If child is between 1 month and 47 months old please summarized your DECA results.** | | |
| | | |

| **Utilization Summary** | |
|---|---|
| Services over the last six months | |
| | |
| Entitlement Status | Hospital Episodes: Date/Number of Days |
| | |
| Reason for level of care change. | |
| | |

| **Recommendations** |
|---|
| Next Step in Recovery Plan |
| Disposition:<br>☐ Transfer to<br>☐ MI ☐ DD<br>☐ Increase Level of Care to<br>☐ Wraparound ☐ Home Based Service ☐Autism ☐ Adult Services ☐Child Case Management<br>☐ Reduce Level of Care to<br>☐ Therapy only<br>☐ Maintain Level of Care; transfer to _____<br>☐ Prepare for Discharge to<br>☐ Outside Provider* ☐ Primary Care<br>*Agency that accepts consumer's Qualified Health Plan |
| Discharge Recommendations |
| |

CSM/SC/Therapist Signature: _____ Date: _____

Supervisors Signature: _____ Date: _____

# Tab 4

# Service Delivery

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:<br>Consumerism</td><td>Chapter: 02 -<br>Customer Services and<br>Recipient Rights</td><td>Subject No: 02.03.01</td></tr>
<tr><td rowspan="2">Effective Date:<br>January 22, 2003</td><td>Date of Review/Revision:<br>2/11/03, 6/12/07, 5/6/09,<br>6/23/10, 6/12/12, 5/22/14,<br>4/7/16, 3/1/18, 3/7/19,<br>2/28/20, 3/11/21, 3/16/22,<br>2/28/23, 3/12/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of<br>Clinical Services<br><br>Authored By:<br>Kristie Wolbert<br><br>Additional Reviewers:<br>Clinical Directors<br>Program,<br>Coding/Compliance<br>Specialist,<br>HRC Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY<br>COMMUNITY MENTAL<br>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<br>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<br>Quality Governance Board |
| Provides services that advocate and promotes the needs, interests and wellbeing 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<br>Network Services Auditing Staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Inclusion</td><td>Chapter: 02 -<br>Customer Services and<br>Recipient Rights</td><td>Subject No: 02.03.02</td></tr>
<tr><td rowspan="2">Effective Date:<br>12/1/02</td><td>Date of Review/Revision:<br>6/12/07, 5/6/09, 6/30/10<br>3/30/12, 3/5/14, 5/22/14,<br>4/7/16, 3/24/17, 3/1/18,<br>3/7/19, 3/4/20, 3/29/21,<br>3/3/22, 3/2/23, 3/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br><br>Responsible Director:<br>Director of Services for Persons with Intellectual and Developmental Disabilities<br><br>Authored By:<br>Jennifer Rieck-Martin<br>Julie Bitterman<br><br>Additional Reviewers:<br>Charlotte Fondren</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY<br>COMMUNITY MENTAL<br>HEALTH AUTHORITY</td></tr>
</table>

**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<br>Executive Director of Clinical Services<br>Network Providers |
| Designs programs and services to be congruent with the norms of the community. | The entire SCCMHA network of providers<br>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 |

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject:<br>Person-Centered Planning</td><td>Chapter: 02 -<br>Customer Services and<br>Recipient Rights</td><td>Subject No: 02.03.03</td></tr>
<tr><td rowspan="2">Effective Date:<br>December 1, 2002</td><td>Date of Review/Revision:<br>5/6/09, 6/30/10, 5/14/12, 5/22/14, 4/7/16, 7/12/16, 3/30/17, 3/1/18, 10/26/18, 3/26/19, 6/8/20, 10/25/21, 6/28/22, 6/6/23, 4/30/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Kristie Wolbert<br><br>Additional Reviewers:<br>Director of NSPP & CE</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 persons 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 person served Individual Plan of Service (IPOS). The use of this process will be based on the services provided without regard to 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 as well as SCCMHA policy 02.03.03 B Family Centered Practice). 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. Including offering an independent facilitator to 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 person served involvement in the process, individuals will be asked by their assigned Case Holder to complete the Life Choices Document (see exhibit below) during the pre-planning aspect of the Individual Plan of Service (IPOS).

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

The goal of a crisis plan, crisis stabilization plan, psychiatric advanced directive or a wellness recovery action plan it to help the individual and their allies identify signs when the person served 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, by offering additional support to the person served to keep the person in the community.

Discussion with the person served about this type of planning should occur:

1) After a hospitalization when the person is healthy enough to discuss or discuss with the person served 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 person served is discussing a lesser restrictive treatment setting such as step down from an Alternative Treatment Order, or a Court Order.
5) After attempted suicide or increase in suicidal thoughts. Please refer to SCCMHA policy 02.03.24 Suicide Prevention

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.

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 persons served, 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 person served 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.

All direct care staff that are tasked with carrying out the individual plan of service, are required to have a copy of the consumer IPOS at the provider setting and will be in-serviced by the person that writes the goals for the plan. For instance, if an occupational therapist writes a goal that will be carried out by a community living support staff person or a residential staff person, the occupational therapist is responsible for in-servicing the staff to assure the staff have understanding of the plan as well as can implement the goals as intended by the writer of the goal. A writer of a goal can in-service a home manager/ or lead designated by the organization to in-service staff. The writer of the goal is required to complete an in-service document (see exhibit E). Once the in-service is complete, the document will be scanned into the person served electronic health record (E.H.R.)-sentri under IPOSs in-service records. An in-service of the plan should be completed at least annually. The goal writer should also in-service if there is an extensive change in staffing, or if there are concerns regarding the implementation of the goal. The role of the case manager is to ensure that all staff are in-serviced and that uploads of the in-service documents are in the consumer chart.

If new staff are hired after the in-service by the goal writer, it is the responsibility of the home manager or lead designated by the organization to in-service staff and have them sign an in-service log (see exhibit E) and to ensure the in-service log is uploaded.

It is the responsibility of SCCMHA contracted providers to maintain a copy of the consumer IPOS and ensure staff are trained prior to service delivery.

**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.

**Independent Facilitator:** A person who attends the pre planning and/planning meeting to discuss the desires of the person served. This person focuses the conversation on the person served an how their desired goals can be met. SCCMHA has a contract with an agency that provides this service.

**References:**
The Michigan Mental Health Code
MDHHS Medicaid Provider Manual
MDHHS Person-Centered Planning Policy (June 5, 2017)
MDHHS Person-Centered Planning Policy and Practice Guideline (updated 1/31/2022)
Policies & Practice Guidelines (michigan.gov)
SCCMHA Policy & Procedure 02.03.03B Family Centered Practice
SCCMHA Policy & Procedure 02.03.24 Suicide Prevention

**Exhibits:**
Exhibit A - Chart of Elements/strategies
Exhibit B – Life Choices Documentation Form
Exhibit C – Person Centered Planning Process-Fidelity Checklist
Exhibit D –IPOS Workflow and Activities
Exhibit E – Inservice Documentation Form

**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<br>Executive Director of Clinical Services<br>Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services |

| | |
|---|---|
| Provides leadership through policy that requires staff and network adherence to Person/family Centered Planning policy and practices. | CEO<br>Executive Director of Clinical Services<br>Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services |
| 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<br>Executive Director of Clinical Services<br>Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services SCCMHA Training Unit<br>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 persons served 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 meeting occurs and all decisions are documented. In the pre-planning the individual chooses:<br>♦ Dreams, goals, desires and any topics which he/she would like to talk about at the meeting. | Case Holder/Parent/guardian when applicable |

| | |
|---|---|
| ♦ Topics he/she does not want discussed at the meeting.<br>♦ Who to invite and who will be responsible for inviting those individuals.<br>♦ Where and when the meeting will be held.<br>♦ Who will facilitate the meeting? The person served must be given choices including the option for independent facilitation.<br>♦ Who will be responsible for recording the meeting?<br>♦ Whether the adult individual 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 and no more than 45 days prior to the person served planning meeting. | Case Holder<br>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. | Person Served<br>Facilitator<br>Case Holder<br>Parent/guardian when applicable<br>Family members and other invited guests |
| Each person served shall be given opportunities to express their 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. | Person Served<br>Facilitator<br>Case Holder<br>Parent/guardian when applicable<br>Family members and other invited guests |
| Each person served is given the opportunity to develop a crisis plan to assist the individual in and those around the person recognize when the person served is regressing in their recovery and assist the person while they are healthy to make | Person Served<br>Facilitator<br>Case Holder<br>Parent/guardian when applicable<br>Family members and other invited guests<br>Customer services |

| | |
|---|---|
| decisions about their care when they are feeling unwell or unable to make decisions about their care.<br>During the meeting, the person served is the focal point of conversation. The person served 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 person served will be empowered to make decisions regarding his/her care. The professionals involved will act as consultants to the person served rather than primary decisions makers. | |
| 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 person served abilities. The individual's choices and preferences about their supports and services should always be given primary consideration in planning. Issues and concerns that the individual or others have about the individual's health, welfare and safety should be shared with the individual/family as they 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. | Person Served<br>Facilitator<br>Case Holder<br>Parent/guardian when applicable<br>Family members and other invited guests<br>Customer services |
| Throughout the planning process, the resources and supports that are already available to the person served including natural/community supports will be identified. The planning team should consider how these natural supports could be utilized to help the person served/family reach their dreams and desires. If the | Person Served<br>Facilitator<br>Case Holder<br>Parent/guardian when applicable<br>Family members and other invited guests<br>Customer services |

| | |
|---|---|
| person served has no natural supports, the team will discuss how such supports will be developed. | |
| Persons Served 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. | Person Served<br>Facilitator<br>Case Holder<br>Parent/guardian when applicable<br>Family members and other invited guests<br>Customer services |
| Person/family centered planning is a dynamic process. Persons Served have the opportunity to reconvene any or all of the planning processes whenever they want or need. Persons Served with dual diagnosis of MI/SUD will have periodic reviews of their PCP completed every 90 days. | Person Served<br>Case Holder |
| Each person served is provided with a copy of their person/family centered plan within 15 business days after the meeting. | Persons Served<br>Case Holder |
| Persons served/families are provided with ongoing opportunities to provide feedback on how they feel 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 person served/family's feedback. | 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 review and approval, then forwarded to 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. | Clinical Supervisor, Case Holder and Care Management Specialist |

| | |
|---|---|
| Annually, the Clinical Supervisor will shadow each assigned Case Holder through at least one person served 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. | Case Holder, Enhanced Health Staff, ABA provider, Community Living Supports Staff, Self Determination Staff, Residential Staff |
| **In-services of the consumer plans:** | |
| All direct care staff responsible for carrying out the person served IPOS must be in-serviced on the consumer goal(s) by the writer of the goal.<br><br>Will sign an in-service document as proof of in-service.<br><br>Will upload the document into the person served E.H.R.<br><br>Will ensure all staff have been in-serviced on the consumer plan. | Home Manager, lead worker of the organization, Case Holder, Enhanced Health Staff, Persons Served under Self Determination |

**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:<br>- The individual.<br>- Family, friends, guardian, and significant others.<br>- Resources in the neighborhood and community.<br>- Publicly-funded supports and services available for all citizens.<br>- 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**

**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☐ | |

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

**I am aware of, and agree to, the following home restriction(s) in place for the safety of fellow residents, 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:_____

**Of those restriction(s) checked, I desire access/accommodations to the following, which will be addressed in my individual plan of service:** (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:_____

_____ _____

Signature of Person Receiving Services or Legal Representative Date

HCBW Choice Document Rev: 12/19, 2/23

Scan as an attachment to Sentri Pre-planning Form

**Saginaw County Community Mental Health Authority Life Choices Documentation Form**

## 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 anytime 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

HCBW Choice Document Rev: 12/19, 2/23 Scan as an attachment to Sentri Pre-planning Form

**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 their 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 person of services. | ☐2 ☐1 ☐0 | |
| 10. Planning meetings are a celebration of the person served | ☐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

b. CH assures any in-sercvice by other goal writers is completed and scanned into E.H.R.
c. Assures ongoing in-services of any new staff.

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

**EXHIBIT E**

Saginaw County Community Mental Health Authority

# Individual Plan of Service Staff Training Log

Date:_____

Consumer:_____ ID: _____

Location:_____ Start Time:_____ End Time:_____

IPOS or addendum dated: ___/____/____

**Staff Trained:**

| Printed Name | Title | Signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

☐Entire IPOS reviewed

☐Aspect(s) of the IPOS reviewed:_____

_____

Notes or Comments:_____

_____

_____

Trained by (print):_____ Title:_____

Signature: _____ (Credentials/Title)

(if not case holder, who trained the trainer listed) _____

Attach to IPOS In-Service Records 9-9-2020

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:<br>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:<br>7/1/07</td><td>Date of Review/Revision:<br>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, 3/7/23, 3/7/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Stacey Farrell<br><br>Additional Reviewers:<br>Jennifer Stanuszek, LMFT</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, as youth become older, is to shift 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.
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 may 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 immediate needs, as well as any crisis needs until 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 primary team. 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<br>Executive Director of Clinical Services<br>Director of Network Services, Public Policy & Continuing Education |
| Provides leadership through policy that requires staff and network adherence to | CEO<br>Executive Director of Clinical Services |

| | |
|---|---|
| Person/Family Centered Planning policy and practices.<br><br>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. | Director of Network Services, Public Policy & Continuing Education<br><br>CEO<br>Executive Director of Clinical Services<br>Director of Network Services, Public Policy & Continuing Education<br>SCCMHA Continuing Education<br>Supervisor of Customer Services |
| Ensure that all decisions involving a child, youth and family are made utilizing family centered practices.<br><br>Schedules a pre-planning meeting in preparation for the family centered planning meeting and ensures that the essential elements of a pre-planning meeting are met.<br><br>Schedules and coordinates the family centered planning meeting according to the choices made by the family during the pre-planning meeting.<br><br>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.<br><br>Once all parties have agreed to all elements of the Individual Plan of Service, authorizations will be submitted to Care Management for approval. | SCCMHA Network of providers<br><br>Case Holder<br>Consumer/Youth/Family<br><br>Case Holder<br>Consumer/Youth/Family<br><br>Case Holder<br>Consumer/Youth/Family<br><br>Case Holder<br>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<br>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<br>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 outlined below. It is this type of situation where an 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:<br>- The individual.<br>- Family, friends, guardian, and significant others.<br>- Resources in the neighborhood and community.<br>- Publicly-funded supports and services available for all citizens.<br>- 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 (45 days prior to IPOS expiration)**

1. Case Holder (CH) reviews information from previous year to inform completions of psychosocial assessment
    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 (as applicable) with the consumer
    b. Determine need or want for Enhanced Health Services (EHS)
    c. Determine need or want for Community Living Supports
4. CH meets with consumer to complete the Pre-Plan form and pre-plan tools (typically 1 to 2 weeks before IPOS expiration)
5. Planning meeting set up (send invites, arrange location, etc.) is completed by parties designated in Pre-Plan
6. CH ensures completion of Assessments in Sentri prior to Planning Meeting
    a. CH ensures that the signed Pre-Plan Signature Page is scanned/signed electronically
    b. CH ensures that copy of Pre-plan tools(s) is scanned
7. CH obtains signature electronically on IPOS Consents or ensures that it is scanned
8. CH enters proposed IPOS goals in Sentri prior to Planning Meeting

**Planning Meeting**

9. 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 and objectives
    c. 15 day copy to consumer “clock” starts from date of planning meeting

**Post Planning Meeting**

10. CH completes the Planning meeting fields in Sentri (may be done after the planning meeting based on notes)
11. Simultaneous submits IPOS for
    a. Supervisor Review, revision (if required) and approval
    b. Submit Authorizations in Sentri, revision (if required) and approval
12. CH signs IPOS after Supervisor and authorization approvals
13. CH sends completed IPOS copy to guardian (if applicable) or consumer for signature/gains signature electronically

a. CH documents date sent in Sentri on IPOS form
b. CH assures that the signed IPOS Meeting Signature Page scanned or signed electronically

14. CH Review IPOS with programs and services
    a. CH documents any in-services(s) on Sentri on PCP Header
15. 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

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Recovery | **Chapter**: 02 - Customer Services and Recipient Rights | **Subject No**: 02.03.05 |
| **Effective Date**:<br>7/20/06 | **Date of Review/Revision**:<br>5/18/09, 6/7/12, 6/3/13, 6/2/14, 4/4/16, 6/13/17, 4/10/18, 3/11/18, 4/9/19, 4/7/20, 4/13/21, 5/10/22, 4/11/23, 4/5/24<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>Executive Director of Clinical Services<br><br>**Authored By**:<br>Barbara Glassheim<br><br>**Additional Reviewers**:<br>None |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | |

**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:**


A. Center for Substance Abuse Treatment. (2009). *What Are Peer Recovery Support Services?* SAMHSA. Rockville, MD. [On-line]. Available: http://store.samhsa.gov/shin/content//SMA09-4454/SMA09-4454.pdf.

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.

C. Copeland, M. (Undated). *Action Planning for Prevention and Recovery.* 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-3720/SMA-3720.pdf.

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.

E. del Vecchio, Paolo. (2012). *SAMHSA's Working Definition of Recovery Updated.* United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. [On-line]. Rockville, MD. Available: http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/.

F. Michigan Department of Community Health. (2005). *Transforming Mental Health Care In Michigan: A Plan For Implementing Recommendations Of The Michigan Mental Health Commission.* [On-line]. Available: http://www.michigan.gov/documents/DCH_Implementation_Plan_April_2005_122025_7.pdf.

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 03.02.31 – Services for Members of the Armed Forces Veterans & their Families
Q. SCCMHA Policy 03.02.46 – Whole-Person Care
R. 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.
S. 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)

**Procedure:**

None

Exhibit A

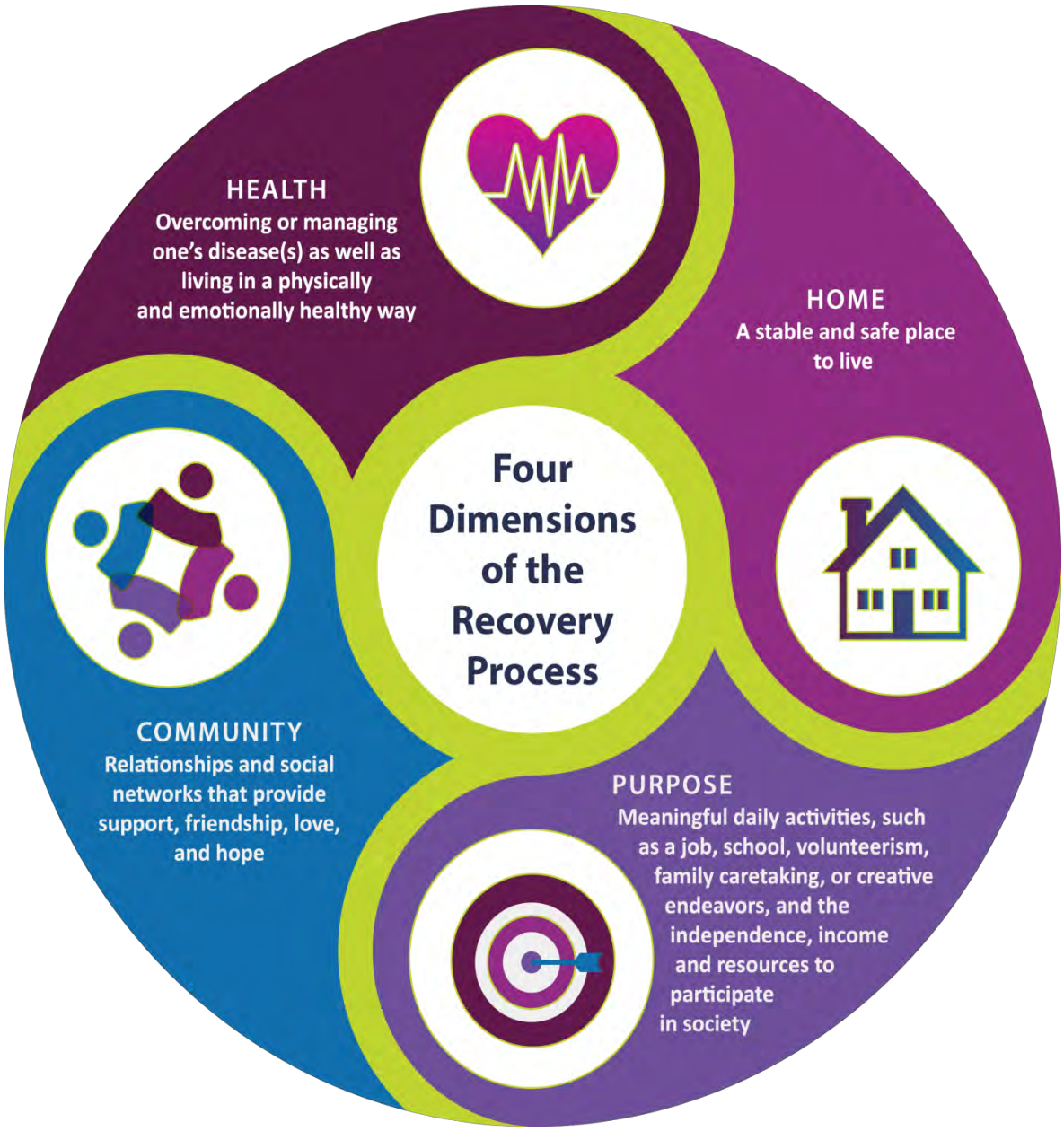

HEALTH
Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
HOME
A stable and safe place to live
Four Dimensions of the Recovery Process
COMMUNITY
Relationships and social networks that provide support, friendship, love, and hope
PURPOSE
Meaningful daily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

Exhibit B

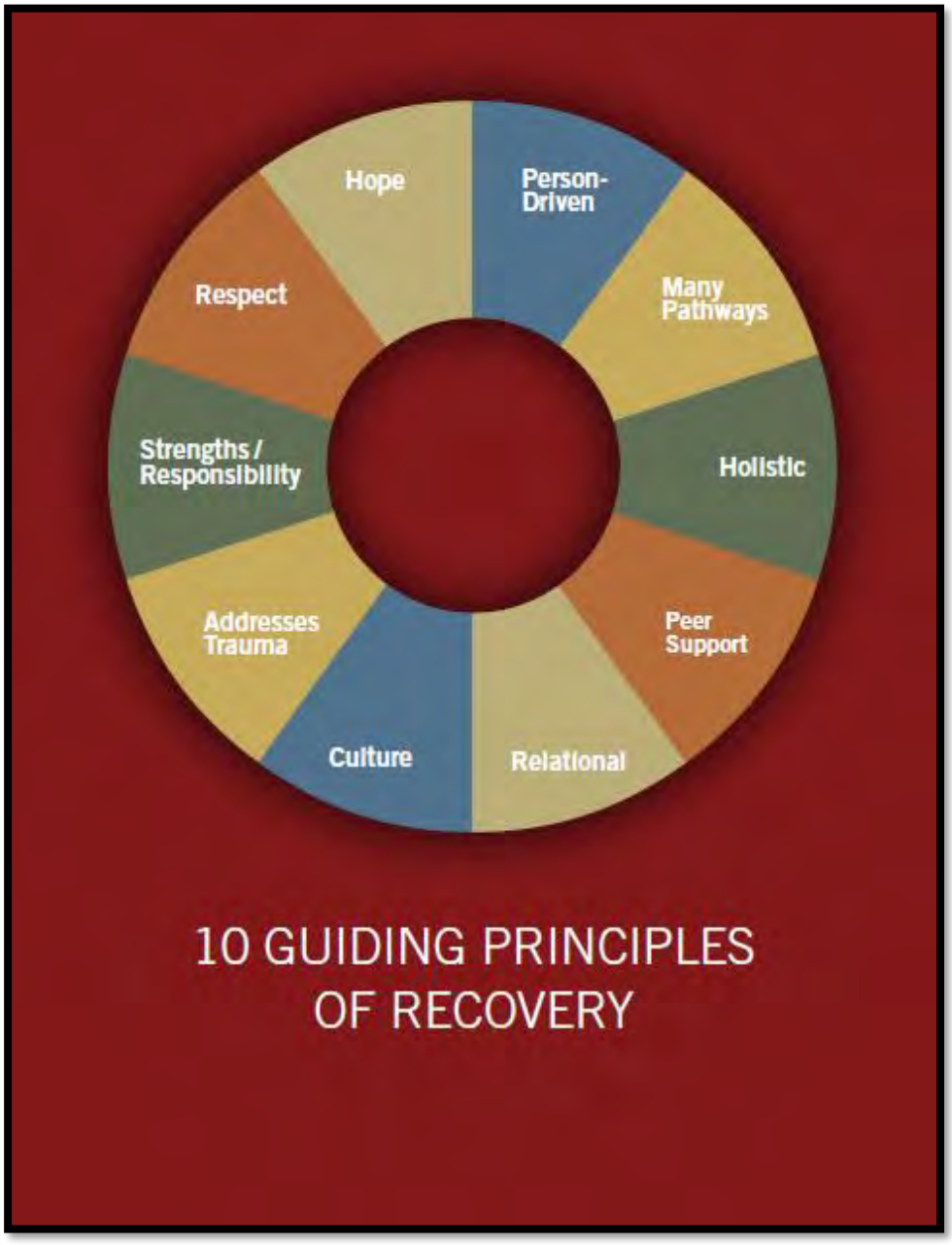
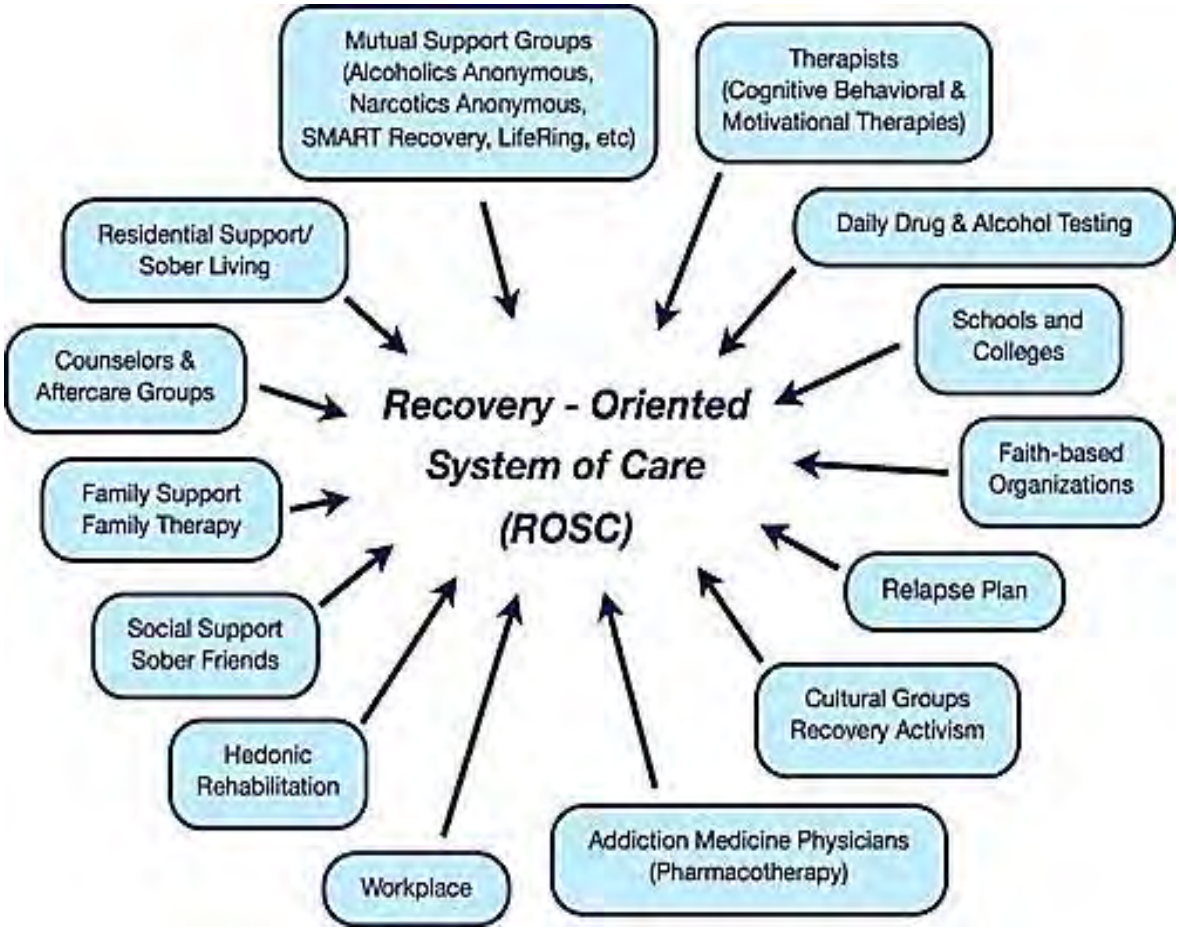

Hope
Person-Driven
Respect
Many Pathways
Strengths / Responsibility
Holistic
Addresses Trauma
Peer Support
Culture
Relational
10 GUIDING PRINCIPLES OF RECOVERY

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

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Employment of Consumers | **Chapter**: 02 - Customer Services and Recipient Rights | **Subject No**: 02.03.07 |
| **Effective Date**:<br>November 1, 2002 | **Date of Review/Revision**:<br>3/11/03, 7/5/07, 5/29/09, 7/15/10, 5/9/12, 6/4/14, 5/6/16, 6/7/16, 6/1/17, 6/1/18, 4/30/19, 4/5/21, 3/24/22, 3/9/23, 4/4/24<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>Executive Director of Clinical Services<br><br>**Authored By**:<br>Rollin Archangeli<br><br>**Additional Reviewers**:<br>Rollin Archangeli, John Burages |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | |

**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 Programs (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 and/or job coach/specialists or other means to assist in job retention and satisfaction.
N. SCCMHA will sponsor an ongoing employment Steering Committee, 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 |
| | Supported Employment Fidelity Scale – www.ipsworks.org |

**Exhibits:**
Exhibit A – SCCMHA Supported Employment Service Flow Chart

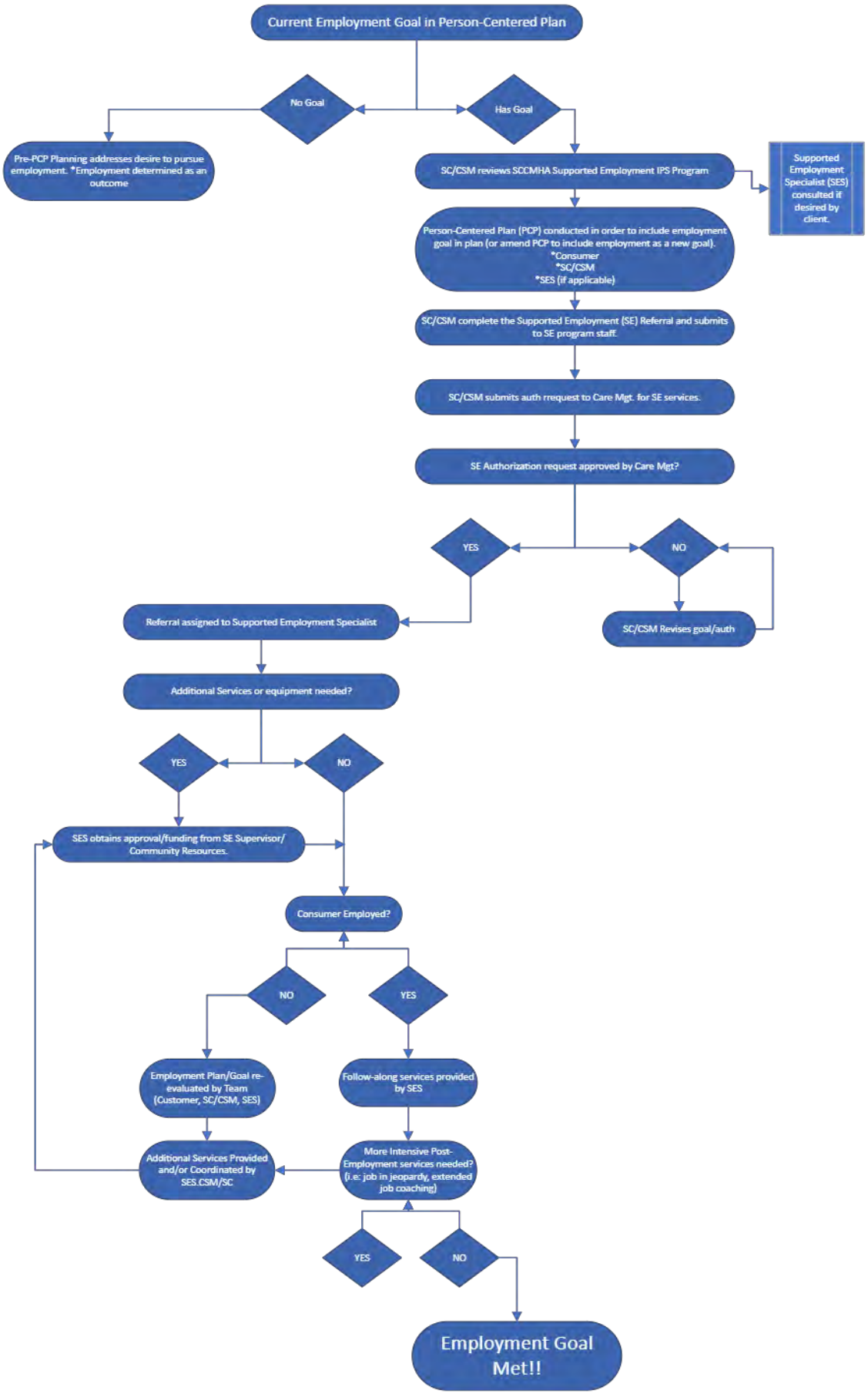
**Procedure:**

| 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 Supervisor to chair SCCMHA's SE Best Practice Team. Employment Supervisor 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, 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 | Director of Services for Persons with Mental Illness |

| | |
|---|---|
| addressed in access, care management & quality areas. Oversees encounter and performance indicator data collection for consumer employment. | |
| Include consumer employment outcomes and preferences in Person-Centered Planning processes. Refer consumers to SCCMHA's SE/IPS 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<br>SCCMHA Employment Specialist |

Exhibit A

**SCCMHA Supported Employment Service Flow Chart**



<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></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:<br>7/1/07</td><td>Date of Review/Revision:<br>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, 4/11/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Barbara Glassheim<br><br>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 developmentally appropriate, culturally sensitive services and supports that supports consumer/family engagement and shared decision-making.

**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 Service
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
N. SCCMHA Policy 03.02.46 – Whole Person Care

**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.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• Each contact should offer explanations and clarifications, and resources and support, especially if the outcome is not quite what was requested. | • 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. |

| | |
|---|---|
| • 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.<br>• Force them to ask where restrooms are located.<br>• 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.<br>• 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 them to fully understand about confidentiality.<br>• 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.<br>• Continue with the interview while the person is crying or showing other signs of emotional distress.<br>• 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.<br>• Neglect to spend a few minutes engaging with the person before gently handing them off to another person or walking them to the front door. |

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

For more information:
SAMHSA LGBT Training Curricula for Behavioral Health and Primary Care Practitioners:

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

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

VA Mental Health: https://www.mentalhealth.va.gov/msthome/index.asp

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

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Evidence-Based Practices (EBPs)</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.09</td></tr>
<tr><td rowspan="2">Effective Date:<br>5/1/06</td><td>Date of Review/Revision:<br>4/21/07, 9/2/08, 5/18/09, 4/2/12, 5/9/14, 11/14/14, 4/5/16, 6/13/17, 4/10/18, 4/9/19, 11/12/19, 6/1/20, 2/10/21, 9/1/21, 1/12/22, 1/10/23, 1/31/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Network Services, Public Policy, & Continuing Education<br><br>Authored By:<br>Mary Baukus, Barbara Glassheim<br><br>Additional Reviewers:<br>EBP Leadership Team</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
To promote the use of services and supports for consumers that exemplify the highest level of scientific evidence and take into consideration the clinical expertise of the practitioner as well as the choices, values, and goals of the consumer.

**Policy:**

A. SCCMHA is committed to implementing and sustaining evidence-based practices (EBPs) while shifting resources away from ineffective or less effective services and supports based on the following beliefs and values:
   1. Judicious use of evidence-based services and supports can lead to optimal functioning for consumers and their families, which, in turn, can promote independence and satisfactory participation as full citizens in community life.
   2. Consumers and their families have a right to be educated about optimal treatments and supports and to make informed decisions regarding receipt of interventions and services.
   3. In an era of shrinking resources and increasing demand, investing in practices that have been proven effective, and moving away from those that have not, makes sound fiscal sense.

B. It is the policy of SCCMHA that all providers will offer services and supports to consumers and their families that are well-grounded in science and have demonstrated to produce beneficial outcomes to provide the most optimal opportunities for recovery, resilience, and participation in community life.
   1. Treatments are provided that are appropriate for the consumer's phase of life and development, specifically considering what is appropriate for children,

adolescents, transition age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment.

a. Specifically, children and adolescents are treated using a family/caregiver-driven, youth guided and developmentally appropriate approach that comprehensively addresses family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.
b. When treating older adults, the individual consumer's desires and functioning are considered, and appropriate evidence-based treatments are provided.
c. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided.

2. These treatments are delivered by staff with specific training in treating the segment of the population being served.

C. SCCMHA shall endeavor to ensure the availability of all SCCMHA-endorsed EBPs to consumers as resources permit.

D. All EBPs shall be delivered in a trauma-informed manner. Please see policy 02.03.14 for more information on trauma-unformed services.

**Application:**

This policy applies to all SCCMHA-funded providers of mental health, developmental disability, and substance use disorder treatment and prevention services and supports.

**Standards:**

A. SCCMHA shall adopt evidence-based practices to provide optimal opportunities for consumers and their families to achieve recovery, build resiliency, and foster opportunities for consumers to fully participate in community life.

B. SCCMHA-funded programs shall incorporate evidence-based practices into their repertoires and monitor fidelity to those practice models.

1. Practitioners shall adhere to evidence-based protocols when appropriate and warranted; consumer choice and need shall govern the selection of services and supports.
2. Staff and supervisors shall identify potential practices/treatments/interventions to meet heretofore unmet consumer needs.
3. Staff and supervisors shall verify the evidence base of potential practices/treatments/interventions prior to submitting a request for approval of their use to the EBP Leadership Team.

C. Practitioners shall seek to become privileged in the EBP(s) they employ and maintain that status on an ongoing basis in accordance with SCCMHA policy.

D. Supervisors shall provide coaching, mentoring and guidance to staff and monitor practices for fidelity to the model.

1. Supervisors shall, in conjunction with staff, help identify EBP training needs.
2. Supervisors shall review relevant reports with staff to help identify consumers appropriate for referral to a specific EBP.

3. Supervisors shall review relevant outcome reports with staff to develop improvement plans that can be implemented as needed.
4. Supervisors shall meet with EBP practitioners for clinical supervision up to weekly or as is recommended for the specific EBP fidelity and keep a log of supervision contacts.

E. SCCMHA shall provide support for the implementation and maintenance of EBPs through an EBP Leadership Team.
1. The EBP Leadership Team shall be comprised of the SCCMHA EBP/TIC Coordinator, SCCMHA Executive Director of Clinical Services and Programs, SCCMHA Chief of Health Services & Integrated Care, SCCMHA Director of Network Services, Public Policy, & Continuing Education, SCCMHA Director of Services for Persons with Mental Illness, SCCMHA Director of Services for Persons with Intellectual and Developmental Disabilities, SCCMHA Director of Children's Services, and two contractual consultants with expertise in EBPs. Other members as needed and approved by the team.

F. Evidence-based practice implementation and ongoing maintenance activities shall be monitored by the EBP Leadership Team with regular ongoing reporting throughout the system, including quality improvement activities.
1. Adoption of practices/intervention/programs shall require a review of the relevant scientific literature to determine the level of evidence that supports the practice as well as the approval of the relevant SCCMHA or contract agency Director.
a. Providers shall inform the EBP/TIC Coordinator and/or member of the SCCMHA EBP Leadership Team of the implementation of additional practices.
2. Assessment tools such as ANSA, CAFAS, PECFAS, and DECA shall be used as appropriate to create reports to measure outcomes for each active EBP.
3. The outcomes for each active EBP will be reviewed at least once yearly.
4. Adaptations to SCCMHA-endorsed EBPs shall be based on consumer needs, reviewed by the appropriate clinical supervisor/director, and communicated to the SCCMHA EBP/TIC Coordinator/EBP Leadership Team.
5. SCCMHA shall, whenever possible, provide ongoing evidence-based practice support, training, and education to providers.
1. The SCCMHA EBP Leadership Team shall endeavor to conduct fidelity reviews of practices that are not reviewed by other entities (e.g., the Michigan Fidelity Assistance Support Team [MIFAST]).
a. Fidelity reviews conducted under the auspices of the SCCMHA EBP Leadership Team shall include the General Organizational Index (GOI) as well as practice-specific fidelity scales (found in Exhibits A and B).
b. The SCCMHA EBP/TIC Coordinator shall provide notification of all impending fidelity reviews to the leadership of the agency/relevant SCCMHA Director, along with program staff supervisors, prior to conducting a fidelity review.

c. Although not compulsory because fidelity reviews are part of quality improvement and meant to be educational in nature, it is nonetheless expected that agencies and programs will respond in writing to fidelity reviews and indicate how items that indicate significant drift from the model will be addressed.

6. All fidelity reviews that are conducted for SCCMHA network providers shall be centralized through the SCCMHA EBP/TIC Coordinator.
    1. All fidelity reviewers must contact the SCCMHA EBP/TIC Coordinator prior to scheduling a review.
    2. SCCMHA network agency staff shall immediately forward all notifications of all impending fidelity reviews to the SCCMHA EBP/TIC Coordinator and inform external reviewers (e.g., MiFAST) of this policy – i.e., that no fidelity reviews may be scheduled directly by any SCCMHA network agency staff without the involvement of the SCCMHA EBP/TIC Coordinator.

**Definitions:**

**Evidence-Based Practice (EBP):** A clinical intervention that has a strongly rooted scientific foundation and produces consistent results in assisting consumers achieve their desired goals or outcomes when implemented to fidelity. An evidence-based practice is comprised of three components: (1) the highest level of scientific evidence; (2) the clinical expertise of the practitioner; and (3) the choices, values, and goals of the consumer.

**Evidence-Based Treatment (EBT):** Treatment that is backed by scientific evidence – i.e., has been proven effective through rigorous research methodologies. EBTs are manualized interventions for specific disorders and populations that have been shown to be effective through controlled research.

**Fidelity:** The level of adherence to the original model as specified in written materials, typically a manual, or by researchers. The degree of fidelity to the model affects outcomes; research has demonstrated that the level adherence to the model strongly affects the ability to achieve the desired outcomes.

**Levels of Evidence:** The strength of evidence for any given practice is referred to as the level of evidence. The term, *levels of evidence*, refers to a ranking system used in the evidence-based practice literature to describe the strength of the results measured in a clinical trial or research study. The design of the study (such as a case report for an individual patient or a double-blinded randomized controlled trial) and the endpoints measured (such as survival or quality of life) affect the strength of the evidence. Levels of evidence range from I-IV:

Ia — Evidence from Meta-analysis of Randomized Controlled Trials

Ib — Evidence from at least one Randomized Controlled Trial

IIa — Evidence from at least one well designed controlled trial which is not randomized

IIb — Evidence from at least one well designed experimental trial

III — Evidence from case, correlation, and comparative studies.

IV — Evidence from a panel of experts

**Recovery:** A process of learning to approach each day's challenges, overcome one's disabilities, acquire skills, live independently, and contribute to society. The process is supported by those who instill hope and a belief in self-efficacy. The recovery framework

is characterized by shared decision-making in which consumers and providers are full partners in the treatment process. Providers are a source of hope, affirmation, and education and collaborate with consumers and their support systems (e.g., family) in a manner that fosters opportunity for choice and building resilience. In an evidence-based organizational culture, practitioners are professionals with expertise who convey information to consumers about the various options available to them to work on their goals and objectives. Consumers determine what will work for themselves based on their own perspectives.

**Resilience:** The ability to weather stresses, both large and small, bounce back from trauma and get on with life, learn from negative experiences and translate them into positive ones, gather the strength and confidence to change directions when a chosen path becomes blocked or nonproductive. It encompasses strengths that function as protective factors to enable one to withstand adversity and maintain well-being. Supporting protective factors helps prevent the negative impact of stress and adversity and promotes health.

**References:**


A. Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics, Updated May 2016, CCBHC-Criteria-Updated-May-2016 (samhsa.gov)
B. Michigan Department of Community Health. (2005). *Transforming Mental Health Care In Michigan: A Plan For Implementing Recommendations Of The Michigan Mental Health Commission*:
C. SCCMHA Network Services and Public Policy Procedure 09.04.05.03 – Privileging of Practitioners in Evidence-Based Practices.
D. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
E. Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practices KITs
F. United States Public Health Service Office of the Surgeon General. (1999). *Mental Health: A report of the Surgeon General*: http://www.surgeongeneral.gov/library/mentalhealth/home.html


**Exhibits:**

A. General Organizational Index (GOI) – Dartmouth Psychiatric Research Center
B. GOI Protocol – Dartmouth Psychiatric Research Center

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Identifies unmet consumer needs. | 1. Staff/Supervisor |
| 2. Secures information about potential EBPs | 2. Staff/Supervisor |
| 3. Submits request or new practice or modification/adaptation of current practice to meet consumer needs | 3. Staff/Supervisor |
| 4. Seeks to obtain/maintain privileges to deliver EPB(s) | 4. Practitioner |

| | |
|---|---|
| 5. Provides coaching and guidance to maintain fidelity to practice(s) | 5. Supervisor |
| 6. Reviews EBPs | 6. SCCMHA EBP Leadership Team |
| 7. Monitors fidelity to EBP models; conducts reviews of practices not reviewed by another entity (e.g., MiFAST) | 7. SCCMHA Fidelity Monitoring Team |
| 8. Coordinates external fidelity reviews | 8. SCCMHA EBP/TIC Coordinator |
| 9. Notifies agency/department leadership of impending fidelity review to be conducted by the SCCMHA Fidelity Monitoring Team. | 9. SCCMHA EBP/TIC Coordinator |
| 10. Responds in writing to any fidelity issues/drift noted in fidelity reviews conducted by the SCCMHA Fidelity Monitoring Team | 10. SCCMHA funded providers of mental health and intellectual and developmental disability services |
| 11. Provides oversight of ongoing system-wide efforts designed to implement and maintain fidelity to evidence-based practices | 11. SCCMHA EBP Leadership Team |
| 12. Assess/review fidelity efforts | 12. SCCMHA EBP Leadership Team |
| 13. Reviews implementation of new evidence-based practices | 13. SCCMHA EBP Leadership Team |
| 14. Reviews adaptations to SCCMHA-endorsed EBPs | 14. SCCMHA EBP Leadership Team |
| 15. Conveys progress to relevant SCCMHA quality teams | 15. SCCMHA EPB leadership Team/EBP/TIC Coordinator |
| 16. Reviews requests for the adoption of additional practices | 16. SCCMHA EBP Leadership Team |

Exhibit A

# General Organizational Index (GOI) Scale

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **G1. Program Philosophy**. The program is committed to a clearly articulated philosophy consistent with the specific evidence-based model, based on the following 5 sources:<br>1. Program leader<br>2. Senior staff (e.g., executive director, psychiatrist)<br>3. Practitioners providing the EBP<br>4. Clients and / or families receiving EBP<br>5. Written materials (e.g., brochures) | No more than 1 of the 5 sources shows clear understanding of the program philosophy<br>OR<br>All sources have numerous major areas of discrepancy | 2 of the 5 sources show clear understanding of the program philosophy<br>OR<br>All sources have several major areas of discrepancy | 3 of the 5 sources show clear understanding of the program philosophy<br>OR<br>Sources mostly aligned to program philosophy, but have one major area of discrepancy | 4 of the 5 sources show clear understanding of the program philosophy<br>OR<br>Sources mostly aligned to program philosophy, but have one or two minor areas of discrepancy | All 5 sources display a clear understanding and commitment to the program philosophy for the specific EBP |
| ***G2. Eligibility / Client Identification.** All clients with severe mental illness in the community support program, crisis clients, and institutionalized clients are screened to determine whether they qualify for the EBP using standardized tools or admission criteria consistent with the EBP.<br>Also, the agency tracks the number of eligible clients in a systematic fashion. | =20% of clients receive standardized screening and / or agency DOES NOT systematically track eligibility | 21%-40% of clients receive standardized screening and agency systematically tracks eligibility | 41%-60% of clients receive standardized screening and agency systematically tracks eligibility | 61%-80% of clients receive standardized screening and agency systematically tracks eligibility | >80% of clients receive standardized screening and agency systematically tracks eligibility |
| ***G3. Penetration.** The maximum number of eligible clients are served by the EBP, as defined by the ratio:<br>$\frac{\text{\# clients receiving EBP}}{\text{\# clients eligible for EBP}}$ | Ratio = .20 | Ratio between .21 and .40 | Ratio between .41 and .60 | Ratio between .61 and .80 | Ratio > .80 |

*These two items coded based on all clients with SMI at the site or sites were the EBP is being implemented; all other items refer specifically to those receiving the EBP.

_____ Total # clients in target population

_____ Total # clients eligible for EBP % eligible: ____%

_____ Total # clients receiving EBP penetration rate: ____

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **G4. Assessment**. Full standardized assessment of all clients who receive EBP services. Assessment includes history and treatment of medical / psychiatric / substance use disorders, current stages of all existing disorders, vocational history, and existing support network, and evaluation of biopsychosocial risk factors. | Assessments are completely absent or completely non-standardized | Pervasive deficiencies in two of the following: Standardization, Quality of assessments, Timelines, Comprehensiveness | Pervasive deficiencies in one of the following: Standardization, Quality of assessments, Timelines, Comprehensiveness | 61%-80% of clients receive standardized, high quality assessments at least annually OR Information is deficient for one or two assessment domains | >80% of clients receive standardized, high quality assessments, the information is comprehensive across all assessment domains, and updated at least annually |
| **G5. Individualized Treatment Plan.** For all EBP clients, there is an explicit, individualized treatment plan *related to the EBP* that is consistent with assessment and updated every 3 months. | =20% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months | 21%-40% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months | 41%-60% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months. OR Individualized treatment plans updated every 6 months for all clients | 61%-80% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months | >80% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months |
| **G6. Individualized Treatment.** All EBP clients receive individualized treatment meeting the goals of the EBP. | =20% of clients served by EBP receive individualized services meeting the goals of the EBP | 21%-40% of clients served by EBP receive individualized services meeting the goals of the EBP | 41%-60% of clients served by EBP receive individualized services meeting the goals of the EBP | 61%-80% of clients served by EBP receive individualized services meeting the goals of the EBP | >80% of clients served by EBP receive individualized services meeting the goals of the EBP |
| **G7. Training.** All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) *within 2 months of hiring*. Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent) | =20% of practitioners receive standardized training annually | 21%-40% of practitioners receive standardized training annually | 41%-60% of practitioners receive standardized training annually | 61%-8-% of practitioners receive standardized training annually | >80% of practitioners receive standardized training annually |
| **G8. Supervision.** EBP practitioners receive structured, weekly supervision (group or individual format) from a practitioner experienced in the particular EBP. The supervision should be client-centered and explicitly address the EBP model and its application of *specific client situations.* | =20% of practitioners receive supervision | 21%-40% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision on an informal basis | 41%-60% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision monthly | 61%-80% of EBP practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision twice a month | >80% of EBP practitioners receive structured weekly supervision, focusing on specific clients, in sessions that *explicitly address the EBP model and its application* |

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **G9. Process Monitoring.** Supervisors and program leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Monitoring involves a standardized approach, e.g., use of a fidelity scale or other comprehensive set of process indicators. | No attempt at monitoring process is made | Informal process monitoring is used at least annually | Process monitoring is deficient on 2 of these 3 criteria: (1) Comprehensive & standardized; (2) Completed every 6 months; (3) Used to guide program improvements<br>OR<br>Standardized monitoring done annually only | Process monitoring is deficient on 1 of these 3 criteria: (1) Comprehensive & standardized; (2) Completed every 6 months; (3) Used to guide program improvements | Standardized comprehensive process monitoring occurs at least every 6 months and is used to guide program improvements |
| **G10. Outcome Monitoring.** Supervisors / program leaders monitor the outcomes for EBP clients every 3 months and share the data with EBP practitioners. Monitoring involves a standardized approach to assessing a key outcome related to the EBP, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate. | No outcome monitoring occurs | Outcome monitoring occurs at least once a year, but results are not shared with practitioners | Standardized outcome monitoring occurs at least once a year, and results are shared with practitioners | Standardized outcome monitoring occurs at least twice a year, and results are shared with practitioners | Standardized outcome monitoring occurs quarterly and results are shared with EBP practitioners |
| **G11. Quality Assurance (QA).** The agency has a QA Committee or implementation steering committee with an explicit plan to review the EBP, or components of the program, every 6 months. | No review or no committee | QA committee has been formed, but no reviews have been completed | Explicit QA review occurs less than annually<br>OR<br>QA review is superficial | Explicit QA review occurs annually | Explicit review every 6 months by a QA group *or steering committee for the EBP* |
| **G12. Client Choice Regarding Service Provision.** All clients receiving EBP services are offered choices; the EBP practitioners consider and abide by client preferences for treatment when offering and providing services. | Client-centered services are absent (or all EBP decisions are made by staff) | Few sources agree that type and frequency of EBP services reflect client choice | Half sources agree that type and frequency of EBP services reflect client choice | Most sources agree that type and frequency of EBP services reflect client choice<br>OR<br>Agency fully embraces client choice with one exception | All sources agree that type and frequency of EBP services reflect client choice |

Exhibit B

**General Organizational Index (GOI)**
**-Item Definitions and Scoring-**

## G1. Program Philosophy

Definition: The program is committed to a clearly articulated philosophy consistent with the *specific* evidence-based practice (EBP), based on the following 5 sources:

- Program leader
- Senior staff (e.g., executive director, psychiatrists)
- Practitioners providing EBP
- Consumers and/or family members (depending on EBP focus)
- Written materials (e.g., brochures)

Rationale: In psychiatric rehabilitation programs that truly endorse EBPs, staff members at all levels embrace the program philosophy and practice it in their daily work.

Sources of Information:

**Overview:** During the course of a site visit, fidelity assessors should be alert to indicators of program philosophy consistent with or inconsistent with the EBP including observations from casual conversations, staff, and consumer activities, etc. Statements that suggest misconceptions or reservations about the practice are negative indicators, while statements that indicate enthusiasm for and understanding of the practice are positive indicators. The intent of this item is to gauge the understanding of and commitment toward the practice. It is not necessary that every element of the practice is currently in place (this is gauged by the EBP-specific fidelity scale), but rather whether all those involved are committed to implementing a high fidelity EBP.

The practitioners rated for this item **are limited to those implementing this practice**. Similarly, the consumers rated are those receiving the practice.

a) Program leader interview, b) Senior staff interview and c) Practitioner interview
d) Consumer interview
e) Written material review (e.g., brochure):

- Does the site have written materials on the EBP? *If no written material, then item is rated done one scale point (i.e., lower fidelity).*
- Does the written material articulate program philosophy consistent with EBP?

Item Response Coding: The goal of this item is *not* to quiz every staff worker to determine if they can recite every critical ingredient. The goal is to gauge whether the understanding is generally accurate and not contrary to the EBP. If, for example, a senior staff member says, "most of our consumers are not work ready," then that would be a red flag for the practice of supported employment. If all sources show evidence of a clear understanding of the program philosophy, the item is coded as a "5". For a source type that is based on more than one person (e.g., Practitioner interviews) determine the majority opinion when rating that source as endorsing or not endorsing a clear program philosophy. Note: If no written material, then count that source as being unsatisfactory.

*Difference between a major and minor area of discrepancy (needed to distinguish between a score of "4" and a score of "3"):* An example of a minor source of discrepancy for ACT might

be larger caseload sizes (e.g., 20-1) or some brokering of services. An example of a major discrepancy would be if the team seldom made home visits or if the psychiatrist was uninvolved in the treatment team meetings.

## G2. Eligibility/Consumer Identification

Definition:

*For EBPs implemented in a mental health center:* All consumers in the community support program, crisis consumers, and institutionalized consumers are screened using standardized tools or admission criteria that are consistent with the EBP.

*For EBPs implemented in a service area:* All consumers within the jurisdiction of the services area are screened using standardized tools or admission criteria that are consistent with the EBP. For example, in New York, county mental health administrations are responsible for identifying consumers who will be served by assertive community treatment programs.

- The *target population* refers to all adults with severe mental illness (SMI) served by the provider agency (or service area). If the agency serves consumers at multiple sites, then **assessment is limited to the site or sites that are targeted for the EBP.** If the target population is served in discrete programs (e.g., case management, residential, day treatment, etc.), then ordinarily all adults with SMI are included in this definition.
- *Screening* will vary according to the EBP. *The intent is to identify any and all for who could benefit from the EBP.* For Integrated Dual Disorder Treatment and Assertive Community Treatment, the admission criteria are specified by the EBP, and specific assessment tools are recommended for each. For Supported Employment, all consumers are invited to receive the service because all are presumed eligible (although the program is intended for consumers at the point, they express interest in working). The screening for Illness Management & Recovery includes an assessment of the skills and issues addressed by this EBP. For Family Psychoeducation, the screening includes the assessment of the involvement of a family member or significant other. In every case, the program should have an explicit, systematic method for identifying the eligibility of every consumer.
- Screening typically occurs at program admission, but for a program that is newly adopting an EBP, there should be a plan for systematically reviewing consumers already active in the program.

Rationale: Accurate identification of consumers who would benefit most from the EBP requires routine review for eligibility, based on criteria consistent with the EBP.

Sources of Information:
a) Program leader interview, b) Senior staff interview and c) Practitioner interview
d) Chart review
e) (Where applicable) County mental health administrators. If eligibility is determined at the service area level (e.g., the New York example), then the individuals responsible for this screening should be interviewed.

Item Response Coding: **This item refers to all consumers with SMI in the community support program or its equivalent at the site(s) where the EBP is being implemented;** it is not limited to the consumers receiving EBP services only. Calculate this percentage and record it

on the fidelity rating scale in the space provided. If 100% of these consumers receive standardized screening, the item would be coded as a "5."

## G3. Penetration

Definition: *Penetration* is defined as the percentage of consumers who have access to an EBP as measured against the total number of consumers who could benefit from the EBP. Numerically, this proportion is defined by:

$$\frac{\text{\# of consumers receiving an EBP}}{\text{\# of consumers eligible for the EBP}}$$

**As in the preceding item, the numbers used in this calculation are specific to the site or sites where the EBP is being implemented.**

Rationale: Surveys have repeatedly shown that persons with SMI often have a limited access to EBPs. The goal of EBP dissemination is not simply to create small exclusive programs but to make these practices easily accessible within the public mental health system.

Sources of Information:

The calculation of the penetration rate depends on the availability of the two statistics defining this rate.

- Numerator: The number receiving the service is based on a roster of names maintained by the program leader. Ideally, this total should be corroborated with service contact sheets and other supporting evidence that the identified consumers are actively receiving treatment. As a practical matter, agencies have many conventions for defining "active consumers" and dropouts, so that it may be difficult to standardize the definition for this item. The best estimate of the number actively receiving treatment should be used.
- Denominator: If the provider agency systematically tracks eligibility, then this number is used in the denominator. (See rules listed above in G2 to determine target population before using estimates below.) If the agency does not, then the denominator must be estimated by multiplying the total target population by the corresponding percentage based on the literature for each EBP. According to the literature, the estimates should be as follows:
    - Supported Employment – 60%
    - Integrated Dual Disorders Treatment – 40%
    - Illness Management & Recovery – 100%
    - Family Psychoeducation – 100% (some kind of significant other)
    - Assertive Community Treatment – 20%

  Example for calculating denominator: Suppose you don't know how many consumers are eligible for supported employment (i.e., the community support program has not surveyed the consumers to determine those who are interested). Let's say the community support program has 120 consumers. Then you would estimate the denominator to be:
  120 x .6 = 72

Item Response Coding: Calculate this ratio and record it on the fidelity scale in the space provided. If the program serves >80% of eligible consumers, the item would be coded as a "5".

## G4. Assessment

Definition: All EBP consumers receive standardized, high quality, comprehensive, and timely assessments.

*Standardization* refers to a reporting format that is easily interpreted and consistent across consumers.

*High quality* refers to assessments that provide concrete, specific information that differentiates between consumers. If most consumers are assessed using identical words, or if the assessment consists of broad, non-informative checklists, then this would be considered low quality.

*Comprehensive* assessments include history and treatment of medical, psychiatric, and substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.

*Timely* assessments are those updated at least annually.

Rationale: Comprehensive assessment/re-assessment is indispensable in identifying target domains of functioning that may need intervention, in addition to the consumer's progress toward recovery.

Sources of Information:
a) Program leader interview, b) Senior staff interview and c) Practitioner interview:
d) Chart review

Item Response Coding:
If >80% of consumers receive standardized, high quality, comprehensive, and timely assessments, the item would be coded as a "5".

## G5. Individualized Treatment Plan

Definition: For all EBP consumers, there is an explicit, individualized treatment plan (even if it is not called this) related to the EBP that is consistent with assessment and updated every 3 months. *"Individualized" means that goals, steps to reaching the goals, services/ interventions, and intensity of involvement are unique to this consumer. Plans that are the same or similar across consumers are not individualized. One test is to place a treatment plan without identifying information in front of the supervisor and see if they can identify the consumer.*

Rationale: Core values of EBP include individualization of services and supporting consumers' pursuit of their goals and progress in their recovery at their own pace. Therefore, the treatment plan needs ongoing evaluation and modification.

Sources of Information:

*Note:* This item and the next are assessed together, i.e., follow up questions about specific treatment plans with question about the treatment.

a) Chart review (treatment plan)
b) Program leader interview
c) Practitioner interview
d) Consumer interview
e) Team meeting/supervision observation, if available

Item Response Coding: If >80% of EBP consumers have an explicit individualized treatment plan that is updated every 3 months, the item would be coded as a 5. IF the treatment plan is individualized but updated only every 6 months, then the item would be coded as a 3.

## G6. Individualized Treatment

Definition: All EBP consumers receive individualized treatment meeting the goals of the EBP. "*Individualized*" treatment means that steps, strategies, services/interventions, and intensity of involvement are focused on *specific* consumer goals and are unique for each consumer. Progress notes are often a good source of what really goes on. Treatment could be highly individualized despite the presence of generic treatment plans.

An example of a low score on this item for Integrated Dual Disorders Treatment: a consumer in the engagement phase of recovery is assigned to a relapse prevention group and constantly told he needs to quit using, rather than using motivational interventions.

An example for a low score on this item for Assertive Community Treatment: the majority of progress notes are written by day treatment staff who see the consumer 3-4 days per week, while the Assertive Community Treatment team only sees the consumer about once per week to issue his check.

Rationale: The key to the success of an EBP is implementing a plan that is individualized and meets the goals for the EBP for each consumer.

Sources of Information:
a) Chart review (treatment plan).
b) Practitioner interview
c) Consumer interview

Item Response Coding: If >80% of EBP consumers receive treatment that is consistent with the goals of the EBP, the item would be coded as a 5.

## G7. Training

Definition: All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) within 2 months of hiring. Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent).

Rationale: Practitioner training and retraining are warranted to ensure that evidence-based services are provided in a standardized manner, across practitioners and over time.

Sources of Information:
a) Program leader interview, b) Senior staff interview and c) Practitioner interview.
d) Review of training curriculum and schedule, if available.
e) Practitioner interview.

Item Response Coding: If >80% of practitioners receive at least yearly, standardized training for [**EBP area**], the item would be coded as a "5".

## G8. Supervision

Definition: EBP practitioners receive structured, weekly supervision from a practitioner experienced in the particular EBP. The supervision can be either group or individual but CANNOT be peers-only supervision without a supervisor. The supervision should be consumer-centered and explicitly address the EBP model and its application to *specific consumer situations.*

Administrative meetings and meetings that are not specifically devoted to the EBP do not fit the criteria for this item. The *consumer specific* EBP supervision should be at least one hour in duration each week.

Rationale: Regular supervision is critical not only for individualizing treatment, but also for ensuring the standardized provision of evidence-based services.

Sources of Information:
a) Program leader interview, b) Senior staff interview and c) Practitioner interview
d) Team meeting/supervision observation, if available.
e) Supervision logs documenting frequency of meetings.

Item Response Coding: If >80% of practitioners receive weekly supervision, the item would be coded as a "5".

## G9. Process Monitoring

Definition: Supervisors/program leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Process monitoring involves a standardized approach, e.g., use of a fidelity scale or other comprehensive set of process indicators. An example of a process indicator would be systematic measurement of how much time individual case managers spend in the community versus in the office. Process indicators could include items related to training or supervision. The underlying principle is that whatever is being measured is related to implementation of the EBP and is not being measured to track billing or productivity.

Rationale: Systematic and regular collection of process data is imperative in evaluating program fidelity to EBP.

Sources of Information:
a) Program leader interview, b) Senior staff interview and c) Practitioner interview
d) Review of internal reports/documentation, if available

Item Response Coding: If there is evidence that standardized process monitoring occurs at least every 6 months, the item would be coded as a "5".

## G10. Outcome Monitoring

Definition: Supervisors/program leaders monitor the outcomes of EBP consumers every 3 months and share the data with EBP practitioners in an effort to improve services. Outcome monitoring involves a standardized approach to assessing consumers.

Rationale: Systematic and regular collection of outcome data is imperative in evaluating program effectiveness. Effective programs also analyze such data to ascertain what is working and what is not working and use the results to improve the quality of services they provide.

The key outcome indicators for each EBP are discussed in the implementation resource kits. A provisional list is as follows:

- Supported Employment – competitive employment rate
- Integrated Dual Disorders Treatment – substance use (such as the Stages of Treatment Scale)
- Illness Management & Recovery – hospitalization rates; relapse prevention plans; medication compliance rates
- Family Psychoeducation – hospitalization and family burden
- Assertive Community Treatment – hospitalization and housing

Sources of Information:
a) Program leader interview, b) Senior staff interview and c) Practitioner interview
d) Review of internal reports/documentation, if available

Item Response Coding: If standardized outcome monitoring occurs quarterly and results are shared with EBP Practitioners, the item would be coded as a "5".

## G11. Quality Assurance (QA)

Definition: The agency's QA Committee has an explicit plan to review the EBP or components of the program every 6 months. The steering committee for the EBP can serve this function. Good QA committees help the agency in important decisions, such as penetration goals, placement of the EBP within the agency, hiring/staffing needs. QA committees also help guide and sustain the implementation by reviewing fidelity to the EBP model, making recommendations for improvement, advocating/promoting the EBP within the agency and in the community, and deciding on and keeping track of key outcomes relevant to the EBP.

Rationale: Research has shown that programs that most successfully implement evidence-based practices have better outcomes. Again, systematic, and regular collection of process and outcome data is imperative in evaluating program effectiveness.

Sources of Information:
a) Program leader interview
b) QA Committee member interview

Item Response Coding: If agency has an established QA group or steering committee that reviews the EBP or components of the program every 6 months, the item would be coded as a "5".

## G12. Consumer Choice Regarding Service Provision

Definition: All consumers receiving EBP services are offered a reasonable range of choices consistent with the EBP; the EBP practitioners consider and abide by consumer preferences for treatment when offering and providing services.

Choice is defined narrowly in this item to refer to services provided. This item does not address broader issues of consumer choice, such as choosing to engage in self-destructive behaviors.

To score high on this item, it is not sufficient that a program offers choices. The choices must be consonant with EBP. So, for example, a program implementing supported employment would score low if the only employment choices it offered were sheltered workshops.

A *reasonable range of choices* means that EBP practitioners offer realistic options to consumers rather than prescribing only one or a couple of choices or dictating a fixed sequence or prescribing conditions that a consumer must complete before becoming eligible for a service.

*Sample of Relevant Choices by EBP:*

- Supported Employment
  - *Type of occupation*
  - *Type of work setting*
  - *Schedules of work and number of hours*
  - *Whether to disclose*
  - *Nature of accommodations*
  - *Type and frequency of follow-up supports*
- Integrated Dual Disorders Treatment
  - *Group or individual interventions*
  - *Frequency of DD treatment*
  - *Specific self-management goals*
- Family Psychoeducation
  - *Consumer readiness for involving family*
  - *Who to involve*
  - *Choice of problems/issues to work on*
- Illness Management & Recovery
  - *Selection of significant others to be involved*
  - *Specific self- management goals*
  - *Nature of behavioral tailoring*
  - *Skills to be taught*
- Assertive Community Treatment
  - *Type and location of housing*
  - *Nature of health promotion*
  - *Nature of assistance with financial management*
  - *Specific goals*
  - *Daily living skills to be taught*
  - *Nature of medication support*
  - *Nature of substance abuse treatment*

Rationale: A major premise of EBP is that consumers can play a vital role in the management of their illnesses and in making progress towards achieving their goals. Providers accept the responsibility of getting information to consumers so that they can become more effective participants in the treatment process.

Sources of Information:
a) Program leader interview
b) Practitioner interview
c) Consumer interview
d) Team meeting/supervision observation
e) Chart review (especially treatment plan)

Item Response Coding: If all sources support that type and frequency of EBP services always reflect consumer choice, the item would be coded as a “5”. If agency embraces consumer choice fully, except in one area (e.g., requiring the agency to assume representative payee-ships for all consumers), then the item would be coded as a “4”.

**General Organizational Index Cover Sheet**

**Date:**_____ **Rater(s):** _____

_____

**Program Name:** _____

**Address:** _____

**Contact Person:** _____ **(Title:** _____**)**

**☎:** _____ **Fax:** _____

**E-mail:** _____

**Sources Used:**

____ Chart review ____ Agency brochure review

____ Team meeting observation ____ Supervision observation

____ Interview with Program Director/Coordinator

____ Interview with Practitioners ____ Interview with consumers

____ Interview with supervisors ____ Interview with supervisors

____ Interview with rehabilitation service providers

____ Interview with QA Committee Member

____ Interview with _____

____ _____

____ _____

**# of EBP Practitioners:** _____ **# of active consumers served by EBP:** _____

**# of consumers served by EBP in preceding year:** _____ # of charts reviewed _____

**Date program was started:** _____

## GOI Score Sheet

Program: Date of Visit:

Informants – Name(s) and Position(s): _____, _____,

_____, _____, _____, _____

Number of Records Reviewed: Rater 1: Rater 2:

| | | Rater 1 | Rater 2 | Consensus |
|---|---|---|---|---|
| G1 | Program Philosophy | | | |
| G2 | Eligibility/Consumer Identification | | | |
| G3 | Penetration | | | |
| G4 | Assessment | | | |
| G5 | Individualized Treatment Plan | | | |
| G6 | Individualized Treatment | | | |
| G7 | Training | | | |
| G8 | Supervision | | | |
| G9 | Process Monitoring | | | |
| G10 | Outcome Monitoring | | | |
| G11 | Quality Assurance (QA) | | | |
| G12 | Consumer Choice Regarding Service Provision | | | |
| | TOTAL MEAN SCORE: | | | |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: SCCMHA Practice Guidelines</td><td>Chapter: Chapter 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.01.01</td></tr>
<tr><td rowspan="2">Effective Date: 10/1/11</td><td>Date of Review/Revision: 6/13/17, 2/27/20, 6/14/20, 4/14/21, 1/12/22, 1/10/23, 1/31/24</td><td rowspan="3">Approved By: Sandra M. Lindsey, CEO<br><br>Responsible Director: Director of Network Services, Public Policy, & Continuing Education<br><br>Authored By: Mary Baukus<br><br>Additional Reviewers: EBP Leadership Team</td></tr>
<tr><td>Supersedes: 02.03.16</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA acts to ensure that all services are delivered in accordance with an array of consistent practice guidelines, whenever and wherever such guidelines or practices are available and applicable, in order to promote consistent and effective service delivery for consumers throughout the network, resulting in better outcomes for persons served as well as the best value use of limited public funds. This policy seeks to encompass all relevant practice guidelines areas of SCCMHA for this purpose.

**Policy:**
It is the policy of SCCMHA that standards for use of acceptable, proven practices will be established and monitored by SCCMHA. Key standard areas for SCCMHA include, but are not limited to, a list of proven Evidence-Based Practices (EBP) which specifically meet the needs of consumer population groups served by SCCMHA, as well as the state issued Service Selection Guidelines and current Michigan Medicaid Manual. Practices include those for whole health, including behavioral health and physical health practices.

**Application:**
The policy applies to the entire SCCMHA service delivery network, including direct operated programs and purchased/contracted services and supports.

**Standards:**
A. Specific practices are reviewed, evaluated for SCCMHA system use, and endorsed for system provider and program use by the Service Management Team.
B. Key standard areas for SCCMHA include various Evidence-Based Practices as supported by valid research and adopted by SCCMHA as delineated in SCCMHA

policy and manuals; other EBP resources are available through the Substance Abuse & Mental Health Services Administration (SAMHSA) current tool kits.

C. Key standard areas for SCCMHA include state issued service selection guidelines which retain their useful value to SCCMHA in the oversight of provision of services and supports.
D. Staff and providers involved in service delivery and the provision of supports for consumers are expected to obtain the knowledge and develop the skill set(s), as well as abide by all applicable guidelines for their scope of service, including population and/or sub-populations being served and other factors including specific job assignments and/or presentation of consumer needs.
E. Staff and providers are not permitted to engage in practices for which they have not been privileged by SCCMHA except under supervision during initial training periods.
F. Staff members actively engaged in specific practices must be individually privileged through an initial and on-going process defined by SCCMHA.
G. Person-centered/family-centered planning practices are embedded in all practices throughout SCCMHA.
H. Foundational practice areas for the SCCMHA network include trauma-informed practice, consumerism, therapeutic environment, motivational interviewing, and positive behavior supports.
I. SCCMHA will promote recovery, development of resilience and self-determination as part of the overall practice guidelines throughout the network.
J. Proactive crisis planning with consumers served is promoted as part of the overall SCCMHA practice guideline framework; this may include advance directives if desired by the consumer.
K. SCCMHA will promote welcoming as part of the practice guideline expectations within the SCCMHA service delivery network.
L. SCCMHA will provide and support training and continuing education to assist staff and providers, including issuing professional continuing education unit credits where feasible.
M. SCCMHA will engage community partners in the mutual sharing of practice resource information.
N. Practice guidelines are a critical component of the overall SCCMHA Quality Assurance and Improvement Program.
O. All policies and procedures that pertain to practice guideline areas are included in the SCCMHA Network Services Provider Manual, updated annually.
P. The Evidence-Based Practices Leadership Team, in concert with lead practice facilitators, will provide continuous monitoring of the use of practices in the network.
Q. SCCMHA will provide educational opportunities for consumers in practice areas where feasible, including but not limited to specific evidence-based practice content, consumer orientation information provided by providers and dissemination of educational information in any relevant area, such as the SCCMHA Residential Directory which provides guidance on licensed adult foster care home selection.
R. Active or referred consumer requests for more detail or additional information on practice methods available at SCCMHA will be responded to in a timely manner.

S. Development or adoption of practices utilized throughout SCCMHA will consider consumer needs, preferences, cultural or ethnic backgrounds, feedback, and outcomes.
T. Practices of SCCMHA will include health care integration models and methods in recognition of the overall wellness and health of individuals served.
U. SCCMHA will conduct clinical management decision making and service array management and development in keeping with practice guidelines.
V. Monitoring venues of the use of practice guidelines includes: the SCCMHA service management team (Executive Director of Clinical Services & Programs, Director of Network Services, Public Policy, & Continuing Education, Chief of Health Services & Integrated Care, and Chief Information Officer & Chief Quality and Compliance Officer); clinical supervisors; varied, specific health care consultants and/or practice experts; Evidence-Based Practices Leadership Team; and Network Auditing Supervisor.
W. Behavioral interventions and management of clinical risk will be in keeping with SCCMHA policies and approved practices.
X. Peer support services are an integral aspect of practice guidelines.
Y. Availability and/or provision of practices endorsed by SCCMHA may vary over time based on consumer needs, training staff capacity and available resources.

**Definitions:**

Practice Guidelines: Any nationally accepted practices that are recommended by MDCH and/or approved by SCCMHA leadership for use, with accompanying guidance to supervisors and staff about practice parameters, implementation, and adherence to elements for fidelity and effectiveness to produce positive consumer outcomes.

Evidence-Based Practice: A clinical intervention that has a strongly rooted scientific foundation and produces consistent results in assisting consumers achieve their desired goals or outcomes.

Care Management Manual: Manual prepared as a guideline for the SCCMHA Care Management unit and other management team members involved in care management and quality systems to assist in service authorization and denial decisions for SCCMHA.

**References:**

- Medicaid Manual: The most current (generally revisions are issued on a quarterly basis on January 1, April 1, July 1 and October 1) of the Michigan Department of Community Health (MDCH) *Medicaid Provider Manual, Mental Health/Substance Abuse* section(s).
- *MDCH Service Selection Guidelines* issued October 1, 2002.
- SCCMHA Care Management Procedure
- SCCMHA Evidence-Based Practices Policy & various, specific EBP Policies
- SCCMHA Policy 02.03.01 – Consumerism
- SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| Reviews and adopts specific practices for use in the SCCMHA service network, and issues relevant policies, training, supervision, and resources to implement and measure outcomes and support the SCCMHA strategic plan and network performance. Updates practices as needed and ensure dissemination to all pertinent providers and programs. Provides direction on practices for specific programs or service areas. Reviews evaluation data to determine sustained use of practices and/or the need for practice changes. | Service Management Team |
| Provide leadership in the initiation and successful implementation of specific practices for specific populations. Identify areas of practice need or interest to enhance system competency to support consumer needs. Provide feedback to leadership and submit requests for adoption consideration. Supervise or assist staff members in specific, relevant practice models. Participate in state sponsored work groups or collaborative sessions for relevant practices and help disseminate information within teams and network. Oversee fidelity to practice models where applicable. | Clinical Supervisors or practice champion designees |
| Provides oversight of system evidence-based practices and related resources. Reviews data, monitors fidelity reviews and facilitates direct consumer leadership oversight and input in practice areas or needs. | Evidence-Based Practices Leadership Team |

| | |
|---|---|
| Adhere to practice guidelines of SCCMHA. Seek and maintain credentials to meet requirements and consumer needs. | Individual Staff and Provider Network Practitioners |
| Provides leadership to network psychiatrists/prescribers regarding best practices. Provides practice consultations with community physicians, including primary care providers. | Medical Director |
| Conducts care management reviews and/or utilization management or level of care assessments in keeping with practice guidelines. Authorizes off panel services in keeping with best practices when indicated to meet unique consumer needs. | Care Management Team |
| Provides leadership/oversight and/or responds to inquiries regarding specific practice models or SCCMHA needs, including emerging /available research evidence, application to SCCMHA system needs and efficacy. Provides support and consultation to practice leaders and other staff. Facilitates fidelity reviews, privileging processes, and tracking of EBP data. | Evidence-Based Practice and Trauma-Informed Care Coordinator |
| Conducts reviews to ensure provider training and performance, as well as credentials, in SCCMHA required or expected practice areas are compliant with SCCMHA policy. | Evidence-Based Practice and Trauma-Informed Care Coordinator/EBPLT and/or Provider Network Auditing Supervisor |
| Review, plan, develop and implement training programs including offering continuing education units which support practice needs and priorities. | Continuing Education Supervisor & Continuing Education Committee |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Assertive Community Treatment (ACT)</td><td>Chapter: 02 - Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.02</td></tr>
<tr><td rowspan="2">Effective Date:<br>7/20/06</td><td>Date of Review/Revision:<br>5/18/09, 6/10/10, 4/2/12, 5/7/14, 10/7/14, 3/22/16, 6/13/17, 4/10/18, 4/9/19, 6/9/20, 3/10/21, 1/12/22, 1/10/23, 1/31/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Network Services, Public Policy & Continuing Education<br><br>Authored By:<br>Mary Baukus, Barbara Glassheim<br><br>Additional Reviewers:<br>EBP Leadership Team</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 delineate standards for the provision of Assertive Community Treatment (ACT) services to eligible consumers.

**Policy:**
A. SCCMHA shall make ACT services available to eligible consumers as resources permit.
B. ACT services shall adhere as closely as possible to the evidence-based practice model of ACT.
C. Adaptations to the model for local community needs may be made with the approval of SCCMHA.

**Application:**
This policy applies to SCCMHA-funded ACT programs.

**Standards:**
A. The Saginaw ACT team shall be approved by and registered with MDHHS in accordance with Michigan Medicaid requirements which include MDHHS re-approval every three years.
B. The Saginaw ACT team shall provide all services for consumers of ACT within the team's structure; billing for ACT services shall occur as part of ACT and services billed outside of ACT shall be limited to those not available in the ACT program (e.g., inpatient hospitalization, community health workers to assist with addressing comorbid medical conditions).

C. The Saginaw ACT team shall provide services and supports to consumers in a trauma-informed manner.

D. ACT shall be delivered in accordance with the following standards:

1. Resources

a. Program Staff: **Team leader** with a minimum of a master's degree in a relevant discipline with appropriate licensure or certification to provide clinical supervision with a minimum of two years clinical experience with adults with serious mental illness (1.0 FTE with direct service provision 50% of the time), **psychiatrist** (1.0 FTE per 100 consumers), a full-time **RN**, **Certified Peer Support Specialist**, other **Qualified Mental Health Professionals (QMHPs)** who hold bachelor's, master's or doctoral degrees in social work, nursing, rehabilitation counseling, psychology, occupational therapy, and a program assistant. In addition, the team shall include an **employment specialist** and a **substance use disorder specialist**.

1). The ACT team shall address co-occurring substance use disorders (SUDs) of consumers within the team service.

a). The ACT team shall provide or obtain co-occurring treatment for consumers with co-occurring mental health and substance use disorders.

b). If the team provides substance abuse services, there must be a designated substance abuse specialist who is certified through the Michigan Certification Board of Addiction Professionals (MCBAP) and have one or more of the following credentials:

(1). Certified Alcohol and Drug Counselor – Michigan (CADC-M)

(2). Certified Alcohol and Drug Counselor - IC & RC (CADC)

(3). Certified Advanced Alcohol and Drug Counselor – IC & RC (CAADC)

(4). Certified Clinical Supervisor – IC & RC (CCS)

(5). Certified Clinical Supervisor – Michigan (CCS-M)

(6). Certified Criminal Justice Professional - IC & RC Reciprocal (CCJP-R)

(7). Certified Co-Occurring Disorders Professional – IC & RC (CCDP)

(8). Certified Co-Occurring Disorders Professional Diplomat – IC & RC (CCDP-D)

c). ACT team members who provide substance use disorder treatment must have appropriate substance use disorder treatment credentials or be supervised by staff with the appropriate credentials.

d). ACT programs shall maintain a substance use disorder treatment license that specifies the integrated treatment service category.

2). The ACT team shall provide employment services for consumers who request this service.

3). The ACT team shall closely monitor consumers who are admitted to inpatient psychiatric hospitals and inpatient substance abuse treatment centers.

a). The ACT team shall participate in treatment team meetings and discharge planning.

b). The ACT team shall closely monitor symptoms during time of admission to provide information about the consumer's baseline functioning

b. Coverage: The ACT team shall provide twenty-four hour/seven-day a week crisis response coverage (including psychiatric availability) that is handled directly by members of the ACT team.

1). The ACT team will provide a rapid response to early signs of relapse, including the capability to provide multiple contacts daily with consumers in acute need or with emergency conditions.

2). The ACT team will participate in the face-to-face screening of consumers who are presenting to an emergency department for admission to an inpatient psychiatric hospital**.**

3). The ACT team will make attempts to avoid hospitalization including: scheduling an emergency medication review, increasing visits, 'eyes on' medication, and/or placement at the Crisis Residential Unit.

4). ACT staff shall conduct pre-screenings for inpatient hospitalizations.

5.) Once the screening is complete and inpatient treatment is recommended, SCCMHA Crisis Intervention Services (CIS) staff will facilitate locating an appropriate placement.

6.) ACT staff shall call CIS to let them know that a prescreen was done and a bed is needed before going to court (court is only necessary if an individual who has been recommended inpatient treatment does not agree to the treatment).

7). ACT staff shall petition the court for an involuntary inpatient treatment order once an inpatient bed has been secured by CIS.

8). ACT and Crisis Screening staff will coordinate monitoring of all consumers in the emergency department while waiting for bed availability.

c. Staff to Consumer Ratio: A staff to consumer ratio of one to ten shall be maintained, inclusive of paraprofessional staff.

d. Team Caseload: The ACT team shall maintain a shared caseload

E. Admission Criteria: ACT shall be reserved for adults with serious and persistent mental illnesses with or without co-occurring substance use disorders who experience the most severe symptoms and therefore face continuous challenges in functioning in adult roles in the community.
   1. ACT shall not be provided to a consumer with a primary personality disorder, a primary SUD, or a primary developmental disability diagnosis.
   2. ACT team services shall be deemed medically necessary to provide treatment in the least restrictive setting, to allow consumers to remain in the community, to improve the consumer's condition and/or allow the consumer to function without more restrictive care.
   3. Consumers who reside in an AFC home without a plan to move out shall not be deemed to meet initial medical necessity for ACT services.

F. Processes: Admission meetings, comprehensive assessments, treatment plans, psychiatric/social functioning timelines, ongoing assessments, daily communication logs, daily team schedules, weekly consumer schedules, and daily team meetings are conducted.
   1. Team meetings shall occur Monday through Friday and shall be attended by all staff members on duty.
      a. The status of all consumers served by the team shall be reviewed.
      b. Documentation of daily team meetings shall include all consumers discussed and all staff members present.
      c. The daily schedule shall be organized, and contacts scheduled.

G. Service Delivery: Services shall be provided in consumers' residences or other community locations by *all* members of the ACT team staff.

H. Discharge/Transition: Services shall be provided on a time unlimited basis as long as the consumer requires ACT (i.e., meets admission and level of care criteria) in order to maintain community tenure. Consumers who no longer meet criteria shall be transitioned to a less intensive level of supports and services in accordance with need.
   1. For consumers who have progressed forward on their journey toward recovery and are ready for a less intensive level of service, their IPOS shall document the transition from ACT to a less intensive service.
   2. If a consumer requests transition to other service(s) because he/she believes maximum benefit has been reached in ACT, consideration for transition into less intensive service shall be reviewed using the person- centered planning process.
   3. If engaging the consumer is not possible using frequent assertive team outreach, discharge will be considered.
   4. If the consumer has moved outside the geographic services area, the ACT team will continue to provide care to the consumer until services have been established in the new location.
   5. Once it is determined that a consumer will be placed in a general or specialized AFC, transition to a lower level of care will occur.
      a. The transition will be reflected in the consumer's IPOS.
      b. The length of transition time shall be specific to the needs of each consumer.

c. There may be exceptions to transitioning to a lower level of care when a consumer is placed in an AFC including a frequent need for new placements, high hospital utilization, high on-call utilization, and when transitioning will cause a disruption in treatment.

d. A transition into ACT will be considered for a consumer who is moving out of an AFC home (dependent setting) into an independent setting.

e. There may be an overlap of ACT services while the consumer is still in an AFC in order to ensure a smooth transition.

f. Consumers who are placed in an AFC on a temporary basis in order to achieve a higher level of stability shall remain in ACT services.

g. SCCMHA Care Management shall conduct a review of each consumer served by the ACT team who has been placed in a residential setting and authorize residential stays for a maximum of thirty days.

1). Residential reauthorizations for such consumers shall also include a concurrent review of ACT services.

I. Consumer Engagement: Consumers shall be assertively engaged, and their progress shall be monitored on an ongoing basis.

J. Legal: The ACT team will monitor the status of treatment orders and complete any necessary paperwork to facilitate the continuing of orders as needed.

1. The ACT team psychiatrist will participate in court hearings for treatment orders as needed.
2. The ACT team will complete comprehensive Alternative Treatment Plans (ATP) as well as MOAs (memorandum of agreement) as needed.

**Definitions:**

**Assertive Community Treatment (ACT)** is a means of delivering comprehensive and effective services to individuals who have been diagnosed with a serious mental illness and whose needs have not been met effectively by traditional approaches to service delivery. ACT is targeted to individuals who have the most serious and intractable symptoms of mental illness and experience the most severe difficulties with basic day-to-day functioning such as caring for basic physical needs, maintaining adequate and safe housing, and keeping themselves safe. Such individuals may have extensive histories of hospitalization, unemployment, substance abuse, homelessness, and involvement in the criminal justice system. ACT services are provided by a transdisciplinary team on a twenty-four-hour, seven day a week basis.

The Michigan Medicaid Provider Manual defines ACT as "a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes case/care management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorders treatment, and employment and rehabilitative services provided in the beneficiary's home or community".

**Alternative Treatment Plan (ATP):** is prepared at the request of the Probate court, for a person who will be adjudicated by the court for involuntary commitment. This document is based on a clinician's assessment of the consumer's needs, resources available in the community, and the recommendations of the clinician for the manner in which the consumer's needs are best met within available resources.

**Individual Plan of Service (IPOS)** directs the provision of supports and services to be provided to the consumer. The IPOS is developed using person-centered planning.

**References:**

A. MDCH. *Medicaid Provider Manual.* Michigan Department of Community Health. Lansing, MI. [On-line]. Available: MedicaidProviderManual.pdf (state.mi.us)

B. Substance Abuse Mental Health Services Administration. (2008). *Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT.* Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Rockville, MD. [On-line]. Available: Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT | SAMHSA Publications and Digital Products

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

**Exhibits:**

A. ACT Fidelity Scale (SAMHSA)

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. ACT services are provided in accordance with the standards of the model to consumers who meet admission and level of care criteria | 1. ACT Team |
| 2. ACT services are monitored on a regular basis for fidelity to the model and outcomes | 2. SCCMHA EBP Leadership/Fidelity Monitoring Team or other SCCMHA-designated body |

Exhibit A

# ACT Fidelity Scale

## Human resources: Structure and composition

| Criterion | | Ratings / Anchors 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| H1 | **Small caseload:** Consumer/ provider ratio = 10:1 | 50 consumers/team member or more | 35–49 | 21–34 | 11–20 | 10 consumers/team member or fewer |
| H2 | **Team approach:** Provider group functions as team rather than as individual ACT team members; ACT team members know and work with all consumers | Less than 10% consumers with multiple team face-to-face contacts in reporting 2-week period | 10–36% | 37–63% | 64–89% | 90% or more consumers have face-to-face contact with >1 staff member in 2 weeks |
| H3 | **Program meeting:** Meets often to plan and review services for each consumer | Service-planning for each consumer usually 1x/month or less | At least 2x/month but less often than 1x/week | At least 1x/week but less than 2x/week | At least 2x/week but less than 4x/ week | Meets at least 4 days/ week and reviews each consumer each time, even if only briefly |
| H4 | **Practicing ACT leader:** Supervisor of Frontline ACT team members provides direct services | Supervisor provides no services | Supervisor provides services on rare occasions as backup | Supervisor provides services routinely as backup or less than 25% of the time | Supervisor normally provides services between 25% and 50% time | Supervisor provides services at least 50% time |
| H5 | **Continuity of staffing:** Keeps same staffing over time | Greater than 80% turnover in 2 years | 60–80% turnover in 2 years | 40–59% turnover in 2 years | 20–39% turnover in 2 years | Less than 20% turnover in 2 years |
| H6 | **Staff capacity:** Operates at full staffing | Operated at less than 50% staffing in past 12 months | 50–64% | 65–79% | 80–94% | Operated at 95% or more of full staffing in past 12 months |
| H7 | **Psychiatrist on team:** At least 1 full-time psychiatrist for 100 consumers works with program | Less than .10 FTE regular psychiatrist for 100 consumers | .10–.39 FTE for 100 consumers | .40–.69 FTE for 100 consumers | .70–.99 FTE for 100 consumers | At least 1 full-time psychiatrist assigned directly to 100-consumer program |
| H8 | **Nurse on team:** At least 2 full-time nurses assigned for a 100-consumer program | Less than .20 FTE regular nurse for 100 consumers | .20–.79 FTE for 100 consumers | .80–1.39 FTE for 100 consumers | 1.40–1.99 FTE for 100 consumers | 2 full-time nurses or more are members for 100-consumer program |
| H9 | **Substance abuse specialist on team:** A 100-consumer program with at least 2 staff members with 1 year of training or clinical experience in substance abuse treatment | Less than .20 FTE S/A expertise for 100 consumers | .20–.79 FTE for 100 consumers | .80–1.39 FTE for 100 consumers | 1.40–1.99 FTE for 100 consumers | 2 FTEs or more with 1 year S/A training or supervised S/A experience |
| H10 | **Vocational specialist on team:** At least 2 team members with 1 year training/experience in vocational rehabilitation and support | Less than .20 FTE vocational expertise for 100 consumers | .20–.79 FTE for 100 consumers | .80–1.39 FTE for 100 consumers | 1.40–1.99 FTE for 100 consumers | 2 FTEs or more with 1 year voc. rehab. training or supervised VR experience |
| H11 | **Program size:** Of sufficient absolute size to consistently provide necessary staffing diversity and coverage | Less than 2.5 FTE staff | 2.5–4.9 FTE | 5.0–7.4 FTE | 7.5–9.9 | At least 10 FTE staff |

## Organizational boundaries

| Criterion | | Ratings / Anchors | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| O1 | **Explicit admission criteria:** Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals. | Has no set criteria and takes all types of cases as determined outside the program | Has a generally defined mission but admission process dominated by organizational convenience | Tries to seek and select a defined set of consumers but accepts most referrals | Typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure | Actively recruits a defined population and all cases comply with explicit admission criteria |
| O2 | **Intake rate:** Takes consumers in at a low rate to maintain a stable service environment | Highest monthly intake rate in the last 6 months = greater than 15 consumers/month | 13–15 | 10–12 | 7–9 | Highest monthly intake rate in the last 6 months no greater than 6 consumers/month |
| O3 | **Full responsibility for treatment services:** In addition to case management, directly provides psychiatric services, counseling/ psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services | Provides no more than case management services | Provides 1 of 5 additional services and refers externally for others | Provides 2 of 5 additional services and refers externally for others | Provides 3 or 4 of 5 additional services and refers externally for others | Provides all 5 services to consumers |
| O4 | **Responsibility for crisis services:** Has 24-hour responsibility for covering psychiatric crises | Has no responsibility for handling crises after hours | Emergency service has program-generated protocol for program consumers | Is available by phone, mostly in consulting role | Provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement | Provides 24-hour coverage |
| O5 | **Responsibility for hospital admissions:** Is involved in hospital admissions | Is involved in fewer than 5% decisions to hospitalize | ACT team is involved in 5%–34% of admissions | ACT team is involved in 35%–64% of admissions | ACT team is involved in 65%–94% of admissions | ACT team is involved in 95% or more admissions |
| O6 | **Responsibility for hospital discharge planning:** Is involved in planning for hospital discharges | Is involved in fewer than 5% of hospital discharges | 5%–34% of program consumer discharges planned jointly with program | 35%–64% of program consumer discharges planned jointly with program | 65–94% of program consumer discharges planned jointly with program | 95% or more discharges planned jointly with program |
| O7 | **Time-unlimited services (graduation rate):** Rarely closes cases but remains the point of contact for all consumers as needed | More than 90% of consumers are expected to be discharged within 1 year | From 38–90% of consumers expected to be discharged within 1 year | From 18–37% of consumers expected to be discharged within 1 year | From 5–17% of consumers expected to be discharged within 1 year | All consumers served on a time-unlimited basis, with fewer than 5% expected to graduate annually |

## Nature of services

| | Criterion | Ratings / Anchors 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| S1 | **Community-based services:** Works to monitor status, develop community living skills in community rather than in office | Less than 20% of face-to-face contacts in community | 20–39% | 40–59% | 60–79% | 80% of total face-to-face contacts in community |
| S2 | **No dropout policy:** Retains high percentage of consumers | Less than 50% of caseload retained over 12-month period | 50–64% | 65–79% | 80–94% | 95% or more of caseload is retained over a 12-month period |
| S3 | **Assertive engagement mechanisms:** As part of ensuring engagement, uses street outreach and legal mechanisms (probation/parole, OP commitment) as indicated and as available | Passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms | Makes initial attempts to engage but generally focuses on most motivated consumers | Tries outreach and uses legal mechanisms only as convenient | Usually has plan for engagement and uses most mechanisms available | Demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate |
| S4 | **Intensity of service:** High total amount of service time, as needed | Average 15 minutes/week or less of face-to-face contact for each consumer | 15–49 minutes/week | 50–84 minutes/week | 85–119 minutes/week | Average 2 hours/week or more of face-to-face contact for each consumer |
| S5 | **Frequency of contact:** High number of service contacts, as needed | Average less than 1 face-to-face contact/week or fewer for each consumer | 1–2x/week | 2–3x/week | 3–4x/week | Average 4 or more face-to-face contacts/week for each consumer |
| S6 | **Work with informal support system:** With or without consumer present, provides support and skills for consumer's support network: family, landlords, employers | Less than .5 contact/month for each consumer with support system | .5–1 contact/month for each consumer with support system in the community | 1–2 contact/month for each consumer with support system in the community | 2–3 contacts/month for consumer with support system in the community | 4 or more contacts/month for each consumer with support system in the community |
| S7 | **Individualized substance abuse treatment:** 1 or more team members provides direct treatment and substance abuse treatment for consumers with substance-use disorders | No direct, individualized substance abuse treatment provided | Team variably addresses SA concerns with consumers; provides no formal, individualized SA treatment | While team integrates some substance abuse treatment into regular consumer contact, no formal, individualized SA treatment | Some formal individualized SA treatment offered; consumers with substance-use disorders spend less than 24 minutes/week in such treatment | Consumers with substance-use disorders average 24 minutes/week or more in formal substance abuse treatment |
| S8 | **Co-Occurring disorder treatment groups:** Uses group modalities as treatment strategy for consumers with substance-use disorders | Fewer than 5% of consumers with substance-use disorders attend at least 1 substance abuse treatment group meeting a month | 5–19% | 20–34% | 35–49% | 50% or more of consumers with substance-use disorders attend at least 1 substance abuse treatment group meeting/month |
| S9 | **Dual Disorders (DD) Model:** Uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence | Fully based on traditional model: confrontation; mandated abstinence; higher power, etc. | Uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehab; recognizes need to persuade consumers in denial or who don't fit AA | Uses mixed model: e.g., DD principles in treatment plans; refers consumers to persuasion groups; uses hospitalization for rehab.; refers to AA, NA | Uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some SA treatment | Fully based in DD treatment principles, with treatment provided by ACT staff members |
| S10 | **Role of consumers on team:** Consumers involved as team members providing direct services | Consumers not involved in providing service | Consumers fill consumer-specific service roles (e.g., self-help) | Consumers work part-time in case-management roles with reduced responsibilities | Consumers work full-time in case management roles with reduced responsibilities | Consumers employed full-time as ACT team members (e.g., case managers) with full professional status |

# ACT Fidelity Score Sheet

Date of visit: _____ / _____ / _____

Agency name: _____

Assessors' names: _____ _____

| | | Assessor 1 | Assessor 2 | Consensus |
|---|---|---|---|---|
| H1 | Small caseload | | | |
| H2 | Team approach | | | |
| H3 | Program meeting | | | |
| H4 | Practicing ACT leader | | | |
| H5 | Continuity of staffing | | | |
| H6 | Staff capacity | | | |
| H7 | Psychiatrist on team | | | |
| H8 | Nurse on team | | | |
| H9 | Substance abuse specialist on team | | | |
| H10 | Vocational specialist on team | | | |
| H11 | Program size | | | |
| O1 | Explicit admission criteria | | | |
| O2 | Intake rate | | | |
| O3 | Full responsibility for treatment services | | | |
| O4 | Responsibility for crisis services | | | |
| O5 | Responsibility for hospital admissions | | | |
| O6 | Responsibility for hospital discharge planning | | | |
| O7 | Time-unlimited services | | | |
| S1 | In vivo services | | | |
| S2 | No drop-out policy | | | |
| S3 | Assertive engagement mechanisms | | | |
| S4 | Intensity of service | | | |
| S5 | Frequency of contact | | | |
| S6 | Work with support system | | | |
| S7 | Individualized substance abuse treatment | | | |
| S8 | Co-Occurring disorder treatment groups | | | |
| S9 | Co-Occurring disorders (Dual Disorders) model | | | |
| S10 | Role of consumers on treatment team | | | |
| **Total mean score** | | | | |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Family Psychoeducation (FPE)</td><td>Chapter: 02 - Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.05</td></tr>
<tr><td rowspan="2">Effective Date:<br>2/7/07</td><td>Date of Review/Revision:<br>5/18/09, 6/10/10, 4/2/12, 5/7/14, 4/19/16, 6/13/17, 4/10/18, 4/9/19, 6/10/20, 3/10/21, 1/10/23, 1/31/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Network Services, Public Policy, & Continuing Education<br><br>Authored By:<br>Mary Baukus, Barbara Glassheim<br><br>Additional Reviewers:<br>EBP Leadership Team</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 delineate standards for the provision of Family Psychoeducation (FPE) services to consumers who can benefit from this program and desire to participate.

**Policy:**

- SCCMHA is committed to supporting the recovery process of consumers using evidence-based practices that are designed to decrease illness symptoms, crises, rehospitalizations, social isolation, and unemployment. FPE is one such evidence-based practice that has been selected to promote services and supports that produce beneficial outcomes. Research has demonstrated that relapse rates and unemployment are significantly decreased when family intervention, multi-family groups, and medication are used concurrently.
- SCCMHA shall make FPE to eligible consumers and their families/support systems available as resources permit.
- FPE shall be delivered in accordance with the standards set forth in the Substance Abuse and Mental Health Service Administration (SAMHSA), Center for Mental Health Services' Family Psychoeducation Resource Toolkit Fidelity Scale (contained in Exhibits A – C), Michigan's standards (contained in Exhibits D – G), and in a trauma-informed manner.

**Application:**
This policy applies to all SCCMHA-funded providers delivering FPE to consumers and their families.

**Standards:**

A. FPE has been shown to be most helpful for individuals with schizophrenia, obsessive compulsive disorder, schizoaffective disorder, bipolar disorder, major depression, and borderline personality disorder. Therefore, consumers with these diagnoses will be offered FPE in accordance with available resources.

B. FPE shall be delivered in accordance with the following standards:

1. Program elements:

a. Engagement sessions, which usually involve caretakers and consumers, who may meet separately or together, depending on clinical condition and other considerations, as determined by the provider. Three or more engagement sessions may be conducted and are optimally offered as early in the course of an episode or illness as possible. These sessions focus on:

1). Exploring precipitants of previous acute episodes of illness
2). Review of prodromal signs and symptoms
3). Reactions of the family in supporting family members with an illness
4). Coping strategies and strengths that have been successful
5). Social supports in the communities
6). Grief and mourning in relation to the illness and a contract for treatment and the development of a treatment plan

b. Educational workshops involve caretaking relatives and, at the determination of the practitioners leading the workshop, consumers. These workshops offer extensive information about the biological, psychological, and social aspects of mental illness, the nature, effects and side effects of psychiatric treatments, what families can do to facilitate recovery and prevention of relapse and guidelines for the management of mental illnesses.

c. Ongoing supportive and problem-solving sessions occur in a multi-family (of five or six families) or single-family format, usually with the consumer present. These sessions follow an empirically tested format and focus on solving problems that interfere with treatment, illness and symptom management, and coping skills. Case management may also be accomplished during these sessions. They are usually biweekly, and become monthly after stability has been achieved. They continue for at least one year and two years is indicated for consumers who experience schizophrenic disorders

2. Core Components:

a. Joining with consumers and their families.

b. Education about the illness and useful coping skills. This includes an education curriculum comprised of the following modules:

1). The psychobiology of mental illness
2). Diagnosis and treatment
3). Family reaction and its stages
4). Psychosis as a family trauma, relapse prevention and family guidelines

c. Problem-solving strategies for difficulties caused by illness. This includes the following problem-solving techniques and process from the multi-family format:

1). Techniques:

a). Select a problem for one consumer/family

b). Define the problem in behavioral terms

c). Generate at least eight suggestions for solution to the problem

d). Explore with the consumer and family pros and cons for each suggestion

e). Have consumer and family select the best suggestion

f). Develop a step-by-step plan with the consumer and family

2). Process:

Step 1: Socializing for 10-15 minutes before group starts.

Step 2: Go around – everyone (consumer and natural support) is asked, "What is going well? and then asked, "What could be going better?"

Step 3: Co-facilitators will discuss between themselves what problem arose during the Go Around to be the focus of the session. The problem or goal is then defined (family, consumer, and practitioners)

Step 4: List all possible solutions (all group members)

Step 5: Discuss first advantages and then disadvantages of each in turn (family, consumer, and practitioners, group members)

Step 6: Choose the solution that best fits the situation (consumer and family)

Step 7: Plan how to carry out this solution by forming a detailed, written action plan (consumer, family, and practitioners)

Step 8: Review implementation (practitioners in concert with consumer and family)

Step 9: At the next meeting, the consumer is asked if the plan was effective.

d. Creating an optimal environment for recovery by establishing a strengths-based environment where all members are respectful of one another.

e. Creating social and support groups wherein families establish connections with others who have similar experience and gain a broader social network.

f. Meetings are held every two weeks for the first months, then once a month thereafter. The most beneficial outcomes are derived from

participation for a minimum of nine months and longer, with an additional two years resulting in the most improvements.

3. FPE facilitation requires the following credentials:
   a. A fully Licensed, Limited Licensed, or Temporally Limited Licensed Master's Level Mental Health Professional or
   b. A fully Licensed or Limited Licensed Bachelor's Level Qualified Mental Health professional, or
   c. A Bachelor's level Qualified Mental Health Professional supervised by a Licensed Master's Level Mental Health Professional.
   d. A Certified Peer Support Specialist trained by the MDDHS-approved curricula, and supervised by a Licensed or Limited License Master's Level Mental Health Professional.
   e. Completion of FPE Facilitator training with approved curricula.
   f. The provision of mental health services to adults with serious mental illnesses.
4. Certification requirements for FPE facilitators are as follows:
   a. Participation in the 3-day FPE training workshop with approved curricula and proof of attendance at all sessions.
   b. Facilitation of an FPE group for 1 year or a minimum of 20 sessions.
   c. Participation in group supervision with a FPE Trainer/ Supervisor for a minimum of 10 monthly supervision sessions, with demonstration of competence and positive outcomes.
   d. The submission of a minimum of 3 videotaped FPE sessions conducted with a FPE facilitator over a 12-month period that includes 3 sessions: Joining session (may be an audio tape), Problem-Solving Group sessions, the FPE Workshop along with a copy of the PowerPoint presentation and agenda from the workshop for review.
   e. Feedback about each recorded FPE session is given to trainees which includes discussion of fidelity to the FPE model, recommendations for improvements, and timelines for additional recording.
   f. Access to at least one Mental Health Professional FPE Trainer/Supervisor for local supervision of FPE sessions during the 12 months supervision period.
   g. Recommendation by the ongoing FPE Trainer/Supervisor to move to next level for certification.
      1). Videotapes will be used to review improvement with the use of the Clinical Competency Checklist.
      2). Specific areas for improvement shall be shared with the FPE Facilitator and Advanced Facilitator Trainee.
      3). At the end of one year if the FPE Facilitator or Advanced Facilitator is not quite ready to move to the next level, they will need to continue be supervised for a minimum of 3 months, and provide one videotape to demonstrate a minimum of 80% on the competency checklist.
   h. Completion of FPE documentation requirements.

i. Receipt of feedback from Trainer/ Supervisor via phone call, email or in person on a monthly basis.

j. Participation in required Fidelity reviews and development of strategies for improving fidelity if warranted.

k. Recertification is required every 2 years and consists of:

1) Attending a 1-day booster session or Recertification Learning Collaborative provided by the FPE Steering Committee / MDHHS / MACMHB, or

2). Attending the 3-day Advanced Facilitator Training

3). Adhering to the guidelines set forth in the FPE Fidelity Workbook

5. Billing for FPE services will adhere to state standards as follows:

a. Face-to-face encounters with a family are reported as one encounter per family irrespective of the number of family members present

b. For multifamily group encounters in which families of several beneficiaries are present, an encounter for each consumer represented is reported.

c. FPE codes:

1). T1015: The single-family joining session. It is a clinic visit and reported as an encounter. The standard length of the encounter is 45 – 60 minutes.

2). S5110: One unit for every 15 minutes for the Family Skills Workshop.

3). G0177: Problem-solving groups. The standard length of group is 90 minutes.

4). Modifiers

a). HS: The consumer is not present for any one of these activities

b). AM: FPE is provided as part of ACT

c). HE: A Peer Support Specialist is involved in delivery of FP

6. SCCMHA's quality improvement activities shall include fidelity monitoring to ensure adherence to the evidence-based practice model using the GOI (Global Organization Index) as a guide.

a. The Evidence-Based Practice and Trauma-Informed Care Coordinator and the Director of Network Services, Public Policy, & Continuing Education will facilitate quarterly meetings for Supervisors of EBP Teams, including FPE as appropriate, to discuss fidelity monitoring.

b. The Adult Strengths and Needs Assessment (ANSA) will be used as a tool to examine outcomes for FPE participants.

c. All active FPE teams shall undergo a MiFAST or internal fidelity review every 3-5 years.

**Definitions:**

**Family** is defined as anyone who is committed to the care and support of the person with mental illness and does not have to be a blood relative.

**Family Psychoeducation** is an evidence-based practice that reduces relapse rates and facilitates recovery by partnering with families and providing education about the illness and teaching specific problem-solving strategies for dealing with difficulties arising from the illness. It is derived from theories of expressed emotion (EE), which are based on observations that individuals with schizophrenia discharged home from hospitalizations to families with high expressed emotion are more likely to suffer a relapse. Expressed emotion has two components: criticism (CR) and emotional over involvement (EOI). Expressed emotion is characterized unsupportive, critical, negative interactions. It has been shown to be a significant and strong predictor of relapse with studies demonstrating that individuals living in household with high levels of EE are much more likely to relapse than those living in households with low-EE.

Family Psychoeducation is designed to replace individual meetings with consumers. It is an approach to working with families in a partnership to help them acquire coping skills for dealing with difficulties posed by mental illness in the family and supporting the recovery of a family member with a mental illness. The partnership is engendered by collaborating with families as consultants to help with the management of the illness. Family Psychoeducation is not family therapy; the focus of intervention is the illness, not the family.

**References:**


A. Dixon. L., McFarlane, W., Lefley, H., et al. (2001). Evidence-Based Practices for Services to Families of People with Psychiatric Disabilities. *Psychiatric Services 52:* 903-910.

B. Drake, R., Goldman, H., Leff, H., et al. (2001). Implementing Evidence-Based Practices in Routine Mental Health Service Settings. *Psychiatric Services 52:* 179-182.

C. Goldman, H., Ganju, V., Drake, R., et al. (2001). Policy Implications for Implementing Evidence-Based Practices. *Psychiatric Services 52:* 1591-1597.

D. Hogarty, G., Anderson, C., Reiss, D., et al. (1991). Family Psychoeducation, Social Skills Training, and Maintenance Chemotherapy in the Aftercare Treatment of Schizophrenia. *Archives of General Psychiatry 48:* 156-163.

E. McFarlane, W. ((2002). Multifamily Groups in the Treatment of Severe Psychiatric Disorders. Guilford Press. New York.

F. McFarlane, W., McNary, S., Dixon, L., et al. (2001). Predictors of Dissemination of Family Psychoeducation in Community Mental Health Centers in Maine and Illinois. *Psychiatric Services 52:* 935-942.

G. McFarlane, W., Lukens, E., Link, B., et al. (1995). Multi-Family Groups and Psychoeducation in the Treatment of Schizophrenia. *Archives of General Psychiatry 52:* 679-687.

H. Michigan Department of Community Health (MDCH) & Family Psychoeducation (FPE) Steering Committee. (November, 2010). *Guide to Family Psychoeducation: Requirements for Certification, Sustainability, and Fidelity.* Michigan Department of Community Health, Lansing, MI. [On-line]. Available: 11-4-2010_final_certification_document_with_all_attachments_338492_7.pdf (michigan.gov)

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

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

K. Substance Abuse and Mental Health Services Administration. (2010). *Family Psychoeducation Evidence-Based Practices (EBP) KIT.* Center for Mental Health

Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Rockville, MD. (Formerly available through SAMHSA, now must be purchased through Amazon or another book seller.)

L. Torrey, W., Drake, R., Dixon, L., et al. (2001). Implementing Evidence-Based Practices for Persons with Severe Mental Illnesses. *Psychiatric Services 52:* 45-50.

**Exhibits:**

A. Checklist—Observation of Multifamily Group Sessions (SAMHSA)
B. Family Psychoeducation Fidelity Scale (SAMHSA)
C. Score Sheet: Family Psychoeducation Fidelity Scale (SAMHSA)
D. Multiple Family Psychoeducation: Joining with Families and Consumers Flowchart (MDCH/FPE Steering Committee)
E. Single and Multiple Family Psychoeducation Flowchart (MDCH/FPE Steering Committee)
F. Competency Checklist for MFG Clinicians: Problem-Solving Meetings of the Multifamily Psychoeducation Group (MDCH/FPE Steering Committee)
G. Competency Checklist for MFG Clinicians: Joining Sessions and Family Workgroup of the Multifamily Psychoeducation Group Treatment (MDCH/FPE Steering Committee)

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. FPE is delivered to consumers and their families. | 1. SCCMHA providers. |
| 2. FPE service delivery is monitored on a regular basis for adherence to the standards set forth in the model as delineated in the SAMHSA Toolkit. | 2. EBP Leadership Team/Designated FPE Fidelity Monitoring Group / Providers |
| 3. All primary case management providers have staff trained in the FPE model and offer FPE to all consumers who can benefit from the program. | 3. SCCMHA Providers |
| 4. SCCMHA secures/develops resources to assure that training is available on a regular basis. | 4. SCCMHA Administration |

**Exhibit A**

# Checklist—Observation of Multifamily Group Sessions

Today's date ____/____/____

Assessors' names _____

_____

_____

Program name (or Program code) _____

Agency name _____

Agency address _____
Street

_____
City State ZIP code

Names of FPE practitioners _____ _____

Number of consumer participants _____

Number of family participants _____

Frequency of sessions _____

## Item 11. Structured Group Sessions

| | Yes | No | |
|---|---|---|---|
| 1. Beginning socialization | ❑ | ❑ | |
| 2. Review progress from last session's action plan | ❑ | ❑ | |
| 3. Go-round | ❑ | ❑ | |
| 4. Selection of a single problem | ❑ | ❑ | |
| 5. Structured problem-solving | ❑ | ❑ | |
| 6. End with socialization | ❑ | ❑ | Rating _____ |

## Item 12. Structured Problem-Solving Technique

| | Yes | No | |
|---|---|---|---|
| 1. Define the problem | ❑ | ❑ | |
| 2. Generate solutions | ❑ | ❑ | |
| 3. Discuss advantages and disadvantages of each solution | ❑ | ❑ | |
| 4. Choose the best solution | ❑ | ❑ | |
| 5. Form an action plan | ❑ | ❑ | |
| 6. Review the action plan | ❑ | ❑ | Rating _____ |

## Exhibit B

**Family Psychoeducation Fidelity Scale**

| Criteria | | Ratings / Anchors 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1. | **Family intervention coordinator:** Designated clinical administrator who performs the following tasks:<br>■ Establishes, monitors, and automates family intake and engagement procedures<br>■ Assigns potential FPE consumers to FPE practitioners<br>■ Monitors and adjusts FPE practitioner caseloads<br>■ Arranges for training new FPE practitioners and continuing education of existing FPE staff<br>■ Supervises FPE staff | Agency does not have a designated staff member<br>OR<br>Cannot rate due to no fit. | Agency has a designated staff member who performs 1 or 2 of the tasks. | Agency has a designated staff member who performs 3 of the tasks. | Agency has a designated staff member who performs 4 of the tasks. | Agency has a designated staff member who performs all tasks. |
| 2. | **Session frequency:** Families and consumers participate biweekly in FPE sessions. | < Every 3 months<br>OR<br>Cannot rate due to no fit. | Every 3 months | Every 2 months | Monthly | At least twice a month |
| 3. | **Long-term FPE:** Families and consumers are provided with long-term FPE; specifically, at least one family member per consumer participates in FPE sessions for at least 9 months. | Most families and consumers receive less than 6 months of FPE sessions<br>OR<br>Cannot rate due to no fit. | Most families and consumers receive 6–7 months of FPE sessions. | Most families and consumers receive 7–8 months of FPE sessions. | Most families and consumers receive 8–9 months of FPE sessions. | More than 90% of families and consumers receive at least 9 months of FPE sessions. |
| 4. | **Quality of practitioner-consumer-family alliance** FPE practitioners engage family members and consumers with warmth, empathy, acceptance, and attention to each individual's needs and desires. | High dropout rate<br>OR<br>Cannot rate due to no fit. | Sources indicate that alliance is often poor, leading to high dropout rate. | MSources indicate alliance is inconsistent or barely adequate, leading to moderate dropout rate,<br>OR<br>Information is inconsistent | Sources indicate a fairly strong alliance. | Sources consistently indicate a strong alliance. |
| 5. | **Detailed family reaction:** FPE practitioners identify and specify the family's reaction to their relative's mental illnesses. | There is consistent evidence for less than 33% of involved families. | There is consistent evidence for 33–49% of involved families. | There is consistent evidence for 50–64% of involved families. | There is consistent evidence for 65–79% of involved families. | There is consistent evidence for 80% or more of involved families. |
| 6. | **Precipitating factors:** FPE practitioners, consumers, and families identify and specify precipitating factors for the consumers' mental illnesses. | There is consistent evidence for less than 33% of involved families and consumers. | There is consistent evidence for 33-49% of involved families and consumers. | There is consistent evidence for 50–64% of involved families and consumers. | There is consistent evidence for 65–79% of involved families and consumers. | There is consistent evidence for 80% or more of involved families and consumers. |
| 7. | **Prodromal signs and symptoms:** FPE practitioners, consumers, and families identify and specify prodromal signs and symptoms of the consumer's mental illnesses. | There is consistent evidence for less than 33% of involved families and consumers. | There is consistent evidence for 33–49% of involved families and consumers. | There is consistent evidence for 50–64% of involved families and consumers. | There is consistent evidence for 65–79% of involved families and consumers. | There is consistent evidence for 80% or more of involved families and consumers. |

## Family Psychoeducation Fidelity Scale

| Criteria | | Ratings / Anchors 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 8. | **Coping strategies:** FPE practitioners identify, describe, clarify, and teach coping strategies. | There is consistent evidence for less than 33% of involved families and consumers. | There is consistent evidence for 33–49% of involved families and consumers. | There is consistent evidence for 50–64% of involved families and consumers. | There is consistent evidence for 65–79% of involved families and consumers. | There is consistent evidence for 80% or more of involved families and consumers. |
| 9. | **Educational curriculum:** FPE practitioners use a standardized curriculum to teach families about mental illnesses. The curriculum covers six topics: ■ Psychobiology of the specific mental illness; ■ Diagnosis; ■ Treatment and rehabilitation; ■ Impact of mental illness on the family; ■ Relapse prevention; and ■ Family guidelines. | Less than 33% of involved families receive a standardized educational curriculum, no standardized educational curriculum exists, OR Only 1–2 topics are covered | 33–49% of involved families receive a standardized educational curriculum covering all 6 topics OR Only 3 topics are covered. | 50–64% of involved families receive a standardized educational curriculum covering all 6 topics OR Only 4–5 topics are covered. | 65–79% of involved families receive a standardized educational curriculum covering all 6 topics. | 80% or more of involved families receive a standardized educational curriculum covering all 6 topics. |
| 10. | **Multimedia education:** Consumers and family members are given educational materials about mental illnesses in several formats (for example, paper, video, and Web sites). | Less than 33% of families and consumers receive educational materials OR Cannot rate due to no fit. | 33–49% of families and consumers receive educational materials OR Materials are given in only 1 format. | 50–64% of families and consumers receive educational materials OR Materials are given in only 2 formats. | 65–79% of families and consumers receive educational materials in all 3 formats. | 80% or more of families and consumers receive educational materials in all 3 formats. |
| 11 | **Structured group sessions:** FPE practitioners follow a structured procedure that includes the following: ■ Beginning socialization; ■ Review progress from last session's action plan; ■ Go-round; ■ Selection of a single problem; ■ Structured problem solving; and ■ Ending with socialization. | Groups include 2 or fewer components. | Groups include 3 of the 6 components. | Groups include 4 of the 6 components. | Groups include 5 of the 6 components. | Groups include all 6 components. |

| Family Psychoeducation Fidelity Scale | | | | | | |
|---|---|---|---|---|---|---|
| | | Ratings / Anchors | | | | |
| Criteria | | 1 | 2 | 3 | 4 | 5 |
| 12. | **Structured problem–solving:**<br>FPE practitioners use a standardized approach to help consumers and families with problem solving, which includes the following:<br>■ Define the problem;<br>■ Generate solutions;<br>■ Discuss the advantages and disadvantages of each solution;<br>■ Choose the best solution;<br>■ Form an action plan; and<br>■ Review the action plan. | No more than 2 of 6 components of the structured problem-solving are used. | 3 of 6 components of the structured problem-solving are used. | 4 of 6 components of the structured problem-solving are used. | 5 of 6 components of the structured problem-solving are used. | All 6 components of the structured problem-solving are used. |
| 13. | **Stage-wise provision of services:**<br>FPE services are provided in the following:<br>■ Engagement;<br>■ 3 or more joining sessions;<br>■ Educational workshop; and<br>■ Multifamily group. | Families and consumers begin multifamily groups with minimal or no engagement, no joining sessions, or no education. | Engagement is minimal and only 1 joining session is completed before entry into the multifamily group. Education is delayed or absent. | Engagement and 2 joining sessions are completed before entry into the multifamily group. Education is delayed or absent. | Most steps are done in order; however, families enter multifamily groups before 3 joining sessions are completed or education is provided. | Engagement, all 3 joining sessions, and education are completed before entry into the multifamily group. |
| 14. | **Assertive engagement and outreach:**<br>FPE practitioners assertively engage all potential consumers and family members by phone, by mail, or in person (in the agency or in the community) on an ongoing basis. | FPE practitioners do not engage potential consumers and family members. | FPE practitioners engage potential consumers and family members only once as part of initial engagement. | FPE practitioners engage potential consumers and family members 2 times as part of initial engagement. | FPE practitioners assertively engage some potential consumers and family members using all necessary means on a time-limited basis. | FPE practitioners assertively engage all potential consumers and family members using all necessary contact means on an ongoing basis.<br>FPE practitioners demonstrate tolerance of different levels of readiness using gentle encouragement. |

**Exhibit C**

## Score Sheet: Family Psychoeducation Fidelity Scale

Date of visit ____/____/____

Agency name _____

Assessors' names _____ _____

| | | Assessor 1 | Assessor 2 | Consensus |
|---|---|---|---|---|
| 1 | Family intervention coordinator | | | |
| 2 | Session frequency | | | |
| 3 | Long-term FPE | | | |
| 4 | Quality of practitioner-consumer-family alliance | | | |
| 5 | Detailed family reaction | | | |
| 6 | Precipitating factors | | | |
| 7 | Prodromal signs and symptoms | | | |
| 8 | Coping strategies | | | |
| 9 | Educational curriculum | | | |
| 10 | Multimedia education | | | |
| 11 | Structured group sessions | | | |
| 12 | Structured problem-solving | | | |
| 13 | Stage-wise provision of services | | | |
| 14 | Assertive engagement and outreach | | | |
| | **Total score** | | | |
| | **Items not rated** | | | |

62-70 = Good implementation
52-61 = Fair implementation
51 and below = Not evidence-based practice

**Exhibit D**

Multiple Family Psychoeducation: Joining with Families and Consumers Flowchart

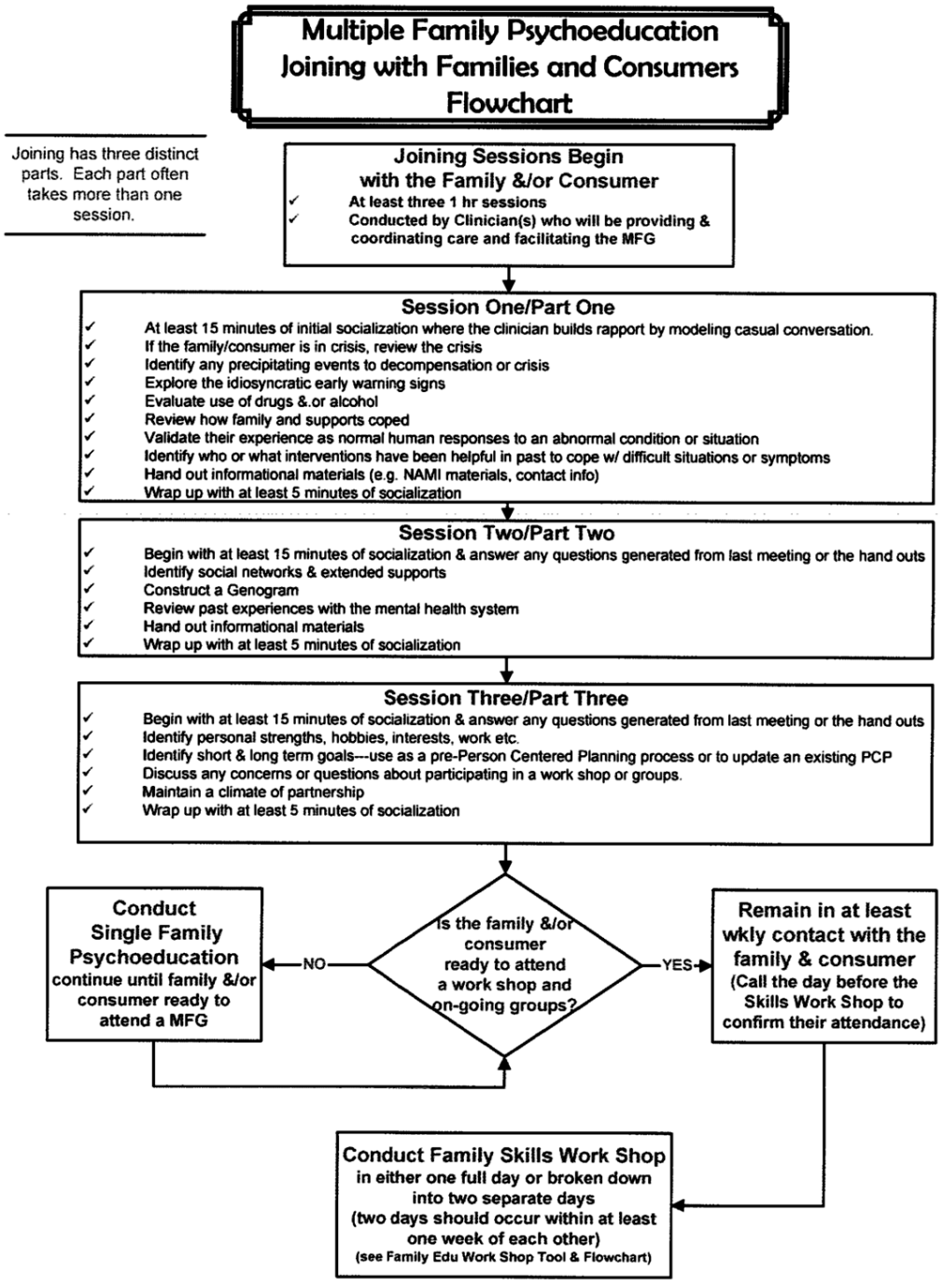


**Exhibit E**

Single and Multiple Family Psychoeducation Flowchart

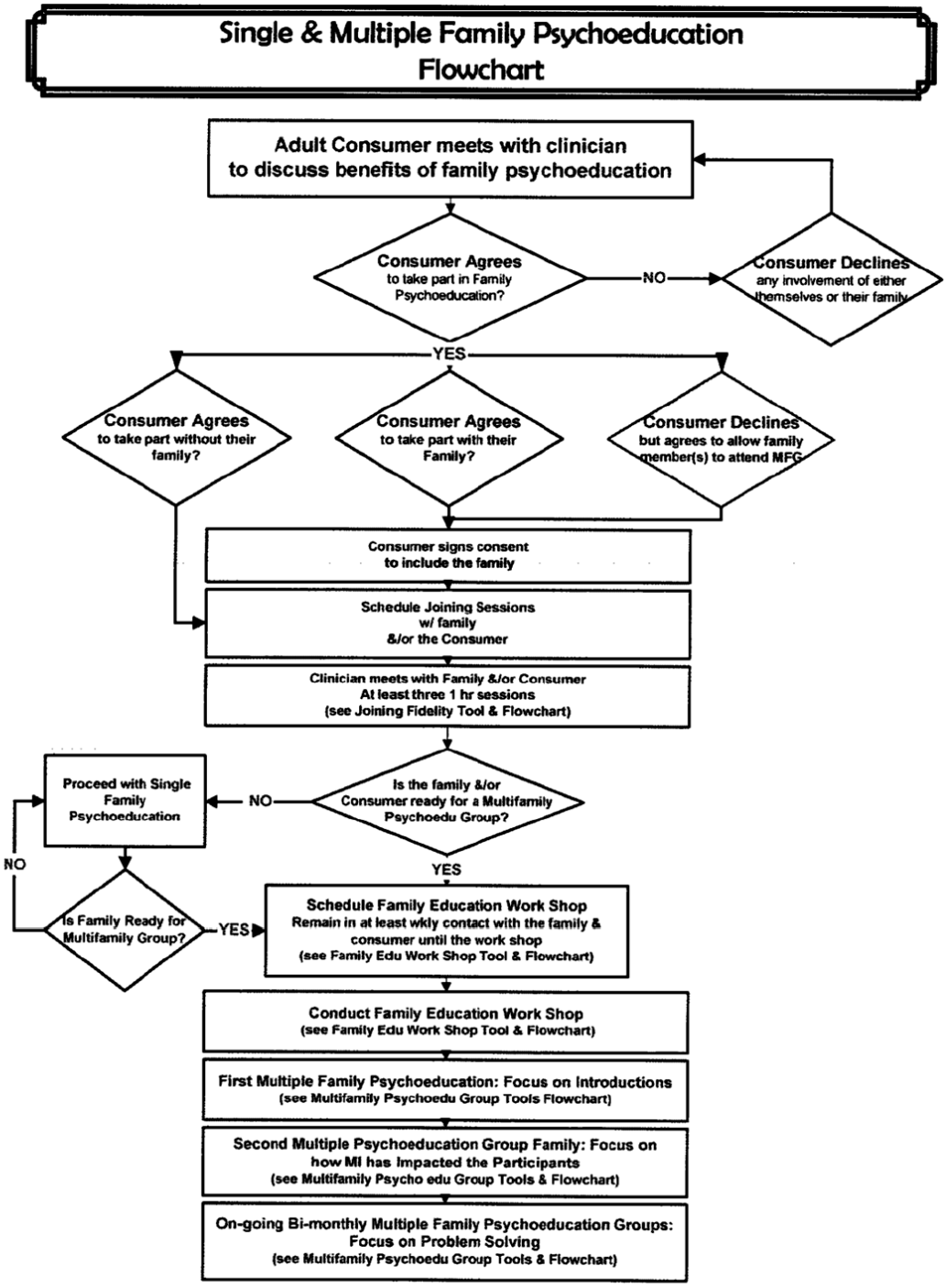


**Exhibit F**

**Competency Checklist for MFG Clinicians**
**Problem-Solving Meetings of the**
**Multifamily Psychoeducation Group**

**Clinicians** _____ **Date of Session** _____

**Session Number** _____ **Date of Rating** _____

**Circle One:** Videotape Audiotape Self monitor/Discussion

**Coding Key:** ✓ = appropriately included **O** = optionally omitted **NA** = not applicable

**Initial Socialization**

____ 1. The meeting began with 10-15 minutes of social conversation.
____ 2. The clinician introduced a topic of conversation.
____ 3. There was balanced participation among group members.
____ 4. Quiet members were encouraged to participate.
____ 5. Group members were encouraged to talk to each other directly without side conversations.
____ 6. The clinician redirected side conversations.
____ 7. The content was light with a place for humor.
____ 8. Comments about the illness or criticisms/ complaints about the consumer were deflected, ignored or reframed.
____ 9. The group started on time.
____ 10. The clinician reminded the group members of the structure of the group (for the first 2-3 months).
____ 11. The clinicians shared relevant, social information about themselves.

**Go Around**

____ 1. The clinician started the go-around with the family who solved a problem in the previous session.
____ 2. The clinician reviewed the implementation of the plan with the family.
____ 3. The clinician praised the family for their efforts.
____ 4. Praise was given for an alternative solutions tried by the family
____ 5. The clinician pointed out specific suggestions made by other family members and thanks them for their participation

____ 6. Factors that might have been overlooked if the solution and plan was unsuccessful were reviewed.

____ 7. The clinician took responsibility for any failed solutions.

____ 8. An alternative solution was suggested if necessary.

____ 9. The clinician checked in with each member of the family.

____ 10. The clinician inquired about pertinent areas of significance.

____ 11. The clinician probed for more information when responses were general.

____ 12. Appropriate biological information was shared with the family.

____ 13. The Family Guidelines were reinforced or integrated into the clinician comments.

____ 14. The clinician offered to intervene directly with the treatment system when appropriate.

____ 15. The family was asked to observe a situation and contact the clinician before the next meeting if the situation persists, if appropriate.

____ 16. The issue was identified as a possible problem solving for the meeting.

____ 17. The clinicians "debriefed" each family situation between families and summarized key issues.

____ 18. The Go-Around was completed in 20-25 minutes.

____ 19. The clinician's voice tone was low key, supportive and nonjudgmental throughout the Go-around.

____ 20. The clinician redirected interruptions from other group members.

____ 21. Everyone was thanked for their participation.

**Problem/Issue Identification**

____ 1. The clinicians openly discussed which problem needed to be worked on in this session.

____ 2. There was an attempt to rotate the problem-solving among the families.

____ 3. Attention was given to factors leading to relapse and issues having to do with the next steps in recovery when considering a problem-solving.

____ 4. Consideration was given to the immediacy of the problem/issue.

____ 5. The clinician offered to meet with the family outside of group if a crisis was presented.

____ 6. A problem solving was not done with a family attending for the first time.

____ 7. The definition of the problem/issue was narrowed so that it leads to a practical solution.

____ 8. The clinician acquired agreement on issue definition from all family members.

**Problem Solving**

____ 1. A problem solving process was facilitated utilizing the 6-step problem-solving model.

____ 2. In the early sessions the families were reminded of the problem-solving steps and guidelines.

____ 3. The clinicians rotated their roles; one lead the group through the six-step process while the other ensured group participation.

____ 4. Clinicians contributed solutions and accepted all solutions to the problem.

____ 5. Clinicians used a brainstorming format for solution generation; deferring evaluation of ideas to discussion of advantages/disadvantages.

____ 6. Six to eight solutions were generated before moving on to discussing the advantages and disadvantages.

____ 7. The advantages then disadvantages to each solution were explored.

____ 8. A solution was identified that the family feels best suits their situation.

____ 9. The solution was broken done into manageable, specific steps.

____ 10. A copy of the problem solving is given to the family.

____ 11. A recorder documented the information.

**Closing Socialization**

____ 1. The group spent five minutes socializing.

____ 2. The content was again light and positive.

____ 2. The clinician facilitated a discussion about the family and consumer's short-term goals.

____ 3. The clinician facilitated a discussion about the family and consumer's long-term goals.

____ 4. The clinician answered questions and provided information about the upcoming Family workshop.

____ 5. Inquires were made regarding the family's experience with groups and any concerns they may have about groups.

____ 6. The clinician asked the family for information regarding their past experiences with the mental health system of care.

____ 7. A discussion occurred regarding the consumer and family's response to living with and/or around the illness.

____ 8. The session ended with 5 minutes of socialization.

**Multifamily Workshop**

____ 1. The workshop was structured in a classroom atmosphere.

____ 2. Information about the nature, etiology, course and outcomes of schizophrenia was presented.

____ 3. Information about medications and current treatment was presented.

____ 4. Information about management of the illness was presented.

____ 5. Information regarding common reactions was presented.

____ 6. The Family Guidelines were presented.

____ 7. The problem solving method was presented.

____ 8. Specific questions were answered.

____ 9. Handouts were included and given to families.

____ 10. The clinicians' manner was collegial, open and encouraged questions from family members.

____ 11. The clinicians acted as hosts, hostesses during the breaks assisting families in feeling comfortable.

**Exhibit G**

**Competency Checklist for MFG Clinicians**

**Joining Sessions and Family Workshop**

**Multifamily Psychoeducation Group Treatment**

**Clinicians** _____ **Date of Session** _____

**Session** _____ **Date of Rating** _____

**Circle One:** Videotape Audiotape Self monitor/Discussion

**Coding Key**: ✓ = appropriately included **O** = optionally omitted **NA** = not applicable

**Session I**

____ 1. The clinician socialized with the family for 15 minutes.
____ 2. The clinician presented self as a colleague and an advocate.
____ 3. The clinician shared relevant personal information about self.
____ 4. The consumer's history was reviewed.
____ 5. Early warning signs were identified.
____ 6. Symptoms of the illness were identified.
____ 7. The clinician explained the basic structure of the multifamily group experience and what the family can expect.
____ 8. Emphasis was placed on the concept that the family is not to blame.
____ 9. The clinician shared relevant information about the illness.
____ 10. The session ended with 5 minutes of socialization.

**Session 2**

____ 1. The clinician socialized with the family for 15 minutes.
____ 2. Exploration of the family's social network and resources occurred.
____ 3. The clinician identified family and consumer strengths.
____ 4. A genogram or sociogram was used in the session.
____ 5. The session ended with 5 minutes of socialization.

**Session 3**

____ 1. The clinician socialized with the family for 15 minutes.

____ 2. The clinician facilitated a discussion about the family and consumer's short-term goals.

____ 3. The clinician facilitated a discussion about the family and consumer's long-term goals.

____ 4. The clinician answered questions and provided information about the upcoming Family workshop.

____ 5. Inquires were made regarding the family's experience with groups and any concerns they may have about groups.

____ 6. The clinician asked the family for information regarding their past experiences with the mental health system of care.

____ 7. A discussion occurred regarding the consumer and family's response to living with and/or around the illness.

____ 8. The session ended with 5 minutes of socialization.

**Multifamily Workshop**

____ 1. The workshop was structured in a classroom atmosphere.

____ 2. Information about the nature, etiology, course and outcomes of schizophrenia was presented.

____ 3. Information about medications and current treatment was presented.

____ 4. Information about management of the illness was presented.

____ 5. Information regarding common reactions was presented.

____ 6. The Family Guidelines were presented.

____ 7. The problem solving method was presented.

____ 8. Specific questions were answered.

____ 9. Handouts were included and given to families.

____ 10. The clinicians' manner was collegial, open and encouraged questions from family members.

____ 11. The clinicians acted as hosts, hostesses during the breaks assisting families in feeling comfortable.

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>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:<br>5/1/08</td><td>Date of Review/Revision:<br>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, 4/11/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Barbara Glassheim<br><br>Additional Reviewers:<br>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 serious emotional disturbances 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 serious emotional disturbances often experience a variety of problems that require solutions from an array of professionals and services.
B. Serving children who have serious 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
        a. Coordination between primary health care and specialty mental health services.
    2. Prevention, early identification and intervention
        a. Incorporating mental health promotion, prevention, screening, early identification, and early intervention services.
    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 are integral to an effective system of care.
12. An explicit focus on achieving equity in mental health care for young people and their families in an effort to mitigate structural and systemic racism, implicit bias, and historical trauma that impact the social determinants of health, such as economic stability, education, housing, health care, nutrition, and safety.

E. The following core services of a system of care shall be made available to eligible children, youth and families as needed and resources permit:
1. Mobile Crisis Response and Stabilization Services (MRSS) shall be provided to children and youth who are experiencing mental health emergencies and their families in order to defuse and stabilize crises, maintain children and youth in their current living arrangements, prevent hospitalization, prevent disruption of child welfare placements, and improve functioning.
2. Intensive care coordination using Wraparound as an approach to providing individualized care for children, youth, and young adults with complex mental health needs and their families.
3. Intensive in-home mental health treatment services provided to improve child, youth, and family functioning and to prevent the need for out-of-home placement, inpatient hospitalization, or residential treatment that includes individual and family therapy, skills training, behavioral interventions, crisis response, and care coordination.
4. Parent and youth peer support provided by individuals who have personal "lived" experience with mental health conditions and navigating service systems, either as a consumer or as a family member or caregiver.
5. Respite care to provide parents and other primary caregivers with planned or emergency short-term care for their child, enabling children and youth with mental health needs to remain in a safe and supportive environment, usually in their own homes.
6. Flex funds using financing mechanisms covered by Medicaid and other sources.
7. Trauma-specific treatments and trauma-informed systems to address traumatic experiences with particular attention to the impact of adverse childhood experience on later mental health needs.
8. The provision of evidence-based services as well as specific evidence-informed and promising practices to ensure treatment effectiveness.
9. Telehealth services including videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communication particularly to provide care to underserved populations and thus increase access to behavioral health care services.

**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 comprehensive spectrum of effective services and supports for children, youth, and young adults with or at risk for mental health or other challenges and their families that is organized into a coordinated network of care, builds meaningful partnerships with families and youth, and is culturally and linguistically responsive in order to help them to thrive at home, in school, in the community, and throughout life. A system of care incorporates mental health promotion, prevention, early identification, and early intervention in addition to treatment to address the needs of all children, youth, and young adults. (Stroul, Blau, Larson 2021)

[MDHHS]

**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. http://cfs.fmhi.usf.edu/tread/PDFs/SOCPR_Monograph%20FINAL-3-5-05.pdf.

C. MDHHS – Mental Health Partnerships (SOC): https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/childrenandfamilies/mh-partnerships

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

E. SCCMHA Policy 02.03.09.09 – Wraparound

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

G. SCCMHA Policy 03.02.46 – Whole Person Care

H. 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. http://gucchd.georgetown.edu/files/products_publications/SOCbrief.pdf

I. Stroul, B., Blau, G., Friedman, R. (2010). Updating the system of care concept and philosophy. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. Washington, DC. https://www.isbe.net/Documents/soc-brief-2010.pdf

J. Stroul, B., Blau, G., Larson, J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation, School of Social Work, University of Maryland. https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

K. 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.

L. 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. 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<br>Saginaw County Community Mental Health Authority</th></tr>
<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>
<tr><td rowspan="2">Effective Date:<br>7/8/2021</td><td>Date of Review/Revision:<br>7/7/21, 2/28/22, 3/2/23, 4/2/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Farrah Wojcik, MRSS Site Program Supervisor<br>Carey Moffett, MRSS Supervisor<br>Marky Baukus, EBP Coordinator<br><br>Additional Reviewers:<br>EBP workgroup</td></tr>
<tr><td>Supersedes:<br>02.03.09.12 MUTT Services</td></tr>
<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 the 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) or will be a current MSW student completing a field placement with MRSS, supervised by a licensed master's prepared clinician.
    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, Juvenile Probation Officer, and/or a current BSW or MSW student completing a field placement with MRSS
        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 After-Hours/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 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 one secondary team member who will provide daily coverage of at least two team members per shift during the hours of 10pm-8am.

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 for in-person/face-to-face and telephonic contacts; secondary staff will complete non-billable supporting documentation of in-person contacts and of telephonic contacts 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. MRSS staff will utilize clinical judgment, standardized screening tools, and risk assessment to determine if the situation is safe and appropriate for in-person crisis intervention.
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)

**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 individual's 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:**

None

**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)<br>Identified team members on-call (primary clinician, secondary staff)<br>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)<br>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)<br>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<br>Secondary staff member (all shifts), non-billable supportive documentation |
| Communicate and coordinate Diversion/Crisis Plans with the next team members covering the next shift<br>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 Supervisor<br>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<br>MRSS Site Program Supervisor |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Trauma Recovery & Empowerment (TREM)</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.13</td></tr>
<tr><td rowspan="2">Effective Date:<br>6/13/17</td><td>Date of Review/Revision:<br>4/10/18, 4/9/19, 10/7/19, 6/1/20, 3/10/21, 1/12/22, 1/10/23, 1/31/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Network Services, Public Policy, & Continuing Education<br><br>Authored By:<br>Mary Baukus, Barbara Glassheim<br><br>Additional Reviewers:<br>EBP Leadership Team</td></tr>
<tr><td>Supersedes:<br>02.03.11</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
The purpose of this policy is to specify the use of Trauma Recovery & Empowerment (TREM).

**Policy:**
A. SCCMHA recognizes that the experience of trauma is the rule rather than the exception among consumers served by the public mental health system.
B. Consumers who have been found to have experienced trauma shall be offered opportunities to participate in trauma-specific, evidence-based interventions.
C. SCCMHA shall, resources permitting, offer W-TREM for women, G–TREM for adolescent girls (aged 12–18), B-TREM for adolescent boys (aged 12–18), and M–TREM for men who have experienced trauma and are being served by SCCMHA-funded providers.
D. TREM can be delivered face-to-face, in-person, or via telehealth technology.

**Application:**
This policy applies to the SCCMHA-funded provider network.

**Standards:**
A. TREM groups shall be offered to consumers who have a history of sexual, physical, and/or emotional abuse.
B. Providers who deliver TREM shall receive SCCMHA-approved training and be privileged to provide TREM in accordance with SCCMHA policy.
C. TREM shall be delivered in accordance with fidelity to the model.

D. SCCMHA's quality improvement activities shall include fidelity monitoring to ensure adherence to the evidence-based practice model using the GOI (Global Organization Index) as a guide.
    1. The Evidence-Based Practice and Trauma-Informed Care Coordinator and the Director of Network Services, Public Policy, & Continuing Education will facilitate quarterly meetings for Supervisors of EBP Teams, including TREM when appropriate, to discuss fidelity monitoring.
    2. When TREM is actively being offered, the Adult Strengths and Needs Assessment (ANSA) will be used as a tool to examine outcomes with reports reviewed at least twice per year (or as is appropriate for how frequently TREM is occurring) for TREM participants ages 18+. For youth participating in TREM who are under the age of 18, the Child and Adolescent Functional Assessment Scale (CAFAS) will be used in a similar manner.

E.
    1. M–TREM shall be conducted by two male co-leaders for groups of eight to ten participants in twenty-four, seventy five-minute sessions held once a week.
        a. The three parts of M–TREM shall be provided as follows:
            1). Part One: Male Messages, Emotions, and Relationships (11 sessions) that focus on:
                a). Facilitating a sense of safety and trust in the group
                b). Discussion of the importance of gender roles
                c). Development of a shared emotional vocabulary
                d). Introducing key relationship themes
                e). Initiating preliminary discussion of the role of violence and abuse in the lives of the participants
            2). Part Two: Trauma Recovery (7 sessions) that focus on:
                a). Helping participants deepen their understanding of trauma and its broad-ranging impact
                b). Identifying characteristic ways of coping with traumatic events
                c). Helping participants understand the connections among trauma and other life difficulties
                d). Framing certain problem behaviors or symptoms as coping attempts
                e). Building on personal strengths in developing alternative coping methods
            3). Part Three: Advanced Recovery Skills (6 sessions) that focus on:
                a). Applying an understanding of trauma's impact to a variety of life domains
                b). Developing, practicing, and consolidating recovery skills
                c). Deepening the mutual help functions of the group
        b. M–TREM shall focus on recovery skills including self-awareness; self-protection; self-soothing; emotional modulation; relational

mutuality; accurate labeling of self and others; sense of agency and initiative-taking; consistent problem-solving; reliable parenting; possessing a sense of purpose and meaning; and judgment and decision-making.

2. W-TREM shall be conducted by two female co-leaders in once weekly seventy five-minute group sessions in four parts.
   a. Part One: Empowerment (11 sessions) includes the following topics:
      1). Introduction to the Group
      2). What It Means to Be a Woman
      3). What Do You Know and How Do You Feel About Your Body?
      4). Physical Boundaries
      5). Emotional Boundaries, Setting Limits, and Asking for What You Want
      6). Self Esteem
      7). Self-Soothing: Developing Ways to Feel Better
      8). Intimacy and Trust
      9). Female Sexuality
      10). Sex with a Partner
      11). Transition Session
   b. Part Two: Trauma Recovery (10 sessions) includes the following topics:
      1). Gaining an Understanding of Trauma
      2). The Body Remembers What the Mind Forgets
      3). What Is Physical Abuse?
      4). What Is Sexual Abuse?
      5). Physical Safety
      6). What Is Emotional Abuse?
      7). Institutional Abuse
      8). Abuse and Psychological and Emotional Symptoms
      9). Trauma and Addictive or Compulsive Behavior
      10). Abuse and Relationships
   c. Part Three: Advanced Trauma Recovery Issues (9 sessions) includes the following topics:
      1). Family: Myths and Distortions
      2). Family Life: Current
      3). Decision Making: Trusting Your Judgment
      4). Communication: Making Yourself Understood
      5). Self-Destructive Behaviors
      6). Blame, Acceptance, and
      7). Forgiveness
      8). Feeling Out of Control
      9). Relationships
      10). Personal Healing
   d. Part Four: Closing Rituals (3 Sessions) includes the following:
      1). Truths and Myths About Abuse

2). What It Means to Be a Woman
3). Closing Ritual

3. G-TREM (Love and Life) shall be targeted to girls aged 12–18 and conducted in accordance with the 16-session, 75–90-minute, 8–10-member, group-based intervention model.
   a. Session 1 – Kicking It Off: Introduction to the Group
   b. Session 2 – The Feminine Mystique: What It Means to Be Female and What I Know About My Body
   c. Session 3 – Your Space, My Space: Managing Emotional and Physical Boundaries in Relationships
   d. Session 4 – A Little TLC: Self-Esteem, Self-Soothing and Self-Care
   e. Session 5 – Can We Talk: Expressing Feelings and Developing Communication Skills
   f. Session 6 – Being Part of the In Crowd: Dealing with Peer Pressure
   g. Session 7 – Words will Never Hurt Me?: When Girls Get Mad, Mean, and Fight
   h. Session 8 – The Caged Bird: Understanding Emotional, Physical, and Sexual Abuse and the Inter-Relationships Among the Three
   i. Session 9 – The Blame Game: Beginning to Accurately Assess Responsibility for Abuse
   j. Session 10 – Let's Get Together: The Development of Intimacy and Trust
   k. Session 11 – Give A Little, Get a Lot: How to Negotiate Relationships Successfully
   l. Session 12 – Why Can't We All Just Get Along?: Working on Relationships Within Your Family
   m. Session 13 – Calm the Storm: How to Manage Overwhelming Feelings and Self-Destructive Behaviors
   n. Session 14 – Learning to Exhale: Anger and Anger Management
   o. Session 15 – The Highs and the Lows: Abuse and Drug and Alcohol use
   p. Session 15 – That's a Wrap: Hope, Accomplishments, and Saying Good-Bye
4. B-TREM shall be targeted to 12–18-year-old boys and adolescents and conducted in accordance with the 12-session, 8–10-member, group-based intervention model.
   a. Session 1 – Introduction
   b. Session 2 – Male Messages Part I
   c. Session 3 – Male Messages Part II
   d. Session 4 – Working Together/Building Trust
   e. Session 5 – Identifying emotions
   f. Session 6 – Sexual Education
   g. Session 7 – Relationships
   h. Session 8 – Community Violence
   i. Session 9 – Abuse
   j. Session 10 – Fight/Flight/Freeze

k. Session 11 – Self-Expression & Communication
l. Session 12 – Saying Goodbye and Finding Hope for the Future

**Definitions:**

**Trauma:** A psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror or helplessness that creates significant and lasting damage to a person's mental, physical, and emotional growth. According to SAMHSA (2014), trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

**Trauma Recovery and Empowerment Model (TREM):** A manualized twenty-four to twenty-nine-session group-based intervention that is designed to facilitate trauma recovery among individuals with histories of exposure to emotional, sexual, and physical abuse. TREM incorporates cognitive restructuring, psychoeducational, and skills-training techniques, and addresses both short-term and long-term consequences of violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse. The TREM model has been adapted for men (M–TREM), boys (B–TREM) and has been translated into Spanish and culturally adapted for Latina women. It has also been adapted for adolescent girls and young women ages 12-18 (Love and Life: G–TREM).

**References:**

A. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
B. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
C. Community Connections: Home | Community Connections (communityconnectionsdc.org)

**Exhibits:**

None

**Procedure:**

None

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Cognitive-Behavior Therapy (CBT)</td><td>Chapter: 02 - Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.16</td></tr>
<tr><td rowspan="2">Effective Date:<br>6/4/14</td><td>Date of Review/Revision:<br>6/13/17, 4/10/18, 4/9/19, 10/21/19, 6/1/20, 3/10/21, 1/12/22, 1/10/23, 1/31/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Network Services Public Policy & Continuing Education<br><br>Authored By:<br>Mary Baukus, Barbara Glassheim<br><br>Additional Reviewers:<br>EBP Leadership Team</td></tr>
<tr><td>Supersedes:<br>02.03.20</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
The purpose of this policy is to delineate a framework for the provision of Cognitive-Behavior Therapy (CBT).

**Policy:**
A. SCCMHA-funded practitioners shall adhere to the tenets of CBT when providing psychotherapeutic interventions for conditions amenable to cognitive and behavioral treatment. CBT interventions shall be provided in a trauma-informed manner.
B. CBT can be delivered face-to-face, in-person, or via telehealth technology.

**Application:**
This policy applies to mental health and intellectual/developmental disability and substance use disorder treatment professionals who are qualified by SCCMHA to provide evidence-based treatment.

**Standards:**
A. Practitioners who have received SCCMHA-approved training may provide CBT in individual or group modalities to treat consumers with a variety of conditions including depression, bipolar disorder, substance use disorders, eating disorders, sleep disorders, psychotic disorders, and anxiety disorders including posttraumatic stress disorder (PTSD), phobias, panic attacks, and obsessive-compulsive disorder (OCD).
    a. Individuals who have received and maintained training in another SCCMHA approved EBP that falls under CBT, do not need to take additional CBT-specific training to be privileged in this EBP. These EBPs

include DBT, DBT-A, IDDT, CBT for HD, and TF-CBT. Maintaining the requirements for privileging in these EBPs will also qualify for CBT.

b. Individuals trained in another CBT-related EBP that is not presently approved by SCCMHA may have their training evaluated on an individual basis by the EBP Coordinator.
c. For all other individuals, initial CBT privileging can be obtained by completing Introduction to Cognitive Behavioral Therapy within the RELIAS training system.
    i. For subsequent privileging in CBT, clinicians will be required to submit a CBT progress note to the EBP Coordinator on an annual basis during the privileging process. See exhibit C for elements to be included.
d. All clinicians who provide psychotherapy to individuals ages 6 and older will be required to be privileged in CBT.

B. Practitioners shall adhere to the principles of CBT:
1. CBT is time-limited
2. CBT sessions are structured
3. CBT entails an ever-evolving formulation of consumers' problems and an individual conceptualization of each consumer in cognitive/behavioral terms – i.e., identification of current thinking that contributes to current feelings and problematic or maladaptive behaviors that includes the identification of precipitating factors or triggers.
4. CBT emphasizes the present and current problems; therapy starts with an examination of here-and-now problems, regardless of diagnosis.
5. CBT entails a psycho-educative orientation which aims to teach the consumer to be his or her own therapist and emphasizes relapse prevention that includes teaching the consumer about the nature and course of their condition(s), goal setting, identification and evaluation of their thoughts and beliefs, and behavioral change plan.
6. CBT includes teaching consumers to identify, evaluate, and respond to their dysfunctional thoughts and beliefs.
7. CBT is goal-oriented and problem-focused – the consumer is helped to enumerate his or her problems and set specific behavioral goals; both the therapist and consumer have a shared understanding of what the consumer is working toward.
8. CBT places emphasis on collaboration and active participation; therapy is teamwork and includes homework assignments for the consumer.
9. CBT requires a sound therapeutic alliance characterized by warmth, empathy, caring, and genuine positive regard.
10. CBT involves the use of a variety of techniques to change thinking, mood, and behavior.

**Definitions:**

**Cognitive-Behavior Therapy (CBT)** is a short-term (typically ranging from five to twenty sessions), goal-oriented psychotherapeutic treatment that takes a hands-on, practical approach to problem-solving. It is a blend of cognitive therapy (CT) and behavioral therapy that focuses on examining the relationships between thoughts, feelings and behaviors and

altering maladaptive patterns of thinking and/or behavior that underlie problems. By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, people with mental illness can modify their patterns of thinking to improve coping. CBT has been found to be effective for a wide range of issues including sleeping difficulties, relationship problems, substance use disorders, eating disorders, anxiety disorders and depressive disorders as well as psychotic disorders. Booster sessions or continuation CBT can be used to reduce the risk of relapse.

**References:**


A. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
B. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
C. Wright, J., Basco, M., Thase, M. (2005). *Learning Cognitive-Behavior Therapy: An Illustrated Guide*. American Psychiatric Publishing, Inc., Washington, D.C.


**Exhibits:**

A. Examples of CBT Methods
B. CBT Model
C. CBT Clinical Progress Note

**Procedure:**

None

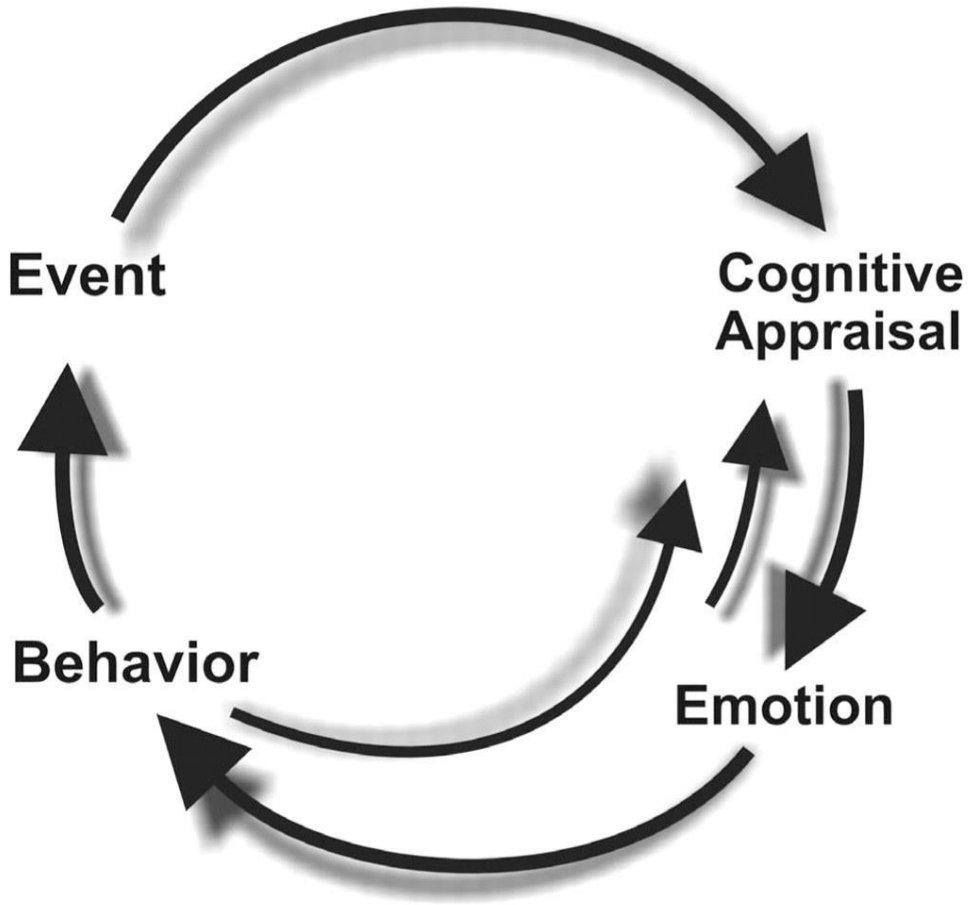
**Exhibit A**

| Examples of CBT Methods |
|---|
| **Socratic Questioning:** Questioning that allows the therapist to stimulate the consumer's self-awareness, focus in on the problem definition, expose the consumer's belief system, and challenge irrational beliefs while revealing the consumer's cognitive processes. |
| **Guided Discovery:** A technique is to help consumers to understand their cognitive distortions. Cognitive errors include all or nothing thinking, overgeneralization, mental filter (dwelling on the negatives and ignoring the positives), discounting the positives, jumping to conclusions, magnification or minimization, emotional reasoning, should statements, labeling, personalization, and blame. Consumers are offered the necessary assistance and guidance to understand how they process information. It allows consumers to alter the way they process information to change the consumer's perception and outlook. A change in perception enables the consumer to modify his/her behavioral patterns. |
| **Behavioral Experiments:** The experiment process includes experiencing, observing, reflecting, and planning. These steps are conducted through thought testing, discovery, activity, and/or observation. |
| **Thought change records:** Like behavioral experiments, thought records are also designed to test the validity of thoughts. |
| **Generating rational alternatives** |
| **Self-Monitoring:** Also called diary work, self-monitoring is used to record the amount and degree of thoughts and behaviors. This provides the client and therapist information regarding the degree of a client's negative affirmations. |
| **Role play:** To help the consumer become aware of their automatic thoughts and resulting emotions the therapist may role play different situations with the consumer, pausing at points to identify what automatic thoughts are occurring |
| **Rehearsal:** Behavioral rehearsal is the process of reproducing the modeled behavior according to explicit and specific guidelines for consumers to effectively acquire novel behaviors through observation, especially if they can try out the target behavior. In cognitive rehearsal, the consumer imagines a difficult situation and the therapist guides them through the step-by-step process of facing and successfully dealing with it. The consumer then works on practicing, or rehearsing, these steps mentally. |
| **Activity and pleasant event scheduling:** Commonly used to help consumers with depression reverse problems with low energy and anhedonia. These techniques involve obtaining a baseline of activities during a day or week, rating activities on the degree of mastery and/or pleasure, and then collaboratively designing changes that will reactivate the patient, stimulate a greater sense of enjoyment in life, or change patterns of social isolation or procrastination. |

| |
|---|
| **Graded task assignments:** Problems are broken down into pieces and a stepwise management plan is developed, are used to assist consumers in coping with situations that seem especially challenging or overwhelming. |
| **Exposure and Response Prevention (ERP):** Confrontation of a fear and discontinuation of the escape response or maladaptive safety behavior while practicing a fear-incompatible behavioral response to the stimulus resulting in habituation to the feared stimulus. |
| **Relaxation training:** Autogenic training, breathing, progressive muscle relaxation, meditation |
| **Systematic Desensitization:** Pairs relaxation with exposure to something stressful. Clients are taught to relax in anxiety producing situations. |
| **Homework Assignments:** To assist with cognitive restructuring, clients are often assigned homework. Typical CBT homework assignments may include activities in behavioral activation, monitoring automatic thoughts, reviewing the previous therapy session, and preparing for the next therapy session. |

**Exhibit B**

# Cognitive Behavior Model




*Source:* From Wright JH, Basco MR, Thase ME: Learning Cognitive-Behavior Therapy: An Illustrated Guide. Washington, DC, American Psychiatric Publishing, 2006, p 5

**Exhibit C**

## CBT Clinical Progress Notes

Treatment Goal and Objective to be addressed in this session:

Results of Client's Homework from last session:

Clinical intervention used in session:

Client's response to intervention used:

Resistance to change/Barriers to goal attainment:

Progress towards goals and objectives witnessed in session:

Homework given client at end of session:

Plan for next session's interventions:

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Mental Health First Aid (MHFA)</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.17</td></tr>
<tr><td rowspan="2">Effective Date:<br>1/1/14</td><td>Date of Review/Revision:<br>6/9/17, 6/1/18, 5/23/19, 10/21/19, 5/26/20, 4/14/21, 1/12/22, 6/11/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Network Services, Public Policy & Continuing Education<br><br>Authored By:<br>Jennifer Keilitz<br><br>Additional Reviewers:<br>Alecia Schabel, EBP Leadership Team</td></tr>
<tr><td>Supersedes:<br>02.03.22</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**

The purpose of this policy is to enhance the reduction of stigma, promote public education on mental health conditions, and facilitate community citizen key skill development in the support of individuals who may be experiencing a mental health crisis or problem, through the endorsement and coordination of a local evidence-based curriculum.

**Policy:**

SCCMHA recognizes that mental health and substance use problems are prevalent and that people who experience such problems often confront negative attitudes and discrimination. SCCMHA also recognizes that many people lack fact-based information about mental health and substance use problems and professional assistance is not always readily available; people often lack knowledge regarding how to respond to a developing mental illness and a psychiatric crisis. Furthermore, individuals with mental health and substance use difficulties often do not seek help.

SCCMHA is committed to reducing stigma and promoting mental health literacy through education and the application of evidence-based interventions. SCCMHA is also committed to promoting early intervention based on research demonstrating that the sooner individuals receive appropriate help for mental health and substance use issues, the more likely they are to experience positive outcomes.

SCCMHA endorses the National Council's Mental Health First Aid (MHFA) Curriculum and will allocate CMHSP resources in the provision of a local training program, including certification of MHFA instructors, to address myths, provide facts and develop community involvement with mental health literacy and intervention skills.

SCCMHA shall promote Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) training as a means to increase the understanding of mental

illness by members of the community in an effort to reduce stigma and help people who are experiencing a mental health or substance use problem expeditiously access professional help.

**Application:**
This policy applies to SCCMHA-sponsored or supported MHFA/YMHFA training.

**Standards:**

A. SCCMHA shall sponsor in-person and virtual MHFA and YMHFA training for members of the general community as well as targeted audiences including first responders and others such as members of faith-based organizations, school personnel, physical health care providers, child welfare staff, foster parents, juvenile justice staff, law enforcement personnel, public health staff, Veterans Administration personnel, and various social/human service agencies as well as SCCMHA community partners.

B. SCCMHA shall communicate the need for increased knowledge about mental illness and substance use problems and related services in the community in a variety of relevant venues.

C. SCCMHA shall, if possible, dedicate resources to sustain MHFA/YMHFA training.
   1. SCCMHA shall actively seek resources that are needed to sustain MHFA/YMHFA training.
   2. Whenever grant funding or other funding is available, MHFA is offered free of charge. When funding is not available, SCCMHA charges a $30/participant fee in order to assist in sustaining continuous MHFA training opportunities for Saginaw County and surrounding communities. This $30 fee is a substantial reduction from the $175/participate cost to train.
      a. Group Rates: SCCMHA will agree to flat fee of a $500 group rate for private MHFA training of 15 to 30 participants
      b. Scholarship form: If there are community partners who are unable to pay the $30 fee to attend the MHFA training there is a scholarship form available. The Continuing Education Committee will review, approve or deny all MHFA Scholarship forms.

D. SCCMHA shall provide leadership to oversee MHFA/YMHFA training, including evaluation of its impact, as long as it has the requisite resources to do so, that may include:
   1. Collecting and reporting data on the number of people trained (including key demographic information such as age, race/ethnicity, and occupation/role).
   2. Self-reported changes in attitude about people with mental illness.
   3. Self-reported changes in knowledge about how to access mental health services.

E. SCCMHA shall help identify champions in the community to help promote awareness of mental health and substance use issues.
   1. SCCMHA shall help stakeholders and champions connect to community organizations and agencies that can benefit from the program.

F. SCCMHA shall tailor MHFA/YMHFA to identified needs of the community in designing the scope and frequency of the training.

G. SCCMHA shall collaborate with key community stakeholders to promulgate the training and promote its implementation and marketing.

H. SCCMHA shall promote and support the development of a cadre of certified MHFA instructors.

I. Mental Health First Aid instructors shall be certified by Mental Health First Aid USA to teach specific modules of MHFA/YMHFA.

1. Certified instructors shall have completed the required three or five-day training, satisfactorily deliver the program, and pass the written exam.
    a. NOTE: Instructor certification is awarded specifically for both the adult and youth courses. Instructors who want to teach both types of courses, must first certify as an instructor through the three or five-day training (for one course type), and then go through a two and one half-day training for the other course they want to teach.
2. Certified instructors will agree to complete at least the minimum number of trainings to maintain their instructor certification (3) as well as any additional trainings at the request of SCCMHA Leadership.
    a. Instructors agree to provide training dates to Continuing Education Unit (CUE) as requested.
    b. If an instructor needs or desires a co-instructor for any course the instructor will identify and advise CEU of a co-instructor.
3. Certified instructors will adhere to training expectations:
    a. Verbally advise participants as a condition of MHFA training participation they are agreeing to follow up surveys and report referrals about 3-6 months from training date. Trainers advise participants SCCMHA will be sending an electronic survey.
    b. In-person Training Only: Ensure each participant completes modules 1-3 in the MHFA Connect database BEFORE the training starts. Completed opinion quizzes MUST be submitted to SCCMHA. The sign in/sign out must be submitted to CEU front office in order for participants to receive their MHFA credit.
    c. Live Training Only: Ensuring participants review the MHFA Connect Instructions – AFTER TRAINING document within the packet: This is how participants will complete their MHFA evaluation (the one directly from National MHFA) and this is also how they RECEIVE their certificate. (on the website here: Log in | MHFA (mentalhealthfirstaid.org)
        i. The trainer is responsible for supporting participants with any follow up needed.
    d. Virtual Training: instructors will maintain communication with the MHFA Coordinator regarding any First Aiders who have not completed their pre-work prior to the start of the instructor led virtual course.
    e. Virtual Training: instructors will complete and pass First Aiders within the MHFA Connect System upon successful completion.

f. Instructors will support First Aiders with training follow up if needed: evaluation completion and certificate.

J. MHFA participants will successfully complete a 6.5 hour or 8-hour training program to receive a Mental Health First Aider certificate in mental health first aid. If First Aiders are participating virtually, they are required to complete 2.5 hours of self-led pre-work online prior to the instructor led virtual training.

1. Key reasons why community members might wish to become a Mental Health First Aider include: to be prepared, to help people who are often suffering alone, because mental illnesses are common, and because they care and want to be there for a friend, family member or colleague.
2. Participants will become familiar with a five step intervention action plan, including: a) assess for risk of suicide or harm; b) listen nonjudgmentally; c) give reassurance and information; d) encourage appropriate professional help; and e) encourage self-help and other support strategies.
3. Participants will understand the prevalence of various mental health disorders in the United States and the need for reduced stigma in the local community.
4. Participants will learn about local resources - including professional, peer, social and self-help – available to help someone treat and manage a mental health problem and achieve recovery.
5. Adult MHFA participants will learn about mental health conditions, including depression, anxiety, psychosis and substance use disorders.
6. Youth MHFA participants will learn about mental health challenges and disorders for youth, ages 12 to 18, including adolescent development, and, depression, anxiety, eating disorders, psychosis, substance use and attention deficit and disruptive behaviors in youth people – with emphasis on the importance of early intervention.
7. Mental Health First Aid for Public Safety provides law officers and staff with more response options to help them de-escalate incidents and better understand mental illnesses so they can respond to mental health-related situations appropriately without compromising safety.
8. Mental Health First Aid for Military, Veterans and Their Families. Military, veterans and their families face significant challenges in accessing mental health care. This evidence-based and early-intervention training program helps to decrease stigma, address tough challenges and allow these adults to show up fully in their daily lives and support those around them.
9. Mental Health First Aid is part of the SCCMHA Continuing Education Unit annual training plan as well as the community health improvement plan.

**Definitions:**

**Mental Health First Aid (MHFA)** is an eight-hour, in-person, evidence-based training program that is designed to teach members of the public about mental illnesses and addictive disorders, including risk factors and warning signs. Participants learn a five-step action plan (listed below) to help people who are developing a mental health problem, experiencing a worsening of an existing mental health problem, or are in a mental health crisis. Like traditional first aid, MHFA does not teach people to treat or diagnose mental

health or substance use conditions but, rather, teaches how to offer initial support until appropriate professional help is received or until the crisis resolves.

Just as Cardio Pulmonary Resuscitation (CPR) training helps a layperson without medical training assist an individual following a heart attack, MHFA training helps a layperson assist someone experiencing a mental health crisis. Evidence demonstrates that MHFA makes people feel more comfortable managing a crisis situation and builds mental health literacy, helping the public identify, understand and respond to signs of mental illness. Studies have found that those who are trained in MHFA have greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes. MHFA is intended for people and family of individuals who make up the fabric of a community. Anyone interested in learning more about mental illness and addiction would benefit.

**Mental Health First Aid Five-Step Action Plan:**

**A**ssess for risk of suicide or harm
**L**isten non-judgmentally
**G**ive reassurance and information
**E**ncourage appropriate professional help
**E**ncourage self-help and other support strategies

**References:**

A. Mental Health First Aid USA: www.MentalHealthFirstAid.org
B. National Council for Mental Wellbeing: www.thenationalcouncil.org
C. Abuse and Mental Health Services Administration's (SAMHSA's) Evidence-Based Practices Resource Center: https://www.samhsa.gov/resource-search/ebp
D. SCCMHA Procedure 09.04.02 Management of Mental Health First Aid Database

**Exhibits:**

Exhibit A: MHFA Training Registration Form link

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| SCCMHA will allocate resources on an annual basis to support a routine training program for the community in mental health first aid, including youth and adult curriculums. | SCCMHA Service Management Team & Director of Network Services, Public Policy & Continuing Education |
| SCCMHA Website and Facebook Marketing: CEU maintain an electronic distribution list and will ensure the appropriate contacts have material for community marketing. | SCCMHA Continuing Education Supervisor |
| Registration Management: SCCMHA CEU ensures proper First Aider | SCCMHA Continuing Education Unit Staff |

| | |
|---|---|
| registration and ensures collection of participant fees for MHFA Training. | |
| MHFA will be part of the SCCMHA Continuing Education Unit annual training plan and training protocols including the routine publication of local MHFA classes. SCCMHA will coordinate the certification of local instructors for Youth, Adult, Public Safety and Veteran modules of MHFA. | SCCMHA Supervisor of Continuing Education Unit Staff |
| SCCMHA will promote the marketing of and participation in MHFA training programs. | SCCMHA Leadership Team members & community partners |

**Exhibit A**

SCCMHA Mental Health First Aid (MHFA) Registration Form (google.com)

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Child-Parent Psychotherapy (CPP) | **Chapter**: 02.03 – Philosophy of Care | **Subject No**: 02.03.09.18 |
| **Effective Date**:<br>6/10/2020 | **Date of Review/Revision**:<br>3/10/21, 1/12/22, 1/10/23, 1/31/24 | **Approved By**:<br>Sandra M. Lindsey, CEO |
| | **Supersedes**: | **Responsible Director:**<br>Director of Network Services, Public Policy, & Continuing Education |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Authored By:**<br>Mary Baukus<br><br>**Additional Reviewers**:<br>Jennifer Stanuszek, EBP Leadership Team |

**Purpose:**
The purpose of this policy is to delineate the provision of an evidence-based trauma intervention for young children, ages 0-5.

**Policy:**
SCCMHA shall insure that all consumers are screened for trauma and that positive screens result in trauma treatment as needed.
SCCMHA shall, resources permitting, make CPP available to children 0-5, who have experienced or have been exposed to at least one traumatic events (e.g., domestic violence, community violence, traumatic loss, sexual abuse or exploitation, etc.) in an effort to help children and families recover from the negative effects of traumatic experiences (e.g., symptoms of Posttraumatic Stress Disorder [PTSD], depression, and other associated problems including difficulties with affect regulation, relationships, attachment, attention and consciousness, somatization, self-perception, and systems of meaning all of which can interfere with adaptive functioning).

**Application:**
This policy applies to SCCMHA-funded providers of services and supports to children and their families/caregivers.

**Standards:**
A. CPP shall be provided by clinical members of the SCCMHA provider network who have completed SCCMHA-approved training and have been privileged to provide CPP in accordance with SCCMHA policy or are in the process of going through an approved cohort.

B. CPP shall be delivered in accordance with the standards set for by the National Child Traumatic Stress Network Learning Collaborative Model.
   1. A master's degree or higher in the mental health field
   2. Professional licensure
   3. Three in-person CPP intensive skills-based training, (3-day, two 2-day) 7 days in total, or as provided during training cohort.
   4. Participation in follow-up consultation or supervision through an approved provider
   5. Completion of required number of separate CPP treatment cases through required number of sessions
   6. Use of at least one standardized instrument to assess CPP treatment progress with each of the cases from the previous step

C. CPP shall be provided with fidelity to the model and in accordance with the needs of each consumer during the course of 20-32 weeks or more, at approximately 60 minutes each, and inclusive of the essential components that will be most beneficial and clinically warranted. CPP usually consists of three phases:
   1. Foundational Phase: Assessment and Engagement
   2. Core Intervention
   3. Recapitulation and Termination: Promoting Sustainability of Gains

D. The essential components of Child-Parent Psychotherapy (CPP) include:

   1. A focus on the parent-child relationship as the primary target of the intervention.

   2. A focus on safety:
      a) Focus on safety issues in the environment as needed;
      b) Promote safe behavior;
      c) Legitimize feelings while highlighting the need for safe/appropriate behavior;
      d) Foster appropriate limit setting;
      e) Help establish appropriate parent-child roles.

   3. Affect regulation:
      a) Provide developmental guidance regarding how children regulate affect and emotional reactions;
      b) Support and label affective experiences;
      c) Foster parent's ability to respond in helpful, soothing ways when child is upset;
      d) Foster child's ability to use parent as a secure base;
      e) Develop/foster strategies for regulating affect.

   4. Reciprocity in Relationships:
      a) Highlight parent's and child's love and understanding for each other;
      b) Support expression of positive and negative feelings for important people;
      c) Foster ability to understand the other's perspective;
      d) Talk about ways that parent and child are different and autonomous;
      e) Develop interventions to change maladaptive patterns of interactions.

5. Focus on the traumatic event:
   a) Help parent acknowledge what child has witnessed and remembered;
   b) Help parent and child understand each other's reality with regards to the trauma;
   c) Provide developmental guidance acknowledging response to trauma;
   d) Make linkages between past experiences and current thoughts, feelings, and behaviors;
   e) Help parent understand link between their own experiences and current feelings and parenting practices;
   f) Highlight the difference between past and present circumstances;
   g) Support parent and child in creating a joint narrative;
   h) Reinforce behaviors that help parent and child master the trauma and gain a new perspective.
6. Continuity of Daily Living:
   a) Foster prosocial, adaptive behavior;
   b) Foster efforts to engage in appropriate activities;
   c) Foster development of a daily predictable routine.
7. Reflective supervision

E. SCCMHA shall support ongoing adherence to the model through fidelity consultation and/or review.
   1. CPP fidelity measures shall focus on the core CPP components (listed above) across the three phases (see section C)
   2. The fidelity framework consists of six interconnected strands of fidelity measured with instruments focused on the specific phase of treatment (see Exhibit A).
      a. Reflective Practice Fidelity
      b. Emotional Process Fidelity
      c. Dyadic Relational Fidelity
      d. Trauma Framework Fidelity
      e. Procedural Fidelity
      f. Content Fidelity
   3. The fidelity of the reflective supervision is also a component (see Exhibit A).

**Definitions:**

**Child-Parent Psychotherapy:** CPP is an intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship.

**Posttraumatic Stress Disorder (PTSD):** A disorder that is characterized by difficulties with managing trauma-related negative emotions and physical reactions caused by memories or reminders of the trauma that may lead to maladaptive coping (e.g., avoidance of reminders). These reactions often interfere with functioning at home, in school, and in interpersonal relationships. Symptoms of PTSD include: intrusive and upsetting memories, thoughts, or dreams about the trauma; avoidance of things, situations, or people which are trauma reminders; emotional numbing; and physical reactions of hyperarousal, trouble concentrating, or irritability).

**Trauma:** A psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror or helplessness that creates significant and lasting damage to a person's mental, physical, and emotional growth. According to SAMHSA (2014), trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

**References:**


A. National Child Traumatic Stress Network (NCTSN)/National Center for Child Traumatic Stress (NCCTS) resources for CPP. Retrieved February 20, 2020, from https://www.nctsn.org/interventions/child-parent-psychotherapy

B. Child-Parent Psychotherapy. Retrieved February 28, 2020, from http://childparentpsychotherapy.com/

C. CPP Fidelity Forms. Fidelity – Child-Parent Psychotherapy (childparentpsychotherapy.com)

D. The California Evidence-Based Clearinghouse for Child Welfare. Retrieved February 28, 2020, from https://www.cebc4cw.org/program/child-parent-psychotherapy/detailed

E. Lieberman, A. F., Horn, P. V., & Ippen, C. G. (2015). *Don't Hit My Mommy!: A Manual for Child-Parent Psychotherapy with Young Children Exposed to Violence and other trauma* (2nd ed.). Washington, DC: Zero to Three...

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

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


**Exhibits:**

A. CPP Fidelity Scale: Supervision Fidelity

**Procedure:**

None

Exhibit A

ChildParent Psychotherapy

# CPP SUPERVISON FIDELITY

V.C./.../...
Completed by: Therapist
Every 2 months for new CPP Supervisors
Every 4 months for established CPP Supervisors

CPP Training Name: _____

Therapist Name: _____ Supervisor Name: _____ Reporting Month/Year: _____

| PROCEDURAL FIDELITY | | |
|---|---|---|
| | Response (check one) | |
| | No | Yes (usually, >80% of time) |
| Supervisor as a rule provides weekly supervision or coverage for absences | ☐ | ☐ |
| Supervisor advises supervisee of vacations and other absences | ☐ | ☐ |
| Supervisee as a rule attends weekly supervision | ☐ | ☐ |
| Supervisee advises supervisor of vacations and other absences | ☐ | ☐ |
| Supervisee comes prepared to supervision with case notes or other case material | ☐ | ☐ |

| Supervisor capacity to . . . | Supervisor Capacity/Focus Given Needs (select one) | | | |
|---|---|---|---|---|
| | Could Do Less | Could Do More | Appropriate | Strength |
| Create a safe space | ☐ | ☐ | ☐ | ☐ |
| Offer supportive feedback | ☐ | ☐ | ☐ | ☐ |
| Remember the cases and supervisee's needs | ☐ | ☐ | ☐ | ☐ |
| Create an atmosphere that promotes reflection | ☐ | ☐ | ☐ | ☐ |
| Help the therapist | | | | |
| Consider their emotional reactions related to the case | ☐ | ☐ | ☐ | ☐ |
| Process their own emotional reactions | ☐ | ☐ | ☐ | ☐ |
| Consider different perspectives (e.g. therapist's, caregiver's, child's, system's) | ☐ | ☐ | ☐ | ☐ |
| Consider possible cultural and contextual influences | ☐ | ☐ | ☐ | ☐ |
| Consider family member's (e.g. child, caregiver's) emotional reactions | ☐ | ☐ | ☐ | ☐ |
| Develop interventions to address family members' dysregulated emotions | ☐ | ☐ | ☐ | ☐ |
| Consider the degree to which interventions held the perspective of different family members | ☐ | ☐ | ☐ | ☐ |
| Develop relationship enhancing interventions | ☐ | ☐ | ☐ | ☐ |
| Understand the connection between child and/or caregiver's trauma history and their behavior in session | ☐ | ☐ | ☐ | ☐ |
| Consider ways to address the trauma | ☐ | ☐ | ☐ | ☐ |
| Recognize CPP goals addressed during the session (e.g. safety, affect regulation, put trauma in perspective) | ☐ | ☐ | ☐ | ☐ |
| Consider ways to address additional CPP goals | ☐ | ☐ | ☐ | ☐ |

| The supervisor helped the supervisee gain knowledge in the areas of . . . | Supervisor Capacity/Focus Given Needs (select one) | | | |
|---|---|---|---|---|
| | Could Do Less | Could Do More | Appropriate | Strength |
| Early childhood development (social, emotional, and cognitive) | ☐ | ☐ | ☐ | ☐ |
| Understanding the impact of trauma for caregivers and children | ☐ | ☐ | ☐ | ☐ |
| The potential meaning of children's play and/or behavior | ☐ | ☐ | ☐ | ☐ |
| Sociological and cultural influences on development | ☐ | ☐ | ☐ | ☐ |
| Understanding and working with caregivers, understanding adult development | ☐ | ☐ | ☐ | ☐ |
| Understanding parenthood as a developmental phase | ☐ | ☐ | ☐ | ☐ |
| Understanding contextual influences on parenting | ☐ | ☐ | ☐ | ☐ |
| The supervisor helped the supervisee gain skills and competencies in the areas of . . . | | | | |
| CPP case conceptualization | ☐ | ☐ | ☐ | ☐ |
| Eliciting the family's cultural values and perspectives | ☐ | ☐ | ☐ | ☐ |
| Observing and understanding child and caregiver behavior | ☐ | ☐ | ☐ | ☐ |
| Developing self-reflection around personal cultural values and beliefs | ☐ | ☐ | ☐ | ☐ |
| Collaborating with other service systems and/or engaging in case management | ☐ | ☐ | ☐ | ☐ |
| Working with ports of entry | ☐ | ☐ | ☐ | ☐ |
| Translation, serving as a conduit between caregiver and child | ☐ | ☐ | ☐ | ☐ |
| Fostering dyadic affect regulation | ☐ | ☐ | ☐ | ☐ |
| Fostering the development of a trauma narrative | ☐ | ☐ | ☐ | ☐ |
| Learning specific CPP intervention techniques | ☐ | ☐ | ☐ | ☐ |

| GLOBAL SUPERVISOR RATINGS (Completed every four months)<br>Note: Ratings made by a supervisee will not be shared with the supervisor | Select one | | | | |
|---|---|---|---|---|---|
| | Not at all | A little | Somewhat | Very | Extremely |
| How knowledgeable is your supervisor in CPP? | ☐ | ☐ | ☐ | ☐ | ☐ |
| How skilled is your supervisor in implementing CPP interventions? | ☐ | ☐ | ☐ | ☐ | ☐ |
| How skilled is your supervisor in teaching CPP? | ☐ | ☐ | ☐ | ☐ | ☐ |

Please highlight strengths and provide suggestions for improvement for your supervisor (below or on another page):

| CPP SUPERVISION LOG<br>Completed by: Supervisee | | | | | |
|---|---|---|---|---|---|
| Date | # supervisees in supervision (Individual-1) | Minutes | % time clinical versus administrative | Counter | Optional Notes |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Copy as needed

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Infant Mental Health- Home Visiting (IMH-HV)</td><td>Chapter: 02.03 – Philosophy of Care</td><td>Subject No: 02.03.09.19</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 10, 2024</td><td>Date of Review/Revision:</td><td rowspan="2">Approved By:<br>Sandra M. Lindsey, CEO</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">  </td><td>Responsible Director:<br>Director of Net Director of Network Services, Public Policy, & Continuing Education<br><br>Authored By:<br>Mary Baukus<br><br>Additional Reviewers:<br>EBP Leadership Team, Jennifer Stanuszek</td></tr>
</table>

**Purpose:**
The purpose of this policy is to delineate the provision of a promising, evidence-informed, practice, Infant Mental Health- Home Visiting (IMH-HV), for services to Families, specifically parents and their infants/toddlers ages 0 (during pregnancy) to 36 months, who present with challenges to the parent-child relationship, and/or have environmental or familial concerns that place their children at risk for developing a variety of emotional, behavioral, social, and cognitive delays.

**Application:**
This policy applies to SCCMHA-funded providers of services and supports to children and their families/caregivers.

**Policy:**
A. Providers shall adhere to the practice standards of IMH-HV as delineated in the IMH-HV Treatment Fidelity Checklist.
B. SCCMHA shall offer IMH-HV to eligible persons served as resources permit.
C. IMH-HV shall be delivered in a trauma-informed manner.
D. IMH-HV can be delivered face-to-face, in-person, or via telehealth technology.

**Standards:**
A. IMH-HV shall be provided by service providers, with minimum qualifications which include a master's degree in social work, psychology or a related field and meet any local state, and/or agency licensing requirements.

a. Providers should also have training in infancy and toddlerhood, early relationship development, and mental health intervention techniques.
b. Clinicians should have a foundation in culturally responsive practices, impacts of trauma, infant, and child development, parent mental health, attachment theory, child temperament, and interpersonal skills.
c. It is assumed that clinicians will have completed master's degree level training, including course work in psychotherapy skills and practices, and that they will have engaged in additional learning to address foundational topics.
d. IMH-HV providers are expected to obtain or be working toward endorsement as an Infant Family Specialist.

B. For supervisors, minimum qualifications include master's degree in social work, psychology, or a related field. Additionally, administrative, organizational, and clinical skills and prior experience as an IMH-HV Home Visitor is preferred. Must meet any local, state, and/or agency licensing requirements.
   a. Supervisors should have a foundation in culturally responsive practices, impacts of trauma, infant and child development, parent mental health, attachment theory, child temperament, and interpersonal skills.
   b. It is assumed that supervisors will have completed masters-level training, including course work in psychotherapy skills and practices, and that they will have engaged in additional learning to address foundational topics.
   c. Supervisors are expected to obtain or be working toward endorsement as an Infant Mental Health Mentor.

C. Infant Mental Health- Home Visiting (IMH-HV) directly provides services to children and addresses the following:
   a. Disruptions and/or disturbances in primary attachment relationships; developmental delays; socio-emotional/behavioral problems or disorders related to the impact of experiences including neglect, abuse, separations, domestic violence, medical conditions, lack of resources and/or emotional/behavioral outcomes associated with being parented by an adult with experiences related to the impact of trauma, stress/adversity (e.g., mental health concerns and/or other familial/environmental stressors)

D. Infant Mental Health- Home Visiting (IMH-HV) also directly provides services to parent/caregivers and addresses the following:
   a. Disruptions and/or disturbances in primary attachment relationships, and/or caregiving experiences related to the impact of past trauma, or stress/adversity, and/or a range of behavioral and/or environmental concerns that impact parenting and the child-parent relationship including unresolved loss, mental health issues (i.e., depression, anxiety), domestic violence, economic deprivation, systemic oppression, and lack of social support.

E. Services Involve Family/Support Structures:
   a. This program involves the family or other support systems in the individual's treatment: The needs and contributions of significant adults (including other parents who are not direct recipients of services) and

other young children in the household are considered and included in the IMH-HV intervention.
    i. This may include biological parents, foster parents, and/or kin; and may also involve coordination of care with child welfare system providers, medical providers, early care and education providers, and other professionals involved in support for the infant/toddler and/or family.

F. Recommended Intensity:
    a. Typically, one 90- to 120-minute weekly session in the infant/toddler and family's home; can be more frequent depending on family need
G. Recommended Duration:
    a. Duration of services varies based on factors, including family need and age of the child; typical duration is between 6-45 months (from pregnancy through infant/toddler aged 36 months)
H. Delivery Settings
    a. This program is typically conducted in a(n):
        i. Adoptive Home
        ii. Birth Family Home
        iii. Foster / Kinship Care
        iv. Shelter (Domestic Violence, Homeless, etc.)
        v. Virtual (Online, Telephone, Video, Zoom, etc.)
I. IMH-HV has a manual for providers.
    a. Program Manual Information: Weatherston, D., & Tableman, B. (2015). *Infant Mental Health Home Visiting: Supporting competencies/reducing risks, manual for early attachments: IMH-HV Home Visiting (3rd edition)*. Michigan Association for Infant Mental Health. This manual is available from the Michigan Association for Infant Mental Health at https://mi-aIMH-HV.org/store/IMH-HVmanual/.
J. Training is delivered via in-person training sessions and bi-weekly phone (or virtual) coaching calls that include case presentations to provide clinicians and their supervisors with tools and skills to deliver IMH-HV.
    a. Provision of ongoing reflective supervision from supervisors/consultants to providers is a requirement for participation.
    b. Additional ongoing training opportunities are regularly provided by the Alliance for the Advancement of Infant Mental Health and the Michigan Association for Infant Mental Health (MI-AIMH-HV), which also has an endorsement program.
K. Fidelity to the IMH-HV model is assessed through a self-rated IMH-HV Treatment Fidelity Checklist.
    a. Use of the fidelity tool is included in the standard model training curriculum.
    b. The adapted fidelity checklist includes broad categories representing key IMH-HV strategies.
    c. Within each category are items that provide specific activities or examples of possible interventions.

d. Providers are asked to select all applicable items that reflect what they did during each home visit.
e. The fidelity checklist can be used to support clinical practice by identifying the broad categories of strategies or interventions that have been employed, as well as to help guide attention to core components and/or specific strategies that have, or have not, been used in the work with the family.
f. This checklist is meant to be used in reflective supervision as part of case conceptualizations and treatment planning.

L. The recommended assessment tool to assist in determining functional impairment for a child ages 0 to 3 years, 364 days is the Devereux Early Childhood Assessment (DECA), Infant, Toddler or Clinical version. A score that falls within the Area of Need in any Protective Factor or Behavior Concern of the DECA would suggest that the child and family would benefit from participation in Infant Mental Health and Early Childhood Services. The DECA is the tool to help determine eligibility and is also used to measure outcomes.
M. Fidelity to the model shall be monitored by SCCMHA.

**Definitions:**

**Infant Mental Health-Home Visiting** (Michigan Model Infant Mental Health Home Visiting, IMH-HV) is a needs-driven, relationship-focused intervention for parents and infants/toddlers aged 0 (pregnancy) to 36 months. IMH-HV aims to meet the needs of families at risk for relationship problems, child abuse and/or neglect, and behavioral health concerns. Families are eligible for IMH-HV if either the parent or child have concerns that make them more susceptible to disruptions in the parent-child relationship (e.g., parent mental health, child social-emotional and regulatory concerns). IMH-HV is delivered weekly (recommended) in families' homes by Master's-level providers. Through a multifaceted approach, IMH-HV aims to increase parental competencies, promote mental health and sensitive caregiving, and thus reduce risk for the infant/toddler and lessen the probability of intergenerational transmission of the effects of unresolved loss and trauma in parents.

**References:**


A. The California Evidence-based Clearinghouse for Child Welfare, 02/27/24, The Michigan Model of Infant Mental Health Home Visiting (IMH-HV-HV) CEBC » Program › The Michigan Model Of Infant Mental Health Home Visiting (cebc4cw.org)
B. Michigan Association for Infant Mental Health, Michigan Association for Infant Mental Health (mi-aimh.org)
C. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
D. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
E. SCCMHA Procedure 09.06.01.04.04 – Infant Mental Health Services Entry Criteria
F. SCCMHA Procedure 09.06.01.05.04 – Infant Mental Health Services Exit Criteria

G. SCCMHA Procedure 09.06.01.07 – Infant Mental Health Devereux Early Childhood (DECA) Assessment

**Exhibits:**
None

**Procedure:**
None

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Parent-Child Interaction Therapy (PCIT)</td><td>Chapter: 02.03 – Philosophy of Care</td><td>Subject No: 02.03.09.20</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 10, 2024</td><td>Date of Review/Revision:</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Net Director of Network Services, Public Policy, & Continuing Education<br><br>Authored By:<br>Mary Baukus<br><br>Additional Reviewers:<br>Angel Gomez, EBP Leadership Team</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 delineate a framework for the provision and monitoring of the Evidence-Based Practice, Parent-Child Interaction Therapy (PCIT).

**Application:** This policy applies to SCCMHA-funded providers of services and supports to children and their families/caregivers.

**Policy:**
A. Providers shall adhere to the practice standards of the 2011 PCIT Protocol and 2013 Clinical Manual for DPICS-IV as disseminated by PCIT International.
B. SCCMHA shall offer PCIT to persons served as resources permit.
C. PCIT shall be delivered in a trauma-informed manner.
D. PCIT can be delivered face-to-face, in-person, or via telehealth technology.

**Standards:**
A. Target population: Children ages 2- 7 years old with behavior and parent-child relationship problems; may be conducted with parents, foster parents, or other caretakers.
B. Certified PCIT Therapists are individuals who have received appropriate and sufficient PCIT training to be qualified to provide PCIT services to children and families. (See Exhibit A: Training Requirements for Certification as a PCIT Therapist)
C. PCIT Goals

1. The goals of the Child-Directed Interaction part of Parent-Child Interaction Therapy (PCIT) are:
    i. Build close relationships between parents and their children using positive attention strategies
    ii. Help children feel safe and calm by fostering warmth and security between parents and their children
    iii. Increase children's organizational and play skills
    iv. Decrease children's frustration and anger
    v. Educate parent about ways to teach child without frustration for parent and child
    vi. Enhance children's self-esteem
    vii. Improve children's social skills such as sharing and cooperation
    viii. Teach parents how to communicate with young children who have limited attention spans
2. The goals of Parent-Directed Interaction part of Parent-Child Interaction Therapy (PCIT) are:
    i. Teach parent specific discipline techniques that help children to listen to instructions and follow directions
    ii. Decrease problematic child behaviors by teaching parents to be consistent and predictable
    iii. Help parents develop confidence in managing their children's behaviors at home and in public

D. Essential Components of Parent-Child Interaction Therapy (PCIT) include:

1. Child Directed Interaction (CDI):

    i. Parent-child dyads attend treatment sessions together and the parent learns to follow the child's lead in play.

    ii. The parent is taught how to decrease the negative aspects of their relationship with their child and to develop positive communication.

    iii. The parent is taught and coached to use CDI skills. These skills help the parents give positive attention to the child following positive (e.g. non-negative) behavior and ignore negative behavior.

    iv. By learning CDI skills, the parent is taught:

        1. To give labeled praise following positive child behavior.

        2. To reflect or paraphrase the child's appropriate talk.

        3. To use behavioral descriptions to describe the child's positive behavior.

        4. To avoid using commands, questions, or criticism because these verbalizations are intrusive and often give attention to negative behavior.

    v. The parent is observed and coached through a one-way mirror at each treatment session.

vi. After the first session, at least half of each session is spent coaching the parent in CDI skills utilizing a 'bug in the ear'—a wireless communications set consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears.

vii. The parent's CDI skills are observed and recorded during the first five minutes of each session to assess progress and to guide skills learned through coaching during session.

viii. Behaviors are tracked and charted on a graph at each session to provide the parent with immediate feedback regarding progress in positive interactions and the achievement of skill mastery.

ix. The parent is provided with homework between sessions to enhance skills learned in the session.

x. Dyads do not proceed to the Parent Directed Interaction (PDI) until the parent demonstrates mastery of the CDI.

2. Parent Directed Interaction (PDI):

i. Parent-child dyads attend treatment sessions together and the parent learns skills to lead the child's behavior effectively.

ii. The parent is taught how to direct the child's behavior when it is important that the child obey their instruction.

iii. The parent is observed and coached through a one-way mirror at each treatment session.

iv. After the first session, at least half of each session is spent coaching the parent in PDI utilizing a 'bug in the ear'—a wireless communications set consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears.

v. Parent's PDI skills are observed and recorded during the first five minutes of each session to assess progress and guide the coaching of the session.

vi. The parent learns to incorporate the effective instructions and commands (e.g. commands that are direct, specific, positively stated, polite, given one at a time, given only when essential, and accompanied by a reason that either immediately precedes the command or accompanies the praise for compliance) learned during the CDI component.

vii. The parent learns to follow through on direct commands by giving labeled praise after every time the child obeys and beginning a time-out procedure after every time the child disobeys.

viii. The parent learns a time-out procedure to use in the event that the child disobeys a direct command. The parent begins by issuing a warning, which will lead to the time-out chair, and then to the time-out room if the child continues disobeying.

ix. The parent is coached to use the PDI algorithm, which gives the child an opportunity to obey and stop the time-out procedure at each step.

x. Behaviors are tracked and charted on a graph at each session to provide the parent with immediate feedback regarding progress in their PDI skills.

xi. Once the parent demonstrates mastery of the procedures, she/he is given homework that gradually increases the intensity of the situations as the child learns to obey.

xii. Treatment does not end until the parent meets pre-set mastery criteria for both phases of treatment and the child's behavior is within normal limits on a parent-report measure of disruptive behavior at home.

E. ***PCIT*** can be delivered in a group format as well. When done so, small groups of 3 or 4 families in 90-minute sessions are recommended. This will allow adequate time for individual coaching of each parent-child dyad while other parents observe, code, and provide feedback in each session.
F. Recommended intensity is 1–2-hour sessions per week with a therapist
G. Duration average is 14 sessions but varies from 10-20 sessions. Treatment continues until the parent masters the interaction skills to pre-set criteria and the child's behavior has improved within normal limits.
H. The fidelity of this intervention is guided by the 2011 PCIT Protocol and 2013 Clinical Manual for DPICS-IV as disseminated by PCIT International.
I. Fidelity to the model shall be monitored by SCCMHA.
J. The CAFAS (Child and Adolescent Functional Assessment Scale) will be used as a tool to examine outcomes by the EBP Leadership Team.

**Definitions:**

***Parent-Child Interaction Therapy (PCIT)*** is a dyadic behavioral intervention for children (ages 2.0–7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. Coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly.

**References:**

A. The California Evidence-based Clearinghouse for Child Welfare, 03/01/24, Parent-Child Interaction Therapy (PCIT) CEBC » Program › Parent Child Interaction Therapy (cebc4cw.org)
B. PCIT Official Website; Official website for PCIT International and Parent-Child Interaction Therapy (PCIT) - Home
C. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
D. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

**Exhibits:**

A. Training Requirements for Certification as a PCIT Therapist

**Procedure:**

None

Exhibit A

**Training Requirements for Certification as a PCIT Therapist**

These requirements were developed by the PCIT International Training Task Force in collaboration with the PCIT International Board of Directors. This document should be considered "dynamic" in that the training and certification requirements will evolve as new research arises in intervention, training, and dissemination. Currently, there are several formats used in training therapists to deliver PCIT effectively with adherence to its essential elements. These training requirements reflect the minimum training necessary within any of these formats to develop competence as a PCIT Therapist using the 2011 PCIT Protocol (Eyberg & Funderburk, 2011).

## I. Definition

Certified PCIT Therapists are individuals who have received appropriate and sufficient PCIT training to be qualified to provide PCIT services to children and families.

## II. Training Requirements for Certified PCIT Therapists.

In order to apply for certification as a PCIT therapist, therapists must document applicable graduate education, basic PCIT training, and consultation training which includes completing two cases as described below.

**A. Graduate Education.**

1. Have a master's degree or higher, or an international equivalent of a master's degree, in a mental health field

**AND**

2. Be an independently licensed mental health service provider (for example, licensed psychologist, psychiatrist, licensed marital and family therapist, licensed practicing counselor, licensed clinical social worker, etc.) or be working under the supervision of a licensed mental health service provider.

**OR**

1. Be a psychology doctoral student who has completed the third year of training and be conducting clinical work under the supervision of a licensed mental health service provider.
2. **Special Note Concerning Timing of Training:** Students may receive PCIT training before completion of their master's degrees. However, they cannot be certified as PCIT therapists until their master's degree is complete or until they have completed the third year of their doctoral training.

**B. Basic Training.** To apply for status as a Certified PCIT Therapist, an applicant must demonstrate appropriate Basic Training, as evidenced by:

1. 40-hours of face-to-face training with a PCIT Level II or Global Trainer that includes an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery

of CDI and PDI skills, and a review of the 2011 PCIT Protocol. The 40 hours of training may be conducted via didactic training, a mentorship model, or any combination of the two. PCIT training is ideally offered over a period of time rather than limited to one timepoint, for example CDI training at one time, followed by PDI training at a later date.

**OR**

2. 10 hours of online training from a program endorsed by PCIT International and 30 hours of face-to-face contact with a PCIT Level II or Global Trainer. Online training must be supplemented with skills review from a PCIT Trainer. Therefore, the 30 hours of face-to-face training may be conducted in didactic training, a mentorship model, or any combination of the two. This training will include an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery of CDI and PDI skills, and a review of the 2011 PCIT Protocol.

**OR**

3. 40 hours of PCIT training with a PCIT International Level 1 Trainer using a combination of didactic training and live co-therapy and supervision. Training from a PCIT Level 1 Trainer must include a minimum of 20 hours of co-therapy and/or live case supervision and continue until the trainee meets CDI and PDI coaching competencies. Video review or phone consultation cannot be used in lieu of the co-therapy or live-supervision requirements. This training will include an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery of CDI and PDI skills, and a review of the 2011 PCIT Protocol.

**C. Consultation Training.**

1. Until the two PCIT cases meet graduation criteria, the applicant must remain in contact via real-time consultation (e.g., telephone conference or live, online, or telehealth observation) or video review with feedback with a certified PCIT Trainer at least twice a month.

2. The applicant must serve as a therapist for a minimum of two PCIT cases to graduation criteria as defined by the 2011 PCIT Protocol. At least one of the cases must be conducted with the applicant as the primary therapist (e.g., lead therapist or equal co-therapist).

**D. Skill Review**

Applicants must have their treatment sessions observed by a certified PCIT Trainer. Observations may be conducted in real time (e.g., live or online/telehealth) or through video recording. Level I Trainers can only use video review after trainees have met competencies in CDI and PDI (see B.3. above).

1. To demonstrate skill development, the applicant's competence will be observed by a PCIT Trainer in the following sessions conducted by the applicant:

   a. CDI Teach
   b. PDI Teach
   c. CDI Coach
   d. PDI Coach

2. The PCIT Trainer will review these sessions and determine whether the applicant has demonstrated mastery of each skillset; as such, the applicant must be prepared to provide additional session observations as necessary to document adequate skill.

## III. Therapist Competency Requirements

**A. Assessment Skills.** By the end of the training process, the applicant should be able to:

1. Administer, score, and interpret the required standardized measures for use in assessment and treatment planning. (Required measures: Eyberg Child Behavior Inventory (ECBI); Recommended measures: Therapy Attitude Inventory (TAI), Parenting Stress Index-Short Form (PSI-SF), Sutter-Eyberg Student Behavior Inventory-Revised (SESBI-R), and Behavior Assessment Scale for Children (BASC) or Child Behavior Checklist (CBCL)

2. Administer behavioral observations from the DPICS-IV Coding System.

3. Achieve a minimum of 80% agreement with a PCIT Trainer using the DPICS-IV during 5minutes of either live coding or continuous coding with a criterion video recording.

**B. CDI-Related Therapist Skills.** By the end of the training process, an applicant should be able to:

1. Conduct the CDI Teach session, adequately explaining all items on the treatment integrity checklist in the 2011 PCIT Protocol as observed by the PCIT Trainer.

2. Meet the parent criteria for CDI skills (10 labeled praises, 10 behavioral descriptions, 10 reflections; 3 or fewer negative talks, questions, plus commands) in a 5-minute interaction with a child or a 5-minute role-play with an adult portraying a child.

3. Demonstrate for the PCIT Trainer how to determine the coaching goals for a CDI session by interpreting the DPICS-IV data from the CDI Progress Record.

**C. PDI-Related Therapist Skills**. By the end of the training process, an applicant should be able to:

1. Present the PDI Teach Session, adequately explaining all items on the treatment integrity checklist in the 2011 PCIT Protocol as observed by the PCIT Trainer.

2. Effectively manage a PDI Coach session and accurately demonstrate the discipline sequence with a child in treatment. In the case when a full discipline sequence does not occur or cannot be video recorded, the applicant must demonstrate the skills through video role-play.

3. Demonstrate the ability to explain the discipline procedure in concise, developmentally appropriate terms to a child (or ability to coach a parent through this).

4. Accurately explain the House Rules procedure as described in the 2011 PCIT Protocol. Accuracy can be assessed through role-play, and does not require observation of an actual session.

5. Accurately explain the Public Behaviors procedure as described in the 2011 PCIT Protocol. Accuracy can be assessed through role-play, and does not require observation of an actual session.

**D. General Coaching Skills**

1. By the end of the training process, an applicant is expected to demonstrate adequate and sensitive coaching as observed by the PCIT Trainer.

2. By the end of the training process, an applicant is expected to model CDI skills during all interactions with parents and children throughout the treatment.

## IV. Application Requirements

**A.** Upon completion of Consultation Training, an applicant for Certified PCIT Therapist status must complete the Certified PCIT Therapist Application (available from PCIT International Certified Trainers or at www.pcit.org.)

**B.** Following acceptance of the Certified PCIT Therapist Application, the applicant must successfully complete the PCIT Certification Experience which reviews concepts covered in Basic and Continuation Training (available at www.pcit.org).

**C.** Final decisions about certification of PCIT Therapists will be made by PCIT International.

## V. Responsibilities of Certified PCIT Therapists

**A.** Use the 2011 PCIT Protocol and 2013 Clinical Manual for DPICS-IV as disseminated by PCIT International.

**B.** Remain current in PCIT research by activities such as attending conferences, reading research or practice articles for continuing education credit, or conducting research.

**C.** Certified PCIT Therapists are required to obtain at least 3 hours of PCIT Continuing Education credit every 2 years through educational activities sponsored by the PCIT International Task Force on Continuing Education. PCIT International is an APA-

approved CE sponsor and provides continuing PCIT education through its online educational and conference programming.

## VI. Maintaining Certification

**A. Certification Period.** Therapists are certified for 2 years from the beginning date on their Certified PCIT Therapist Certificate.

**B. Re-Certification.** Certification as a PCIT Therapist is renewable every 2 years. To renew, Certified PCIT Therapists must submit a brief application for re-certification and document successful completion of 3 hours of PCIT Continuing Education in programs of learning that have been preauthorized by PCIT International. The Certification Experience is required only for the initial certification application.

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Picture Exchange Communication System (PECS) | **Chapter**: 02 - Customer Services & Recipient Rights | **Subject No**: 02.03.09.22 |
| **Effective Date**: 6/13/17 | **Date of Review/Revision**: 4/10/18, 4/9/19, 3/4/20, 3/10/21, 1/12/22, 1/10/23, 1/31/24<br>**Supersedes**: 02.03.30 | **Approved By**: Sandra M. Lindsey, CEO<br><br>**Responsible Director:** Director of Network Services, Public Policy, & Continuing Education<br><br>**Authored By:** Mary Baukus, Barbara Glassheim<br><br>**Additional Reviewers**: EBP Leadership Team |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | |

**Purpose:**
The purpose of this policy is to specify and promote the use of Picture Exchange Communication System (PECS) for consumers and members of their natural support systems who, because of expressive language challenges, may benefit from the system.

**Policy:**
SCCMHA shall, resources permitting, make PECS available to consumers who may benefit from PECS (e.g., those with autism spectrum disorders). PECS shall be utilized in a trauma-informed manner.

**Application:**
This policy applies to SCCMHA-funded services for consumers who are nonverbal, as well those who are primarily echolalic, or have unintelligible speech, and those who have only a small set of meaningful words or signs in their communication repertoire.

**Standards:**
A. PECS training shall transpire during typical activities within the natural settings (i.e., the classroom and the home).
B. PECS training shall be targeted to intentional communicators (i.e., those who are aware of the need to communicate their message to someone).
C. Picture discrimination ability shall not be considered a prerequisite criterion for PECS training.
D. PECS training shall be targeted at consumers with identifiable personal preferences.

1. A repertoire of preferences and dislikes shall be developed through trial and error or through a history of exposure to several types of food, objects, or activities in any instance of a paucity of strong preferences.

E. Training techniques shall include a variety of strategies such as chaining, prompting/cuing, modeling, and environmental engineering.

F. PECS trainers shall adhere to the training format as follows:

1. The PECS protocol includes three individuals in the training situation: (1) the individual who will be transmitting a message, (2) the person who will be receiving the message (e.g., parent or teacher), and (3) the facilitative participant who will deliberately assist the message sender to make the targeted response.
2. Phase I – How to Communicate: During this phase, the program shall be initiated with enticement whereby a preferred object or food item is displayed or shown to the consumer.
    a. As the consumer reaches for the desired object, the facilitator shall provide assistance in picking up a picture for the desired object or food item.
    b. The consumer shall be given physical assistance to give the picture to the message receiver who must be within close physical proximity to the consumer.
        1). Two trainers shall be utilized, one of whom shall function as the consumer's communicative partner, and the other as the physical prompter, who will prompt the consumer to reach towards the communicative partner with the picture in exchange for a reward.
3. Phase II – Distance and Persistence: During this phase, the exchange shall continue with attempts to increase the consumer's independence. The consumer will learn to remove the picture from a display board for the exchange and, in doing so, engage in more physical movement than during Phase I in order to accomplish the exchange.
    a. The facilitator shall be available as needed to provide assistance.
    b. The consumer shall be encouraged to be responsible for carrying their own communication book.
4. Phase III – Discrimination Between Symbols (Picture Discrimination): During this phase, the consumer learns to select the target picture from a choice of multiple pictures that differ in various dimensions.
    a. Error correction strategies shall be used when the response is incorrect.
5. Phase IV – Using Phrases (Sentence Structure): During this phase, the consumer will combine the object picture with the carrier phrase "I want" on a sentence strip and give the strip to the communication partner.
6. Phase V – Answering a Direct Question (Answering Questions): In this phase, the consumer will learn to respond to the question "What do you want?" by exchanging the sentence strip.

    NOTE: Use of the questioning phrase is delayed until Phase V because the exchange behavior should be automatic by that point in the

programming sequence and earlier use of the carrier phrase, or an extended hand gesture is believed to provide undesirable cues relative to the desired behavior.

7. Phase VI – Commenting: In this phase, the consumer will learn to respond to the questions "What do you want?" vs. "What do you see?" vs. "What do you have?"

   NOTE: The last phase is designed to introduce the consumer to commenting behavior while the previous stages focused on requesting behavior.

G. Implementation of PECS by a practitioner shall be predicated upon the completion of SCCMHA-approved training.
   1. Training shall (typically) include attendance at a two-day workshop.
   2. SCCMHA reserves the right to limit PECS teaching to practitioners who have been privileged in this practice.

**Definitions:**

**Picture Exchange Communication System (PECS):** The Picture Exchange Communication System or PECS approach is a modified applied behavior analysis program designed for early nonverbal symbolic communication training. While it is not designed to teach speech, the latter is encouraged indirectly, and some consumers begin to spontaneously use speech while in the program. In addition, although PECS is commonly used as a communication aid for children with autism spectrum disorder (ASD), it has been used with a wide variety of learners, from preschoolers to adults, who have various communicative, cognitive, and physical impairments, including cerebral palsy, blindness, and deafness. The program may take several months or several years to complete.

**References:**

A. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
B. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

**Exhibits:**

None

**Procedure:**

None

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Permanent Supportive Housing (PSH) | **Chapter**: 02 - Customer Services & Recipient Rights | **Subject No**: 02.03.09.24 |
| **Effective Date**:<br>6/13/17 | **Date of Review/Revision**:<br>4/10/18, 4/9/19, 3/4/20, 07/29/20, 3/10/21, 1/12/22, 1/10/23, 1/31/24 | **Approved By**:<br>Sandra M. Lindsey, CEO |
| | **Supersedes**:<br>02.03.32 and<br>02.03.06 – Housing Best Practice | **Responsible Director:**<br>Director of Network Services, Public Policy, & Continuing Education |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Authored By**:<br>Mary Baukus, Barbara Glassheim<br><br>**Additional Reviewers**:<br>EBP Leadership Team, Debbie Jones-Burt |

**Purpose:**
The purpose of this policy is to articulate standards for the provision of housing-related services and supports to consumers served by SCCMHA-funded programs and agencies.

**Policy:**
SCCMHA recognizes that individuals who experience psychiatric disabilities have the same right to live in a home of their own as does everyone else and that they can enjoy the same rights and responsibilities as other people, irrespective of their support needs. Therefore, SCCMHA shall advocate for the elimination of the housing disparities that are often experienced by consumers by taking appropriate actions to: (1) support their rights to live in the community; (2) rent or buy housing on the same terms as others do (without any special conditions or agreements); and (3) ask landlords and property managers to make reasonable accommodations for persons with psychiatric disabilities.

**Application:**
This policy applies to SCCMHA-funded providers of services and supports for consumers who need assistance to live in the community, particularly those with histories of homelessness, those who have spent time in institutional or congregate settings (e.g., hospitals, correctional facilities, nursing homes, adult foster care group homes, etc.), and those who have never established their own household (e.g., have always lived with their family).

**Standards:**

A. Providers shall advocate and promote the fundamental right of consumers to live in the most integrated setting possible with accessible, individualized supports.

B. Consumers' housing preferences shall be fully explored, in a trauma-informed manner, prior to the initiation of housing-related services and supports. (See Exhibit C for a tool to elicit preference.)
   1. Housing choice and supportive services shall be consumer-directed.
   2. Case holders and others who are working with the consumer shall strive to elicit the consumer's unique housing preferences (e.g., desired living situation; types of roommates/housemates, or desire to live alone; type of neighborhood or area that is desirable; types of support services desired and needed).

C. Consumers shall be offered choice of housing that adheres to the following principles:
   1. Functional separation of housing and services[1].
      a. Consumers shall have rights of tenancy.
         1). Consumers shall hold leases in their own names.
            a). Terms and provisions of leases shall be the same as those found in leases held by individuals who do not have a psychiatric disability.
         2). Consumers shall be able to maintain their homes even if their service and support needs change.
   2. Decent, safe, and affordable housing.
      a. Affordability shall be measured by the standard that tenants must pay no more than thirty percent of their adjusted income toward rent plus basic utilities.
         1). Housing subsidies or financial assistance shall be pursued when needed to meet this standard.
      b. Housing shall adhere to the U.S. Department of Housing and Urban Development's (HUD's) Housing Quality Standards (HQS).
   3. Housing integration.
      a. Consumers shall have access to housing in the most integrated settings such as mixed-use buildings in the rental market and scattered-site homes.
   4. Access to housing.
      a. Consumers shall have access to housing that is not predicated upon the acceptance of services, including mental health treatment or medication, except in the case of HUD funded housing that requires treatment for a mental disability pursuant to HUD requirements for Special Needs Assistance Housing Programs
      b. SCCMHA will strive to adopt a housing-first approach.
      c. Housing shall not be time-limited; leases shall be renewable at tenants' and owners' options.
   5. Flexible, voluntary, and recovery-focused services.

[1] Permanent Supportive Housing has been found to be most successful when a functional separation exists between housing matters (rent collection, physical maintenance of the property) and services and supports (e.g., case management.)

a. Consumers shall have the right to select the services and supports they wish to receive.
    1). Housing shall not be predicated on acceptance of services; rights of tenancy shall be maintained even if the consumer refuses services, except in the case of HUD funded housing that requires treatment for a mental disability pursuant to HUD requirements for Special Needs Assistance Housing Programs.
b. Consumer input shall be sought to ascertain services and supports they believe will be most effective for maintaining community tenure.
c. Services shall be focused on recovery, improved functioning, and life satisfaction rather than symptom reduction.
d. Services shall be provided in vivo whenever possible (rather than in offices or clinics).

D. SCCMHA shall monitor housing-related services for fidelity to the PSH model.

**Definitions:**

**Housing First** (also known as **low demand housing**) is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry. Permanent supportive housing models that use a Housing First approach have been proven to be highly effective for ending homelessness, particularly for people experiencing chronic homelessness who have higher service needs. (*Source: HUD*)

Housing first, or low-demand housing, has three critical components: (1) it avoids complex application processes such as multiple site visits, interviews, extensive documentation, and waiting lists; (2) it does not require that applicants be "housing ready" (in terms of medication, sobriety, money management, etc.); and (3) it has no or few conditions that impinge on residents' autonomy (such as requirements for treatment, money management, or curfews). (*Source: SAMHSA PSH EBP KIT*)

**Permanent Supportive Housing (PSH):** is an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wraparound supportive services for people experiencing homelessness, as well as other people with disabilities. PSH offers decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local property owner, tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences. PSH makes housing affordable to someone on SSI, (either through rental assistance or housing development). (*Source: SAMHSA PSH EBP KIT*)

**Reasonable accommodation** is any change in the landlord's policies that enables a person with disabilities to apply for, obtain, or live in housing (e.g., allowing a support person who is not listed on the lease stay overnight in the unit, or allowing someone who lives in a unit that does not allow pets to have a companion animal).

It should be noted that housing providers are not required to provide accommodations that are not considered reasonable. An accommodation is not reasonable

if it imposes an "undue financial and administrative burden" on the housing provider or would create a "fundamental alteration" in its programs or services.

**References:**

A. HUD. *Housing Quality Standards (HQS)*: Housing Quality Standards - HCV | HUD.gov / U.S. Department of Housing and Urban Development (HUD)
B. New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America*: Achieving the Promise: Transforming Mental Health Care in America Report | dmh.mo.gov
C. SAMHSA. *Permanent Supportive Housing Evidence-Based Practices KIT*: https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509
D. SCCMHA Policy 02.03.05 – Recovery
E. SCCMHA Policy 02.03.06 – Housing Best Practice
F. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
G. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

**Exhibits:**

A. PSH Fidelity Scoresheet (SAMHSA)
B. PSH Fidelity Scale (SAMHSA)
C. PSH Tools for Tenants – Tool 3: Your Housing Preferences (SAMHSA)

**Procedure:**

None

Exhibit A

## Fidelity Scoresheet

Today's date: ____/__/____

Agency name: _____

Assessors' names: _____

| Dimension | Indicator | Item Scores (unshaded lines only) | Average Score for Dimension |
|---|---|---|---|
| 1. Choice of housing | **1.1:** Housing Options | | |
| | 1.1.a: Tenants have choice of type of housing | | |
| | 1.1.b: Real choice of housing unit | | |
| | 1.1.c: Tenant can wait without losing their place in line | | |
| | **1.2:** Choice of living arrangements | | |
| | 1.2.a: Tenants have control over composition of household | | |
| | **Dimension Subtotal** $\frac{1.1.a + 1.1.b + 1.1.c + 1.2.a}{4 \text{ items}}$ = average score for dimension | | |
| 2. Separation of housing and services | **2.1:** Functional Separation | | |
| | 2.1.a Housing management role in service provision | | |
| | 2.1.b Service staff have no housing role | | |
| | 2.1.c Location of service providers | | |
| | **Dimension Subtotal** $\frac{2.1.a + 2.1.b + 2.1.c}{3 \text{ items}}$ = average score for dimension | | |
| 3. Decent, safe, and affordable housing | **3.1:** Housing Affordability | | |
| | 3.1.a: Reasonable amount of income for housing | | |
| | **3.2:** Decent and Safe | | |
| | 3.2.a: Housing quality standards | | |
| | **Dimension Subtotal** $\frac{3.1.a + 3.2.a}{2 \text{ items}}$ = average score for dimension | | |
| 4. Housing integration | **4.1:** Housing Integration | | |
| | 4.1.a Integration | | |
| | **Dimension Subtotal** 4.1a. is the score for *this* dimension. | | |
| 5. Rights of tenancy | **5.1:** Tenant Rights | | |
| | 5.1.a: Legal rights of tenancy | | |
| | 5.1.b: Compliance with program rules | | |
| | **Dimension Subtotal** $\frac{5.1.a + 5.1.b}{2 \text{ items}}$ = average score for dimension | | |

| Dimension | Indicator | Item Scores (unshaded lines only) | Average Score for Dimension |
|---|---|---|---|
| **6. Access to housing** | **6.1:** Access to Housing | | |
| | 6.1.a: Housing readiness required? | | |
| | 6.1.b: People with housing obstacles are given priority | | |
| | **6.2:** Privacy | | |
| | 6.2.a: Extent to which tenants control entry to housing unit | | |
| | **Dimension Subtotal** $\frac{6.1.a + 6.1.b + 6.2.a}{3 \text{ items}}$ = average score for dimension | | |
| **7. Flexible, Voluntary, Services** | **7.1:** Tenant Service Preferences | | |
| | 7.1.a: Tenants choose services | | |
| | 7.1.b: Opportunity to modify services | | |
| | **7.2:** Service Options | | |
| | 7.2.a: Service Options | | |
| | 7.2.b: Change in services | | |
| | **7.3:** Consumer-Driven Services | | |
| | 7.3.a: Consumer-driven Services | | |
| | **7.4:** Availability and Adequacy of Services | | |
| | 7.4.a: Caseload size: Optimum caseload size = 12 to 15 people per staff team member | | |
| | 7.4.b: Service structure: Services are provided by a team. | | |
| | 7.4.c: Service availability: Services are available 24/7 | | |
| | **Dimension Subtotal** $\frac{7.1.a + 7.1.b + 7.2.a + 7.2.b + 7.3.a + 7.4.a + 7.4.b + 7.4.c}{8 \text{ items}}$ = average score for dimension | | |

Exhibit B

## Fidelity Scale

| Dimension 1: Choice of Housing | | | | |
|---|---|---|---|---|
| **Indicator 1.1: Housing options** | Measures the degree of choice offered to tenants. If the program has a range of housing choices sufficient to meet consumer preferences, and when an integrated, affordable apartment is one housing choice, the score is 4. If the program does not have the capacity to offer choice (e.g., the program operates one apartment complex and tenants must take the open apartment), the score is 1. | | | |
| **Score 1.1.a =** | **4** | | **2.5** | **1** |
| 1.1.a: Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment) | Tenants choose the type of housing they prefer from a range of housing types, with an integrated, affordable apartment as 1 choice. | | Tenants have a restricted choice of housing types (e.g., 2 types of project-based housing). | Tenants are not given a choice of type of housing and are assigned to a type of housing. |
| **Score 1.1.b =** | **4** | | | **1** |
| 1.1.b: Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units. | Tenants choose among multiple units. | | | Tenants are assigned to a unit. |
| **Score 1.1.c =** | **4** | **3** | **2** | **1** |
| 1.1.c: Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists. | Tenants can wait for the unit of their choice without risking discharge from the program or losing priority for services or units. A reasonable waiting period is the allowed "search" time for the local Housing Choice/Section 8 voucher program (usually 60 days). | Tenants can wait for the unit of their choice, but they are allowed a set number of choices before they lose priority on the list for units (e.g., 3 choices and then go to the bottom of the list). | Tenants must accept the unit offered; no waiting for units is allowed. Prospective tenants who refuse the unit offered are not discharged from the program but go to the end of the waiting list. | Tenants must accept the unit offered or be discharged from the program. |
| **Indicator 1.2: Choice of living arrangements** | Measures the degree to which tenants can choose their living arrangements, particularly about roommates and any shared space. If tenants choose the members of their household and have a private bedroom, the score is 4. If tenants are required to accept a predetermined household, not of their choosing, and share a bedroom, the score is 1. | | | |
| **Score 1.2.a =** | **4** | | **2.5** | **1** |
| 1.2.a: Extent to which tenants control the composition of their household. | Tenants choose the members of their household or can choose to live alone and have a private bedroom. | | Tenants must accept a predetermined household not of their choosing but have a private bedroom. | Tenants must accept a predetermined household not of their choosing and must share a bedroom. |

| Dimension 4: Housing integration | | | | |
|---|---|---|---|---|
| **Indicator 4.1: Community integration** | Measures the extent to which an individual's housing unit is clustered with housing units occupied by people with disabilities vs. scattered throughout the community. The ideal is for individuals to live in housing units typical of the community, without clustering people with disabilities. All disability-only settings receive a score of 1, regardless of location in the community. For example, an apartment complex with five or more units with 100% occupancy by people with disabilities scores 1 on this dimension even if the apartment complex is located among other apartment complexes that do not exclusively serve people with disabilities. | | | |
| **Score 4.1.a =** | **4** | **3** | **2** | **1** |
| 4.1.a: Extent to which housing units are integrated.<br><br>(See below for special scoring instructions for providers with multiple housing programs.) | People live in housing units where 0-25% of all units have been set aside for people meeting disability-related eligibility criteria and the remaining units are not set aside for any special needs groups, including people who are homeless. | People live in housing units where 26-50% of all units have been set aside for people meeting disability-related eligibility criteria and the remaining units are not set aside for any special needs groups, including people who are homeless. | People live in housing units where 51-75% of all units have been set aside for people meeting disability-related eligibility criteria and the remaining units are not set aside for any special needs groups, including people who are homeless. | People live in settings where 76-100% of the tenants meet disability-related eligibility criteria and the remaining units are not set aside for any special needs groups, including people who are homeless. |
| **Dimension 5: Rights of Tenancy** | | | | |
| **Indicator 5.1: Tenant rights** | Measures the extent to which tenants have full rights of tenancy. | | | |
| **Score 5.1.a =** | **4** | | | **1** |
| 5.1.a: Extent to which tenants have legal rights to the housing unit. | Tenants have full legal rights of tenancy according to local landlord/tenant laws. | | | Tenants do not have full legal rights of tenancy according to local landlord/tenant laws. |
| **Score 5.1.b =** | **4** | | **2.5** | **1** |
| 5.1.b: Extent to which tenancy is contingent on compliance with program provisions. | Tenancy is not contingent in any way on compliance with program or treatment participation (e.g., sobriety or medication compliance). | | Program rules require participating in ongoing services, but failure to comply with this requirement does not lead to eviction. | Tenancy is revoked based on noncompliance with program or failure to participate in treatment (e.g., not maintaining sobriety or keeping to a required medical regime). |

| Dimension 6: Access to Housing | | | | |
|---|---|---|---|---|
| **Indicator 6.1** | Measures the extent to which tenants have access to housing with no required demonstration of housing readiness. | | | |
| **Score 6.1.a =** | **4** | **3** | **2** | **1** |
| 6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to units. | Tenants have access to housing with no requirements to demonstrate readiness (other than provisions in a standard lease). | Tenants have access to housing with minimal readiness requirements, such as engagement with case management. | Tenant access to housing is determined by successfully completing a period of time in a program (e.g., transitional housing). | To qualify for housing, tenants must meet requirements such as sobriety, medication compliance, or willingness to comply with program rules. |
| **Score 6.1.b =** | **4** | | **2.5** | **1** |
| 6.1.b. Extent to which tenants with obstacles to housing stability have priority. | Program proactively seeks tenants who have obstacles to housing stability. | | Tenants who meet program eligibility have equal access to housing. | Tenants are prioritized based on positive clinical or functional criteria (e.g., stability or sobriety). |
| **Indicator 6.2: Privacy** | Measures the extent to which the tenant has privacy in the unit. | | | |
| **Score 6.2.a =** | **4** | **3** | **2** | **1** |
| 6.2.a: Extent to which tenants control staff entry into the unit. | Service staff may not enter the unit unless tenants invite them. | Service staff may enter the unit uninvited only under specific circumstances agreed on in advance. | Service staff may enter the unit uninvited only in a crisis. | Service staff has free access to housing units, including the right to make unannounced visits. |
| **Dimension 7: Flexible, Voluntary Services** | | | | |
| **Indicator 7.1: Exploration of tenant preferences** | Measures the degree to which tenants are offered a range of services. Only if an array of service choices is offered, the score is 4. | | | |
| **Score 7.1.a =** | **4** | | | **1** |
| 7.1.a: Extent to which tenants choose the type of services they want at program entry. | Tenants are the primary authors of their service plans. | | | Tenants are not the primary authors of their service plans. |
| **Score 7.1.b =** | **4** | | | **1** |
| 7.1.b: Extent to which tenants have the opportunity to modify service selection. | Tenants initiate and are offered routine opportunities to modify their service selections. | | | Tenants do not have the opportunity to modify their service selection. |
| **Indicator 7.2: Service options** | Measures the degree of service choice offered to tenants. If the program has a broad array of services sufficient to meet consumer preferences, and if tenants may choose not to participate in services, the score is 4. If the program does not have the capacity to offer choice (the program operates with a standard service package and tenants must accept the service package), the score is 1. | | | |
| **Score 7.2.a =** | **4** | **3** | **2** | **1** |
| 7.2.a: Extent to which tenants are able to choose the services they receive. | Tenants may choose from an array of services, including the option of no services. | Tenants may choose from an array of services, but choosing no services is not an option. | Tenants must participate in services that staff identify. | Tenants must participate in a standard service package. |
| **Score 7.2.b =** | **4** | **3** | **2** | **1** |
| 7.2.b: Extent to which services can be changed to meet tenants' changing needs and preferences. | Service mix is highly flexible and can adapt type, location, intensity and frequency based on tenants' changing needs and preferences. | Service mix is predictable, but significant variations can occur at tenant request. | Service mix can be adapted in minor ways. | Service mix cannot be adapted to meet tenants' changing needs and preferences. |

| **Indicator 7.3: Consumer-driven services** | Measures the degree to which services are consumer driven. | | | |
|---|---|---|---|---|
| **Score 7.3.a =** | **4** | **3** | **2** | **1** |
| 7.3.a: Extent to which services are consumer driven. | All services are consumer driven. | Significant consumer control of services exists in design and provision. | Some consumer input into design and provision of services (e.g., consumer advisory board). | Program is staff-controlled without meaningful consumer input. |
| **Indicator 7.4: Quality and adequacy of services** | Measures the degree to which caseloads, service structure, and service availability are adequate. | | | |
| **Score 7.4.a =** | **4** | **3** | **2** | **1** |
| 7.4.a: Extent to which services are provided with optimum caseload sizes. | Caseload is no more than 15 tenants to each staff member. | Caseload is 16–25 tenants to each staff member. | Caseload is 26–35 tenants to each staff member. | Caseload is 36 or more tenants to each staff member. |
| **Score 7.4.b =** | **4** | **3** | **2** | **1** |
| 7.4.b: Behavioral health services are team based. | All behavioral health services are provided through a team, including psychiatric services. A good example is an Assertive Community Treatment team. | All behavioral health services except psychiatric services are provided through a team. A good example is a Continuous Treatment Team, such as those found in providing Integrated Dual Diagnosis Treatment (IDDT). | Individual service providers are primarily responsible for behavioral health services, but specialists are routinely consulted. For example, a case manager provides services, but may call a substance abuse treatment provider to assess and make recommendations. | The primary responsibility for behavioral health services falls to one provider. |
| **Score 7.4.c=** | **4** | **3** | **2** | **1** |
| 7.4.c: Extent to which services are provided 24 hours a day, 7 days a week. | Services are available 24/7. | Services are available on flexible schedules, but not 24/7. | Services are available 8 a.m. to 5 p.m., Monday-Friday, with some weekend availability (4-12 hours scheduled on weekends). | Services are available from 8 a.m. to 5 p.m., Monday through Friday. |

Exhibit C

| | Comments | Importance |
|---|---|---|
| **Living arrangements** | | |
| Would you like to live in a house? An apartment building with just a few units? A building with many units? | | |
| Would you prefer living by yourself or with other people? | | |
| Would you like to live with specific people—a girlfriend or boyfriend, family members, or a friend? | | |
| Would you share an apartment if you had your own room? | | |
| If you had a roommate, what would you want the person to be like? | | |
| Is a building with private bedrooms and shared kitchens acceptable? | | |
| Is a shared bathroom in the hall acceptable? | | |
| Would a bathroom shared only with one or two other people be all right? | | |
| Do you prefer living with all women (or men), younger people, etc? | | |
| Would you prefer to live around other people who have psychiatric disabilities? Would you prefer not to? | | |
| **Features** | | |
| What features in a home are important to you—air conditioning, dishwasher, onsite laundry, etc.? | | |
| Do you need any special accommodations for a physical or sensory disability, such as ramps, elevators, or doorbell signalers? | | |
| **Neighborhood** | | |
| Do you want to live in a specific neighborhood? | | |
| What features of the neighborhood are important to you? Examples of things you might want are a quiet environment, parks, well-lit streets, shopping, libraries, or public transportation. | | |
| Do you need to have easy access to any specific place—for example, your job, treatment facility, place of worship, or family home? | | |

| | Comments | Importance |
|---|---|---|
| **Support needs** | | |
| Would you like to have onsite staff available any time of the day or night? | | |
| Would you prefer to live in a place that has no staff onsite and have staff visit you instead? | | |
| **Security and visitors** | | |
| Do you like having company? Do you want to have overnight guests? How often? | | |
| How do you feel about having your guests screened at a front desk? Do you like knowing that other people's guests are screened? | | |
| **Alcohol and other drugs** | | |
| Is a community that strongly supports sobriety important to you? | | |
| How do you feel about being in a setting where some people may be using drugs or alcohol? | | |
| **Activities** | | |
| Would you like to have access to in-house groups? | | |
| Do you like the idea of having staff-sponsored activities like trips and movies? | | |
| **Pets** | | |
| Do you have a pet? | | |
| Would you like to have a pet? | | |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Seeking Safety</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.25</td></tr>
<tr><td rowspan="2">Effective Date:<br>6/13/17</td><td>Date of Review/Revision:<br>4/10/18, 4/9/19, 3/4/20, 4/14/21, 1/12/22, 1/10/23, 1/31/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Network Services Public Policy & Continuing Education<br><br>Authored By:<br>Mary Baukus, Barbara Glassheim<br><br>Additional Reviewers:<br>EBP Leadership Team</td></tr>
<tr><td>Supersedes:<br>02.03.33</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
The purpose of this policy is to delineate the scope of Seeking Safety as a treatment for trauma, including PTSD (posttraumatic stress disorder) within the context of a primary or co-occurring substance use disorder.

**Policy:**
SCCMHA, through its network of funded providers, shall make Seeking Safety available for consumers with a history of trauma and/or substance abuse as resources permit.
Seeking Safety shall only be provided by practitioners who are familiar with the manual to be able to provide this evidence-based practice to fidelity and are privileged to provide this intervention.
Seeking Safety can be delivered face-to-face, in-person, or via telehealth technology.

**Application:**
This policy applies to SCCMHA-funded providers.

**Standards:**
A. Seeking Safety may be delivered by peers or case managers; there is no requirement for a degree or licensure. All persons wishing to implement this evidence-based practice should be familiar with the Seeking Safety Manual. SCCMHA reserves the right to credential providers to conduct this practice as well as monitor the practice for fidelity to the model.
B. Seeking Safety shall be delivered in accordance with its key principles:
    1. Safety is the overarching goal
        a. Helping consumers to attain safety in their relationships, thinking, behavior, and emotions

2. Integrated treatment shall be provided
    a. Both trauma and substance abuse shall be addressed simultaneously
3. Focusing on ideals to counteract the loss of ideals in both trauma and substance abuse
4. The inclusion of four content areas:
    a. Cognitive
    b. Behavioral
    c. Interpersonal
    d. Case management
5. Attention to clinician processes
    a. Helping clinicians work on countertransference, self-care, and other issues

C. Providers shall include as many of Seeking Safety's twenty-five topics (see Exhibit A) in accordance with the needs of the consumer(s) being served and in any order as authorized.
    1. Since each topic is independent of the others, they can be used in any order and for as long or short as the duration of the consumer's treatment.

D. Providers shall also focus on engaging consumers in community resources.

E. SCCMHA's quality improvement activities shall include fidelity monitoring to ensure adherence to the evidence-based practice model using the GOI (Global Organization Index) as a guide.
    1. The Evidence-Based Practice and Trauma-Informed Care Coordinator and the Director of Network Services, Public Policy, & Continuing Education will facilitate quarterly meetings for Supervisors of EBP Teams, including Seeking Safety, to discuss fidelity monitoring.
    2. The Adult Strengths and Needs Assessment (ANSA) will be used as a tool to examine outcomes when Seeking Safety is being offered) for Seeking Safety participants ages 18+. For youth participating in Seeking Safety who are under the age of 18, the Child and Adolescent Functional Assessment Scale (CAFAS) will be used in a similar manner.

**Definitions:**

**Seeking Safety** is an evidence-based, present-focused (i.e., avoids delving into painful, emotionally distressing trauma narratives) model for adolescents and adults that is designed to enhance coping skills and help individuals attain safety from trauma and/or substance abuse. It can be conducted in a group (of any size) or an individual format and can be provided for any duration of treatment that is clinically warranted.

**Trauma:** A psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror or helplessness that creates significant and lasting damage to a person's mental, physical, and emotional growth. According to SAMHSA (2014), trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

**References:**

A. Najavits, L. (2002). Seeking Safety: *A New Psychotherapy for Posttraumatic Stress Disorder and Substance Abuse*. In *Trauma and Substance Abuse: Causes, Consequences and Treatment of Comorbid Disorders*. (Eds. P. Ouimette & P. Brown). American Psychological Association. Washington, DC.
B. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
C. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
D. Seeking Safety website: http://www.seekingsafety.org/

**Exhibits:**

A. Seeking Safety Treatment Topics (Najavits)

**Procedure:**

None

Exhibit A

*Seeking Safety* treatment topics

Domains (cognitive, behavioral, interpersonal, or a combination) are listed in parentheses.

| |
|---|
| (1) **Introduction to treatment / Case management**<br>This topic covers: (a) Introduction to the treatment; (b) Getting to know the patient; and (c) Assessment of case management needs. |
| (2) **Safety** *(combination)*<br>Safety is described as the first stage of healing from both PTSD and substance abuse, and the key focus of this treatment. A list of over 80 *Safe Coping Skills* is provided, and patients explore what safety means to them. |
| **(3) PTSD: Taking Back Your Power** *(cognitive)*<br>Four handouts are offered: (a) "What is PTSD?"; (b) "The Link Between PTSD and Substance Abuse"; (c) "Using Compassion to Take Back Your Power"; and (d) "Long-Term PTSD Problems". The goal is to provide information as well as a compassionate understanding of the disorder. |
| **(4) Detaching from Emotional Pain: Grounding** *(behavioral)*<br>A powerful strategy, "grounding", is offered to help patients detach from emotional pain. Three types of grounding are presented (mental, physical, and soothing), with an experiential exercise to demonstrate the techniques. The goal is to shift attention toward the external world, away from negative feelings. |
| **(5) When Substances Control You** *(cognitive)*<br>Eight handouts are provided, which can be combined or used separately: (a) "Do You Have a Substance Abuse Problem?" (b) "How Substance Abuse Prevents Healing From PTSD"; (c) "Choose a Way to Give Up Substances"; (d) "Climbing Mount Recovery", an imaginative exercise to prepare for giving up substances; (e) "Mixed Feelings"; (f) "Self-Understanding of Substance Use"; (g) "Self-Help Groups"; and (h) "Substance Abuse And PTSD: Common Questions". |
| **(6) Asking for Help** *(interpersonal)*<br>Both PTSD and substance abuse lead to problems in asking for help. This topic encourages patients to become aware of their need for help and provides guidance on how to obtain it. |
| **(7) Taking Good Care of Yourself** *(behavioral)*<br>Patients are guided to explore how well they take care of themselves, using a questionnaire listing specific behaviors (e.g., "Do you get regular medical check-ups?"). They are asked to take immediate action to improve at least one self-care problem. |
| **(8) Compassion** *(cognitive)*<br>This topic encourages the use of compassion when trying to overcome problems. Compassion is the opposite of "beating oneself up", a common tendency for people with PTSD and substance abuse. Patients are taught that only a loving stance toward the self produces lasting change. |
| **(9) Red and Green Flags** *(behavioral)*<br>Patients are guided to explore the up-and-down nature of recovery in both PTSD and substance abuse through discussion of "red and green flags" (signs of danger and safety). A *Safety Plan* is developed to identify what to do in situations of mild, moderate, and severe relapse danger. |
| **(10) Honesty** *(interpersonal)*<br>Patients are encouraged to explore the role of honesty in recovery and to role-play specific situations. Related issues include: What is the cost of dishonesty? When is it safe to be honest? What if the other person doesn't accept honesty? |
| **(11) Recovery Thinking** *(cognitive)*<br>Thoughts associated with PTSD and substance abuse are contrasted with healthier "recovery thinking". Patients are guided to change their thinking using rethinking tools such as *List Your* |

| |
|---|
| *Options*, *Create a New Story*, *Make a Decision*, and *Imagine*. The power of rethinking is demonstrated through think-aloud and rethinking exercises. |
| **(12) Integrating the Split Self** *(cognitive)*<br>Splitting is identified as a major psychic defense in both PTSD and substance abuse. Patients are guided to notice splits (e.g., different sides of the self, ambivalence, denial) and to strive for integration as a means to overcome these. |
| **(13) Commitment** *(behavioral)*<br>Making and keeping promises, both to self and others, are explored. Creative strategies for keeping commitments, and feelings that can get in the way, are described. |
| **(14) Creating Meaning** *(cognitive)*<br>Meaning systems are discussed with a focus on assumptions specific to PTSD and substance abuse, such as *Deprivation Reasoning, Actions Speak Louder Than Words,* and *Time Warp*. Meanings that are harmful versus healing in recovery are contrasted. |
| **(15) Community Resources** *(interpersonal)*<br>A lengthy list of national non-profit resources is offered to aid patients' recovery (including advocacy organizations, self-help, and newsletters). Also, guidelines are offered to help patients take a consumer approach in evaluating treatments. |
| **(16) Setting Boundaries in Relationships** *(interpersonal)*<br>Boundary problems are described as either too much closeness (difficulty saying "no" in relationships) or too much distance (difficulty saying "yes" in relationships). Ways to set healthy boundaries are explored, and domestic violence information is provided. |
| **(17) Discovery** *(cognitive)*<br>Discovery is offered as a tool to reduce the cognitive rigidity common to PTSD and substance abuse (called "staying stuck"). Discovery is a way to stay open to experiences and new knowledge, using strategies such as *Ask Others, Try It and See, Predict,* and *Act "As If"*. Suggestions for coping with negative feedback are provided. |
| **(18) Getting Others to Support Your Recovery** *(interpersonal)*<br>Patients are encouraged to identify which people in their lives are supportive, neutral, or destructive toward their recovery. Suggestions for eliciting support are provided, as well as a letter they can give to others to promote understanding of their PTSD and substance abuse. A safe family member or friend can be invited to attend the session. |
| **(19) Coping with Triggers** *(behavioral)*<br>Patients are encouraged to actively fight triggers of PTSD and substance abuse. A simple three-step model is offered: change *who* you are with, *what* you are doing, and *where* you are (similar to "change people, places, and things" in AA). |
| **(20) Respecting Your Time** *(behavioral)*<br>Time is explored as a major resource in recovery. Patients may have lost years to their disorders, but they can still make the future better than the past. They are asked to fill in schedule blanks to explore issues such as: Do they use their time well? Is recovery their highest priority? Balancing structure versus spontaneity; work versus play; and time alone versus in relationships are also addressed. |
| **(21) Healthy Relationships** *(interpersonal)*<br>Healthy and unhealthy relationship beliefs are contrasted. For example, the unhealthy belief "Bad relationships are all I can get" is contrasted with the healthy belief "Creating good relationships is a skill to learn." Patients are guided to notice how PTSD and substance abuse can lead to unhealthy relationships. |

| |
|---|
| **(22) Self-Nurturing** *(behavioral)*<br>Safe self-nurturing is distinguished from unsafe self-nurturing (e.g., substances and other "cheap thrills"). Patients are asked to create a gift to the self by increasing safe self-nurturing and decreasing unsafe self-nurturing. Pleasure is explored as a complex issue in PTSD/substance abuse. |
| **(23) Healing from Anger** *(interpersonal)*<br>Anger is explored as a valid feeling that is inevitable in recovery from PTSD and substance abuse. Anger can be used constructively (as a source of knowledge and healing) or destructively (a danger when acted out against self or others). Guidelines for working with both types of anger are offered. |
| **(24) The Life Choices Game** *(combination)*<br>As part of termination, patients are invited to play a game as a way to review the material covered in the treatment. Patients pull from a box slips of paper that list challenging life events (e.g., "You find out your partner is having an affair"). They respond with how they would cope, using game rules that focus on constructive coping. |
| **(25) Termination**<br>Patients express their feelings about the ending of treatment, discuss what they liked and disliked about it, and finalize aftercare plans. An optional Termination Letter can be read aloud to patients as a way to validate the work they have done. |

From: Najavits, L.M. (2002). Seeking Safety: A New Psychotherapy for Posttraumatic Stress Disorder and Substance Abuse. In *Trauma and Substance Abuse: Causes, Consequences and Treatment of Comorbid Disorders* (Eds. P. Ouimette & P. Brown). Washington, DC: American Psychological Association.

(Source: Najavits, L. [2002])

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.27</td></tr>
<tr><td>Effective Date:<br>6/13/17</td><td>Date of Review/Revision:<br>4/10/18, 4/9/19, 2/7/20, 6/14/20, 4/14/21, 1/12/22, 1/10/23, 1/31/24<br>Supersedes:<br>02.03.37</td><td rowspan="2">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Network Services Public Policy & Continuing Education<br><br>Authored By:<br>Mary Baukus, Barbara Glassheim<br><br>Additional Reviewers:<br>EBP Leadership Team</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
The purpose of this policy is to delineate the provision of an evidence-based trauma intervention for children.

**Policy:**
A. SCCMHA shall ensure that all consumers are screened for trauma and that positive screens result in trauma treatment as needed. See also the SCCMHA Procedure 04.01.04 – Trauma Screening, Assessment, and Treatment.
B. TF-CBT can be delivered face-to-face, in-person, or via telehealth technology.

SCCMHA shall, resources permitting, make TF-CBT available to children and adolescents aged three to eighteen who have experienced or have been exposed to traumatic events (e.g., domestic violence, community violence, traumatic loss, sexual abuse or exploitation, etc.) in an effort to help children and families recover from the negative effects of traumatic experiences (e.g., symptoms of Posttraumatic Stress Disorder [PTSD], depression, and other associated problems including difficulties with affect regulation, relationships, attention and consciousness, somatization, self-perception, and systems of meaning all of which can interfere with adaptive functioning).

**Application:**
This policy applies to SCCMHA-funded providers of services and supports to children and adolescents and their families/caregivers.

**Standards:**

A. TF-CBT shall be provided by clinical members of the SCCMHA provider network who have completed SCCMHA-approved training and have been privileged to provide TF-CBT in accordance with SCCMHA policy.

B. TF-CBT shall be delivered in accordance with the standards set for by the TF-CBT National Therapist Certification Program, which outlines eight specific criteria a TF-CBT trainee must complete for certification:
   1. A master's degree or higher in the mental health field
   2. Professional licensure
   3. Completion of the free, web-based learning course TF-CBTWeb (https://tfcbt.musc.edu/)
   4. One three-day and one two-day session of in-person TF-CBT intensive skills-based training (or the live virtual equivalents).
   5. Participation in follow-up consultation or supervision through an approved provider
   6. Completion of three separate TF-CBT treatment cases
   7. Use of at least one standardized instrument ( Young Child PTSD Checklist, YCPC, for ages 3-6 or UCLA Child/Adolescent PTSD Reaction Index for DSM 5, for ages 7-18) to assess TF-CBT treatment progress with each of the cases from the previous step
   8. Passing the TF-CBT Therapist Certification Program Knowledge-Based Test

C. TF-CBT shall be provided with fidelity to the model and in accordance with the needs of each consumer during the course of twelve to twenty-five sessions and inclusive of the core components (which are summarized by the acronym PRACTICE) that will be most beneficial and clinically warranted as follows:

   **P**: Psychoeducation and parenting skills:
   Psychoeducation is provided to children and their caregivers about the impact of trauma and common childhood reactions. Parenting skills are provided to optimize children's emotional and behavioral adjustment.

   **R**: Relaxation skills:
   Relaxation and stress management skills are individualized for each child and parent.

   **A**: Affective expression and modulation skills:
   Affective expression and modulation are taught to help children and parents identify and cope with a range of emotions.

   **C**: Cognitive coping and processing skills:
   Cognitive coping and processing are enhanced by illustrating the relationships among thoughts, feelings, and behaviors. This helps children and parents modify inaccurate or unhelpful thoughts about the trauma.

   **T**: Trauma narration and processing:
   Trauma narration, in which children describe their personal traumatic experiences, is a key component of the treatment.

   **I**: In vivo mastery of trauma reminders:

In vivo mastery of trauma reminders is used to help children overcome their avoidance of situations that are no longer dangerous, but which remind them of the original trauma.

**C**: Conjoint child–parent sessions:
Conjoint child-parent sessions help the child and parent talk to each other about the child's trauma.

**E**: Enhancing safety and future developmental trajectory:
The final phase of the treatment, Enhancing future safety and development, addresses safety, helps the child to regain developmental momentum, and covers any other skills the child needs to end treatment.

D. SCCMHA shall support ongoing adherence to the model through fidelity consultation and/or review.

1. TF-CBT fidelity measures shall focus on the core TF-CBT components (listed above) and the sequence in which they are provided to the child and family.
    a. TF-CBT shall be delivered in the sequence in which the components are described in the treatment manual and in training because later sessions build on skills learned in earlier sessions.
    b. Any materials created in the process of TF-CBT therapy will be addressed per the SCCMHA Procedure for Consumer Records, 08.04.01. and the following:
        1. In an attempt to maintain compliance with the storage of TF-CBT documentation, the following initiatives have been created to ensure proper confidential storage.
            a. Screening and Assessment
                i. CTAC checklist- Organizations will complete the checklist without additional notes or descriptions of specific traumas.
                ii. UCLA PTSD assessment- All TF-CBT clinicians will submit for scanning: pre, mid and post UCLA PTSD Symptom Analysis (stoplight page). The UCLA PTSD assessment is one of many clinical factors that determine whether the model of TF-CBT is appropriate- it is not used to rule in or out the model. (With the DSM revision it is not to be used as the exclusive determinant of PTSD diagnosis.)
            b. Documentation of trauma processing- The trauma narration process is collaborative and therapeutic and is not forensic in nature. Therefore, no formal physical documentation is maintained during this process. Written documentation in progress notes and periodic reviews will reference processing trauma experiences, connecting thoughts and

feelings related to the trauma experience, working towards desensitization, and mastering triggers.

c. Per progress notes, any products referenced will be placed in the physical chart (i.e., progressive muscle relaxation; assessment results (see above)).

d. In summary, this process is intended to help the child in the context of a confidential therapist relationship and is not forensic in nature.

NOTE: Treatment is fluid, and components may overlap and/or be repeated in order to maximize the opportunity to achieve beneficial outcomes.

2. SCCMHA's quality improvement activities shall include fidelity monitoring to ensure adherence to the evidence-based practice model using the GOI (Global Organization Index) as a guide.

a. The Evidence-Based Practice and Trauma-Informed Care Coordinator and the Director of Network Services, Public Policy, & Continuing Education will facilitate quarterly meetings for Supervisors of EBP Teams, including TF-CBT, to discuss fidelity monitoring.

b. The Child and Adolescent Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Assessment Scale (PECFAS), depending on the age of the participant, will be used as a tool to examine outcomes for TF-CBT participants.

**Definitions:**

**Posttraumatic Stress Disorder (PTSD):** A disorder that is characterized by difficulties with managing trauma-related negative emotions and physical reactions caused by memories or reminders of the trauma that may lead to maladaptive coping (e.g., avoidance of reminders). These reactions often interfere with functioning at home, in school, and in interpersonal relationships. Symptoms of PTSD include intrusive and upsetting memories, thoughts, or dreams about the trauma; avoidance of things, situations, or people which are trauma reminders; emotional numbing; and physical reactions of hyperarousal, trouble concentrating, or irritability).

**Trauma:** A psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror or helplessness that creates significant and lasting damage to a person's mental, physical, and emotional growth. According to SAMHSA (2014), trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):** An evidence-based treatment model designed to assist children, adolescents, and their families in overcoming the negative effects of a traumatic experience.

**References:**

A. Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network. (2004). *How to Implement Trauma-Focused Cognitive Behavioral Therapy.* Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress: (Microsoft Word - 04-29-08ImplManual2004v2.doc (musc.edu))
B. Feldman & Dorsey. (2010). *TF-CBT PRACTICE Checklist* (University of Washington): https://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/Theoretical%20Perspective/TF-CBT%20Components,%20Rationale,%20&%20Methods%20Worksheet.pdf
C. National Child Traumatic Stress Network (NCTSN)/National Center for Child Traumatic Stress (NCCTS) resources for TF-CBT: tfcbt@musc.edu
D. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
E. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
F. SCCMHA Procedure 08.04.01 – Consumer Records
G. SCCMHA Procedure 04.01.04 – Trauma Screening, Assessment and Treatment

**Exhibits:**

A. Organizational Readiness and Capacity Assessment
B. TF-CBT Brief Practice Checklist - Revised

**Procedure:**

None

Exhibit A

| Organizational Readiness and Capacity Assessment[1,2]<br><br>This assessment is intended to help your agency identify issues that are known to impact readiness for adoption of a new practice. Please circle the number that corresponds to how true each statement is with respect to current conditions and practices at your agency. | Not at all | To a slight extent | To a moderate extent | To a large extent | Consistently |
|---|---|---|---|---|---|
| **Clients** | | | | | |
| 1. Clients are currently able to be screened for trauma-related symptoms that could qualify them for the new practice. | 1 | 2 | 3 | 4 | 5 |
| 2. We already have many clients who will benefit from the new practice based on their clinical presentation, diagnosis, and histories. | 1 | 2 | 3 | 4 | 5 |
| **Leadership/Clinicians/Staff** | | | | | |
| 3. Clinicians in our agency agree with the rationale for using the new practice. | 1 | 2 | 3 | 4 | 5 |
| 4. Agency and clinical leadership actively support the adoption of the new practice for reasons clinicians can share. | 1 | 2 | 3 | 4 | 5 |
| 5. We have on staff seasoned professionals to whom clinicians look for support, consultation, and guidance. | 1 | 2 | 3 | 4 | 5 |
| 6. All staff who will be affected by the new practice know that changes are coming and are prepared to offer feedback for its success. | 1 | 2 | 3 | 4 | 5 |
| 7. Our agency has a tradition of learning and changing so we do not become entrenched in the status quo. | 1 | 2 | 3 | 4 | 5 |
| 8. The clinical orientation of the new practice is not inconsistent with that of the existing staff and leadership. | 1 | 2 | 3 | 4 | 5 |
| 9. Staff at all levels perceives the advantage of implementing the new practice. | 1 | 2 | 3 | 4 | 5 |
| 10. Our staff has opportunities for interaction with others in our community or around the nation who have implemented or are currently implementing the new practice. | 1 | 2 | 3 | 4 | 5 |
| **Supervision** | | | | | |
| 11. Our supervisors are clear about how the new practice will benefit clients. | 1 | 2 | 3 | 4 | 5 |
| 12. Our agency currently provides case-specific clinical supervision (as opposed to administrative supervision) to our clinicians. | 1 | 2 | 3 | 4 | 5 |
| 13. Supervisors are prepared to learn about the new practice through training. | 1 | 2 | 3 | 4 | 5 |
| 14. Weekly one-hour clinical supervision is the norm for new treatments implemented in our agency. | 1 | 2 | 3 | 4 | 5 |
| 15. Clinician direct care hours can be adjusted to allow for supervision in the new practice. | 1 | 2 | 3 | 4 | 5 |

| Circle the number that corresponds to how true each statement is with respect to current conditions and practices at your agency. | Not at all | To a slight extent | To a moderate extent | To a large extent | Consistently |
|---|---|---|---|---|---|
| **Internal and External Stakeholders** | | | | | |
| 16. We have collected information about key stakeholders within our agency (e.g. intake, records, and billing personnel) that might be affected by the new practice. | 1 | 2 | 3 | 4 | 5 |
| 17. Internal and external "champions" or "cheerleaders" are in place to support implementation of the new practice. | 1 | 2 | 3 | 4 | 5 |
| 18. We have developed or are developing targeted information for our identified stakeholders that answers their specific questions about the new practice. | 1 | 2 | 3 | 4 | 5 |
| **Program/Culture/Services** | | | | | |
| 19. Our supervisors, clinicians, and staff are generally positive about changes in practice, especially when they can see how it will benefit the clients. | 1 | 2 | 3 | 4 | 5 |
| 20. There are components of the new practice that are consistent with ongoing practice in our agency. | 1 | 2 | 3 | 4 | 5 |
| 21. Case load and direct-care hours can be adjusted in response to the requirements of the new practice. | 1 | 2 | 3 | 4 | 5 |
| 22. We have measurement systems that will provide feedback on our progress in adoption of the new practice. | 1 | 2 | 3 | 4 | 5 |
| **Finance and Administration** | | | | | |
| 23. Current reimbursement mechanisms cover the new practice. | 1 | 2 | 3 | 4 | 5 |
| 24. Current service definitions, units, provider qualifications, or financing mechanisms can accommodate the new practice. | 1 | 2 | 3 | 4 | 5 |
| 25. Funds are available to pay for the added cost of implementing and delivering the service, even if they must be shifted from other areas. | 1 | 2 | 3 | 4 | 5 |
| **Education** | | | | | |
| 26. Therapists have adequate time to formally learn about the new practice. | 1 | 2 | 3 | 4 | 5 |
| 27. We traditionally provide ongoing learning opportunities and consultation to clinicians learning a new practice. | 1 | 2 | 3 | 4 | 5 |
| 28. We can provide financial support and time to clinicians wishing to learn a new practice. | 1 | 2 | 3 | 4 | 5 |
| **Technology** | | | | | |
| 29. Our clinicians and supervisors have high-speed broadband access to the Internet, intranet, e-mail, and learning and feedback about the new practice. | 1 | 2 | 3 | 4 | 5 |

[1] Allred, C., Markiewicz, J., Amaya-Jackson, L., Putnam, F., Saunders, B., Wilson, C., Kelly, A., Koiko, D., Berliner, L., & Rosch, J. (2005). *The Organizational Readiness and Capacity Assessment*. Durham NC: UCLA-Duke National Center for Child Traumatic Stress.

[2] This project was funded in part by the US Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of HHS, SAMHSA, or CMHS.

Exhibit B

TF-CBT Brief Practice Checklist

**Which PRACTICE component did you implement today? Mark only ONE component for each session.**

**Therapist Identifier:_____ (May also check caregiver participation for any session)**

| TF-CBT Treatment Component | Session #: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Date: | / | / | / | / | / | / | / | / | / | / |
| **Caregiver participation:** Meet with caregiver > 15 minutes | | | | | | | | | | | |
| **P:** Provide psychoeducation about traumatic experiences, trauma reactions, youth's symptoms and trauma reminders<br>**GE:** identify trauma triggers; use proper words for traumas and body parts | | | | | | | | | | | |
| **P:** Provide parenting skills (praise, selective attention, time out, contingency reinforcement)<br>**GE:** connect parental response and youth's behavior problems to trauma | | | | | | | | | | | |
| **R:** Provide individualized relaxation skills<br>**GE:** Connect use of relaxation skills to youth's trauma reminders | | | | | | | | | | | |
| **A:** Provide affect identification and modulation skills<br>**GE:** Connect use of skills to youth's trauma reminders | | | | | | | | | | | |
| **C:** Introduce cognitive triangle; encourage more accurate/helpful thoughts<br>**GE**: Help PARENT use cognitive coping for trauma related maladaptive thoughts | | | | | | | | | | | |
| **T:** Develop youth's trauma narrative in calibrated increments with thoughts, feelings and worst moments. Cognitively process maladaptive cognitions. Share with parent as TN is developed<br>**GE:** Re-read the TN at the beginning of *each* session | | | | | | | | | | | |
| **I:** GE: Develop in-vivo desensitization plan for generalized avoidant behaviors | | | | | | | | | | | |
| **C:** Conjoint youth-parent sessions: share youth's TN ; youth and parent Q&A; improve communication<br>GE: Share TN with parent or address other trauma related issues conjointly | | | | | | | | | | | |
| **E:** Address personal safety skills and assertive communication; increase awareness of problem-solving skills and/or social skills<br>**GE:** Address safety skills related to youth's trauma | | | | | | | | | | | |
| **© Deblinger, Cohen, Mannarino, Murray & Epstein, 2008** | | | | | | | | | | | |

| TF-CBT Treatment Component | Session #: | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Date: | / | / | / | / | / | / | / | / | / | / |
| **Caregiver participation:** Meet with caregiver > 15 minutes | | | | | | | | | | | |
| **P:** Provide psychoeducation about traumatic experiences, trauma reactions, youth's symptoms and trauma reminders<br>**GE:** identify trauma triggers, use proper words for traumas and body parts | | | | | | | | | | | |
| | | | | | | | | | | | |
| **P:** Provide parenting skills (praise, selective attention, time out, contingency Reinforcement)<br>**GE:** connect parental response and youth's behavior problems to trauma | | | | | | | | | | | |
| | | | | | | | | | | | |
| **R:** Provide individualized relaxation skills<br>**GE:** Connect use of relaxation skills to youth's trauma reminders | | | | | | | | | | | |
| | | | | | | | | | | | |
| **A:** Provide affect identification and modulation skills<br>**GE:** Connect use of skills to youth's trauma reminders | | | | | | | | | | | |
| | | | | | | | | | | | |
| **C:** Introduce cognitive triangle; encourage more accurate/helpful thoughts<br>GE: Help PARENT use cognitive coping for trauma related maladaptive thoughts | | | | | | | | | | | |
| | | | | | | | | | | | |
| **T:** Develop youth's trauma narrative in calibrated increments with thoughts, feelings and worst moments. Cognitively process maladaptive cognitions. Share with parent as TN is developed<br>**GE:** Re-read the TN at the beginning of *each* session | | | | | | | | | | | |
| | | | | | | | | | | | |
| **I:** GE: Develop in-vivo desensitization plan for generalized avoidant behaviors | | | | | | | | | | | |
| | | | | | | | | | | | |
| **C:** Conjoint youth-parent sessions: share youth's TN ; youth and parent Q&A; improve communication<br>GE: Share TN with parent or address other trauma related issues conjointly | | | | | | | | | | | |
| | | | | | | | | | | | |
| **E:** Address personal safety skills and assertive communication; increase awareness of problem-solving skills and/or social skills<br>**GE:** Address safety skills related to youth's trauma | | | | | | | | | | | |
| | | | | | | | | | | | |
| **© Deblinger, Cohen, Mannarino, Murray & Epstein, 2008** | | | | | | | | | | | |

## Meeting Fidelity Standards

The following criteria are used when evaluating whether fidelity standards are being met:

- Each TF-CBT component must be implemented for each child unless there are clinical reasons for deleting a component (for example, there are no trauma reminders the child is avoiding, so *in vivo* mastery is not needed).
- The TF-CBT components must be implemented in the "PRACTICE" order unless there is a compelling reason to change the sequencing. (However, returning to a previously provided component to reinforce its use is permitted.)
- Progression from one component to the next must occur within a reasonable time period (i.e., treatment is completed within 12 to 16 sessions for usual cases, and 16 to 20 sessions for complex cases).

(Source: *How to Implement Trauma-Focused Cognitive Behavioral Therapy* [2004])

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Whole Health Action Management (WHAM)</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.28</td></tr>
<tr><td rowspan="2">Effective Date:<br>6/13/17</td><td>Date of Review/Revision:<br>4/10/18, 4/9/19, 3/11/20, 4/14/21, 1/12/22, 1/10/23, 1/31/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Network Services Public Policy & Continuing Education<br><br>Authored By:<br>Mary Baukus, Barbara Glassheim<br><br>Additional Reviewers:<br>EBP Leadership Team</td></tr>
<tr><td>Supersedes:<br>02.03.39</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA recognizes the value of peer support in building resiliency and promoting recovery as well as preventing and/or managing general health conditions. Therefore, SCCMHA supports the provision of training and evidence-based practices that peers can draw upon to help consumers envision and achieve recovery.

**Policy:**
SCCMHA shall, resources permitting, make WHAM training available to peer support staff who are interested in developing and working toward a whole health and resiliency goal; providing peer support to help consumers reach their whole health and resiliency goals; and facilitating or participating in an eight-week whole health and resiliency peer group. WHAM shall be delivered in a person-centered, recovery-oriented, and trauma-informed manner that is respectful of consumers' needs, preferences, and values

WHAM can be delivered face-to-face, in-person, or via telehealth technology.

**Application:**
This policy applies to SCCMHA-funded peer services for adults with mental illnesses and/or co-occurring substance use disorders as well as those with co-morbid general health conditions.

**Standards:**
A. Peers shall be required to attend the two-day, in-person WHAM facilitator training, or an SCCMHA-approved alternative, in order to facilitate WHAM sessions.

1. WHAM training guides participants through a person-centered planning process to set a whole health and resiliency goal.
2. WHAM training includes teaching participants how to do weekly action plans, create a daily/weekly personal log, and the importance of the one-to-one peer support and the weekly WHAM support group.

B. WHAM teaches consumers how to set and achieve whole health goals via weekly action plans and eight-week support groups.

C. The provision of WHAM incorporates the following goals:
1. Write an achievable whole health goal and weekly action plans
2. Participate in peer support groups to create new health behaviors
3. Elicit the relaxation response to manage stress
4. Engage in cognitive skills to avoid negative thinking
5. Know basic whole health screenings and how to prepare for them
6. Complete a shared-decision-making form for more engaging meetings with doctors

D. WHAM includes the provision of education about basic health screenings for prevention and encourages shared decision-making with health professionals.

E. The ten sessions of WHAM include two major components in accordance with the model.
1. The first component follows the Participant Guide and uses a person-centered planning process in ten health and resiliency factors to help participants create a concise whole health goal to begin the self-management process.
   a. The whole health goal can also be added to a treatment plan.
   b. The guide provides learning skills to enhance self-management, including eight weeks of WHAM peer support groups and a weekly action plan to create new health habits.
2. WHAM training also focuses on mind-body resiliency to promote self-management skills.
   a. Ten health and resiliency factors are incorporated into the provision of WHAM in accordance with the established training model:
      1). Stress management
      2). Healthy eating
      3). Physical activity
      4). Restful sleep
      5). Service to others
      6). Support network
      7). Optimism based on positive expectations
      8). Cognitive skills to avoid negative thinking
      9). Spiritual beliefs and practices
      10). A sense of meaning and purpose

F. WHAM shall be provided in accordance with the established format of the program over the course of six sessions during three two-hour meetings that cover three sections:
1. Section I:

a. *Session 1: Welcome and Introduction/Overview* – This session includes an introduction to the program, a discussion of the 10 health and resiliency factors, an overview of the person-centered planning process and "5 keys to success."
b. *Session 2: The Science of Stress* – This session describes the stress response, the relaxation response, and stress management techniques.
c. *Session 3: Improving Your Health* – This session covers the importance of and strategies for healthy eating, physical activity, and restful sleep.

2. Section II:
   a. *Session 4: The Power of Human Connections* – This session discusses the benefits of providing service to others and developing a strong support network.
   b. *Session 5: Maintaining a Positive Attitude* – This session introduces the value of optimism based on positive expectations and how to use cognitive skills to avoid negative thinking.
   c. *Session 6: Connecting With More Than Self* – This session discusses spiritual beliefs and practices and the importance of finding a sense of meaning and purpose in one's life.

NOTE: *Session 7: Health Risk, Screening, and Shared Decision-Making* – This session covers common health risks, recommended health screenings, how to have effective shared decision-making about health issues with health care providers, and useful health screening resources. This material can be taught anytime, and is not structured into the implementation process

3. Section III:
   a. *Session 8: Key to Success 1* – This session describes the first of the five keys to success, which is setting a person-centered goal. It also includes a review and prioritization of the ten health and resiliency factors, and applying six IMPACT Criteria to maximize the likelihood of achieving the personal goal:
      I Improve – Does it improve the quality of my health and resiliency? (*This criterion is usually easy to meet because we have been talking about improving one's health.*)
      M Measurable – Is it measurable in terms of my supporter knowing if I have accomplished it? (*For something to be objectively measurable, it usually has to state an amount - how much, how often, or how many one wants.*)
      P Positively Stated – Is it positively stated as something new I want in my life? (*It is more motivating to work toward getting something you want than working toward getting rid of something you don't want or want to avoid or change.*)
      A Achievable – Is it achievable for me in my present situation and current abilities? (*Achievable involves you being in control of the actions required to accomplish the goals.*)

C Calls Forth Actions – Does it call forth actions that I can take on a regular basis to begin to create healthy habits? *(The goal needs to be something you work to achieve over a period of time; there are actions you can take to achieve your goal.*)

T Time Limited – Is it time limited in terms of when I will begin and when I plan to accomplish it? (*You know by when you plan to accomplish the goal.*)

b. *Session 9: Keys to Success 2 & 3* – This session covers the second and third keys to success: having a weekly action plan and a daily/weekly personal log.

c. *Session 10: Keys to Success 4 & 5* – This final session covers the last two keys to success: one-to-one peer support and a peer support group.

G. One-to-one peer support is provided to participants in addition to the group sessions.

H. SCCMHA's quality improvement activities shall include fidelity monitoring to ensure adherence to the evidence-based practice model using the GOI (Global Organization Index) as a guide.

a. The Adult Strengths and Needs Assessment (ANSA) will be used as a tool to examine outcomes (when WHAM is being offered).

**Definitions:**

**Relaxation Response:** A state of deep rest that changes the short- and long-term physical and emotional responses to stress (e.g., decreases in heart rate, blood pressure, rate of breathing, and muscle tension). Methods to elicit the relaxation response include meditation, mindfulness, progressive muscle relaxation, tai chi, and yoga. The Relaxation Response was defined by Herbert Benson, MD, in 1974 when he found that there was an opposite state to the stress response (i.e., the fight-or-flight response).

**Whole Health Action Management (WHAM):** A peer-led program to activate self-management to reach a person-centered whole health goal that was developed by the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). WHAM is an integrated health approach that is designed to help consumers more effectively manage mental health and substance use issues. It is based on long-term disease self-management programs such as HARP (Health and Recovery Peer Program) and research-based approaches such as the Relaxation Response. WHAM training is intended to teach the following whole health self-management skills:

- Engage in person-centered planning to identify strengths and supports in ten science-based whole health and resiliency factors
- Write a whole health and resiliency goal based on person-centered planning
- Create and log a weekly action plan
- Participate in WHAM peer support groups to create new health behavior
- Elicit the Relaxation Response to manage stress
- Engage in cognitive skills to avoid negative thinking
- Use tools for shared decision-making
- Promote prevention health screenings

**References:**

A. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
B. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
C. SCCMHA Policy 02.03.09.15 – Peer Support Services
D. SCCMHA Policy 02.03.25 – Wellness
E. WHAM Implementation Manual for Peer Providers (SAMHSA-HRSA, 2014): https://www.center4healthandsdc.org/uploads/7/1/1/4/71142589/12-week_format_research_intervention_facilitator_manual_uic_study.pdf
   WHAM Peer Support Training Participant Guide (SAMHSA-HRSA, 2015): wham_participant_guide.pdf (kff.org)

**Exhibits:**

None

**Procedure:**

None

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: SBIRT/YSBIRT | **Chapter**: 02 - Customer Services & Recipient Rights | **Subject No**: 02.03.09.40 |
| **Effective Date**: 4/13/21 | **Date of Review/Revision**: 3/15/22, 3/8/23, 1/23/24<br>**Supersedes**: | **Approved By**: Sandra M. Lindsey, CEO |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Responsible Director:** Director of Network Services Public Policy & Continuing Education<br><br>**Authored By**: Mary Baukus, Barbara Glassheim<br><br>**Additional Reviewers**: SCCMHA EBP Leadership Team |

**Purpose:**
The purpose of this policy is to delineate the use of SBIRT (Screening, Brief Intervention, Referral to Treatment) for adults and youth (YSBIRT) as part of SCCMHA's commitment to identifying consumers with substance use issues and providing intervention in order to reduce risk and successfully engage consumers in treatment when indicated.

**Application:**
This policy applies to the entire SCCMHA Provider Network.

**Policy:**
SCCMHA will use a comprehensive, integrated, whole-person, public health approach, based on universal screening, to identify, reduce, and prevent risky substance use, misuse, and dependence.

**Standards:**
A. SCCMHA is committed to engaging in shared decision-making with consumers and to the enhancement of opportunities for consumer recovery.
B. SCCMHA shall conduct universal screening to help identify the appropriate level of services needed based on the consumer's level of risk.
    1. Universal screening and brief intervention shall be delivered to consumers in order to help strengthen individual commitment to and success in reduction or absence of alcohol or drug use/misuse and assist in promoting optimum wellness.

2. Universal screening for alcohol and substance use shall be conducted with all consumers aged 12 and older.
    a. SCCMHA shall consider adhering to the NIAAA's (National Institute on Alcohol Abuse and Alcoholism) recommendation that screening for alcohol use begin as early as age 9 or as soon as children can be interviewed alone without a parent present.
        1). Screening younger children shall be considered in order to present a prevention message to younger children prior to their first opportunity to try substances as well as to identify children who initiate substance use early.

C. Consumers with SUDs shall have access to a coordinated approach to chronic disease management.

D. Consumers shall be given tools to maximize the use of proven self-management techniques to improve their health status outcomes.

E. Consumers shall be part of a recovery-oriented system of care that honors each of their familial, cultural, spiritual, economic, and social and emotional needs.

F. Consumer participation in SBIRT/YSBIRT shall be deemed voluntary and can be terminated by the consumer at any time with no consequence to the consumer.

G. SBIRT shall be delivered to adults, and YSBIRT shall be delivered to youth aged 12 to 21 by trained and credentialed staff.
    1. Such practitioners include licensed physicians, RNs supervised by licensed physicians, physician assistants, nurse practitioners, psychologists, and licensed masters prepared clinicians.

H. SBIRT/YSBIRT shall be delivered with fidelity to the model:
    1. **S**creening to identify a consumer's place on a spectrum from non-use to substance use in order to deliver an appropriate response.
    2. **B**rief **I**ntervention (BI) to raise consumer awareness of risks, elicit internal motivation for change, and help set behavior-change goals.
    3. **R**eferral to **T**reatment to facilitate access to and engagement in specialized services and coordinated care for consumers at highest risk.

I. SCCMHA shall, as resources permit, make training in SBIRT/YSBIRT available to the provider network.
    1. Case managers, supports coordinators, nurses, social workers, care coordinators, and other relevant, interested health professionals shall be eligible to access Wayne State University's synchronous online SBIRT training free of charge via the secure SCCMHA Intranet.
        a. For new hires, training should be completed within 90 days of hire.
        b. Social Workers who complete course and pass the quiz with an 80% or higher score within 3 attempts shall be eligible to receive CEs from SCCMHA.

**Definitions:**

**AUDIT:** The Alcohol Use Disorders Identification Test identifies preliminary signs of hazardous drinking and mild dependence. It is used to detect alcohol problems experienced within the last year. It is one of the most accurate alcohol screening tests available, rated 92% effective in detecting hazardous or harmful drinking. The test (see Exhibit A) contains 10 multiple choice questions on quantity and frequency of alcohol consumption, drinking

behavior and alcohol-related problems or reactions. Each question ranges in point value from 0 to 4.

**Brief Intervention (BI):** A collaborative conversation between a health professional and a consumer to promote behavior change in order to reduce substance use. BI (see Exhibit F) is designed to educate consumers and increase their motivation to reduce risky behavior. Using Motivational Interviewing techniques, individuals are provided information specific to their alcohol or drug use. Substance use/misuse occurs on a continuum and services are prescribed based on where the individual screened resides on that continuum. BI takes about 5 minutes and consists of having a brief motivational conversation with an individual and guides the person through the standard drink sizes and safe drinking levels (recommended limits), the Drinker's Pyramid (see Exhibit C), and the physical effects diagram. The clinician gauges the individual's readiness to change and motivation for change and provides feedback about the results, discusses the individuals AUDIT/DAST-10/CRAFFT+N score, discusses the area(s) of concern, provides encouragement to reduce their risks and discusses the risks of continued drug and/or alcohol use. The clinician assists the individual in setting a wellness goal and ends the session with praise and encouragement.

**Brief Treatment:** Brief Treatment (usually 5-12 sessions) aims to change not only the immediate behavior or thoughts about a risky behavior, but also to address long-standing problems with harmful drinking and drug misuse and help individuals with higher levels SUD obtain more long-term care. Brief Treatment typically entails the use of Motivational Enhancement and Cognitive Behavioral approaches to help consumers address unhealthy cognitions and behaviors associated with current use patterns and adopt change strategies.

Brief Treatment consists of sessions matched to the individual's motivational level and stage of change. Stages of change include: Pre-contemplation (feedback about results and information of misuse); Contemplation (benefits of change, resource sharing, pros/cons of use, risks of delaying, ambivalence challenge, goal review); Preparation (choosing a goal, praise, and encouragement) action (trigger reduction, putting plan in action, healthy behavior substitution, support network) and Maintenance (continued goal setting for relapse prevention).

**CRAFFT+N:** A health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21. There are two versions; one that is administered by a clinician (see Exhibit D) and the other is self-administered (see Exhibit E). CRAFFT stands for the key words of the 6 items in the second section of the assessment – Car, Relax, Alone, Forget, Friends, Trouble.

**DAST:** The Drug Abuse Screening Test was designed to provide a brief instrument for clinical screening and treatment evaluation research. The test (see Exhibit B) contains 10 self-report items that are combined in a total DAST score to yield a quantitative index of problems related to drug misuse. For all questions, with the exception of question 3, each "yes" response receives 1 point and each "no" response receives 0. For question 3, a "no" reply receives 1 point and 'yes" receives a 0. The answers are scored on a point system.

**Referral to Treatment:** Discussions with the consumer to support them in getting specialized SUD treatment using motivational interviewing and the provision of feedback about results (e.g., use exceeds limits, current problems that exist, dependence symptoms, dangers to health [medical, psychiatric, social]), and clear messages about continued risk of use. The clinician provides resources and referrals and may obtain assistance from the

co-located substance abuse professional. The clinician coordinates medical, psychiatric and or substance abuse referrals and provides encouragement and support.

**SBIRT:** An integrated and comprehensive evidence-based approach to delivering early intervention treatment services for persons with substance use disorders, and those at risk of developing a substance use disorder. SBIRT/YSBIRT is implemented to identify, reduce, and prevent alcohol and drug use, misuse, and dependence. It is an early intervention for individuals with non-dependent substance use to help before the person needs more extensive or specialized treatment. This approach differs from specialized treatment of individuals with more severe substance misuse or those who meet criteria for a substance use disorder.

**References:**


A. Agerwala, S., McCance-Katz, E., (2012). Integrating Screening, Brief Intervention, and Referral to Treatment (SBIRT) into Clinical Practice Settings: A Brief Review. *Journal of Psychoactive Drugs 44(4):* 307–317. {on-line]. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3801194/pdf/nihms404111.pdf
B. AUDIT: https://auditscreen.org/
C. CRAFFT: https://crafft.org/
D. DAST: https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69
E. Massachusetts Department of Public Health. (June 2012). *SBIRT A Step-By-Step Guide for Screening and Intervening for Unhealthy Alcohol and Other Drug Use*: https://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf
F. National Council for Behavioral Health. (Undated). *Improving Adolescent Health: Facilitating Change for Excellence in SBIRT*: https://www.thenationalcouncil.org/wp-content/uploads/2021/12/2021.09.28_NC_SBIRT_FaCES_ChangePackage.pdf
G. SCCMHA Policy 02.03.09.30 – Motivational Interviewing
H. The Center for Adolescent Substance Use Research. (2018). The CRAFFT 2.1 Manual : https://crafft.org/wp-content/uploads/2018/08/FINAL-CRAFFT-2.1_provider_manual_with-CRAFFTN_2018-04-23.pdf


**Exhibits:**

A. AUDIT
B. DAST
C. The Drinker's Pyramid
D. CRAFFT+N – Clinician Administered
E. CRAFFT+N – Self-Administered
F. Brief Intervention (from the Massachusetts Department of Public Health: SBIRT Screening Toolkit, June 2012)
G. SBIRT/YSBIRT Flow Charts

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Conducts pre-screening of all individuals aged 12 and older presenting for services using 2 questions: | CAI/CIS/MRSS/Nurse/Case Holder |

| | |
|---|---|
| How many times in the past year have you had 5 (male) or 4 (female) or more drinks in a day?<br>How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?<br>2. Refers individuals who score above a zero on either question (i.e., positive pre-screen) for an AUDIT (alcohol question) and/or DAST-10 (drug question) full screen or the CRAFFT 2.1+N for youth (either question).<br>3. Conducts screening administering and scoring the DAST, AUDIT or CRAFFT+N.<br>4. Provides Brief Intervention (BI):<br>Establish rapport – understand the consumer's views of use.<br>Elicit thoughts and provide information/feedback.<br>Enhance motivation to change.<br>Give advice and negotiate a plan.<br>5. Conducts brief treatment using CBT and Motivational Enhancement techniques.<br>6. Provides a referral to treatment using educational, motivational interviewing and feedback about the consumer's substance use. | |

Exhibit A

Patient name: _____

Date of birth: _____

## Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:   12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

| | | | | | |
|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times a month | 2 - 3 times a week | 4 or more times a week |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | 0 - 2 | 3 or 4 | 5 or 6 | 7 - 9 | 10 or more |
| 3. How often do you have five or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 9. Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, in the last year |
| 10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, in the last year |
| | 0 | 1 | 2 | 3 | 4 |

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

| I | II | III | IV |
|---|---|---|---|
| 0-3 | 4-9 | 10-13 | 14+ |

*(For the Provider)*

**Scoring and interpreting the AUDIT:**

**1.** Each response has a score ranging from 0 to 4. All response scores are added for a total score.

**2**. The total score correlates with a risk zone, which can be circled on the bottom left corner.

| Score | Zone | Explanation | Action |
|---|---|---|---|
| 0-3 | I – Low Risk | "Someone using alcohol at this level is at low risk for health or social complications." | Positive Health Message – describe low risk drinking guidelines |
| 4-9 | II – Risky | "Someone using alcohol at this level may develop health problems or existing problems may worsen." | Brief intervention to reduce use |
| 10-13 | III – Harmful | "Someone using alcohol at this level has experienced negative effects from alcohol use." | Brief Intervention to reduce or abstain and specific follow-up appointment (Brief Treatment if available) |
| 14+ | IV – Severe | "Someone using alcohol at this level could benefit from more assessment and assistance." | Brief Intervention to accept referral to specialty treatment for a full assessment |

**Positive Health Message:** An opportunity to educate patients about the NIAAA low-risk drinking levels and the risks of excessive alcohol use.

**Brief Intervention to Reduce Use:** Patient-centered discussion that uses Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhance his/her motivation to change behavior. Brief interventions are typically 5-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

**Brief Intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up:** Patients with numerous or serious negative consequences from their alcohol use, or patients who likely have an alcohol use disorder who cannot or are not interested in obtaining specialized treatment, should receive more numerous and intensive BIs with follow up. The recommended behavior change is to cut back to low-risk drinking levels or abstain from use. Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available. If brief treatment is not available, secure follow-up in 2-4 weeks.

**Brief Intervention to Accept Referral:** The focus of the brief intervention is to enhance motivation for the patient to accept a referral to specialty treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for diagnostic assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

* Johnson J, Lee A, Vinson D, Seale P. "Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol Dependence in Primary Care: A Validation Study." Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

Exhibit B

## Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

_____

_____

- ☐ methamphetamines (speed, crystal)
- ☐ cannabis (marijuana, pot)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ tranquilizers (valium)
- ☐ cocaine
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

| | | |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons? | No | Yes |
| 2. Do you abuse more than one drug at a time? | No | Yes |
| 3. Are you unable to stop using drugs when you want to? | No | Yes |
| 4. Have you ever had blackouts or flashbacks as a result of drug use? | No | Yes |
| 5. Do you ever feel bad or guilty about your drug use? | No | Yes |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | No | Yes |
| 7. Have you neglected your family because of your use of drugs? | No | Yes |
| 8. Have you engaged in illegal activities in order to obtain drugs? | No | Yes |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | No | Yes |
| 10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)? | No | Yes |
| | 0 | 1 |

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

| I | II | III | IV |
|---|---|---|---|
| 0 | 1-2 | 3-5 | 6+ |

*(For the health professional)*

**Scoring and interpreting the DAST:**

"Yes" responses receive one point each and are added for a total score. The score correlates with a zone of use that can be circled on the bottom right corner of the page.

| Score | Zone of use | Indicated action |
|---|---|---|
| **0** | **I – No risk**<br>No risk of related health problems | None |
| **1 - 2,** plus the following criteria:<br>No daily use of any substance; no weekly use of drugs other than cannabis; no injection drug use in the past 3 months; not currently in treatment. | **II – Risky**<br>Risk of health problems related to drug use. | Offer brief education on the benefits of abstaining from drug use. Monitor at future visits. |
| **1 - 2** (without meeting criteria) | | Brief intervention |
| **3 - 5** | **III – Harmful**<br>Risk of health problems related to drug use and a possible mild or moderate substance use disorder. | Brief intervention (offer options that include treatment) |
| **6+** | **IV – Severe**<br>Risk of health problems related to drug use and a possible moderate or severe substance use disorder. | |

**Brief education:** Inform patients about low-risk consumption levels and the risks of excessive alcohol use.

**Brief intervention:** Patient-centered discussion that employs Motivational Interviewing concepts to raise an patient's awareness of their substance use and enhances their motivation to change their use. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention.

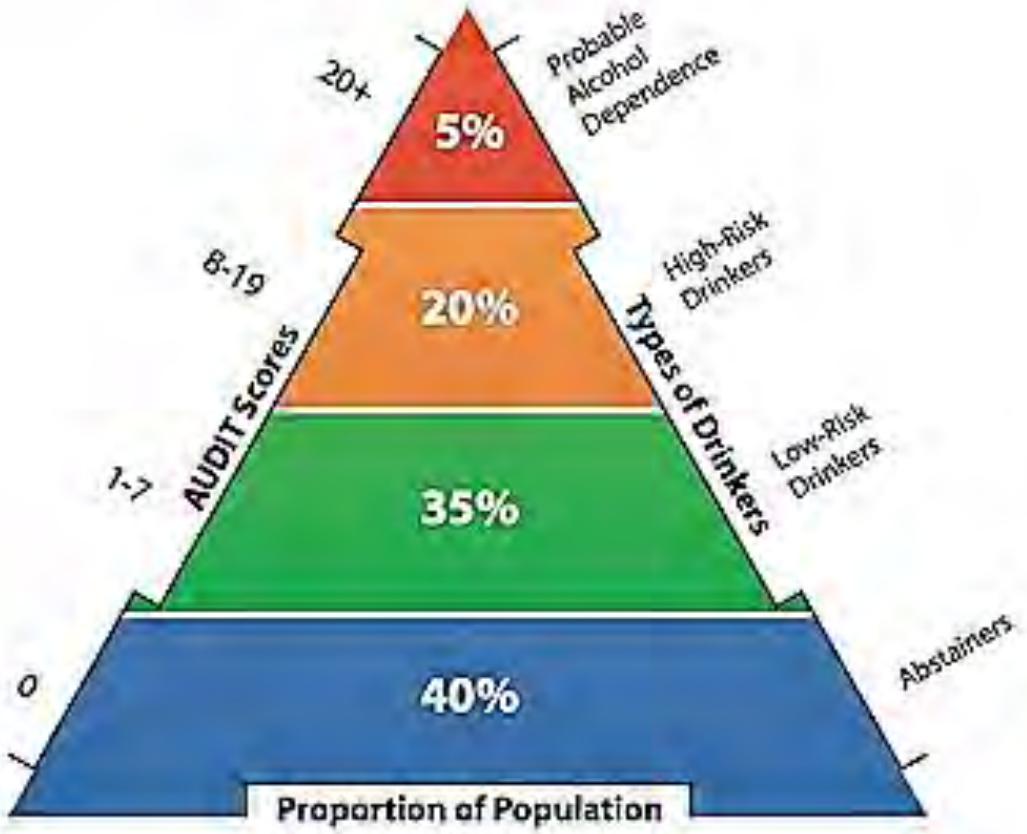
If a patient is ready to accept treatment, a referral is a proactive process that facilitates access to specialized care for individuals likely experiencing a substance use disorder. These patients are referred to alcohol and drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. However, treatment also includes prescribing medications for substance use disorder as part of the patient's normal primary care.

More resources: www.sbirtoregon.org

Exhibit C

# Determining Risk
# AUDIT Scores & Drinking Types

**The Drinkers' Pyramid:**




**Something to think about:**

25% of the population will score an 8 or above on the AUDIT. That means 1 in 4 people are probably high-risk or dependent drinkers.

sbirtinaction.org

Exhibit D

# The CRAFFT+N Interview

**To be verbally administered by the clinician**

**Begin:** *"I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."*

## *Part A*

**During the PAST 12 MONTHS, on how many days did you:**

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Say "0" if none. ☐ # of days
2. Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Say "0" if none. ☐ # of days
3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Say "0" if none. ☐ # of days
4. Use a **vaping device* containing nicotine or flavors,** or use any **tobacco products†?** Say "0" if none. ☐ # of days
   **Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. †Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches.*

**If the patient answered…**

| "0" for all questions in Part A | "1" or more for Q. 1, 2, or 3 | "1" or more for Q. 4 |
|---|---|---|
| ↓ | ↓ | ↓ |
| **Ask 1st question only in Part B below, then STOP** | **Ask all 6 questions in Part B below** | **Ask all 10 questions in Part C on next page** |

## *Part B*

| | | Circle one | |
|---|---|---|---|
| **C** | Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | **No** | **Yes** |
| **R** | Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in? | **No** | **Yes** |
| **A** | Do you ever use alcohol or drugs while you are by yourself, or **ALONE**? | **No** | **Yes** |
| **F** | Do you ever **FORGET** things you did while using alcohol or drugs? | **No** | **Yes** |
| **F** | Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use? | **No** | **Yes** |
| **T** | Have you ever gotten into **TROUBLE** while you were using alcohol or drugs? | **No** | **Yes** |

**Two or more YES answers in Part B suggests a serious problem that needs further assessment. See Page 3 for further instructions.** →

## *Part C*

*"The following questions ask about your use of any **vaping devices containing nicotine and/or flavors**, or use of any **tobacco products.***"*

| | Circle one | |
|---|---|---|
| **1.** Have you ever tried to **QUIT** using, but couldn't? | **Yes** | **No** |
| **2.** Do you vape or use tobacco **NOW** because it is really hard to quit? | **Yes** | **No** |
| **3.** Have you ever felt like you were **ADDICTED** to vaping or tobacco? | **Yes** | **No** |
| **4.** Do you ever have strong **CRAVINGS** to vape or use tobacco? | **Yes** | **No** |
| **5.** Have you ever felt like you really **NEEDED** to vape or use tobacco? | **Yes** | **No** |
| **6.** Is it hard to keep from vaping or using tobacco in **PLACES** where you are not supposed to, like school? | **Yes** | **No** |
| **7.** When you **HAVEN'T** vaped or used tobacco in a while (or when you tried to stop using)… | | |
| **a.** did you find it hard to **CONCENTRATE** because you couldn't vape or use tobacco? | **Yes** | **No** |
| **b.** did you feel more **IRRITABLE** because you couldn't vape or use tobacco? | **Yes** | **No** |
| **c.** did you feel a strong **NEED** or urge to vape or use tobacco? | **Yes** | **No** |
| **d.** did you feel **NERVOUS**, restless, or anxious because you couldn't vape or use tobacco? | **Yes** | **No** |

**One or more YES answers in Part C suggests a serious problem with nicotine that needs further assessment. See Page 3 for further instructions.** ⟶

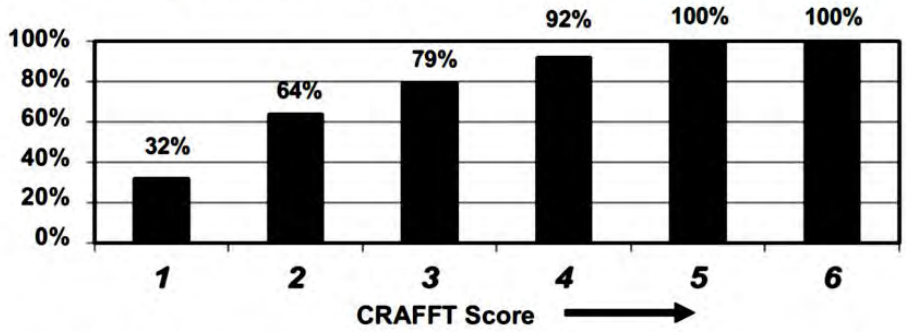
*References:*

Wheeler, K. C., Fletcher, K. E., Wellman, R. J., & DiFranza, J. R. (2004). Screening adolescents for nicotine dependence: the Hooked On Nicotine Checklist. *J Adolesc Health*, *35*(3), 225–230;

McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and Young Adults' Use and Perceptions of Pod-Based Electronic Cigarettes. *JAMA Network Open*, *1*(6), e183535.

## CRAFFT Score Interpretation

**Probability of a DSM-5 Substance Use Disorder by CRAFFT score***




*Data source: Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: a reevaluation and reexamination. Substance Abuse, 35(4), 376–80.

**Use the 5 R's talking points for brief counseling.**

1. **REVIEW** screening results
   For each "yes" response: *"Can you tell me more about that?"*
2. **RECOMMEND** not to use
   *"As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, nicotine, marijuana or other drug because they can: 1) Harm your developing brain; 2) Interfere with learning and memory, and 3) Put you in embarrassing or dangerous situations."*
3. **RIDING/DRIVING** risk counseling
   *"Motor vehicle crashes are the leading cause of death for young people. I give all my patients the Contract for Life. Please take it home and discuss it with your parents/guardians to create a plan for safe rides home."*
4. **RESPONSE** elicit self-motivational statements
   Non-users: *"If someone asked you why you don't drink, vape, or use tobacco or drugs, what would you say?"* Users: *"What would be some of the benefits of not using?"*
5. **REINFORCE** self-efficacy
   *"I believe you have what it takes to keep substance use from getting in the way of achieving your goals."*

**Give patient Contract for Life.** Available at www.crafft.org/contract



crafft@childrens.harvard.edu www.crafft.org

For more information and versions in other languages, see www.crafft.org.

Exhibit E

# The CRAFFT+N Questionnaire

**To be completed by patient**

Please answer all questions **honestly**; your answers will be kept **confidential**.

**During the PAST 12 MONTHS, on how many days did you:**

| | | |
|---|---|---|
| **1.** | Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none. | ☐ # of days |
| **2.** | Use any **marijuana** (weed, oil, or hash by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none. | ☐ # of days |
| **3.** | Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none. | ☐ # of days |
| **4.** | Use **any tobacco or nicotine** products (for example, cigarettes, e-cigarettes, hookahs or smokeless tobacco)? | ☐ # of days |

**READ THESE INSTRUCTIONS BEFORE CONTINUING:**

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 5, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 5-10.**

| | | No | Yes |
|---|---|---|---|
| **5.** | Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | ☐ | ☐ |
| **6.** | Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in? | ☐ | ☐ |
| **7.** | Do you ever use alcohol or drugs while you are by yourself, or **ALONE**? | ☐ | ☐ |
| **8.** | Do you ever **FORGET** things you did while using alcohol or drugs? | ☐ | ☐ |
| **9.** | Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use? | ☐ | ☐ |
| **10.** | Have you ever gotten into **TROUBLE** while you were using alcohol or drugs? | ☐ | ☐ |

**NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:**
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.



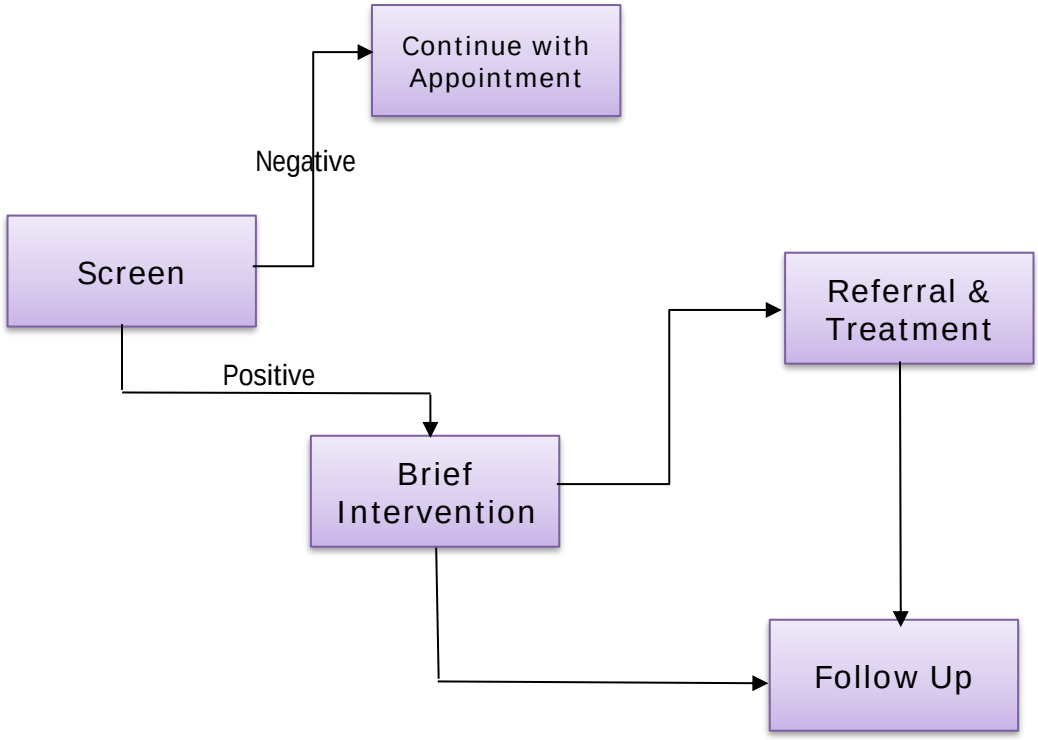
For more information and versions in other languages, see **www.ceasar.org**

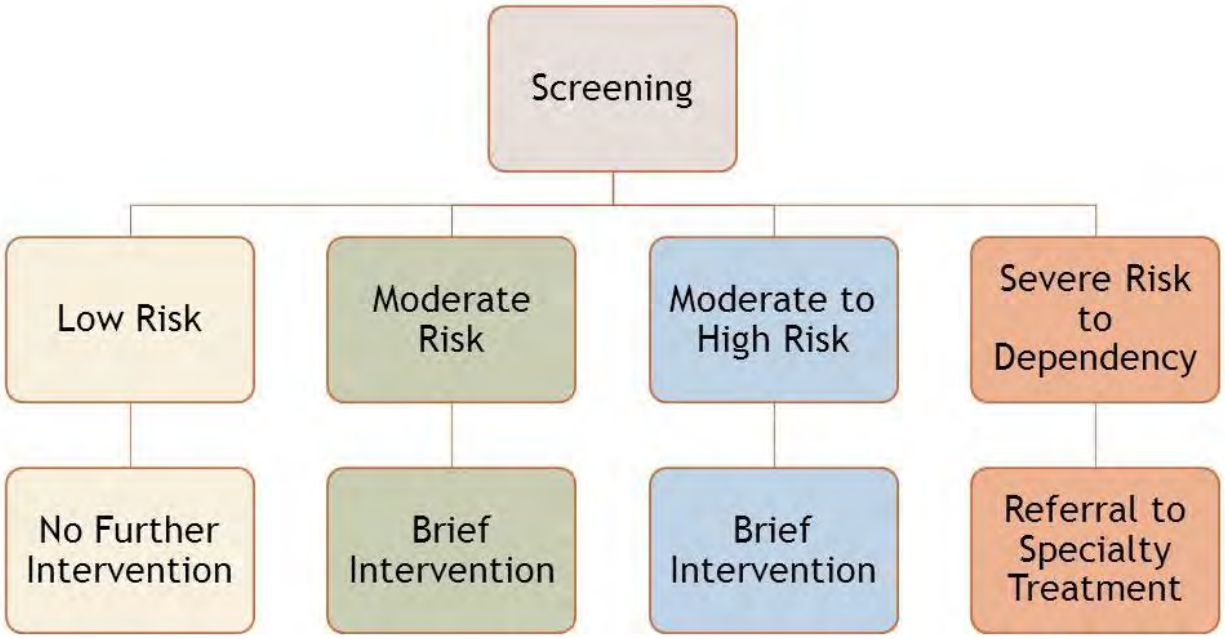
Exhibit F

| BI STEPS | DIALOGUE/PROCEDURES |
|---|---|
| ***1. Understand the patient's views of use***<br><br>• Develop discrepancy between patient's goals and values and actual behavior | **Ask Pros and Cons**<br>*"I'd like to know more about your use of [X]. Help me to understand what you enjoy about using [X]? What else?"*<br>*"What do you enjoy less about using [X] or regret about your use".*<br>**Summarize Pros and Cons**<br>*"So, on the one hand you say you enjoy X because…"*<br>*"And on the other hand you said…."* reiterate negative consequences, as stated by patient. |
| ***2. Give information/ feedback***<br><br>• Ask permission to give feedback<br>• Use reflective listening, | **Review Health Risks**<br>*"Is it OK if we review some of the health risks of using X?"*<br>*"Are you aware of health risks related to your use of X?"*<br>**If YES:** *Which ones are you aware of?*<br>**If NO:** *Indicate problems. Refer to NIDA Commonly Abused Drugs chart for drug consequences, as needed on p. 18.*<br>**If focus is on risky alcohol use and abstinence is not indicated:**<br>*"Is it OK if I review with you what is considered safe drinking limits for your age and gender?" (No more than 4/3 drinks in one day and no more than 14/7 drinks in one week.) "Drinking more than this puts you at risk for experiencing illness or injury from your alcohol use."* |

| | |
|---|---|
| ***3. Enhance motivation to change***<br>• Ask readiness and confidence scales | **Readiness Scale**<br>*"Given what we have been discussing, help me better understand how you feel about making a change in your use of X. On a scale from 0 -10, how ready are you to change any aspect of your use of [X]? A 10 would mean you are fully ready to change and a 0 means you are not at all ready."*<br>Then, Ask: *"Why did you choose that number and not a lower one like a 1 or a 2?"* Patient will indicate reasons to change. You also ask the patient for other reasons for change. *"How does this fit with where you see yourself in the future? If you make these changes what would be different in your life?"*<br>If the patient, answers "0" ask, *"What would need to happen to be at a higher number?"*<br>**Confidence Scale**<br>*"On a scale from 0-10, how confident do you feel to make these changes?"*<br>*"A 10 would mean total confidence and a 0 means no confidence at all."*<br>*"What needs to happen for you to feel more confident? What have you successfully changed in the past? How? Could you use these methods to help you with the challenges of this change?"* |
| ***4. Give advice and negotiate goal*** | **Give Advice**<br>Review concerns, as discussed with patient. Advise abstinence or decrease in use, according to screening and assessment. Give referrals for further assessment, if appropriate.<br>**Negotiate Goal**<br>*"What can you do to stay healthy & safe? Where do you go from here?"*<br>SUMMARIZE: "*Let me summarize what we've been discussing…*<br>*Is that accurate? Is there anything I missed or you want to add?"*<br>Suggest discussing progress of plan at next appointment. |
| ***Close: Thank Patient*** | *"Thank you for taking the time to discuss this with me and being so open."* |

Exhibit G


Continue with Appointment
Negative
Screen
Positive
Referral & Treatment
Brief Intervention
Follow Up


Screening
Low Risk
Moderate Risk
Moderate to High Risk
Severe Risk to Dependency
No Further Intervention
Brief Intervention
Brief Intervention
Referral to Specialty Treatment

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Mindfulness</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.09.42</td></tr>
<tr><td rowspan="2">Effective Date:<br>12/09/2021</td><td>Date of Review/Revision:<br>1/10/23, 1/31/24</td><td rowspan="2">Approved By:<br>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:<br>Director of Network Services, Public Policy, & Continuing Education<br><br>Authored By:<br>Mary Baukus<br><br>Additional Reviewers:<br>EBP Leadership Team</td></tr>
</table>

**Purpose:**
The purpose of this policy is to specify the use of Mindfulness.

**Application:**
This policy applies to the SCCMHA-funded provider network.

**Policy:**
A. SCCMHA shall, resources permitting, offer Mindfulness.
B. Mindfulness is now being scientifically examined and has been found to be a key element in stress reduction, emotional regulation, and overall happiness.
C. Mindfulness is a promising practice that SCCMHA has decided to adopt as a practice. There is much research about the efficacy of mindfulness for a variety of symptoms and diagnoses.
D. Mindfulness can be delivered face-to-face, in-person, or via telehealth technology.
E. Mindfulness can be offered in individual contacts or in group settings and is appropriate for ages 3 and up.
F. Mindfulness will be provided in a trauma-informed manner.

**Standards:**
A. Mindfulness is the practice of purposely focusing one's attention on the present moment and accepting it without judgment.
B. Mindfulness may be delivered by peers, case managers, therapists, or other clinical professionals; there is no requirement for a degree or licensure.
C. All persons wishing to implement this promising practice should be familiar with Mindfulness and be able to demonstrate having completed training that included

information on Mindfulness. Refresher trainings should be completed on an annual basis.

D. SCCMHA reserves the right to credential providers to conduct this practice as well as monitor the practice for fidelity to the model.
E. Mindfulness includes:
    a. Mindful breathing: This is a practice where individuals use the breath as the object of attention to which we return every time we notice that the mind has wandered. It is most practiced with attention centered on the breath, without any effort to change the breathing.
        i. There are four postures which are suggested to practice mindful breathing: standing, sitting, reclining, and walking. Sitting and lying down are the best postures for beginners.
    b. The basics of Mindfulness Practice that the practitioner uses as a guide for the individuals served, when facilitating mindfulness includes:
        i. **Set aside some time.** One does not need a meditation cushion or bench, or any sort of special equipment to access one's mindfulness skills—but one does need to set aside some time and space.
        ii. **Observe the present moment as it is.** The aim of mindfulness is not quieting the mind or attempting to achieve a state of eternal calm. The goal is simple: we're aiming to pay attention to the present moment, without judgment.
        iii. **Let one's judgments roll by.** When we notice judgments arise during our practice, we can make a mental note of them, and let them pass.
        iv. **Return to observing the present moment as it is.** Our minds often get carried away in thought. That's why mindfulness is the practice of returning, again and again, to the present moment.
        v. **Be kind to one's wandering mind.** Don't judge oneself for whatever thoughts crop up, just practice recognizing when one's mind has wandered off, and gently bring it back.
    c. Mindfulness activities. Activities may include:
        i. Mindfulness meditation
        ii. Yoga
        iii. Coloring
        iv. Body relaxation/scan
        v. Walking
        vi. Crafts
        vii. Any variety of activities that require focus on the present moment.

**Definitions:**

**Mindfulness:** The practice of being aware of one's body, mind, and feelings in the present moment, thought to create a feeling of calm: Mindfulness can be used to alleviate feelings of anxiety and depression.

**References:**

A. DBT Institute of Michigan (2014) *Dialectical Behavior Therapy (DBT) Mindfulness Activities Guide*
B. Getting Started with Mindfulness - Mindful: https://www.mindful.org/meditation/mindfulness-getting-started/
C. MINDFULNESS | definition in the Cambridge English Dictionary: https://dictionary.cambridge.org/us/dictionary/english/mindfulness
D. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
E. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

**Exhibits:**
None

**Procedure:**
None

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Problem-Solving Skills Training (PSST) | **Chapter**: 02 - Customer Services & Recipient Rights | **Subject No**: 02.03.09.43 |
| **Effective Date**: 2/8/23 | **Date of Review/Revision**: 1/31/24<br>**Supersedes**: | **Approved By**: Sandra M. Lindsey, CEO |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Responsible Director:** Director of Network Services, Public Policy, & Continuing Education<br><br>**Authored By**: Mary Baukus<br><br>**Additional Reviewers**: EBP Leadership Team |

**Purpose:**
The purpose of this policy is to delineate a framework for the provision and monitoring of Problem-Solving Skills Training (PSST).

**Policy:**
SCCMHA shall, resources permitting, provide PSST to eligible youth and their families in accordance with the standards delineated below.

**Application:**
This policy applies to all providers who have received appropriate training and have been privileged by SCCMHA to provide PSST.

**Standards:**

A. Providers shall adhere to the practice standards of PSST.
B. SCCMHA shall offer PSST to eligible consumers as resources permit.
C. PSST shall be delivered in a trauma-informed manner.
D. PSST can be delivered face-to-face, in-person, or via telehealth technology.
E. PSST shall be delivered in accordance with the following standards:
    1. Target population: Youth from age 7-14 who display serious behavior problems including:
        a. Overt antisocial behavior (e.g., aggression, defiance, hyperactivity, fighting)
        b. Covert antisocial behavior (e.g., lying, stealing, truancy, fire setting)
        c. Internalizing problems (e.g., depressed mood, peer relationship problems, deviant peer associations)

d. Delinquency
e. Substance misuse
f. School Failure

F. Model:
1. PSST can be used in groups of three to five children for eleven sessions over an approximately three-to-five-month period.
2. The therapist provides coaching and modeling for the skills taught through role plays of social situations so that skills are practiced with the therapist providing cues, feedback, and praise.
3. Homework tasks are assigned between sessions and include active parental involvement.
4. A parent component teaches problem-solving skills to families to manage interpersonal situations through practice, modeling, and role playing, corrective feedback, and the use of social and token reinforcements.

G. Goals:
1. Train the child to think differently about situations and behave differently in diverse situations
2. Help the child internalize the problem-solving steps so that they are able to use them to evaluate potential solutions to problems occurring outside of therapy
3. Learn and generalize problem solving skills and how to apply problem solving skills using self-instruction
4. Learn how to generate positive solutions that would enable the child to avoid physical aggression, resolve the conflict, and keep themselves out of trouble

H. In order to provide this intervention, Master's level clinicians must complete a 1-day training through the Parent Management Training Institute.

I. Fidelity shall be monitored by SCCMHA using the General Organization Index tool.

J. The CAFAS (Child and Adolescent Functional Assessment Scale) will be used to as a tool to examine outcomes by the EBP Leadership Team.

**Definitions:**

**Problem-Solving Skills Training (PSST)** entails the use of modeling and reinforcement to help children and adolescents develop and use appropriate cognitive problem-solving skills. It focuses on altering the cognitive processes that underlie interpersonal behavior by targeting cognitive distortions and impulse control problems that are common in youth who display aggression. Children and adolescents are helped to develop skills that reduce the extent to which they attribute hostile intent to the actions of others and develop non-aggressive responses to perceived provocations by peers.

**References:**


A. Glassheim, B. (2006). *A Guide to Evidence-Based Psychotherapies for Children, Adolescents, and their Families*. (p. 106). Saginaw County Community Mental Health Authority.

B. Kazdin, A.E. (2017). *Parent management training and problem-solving skills training for child and adolescent conduct problems.* In J.R. Weisz & A.E. Kazdin (Eds.).

Evidence-based Psychotherapies for Children and Adolescents (3rd ed., pp. 142-158). New York: Guilford Press.

C. *Problem Solving Skills Training (PSST)*. (2009, April). The California Evidence-Based Clearinghouse for Child Welfare. Retrieved August 1, 2022, from https://www.cebc4cw.org/program/problem-solving-skills-training/
D. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
E. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
F. The Parent Management Training Institute: https://www.parentmanagementtraininginstitute.com/professional-training.html

**Exhibits:**

A. Components and Overview of Treatment by Dr. Alan Kazdin

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| Offers PSST to eligible consumers and families by trained PSST therapists. | Therapists/Case Holders |
| Monitor PSST program for adherence to the model on an ongoing basis using the GOI. | PSST Therapists |
| Record family member participation in PSST within the active youth consumer's Functional Assessment Systems (FAS) record. | PSST Therapists |
| Monitors outcomes. | EBP Leadership Team |

**Exhibit A**

# COMPONENTS AND OVERVIEW OF TREATMENT

**Dr. Alan Kazdin**

This manual delineates a cognitive-behavioral treatment procedure developed to assist children who engage in impulsive, nonself-controlled behavior to learn to "stop, slow down, and to consider all of the possibilities." The components of this procedure, detailed below, include: problem-solving tasks, verbal self-instruction, modeling, reinforcement and mild penalty contingencies, and the reward menu.

The therapy procedures are provided in 11 sessions over approximately a three to five month period. Optional sessions can be provided if the child needs additional assistance in grasping the approach (early in treatment) or its application to everyday situations (later in treatment). Each of the treatment sessions is approximately 40 to 50 minutes; one session is scheduled each week. Throughout the course of treatment, modeling is utilized to teach the child the problem-solving skills. These skills consist of applying various steps to solve a problem. After the child has demonstrated mastery, he or she is taught to apply these skills to academic, personal and interpersonal problems.

In order to facilitate acquisition of the problem-solving skills response cost (or a fine) is combined with reinforcement contingencies. At the beginning of each session, the child is given 20 tokens. When the child makes an error, a token is withdrawn. In addition, social reinforcement such as praise and encouragement is combined with self-reward to enhance successful performance and appropriate behavior.

## The Problem-solving Tasks

In order to assist the children in the acquisition and generalization of the problem-solving skills, the tasks are taught sequentially. Initially, the child is taught the problem-solving skills and they are applied to simple problem situations. Later he is gradually shown how to utilize the skills in confronting personal problem situations. To promote further generalization, positive reinforcement is

provided for applications of the approach to problem situations outside of the treatment setting.

The primary goal of the initial tasks is to teach the child to apply problem-solving skills through the use of self-instructions. Therefore, the first sessions are intended to be nonstressful and emphasize interpersonal play situations. During the final stages of treatment, the sessions focus on the child's particular problems. The child is asked to apply the problem-solving skills as he role-plays certain situations which he finds problematic. The more difficult interpersonal situations are approached gradually to ensure that the child fully grasps the method of self-instruction and that the therapist and the child have established rapport.

Verbal Self-Instructions/Problem-Solving Steps

In order to break down the process of problem-solving into discrete steps, 5 verbal self-instructions or problem-solving steps are utilized. Each self-instruction or self-statement represents one step in solving a problem. These verbal self-instructions are outlined in Table 1 (see next page). As shown in Table 1, the content of the problem-solving steps include the following 5 types of statements. The first step requires that the child identify or generate a problem. The second step asks him to come up with an appropriate solution to the problem. In the third step, he comes up with a consequence to that solution. The second and third steps are repeated three times so the child comes up with three different solutions to the same problem. During the fourth step he chooses the solution which he thinks would work the best. The fifth step entails evaluating how he did with his choice, and self-reinforcing if the solution is appropriate.

In order to help the child learn the problem-solving steps, cue cards are employed. Each card features the written problem-solving step accompanied by a drawing. The child and therapist take turns completing the tasks, each using the problem-solving steps. One of the therapeutic objectives is to help the child internalize the problem-solving steps so that he is able to use them to evaluate potential solutions to problems occurring outside of therapy.

A fading procedure is employed so that the child may utilize his problem-solving skills without disrupting the activities of others. The problem-solving steps are first faded from saying all the five steps out loud to just saying steps two and three out loud (still using all five fingers). The next level of fading is saying all the steps in your head (still using all five fingers). The last level of fading is saying all the steps in your head and not using fingers.

From session 4 through the completion of therapy, the therapist and child role-play interpersonal problem situations. Three different levels of fading, explained above, are used over the course of these sessions in order to help the child move from overt self-statements to covert speech. From session 5 through session10, spot checks are utilized. These spot checks require the child to return to the initial level of fading. This gives the therapist information on whether the child is actually internalizing the problem-solving steps or whether he is progressing through the use of rote memory.

Modeling

The therapist alternates tasks with the child and models problem-solving skills and the use of the self-statements. This therapy relies heavily on teaching through modeling, and to a much lesser extent through direct instructions. Instructions are employed only to provide task directions which ensure that the child understands what he or she is being asked to do. Therefore, the therapist functions as a model who participates and demonstrates rather than as a teacher who instructs.

Table 1 The Problem-Solving Steps and Self-Statements

| Specific Steps | Self-Statements |
|---|---|
| 1. Problem definition | 1. What am I supposed to do? |
| 2. Problem approach | 2. What could I do? |
| 3. Evaluating approach | 3. What would happen? |
| 4. Choosing an answer | 4. I need to make a choice. |
| 5. Self-reinforcement or coping | 5. I need to find out how I did. |

statement

In the social learning literature, two types of models have been described: the mastery model and the coping model. The mastery model performs problems perfectly, demonstrating ideal task performance; such a model would complete the therapy tasks without difficulty and without making mistakes. In contrast, a coping model makes mistakes occasionally and shares any difficulties that are encountered while completing the tasks. The coping model demonstrates coping strategies for dealing with difficulties and failures. Some children are reluctant to attempt difficult problems. Random guessing enables them to avoid possible failure and frustration. For children with these difficulties, the coping strategies demonstrated in treatment are particularly important. Therefore, it is the coping model which is used here.

Contingencies: Social Reinforcement

One of the most salient elements of therapy is the systematic use of social reinforcement to shape and maintain high rates of child involvement and skill. Research has established that practice followed by praise usually results in higher performance than practice alone. Skillful delivery of contingent therapist attention, affection, and approval within sessions rests on a clear definition of specific target behavior and the ability to assess the child's performance objectively within each session. When the desired behaviors occur, therapist smiles, hugs, praise, and applause are immediately and enthusiastically delivered.

The early stages of therapy entail a "shaping" process in which social reinforcement is contingent upon the child's success with small components of the task (e.g., learning one step). Throughout therapy, and as the child masters component skills, the performance criterion is gradually raised, so that social reinforcement is delivered for increasingly complex and independent applications of the skills.

Some children initially may not respond to social reinforcement by observed increases in the behaviors that are praised or may not appear to react enthusiastically to the praise. Often both

behavior change and reactions to the praise increase over the course of treatment. In any case, in all treatment sessions therapists provide high rates of social reinforcement using diverse ways to convey approval and praise.

An abbreviated list of therapist social reinforcers, ranging from mild to quite enthusiastic would be:

1. Nonverbal attention (eye contact, smiles, nods, posture)

2. Verbal (specific praise)

3. Affection (touching, hugs)

4. "Total Cheerleader" (combining all three with heightened enthusiasm) Contingencies:

Response Cost

Aggressive children often respond impulsively without carefully evaluating all possible alternative solutions to problems. Consequently, they make many errors. However, in spite of their impulsive responses, they occasionally answer correctly. They may select the correct answer randomly or because the problem was so easy that the answer was readily apparent. If the therapist only reinforces the correct answers, the child's impulsive behavior may also be reinforced.

Two separate procedures are included in the treatment to deter impulsive behavior. First, positive reinforcement, mentioned earlier, is directed at use of the steps in a slow and methodical fashion. Thus, at the beginning of treatment, correct answers are de-emphasized to focus and reinforce use of the problem-solving steps.

Second, the implementation of response cost also is directed to decrease impulsive behavior. At the outset of each session, the child is given a number of tokens. Response cost consists of taking a token away from the child each time he makes a mistake on the task. The child relinquishes a token (is fined) each time he makes a mistake on the task, fails to use the problem-solving steps (or misuses the steps), or goes too quickly through the task. Response cost contingencies usually are instituted in the first session, but only if the child has attained mastery in memorizing the 5 problem-solving steps.

Mastery is defined as that level of performance where the child can fluently and correctly complete the task at least two times without therapist reminders and/or prompts.

Response cost procedures are the same throughout treatment. Each time the child makes an error, the therapist consequates the child with a chip loss and encourages the child to start again. The therapist takes the next turn and makes an intentional error followed by a coping statement (e.g., "Oops, I made a mistake. I guess I was going to fast on that one. I'm going to start again and this time I'll do it perfectly"). The therapist's use of the coping statement models for the child a positive way of handling mistakes.

Although positive reinforcement and response cost are used to develop use of the problem solving approach, there is no question that emphasis is on positive reinforcement. In fact, we are reluctant to use response cost heavily within the individual sessions. We do so as specified here, but the actual invocation of fines is relatively infrequent.

Labeling

When the child loses a token, it is important that he understands why the token was retracted, so that he can avoid the same mistake in the future. Therefore, the therapist explains or labels the mistake. Two labeling approaches are used: concrete labeling and conceptual labeling. Concrete labeling is explicit and typically applies to one specific mistake. The child is told exactly what he did wrong. Conceptual labels are more general and apply to a variety of mistakes and situations. The child is provided with a more global description of his error.

Research suggests that the conceptual labeling process facilitates the transfer of learning from the therapy sessions to natural settings more effectively than concrete labeling. However, concrete labeling provides an unambiguous explanation of errors, which in the early stages enables the child to produce the particular changes specified. Therefore, concrete labels are utilized during the early stages of training. As treatment progresses, however, the therapist gradually decreases his or her use of concrete labeling and increases his or her use of conceptual labeling.

Examples of Concrete Labeling

"You lose a chip because you didn't say 'What would happen'."'

or

"You lose a chip for saying the negative solution, "I would hit him."

Instead you need to come up with a positive solution such as, "I would ask the teacher for help."

Concrete labeling is explicit. The child is provided with a precise statement of his error.

Examples of Conceptual Labeling

"You lose a chip for not taking your time and getting the correct answer."

or

"You lose a chip for not going through all of the steps."

Conceptual labeling is more general. The child is provided with a global statement of his mistake.

When explaining mistakes the therapist's voice and manner should remain calm and nonpunitive.

Throughout each session the therapist models several coping statements. Every time the child loses a chip, the therapist follows with an intentional error and a coping statement when modeling the next task.

The response cost contingency is employed following errors on the tasks, fast guessing, or failure to use all of the problem-solving steps when self-instructing aloud. The contingency is designed to assist the child in remembering to "stop and think" prior to responding.

Contingencies: Self-Evaluation

The response cost procedure is not the only contingency employed. As described previously, social reinforcement and self-reinforcement are provided. The therapist uses frequent and

enthusiastic smiles and praise, and affection. One of the problem-solving steps the child is taught is a self-reward statement with which to reinforce his successful performance. In addition, at the end of the sessions, the child is encouraged to make an accurate self-evaluation of his performance for each session. If his self-evaluation is consistent with that of the therapist he earns an additional token. A chart describing the 3 levels of performance is shown to the child.

Table 2 Chart Provided to the Child to Assist with Self-Evaluation

| How I Did Today | | |
|---|---|---|
| 1 | 2 | 3 |
| Not So Good | Good | Great |

At the conclusion of the sessions, the therapist rates the child's performance and provides feedback to the child with "How I Did Today". The therapist provides a complete explanation as to why this particular rating was chosen. Beginning with the second session, the child is also asked to evaluate his own performance. If the child and therapist ratings match, the child earns one bonus chip. The goal of this procedure is to teach the child to make accurate self-evaluations. Guidelines for discussing self-evaluations are found in Appendix B and Session Two.

Contingencies: Reward Menu

At the end of each therapy session the child uses the chips to purchase a prize from the "Reward Menu" (see Table 3). The child must buy one prize at the end of each session, but may choose to save some chips in order to buy a more expensive prize after a future session. (See Appendix C for sample Bank that records the child's earnings and Appendix D for the "Reward Menu".) Appropriate rewards may vary from child to child. Therefore, a wide variety of rewards is made available. A variety of prices for different rewards is desirable; some rewards should be made available for as few as five chips. This ensures that each child will be able to earn some type of reward and also allows the child to purchase an inexpensive prize, while he saves for a more costly item.

Table 3 Reward Menu

Appendix D

REWARD MENU FOR_____

| | COST |
|---|---|
| CARD GAME | 5 chips |
| MARBLES | 5 chips |
| JACKS | 10 chips |
| NERF BALL | 10 chips |
| POSTER | 15 chips |
| COMIC BOOK | 20 chips |
| BASEBALL CARDS | 25 chips |
| CANDY | 25 chips |
| BOOKS | 30 chips |
| STAR WARS GAME | 40 chips |
| KITE | 45 chips |
| YO-YO | 50 chips |
| VIDEO TAPE | 60 chips |
| BUBBLE GUM MACHINE | 75 chips |

An initial inquiry should be made regarding the acceptability of rewards in the home, and if there are any restrictions on rewards (i.e., no candy). Social reinforcement, therapist praise, and affection is always paired with the presentation of session prizes.

Challenge

A central purpose of treatment is to provide the child with special skills and processes that apply to everyday life including those situations in which performance has been problematic. Over the course of treatment, explicit efforts are enacted to increase the realism and relevance of the situations in which problem-solving skills can be used by the child. The realism and relevance of the situations are addressed in separate ways. Outside of the session, "supersolvers" or special assessments are provided to extend application of problem solving skills in everyday life (see below). Within the sessions, the nature of the interactions between the therapist and child and the situations they enact also evolve over the course of treatment. Children are provided with individualized situations based on interactions derived from their home, school, and community life. Over the

course of treatment, an effort is made to make these interactions more realistic and to provide problems and dilemmas as they are encountered by the child.

Beginning in session 6 and continuing through the end of treatment, the therapist gradually increases the realism of the role-plays. It is useful to conceive of the changes along three dimensions.

1. Compliance: Through the role plays, therapists usually are placed in a position of authority and can decide whether to accept or reject the child's solution to the problem. In the early stages of treatment, the child's solutions are readily accepted to help develop the child's use of the approach. Over time, the therapist's compliance is reduced and eventually not automatic. This requires the child to spontaneously generate new solutions and to apply the approach in the face of more difficult circumstances.

2. Therapist Demeanor: The behavior of the therapist also evolves over the course of the role-plays. With the assistance of the child, the therapist tries to add to the realism by using the tone and intonation of others with whom the child interacts (e.g., slightly raised voice, facial expressions).

3. Child Prompts: The child is instructed by the therapist in advance of situations that this may be more difficult, that the therapist may be unreasonable, and so on to ensure that the task is not frustrating. Throughout the procedure, the game-like quality is retained. At the same time, the difficult situations and dilemmas relevant to the child's life are addressed in reasonable although tame fashion.

The therapist will gradually increase the amount of the realism or challenge for the role plays along these dimensions as treatment progresses. A guideline for progression of realism follows but it is expected that each child will vary according to the amount of challenge they can usefully work through at any particular time.

Sessions 6 & 7

a) Prompts that a challenging situation will arise are given

b) Therapist begins to reject child's original response

Sessions 8 & 9

a) Prompting continues

b) Therapist continues to reject child's response

c) Therapist begins to employ a more realistic or challenging demeanor

Sessions 10 & 11

a) Therapist continues to reject child's response

b) Therapist continues to employ a more realistic or challenging demeanor

c) Therapist discontinues prompts given to child that challenging role plays will ensue

Supersolvers (Homework)

To encourage the child to use the steps in real-life situations, the child is given homework assignments. These begin early in treatment and consist of applications of the problem-solving steps to every day life. Initially the child is asked to think of situations to which the problem-solving steps could be applied and then applies the steps to easy and eventually more complex situations. Related to the homework (supersolver) assignments, parents are integrated into real-life applications with the child. Here too, early in treatment, parents and children are given supersolver assignments where they work together and the child applies the steps to real life problems. The supersolver procedures constitute a major facet of treatment. They involve their own reward programs, graduated tasks, monitoring forms, and fading procedures. Consequently these procedures are described in a separate supplement to this manual.

Materials Checklist and Therapist's Checklist Before Starting Session

These sheets need to be filled out before the therapy session starts.

Session Summary Sheet and Therapy Checklist

This sheet is to be filled out by the therapist at the end of each session (not with child present). (For explicit content of Materials Checklist, Therapy Checklist, and Session Summary, see Appendices E and F.)

Therapy Procedures Section

In the previous section the components of cognitive therapy aimed toward the development of self-control have been highlighted. Problem-solving tasks, self-instruction procedures, modeling, and contingencies, have been detailed and a suggested reward menu has been proposed. The next section details how these procedures are implemented and integrated into each session. It is important to reiterate that a significant segment of treatment is conducted outside of the session as part of the supersolver and in vivo assignments. These are detailed in a separate manual supplement.

The conceptual basis of each session is reiterated. Procedures essential to the session are defined and sequenced. Model therapist statements are provided. Special considerations are offered to enrich the therapist's understanding of particular individual needs of children, as well as to include some of the subtle "fine tuning" that is required in clinical practice.

Overview of the Sessions

**Session One**. The purpose of this initial session is to establish rapport with the child, to teach the problem-solving steps and to explain the procedures of the cognitively based treatment program. The child is acquainted with the system and the use of token reward (chips), reward menus, and response cost contingencies. The session is concluded with an introduction and explanation of self-evaluation.

**Session Two**. This session teaches the child to employ the problem-solving steps to complete a relatively simple task. The child applies the steps to simple problem situations presented in a board game fashion. During the session, the therapist demonstrates how to use the problem-solving steps in decision making, how to provide self-reinforcement for successful performance, and how to cope with mistakes and failure. One of the goals of this session is to illustrate how the self-statements can be used to help "stop and think" rather than respond impulsively when confronted with a problem. During this session, the therapist makes errors and models their correction by using appropriate, self-controlled responses.

**Session Three**. This session involves presenting the child with hypothetical interpersonal problem situations and asking him to evaluate potential solutions and examine the consequences of each possibility. Because of the nature of the task for this session, it is often referred to as the DO-HAPPEN session.

**Session Four - Ten.** In these sessions the child uses the problem-solving steps to generate prosocial solutions to provocative interpersonal problems or situations. The interpersonal problems are presented in a variety of ways using various approaches, materials, and tasks to encourage the child to think about different nonaggressive ways to handle difficult problems with others. In most sessions, role-playing is utilized to give the child the opportunity to physically enact what he would do in a situation, thus making these interactions similar to real-life exchanges.

Each session concentrates on a different category of social interaction which the child might realistically encounter (i.e., peers, parents, siblings, teachers, etc.). This categorization organizes and structures the material to be presented and also communicates to the child that his responses may vary as a function of the category of person with whom he is interacting (i.e., responses to siblings may differ from responses to the school principal). Real-life situations, generated by the child, are employed alone with the hypothetical situations presented by the therapist, to promote generalization into the child's daily environment. The child's homework assignments (supersolvers) also become a more integral part of each session; they are re-enacted with the therapist beginning in session 8 in order to better evaluate how the child is transferring skills to his daily environment.

**Session Eleven**. This "wrap-up" session is included: 1) to help the therapist generally assess what the child has learned in the session, 2) to clear up any remaining confusions the child may have concerning the therapy, and 3) to provide a final summary for the child of what has been covered in the meetings. A role-reversal task with the child playing therapist is used to give the child a final opportunity to pose and defend nonaggressive solutions to problems. In addition, this session provides closure for the therapy, and allows unfinished business ("spending" remaining chips, completing final supersolvers, etc.) to be completed.

**Optional Sessions**. Additional sessions are provided to the child, as needed, if the child has special difficulty in grasping any features of the problem-solving steps or their application. For example, the child may have difficulty in applying the steps, learning to state them covertly, and so on. An additional session may be applied to repeat material of a previous session, so that the child has a solid grasp of the approach. Optional sessions may be implemented at any point that the child's progress lags behind the level appropriate to the session that has been completed. For example, if a facet of treatment has not been learned (e.g., memorization of steps, fading of steps) associated with the particular session that has been completed, an optional session may be implemented. These sessions can only be scheduled after supervisory consultation about the case. It is likely that optional sessions will occur at particular points in treatment. One such place might be very early in treatment if the child has special difficulty in learning the steps. Alternatively, optional sessions might occur between sessions 11 and 16 where additional opportunities would be provided for the child to practice the steps in role-play situations in which he has had difficulty.

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></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:<br>5/1/08</td><td>Date of Review/Revision:<br>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, 4/11/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Barbara Glassheim<br><br>Additional Reviewers:</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**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 approval.

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, substance use disorder, co-occurring condition(s), and/or an 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

[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.

to essential public benefits. They can also be used to purchase a 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 is 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).

**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

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

**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 | 5. SCCMHA Guardianship Committee |

| | |
|---|---|
| guardianship and whether or not to 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 Customer Service/Recipient Rights |
| 8. Approves guardianship for a period of one year only. | 8. Guardianship Committee |
| 9. Completes and submits a new referral to the Guardianship Committee if the guardianship is not completed within one year. | 9. Case Holder |
| 10. Works with family/advocate/supporter to establish an alternative to guardianship if the committee determines the Case Holder should not pursue guardianship. | 10. SCCMHA Guardianship Committee and Case Holder |
| 11. Completes the Authorization for Payment form and sends it to Guardianship Services when there is a vacancy in the list kept by Guardianship Services. | 11. Director of Recipient Rights, Customer Service, & Security |

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: _____

**********

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Outcome Tool for Adults (ANSA) | **Chapter**: 02.03 – Philosophy of Care | **Subject No**: 02.03.17 |
| **Effective Date**:<br>9/27/13 | **Date of Review/Revision**:<br>5/4/16, 3/28/17, 5/18/18, 4/9/19, 4/7/20, 3/29/21, 3/14/22, 3/17/23, 3/11/24<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>Executive Director of Clinical Services<br><br>**Authored By**:<br>Heidi Wale Knizacky<br><br>**Additional Reviewers**:<br>Clinical Directors<br>Sara Anani, John Burages |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | |

**Purpose:**
In order to ensure 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><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></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:<br>June 4, 2014</td><td>Date of Review/Revision:<br>5/6/16, 3/30/17, 4/10/18, 4/8/19, 3/29/20, 3/4/21, 2/28/22, 3/17/23, 3/7/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Heidi Wale Knizacky<br><br>Additional Reviewers:<br>Jennifer Stanuszek, Heidi Wale Knizacky, 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 Systems Inc. (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: FY23 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; for the most current version of this document visit: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder44/Folder2/Folder144/Folder1/Folder244/PECFAS-CAFAS_Guidance.pdf?rev=ee2dc4d0a25f49be98968de5cd40e529.)

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." (Technical Requirement for SED Children, MDHHS/CMHSP Managed Mental Health Supports and Services Contract, 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 Michigan Medicaid Provider Manual, 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: (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)
    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 (i.e., Initial Assessment), during initial person centered planning process (i.e., Revised Initial), 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 when:
   a. Completing the assessment phase of the initial Individual Plan of Service (IPOS). Ongoing quarterly assessments will be based from this Revised Initial date and are to correspond with quarterly and annual reviews, including IPOS updates.
   b. A case has been open to SCCMHA but no services have been provided, for example, a youth has been assigned to a clinical treatment team after having been found ineligible for ASD benefit.
   c. A case had been open to SCCMHA for 90 or more days without provision of services, for example, a youth has been assigned to a treatment team, but fails to attend/participate in services.
4. The case holder will continue the sequential 3 month assessment should a youth's case close and then reopen within a 90 day time period.
5. Having a current PECFAS/CAFAS will be a requirement in order to attain authorization for services.
6. 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 MidState Health Network for PIHP submission 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: ATTACHMENT C6.5.1.1; see 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 Episode by designating the next assessment "Revised Initial" as part of the assessment phase of the person-centered planning process. The date of the Revised Initial will be used to calculate subsequent due dates of quarterly and annual assessments.
    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 - Central Access and Intake Unit
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 Health and Human Services
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:** A Revised Initial Assessment replaces the Initial Assessment as the treatment baseline, is reflected in the Individual Plan of Service, 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 2021
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 as a requirement for authorization of services. | Utilization and Care Management staff |
| 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 2021

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. **The FAS system, operated by MHS, is to be used when scoring the PECFAS or CAFAS for each child at intake, quarterly thereafter and at exit from CMHSP.**

| 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.<br><br>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.<br><br>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 CMHSP contract requirement. | |
| **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:<br>• A total score of 50 (using the eight subscale scores on the CAFAS, or<br>• Two 20s on any of the first eight subscales of the CAFAS, or<br>• One 30 on any subscale of the CAFAS, except for substance abuse only. | 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 determination of functional impairment at this time.<br><br>The PECFAS:<br>• is used as a criterion 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. |

<table>
<tr><th>Issue</th><th>CAFAS</th><th>PECFAS</th></tr>
<tr><td></td><td>The CAFAS<ul><li>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.</li><li>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.*</li></ul></td><td><ul><li>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.*</li></ul>For young children, ages 3-4, that are involved in the SED Waiver and Wraparound, the PECFAS is required.</td></tr>
<tr><td></td><td colspan="2">* 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 not required nor are the scores reported to the Department.</td></tr>
<tr><td></td><td colspan="2">** 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</td></tr>
<tr><td></td><td colspan="2">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.</td></tr>
<tr><td>Using the LOCUS and CAFAS for youth, ages 18-21</td><td colspan="2">For children/youth receiving Children's Services in the CMHSP system, the CAFAS needs to be completed at intake, quarterly and at exit up to age 21. If the youth, aged 18-21 years, is also receiving CMHSP Adult Services the LOCUS should be completed by their Adult Services provider.</td></tr>
<tr><td>Transitioning from PECFAS to CAFAS</td><td colspan="2">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 child, data is not captured for that child in state aggregate reports.</td></tr>
<tr><td>Evidence Based Practice-Treatment Labeling (EBPs)</td><td colspan="2">The Evidence Based Treatment labels has been updated (Spring 2020). Please use the labels to identify what treatments are being used with each child rated. Please note that clinicians being trained or certified in the following treatments are to use the labeling provided.<ul><li>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).</li></ul></td></tr>
</table>

| Issue | CAFAS | PECFAS |
|---|---|---|
| | • *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.<br><br>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.<br>All CAFAS and PECFAS training and booster records for raters and trainers must be maintained by the CMHSP/PIHP. | |
| **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 the face-to-face training but is not a substitute for face-to-face rater training.<br><br>**Booster for Raters**<br>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**<br>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:<br><br>*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.*<br><br>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.<br><br>If you are having problems with downloading the CAFAS or PECFAS annual report, please contact MHS via their website, https://mhs.com/contact-us/.<br><br>**PLEASE NOTE**: MHS, Inc. has guidance on their website regarding training, booster for raters. Their guidance is not reflective of the Department's guidance. Please see MDHHS's requirements for rater training and boosters (Training Requirements, above). | |
| | **Licensing Fee** | |

| Issue | CAFAS | PECFAS |
|---|---|---|
| **MDHHS Support** | 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**<br>MDHHS will continue to provide CAFAS and PECFAS Train the Trainer trainings and CAFAS and PECFAS Trainer Boosters through the Community Mental Health Association of Michigan (CMHAM). Please go to the CMHAM's website for training details and registration, www.cmham.org. | |
| **Questions** | Mary Ludtke, MA, Innovative Services Section, Division of Mental Health Services to Children and Families, MDHHS<br>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

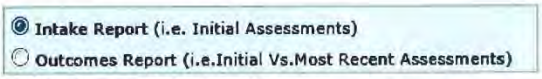
***NOTE: Only persons with the role of Business Administrators are able to view Aggregate Reports. See left navigation bar to begin the process. If you do not have this access, then contact your IT department or your CAFAS lead at your site.***

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:

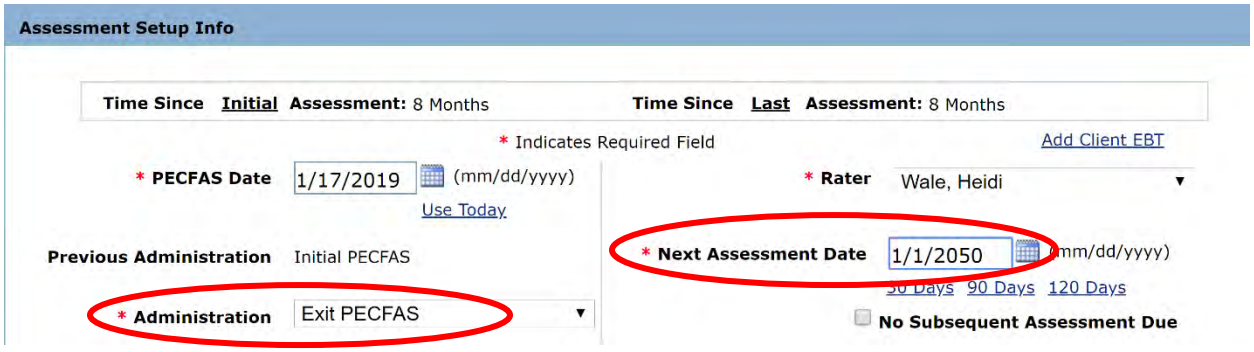
1. They have a planned exit from services
2. They drop out of services
3. They turn SEVEN years old

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"*

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Autism Spectrum Disorder (ASD) Program | **Chapter**: 02 – Customer Service & Recipient Rights | **Subject No**: 02.03.21 |
| **Effective Date**:<br>3/10/15 | **Date of Review/Revision**:<br>5/6/16, 8/10/16, 6/13/17, 4/10/18, 3/31/20, 3/23/21, 3/3/22, 3/6/23, 3/15/24 | **Approved By**:<br>Sandra M. Lindsey, CEO |
| | **Supersedes**: | **Responsible Director:**<br>Executive Director of Clinical Services |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Authored By**:<br>Heather Beson<br><br>**Additional Reviewers**:<br>Clinical Directors<br>Amanda Elliott |

**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 *in conjunction with* the ADOS-2)**

• **Clinical interview**, including thorough assessment of developmental symptom history (medical, behavioral, and social history [ADI-R or clinical equivalent]) and review of any documentation and information from others working with the person.

• **Developmental evaluation** (Mullen Scales of Early Learning, Bayley Scales of Infant Development- Third Edition, DAYC-2) **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, ABAS-3 or similar measure)

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

• **Developmental Disabilities Modification of the Children's Global Assessment Scale (DD-CGAS) to characterize current functioning abilities**

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), Assessment of Functional Living Skills (AFLS) or Vineland, 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 Therapy, Psychiatric, Community Living Supports, 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<br>Behavioral intervention<br>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<br>Behavioral intervention<br>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).<br>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<br>Behavioral intervention<br>Behavioral observation and direction |
| **Licensed Psychologist (LP)**<br>*(Must be certified as a BCBA by 09/30/2025)* | A minimum of one year experience in treating children with ASD based on the principles of behavior analysis.<br>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:<br>1. Ethical considerations.<br>2. Definitions & characteristics and principles, processes & concepts of behavior.<br>3. Behavioral assessment and selecting interventions outcomes and strategies.<br>4. Experimental evaluation of interventions.<br>5. Measurement of behavior and developing and interpreting behavioral data.<br>6. Behavioral change procedures and systems supports.<br>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<br>Behavioral intervention<br>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 09/30/2025)* | A minimum of one year experience in treating children with ASD based on the principles of behavior analysis.<br>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:<br>1. Ethical considerations.<br>2. Definitions & characteristics and principles, processes & concepts of behavior.<br>3. Behavioral assessment and selecting interventions outcomes and strategies.<br>4. Experimental evaluation of interventions.<br>5. Measurement of behavior and developing and interpreting behavioral data.<br>6. Behavioral change procedures and systems supports.<br>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<br>Experience requirements. | Behavioral assessment<br>Behavioral intervention<br>Behavioral observation and direction |
| **Qualified Behavioral Health Professional (QBHP)** *(Must be certified as a BCBA by 09/30/2025)* | Must meet at least one of the following state requirements:<br>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.<br>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.<br>May hold a master's degree in a Behavior Analyst Certification Board (BACB) approved degree category from an accredited institution<br>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:<br>1. Ethical considerations.<br>2. Definitions & characteristics and principles, processes & concepts of behavior. | Must be certified as BCBA within two years of successfully completing ABA graduate coursework | Behavioral assessment<br>Behavioral intervention<br>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.<br>4. Experimental evaluation of interventions.<br>5. Measurement of behavior and developing and interpreting behavioral data.<br>6. Behavioral change procedures and systems supports.<br>Works under the supervision of the BCBA/BCBA-D. | | |
| **Behavior Technician (BT)**<br>*(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.<br>Must be at least 18 years of age<br>Must be able to practice universal precautions to protect against the transmission of communicable disease<br>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<br>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)<br>Must be able to perform and be certified in basic first aid procedures<br>Must be trained in the IPOS/behavioral plan of care utilizing the person-centered planning process.<br>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<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Care Coordination</td><td>Chapter: 02 - Customer Services & Recipient Rights</td><td>Subject No: 02.03.23</td></tr>
<tr><td rowspan="2">Effective Date:<br>4/1/16</td><td>Date of Review/Revision:<br>6/13/17, 6/1/18, 5/13/19, 6/8/20, 4/27/21, 9/27/22, 3/22/23, 5/8/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Chief of Health Services and Integrated Care<br><br>Authored By:<br>Jennifer Keilitz<br><br>Additional Reviewers:<br>Director of Provider Network Executive Director of Clinical Services</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 outline the process of care coordination within the Saginaw County Community Mental Health Authority (SCCMHA) network and with our community partners. This approach is essential in enhancing the experience of persons served, promoting positive outcomes, and optimizing the use of available resources.

**Policy:**
It is the policy of SCCMHA to ensure all persons served receive coordinated, comprehensive, and person-centered care through effective communication, collaboration, and management of all health and social services. SCCMHA requires that all service delivery staff members and particularly those in case management or supports coordination roles provide and ensure care coordination for persons served on a continuous basis.

**Application:**
This policy applies to all SCCMHA services and programs, including direct operated services and supports as well as contracted agencies or any other entities with a service delivery or coordination related agreement with SCCMHA.

**Standards:**
A. Care coordination occurs with any internal program and/or external organization, as well as any individual and/or entity with an identified role in supporting a person receiving services person-centered plan.
B. Care coordination encompasses physical, behavioral, and social supports in the community, including access to acute and chronic health settings, primary and specialty health providers, multiple service providers whenever applicable, and

housing, education, and employment systems. Staff will ensure that care coordination is integrated across physical health, mental health, and substance use disorder service needs.

C. Care coordination must identify, address, and seek to reduce or eliminate barriers and risk for persons served. Staff will address social determinants of health in care coordination.
D. While generally care coordination is most often directed by designated case managers and supports coordinators in the SCCMHA network, others may often share care coordination functions, as defined in each person-centered plan, including but not limited to nurses, peers, community health workers, and clinicians, as well as various medical and ancillary health professionals.
E. Care coordination activities support the concepts of recovery, self-determination, self-management, whole health, wellness, appropriate medical supports, and interventions for acute or chronic conditions, prevention, people served education, healthcare integration, and any and all aspects of quality-of-life domains for persons served.
F. Care coordination occurs in clinical settings, in the person served living environment and in various community settings as appropriate to best meet each person's needs.
G. Care coordination is supported by the 'no wrong door' access to treatment and supports philosophy of SCCMHA.
H. Staff will use a team-based approach to care, involving a multidisciplinary team of providers in the planning and delivery of care.
I. Care coordination endorses the four concepts of: clarity of goals and communications; recognition of differences in the management of processes; making no assumptions; and involvement of stakeholders.
J. SCCMHA programs will adhere to defined admission and discharge criteria and protocols, including provision of notice, processes for the transfer of care, follow-up, and recognition of risk for people receiving services.
K. Care coordination includes recognition of the needs of special populations, including, but not limited to: older adults and/or persons with significant or multiple health conditions; persons with unique cultural needs such as those with tribal affiliations or associations with military culture; persons with limited speech, hearing, mobility or communication skills; persons with unique disorders such as eating or hoarding conditions; persons with history of traumatic experience; and, those who are at high risk due to their dependence upon others to meet their daily needs.
L. Documentation of full person served or guardian consents are part of the care coordination expectations at SCCMHA, in keeping with privacy and confidentiality requirements.
M. An important aspect of care coordination is the ability of health care providers to <u>listen</u> to a person served family, friends, or others whenever appropriate, even if privacy requirements and/or absence of the person served consent do not allow for the exchange and/or provision of information to natural supports or other key informants.

N. Person receiving services choices, preferences and goals are a critical aspect of care coordination as documented in the clinical record.
O. Care coordination includes the offer of the development of a crisis plan to ascertain in advance the desires of individual people served, including advanced directives, wellness recovery or other relevant advance preparation action plans. If a person served declines the development of a crisis plan, this will be noted in the record and revisited on some frequency for person served reconsideration or confirmation.
P. Documentation of all person served medications in the clinical record will include monitoring by prescribers, critical event reviewers and pharmacy management personnel.
Q. No policies, practices, and/or provider agreements/contracts of SCCMHA impact the ability of a person served to freely select their own provider.
R. Care coordination and clinical decision support at SCCMHA is facilitated by the centralized electronic medical/health record, which includes demographic, diagnoses, medication, individual plans, consents/releases, and person served progress/outcome information, including the provision of electronic prescribing to pharmacies by prescribing medical providers.
S. SCCMHA will engage all appropriate partner entities in care coordination activities, as supported by contracts or other agreements whenever possible as relevant to the SCCMHA service array and needs of people served, to promote clear procedures and processes in routine and ad hoc care coordination.
T. Care coordination will be supported by routine training and education for all relevant staff.
U. Care coordination is the implementation of the comprehensive treatment and care management/person or family centered plan, through appropriate linkages, referrals, coordination, and follow-up to needed services and support.
V. Staff will use evidence-based practices in care coordination. This means using interventions that have been proven effective through scientific research.
W. Care coordination examples include:
    a. Providing telephonic reminders of appointments.
    b. Providing telephone outreach and follow-up to low-risk people receiving services who do not need face-to-face contact.
    c. Communication with family members.
    d. Administering risk assessment.
    e. Use of survey assessments.
    f. Follow-up reminders and assistance with making appointments, including warm hand offs for referrals.
    g. Identifying outstanding items on patient visit summaries.
    h. Assisting with medication reconciliation.
    i. Making appointments.
    j. Providing patient education materials.
    k. Assisting with arrangement such as transportation, directions, and completion of durable medical equipment requests.
    l. Obtaining missing medical records, laboratory testing and consultation reports.
    m. Participating in hospital and emergency room transition care.

n. Documenting in the integrated care management system/electronic medical record.

X. Care Coordination is also focused on assisting individuals to improve self-management of chronic mental and physical health conditions and includes:
   a. Participation in the development and implementation of a person served PCP addressing dimension of behavioral health recovery, stabilization, and improvement in chronic physical conditions.
   b. Assistance and support to the person served in stressor situations.
   c. Mental health and physical health education, support and consultation to people served families and support system, including care for children in custody or share custody arrangements, which is directed exclusively to the well-being and benefit of the person served.
   d. Individual assistance for the development of interpersonal, community coping and self-management skills, including adapting to home, school, and work environments.
   e. Assisting the person served in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric and physical health symptoms that interfere with the people receiving services daily living, financial management, personal development or school or work performance.
   f. Assistance to the person served to increase social support skills and networks that reduce life stresses resulting from the person served mental illness or physical health conditions and are necessary to enable and maintain the person served independent living.
   g. Developing strategies and supportive mental and physical health interventions for avoiding out-of-home placement for people receiving services and building strong family support skills and knowledge of the person served strengths and limitations.
   h. Developing mental and physical health relapse prevention strategies and plans.

**Definitions:**

Care Coordination, as defined by the Agency for Healthcare Research and Quality (2014): "*Deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care. This means that the patient'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 patient."* Care coordination is an activity rather than a service, and includes directly provided services, services, and supports provided by other entities, including both behavioral and physical healthcare.

SAMHSA refers to care coordination as "the cornerstone of many healthcare redesign efforts, including primary and behavioral healthcare integration. It involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care. Research

shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care."

**References:**
Substance Abuse and Mental Health Services Administration (SAMHSA)

MDHHS
- CCBHC Handbook
- BHH Handbook

National Council for Behavioral Health

SCCMHA Policies: *02.01.01.02-Cultural Competence; 02.03.03-Person-Centered Planning; 02.03.03B-Family-Centered Practice; 02.03.04-Self-Determination; 02.03.05-Recovery; 02.03.14-Trauma-Informed Services and Supports; 02.03.09.01.01-Practice Guidelines; 03.01.03-Consumer Choice and Service Management; 03.02.05-Plans of Services and Supports; 03.02.06-Consumer Health and Safety; 03.02.13-Transition/Discharge Services; 03.02.14-Advance Directives; 03.02.29-Closure/Discharge Criteria; 08.04.01-Consumer Records. 02.03.05-Recovery; 03.02.49.01 Care Transitions*

**Exhibits:**
None

**Procedure:**
None

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Suicide Prevention | **Chapter**: 02 – Customer Services & Recipient Rights | **Subject No**: 02.03.24 |
| **Effective Date**:<br>8/1/16 | **Date of Review/Revision**:<br>6/13/17, 5/11/18, 4/9/19, 7/29/20, 4/13/21, 5/10/22, 4/11/23<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>Executive Director of Clinical Services<br><br>**Authored By**:<br>Barbara Glassheim<br><br>**Additional Reviewers**: |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | |

**Purpose:**
The purpose of this policy is to delineate a framework for addressing suicidality and preventing suicide from occurring.

**Policy:**

Suicide is a major contributor to premature death in the United States, especially among people aged 10–34, for whom it is the second leading cause of death. It is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities. In 2021, more than forty seven thousand (47,646) Americans died from suicide, 4% higher than in 2020 (45,979).

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 and shall include the components enumerated below.

a. Identification of warning signs (e.g., feelings of hopelessness or irritability; thoughts like, "I'll always be alone"; behaviors like arguing with a parent; and/or physiological sensations such as intense pain from a chronic medical condition; or events, such as the anniversary of the death of a loved one) that risk for suicide is increasing in order to help consumers gain awareness of when they need to access and use their safety plan.

b. Identification of different categories of coping strategies consumers will use once they have recognized that they are at heightened risk for suicide.

1). Safety plans start with internal coping strategies (e.g., experiences that distract from suicidal thoughts, emotional distress, or urges by diverting attention to other activities, stimuli, or sensations) consumers can use without assistance from others and progress through incrementally more intensive strategies that can be used if the initial strategies prove ineffective.

c. Identification of individuals and social settings that can serve as a distraction during a suicidal crisis.

d. Identification of individuals that can be contacted to request support.

e. Mental health providers or facilities (e.g., the treating clinician, hotline services including 988) that can provide professional help if the consumer is still in suicidal crisis after using the previous coping strategies.

f. Reduce the consumer's access to their identified means for suicide.

g. Identification of reasons for living.

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 (and beyond as applicable to CCBHC [Certified Behavioral Health Clinic] consumers) 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. CDC National Vital Statistics System (Mortality Data).
B. 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
C. Michigan Association for Suicide Prevention. (2012). *Suicide Prevention Plan for Michigan Evaluation:* https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder52/Folder1/Folder152/State_Suicide_Prevention_Plan_Evaluation.pdf?rev=f246e48f3b0a45cda80a3f38522c67c3&hash=9DE0D76F337E01759A4868726FC485BA
D. Saginaw County's First Responders Guide for Behavioral Health Interventions: https://www.sccmha.org/userfiles/filemanager/12403/
E. SCCMHA Policy 02.03.09.12– Mobile Response and Stabilization Services (MRSS)
F. SCCMHA Policy 02.03.09.17 – Mental Health First Aid (MHFA)
G. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
H. SCCMHA Policy 03.02.31 – Services for Members of the Armed Forces, Veterans and their Families
I. SCCMHA 03.02.34 – Services for American Indians
J. SCCMHA Policy 03.02.35 – Serving LGBTQ+ Consumers
K. 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)

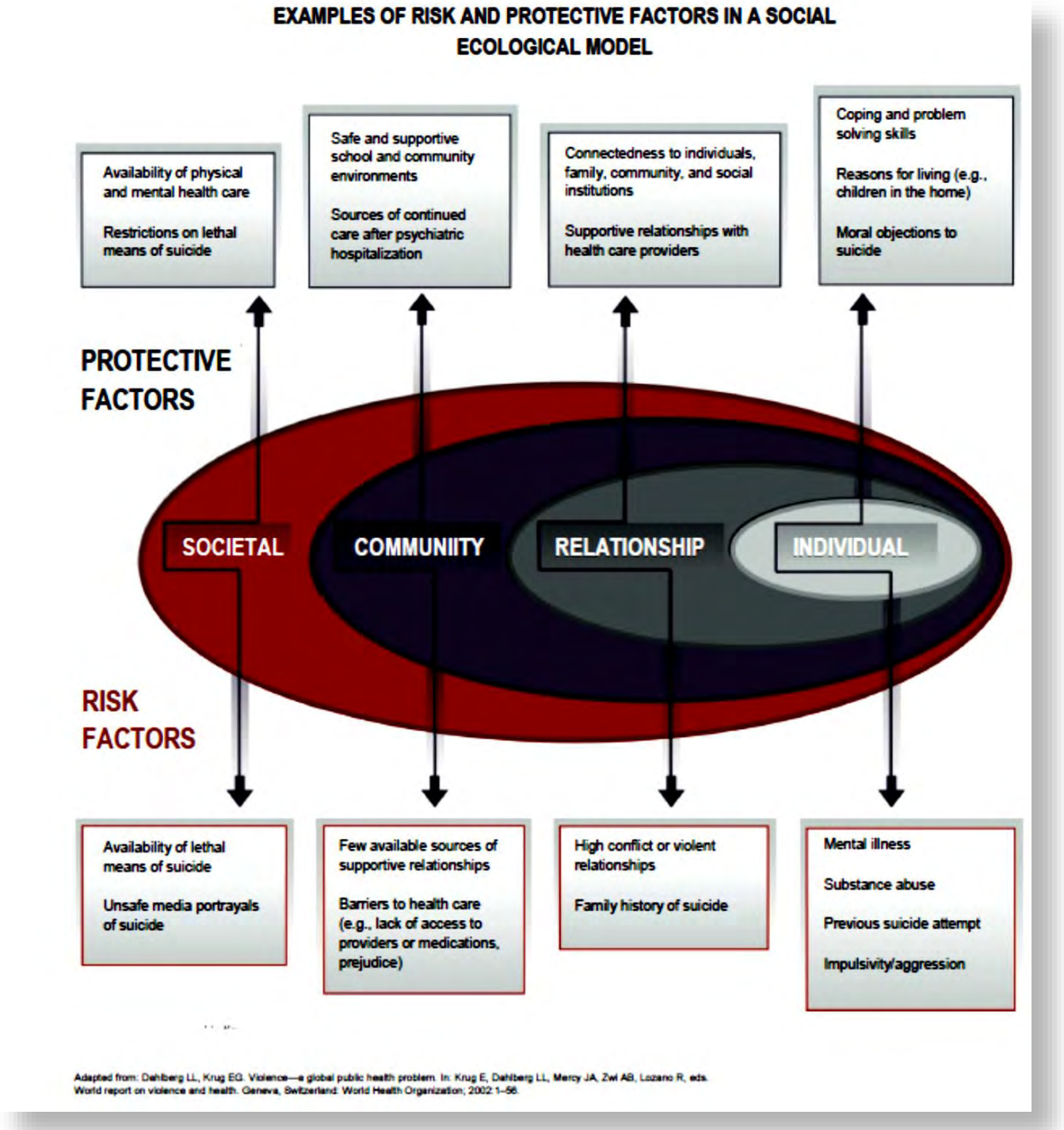
D. Columbia-Suicide Severity Rating Scale (C-SSRS) – for Individuals with Cognitive Impairment

**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).<br>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.<br>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. | Case Holder |
| 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.<br>Seeks consultation with supervisor and/or clinical leadership for all consumers with identified risk.<br>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?***<br>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?***<br>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?***<br>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.<br>**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**<br>Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.<br>***Have you thought about being dead or what it would be like to be dead?***<br>***Have you wished you were dead or wished you could go to sleep and never wake up?***<br>***Do you ever wish you weren't alive anymore?***<br>If yes, describe: | **Yes** ☐ **No** ☐ | **Yes** ☐ **No** ☐ |
| **2. Non-Specific Active Suicidal Thoughts**<br>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.<br>***Have you thought about doing something to make yourself not alive anymore?***<br>***Have you had any thoughts about killing yourself?***<br>If yes, describe: | **Yes** ☐ **No** ☐ | **Yes** ☐ **No** ☐ |
| **3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act**<br>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."*<br>***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?***<br>If yes, describe: | **Yes** ☐ **No** ☐ | **Yes** ☐ **No** ☐ |
| **4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan**<br>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."*<br>***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?***<br>***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.***<br>If yes, describe: | **Yes** ☐ **No** ☐ | **Yes** ☐ **No** ☐ |
| **5. Active Suicidal Ideation with Specific Plan and Intent**<br>Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.<br>***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?***<br>***What was your plan?***<br>***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?***<br>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).*<br>***Lifetime - Most Severe Ideation:*** _____ _____<br>***Type # (1-5)*** ***Description of Ideation***<br>***Recent - Most Severe Ideation:*** _____ _____<br>***Type # (1-5)*** ***Description of Ideation*** | Most Severe | Most Severe |
| **Frequency**<br>***How many times have you had these thoughts?*** ***Write response***_____<br>(1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable | ____ | ____ |

| ***SUICIDAL BEHAVIOR***<br>*(Check all that apply, so long as these are separate events; must ask about all types)* | **Lifetime** | **Past 3 Months** |
|---|---|---|
| **Actual Attempt:**<br>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.<br>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.<br>***Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?***<br>***Did you ever hurt yourself on purpose? Why did you do that?***<br>***Did you_____ as a way to end your life?***<br>***Did you want to die (even a little) when you_____?***<br>***Were you trying to make yourself not alive anymore when you _____?***<br>***Or did you think it was possible you could have died from_____?***<br>***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)<br>If yes, describe: | Yes ☐ No ☐<br>Total # of Attempts<br>_____ | Yes ☐ No ☐<br>Total # of Attempts<br>_____ |
| **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:**<br>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).*<br>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.<br>***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?***<br>If yes, describe: | Yes ☐ No ☐<br>Total # of interrupted<br>_____ | Yes ☐ No ☐<br>Total # of interrupted<br>_____ |
| **Aborted or Self-Interrupted Attempt:**<br>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.<br>***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?***<br>If yes, describe: | Yes ☐ No ☐<br>Total # of aborted or self-interrupted<br>_____ | Yes ☐ No ☐<br>Total # of aborted or self-interrupted<br>_____ |
| **Preparatory Acts or Behavior:**<br>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).<br>***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?***<br>If yes, describe: | Yes ☐ No ☐<br>Total # of preparatory acts<br>_____ | Yes ☐ No ☐<br>Total # of preparatory acts<br>_____ |

| | Most Recent Attempt Date: | Most Lethal Attempt Date: | Initial/First Attempt Date: |
|---|---|---|---|
| **Actual Lethality/Medical Damage:**<br>0. No physical damage or very minor physical damage (e.g., surface scratches).<br>1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).<br>2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).<br>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).<br>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).<br>5. Death | *Enter Code*<br>_____ | *Enter Code*<br>_____ | *Enter Code*<br>_____ |
| **Potential Lethality: Only Answer if Actual Lethality=0**<br>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).<br>0 = Behavior not likely to result in injury<br>1 = Behavior likely to result in injury but not likely to cause death<br>2 = Behavior likely to result in death despite available medical care | *Enter Code*<br>_____ | *Enter Code*<br>_____ | *Enter Code*<br>_____ |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Wellness</td><td>Chapter: 02.03. – Philosophy of Care</td><td>Subject No: 02.03.25</td></tr>
<tr><td rowspan="2">Effective Date:<br>6/13/17</td><td>Date of Review/Revision:<br>4/10/18, 4/9/19,7/29/20, 4/13/21, 5/10/22, 4/11/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Barbara Glassheim<br><br>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 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 (with an average age of death of 45 years). 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 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])

**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. Glassheim, B. (March 2022). *A Guide to Evidence-Based Wellness Practices.* SCCMHA: https://www.sccmha.org/userfiles/filemanager/1058/
B. SCCMHA Consumer Health Education Council Workgroup Charter
C. SCCMHA Employee Handbook Policy Number 528 – Better Together Bank
D. SCCMHA Employee Wellness Committee Workgroup Charter
E. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
F. SCCMHA Policy 03.02.46 – Whole-Person Care
G. SCCMHA Wellness Incentive Program

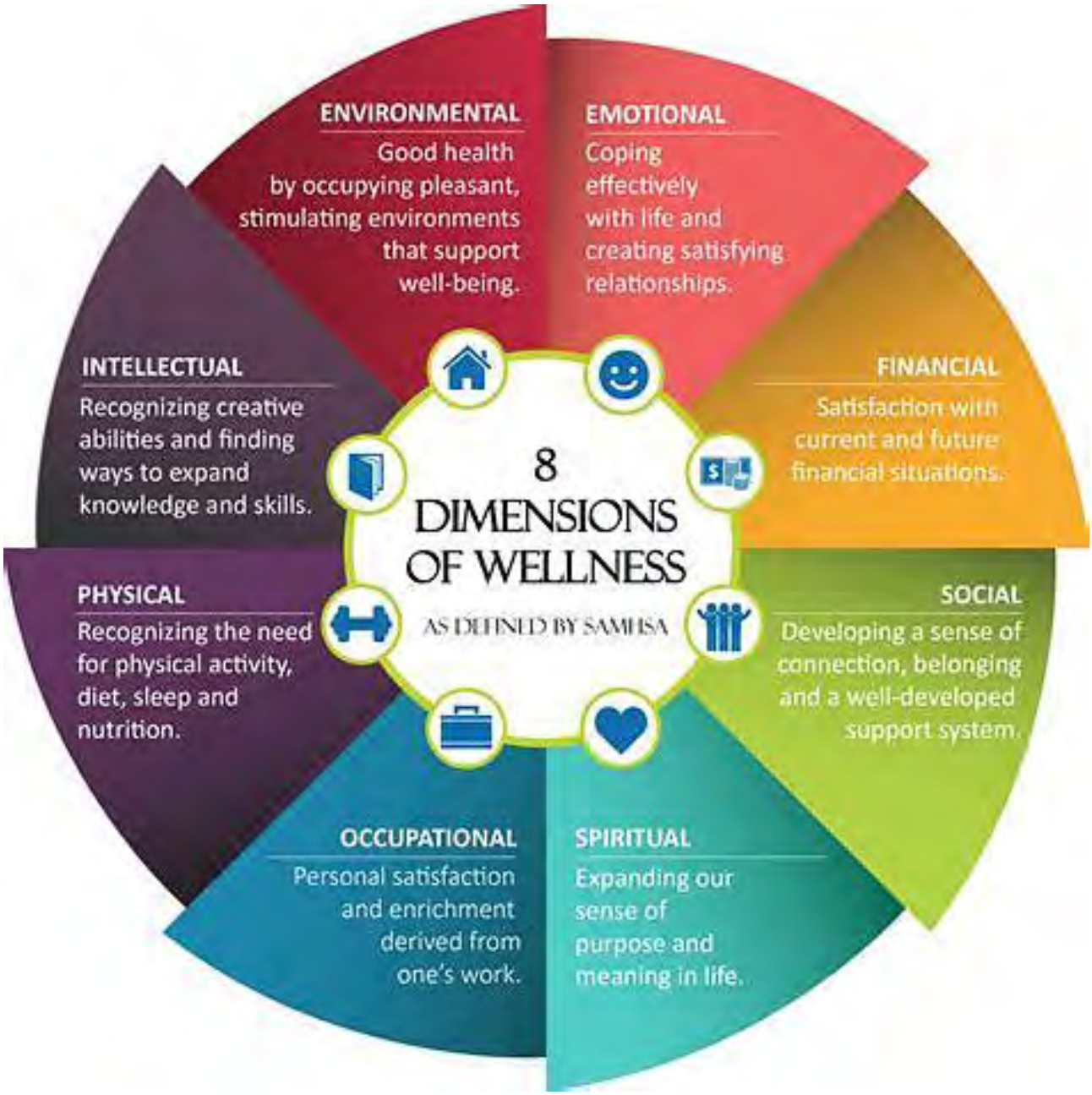
**Exhibits:**

A. SAMHSA Wellness Wheel

**Procedure:**

None

Exhibit A: SAMHSA Wellness Wheel



<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: SOGI Safe</td><td>Chapter: 02 - Customer Services and Recipient Rights</td><td>Subject No: 02.03.41</td></tr>
<tr><td rowspan="2">Effective Date:<br>4/10/18</td><td>Date of Review/Revision:<br>4/9/19, 8/21/20, 5/10/21, 4/12/22, 5/10/22, 4/11/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Barbara Glassheim, Heidi Wale Knizacky<br><br>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 apply specific staff development training that is designed to promote a safe, supportive and welcoming environment for LGBTQAI+ consumers as well as to enhance the competency and effectiveness of providers who serve LGBTQAI+ consumers and their families.

**Application:**
This policy applies to SCCMHA-funded providers.

**Policy:**

SCCMHA recognizes that LGBTQAI+ 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 LGBTQAI+ 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 LGBTQAI+ 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 LGBTQAI+ 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 LGBTQAI+ individuals in order to be able to effectively assess

and provide and/or coordinate appropriate, supportive services within a safe environment for LGBTQAI+ 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 LGBTQAI+ 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 identifies as LGBTQA+.
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 LGBTQAI+ 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 may not be linear. 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.

**LGBTQAI+:** An acronym for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and other sexual and gender minorities. 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 the person turns out to actually be of a gender or sexual minority 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. It's Pronounced Metrosexual: http://itspronouncedmetrosexual.com/
B. National LGBT Health Education Center: https://www.lgbthealtheducation.org/
C. SCCMHA LGBTQAI+ & SOGI (Sexual Orientation Gender Identity: https://www.sccmha.org/about/diversity-equity-and-inclusion-initiative/lgbtqia-and-and-sogi.html
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 LGBTQAI+ 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?

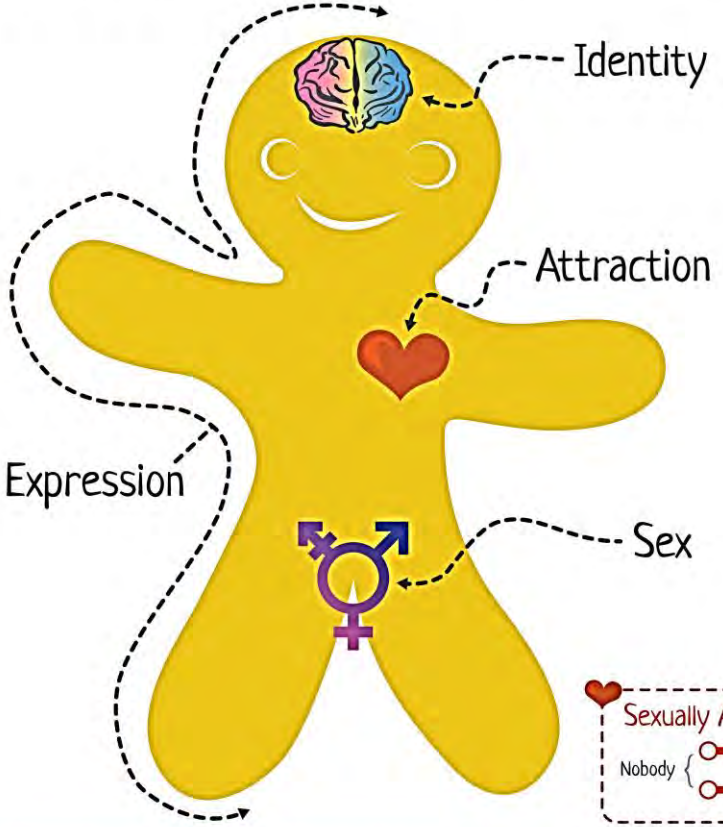
What support do you hope to receive from the group leaders and other group members to help you achieve your objective?

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<br>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:<br>August 1, 2002</td><td>Date of Review/Revision:<br>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, 3/2/23, 3/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Services for Persons with Intellectual and Developmental Disabilities<br><br>Authored By:<br>Jennifer Rieck-Martin, Julie Bitterman<br><br>Additional Reviewers:<br>CAC, 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:<br>a. consumer employment and generation of income;<br>b. greater freedom and independence;<br>c. normalization of residential living situations;<br>d. development and use of natural supports;<br>e. community integration;<br>f. fostering of recovery and prevention of relapse;<br>g. keeping children at home with their families; and<br>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><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></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:<br>8/6/01</td><td>Date of Review/Revision:<br>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, 4/6/23, 3/7/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services, Kristie Wolbert LMSW<br><br>Authored By:<br>Steve Gonzalez<br><br>Additional Reviewers:<br>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 are to 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 disorder persons 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 427 330.1207 Diversion from jail incarceration.
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 include information on how to identify persons | 4. Forensic Team Supervisor CSS Team 2 and Crisis Intervention Services Supervisor for adults and Family Services Supervisor for youths. |

| | |
|---|---|
| with mental illness, emotional disturbance, and developmental disabilities and how to access emergency assessment for persons in protective custody or under arrest. | |
| 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:<br>• 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.<br>• Safety Planning to avert future contacts with law enforcement.<br>• 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 specify persons responsible for monitoring and | 8. Case Record Holder, Therapist, Family |

| | |
|---|---|
| reporting to the police department, prosecutor, probation officer, judge or other officer of the court if required. | 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 serious emotional disturbance. | 12. Directors of Children Services and Family Services Supervisors |

| | |
|---|---|
| 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 Court 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<br>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:<br>August 12, 2004</td><td>Date of Review/Revision:<br>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, 3/2/23, 3/7/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Tom Peck<br><br>Additional Reviewers:<br>Wardene B. Talley<br>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<br>Director of Clinical Services<br>Director of Network Services<br>CCBHC |
| Assures that when possible, contractual arrangements and memoranda of understanding with local agencies address academic and vocational continuity. | CEO<br>Director of Clinical Services<br>Director of Network Services<br>Contract Manager |
| Educates staff with primary record holder responsibility regarding the methods of advocating for educational and vocational continuity. | Director of Clinical Services<br>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<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Monitoring and Reassessment | **Chapter**: 03 - Continuum of Care | **Subject No**: 03.02.03 |
| **Effective Date**:<br>June 22, 2007 | **Date of Review/Revision**:<br>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, 4/3/23, 3/15/24<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>Director of Services for Persons with Intellectual and Developmental Disabilities<br><br>**Authored By:**<br>John Burages<br><br>**Additional Reviewers**:<br>Clinical Directors,<br>Charlotte Fondren<br>Amanda Elliott |
| 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 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 at least once **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 at least once **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. This includes consumers admitted to Caro Center, Kalamazoo Psychiatric Hospital, Center for Forensic Psychiatry, Walter Reuther and Hawthorn Center. 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 recoveryand 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 | Care Management Staff |

| | |
|---|---|
| exist. | |
| 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<br>SCCMHA auditing staff<br>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<br>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>
<tr><td rowspan="2">Effective Date:<br>11/11/02</td><td>Date of Review/Revision:<br>11/11/02, 6/11/07, 5/6/09, 3/8/10, 6/12/12, 5/23/14, 5/14/15, 4/7/16, 4/16/16, 6/22/16, 7/12/16, 1/9/17, 4/19/17, 6/16/17, 3/1/18, 3/5/19, 3/4/20, 3/29/21, 3/22/22, 3/2/23, 3/7/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Services for Persons with Intellectual and Developmental Disabilities<br><br>Authored By:<br>Thomas Peck<br><br>Additional Reviewers:<br>Aisleen Morr<br>Kelley Feltman</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**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 three (3) 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<br>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 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 | Case Holder |

| | |
|---|---|
| consumer identifies:<br>• Dreams, goals, desires, and any topic which he or she would like to talk about.<br>• Topics he/she does not want talked about at the planning meeting.<br>• Who to invite to the planning meeting and who will send out the invitations.<br>• Where and when the planning meeting will be held.<br>• Who will facilitate.<br>• Who will record.<br>• If the consumer would like to participate in self-determination.<br>• 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.<br>• 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:<br>• If desired by the consumer, coordinates with the Independent Facilitator<br>• Reviews the entire consumer's record including the previous IPOS and Reviews, progress notes, Medication Reviews, assessments and screenings, Incident Reports, etc.<br>• 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<br>• Requests an evaluation or assessment or status from any services the consumer is receiving or may need (as determined in the pre-planning process).<br>• Completes an updated Psycho-social Assessment<br>• Prepares the IPOS by entering the dreams, desires, | Case Holder and/or Facilitator |

| | |
|---|---|
| and goals. | |
| Meets for the person-centered planning meeting at the date and place requested by the consumer, documenting who attended the meeting.<br>• 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.<br>• Identifies and discusses the consumer's desired outcomes, including any health and safety needs.<br>• Determines what natural supports are available to assist the consumer in achieving their desired outcomes.<br>• If no natural supports exist, develops a plan for developing natural supports if the consumer desires<br>• Identifies what services and supports will be provided to assist the consumer in achieving their desired outcomes.<br>• Determines the scope, amount, and duration of each service that is to be provided.<br>• 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.<br>• The service and support plan should include measurable goals and objectives.<br>• 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:<br>• 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 authorization. In the event there is a concern over Medical Necessity being shown in the IPOS, the | Care Management Specialist |

| | |
|---|---|
| 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.

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject:<br>Residential Services</td><td>Chapter: 03 -<br>Continuum of Care</td><td>Subject No: 03.02.07</td></tr>
<tr><td rowspan="2">Effective Date:<br>6/16/05</td><td>Date of Review/Revision:<br>6/14/05, 8/30/06, 1/5/07, 6/28/07, 6/30/09, 3/2/10, 7/30/10,1/5/11, 8/15/11, 6/11/12, 7/2/14, 8/11/14, 8/14/14, 12/23/14, 2/4/16, 5/2/16, 4/5/18, 2/26/19, 3/21/22, 10/5/22, 4/11/23, 3/7/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Network Services, Public Policy, and Continuing Education<br><br>Authored By:<br>Kristie Wolbert<br><br>Reviewed By:<br>Residential Watch Committee, Quality of Life Committee, Provider Network Auditors, Mary Baukus, Kelley Feltman</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
To identify and clarify residential options available for Saginaw County Community Mental Health Authority (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 principles 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. (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.
- The 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 03.02.07.08)
- 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.
- The provider will ensure proper maintenance is occurring at the residential facility as documented by the completion of preventative maintenance logs at least quarterly.
- The 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 Health and Human Services under the Division of Adult Foster Care Licensing 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 member 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 need 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 intranet under *Network Services, Provider Manual & Directories.* This resource is meant to be used by the consumer and those assisting the consumer in choosing an AFC that will meet the consumer's 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 holder has to make a monthly visit to the facility to assure staff are providing the additional care needed. The case holder has to initial the paperwork as proof of review and that the provider is giving the care that was prescribed by the case holder. Usually, the case holder will initial above the date they visit. The case

holder 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 is 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 number 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 Procedure 09.09.05.08 Specialized Medical Equipment and Supplies, Assistive Technology, Enhanced Pharmacy, and Environmental Modifications.)

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 Procedure 09.09.05.08 Specialized Medical Equipment and Supplies, Assistive Technology, Enhanced Pharmacy, and Environmental Modifications.)

*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 and Medicaid considers the following as guidance for billing days of service:

The Medicaid rule regarding not reporting/billing day of discharge is assumed to be a primary rule governing which provider can report/bill that day. The CMHSP/PIHP cannot report the day of exit when the consumer is going to another per diem setting.

The same day may **NOT** be reported by two homes (transfers**); NOR** if the person is moving from a certified/licensed setting to a non-licensed setting **NOR** if persons have a hospitalization or nursing home stay; **NOR** as persons terminate the licensed/certified CLS/PC services, including leaving the CMH system. The discharge day or the day the person "moves" to the other setting is not reportable as a CLS/PC per diem by the home for the person who is "leaving".

The "day" of attendance/service is based on the beneficiary receiving at least one activity in Personal Care and/or CLS, and as noted above is not moving that day to another setting (permanently or in the case of hospitalization on a temporary basis).

However, the beneficiary may be absent from the home for other leave, e.g., visits with family/friends. For both the day they leave and the day they return, IF they receive at least one activity in Personal Care and/or CLS, then that day may be reported. If the person is out of the home on leave for an entire 24-hour day, that day is not reportable.

**References:**

Final HCBS Residential Readiness Tool
MDHHS Medicaid Provider Manual: Mental Health/ Substance Abuse Section
SCCMHA Procedure 09.04.04.03- Personal Care and Community Living Supports Service Log Documentation
SCCMHA Procedure 09.04.01.04 Quality of Life Visits
SCCMHA Procedure 09.04.03.07 Residential Provider Watch Program
SCCMHA Procedure 09.09.05.08 Specialized Medical Equipment and Supplies, Assistive Technology, Enhanced Pharmacy, and Environmental Modifications
SCCMHA Policy 02.03.04 Self Determination
SCCMHA Policy 02.02.28 Recipient Rights – Dignity and Respect
SCCMHA Policy 03.02.07.01 Specialized-Contracted Residential Provider Admissions and Discharge
SCCMHA Policy 03.02.07.02 AFC Community Inclusion
SCCMHA Policy 03.02.07.03 Community Living Supports (CLS)
SCCMHA Policy 03.02.07.05 ASAP Payments
SCCMHA Policy 03.02.07.06 Moving Consumer into Independent Housing
SCCMHA Policy 03.02.07.07 Adult Foster Care Maintenance of Physical Plant
SCCMHA Policy 03.02.07.08 Nutrition Standards for Specialized Residential
SCCMHA Policy 03.02.07.09 Emergency Preparedness for Specialized Residential
SCCMHA Policy 03.02.07.10 Medication Management in Licensed Residential Settings
SCCMHA Policy 03.02.07.11 Management of Consumer Funds
SCCMHA Policy 04.01.02- Incident Reporting and Review

**Exhibits:**

Exhibit A: Summary of Resident Rights for AFC Group Homes (https://www.michigan.gov/lara/bureau-list/bchs/adult/legal/resident-rights-for-afc-group-home)
Exhibit B: Guidelines for Specialized Residential Services

Attachment 1: Staff Schedule
Attachment 2: Consumer Inventory List
Exhibit C: Samples of Assessment Plan for AFC Residents
Exhibit D: Leave of Absence Form
Exhibit E: 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 03.02.07.01 Specialized Residential – Contracted Provider Admission and Discharge) for placement into Specialized Residential settings. Also see Checklist for Moving consumers into Licensed Residential Settings (See Exhibit C in SCCMHA Policy 03.02.07.01 ). | Case Holder<br>Clinical Supervisor<br>Care Management Specialist<br>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 | Case Holder/Chair of the Residential Placement Committee |

| | |
|---|---|
| setting. A review of the person's file will occur, and a decision will be made in 7-10 business days. | |
| Assist with the procurement of needed Equipment or Environmental Modification<br>Utilizing the "Request for Additional Funds Form" only after all outside resources have been exhausted. (See SCCMHA Procedure 09.09.05.08 Specialized Medical Equipment and Supplies, Assistive Technology, Enhanced Pharmacy, and Environmental Modifications.) | 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 B. | Residential Provider |
| Attends residential facility staff meetings as needed to provide in-services on consumer plans, help resolve issues, clarify concerns, etc. | Case Holder |
| Initial and any additional in services on consumer plans are scanned into the record. | Case Holder |

Exhibit A

# SUMMARY OF RESIDENT RIGHTS FOR AFC GROUP HOMES (R400.14104/R400.15104) RESIDENTS HAVE THE FOLLOWING RIGHTS:

The administrative rule cited below provides the rights of licensees and applicants of adult foster care group homes. This information may also be found in:

- Licensing Rules for Adult Foster Care Small Group Homes
- Licensing Rules for Adult Foster Care Large Group Homes

**R 400.14104/R 400.15104 Licensee and applicant rights**

(1) A licensee or an applicant shall have the right to be treated with courtesy, dignity, and fairness by the adult foster care licensing division staff of the department and shall not be discriminated against on the basis of race, religion, color, national origin, sex, age, handicap, height, weight, or marital status.

(2) The department shall provide a licensee or an applicant with written notice regarding appeal rights as provided by Act No. 306 of the Public Acts of 1969, as amended, being S24.201 et seq. of the Michigan Compiled Laws, and the act when there is official notification of the intent to take an adverse action against an applicant or a licensee.

(3) A licensee or an applicant shall be informed of, and shall have the right to bring to the attention of the supervisor of the licensing representative, any alleged misapplication of enforcement of regulations by a licensing representative or any substantial differences of opinion as may occur between the licensee or the applicant and any licensing representative concerning the proper application of the act or these rules. A meeting with the supervisor shall be afforded upon request. This subrule notwithstanding, the licensee or the applicant may contact any other official of the department regarding issues relating to the licensing activities of the department. Any contact with the supervisor or any other departmental official shall not result in any retaliation by the licensing representative.

(4) All written communications, scheduled and unscheduled visits, routine licensing investigations, and complaint investigations shall be conducted according to the provisions of the act and these rules.

(5) A licensee or an applicant may request, pursuant to the provisions of Act No. 442 of the Public Acts of 1976, as amended, being S15.231 et seq. of the Michigan Compiled Laws, copies of department policies or other documents that govern the licensing activities of the department.

(6) A licensee or an applicant shall be afforded the opportunity to have a

conference with the licensing representative before the conclusion of a routine licensing investigation or complaint investigation and, as soon as practicable thereafter, shall receive a written response that indicates the findings of the licensing representative or any other licensing official.
(7) A licensee or an applicant shall have the right to review a licensing study report in which refusal to renew, revocation, or denial of license issuance is being recommended before that report is finalized, except in situations where the department finds cause to invoke a summary suspension action. The licensee or the applicant shall have the right to submit a written response. The written response shall be considered a part of the official record and shall be subject to disclosure pursuant to the provisions of Act No. 442 of the Public Acts of 1976, as amended, being S15.231 et seq. of the Michigan Compiled Laws.
(8) A licensee or an applicant shall have the right to provide a written response to the findings of the licensing representative or other department official if a licensing investigation report or a complaint investigation report is issued. The written response shall become a part of the department's official licensing record and shall be public information according to the provisions of Act No. 442 of the Public Acts of 1976, as amended, being S15.231 et seq. of the Michigan Compiled Laws, and the act.
(9) A licensee or an applicant may request, in writing, a declaratory ruling as to the applicability of a rule as provided in section 63 of Act No. 306 of the Public Acts of 1969, as amended, being S24.263 of the Michigan Compiled Laws.
(10) The department shall provide advice and technical assistance to the licensee or the applicant to assist the licensee in meeting the requirements of the act and these rules. The department shall offer consultation upon request in developing methods for the improvement of service.
(11) The department shall provide a licensee or an applicant with a written copy of the rights outlined in subrules (1) to (10) of this rule at the time of license application or license renewal.
History: 1994 MR 3, Eff. May 24, 1994.

Exhibit B

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# Guidelines for Specialized Residential Service Providers

Revised: 1/5/07; 12/2014; 04/2023

All providers offering Specialized Residential Services under the auspices of Saginaw County Community Mental Health Authority (SCCMHA) must comply with the following regulations:

- Michigan Department of Licensing and Regulatory Affairs (LARA) ( Licensing information can be found at https://www.michigan.gov/lara/bureau-list/bchs/adult )
- 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 assistance/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.

(ASAP) Adult Services Authorized Payments (*formerly known as Model 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.

**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 team members (i.e. nurse, OT, PT, Speech Therapist, etc.) regarding the emergency treatment and any medical or health changes that may have occurred.

**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. Case Holders will need to assure the consumer plan specifies the need for 1:1 staffing and how the staff providing 1:1 will interact with the consumer. This interaction includes activities to engage in, how close the staff person will be in proximity to the consumer, and any other information for the staff to follow in order to understand the purpose of the 1:1 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 Health and Human Services 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) Culture of Gentleness and Crisis Response (3-year renewal)
5) Nutrition and Food Safety
6) Environmental Emergencies/ Fire Safety
7) CPR (every two-year renewal)
8) First Aid (every two-year renewal
9) Basic Health
10) Basic Medications (medication renewal every three years)
11) Blood borne Pathogens/ Infection Control (annual renewal)
12) Non-Violent Psychological Verbal De-Escalation (2- or 3-year renewal based on DC provider type)

Providers must also require all home staff to participate in training as required by MSHN, 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:

13) Limited English Proficiency (LEP)
14) Ethics of Touch
15) Cultural Diversity
16) Compliance Program and False Claims/HIPAA Privacy, HIPAA Security (annual renewal)
17) Advance Directives (home managers only)
18) Home Manager Training
19) Trauma Training
20) Orientation to Training
21) Basic Military Cultural Competency

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 03.02.07.10 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**.**

**Incident Reporting**:
The provider agrees to immediately report via Incident Report any of the following situations (per SCCMHA Policy 04.01.02- Incident Reporting and Review, also see this policy for additional information):

1) Unusual or unexpected events that occur in the life of a consumer while under the services of SCCMHA and the Provider Network will be reported to the SCCMHA Quality Department within one (1) business day of the incident.

2) Any death of a consumer expected or unexpected, who at the time of their death was actively receiving services or received an emergent service within the last 30 calendar days will be reported to the SCCMHA Quality Department within 24 hours of notification of the death.

3) Incidents involving a death, or significant physical or psychological injury or suspected recipient rights violation should be immediately reported by phone to the SCCMHA Office of Recipient Rights (ORR).

4) Incidents for Licensed Residential Settings will be completed using the

MDLARA AFC Licensing Division – Incident/Accident Report (BCAL-4607) form (exhibit 1).

5) Incidents for other programs, such as Skill Building and outpatient settings, should be completed on the MDCH Incident Report (DCH-0044) form (exhibit 2). The death of a consumer should be reported on the SCCMHA Report of Consumer Death form (exhibit 3).

6) Use of any Physical Intervention will be documented on the Incident Report form. In addition, the SCCMHA Physical Intervention Report form (exhibit 4) will be completed and submitted with the Incident Report.

7) Suspected Abuse or Neglect will be reported on the SCCMHA Staff Action –Regarding Alleged Abuse/Neglect/Exploitation form (exhibit 5). Reference SCCMHA Policy 02.02.11 Recipient Rights – Abuse and Neglect.

8) All forms must be filled out completely and neatly with black ink by the involved or observing staff person. The incident should be described thoroughly and include actions taken by staff/treatment given and corrective measures taken to remedy and/or prevent recurrence of the incident. If an Incident Report form is not completed in its entirety, it will be returned to the submitter for completion.

9) An Incident Report form must include the full first and last name of the involved consumer(s) and their SCCMHA consumer I.D. If the incident involves a consumer from another county, only their initials should be included.

10) Incidents involving emergency medical treatment and/or hospitalization must include the name of the treatment facility.

11) Incidents involving medication errors or refused medications must include the name of the medication, the dosage, and the name of involved staff.

12) Home Managers and Program Supervisors are responsible to ensure that their staff report and accurately document incidents as outlined in this policy and that the appropriate follow up care is provided.

13) All Incident Reports will be reviewed by the Quality Department, the Office of Recipient Rights, the Clinical Services Department, and the Director of Network Services, Public Policy & Continuing Ed.

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 Quality Department within one business day of the incident. 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. 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 details which discuss 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 waterproof 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)
- Raincoats
- 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)

**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" (*See SCCMHA Policy 03.02.07.07 Adult Foster Care Maintenance of Physical Plant*). 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 Procedure 09.09.05.08 Specialized Medical Equipment and Supplies, Assistive Technology, Enhanced Pharmacy, and Environmental Modifications)*. 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 60-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 "Leave of Absence Form" Exhibit D)*

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

The Medicaid rule regarding not reporting/billing day of discharge is assumed to be a primary rule governing which provider can report/bill that day. The CMHSP/PIHP **cannot** report the day of exit when the consumer is going to another per diem setting.

The same day may **NOT** be reported by two homes (transfers); **NOR** if the person is moving from a certified/licensed setting to a non-licensed setting **NOR** if persons have a hospitalization or nursing home stay; **NOR** as persons terminate the licensed/certified CLS/PC services, including leaving the CMH system. The discharge day or the day the person "moves" to the other setting is not reportable as a CLS/PC per diem by the home for the person is who "leaving".

The "day" of attendance/service is based on the beneficiary receiving at least one activity in Personal Care and/or CLS, and as noted above is not moving that day to another setting (permanently or in the case of hospitalization on a temporary basis).

However, the beneficiary may be absent from the home for other leaves, e.g., visits with family/friends. For both the day they leave and the day they return, **IF** they receive at least one activity in Personal Care and/or CLS, then that day may be reported. If the person is out of the home on leave for an entire 24-hour day, that day is not reportable.

**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 SCCMHA Procedure 09.04.04.03- Personal Care and Community Living Supports Service Log Documentation.)*

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 (including OT, PT, ST), 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.

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 as part of the room and board payment. 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). MyPlate should be used when preparing menus and meals. Provider is encouraged to learn more about MyPlate and meal planning at www.choosemyplate.gov. Providers must pay close attention to any written diet orders. Therapeutic and mechanically altered diets must be ordered by a physician and followed at all times. Most SCCMHA consumers may benefit from avoiding food textures that increase the risk for choking such as sticky, tough, hard, or crunchy foods.

**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. Any adaptive equipment should be noted as an 1915 (i) SPA (State Plan Amendment).

**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. Consumers must be able to secure and store their belongings away from others. *(Please see attached sample "Consumer Inventory List", Attachment 2).* Providers will maintain consumer funds according to SCCMHA policy 03.02.07.11 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. The Home and Community Based Services Rules (HCBS) require all consumers to be offered more than one community based outing per week.

**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. Consumer Inventory List

# 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

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:**_____

# ASSESSMENT PLAN FOR AFC RESIDENTS

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

Exhibit C

**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 | | |
|---|---|---|---|
| | Yes | No | IF YES, Describe Needs and How The Will Be Met |
| 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

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Exhibit D

**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)

Exhibit E

**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 an 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 the is an intruder in the home or there is an eminent threat outside the home. An additional example is always when the home needs immediate medical response. (police vs. ambulance or fire) SCCMHA will not second guess or penalize home for contacting 911, if in their best judgement, such intervention is needed to prevent serous harm.

However, SCCMHA as well as MDHHS do emphasize 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 readily available. 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 or a similar occurrence wherever 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 consumers 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 people, but this should always be the preferred goal. Emphasis on the development of positive relationships and interactions with consumers, at 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 calling 911 be used as a routine or periodic threat or consequence of any kind of 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 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.

Original document March 2012. Revised April 2023.

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></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, 4/11/23, 4/8/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Services for Individuals with I/DD<br><br>Authored By: Char Fondren, Barb Glassheim<br><br>Additional Reviewers:<br>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).
      2). Consumers and their parents and/or guardians work with SCCMHA to work on alternative solutions i.e., interdisciplinary meeting.
   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."

5. 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.

6. 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 able to attend the BTPRC meeting, it is requested that their supervisor attend on their behalf. Case Holder to brief supervisor prior to BTPRC meeting.
c. The BTPRC may make recommendations to address the concerns.
d. It is expected that the author of the plan will present the initial BTP and quarterly review reports of BTPs.
    1). If Author is unable to attend BTPRC meetings, the author of the plan may appoint a proxy to represent them at the meeting.

7. 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.

8. 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

9. 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, 2024 |
| *Psychiatrist | Dr. Ali Ibrahim, Medical Director | December 31, 2024 |
| *Psychologist | Heidi Wale Knizacky, MS, LLP | December 31, 2024 |
| *Recipient Rights | Judy Sausedo, Recipient Rights Supervisor | Ex officio |
| Member | Jenipher Swanson, Supervisor of Autism Services | December 31, 2024 |

* 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.

**Submission Date:** Click or tap to enter a date.

**Recurring Behavior(s) of Concern:** *(list all)* Click or tap here to enter text.

**There has been:** ☐ Regression ☐ No Change ☐ Progress

**Reason for BTC Review:** *(check one option below)*

☐ **New** Behavior Treatment Plan (BTP) & Functional Behavior Assessment (FBA) *(must submit BTP & FBA)*
☐ **Amended** Behavior Treatment Plan (requested edits made)
☐ **Quarterly Review** of approved Behavior Treatment Plan *(see Notes/Comments section below)*
☐ Positive Support Plan (PSP) – includes no intrusive/restrictive interventions
☐ Health & Safety Consult
☐ Medication Consult

This an **ABA** Plan? ☐ Yes ☐ No

**Intrusive and/or Restrictive Intervention(s) included in the BTP:**
Please check all that apply from below:

| | | | |
|---|---|---|---|
| ☐ 1:1 Supervision | ☐ Restrict Environment | ☐ Search & Seizure | ☐ Physical Prompt |
| ☐ ABA 2:1 | ☐ Planned Inquiry (i.e. request to see purchases made) | ☐ Overcorrection | ☐ Medication(s) |
| ☐ Restrict Access to Property | ☐ Anatomical/Physical Support Rx MD/PT/OT | ☐ Special Clothing | ☐ Limit Access to Phone |
| ☐ Restitution/Response Cost | ☐ Limited Access to Activity, Environment | ☐ Limit Access to Visits | ☐ Limit Access to Mail |
| ☐ Restrict Access to Money | ☐ Therapeutic De-Escalation (required relaxation) | ☐ Limit Access to Other Persons | ☐ Restrict Access to Viewing, Listening |
| ☐ Protective Device (describe): | Click or tap here to enter text. | | |
| ☐ Other (describe): | Click or tap here to enter text. | | |

**Notes/Comments:** (If this is a **Quarterly Review**, please include baseline data and data for the last 3 months along with your progress summary here.) Click or tap here to enter text.

Exhibit C

# Behavior Treatment Plan (BTP) Decline

Saginaw County Community Mental Health Authority Behavior Treatment Committee (BTC)

**Consumer Name:** Click or tap here to enter text.

**Consumer ID #:** 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. I further understand that by declining the implementation of behavior treatment plan, the consumer could be at risk of losing their residential placement.

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

Revised 6/17/2021

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></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:<br>10/24/96</td><td>Date of Review/Revision:<br>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, 3/31/23, 3/7/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>John Burages<br><br>Additional Reviewers:<br>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 to the Executive Director of Clinical Services and Clinical Records Coordinator (EDCSCRC)
    d. Referrals may be made by other entities (such as Professional Staff, Treating Prescriber, Supervisor of other departments/providers, Executive Director of Clinical Services) 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. This includes when other entities make the referral. Depending on the urgency of the risk, Record Holder, Supervisor or other representative will be made aware at least one week prior.
    a. When a Clinical Risk Committee member requests updates, a plan of action or additional information, Record Holder, Supervisor or other representative will not be required to complete a Referral Form.

**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 | Community Support Services Team 2 Supervisor 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<br>Supervisor |
| If the concern continues, the Supervisor refers to Clinical Risk directly to the CSS Team 2 Supervisor or Administrative Assistant to the EDCSCRC. | Record Holder<br>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<br>Treating Prescriber<br>Supervisor of other departments / providers<br>Executive Director of Clinical Services |
| Establishes an agenda for the committee based on level of risk that a referral may pose. | CSS Team 2 Supervisor or assigned chairperson or Administrative Assistant EDCSCRC. |
| 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/)<br>Case Holder (and/or)<br>Supervisor (and/or)<br>Other Representative |

| | |
|---|---|
| Makes recommendations which are documented and forwarded to the primary record holder for follow through and inclusion in the clinical record. | Clinical Risk Committee or Administrative Assistant EDCSCRC. |
| Reports back to the committee regarding effectiveness of recommendations, when requested. | Referring person (and/or)<br>Record Holder<br>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<br>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:<br>June 30, 2003</td><td>Date of Review/Revision:<br>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, 3/7/23, 5/4/23, 3/12/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Carey Moffett LMSW<br><br>Additional Reviewers:<br>Erin M. Nostrandt, Clinical Directors,</td></tr>
<tr><td>Supersedes:<br>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. If the training is an external source, staff are required to submit their training documentation on the External Training Documentation form (Exhibit D).

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 supervisor.

**Definitions:**
External Training: any education, conference or training completed outside of SCCMHA CEU. This includes: any online training platform (ex. Relias, CMHAM, PESI, etc.)

**References:**
Michigan Mental Health Code,
Michigan Department of Community Health, Mental Health and Substance Abuse Services, Administrative Code,
MDHHS Indicators: SEDW-CLS
MDHHS Indicators: HSW
WIP-HSW SED CWP 1915 (c) Waivers Final Site Review Protocol

**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
Exhibit D: External Training Documentation Form

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|

| | |
|---|---|
| Responsible for assuring compliance with this policy. | Chief Executive Officer,<br>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<br>• 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<br>• Departmental Trainings: Department supervisor is encouraged to submit the completed form (Exhibit A: Documentation of Child Diagnostic Credits: General) to the Continuing Education Department<br>• 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 |

| | |
|---|---|
| • Staff submit an External Training Documentation form along with any external training documentation to CEU | |
| How Child Diagnostic Credits are awarded.<br>• 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.<br>• 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:<br>1. Sentri II<br>2. Training Management Report<br>3. Print Transcript<br>4. Select green 'lookup' after provider<br>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)<br>6. Choose 'Search'<br>7. Choose 'select' in blue to the right of the provider you need<br>a. If department search is SCCMHA in-house, always be sure to choose 'Direct Program as identified in the 'Org Type/Panel Type' | Continuing Education Assistant or Designated Continuing Education Unit Staff |

| | |
|---|---|
| Column<br>b. If the department search is a contracted provider you will need to select 'Contracted Service Provider.<br>8. Start Date = the start of the previous quarter (example Jan 1 "Year") > End date = Reporting Date<br>9. Generate PDF File<br>10. Refer to your Sentri II Mail (white envelope next to HELP at top of Sentri page) to Open the report<br>11. Save As (go to this folder in G-Drive):<br>*G:\Network Services\Training\Reports\Child Diagnostic Reports*<br>12. Find (or create) the file for the correct quarter<br>13. Title should be saved as: "Department Supervisor last name (or contracted program name) Child Dx __ Quarter [Year]".<br>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,*

Exhibit D

# External Training Documentation Form

| | |
|---|---|
| Staff First and Last name | [Click or tap here to enter text.] |
| Job Title | [Click or tap here to enter text.] |
| Department/Provider Name | [Click or tap here to enter text.] |
| Sponsoring Organization *(SCCMHA, CMHAM, Relias, PESI, improvingmipractices.org, etc.)* | [Click or tap here to enter text.] |
| Are you seeking credit for Annual Renewal Training? | [Choose an item.] |
| Choose the Annual Renewal Training you are seeking credit for *(skip if above answer was no)* | [Choose an item.] |
| Are you seeking credits such as Social Work Continuing Education/ MCBAP/Child Diagnostics? | [Choose an item.] |
| If above answer is "yes": Please identify all credits you are seeking **be sure your certificate identifies a source for SW CEs and/or MCBAP credits* | [Click or tap here to enter text.] |

Please ensure all information above is completed. Once complete (1) please attach certificate or notice of training completion; (2) agenda and/or identifying training information; and (3) email to: registrations@sccmha.org

Continuing Education

Saginaw County Community Mental Health Authority

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>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:<br>6/15/05</td><td>Date of Review/Revision:<br>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, 3/17/23, 3/11/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>John Burages<br><br>Additional Reviewers:<br>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<br>Family Advocates |

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject:<br>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:<br>7/1/07</td><td>Date of Review/Revision:<br>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, 3/17/23, 3/11/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Sara Anani<br><br>Additional Reviewers:<br>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 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. The Notice of Adverse Benefit Determination must be completed and sent to the consumer prior to completing the discharge summary. Medicaid beneficiaries may request continuation of services if requested within 10 calendar days or 30 days for Non-Medicaid beneficiaries of the effective date of the Notice of Benefit Determination. 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. Consumers on Alternative Treatment Orders cannot be discharged from services prior to the expiration date.

**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.<br><br>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.<br>*Case /Record Holder<br>*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<br>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<br>Supervisors<br>Case/Record Holder |
| Reviews and signs the discharge plan | Supervisors<br>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<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:<br>Advance Directives</td><td>Chapter: 03 -<br>Continuum of Care</td><td>Subject No: 03.02.14</td></tr>
<tr><td rowspan="2">Effective Date:<br>9/1/05</td><td>Date of Review/Revision:<br>7/9/24, 9/20/22, 8/1/21, 6/11/19, 6/1/18, 3/15/17, 8/7/15, 8/7/10, 7/7/09, 8/7/06, 3/9/06, 8/15/05</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, Chief Executive Officer<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
To ensure Saginaw County Community Mental Health Authority (SCCMHA)compliance with Federal and state regulations and contractual responsibilities to provide appropriate enrollees with information regarding advance directives and provide appropriate information to staff and the public.

**Policy:**
It is SCCMHA's policy to provide adult beneficiaries who receive services from SCCMHA, or its network, with a written summary of current Michigan law relative to Advance Directives. Furthermore, it is SCCMHA's policy to provide information to relevant staff regarding SCCMHA policies and procedures on advance directives. SCCMHA will also make informational materials available to the public regarding this subject.

It is the policy of SCCMHA to provide written information to all adult persons served who receive services from SCCMHA or its network prior to the reception of such services regarding their right to prepare advance directives and of SCCMHA's written policies respecting the implementation of such rights.

It is the policy of SCCMHA that each competent adult consumer receiving services from SCCMHA, or its network, will be provided information regarding advance directives. SCCMHA will document the person served decision to accept or decline the opportunity

to prepare advance directives, as well as the existence of such advance directives. If the person served has executed an advance directive, SCCMHA will request a copy of the document for placement within the record of the person served. A copy of the advance directive will also be maintained in the relevant Community Ties setting, residential setting, and/or SCCMHA Crisis Center, as applicable.

It is the policy of SCCMHA that the decision of the person served to execute or not to execute an advance directive will have no impact on the provision of SCCMHA services to that person served.

It is SCCMHA's policy to provide information to staff and the community regarding advance directives.

**Application:**
This policy applies to all Board Operated Programs as well as the SCCMHA Network Providers who provide services to SCCMHA persons served. While residential providers are not responsible for providing information about advance directives to persons served, the providers should have a working knowledge about advance directives and how the subject may affect the residents of their respective homes. In addition, residential providers should be aware of the individual decisions of their residents regarding advance directives to ensure appropriate response.

**Standards:**
1. SCCMHA provides all adult beneficiaries with written information on advance directives at the time of their intake with SCCMHA.
2. In the event an individual is temporarily unable to make an informed consent regarding the advance directive information, arrangements will be made to provide the information to the individual when the circumstances change through the primary worker assigned to the person served.
3. The written information provided to adult beneficiaries will include a description of Michigan law and their applicable rights under Michigan law.
4. The written information will consist of a summary and explanation of current Michigan law. In the event Michigan law and/or the beneficiaries' rights change, the written information provided by SCCMHA will be updated within 90 days of the effective date of such change.
5. In addition, the written information provided by SCCMHA will include items such as the consumer's right to make decisions concerning their mental health care as well as their medical care, including the right to accept or refuse treatment and the right to formulate, at the person served option, advance directives.
6. The person served has the choice whether to execute an advance directive will be documented in the person served medical record, and distributed to the relevant Community Ties Program, Residential Setting, and SCCMHA Crisis Center, as applicable.
7. SCCMHA will not condition the provision of care or otherwise discriminate against a person served based on whether the person served has executed an advance directive.

8. SCCMHA will provide for the education of staff concerning the policies and procedures related to advance directives.
9. SCCMHA will provide community information regarding advance directives.
10. The person served will be informed that complaints concerning non-compliance with the advance directive may be filed with the SCCMHA Office of Recipient Rights or the SCCMHA Office of Regulatory Compliance.

**Definitions:**

Advance Directive:

A written document in which a competent individual gives instruction about his or her health care, (medical or mental) that will be implemented at some future time should that person lack the ability to make decisions for himself or herself, or in which the competent individual designates an individual authorized to make such decisions for them at some future time should that person lack the ability to make decisions for himself or herself

Crisis Plan: A document used by SCCMHA which allows the person served to provide directions for their future care, including decisions affecting their personal life, when they are unable to provide for their own needs due to a hospitalization or incapacitating illness. This document is distinct from an 'Advance Directive' and is not intended to fulfill the requirements for an Advance Directive.

Do-not-resuscitate order (DNRO):

A Do-Not-Resuscitate Order, also known as a 'DNR" or "DNRO," is a special kind of Advance Directive, prepared by a competent adult. The DNRO may direct that if a patient "suffers cessation of both spontaneous respiration and circulation in a setting outside of a hospital, a nursing home, or a mental health facility owned or operated by the Department of Community Health, no resuscitation will be initiated." The document may provide for special instructions for treatment when the person served death is imminent or when the person served is incurable terminally ill.

It is the current position of SCCMHA that staff of Adult Foster Care Homes should be thoroughly trained regarding the concepts of Advance Directives and Do-Not-Resuscitate Orders (DNROs). Staff of such facilities should be thoroughly familiar with the wishes of their individual residents regarding this matter. However, in the event a resident's heart and breathing have stopped, CPR should be initiated, and the home must still contact the local EMS and have a copy of the DNR order available when the EMS arrives. **Be aware that this does NOT constitute legal advice and Adult Foster Care Homes and other contracted providers should contact their own legal counsel regarding this matter.**

Durable Power of Attorney for Health Care (DPAHC):

Also known as a health care proxy, a document in which individual delegates to another person, the patient advocate, the power to make medical treatment and related personal care and custody decisions for them. This form of an advance directive is fully recognized by Michigan courts.

Living will:

A type of advance directive is not legally binding in Michigan. A living will allow an individual to specify what type of treatment they do or do not want at a future date in the event they are unable to participate in their health care decisions. A living will does not designate a patient advocate.

Patient Advocate:

A surrogate designated by a competent adult to make health care decisions on his or her behalf in the event of losing decision-making capacity. The term applies to a person appointed in a Durable Power of Attorney for Healthcare by a presumed competent adult. The Patient Advocate may also be known as the 'agent' or 'proxy.'

Psychiatric Advance Directive (PAD): This document may also be known as an Advance Psychiatric Directive. These documents are like Living Wills. These documents are not legally recognized in Michigan – unless they also appoint a patient advocate.

**References:**

**Michigan Patient Self-Determination Act, Michigan Law PA of 312 of 1990:**

This allows Michigan citizens to establish a Durable Power of Attorney for Health Care in the event a citizen becomes unable to make those decisions.

**Michigan Do-Not-Resuscitate Procedure Act (Public Act 193 of 1996):**

This authorizes Michigan residents to execute orders instructing primarily Emergency Medical Technicians (EMTs) not to resuscitate them if their heart or respiratory functions stop working. This Act responds to the concerns of persons in the latter stages of a serious or terminal illness who have chosen to live out their final days at home or in a hospice.

**Patient Self-Determination Act (PSDA)**:

Effective December 1, 1991, as an amendment to the Omnibus Budget Reconciliation Act of 1990. The PDSA requires many Medicare and Medicaid providers to give adult individuals, at the time of inpatient admission or enrollment, certain information about their rights under state laws governing advance directives, including: (1) the right to participate in and direct their own health care decisions; (2) the right to accept or refuse medical or surgical treatment; (3) the right to prepare an advance directive; (4) information on the provider's policies that govern the utilization of these rights. The act also prohibits institutions from discriminating against a patient who does not have an advance directive. The PSDA further requires institutions to document patient information and provide ongoing community education on advance directives.

**State of Michigan Attorney General Opinion No. 7056** opinion that a guardian of a developmentally disabled adult who is not of sound mind lacks authority under the patient Advocate Act to sign a designation of patient advocate on behalf of the ward. In addition, a guardian of a developmentally disabled adult who is not of sound mind lacks authority under the Michigan Do-Not-Resuscitate Procedure Act to sign a do-not-resuscitate order on behalf of the ward.

**State of Michigan Attorney General Opinion No.** 7009 opinion that the Michigan Do-Not-Resuscitate Act does not authorize a do-not-resuscitate order executed by a person under 18 years of age, or by a patient advocate for a person under 18 years of age.

**State of Michigan Attorney General Opinion No. 6986** opinion that the Adult Foster Care Facility Licensing Act does not require that an adult foster care facility resuscitate its resident whose heart and breathing have stopped and who has executed a valid do-not-resuscitate order pursuant to the Michigan Do-Not-Resuscitate Procedure Act.
**Advance Directive for Mental Health Care** Planning for Mental Health Care in the Event of Loss of Decision-Making Ability

**Exhibits:**
Exhibit A – SCCMHA Fact Sheet regarding Michigan's Do-Not-Resuscitate Procedure Act
Exhibit B – SCCMHA Advanced Directive Acknowledgement

**Procedure:**

| | ACTION | RESPONSIBILITY |
|---|---|---|
| 1. | SCCMHA will maintain current information regarding SCCMHA's legal obligations related to Advance Directives. | 1. Compliance Officer |
| 2. | SCCMHA (PIHP) will provide adult beneficiaries who receive services (by or through SCCMHA as the PIHP) with written information on advance directives at the time of their intake with SCCMHA, unless the individual is unconscious, temporarily unable to provide informed consent, or unable to receive the necessary information. | 2. Intake Staff |
| 3. | Regarding individuals who are unconscious, are temporarily unable to provide informed consent, or unable to receive the above referenced information, arrangements will be made to provide the information to the individual when the circumstances change. | 3. Intake Staff, Primary Worker |
| 4. | The written information provided to adult beneficiaries will include a description of | 4. Compliance Officer, Supervisor of Customer Service |

| | | |
|---|---|---|
| | Michigan law and their rights under Michigan law. | |
| 5. | The enrollee's response whether to execute an advance directive will be documented in the individual's medical record. | 5. Intake Staff |
| 6. | SCCMHA will provide for the education of staff concerning the policies and procedures related to advance directives. | 6. Compliance Officer, Customer Services, Clinical Supervisors |
| 7. | SCCMHA will provide information to the community regarding advance directives. | 7. Compliance Officer, Supervisor of Customer Service |
| 8. | Enrollees will be informed that complaints concerning non-compliance with the advance directive may be filed with the SCCMHA Office of Recipient Rights or the SCCMHA Office of Regulatory Compliance. | 8. Compliance Officer, Supervisor of Customer Service |
| 9. | Community Ties staff and Residential setting providers should make reasonable efforts to be aware of Advance Directives or Do Not Resuscitate Orders for consumers under their care, as well as the contents of the Advance Directive or Do-Not-Resuscitate Order. Individuals with valid DNR orders should be encouraged to wear a bracelet identifying their desires. | 9. Community Ties Staff, Residential setting staff |

Exhibit A

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# SCCMHA Fact Sheet
# Michigan's Do-Not-Resuscitate Procedure Act

**What is an "advance directive?"**

An advance directive is a written document in which a consumer specifies the type of medical care they want in the future, or who they want to make decisions for them should they lose the ability to make decisions for themselves.

## What is A *Do-Not-Resuscitate Order*?

A Do-Not-Resuscitate Order, also known as a 'DNR," is a specific kind of Advance Directive. Some people do not want any special efforts made to prolong their life. The State of Michigan provides guidance in this area under the *Michigan Do-Not-Resuscitate Procedure Act* (MDNRPA). Under Michigan law people may choose to sign a DNR. The DNR Order may direct that if a patient "suffers cessation of both spontaneous respiration and circulation in a setting outside of a hospital, a nursing home, or a mental health facility owned or operated by the Department of Community Health, no resuscitation will be initiated." In other words, the order provides directions to health care professionals regarding the consumer's wishes for medical treatment when death is imminent or during a terminal illness.

**Who May Complete a Do-Not-Resuscitate Form?**

A competent adult who has discussed the issue with his or her physician may complete a DNR Order. "A competent adult" is someone over the age of eighteen, and who is of sound mind. The physician must also sign the order. People whose religion opposes medical treatment do not need a doctor's signature.

**Where are the DNR forms found?**

The forms are available from most hospices.

**What happens to the form after it is signed?**

The form should be placed in a visible place. The person served should tell their family or friends that they have signed a do-not-resuscitate order, and where it can be found. The person served may also choose to wear a do-not-resuscitate bracelet.

**Can a consumer be forced to sign a Do-Not-Resuscitate Order?**

Absolutely not. No one may require it as a condition for care or treatment.

**Can a consumer change their mind after the form is signed?**

Yes. The form may be canceled at any time by any means of communication possible.

**Will the consumer's insurance coverage be affected if they sign a DNR Order?**

No. The law says that an insurance provider cannot change, stop, refuse to renew, or invoke a suicide exemption or exclusion.

**Have Do-Not-Resuscitate Orders changed?**

Yes. Before, they applied only in health care facilities such as hospitals. They did not cover people outside of these facilities, such as terminally ill patients at home. Licensed health care professionals were required to try and revive anyone who had no heartbeat or sign of breathing.

Under current state law, a do-no-resuscitate order is valid outside of a health care facility. A specific bracelet may be worn to signal that an order has been signed. When a valid order is present or the bracelet is worn, an emergency responder cannot start resuscitation.

**Is an adult foster care facility required to resuscitate a resident whose heart and breathing have stopped and who has executed a valid do-not-resuscitate order?**

According to Michigan Attorney General Opinion No 6986, the "Adult Foster Care Facility Licensing Act does not require that an adult foster care facility resuscitate its resident whose heart and breathing have stopped and who has executed a valid do-not-resuscitate order pursuant to the Michigan Do-Not-Resuscitate Procedure Act."

In accordance with the Act, Michigan Attorney General Opinions, the Michigan Assisted Living Association, and SCCMHA, an adult foster care home, which has a person served that has signed a valid DNR Order, may honor the DNR Order. However, the home must still contact the local EMS and have a copy of the order available when EMS arrives.

**What effect does a DNR Order have in an AFC Hospice situation?**

An adult foster care home which has a resident that has signed a valid DNR order and is in a licensed hospice program, does not need to contact the local EMS. However, the home is required to contact the licensed hospice program when the resident suffers cessation of both spontaneous respiration and circulation.

**Is a Provider subject to criminal or civil liability for following a DNR Order?**
When there is a valid DNR Order, a person or organization is not subject to civil or criminal liability for withholding resuscitative procedures from the declarant in accordance with this law.

Information for this Fact Sheet is derived from, and additional information may be found at, the following sources:
Michigan Attorney General Opinions 6986, 7009, and 7056.
http://www.michigan.gov/mdch/0,1607,7-132-2940_3183_4895-19875--,00.html
http://www.med.umich.edu/1libr/aha/umlegal05.htm
http://www.michbar.org/elderlaw/adpamphlet.cfm

**A Product of the SCCMHA Compliance Office**
**August 2015 March 2017 June 2024**

Exhibit B

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# Advance Directive Acknowledgement

Making choices is an important part of our lives. Health care choices are especially important. Some day you may not be able to communicate what your health care choices are. Someone may have to make health care choices for you. An **Advance Directive** is a way to describe the choices you want made in the future. There are three types of Advance Directives.

1. A **durable power of attorney for health care** lets you appoint a patient advocate. Your patient advocate will make health care choices for you if you are not able to make them for yourself. Your patient advocate can make treatment and placement decisions for you. You can describe your choices in writing.

2. A **do-not-resuscitate order (DNR)** is a special advance directive. A DNR describes the medical services you choose to receive when you are terminally ill and in the final stages of life.

3. A **living will** tell health care providers and the courts about your health care choices. Living will usually deal with specific situations. Living wills may not be helpful in all situations. Michigan courts may look at a living will. But the courts do not have to follow what a living will says.

- SCCMHA Customer Services has more information about advance directives. You can contact Customer Services at 797-3452.
- The choice to write an advance directive is completely up to you. The services SCCMHA provides will not be changed by your choice about an advance directive.
- If you create an advance directive, you should give a copy to SCCMHA. We will put it in your medical record.

_____ _____

Signed Date

SCCMHA Staff Only:
In my opinion _____, is unable to understand this information about advance directives currently. The primary worker will follow-up on this material when the person served is able to understand the content.

_____ _____

SCCMHA Staff Date

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></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:<br>1/5/07</td><td>Date of Review/Revision:<br>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, 3/3/23, 4/4/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Children’s Services<br><br>Authored By:<br>Carey Moffett<br><br>Additional Reviewers:<br>Clinical Directors</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, volunteers, 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 | Supervisors |

| | |
|---|---|
| person transporting a child under the auspices of SCCMHA know the requirements of this policy and responsibilities when transporting children and teens. | |
| 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><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></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>Effective Date:<br>6/1/08</td><td>Date of Review/Revision:<br>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, 3/31/23, 3/7/24<br>Supersedes:</td><td rowspan="2">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Services for Persons with Intellectual and Developmental Disabilities<br><br>Authored By:<br>Jennifer-Rieck-Martin<br><br>Additional Reviewers:<br>Clinical Directors, John Burages</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<br>Case Holder<br>or Director of SCCMHA provided program<br>Behavioral Specialist<br>Others as needed or required. |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></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:<br>1/1/06</td><td>Date of Review/Revision:<br>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, 3/6/23, 3/15/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Services for Persons with Intellectual and Developmental Disabilities<br><br>Authored By:<br>Erin Nostrandt<br><br>Additional Reviewers:<br>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 caregiving 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 – 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<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Structured Daytime Activity Programming | **Chapter**: 03 – Continuum of Care | **Subject No**: 03.02.21 |
| **Effective Date**:<br>10/20/17 | **Date of Review/Revision**:<br>2/25/19, 2/26/20, 3/11/21, 3/16/22, 3/2/23, 3/5/24 | **Approved By**:<br>Sandra M. Lindsey, CEO |
| | **Supersedes**: | **Responsible Director:**<br>Executive Director of Clinical Services |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Authored By:**<br>Jennifer Rieck-Martin and Julie Bitterman<br><br>**Additional Reviewers**:<br>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.<br><br>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.<br>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.<br>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.<br>Things to watch for are:<br>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.*<br>2. Things not considered as Structured Daytime Activities as noted above**.<br>3. Outing appropriateness<br>4. Start and end times of activities are being recorded.<br>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. | Case Holder |

| | |
|---|---|
| 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.<br>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.<br>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<br>What has been your level of interest?<br>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<br># 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 Y | Refused N | Start Time | Stop Time | Staff Signature | Consumer Repsonse (1-Dislike 2-Neutral 3-Like) |
|---|---|---|---|---|---|---|---|
| 10/10 | BOWLING | ☐ | ☒ | 9:00 AM | 11:00 AM | Amy Kuhn | 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 | ☐ | ☒ | 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 | ☒ | ☐ | 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 | ☐ | ☐ | | | | |
| Narrative: | | | | | | | |
| 10/24 | MOVIE | ☐ | ☐ | | | | |
| Narrative: | | | | | | | |
| 10/26 | BOWLING | ☐ | ☐ | | | | |
| Narrative: | | | | | | | |
| 10/31 | TRUNK OR TREAT | ☐ | ☐ | | | | |
| Narrative: | | | | | | | |

**HM Review:** **OT Review:** **CM Review:**

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:<br>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:<br>1/23/13</td><td>Date of Review/Revision:<br>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 3/2/23 4/4/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Steve Gonzalez<br><br>Additional Reviewers:<br>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 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 structured daily routine in the residence and include the consumer in this planning step. Minimizing change in daily routines 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. Whenever possible, 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 Community Mental Health Service Provider (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 the residential transition process can be stressful 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:<br>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.<br>2. Consider the consumer's method of communication in order to ensure he/she has the opportunity to express choice and control so that caregiver providing service in that setting can communicate with the consumer.<br>3. Focus on building relationships based on trust, respect, and caring between the consumer and caregivers.<br>4. Establish a structured daily routine in the residence and include the consumer in this planning step. Minimizing change in daily routines adds a level of comfort to the consumer and can help prevent behavior escalation.<br>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.<br>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.<br>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.<br>7. Provide consistent, experienced and well-trained caregivers, especially during the first few weeks after the move.<br>8. Assure the CMHSP and the provider is accessible and supportive of home staff, including on-site visits to the home.<br>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 | |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Behavior Treatment Plans (BTPs)</td><td>Chapter: 03 – Continuum of Care</td><td>Subject No: 03.02.27</td></tr>
<tr><td rowspan="2">Effective Date: 5/16/14</td><td>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, 4/11/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Director of Services for Persons with I/DD<br><br>Authored By: Char Fondren, Barb Glassheim<br><br>Additional Reviewers:<br>SCCMHA Behavior Treatment Plan Review Committee</td></tr>
<tr><td>Supersedes: Behavioral Plans</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 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, which 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:
1. A BTP shall be part of the IPOS and shall require special consent of individual and/or guardian. (See Exhibit C)
2. All planned interventions shall be outlined in the consumer's BTP.
3. Implementation of a BTP shall be documented in progress notes in the consumer's electronic health record in a timely manner.
4. 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 titrated 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 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:

4. 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.)

5. 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).

6. 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 increasingly 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. Additions to the BTP must be approved by the BTPRC *prior* to implementation *if* additional restrictive or intrusive techniques are proposed.
      1). BTP additions 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.
   d. Quarterly reviews shall include:
      1). A completed Request to use Intrusive/Restrictive Interventions(s) in a Behavior Treatment Plan (BTP) form
      2). Baseline data and data for the last three (3) months
      3). A progress summary encompassing the last three (3) months

**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

[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.

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 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, which 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, which 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 to use Intrusive/Restrictive Intervention(s) in a Behavior Treatment Plan (BTP)
I. Recurring Behavior(s) of Concern Checklist – Case Holder
J. BTC Review form

Exhibit A

| Behavior Modification Procedures<br>that do not Require a Behavior Treatment Plan or Authorization by<br>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.<br>• 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.<br>• 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.<br>• 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.<br>**Differential Reinforcement of Other Behavior(s) (DRO)** - is a procedure where any behavior other than the target behavior is reinforced on a periodic schedule<br>**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<br>**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<br>**Differential Reinforcement of Low Rates of Behavior(s) (DRL)** -is a procedure where the infrequent occurrence (rate) of a target behavior is reinforced<br>**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, which 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.<br>a. Verbal prompts are defined as oral sounds or sign language signs presented to a person to cue performance of a specific task<br>b. Gestural prompts are defined as pointing, hand movements, or other body movements presented to a person to cue performance of a specific task<br>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:<br>• Anger Management Techniques/Calming Strategies/Self-Control Activities & Exercises<br>• Social Skills Training<br>• Social Stories<br>• Picture Activity Schedules<br>• Structured Social/Activity Involvement<br>• Daily Positive Interaction Time (with parent or staff member)<br>• Daily/Weekly Outings or Other Rewards (beyond what is specified in the consumer's PCP)<br>• Problem Solving Discussions<br>• Structured Relaxation Training |

| | |
|---|---|
| | • Suggested Relaxation<br>• Teach/Train Positive Activity with Property (for individuals who exhibit property damage)<br>• Nighttime Bed Checks for Enuresis/Encopresis (Toileting Schedule)<br>• Behavioral Contracting/Contingency Contracting<br>• Visual Demonstration of Personal Space (arm's length away)<br>• Compliance Training<br>• 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)<br>• Structured Alone Time<br>• Daily Journaling<br>• 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<br>**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, which 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:<br>• Removal of Inedible Item from Hand/Mouth Area (pica behaviors)<br>• Contingent Apology<br>• Planned Ignore Strategy/Selective Inattention<br>• Non-Exclusionary Required Relaxation<br>• Non-Exclusionary Time-Out Procedure<br>• Meal Interruption of sixty (60) Seconds or More<br>• Stimulus Change<br>• Loss of Privileges<br>• Request to Turn Over Stolen Items |

Exhibit C

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# Behavior Treatment Plan (BTP)
# Special Informed Consent

**Saginaw County Community Mental Health Authority Behavior Treatment Committee (BTC)**

**Consumer Name:** Click or tap here to enter text. **Consumer ID #:** 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: _____



Revised 03/22/2023

*Only include applicable intrusions/restrictions above. Remove those that are not included in BTP.

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<br><br>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<br>*What was happening before the behavior occurred?* | Behavior<br>*What does the behavior of interest look like?* | Consequence<br>*What happened after the behavior was presented?* |
|---|---|---|
| **Date:** _____ **Time:** _____<br>**Describe:** | ☐hit others<br>☐pinch others<br>☐hit self in chest<br>☐spit at others<br>☐bite self<br>☐Other: _____<br>☐Other: _____ | **Describe:** |

| Antecedent<br>*What was happening before the behavior occurred?* | Behavior<br>*What does the behavior of interest look like?* | Consequence<br>*What happened after the behavior was presented?* |
|---|---|---|
| **Date:** _____ **Time:** _____<br>**Describe:** | ☐hit others<br>☐pinch hair<br>☐hit self in chest<br>☐spit at others<br>☐bite self<br>☐Other: _____<br>☐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.

**Submission Date:** Click or tap to enter a date.

**Recurring Behavior(s) of Concern:** *(list all)* Click or tap here to enter text.

**There has been:** ☐ Regression ☐ No Change ☐ Progress

**Reason for BTC Review:** *(check one option below)*

☐ **New** Behavior Treatment Plan (BTP) & Functional Behavior Assessment (FBA) *(must submit BTP & FBA)*
☐ **Amended** Behavior Treatment Plan (requested edits made)
☐ **Quarterly Review** of approved Behavior Treatment Plan *(see Notes/Comments section below)*
☐ Positive Support Plan (PSP) – includes no intrusive/restrictive interventions
☐ Health & Safety Consult
☐ Medication Consult

This an **ABA** Plan? ☐ Yes ☐ No

**Intrusive and/or Restrictive Intervention(s) included in the BTP:**
Please check all that apply from below:

| | | | |
|---|---|---|---|
| ☐ 1:1 Supervision | ☐ Restrict Environment | ☐ Search & Seizure | ☐ Physical Prompt |
| ☐ ABA 2:1 | ☐ Planned Inquiry (i.e. request to see purchases made) | ☐ Overcorrection | ☐ Medication(s) |
| ☐ Restrict Access to Property | ☐ Anatomical/Physical Support Rx MD/PT/OT | ☐ Special Clothing | ☐ Limit Access to Phone |
| ☐ Restitution/Response Cost | ☐ Limited Access to Activity, Environment | ☐ Limit Access to Visits | ☐ Limit Access to Mail |
| ☐ Restrict Access to Money | ☐ Therapeutic De-Escalation (required relaxation) | ☐ Limit Access to Other Persons | ☐ Restrict Access to Viewing, Listening |
| ☐ Protective Device (describe): | Click or tap here to enter text. | | |
| ☐ Other (describe): | Click or tap here to enter text. | | |

**Notes/Comments:** (If this is a **Quarterly Review**, please include baseline data and data for the last 3 months along with your progress summary here.) Click or tap here to enter text.

Exhibit I

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# Recurring 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 recurring 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 recurring 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 recurring 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

# Recurring 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:**<br>• **this Recurring Behavior(s) of Concern Checklist**<br>• **at least 1-month of ABC chart(s)**<br>• **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

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Use of Pro Re Nata (PRN) Psychotropic Medications in Mental Health Settings</td><td>Chapter: 03 - Continuum of Care</td><td>Subject No: 03.02.30</td></tr>
<tr><td rowspan="2">Effective Date:<br>1/21/16</td><td>Date of Review/Revision:<br>3/15/17, 7/28/17, 3/1/18, 6/12/19, 12/10/20, 4/26/2021, 9/3/21, 9/14/22, 5/8/24</td><td rowspan="2">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Chief of Health Services & Integrated Care<br><br>Authored By: Jen Kreiner<br><br>Additional Reviewers:<br>SCCMHA Medical Director, SCCMHA BTC Chair</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 describe the acceptable use of PRN (as needed) medications in mental health settings in accordance with MDHHS regulations to avoid unnecessary exposure to psychotropic medications, or psychotropic medications used as an aversive or intrusive technique.

**Policy:**
It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) that PRN medications shall be prescribed and administered in a manner that respects the rights, dignity, and autonomy for individuals receiving our services.

**Application:**
This policy applies to all licensed prescribers and settings within the SCCMHA service delivery network.

**Standards:**
A. Psychotropic medications, including PRN medications, will be prescribed after a psychiatric evaluation or psychiatric medication review, informed consent process, and determination of medical necessity, not for convenience of caregivers, as a form of punishment, or as a means of restraint.
B. PRN medications shall be used as a last resort to manage deleterious behaviors.
    1. Behavior treatment plans shall be considered first-line interventions for harmful behaviors.

C. 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 Behavior Treatment Plan Review Committee (BTC).
    1. Case Holders shall be required to enumerate failures to respond to behavioral treatment(s) prior to initiating a request for consideration of PRN medications for behavior management.
    2. Case Holders shall submit a completed Recurring Behavior of Concern Checklist to the Chair of the BTC (Exhibit A).
    3. The SCCMHA BTC shall conduct a review of all PRN medications prescribed for managing and/or controlling behavior(s) (Exhibit B).

D. Psychotropic medications will be reviewed by the prescriber at least every 3 months for ongoing efficacy and monitoring for side effects or adverse response.

E. PRN medication orders must include a description of the target symptoms of a diagnosed mental disorder for which the medication is being prescribed, and is to be administered by the caregiver. The Intensity Scale for PRN (Exhibit C) medication use and the Recurring Behavior of Concern Checklist (Exhibit A) will be utilized by caregivers to assist in decision-making and documentation of PRN medication administration.

F. The medication order will include all required prescription information plus the following information:
    a. The condition(s)/symptoms under which and when the PRN medication(s) will be administered.
    b. The minimum interval between doses.
    c. The maximum dose allowed within a twenty-four (24) hour period.

G. All treatment team members are expected to be observant regarding any physical or mental health changes for all persons served, including discomfort and unusual or abnormal signs or symptoms, and to document and seek assistance or treatment as appropriate to the urgency or seriousness of the symptoms.

H. The medication administration record (MAR) will be maintained accurately, and made available for review by the treatment team.

I. The PRN medication review committee will review PRN psychotropic medications for approval and recommendations by the Medical Director.

**Definitions:**

**Medication Administration:** The direct application of a medication by mouth (orally), inhalation, ingestion, transdermal patch, suppository or any other means to the body of a person.

**Psychotropic Medications:** Psychotropic medications, also known as psychiatric or psychoactive drugs, refer to a class of pharmaceutical compounds that are used to treat, manage, or prevent mental health disorders or conditions. They primarily affect brain functions and can alter mood, behavior, cognition, and perception. These medications are typically prescribed by psychiatrists or other medical professionals and include various

types such as antidepressants, antipsychotics, mood stabilizers, stimulants, and anxiolytics. They are typically used in conjunction with other therapies to manage conditions like depression, anxiety, bipolar disorder, schizophrenia, and ADHD.
**Pro Re Nata (PRN)**: As needed (Latin).

**References:**


A. Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration. (July 29, 2020). *Technical Requirement for Behavior Treatment Plans*. MDHHS: **https://www.michigan.gov/documents/mdhhs/Technical_Requirement_for_Behavior_Treatment_Plans_P-1-4-1_638408_7.pdf**.
B. *Michigan Medicaid Provider Manual* (MDHHS): **https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf**.
C. SCCMHA Policy 03.02.08 – Behavioral Interventions
D. SCCMHA Policy 03.02.09 – Behavior Treatment Plan Review Committee (BTPRC)
E. SCCMHA Policy 03.02.10 – Clinical Risk Committee
F. SCCMHA Policy 03.02.20 – Medication Review
G. SCCMHA Policy 03.02.27 – Behavior Treatment Plans (BTPs)


**Exhibits:**

A. Recurring Behavior of Concern Checklist
B. SCCMHA PRN and/or Medication Review form
C. PRN Intensity Chart
D. PRN Medication Review Committee Form

**Procedure:**

None

Exhibit A

# Recurring Behavior of Concern Checklist

**Consumer Name:** Click or tap here to enter text. **ID#:** Click or tap here to enter text. **Case Holder:** Click or tap here to enter text.

| **Before implementing a Positive Support Plan, please review the following:** | **Check Box** | **Insert Date or N/A** |
|---|---|---|
| What has changed with consumer (recurring behavior)? | ☐ | |
| Time frame change has occurred with consumer: | ☐ | |
| Possible Trauma explanations for the behavior? | | |
| What is target behavior identified? | | |
| o Sensory: | ☐ | |
| o Escape: | ☐ | |
| o Attention: | ☐ | |
| o Tangible: | ☐ | |
| When was last appointment with Primary Care Physician? | ☐ | |
| o What was outcome of appointment? | ☐ | |
| o Labs – when completed last? | ☐ | |
| Schedule an appointment for Primary Care Physician to rule out Medical | ☐ | |
| Nurse Assessment: | ☐ | |
| o Rule out change in physical health | ☐ | |
| ***Once Medical has been ruled out – Implement ABC chart(s) for recurring behavior(s) of concern*** | | |
| OT Assessment: | ☐ | |
| o Rule out Sensory | ☐ | |
| o Rules out environment causes to behavior | ☐ | |

Revised 5/13/2021

| | | |
|---|---|---|
| PT Assessment: | ☐ | |
| ○ Exercises and equipment to help regain or improve physical ability | ☐ | |
| ○ Assist with improving/enhancing body mechanics | ☐ | |
| Dietary Assessment: | ☐ | |
| ○ Rule out need of modification of diet | ☐ | |
| Speech Assessment: | ☐ | |
| ○ Improve on speech and ability to understand & express language, including nonverbal language | ☐ | |
| ○ Rule out swallowing disorder | ☐ | |
| ○ Rule out communication barrier | ☐ | |
| Evidence of prior interventions for challenging behavior (list): | | |
| **Once all the above have been ruled out and ABC charts have been collected:** | | |
| Prepare a Positive Support Plan (if needed, request Psychological Consultation) | ☐ | |
| Request Functional Behavioral Assessment (if restrictive or intrusive interventions are needed) | ☐ | |

Click or tap to enter a date.

Click or tap to enter a date.

X _____

Case Holder Signature

X _____

Unit Supervisor Signature

Revised 5/13/2021

Exhibit B

☐ ***Expedited Review*** ***(needed within 24 – 48 hours)*** Click or tap to enter a date.

If not expedited, please return within 7 business days from date above.

# PRN and/or Medication Review

Saginaw County Community Mental Health Authority Behavior Treatment Committee

**Prescriber:** Click or tap here to enter text.

| | |
|---|---|
| **Consumer Name:** Click or tap here to enter text. | **ID#:** Click or tap here to enter text. |
| **DD Diagnosis:** Click or tap here to enter text. | |
| **MI Diagnosis:** Click or tap here to enter text. | |
| **Medical Diagnosis:** Click or tap here to enter text. | |
| **PRN Medication(s):** Click or tap here to enter text. | |
| **CMH Prescribed Medication(s):** Click or tap here to enter text. | |
| **Non CMH Medication(s):** Click or tap here to enter text. | |
| **Medications and how they can be used for off label:** Click or tap here to enter text. | |
| **Medications Appropriate for Diagnosis:** Click or tap here to enter text. | |

****MSHN/MDHHS seeking correlation between diagnosis and prescribing of PRN and psychotropic medications.***

**PRN Prescribed for Behavior(s):** Click or tap here to enter text.

**PRN Prescribed for Agitation:** Click or tap here to enter text.

**Medication Review Documentation:** Click or tap here to enter text.

**Seizure Medication for Controlling Behaviors:** Click or tap here to enter text.

**Functional Assessment Completed:** Click or tap here to enter text.

**Positive Support Plan Developed:** Click or tap here to enter text.

**Have all environmental and/or enhance supports been tried (Speech, OT, PT, RN, RD):** Click or tap here to enter text.

**Other options explored (therapy) before prescribing medications:** Click or tap here to enter text.

**How frequent are behaviors occurring (review incident reports):** Click or tap here to enter text.

**Incident Report Dates:** Click or tap here to enter text.

Revised 5/25/2021

**Additional Information:** Click or tap here to enter text.

**Prescriber Feedback on PRN and/or Medication(s):**

☐Current medications are at the fewest number of medications, are ≤ standard dosages for optimum functioning, are not considered intrusive, and are being prescribed to address specific diagnoses consistent with DSM 5

☐Attempts to lower the number and dosage have occurred in the past and I have determined they are currently at an acceptable maintenance level

☐Consumer is currently undergoing medication titration

☐Medications will be reduced in number to eliminate multiple classes (list medications to be phased out below)

☐PRN medications for behavior have been reviewed any changes have noted below

**Prescriber Comments:** Click or tap here to enter text.

***REQUIRED:** **Prescriber's justification for prescribing medications that are NOT diagnosis specific:**

Click or tap here to enter text.

Click or tap to enter a date.

X _____

Prescriber Signature

*Section below to be filled out by BTC Chairperson/Designee:*

**Sent to Recipient Rights:** ☐ Acknowledged & Reviewed

**BTC Reviewed PRN and/or Medication(s) on** Click or tap to enter a date.

☐ **Approved** ☐ **Denied** **Review at BTC Meeting:** Click or tap to enter a date.

**Rational indicating that this plan requires immediate/continued implementation due to a current emergent situation that would be present if the restriction were to be immediately removed:** Click or tap here to enter text.

**Committee Feedback/Next Steps:** Click or tap here to enter text.

Revised 5/25/2021

Exhibit C

## Intensity Scale for PRN

| | | |
|---|---|---|
| 5 | I AM GOING TO EXPLODE!!! | Hitting others, throwing items, breaking items, pushing, biting, kicking, physical aggression, etc. |
| 4 | I am getting angry. | Verbal aggression, yelling, swearing, talking loudly, using middle finger, making gestures, calling names, stomping around, etc. |
| 3 | I am a little nervous. | Starts pacing, rocking back and forth, hand slapping, talking to self, will notice a slight change in my mood, etc. |
| 2 | I am feeling ok. | Not feeling happy, feeling bored, can sit or stay where I am, able to control myself, etc. |
| 1 | I am feeling calm and relaxed. | Smiling, engaging with others, watching TV or listening to music, talking to others, participating in activities, etc. |

**Stages 2 & 3:** If intervention does not occur, it can lead to behavior. Positive intervention or redirection is needed to help reduce anxiety and behavior. If there is an increase from 2 to 3 and a PRN is prescribed, give the PRN at 3.

*Please add to the Assessment and Individual Plan of Service consumer's precursors and/or antecedents that indicate symptoms/signs for each level above. This will assist community living staff and/or family with implementing positive interventions and/or redirection.

4/23/2024

Exhibit D

# PRN and/or Medication Review

Saginaw County Community Mental Health Authority Behavior Treatment Committee

**Consumer Name:** _____ **ID#:** _____

**Prescriber:** _____

**Peer Review Feedback:**

☐ Medications are appropriate for diagnosis and are prescribed within the standard of care.

☐ Medications may be intrusive/restrictive because: (check all that apply)

- ☐ Multiple classes of medications
- ☐ Medications(s) not standard for the diagnosis
- ☐ Higher than standard dosage(s)
- ☐ Individual has been on meds for behavior for 18 months (or longer) and behaviors persist
- ☐ Other (explain): _____

Comments: _____

_____

_____

***REQUIRED*** Justification for prescribed medications that are NOT diagnosis specific:

_____

_____

_____ _____

Dr. Ibrahim Date

Revised 4/3/2023

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>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, 4/11/23, 4/4/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Barbara Glassheim<br><br>Additional Reviewers:<br>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 to 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: https://store.samhsa.gov/sites/default/files/d7/priv/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, Amended September 17, 2021). *Informed Consent for Clinical Treatments and Procedures. VHA Handbook 1004*


[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*

**Exhibits:**
None

**Procedure:**
None

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>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 rowspan="2">Effective Date:<br>5/26/16</td><td>Date of Review/Revision:<br>2/16/21, 3/16/22, 5/24/23, 3/12/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Allison Kalmes, Monique Taylor-Whitson, Diane Cranston (Genoa)<br><br>Reviewed By:<br>Erin Nostrandt, Jennifer Keilitz</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 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 disorder (SED), 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, appearance of the medication, and how and when to take 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, unless a court order specifies a frequency and duration. If the consumer is prescribed medications that are to be taken three (3) or more times a day, the MED DROP™ Staff will leave dosages with the parents/guardians. The Treating Prescriber/Primary Case Holder is notified that medications are being left at the home. If the consumer is in school and medications are to be taken during school hours, medication will be delivered weekly to the school and be administered per the school's policy. Medication drops occur in the AM typically between the hours of 8:00 AM and 11:00 AM and in the PM typically between the hours of 5:00 PM to 8:00 PM. Drops occur 365 days a 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 with the

consumer/parent/guardian/authorized adult. 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, currently receiving psychiatric services from an SCCMHA prescriber, have eligible CAFAS item numbers, and at least one (1) of the following is 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 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 drops 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
Exhibit F: Genoa CAFAS Score Eligibility for the MDS Program for Children

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| Determine the least restrictive means of ensuring medication compliance for | Primary Case Holder |

| | |
|---|---|
| children having trouble taking their medications as prescribed. Additionally, the consumer's parent/guardian agrees to 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<br>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 | MED DROP™ Program Coordinator<br>Primary Case Holder |

| | |
|---|---|
| DROP™ Program Coordinator. Communication between the MED DROP Program Coordinator and the 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 The Program Orientation Session is facilitated by the MED DROP™ Program Coordinator. | Primary Case Holder<br>MED DROP™ Program Coordinator |
| 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 Coordinator |
| 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 |
| Complete daily documentation in Sentri II system for all medication drops 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 | MED DROP™ Program Coordinator |

| | |
|---|---|
| consumers participating in the MED DROP™ Program for Children. Form 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<br>MED DROP™ Program Coordinator |

Exhibit A

## MED DROP Program Overview - CHILDREN

### Clients who could benefit from the MDS Program: (Children Ages 7-17)

- ✓ Clients Exiting Hospital/having frequent Behavioral Health Admits.
- ✓ Clients with a LARGE volume of medication.
- ✓ Clients/Guardians with confusion about their meds or poor organization of meds.
- ✓ Clients with active clinical symptoms or those decompensating.

****CLIENTS CANNOT HAVE CLS STAFFING AND BE IN THE MED DROP PROGRAM****

### Process of Beginning Medication Drop Services:

1. Submit a referral to Med Drop Coordinator.
2. Request an authorization for the Med Drop Program.
    a. **ALL MEDS MUST BE TRANSFERRED TO GENOA, BILLED and FILLED in DISPILL PACKAGING BEFORE DROPS CAN OFICIALLY BEGIN**
3. Complete Assessment of needs with Coordinator via phone.
4. Coordinator & CSM/SC set up intake. (At least 2 days out)

****All clients that are in the medication drop program must have the following included in their IPOS:**

"The parent/guardian/authorized adult is responsible for passing scheduled medications to the child (client) and observing the child ingest those scheduled medications. If the child has any untaken medications, the parent/guardian/authorized adult will return these to Med Drop Staff at next scheduled drop."

### Requesting the Authorization:

- Authorization Under: Genoa Healthcare, LLC Child Med Administration (4700)
  ***(Authorizations are generally requested for a 3 month period)***

- **H0031**: 1 unit for the initial program orientation (Intake)
- **H2015**: (CLS Units) If 1 drop per day 94 units (4 are in case of the need of special drops). If 2 drops per day 180 units.
- **H0032 TS** – 2 units (Treatment Planning sessions) This is for meetings between Med Drop Coordinator, CSM, Parent/Guardian and Client or for Med Drop Coordinator to attend med reviews.

### For the Intake (Which is to be at client's home):

- Medications are required to be filled at Genoa Pharmacy in order for the intake to take place.
- Case managers/Supports coordinators are expected to be physically present along with the parent/guardian and client. (When both parents have custody of the child, it is preferred that both parents are present)
- Intakes last approximately 45 minutes to an hour and half.
- Drops are scheduled minimally two days after the intake occurs.

*****Please be aware that the required time of a drop is 15 minutes, and the consumer and guardian/authorized adult must be present at the drop. Guardian/Authorized Adult will dispense med *****

Exhibit B

**MED DROP™ Program- Children**
**Program Referral Form**

Date: _____

**Child's Information:**

Name: _____ DOB: _____

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?

Exhibit F


**CAFAS Score Eligibility for the MDS Program for Children**

**Age:** The child is between the ages of 7 and 17. Children 6 and under are excluded. If a child is 18 or turns 18, he or she is to be referred to the Adult MDS Program. **AND**

**CAFAS:** The child is to have a CAFAS administered within 90 days of the referral. If the current CAFAS is more than 90 days old, the primary clinician will administer a CAFAS prior to submitting the referral.

If the child has any of the following CAFAS items, he/she is **NOT** eligible for the MDS Program:

| Subscale Title | Item Number | Reason for Exclusion |
|---|---|---|
| **School/Work** | 003 | Aggressive toward others-could be teachers (authority figures) or peers |
| | 004 | Aggressive toward teachers (authority figures) or peers |
| | 006 | Chronic truancy- if a medication dosage is prescribed during the day, most likely child will not be at school to take the meds- not cost effective for the MDS Provider. |
| | 007 | Chronic absences- if a medication dosage is prescribed during the day, most likely child will not be at school to take the meds-not cost effective for the MDS Provider. |
| | 014 | Frequently truant- if a medication dosage is prescribed during the day, most likely child will not be at school to take the meds-not cost effective for MDS Provider. |
| | 015 | Frequent absences from school- - if a medication dosage is prescribed during the day, most likely child will not be at school to take the meds-not cost effective for MDS Provider. |
| **Home** | 043 | Aggressive toward household members |
| | 044 | Aggressive toward household members |
| | 045 | Parent has no control over the child |
| | 048 | Running away from home-not cost effective for MDS Provider |
| | 054 | Running away from home-not cost effective for |

| | | |
|---|---|---|
| | | MDS Provider |
| **Subscale Title** | **Item Number** | **Reason for Exclusion** |
| **Community** | No Exclusions | --------- |
| **Behavior Toward Others** | 089 | Aggressive toward others |
| **Moods/Emotions** | 119 | Suicidal Intent- beyond scope of MDS Program |
| **Self-Harmful Behavior** | 142, 143, 144 | Risk for Self-Harm- beyond scope of MDS Program |
| | 146,147 | Risk for Self-Harm-beyond scope of MDS Program |
| **Substance Use** | 160, 161 | Teenage Pregnancy -beyond scope of MDS Program |
| **Thinking** | No Exclusions | ------- |

**Home- 041** is acceptable under the following conditions: 1) The child is living in Saginaw County and 2) The child's parent authorizes the adult in the household where child is staying to observe the child self-administering his/her medications and 3) The authorized adult is willing to participate in the program and engage in the educational component of the program. The educational component consists of medication education and identifying and implementing medication organizational strategies.

**Home-046** is acceptable under the following condition: The child needs constant monitoring due to impulsive behavior versus aggression toward others. If the child is aggressive toward adults (including parents/guardians) in the household, he/she is excluded from the program.

**Home-047** is acceptable under the following condition: The child needs supervision due to impulsive behavior versus aggression toward others. If the child is aggressive toward adults (including parents/guardians) in the household, he/she is excluded from the program

**Home-051** is acceptable on a "trial basis" for 30 days. After the initial 30 days, the "trial basis" can be extended for another 90 days if the child's adherence rate is 59% or less (non-adherent rate). It may not be cost effective for MDS Provider due to the child not being available for scheduled med drops.

**Behavior Toward Others- 097** is acceptable; however, if the child displays an angry outburst in the presence of the MDS Staff, depending upon the intensity of the outburst, the child may be discharged from the program on the basis of the potential for the outburst escalating to physical aggression or threats of physical aggression toward an authority figure, including the MDS Staff.

**Self-Harmful Behavior-149** is acceptable; however, if there is any escalation of the self-harmful behavior, even one incident, the child will be discharged from MDS Program. Self-Harmful behaviors are beyond the scope of the MDS Program.

**AND Child and/or Parent(s)/Guardian(s) meets one (1) of the following referral reason(s): (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): _____

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<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:<br>5/5/16</td><td>Date of Review/Revision:<br>6/13/17, 4/10/18, 4/9/19, 7/29/20, 5/10/22, 4/11/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Barbara Glassheim<br><br>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 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, resources permitting, 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.

**Diversity:** Differences in geographic location (rural, urban), sexual orientation, age, religion or spiritual practice, socioeconomic status, and physical and mental capacity.

**Ethnicity**: A population or group having a common cultural heritage that is distinguished by customs, characteristics, language, and common history.

**References:**


A. Cross, T., Bazron, B., Dennis, K., and Isaacs, M. (1989). *Towards A Culturally Competent System of Care Volume I.* Georgetown University Child Development Center, CASSP Technical Assistance Center. Washington, D.C. [On-line]. Available: https://spu.edu/~/media/academics/school-of-education/Cultural%20Diversity/Towards%20a%20Culturally%20Competent%20System%20of%20Care%20Abridged.ashx

B. National Association of State Mental Health Program Directors (NASMHPD). (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives.* National Association of State Mental Health Program Directors. Alexandra, VA. NTAC. [On-line]. Available: http://www.azdhs.gov/bhs/pdf/culturalComp/ccna.pdf.

C. Saginaw Chippewa Indian Tribe Behavioral Health Programs: http://www.sagchip.org/behavioralhealth/#.VzXvivkrKpA.

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

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Serving LGBTQIA+ Consumers</td><td>Chapter: 03 – Continuum of Care</td><td>Subject No: 03.02.35</td></tr>
<tr><td rowspan="2">Effective Date:<br>5/5/16</td><td>Date of Review/Revision:<br>6/13/17, 4/10/18, 4/9/19, 8/21/20, 4/8/21, 5/10/22, 4/11/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Barbara Glassheim, Heidi Wale Knizacky<br><br>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 provide basic information regarding LGBTQIA+ 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 (LGBTQIA+) are provided with high-quality, culturally competent services and supports.

**Policy:**

SCCMHA recognizes that health disparities among LGBTQIA+ individuals, including higher rates of sexually transmitted infections (STIs), HIV, depression, anxiety, suicidality, tobacco use, and substance use disorders, result from bias presented at individual, interpersonal, social, and structural levels. SCCMHA also recognizes that it is especially important to build rapport as a way to counteract the exclusion, discrimination, and stigma that many LGBTQIA+ people have historically experienced in health care settings. SCCMHA further recognizes that providers need to be aware of their own implicit biases that may affect the way they interact with LGBTQIA+ people they serve.

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 LGBTQIA+ in a manner that promotes consumer engagement and shared decision-making.

**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 LGBTQIA+.
   1. SCCMHA shall create a safe and welcoming atmosphere safe for LGBTQIA+ 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 LGBTQIA+ people.

D. SCCMHA shall deliver services and supports that are LGBTQIA+-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 LGBTQIA+ does not imply need for treatment, individuals who are LGBTQIA+ 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 LGBTQIA+ 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. LGBTQIA+-affirmative values shall be reflected in employee training, supervision, and evaluation.

F. SCCMHA shall include topics regarding LGBTQIA+ cultures and communities during cultural awareness and competency trainings.

1. SCCMHA shall provide staff education regarding the LGBTQIA+ population.
2. Training will encourage culturally affirmative environments of care for LGBTQIA+ consumers and family members.

G. SCCMHA shall promote LGBTQIA+ tolerance in the community and speak out against discrimination and intolerance.
   1. SCCMHA shall forge relationships with LGBTQIA+ 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 LGBTQIA+ people, and to foster a deeper sense of heritage and community.

H. SCCMHA recognizes the dangers of conversion or "reparative" therapy for LGBTQIA+ people and does not provide or support it; SCCMHA supports only those therapies that affirm the identities of LGBTQIA+ 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 LGBTQIA+ needs.
   1. SCCMHA shall ensure that all family services are available for domestic partners and significant others of LGBTQIA+ consumers.

L. SCCMHA providers shall avoid inadvertently outing LGBTQ+ consumers to others, including to the families of youth being served.

**Definitions:**

***Note:*** *Discussion of topics that have a history of oppression (such as LGBTQIA+ experiences) creates localized and covert communication. As conversations become increasingly open and inclusive, more accurate terms are identified and disseminated. 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 or who does not experience gender as a primary identity component.

**Ally:** A person who identifies as heterosexual and cisgender but is connected to or a part of the LGBTQIA+ community and is an advocate of rights for LGBTQIA+ 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.

**Aromantic:** A person who experiences little or no romantic attraction to others, and/or lacks interest in forming romantic relationships. Aromantic people may still have intimate relationships.

**Asexual:** An individual who does not identify with any sexual orientation because they do not experience sexual attraction; a person who experiences little or no sexual attraction to others. Asexual people may still engage in sexual activity.

**Assigned Female at Birth/Assigned Male at Birth:** The sex that is assigned to an infant, most often based on the infant's anatomical and other biological characteristics. Commonly abbreviated as AFAB (assigned female at birth) or AMAB (assigned male at birth).

**Bigender:** A person who has two genders; exhibiting cultural and/or physical characteristics of male and female roles.

**Binding:** The process of tightly wrapping one's chest in order to minimize the appearance of having breasts. This is achieved through use of constrictive materials such as cloth strips, bandages, or specially designed undergarments, called binders.

**Biphobia:** Discrimination towards, fear, marginalization, and hatred of bisexual people, or those who are perceived as bisexual. Individuals, communities, policies, and institutions can be biphobic.

**Bisexual:** An individual who is attracted to people of both genders or 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.

**Bottom:** A slang term for genitals and buttocks. Also used to refer to the receptive partner in anal sex.

**Bottom Surgery:** Slang term for gender-affirming genital surgery.

**Chosen Name/Name Used:** The name a person goes by and wants others to use in personal communication, even if it is different from the name on that person's insurance or identification documents (e.g., birth certificate, driver's license, and passport). Use of the term 'chosen name' is recommended over 'preferred name.' The terms Chosen Name or Name used can be put on patient health care forms alongside Name on your insurance (if different) and Name on your legal identification documents (if different). In conversation with patients, health care staff can ask, "What name do you want us to use when speaking with you?", or "What is your chosen name?"

**Cisgender:** An individual who identifies with the gender assigned to them at birth; someone who is not transgender. The term cisgender comes from the Latin prefix cis, meaning "on the same side of."

**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.
**Drag:** The theatrical performance of a gender or multiple genders that are not your own. Performers are called Drag Kings and Drag Queens. Most drag performers are cisgender. The terms Drag King and Drag Queen can also be used as an insult.
**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.
**Enby/N.B.:** Non-binary. Refers to individuals and social systems that do not limit their experience and understanding of gender as being restricted to only male and/or female.
**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 sexual relations with someone of the same sex, the opposite sex, or may not have sexual relations.
**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 Affirmation:** The process of making social, legal, and/or medical changes to recognize, accept, and express one's gender identity. Social changes can include changing one's pronouns, name, clothing, and hairstyle. Legal changes can include changing one's name, sex designation, and gender markers on legal documents. Medical changes can

include receiving gender-affirming hormones and/or surgeries. Although this process is sometimes referred to as transition, the term gender affirmation is recommended.

**Gender-Affirming Chest Surgery:** Surgeries to remove and/or construct a person's chest to be more aligned with that person's gender identity. Also referred to as top surgery. Types of chest surgeries include feminizing breast surgery (breast augmentation, chest construction, or breast mammoplasty) and masculinizing chest surgery (mastectomy and chest contouring).

**Gender-Affirming Genital Surgeries:** Surgeries that help align a person's genitals and/or internal reproductive organs with that person's gender identity, including: clitoroplasty (creation of a clitoris); hysterectomy (removal of the uterus; may also include removal of the cervix, ovaries, and fallopian tubes); labiaplasty (creation of inner and outer labia); metoidioplasty (creation of a masculine phallus using testosterone-enlarged clitoral tissue); oophorectomy (removal of ovaries); orchiectomy (removal of testicles); penectomy (removal of the penis); phalloplasty (creation of a masculine phallus); scrotoplasty (creation of a scrotum and often paired with testicular implants); urethral lengthening (to allow voiding while standing); vaginectomy (removal of the vagina); vaginoplasty (creation of a neo-vagina); and vulvoplasty (creation of a vulva).

**Gender-Affirming Hormone Therapy:** Feminizing and masculinizing hormone treatment to align secondary sex characteristics with gender identity.

**Gender-Affirming Surgery (GAS):** Surgeries to modify a person's body to be more aligned with that person's gender identity. Types of GAS include chest and genital surgeries, facial feminization, body sculpting, and hair removal.

**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 Diverse:** The community of people who fall outside of the gender binary structure (e.g., non-binary, genderqueer, gender fluid people).

**Gender Dysphoria:** Distress experienced by some people whose gender identity does not correspond with their sex assigned at birth.

**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. A person who is gender fluid may always feel like a mix of more than one gender but may feel more aligned with a certain gender some of the time, another gender at other times, both genders sometimes, and sometimes no gender at all.

**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 or Gender Queer :** 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. Also refers to societal pressure for everyone to look and act in a stereotypically heterosexual way. Heteronormativity can manifest as heterosexism, the biased belief that heterosexuality is superior to all other sexualities.
**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 LGBTQIA+ people by causing internalized homophobia, shame, and a negative self-concept.
**Heterosexual ("Straight"):** A person who is attracted to people of the other binary 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 sexual relations.
**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 LGBTQIA+ 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**.** Individuals, communities, policies, and institutions can be homophobic.
**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 sexual relations 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 LGBTQIA+ people in reaction to society's homophobia and discrimination due to their acceptance and belief of the negative messages of the dominant group regarding LGBTQIA+ 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. Individuals 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.

**Intersectionality:** The idea that comprehensive identities are influenced and shaped by the interconnection of race, class, ethnicity, sexuality/sexual orientation, gender/gender identity, physical disability, national origin, religion, age, and other social or physical attributes.

**"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 used by some to include *allies* and in other uses refers to *asexual*. In recent years, usage of this acronym has evolved in widening circles to *LGBTQ+2-S,* where *Q* represents *queer* or *questioning*; *I* represents *intersex*; and *2-S* refers to the Native American term that means *two-spirit*.

**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.
**LGBTQIA+:** An acronym for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and other sexual and gender minorities.
**LGBTQIA2S+:** An acronym that stands for Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual and Two-Spirit.
**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 girl/woman.
**Men Who Have Sex with Men/Women Who Have Sex with Women (MSM/WSW):** Categories used in public health research and programs to describe people who engage in same-sex sexual behavior, regardless of how they identify their sexual orientation. People rarely use the terms MSM or WSW to describe themselves.
**Minority Stress:** The chronic stress experienced by LGBTQIA+ 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 LGBTQIA+ people results in negative mental health outcomes. Minority stress is caused by external, objective events and conditions, expectations of such events, the internalization of societal attitudes, and/or concealment of one's sexual orientation or gender identity. Minority stress is compounded when a person holds multiple marginalized identities.
**Misgender:** To refer to a person by a pronoun or other gendered term (e.g., Ms./Mr.) that incorrectly indicates that person's gender identity.
**Non-Binary:** A person whose gender identity falls outside of the traditional gender binary structure of girl/woman and boy/man. Sometimes abbreviated as NB or *enby*.
**Open Relationship:** A relationship between two partners who consensually agree to non-monogamy (i.e., intimacy outside the primary partnership).
**Outing:** Involuntary or unwanted disclosure of another person's sexual orientation or gender identity.
**Pangender:** A person whose gender identity is comprised of many genders or falls outside the traditional cultural parameters that define gender.
**Pansexual:** A person who does not consider the gender label of others as a criterion for determining sexual or romantic attraction; a person who is emotionally and physically attracted to people of all gender identities, or whose attractions are not related to other people's gender.
**Polyamorous:** A sexual and/or romantic relationship comprising three or more people; a person in a polyamorous relationship. Sometimes abbreviated as *poly*.
**Pronouns:** The words people should use when they are referring to a person, but not using their name. Examples of pronouns are she/her/hers, he/him/his, and they/them/theirs. The appropriate phrasing is "What are your pronouns?" when seeking this information.
**QPOC:** An acronym that stands for Queer Person of Color or Queer People of Color.
**Queer:** An umbrella term used by some LGBTQIA+ 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 LGBTQIA+ individuals, some members of the LGBTQIA+ 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 (SGL):** 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.
**Same-Sex Attraction/Attracted (SSA):** The experience of a person who is emotionally and/or physically attracted to people of the same sex or gender but does not necessarily engage in same-sex sexual behavior. This term is used most commonly by people who live in religious communities that are not accepting of LGBTQIA+ identities. People who use SSA as an identity term may not feel comfortable with the terms gay, lesbian, queer, or bisexual.
**Sex:** A biological construct that is based primarily on physical attributes such as chromosomes, external and internal genital and reproductive anatomy and hormones.
**Sex Assigned at Birth:** The sex (male or female) assigned to an infant, most often based on the infant's anatomical and other biological characteristics. Sometimes referred to as birth sex, natal sex, biological sex, or sex; however, sex assigned at birth is the recommended term.
**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 in relation to their own gender. 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).
**Social Stigma:** Negative stereotypes and lower social status of a person or group based on perceived characteristics that separate that person or group from other members of a society.
**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.
**Structural Stigma:** Societal conditions, policies, and institutional practices that restrict the opportunities, resources, and well-being of certain groups of people.
**Top:** A slang term for the chest. Also refers to the insertive partner in anal sex.
**Top Surgery:** Slang term for gender-affirming chest surgery.
**Transfeminine:** A person who was assigned male sex at birth and identifies with femininity to a greater extent than with masculinity.
**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 a different gender group; those who seek gender-affirming 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 / Trans 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." Some transgender males identify their gender as "transgender male," whereas others identify their gender as simply "male."
>
> **Transgender Woman / Trans 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." Some transgender females identify their gender as "transgender female," whereas others identify their gender as simply "female."

**Trans Masculine:** A person who was assigned female sex at birth and identifies with masculinity to a greater extent than with femininity.

**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. Individuals, communities, policies, and institutions can be transphobic.

**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. This term is most often used to describe the subgroup of transgender individuals who seek out or desire medical interventions to make their body more gender congruent with their internal gender identity through surgery and/or hormonal treatment. Transsexuals may be heterosexual, bisexual or homosexual in their orientation. Some people experience the term transsexual as pejorative, and the term *transgender* should be used unless an individual specifically asks to be described as transsexual.

**Trauma-Informed Care:** An organizational structure and treatment framework that centers on understanding, recognizing, and responding to the effects of all types of trauma.

**Tucking:** The process of hiding one's penis and testes with tape, tight shorts, or specially designed undergarments.

**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. This culture-specific term is used among some Native American, American Indian, and First Nations people.

**References:**

A. Intersex Society of North America: www.isna.org/faq

B. Lucksted, A., Elven, J., Pendegar, E. (Undated). *Enhancing Cultural Competence: Welcoming Lesbian, Gay, Bisexual and Transgender Clients in Mental Health Services.* [On-line]. Available: http://medschool.umaryland.edu/facultyresearchprofile/uploads/59eabd4ebe674d01ae00ebfad157c442.pdf.
C. Movement Advancement Project (2019). *Where We Call Home: LGBT People in Rural America.* Boulder, CO. [On-line]. Available: https://www.lgbtmap.org/file/lgbt-rural-report.pdf.
D. NAMI and the UPenn Collaborative on Community Integration and National Alliance on Mental Illness. (2009). *GLBTQI Mental Health: Recommendations for Policies and Services*. [On-line]. Available: https://www.naminys.org/images/uploads/pdfs/GLBTQI%20Mental%20Health%20Recommendations%20for%20Policies%20and%20Services.pdf.
E. National Association of Social Workers. (2015). *Sexual Orientation Change Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender Persons.* Washington, DC. [On-line]. Available: https://www.socialworkers.org/LinkClick.aspx?fileticket=IQYALknHU6s%3D&portalid=0
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.
K. Substance Abuse and Mental Health Services Administration. (2013). *Building Bridges: LGBT Populations: A Dialogue on Advancing Opportunities for Recovery from Addictions and Mental Health Problems.* Substance Abuse and Mental Health Services Administration. Rockville, MD.: https://store.samhsa.gov/shin/content/SMA13-4774/SMA13-4774.pdf.
L. Substance Abuse and Mental Health Services Administration. (2015). *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth.* SAMHSA. Rockville, MD.: https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4928.pdf.
M. The Center for Counseling Practice, Policy, and Research. (2009). *ALGBTIC Competencies for Counseling LGBQIQA*. American Counseling Association. [On-line]. Available: https://www.counseling.org/docs/default-source/competencies/algbtic-competencies-for-counseling-lgbqiqa.pdf?sfvrsn=1c9c89e_14.

**Exhibits:**
None

**Procedure:**
None

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Psychiatric Hospitalization of Consumers with Intellectual and Developmental Disabilities and Children with Autism</td><td>Chapter: 03 – Continuum of Care-Integrated Service System</td><td>Subject No: 03.02.39</td></tr>
<tr><td rowspan="2">Effective Date:<br>10/1/2019</td><td>Date of Review/Revision:<br>6/1/20, 3/19/21, 4/27/22, 3/2/23, 4/4/24</td><td rowspan="2">Approved By:<br>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:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Director of Network Services, Public Policy and Continuing Education & Director of Services for Persons with Intellectual and Developmental Disabilities<br><br>Additional Reviewers:<br>Residential Watch Committee, Supervisor of Crisis Services, Autism Program Supervisor</td></tr>
</table>

**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 Saginaw County Community Mental Health Authority (SCCMHA) to provide services to all individuals in the least restrictive setting. Since psychiatric 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. Case holders should complete a Health and Safety Regulation form with consumer, home staff, family and/or guardian to determine how consumer presents on a good day, how consumer presents when not feeling well, how consumer presents when becoming worried or anxious, and how consumer presents when angry or agitated. Knowing whether a consumer is not feeling well or becoming anxious will determine if calling a primary care physician or providing positive intervention techniques is necessary. (See exhibit A)
3. Once the health and safety form has been completed, Case holder should transfer this information into the assessment and individual plan of service to help differentiate when not feeling well and/or becoming anxious or agitated. Positive interventions or strategies should be developed to help each individually per centered person process.
4. 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.

5. 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. Biting side of hand or thumbs? (sinus or ears)
6. Fist jammed in mouth/down throat? (reflux, eruption of teeth)
7. When was the last time the consumer saw a dentist?
8. Increase in symptoms for a known health concern?
9. Has there been any indication the consumer could be experiencing a new health concern?
10. Could the consumer potentially have a Urinary Tract Infection? Is the person prone to these types of infections or other infections?
11. When was the last time the consumer had a bowel movement?

iii. Environmental change:

1. Has there been a change in consumer routine?
2. No longer attending day program
3. Insufficient staffing resources in the home or program
4. Loss of family member in the home

6. 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.
7. 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. It is asked that you request the interdisciplinary meeting first before submitting to the Clinical Risk Committees.
8. 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.

9. 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).
10. 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:**

Exhibit A – Health and Safety Regulation

**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 | 1. Consumer Treatment Team and Case Holder |

| | |
|---|---|
| functional behavior through monitoring and periodic reviews. | |
| 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 positive supports plan or behavior treatment plan. | 7. Case Holder |
| 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 |

Exhibit A

## Health and Safety Regulation

Consumer Name: _____ SC Name: _____

Consumer ID#: _____ Date: _____

| |
|---|
| **How I feel when I am feeling good:** |
| **How I feel when I am feeling ill/sick/sad/lonely:** |
| **How I feel when I am bothered/anxious/worried/frustrated:** |
| **How I feel when I am upset/angry/mad/annoyed/outraged:** |

03/04/2024

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Serious Emotional Disturbance Waiver Program (SEDW) - Children</td><td>Chapter: 03-Continuum of Care</td><td>Subject No: 03.02.40</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, 3/2/23, 3/11/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Erin Nostrandt, Executive Director of Children’s Services<br><br>Authored By: Stacy Farrell, MSW<br><br>Additional Reviewers:<br>Hannah Rousseau, LMSW</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**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 DHHS Access Specialist. CMHSP SEDW DHHS Access 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.) for 90 days or more will require the SEDW recipient's service status to be switched to inactive in the WSA.<br>• A child can remain enrolled in the SEDW up to 90 days maximum with an inactive service status.<br>• 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.<br>• 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 DHHS Access 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<br>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, 3/2/23, 3/11/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Erin Nostrandt, Director of Children’s Services<br><br>Authored By: Stacy Farrell, MSW<br><br>Additional Reviewers:<br>Hannah Rousseau, LMSW</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**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. Demonstrate serious functional limitations that impair the ability to function in the community. Functional limitation will be identified using the CAFAS/PECFAS scales. CAFAS®/PECFAS score of 90 or greater for children age 7-12; 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. CAFAS® score of 120 or greater for children age 13 to 18; CAFAS® score of 120 or greater for children aged 13 to 18; Be under the age of 18 when approved for the Waiver,
D. Be under the age of 21;
E. Express willingness and capacity to actively engage in the Wraparound Program,
F. 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.

G. Meet Medicaid eligibility criteria and become a Medicaid beneficiary
H. Need waiver services to remain in the community
I. SEDW beneficiaries must receive at least one SEDW service per month in addition to Wraparound 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 status in the Waiver Application Status (WSA) is accurately reported as inactive, 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.

J. 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<br>Be under the age of 18 when approved for the Waiver,<br><br>CAFAS® score of 120 or greater for children aged 13 to 18.<br><br>Be under the age of 21.<br><br>Express willingness and capacity to actively engage in the Wraparound Program,<br><br>Reside with his/her birth or adoptive parents(s), or<br>-In the home of a relative who is the child's legal guardian, or<br>-In foster care or therapeutic foster care, with a permanency plan to return home.<br><br>Be financially eligible for Medicaid when viewed as a family of one (i.e., when parental income and assets are waived).<br><br>Need waiver services to remain in the community. | |
| SEDW beneficiaries must receive at least one SEDW service per month in addition to Wraparound in order 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:<br><br><u>Medical necessity</u>: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, | SED Waiver DHHS Access Specialist and Wraparound Care Coordinator |

| | |
|---|---|
| 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.<br><br>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.<br><br>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.<br><br>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:<br>Level of Care Change form is completed and sent to Care Management, who approves transfer to Wraparound Department. | Case holder<br>Care Management Specialist |
| For intake referrals:<br>CAI intake worker will assess for eligibility during intake appointment, and coordinate with Care Management for assignment to Wraparound Department. | CAI intake worker<br>Care Management |

| Policy and Procedure Manual<br>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, 3/2/23, 3/11/24<br>**Supersedes**: | **Approved By**: Sandra M. Lindsey, CEO |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Responsible Director:** Erin Nostrandt, Director of Children's Services<br><br>**Authored By**: Stacy Farrell, MSW<br><br>**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 (Hawthorn) 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.<br>Developmental Exit:<br>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**<br>When a child's CAFAS® score is 80 or less for children aged 7 to 12;<br>or CAFAS® score of 110 or less for children aged 13 to 18;<br>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.<br>The case will be referred to another service provider or the case will be closed per family request. | Wraparound Care Coordinator |

| | |
|---|---|
| **Administrative Exit: Other**<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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<br>SED Waiver DHHS Access Specialist |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Interdisciplinary Treatment Teams</td><td>Chapter: 03 – Continuum of Care</td><td>Subject No: 03.02.45</td></tr>
<tr><td rowspan="2">Effective Date:<br>7/16/2021</td><td>Date of Review/Revision:<br>5/10/22, 4/11/23, 4/4/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Barbara Glassheim<br><br>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 delineate standards for the provision of interdisciplinary treatment team-based consumer care that supports the health and well-being of consumers in a collaborative, structured, and person-centered manner.

**Policy:**
SCCMHA recognizes that no single individual can provide all of the services and supports that may be of benefit to a consumer; effective service delivery most often entails a variety of professionals and other staff with a variety of roles, responsibilities, skills and competencies working collaboratively together and in partnership with the consumer/family/caregiver. SCCMHA also recognizes that effective collaboration among professionals and consumers/families: (1) reduces fragmentation and siloed care; (2) leads to improved consumer outcomes and satisfaction; (3) results in improved staff morale, job satisfaction and organizational productivity; (4) allows professionals to work at the top of their training, licenses and credentials; and (5) is cost effective. In addition, studies have demonstrated that team-based care results in improved health outcomes for consumers when compared to standard care. Accordingly, SCCMHA shall foster teamwork by encouraging the provision of interdisciplinary team-based, person-centered consumer care.

**Application:**
This policy applies to services and supports for consumers enrolled in the SCCMHA CCBHC (Certified Community Behavioral Health Clinic) and SCCMHA Health Home & Wellness Center. Other programs shall consider implementing team-based care as warranted.

**Standards:**

A. Department/unit teams shall develop and implement standardized workflows for significant and recurrent situations commonly experienced by the consumer population(s) they serve.

B. Teams shall have a designated leader and/or facilitator.
   1. Teams may elect to rotate the role of the facilitator to expedite team-building and participatory leadership.

C. The team facilitator/leader shall, in concert with the treatment team and consumer/family/caregiver, establish expectations, including the articulation of norms and shared values, for teamwork and collaboration.
   1. All team members shall be made to feel valued and empowered to speak up when necessary.
   2. Teams shall select technology that allows visibility to the entire team and the work at hand in order to accommodate members who are not in a shared workspace (i.e., accessing meetings remotely).
   3. Each team member's roles and responsibilities shall be clearly articulated and teams shall promote a shared understanding of each member's roles and responsibilities.
   4. Teams shall use shared decision-making (see definition below) to foster collaborative relationships with consumers and families/caregivers and among team members.
   5. Teams shall consider holding briefing meetings to ensure that all members understand goals, everyone's roles and responsibilities, and have a chance to voice concerns.
   6. Teams shall consider holding debriefing (i.e., self-audit) meetings in order to review their effectiveness, promote team building and trust, celebrate successes and learn from breakdowns.
   7. Teams shall promote ongoing communication among members using a variety of mechanisms including curbside consults (see definition below), secure messaging via the EHR, telephone contacts, etc.

D. Team meetings shall consist of regular structured formal meetings that include consumers and families/caregivers as well as smaller, two-to-three-person teams that gather for huddles as well as curbside consults.
   1. Consumers and/or families/caregivers may be included in a huddle to promote quick shared decision making when an issue that requires consumer/family input arises.

E. The frequency of team meetings shall be flexible and based upon consumer needs and functional status.
   1. Some teams may engage in daily or weekly huddles while others may huddle on a monthly basis.
   2. Some teams may hold formal meetings on a weekly or monthly basis depending on the needs and health status of the consumer.
      a. At a minimum, teams shall hold formal meetings every 90-days to conduct periodic reviews in accordance with CCBHC standards.
   3. Team meetings or huddles shall be triggered by sentinel events which include, but are not limited to, the following:

a. Change in level of care
b. Care transition
c. Change in living situations
d. 90-day periodic review
e. Significant life event (e.g., loss of a loved one or caregiver)
f. Medical or mental health crisis
g. Change in health or functional status
h. A new diagnosis or diagnoses
i. Addressing complex comorbidities

F. External providers shall be integrated into the person-centered planning process and development of shared plans of care in accordance with consumer/family/caregiver wishes and needs.
   1. External providers shall be included in team meetings as warranted.

G. The composition of interdisciplinary teams shall be flexible and consumer/family-driven with a focus on whole-person care that integrates mental health, substance use disorder treatment, social care, and general health care in a seamless, coordinated manner.
   1. The initial composition of the team shall start with those members the consumer/family wishes to have included in the initial person-centered planning process.
   2. Additional members shall be added in accordance with consumer/family wishes and treatment and support needs.
      a. Additional members may include the primary care provider, PA, RN, PT, OT, RD, MA, speech and language therapist as well as employment specialist, housing resource Center staff, pharmacist, peer(s), residential services provider, etc.

H. All formal team meetings shall be documented in the consumer's EHR in accordance with SCCMHA policy.
   1. Documentation of huddles shall be optional and based on any significant biopsychosocial updates discussed.
   2. All formal meetings shall be accounted for by an authorized billing code that aligns with the services provided.

I. A team meeting shall be held when the team is considering presenting a case to the SCCMHA Adult Clinical Risk Committee. (See Exhibit A for a suggested conceptual framework.)
   1. Should the case be sent to the Clinical Risk Committee, information gleaned from the team meeting shall be used to help inform the committee's work.

**Definitions:**

**Certified Community Behavioral Health Clinic (CCBHC):** A non-profit organization or unit of a local government behavioral health authority that must directly provide (or contract with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care. (Richardson & Ingoglia)

**Curbside Consult:** A meeting held between two practitioners for the purpose of seeking information or advice regarding a consumer's care from a colleague.

**Five Components of Effective Interdisciplinary Teams:** (1) Established, open, safe communication patterns. (2) Well-defined and appropriate team goals. (3) Clear role definitions and expectations for team members. (4) A real-time, structured yet flexible decision-making process. (5) The ability of the team to "treat itself" by celebrating accomplishments and addresses breakdowns. (Leipzig, et al.)

**Shared Decision-Making (SDM):** An approach to care through which providers and consumers of health care come together as collaborators in determining the course of care. Key characteristics include having the health care provider, consumer, and sometimes family members and friends acting together, including taking steps in sharing a treatment decision, sharing information about treatment options, and arriving at consensus regarding preferred treatment options (Schauer, et al.).

**Team Huddle:** A brief meeting (e.g., 10 to 30 minutes) that can occur at a variety of frequencies and is scheduled to meet the unique needs of each team. Huddles are designed to address immediate consumer care coordination needs in contrast to **team meetings** which occur on a regularly scheduled basis and include everyone involved in the consumer's care and may also include the consumer and their family/caregiver.

**References:**


A. Leipzig, R., Hyer, K., Ek, K., et al. (2002). Attitudes Toward Working on Interdisciplinary Healthcare Teams: A Comparison by Discipline. *Journal of the American Geriatrics Society 50:* 1141–1148.

B. Richardson, J., Ingoglia, C. (August 5, 2020). *What is a CCBHC?* National Council for Behavioral Health.

C. SAMHSA. Criteria for Certified Community Behavioral Health Clinic: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf.

D. Schauer, C., Everett, A., del Vecchio, P., et al. (2007). Promoting the value and practice of shared decision-making in mental health care. *Psychiatric Rehabilitation Journal 31(1):* 54-61.

E. SCCMHA Departmental Procedures for Interdisciplinary Treatment Teams – Children's Services, Community Support Services (CSS), Supports Coordination Services (SCS), and Health Home Huddle.


**Exhibits:**

A. SCCMHA Case Presentation Format for Behavioral Health Consultation

**Procedure:**

Each department shall be responsible for developing procedures, protocols and work flows that are tailored to meet the needs of the consumer population(s) they serve as well as the unique needs of the department or unit itself.

Exhibit A

# SCCMHA Case Presentation Format for Behavioral Health Consultation

*Provide a brief answer to each question:*

1. **Purpose:** What are you hoping to gain from the consultation?

2. **Problem:** What are the consumer's current symptoms and diagnoses (both physical and emotional/behavioral)?

3. **Motivation:** What does the consumer want? What are their relevant goal(s), desires, or functions of a behavior (i.e. what is being gained from repeating a problem behavior: sensory [e.g. self-soothing], escape, attention, tangible) at this time? What are their values?

4. **Context:** What is going on in the consumer's life that is impacting their ability to achieve their goals and desires? Summarize relevant information such as precipitating events (e.g. changes in environment, staffing [therapist, case manager/supports coordinator, teacher/coach, AFC staff, etc.], living arrangements, or medication).

5. **Barriers:** What personal circumstances pose significant barriers to achieving goals (e.g. financial or time constraints, limitations in communication abilities, lack of necessary education or training, trauma history, comorbid issues, etc.)?

6. **Strengths:** What are the consumer's personal strengths? Who are their natural supports? What skills and resources do they possess? What are their interests or hobbies?

7. **Efforts:** What has already been tried to support the consumer (e.g. medication change)? What services are in place? Are services being provided as planned? (If no, why not?)

8. **Progress:** What progress has been made toward goal(s)? Does the consumer and providers agree on perceived progress? (If no progress or no agreement on progress, why?)

*{Consultation Input}*

9. **Plan:** What specific actions will be taken/steps implemented as a result of this consultation?

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Whole-Person Care</td><td>Chapter: 03 – Continuum of Care</td><td>Subject No: 03.02.46</td></tr>
<tr><td rowspan="2">Effective Date: 11/02/21</td><td>Date of Review/Revision: 5/8/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Chief of Health Services & Integrated Care<br><br>Authored By: Colleen Sproul, Barbara Glassheim, Jen Kreiner<br><br>Additional Reviewers:<br>SCCMHA Service Management Team</td></tr>
<tr><td>Supersedes: 10.01.02 – Health Home Services</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
The purpose of this policy is to provide a framework for the delivery of integrated care to individuals receiving services and supports provided by Saginaw County Community Mental Health Authority (SCCMHA), which are designed to improve health outcomes by addressing whole-person health care needs through the provision of comprehensive, integrated health care, care coordination, and care management services, the experience of care, population health, and financial impact of health care spending.

**Application:**
This policy applies to all SCCMHA-funded providers and programs.

**Policy:**
It is the policy of SCCMHA to comprehensively approach the provision of services with a commitment to whole-person care recognizing the complexity of the individuals we serve and the intrinsic link between mental health, physical health, and social circumstances. Therefore, our services will not focus solely on treating symptoms or disorders but will aim to address all areas of a person's life that may affect their mental health. This includes their physical health, social connections, housing, employment, education, and other personal circumstances.

**Standards:**
A. **Population served:** SCCMHA shall serve people receiving services with a mental health condition, substance use disorder, severe emotional disturbance, intellectual/developmental disability and one or more chronic health conditions as well as those who are at risk of developing a chronic health condition.

1. Individuals seeking eligibility for SCCMHA services shall be screened at intake (per the Eligibility Assessment and Determination for Consumers Requesting SCCMHA Services policy – 09.06.07.01) and triaged based upon acuity of need.
2. People served shall be identified for whole-person care services at the time of admission through the use of population health data stratification (derived from Care Connect 360 and ZENITH-ICDP[1]) as well as through quality improvement initiatives.
    a. People receiving services claims data shall be reviewed at admission using Care Connect 360 data, which generates individualized encounter data profiles, which group similar diagnoses for Emergency Department (ED) and inpatient utilization, in addition to pharmacy, primary and specialty care, and psychiatric services.

B. **Other populations served:** SCCMHA shall serve children and youth with a serious emotional disorder as well as individuals with an intellectual/developmental disability who have a co-occurring mental health and/or substance use diagnosis.
1. Incorporating the same identification methodology above, children and youth are identified for participation in whole-person care with the goal to improve primary care engagement and connectivity, increased adherence to EPSDT services including immunizations and to address the prevalence of obesity in this group.

C. A **health assessment** shall be completed for each person served which shall include appropriate **testing to monitor health status**.
1. People receiving services who elect to participate in whole-person care shall be assessed for self-identified chronic health conditions, level of activation and overall rating of their health status
2. All enrollees shall be offered baseline, six month and annual health testing and screening.
3. People receiving services shall be assessed at initial enrollment for chronic health conditions identified through existing databases (Care Connect 360 or ZENITH-ICDP) in addition to the identified chronic health conditions within the initial assessment (in the EHR).
    a. Baseline **health metrics** shall be taken at this appointment, which include six-month and annual health testing.
        1). Testing at baseline for adults shall include CLIA waived administration of HbA1c, lipid panel, blood pressure, BMI, waist circumference, and carbon monoxide levels.
        2). Testing at baseline for children shall include blood pressure, weight, height and waist circumference.
        3). A nurse or Care Coordinator shall administer biometrics at regular intervals or at least every six months as well as annual lipid panel and HbA1c tests for adults.
    b. **Health literacy** score, self-assessment of overall health, current perception of level of pain, as well as the establishment of a person

[1] ICDP = Integrated Care Delivery Platform

served identified wellness goal, shall be part of the initial and annual assessments.

c. Information shall be shared with primary care providers and documented within the appropriate electronic health records (EHRs).

d. Based upon the overall health status of the person served, a nurse or other general health care professional shall review the assessment and make recommendations to the person receiving services interdisciplinary treatment team, including the person receiving services case holder, for wellness education, nutritional support or initiate a referral to the Enhanced Health Services department for assessment.

e. People receiving services shall be encouraged to make an appointment with their primary care provider.

1). SCCMHA shall schedule appointments with the on-site primary care provider via that provider's s HER scheduling module.

f. If the person served identifies a primary care physician other than SCCMHA's on-site provider, the RN or Care Coordinator shall contact the provider with the information gathered in the assessment and, with the person receiving services or guardian's consent, share the wellness goal(s) established by the person served.

D. SCCMHA shall ensure that each person served has a **comprehensive care plan** that includes the provision of services that are quality-driven, cost effective, culturally appropriate, trauma-informed, person-/family centered, developmentally appropriate, and evidenced-based.

1. An interdisciplinary team shall develop a **care plan** that is guided by the person served and includes person-centered health goals or a **"wellness goal"** that incorporates self-management objectives.
2. The assessment and person served **wellness goal** shall determine recommendations to the person served.
3. SCCMHA shall provide access to **community and social support services** as a focus within the person-centered plan, including access to the clubhouse and the wellness-focused SCCMHA-funded Drop-In Center to further support adult individuals in their overall **recovery** goals.
4. The **person-centered plan** shall address the general (i.e., physical health) needs as well as behavioral health needs, and shared with the person served and the person served identified primary physical health care provider.
   a. Ongoing monitoring of the person-centered plan shall be conducted and updates shall be made as needed or on an annual basis at a minimum by the case holder (per SCCMHA policy 02.03.03).
5. The person served **cultural preferences** shall be taken into consideration with the overall goal of health care integration that is achieved by informing and coordinating all care with the person served identified physical health providers.

E. **Care coordination** services shall be provided to each person served that include, but are not limited to: an individualized plan of care; prevention and health promotion; general healthcare; mental health and substance use disorder treatment; linkages to community support and social services; employment; housing; educational systems comprehensive care management for people receiving services with complex comorbidities; transitional care from the hospital to the community;.

1. **Communication** as part of **care coordination** will occur at the time of transition between inpatient and outpatient care, changes in level of care and with outpatient care providers in accordance with SCCMHA Policy 10.01.01.01 – Care Transitions which outlines the "9-Touch" approach and specifies a series of assessment, face-to-face meetings, medication reconciliation and other transition of care activities specific to hospital discharge back to home or community.
2. **Care coordination with person served primary care physician** shall be initiated to ensure that person receiving services have access to hospital and specialty medical care.
    a. As part of the person-centered planning process (in accordance with SCCMHA policies 0.3.02.01 and 02.03.03), the person served overall health and nutrition status will be reviewed and a determination made as to whether there are issues to bring to the attention of the primary health care provider.
    b. In close communication with identified physical health providers, interdisciplinary treatment team members shall monitor and assess the people receiving services health for acuity and exacerbation of identified chronic health conditions or for life-threatening conditions that require immediate attention.
        NOTE: SCCMHA staff is trained to immediately contact emergency transportation to transport a person receiving services to the nearby emergency room for care for people served who report or present with symptoms that indicate a medical crisis.
    d. Care coordination shall be provided in conjunction with case holders and physical health providers to ensure that people receiving services follow up with referrals to specialty medical providers and follow consumers for three weeks post hospital discharge with the 9-Touch protocol that utilizes face-to-face visits to assess recovery from treatment.
    e. The **physician assigned by the Medicaid Health Plan (MHP)** will be indicated in the electronic health record as the Primary Health Care Physician for the person served.
        1). Each person served will be routinely asked to update or identify the name of their primary care physician (in accordance SCCMHA policy).
        2). Each person served will be requested to consent to allow for SCCMHA to coordinate care with the identified primary

health care provider if consent is not present or current for that provider.

3). People receiving services who do not identify a primary care physician at the time of intake shall be recommended to select the physical health provider co-located at SCCMHA and contact their MHP to inform the MHP of their selection.

4). The absence of a primary care provider shall be indicated as a health and safety concern in the person served Individual Plan of Service.

5). If the person served prefers to select from other available physicians, the person served shall be provided education on how to contact their MHP to identify a primary care provider.

F. SCCMHA service delivery shall encompass **continuing care strategies**, including care coordination and transitional care from the hospital to the community as well as the full array of SCCMHA and community-based services and supports.

1. **Comprehensive transitional care** from inpatient to other settings, including follow-up, shall encompass a set of actions that are designed to ensure the coordination and continuity of health care, and consider the person served goals, preferences and clinical status.

a. Activities shall include (but not be limited to):

1). Receiving notification of discharges and admissions from hospitals and other care facilities.

2). Performing outreach to people receiving services to ensure appropriate follow-up after transition.

3). Reviewing discharge summaries.

4). Conducting medication reconciliation.

5). Assessing a person served risk status to reduce avoidable readmissions.

b. **Admissions, discharges and transfers (ADTs)** transmitted through the **HIE** (health information exchange) shall be reviewed twice daily for the purpose of tracking all admissions, discharges and transfers.

1). People receiving services who transition from one setting to another shall be assessed for level of care based upon diagnoses.

2). Interdisciplinary treatment teams shall be notified of person served activity.

3). Interdisciplinary treatment teams shall meet to determine the level of support needed by the person served and their natural support system to ensure that the person served is provided adequate and appropriate support and follow-up for smooth transitions of care that optimize the potential for positive outcomes.

G. The interdisciplinary treatment team shall ensure that a **full array of services** is available and coordinated.

1. Any **gaps** in treatment shall be identified and services outside of SCCMHA shall be arranged when necessary.
    a. Any **gaps in behavioral health treatment** shall be identified and services outside of SCCMHA shall be arranged when necessary in conjunction with the case holder.
    b. Any **gaps in physical health care** shall be identified through ongoing assessment and communicated to the person receiving services primary care provider.
        1). Activities shall include, but not be limited to:
            a). Ensuring follow-up with specialist and ancillary provider referrals initiated by the primary care physician for routine or post hospitalization care.
            b). Securing referrals from the person receiving services primary care physician for PT, OT and Speech and Language Therapy assessment when indicated.
            c). Assisting person served in obtaining DME (durable medical equipment) or a script for DME from the prescribing provider.
            d). Assisting the person served in accessing or securing referrals for community provided health education classes.
            e). Assisting the person served in accessing dental care.
            f). Providing navigation assistance to people receiving services who request assistance in managing their health care.
2. All referrals and follow-up conducted to ensure the efficacy of those referrals shall be documented in the person served HER.

H. SCCMHA shall offer services that include **prevention and health promotion**, general healthcare, mental health and substance use disorder treatment, and linkages to long-term care services and other community supports and resources.
1. **Health education**, especially education that focuses upon management of chronic health conditions, shall be targeted to people receiving services and their families when appropriate.
    a. This education shall include teaching the person served about how to manage their mental and physical health, pursue recovery and wellness including exercise, diet and nutrition.
    b. Classes for diabetes, hypertension, asthma, smoking/tobacco/vaping cessation, safe sex, and managing high cholesterol shall be provided or made available to people receiving services in accordance with need and identified health goals.
    c. Approaches for educating people served shall be predicated on the administration of a health literacy evaluation (Exhibit E) and engagement of people served as well as their family or support systems, consider reading and numeracy comprehension, learning styles and other factors that may impact the ability to understand and follow a plan of care.

2. **Health promotion** activities shall include the provision of health education to the person served (and their identified family member[s] when appropriate) that is specific to the person served chronic illness or needs as identified in the assessment.
3. SCCMHA shall help people receiving services access the following health and wellness activities and programs:
    a. Smoking cessation program
    b. Journey for Control Diabetes classes
    c. Drop-In Blood Pressure Clinics
    d. DIMENSIONS: Tobacco Free Program
    e. Peer walking appointments
    f. Nutritional assessment and education
    g. Weight Loss Class and Mindful Eating
    h. Diabetes education classes
    i. SCCMHA-sponsored People Served Health Fairs
    j. Education that focuses on self-management of hypertension
    k. Yoga
    l. SCCMHA's Learning Links programs for people served
    m. WHAM (Whole Health Action Management) provided by the Friends for Recovery Drop-In Center
    n. myStrength™
    o. Auricular Acupuncture (National Acupuncture Detoxification Association (NADA) Acupuncture)
4. One-to-one educational sessions shall also be made available to people receiving services who prefer individual support.
5. SCCMHA shall provide access to interventions for people receiving services, as clinically indicated, in order to improve and support personal health goals, including, but not limited to:
    a. Cognitive Behavior Therapy
    b. Integrated Dual Disorders Treatment groups (for co-occurring mental health and substance use disorders)
    c. TREM (Trauma Recovery and Empowerment Model) groups
    d. DBT (Dialectical Behavior Therapy)
    e. FPE (Family Psychoeducation)
    f. Motivational Enhancement Therapy
    g. Medication Assisted Treatment (MAT)
    h. Seeking Safety
    i. Ask Me 3
    j. 5 A's
    k. SBIRT/YSBIRT (Screening, Brief Intervention, Referral to Treatment)

I. **Individual and family support services** provided by SCCMHA shall include the coordination of access to and delivery of services that support effective management of chronic conditions.

J. **Referral to community and social support services**[2] by SCCMHA shall include, but not be limited to, the establishment of referral and follow-up procedures in order to ensure that people receiving services in need of community-based social support services are assisted to overcome access or service barriers in a manner that fosters the development of self-efficacy and builds self-management skills.

1. Referrals to community and social support shall entail facilitating access to support assistance for individuals to address medical, behavioral, educational, social and community issues that may impact overall health and address **social determinants of health (SDOH)** as needed.
    a. SCCMHA shall develop collaborative relationships with community and/or social support services.
    b. The Saginaw Community Care HUB shall provide a central referral registry and contract with Community Care Agencies (CCAs) that employ Community Health Workers (CHWs).
        1). CHWs shall be available to assist people receiving services in addressing relevant SDOH as well as the systems that are in place to deal with acute illnesses and chronic health conditions.
    c. People receiving services shall be offered and encouraged to join in peer support organizations, self-help groups, senior centers, exercise facilities and other community-based programs based upon their preferences.
    d. **Transportation** shall be provided to overcome attendance barriers.
2. All referrals and follow-up conducted to ensure the efficacy of those referrals shall be documented in the person served HER.

K. **Disease management services** shall be individualized and target identified chronic illnesses provided through the use of person served level claims data encounters.

L. SCCMHA shall endeavor to maintain a close collaboration in a partly **integrated system** or level 4[3] Health Home and Wellness Center whereby mental health and health care providers share the same site and have some shared systems, such as scheduling and charting, as well as regular face-to-face interactions among primary care and SCCMHA behavioral health providers, coordinated treatment plans for patients with complex needs, and a basic understanding of each other's roles and culture[4].

1. While job descriptions outline **roles and responsibilities** that align with professional scope of practice, **interdisciplinary treatment team** members shall present their services as a team without designation of role to the person served in order to offer the person served their own **"wellness" team** which is focused upon the persons served overall health and wellness as well as on the provision of support for the persons served health improvement efforts from anyone on the team.

---

[2] It is well established that by addressing the social determinants of health, overall health is improved.

[3] The level of integration is most aptly described by Doherty, McDaniel and Baird (1995, 1996) who proposed the first classification for integrated health care by identifying five levels of collaboration and integration.

[4] "We are a team in the care of consumers" best describes the level of care integration at this time (Collins, et.al., 2010; Peek, 2007; Reynolds, 2006: Seaburn, Lorenz, Gunn, Gawinski & Mauksch, 1996; Strohsal, 1998).

2. **Primary health care** shall be provided **on-site** at SCCMHA's main location in the Health Home and Wellness Center.
    a. The designated PCP (primary care provider) shall provide a primary care practitioner, nurse (RN) and Care Coordinator three days per week to the SCCMHA Health Home and Wellness Center through a Memorandum of Understanding (MOU).
    b. SCCMHA person served may opt to receive care at this co-located physical health clinic by identifying this PCP as their primary care provider to their Managed Care Organization.
3. The person served **primary care provider** shall be considered part of the team as is the case holder, peer support specialist (PSS), wellness specialist, behavioral health consultant, physical therapist (PT), occupational therapist (OT), registered dietician (RD), RN, and, in some cases, a Community Health Worker (CHW) along with the psychiatrist, case manager, and therapist.
4. Health Home and Wellness Center team members shall conduct a "huddle" each day before the clinic opens to review the person served information, including behavioral health diagnosis, risk level, recent ED admissions and overdue annual labs, including information related to a person served physical health care appointments within the co-located physical health care provider clinic.
5. People receiving services shall receive **behavioral health care** based upon their specific needs in the initial assessment and/or when presenting for psychiatric inpatient care.
    a. **Behavioral health care** shall be provided to people receiving services through the SCCMHA specialty Medicaid benefit and their services shall be complimented by the presence of a Behavioral Health Consultant (BHC) who shall be present during on-site PCP clinic hours.
    b. People receiving services enrolled with the on-site primary health care clinic shall have the assistance of a fully licensed master's social worker (LMSW) who provides behavioral health consultation during primary care visits.
        1). While it is the express purpose of the BHC to address needs of people served in real time during an office visit with brief interventions and follow up as needed, the BHC shall maintain direct contact with the person served case holder and shall coordinate necessary support if the person served presents with immediate needs.
    c. Psychiatrists and other SCCMHA practitioners, including complimentary providers such as OT, PT, RD, the SCCMHA Health Educator, peer support specialists, and wellness coaches shall be located within the same physical space as the physical health clinic and interact with people receiving services who are physically present within the SCCMHA Health Home and Wellness Center.

6. SCCMHA shall staff an **on-site laboratory** for lab draws for both psychiatric and primary care physician providers as well as house a full-service **pharmacy** which is located on the same floor within close proximity of Health Home and Wellness Center.

M. The Health Home and Wellness Center shall provide services during **core business hours**, 8:00 a.m. – 6:00 p.m. five days per week and shall coordinate these hours with the on-site physical health provider that provides services between 8:30 a.m. – 4:45 p.m. three days per week.

1. Health Home and Wellness center personnel and complimentary staff shall be available during core business hours and conduct care coordination and wellness services five days per week.
   a. **Walk-ins** without a prior appointment shall be welcomed into the Health Home and Wellness Center.
2. Additional resources shall be made available through the designated primary care provider's other clinics with walk-in capacity that are located within the vicinity of SCCMHA.
3. SCCMHA shall provide twenty four-hour, seven-day per week response to people receiving services with emergency health care needs including mental health and substance use disorder treatment access.
   a. Case holders shall serve as the initial point of contact when a person served is requesting access to Health Home and Wellness Center services outside of core business hours, 8:00 a.m. – 6:00 p.m. Monday through Friday.
4. SCCMHA-employed psychiatric providers, including mid-level practitioners, shall be located within a few steps of the physical health clinic and shall be available during core business hours for consultation with the on-site primary care provider or behavioral health services.
   a. Health Home and Wellness Center staff shall be available during core business hours and can be reached by case holders to arrange or secure access to health care services or primary care visits for the people they serve they serve.
5. People receiving services may contact Health Home and Wellness Center staff directly by telephone to arrange for **wellness consultation** and may schedule appointments in conjunction with their psychiatrist visit or medication reviews, therapy appointments, prescription pick-up, or for laboratory services (which are all located on the same floor in one location).
6. SCCMHA staff shall access the PCP's EHR for the purpose of advance scheduling, same day scheduling of physician office appointments at the PCP clinic, and viewing scheduled physical health appointments.
   a. Health Home and Wellness Center staff shall routinely review case management scheduled appointments and psychiatric appointments to connect with people receiving services who have either no-showed their appointments with the Health Home and Wellness Center or PCP practitioner or who are due for follow up appointments or services.

7. SCCMHA's front desk staff shall aid in scheduling people receiving services who are scheduled for a physician office visit and are able to schedule follow up visits upon conclusion of their visit.
8. **Outbound phone calls** to people served for appointment reminders, no-show follow-up, and wellness checks shall be performed as part of comprehensive care management that includes reporting of blood sugar and blood pressure readings, monitoring exercise activity, food logs and assistance with transportation to provider appointments and community and social supports.
    a. Frequent outbound telephone calls shall be initiated to people served to follow up with lab value results, emergency room encounters, coordination of **transportation** to and from physical health provider appointments including specialist providers as well as dentists and optometrists.
        1). The Health Home and Wellness Center Specialist shall place reminder calls to people receiving services who are either enrolled or would benefit from enrollment in self-management classes such as diabetes, smoking cessation and nutritional education.
            a). The Health Home and Wellness Center Specialist shall reach out to people receiving services who are registered as well as contact potential people receiving services and their case holders to assess their interest in participating.

N. **Health information technology (HIT)** shall be used to inform and facilitate the work of the Health Home and Wellness Center and to guide quality improvement efforts.
1. Data shall be used at the population and individual levels to inform clinical decision-making, provide feedback to clinicians and people served, as well as to deliver reminders to providers and people served.
2. Information shall be gathered to identify people receiving services who are at greater risk of morbidity and mortality due to multiple chronic health conditions, hospitalizations, and re-admissions at the time of eligibility determination and throughout their enrollment in SCCMHA specialty benefit services.
3. Clinical decision-making, care plan development, and quality improvement activities shall be informed by ongoing surveillance and data mining of two Medicaid claims databases populated by the State of Michigan.
    a. SCCMHA shall utilize available clinical information systems, **ZENITH-ICDP** and **Care Connect 360**, which capture and report population-level data for the purpose of clinical decision-making and care coordination for SCCMHA adult person served with chronic health conditions.
        NOTE: This data is organized at the aggregate and individual level with the intention of optimizing individual outcomes and influencing quality improvement.

NOTE: Claims data is aggregated for the purpose of grouping chronic health conditions to inform clinical decision-making.

b. SCCMHA shall collect and analyze data obtained through Care Connect 360 which includes medical and behavioral health claims data that provide summaries of people served institutional encounters.

c. SCCMHA shall utilize notification of admissions, discharges and transfers (ADTs) for SCCMHA people served which are communicated twice daily through the ZENITH-ICDP site and transmitted via the Health Information Exchange (HIE).

NOTE: Individual people receiving services are identified with their chronic health conditions, including behavioral health conditions.

NOTE: Risk status is calculated by ZENITH-ICDP using a predictive modeling tool, LACE, and it is noted within the person served profile.

NOTE: The reason for admission is documented and LACE scoring is used to predict the level of risk a person served has for readmission to the hospital.

1). This data shall be reviewed by the Supervisor of Clinical Practice and other team members for the purpose of identifying people served who may be at risk of hospital readmission.

a). People receiving services who are at high risk shall be identified and assigned to a nurse who coordinates with the person served case holder to ensure the transition of care using the 9-Touch protocol for that person served.

b). People receiving services who are identified as admitted to a hospital inpatient setting shall be assessed by a nurse for transition of care protocols and care coordination to ensure that the person served successfully transitions from inpatient care back to their home or to the community.

c). Interventions and assessments shall be documented within the electronic health record.

d). Additional data (from Care Connect 360 and ZENITH-ICDP) shall also be reviewed at the time of admission into SCCMHA's services.

4. Interdisciplinary treatment teams shall utilize SCCMHA's **electronic health record** for the purpose of viewing and documenting physical and behavioral health information collected in the chart documents.

a. Information regarding health indicators, health education and health promotion activities, individual contacts and overall risk status shall be used to inform clinical decision making.

1. Health metrics are captured in SCCMHA's EHR in the "Vitals" section. Information collected includes blood pressure, lipid panel, A1c, BMI, waist circumference and CO levels.

O. SCCMHA shall provide **cross-system, bi-directional** primary care and behavioral health **staff training** on integrated care as well as foster greater awareness and understanding of both mental illness, substance use disorder and physical health issues that impact people receiving services as well as the cultures of both primary and behavioral health care. Trainings may include, but not be limited to the following:
   1. People Receiving Services Health (physical health conditions)
   2. Taking Care of Yourself (physical and emotional health conditions)
   3. Understanding Disabilities
   4. Understanding Medications
   5. Integrated Treatment of Co-occurring Mental Health & Substance Use Disorders
   6. Modifying Approaches and Medications Used to Treat the Disease of Opiate Addiction
   7. PTSD and Substance Abuse Disorder
   8. The Medical Aspects of Behavioral Health and the Role of Behaviorism in Recovery
   9. Trauma 101
   10. Virtual Hallucinations
   11. CBT for Hoarding Disorder
   12. Mental Health Ambassador Training
   13. Mental Health First Aid

P. SCCMHA shall engage in **quality improvement (QI) activities** with Performance Improvement Projects (PIPs) reported to the SCCMHA Board of Directors.
   1. SCCMHA shall conduct surveys of **people served satisfaction** in order to inform care processes and ascertain areas for improvement (see Exhibit H).
   2. Performance Improvement Projects shall include diabetes screening for people served taking second generation antipsychotics (SGAs) and blood pressure monitoring for people served with uncontrolled hypertension.
   3. SCCMHA will use population health methodologies to stratify people served for prioritization of interventions, work flow improvements and aligning resources.
   4. SCCMHA will actively initiate **PDSA** (Plan-Do-Study-Act) cycles to process information and data.

Q. SCCMHA will collaborate with its PCP partner to implement and **maintain shared plans of care**.

R. SCCMHA shall make the option of **telehealth** visits available to people receiving services who wish to meet virtually, when clinically appropriate.

**Definitions:**

**LACE Index:** A tool that identifies individuals who are at risk for hospital readmission or death within thirty days of discharge. It incorporates four parameters: "**L**" stands for length of stay of the index admission; "**A**" stands for acuity of admission; "**C**" stands for

comorbidities of patients; and "**E**" stands for the number of Emergency Department visits within the last six months. LACE scores range from 1–19. A score of 0 – 4 = Low; 5 – 9 = Moderate; and a score of ≥ 10 = High risk of readmission.

**myStrength™:** An evidence-based web-based application that is suitable for both adults and adolescents. myStrength™ assists individuals with decision support for a wide range of behavioral health and substance use disorders including comprehensive resources on parenting, nutrition and mindfulness. myStrength™ is a confidential and free service to people receiving services who have internet access.

**PDSA Cycle:** Testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

**References:**

A. SCCMHA Policy 02.03.03 – Person-Centered Planning
B. SCCMHA Policy 02.03.09.40 – SBIRT/YSBIRT
C. SCCMHA Policy 03.02.45 – Interdisciplinary Treatment Teams
D. SCCMHA Policy 10.01.01 – Hospital Discharge Planning
E. SCCMHA Policy 10.01.01.01 – Care Transitions
F. SCCMHA Policy 06.01.01 – Health Literacy
G. CCBHC Handbook
H. BHH Handbook
I. Social Determinants of Health Assessment Tool: https://www.cms.gov/priorities/innovation/media/document/ahcm-screeningtool-companion

**Exhibits:**

A. Health Home Flow Charts
B. Four Quadrant Model
C. Example of ZENITH-ICDP information
D. Consumer Fact Sheet
E. Consumer Satisfaction Survey
F. Ask Me 3
G. The 5 A's

**Procedure:**

None

Exhibit A

Other RN duties: call in RX refills, Care Alerts, 9-Touch, PIPBHC assessments, Personal Health Reviews
Other Care Coordinator duties: schedule 'other' appointments (PCP, EKG) prior auths, keeps lab & vital rooms clean- including controls, use ICDP, lab draws

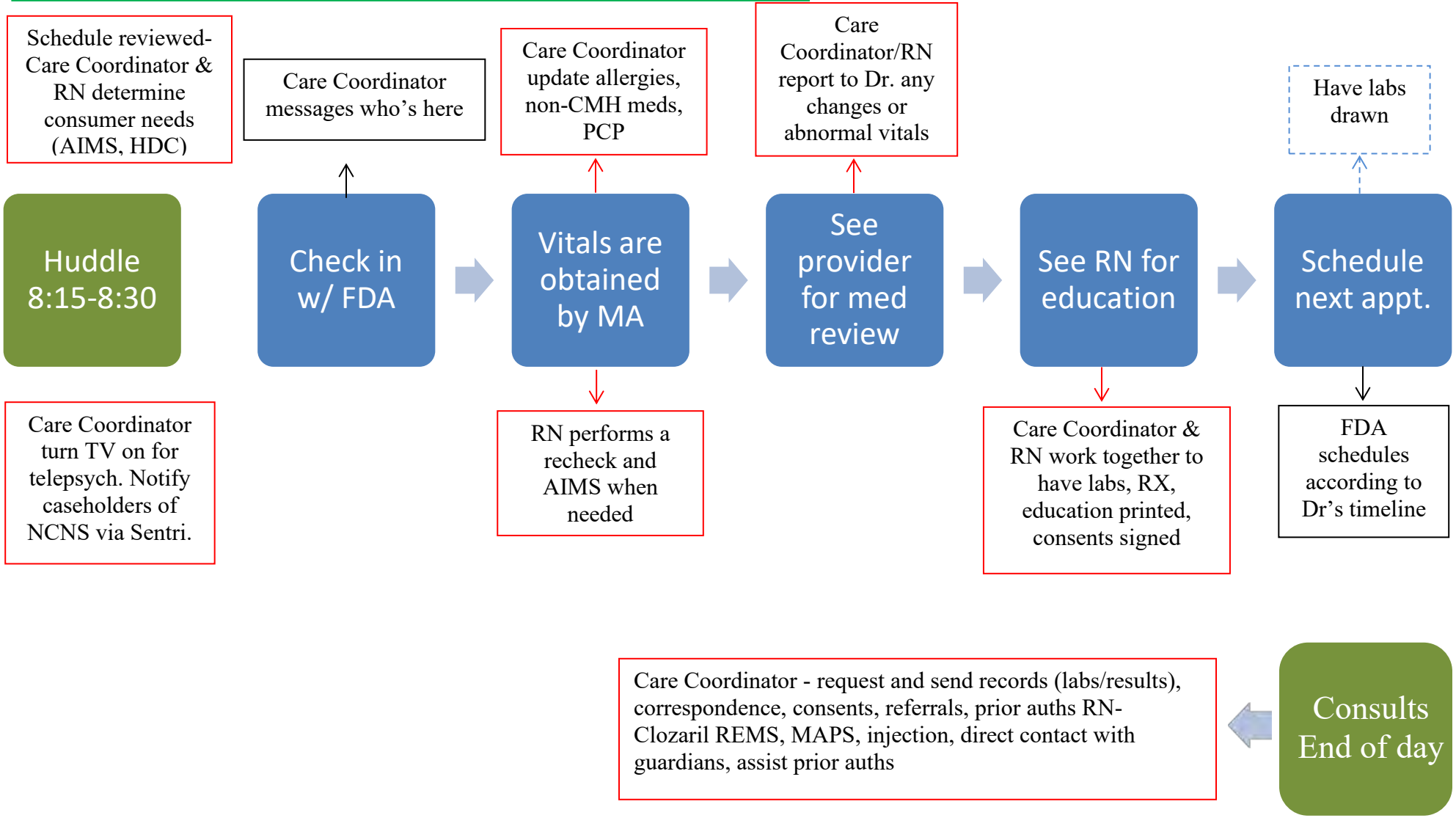


Exhibit B

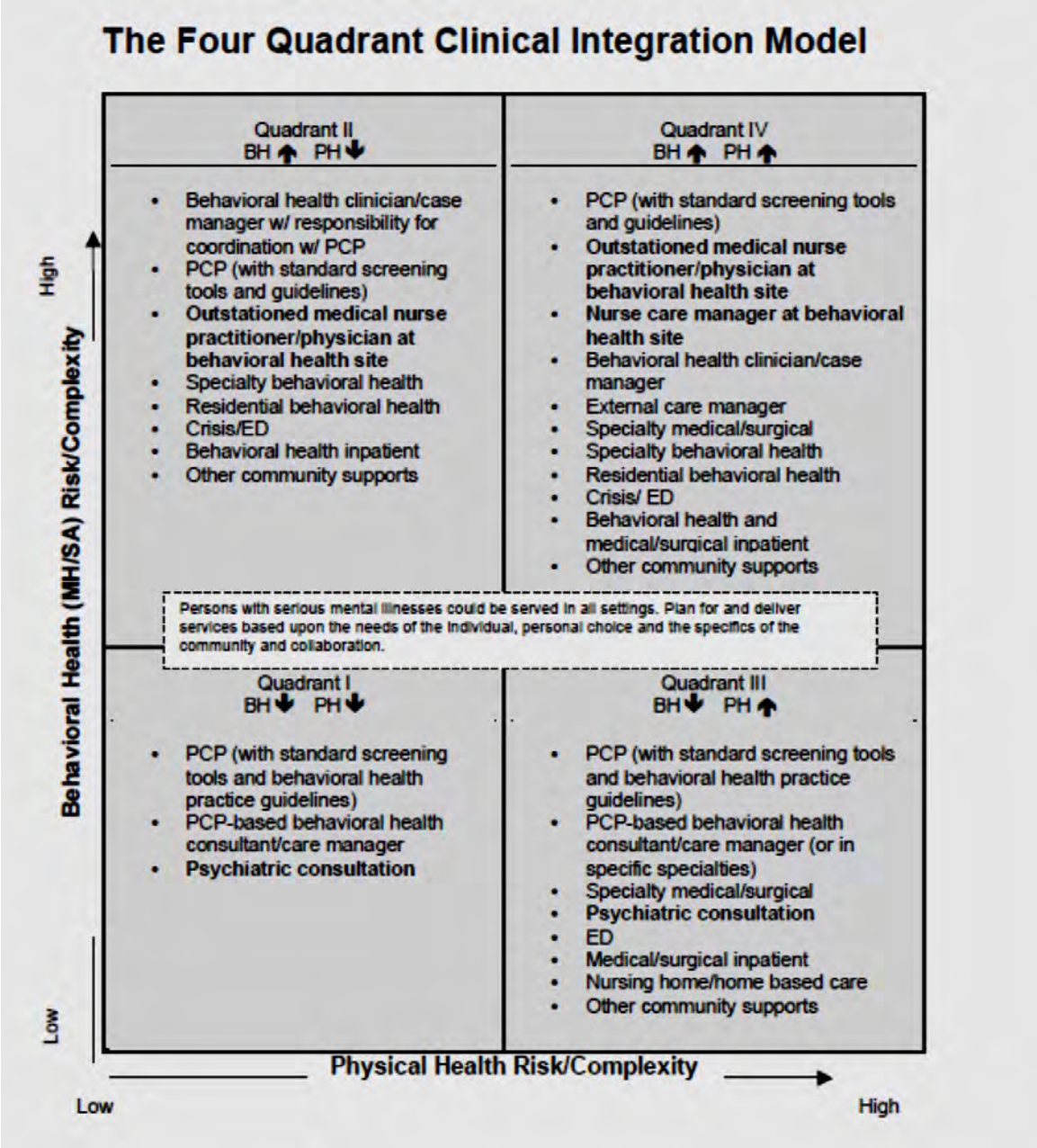

The Four Quadrant Clinical Integration Model
Quadrant II
BH ↑ PH ↓
Behavioral health clinician/case manager w/ responsibility for coordination w/ PCP
PCP (with standard screening tools and guidelines)
Outstationed medical nurse practitioner/physician at behavioral health site
Specialty behavioral health
Residential behavioral health
Crisis/ED
Behavioral health inpatient
Other community supports
Quadrant IV
BH ↑ PH ↑
PCP (with standard screening tools and guidelines)
Outstationed medical nurse practitioner/physician at behavioral health site
Nurse care manager at behavioral health site
Behavioral health clinician/case manager
External care manager
Specialty medical/surgical
Specialty behavioral health
Residential behavioral health
Crisis/ ED
Behavioral health and medical/surgical inpatient
Other community supports
Persons with serious mental illnesses could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.
Quadrant I
BH ↓ PH ↓
PCP (with standard screening tools and behavioral health practice guidelines)
PCP-based behavioral health consultant/care manager
Psychiatric consultation
Quadrant III
BH ↓ PH ↑
PCP (with standard screening tools and behavioral health practice guidelines)
PCP-based behavioral health consultant/care manager (or in specific specialties)
Specialty medical/surgical
Psychiatric consultation
ED
Medical/surgical inpatient
Nursing home/home based care
Other community supports
High
Behavioral Health (MH/SA) Risk/Complexity
Low
Physical Health Risk/Complexity
Low
High

Exhibit C

## ZENITH-ICDP Information Example

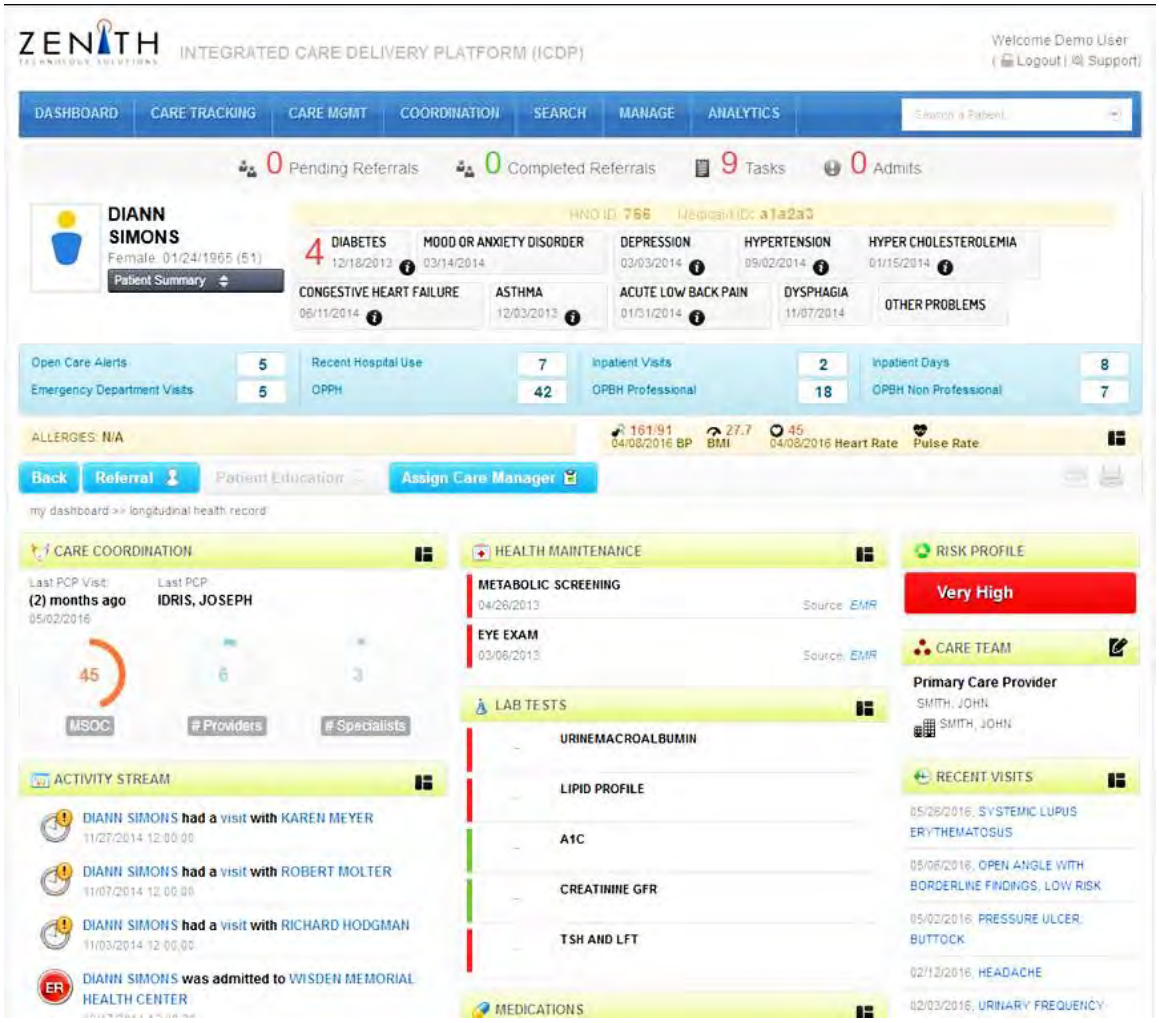


Exhibit D

# Consumer Information For In-Patient Admission

*please keep with consumer and include medication sheet*

**E Fax 583-1365 Attn: Gretchen**
**Upon discharge call report to**

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Consumer Name: _____ DOB: _____

Medicaid/Medicare ID: _____ SSN: _____

Language: _____ Interpreter needed? YES NO

Resides at: _____ Specialized Residential AFC (circle one)

Home Manager Name: _____ Phone Number: _____

Case Manager/
Support Coordinator: _____ Phone Number: _____

Guardian/ Status/
DPOA/ Next of Kin: _____ Phone Number: _____

Advance Directives (Living will, Durable Power of Attorney): YES NO

If NO, would you like more information? YES NO

Primary Care Physician: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

Diagnosis: _____

Allergies: _____

Previous Surgeries/ Hospitalizations: _____

Special Requests: _____

Behavior challenges that require accommodation: _____

Equipment Used _____
(glasses, hearing aids, dentures etc.):

Assistance required for verbal or written instructions: _____

Community Service in place: _____
(i.e., Directive on Aging, CHW etc.)

Home Care Service received: _____
(i.e., VNA, Heartland, etc.)

**Please circle the number that best describes the consumer's current situation:**

| **Ambulation Mobility** | **Mobility** | **Transferring** | **Food/Eating** | **Special Diet** |
|---|---|---|---|---|
| 1. Walker | 1. Ambulatory | 1. Two person | 1. Discomfort swallowing | 1. Soft |
| 2. Wheelchair | 2. Ambulatory w/ assist. | 2. Four person | 2. Difficulty swallowing | 2. Peg tube |
| 3. Cane | 3. Transfer w/ assist. | 3. Lift | 3. Difficulty chewing | 3. Liquids |
| 4. Rotator | 4. Bed rest | | | 4. DM |
| | | | | 5. NA |
| **Grooming** | **Bathing** | **Dressing** | **Taking Meds** | **Med Administration** |
| 1. Independent | 1. Independent | 1. Independent | 1. Independent | 1. Crushed |

Updated 9/14/15

## Consumer Information For In-Patient Admission

*please keep with consumer and include medication sheet*

| | | | | |
|---|---|---|---|---|
| 2. With assistance | 2. With assistance | 2. With assistance | 2. With assistance | 2. In soft foods |
| 3. Dependent | 3. Dependent | 3. Dependent | 3. Dependent | 3. With liquids |

Updated 9/14/15

Exhibit E

# Consumer Satisfaction Survey

Health Home at Hancock

**To Our Consumers:**
We want to know how you feel about the care you get at our Health Home and Wellness Center. Please take a few minutes to complete this survey and then return it to us. Let us know your feelings about today's visit any visits during the last year or so. Safe and effective care is our goal. Your answers are important to us.

## About Consumer

What is your age?
O 0-12 O 20-29 O 40-49 O 65+
O 13-19 O 30-39 O 50-64

What is your gender?
O Male
O Female
O Transgender

Do you consider yourself Hispanic or Latino?
O Yes, Hispanic or Latino
O No, not Hispanic or Latino

What is your race? (mark one or more)
O Asian O Black/African American O White
O Native Hawaiian O Other Pacific Islander O American Indian/Alaskan Native

How would you rate your general health?
O Very Good O Good O Fair O Poor

## Ease of Getting Care

Able to get appointment for checkups (yearly exams, well-visits, regular follow-up visits)
O Very Good O Good O Fair O Poor

Able to make same day appointment when sick or hurt
O Very Good O Good O Fair O Poor

Health center hours work for me
O Very Good O Good O Fair O Poor

Phone calls get through easily
O Very Good O Good O Fair O Poor

I get called back quickly
O Very Good O Good O Fair O Poor

Able to get medical advice when the office is closed
O Very Good O Good O Fair O Poor

Length of time waiting at the clinic
O Very Good O Good O Fair O Poor

## Facility

Easy to find clinic
O Very Good O Good O Fair O Poor

Lobby and waiting room was comfortable and clean
O Very Good O Good O Fair O Poor

Handicap accessibility
O Very Good O Good O Fair O Poor

Health Home at Hancock

**Front Desk**

Friendly and helpful to you

O Very Good O Good O Fair O Poor

**The person who took care of you**

Listened to you

O Strongly Agree O Agree O Disagree O Strongly Disagree

Was friendly and helpful

O Strongly Agree O Agree O Disagree O Strongly Disagree

Answered your questions

O Strongly Agree O Agree O Disagree O Strongly Disagree

Spent enough time with you

O Strongly Agree O Agree O Disagree O Strongly Disagree

Gave you information you can understand

O Strongly Agree O Agree O Disagree O Strongly Disagree

Considered your personal or family beliefs

O Strongly Agree O Agree O Disagree O Strongly Disagree

Gave you good advice and treatment

O Strongly Agree O Agree O Disagree O Strongly Disagree

**Experience with Today's Visit**

Did anyone ask if you have problems with the medications you take?

O Yes O No O Not Applicable

Do you have problems getting your medication?
(transportation, pharmacy hours or cost)

O Yes O No O Not Applicable

Did someone talk with you about your goals for your health?

O Yes O No O Not Applicable

Were you helped with making appointments to see other providers or for specialty care?

O Yes O No O Not Applicable

**General**

Have you ever been given information on what it means to have a "health home" or a "medical home"?

O Yes O No

If yes, do you feel that we are your health/medical home?

O Yes O No O Not Applicable

Have we helped you find other services you need?

O Yes O No O Not Applicable

Do you feel that we help you to make healthy lifestyle choices?

O Yes O No O Not Applicable

**Comments**

What one thing could we do to make your visits with us better?

_____

_____

_____

_____

_____

_____

Exhibit F


Every time you talk with a health care provider
ASK THESE 3 QUESTIONS
1
What is my main problem?
2
What do I need to do?
3
Why is it important for me to do this?
When to ask questions
You can ask questions when:
• You see a doctor, nurse, pharmacist, or other health care provider.
• You prepare for a medical test or procedure.
• You get your medicine.
What if I ask and still don't understand?
• Let your health care provider know if you still don't understand what you need.
• You might say, "This is new to me. Will you please explain that to me one more time?"
Who needs to ask 3?
Everyone wants help with health information. You are not alone if you find things confusing at times. Asking questions helps you understand how to stay well or to get better.
Ask Me 3
Good Questions for Your Good Health
Institute for Healthcare Improvement
NPSF
TOGETHER FOR SAFER CARE
To learn more, visit ihi.org/AskMe3
Ask Me 3 is a registered trademark licensed to the Institute for Healthcare Improvement. IHI makes Ask Me 3 materials available for distribution. Use of Ask Me 3 materials does not mean that the distributing organization is affiliated with or endorsed by IHI.

## Write your health care provider's answers to the 3 questions here:

### 1. What is my main problem?

### 2. What do I need to do?

### 3. Why is it important for me to do this?

**Asking these questions can help me:**

- ☑ Take care of my health
- ☑ Prepare for medical tests
- ☑ Take my medicines the right way

I don't need to feel rushed or embarrassed if I don't understand something. I can ask my health care provider again.

When I Ask 3, I am prepared. I know what to do for my health.

## Your provider *wants* to answer 3

Are you nervous to ask your provider questions? Don't be. You may be surprised to learn that your medical team wants you to let them know that you need help.

Like all of us, health care providers have busy schedules. Yet they want you to know:

- All you can about your condition.
- Why this is important for your health.
- Steps to take to keep your condition under control.

**Bring your medicines with you** the next time you visit a health care provider. Or, write the names of the medicines you take on the lines below.

Like many people, you may see more than one health care provider. It is important that they all know about all of the medicines you are taking so that you can stay healthy.

Ask Me 3® is an educational program provided by the Institute for Healthcare Improvement / National Patient Safety Foundation to encourage open communication between patients and health care providers.

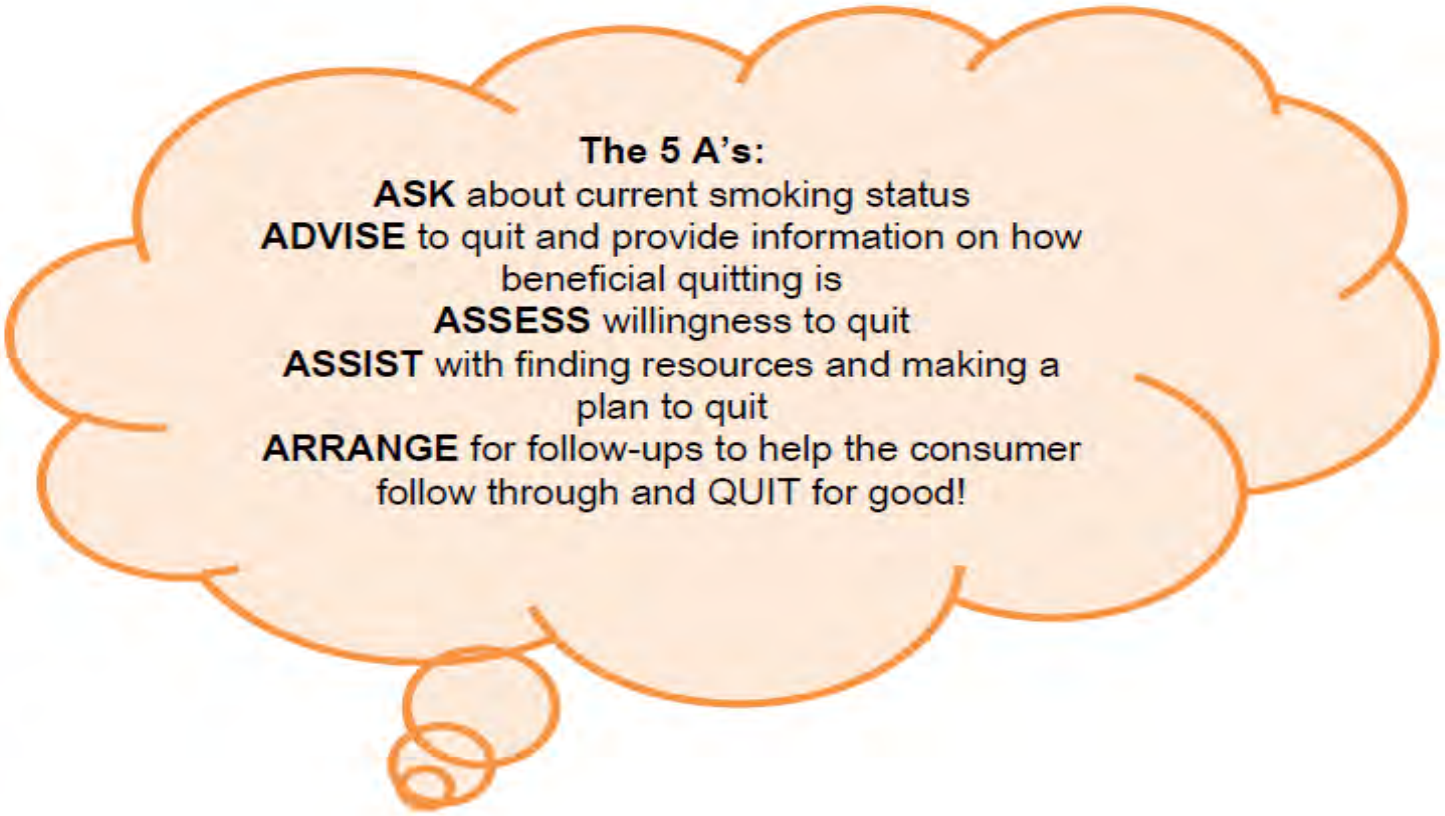
Institute for Healthcare Improvement NPSF

TOGETHER FOR SAFER CARE

Ask Me 3®

Good Questions for Your Good Health

Exhibit G


The 5 A's:
ASK about current smoking status
ADVISE to quit and provide information on how beneficial quitting is
ASSESS willingness to quit
ASSIST with finding resources and making a plan to quit
ARRANGE for follow-ups to help the consumer follow through and QUIT for good!

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Children’s Home and Community – Based Waiver Program (CWP) Overview</td><td>Chapter: 03-<br>Continuum of Care</td><td>Subject No: 03.02.47</td></tr>
<tr><td rowspan="2">Effective Date:<br>5/10/2022</td><td>Date of Review/Revision:<br>3/2/23, 3/11/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Charlotte Fondren, Director of Director of Services for Persons with IDD<br><br>Authored By: Kristie Wolbert, LMSW<br><br>Additional Reviewers:<br>Kelley Feltman<br>Rebecca Serrano<br>Lynn White</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**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).<br><br>Individuals are enrolled based upon eligibility criteria:<br>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.<br>2. Has a developmental disability as defined in federal law.<br>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).<br>4. Under the age of 18.<br>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<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Children's Home and Community – Based Waiver Program (CWP) Eligibility and Enrollment | **Chapter**: 03-<br>Continuum of Care | **Subject No**: 03.02.47.01 |
| **Effective Date**<br>5/10/2022 | **Date of Review/Revision**:<br>3/2/23, 3/11/24 | **Approved By**:<br>Sandra M. Lindsey, CEO |
| | **Supersedes**: | |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Responsible Director:**<br>Charlotte Fondren, Director of Director of Services for Persons with IDD<br><br>**Authored By**: Kristie Wolbert, LMSW<br><br>**Additional Reviewers**:<br>Rebecca Serrano<br>Lynn White<br>Kelley Feltman |

**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 does not qualify for Medicaid and must qualify for specialty mental health services. Intake will provide the family with The Children's Waiver Specialist contact information. 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 an eligibility 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 then will complete the CWP prescreen, 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 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 Category of Care 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.
- Family meets Medicaid eligibility.

**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
SCCMHA Children's Waiver Overview Policy

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| Child is assessed to ensure eligibility criteria is met. | 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:<br>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.<br>2. Has a developmental disability as defined in federal law.<br>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).<br>4. Under the age of 18.<br>5. Medicaid eligible when viewed as a family of one. | Children's Waiver Specialist |
| **Enrollment:**<br>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:<br>• Certification form completed and uploaded to the Document tab in the WSA.<br>• Add/Update Parent/Guardian demographics in the WSA.<br>• Medical Examination Form (DHS-49) details entered in the WSA.<br>• 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. | 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. | Case Holder |
| **Annual Recertification**:<br>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. | Children's Waiver Specialist |
| **Disenrollment:**<br>The child will be disenrolled from the CWP when:<br>• The child turns 18<br>• The child no longer resides in the community with biological/adoptive parents or with relatives who have been named legal guardian.<br>• The child in specialized foster care does not return home within six months of inception of waiver services.<br>• The child no longer meets criteria for ICF/IID facility.<br>• Parent(s) or guardian(s) withdraw consent for participation in Children's Waiver Services Program.<br>• Family meets Medicaid eligibility. | Case Holder/ Children's Waiver Specialist |

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Older Adult Services</td><td>Chapter: 03-Continuum of Care</td><td>Subject No: 03.02.48</td></tr>
<tr><td rowspan="2">Effective Date:<br>7/1/24</td><td>Date of Review/Revision:</td><td rowspan="2">Approved By:<br>Sandra M. Lindsey, CEO</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">  </td><td>Responsible Director:<br>Executive Director of Clinical Services<br><br>Author: Barbara Glassheim<br><br>Additional Reviewers:</td></tr>
</table>

**Purpose:**
The purpose of this policy is to set forth principles and standards for delivering services to persons aged 50 and older with a diagnosed mental illness, substance use disorder (SUD), or intellectual/developmental disability (I/DD), including those with co-occurring or multiple diagnoses, including co-morbid general health conditions.

**Application:**
This policy applies to all SCCMHA-funded services and supports delivered by the entire provider network to older adults with a mental illness, SUD, and/or I/DD.

**Policy:**

SCCMHA recognizes that older adult persons served are at higher risk for complex health problems, chronic illness, and disability than their younger counterparts.

According to the US Administration on Aging and the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately twenty percent (20%) of adults fifty (50) years and older have mental health concerns. Depression, anxiety, alcohol misuse, and psychoactive medication misuse are the most common types of mental health and substance use issues among older adults. Older men have the highest suicide rates. While there are effective prevention, treatment, recovery services, and supports for older adults, this population is significantly less likely to be diagnosed and referred to treatment than younger adults. Moreover, older adults may be reluctant to seek help from mental health providers due to misattribution of symptoms to general health conditions (i.e., medical problems) as well as the stigma associated with behavioral health treatment.

Adults with a diagnosis of a serious mental illness (SMI) are disproportionately affected by medical comorbidity, earlier onset of disease, and die up to 25 years earlier than their counterparts in the general population, and those with SUDs die up to 35 years earlier. (The average age of death for a person with an SMI is 53 and 45 years of age for a person with a substance use disorder.) Moreover, age-related changes in metabolism, physiology, and activity may contribute to the development of additional illnesses and

worse health outcomes. Comorbidities are common in this population; mental health disorders often co-occur with a number of common chronic illnesses such as diabetes, cardiac disease, and arthritis. In addition to co-morbid physical and behavioral health conditions, older adults are at greater risk for social isolation which is associated with poor health and emotional distress, particularly for those with multiple chronic conditions or functional limitations.

While adults with intellectual/developmental disabilities are living longer, healthier, more meaningful lives, adults with I/DD can have a shorter life span compared to older adults in the general population. This is thought to be caused by an accelerated aging process, manifest in increased rates of cataracts, hearing loss, osteopenia, and hypothyroidism and a genetically elevated risk of developing Alzheimer's disease. There is a higher incidence of dental disease, functional decline, mental illness, bowel obstruction, gastrointestinal cancer, and obesity among older adults with I/DD. Additionally, hearing impairment and vision loss are common in older adults with I/DD due to preexisting undiagnosed pathologies. Providers may be challenged to accommodate adults with I/DD who have communication and behavioral difficulties that create barriers to effective assessment and treatment. This population may display behavioral issues that could negatively impact their ability to cooperate with tests, injections, and other procedures. Communication issues may make interaction among the provider, caregiver, and person served challenging. Finally, physical challenges (e.g., cerebral palsy) may make it physically difficult to access a health care facility and environmental issues that may involve sensory challenges (e.g., lighting, sound, smells) can interfere with the ability of a person served to effectively participate in the visit.

SCCMHA recognizes the detrimental impact ageism has on both physical and mental health. It plays a role in social isolation, worse overall health, and reduced life expectancy. It also affects people in multiple areas including school, work, leisure activities and healthcare. SCCMHA also recognizes that good general health and social care are important for the promotion of older adults' health, disease prevention and the effective management of chronic illnesses.

Therefore, SCCMHA providers need to be knowledgeable about issues specific to older adults in order to ensure that services and supports are appropriate to the phase of life occupied by older adults. SCCMHA providers also need to be aware of specific resources for older adults and their caregivers such as wellness programs, nutritional support, educational programs about health and aging, and counseling services for caregivers, as well as general assistance with housing, finances, and home safety.

Specifically, SCCMHA providers need to take into consideration a number of factors when serving older adults including the following: (1) age-related changes in the metabolism of medications and alcohol that can exacerbate mental, physical and substance use disorders; (2) losses often occur in older age such as the death of a spouse, partner, close family member, or friend which can trigger emotional responses that can exacerbate mental health symptoms; (3) medications used to treat acute and chronic health conditions that can cause or exacerbate mental health conditions; (4) cognitive, functional and sensory impairments that can complicate the detection or diagnosis of mental health conditions as well as impair an older person's ability to adhere to recommended treatment regimens; (5) older adults are less likely to seek mental health treatment than their younger counterparts and may, instead, seek help from clergy or other trusted members of their community; and

(6) cultural and linguistic competence needed to effectively serve the growing diversity of the older adult population.

**Standards:**

A. SCCMHA shall promote healthy aging (see definition below) by encouraging older adult persons served to proactively take preventive health measures, learn how to self-manage chronic conditions, and participate in engaging, stimulating, and meaningful activities.

B. SCCMHA shall, resources permitting, offer continuing education regarding the unique needs of older adult persons served.
   1. SCCMHA shall encourage staff to understand issues associated with substance misuse, mental health, and I/DD conditions in older adults.
   2. SCCMHA shall encourage staff to become familiar with comorbid general health issues associated with older adults who have an SMI, SUD, COD, I/DD.
   3. SCCMHA shall encourage staff to understand, appreciate and combat the many myths associated with aging, particularly those associated with mental health issues and substance misuse in older adults.

C. The desires and functioning of each individual older adult person served shall be taken into consideration in the planning and delivery of services and supports.

D. Practitioners shall use standardized screening and assessment instruments to evaluate older adults that have been validated for this populations (e.g., PHQ-9, GAD-7).
   1. Universal screening for suicidality is recommended.

E. Practitioners shall use evidence-based interventions and treatments that are appropriate for older adults (e.g., CBT, DBT, Interpersonal Psychotherapy).
   1. Treatment decisions shall be made in a collaborative manner in partnership with the person served and their family/support system (where appropriate and available) using a shared decision-making approach.

F. Services and supports provided to older adult persons served shall be culturally relevant.
   1. Providers shall be aware of and seek to avoid stigma and ageism when working with older adult persons served.

G. Providers shall offer care management services to older adult persons served in order to help those with co-occurring conditions manage their health conditions. These care management services shall include:
   1. Assessing the needs of the person served.
   2. Developing a care plan in collaboration with the older adult person served and their natural and paid support system using shared decision-making.
   3. Ensuring preventive care services are provided.
   4. Providing medication reconciliation.
   5. Managing care transitions between providers/settings.
   6. Coordinating with home- and community-based providers.

H. SCCMHA providers shall support aging in place in accordance with the goals and wishes of person served.
   1. Providers shall focus on helping older adult persons served maintain their health and enabling them to remain safely in the community.

2. Providers shall ensure necessary supports (e.g., transportation, assistance with homemaking [domestic duties], recreation/leisure activities, etc.) are made available to older adult persons served.
3. Providers shall avoid nursing home placement to the greatest extent possible.
    a. Institutionalization shall be deemed a last resort *only* available after *all* other possible options have been exhausted.

    NOTE: Nursing homes are not considered appropriate settings for the care of individuals with a serious mental illness absent other functional impairments or medical conditions that warrant nursing home care.

I. SCCMHA network providers shall focus on helping older adult persons served function as independently as possible in the community.
    1. Providers shall assist older adult persons served to establish and maintain meaningful connections in the community.

J. SCCMHA network providers shall endeavor to recruit older adult peer support specialists and community health workers (CHWs) when feasible to help engage older adult persons served in their own care and self-management of chronic conditions.

K. SCCMHA network providers shall offer support to family caregivers of older adult persons served and link them to community resources (e.g., respite services, support groups, caregiver trainings) with a focus on helping families and caregivers maintain their own health and well-being to lessen caregiver burden and prevent burnout.

L. SCCMHA network providers shall endeavor to promote advance care planning, including resources for the provision of help with palliative care and end-of-life decision-making.
    1. SCCMHA providers shall connect older adult persons served and their caregivers with legal and social services as needed.

**Definitions:**

**Ageism:** Stereotypes, prejudice and discrimination towards others or oneself based on age (WHO). There are two primary types of ageism. The term ageism is usually used to apply to discrimination against older adults, while reverse ageism has been used to describe how younger adults can also face prejudice and discrimination because of their age (e.g.,. dismissing younger workers as too inexperienced, unprofessional, or not qualified for advancement).

Everyday examples of ageism include, but are not limited to:

- ‘Anti-aging’ products and services
- Praising older individuals by comparing them to younger ones (e.g., "You look good for [your age]," "You're young at heart" or "Inside, I feel 30 years younger)
- Describing minor forgetfulness as a "senior moment"
- Patronizing language (e.g., “sweetie”, “dear”, “honey”, “he's so sweet”, “isn't she cute”)
- Assuming that young people are computer whizzes and older people are technologically inept

- Pejorative labels (e.g., “geezer”, “gramps”, “little old lady”, “old bag”, “biddy”, “old fogey”)
- Directing comments about an older person at a younger companion or child of the older person

Ageism, a systemic form of oppression, can range from subtle actions to blatant acts of discrimination in the workplace, including but not limited to:

- Being excluded from the rest of the group
- Being passed over for promotions or raises
- Forcing older people to retire or laying off older workers
- Negative comments about a person's age
- Not accepting input from younger people or dismissing their input due to lack of experience
- Not getting the same benefits such as paid time off
- Only providing learning opportunities to younger people

**Functional Abilities:** The abilities to meet basic needs; learn, grow and make decisions; be mobile; build and maintain relationships; and contribute to society. (WHO)

**Healthy Aging:** The process of developing and maintaining the functional ability that enables wellbeing in older age. (WHO)

**References:**


A. SCCMHA. (2013). *A Guide to Evidence-Based Practices for Older Adults with Mental Illness*: https://www.sccmha.org/userfiles/filemanager/293/
B. SCCMHA Policy 02.03.12 – Alternatives to Guardianship
C. SCCMHA Policy 03.02.18 – Respite Services
D. SCCMHA Policy 03.02.46 – Whole-Person Care
E. SCCMHA Policy 10.01.01.01 – Care Transitions
F. Substance Abuse and Mental Health Services Administration. (2019). *Get Connected: Linking Older Adults with Resources on Medication, Alcohol, and Mental Health*. SAMHSA Rockville, MD.: https://www.store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-011%20PDF%20508c.pdf
G. Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration. (2016*). Growing Older: Providing Integrated Care for an Aging Population*. SAMHSA. Rockville, MD.: https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4982.pdf
H. World Health Organization. Decade of Healthy Aging: 2020–2030. Update 1: March, 2019. WHO. Geneva, Switzerland.: https://www.who.int/docs/default-source/documents/decade-of-health-ageing/decade-healthy-ageing-update-march-2019.pdf?sfvrsn=5a6d0e5c_2


**Exhibits:**

None

**Procedure:**

None

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Care Transitions | **Chapter**: 10 – Health Home | **Subject No**: 03.02.49.01 |
| **Effective Date**: 12/8/2020 | **Date of Review/Revision**: 6/17/21, 9/14/22, 5/9/24<br>**Supersedes**: | **Approved By**: Sandra M. Lindsey, CEO |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Responsible Director:** Chief of Health Services & Integrated Care<br><br>**Authored By**: Jen Kreiner<br><br>**Additional Reviewers**: Executive Director of Clinical Services, Director of Provider Network |

**Purpose:**
The purpose of this policy is to delineate the roles and responsibilities of various members of the person receiving services care team in coordinating and ensuing smooth transitions between institutional/facility-based (e.g., hospital) care and community living, particularly residential settings such as adult foster care (AFC).

**Application:**
The policy applies to SCCMHA-funded providers of services and supports to adult people receiving services who experience an inpatient episode of medical care.

**Policy:**
It is the policy of SCCMHA to ensure a seamless and safe transition for persons served, enhancing the quality of care, minimizing hospital readmissions, and improving patient outcomes. It is expected that all staff involved in the care of persons served adhere to these standards to ensure a consistent, high-quality approach to patient transition.

**Standards:**
Residential services providers shall notify case holders of all persons served admissions to inpatient medical facilities within twenty-four (24) hours of the admission by phone call or secure email or fax.

A. Discharge planning should commence upon notification of an inpatient admission. This includes initiating a collaborative partnership with the designated hospital discharge planning staff and keeping relevant healthcare professionals informed.
B. Case holders shall fax person served information to the designated hospital discharge planning staff. (Exhibit A)
C. Case holders shall fax the SCCMHA checklist for hospital discharge requirements to the discharge planner. (Exhibit B)

D. Case holders shall ensure the person served residential setting has a checklist of any needed resources in order to ensure that the setting can accommodate the consumer's needs following discharge.
E. Case holders shall contact the SCCMHA Registered Nurse to keep the nurse apprised of the discharge planning process.
    1. Case Holders, in conjunction with the nurse or another medical professional, shall conduct a medication check and follow up with prescribers as needed when there is a discrepancy or potential for a drug-drug interaction or potential polypharmacy issues.
F. Case holders shall monitor person served throughout the course of an inpatient hospital stay for medical care.
    1. Case holders shall conduct at least one face-to-face meeting with the person served while the person served is hospitalized.
    2. Case holders shall conduct weekly face-to-face meetings with the person served during an inpatient episode of care if warranted.
G. Case holders shall maintain ongoing communication with appropriate residential services staff throughout the persons served inpatient hospitalization in order to keep the staff apprised of the persons served status and potential post discharge needs including any appointments and resources that the person served may require.
    1. Case holders and/or hospital discharge planners shall communicate with the residential services staff regarding any follow-up care appointments and community resources that will be needed by the person served post discharge.
    2. Case holders, hospital discharge planners and residential services staff shall assure all necessary durable medical equipment (DME) is acquired prior to or on the day of discharge.
        a. DME equipment shall be present in the residential setting prior to the persons served return to that setting.
H. Case holders, hospital discharge planners and residential services staff shall make sure that all new medications prescribed by the discharging physician are obtained on the day of the discharge from the hospital.
    1. Residential services staff shall ensure the hospital has complete and accurate medication information upon admission of the person served.
    2. Residential services staff shall complete a medication reconciliation process at the home in order to assure all medications discontinued on the medication administration record (MAR) are clearly marked as discontinued and any new medications that have been prescribed per hospital discharge plan are noted on the MAR at the home.
        a. Residential services staff shall also ensure there is absolute clarity regarding which medications will be continued, and which medications are newly prescribed upon hospital discharge as part of obtaining all written discharge instructions.
    3. Residential services staff shall coordinate medication changes at the time of a hospital admission and the discharge.

4. Upon discharge, whenever indicated, the pharmacy provider, nurse practitioner or physician(s) shall be consulted for clarification regarding medications.

I. The case holder or SCCMHA Registered Nurse shall place outbound phone calls to the person served/guardian and the residential services provider on the day of discharge.
J. The case holder or the SCCMHA Registered Nurse shall conduct a face-to-face meeting with the person served within twenty-four (24) business hours of the persons served discharge.
K. Case holders and SCCMHA Registered Nurses shall document all care transition planning throughout the discharge planning process in the persons served SCCMHA electronic health record (EHR).

**Definitions:**

**Care Transitions:** The movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

**Community Resource:** Anything that has the potential to improve the quality of life in a community. Community resources may include, but are not limited to, organizations, places, services, businesses, and individuals.

**Discharge Planning:** The activities that facilitate a person served movement from one health care setting to another or to home. Discharge planning is a multidisciplinary process that may include physicians, nurses, social workers and others and is designed to enhance continuity of care. Discharge planning begins upon admission.

**Home Health Care Agency:** A public or private organization that provides, either directly or through arrangements with other organizations, skilled or paraprofessional home health care to individuals in out-of-hospital settings such as private homes, boarding homes, hospices, shelters, etc. A home health care agency's policies must be established and supervised by professional staff including one or more licensed physicians and one or more registered nurses. The agency must maintain clinical records on all patients it serves.

**Medication Check:** For purposes of this policy, a Medication Check is conducted during each person served contact by a Case Holder and consists of asking the person served whether they have had a changes to their medication regimen since their last contact with the Case Holder. This includes over-the-counter medications and dietary supplements.

**Medication Reconciliation**: The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

**Transition Management:** The ongoing support of patients and their families/support systems over time as they navigate care and relationships among more than one provider and/or more than one health care setting and/or more than one health care service.

**References:**

A. SCCMHA Policy 03.02.17 – Medication Management in a Licensed Residential Setting
B. SCCMHA policy 02.03.23 – Care Coordination
C. SCCMHA Policy 10.01.02 – Hospital Discharge Planning

D. SCCMHA Policy 03.02.20 – Medication Review

**Exhibits:**

A. Consumer Information for Inpatient Admission
B. Hospital Discharge Responsibilities Checklist
C. Hospital Discharge Requirements Checklist – Residential Services Provider
D. Hospital Discharge Requirements Checklist – Case Holder
E. Hospital Discharge Requirements Checklist – Nursing Staff

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| Review Medical/surgical Hospital Discharge Policy/Standards | Case Holder/Nursing and Residential Services Provider staff |
| Case holders shall contact the designated hospital discharge planning staff on the date they are notified of the person served admission to initiate a collaborative discharge planning partnership and begin the discharge planning process. | Case Holder |
| Obtain copy of Medication Administration record from the home | Case Holder/Nursing Staff |
| Obtain signed Physician orders from the discharging hospital facility | Case Holder/Nursing and Residential Services Provider staff |
| Compare new orders to previous orders, to include, treatments, medications, diet, activity, any applicable precautions, etc. | Case Holder/Nursing and Residential Services Provider staff |
| Conduct a Medication Check. | Case Holder/Nursing Staff/Home Manager or Designee |
| Conduct a Medication Reconciliation. | RN/NP/PA/Psychiatrist |
| Follow up with care Agencies(Home Health Care), DME | Hospital Discharge Planner/Case Holder/Nursing Staff |
| Verify post hospital follow up appointments, including labs, x-rays, primary care provider, psychiatric appointments, specialists, etc. | Case Holder/Nursing and Residential Services Provider staff |
| Contact the pharmacy to ensure all of the discharge medications are available for immediate dispensing. | Case Holder/Nursing Staff and Residential Services Provider staff |

| | |
|---|---|
| If unavailable, locate a pharmacy that has them in stock.<br>Contact discharge planner to identify a substitute medication that would be equally effective and is available if the current drug is unavailable or not covered by insurance.<br>Check the discharging facility's pharmacy for availability and fill prescriptions there before leaving the facility, if applicable. | |
| Discuss any discrepancies with the discharge planner before allowing the persons served to leave the discharging facility. | Case Holder/Nursing Staff and Residential Services Provider staff |
| Make contact with the AFC home manager to update him/her.<br>Keep the home manger updated on the discharge process. | Case Holder/ SCCMHA Health Care Services and Coordination Nurse |

Exhibit A

## Consumer Information For Inpatient Admission

*please keep with consumer and include medication sheet*

**Upon discharge call report to**

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Consumer Name: _____ DOB: _____

Medicaid/Medicare ID: _____

Language: _____ Interpreter needed? YES NO

Resides at: _____ Specialized Residential AFC (circle one)

Home Manager Name: _____ Phone Number: _____

Case Manager/
Support Coordinator: _____ Phone Number: _____

Guardian/ Status/
DPOA/ Next of Kin: _____ Phone Number: _____

Advance Directives (Living will, Durable Power of Attorney): YES NO

If NO, would you like more information? YES NO

Primary Care Physician: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

Diagnosis: _____

Allergies: _____

Previous Surgeries/ Hospitalizations: _____

Special Requests: _____

Behavior challenges that require accommodation: _____

Equipment Used _____
(glasses, hearing aids, dentures etc.):

Assistance required for verbal or written instructions: _____

Community Service in place: _____
(i.e., Directive on Aging, CHW etc.)

Home Care Service received: _____
(i.e., VNA, Heartland, etc.)

**Please circle the number that best describes the consumer's current situation:**

| Ambulation Mobility | Mobility | Transferring | Food/Eating | Special Diet |
|---|---|---|---|---|
| 1. Walker | 1. Ambulatory | 1. One person | 1. Discomfort swallowing | 1. Soft |
| 2. Wheelchair | 2. Ambulatory w/ assist. | 2. Two person | 2. Difficulty swallowing | 2. Peg tube |
| 3. Cane | 3. Transfer w/ assist. | 3. Lift | 3. Difficulty chewing | 3. Liquids |
| 4. Rotator | 4. Bed rest | | 4. Independent | 4. DM |
| | | | 5. With assistance | 5. NA |

| Grooming | Bathing | Dressing | Taking Meds | Med Administration |
|---|---|---|---|---|
| 1. Independent | 1. Independent | 1. Independent | 1. Independent | 1. Crushed |

## Consumer Information For Inpatient Admission

*please keep with consumer and include medication sheet*

| | | | | |
|---|---|---|---|---|
| 2. With assistance | 2. With assistance | 2. With assistance | 2. With assistance | 2. In soft foods |
| 3. Dependent | 3. Dependent | 3. Dependent | 3. Dependent | 3. With liquids |

**Updated 5/2018**

Exhibit B

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

## HOSPITAL DISCHARGE RESPONSIBILITIES CHECKLIST

Person Served Name: _____

Dates of Hospitalization: _____

Please check off and initial each item after it is completed

Please note that *prior approval* must be obtained from SCCMHA for all discharges to a new community living facility (AFC, CLS)

- ☐ Prescriptions. (An order is needed to resume home medications and treatments as well as for any new medications prescribed by the hospital/facility. Also, a discontinue order or change order is needed for any medication that the hospital has discontinued or changed.) **PLEASE WRITE "RESUME ALL HOME MEDICATIONS AND TREATMENTS UNLESS OTHERWISE NOTED ON THE DISCHARGE PAPERWORK"**
- ☐ All prescriptions written, faxed, or electronically prescribed should also be listed on the discharge papers. (These documents should match.)
- ☐ Coordinate with the SCCMHA case holder when the discharge is approaching. Fax the discharge plan to the SCCMHA case holder before the discharge is completed. The SCCMHA case holder will review it and notify the discharge planner of any needed changes.
- ☐ Provide a transfer summary to the SCCMHA case holder and residential provider (if applicable).
- ☐ Provide the admitting notes to the SCCMHA case holder and residential provider (if applicable).
- ☐ Provide a copy of all labs to the SCCMHA case holder and residential provider (if applicable).
- ☐ Provide a copy of any consults to the SCCMHA case holder and residential provider (if applicable).
- ☐ Coordinate home care agency service delivery (OT, PT, RN, RD) to ensure the first visit to the person receiving services home occurs on the same day as their discharge.
- ☐ Ensure all prescribed equipment is in the person receiving services residence at the time of discharge.
- ☐ Provide the residential services provider with a prescription for DME that cannot be obtained prior to discharge.
- ☐ Provide the discharge diagnosis to the SCCMHA case holder and residential services provider (if applicable).
- ☐ Provide a list of follow-up appointments to the SCCMHA case holder and residential services provider (if applicable).
- ☐ Provide verbal and written instructions to residential services staff regarding ongoing medical needs of the person served.
- ☐ Provide a list of any restrictions (e.g., dietary, activities) to residential services staff.

Revised 6/16/21

Exhibit C

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

**HOSPITAL DISCHARGE REQUIREMENTS CHECKLIST**
**RESIDENTIAL SERVICES PROVIDER RESPONSIBILITIES**

- ☐ Confirm SCCMHA's approval of the discharge.
- ☐ Provide updates to the guardian (if applicable) about the discharge.
- ☐ Contact the SCCMHA case holder and/or nurse with any questions or concerns regarding the discharge (e.g., difficulty with prescriptions, equipment, or home care).
- ☐ Ensure all listed documents are provided:
  - ☐ Prescriptions
  - ☐ Discharge plan
  - ☐ Transfer summary
  - ☐ Admitting notes
  - ☐ Labs
  - ☐ Consults
  - ☐ Prescribed equipment
  - ☐ Prescription(s) for equipment
  - ☐ Discharge diagnosis
  - ☐ List of follow up appointments
  - ☐ Restrictions (if any)
- ☐ Compare new orders to previous orders and make adjustments as needed in the medication administration record.
- ☐ List all follow-up appointments on the calendar.
- ☐ Bring all necessary items when picking up the client from the hospital such as wheelchair, briefs, glasses, coat, clothes, shoes, etc.
- ☐ Ensure all of the person receiving services belongings that went to the hospital with the person served (hearing aids, glasses, dentures, etc.) return home with them.

Per SCCMHA Policy 03.02.71 – Medication Management in Residential Settings:
"Home managers and residential staff must coordinate medication changes upon hospital admissions and discharges for persons served. Home staff should ensure the hospital has complete and accurate medication information upon admission; home staff must also ensure they are clear what medications will be continued, what medications will be discontinued and what medications will be newly prescribed upon hospital discharge, as part of obtaining any and all written discharge instructions. Whenever indicated, pharmacy, nurse practitioner or physician(s) clarification should be sought regarding medications upon discharge."

Exhibit D

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# HOSPITAL DISCHARGE REQUIREMENTS CHECKLIST
# CASE HOLDER RESPONSIBILITIES

- ☐ Coordinate discharge with the discharge planner. [The case holder should have frequent contact with the Discharge Planner at the hospital.]
- ☐ Coordinate with the home regarding discharge. [The case holder should have frequent contact with the home about status of person served move back to the home.]
- ☐ Keep the person served home health care nurse (if applicable) updated or the supervisor of the SCCMHA Health Home if person served may need nursing beyond visiting nurse post discharge.
- ☐ Review the discharge summary, medication profile, and any applicable discharge instructions with the home health care nurse (if applicable) or the supervisor of the SCCMHA Health Home and send back to discharge planner with any needed changes.
- ☐ Verify the home health care agency choice with the person served/guardian and obtain releases of information for all home health care providers (if applicable).
- ☐ Notify the person receiving services psychiatrist of hospitalization (if applicable).
- ☐ Notify the SCCMHA Health Home Supervisor of hospitalization (if applicable).
- ☐ Assure the person receiving services residential services provider (if applicable) is aware of and schedules follow-up appointments and obtain necessary equipment that was not delivered via the hospital at the time of the person receiving services discharge.

Exhibit E

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# HOSPITAL DISCHARGE REQUIREMENTS CHECKLIST
# NURSE RESPONSIBILITIES

- ☐ Maintain contact with the case holder and residential services provider
- ☐ Inform the SCCMHA Health Home supervisor of the discharge.
- ☐ Initiate a face-to-face contact with the person served within twenty-four business hours of discharge.

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></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 rowspan="2">Effective Date:<br>06/01/2020</td><td>Date of Review/Revision:<br>3/31/21, 2/28/22, 3/7/23, 3/7/24</td><td rowspan="2">Approved By:<br>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:<br>Kristie Wolbert,<br>Executive Director of Clinical Services<br><br>Authored By:<br>Erin M. Nostrandt<br><br>Additional Reviewers:<br>Trauma-Informed Workgroup<br>Jennifer Stanuszek, LMFT</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 as part of the treatment plan if consumer/parent/guardian is in agreement. 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 elicit 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 | Intake Specialist |

| | |
|---|---|
| results of the screening within the consumers Sentri record (Section 7; under- *Observation and Reported Information*). | |
| Following approval for service eligibility by Care Management the Trauma Screen will be reviewed by the receiving team's Supervisor (or designee) 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:<br>• 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. | Supervisor/designee |
| • 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 progress note clearly explaining the reason for declining further assessment. | Supervisor/designee |

| | |
|---|---|
| • 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/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.<br>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 expected to follow the above steps. | Case Holder |

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

Exhibit F



| TRAUMA/LOSS HISTORY SCREENING QUESTIONS | |
|---|---|
| ☐ | **13) Sexual Assault**: Did someone outside your family ever force you to do something sexual? Did you ever see someone else being forced to do something sexual? |
| ☐ | **14) 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? |
| ☐ | **15) Terrorism**: Were you ever there when a terrorist attack happened, like a bombing, chemical attack or where people were taken hostage? |
| ☐ | **16) Bereavement**: Has someone really close to you ever died? |
| ☐ | **17) 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? |
| ☐ | **18) War/Political Violence**: Have you lived in a country where a war or armed conflict was happening (like soldiers or armed groups were fighting)? Did you see people who had been badly hurt or killed in a war or armed conflict? |
| ☐ | **19) 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? |
| ☐ | **20) Trafficking/Sexual Exploitation**: Have you ever done sexual things for money, food, clothes or protection? Were you ever sold to someone to work for them? Have you been forced into prostitution or pornography? |
| ☐ | **21) 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? |
| ☐ | **22) Attempted Suicide**: Have you ever tried to kill yourself? |
| ☐ | **23) Witnessed Suicide**: Have you ever seen someone after he/she attempted or 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<br>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 |
|---|---|---|---|
| **Serious Accidental Injury** | ☐ Motor Vehicle Accident<br>☐ Fall with Serious Injury<br>☐ Severe Burn ☐ Dog Bite Requiring Stitches ☐ Near Drowning ☐ Hospitalized<br>☐ Other_____ | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

| Trauma Type | Trauma Details | Role in Event | Age(s) Experienced<br>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 |
|---|---|---|---|
| **Illness/Medical Trauma** | ☐ Child ☐ Family ☐ Friend<br>☐ Type of Illness<br>_____<br>☐ Extended Hospitalization<br>☐ Major Medical Procedures<br>☐ Catastrophic Medical Event | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Community Violence** | ☐ Someone Injured or Killed<br>☐ Mugging ☐ Drug Dealing<br>☐ Gang-Related<br>☐ Home Robbery<br>☐ High Crime Community<br>☐ Witness Arrest of a Family Member<br>☐ Other _____ | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Domestic Violence** | ☐ Witnessed Physical Attack or Fight<br>☐ Heard Threatened Harm<br>☐ Heard Screams of Distress<br>☐ Witnessed Sexual Assault<br>☐ Weapon Used<br>☐ Serious Injury<br>☐ Police Response<br>☐ Restraining Order | ☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **School Violence/Emergency** | ☐ Shooting ☐ Stabbing ☐ Fire<br>☐ Bomb threat<br>☐ Hostage Situation<br>☐ Suicide ☐ Homicide<br>☐ Acute Medical Death<br>☐ Witnessed Resuscitation Efforts<br>☐ Other _____ | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Physical Assault** | ☐ Punched ☐ Kicked<br>☐ Stabbed ☐ Shaken<br>☐ Weapon Used<br>☐ Reported to police<br>☐ Other _____ | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

| Trauma Type | Trauma Details | Role in Event | Age(s) Experienced<br>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 |
|---|---|---|---|
| **Disaster** | ☐ Earthquake ☐ Fire ☐ Flood<br>☐ Hurricane ☐ Tornado<br>☐ Chemical spill ☐ Explosion<br>☐ Evacuated ☐ Lost Home<br>☐ Injury<br>☐ Death of family member<br>☐ Other _____ | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Sexual Abuse** | ☐ Forced sexual behavior<br>☐ Watch something sexual<br>☐ Penetration occurred<br>☐ Perpetrator _____<br>☐ Child Protective Services Report<br>☐ Investigation conducted<br>☐ Charges filed<br>☐ Conviction<br>☐ Perpetrator removed from home<br>☐ Child Removed from Home | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Physical Abuse** | ☐ Badly Physically Hurt<br>☐ Punched ☐ Kicked<br>☐ Stabbed<br>☐ Shaken ☐ Weapon Used<br>☐ Perpetrator _____<br>☐ Child Protective Services Report<br>☐ Investigation Conducted<br>☐ Charges Filed<br>☐ Conviction<br>☐ Perpetrator Removed From Home<br>☐ Child Removed From Home | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

| Trauma Type | Trauma Details | Role in Event | Age(s) Experienced<br>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 |
|---|---|---|---|
| **Neglect** | ☐ Medical Neglect<br>☐ School Neglect<br>☐ Left Alone/Unsupervised<br>☐ Failure to promote health<br>☐ Failure to promote safety<br>☐ Other _____<br>☐ Perpetrator<br>☐ Child Protective Services Report<br>☐ Investigation Conducted<br>☐ Charges Filed<br>☐ Conviction<br>☐ Perpetrator Removed from Home<br>☐ Child Removed from Home | ☐ Victim<br>☐ Witness | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Psychological Maltreatment/ Emotional Abuse** | ☐ Berating<br>☐ Threatened Abandonment<br>☐ Excessive Punishment<br>☐ Other _____<br>☐ Perpetrator<br>☐ Child Protective Services Report<br>☐ Investigation Conducted<br>☐ Charges Filed<br>☐ Conviction<br>☐ Perpetrator Removed From Home<br>☐ Child Removed From Home | ☐ Victim<br>☐ Witness | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

| Trauma Type | Trauma Details | Role in Event | Age(s) Experienced<br>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 |
|---|---|---|---|
| **Interference with Caregiving** | **Impairment Due to:**<br>☐ Medical illness<br>☐ Mental health problem<br>☐ Alcohol use/abuse/addiction<br>☐ Drug use/abuse/addiction<br>☐ Extended hospitalization or rehabilitation<br>**Affected Caregiver:**<br>☐ Mother<br>☐ Father<br>☐ Other relative<br>☐ Other (non-related) adult<br>☐ Other _____ | ☐ Victim<br>☐ Witness | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Sexual Assault** | **Perpetrator**:<br>☐ Relative<br>☐ Position of trust (teacher, coach, step-parent, minister, clergy, relative not in the home)<br>☐ Acquaintance (neighbor, etc.)<br>☐ Stranger<br>**Trauma Details:**<br>☐ Weapon used<br>☐ Object used<br>☐ Penetration occurred<br>☐ Date/Acquaintance rape<br>☐ Reported to police<br>☐ Investigation conducted<br>☐ Charges filed<br>☐ Conviction<br>☐ Other _____ | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

| Trauma Type | Trauma Details | Role in Event | Age(s) Experienced<br>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 |
|---|---|---|---|
| **Kidnapping/ Abduction** | **Perpetrator**:<br>☐ Parent ☐ Relative<br>☐ Step-parent<br>☐ Position of trust (teacher, coach, clergy)<br>☐ Acquaintance (neighbor, etc.)<br>☐ Stranger<br>☐ Length of time<br>☐ Reported to police<br>☐ Investigation conducted<br>☐ Charges filed<br>☐ Conviction | ☐ Victim<br>☐ Witnessed<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Terrorism** | ☐ Shooting<br>☐ Bombing<br>☐ Suicide bombing<br>☐ Chemical agent<br>☐ Biological agent<br>☐ Radiological agent<br>☐ Hostages taken<br>☐ Parent or caregiver injured<br>☐ Parent or caregiver killed<br>☐ Other _____ | ☐ Victim<br>☐ Witnessed<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

| Trauma Type | Trauma Details | Role in Event | Age(s) Experienced<br>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 |
|---|---|---|---|
| **Bereavement** | **Deceased/Cause**<br>☐ Primary Caregiver #_____<br>☐ Parent #_____<br>☐ Sibling #_____<br>☐ Grandparent #_____<br>☐ Other Relative #_____<br>☐ Friend #_____<br>☐ Other _____ #_____<br>**Cause of Death**<br>1.Natural Causes (illness, age)<br>2.Accident (car, drowning, fall)<br>3.Drug overdose<br>4.Natural disaster<br>5.Homicide<br>6.Suicide<br>7.Other _____ | ☐ Witnessed<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Separation** | **Cause of Separation**<br>☐ Parental death<br>☐ Parents separated<br>☐ Parents divorced<br>☐ Parent hospitalized<br>☐ Parent/sibling incarcerated<br>☐ Immigration proceeding<br>☐ Military deployment<br>☐ Combat<br>☐ Child placed in foster care<br>☐ Parent removed from the home<br>☐ In refugee situation<br>☐ Due to immigration situation<br>☐ Other _____ | ☐ Victim | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

| Trauma Type | Trauma Details | Role in Event | Age(s) Experienced<br>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<br>☐ Experienced armed conflict<br>☐ Saw wounded people<br>☐ Saw dead bodies<br>☐ Family members taken as prisoners<br>☐ Home damaged/destroyed<br>☐ Internally displaced<br>☐ War refugee<br>☐ Other _____ | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Forced Displacement** | **Cause of Displacement:**<br>☐ War/political violence<br>☐ Disaster<br>☐ Other _____<br>**Site of Displacement:**<br>☐ Trailer<br>☐ Refugee camp<br>☐ Relocation center<br>☐ Other _____ | ☐ Victim<br>☐ Witness | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Trafficking/Sexual Exploitation** | ☐ Sex for money, food, clothes<br>☐ Pornography<br>☐ Sold into prostitution<br>☐ Sold into slave labor (unpaid servant or worker)<br>☐ Other | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Bullying** | ☐ Verbal insults<br>☐ Threats of physical harm<br>☐ Injury<br>☐ Sexual comments<br>☐ Rumors at school/internet<br>☐ Exclusion from social activities<br>☐ Other _____ | ☐ Victim<br>☐ Witness | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

| Trauma Type | Trauma Details | Role in Event | Age(s) Experienced<br>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 |
|---|---|---|---|
| **Attempted Suicide** | **Method:**<br>☐ Drug<br>☐ Hanging<br>☐ Drowning<br>☐ Firearm<br>☐ Other | ☐ Victim<br>☐ Witness<br>☐ Learned about | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| **Witnessed Suicide** | ☐ Completed suicide<br>☐ Attempted suicide<br>**Method**<br>☐ Overdose<br>☐ Knife/Razor<br>☐ Firearm<br>☐ Hanging<br>☐ Jumping from a height<br>☐ Other<br>**Person**<br>☐ Mother ☐ Father ☐ Brother<br>☐ Sister ☐ Other relative<br>☐ Close friend<br>☐ Acquaintance/schoolmate<br>☐ Stranger | ☐ Witness | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

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." | 0 | 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 |

| *HOW MUCH OF THE TIME DURING THE PAST MONTH…* | | None | Little | Some | Much | Most |
|---|---|---|---|---|---|---|
| 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: _____

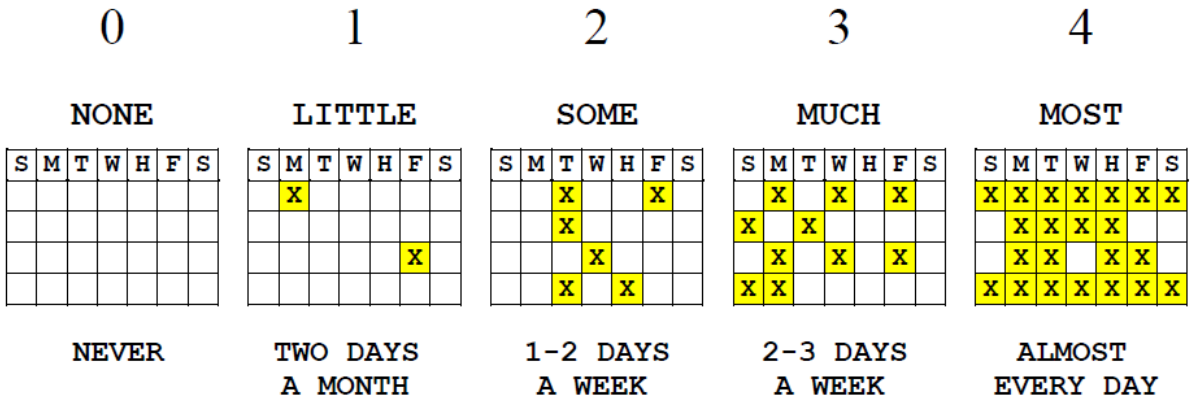
☐ **School**: (check if youth endorses #1 *or* #2 below)
☐ Yes ☐ No 1. Do these reactions (thoughts and feelings) make it harder for you to do well in school?
☐ Yes ☐ No 2. Do these reactions (thoughts and feelings) cause other problems at school?
Describe: _____

☐ **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?



# UCLA PTSD REACTION INDEX FOR CHILDREN/ADOLESCENTS - DSM-5©

## 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?<br>For example, lost toilet training?<br>Or, lost language skills?<br>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)?<br>What about going to the bathroom alone?<br>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?"<br>Is it harder to go out with your child to places like the grocery store?<br>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**

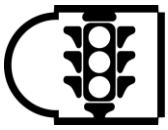
The Traumatic Events page (items 1-13) is important to include before administering the symptom portion because it is important to know all of the traumatic events one has experienced that may be linked to symptoms. This page provides a systematic menu to facilitate recall of all events.

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 |

<table>
<tr><td colspan="3">Care Management Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Level of Care Reviews</td><td>Chapter: 09.03-<br>Care Management Services-Department Procedures</td><td>Subject No: 09.03.01.04</td></tr>
<tr><td colspan="3">  Care Management</td></tr>
<tr><td rowspan="2">Effective Date:<br>5/22/09</td><td>Date of Review/Revision:<br>7/22/09, 5/17/16, 6/28/18, 10/8/19, 10/1/20, 8/1/22, 6/10/24</td><td rowspan="2">Approved By:<br>Chief of Network Business Operations<br><br>Authored By:<br>Director of Utilization Care Authorizations<br><br>Reviewed By:<br>Care Management Specialists</td></tr>
<tr><td>Supersedes:</td></tr>
</table>

**Purpose:**
The purpose of this procedure is to establish the protocol and steps required for identifying, gathering medical necessity criteria, determining, and recommending either discharge of persons served from SCCMHA services, decreasing particular services being provided, or changing the service array an individual is receiving in order to best meet his/her needs. This is in accordance with the Utilization Management function within SCCMHA's Care Management Department.

**Policy:**
SCCMHA will provide an array of services to persons most severely affected according to the availability of resources. This shall be done without unnecessary wait times due to concerns regarding capacity. SCCMHA will maintain best practice standards when working with persons served and be fiscally responsible in the use of resources available.

**Application:**
All SCCMHA and SCCMHA Network Primary Team Providers.

**Standards:**
None

**Definitions:**
Provider: Case Record Holders'

CMS: Care Management Specialist within the Care Management Department

RFA: Request for Authorization

LOCR: Level of Care Review

LOCUS: Level of Care Utilization System

Care Management Services: An integrated system of managing capitated funds for covered services to a defined population including the policies, protocols and tools established by the Authority governing the provision of services to eligible persons.

Eligibility Criteria: A statement of conditions necessary for a person served to be eligible for services. Criteria for SCCMHA services include County of Residence, Diagnosis, Level of Function, and Prior Utilization.

Medical Necessity: Describes those services necessary for screening and assessing the presence of a mental illness, and/or required to identify and evaluate a mental illness that is inferred or suspected; and/or intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, including impairment of functioning; and/or designed to provide rehabilitation or habilitation for the recipient to attain or maintain an adequate level of functioning. The determination of a medically necessary service must be based upon a person centered planning process.

Utilization Management: This dimension of Care Management is the array of strategies employed to ensure the right amount and mix of services. Utilization Management includes: pre-admission screening, pre-authorization, authorization, claims review, concurrent review, retrospective review and consumer and provider profiling.

Authorization: Authorization is the approval of services and the process of determining service necessity and the level of care based on scope, amount and duration. Authorization is typically a computerized function which is closely involved in processing the service provider's claims. The authorization is issued to the service provider with a unique number to which claims are processed.

**References:**

- SCCMHA Department Exit Criteria Policy (i.e. Wraparound, SED, ACT)
- MDHHS Medicaid Provider Manual
- Care Management Conference Procedure, 09.03.01.03
- Care Management Services Policy, 05.04.01

**Exhibits:**

Exhibit A - SCCMHA Care Management Continuing Stay Review for Adults, SCCMHA Care Management Continuing Stay Review for Children

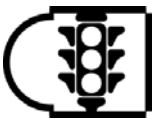
Exhibit B - Care Management Specialist Disposition
Exhibit C - Adverse Benefit Determination for Non-Medicaid Consumers
Exhibit D - Adverse Benefit Determination for Medicaid Consumers

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Care Management Specialists will identify persons served through service utilization, Care Conference review, request of Provider for review of level of care change or review of RFA that necessitates a LOCR. | 1. Care Management Specialist |
| 2. Once a person served is identified, the Provider will be asked to complete a LOCR form, and send via inter-office mail, Sentri email or fax to the appropriate CMS. | 2. Provider and Care Management Specialist |
| 3. Once the CMS receives the completed form, a review will be conducted based on medical necessity and eligibility criteria to determine if the person served continues to meet service eligibility guidelines for SCCMHA services. The CMS may request that the LOCR be taken to Care Conference or reviewed in other venues, such as Care Management Team meetings. A review and disposition are to be made within 14 business days of receiving the completed form. | 3. Care Management Specialist |
| 4. When a decision is made regarding services provided to the person served, the CMS will complete the Care Management Specialist Disposition form. If a reduction or termination of services decision is made, authorizations will be provided for up to 30 days from written decision date. After that, no additional RFA's will be | 4. Care Management Specialist |

| | |
|---|---|
| approved. Providers will be notified of the CMS decision via e-mail, fax, Sentri upload, encrypted email or inter-office mail within 24 hours of making the decision.<br><br>5. It is the responsibility of the CMS to forward Advance Action Notice to the person served within 7 days of making a decision.<br><br>6. Providers must continue to offer services to the person served through 30 days and prepare persons served for discharge, following proper exit procedures for your department, unless otherwise chosen by the person served. | 5. Care Management Specialist<br><br>6. Provider |

Exhibit A



## SCCMHA Level of Care Change for Adults

| Person Served Name: | Sentri ID: |
|---|---|
| CSM/SC Name/Team: | Supervisor: |
| Date: | Current IPOS Date: |
| **Diagnosis Review** | |
| **Diagnosis Import from Sentri** | **Supported in Record** |
| Axis I | |
| Axis II | |
| Axis III | |
| Axis IV | |
| Axis V | |
| **General Information** | |
| Review Purpose<br>☐ Initial ☐ Ongoing ☐ Discharge ☐ Acute Crisis<br>Did you discuss this change with person served/parent/guardian: ☐ Yes ☐ No<br>Supported in record (progress note/periodic review date): | |
| 1. Risk of Harm within last year & history of attempts, ideations, and self-harm behaviors. | |
| **Supported in record (progress note/periodic review date):** | |
| 2. Current level of function to include psychiatric symptoms and medications used. | |
| **Supported in record (progress note/periodic review date):** | |
| 3. Medical risk | |
| **Supported in record (progress note/periodic review date):** | |
| 4. Substance abuse risk | |
| **Supported in record (progress note/periodic review date):** | |
| 5. Treatment and Recovery History | |
| **Supported in record (progress note/periodic review date):** | |
| 6. Benefits: adherence/non-adherence to current services. | |
| | |

**Supported in record (progress note/periodic review date):**

| **Utilization Summary** | |
|---|---|
| Services over the last six months | |
| | |
| Entitlement Status | Hospital Episodes: Date/Number of Days |
| | |
| Reason for level of care change. | |
| | |

| **Recommendations** |
|---|
| Next Step in Recovery Plan |
| Disposition:<br>☐ Transfer to<br>☐ MI ☐ DD<br>☐ Increase Level of Care to<br>☐ Case Management ☐ ACT<br>☐ Maintain Level of Care; transfer to _____<br>☐ Reduce Level of Care to<br>☐ Therapy only ☐ Case Management<br>☐ Prepare for Discharge to<br>☐ Outside Provider* ☐ Primary Care<br>*agencies that accept consumer's Qualified Health Plan |
| Discharge Recommendations |
| |

CSM/Therapist Signature: _____Date: _____

Supervisor Signature: _____ Date: _____

## SCCMHA Level of Care Change for Children

| | |
|---|---|
| Person Served Name: | Sentri ID: |
| CSM/SC Name: | Supervisor: |
| Date: | Current IPOS Date: |

| **Diagnosis Review** | |
|---|---|
| **Diagnosis Import from Sentri** | **Supported in Record** |
| Axis I | |
| Axis II | |
| Axis III | |
| Axis IV | |
| Axis V | |

| **General Information** | | |
|---|---|---|
| Review Purpose<br>☐ Initial ☐ Ongoing ☐ Discharge ☐ Acute Crisis<br>Did you discuss this change with consumer/parent/guardian: ☐ Yes ☐ No<br>Supported in record (progress note/periodic review date): | CAFAS/PECFAS Total | |
| 1. Schoolwork | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 2. Home | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 3. Community | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 4. Behavior towards others | CAFASPECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 5. Moods and emotions | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 6. Self-harm behavior | CAFASPECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 7. Substance Abuse | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |
| 8. Thinking; symptoms and medications | CAFAS/PECFAS Score | |
| **Supported in record (progress note/periodic review date):** | | |

| 9. Adherence/non-adherence to current service (child and parent). |
|---|
| **Supported in record (progress note/periodic review date):** |
| **DECA: If child is between 1 month and 47 months old please summarized your DECA results.** |
| |

| **Utilization Summary** | |
|---|---|
| Services over the last six months | |
| | |
| Entitlement Status | Hospital Episodes: Date/Number of Days |
| | |

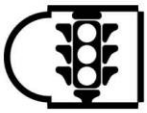
| Reason for level of care change. |
|---|
| |

| **Recommendations** |
|---|
| Next Step in Recovery Plan |
| Disposition:<br>☐ Transfer to<br>☐ MI ☐ DD<br>☐ Increase Level of Care to<br>☐ Wraparound ☐ Home Based Service ☐Autism ☐ Adult Services ☐Child Case Management<br>☐ Reduce Level of Care to<br>☐ Therapy only<br>☐ Maintain Level of Care; transfer to _____<br>☐ Prepare for Discharge to<br>☐ Outside Provider* ☐ Primary Care<br>*Agency that accepts consumer's Qualified Health Plan |
| Discharge Recommendations |
| |

CSM/Therapist Signature: _____ Date: _____

Supervisors Signature: _____ Date: _____

Exhibit B



**Care Management**

## Care Management Specialist Disposition

**Consumer's Name:** **Case Manager's Name:**

**Consumer's Sentri ID:** **Supervisor's Name:**

**Medical Necessity (please check one):**

☐ Medical Necessity Criteria Met
Comments:

☐ Medical Necessity Criteria Not Met
Specify Reason:

☐ Medical Necessity Criteria Met, but Service Array Modification Requested
Specify Change Requested and Reason:

**Actions Taken/Date:**

**LOCUS Score: _____** **CAFAS Score: _____**

_____ _____
Care Management Specialist Date

_____ _____
Care Management Supervisor Date

**Case Managers: Please fill out below and return copy to assigned Care Management Specialist once appointment has been set.**

New Team Assigned: _____ Orientation Date: _____
Outside Provider Assigned: _____ Appointment Date: _____
Primary Care Provider: _____ Appointment Date: _____

Case Manager Signature: _____

Revised 1/29/16

Exhibit C

NOTICE OF ADVERSE BENEFIT DETERMINATION

***Saginaw County Community Mental Health Authority (SCCMHA)***

verla Test
2229 Lively Drive
Saginaw, MI 48601

**Important:** The notice explains your internal appeal rights. Please read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed in the "Get Help & More Information" section of this Notice.

**Provided/Mailed Date:** 06/22/2022 **Member ID:** 002018398

**Name:** verla Test

| **This is to tell you that the following action has been taken:** |
|---|
| Your current service(s) will be: Terminated. |
| 9083X Psychotherapy |
| **Effective:** 07/22/2022 |
| **This action is based on the following:** |
| Saginaw does not have provider capacity to provide the service(s). |

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your Provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

**IF YOU DON'T AGREE WITH THIS ACTION, YOU HAVE THE RIGHT TO AN INTERNAL APPEAL**

You have to ask Saginaw for an internal appeal within 30 days of the date of this notice. You can also provide any evidence you want us to review, such as medical records, doctors' letters or other information that explains why you need the item or service.

**Please keep a copy of everything you send us for your records.**

**There are 2 kinds of internal appeals:**

**Standard Appeal:** We'll give you a written decision on a standard appeal within 45 days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed.

**Expedited or "Fast" Appeal:** You can ask for a fast appeal if you believe your health could be seriously harmed by waiting up to 45 days for a decision. We'll give you a decision on a fast appeal within 3 business days after we get your appeal. If we don't give you a fast appeal, we'll give you a decision within 45 days.

**If you want to ask for an Internal Appeal either call or send in a written request to:**

**Saginaw**
**500 Hancock St.**
**Saginaw, MI 48602**
**Phone Number: (989) 797-3452**
**Fax Number: (989) 797-3595**

**For hearing or speech assistance, please call 711.**

## IF YOU WANT SOMEONE ELSE TO ACT FOR YOU

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at (989) 797-3452 to learn how to name your representative. For hearing or speech assistance, call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

## ACCESS TO DOCUMENTS

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

## WHAT HAPPENS NEXT?

- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If you do not agree with the outcome, you can request an Alternative Dispute Resolution from the Michigan Department of Health and Human Services.
- The Notice of Appeal Denial will give you additional information about Alternative Dispute Resolution from the Michigan Department of Health and Human Services and how to file a request.

## Get Help & More Information

**If you need additional help or additional information about our decision and the internal appeal process, please call**

**Saginaw Customer Service Department**

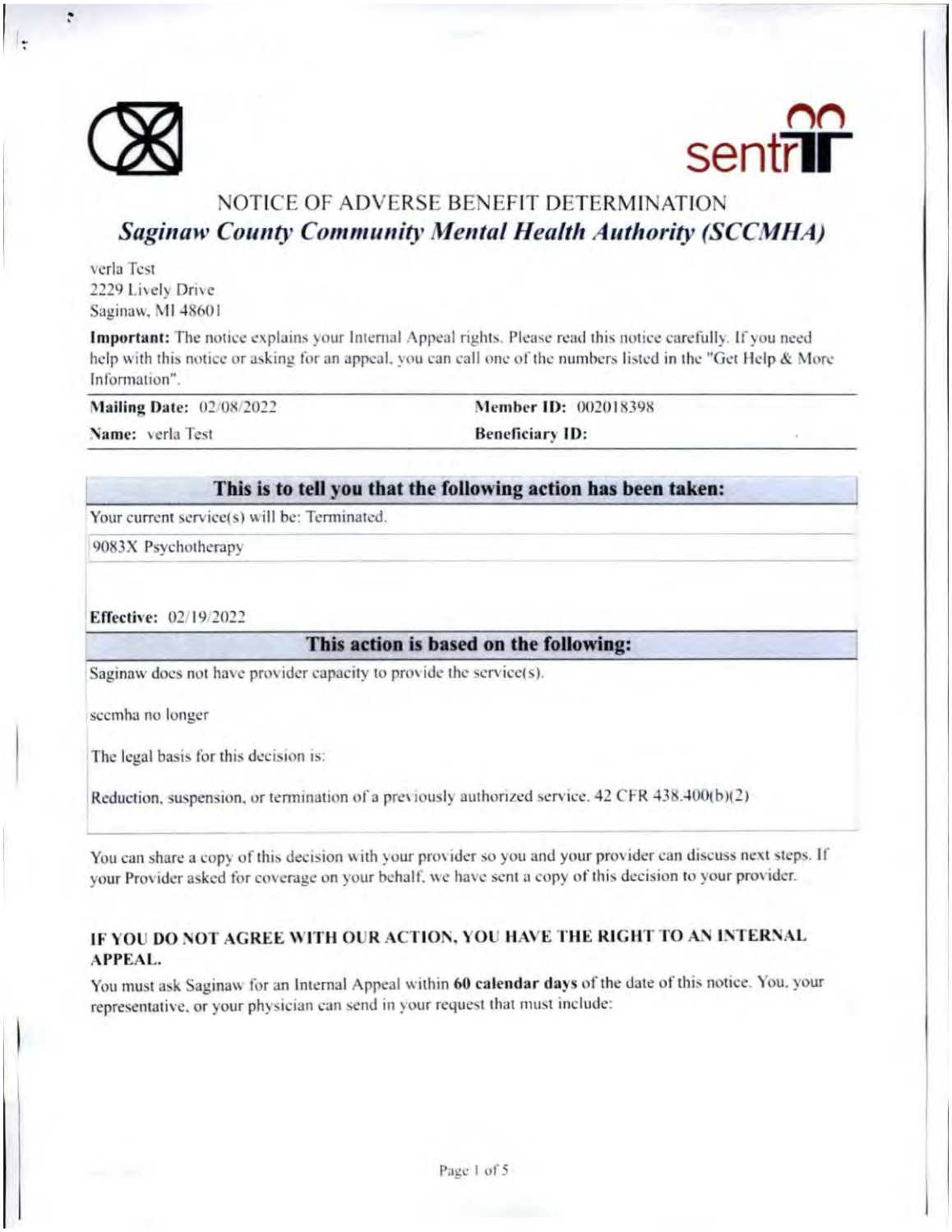
**(989) 797-3452**

**For hearing or speech assistance, please call 711 for assistance.**

**Our hours of operation are Mon-Fri 8a-5p Except for holidays**

**You can also visit our website at www.sccmha.org**

Exhibit D



NOTICE OF ADVERSE BENEFIT DETERMINATION

***Saginaw County Community Mental Health Authority (SCCMHA)***

verla Test
2229 Lively Drive
Saginaw, MI 48601

**Important:** The notice explains your Internal Appeal rights. Please read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed in the "Get Help & More Information".

| | |
|---|---|
| **Mailing Date:** 02/08/2022 | **Member ID:** 002018398 |
| **Name:** verla Test | **Beneficiary ID:** |

**This is to tell you that the following action has been taken:**

Your current service(s) will be: Terminated.

9083X Psychotherapy

**Effective:** 02/19/2022

**This action is based on the following:**

Saginaw does not have provider capacity to provide the service(s).

sccmha no longer

The legal basis for this decision is:

Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2)

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your Provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

**IF YOU DO NOT AGREE WITH OUR ACTION, YOU HAVE THE RIGHT TO AN INTERNAL APPEAL.**

You must ask Saginaw for an Internal Appeal within **60 calendar days** of the date of this notice. You, your representative, or your physician can send in your request that must include:

Page 1 of 5

- Your Name
- Your Address
- Your Member Number
- Your Reason for appealing
- Whether you want a Standard or Expedited Appeal (for an Expedited Appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, letters from your physicians, or other information that explains why you need the item or service. If you are asking for an Expedited Appeal, you will need a physician's supporting statement. Call your physician if you need this information.

Please keep a copy of everything you send us for your records.

**There are 2 kinds of internal appeals:**

**Standard Appeal:** You will be given a written decision on a Standard Appeal within **30 calendar days** after your Appeal is received. Our decision might take longer if you ask for an extension, or if we need more information about your case. You will be told if extra time is being taken and will receive an explanation why more time is needed. If your Appeal is for payment of a service you have already received, you will receive a written decision within **60 calendar days.** If you want to ask for an Internal Appeal, you can either call or send in a written request to:

**Saginaw**

**500 Hancock St.**
**Saginaw, MI 48602**

**Phone Number: (989) 797-3452**

**711**

**Fax Number: (989) 797-3595**

**Expedited Appeal:** You will be given a decision on an Expedited Appeal within **72 hours** after your Appeal is received. You can ask for an Expedited Appeal if you or your physician believe your health could be seriously harmed by waiting up to **30 calendar days** for a decision. **You will automatically be given an Expedited Appeal if your physician asks for one for you or if your physician asks for one for you or if your physician supports your request.** If you ask for an Expedited Appeal without support from your physician, the State will decide if your request requires an Expedited Appeal. If you are not given an Expedited Appeal, you will be given a decision within **30 calendar days.** To ask for an Expedited Appeal, you must call: (989) 797-3452 711.

## CONTINUATION OF SERVICES DURING AN INTERNAL APPEAL

If you are receiving a Michigan Medicaid service and you file your Appeal within **10 calendar days** of this Notice of Adverse Benefit Determination (02/18/2022), you may continue to receive your same level of services while your Internal Appeal is pending, and should submit to the Saginaw.

Your benefits for that service will continue if you request an Internal Appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action, whichever is later.

## IF YOU WANT SOMEONE ELSE TO ACT FOR YOU:

You can name a relative, friend, attorney, physician, or someone else to act as your representative. If you want someone else to act for you, call us at (989) 797-3452 to learn how to name your representative. TTY users, call 711. Both you and the individual you want to act for you must sign and date a statement confirming this is what you want. You will need to mail or fax this statement to us. Keep a copy for your records.

## ACCESS TO DOCUMENTS

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the Appeal process. You must submit the request in writing.

## WHAT HAPPENS NEXT?

- If you ask for an Internal Appeal and are continually denied your request for coverage or payment of a service, you will be sent a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing.
- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process (or Patient Right to Independent Review Act) and how to file the request.
- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR).

## Get Help & More Information

**If you need help or additional information about the decision and the Internal Appeal process, call**

**Saginaw Customer Service Department**

**Phone: (989) 797-3452**

**TTY: 711**

**Our hours of operation are Mon-Fri 8a-5p Except for holidays**

**You can also visit our website at www.sccmha.org**

MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 ( if calling from an internet based phone service).

**The legal basis for this decision is 42 CFR 440.230(d), Michigan's Mental Health Code, Public Act 258, and/or applicable policy found in the Medicaid Provider Manual, Mental Health and Substance Abuse Services. These provide the basic legal authority for us to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.**

**Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination based on race, color, national origin, sex, age, or disability.**

# Tab 5

# Regulatory Management/ HIPAA Compliance

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Compliance and Ethics Program - Corporate Compliance Plan (CCP)</td><td>Chapter: 05 - Organizational Management</td><td>Subject No: 05.07.01</td></tr>
<tr><td>Effective Date:<br>August 15, 2002</td><td>Date of Review/Revision:<br>8/15/05, 3/9/06, 8/7/06, 7/7/09, 8/10/15, 5/9/16 3/15/17, 6/1/18, 6/11/19, 8/1/21, 8/26/22, 6/23/23, 7/9/24<br>Supersedes:</td><td rowspan="2">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
To ensure that Saginaw County Community Mental Health Authority (SCCMHA) conducts all aspects of service delivery and administration with integrity, in conformance with the highest standards of accountability and applicable laws, while utilizing sound business practices, through the development of and adherence to the SCCMHA Corporate Compliance Plan (CCP), guaranteeing the highest standards of excellence.

**Policy:**

**A. Corporate Compliance**

1. SCCMHA shall establish, implement, and maintain a Corporate Compliance Plan that is in accordance with federal and state statutes, laws, and regulations. SCCMHA will furthermore adhere to regulations required by the Mid-State Health Network (MSHN), the Michigan Department of Health and Human Services (MDHHS), the Michigan Attorney General's Office, Office of Inspector General, Centers for Medicaid and Medicare, and relevant accrediting bodies.

2. The SCCMHA Corporate Compliance Plan provides the framework for SCCMHA to comply with applicable laws, regulations, and program

requirements, minimize organizational risk, maintain internal controls, and encourage the highest level of ethical and legal behavior.

3. SCCMHA shall maintain policies and procedures necessary to comply with the SCCMHA CCP and shall ensure effective processes for identifying and reporting suspected fraud, abuse and waste, and timely response to detected offenses with appropriate corrective action, including the reporting thereof to the SCCMHA Chief Executive Officer.

4. SCCMHA shall identify a Chief Compliance Officer, a Compliance Officer, and a Compliance and Policy Team.

5. SCCMHA shall provide staff training in compliance with the SCCMHA CCP and will maintain records of staff attendance. Trainings shall include but are not limited to: Federal False Claims Act, Michigan False Claims Act, Whistleblowers Protection Act, Advance Directives and Consumer Privacy Protections.

6. SCCMHA shall require all Board members, employees, and contractors to comply with corporate compliance requirements including any necessary reporting to other agencies.

7. SCCMHA shall review its compliance activities at least annually and will participate in an annual review of the SCCMHA CCP and provide recommendations for revisions as needed.

**B. Ethical Standards/Program Integrity**

1. All services within SCCMHA shall be provided with commitment to appropriate business, professional and community standards for ethical behavior.
2. SCCMHA shall develop and maintain Standards of Conduct applicable to all SCCMHA staff.
3. SCCMHA shall conduct business with integrity and not engage in inappropriate use of public resources.
4. SCCMHA shall ensure that services are provided in a manner that maximizes benefit to persons served while avoiding risk of physical, emotional, social, spiritual, psychological, or financial harm.
5. All SCCMHA staff shall conduct themselves in such a way as to avoid situations where prejudice, bias, or opportunity for personal or financial gain, could influence, or have the appearance of influencing, professional decisions.
6. Those individuals with “day-to-day operational responsibility” for the Compliance and Ethics Program will be provided adequate resources, appropriate authority, and direct access to the operational and governing authority of SCCMHA.

**Application:**
This policy applies to all provider network members, including contracted and direct board operated service programs that provide services to persons served.

**Standards:**
None

**Definitions:**
None

**References:**
None

**Exhibits:**
None

**Procedure:**
None

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Deficit Reduction Act Compliance (False Claims)</td><td>Chapter: 05 – Organizational Management</td><td>Subject No: 05.07.03</td></tr>
<tr><td rowspan="2">Effective Date:<br>11/1/07</td><td>Date of Review/Revision:<br>6/26/09, 6/4/14, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 8/26/22, 6/23/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>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 provide information about SCCMHA's responsibility to prevent fraud and abuse by presenting accurate claims for payment to all payers, including federal and state programs. This policy describes SCCMHA's procedures for detecting, correcting, and avoiding circumstances under which fraud, waste, and abuse could occur at SCCMHA and its network of providers. This policy is also intended to provide SCCMHA employees and providers educational opportunities regarding the Federal and Michigan False Claims Acts, and related whistleblower provisions.

**Policy:**
SCCMHA, through its compliance plan and other policies, is committed to the highest standards of ethical behavior, and the submission of accurate claims to all payers, including federally funded payers such as Medicare and Medicaid.

**Application:**
SCCMHA operated programs and network of providers.

**Standards:**

- **<u>SCCMHA POLICIES FOR PREVENTING FRAUD, WASTE AND ABUSE</u>**
  SCCMHA has established policies and practices to prevent fraud, waste and abuse of the Medicaid and Medicare programs. These policies help to ensure appropriate claims are made to all payers, including government programs, through:

- Development of policies which support the appropriate submission and processing of claims for services rendered by SCCMHA and/or its network of providers.
- Education regarding the SCCMHA Compliance and Ethics Program.
- Monitoring and auditing to detect and prevent errors in coding or billing.
- Investigation of all reported concerns and correcting errors that are discovered.
- Promotion of the SCCMHA Compliance Hotline for reporting instances and potential instances of fraud, waste, and abuse of the Medicaid and Medicare programs.
- Development and maintenance of SCCMHA policy which prevents retaliation when concerns about fraud, waste, or abuse are reported in good faith.
- The SCCMHA Compliance Plan is available for review by any SCCMHA employee, volunteer, or contractual provider. In addition, it is available on the SCCMHA's website https://www.sccmha.org/.

- **THE FEDERAL CIVIL FALSE CLAIMS ACT (FCA)**

  The False Claims Act is a federal law that addresses fraud involving federally funded programs. Claims to Medicare and Medicaid for payment make up most health care claims paid by the U.S. government. This law defines a false claim to the U.S. Government as follows:

  1. Knowingly presenting a false or fraudulent claim for payment or approval.
  2. Knowingly making or using a false record or statement to get a false or fraudulent claim paid or approved.
  3. Conspiring with another to get a false or fraudulent claim paid or allowed.
  4. Knowingly making or using a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.

  The FCA does not require an intent to defraud. The requirement of doing something in a knowing manner is met by showing either (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the truth or falsity of the information.

  **Penalties**: Violations of the federal false claims act can result in penalties of not less than $5,500.00 and not more than $11,000.00 per claim, plus three times the amount of damages that the government sustains.

- **ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS**

  Under a second regulation addressing health care fraud, the Department of Health and Human Services (MDHHS) may impose on a person who

submits certain claims to the government of the United States a penalty of up to $5,500 for each False Claim, plus twice the amount of the False Claim.

This law applies to any claim that a representative of SCCMHA knows or has reason to know:

1. Is false, fictitious, or fraudulent.
2. Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent.
3. Includes or is supported by any written statement that (i) omits a material fact, (ii) is false, fictitious, or fraudulent as a result of such omission, (iii) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or
4. Is for payment for the provision or property or services, which the person has not provided as claimed.

- **FEDERAL QUI TAM (WHISTLEBLOWER) ACTIONS**

The FCA provisions are enforced by the United States Department of Justice. Any person with direct and independent knowledge, otherwise known as "original source knowledge," of false claims to the government may initiate a formal complaint or "qui tam" lawsuit on behalf of the government. The plaintiff must notify the United States Department of Justice of all information regarding the fraudulent activity. If the Department of Justice accepts the case and fraud is proven, the qui tam plaintiff is entitled to a portion of the funds recovered by the government. Under the FCA a "qui tam" plaintiff is protected from retaliation that may result from his or her involvement in the case. If the Department of Justice declines the case, the individual may still proceed with the case on his or her own, unless the allegation involves a state agency, but without the government's assistance, and at his or her own expense. A private legal action under the FCA must be brought within six years from the date that the false claim was submitted to the government (A government-initiated claim may be brought up to ten years after the false claim, depending on the circumstances).

- **MICHIGAN FALSE CLAIMS ACT**

Michigan has enacted a Michigan False Claims Act which closely resembles the Federal False Claims Act. This act imposes prison terms of up to four (4) years and fines of up to $50,000 for:

1. Knowingly making a false statement or false representation of a material fact in any application for Medicaid benefits or for use in determining rights to a Medicaid benefit.
2. Soliciting, offering, or receiving kickbacks or bribes for referrals to another for Medicaid-funded services.

3. Entering into an agreement with another to defraud Medicaid through a False Claim; or
4. Making or presenting to the State of Michigan a False Claim for payment.

- **MICHIGAN QUI TAM (WHISTLEBLOWER) ACTIONS**

  Any person (Qui Tam Relater) may bring a civil action on behalf of the State of Michigan to recover losses that the State suffered from a person violating the Michigan Medicaid False Claims Act, and the Michigan Attorney General is to be notified and has an opportunity to appear and intervene in the action brought on behalf of the State of Michigan. If the Michigan Attorney General intervenes, in addition to the person receiving his or her expenses, costs and reasonable attorney fees, the person may also receive a percentage of the monetary proceeds resulting from the action or any settlement.

- **WHISTLEBLOWER PROTECTION LAWS**

  Both the federal and Michigan state laws protect individuals who investigate or report possible False Claims made by their employer against discharge or discrimination in employment because of such investigation. Employees who are discriminated against based on whistle blowing activities may sue in court for damages. Under either the federal or Michigan law, any employer who violates the whistleblower protection law is liable to the employee for (1) reinstatement of the employee's position without loss of seniority, (2) two times the amount of lost back pay, (3) interest and compensation for any special damages, and such other relief necessary to make the employee whole.

**Definitions:**
Please see *SCCMHA Policy 08.05.00.01 - Compliance Definitions Policy for the following terms.*

- Knowing/Knowingly

**References:**
SCCMHA Compliance and Ethics Program - Corporate Compliance Plan (CCP)
SCCMHA Code of Conduct
SCCMHA Regulatory Compliance Hotline Brochure
Section 6032 of the Deficit Reduction Act of 2005
The federal Civil False Claims Act, Section 3279 of Chapter 31 of the United States Code
The Michigan Medicaid False Claims Act, MCL §§ 400.601 *et al*

**Exhibits:**
None

**Procedure**:
None

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**: Reporting of Medicaid Fraud, Waste, and/or Abuse | **Chapter**: 05 - Organizational Management | **Subject No**: 05.07.05 |
| **Effective Date:**<br>August 6, 2015 | **Date of Review/Revision**:<br>3/15/17, 6/1/18, 6/11/19, 8/1/21, 8/26/22, 6/23/23, 7/9/24 | **Approved By**:<br>Sandra M. Lindsey, CEO |
| | **Supersedes**: | **Responsible Director:**<br>AmyLou Douglas, Chief Information Officer \| Chief Quality and Compliance Officer |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Authored By**:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>**Additional Reviewers**: |

**Purpose:**
SCCMHA will maintain a process to collect information about the nature of fraud, waste, and abuse complaints, as well as maintain a process to report to the Mid-State Health Network information regarding the complaints of fraud, waste, and abuse that warrant investigations.

**Policy:**
It is the policy of SCCMHA to collect information about the nature of fraud, waste, and abuse complaints, and to report to Mid-State Health Network on a semi-annual basis any suspicion of fraud, waste, or abuse within the Medicaid program.

**Application:**
This policy applies to all provider network members, including contracted and direct board operated service programs that provide services to persons served.

**Standards:**
1. SCCMHA will collect information about the nature of fraud, waste, and abuse complaints which will include:
    a. The name of the individual(s) or entity involved in the suspected fraud, waste, or abuse
    b. The address of the individual(s) or entity involved in the suspected fraud, waste, or abuse

c. The telephone number of (or other contact information for) the individual(s) or entity involved in the suspected fraud, waste, or abuse
d. The Medicaid identification number and/or any other identifying information.
e. The source of the complaint of the suspected fraud, waste, or abuse,
f. The nature of the complaint of the suspected fraud, waste, or abuse,
g. The type of provider involved in the suspected fraud, waste, or abuse,
h. The approximate number of dollars involved in the suspected fraud, waste, or abuse,
i. The legal or administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred.

2. SCCMHA will report semi-annually (on or about April 1 and October 1) to Mid-State Health network regarding the complaints of fraud, waste, and abuse made to SCCMHA that warrant investigation.

**Definitions:**
None

**References:**
None

**Exhibits:**
Exhibit A - SCCMHA Health Care Fraud Hot Line Poster

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| **Written Policies, Procedures and Standards of Conduct:** | |
| 1. SCCMHA maintains a Health Care Fraud Hot Line telephone number to facilitate the reception of notification of suspected fraud, waste, or abuse occurrences. This contact opportunity (local number as well as toll free number) is one of several avenues available for SCCMHA employees, Network Providers, persons served, or general public to report instances of suspected health care fraud, waste, or abuse to SCCMHA. | SCCMHA Compliance Officer or the Quality & Medical Records Supervisor if not available |
| 2. SCCMHA will collect and maintain information about the nature of fraud, waste, and abuse complaints which | SCCMHA Compliance Officer or the Quality & Medical Records Supervisor if not available |

| | |
|---|---|
| include the information listed under Standard 1 items a-i. | |
| 3. SCCMHA will report to Mid-State Health Network on a semi-annual basis the information maintained under Standard 1 items a-i. | SCCMHA Compliance Officer or the Quality & Medical Records Supervisor if not available |

Exhibit A


Saginaw County
Community Mental
Health Authority
Report
Health Care Fraud
Report fraud and/or misconduct relating
to Medicare or Medicaid Services
If you know, or have a good faith suspicion,
that fraud or misconduct relating to
Medicare or Medicaid has been committed,
contact the SCCMHA hotline.
SCCMHA has a no retaliation policy.
SCCMHA Hotline: 855-797-3417
Local Phone: 989-797-3574
SCCMHA Compliance Office
500 Hancock Street
Saginaw, MI 48602

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:<br>Consumer Records</td><td>Chapter: 08 -<br>Management of Information</td><td>Subject No: 08.04.01</td></tr>
<tr><td rowspan="2">Effective Date:<br>12/18/02</td><td>Date of Review/Revision:<br>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, 4/6/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Allison Kalmes-Hadd<br><br>Additional Reviewers:<br>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 II) 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 via signature, or for proof of delivery.

Hard copy documents are to 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, Psychotherapy 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, accreditation 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 Resuscitate, 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) days after the service is rendered.

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 acronyms is allowed only when the full title is first indicated, and the acronym 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 title – Case Holder, Therapist, etc.

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 requested 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 Customer Service Department will maintain a description of Documentation Types. This list will be updated at least annually or as needed.

The Customer Service 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
MDHHS 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<br>Executive Director of Clinical Services<br>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<br>Clinical Records Coordinator<br>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 exclude 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 received.
    - However, a fax transmittal sheet should be added as an attachment to the IPOS Healthcare Coordination Form for proof that this was sent to the primary physician.
- 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 should be scanned as well as documented in 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 needs 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 a 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 atypical 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. Customer Service 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 at the bottom of document(s).
    - Only copies of Sentri documents that contain a consumer/guardian signature should be submitted for filing or scanning if signature is a requirement on that document.
    - 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.

    - New SCCMHA forms are required to be approved by the Executive Director of Clinical Services (per policy 08.04.08 Agency Forms). These should also be submitted to Clinical Records Coordinator 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 the Clinical Records Coordinator in accordance with procedures and policy.
- Staff handwritten 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 in a Sentri document (unless a consumer signature is required).
- Staff may need to "create" a Sentri page, such as the Consent to Share Behavioral Health Information/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 Clinical Records Coordinator and/or Customer Service department.

If a document is returned to the submitting staff or Case Holder (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 Customer Service clerks.

Exhibit B

## Quality Protocol for Scanning and Uploading 2023

**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 document 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 needs 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 Clinical Records Coordinator 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<br>Previous paper appeal documents completed prior to SENTRI<br>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<br>Tools used such as CAFAS, OQ 45, Psych testing etc.<br>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<br>Behavior Management Review<br>Behavior Plan<br>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<br>COFR Correspondence, Assessment, TX notes, Plan |
| **Consents – Treatment/Services** | Consents not housed elsewhere | Consent / revocation for treatment<br>Other consents<br>Consent / revocation for emergency medical care<br>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<br>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<br>Disability for work documents<br>MRS / MI Works / Other outside referral documents<br>Competitive employment documents |
| **Entitlement and Benefits** | Document Entitlements & Benefits efforts | Applications for Benefits<br>SSI / SSD applications<br>SSSD / SSI information / determination<br>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<br>Letters to / from healthcare providers<br>Health Reviews<br>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<br>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<br>Other court or legal document<br>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<br>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<br>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<br>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<br>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<br>Certificates of eligibility |
| **Wrap Around** | For use by Wrap Around | Wrap Documents |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Ownership and Retention of Hard Copy Consumer Records</td><td>Chapter: 08 – Management of Information</td><td>Subject No: 08.04.09</td></tr>
<tr><td rowspan="2">Effective Date:<br>2/11/15</td><td>Date of Review/Revision:<br>3/8/17, 3/1/18, 8/6/18, 4/6/20, 2/24/21, 4/29/22, 4/6/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Jennifer Keilitz<br><br>Additional Reviewers:<br>Allison Kalmes-Hadd, Clinical Directors</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 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 | |

| 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.

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Compliance Definitions</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.00.01</td></tr>
<tr><td rowspan="2">Effective Date:<br>9-8-23</td><td>Date of Review/Revision:<br>7/9/24</td><td rowspan="2">Approved By:<br>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:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Christina Saunders<br><br>Reviewed By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance</td></tr>
</table>

**Purpose:**
The purpose of this policy is to establish standard definitions for all Compliance policies and procedures.

**Policy:**
All terms identified in this policy shall be referenced when they are used in any SCCMHA policies and procedures.

**Application:**
This policy applies to all staff, contractors, and business associates of SCCMHA.

**Standards:**
These definitions will be updated annually to reflect any additions or modifications that are needed.

- **Access:** Means the ability or the means necessary to read, write, modify, or communicate data/ information or otherwise use any system resource. (In accordance with Sec. 164.304)
- **Advance Directives**: A written document in which a competent individual gives instruction about his or her health care, (medical or mental) that will be implemented at some future time should that person lack the ability to make decisions for himself or herself, or in which the competent individual designates an

individual authorized to make such decisions for them at some future time should that person lack the ability to make decisions for himself or herself.

- **Breach:** In accordance with Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, a breach is defined as "the acquisition, access, use, or disclosure of protected health information (PHI) in a manner not permitted under [the HIPAA Privacy Rule] which compromises the security or privacy of the protected health information." For purpose of this definition, "compromises the security or privacy of the PHI" means poses a significant risk of financial, reputational, or other harm to the individual. A use or disclosure of PHI that does not include the individual's zip code, date of birth, or the identifiers listed at §164.514(e)(2), limited data set, (e.g., name, postal address information, telephone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, IP address numbers, biometric identifiers or full face photographic images and any comparable images), does not compromise the security or privacy of the PHI.
    - The definition of breach includes three exceptions to the presumption that a breach has occurred:
        - Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of SCCMHA or Business Associate (BA) of SCCMHA, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.
        - Any inadvertent disclosure by a person who is authorized to access PHI by SCCMHA or BA of SCCMHA to another person authorized to access PHI at SCCMHA or BA of SCCMHA, and the information received because of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.
        - A disclosure of PHI where SCCMHA or BA of SCCMHA has a good faith belief that an unauthorized person to whom the disclosure was made would not have been able to retain such information. (In accordance with ARRA/HITECH Title XIII Section 13400; Sec 164.402)
- **Business Vehicle:** Means a car, bus, van, truck or other motorized unit which is owned, leased or rented by SCCMHA.
- **Central Registry:** Means an organization which obtains from two or more member programs person served identifying information about individuals applying for withdrawal management or maintenance treatment for the purpose of avoiding an individual's concurrent enrollment in more than one treatment program.
- **Closed Session:** In accordance with MCL 15.262, the phrase "closed session' means a meeting or part of a meeting of the SCCMHA Board that is closed to the public.
- **Crisis Plan:** A document used by SCCMHA which allows the consumer to provide directions for their future care, including decisions affecting their personal life, when they are unable to provide for their own needs due to a hospitalization or

incapacitating illness. This document is distinct from an 'Advance Directive' and is not intended to fulfill the requirements for an Advance Directive.

- **Debarment:** An action taken by a debarring official in accordance with federal regulations to exclude a person from participating in covered transactions. A person so excluded is disbarred.
- **Debarring official:** An official authorized to impose debarment under federal regulation.
- **Decision:** In accordance with MCL 15.262, the word "decision" means a determination, action, vote, or disposition upon a motion, proposal, recommendation, resolution, order, ordinance, bill, or measure on which a vote by SCCMHA Board members is required and by which the SCCMHA Board effectuates or formulates public policy.
- **De-identified Information**: Information that has been stripped of any elements that may identify the consumer, such as name, birthdate, or social security number.
- **Designated Record Set:** As defined by the Privacy Rule §164.501, this term means:
    - A group of records maintained by or for a covered entity that is
        - The medical records and billing records about individuals maintained by or for a covered health care provider.
        - The enrollment, payment, claims adjudication. And case or medical management record systems maintained by or for a health plan; or
    - Used, in whole or in part, by or for the covered entity to make decisions about individuals.
- **Diagnosis:** Means any reference to an individual's substance use disorder or to a condition which is identified as having been caused by that substance use disorder which is made for the purpose of treatment or referral for treatment.
- **Direct Treatment Relationship:** As defined by the HIPAA Privacy Rule §164.501, means a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.
- **Disclose:** Means to communicate any information identifying a person served as being or having been diagnosed with a substance use disorder, having or having had a substance use disorder, or being or having been referred for treatment of a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person.
- **Disclosure:** As defined by the Privacy Rule, §164.501, means the release, transfer, provision of access to, or divulging in any of manner of information outside the entity holding the information.

- **Do-Not- Resuscitate Order (DNRO)**: A Do-Not-Resuscitate Order, also known as a 'DNR" or "DNRO," is a special kind of Advance Directive, prepared by a competent adult. The DNRO may direct that if a person served "suffers cessation of both spontaneous respiration and circulation in a setting outside of a hospital, a nursing home, or a mental health facility owned or operated by the Department of Community Health, no resuscitation will be initiated." The document may provide for special instructions for treatment when the person served death is imminent or when the person served is incurable terminally ill.

> It is the current position of SCCMHA that staff of Adult Foster Care Homes should be thoroughly trained regarding the concepts of Advance Directives and Do-Not-Resuscitate Orders (DNROs). Staff of such facilities should be thoroughly familiar with the wishes of their individual person served regarding this matter. However, in the event a person served heart and breathing have stopped, CPR should be initiated, and the home must still contact the local EMS and have a copy of the DNR order available when the EMS arrives. **Be aware that this does NOT constitute legal advice and Adult Foster Care Homes and other contracted providers should contact their own legal counsel regarding this matter.**

- **Durable Power of Attorney for Health Care (DPAHC):** Also known as a health care proxy, a document in which individual delegates to another person, the patient advocate, the power to make medical treatment and related personal care and custody decisions for them. This form of an advance directive is fully recognized by Michigan courts.
- **Employee:** Means any person who is employed by SCCMHA in the consideration for direct or indirect monetary wages or profit, and any person who volunteers his or her services to SCCMHA.
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Federal privacy regulation that created national standards to protect medical records and other protected health information.
- **Human Subject:** (as defined by 45 CFR, Part 46.102) Means a living individual about whom an investigator (whether professional or student) conducting research obtains.
    - Data through intervention or interaction with the individual, or
    - Identifiable private information.
- **Indirect Treatment Relationship:** As defined by the HIPAA Privacy Rule §164.501, means a relationship between and individual and a health care provider in which:
    - The health care provider delivers health care to the individual based on the orders of another health care provider; and
    - The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.
- **Informant:** means an individual:
    - Who is a person served or employee of a Part 2 program or who becomes a person served or employee of a Part 2 program at the request of a law enforcement agency or official; and

    - Who at the request of a law enforcement agency or official observes one or more person served or employees of the Part 2 program for the purpose of reporting the information obtained to the law enforcement agency or official.
- **Institute Review Boards (IRB):** Organization that reviews, approves, and monitors research that directly or indirectly involves a living person, their issues or personal information, to protect the rights of the participants.
- **Knowing or Knowingly:** Term means that a person, with respect to information has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, acts in reckless disregard of the truth or falsity of the information, and require no proof of specific intent to defraud.
- **Law Enforcement Official:** Any officer or employee of an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to investigate or conduct an official inquiry into a potential violation of law; or prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law (In accordance with 45 CFR Sec 164.503).
- **Limited Data Set:** Protected Health Information that excludes certain direct identifiers of the individual, or of relatives, employers, or household members of the individual as presented in §164.514(e)(2).
- **Living Will:** A type of advance directive not legally binding in Michigan. A living will allow an individual to specify what type of treatment they do or do not want at a future date in the event they are unable to participate in their health care decisions. A living will does not designate a patient advocate.
- **Maintenance Treatment:** Means long-term pharmacotherapy for individuals with substance use disorders that reduces the pathological pursuit of reward and/or relief and supports remission of substance use disorder-related symptoms.
- **Meeting:** In accordance with MCL 15.262, the word "meetings" for purposes of this policy means convening of the SCCMHA Board and any of the standing or special meetings of the Committee's of the SCCMHA Board of Directors at which a quorum is present for the purpose of deliberating toward or rendering a decision.
- **Member Program:** Means a withdrawal management or maintenance treatment program which reports person served identifying information to a, central registry and which is in the same state as that central registry or is in a state that participates in data sharing with the central registry of the program in question.
- **Michigan Department of Health and Human Services (MDHHS):** The Michigan Department of Health and Human Services (MDHHS) is a principal department of state of Michigan, headquartered in Lansing, that provides public assistance, child, and family welfare services, and oversees health policy and management, including mental health and substance abuse services.
- **Mid-State Health Network (MSHN)**: Is the Prepaid Inpatient Health Plan (PIHP) for twenty-one Michigan counties and is in partnership with the Community Mental Health (CMH) agencies of these counties. MSHN, in partnership with the CMH's and local providers, provides mental health services to adults with severe and persistent mental illness, children with severe emotional disturbance, individuals

with intellectual/developmental disabilities, and individuals with substance use disorders.

- **Minor:** As used in the regulations in this part, means an individual who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, the age of 18 years.
- **Part 2 Director:** Means:
    - In the case of a Part 2 program that is an individual, that individual.
    - In the case of a Part 2 program that is an entity, the individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer of the Part 2 program.
- **Part 2 Program:** Means a federally assisted program (federally assisted as defined in § 2.12(b) and program as defined in this section). See § 2.12(e)(1) for examples.
- **Parties excluded from Federal Procurement and Non-procurement Programs:** As defined by 29CFR98, this is a list compiled, maintained, and distributed by the General Services Administration (GSA) containing the names and other information about persons who have been debarred, suspended, or voluntarily excluded under Executive Orders 12549 and 12689 and as well additional federal regulations. As defined under 42 CFR Part 2, An individual or entity (other than a general medical facility) who holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or An identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.
- **Person served :** Means any individual who has applied for or been given diagnosis, treatment, or referral for treatment for a substance use disorder at a Part 2 program. Person served includes any individual who, after arrest on a criminal charge, is identified as an individual with a substance use disorder to determine that individual's eligibility to participate in a Part 2 program. This definition includes both current and former patients.
- **Patient Advocate:** A surrogate designated by a competent adult to make health care decisions on his or her behalf in the event of losing decision-making capacity. The term applies to a person appointed in a Durable Power of Attorney for Healthcare by a presumed competent adult. The Patient Advocate may also be known as the ‘agent’ or ‘proxy.’
- **Patient identifying information:** As defined by 42 CFR Part 2, Patient Identifying Information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient, as defined by 42 CFR Part 2, can be determined with reasonable accuracy either directly or by reference to other information. The term does not include a number assigned to a patient by a part 2 program, for internal use only by the part 2 program, if that number does not consist of or contain numbers (such as a social security, or driver’s license number) that could be used to identify a patient with reasonable accuracy from sources external to the part 2 program.

- **Person:** Means an individual, partnership, corporation, federal, state or local government agency, or any other legal entity, (also referred to as "individual or entity").
- **Principal:** Officer, director, key employee or other person with primary management or supervisory responsibilities; or a person who has a critical influence on or substantive control over a covered transaction, whether employed by SCCMHA.
- **Procurement Activities:** All acquisition programs and activities involving Federal financial and non-financial assistance and benefits as Covered by Executive Order No. 12549 and the Office of Management and Budget guidelines implementing that order.
- **Program:** Means:
    - An individual or entity (other than a general medical facility) who holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or
    - An identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or
    - Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.
- **Provider Network:** Refers to an SCCMHA that is directly under contract with SCCMHA to provide services and/or support through direct operations.
- **Psychiatric Advance Directive (PAD):** This document may also be known as an Advance Psychiatric Directive. These documents are like Living Wills. These documents are not legally recognized in Michigan – unless they also appoint a patient advocate.
- **Psychotherapy Notes:** Any 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 exclude medication prescriptions and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, result of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
- **Protected Health Information (PHI):** Is health information collected from an individual, created or received by a covered entity and relates to past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. This can be maintained in an electronic or any other form, excluding educational and employment records.
    - **HIPAA Defined Identifiers are:**
        - Names, including initials;

        - Street address, city, county, precinct, zip code, and equivalent geo-codes;
        - All elements of dates (except year) for dates directly related to an individual and all ages over 89;
        - Telephone Numbers;
        - Fax Numbers;
        - Electronic mail addresses;
        - Social Security Numbers;
        - Medical record numbers;
        - Health plan ID numbers;
        - Account numbers ;
        - Certificate/license numbers;
        - Vehicle identifiers and serial numbers, including license plate numbers;
        - Device identifiers/serial numbers;
        - Web addresses (URLs);
        - Internet IP addresses;
        - Biometric identifiers, including finger and voice prints;
        - Full face photographic images and comparable images; and
        - Any other unique identifying number, characteristic, or code.
- **Qualified Protective Order (QPO)**: As defined by the HIPAA Privacy Rule §164.512(e)(1)(v). A QPO means, with respect to protected health information requested in response to a subpoena, discovery request, or other lawful process, which is not accompanied by an order of a court or administrative tribunal, a QPO is an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:
    - Prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and
    - Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding.
- **Qualified Service Organization**: Means an individual or entity who:
    - Provides services to a Part 2 program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and childcare and individual and group therapy, and
    - Has entered into a written agreement with a Part 2 program under which that individual or entity:
        - Acknowledges that in receiving, storing, processing, or otherwise dealing with any person served records from the Part 2 program, it is fully bound by the regulations in this Part; and
        - If necessary, will resist in judicial proceedings any efforts to obtain access to person served identifying information related

to substance use disorder diagnosis, treatment, or referral for treatment except as permitted by the regulations in this part.

- **Reasonable Distance:** Is defined as a distance sufficient to ensure that persons entering or leaving the building or facility shall not be subjected to breathing smoke, aerosols, or vapors to ensure that it does not enter the building or facility through entrances, windows, ventilation systems or any other means.
- **Record:** Means any information, whether recorded or not, created by, received, or acquired by a Part 2 program relating to a person served (*e.g.,* diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts), provided, however, that information conveyed orally by a Part 2 program to a non-Part 2 provider for treatment purposes with the consent of the person served does not become a record subject to this Part in the possession of the non-part 2 provider merely because that information is reduced to writing by that non-part 2 provider. Records otherwise transmitted by a Part 2 program to a non-part 2 provider retain their characteristic as records in the hands of the non-part 2 provider but may be segregated by that provider. For the purpose of the regulations in this part, records include both paper and electronic records.
- **Relationship:** In accordance with 42 C.F.R. §438.610, 'relationship' is defined as:
  - A director or officer, of SCCMHA
  - A person with an employment consulting or other agreement with SCCMHA for the provision of items and services that are significant and material to SCCMHA's obligation under its contract with the State of Michigan.
- **Research:** (as defined by 45 CFR, Part 46.102) Means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.
- **Research Review Board:** A body appointed by SCCMHA with the knowledge and experience required to function as an IRB.
- **Subpoena:** Is a legal document or order requiring an individual (i.e., case manager, psychotherapist) to appear, and usually to testify, in court on a certain date and/or to produce documents.
  - Subpoenas for Records may be divided into two types:
    - Subpoenas for the Medical Records of a person served
    - Subpoenas for other SCCMHA records
- **Subpoena duces tecum**: is derived from the Latin meaning "bring it with you." It is an order requiring a witness to bring specific documents, reports, tapes, or any other specified records that are in the possession or under the control of the witness to a certain place at a certain time.
- **Substance Abuse Disorder:** Means a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control,

social impairment, risky use, and pharmacological tolerance and withdrawal. For the purposes of the regulations in this part, this definition does not include tobacco or caffeine use.

- **Third Party Payer:** Means an individual or entity who pays and/or agrees to pay for diagnosis or treatment furnished to a person served on the basis of a contractual relationship with the person served or a member of the person served family or on the basis of the person served eligibility for federal, state, or local governmental benefits.
- **Treating Provider Relationship:** Means that, regardless of whether there has been an actual in-person encounter:
    - A person served is, agrees to, or is legally required to be diagnosed, evaluated, and/or treated, or agrees to accept consultation, for any condition by an individual or entity, and;
    - The individual or entity undertakes or agrees to undertake diagnosis, evaluation, and/or treatment of the patient, or consultation with the person served, for any condition.
- **Treatment**: Means the care of a person served suffering from a substance use disorder, a condition which is identified as having been caused by the substance use disorder, or both, in order to reduce or eliminate the adverse effects upon the Person served.
- **Undercover Agent**: Means any federal, state, or local law enforcement agency or official who enrolls in or becomes an employee of a Part 2 program for the purpose of investigating a suspected violation of the law or who pursues that purpose after enrolling or becoming employed for other purposes.
- **Unsecured Protected Health Information**: Protected health information (PHI) that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Pub. L.111-5 on the HHS website.
    - Electronic PHI has been encrypted as specified in the HIPAA Security rule by the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools should be stored on a device or at a location separate from the data they are used to encrypt or decrypt. (In accordance with 45 CFR Parts 160 and 164; Final Rules Issued 8.18.09). The following encryption processes meet this standard.
        - Valid encryption processes for data at rest (i.e., data that resides in databases, file systems and other structured storage systems) are consistent with NIST Special Publication 800-111, Guide to Storage Encryption Technologies for End User Devices.
        - Valid encryption processes for data in motion (i.e. data that is moving through a network, including wireless transmission) are those that comply, as appropriate, with NIST Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations; 800-77, Guide to IPsec VPNs; or

800-113, Guide to SSL VPNs, and may include others which are Federal Information Processing Standards FIPS 140-2 validated.

- The media on which the PHI is stored or recorded has been destroyed in the following ways:
- Paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed.
    - Redaction is specifically excluded as a means of data destruction.
- Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publications 800-88, Guidelines for Media Sanitization, such that the PHI cannot be retrieved.

- **Use**: As defined by the Privacy Rule, §164.501, means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.
- **Withdrawal Management**: Means the use of pharmacotherapies to treat or attenuate the problematic signs and symptoms arising when heavy and/or prolonged substance use is reduced or discontinued.
- **Workforce**: Workforce means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity (In accordance with 45 CFR Sec 164.103).

**References:**
None.

**Exhibits:**
None.

**Procedure:**
None

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject HIPAA Privacy Set: The Right to Request Privacy Protection for PHI – Requesting Restrictions on Uses and Disclosures</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.03.01</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
HIPAA Privacy Rule requirements (45 CFR §164.522) provide an individual with the right to request restrictions to the use and disclosure of his or her protected health information. While SCCMHA is not required to agree to the requested restriction, SCCMHA (and applicable Providers) is required to permit the request. If SCCMHA (or applicable providers) agrees to the requested restriction, SCCMHA (or applicable providers) may not make uses or disclosures that are inconsistent with such restrictions, unless such uses or disclosures are mandated by law. This provision does not apply to health care provided to an individual on an emergency basis.

**Policy:**
SCCMHA will allow an individual to request restrictions on the use and disclosure of their protected health information.

**Application:**
SCCMHA Board operated programs and applicable Network providers.

**Standards:**
SCCMHA will respond to a request by a person served within 30 days from date of request.

**Definitions:**
Please see *SCCMHA Policy 08.05.00.01 - Compliance Definitions Policy for the following terms.*

- Disclosure
- Use
- Protected Health Information (PHI)

**References:**
HIPAA Privacy Rule, 45 CFR §164.522
Consumer Request for Restrictions on Uses and Disclosures of PHI

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA (and applicable Providers) will allow a person served to request, in writing, restrictions on the use and disclosure of their protected health information. | All SCCMHA (and applicable Provider) employees |
| 2. Upon receiving a written request for a restriction on the use or disclosure of PHI, the Medical Records Staff will evaluate the request, and if necessary, forward the written request to the appropriate clinical supervisor for review. | Medical Records Staff, appropriate clinical supervisor. |
| 3. The appropriate clinical supervisor will consult with the Executive Director of Clinical Services and the Privacy Officer, if necessary, regarding the request. The supervisor will forward the decision to the Medical Records Staff, who will ensure granted requests are properly entered in the file of a person served and forward the written response to the person served. | Executive Director of Clinical Services, Privacy Officer, Medical Records Staff |
| 4. If the decision has been made to agree with the requested restriction, the agreement will be documented on the request form, such restriction will be placed in the record of a person served, flagged in the EMR system, and the Privacy Officer will retain a copy of such restriction. SCCMHA (and applicable Provider) will not violate such restriction, unless as specified within this policy and procedure. | Medical Records Staff, Privacy Officer |
| 5. SCCMHA (and applicable provider) will attempt to respond to a request from a persons served for restrictions on the use and disclosure of PHI within 30 days. | Medical Records Staff |

| | |
|---|---|
| 6. SCCMHA (and applicable Providers) is not required to honor an individual's request in the following situation(s):<br>a. when the individual who requested the restriction needs emergency treatment and the restricted protected health information is needed to provide the emergency treatment.<br>b. If restricted protected health information is disclosed to a health care provider for emergency treatment, SCCMHA (and applicable Provider) will request that such health care provider not further use or disclose the information. | Emergency Service Providers |
| 7. If SCCMHA agrees to a requested restriction by a person served, the restriction does not apply to the following uses and disclosures:<br>a. to an individual accessing their own protected health information.<br>b. to an individual requesting an accounting of their own protected health information.<br>c. facility directories.<br>d. instances for which consent, an authorization, or opportunity to agree or object is not required, such as judicial and administrative purposes; health oversight; research; law enforcement; public health; to avert a serious threat to health and safety; cadaveric organ, eye, or tissue donation; decedents; Worker's Compensation; victims of abuse, neglect, or domestic violence, specialized government functions; required by law (§164.512). | All SCCMHA (and applicable Provider) employees |
| 8. SCCMHA (and applicable Provider) may terminate its agreement to a restriction in the following situations:<br>a. The person served agrees to or requests the termination in writing.<br>b. the person served orally agrees to the termination and the oral agreement is documented.<br>c. SCCMHA (and applicable Provider) informs the person served that it is terminating its agreement to a restriction. Such termination is only effective with respect to protected health information created or received after it has so informed the person served. | Medical Records Staff |
| 9. SCCMHA will document and retain the restriction for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. | Privacy Officer |

| | |
|---|---|
| 10. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Office, or to the Regulatory Compliance hotline. | All SCCMHA (and applicable Provider) employees |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: The Right to Request Privacy Protection for PHI -Confidential Communications for PHI</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.03.02</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance & Privacy<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
It is important to ensure that persons served are able to receive communications regarding their protected health information in a method and location that the individual feel is safe from unauthorized use or disclosure. In compliance with the HIPAA Privacy Rule (§164.522(b)), a covered health care provider must permit individuals to request and must accommodate reasonable requests by persons served to receive communications of protected health information from the covered health care provider by alternative methods or at alternative locations.

**Policy:**

1. SCCMHA (and applicable providers) will take necessary steps to accommodate reasonable requests by persons served to receive confidential communications of protected health information.

2. Persons served desiring to receive communications of protected health information from SCCMHA (and applicable providers) by alternative means or at an alternative location must present such a request to SCCMHA (and applicable providers) in writing.

3. SCCMHA (and applicable providers) may condition the provision of a reasonable accommodation on information as to how payment, if any, will be handled, as well as specification by the consumer of an alternative address or other method of contact.

**Application:**
SCCMHA Board operated programs and applicable Network providers.

**Standards:**
None

**Definitions:**
Please see *SCCMHA Policy 08.05.00.01 - Compliance Definitions Policy for the following terms.*

- Disclosure
- Use
- Protected Health Information (PHI)

**References:**
HIPAA Privacy Rule, §164.522(b)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA (and applicable providers) will accept a request from a person served for the provision of PHI through alternative means or alternative locations when the request is presented to SCCMHA (and applicable providers) in writing. | Medical Records Staff |
| 2. SCCMHA (and applicable providers) will not require an explanation from the individual as to the basis for the request as a condition of providing communications on a confidential basis. | Medical Records Staff |
| 3. When appropriate, SCCMHA (and applicable providers) may condition the provision of reasonable accommodation on information as to how payment, if any, will be handled, and specification of an alternative address or other method of contact. The Privacy Officer may be consulted in such situations. | Medical Records Staff, Privacy Officer |

| | |
|---|---|
| 4. An alternative means or location will be designated on a case-by-case basis, which is satisfactory to both SCCMHA (and applicable providers) and the person served before communication of protected health information is made. | Medical Records Staff |
| 5. The Privacy Officer, using professional judgment and considering all relevant factors, will be responsible for deciding the alternative method or location to communicate protected health information to a person served. | Privacy Officer |
| 6. Once it is determined that use or disclosure is appropriate, the Medical Records Staff (or designee) will access the protected health information of a person served using proper access and authorization procedures. | Medical Records Staff |
| 7. The requested protected health information will be delivered to the person served in a secure and confidential manner, such that the information cannot be viewed or accessed by employees or other persons who do not have appropriate access clearance to that information. | Medical Records Staff |
| 8. Medical Records staff will appropriately document the request and delivery of the protected health information. | Medical Records Staff |
| 9. If the identity and legal authority of an individual or entity requesting Protected Health Information cannot be verified, personnel will refrain from disclosing the requested information and report the case to the Privacy Officer in a timely manner. | Medical Records Staff |
| 10. SCCMHA will retain a copy of this policy for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. | Privacy Officer |
| 11. Knowledge of a violation or potential violation of this policy must be reported directly to the | All SCCMHA employees |

| | |
|---|---|
| Compliance Office, or to the Regulatory Compliance hotline. | |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: The Individual's Right to Access PHI - Granting Access to Inspect and Obtain a Copy (Inclusive of 42 CFR Part 2)</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.04.01</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 9/9/10, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer, Chief Quality & Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**

SCCMHA (and applicable Providers) recognize that individual persons served rights are a critical aspect of maintaining quality care and service. Accordingly, SCCMHA (and applicable Providers) are committed to allowing persons served to exercise their rights under the HIPAA Privacy Rule (45 CFR §164.524), and other applicable federal, state, and/or local laws and regulations, such as the Michigan Mental Health Code (MCL 330.1748) and federal regulations related to substance use disorders (42 CFR Part 2). To support this commitment, SCCMHA (and applicable Providers) will maintain and update, as appropriate, written policies, and procedures to provide guidance on employee and organizational responsibilities regarding the rights of persons served to access, inspect, and obtain a copy of their protected health information.

**Policy:**

1. SCCMHA (and applicable Providers) will take necessary steps to address requests from persons served to access, inspect, and/or obtain a copy of their protected health information that is maintained in their designated record set in a timely and professional manner. This period will not exceed 30 days.

2. SCCMHA will provide, without charge, a single printed copy of any document from the person served record to a person served, the exception being those documents that a copy is required to be given to the persons served such as the Person-Centered Plan. Additional copies of documents already provided will be charged at the current reimbursement rate.

3. 42 CFR Part 2 (§2.23) specifically provides that those regulations do not prohibit a part 2 program from giving a person served access to their own records, including the opportunity to inspect and copy any records that the part 2 program maintains about the person served. Part 2 program is not required to obtain a 's written consent from a person served or other authorization under the regulations to provide such access to the person served.

4. The HIPAA Privacy Rule provides that persons served do not have the right to access the following types of information:
    a. Psychotherapy notes, as defined by the Privacy Rule.
    b. Information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
    c. Protected health information that is:
        (i) Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C.§263a, to the extent the provision of access to the individual would be prohibited by law; or
        (ii) Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR §493.3(a)(2).

5. In the event a person served seeks access to their records, and the Medical Records Staff or an appropriate clinical professional makes the good faith determination that information exists in the designated record set which would qualify for one of the Privacy Rule exceptions listed above, the matter will be referred to the Executive Director of Clinical Services for disposition.

6. The Executive Director of Clinical Services will review the facts of the case, and a decision will be made on a case-by-case basis. Consultation may be had with the Privacy Officer and/or outside counsel. In the event access is denied, refer to Policy 'Denying Access to Inspect and Obtain a Copy.'

7. The following persons are responsible for receiving and processing requests for access to protected health information by individuals: SCCMHA Privacy Officer, SCCMHA Executive Director of Clinical Services, Quality and Medical Records Supervisor, Medical Records Staff.

**Application:**
SCCMHA Board operated programs and applicable Network providers.

**Standards:**

None

**Definitions:**
*Please see SCCMHA Policy 08.05.00.01 - Compliance Definitions Policy for the following terms.*

- Designated Record Set
- Protected Health Information (PHI)
- Psychotherapy Notes

**References:**
45 CFR 164.524, Privacy Rule
MCL 330.1746, Michigan Mental Health Code
MCL 330.1748, Michigan Mental Health Code
42 U.S.C. §263a
42 CFR §493.3(a)(2)
Request for Health Information (Form)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Persons served wishing to exercise their right of access to inspect or obtain a copy of PHI should direct their request to the Medical Records Staff, or other designated staff, | Medical Records Staff |
| 2. The person served will be informed that a request for access is required to be in writing, using the current Release of Information form. | Medical Records Staff |
| 3. Upon receipt of a signed Release of Information form, the Medical Records Staff will act on the request by:<br>(i) Consulting with the Privacy Officer and/or the Quality and Medical Records Supervisor if necessary.<br>(ii) informing the person served of the acceptance and providing the access requested or<br>(iii)providing the person served with a written denial if appropriate:<br>To determine whether a request should be denied, See Policy *Denying Access to Inspect and Obtain a Copy of Protected Health Information*, and policy on *Reviewing a Denial to Access to Protected Health Information*. | Medical Records Staff,<br>Privacy Officer,<br>Quality and<br>Medical Records<br>Supervisor |
| | Medical Records Staff, |

| | |
|---|---|
| 4. For case record entries made prior to March 28, 1996, action taken pursuant to procedure must be taken (in accordance with the HIPAA Privacy Rule, 45 CFR §164.524.)<br>a. no later than 30 days after the request is made: or<br>b. if the request is for protected health information that is not maintained or accessible on-site to SCCMHA, no later than 60 days after the request. | Privacy Officer<br><br>Medical Records Staff, |
| 5. If SCCMHA (and applicable Providers) cannot act on a request for access to protected health information within the relevant time periods listed in Procedure 4; SCCMHA (and applicable Providers) may extend the time required by 30 days. | Privacy Officer<br><br>Medical Records Staff, |
| 6. For case record entries subsequent to March 28, 1996, action taken pursuant to procedure shall be disclosed to competent adult persons served, in accordance with the Michigan Mental Health Code (MCL 330.1748(4)), as expeditiously as possible but in no event later than the earlier of 30 days after receipt of the request or, it the recipient is receiving treatment from the holder of the record, before the recipient is released from treatment. | Medical Records Staff |
| 7. In the event a person served seeks access to their records, and the Medical Records Staff or an appropriate clinical professional makes the good faith determination that information exists in the file which would qualify under one of the HIPAA Privacy Rule exceptions listed above, the matter will be referred to the Executive Director of Clinical Services for disposition. (See Policy 08.05.04.02) | Executive Director of Clinical Services<br><br>Medical Records Staff |
| 8. When a person served is allowed access, inspection, and/or copies of the requested protected health information it will be provided or accessed in a secure and confidential manner. | Medical Records Staff |
| 9. When SCCMHA (or applicable Providers) provides the individual with access to the protected health information, it will be in the form or format requested by the individual, if it is readily producible in such form or format. | Medical Records Staff |
| 10. If the requested format is not readily producible, then SCCMHA (and applicable Providers) will provide the individual with access to the protected health information in a readable hard copy form or such other form as agreed to by the individual. | Medical Records Staff |

| | |
|---|---|
| 11. If requested by the individual, SCCMHA (and applicable Providers) will arrange with the individual for a convenient time and place to inspect or obtain a copy of the protected health information, or mailing of protected health information, within the specified time. | Appropriate Clinical Professional |
| 12. A summary of the requested protected health information will be provided in lieu of access to the information only when the individual agrees in advance to a summary, and to any related fees imposed. | Appropriate Clinical Professional |
| 13. An explanation of the requested protected health information to which access has been provided will accompany the access only when the individual agrees in advance to a summary, and to any related fees imposed. | Appropriate Clinical Professional |
| 14. If a summary or explanation of the requested information is to be prepared, such a summary or explanation will be completed only by the appropriate clinical personnel and reviewed by the Records Supervisor. | Medical Records Staff |
| 15. The Medical Records Staff will provide the appropriate documentation of the request and delivery of the protected health information. | Finance Department |
| 16. Any fees imposed on the individual for a copy of the protected health information, or a summary or explanation of such information will:<br>a. be collected by the Finance Office at the time of provision of the requested documents.<br>b. be reasonable and cost based.<br>c. will be only for the cost of the following:<br>i. Copying, including the cost of supplies for and labor of copying, the protected health information requested by the individual.<br>ii. Postage, when the individual has requested the copy, or the summary or explanation, be mailed; and<br>iii. Preparing an explanation or summary of the protected health information. | Privacy Officer, Medical Records Staff |
| 17. SCCMHA (and applicable Providers) will document and retain records that are subject to access by individuals for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. (See Records Retention Policy) | |

| | |
|---|---|
| 18. This policy and procedure will be documented and retained for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. | Privacy Officer, Medical Records Staff |
| 19. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Office, or to the employee compliance hotline. | All SCCMHA, and applicable providers, employees |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: The Individual’s Right to Access PHI – Denying Access to Inspect and Obtain a Copy</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.04.02</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer, Chief Quality & Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA recognizes that individual rights are a critical aspect of maintaining quality care and service and is committed to allowing individuals to exercise their rights under The HIPAA Privacy Rule, 45 CFR §164.524, and other applicable federal, state, and/or local laws and regulations. To support this commitment, SCCMHA (and applicable Providers) will maintain and update, as appropriate, written policies, and procedures to provide guidance on employee and organizational responsibilities regarding the rights of individuals to access, inspect, and obtain a copy of their protected health information.

However, situations may arise when SCCMHA personnel (and applicable Providers) must decide to deny a person served access to their protected health information, in accordance with applicable laws and regulations.

The policies and procedures herein have been established to assist personnel in evaluating the appropriateness of such a determination. Personnel should also refer to *HIPAA Privacy Set: The Individual’s Right to Access PHI - Granting Access to Inspect and Obtain a Copy*, in responding to a request from a person served for access to protected health information.

**Policy:**

1. SCCMHA (and applicable Providers) will take necessary steps to address requests from a person served to access, inspect, and/or obtain a copy of their protected health information that is maintained in a person served designated record set in a timely and professional manner.

2. SCCMHA (and applicable Providers) will adhere to the procedures herein when denying access to inspect or obtain a copy of protected health information.

**Application:**
SCCMHA Board operated Programs and applicable Network Providers.

**Standards:**
None

**Definitions:**
*Please see SCCMHA Policy 05.08.00.01 - Compliance Definitions Policy for the following terms.*

- Designated Record Set
- Protected Health Information (PHI)

.

**References:**
HIPAA Privacy Rule: 45 CFR §164.524
Michigan Mental Health Code: MCL 330.1748

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Persons served wishing to exercise their right of access to inspect or obtain a copy of their PHI should direct their written request to the Medical Records Staff. | Medical Records Staff |
| 2. An appropriate written request from a person served regarding their protected health information will, within a reasonable time, be forwarded to the Medical Records Staff. | Medical Records Staff |
| 3. Upon receipt of a written request, the Medical Records Staff will act on the request by (1) informing the individual of the acceptance and providing the access requested; or (2) providing the individual with a written denial after consultation with the Privacy Officer if necessary. | Medical Records Staff, Privacy Officer |
| 4. Action taken pursuant to procedure #3 must be taken:<br>a. no later than 30 days after the request is made: or | Medical Records Staff |

| | |
|---|---|
| b. if the request is for protected health information that is not maintained or accessible on-site to SCCMHA (or applicable provider), no later than 60 days after the request. | |
| 5. If SCCMHA (or applicable provider) cannot act on a request for access to protected health information within the relevant time periods listed in procedure #3; SCCMHA may extend the time required by 30 days. | Medical Records Staff |
| 6. In the event a person served seeks access to their records, and the Medical Records Staff or an appropriate clinical professional makes the good faith determination that information exists in the file which would qualify as one of the HIPAA Privacy Rule exceptions listed below, the matter will be referred to the Executive Director of Clinical Services for disposition. | Medical Records Staff, Executive Director of Clinical Services, appropriate clinical professional |
| 7. The Executive Director of Clinical Services will review the facts of the case, and a decision will be made on a case-by-case basis. Consultation may be had with the Privacy Officer and/or outside counsel. | Executive Director of Clinical Services, Privacy Officer |
| 8. The HIPAA Privacy Rule provides that person served do not have the right to access, nor to a review of such denial, to the following types of information:<br>a. Protected Health Information that is:<br>i. Psychotherapy notes, as defined by the Privacy Rule.<br>ii. Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and<br>iii. Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C.§263a, to the extent the provision of access to the individual would be prohibited by law; or exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR §493.3(a)(2).<br>b. When SCCMHA (or an applicable Provider) is acting under the direction of a correctional institution upon an inmate's request for a copy of the protected health information and obtaining a copy would jeopardize the health, safety, custody, or rehabilitation of the individual or of other inmates, or of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate. | Privacy Officer, Medical Records Staff |

| | |
|---|---|
| c. Access to protected health information that was created or obtained by SCCMHA in the course of research that includes treatment maybe temporarily suspended for as long as the research is in progress, provided that the individual has agreed to the denial of access when consenting to participate in the research and has been informed that the right of access will be reinstated upon completion of the research.<br>d. The individual's access to protected health information that is contained in records that are subject to the Privacy Act, 5 USC §552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law.<br>e. The individual's access may be denied if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. | |
| 9. The HIPAA Privacy Rule (see Also Michigan Mental Health Code, MCL 330.1748(6)(b)) provides that a denial of a request from the person served to access protected health information in the following situations may be reviewed:<br>a. a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.<br>b. the protected health information refers to another person (unless such other person is a health care provider) and a licensed healthcare professional has determined, in the exercise of professional judgment; that the access requested is reasonably likely to cause substantial harm to such other person; or<br>c. the request for access is made by the individual's personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person. | Privacy Officer, Medical Records Staff |
| 10. In denying access in whole or in part, to the extent possible, Medical Records Staff will give the individual access to | Medical Records Staff |

| | |
|---|---|
| any other protected health information requested, after excluding the protected health information that was denied. | |
| 11. When denying an individual access to protected health information, the denial will:<br>a. be written in plain language.<br>b. contain the basis for the denial.<br>c. contain the following statement, if applicable:<br>THE INDIVIDUAL HAS THE RIGHT TO HAVE THE DENIAL REVIEWED BY A LICENSED HEALTH CARE PROFESSIONAL, DESIGNATED BY SCCMHA TO ACT AS A REVIEWING OFFICIAL AND WHO DID NOT PARTICIPATE IN THE ORIGINAL DENIAL DECISION.<br><br>INDIVIDUALS MAY EXERCISE THEIR REVIEW RIGHTS BY CONTACTING THE PRIVACY OFFICE AND REQUESTING SUCH A REVIEW.<br><br>d. contain a description of how the individual may complain to SCCMHA pursuant to its complaint procedures. | Medical Records Staff |
| 12. The description of how the individual may complain will include the name, or title, and telephone number of the contact person or office designated to review such complaints. | Medical Records Staff |
| 13. This policy and procedure will be documented and retained for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. | Privacy Officer |
| 14. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Office, or to the employee compliance hotline. | All SCCMHA employees |

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject HIPAA Privacy Set: The Individual's Right to Access PHI – Reviewing a Denial to Access PHI</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.04.03</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer, Chief Quality & Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA recognizes that individual rights are a critical aspect of maintaining quality care and service and is committed to allowing individuals to exercise their rights under The HIPAA Privacy Rule, 45 CFR §164.524, and other applicable federal, state, and/or local laws and regulations, such as The Michigan Mental Health Code, MCL 330.1748. To support this commitment, SCCMHA will maintain and update, as appropriate, written policies, and procedures to provide guidance on employee and organizational responsibilities regarding the rights of individuals to access, inspect, and obtain a copy of their protected health information.

However, situations may arise when SCCMHA (or applicable Providers) personnel must decide to deny an individual access to their protected health information, in accordance with applicable laws and regulations.

In certain circumstances, individuals may request that the denial be reviewed. The policies and procedures herein have been established to assist personnel in such a review.

**Policy:**

1. SCCMHA (or applicable providers) will take necessary steps to address individual requests to access, inspect, and/or obtain a copy of their protected health information that is maintained in an SCCMHA record in a timely and professional manner.

2. SCCMHA (or applicable providers) will adhere to (HIPAA Privacy Set: The Individual's Right to Access PHI – Denying Access to Inspect and Obtain a Copy) procedures herein when denying access, inspection, or copying of protected health information.

3. SCCMHA will adhere to the following procedures when reviewing a denial to access protected health information.

**Application:**
SCCMHA Board operated Programs, and applicable Network Providers.

**Standards:**
None

**Definitions:**
*Please see SCCMHA Policy 08.05.00.01 - Compliance Definitions Policy for the following terms.*

- Protected Health Information (PHI)

.

**References:**
HIPAA Privacy Rule 45 CFR §164.524
Michigan Mental Health Code MCL 330.1748(6)(b)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA will review a denial of a request from a person served for access to protected health information, in the following situations:<br>a. a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.<br>b. the protected health information refers to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person, or | Clinical staff |

| | |
|---|---|
| c. the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person. | |
| 2. All denial reviews will be conducted by a licensed health care professional who is designated by SCCMHA to function as a reviewing official and who did not participate in the original decision to deny. | Clinical staff, Privacy Officer |
| 3. The designated reviewing official will be determined on a case-by-case basis by the Executive Director of Clinical Services. | Executive Director of Clinical Services |
| 4. The Medical Records Staff will promptly refer a request for review to the Executive Director of Clinical Services. | Medical Records Staff |
| 5. The designated reviewing official will determine, within a reasonable period, whether or not to deny the access requested based on the applicable standards. | Designated reviewing official |
| 6. Medical Records Staff will promptly provide written notice to the individual of the determination of the designated reviewing official and take other actions required to conduct the designated reviewing official's determination. | Medical Records Staff |
| 7. This policy and procedure will be documented and retained for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. | Privacy Officer |
| 8. Knowledge of a violation or potential violation of this policy must be reported directly to the Privacy Officer, or to the employee compliance hotline. | All SCCMHA employees |

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject HIPAA Privacy Set: The Individual's Right to Access PHI – Extending Time to Respond to Request for Access to PHI</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.04.04</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer, Chief Quality & Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**

SCCMHA recognizes that individual rights are a critical aspect of maintaining quality care and service and is committed to allowing individuals to exercise their rights under the HIPAA Privacy Rule,45 CFR §164.524, and other applicable federal, state, and/or local laws and regulations, such as the Michigan Mental Health Code, MCL 330.1748. To support this commitment, SCCMHA (and applicable providers) will maintain and update, as appropriate, written policies, and procedures to provide guidance on employee and organizational responsibilities regarding the rights of individuals to access, inspect, and obtain a copy of their protected health information. However, situations may arise when the requested information is not readily available for access, and therefore, the time for responding to the request may be extended. The policies and procedures herein have been established to assist personnel in the provision of such an extension. Personnel should also refer to *[Policy & Procedure, Granting Access to Inspect and Obtain a Copy)* in responding to an individual's request for access to protected health information.

**Policy:**

1. SCCMHA (and applicable providers) will take necessary steps to address individual requests to access, inspect, and/or obtain a copy of their protected

health information that is maintained in a designated record set in a timely and professional manner.

2. SCCMHA will adhere to (HIPAA Privacy Set: The Individual's Right to Access PHI - Granting Access to Inspect and Obtain a Copy) in providing individuals access, inspection, and/or copies of their protected health information.

3. If SCCMHA must extend the time for responding to a request, we will adhere to the procedures herein.

**Application:**
SCCMHA Board operated Programs, applicable Network Providers

**Standards:**
None

**Definitions:**
*Please see SCCMHA Policy 08.05.00.01 - Compliance Definitions Policy for the following terms.*

- Designated Record Set
- Protected Health Information (PHI)

.

**References:**
HIPAA Privacy Rule, 45 CFR §164.524
Michigan Mental Health Code, MCL 330.1748

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Once SCCMHA (or applicable Network Provider) receives a request from a person served, the Medical Records Staff will act on the request within 30 days after receipt of the request by (1) informing the individual of the acceptance and providing the access requested [see Policy, Granting Access to Inspect and Obtain a Copy]; or (2) providing the individual with a written denial [see Policy Denying Access to Inspect and Obtain a Copy of Protected Health Information]. | Medical Records Staff |
| 2. If the request is for access to protected health information that is not maintained or accessible | Medical Records Staff |

| | |
|---|---|
| to the facility on-site, then SCCMHA (or applicable Network Provider) will act on the individual's request for access no later than 60 days from the receipt of such a request. | |
| 3. If the time period for the action must be extended, then SCCMHA will, within the time allowed in procedure #1, provide the individual with a written statement of the reasons for the delay and the date by which SCCMHA (or applicable Network Provider) will complete its action on the request. | Medical Records Staff |
| 4. If necessary, SCCMHA (or applicable Network Provider) may extend the time for the action by no more than 30 days. | Medical Records Staff |
| 5. SCCMHA (or applicable Network Provider) will not extend the time more than once. | Medical Records Staff |
| 6. The Medical Records Staff will access the individual's protected health information using proper access and authorization procedures. | Medical Records Staff |
| 7. This policy and procedure will be documented and retained for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. | Privacy Officer |
| 8. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Office, or to the employee compliance hotline. | All SCCMHA employees |

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject:** HIPAA Privacy Set – The Right of Individuals to Amend PHI– Accepting Requests for Amendment to PHI | **Chapter**: 08 - Management of Information | **Subject No**: 08.05.05.01 |
| **Effective Date**:<br>April 14, 2003 | **Date of Review/Revision**:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>AmyLou Douglas, Chief Information Officer, Chief Quality & Compliance Officer<br><br>**Authored By**:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>**Additional Reviewers**:<br>Holli McGeshick Quality and Medical Records Supervisor |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | |

**Purpose:**
Under the HIPAA Privacy Rule, §164.526, and the Michigan Mental Health Code, MCL 330.1749, individuals have the right to request that SCCMHA (and applicable Network Providers) amend protected health information or a record about the individual for as long as the protected health information is maintained in the record. SCCMHA (and applicable Network Providers) retain the right to deny the request in compliance with §164.526(a)(2). Unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment, this provision applies to protected health information created only by SCCMHA. For both situations, SCCMHA (and applicable Network Providers) has created policies and procedures to address the issue and to comply with any applicable laws.

**Policy:**
1. SCCMHA (and applicable Network Providers) will provide for an individual to request an amendment to their protected health information or record for as long as the information is maintained by SCCMHA (and applicable Network Providers).

2. SCCMHA (and applicable Network Providers) will allow an individual's request to amend protected health information that was not created by SCCMHA (or applicable Network Providers) if provided a reasonable basis to believe that the originator of the information is no longer available to act on the request.

3. SCCMHA (and applicable Network Providers) will permit an individual to request that SCCMHA (or applicable Network Providers) amend the protected health information maintained in the designated record set. SCCMHA (and applicable Network Providers) requires that such requests for amendment be provided in writing and provide a reason to support a requested amendment.

**Application:**
SCCMHA Board operated programs, and applicable Network providers.

**Standards:**
Requests from persons served to amend health information will be responded to no later than 60 days after the request is received.

**Definitions:**
*Please see SCCMHA Policy 05.08.00.01 - Compliance Definition Policy for the following terms.*

- Designated Record Set
- Protected Health Information (PHI)

**References:**
HIPAA Privacy Rule: 45 CFR §164.526
Michigan Mental Health Code 330.1749

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. The Medical Records Staff will be responsible for receiving, processing, and responding to written requests for amendments to protected health information. | Medical Records Staff |
| 2. All individual requests for amendments to protected or other health information will be in writing and directed to the Medical Records Staff. | Medical Records Staff |
| 3. Written requests for amendment must document the reason(s) to support the requested amendment. | Medical Records Staff |
| 4. The request will be referred to an appropriate health care professional for review, who will be selected by the | Executive Director of Clinical Services, |

| | |
|---|---|
| Executive Director of Clinical Services or the Privacy Officer on a case-by-case basis. | Privacy Officer, appropriate Clinical staff |
| 5. An individual's request for amendment may, in accordance with the HIPAA Privacy Rule, be denied if SCCMHA (or appropriate Network provider) determines that the requested protected health information or record:<br>a. was not created by SCCMHA.<br>b. is not part of the record.<br>c. would not be available for inspection under the HIPAA requirements for individual rights to access protected health information; or<br>d. is accurate and complete. | Medical Records Staff, Privacy Officer, appropriate Clinical staff |
| 6. If SCCMHA denies in good faith a request from a person served to amend protected health information based upon one of the situations provided for under the HIPAA Privacy Rule, the situation will be referred to the Executive Director of Clinical Services for review on a case-by-case basis. | Medical Records Staff, Executive Director of Clinical Services, Privacy Officer |
| 7. If the requested amendment is denied, see Policy, Denying Requests for Amendments to PHI. | Medical Records Staff |
| 8. Medical Records Staff will inform the individual no later than 60 days after receipt of such a request if the amendment is accepted. | Medical Records Staff |
| 9. The time for the action by SCCMHA will be extended by no more than 30 days. | Medical Records Staff |
| 10. If the time for the action is extended, SCCMHA will, within 30 days after the receipt of the request, provide the individual with a written statement of the reasons for the delay and the date by which SCCMHA will complete the action on the request. | Medical Records Staff |
| 11. The time for action will not be extended more than once. | Medical Records Staff |
| 12. If the requested amendment is accepted, Medical Records will make the appropriate amendment, in conjunction with the appropriate clinical staff. | Medical Records Staff, appropriate clinical staff. |
| 13. Upon accepting and completing a requested amendment, Medical Records will perform the following tasks:<br>a. inform the individual, in a timely manner, and obtain the individual's authorization of and agreement to have | Medical Records Staff |

| | |
|---|---|
| SCCMHA notify the relevant persons with which the amendment needs to be shared.<br>b. make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by the individual as needing the amendment.<br>c. make reasonable efforts to inform and provide the amendment within a reasonable time to persons, including business associates, which are known to have the affected protected health information and that may have relied, or could foreseeably rely, on such information to the detriment of the individual. | |
| 14. In completing the amendment Medical Records and the relevant clinical staff, will, at a minimum, identify the affected information in the designated record set and append or otherwise provide a link to the location of the amendment. | Medical Records Staff |
| 15. If another covered entity notifies SCCMHA (or appropriate Network provider) of an amendment to an individual's protected health information, SCCMHA (or appropriate Network provider) will amend the respective information by, at minimum, identifying the affected information in the designated record set and appending or otherwise providing a link to the location of the amendment. | Medical Records Staff, Appropriate Network provider |
| 16. This policy and procedure will be retained for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. | Privacy Officer |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set – The Right of Individuals to Amend PHI – Denying Requests for Amendment to PHI</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.05.02</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer, Chief Quality & Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
Under the HIPAA Privacy Rule, §164.526, and the Michigan Mental Health Code, MCL 330.1749, individuals have the right to request that SCCMHA (and applicable Network Providers) amend protected health information or a record about the individual for as long as the protected health information is maintained in the record. SCCMHA (and applicable Network Providers) retains the right to deny the request in compliance with §164.526(a)(2). Unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment, this provision applies to protected health information created only by SCCMHA. For both situations, SCCMHA (and applicable Network Providers) has created policies and procedures to address the issue and to comply with any applicable laws.

**Policy:**
1. SCCMHA (and applicable Network Providers) will provide for an individual to request an amendment to their protected health information or record for as long as the information is maintained by SCCMHA (and applicable Network Providers).

2. In accordance with the Privacy Rule, SCCMHA reserves the right to deny an individual's request for amendment if it determines that the requested protected health information or record:
    a. was not created by SCCMHA, unless the person served provides a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment.
    b. is not part of the designated record set.
    c. would not be available for inspection under the requirements for individual rights to access protected health information; or
    d. is accurate and complete.

3. Where a potential conflict is presented between the HIPAA Privacy Rule, presented under Policy #2, and the Michigan Mental Health Code which states:

    > A recipient, guardian, or parent of a minor recipient, after having gained access to treatment records, may challenge the accuracy, completeness, timeliness, or relevance of information in the recipient's record. The recipient, guardian, or parent of minor recipient shall be allowed to insert into the record a statement correcting or amending the information at issue. The statement shall become a part of the record.

    The situation will be presented to the Executive Director of Clinical Services who, after consultation with the Privacy Officer and outside counsel, if necessary, will decide regarding the request for amendment to the record on a case-by-case basis.

**Application:**
All SCCMHA Board operated Programs, applicable Network Providers.

**Standards:**
Persons served will be informed within 60 days of receipt of the request to amend health information.

**Definitions:**
*Please see SCCMHA Policy 08.05.00.01 - Compliance Definitions Policy for the following terms.*

- Designated Record Set

.

**References:**
§164.526, HIPAA Privacy Rule
MCL 330.1749, Michigan Mental Health Code

**Exhibits:**

None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|

| | |
|---|---|
| 1. The Medical Records Staff will be responsible for receiving, processing, and responding to requests for amendments to protected health information. | Medical Records Staff |
| 2. All individual requests for amendments to protected or other health information will be in writing and directed to the Medical Records Staff. | Medical Records Staff |
| 3. Individuals must document the reason(s) to support the requested amendment. The Medical Records Staff must ensure that such documentation is presented before proceeding with the request. | Medical Records Staff |
| 4. The request may be referred to an appropriate clinical supervisor for a review of the merits. | Appropriate Clinical Supervisor |
| 5. In accordance with §164.526(b)(2), the Medical Records Staff will inform the individual no later than 60 days after receipt of such a request if the amendment is denied. | Medical Records Staff |
| 6. On occasions where SCCMHA needs more than 60 days to decide, the time period for the action will be extended by no more than 30 days provided that:<br>a. SCCMHA provides the individual with a written statement of the reasons for the delay, and the date by which SCCMHA will complete the action on the request; and<br>b. SCCMHA extends the time for the action not more than once. | Medical Records Staff<br>Appropriate clinical supervisor |
| 7. Upon denying a request for amendment, in whole or in part, SCCMHA will provide the individual with a written denial in accordance with the timeframes outlined above. | Appropriate clinical supervisor, Medical Records Staff |
| 8. In the event of a potential conflict between the regulations under the Privacy Rule, and the Michigan Mental Health Code regarding this issue, the matter will be referred to the Executive Director of Clinical Services. | Appropriate clinical supervisor, Medical Records Staff |
| 9. The Executive Director of Clinical Services, after consultation with the Privacy Officer, and outside counsel, if necessary, will resolve the situation on a case-by-case basis. | Medical records Staff, Privacy Officer |

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject:** HIPAA Privacy Set: Scope of Use and Disclosure - Identifying When Routine Health Information Becomes PHI – Inclusive of 42 CFR Part 2 | **Chapter**: 08 - Management of Information | **Subject No**: 08.05.06.01 |
| **Effective Date**:<br>April 14, 2003 | **Date of Review/Revision**:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>AmyLou Douglas, Chief Information Officer, Chief Quality & Compliance Officer<br><br>**Authored By**:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>**Additional Reviewers**:<br>Holli McGeshick, Quality and Medical Records Supervisor |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | |

**Purpose:**
SCCMHA is committed to ensuring the privacy and security of person served health information. To support this commitment, SCCMHA will ensure that the appropriate steps are taken to properly identify and secure individuals' protected health information, as required by the HIPAA Privacy Rule, 45 CFR Part 164, and other applicable federal, state, and/or local laws and regulations.

**Policy:**
1. Consistent with the definitions provided by the Privacy Rule, §160.103 and §164.501, the following information will be designated as protected health information: Any health information, including demographic information collected from a person served, transmitted, or maintained in any form or medium, that:
   a. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

b. Relates to the past, present, or future physical or mental health or condition of a person served; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to a person served; and
    i. That identifies the person served; or
    ii. With respect to which there is a reasonable basis to believe the information can be used to identify the person served.
2. Routine health information meeting the above definition will be automatically designated as protected health information immediately upon its creation or receipt by SCCMHA.
3. SCCMHA will adhere to all applicable laws, regulations, policies, and procedures when maintaining, using, and disclosing protected health information.
4. Consistent with 42 CFR Part 2, the similarity with as well as the distinctions from HIPAA Protected Health Information should be made concerning the 42 CFR Part 2 definition of Patient Identifying Information.

**Application:**
All SCCMHA Board operated programs, applicable providers.

**Standards:**
None

**Definitions:**
*See the SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Patient identifying information.
- Protected Health Information (PHI)

**References:**
§160.103
§164.501

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. In the event of a discrepancy, the following persons, respectively, will be responsible for designating routine health information as protected health information:<br>a. Medical Records<br>b. Finance<br>c. Executive Director of Clinical Services<br>d. Privacy Officer | Medical Records Staff,<br>Finance Office,<br>Privacy Officer,<br>Executive Director of Clinical Services |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Scope of Use and Disclosure - Creating De-identified Information</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.06.02</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer, Chief Quality & Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA is committed to ensuring the privacy and security of person served health information. Federal law allows certain health care organizations to use or disclose protected health information for the purpose of creating de-identified information – that is, information that has been stripped of any elements that may identify the consumer, such as name, birth date, or social security number. SCCMHA will, from time to time, use de-identified date for various purposes such as utilization review. In doing so, SCCMHA will ensure that the appropriate administrative and technical processes are in place to properly de-identify protected health information, as well as to secure any methods of re-identification, as required in the HIPAA Privacy Rule, 45 CFR §164.514 and other applicable federal, state, and/or local laws and regulations.

**Policy:**
1. SCCMHA may create de-identified information for purposes such as utilization review or quality assurance.
2. De-identification of information will be performed only under the close supervision of the Executive Director of Clinical Services (or designee) and Chief Compliance Officer (or designee), who shall have the appropriate knowledge of and experience with

accepted statistical and scientific principles and methods for rendering information not individually identifiable.

3. SCCMHA will not use or disclose the code or other means of record identification or mechanism used to re-identify health information unless authorized by the Executive Director of Clinical Services (or designee) and Chief Compliance Officer (or designee).
4. De-identified information will not be disclosed if those SCCMHA employees creating or disclosing the information, or any other employees of SCCMHA, have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

**Application:**
SCCMHA Board operated programs and applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- De-identified information
- Disclose
- Use

**References:**
45 CFR § 164.502(d), 164.514(a-c)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. The SCCMHA Executive Director of Clinical Services or Chief Compliance Officer will make decisions as to whether protected health information should be de-identified. | Executive Director of Clinical Services<br>Chief Compliance Officer |
| 2. The reason for de-identification will be documented and maintained. | Executive Director of Clinical Services, Chief Compliance Officer |
| 3. The following individually identifying elements will be removed or otherwise concealed from protected health information to create de-identified information:<br>a. Names.<br>b. All elements of dates (except year) for dates related to an individual, including: | Executive Director of Clinical Services, Chief Compliance Officer |

i. birth date.
ii. admission date
iii. discharge date.
iv. date of death
v. all ages over eighty-nine
vi. all elements of dates (including year) indicative of age 89, except that such ages and elements may be aggregated into a single category of age 90 or older.

c. Telephone numbers.
d. Fax numbers.
e. Electronic mail addresses.
f. Social security numbers.
g. Medical record numbers.
h. Health plan beneficiary numbers.
i. Account numbers.
j. Certificate/license numbers.
k. Vehicle identifiers and serial numbers, including license plate numbers.
l. Device identifiers and serial numbers.
m. Web universal resource locators (URLs).
n. Internet Protocol (IP) address numbers.
o. Biometric identifiers, including finger and voice prints.
p. Full face photographic images and any comparable images.
q. All geographic subdivisions smaller than a State, including:
   i. street address
   ii. city
   iii. county
   iv. precinct
   v. zip code, and their equivalent geocodes.
r. any other unique identifying number, characteristic, or code
s. the initial three digits of a zip code may be used if, according to the current publicly available date from the Bureau of the Census: (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000).

4. If any of the listed identifiers are not removed, then the information will only be disclosed when the Executive

| | |
|---|---|
| Director of Clinical Services, or Chief Compliance Officer<br>a. determines that the risk is small that the information could be used, alone, or in combination with other available information, by an anticipated recipient to identify an individual who is a subject of the information, and<br>b. documents the methods and results of the analysis that justify such determination. | Executive Director of Clinical Services, Chief Compliance Officer |
| 5. The code or other means of record identification used to re-identify information will not be derived from or related to information about the individual and should not otherwise be capable of being translated to identify the individual. | Executive Director of Clinical Services, Chief Compliance Officer |
| 6. Knowledge of a violation or potential violation of this policy must be reported directly to the Privacy Officer, or to the compliance hotline. | All SCCMHA staff |
| 7. Questions concerning de-identification of consumer information should be forwarded to the SCCMHA Compliance Officer. | All SCCMHA staff, Compliance Officer |

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject:** HIPAA Privacy Set: Scope of Use and Disclosure - Creation and uses of a Limited Data Set | **Chapter**: 08 - Management of Information | **Subject No**: 08.05.06.03 |
| **Effective Date**:<br>April 14, 2003 | **Date of Review/Revision**:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/26/23, 7/9/24<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>AmyLou Douglas, Chief Information Officer, Chief Quality & Compliance Officer<br><br>**Authored By**:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>**Additional Reviewers**:<br>Holli McGeshick, Quality and Medical Records Supervisor |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | |

**Purpose:**
SCCMHA is committed to ensuring the privacy and security of person served health information. Federal law allows certain health care organizations to create and use a limited data set under certain conditions. A limited data set contains information from which all direct identifiers, such as name, have been removed, but which may contain some indirect identifiers. SCCMHA may, from time to time, use or disclose limited data sets for the purposes of research, public health, and health care operations. In doing so, SCCMHA will ensure that the appropriate administrative and technical processes are in place to safely remove direct identifiers from protected health information, as required under the HIPAA Privacy Rule, 45 CFR §164.514(e) and other applicable federal, state, and/or local laws and regulations.

**Policy:**
1. SCCMHA may use protected health information to create, or may disclose protected health information to a business associate to create a limited data set for the following purposes:
   a. Research.
   b. Public health; or

c. Health care operations.

2. SCCMHA will enter into a date use agreement that meets the requirements of 45 CFR § 164.514(e) with any proposed recipients of a limited data set, before disclosing any information contained in such limited data set to the recipient.

3. If SCCMHA has knowledge that a limited data set recipient has breached or violated a data use agreement, SCCMHA will take steps to cure the breach or end the violation, and, in the event such actions are unsuccessful, SCCMHA will:
   a. discontinue disclosure of protected health information to the recipient; and
   b. Report the problem to the Secretary of Health and Human Services.

4. In the case that SCCMHA is the recipient of a limited data set, SCCMHA will enter and comply with the terms of a data use agreement consistent with the policies and procedures herein.

**Application:**
SCCMHA Board operated programs, applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 08.05.00.01 – Compliance Definitions Policy for the following terms.*
- Limited Data Set
- Protected Health Information (PHI)

**References:**
45 CFR § 164.502(d), 164.514(a-c), 164.514(e)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. The SCCMHA Executive Director of Clinical Services will make decisions as to whether a limited data set should be created and/or disclosed. | Executive Director of Clinical Services |
| 2. The reason for creating and/or disclosing information in a limited data set will be documented and maintained. | Executive Director of Clinical Services, Privacy Officer, |
| 3. The following individually identifying elements of a person served, relatives, employers and household members of the person served will be removed or otherwise excluded from protected health information to create a limited data set: | Executive Director of Clinical Services, Privacy Officer, |

| | |
|---|---|
| a. Names.<br>b. Postal address information, other than town or city, State, and zip code.<br>c. Telephone numbers.<br>d. Fax numbers.<br>e. Electronic mail addresses.<br>f. Social security numbers.<br>g. Medical record numbers.<br>h. Health plan beneficiary numbers.<br>i. Account numbers.<br>j. Certificate/license numbers.<br>k. Vehicle identifiers and serial numbers, including license plate numbers.<br>l. Device identifiers and serial numbers.<br>m. Web Universal Resource Locators (URLs).<br>n. Internet Protocol (IP) address numbers.<br>o. Biometric identifiers, including finger and voice prints.<br>p. Full face photographic images and any comparable images. | Medical Records Staff |
| 4. SCCMHA will comply with *Policy 08.05.07.01, Disclosing and Requesting Only the Minimum Amount of PHI Necessary* in determining what information to include in a limited data set. | Medical Records Staff |
| 5. The data use agreement, which may be in the form of a formal contract, will not authorize the limited data set recipient to use or further disclose the information in a manner that is inconsistent with the requirements of 45 CFR Part 164, if done by the covered entity. | Medical Records Staff |
| 6. The data use agreement between SCCMHA and the limited data set recipient will establish:<br>a. who is permitted to use or receive the limited data set; and<br>b. the permitted used and disclosures of such information by the recipient consistent with the limited purposes of research, public health, or health care operations. | Medical Records Staff |
| 7. The data use agreement between SCCMHA and the limited data set recipient will provide SCCMHA with adequate assurances that the recipient of the limited data set will:<br>a. not attempt to re-identify or contact the person served whose information is contained in the limited data set.<br>b. use appropriate safeguards to prevent uses or disclosures outside the terms of the data use agreement. | Privacy Officer |

| | |
|---|---|
| c. ensure that any subcontractors or other tertiary recipients of the data agree to and abide by the terms of the data use agreement; and<br>d. report any breaches of the information or agreement to SCCMHA in a timely manner. | |
| 8. Knowledge of a violation or potential violation of this policy must be reported directly to the Privacy Officer, or to the compliance hotline. | All SCCMHA staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject HIPAA Privacy Set: Minimum Necessary Standard - Disclosing and Requesting only the Minimum Amount of PHI Necessary – Inclusive of 42 CFR Part 2</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.07.01</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA is committed to ensuring the privacy and security of person served health information. While person served information must be available to health care professionals in the process of ensuring proper care, disclosing more person served information than needed to perform official duties should be avoided. To support the commitment to confidentiality of persons served, SCCMHA will ensure that the appropriate steps are taken to disclose only the minimum amount of protected health information necessary to accomplish the particular use or disclosure, as required under the HIPAA Privacy Rule, 45 CFR §164.502(b), and other applicable federal, state, and/or local laws and regulations, such as the Michigan Mental Health Code, MCL 330.1748(2), and 42 CFR Part 2 §2.13(a).

**Policy:**
1. SCCMHA employees will follow proper procedures to ensure that only the minimum amount of person served health information that is necessary to accomplish the specific purpose of a use or disclosure is used or disclosed.

2. SCCMHA employees will request only the minimum amount of person served health information necessary to accomplish the specific purpose of the request.

3. In accordance with HIPAA, this policy does not apply to the following uses or disclosures:
   a. disclosures to or requests by a provider for treatment.
   b. uses or disclosures made to the individual who is the subject of the information.
   c. uses or disclosures pursuant to an authorization.
   d. disclosures made to the Department of Health and Human Services.
   e. uses or disclosures required by law; and
   f. uses or disclosures required for compliance with applicable laws and regulations.

4. In accordance with 42 CFR Part 2, any disclosure made under the regulations of 42 CFR Part 2 must be limited to that information which is necessary to conduct the purpose of the disclosure.

**Application:**
All SCCMHA Board operated Programs, and applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*
- Disclosure
- Use

**References:**
45 CFR §164.502(b), 45 CFR §164.514(d), MCL 330.1746

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. All persons will review requested disclosures of person served health information understanding SCCMHA's privacy policies and practices, and sufficient expertise to understand and weigh the necessary factors. | All relevant SCCMHA staff |
| 2. SCCMHA will only use, disclose, or request an entire medical record when the entire medical record is specifically | All SCCMHA staff |

| | |
|---|---|
| justified as being necessary to accomplish the purpose of the use, disclosure, or request. | |
| 3. Within SCCMHA, the following classes of personnel require and will maintain the indicated levels of access to protected health information on a routine basis to appropriately accomplish their duties and responsibilities. Access is determined by the amount of information necessary to complete their job and is limited by a need to know. | |
| a. Medical Records Personnel | Clerk Typist – Medical Records & ROI |
| b. Reimbursement & Finance Personnel | Reimbursement & Finance Staff |
| c. Case Management Personnel | Case Management Staff |
| d. Medical/Clinical Personnel – access is determined by the amount of information necessary to complete their job and is limited by a need to know. | Clinical staff |
| 4. The following criteria will be used in limiting the amount of protected health information requested, used, or disclosed by SCCMHA personnel:<br>a. Does the individual who is requesting the protected health information have a complete understanding of the purpose for the use, or disclosure of the protected health information?<br>b. Are all the individuals identified for whom the use or disclosure of the protected health information is required? | All SCCMHA staff<br>HIPAA Privacy Officer<br>Executive Director of Clinical Services |
| 5. Requests for disclosures of protected health information will be reviewed on an individual basis in accordance with criteria listed in the policy. | Clerk Typist – Medical Records & ROI |

| | |
|---|---|
| 6. SCCMHA personnel may rely on requests by:<br>a. public health and law enforcement agencies in determining the minimum necessary information for certain disclosures.<br>b. other covered entities in determining the minimum necessary information for certain disclosures; or<br>c. by a professional who is a member of its workforce or is a business associate of SCCMHA, if the professional represents that the information requested is the minimum necessary for the stated purpose. | Clerk Typist – Medical Records & ROI |
| 7. In the event of disclosures for research purposes, the SCCMHA Executive Director of Clinical Services will review the documentation in determining the minimum amount of protected health information necessary. | Executive Director of Clinical Services |
| 8. Knowledge of a violation or potential violation of this policy must be reported directly to the HIPAA Privacy Officer, Compliance Officer, or to the compliance hotline. | All SCCMHA staff<br>HIPAA Privacy Officer<br>Compliance Officer |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consents - Obtaining a Consent for Use or Disclosure of PHI</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.09.01</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
For all uses and disclosures of an individual's protected health information, other than those required by law or for treatment, payment and health care operations, the HIPAA Privacy Rule requires a covered entity to obtain a consent that is signed by the individual. The purpose of obtaining consent is to provide the individual with an opportunity to determine how his or her protected health information may be used or disclosed, and to inform the individual of his or her rights under the Privacy Rule. To support our commitment to person served confidentiality, SCCMHA has developed policies and procedures for obtaining consent for uses or disclosures of protected health information.

**Policy:**
1. For all uses and disclosures of an individual's protected health information, SCCMHA (and applicable Network Providers) will obtain a signed consent from the individual, unless the use or disclosure is required, or otherwise permitted without an consent, by 45 CFR Part 164 (the Privacy Rule), or the Michigan Mental Health Code.

2. SCCMHA will comply with the requirements set forth in 45 CFR 164.508 and the Michigan Mental Health Code, to obtain consent to use or disclose protected health information.

3. Except as stated in *(Policy, Conditioning Services or Eligibility on the Provision of an Consent to Disclose Protected Health Information For Health Plans; or Policy, Conditioning Services on the Provision of an Consent to Disclose PHI – Providers),* SCCMHA will not condition treatment, payment, enrollment in the health plan, or eligibility for benefits, if applicable, on the provision of an consent.

4. The Use and Disclosure of an individual's health records maintained by SCCMHA as a Part 2 Program is covered by SCCMHA Policy 08.05.01.

**Application:**
All SCCMHA Board operated programs, and applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Disclosures
- Protected Health Information (PHI)
- Uses

**References:**
The HIPAA Privacy Rule, 45 CFR 164.508
SCCMHA Consent to Use and/or Disclose Protected Health Information
Michigan Mental Health Code

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA will obtain signed consent from all individuals before using or disclosing their protected health information for purposes other than treatment, payment, or health care operations. | Clerk Typist – Medical Records & Release of Information |
| 2. Prior to all marketing communications, SCCMHA will obtain consent from the individuals who would receive such communications, except if:<br>a) the communication is made face-to-face by an employee of SCCMHA; or | HIPAA Privacy Officer<br>Executive Director of Clinical Services |

| | |
|---|---|
| b) Communication is a promotional gift of nominal value provided by SCCMHA. | |
| 3. Prior to any use or disclosure of psychotherapy notes, including for treatment, payment, or health care operations, SCCMHA will obtain consent from the individual, except if the use or disclosure is for:<br>a) the treatment activities of the originator of the psychotherapy notes.<br>b) SCCMHA own training programs in which mental health students, trainees, or practitioners practice, under supervision, their skills in counseling; or<br>c) SCCMHA own defense in a legal action or other proceeding brought by the individual. | Clerk Typist – Medical Records & Release of Information<br>All Clinical Staff |
| 4. SCCMHA is not required by the HIPAA Privacy Rule to obtain consent for the following purposes:<br>a) to conduct treatment, payment, or health care operations (TPO).<br>b) uses and disclosures required by law (see Policy, Disclosing PHI as Required by Law)<br>c) uses and disclosures for public health activities (see Policy, Disclosing PHI for Public Health Release)<br>d) disclosures about victims of abuse, neglect, or domestic violence (see Policy, Disclosing PHI about Victim of Abuse, Neglect or Domestic Violence)<br>e) uses and disclosures for health oversight activities (see Policy, Disclosing PHI for Health Oversight Release)<br>f) disclosures for judicial and administrative proceedings (see Policy, Disclosing PHI for Judicial and Administrative Release)<br>g) disclosures for law enforcement purposes (see Policy, Disclosing PHI for Law Enforcement Release)<br>h) disclosing PHI about decedents (see Policy, Disclosing PHI about Decedents)<br>i) uses and disclosures for cadaveric organ, eye, or tissue donation purposes (see Policy, Disclosing PHI for Cadaveric Organ, Eye, or Tissue Donation)<br>j) uses and disclosures for research purposes (see Policy, Disclosing PHI for Research Release)<br>k) uses and disclosures to avert a serious threat to health or safety (see Policy Disclosing PHI to Avert Serious Threat to Health and Safety).<br>l) uses and disclosures for specialized government functions (see Policy, Disclosing PHI for Specialized Government Functions) | Clerk Typist – Medical Records & Release of Information<br>All Clinical Staff |

| | |
|---|---|
| m) disclosures for workers' compensation (see Policy, Disclosing PHI for Workers' Compensation) | |
| 5. When a person served is asked to sign a consent, the consent will be written in plain language. | HIPAA Privacy Officer |
| 6. The consent document will allow individuals to request that their protected health information be used or disclosed for specific purposes. | HIPAA Privacy Officer |
| 7. When SCCMHA initiates a consent to use or disclose protected health information for its own purposes, SCCMHA will provide individuals with any facts they need to make an informed decision as to whether to allow release of the information. | Clerk Typist – Medical Records & Release of Information<br>All Clinical Staff |
| 8. The consent will not be combined with another document to create a compound consent, unless:<br>a) The other document is a similar consent.<br>b) if the consent is for the disclosure of psychotherapy notes, the other document is also a consent for the disclosure of psychotherapy notes; or<br>c) The consent is for the use or disclosure of protected health information created for research study and is to be combined with another written permission for the study. | Clerk Typist – Medical Records & Release of Information<br>HIPAA Privacy Officer |
| 9. Any consent for the use or disclosures of protected health information requested by the individual subject of that information will contain the following:<br>a) a description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.<br>b) the name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.<br>c) the name or other specific identification of the person(s), or class of persons, to whom SCCMHA may make the requested use or disclosure.<br>d) an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.<br>e) a statement of the individual's right to revoke the consent in writing and the exceptions to the right to revoke.<br>f) a description of how the individual may revoke the consent.<br>g) a statement that the entity will not condition treatment, payment, enrollment in a health plan, or eligibility for | Clerk Typist – Medical Records & Release of Information<br>All Clinical Staff |

| | |
|---|---|
| benefits on the provision of a consent, except as permitted by law.<br>h) a statement that information used or disclosed pursuant to the consent may be subject to redisclosure by the recipient and no longer be protected by 45 CFR Part 164.<br>i) the signature of the individual and date. | |
| 10. If a personal representative of the individual signs consent, the consent will contain a description of the representative's authority to act for the individual. | Clerk Typist – Medical Records & Release of Information |
| 11. SCCMHA will provide the individual with a copy of the signed consent. | Clerk Typist – Medical Records & Release of Information |
| 12. SCCMHA will invalidate the consent if:<br>a) any material information in the consent is known by SCCMHA to be false.<br>b) the requirements of the consent have not been filled out completely.<br>c) the expiration date has passed, or the expiration event is known by SCCMHA to have occurred. | Clerk Typist – Medical Records & Release of Information |
| 13. SCCMHA will document and retain the signed consent for a period of at least six years from the date of its creation or the date when it last was in effect, whichever is later. The signed consent will be scanned and placed within the persons served record. | HIPAA Privacy Officer<br>Clerk Typist – Medical Records & Release of Information<br>Scanning Staff |

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: HIPAA Privacy Set: Authorizations - Conditioning Services on the Provision of an Authorization to Disclose PHI</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.09.02</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003,</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
Generally, a covered entity may not condition the provision to an individual of treatment on the provision of an authorization to use or disclose protected health information (See the HIPAA Privacy Rule §164.508(b)(4)). However, certain exceptions apply. SCCMHA (and applicable Network Providers) is committed to ensuring that all persons served receive the highest quality of care and services, and therefore will take necessary steps to comply with applicable laws and regulations regarding the conditioning of treatment on an authorization.

**Policy:**
1. SCCMHA may, if deemed necessary within professional judgment, condition the following on obtaining an authorization:
   a. provision of research-related treatment on obtaining an authorization for protected health information for such research.
   b. provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on obtaining an authorization for the disclosure of the protected health information to such third party.

**Application:**
SCCMHA Board operated programs, and applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Disclosure
- Protected Health Information (PHI)
- Use

**References:**
HIPAA Privacy Rule, §164.508(b)(4)
SCCMHA Authorization to Use and/or Disclose Protected Health Information

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. All requests for disclosures of protected health information that require authorization will be directed to Medical Records Staff. | All SCCMHA Staff |
| 2. Medical Records Staff, in close consultation with the requesting party, will determine the nature of the request, and whether it is necessary to condition payment or services on obtaining the authorization. The policies stated herein will be the deciding factors. | Medical Records Staff, Privacy Officer |
| 3. If such conditions are determined necessary, then Medical Records Staff and/or clinical staff will inform the enrollee, potential enrollee, or applicable provider, including the reason for the conditioning of services. | Medical Records Staff, Privacy Officer |
| 4. All authorization forms for the use or disclosure of protected health information will include a statement that the individual's treatment and payment for services will not be conditioned on the provision of the authorization, except as permitted by law. | Privacy Officer |
| 5. When SCCMHA is permitted to condition an individual's treatment on provision of an authorization under this policy, the authorization form will state the | Privacy Officer |

| | |
|---|---|
| consequences to the individual of refusing to sign the authorization. | |
| 6. SCCMHA will retain a copy of this Policy for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. | Privacy Officer |
| 7. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Office, or to the Compliance hotline. | All SCCMHA staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consents - Individual Revocation of an Authorization to Disclose PHI / Inclusive of 42 CFR Part 2</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.09.03</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor;</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
As organizations request consent from individuals to use their protected health information, there will be cases where individuals will initially grant consent, only to change their mind later. In these instances, SCCMHA has created policies and procedures to accommodate individuals who may wish to revoke their consent, in accordance with §164.508(b)(5) of the Privacy Rule and §2.35 (c) of 42 CFR Part 2.

**Policy:**
1. SCCMHA will allow an individual to revoke a consent to use or disclose their protected health information, except in situations where:
   a. SCCMHA has acted in reliance thereon.
   b. The consent was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy.

2. SCCMHA will take all necessary steps to honor and comply with an individual revocation of a consent to use or disclose protected health information, unless stated otherwise in this policy.

3. In accordance with 42 CFR Part 2 §2.35 (c), a written consent under 42 CFR Part 2 must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

**Application:**
All SCCMHA Board operated Programs.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 08.05.00.01 – Compliance Definitions Policy for the following terms.*

- Protected Health Information (PHI)

**References:**
HIPAA Privacy Rule, §164.508(b)(5)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA will not impose a time restriction on when an individual may revoke consent to use or disclose their protected health information. | HIPAA Privacy Officer |
| 2. SCCMHA will require individuals to request the revocation of consent to use or disclose protected health information in writing. | Clerk Typist – Medical Records & Release of Information |
| 3. Revocations of consent to use or disclose protected health information will be submitted to the Medical Records department and scanned into the consumer's chart. | HIPAA Privacy Officer<br><br>Clerk Typist – Medical Records & Release of Information, Scanning Staff |

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: HIPAA Privacy Set: Consents - Prohibiting the Use of an Invalid Consent to Disclose PHI / Inclusive of 42 CFR Part 2</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.09.04</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
When complying with a consent for the use or disclosure of protected health information under HIPAA or a consent for disclosure under 42 CFR Part 2, it is important that the document contains all necessary information. The requirements of a valid consent under HIPAA are presented in §164.508(b)(2) of the Privacy Rule. The required elements for a written consent under 42 CFR Part 2 are presented in §2.31. This Policy is intended to assure compliance with the requirements of a valid consent under HIPAA as well as a valid consent for disclosure under Part 2 where appropriate.

SCCMHA has created policies and procedures addressing how a consent could be defective to assist in preventing invalid consents under HIPAA or invalid consent under 42 CFR Part 2.

**Policy:**
1. SCCMHA prohibits the use of a defective or an invalid consent to use or disclose protected health information under HIPAA. If the necessary elements are not present, the consent is defective and therefore invalid, in accordance with the Privacy Rule.

2. A consent will become invalid if SCCMHA knows that the consent has been revoked.
3. A disclosure of an individual's health records under part 2 may not be made on the basis of a consent which: (1) has expired; (2) On its face substantially fails to conform to any of the requirements of §2.31; is known to have been revoked; or is known, or through reasonable diligence could be known, by the individual or entity holding the records to be materially false.

**Application:**
All SCCMHA Board operated Programs, and all applicable Network Providers.

**Standards:**
The elements of a valid consent to disclosure the protected health information related to SUD services are contained in SCCMHA Policy 08.05.01.

**Definitions:**
None

**References:**
§164.508(b)(2)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA will not honor a defective or invalid consent upon the following events:<br>a. the expiration date has passed, or the expiration event is known by SCCMHA to have occurred.<br>b. All the required elements of the consent have not been filled out completely, as applicable.<br>c. The consent lacks any of the required elements specified in {Policy, obtaining Consent for Use or Disclose of PHI} as required for the purpose of applicable use or disclosure.<br>d. The consent is inappropriately combined with any other document to create a compound consent.<br>e. If any material information in the consent is known by SCCMHA to be false.<br>f. Treatment, payment, enrollment, or eligibility for benefits have been unlawfully conditioned on the provision of such consent. | Clerk Typist – Medical Records & Release of Information |
| 2. Any questions regarding this policy, or the validity of a specific consent, should be directed to the HIPAA Privacy Officer. | Clerk Typist – Medical Records & Release of Information, HIPAA Privacy Officer |

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject:** HIPAA Privacy Set: Consents - Authorization for the Use or Disclosure of Psychotherapy Notes | **Chapter**: 08 - Management of Information | **Subject No**: 08.05.09.05 |
| **Effective Date**:<br>April 14, 2003 | **Date of Review/Revision**:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>AmyLou Douglas, Chief Information Officer \| Chief Quality and Compliance Officer |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Authored By**:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>**Additional Reviewers**:<br>Holli McGeshick, Quality and Medical Records Supervisor |

**Purpose:**
In most cases, HIPAA requires that covered entities obtain individual consent before using or disclosing psychotherapy notes (as defined by the Privacy Rule, §164.501). SCCMHA is committed to ensuring that it obtains valid consent for its use or disclosure or protected health information, specifically psychotherapy notes. Psychotherapy notes mean any notes recorded (in any medium) by a health care provider who is a mental health professional. These notes could be 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 do not include 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.

**Policy:**
1. SCCMHA will obtain an individual's consent prior to use or disclosure of psychotherapy notes, except as provided below, in accordance with §164.508(a)(2).

2. SCCMHA may use or disclose psychotherapy notes in the following instances without obtaining consent:

    a. to conduct treatment, payment, or healthcare operations, if those functions are consistent with the consent requirements of the Michigan Mental Health Code, MCL 330.1748:
        - for use by the originator of the psychotherapy notes for treatment.
        - use or disclosure by SCCMHA in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.
        - use or disclosure by SCCMHA to defend a legal action or other proceeding brought by the individual.
    b. use or disclosure that is required by 45 CFR §164.502(a)(2)(ii) [compliance investigations].
    c. use or disclosure permitted by 45 CFR §164.512(a) [as required by law].
    d. use or disclosure permitted by 45 CFR §164.512(d) [health oversight] with respect to the oversight of the originator of the psychotherapy notes.
    e. use or disclosure permitted by 45 CFR§164.512(g)(1) [decedents].
    f. use or disclosure permitted by 45 CFR §164.512(j)(1)(i) [threat to public safety].

**Application:**
All SCCMHA Board operated Programs, all applicable Network Providers

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 08.05.00.01 – Compliance Definitions Policy for the following terms.*

- Psychotherapy Notes

**References:**
§164.501
§164.508(a)(2)
MCL 330.1748

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA will not condition treatment of an individual on a requirement that the individual provide a specific consent for the disclosure of psychotherapy notes. | HIPAA Privacy Officer, All SCCMHA staff |
| 2. The consent will be written in plain language. | HIPAA Privacy Officer |

| | |
|---|---|
| 3. The consent may only be combined with another consent for a use or disclosure of psychotherapy notes. | HIPAA Privacy Officer, All SCCMHA staff |
| 4. Any consent for the use or disclosure of psychotherapy notes will contain the following:<br>a. a description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.<br>b. the name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.<br>c. the name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.<br>d. the signature of the individual and date.<br>e. an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.<br>f. a statement of the individual's right to revoke the consent in writing and the exceptions to the right to revoke.<br>g. a description of how the individual may revoke the consent.<br>h. a statement that information used or disclosed pursuant to the consent may be subject to redisclosure by the recipient and no longer protected by 45 CFR Part 164.<br>i. A statement that SCCMHA will not condition treatment, payment, enrollment, or eligibility for benefits of an individual on a requirement that the individual provides a specific consent, except to the extent the law permits.<br>(i) conditioning of research-related treatment on provision of a consent for disclosures related to such research; or<br>(ii) conditioning of health care that is solely for the purpose of creating protected health information for disclosure to a third party, on a consent to disclose such information to the third party. | HIPAA Privacy Officer, All SCCMHA staff |
| 5. If a personal representative of the individual signs consent, the consent will contain a description of the representative's authority to act for the individual. | HIPAA Privacy Officer, Quality & Medical Records Supervisor |

| | |
|---|---|
| 6. SCCMHA will invalidate the consent if:<br>a. the expiration date has passed, or the expiration event is known by SCCMHA to have occurred.<br>b. the consent is known by SCCMHA to have been revoked.<br>c. any material information in the consent is known by SCCMHA to be false.<br>d. the requirements of the consent have not been filled out completely. | Clerk Typist – Medical Records & ROI |
| 7. SCCMHA will document and retain the signed consent for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later. | HIPAA Privacy Officer |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Uses and Disclosures that Require an Opportunity to Agree or Object - Using PHI for Involvement in and Notification of the Individual's Care – Inclusive of 42 CFR Part 2</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.10.01</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**

For the benefit of consumer care and public health, SCCMHA sometimes needs to use or disclose protected health information to a family member of a person served or others involved in the person served care to ensure quality care, or to notify family members or others of the person served condition or location. In these situations, when the person served is present and capacitated, SCCMHA must provide the person served with an opportunity to agree or disagree to the use or disclosure of such information, and if agreement is obtained, SCCMHA is not required to obtain the written consent or consent of the person served. Employees may verbally inform the individual of and obtain the individual's verbal agreement or objection to such uses or disclosures. This policy is intended to follow §164.510(b) of the Privacy Rule.

**Policy:**

1. SCCMHA may disclose to a family member, other relative, close friend, or any other person identified by the person served, protected health information that is directly relevant to such person's involvement with, or payment related to the persons served care.

2. SCCMHA may use or disclose the protected health information of a person served to notify or assist in the notification of (including identifying or locating), a family member, a personal representative of the person served, or another person responsible for the care of the person served location, general condition, or death.

3. SCCMHA will follow all applicable laws and regulations when disclosing protected health information relevant to the care of a person served or for notification to the person served family member, friend, or any other person identified by the individual.

4. **Substance Use Disorder Records:**

    a. 42 CFR Part 2 prohibits the disclosure and use of patient records unless certain circumstances exist. §2.2.
    b. If a patient consents to a disclosure of their records, a part 2 program may disclose those records in accordance with that consent to any person or category of persons identified or designated in the consent. §2.33.
    c. The use or disclosure of an individual's health records maintained by SCCMHA as a Part 2 program requires the consent of the person served. Consideration of Policy 08.05.01 should be made prior to the use or disclosure of information related to SUD services.

**Application:**
All SCCMHA Board operated programs

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 08.05.00.01 – Compliance Definitions Policy for the following terms.*

- Disclosure
- Protected Health Information (PHI)
- Use

**References:**
§164.510(b)
42 CFR Part 2

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA will seek agreement from all individuals upon initial service to disclose their protected health information relevant to the care of the person served or for notification to the person served family member, friend, or any other person identified by the individual. | Clinical staff |
| 2. If necessary, given the condition of the person served or critical circumstances involved, SCCMHA may reasonably infer from the circumstances, based on the exercise of professional judgment, that the individual does not object to the disclosure of health information relevant to the care of the person served to the person served family member, friend, or any other person identified by the individual. | Clinical staff |
| 3. SCCMHA may reasonably infer from the circumstances, based on the exercise of professional judgment, which protected health information relevant to the care of the person served may be disclosed to notify, or assist in the notification of a family member, a personal representative of the individual, or another person responsible for the care of the individual, of the individual's death. In such circumstances, the Executive Director of Clinical Services or the HIPAA Privacy Officer should be consulted. | Clinical staff, Executive Director of Clinical Services, HIPAA Privacy Officer |
| 4. SCCMHA may use or disclose protected health information to a public or private entity, authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with the entity to notify, or assist in the notification of a family member, a personal representative of the individual, or another person responsible for the care of the individual, of the individual's location, general condition, or death. | Clinical staff or Clerk Typist – Medical Records & ROI with consultation with HIPAA Privacy Officer |
| 5. In the event that the individual is not present for, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, SCCMHA may in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is | Clinical staff |

| | |
|---|---|
| directly relevant to the person's involvement with the individual's health care. | |
| 6. Appropriate personnel may use professional judgment and their experience with common practice to make reasonable inferences of the best interest of the person served in allowing a person to act on behalf of the person served to pick up filled prescriptions, medical supplies, or other similar forms of protected health information. | Clinical staff |
| 7. Appropriate personnel will exercise professional judgment in determining that disclosing protected health information pursuant to the applicable policies and procedures herein, when the person served is present or when the person served is not present; will interfere with the ability to respond to the emergency circumstances. | Clinical staff |
| 8. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Office, or to the employee compliance hotline. | All SCCMHA employees |

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject:** HIPAA Privacy Set: Consent or Opportunity to Agree or Object - Disclosing PHI as Required by Law | **Chapter**: 08 - Management of Information | **Subject No:** 08.05.11.01 |
| **Effective Date**:<br>April 14, 2003 | **Date of Review/Revision**:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24<br>**Supersedes**: | **Approved By**:<br>Sandra M. Lindsey, CEO<br><br>**Responsible Director:**<br>AmyLou Douglas, Chief Information Officer \| Chief Quality and Compliance Officer |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Authored By**:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>**Additional Reviewers**:<br>Holli McGeshick, Quality and Medical Records Supervisor |

**Purpose:**
In accordance with the HIPAA Privacy Rule, 45 CFR 164.512(a)(1) and the Michigan Mental Health Code, MCL 330.1748(5)(d), a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. This policy is designed to give guidance and ensure compliance with all relevant laws and regulations when using or disclosing protected health information as required by law.

**Policy:**
1. If federal, state, and/or local law require a use or disclosure of protected health information, SCCMHA may use or disclose protected health information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law.

2. SCCMHA will refer to specific policies and procedures to determine whether SCCMHA must obtain consent or give the individual the opportunity to agree or object to use or disclose protected health information.

3. If two or more laws or regulations governing the same use or disclosure conflict, SCCMHA will comply with the more restrictive laws or regulations.

4. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of individuals receiving SUD services from SCCMHA.

**Application:**
All SCCMHA Board operated Programs

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Disclosure
- Protected Health Information (PHI)
- Use

**References:**
45 CFR 164.512(a)(1)
MCL 330.1748(5)(d)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA may use or disclose protected health information to the extent that such use or disclosure is required by law including, but not limited to:<br>a. For public health activities required by law [see Policy, Disclosing Protected Health Information for Public Health Release].<br>b. For disclosures about victims of abuse, neglect, or domestic violence [see Policy Disclosing Protected Health Information about Victims of Abuse, Neglect, or Domestic Violence]<br>c. To comply with judicial release [see Policy, Disclosing Protected Health Information for Judicial and Administrative Release].<br>d. To comply with law enforcement [see Policy, Disclosing Protected Health Information for Law Enforcement Release].<br>e. For health release [see Policy, Disclosing Protected Health Information for Health Oversight Release]. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| f. To avert serious threat [see Policy, Disclosing Protected Health Information to Avert Serious Threat to Health and Safety].<br>g. To comply with special government functions or requests [see Policy, Disclosing Protected Health Information for Specialized Government Functions]. | |
| 2. When disclosing protected health information in accordance with procedure #1, SCCMHA will follow the policies and procedures relating to the applicable policy. | Clerk Typist - Medical Records & ROI |
| 3. Personnel receiving a request from an individual or entity for use or disclosure of protected health information will utilize SCCMHA records to determine whether the requesting individual is a person whom SCCMHA has a knowing relationship. | Clerk Typist - Medical Records & ROI |
| 4. Personnel will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting Protected Health Information [see Policy, Verification of Entities Requesting Use or Disclosure of Protected Health Information. | Clerk Typist - Medical Records & ROI |
| 5. Once it is determined that use or disclosure is appropriate, Medical Records personnel with appropriate access clearance will access the individual's protected health information using proper access and consent procedures. | Clerk Typist - Medical Records & ROI, HIPAA Privacy Officer |
| 6. The requested protected health information will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Clerk Typist - Medical Records & ROI, HIPAA Privacy Officer |
| 7. Medical Records personnel will appropriately document the request and delivery of the protected health information. | Clerk Typist - Medical Records & ROI, HIPAA Privacy Officer |
| 8. If the identity and legal authority of an individual or entity requesting protected health information cannot be verified, personnel will refrain from disclosing the requested information and report the case to the HIPAA Privacy Officer in a timely manner. | Clerk Typist - Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| 9. Knowledge of a violation or potential violation of this policy must be reported directly to the HIPAA Privacy Officer, the Compliance Officer or to the compliance hotline. | All SCCMHA employees |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Authorization or Opportunity to Agree or Object - Disclosing PHI for Public Health Release</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.02</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
In accordance with the HIPAA Privacy Rule §164.512(b), SCCMHA is permitted to disclose protected health information to public health authorities for a full range of public health activities conducted by federal, state, and local public health authorities. The actual authorities and terminology used for public health activities will vary under different jurisdictions. This policy is designed to provide guidance and to ensure full compliance with all applicable laws related to the use and disclosure of protected health information for public health release purposes.

**Policy:**
1. SCCMHA may disclose protected health information for public health activities and purposes to public heath authorities, entities, and persons authorized by law to receive such information.
2. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of individuals receiving SUD services from SCCMHA.

**Application:**

All SCCMHA Board operated Programs.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Disclosure
- Protected Health Information
- Use

**References:**
HIPPA Privacy Rule, § 164.512(b)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. The Medical Records Staff may consult with the Privacy Officer for clarification regarding these issues: SCCMHA may disclose protected health information to a public health authority that is authorized by law to collect or receive such information (or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority) for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to the report of:<br>a. disease.<br>b. injury.<br>c. vital events such as birth or death; and<br>d. the conduct of public health surveillance, public health investigations, and public health intervention. | Medical Records Staff, Privacy Officer |
| 2. SCCMHA may disclose protected health information to a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect. | Medical Records Staff, Privacy Officer |
| 3. SCCMHA may disclose protected health information relating to a product or service regulated by the Food and Drug Administration (FDA), to a person subject to the jurisdiction of the FDA to assist such person in activities to ensure the quality, safety or effectiveness of such product or service. | Medical Records Staff, Privacy Officer |

| | |
|---|---|
| 4. SCCMHA may disclose protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease, if SCCMHA or a public health authority is authorized by law to notify such person in the conduct of a public health intervention or investigation. | Medical Records Staff, Privacy Officer |
| 5. SCCMHA may disclose protected health information to an employer about an individual who is a member of the employer's workforce if SCCMHA either provides health care to the individual at the request of the employer; or is a member of the employer's workforce:<br>a. to conduct an evaluation relating to medical surveillance of the workplace; or<br>b. to evaluate whether the individual has a work-related illness or injury.<br>c. If the protected health information that is disclosed consists of findings concerning a work-related illness or injury or workplace-related medical surveillance.<br>d. If the employer needs such findings to comply with its obligations, under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose, to record such illness or injury or to fulfill responsibilities for workplace medical surveillance.<br>e. SCCMHA provides written notice to the individual that protected health information relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to the employer:<br>• By giving a copy of the notice to the individual at the time the health care is provided; or<br>• If the health care is provided on the work site of the employer, by posting the notice in a prominent place at the location where the health care is provided. | Medical Records Staff, Privacy Officer |
| 6. Personnel receiving a request from an individual or entity for use or disclosure of Protected Health Information will utilize SCCMHA records to determine whether the requesting individual is a person who SCCMHA has a knowing relationship with. | Medical Records Staff, Privacy Officer |
| 7. Personnel will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting Protected Health Information [see Policy, | Medical Records Staff, Privacy Officer |

| | |
|---|---|
| Verification of entities Requesting Use or Disclosure of Protected Health Information]. | |
| 8. Once it is determined that use or disclosure is appropriate, Medical Records staff with appropriate access clearance will access the individual's protected health information using proper access and authorization procedures. | Medical Records Staff, Privacy Officer |
| 9. The requested protected health information will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Medical Records Staff, Privacy Officer |
| 10. Medical Records staff will appropriately document the request and delivery of the protected health information. | Medical Records Staff, Privacy Officer |
| 11. If the identity and legal authority of an individual or entity requesting protected health information cannot be verified, personnel will refrain from disclosing the requested information and report the case to the Compliance Office in a timely manner. | Medical Records Staff, Privacy Officer |
| 12. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Office or to the compliance hotline. | All SCCMHA staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object - Disclosing PHI about Victims of Abuse, Neglect, or Domestic Violence</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.03</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**

Covered entities are required to exercise professional judgment in conjunction with applicable statutes and regulations when disclosing protected health information regarding a person served who is a victim of abuse, neglect, or domestic violence. SCCMHA has developed this policy to ensure any use or disclosure of protected health information related to victims of abuse, neglect, or domestic violence follows all applicable laws and regulations, such as the HIPAA Privacy Rule, 45 CFR 164.512(b)(1)(ii) and the Michigan Mental Health Code, MCL 330.1748.

**Policy:**

1. SCCMHA may disclose protected health information about a person served whom it believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive such reports.

2. Issues related to requests for mental health records in situations involving child abuse or neglect investigations are referred to SCCMHA Policy, Disclosing Protected health Information involving Child Abuse or Neglect.
3. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of individuals receiving SUD services from SCCMHA.

**Application:**
All SCCMHA Board operated programs and applicable Network providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Disclosure
- Protected Health Information
- Use

**References:**
45 CFR 164.512(b), MCL 330.1748

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA may disclose protected health information about a person served who the covered entity believes to be a victim of abuse, neglect, or domestic violence: The Privacy Rule, §164.512(c)(1).<br>a. to the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law or<br>b. if the person served agrees to the disclosure (communication between SCCMHA and person served, including agreement, may be verbal); or<br>c. to the extent the disclosure is expressly authorized by statute or regulations and:<br>i. SCCMHA, in the exercise of professional judgment, believes the disclosure to be necessary to prevent serious harm to the person served or other potential victims; or<br>ii. If the person served is incapacitated and unable to agree to the disclosure of their protected health information, a law enforcement or public official | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| authorized to receive the report must represent that the protected health information, for which disclosure is sought, is not intended to be used against the person served . The official must also represent that immediate enforcement activity is dependent upon the disclosure and would be adversely affected by waiting until the individual is able to agree to the disclosure. | |
| 2. In accordance with §164.512(c)(2), if SCCMHA discloses protected health information about a person served, in accordance with Procedure #1, SCCMHA will promptly inform the person served that such a disclosure has been or will be made except when SCCMHA:<br>a. In the exercise of professional judgment, believes informing the person served would place him/her at risk of serious harm; or<br>b. Would be informing a personal representative, and SCCMHA believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the person served as determined by SCCMHA in the exercise of professional judgment. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 3. Uses and disclosures under this policy will be made in conjunction with the limitations provided in the Michigan Mental Health Code, MCL 330.1748. Any questions regarding this should be directed to the Privacy Officer prior to the use or disclosure of PHI. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object - Disclosing PHI Involving Child Abuse or Neglect</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.04</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
Covered entities are required to exercise professional judgment in conjunction with applicable statutes and regulations when disclosing protected health information regarding reports or investigations involving child abuse or neglect. SCCMHA has developed this policy to ensure any use or disclosure of protected health information related to reports or investigations involving child abuse or neglect follows all applicable laws and regulations, such as the HIPAA Privacy Rule, 45 CFR 164.512(b)(1)(ii) and the Michigan Mental Health Code, MCL 330.1748a.

**Policy:**
1. SCCMHA may disclose protected health information to a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect, in accordance with §164.512(b)(1)(ii).
2. Issues related to requests for mental health records in situations involving child abuse or neglect investigations should be responded to in such a way as to remain compliant with MCL 330.1748a.

3. In accordance with MCL 330.1748a (2), the following privileges do not apply to mental health records or information to which access is given under MCL 330.1748a:
    - The physician-patient privilege
    - The licensed professional counselor-client and limited licensed counselor-client privilege.
    - The psychologist-patient privilege
    - Any other health professional-patient privilege created or recognized by law.
4. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of individuals receiving SUD services from SCCMHA.

**Application:**
All SCCMHA Board operated programs, applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Protected Health Information

**References:**
45 CFR 164.512(b),
MCL 330.1748a

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Written requests for protected health information regarding an allegation of child abuse or neglect should be forwarded to the Clerk Typist - Medical Records & ROI. The Clerk Typist – Medical Records & ROI will make an initial determination regarding what other SCCMHA parties need to become involved in the situation. | Clerk Typist – Medical Records & ROI |
| 2. The relevant parties involved in the request (HIPAA Privacy Officer, Executive Director of Clinical Services, Clinical staff) shall review all Mental Health records and information in SCCMHA possession to determine if there are mental health records or information that is pertinent to that investigation. | HIPAA Privacy Officer, Executive Director of Clinical Services, appropriate clinical staff |

| | |
|---|---|
| 3. In accordance with MCL 330.1748a(1), SCCMHA will release those pertinent mental health records and information to the appropriate caseworker or administrator directly involved in the child abuse or neglect investigation within 14 days after a receipt has been made. | Clerk Typist - Medical Records & ROI |
| 4. Clerk Typist - Medical Records & ROI will appropriately document the request and delivery of the protected health information. | Clerk Typist – Medical Records & ROI |
| 5. Knowledge of a violation or potential violation of this policy must be reported directly to the HIPAA Privacy Officer, Compliance Officer or to the compliance hotline. | All SCCMHA staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object - Disclosing PHI for Health Oversight Release</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.05</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA may use or disclose Protected Health Information without a person served consent for health oversight activities pursuant to the HIPAA Privacy Rule, 45 CFR §164.512(d). SCCMHA is committed to ensuring the privacy of people served health information. To support this commitment, SCCMHA will ensure any use or disclosure of Protected Health Information for health oversight release follows all applicable laws and regulations. This policy is designed to provide guidance when using or disclosing Protected Health Information for health oversight activities, while protecting person served health information in our possession.

**Policy:**
1. SCCMHA may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the following:
   a. The health care system.

b. Government benefit programs for which health information is relevant to beneficiary eligibility.
c. Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards.
d. Entities subject to civil rights laws for which health information is necessary for determining compliance.

2. SCCMHA may disclose protected health information without consent to a health oversight agency if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health.

3. If a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits unrelated to health, SCCMHA considers the joint activity or investigation to be a health oversight activity.

4. SCCMHA will not disclose protected health information without consent in cases where a person served is the subject of the investigation or other activity; of such investigation or other activity does not arise out of and is not related to:
   a. The receipt of health care.
   b. A claim for public benefits related to health.
   c. Qualification for or receipt of public benefits or services when a person served 's health is integral to the claim for public benefits or services.

5. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of individuals receiving SUD services from SCCMHA.

**Application:**
All SCCMHA operated Programs, applicable Network Providers

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*
- Disclosure
- Protected Health Information
- Use

**References:**
HIPAA Privacy Rule, 45 CFR §164.512(d)

**Exhibits:**
None

**Procedure:**

| | ACTION | RESPONSIBILITY |
|---|---|---|
| 1. | Personnel receiving a request from an individual or entity for use or disclosure of Protected health Information will utilize SCCMHA records to determine whether the requesting individual is a person who SCCMHA has a knowing relationship. | Clerk Typist – Medical Records & ROI |
| 2. | Personnel will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting Protected Health Information [see Policy, Verification of entities Requesting Use or Disclosure of Protected Health Information]. | Clerk Typist - Medical Records & ROI |
| 3. | Once it is determined that use or disclosure is appropriate, Clerk Typist – ROI with appropriate access clearance will access the person served protected health information using proper access and consent procedures. | Clerk Typist - Medical Records & ROI |
| 4. | The requested protected health information will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Clerk Typist - Medical Records & ROI |
| 5. | Medical Records personnel will appropriately document the request and delivery of the protected health information. | Clerk Typist - Medical Records & ROI |
| 6. | If the identity and legal authority of an individual or entity requesting protected health information cannot be verified, personnel will refrain from disclosing the requested information and report the case to the HIPAA Privacy Officer or the Compliance Officer in a timely manner. | Clerk Typist - Medical Records & ROI |
| 7. | Knowledge of a violation or potential violation of this policy must be reported directly to the HIPAA Privacy Officer, Compliance Officer or to the compliance hotline. | All SCCMHA staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object - Disclosing PHI as Required by Legislative Subpoena</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.06</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA is committed to ensuring the privacy and security of person served health information. For most disclosures other than the usual course of treatment, payment, or health care operations, SCCMHA must obtain individual consent before using or disclosing the individual's protected health information. However, non-privileged protected health information may be disclosed pursuant to a legislative subpoena without the written consent or consent of the person served, or the opportunity for the individual to agree or object, in the situations and subject to the applicable requirements of the Michigan Mental Health Code, MCL 330.1748(5).

**Policy:**
1. In compliance with MCL 330.1748(5), and pursuant to an order or a subpoena of a legislature, information made confidential by MCL 330.1748 will be disclosed unless it is privileged by law.
2. In compliance with MCL 330.1748(5), information made confidential by MCL 330.1748 will not be disclosed if it is privileged by law.

3. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of individuals receiving SUD services from SCCMHA.

**Application:**
All SCCMHA operated Programs, applicable Network Providers.

**Standards:**
None

**Definitions:**
**For the following definitions see *SCCMHA Policy 08.05.00.01 Compliance Definitions***
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Disclosure
- Protected Health Information
- Use

**References:**
Michigan Mental Health Code, MCL 330.1748(5).

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA will disclose protected health information after the receipt of a legislative subpoena to the degree that the information requested is not privileged by law. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 2. Personnel receiving a request from an individual or entity for use or disclosure of Protected health Information will utilize SCCMHA records to determine whether the requesting individual is a person who SCCMHA has a knowing relationship. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 3. Personnel will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting Protected Health Information [see Policy, Verification of entities Requesting Use or Disclosure of Protected Health Information]. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 4. Once it is determined that use or disclosure is appropriate, Clerk Typist – ROI with appropriate access clearance will access the person served protected health information using proper access and consent procedures. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| 5. The requested protected health information will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 6. Medical Records staff will appropriately document the request and delivery of the protected health information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 7. If the identity and legal authority of an individual or entity requesting protected health information cannot be verified, personnel will refrain from disclosing the requested information and report the case to the HIPAA Privacy Officer or Compliance Officer in a timely manner. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 8. Knowledge of a violation or potential violation of this policy must be reported directly to the HIPAA Privacy Officer, Compliance Officer or compliance hotline. | All SCCMHA staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object – Disclosing Non-Privileged PHI for Judicial and Administrative Release</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.07</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA is committed to ensuring the privacy and security of person served health information. For most disclosures other than the usual course of treatment, payment, or health care operations, SCCMHA must obtain individual consent before using or disclosing the individual's protected health information. However, protected health information may be disclosed pursuant to a judicial or administrative process without the written consent or consent of the individual, or the opportunity for the individual to agree or object, in the situations and subject to the applicable requirements of the HIPAA Privacy Rule, 45 CFR §164.512(e), and the Michigan Mental Health Code, MCL 330.1748(5) and MCL 330.1750.

To support our commitment to person served confidentiality, SCCMHA will ensure any use or disclosure of protected health information for judicial and/or administrative release follows all applicable laws and regulations. From time-to-time SCCMHA will receive a subpoena or an order from a court or administrative tribunal requesting protected health information. SCCMHA is committed to ensuring the privacy and security of person served health information.

**Policy:**

1. SCCMHA will comply with all lawful and appropriate requests from regulatory and judicial authorities and may disclose non-privileged protected health information necessary to respond to a subpoena of a court, grand jury subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal, providing that:

    (a) SCCMHA receives satisfactory assurance, from the party seeking the information, that such party has made reasonable efforts to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or
    (b) SCCMHA receives satisfactory assurance from the party seeking the information that such party has made reasonable efforts to secure a qualified protective order.

2. SCCMHA will comply with all lawful and appropriate requests from regulatory and judicial authorities and may disclose protected health information necessary to respond to a subpoena of a court, grand jury subpoena, discovery request, or other lawful process that is accompanied by an order of a court or administrative tribunal.

3. Disclosures will be made of only that PHI that is expressly authorized in an appropriate request, such as in response to a subpoena, discovery request, or other lawful process.

4. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of individuals receiving SUD services from SCCMHA.

**Application:**

All SCCMHA Board operated Programs, applicable Network providers

**Standards:**

None

**Definitions:**

*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Disclosure
- Protected Health Information
- Qualified Protective Order (QPO)
- Use

**References:**

HIPAA Privacy Rule, 45 CFR §164.512

**Exhibits:**

None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA will disclose non-privileged protected health information pursuant to a court order. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 2. SCCMHA will disclose non-privileged protected health information pursuant to a subpoena without a court order only after obtaining satisfactory assurances from the requesting party that they have made reasonable efforts to provide notice to the individual who is the subject of the requested PHI or to secure a qualified protective order. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 3. SCCMHA will obtain a written statement and accompanying documentation demonstrating that a notice has been given to the individual that contained sufficient information about the litigation or proceeding in which the PHI is requested to permit the individual to raise an objection to the court or administrative tribunal. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 4. Where reasonable efforts have been made to ensure that the individual has been given notice of the request, SCCMHA will obtain from the requesting party a written statement and accompanying documentation demonstrating that:<br>a. Time for raising objections to the court or administrative tribunal has elapsed, and<br>b. No objections were filed, or<br>c. The court has resolved all objections filed by the individual or the administrative tribunal and the disclosures being sought are consistent with such resolution. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 5. Where reasonable efforts have been made to secure a qualified protective order, SCCMHA will obtain from the requesting party a written statement and accompanying documentation demonstrating that:<br>a. Parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| presented it to the court or administrative tribunal with authority over the dispute, or<br>b. Party seeking the PHI has requested a qualified protective order from such court or administrative tribunal. | |
| 6. Personnel receiving a request from an individual or entity for use or disclosure of PHI will utilize the Electronic Medical Records system to determine whether SCCMHA has a knowing relationship with the requesting individual. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 7. Personnel will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting PHI. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 8. Once it is determined that use or disclosure is appropriate, medical records personnel with appropriate access clearance will access the individual's PHI using proper access and consent procedures. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 9. The requested PHI will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 10. Medical records personnel will appropriately document the request and delivery of the PHI. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 11. If the identity and legal authority of an individual or entity requesting PHI cannot be verified, personnel will refrain from disclosing the requested information and report the case to the HIPAA Privacy Officer in a timely manner. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 12. Knowledge of a violation or potential violation of this policy must be reported directly to the HIPAA Privacy Officer, or to the Compliance hotline. | All SCCMHA staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object – Disclosing Privileged PHI for Judicial and Administrative Release</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.08</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:<br>None</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA is committed to ensuring the privacy and security of person served health information. For most disclosures other than the usual course of treatment, payment, or health care operations, SCCMHA must obtain individual consent before using or disclosing the individual's protected health information. However, protected health information may be disclosed pursuant to a judicial or administrative process without the written consent or consent of the individual, or the opportunity for the individual to agree or object, in the situations and subject to the applicable requirements of the HIPAA Privacy Rule, 45 CFR §164.512(e), and the Michigan Mental Health Code, MCL 330.1748(5) and MCL 330.1750.

To support our commitment to person served confidentiality, SCCMHA will ensure any use or disclosure of protected health information for judicial and/or administrative release follows all applicable laws and regulations. From time-to-time SCCMHA will receive a subpoena or an order from a court or administrative tribunal requesting protected health

information. SCCMHA is committed to ensuring the privacy and security of health information of the person served.

**Policy:**

1. SCCMHA will comply with all lawful and appropriate requests from regulatory and judicial authorities. In accordance with the Michigan Mental Health Code, MCL 330.1748(5), SCCMHA will not disclose information made confidential by MCL 330.1748 if that information is privileged by law, unless in accordance with 330.1750, the consumer has waived the privilege., or under the following conditions:

    a.) if the privileged communication is relevant to a physical or mental condition of the person served that the person served has introduced as an element of the person served claim or defense in a civil or administrative case or proceeding or that, after the death of the person served, has been introduced as an element of the person's served claim or defense by a party to a civil or administrative case or proceeding.
    b.) If the privileged communication is relevant to a matter under consideration in a proceeding governed by the Michigan Mental Health Code, but only after the person served was informed that any communication could be used in the proceeding.
    c.) If the privileged communication is relevant to a matter under consideration in a proceeding to determine the legal competence of the person served or the person served need for a guardian but only if the person served were informed that any communication made could be used in such a proceeding.
    d.) In a civil action by or on behalf of the person served or a criminal action arising from the treatment of the person served against the mental health professional for malpractice.
    e.) If the privileged communication were made during an examination ordered by a court, prior to which the person served was informed that a communication made would not be privileged, but only with respect to the particular purpose for which the examination was ordered.
    f.) If the privileged communication was made during treatment that the person served was ordered to undergo to render the person served competent to stand trial on a criminal charge, but only with respect to issues to be determined in proceedings concerned with the competence of the person served to stand trial.

2. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of individuals receiving SUD services from SCCMHA.

**Application:**

All SCCMHA Board operated Programs, applicable Network providers.

**Standards:**

None

**Definitions:**

*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*

- Disclosure
- Protected Health Information
- Use

**References:**
HIPAA Privacy Rule, 45 CFR §164.512
Michigan Mental Health Code, MCL 330.1748
Michigan Mental Health Code, MCL 330.1750

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA will not disclose privileged protected health information, unless the person served waives the privilege, except under the conditions provided in MCL 330.1750 | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 2. In the event SCCMHA receives a subpoena requesting protected health information that is privileged by law, and that has not been waived by the person served, and that does not fall within one of the exceptions provided for under MCL 330.1750, SCCMHA will take appropriate legal actions to prevent enforcement of the subpoena. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object - Disclosing PHI for Law Enforcement Release</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.09</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>4/7/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**

SCCMHA is committed to ensuring the privacy and security of person served health information. For most disclosures other than the usual course of treatment, payment, or health care operations, we must obtain individual consent before using or disclosing the individual's protected health information. However, pursuant to a law enforcement process, and subject to the applicable requirements of 45 CFR §164.512(f) and MCL 330. 1748, protected health information may be disclosed without the written consent or consent of the individual, or the opportunity for the individual to agree or object. To support our commitment to the confidentiality of the person served, SCCMHA will ensure any use or disclosure of protected health information for law enforcement release follows all applicable laws and regulations. From time to time a law enforcement agency or court may request protected health information. This policy has been developed to provide guidance and to ensure full compliance with such requests, while protecting person served health information in our possession.

**Policy:**
1. SCCMHA may disclose protected health information for law enforcement purposes to a law enforcement official if all applicable conditions have been met.
2. If a medical emergency is based on a belief of abuse, neglect, or domestic violence, or on reports relating to child abuse or neglect, or instances where disclosure is limited by law, refer to applicable SCCMHA policy.
3. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of individuals receiving SUD services from SCCMHA.

**Application:**
All SCCMHA Board operated programs and applicable network providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 05.08.00.01 – Compliance Definitions Policy for the following terms.*
- Disclosed
- Protected Health Information
- Use

**References:**
45 CFR §164.512(f)
MCL 330.1748

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA may disclose protected health information without individual consent in compliance with and as limited by the relevant requirements of a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer, or a grand jury subpoena. Questions related to this should be directed to the HIPAA Privacy Officer at the time they arise, and prior to any disclosure. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 2. SCCMHA may disclose requested protected health information pursuant to an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| process authorized under law, under the following conditions:<br>a. SCCMHA determines, in conjunction with the requesting party, that the information sought is relevant and material to a legitimate law enforcement inquiry.<br>b. SCCMHA determines, in conjunction with the requesting party, that the request is specific and limited in scope to the extent reasonably practicable considering the purpose for which the information is sought.<br>c. SCCMHA determines, in conjunction with the requesting party, that deidentified information could not reasonably be used. | |
| 3. Other than stated within this policy, SCCMHA will not disclose any protected health information related to an individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 4. SCCMHA may disclose the following protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person provided that SCCMHA only disclose the following:<br>a. Name and address.<br>b. Date and place of birth.<br>c. Social security number.<br>d. ABO blood type and rh factor<br>e. Type of injury.<br>f. Date and time of treatment.<br>g. Date and time of death, if applicable; and<br>h. A description of distinguishing physical characteristics, including height, weight, gender, race, hair, and eye color, presence, or absence of facial hair (beard or moustache), scars, and tattoos. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| 5. SCCMHA may disclose to a law enforcement official protected health information that SCCMHA believes in good faith constitutes evidence of criminal conduct that occurred on the premises of SCCMHA. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 6. SCCMHA may, in providing emergency health care in response to a medical emergency, other than emergency care provided on the premises of SCCMHA, disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to:<br>a. The commission and nature of a crime.<br>b. The location of such crime or of the victim(s) of such crime; and<br>c. The identity, description, and location of the perpetrator of such crime. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 7. SCCMHA may disclose protected health information about an individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the individual if SCCMHA has a suspicion that such death may have resulted from criminal conduct. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 8. SCCMHA may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime if the individual agrees to the disclosure. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 9. In cases where the individual is suspected to be a victim of a crime and where SCCMHA is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, SCCMHA will:<br>a. Obtain representation from the requesting law enforcement official that such information is needed to determine whether a violation of a law by a person other than the victim occurred, and such information is not intended to be used against the victim. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| b. Obtain representation from the law enforcement official that immediate law enforcement activity which depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and<br>c. In the exercise of professional judgment, decide that the disclosure is in the best interest of the individual before disclosing protected health information. | |
| 10. Personnel receiving a request from an individual or entity for use or disclosure of Protected Health Information will utilize SCCMHA records to determine whether SCCMHA has a knowing relationship with the requesting individual. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 11. Personnel will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting Protected Health Information [see Policy, Verification of entities Requesting Use or Disclosure of Protected Health Information]. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 12. Once it is determined that use or disclosure is appropriate, Medical Records personnel with appropriate access clearance will access the individual's protected health information using proper access and consent procedures. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 13. The requested protected health information will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 14. Medical Records personnel will appropriately document the request and delivery of the protected health information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 15. If the identity and legal authority of an individual or entity requesting protected health information cannot be verified, personnel will | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| refrain from disclosing the requested information and report the case to the Compliance Officer in a timely manner. | |
| 16. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Officer or to the compliance hotline. | All SCCMHA staff |

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object - Disclosing PHI about Decedents</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.10</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
Covered entities are permitted to disclose protected health information to coroners and medical examiners and to funeral directors, as necessary and consistent with applicable law. This policy is designed to give guidance and ensure compliance with applicable laws and regulations when disclosing protected health information to coroners, medical examiners, and funeral directors. In addition, individuals claiming to have authority to act on behalf of a deceased person serving estate may seek protected health information from SCCMHA.

It is SCCMHA's intent that its policies comply with all applicable laws and regulations. This policy has been developed with the understanding that the HIPAA Privacy Rule, 45 CFR §164.502(f), §164.502(g) and §164.510(b)(1)(ii) preempt the Michigan Mental Health Code, MCL 330.1748(5)(g) in as much as the Rule limits disclosures to persons who have authority to act on behalf of the deceased's estate, and requires disclosures for all purposes relevant to the personal representation. While the Rule provides for notification of death to be given to relatives, relatives who are not personal representatives otherwise entitled to benefits under state law would have to obtain necessary information

about the deceased from a source other than SCCMHA. Those additional requirements are reflected in this policy.

**Policy:**

1. SCCMHA may disclose protected health information to coroners, medical examiners, and funeral directors pursuant to applicable law.

2. SCCMHA may use or disclose protected health information to notify or assist in the notification of (including identifying or locating), a family member, a personal representative of the person served, or another person responsible for the care of the person served of the person served location, general condition, or death.

3. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of persons served receiving SUD services from SCCMHA.

**Application:**
All SCCMHA Board operated Programs and applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 08.05.00.01 Compliance Definitions for the following terms.*

- Disclosure
- Protected Health Information
- Use

**References:**
HIPAA Privacy Rule, 45 CFR §164.502(f), §164.502(g) and §164.510(b)(1)(ii)
Michigan Mental Health Code, MCL 330.1748(5)(g)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA may disclose protected health information about a deceased person, without person served consent, to coroners, medical examiners, or funeral directors for the following purposes:<br>a. Identifying a deceased person, determining a cause of death, or other duties as authorized by law.<br>b. To assist funeral directors, in performing their duties with respect to the decedent including, if necessary, | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| disclosing protected health information prior to, and in reasonable anticipation of, the person served death. | |
| 2. SCCMHA may use or disclose protected health information to notify or assist in the notification of (including identifying or locating), a family member, a personal representative of the person served, or another person responsible for the care of the person served of the person served location, general condition, or death. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 3. Personnel will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting protected health information [see Policy, Verification of Entities Requesting Use or Disclosure of Protected Health Information]. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 4. Once it is determined that use or disclosure is appropriate, Clerk Typist – ROI with appropriate access clearance will access the person served protected health information using proper access and consent procedures. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 5. The requested protected health information will be delivered to the individuals in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 6. Medical records personnel will appropriately document the request and delivery of the protected health information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 7. If the identity and legal authority of a person served or entity requesting protected health information cannot be verified, personnel will refrain from disclosing the requested information and report the case to the Compliance Officer in a timely manner. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 8. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Officer or the compliance hotline. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object - Disclosing PHI to Avert Serious Threat to Health and Safety</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.11</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
In accordance with the HIPAA Privacy Rule, §164.512(j), SCCMHA is permitted, consistent with applicable law and standards of ethical conduct, to disclose protected health information based on a reasonable belief that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. This policy provides guidance to ensure full compliance with all laws when using or disclosing protected health information to prevent or lessen a threat to the health or safety of a person or the public.

**Policy:**
1. SCCMHA, consistent with all applicable laws, may use or disclose protected health information, if SCCMHA, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

2. SCCMHA may make disclosures to persons or entities that are reasonably able to prevent or lessen the threat, including the target of the threat.

3. SCCMHA will make such disclosures only when the belief is based upon SCCMHA's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

**Application:**
All SCCMHA Board operated Programs and applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 08.05.00.01 Compliance Definitions for the following terms.*

- Disclosure
- Protected Health Information
- Use

**References:**
45CFR 164.512(b), MCL 330.1748, MCL 325.75

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Consistent with applicable law, standards of ethical conduct, and this policy, SCCMHA may use or disclose protected health information under the following circumstances:<br>a. To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.<br>b. For law enforcement authorities to identify or apprehend a person served because of a statement by a person served admitting participation in a violent crime that SCCMHA reasonably believes may have caused serious physical harm to the victim.<br>c. For law enforcement authorities to identify or apprehend a person served where it appears from all the circumstances that the person served has escaped from a correctional institution or from lawful custody.<br>d. To identify or apprehend a person served made pursuant to a statement by the person served admitting participation in a violent crime that SCCMHA reasonably believes may have caused serious physical harm to the victim. The disclosure | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| shall contain only that specific statement, and shall contain only the following protected health information:<br>• Name and address.<br>• Date and place of birth.<br>• Social Security number.<br>• ABO blood type and rh factor<br>• Type of injury<br>• Date and time of treatment.<br>• Date and time of death, if applicable; and<br>• A description of distinguishing physical characteristics, including height, weight, gender, race, hair, and eye color, presence, or absence of facial hair) beard or moustache), scars, and tattoos. | |
| 2. SCCMHA will not use or disclose protected health information for law enforcement authorities to identify or apprehend a person served because the person served makes a statement admitting participation in a violent crime that SCCMHA reasonably believes may have caused serious physical harm to the victim:<br>a. If such admission in participation is learned by SCCMHA during treatment to affect the inclination to commit criminal conduct that is the basis for the disclosure, or counseling or therapy; or<br>b. If such admission in participation is learned by SCCMHA through a request by the person served to initiate or to be referred for the treatment, counseling, or therapy to affect the inclination to commit the criminal conduct that is the basis for the disclosure. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 3. Personnel receiving a request from an individual or entity for use or disclosure of Protected Health Information will utilize SCCMHA records to determine whether the requesting individual is a person whom SCCMHA has a knowing relationship. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 4. Personnel will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting Protected Health Information (re: Policy, Verification of Entities Requesting Use or Disclosure of Protected Health Information). | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 5. Once it is determined that use or disclosure is appropriate, Medical Records staff with appropriate | |

| | |
|---|---|
| access clearance will access the person served protected health information using proper access and consent procedures. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 6. The requested protected health information will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 7. Medical Records staff will appropriately document the request and delivery of the protected health information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 8. If the identity and legal authority of an individual or entity requesting Protected Health Information cannot be verified, personnel will refrain from disclosing the requested information and report the case to the Compliance Officer in a timely manner. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Authorization or Opportunity to Agree or Object - Disclosing PHI for Specialized Government Functions</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.12</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
Under certain circumstances, and if certain requirements are met, SCCMHA may use and disclose protected health information for specialized government functions, in accordance with the HIPAA Privacy Rule, §164.512(k). This policy has been developed to provide guidance and to ensure compliance with all applicable laws and regulations when disclosing protected health information for specialized government functions.

**Policy:**
1. SCCMHA may use and disclose protected health information without person served authorization for the following specialized government functions: military and veterans' activities; National security and intelligence activities; Protective services for the President and others; Medical suitability determinations; Correctional institutions and other law enforcement custodial situations.

2. SCCMHA will comply with all requirements under 45 CFR 164.512(k) when using or disclosing protected health information for specialized government functions.

3. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of persons served receiving SUD services from SCCMHA.

**Application:**
All SCCMHA Board operated Programs and applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 08.05.00.01 Compliance Definitions for the following terms.*

- Disclosure
- Protected Health Information
- Use

**References:**
HIPAA Privacy Rule, §164.512(k)

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. SCCMHA may disclose protected health information of persons served in the Armed Forces without person served authorization for activities deemed necessary by appropriate military command authorities to assure proper execution of the military mission, given that the appropriate military command authorities and the purposes for which the protected health information may be used or disclosed must be published in the Federal Register. | Privacy Officer, Medical Records Staff |
| 2. SCCMHA may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 USC 401, et seq.) and implementing authority (e.g. Executive Order 12333), or; for the provision of protective services to the President or other persons authorized by 18USC 3056, or; to foreign heads of state or other persons authorized by 22 USC 2709(a)(3), or for the conduct of investigations authorized by 18 USC 871 and 879. | Privacy Officer, Medical Records Staff |
| 3. SCCMHA may use and disclose the protected health information of persons served who are foreign military staff | |

| | |
|---|---|
| to their appropriate foreign military authority for the same purposes for which uses and disclosures are permitted for Armed Forces staff under Procedure #1. | Privacy Officer, Medical Records Staff |
| 4. SCCMHA may disclose protected health information to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual, if the correctional institution or law enforcement official represents that such information is necessary for:<br>a. the provision of health care to such individuals.<br>b. the health and safety of such individuals or other inmates.<br>c. the health and safety of the officers or employees, or of others at the correctional institution.<br>d. the health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another.<br>e. law enforcement on the premises of the correctional institution; and<br>f. the administration and maintenance of the safety, security, and good order of the correctional institution. | Privacy Officer, Medical Records Staff |
| 5. SCCMHA, which is a government agency administering a government program providing public benefits, may disclose protected health information relating to the program to another covered entity that is a government agency administering a government program providing public benefits if the programs serve the same or similar populations and the disclosure of protected health information is necessary to coordinate the covered functions of such programs or to improve administration and management relating to the covered functions of such programs. | Privacy Officer, Medical Records Staff |
| 6. Staff receiving a request from an individual or entity for use or disclosure of Protected Health Information will utilize SCCMHA records to determine whether the requesting individual is a person whom SCCMHA has a knowing relationship with. | Privacy Officer, Medical Records Staff |
| 7. Staff will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting Protected Health Information [see Policy, Verification of Entities Requesting Use or Disclosure of Protected Health Information]. | Privacy Officer, Medical Records Staff |

| | |
|---|---|
| 8. Once it is determined that use or disclosure is appropriate, Medical Records Staff with appropriate access clearance will access the person served protected health information using proper access and authorization procedures. | Privacy Officer, Medical Records Staff |
| 9. The requested protected health information will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Privacy Officer, Medical Records Staff |
| 10. Medical records staff will appropriately document the request and delivery of the protected health information. | Medical Records Staff |
| 11. In the event the identity and legal authority of an individual or entity requesting Protected Health Information cannot be verified, staff will refrain from disclosing the requested information and report the case to the Compliance Office in a timely manner. | Privacy Officer, Medical Records Staff |
| 12. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Office or to the employee compliance hotline. | All SCCMHA staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Consent or Opportunity to Agree or Object - Disclosing PHI for Workers' Compensation</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.11.13</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 6/2/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/24/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights and Compliance<br><br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
In accordance with the HIPAA Privacy Rule, §164.512(l), SCCMHA may disclose protected health information as authorized by and to comply with laws relating to workers' compensation or other similar programs established by law, which provide benefits for work-related injuries or illness without regard to fault. This policy was developed to provide guidance and ensure compliance with applicable laws when disclosing protected health information related to workers compensation and other similar programs.

**Policy:**
SCCMHA may disclose protected health information as authorized by and comply with laws relating to workers' compensation or other similar programs, established by law, which provide benefits for work-related injuries or illness without regard to fault.

The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of persons served receiving SUD services from SCCMHA.

**Application:**
All SCCMHA Board operated programs and applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 08.05.00.01 Compliance Definitions for the following terms.*

- Disclosure
- Protected Health Information
- Use

**References:**
HIPAA Privacy Rule, §164.512(l),

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Staff receiving a request from an individual or entity for use or disclosure of Protected Health Information will utilize SCCMHA records to determine whether SCCMHA has a knowing relationship with the requesting individual. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 2. Staff will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting Protected Health Information [see Policy, Verification of entities Requesting Use or Disclosure of Protected Health Information]. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 3. Once it is determined that use or disclosure is appropriate, Clerk Typist - Records with appropriate access clearance will access the individual's protected health information using proper access and consent procedures. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 4. The requested protected health information will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 5. Clerk Typist – ROI will appropriately document the request and delivery of the protected health information. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |
| 6. If the identity and legal authority of an individual or entity requesting protected health information cannot be verified, personnel will refrain from disclosing the requested information and report the case to the Compliance Officer in a timely manner. | Clerk Typist – Medical Records & ROI, HIPAA Privacy Officer |

| | |
|---|---|
| 7. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Officer or to the employee compliance hotline. | All SCCMHA staff |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Privacy Set: Marketing – Using and Disclosing PHI for Marketing</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.05.15.01</td></tr>
<tr><td rowspan="2">Effective Date:<br>April 14, 2003</td><td>Date of Review/Revision:<br>3/5/03, 6/30/09, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/26/22, 6/27/23, 7/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer<br><br>Authored By:<br>Kentera Patterson, Compliance Officer<br>Additional Reviewers:<br>Holli McGeshick, Quality and Medical Records Supervisor</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
SCCMHA is committed to ensuring the privacy and security of person served health information. To enhance our services, we may engage in limited marketing activities, which may serve to solicit feedback relative to person served care and services. To support our commitment to person served confidentiality, SCCMHA will ensure that any protected health information used or disclosed for marketing purposes will comply fully with the HIPAA Privacy Rule, 45 CFR §164.508 and other applicable federal, state, and/or local laws and regulations.

**Policy:**
1. SCCMHA will obtain the person served consent to use and disclose person served health information for the purpose of marketing, except as otherwise stated in this policy and procedure.
2. SCCMHA may, without obtaining person served consent, use and disclose person served health information for the purpose of marketing only in accordance with the procedures stated below.
3. The regulations under 42 CFR Part 2 differ from HIPAA. Policy 08.05.01 should be consulted prior to disclosing the records of persons served receiving SUD services from SCCMHA.

**Application:**

All SCCMHA Board operated Programs and applicable Network Providers.

**Standards:**
None

**Definitions:**
*See SCCMHA Policy 08.05.00.01 Compliance Definitions for the following terms.*

- Disclose
- Protected health Information
- Use

**References:**
HIPAA Privacy Rule, 45 CFR §164.508

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1. Except as otherwise provided in these procedures, SCCMHA will obtain person served consent for the purpose of marketing in accordance with the SCCMHA policy: Obtaining a Consent for Use or Disclosure of Treatment, Payment, Health Care Operations (TPO). | HIPAA Privacy Officer, Clerk Typist - Medical Records & ROI, appropriate clinical staff |
| 2. If applicable, the consent for marketing will state that remuneration to SCCMHA is involved in the marketing activity, regardless of whether such remuneration is direct or indirect. | HIPAA Privacy Officer |
| 3. Blanket consents for marketing will be considered by SCCMHA to be defective. | All SCCMHA staff |
| 4. SCCMHA will document and retain the signed consent for a period of at least six years from the date of its creation or the date when it last was in effect, whichever is later. | HIPAA Privacy Officer, Clerk Typist – Medical Records & ROI |
| 5. SCCMHA may, without obtaining person served consent, use or disclose PHI for the following purposes: | HIPAA Privacy Officer, Clerk Typist - Medical Records & ROI |

| | |
|---|---|
| a. to make a face-to-face marketing communication to a person served; and<br>b. to provide a promotional gift of nominal value to the person served. | |
| 6. SCCMHA will not disclose PHI to a business associate or other third party, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a marketing communication that promotes that entity's products or services. | HIPAA Privacy Officer, Clerk Typist - Medical Records & ROI |
| 7. Consistent with the policies and procedures herein, SCCMHA may otherwise disclose protected health information to a business associate to assist in SCCMHA's marketing activities. | HIPAA Privacy Officer, Clerk Typist - Medical Records & ROI |
| 8. SCCMHA may, without consent, communicate information to persons served:<br>a. to describe a health-related product or service, or payment for such product or service, which is provided by, or included in a plan of benefits of SCCMHA.<br>b. for treatment of the person served.<br>c. for case management or care coordination for the person served; or<br>d. to direct or recommend to the person served alternative treatments, therapies, health care providers or settings of care. | HIPAA Privacy Officer, Quality & Medical Records Supervisor, appropriate clinical staff |
| 9. Knowledge of a violation or potential violation of this policy must be reported directly to the HIPAA Privacy Officer, Compliance Officer or to the Compliance hotline. | All SCCMHA staff |

# Tab 8

# Network Services

| Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority | | |
|---|---|---|
| **Subject**<br>Media/Communications Request for Agency Information | **Chapter**: 01 - Leadership | **Subject No**: 01.03.03 |
| **Effective Date**:<br>10/1/02 | **Date of Review/Revision**:<br>10/10/03, 4/8/14, 5/5/16, 8/8/16, 7/10/17, 7/10/18, 7/9/19, 8/11/20, 7/13/21, 9/27/22, 7/11/23,7/9/24 | **Approved By**:<br>Sandra M. Lindsey, CEO |
| | **Supersedes**: 04.01.00.00 Community Relations Policy | **Responsible Director:**<br>Sandra Lindsey, CEO |
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | | **Authored By**:<br>Sandra Lindsey, CEO<br><br>**Additional Reviewers**:<br>None |

**Purpose:**
To establish procedures and guidance to SCCMHA staff, contractors, volunteers and students regarding requests for agency information, expertise and interface with the public and outside media or other agents external to the organization.

**Policy:**
All external communications including requests for agency information, interface with all media forms and the external public must represent the professionalism and integrity of the Saginaw County Community Mental Health Authority (SCCMHA), its programs and services whether they be board operated or contracted and its personnel. External communications on behalf of the SCCMHA will reflect this professionalism to protect the image of the agency, the persons served/families served by the agency, its network of service providers and its staff.

**Application:**
This policy applies to all staff, students, volunteers and consultants of SCCMHA. A limited number of sections also apply to SCCMHA contract agencies or individuals. Those sections are marked with an asterisk (*).

**Standards:**
A. Compliance with this policy is the responsibility of the director of each SCCMHA department and their unit supervisors. The Chief Executive Officer (CEO) or their designee, reserves the right to review department/unit decisions to ensure compliance with communication policies and procedures. In the case of contracted agencies or individuals**,** select sections apply.

B. External Communication includes the use of letterhead, electronic mail (e-mail), voice mail, business cards, website, and other hard copy, audio voice or electronic marketing materials including but not limited to advertising premiums, flyers, posters, brochures, print advertising, radio/television advertising, billboards, banners, website content, web advertising, social media and event participation and partnership/sponsorship.

*C. The office of the CEO controls the use of the SCCMHA logo, subject matter icons and art (i.e. Person Centered Planning and Self Determination) and will provide guidelines for the proper use of the organizations name as well as these symbols. Departments/units seeking to use these symbols, agency art, and agency name, etc. on external communication materials must seek permission and guidance from the CEO's office. Permission to use logos and unique art under the control of SCCMHA by contracted agencies or individuals must also be sought from the CEO.

D. The Office of the CEO must approve the development of any new or special program or logo/graphic including any updates to current brochures, flyers, pamphlets, publications or SCCMHA website.

E. Staff proposing external communication efforts that are not considered in the procedures section of this document must make a formal request to the CEO's office, Attention Executive Assistant to the CEO for review and approval before proceeding.

*E. Communications with the media on issues/events related to SCCMHA must be managed by the CEO's office or official designee.

F. It is not permissible for departments, programs or units of SCCMHA to market themselves individually. All marketing efforts will be coordinated by the CEO's office or official designee.

*G. Every employee (includes contracted staff, students and volunteers) is an ambassador and representative of SCCMHA and must represent themselves in a professional manner on behalf of the Agency when in the community. Employees are asked to forward copies of articles appearing in their local media or on social media that cover SCCMHA or a member of its service network to the office of the CEO. Employees are also asked to report community perceptions (positive or negative) of SCCMHA or its network members to the CEO's office to further the understanding. Contracted agencies and individuals are requested to forward such information to the office of the CEO to enhance efforts to promote a positive community image.

H. Public inquiries and requests for information concerning the following should be directed to:
    1. General Requests or information, publications, speakers – Customer Service
    2. Trainings or events – Continuing Education Unit

3. Advertising / sponsorship or letters of support for grants – CEO Office
4. Use of agency videos – CEO Office
5. Engagement on social media or electronic promotions – CEO Office
6. Inquiries about SCCMHA Board or Board Membership – CEO Office
7. Inquiries about SCCMHA Citizens Advisory Committee – CEO Office
8. Professional Speakers to Media or by invitation to community, state or national events

*I. "Person-First Language" shall be utilized in all publications, formal communications, and daily discussions.

**Definitions:**
"Person-First Language" refers to a person first before any description of disability. "Persons Served" will replace the term "consumer" beginning in Quarter 4 / 2024 as requested by SAMHSA in FY 2023 CCBHC Certification standards in effect in 2025.

**References:**
See 02.03.01 – Consumerism Policy

**Exhibits:**
#1 SCCMHA Letterhead (500 Hancock)
#2 SCCMHA Logo with Text
#3 SCCMHA Icon List

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| **A. Letterhead/Envelopes/Business Cards** | |
| 1. SCCMHA has a standard design of agency letterhead, and envelopes for official agency business. No other letterhead or business cards should be used by anyone conducting SCCMHA business. | 1. Executive Assistant to CEO is in control of all letterhead design. Director and Supervisors are responsible for the use of agency letterhead in their departments / units and the ordering of business cards for their staff. |
| 2. Business cards can be ordered through the Human Resources Department. | 2. Human Resources Department |
| 3. Letterhead and envelope stock may be obtained through contact with purchasing agent in the Finance Department. | 3. Director of Finance or designee (Direct contact for ordering letterhead and envelopes is Accounting Assistant II. |
| 4. Letterhead and envelopes will not carry the names of department personnel in any standing format on the materials since this creates waste and additional expense | 4. Director of Finance or designee. |

| | |
|---|---|
| whenever there is a personnel change. | |
| 5. SCCMHA also has a standard self-addressed envelope with postage included. When the need to include such an envelope exists this envelope must be used. | 5. Finance Department designee. All Directors and Supervisors to oversee proper use. |
| 6. SCCMHA Finance Department will use windowed envelopes for payables that are mailed. | 6. Finance Department or designee. |
| 7. SCCMHA has a standard label for larger envelopes which should be consistently used. This label has a return address on it. | 7. Finance Department or designee. All Directors and supervisors to oversee proper use. |
| 8. SCCMHA will also regularly send multiple pieces of mail out to lists of audiences. When merge mail processes are used or regular mailings to such lists of persons are used, plain white Avery labels are permissible for use with printer. | 8. All staff, volunteers and students |
| 9. In all SCCMHA correspondence, the following information must be included in the body of the letter.<br>a. Department/Unit name<br>b. Phone number of author<br>c. Fax number if different from letterhead<br>d. E-mail address of author | 9. All staff, volunteers and students. |
| 10. All proposed publication materials carrying the SCCMHA name & logo must be reviewed and approved by the Office of the CEO. Directors reporting to the CEO may grant authority to use the agency name and logo in its standard formats for unit / departmental sponsored or initiated trainings and events. | 10. All staff, volunteers and students. |
| **B. Media Coverage** | |
| 1. All media inquiries must be referred to and handled by the Office of the CEO. This includes contacts by phone, e-mail, or visits by reporters or camera crews. Staff members receiving media calls and inquiries should | 1. All staff, volunteers and students, Contract agencies and individuals |

| | |
|---|---|
| immediately transfer the call to the CEO's office. In doing so, staff may explain to the media the Agency policy by saying something like the following: "All media calls are handled by the CEO's office. I will transfer you to that department." If the line is busy and the call cannot be transferred, either take a message or ask if they would like voice mail for the Executive Assistant to the CEO. Following the call, alert the CEO's office to the inquiry. Contract agencies and individuals shall never speak on behalf of SCCMHA to the media. If they are approached about SCCMHA business or information, such contacts should be referred to the office of the CEO. | |
| 2. SCCMHA personnel who wish to explore interviews or story ideas with members of the media must first consult with the CEO through their reporting chain of command. Contract agencies or individuals should also seek consultation from the office of the CEO if a SCCMHA funded person served or program story is to be pursued. | 2. All staff, volunteers and students, Contract Agencies and Individuals |
| 3. Only the Office of the CEO may issue news releases on behalf of SCCMHA and its divisions, departments, programs and units. Associated press style will be followed in all communications with the media. | 3. Office of the CEO |
| 4. It is the responsibility of the Office of the CEO to access all media contacts and to approve, authorize or arrange involvement of SCCMHA staff in interview, provisions of information, photo shoots or news conferences. | 4. Office of the CEO |
| 5. Where persons served / their families are directly involved, client confidentiality will guide all interactions between SCCMHA staff members and the media. SCCMHA will review all requests for client interview with appropriate parties (client, guardian, or parent) and SCCMHA staff to access understanding and control level. Signed photo/video release | 5. All staff, volunteers and students. Contracted agencies and individuals |

| | |
|---|---|
| statements will be required. | |
| 6. To track coverage, SCCMHA staff who are cited in printed articles or electronic interviews should send clippings or air dates of coverage to the Office of the CEO as soon as possible. | 6. All staff, volunteers and students. Contracted agencies and individuals |
| **C. Publications** | |
| 1. The Office of the CEO or their designee will access the need for and coordinate the production of all publications (brochures, flyers, booklets, web activities, annual reports, newsletters, report cards and posters) intended for external distribution. This work will be done in partnership with the Customer Services Office, Citizens Advisory Committee and other persons served groups with important contributions to make these products. | 1. Office of the CEO, Supervisor of Customer Services, Citizens Advisory Committee |
| 2. A single set of telephone numbers and contact information for SCCMHA shall be published for access to agency/network services. Exhibit # 4 | 2. Office of the CEO, Supervisor of Customer Services |
| 3. All publications will be identified to the SCCMHA organization not to divisions, departments, programs or staff members. | 3. Office of the CEO, Supervisor of Customer Services, All Directors and Supervisors |
| 4. Publications will follow a standard style of identifying the organization as "Saginaw County Community Mental Health Authority" on first reference, SCCMHA on all subsequent references. | 4. All staff, volunteers and students. |
| 5. Clear SCCMHA identification must appear prominently on the cover of all publications by name or logo. Address and phone numbers must appear when and where appropriate. | 5. Office of the CEO, Supervisor of Customer Services, All Directors and Supervisors |
| 6. Photo releases must be secured for use of photos of clients, staff, and community to be included in any publication. | 6. All staff, volunteers and students, Contracted agencies and individuals |
| 7. Where appropriate, the Americans with | 7. Office of the CEO, Supervisor |

| | |
|---|---|
| Disabilities Act (ADA) and Equal Opportunity Employers/Affirmative Action Statements will appear in publications. | of Customer Services, All Directors and Supervisors |
| 8. Affirmative Action Statement – Full version. (Extensive public reports, journals, website, etc.).<br><br>a. "Saginaw County Community Mental Health Authority will not discriminate, harass and/or retaliate in employment because of race (including traits historically associated with race such as hair texture and protective hairstyles), religion, color, national origin, age, sex (including pregnancy), height, weight, familial status, marital status, disability, genetic information, religion, sexual orientation, gender identity or expression, and service in the uniformed services or any other characteristic protected by law. This policy applies to all terms, conditions, and privileges of employment including recruitment, hiring, training, placement, employee development, promotion, transfer, compensation benefits, discipline, and termination".<br><br>b. Affirmative Action Statement-Abbreviated version (brochures, pamphlets and flyers)<br>"The Saginaw County Community Mental Health Authority (SCCMHA) and all Service Network Providers adhere to non-discrimination in hiring practice and service delivery, because of race, color, religion, national origin, age, sex (including pregnancy), sexual orientation, gender identity, disability, veteran status, or any other characteristic protected by law". | 8. Office of the CEO, Supervisor of Customer Services, All Directors and Supervisors |
| 9. Americans with Disabilities Act Statement (ADA) (All lengthy publications with an extended shelf life.) "This publication, as well | 9. Office of the CEO. Supervisor of Customer Services |

| | |
|---|---|
| as any other document produced by SCCMHA, can be made available in alternative formats. To request a copy of this publication in large print, audio or in an electronic format contact the Customers Service Office (989/797-3452)." | |
| 10. Where appropriate, the names of the SCCMHA Board of Directors and administrative staff will appear in publications. | 10. All staff, volunteers and students. |
| **D. Use of Agency Logo**<br>SCCMHA has a standard logo accompanied by the organizations name in a specific font and color. Black & White versions are also available. The logo and accompanying agency name is to be used together whenever possible. See Exhibit #2 | D. Technical Assistance in access to and use of the logo can be obtained through the Executive Assistant to CEO. |
| 1. The logo and name can be used in black and white or, in color. | |
| 2. The logo color must be Pantone 518U (berry color) and Pantone 350U (green) | |
| 3. The font of the agency name called Friz Quadrata Bold cannot be changed or abbreviated. The logo must be used in its entirety. But may also be used in a watermark format either black & white or color. | |
| 4. The SCCMHA logo can only be used on official SCCMHA documents. Exceptions to this must be made with the approval of the CEO. | 4. All staff, volunteers and students, Contracted agencies and individuals |
| **E. Use of Agency Icons**<br>SCCMHA has approximately **35** different icons unique to functions and subject matter of the organizations business. The icons are assigned for use to senior managers of the organization. The icons are available on the G: Drive at G\ICONS. See Exhibit #3. | E. Director of Network Services, Public Policy & Continuing Ed, Chief Information Officer & Chief Quality and Compliance Officer, Officer of Recipient Rights and Compliance, Executive Director of Clinical Services & Programs, Director of Environmental Services, Customer Service & Security, |
| The rules for the use of icons follow: | |

| | |
|---|---|
| 1. Icons cannot be altered; they may however be separated from the accompanying text title, but not re-titled.<br><br>2. The icons cannot be colored.<br><br>3. To maintain consistency, the font, Friz Quadrata Bold cannot be changed. See Exhibit #3 for icon listing. | Chief of Health Services and Integrated Care, Director of Human Resources, Transportation & Facilities, Chief of Network Business Operations |
| **F. Electronic Mail**<br>*(See SCCMHA E-mail policy #08.01.01)* | F. All staff, volunteers and students. |
| **G. Voice Mail**<br>(See SCCMHA Voice Mail policy # 01.03.02) | G. All staff, volunteers and students |
| **H. Conflict of Interest**<br>1. SCCMHA staff who are asked, as individual professionals and not as SCCMHA employees, to represent their professional missions or positions on sensitive issues in media coverage or public presentations should notify the Office of the CEO to ensure that their affiliation with SCCMHA is not misrepresented. | 1. All staff, volunteers and students. |
| **2.** From time to time, staff is asked to write opinion pieces for external publications. When this occurs, the Office of the CEO must be notified where representation of SCCMHA policies, mission and work of the organization are to be included. Staff members, groups of staff from units or departments, unions or individual board members are not authorized to speak on behalf of SCCMHA without prior approval from the CEO (SCCMHA Board Chair for Board Members) for each individual appearance and/or written document or from the board chairman in the case of board members. | 2. All staff, volunteers and students. |
| **3.** SCCMHA staff members may not free-lance or otherwise maintain dual employment with a broadcast of print medium or electronic media without the express agreement of the SCCMHA CEO. | 3. All staff, volunteers and students, all contracted staff. |

| | |
|---|---|
| **4.** Disclosure of such employment with a media agency is mandatory. For those staff that are paid by contract as employees, they too must disclose such arrangements and seek expressed permission from the CEO. | |
| **5.** Failure to disclose may be grounds for dismissal from SCCMHA, or cancellation of any contractual agreement. | |
| **I. Endorsements**<br>1. Political – staff members may not endorse any political position or candidate on behalf of SCCMHA. SCCMHA will carefully review and endorse only those issues appropriate to its mission and not in conflict with law or statute or regulation. The communication of such endorsements will be through the CEO. | I. All staff, volunteers and students. |
| 2. Promotional – staff members may not endorse vender products or services while representing themselves as SCCMHA employees or affiliate business associates. SCCMHA will not endorse any commercial service or product including products or promotional items. | |
| **J. Health Fair and Other Events.**<br>It is the responsibility of the Customer Services Supervisor to assess all requests for appearances by SCCMHA staff at health fairs or other events. Staff members may not represent SCCMHA, its policies, mission and work without the express authorization of the CEO through the Supervisor of Customer Services. | J. All staff, volunteers and students, Supervisor of Customer Services. |
| **K. Request for speakers from SCCMHA must be made to and approved by the CEO or their designee.** | K. All Staff, volunteers and students, CEO Office Manager |
| **L. Stipends**<br>It is the policy of SCCMHA that employees asked to represent it at speaking and other engagements may not accept any form of stipend or honorarium. **They may choose to** | L. All staff, volunteers and students. |

| | |
|---|---|
| **have such an honorarium or stipend directed to the Finance Department of SCCMHA to be used for person served benefit or to First Choice.** | |

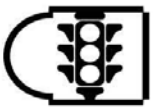
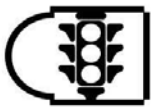
Exhibit #1: See Office Supply Stock room for Letterhead

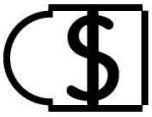
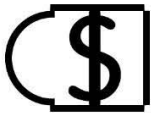
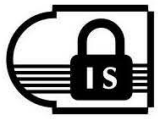
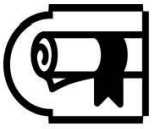
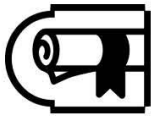
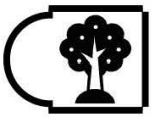
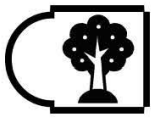
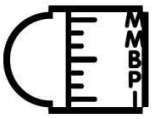
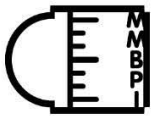
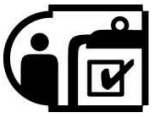
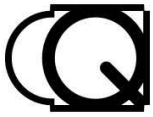
SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

500 HANCOCK ST. • SAGINAW, MI • 48602-4292 • PHONE (989) 797-3400 • FAX (989) 799-0206

Exhibit #2: See G:/Logos for electronic file

Exhibit #3: Sample, see current document at G:/Icons/Master list.doc

| SCCMHA ICONS January 2014 | | |
|---|---|---|
| ICON w/ TEXT | ICON | TEXT ONLY |
|  **Accommodations** |  | **Accommodations** |
|  **Care Management** |  | **Care Management** |
|   **CARF** |   | **CARF** |
|  **Contracts & Property Management** |  | **Contracts & Property Management** |
|  **Continuing Education** |  | **Continuing Education** |
|  **Collaboration & Community Benefit** |  | **Collaboration & Community Benefit** |
|  **Customer Service** |  | **Customer Service** |
|  **Diversity** |  | **Diversity** |
|  **Environment of Care/Health/Safety** |  | **Environment of Care/Health/Safety** |
|   **Evidence-Based Practice** |   | **Evidence-Based Practice** |
|  **Facilities** |  | **Facilities** |

| | | | |
|---|---|---|---|
|  | **Family Centered Planning** |  | **Family Centered Planning** |
|  | **Finance** |  | **Finance** |
|  | **Human Resources** |  | **Human Resources** |
|  | **Information Systems** |  | **Information Systems** |
|  | **Leadership and Governance** |  | **Leadership and Governance** |
|  | **Learning Links** |  | **Learning Links** |
|  | **Meaningful Life** |  | **Meaningful Life** |
|  | **MMBPI Measurement** |  | **MMBPI Measurement** |
|  | **Person Centered Planning** |  | **Person Centered Planning** |
|  | **Prevention** |  | **Prevention** |
|  | **Provider Network Auditing** |  | **Provider Network Auditing** |
|  | **Quality Improvement** |  | **Quality Improvement** |

| | | | |
|---|---|---|---|
|  | Quality of Life |  | Quality of Life |
|  | Recipient Rights<br>Complaints<br>Appeals |  | Recipient Rights<br>Complaints<br>Appeals |
|  | Recovery |  | Recovery |
|  | Regulatory Compliance |  | Regulatory Compliance |
|  | Security |  | Security |
|  | Self Determination |  | Self Determination |
|  | Sentinel Events |  | Sentinel Events |
|  | Strategic Planning |  | Strategic Planning |
|  | Substance Use Disorders |  | Substance Use Disorders |
|  | Suggestions |  | Suggestions |
|  | Supported Employment |  | Supported Employment |
|  | Transportation |  | Transportation |

| | |
|---|---|
| Wellness | Wellness |

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject:<br>SCCMHA ListServer</td><td>Chapter: 01 - Leadership</td><td>Subject No: 01.03.05</td></tr>
<tr><td rowspan="2">Effective Date:<br>March 2, 2020</td><td>Date of Review/Revision:<br>3/22/21, 4/28/22, 4/6/23, 4/6/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Allison Kalmes-Hadd<br><br>Additional Reviewers:<br>Jennifer Keilitz, Clinical Directors</td></tr>
<tr><td>Supersedes:<br>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 be 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 not 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 is 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

<table>
<tr><th colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: SCCMHA Continuing Education Program</td><td>Chapter: 05 - Organizational Management</td><td>Subject No: 05.06.06</td></tr>
<tr><td rowspan="2">Effective Date:<br>9/1/03</td><td>Date of Review/Revision:<br>8/11/05, 8/24/06, 1/25/07, 6/23/09, 8/30/10, 6/6/12, 6/3/14, 4/3/16, 6/13/17, 6/1/18, 8/7/19, 6/8/20, 1/10/22, 5/3/23, 8/8/23, 5/9/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Network Services, Public Policy & Continuing Education<br><br>Authored By:<br>Jennifer Keilitz<br><br>Additional Reviewers:<br>Alecia Schabel</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

**Purpose:**
It is the expectation that Saginaw County Community Mental Health Authority (SCCMHA) will ensure a competent network of service providers. SCCMHA specifies required instruction in specific areas for service delivery providers of mental health and substance use disorder services. When on-site audits and other compliance reviews of SCCMHA operations are conducted, proof of those required education standards for employees, staff and providers must be provided. In addition, the provision of ongoing education and competency testing ensures at a minimum, compliance with the State and Federal standards, and also the provision of appropriate and quality services that maintain and promote the health, safety, goal achievement, and health equity of persons served by the SCCMHA network.

**Policy:**
It is the policy of SCCMHA to have a continuing education program that meets State and Federal requirements, and ensures competent staff and provider network members. In order to ensure a properly instructed and competent provider and staff workforce, SCCMHA chooses to both directly provide as well as procure, as needed, a full complement of routine and ad hoc quality and comprehensive training opportunities. SCCMHA requires staff and provider network members to meet minimum education requirements, including some annual renewals, in accordance with the person's and/or programs' role or scope of service delivery. SCCMHA expects that staff and providers will demonstrate competency in these areas in the performance of their work on behalf of SCCMHA. SCCMHA may also require from time to time, staff and provider attendance at ad hoc education programs to either meet new or changed requirements, to refresh

expertise, or to ensure the maintenance of competency in certain continuing education areas.

**Application:**
This policy applies to all staff and relevant members of the SCCMHA service provider Network including Designated Collaborative Organizations (DCO's). This policy pertains only to ongoing education; it does not address employee orientation, program specific in-services, or attendance at external conferences or workshops as approved by supervisors of employees, covered by other SCCMHA and/or Human Resources policies and/or procedures, or such of any SCCMHA contractor.

**Standards:**
A. SCCMHA will establish minimum education standards for providers and staff by type, department or position; updates will be provided to staff and contractors as appropriate. Standards will be used to measure performance and compliance.
B. SCCMHA minimum continuing education standards will be established with input from SCCMHA supervisors and management, and approved by the SCCMHA Management Team and Continuing Education Committee.
C. SCCMHA will educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
D. SCCMHA will ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
E. SCCMHA will publish education protocols of core required courses, to include course topic/title, values, identified outcomes/objectives, duration and frequency of course, competency test tool, summary of course content, criteria for successful completion, targeted audience, pre-requisites (if any) and educator qualifications.
F. SCCMHA provided courses will adhere to an established, published education plan and calendar. The education plan will be approved by the SCCMHA Continuing Education Committee and the SCCMHA Management Team.
G. SCCMHA provided courses will adhere to written education protocols for all continuing education areas routinely conducted.
H. Routine courses contained in the SCCMHA minimum education requirements will be offered at regular intervals and advertised with sufficient notice to staff and/or provider relevant audiences.
I. Education protocols will be kept current by SCCMHA staff and will be adopted by SCCMHA through Management Team review.
J. Ad hoc courses sponsored or provided by SCCMHA must have an established protocol; ad hoc courses must be reviewed by the Continuing Education Supervisor who will submit the courses to the SCCMHA Continuing Education Committee and the SCCMHA Management Team for approval.
K. Education protocols will include the course topic and definition, values, outcomes or objective(s), summary of content, criteria for completion, desired or intended audience, duration, and frequency.
L. All SCCMHA education offerings that award continuing education credits will include the following:

a. Advance notice to the correct audience(s)
b. Course posting (may be electronic) that includes:
    1. The ACE statement and provider number for social workers
    2. Number of continuing education clock hours
    3. Presenter information
    4. Educational goals and objectives
    5. Written notice of Continuing Education Units (CEUs) granted.
    6. Contact information for filing a grievance.
    7. Accommodation for individuals with disabilities.
    8. How certificates will be awarded and time frames.
    9. Criteria for successful completion
    10. Time frame
    11. Location
    12. Target audience
    13. Clarification on RSVP and/or mandatory attendance requirements
c. Agenda with presenter(s) information and written goals and objectives
d. Handouts/Written Materials.
e. Sign-in sheet and sign out sheet.
f. Certificate awarding Continuing Education (CE) credits.
g. Sufficient allowance of time for audience question and answers.
h. Method or tool to assess attendee competency on the course topic post training session.
i. Follow-up by educator on any specific course topic or session issues.
j. Audience Evaluation to assess adherence to the written goals and objectives
k. Data entry to SCCMHA network services data base.

M. Handout materials for non-mandatory education sessions may be provided to absent audience members upon request at the discretion of SCCMHA.

N. Ad hoc courses will be evaluated for possible insertion into standing education programs. These must first be reviewed and approved by the SCCMHA CE Committee.

O. SCCMHA will make arrangements to record standing courses whenever feasible to accommodate staff and provider needs and has an established check- out system for staff and provider use.

P. SCCMHA will establish a periodic continuing education work group - composed of the Continuing Education Supervisor, SCCMHA Human Resources, Provider/Clinical program representatives, as well as representatives from Medical Services, person served representative(s), and Social Work Consultant – to review continuing education procedures, coordination, and standards.

Q. Providers who receive required education courses from sources other than SCCMHA must have approval from the designated continuing education unit staff or supervisors to meet minimum education requirements application; staff must have supervisory approval on external continuing education to meet minimum posted standards.

R. Providers may be offered the opportunity for some course offerings to ‘test out’ as proof of competency, in lieu of face-to-face attendance at an education session.

S. Participants may be offered reasonable opportunity for remedial education to ensure minimum competency level achievement.

T. SCCMHA will continue to seek to develop alternative and flexible methods of education offerings, including on-line and/or self-testing course formats when feasible as well as virtual format.

U. SCCMHA in 2019 started offering clinical staff the opportunity to obtain additional training through the Relias® training platform. These do not replace the training provided by SCCMHA that is specifically designed to support SCCMHA mission and vision statement. However, it is meant to offer additional training on topics where staff can develop additional skills to perform their work with persons served. SCCMHA also encourages staff to use the Improving MI Practices website https://www.improvingmipractices.org/online/ to gain knowledge and skills.

V. Provider network members and SCCMHA supervisors and staff will receive routine, quarterly reports of individual course completion and compliance with minimum education requirements.

W. SCCMHA provider network audits will include measurement of performance in education areas.

X. SCCMHA will require SCCMHA staff and network providers to maintain at a minimum 95% compliance in education requirements.

Y. SCCMHA Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services or Contracts Unit may consider issuing a sanction to providers who fail to meet the minimum education compliance requirement.

Z. SCCMHA Network Services & Public Policy Department will routinely publish acknowledgements of network providers who consistently meet or exceed the minimum required education requirements.

AA. Education focused on/for persons served will be planned by the Continuing Education Unit and/or the Customer Services Department and published to providers.

BB. Whenever feasible, SCCMHA will seek to obtain CEU and Michigan Certification Board for Addiction Professionals (MCBAP) credits to be available to participants of education offerings to meet professional continuing education requirements of staff and providers.

CC. For classroom-based courses, SCCMHA reserves the right to limit class audience size for optimal learning.

DD. SCCMHA will maintain for at least seven years in a secure location:

a. Names and resumes of continuing education supervisor and social work consultant
b. Participant name, profession, and license/certification/registration number as applicable to position
c. Course title, date, location and credits awarded
d. Course outline/syllabus and learning objectives
e. Course instructor's qualifications and professional affiliations
f. Americans with Disabilities Act (ADA) requests and services provided
g. Grievances and resolutions
h. Course evaluations

EE. SCCMHA will implement all state and regional reciprocity standards to attempt to bring uniformity and consistency in providing introductory training of direct support staff and others involved in more than one Community Mental Health Speciality Provider (CMHSP) service.

**Definitions:**
For purposes of this policy, the following definitions apply:

Competency – Having the requisite or adequate abilities or qualities as well as the capacity to appropriately function and respond.

Continuing Education – May be standing education schedule or ad hoc; instruction programs specifically designed to meet certain standards and promote minimum level of competency.

Credentialing – Affirming the background and qualifications and/or education and course record of an individual; may be direct-source verification.

Development – The ongoing enhancement of an individual's knowledge and expansion or refinement of their skills in existing or new areas of expertise.

In-Service - Department or program specific offerings that promote advancement of staff knowledge on a specific topic, including adherence to policies and procedures.

Orientation – Acquainting an individual employee with their position duties, environment and resources to perform their job through proper introductions to supervisors and co-workers and SCCMHA policies and practices; may be department specific and/or broad to the scope of SCCMHA.

**References:**
Improving MI Practices Website: https://www.improvingmipractices.org/online/
SCCMHA Education Protocols Manual (most current version)
SCCMHA Minimum Education Requirements
SCCMHA Competency Requirements for the SCCMHA Provider Network Policy
SCCMHA HR policies as applicable
*MDHHS Prepaid Inpatient Health Plans, Specialty Mental Health and Substance Use Disorder Services and Supports Network Management Reciprocity & Efficiency* policy April 2014
Network Providers Background Verification & Credentialing Procedure & Plan
SCCMHA Provider Participation Agreement
Relias® training platform.
U.S. Department of Health and Human Services Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

**Exhibits:**
None

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|

| | |
|---|---|
| Approve SCCMHA annual continuing education program/plan, standing education protocols and minimum education requirements for SCCMHA network and staff. | SCCMHA Management, Service Management Teams, & Continuing Education Committee (as documented in minutes) |
| Approve and develop ad hoc courses and in-services to meet needs; ensure qualifications of instructors. | SCCMHA Continuing Education Supervisor |
| Ensure staff and self-schedule of attendance/completion of required courses and monitor staff adherence to minimum education requirements. | Supervisors and Directors |
| Assure arrival on time as continuing education cannot allow late arrivals and offer CE's. Any late arrivals to classes will be turned away at the security desk. | Staff and Supervisors |
| Oversee Continuing Education Unit functions and development of continuing education schedules, protocols and resources. | SCCMHA Director of Network Services, Public Policy, & Continuing Education |
| Chairs Continuing Education Committee | SCCMHA Continuing Education Supervisor |
| Provides or coordinates all standing education offerings and materials. Ensures record keeping of course attendance and competency tests. Develops and refines education programs, protocols, and curricula. Provides consultation to providers and programs on continuing education issues. | SCCMHA Continuing Education Supervisor |
| Meets on a quarterly and ad hoc basis as needed to review and provide feedback on SCCMHA continuing education program structure and goals. | Continuing Education Committee |
| Provides input on continuing education issues and needs for the SCCMHA system and makes suggestions for improvement. | Quality Governance Committee<br>SCCMHA Supervisors<br>SCCMHA Provider Network Members<br>Continuing Education Committee |

<table>
<tr><td colspan="3">Policy and Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Agency Forms</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.04.08</td></tr>
<tr><td rowspan="2">Effective Date:<br>6/11/07</td><td>Date of Review/Revision:<br>3/8/17, 3/1/18, 2/25/19, 3/30/20, 3/11/21, 4/29/22, 4/6/23, 4/5/24</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Executive Director of Clinical Services<br><br>Authored By:<br>Allison Kalmes-Hadd<br><br>Additional Reviewers:<br>Clinical Directors, Jennifer Keilitz, Jen Kreiner</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 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 or Chief 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 Chief 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.

Copies of forms may be maintained by staff on their personal drives (H: Drive) 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 or Chief.

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 or Chiefs |
| Placement of approved electronic hard-copy documents within the Agency Forms on the G: Drive | Administrative Assistant to the Executive Director of Clinical Services and Clinical Records Coordinator |
| Organization of the Clinical Forms on G: Drive in Agency Forms folder | Administrative Assistant to the Executive Director of Clinical Services and Clinical Records Coordinator |
| 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 or Chief |
| 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 |

<table>
<tr><td colspan="3">Network Services and Public Policy Procedure Manual<br>Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Auditing</td><td>Chapter: 09.04.01 - Auditing</td><td>Subject No: 09.04.01.01</td></tr>
<tr><td colspan="3">  Provider Network Auditing</td></tr>
<tr><td rowspan="2">Effective Date:<br>10/1/04</td><td>Date of Review/Revision:<br>9/21/04, 11/18/05, 9/21/06, 7/3/07, 2/1/08, 6/23/09, 1/5/11, 3/30/12, 4/16/14, 6/10/16, 5/7/19, 5/11/20, 3/24/21, 10/11/22, 6/1/23. 5/23/24</td><td>Approved By:<br>Jennifer Keilitz, Director of Network Services, Public Policy & Continuing Education</td></tr>
<tr><td>Supersedes:</td><td>Authored By:<br>Director of Network Services Public Policy & Continuing Education<br><br>Reviewed By: Melynda Schaefer</td></tr>
</table>

**Purpose:**
To provide guidance to service providers on the provider performance audit process of Saginaw County Community Mental Health Authority (SCCMHA).

**Application:**
SCCMHA Network Providers, both contracted and board operated programs.

**Policy:**
Formal Audits are required for all service areas on an annual basis. SCCMHA conducts audits of all service provider programs to meet Michigan Department of Health and Human Services (MDHHS) contractual requirements for annual provider performance measurement. The MDHHS requirement is as follows: "***The (PIHP) conducts performance reviews annually and more often for all providers in the provider network. These reports and any provider comments are contained in files available for review. Written reports of findings are prepared and shared with providers for comments and plans of correction are submitted by the providers, as necessary. Provider performance reports are available for review by individuals, families, advocates and the public." MDHHS also has required SCCMHA to "implement and monitor plans for increasing the use of consumers and family members in monitoring the performance of network providers."***

Audits are conducted to ensure the provider network is meeting a minimum set of standards. Audit standard content is based upon written policy and/or contractual requirements known by and given to the provider. The goal of annual audits is to demonstrate system improvement in the performance of network providers. Audit content is based on SCCMHA policies and any other requirements of providers with consistent standards for each distinct service area, per MDHHS, Mid-State Health Network (MSHN), SCCMHA's pre-paid inpatient health plan (PIHP), all quality standards required as a CCBHC and for any Designated Coordinating Organizations (DCO's) and other regulatory requirements.

Audit outcomes may result in network quality improvement goals for individual providers, provider groups and/or the SCCMHA network. Provider input on the audit process is always welcomed at any time.

SCCMHA has made a commitment to having persons served involved with aspects of the agency business. One of these areas is the audit process. SCCMHA invites representative persons receiving services to participate in the audit process. SCCMHA seeks to have a minimum of one person served involved in each type of service audit during each annual audit process. Persons receiving services observations and input will be documented and whenever possible persons served suggestions for audit process involvement will be implemented.

**Standards:**
Each provider program or site within the Network of SCCMHA providers, including board operated will have an annual audit or event verification audit at minimum. Each provider will be audited against general audit items, per their SCCMHA contract and a standard set of program specific areas. Audit scores will be published by SCCMHA.

It is the responsibility of the provider to ensure all documents are available at the time of the audit. Auditors will accept documents for the audit up to the time they leave the premises unless mutually agreed upon at the time of the audit by the provider and the auditor.

**Definitions:**
**Annual Audit:**
Audit performed to review Provider Performance against established standards.
This audit occurs annually and also includes an event verification and a review of training reports to verify compliance.
**Ad Hoc Audit:**
Audit performed outside the planned annual audit cycle for causes such as: contract compliance issues, previously low audit score, or quality of care is questionable. This audit may be planned or unplanned. This audit may also include an event verification and a review of training reports to verify compliance.
**Provider Termination Audit:**

Audit performed due to one provider leaving and a new provider taking over the same program. This also refers to an audit that takes place at contract end. This audit may also include an event verification once the contract is ended.

**Event Verification Audit:**

Audit performed to verify the provider has proof documents to support claims or reported services submitted to SCCMHA for payment. The events are randomly selected for review. The sample size varies by provider type. Training reports are reviewed to verify compliance for the program in addition to citations received from the previous annual audit for the program.

**Follow up Audit:**

Audit performed when a provider scores below 80% on their annual audit. Follow-Up audits review the areas of the audit that were cited on the annual audit. If the provider scores between 70%-79%, the provider will receive a follow-up audit in the next six (6) months. If the provider scores below 70% the provider will receive a follow-up audit in the next months (4) months and then another follow-up will occur seven (7) months post the annual audit to ensure the plan of corrections implemented are being followed. Training reports are reviewed to verify compliance standards and an event verification can be completed if the provider received a citation in this area during the annual audit.

**Corrective Action Plan (CAP):**

Response completed by Network Provider to address audit deficiencies found during an audit. This plan is submitted within SCCMHA's electronic Sentri II system or other means as noted in the audit report. Providers may have to submit proof of changes that the program has come into compliance in the designated areas. Plan of correction must be reviewed by the auditor who conducted the audit and then submitted to the Provider Network Auditing Supervisor for final approval.

**Sanction:**

Refers to any negative consequence generally applied when a provider does not follow policy, procedure, or contract language and is noted to be of a serious nature or a continued concern. Types should vary to fit the nature of the non-compliance. Sanctions could include payment withhold, repayment, discontinuation of referrals, discontinuation of services or contract cancellation.

**Person Served/Person Receiving Services:**

Refers to any individual receiving services from SCCMHA, any designated coordinating agency, or any contracted provider.

**References:**

SCCMHA Network Services Data Base Procedure
SCCMHA contract with Michigan Department of Health and Human Services (MDHHS)
SCCMHA contract with Mid-State Health Network (MSHN)
SCCMHA Competency Requirements for the SCCMHA Provider Network Policy
SCCMHA Network Development and Management Policy
SCCMHA Event Verification Policy

**Exhibits:**

Exhibit A – Audit Files and Organization Details
Exhibit B - Provider Record Review Questionnaire new will attach to email

Exhibit C- Volunteer and Student Application
Exhibit D – Student -Volunteer Background Check Release Form
Exhibit E - Consumer Confidentiality Statement
Exhibit F - Consumer Questionnaire.
Exhibit G – Consumer Brochure for Audit Recruitment

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| **General:** | |
| 1. Audit tools will be developed and approved. Reviewed annually and revised as needed. | 1. SCCMHA Provider Network Auditing Supervisor and approval of SCCMHA Service Management Team |
| 2. An auditing schedule will be organized each fiscal year with staff assignments attached to the audit schedule. This schedule may be subject to change based on other factors explained later in the procedure. | 2. SCCMHA Provider Network Auditing Supervisor with approval of SCCMHA Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services |
| 3. Notifies auditors of the tentative schedule for the audit year. | |
| 4. Auditors will be given a list of people receiving services who are interested in being involved in auditing of Network Providers. | 3. SCCMHA Provider Network Auditing Supervisor |
| 5. Discusses with auditors which audits persons receiving services will be involved with as part of SCCMHA Contract requirements. A person receiving services should be involved in at least one audit per audit type per year when possible. Also, assures that persons served participating in audits have had the appropriate orientation and background checks required by SCCMHA policy. Attached are some of the documents used as part of the orientation of persons served. | 4. SCCMHA Provider Network Auditing Supervisor<br>5. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |
| **Pre-Audit:** | |
| 6. All providers have a specific training curriculum, which is considered their training minimum standards requirements. Auditors print current copy of trainings listed in the SCCMHA training | 6. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |

| | |
|---|---|
| curriculum data base within Sentri II. Compare with SCCMHA Training Grid attached to Competency Requirements for SCCMHA Provider Network policy. These are also located on the SCCMHA website. | |
| 7. Each provider will be notified in writing or via email two (2) weeks or more in advance of a routine annual audit. (Exceptions to this time frame include Ad Hoc, Follow up, and Termination audits) A notification letter will be mailed, or emailed to audit site manager and to the corporate contact/contract person along with:<br>a. Provider checklist/ audit tool to be used from the SCCMHA Auditing data base.<br>b. Provider list of trainings required which shows the staff and staff trainings we have currently in the SCCMHA Network Services Training Data Base/Sentri II. | 7. SCCMHA Provider Network Auditing Supervisor, SCCMHA Auditors, SCCMHA Network Providers |
| 8. Auditors will discuss with provider at the first contact the need for the following items:<br>a. Date of audit that both parties mutually agreed to.<br>b. List of Documents to submit prior to the audit in order to decrease the amount of on-site time needed to complete the audit.<br>c. Suggest provider submit any needed changes on the Trainings Report sent with audit notice to the Continuing Education Unit prior to the day of the audit, as the auditors will score the providers training report the day before the on-site audit review.<br><br><u>For Licensed Residential</u>:<br>a. List of staff working presently in the home or with persons receiving services. Auditors will then check the list of staff given by the provider against the SCCMHA training curriculum report in Sentri II data base. Forward list of any termination dates to the SCCMHA Continuing Education Unit for entry into the training data base.<br>b. List of current SCCMHA persons receiving services residing in the home. | 8. SCCMHA Auditors, Provider Network Auditing Supervisor, SCCMHA Network Providers |
| 9. Auditors will export a sample of the events billed by the provider for the specified audit period. For | 9. SCCMHA Provider Network Auditing |

| | |
|---|---|
| events paid by General Fund, auditor will follow up with primary worker to find out the status of Medicaid application for the time period covered for the random sample.<br><br>Some providers, due to the way they bill for services and the number of persons served by the provider, may have a lesser sample of events reviewed for event verification unless errors have been found then additional events will be exported for review. Those providers are:<br>a. Hospital audits - SCCMHA will take 5% of services billed or 40 persons served whichever is less.<br>b. Skill Building - SCCMHA will take 5% of services billed or 20 persons served, whichever is less.<br>c. Outpatient - SCCMHA will have 5% of services billed or 20 persons served, whichever is less.<br>d. Pharmacy - SCCMHA will have 5% of services billed or 100 persons served, whichever is less. | Supervisor SCCMHA Auditors, SCCMHA Financial Intake Specialist |
| 10. Conduct the pre-audit portion of the auditing checklist which includes reviewing of the contract file for:<br>a. Any compliance issues with the provider<br>b. Any accreditations<br>c. Any reports submitted to the Contracts Unit.<br>d. Review Sentri for persons served, Individual Plan of Service, progress notes, and for specialized residential audit; review licensed residential authorization or clinical determination, periodic reviews and addendums.<br>For Licensed Residential:<br>a. Check the MDHHS LARA website to verify license type, effective and expiration dates, facility type, etc. Also, check for the last inspection report and any special investigations that have occurred.<br>b. SCCMHA Quality of Life reports, noting any concerns to follow up during the audit. | 10. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |

| | |
|---|---|
| Check with SCCMHA Office of Recipient Rights for:<br>a. Any issues from SCCMHA Recipient Rights Office.<br>b. Any grievances filed.<br>c. Review Sentri for incident reports filed by the provider. Check for trends and problem areas for the provider.<br><br>Review of audit files for:<br>a. Last year audit and problems noted during last audit for follow up during this audit.<br>b. Any correspondence since last audit. | |
| 11. Call or email the provider the day prior to the audit to confirm time of audit and give provider the specific list of the names for files of persons served needed to perform either the annual audit or the event verification audit (can be two days prior depending on the number of charts the provider needs to have available for review). Individual names can be sent through encrypted email via Sentri II or faxed. | 11. SCCMHA Provider Network Auditing Supervisor SCCMHA Auditors, SCCMHA Network Providers |
| **On Site:**<br>12. Auditor then visits the site where they will sit down with persons/staff/provider involved with the audit and explain the audit process, what is expected of provider during the process and what assistance auditor will need of the provider. This process is called the entrance interview. Ask for a tour of the facility, and complete audit checklist items as well as event verification process (see event verification procedure). | 12. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |
| 13. Sit down with provider prior to leaving the audit to explain strengths of the provider, audit findings, and areas that were lacking. This gives the provider the opportunity to ask questions as well as provide additional information that might have been missed during the audit process. This process is called the exit interview.<br><br>*** Please note: Auditors will accept documents up to the time they leave the premises, unless mutually | 13. SCCMHA Provider Network Auditing Supervisor, SCCMHA Auditors, and SCCMHA Provider Network |

| | |
|---|---|
| agreed upon between the provider and the auditor prior to leaving the premises. | |
| 14. Send Provider Audit/Site Visit/Provider Record Review Questionnaire via email for provider to email back to Auditing Supervisor with the final audit report.<br>Upon request, a postage paid envelope can be provided. | 14. SCCMHA Provider Network Auditing Supervisor, SCCMHA Auditors, and SCCMHA Network Providers |
| **Post Site visit:**<br>15. Audit data is then entered into SCCMHA Sentri II System.<br>a. All audit items will have a brief description of what auditor found or reviewed to obtain the score noted on the audit. Scoring is based on a 2-point scale. The scale is as follows:<br>Score 2 = 95 % or higher<br>Score 1 = 76 % - 94%<br>Score 0 = 75% or less<br>b. If a citation is given a recommendation has to be noted. This recommendation should include how the provider can obtain compliance with the standard and the specific policy/procedure the provider needs to follow for compliance.<br>c. A repeat citation in any area will automatically result in a 0 score, or non-compliance, in that area. This indicates provider has not made the necessary changes to obtain compliance given in the previous audit report. However, if auditor finds the recommendation has been followed, but a new concern arises in that same area, provider will receive the appropriate score based on the above scale.<br>d. Audit Findings will include a basic description of the facility, the location of the facility, and any pre-audit findings. This will also include any areas that were of particular significance either positive or negative findings.<br>e. Provider strengths will include anything auditors feel the provider is doing particularly well that was noted during the audit. These might also be | 15. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |

| | |
|---|---|
| areas that qualify for a Certificate of Excellence to be completed.<br>f. Recommendations will include any additional items not already noted in the database as part of the audit tool. Recommendations will also include any specific policies/procedures that the provider needs to review for compliance standards.<br>g. Event Verification should include number of events reviewed, number of charts of persons served that were reviewed, and number of event discrepancies found in the Annual Audit Report.<br>h. Summary should include due date of corrective action plan and notice to the provider that audit scores will be shared with the SCCMHA Board of Directors and the provider network.<br>i. All proof documents obtained to complete the audit should be scanned in the SCCMHA G drive under the provider file in the appropriate year folder. Auditing no longer maintains paper files. | |
| 16. Event Verification Letter is sent under a separate cover only if there are discrepancies noted during the audit. Information from event verification will be recorded on a separate spread sheet tracking the Event Verification reviews that have been completed. This report is due at the end of the fiscal year for annual reporting. | 16. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |
| 17. If provider audit score is:<br><u>80%- 99%</u> a written corrective action plan is needed.<br><u>70%-79%</u> a written corrective action plan is needed and an onsite follow up audit will occur within 6 months of annual audit date. This will be noted in the audit Summary Report sent to the provider. This audit may be announced or unannounced depending on the nature of the citations from the audit.<br><u>69% or below</u> a written corrective action plan is needed and an onsite follow up audit will occur within 4 months then again within 7 months of annual audit date. This will be noted in the audit Summary Report sent to the provider. These follow up audits may be announced or | 17. SCCMHA Provider Network Auditing Supervisor, SCCMHA Auditors, and SCCMHA Provider Network. |

| | |
|---|---|
| unannounced depending on the nature of the citations from the audit. | |
| 18. Follow-up audits may be scheduled for other reasons as well. If provider has a significant number of repeat citations from last audit. Provider will receive a follow up audit to assure provider has implemented their plan of correction and any cited areas are addressed. If there are significant training problems a follow-up audit may be scheduled. If provider has several multiple year repeat citations (for example a 2nd year citation indicates Provider has been cited initially and then twice after that for same area). | 18. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |
| 19. A report is emailed back to Provider within 30 days of audit completion. Any delay in audit report being sent should be noted in the Audit Findings and provider notified. The audit report will include:<br>a. Audit Report which includes audit narrative and the audit score.<br>b. Trainings Minimum Standard Curriculum Report as listed in the SCCMHA Training Sentri II Data Base.<br>c. Any attachments listed in the report.<br>d. Audit Questionnaire. | 19. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |
| 20. Auditor to enter a date in Sentri II system to request a Corrective Action Plan response from the provider. Sentri II system generates an automatic email notice that is sent to the provider and auditor as a reminder of the Corrective Action Plan due date. Auditor can also make notation in personal tickler file or on personal calendar of when Corrective Action Plan is due back to assure proper follow through by the provider. | 20. SCCMHA Provider Network Auditing Supervisor, SCCMHA Auditors |
| 21. Provider is given a deadline to respond to the audit with a corrective action plan noted in SCCMHA Sentri II System. The deadline is typically within 30 days of the completion of the report. May be longer depending on the volume of deficiencies or a mutually agreed upon date with the auditor. This plan of correction will be submitted electronically in the SCCMHA Sentri II system. | 21. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors, SCCMHA Provider Network |

| | |
|---|---|
| 22. Audit sent date is then entered into the SCCMHA Sentri II system. | 22. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |
| 23. Provider is expected to respond to the audit with a written plan of correction in the SCCMHA Sentri II system by the date indicated on the audit letter. | 23. SCCMHA Provider Network |
| **Appeal:** | |
| 24. Provider has the right to appeal audit results, within 30 days of audit report, by doing the following:<br>a. Send a written letter to SCCMHA Provider Network Auditing Supervisor who will review and respond to the appeal in writing back to the provider.<br>b. If the provider is not satisfied with the decision from this first appeal the provider can make a second appeal to the Director of Network Services and Public Policy.<br>c. If provider wishes to complete a third appeal, then a letter can be sent to the SCCMHA CEO, who may assign a committee to review the appeal. All decisions made at this level are final.<br>d. See Provider Dispute Resolution Policy for further details. | 24. SCCMHA Provider Network, SCCMHA Provider Network Auditing Supervisor, SCCMHA Director of Network Services, Public Policy & Continuing Education, SCCMHA CEO |
| **Corrective Action Plan:** | |
| 25. Once the written corrective action plan is received from the provider, each audit item will be addressed as to whether the corrective action plan submitted is accepted for the item. Any additional suggestions can be made at this time. The assigned auditor approves the acceptable plan and then submits the report to the Provider Network Auditing Supervisor for final approval. An automated notice indicating the corrective action plan has been approved will be sent to the provider via the SCCMHA Sentri II system to the provider's email. | 25. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |
| 26. If a plan of correction is not accepted, the provider will receive an automated email from SCCMHA Sentri system indicating the plan of correction has not been accepted and further response is needed from the provider. This may occur several times until the plan of correction is accepted. | 26. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |

| | |
|---|---|
| 27. If provider does not respond, a follow up phone call, email or letter will be made to the provider. At that point, the auditor and provider will discuss a deadline for a response. If provider needs assistance with the response, the auditor will discuss the concerns with the provider and guide provider through the process. The provider will still need to submit a plan of correction via the SCCMHA Sentri II system. | 27. SCCMHA Provider Network Auditing Supervisor, SCCMHA Auditors, and SCCMHA Network Providers |
| 28. If the provider chooses not to respond to the initial contact then a follow-up phone call will be made. If the provider chooses not to respond to that follow up phone call within two weeks, an additional telephone call will be made along with a certified letter mailed to the provider requesting a response to the corrective action plan within two weeks. If the provider chooses not to respond to the certified letter the provider will receive a written contract noncompliance notice. Notices to provider need to be within 2 months of when the plan of correction is due. | 28. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |
| 29. Auditor will notify Provider Network Auditing Supervisor of lack of response on the part of the provider. Auditor will indicate dates and method (i.e. Email, telephone certified letter) of contacts. Provider Network Auditing Supervisor will in turn notify The Director of Network Services and Public Policy of the need for a contract noncompliance or sanction notice to the provider. | 29. SCCMHA Auditor, Provider Network Auditing Supervisor, and Director of Network Services and Public Policy |
| 30. A contract noncompliance notice is then mailed to the provider with a deadline to respond. | 30. SCCMHA Provider Network Auditing Supervisor and Director of Network Services Public Policy, & Continuing Education. |
| **Ad Hoc Audits:**<br>31. Ad Hoc audits may occur when a concern that comes to the attention of SCCMHA, that may indicate issues of:<br>a. Persons served Care.<br>b. Recipient Right issues. | 31. SCCMHA Provider Network Auditing Supervisor and Director of Network Services, Public Policy, |

| | |
|---|---|
| c. An on-site follow-up is necessary based on prior audit score.<br>d. Business practice concerns.<br>e. Event verification concerns.<br>f. Policy/ Procedure concerns. | & Continuing Education |
| **Termination Audit:** | |
| 32. A provider Termination audit may be completed when a program is being transitioned from one provider to a new provider. This audit is completed prior to the new provider taking over. When applicable, the expectation is that the new provider will respond to the audit to make sure the areas of concern do not continue to happen. Or a termination audit will be completed when a contract ends. | 32. SCCMHA Provider Network Auditing Supervisor and SCCMHA Auditors |
| 33. Audit scores will be published annually to the SCCMHA Board of Directors and the Provider Network to show how providers are doing within the overall SCCMHA Provider Network. | 33. SCCMHA Director of Network Services, Public Policy & Continuing Education |
| 34. At least annually the following items will be reviewed and approved.<br>a. The Audit Process<br>b. Audit Tools<br>c. Audit Triggers<br>d. Provider input<br>e. Input from persons served<br>f. Audit feedback<br>g. Goals for the Provider Network<br>h. Audit Policies/Procedures | 34. SCCMHA Provider Network Auditing Supervisor, SCCMHA Auditors, SCCMHA Director of Network Services, Public Policy & Continuing Education, SCCMHA Service Management Team, and approved by SCCMHA CEO |

Exhibit A

Audit Files and Organization Details if needed. All information is located in the SCCMHA G Drive under Network Services /Auditing folder.

## *Audit Information File*

Section 1: Audit Reports / Data

This section should include:

- Final Audit report
- Final Audit Letter
- Final Audit Score Card
- Audit Preparation List
- Listing of Persons Served Form (Licensed Residential)
- Staff Listing
- Any information that is gathered as proof for the audit obtained during the audit
- Provider's response to Audit Corrective Action Plan is located in Sentri 2
- Auditor's corrective action response to provider plan is located in Sentri 2

Section 2: Correspondence

This section includes (most recent should be on top):

- Any other type of incoming or outgoing correspondence with provider
- Memos to/from providers
- Licensing Reports
- Quality of Life and Advocacy Reports.
- Documentation of correspondence with the provider
- Contract Sanction Letters

Section 3: Pre-Audit Data

This section includes any data relating to the pre-audit preparation process, specifically but not limited to:

- Audit notification letter with enclosures
- Recipient Rights responses/comments
- Case Manager responses/comments (when applicable)
- Any information that is used as proof for the audit obtained prior to the audit such as provider policies, staff schedules or anything that pertains to the pre-audit list.

Section 4: Training Reports

This section includes any training that the provider and/or staff have completed to ensure compliance with the standard requirements for their program, specifically but not limited to:

- Training Curriculum Reports
- Internal Transcripts
- Case Holder Required Trainings (if applicable)
- Children's Treatment and Diagnostic training (if applicable)

Section 5: Credentials
This section should include, specifically but not limited to:

- Credentialing documentation required for staff according to their job title (Degrees, Diploma, Licenses, Certifications, etc.)

Section 6: Policies
This section includes policies and procedures the program operates within per their contract with SCCMHA:

- Providers Policies and Procedures that are used to train staff and serve individuals.

## *Event Verification Folder*

The Event Verification folder includes:

- Notification letter if one sent separate from Annual Audit Notification
- Claims Listing with several tabs labeled as:
    - Total events and persons served pulled (this is the original)
    - Use on audit/Random Sample
    - Discrepancies (if any)
- List of names for persons served that will be reviewed for the event verification (this list is the list sent to provider prior to audit)
- Final Event Verification Letter to Provider
- Be sure to sign event verification document.
- Routing Form completed prior to sending to Finance for any adjustments
- Information from finance about payment or withholding.
- Copies of proof documents from provider for claims billed
    - APPEALS FOLDER (Sub folder in Event Verification folder)
    - Provider 1st level appeal information
    - Provider 2nd level appeal information
    - Provider 3rd level appeal information

Exhibit B

## SCCMHA Provider Audit - Quality Survey Questionnaire

Thank you for your cooperation in Saginaw County Community Mental Health Authority's (SCCMHA) annual audit process. The audit process is required by the Department of Consumer and Industry Services as part of our contract, and by the Michigan Mental Health Code.
We would like to hear your comments on how you feel the audit process went and what we could do to improve our process to make future audits go as efficiently as possible. Please take a few minutes to answer the questions listed below, by marking each question as YES or NO. Thank you for your time, your input is important to us.

1) Did you receive sufficient documentation at the beginning of your audit to prepare you for the overall process? YES ☐ NO ☐
   a. Please list any additional documentation you feel would be beneficial for your audit preparation process: _____

2) Was an overview of the audit process given at the start of your audit?
   YES ☐ NO ☐

3) Do you feel as though you were given sufficient time for preparation throughout the process of your audit?
   YES ☐ NO ☐

4) Were your scheduling needs considered when arranging a date for your audit meeting?
   YES ☐ NO ☐

5) Did the auditor(s) arrive to the scheduled meeting at the agreed upon time?
   YES ☐ NO ☐

6) Was a discussion regarding audit expectations given at the time of your scheduled audit meeting?
   YES ☐ NO ☐

7) Did you find you were given opportunities to ask questions throughout the audit process?
   YES ☐ NO ☐

8) Did you receive sufficient answers to each question asked throughout the process of your audit?
   YES ☐ NO ☐
   a. Would you like someone to reach out to you for assistance regarding any areas you still have questions or concerns? YES ☐ NO ☐

9) Did the auditor(s) do a satisfactory job of explaining areas of concern so that you understood expectations for corrections?

YES ☐ NO ☐

10) Do you feel you received timely responses to your communications throughout the audit process?

YES ☐ NO ☐

11) Did you find the auditing staff to be friendly and courteous during your communications throughout the auditing process, including any emails sent, phone calls made, and during your exit interview?

YES ☐ NO ☐

12) Do you feel your improvements since the last annual audit were recognized within your annual audit/report?

YES ☐ NO ☐

13) Did the overall audit process meet your expectations?

YES ☐ NO ☐

a. Do you have any suggestions for improvement? _____

_____.

14) Are there any changes to the audit process that would help you feel more confident/comfortable in achieving the score you feel you deserve? YES ☐ NO ☐

a. If yes, please list those your suggestions here _____

_____.

15) Were there any areas during the audit that stuck out to you as areas you would like to receive more in-depth training? YES ☐ NO ☐

a. If yes, please list those areas here: _____.

Any additional comments: _____

_____.

Name of Provider (optional): _____

Name of person filling out form (optional): _____

Date of Exit Interview/Meeting: _____

Please return this questionnaire via email to mschaefer@sccmha.org. Thank-you.

AKH 5/5/21 Reviewed 9/2021

Exhibit C

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

## VOLUNTEER / STUDENT-INTERN APPLICATION AND AGREEMENT

A person with a disability or handicap requiring accommodation for completing the application process should notify the Human Resource Office at (989) 797-3472 as soon as possible.

It is the policy of SCCMHA to afford equal opportunity regardless of race, religion, color, national origin, sex, age, marital or familial status, height, weight, disability or handicap.

**PERSONAL INFORMATION**

_____
Date of Application

_____
Name (first, middle, last)

_____
Present Address (street, city, state, zip code)

_____ _____
Home Telephone (or number you can be reached at) Social Security Number

_____ _____
Volunteer/Student-Intern Position Applied For Date Available for Volunteer Assignment

_____ _____
Name of School the Student is Currently Attending Beginning and Ending Dates of Internship

**EDUCATIONAL HISTORY**

| | High School | College | Post Graduate |
|---|---|---|---|
| Circle highest grade completed | 9 10 11 12 | 1 2 3 4 | 5 6 7 8 |

**ADDITIONAL INFORMATION**

1. Are you at least 18 years old? Yes_____ No _____

2. Have you ever been convicted of a felony, which has not been annulled, expunged or sealed by the court? (A "Yes" answer will not automatically disqualify you.)

   Yes _____ No _____ Are there any felony charges pending against you? Yes _____ No _____

   If yes to either question above, please explain conviction: when, where and disposition:

   _____

   _____

   Under what name: _____

G:\Human Resource Department\HR Forms\100-Pre-Employment\HR 101-Volunteer and Student Application
HR 101 (2/04)

**Complete the following only if the position requires a driver's license:**

Drivers license number: _____

Has your driver's license ever been revoked or suspended? Yes _____ No _____

If yes, for what reason: _____

List any moving violations during the last three (3) years: _____

**Please initial next to each to acknowledge having read and understood the statement.**

1. _____ I affirm that the information provided on this application (and accompanying resume and notes, if any) is true and complete. I also agree than any false information, misrepresentations, or omissions – oral or written – may disqualify me from further consideration for the SCCMHA Volunteer/Student Program and may result in dismissal if discovered at a later date.

2. _____ I authorize SCCMHA to investigate all statements contained in this application, including records of any former employers, police departments, and other references or sources concerning me. I authorize all such references and sources (and SCCMHA) to release this information without liability for damage incurred in giving it. I waive any written notice of the release of such records that may be required by state or federal law.

3. _____ I understand that a test for illegal use of drugs may be part of the application process.

4. _____ I understand that any position may be contingent on the satisfactory result of a post-offer medical examination, which may include a test for illegal drugs.

5. _____ I hereby attest that I am presently not using any illegal drugs and/or substances.

6. _____ I understand that as a participant in this program, I am not considered an employee of SCCMHA, and consequently am not entitled to the pay and benefit programs normally associated with being a SCCMHA employee.

7. _____ I understand that SCCMHA will not provide liability insurance to me during this period of being a Volunteer/Student-Intern or indemnify me with respect to professional liability claims arising pursuant to my activities at SCCMHA.

8. _____ I will follow and comply with all applicable policies, rules and regulations.

9. _____ I will keep all data information collected from consumers, families and staff confidential and will use data and information for health care and educational purposes only. I understand that the consumer's record is the property of SCCMHA, and will not take, copy, or divulge the contents of any consumer's record, except in the course of my tasks or function at SCCMHA.

10. _____ I understand that Volunteers/Students will respect the rights of the consumers as documented in the Michigan Mental Health Code P.A. 258 of 1974, as amended.

11. ____ I agree to complete all mandatory training as required by SCCMHA policy.

12. ____ I understand that Volunteers are not to be left alone with consumers under and circumstances nor are they permitted to provide any personal care services to Consumers.

13. ____ I understand that accepting gifts or gratuities for favors or special treatment in providing services is prohibited, unless it is of very nominal value and/or has been determined to have special meaning to the consumer.

14. ____ I understand that SCCMHA may, in its sole discretion, terminate my assignment/internship with SCCMHA at any time in the even I violate SCCMHA policies or conduct myself in an inappropriate manner with a SCCMHA consumer.

Date: _____ Signature: _____

G:\Human Resource Department\HR Forms\100-Pre-Employment\HR 101-Volunteer and Student Application
HR 101 (2/04)

**In Case of Emergency, contact:** _____

Address: _____

Phone: _____

---

**For SCCMHA use only**

This applicant for the SCCMHA Volunteer/Student Internship Program has been approved.

This assignment/internship is to begin on or about _____, and will conclude no later than _____.

During this Volunteer's /Student's time with SCCMHA, he/she will be assigned to the following service unit: _____.

The Volunteer/Student will report to the following supervisor:_____.

The Student's faculty representative is _____, and may be contacted at _____.

G:\Human Resource Department\HR Forms\100-Pre-Employment\HR 101-Volunteer and Student Application
HR 101 (2/04)

Exhibit D

SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

## BACKGROUND CHECK RELEASE FORM

It is required that all student interns and volunteers at Saginaw County Community Mental Health Authority must have a background check. Please complete the information requested below and sign below to release Saginaw County Community Mental Health Authority to obtain information regarding any statements contained on this form and the SCCMHA Student/Volunteer Application. This information may include former employers, police departments or other references or sources concerning you.

_____ _____ _____
Last Name Initial First Name

_____
Date of Birth

_____ _____
Sex Ethnicity

_____ _____
Signature Date

**All information obtained on this form will be kept strictly confidential and will be retained in your student internship/volunteer file in the Human Resource Department at Saginaw County Community Mental Health Authority.**

Exhibit E

| | | |
|---|---|---|
| SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY | **CONFIDENTIALITY AGREEMENT FOR PERSONS SERVED QUALITY IMPROVEMENT** | **Recipient Rights Complaints Appeals** |

## CONFIDENTIAL INFORMATION

Information concerning persons served and their families is confidential. SCCMHA is responsible for safeguarding the confidentiality of this information. Any and all information concerning any person served or their family may only be discussed in the performance of necessary job duties relating to the person served. Confidential information must never be discussed with or disclosed to any other persons without prior authorization.

## CONFIDENTIALITY OF PERSONS SERVED RECORDS

The record of persons served is the property of SCCMHA. All SCCMHA employees, temporary employees, and volunteers have a legal and ethical responsibility to protect the record and the information it contains. Violations of SCCMHA policies or legal precedents relating to the release of any person served information, persons right of privacy, or release of privileged information can result in legal and/or disciplinary action against the individual(s) who violates such policies or legal precedents. Employees will not take, copy, or divulge contents of any record of person's served, except in the course of SCCMHA care of that person served or in the evaluation of a record as it relates to designated individual's duties or functions.

In the event an employee, whose job duties require interaction with a person served records, discovers or reasonably should discover, that they have a potential conflict with a particular record of a person served (e.g., such as a family relationship with that person served), the employee has the obligation to immediately bring such potential conflict to their supervisor's attention. The supervisor will then take such action as necessary to prevent the employee's interaction with the record of that person served.

| | |
|---|---|
| **NAME** | **DATE** |
| **WITNESS** | **DATE** |

Exhibit F

TO: Representative(s) of Persons Served
FROM: Jennifer Keilitz Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services
Date: May 22, 2024
Re: **SCCMHA Provider Audit Participation**

Thank you so much for agreeing to assist SCCMHA with the monitoring of provider services to people served. Your participation will greatly assist us in not only meeting our goal of to have persons served or their families, direct involvement in this process, but will also provide us with the unique perspective that only persons who have been or are direct recipients of services have to offer.

The lead or assigned auditor for the type of audit that you will participate in will schedule a time and day convenient for you, the provider of services and the auditor. It is anticipated that your presence will be needed for several hours. The audit will be conducted at the program site to be audited. The lead auditor will have conducted some preliminary work in preparation for the audit and can familiarize you with the tool to be used in the audit process. If you need special accommodations, such as transportation, just let the auditor know. You will be paid a persons served meeting stipend for your time, simply fill out the form and submit this to the auditor as well.

A portion of the audit you may wish to focus on is the area of involvement as a person receiving services and input. You may wish to inquire of specific persons served, their general satisfaction with the services or provide any feedback to you they wish to provide. Be sure to document this specific feedback on the attached form. We would also appreciate any comments you could provide for our improvement of the process, including the involvement of persons served. Your observations and comments here would be most helpful to SCCMHA in the continual improvement of this process. Since you may be privy to confidential information by being involved in an audit process you need to understand your obligations in keeping any and all information related to persons served confidential; you will also be asked to sign a SCCMHA confidentiality agreement for this purpose. If you have questions at any time do not hesitate to contact me at 989-797-3486. Again, thank you so much for your time and participation.

Representative of Persons Served Name: _____
Lead Auditor Signature: _____
Audit Type: _____ Date of Audit: _____
Name of Provider/Program Site: _____

| | |
|---|---|
| 1. | Feedback obtained from audit site visit, observations, service recipient direct feedback, etc. |
| | |
| 2. | Suggestions for improvement of audit process, input including from the person served/ person served involved in this review. |
| | |
| 3. | Other comments: |
| | |

Exhibit G

## OUR MISSION:

The mission of the Network Services and Public Policy Department of SCCMHA is to develop a sufficient and competent provider network to meet persons served needs; to implement and refine a network management plan and program; to continually educate and train network providers about SCCMHA requirements; to monitor, address, improve and recognize provider performance to ensure quality of services and supports; and to promote consistency and fairness in provider relations.

## WHO ARE WE?

The Network Services & Public Policy Department of SCCMHA is responsible for service provider network monitoring, Designated Coordinating Organizations (DCO's) all contractual and purchased services and SCCMHA provided training. The Auditing Unit conducts annual provider or program audits of all SCCMHA services and programs to ensure that the network meets SCCMHA, MDHHS, and CCBHC standards. Audit outcomes are reported through SCCMHA quality and compliance systems as well as to MSHN, CCBHC and MDHHS. The Continuing Education Unit provides core required training and issues staff training summary reports to supervisors and providers. The Contracts and Properties Management Unit is responsible for the management of service contracts and leases as well as the procurement of provider services to meet persons served and system needs.

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY
500 Hancock Street
Saginaw, Michigan 48602
Phone (989) 797-3400
Fax (989) 498-4219
Network Services Fax

# SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# NETWORK SERVICES & PUBLIC POLICY DEPARTMENT

# PROVIDER NETWORK AUDITING UNIT

## *Persons Served Recruitment*

Bringing all the parts together to build an effective team!

# Network Services Auditing Unit

## *Purpose of this brochure:*

The purpose of this brochure is to give a brief overview of SCCMHA's Auditing Unit, and to seek involvement of persons receiving services in the auditing process.

## *Types of Audits:*

Clubhouse; Community Living Supports; Crisis; Enhanced Health; Licensed Residential; Outpatient; Supports Coordination; Case Management; Skill Building; and Hospital and Quality of Life visits.

## *How can you Help?*

SCCMHA Mission: As the public manager of supports and services for citizens with mental illness, developmental disabilities and chemical dependency and their families, SCCMHA actively strives to develop a system of care and a community that values and embraces the potential and contributions of all individuals with disabilities.
Here at SCCMHA we are aware that all persons served may not be able to perform the same tasks on every audit. We strive to make sure that we are always mindful of the confidentiality of all individuals served when including persons receiving services on audits. It is important to discuss with the lead auditor prior to going on audits your confidence level in performing the tasks. Our mission statement at SCCMHA says it best: **Belief in Potential, a Right to Dream, and an Opportunity to Achieve**. It is your choice and your comfort level that we want to ensure. Depending on your time you can be involved an hour on up to eight hours. We would like to know your time commitment.
The list below is an example of some items that you may feel that you would like to assist with at the audit site. Persons Served are reimbursed for their time.

1. Do a physical plant inspection to see if there are any health and/or safety hazards.
2. Check to make sure there are no full names of any persons served visible in common areas of the facility.
3. Review records of persons served for certain items.
4. Review staff files for certain items.
5. Review goals in the person served IPOS

For Specialized Residential settings:

-Look over activity calendar for persons living in the facility.

-Look over any task lists of items offered to persons living at the facility.

-Check out the emergency evacuation procedure.

-Look through the emergency kit for contact information and emergency supply list.

-Is the License for the home posted, current, what population does the home serve?

- Talk with persons living in the home about the care they receive. Things like outings, food, staff treatment, etc.

-Does the home have a home like atmosphere?

-Does the individual living in the facility have space for their own belongings?

-Do individuals living in the facility have their own personal care items? Razors, toothpaste, deodorant, toothbrushes, shampoo, etc.

*To find out more or ask questions, or submit your Name for involvement please contact:*

***Melynda Schaefer***

***989-797-3491***