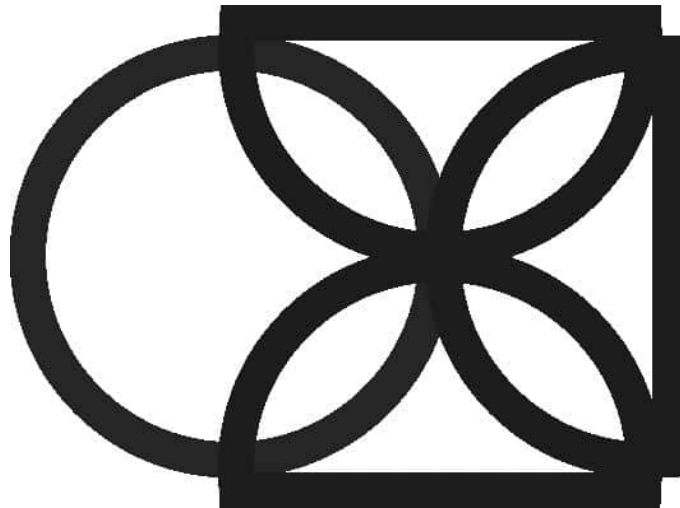


Saginaw County Community Mental Health Authority (SCCMHA)

Network Services Provider Manual



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

Fiscal Year 2026



SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

REPORT

If you know or have a good-faith suspicion that any of the following has occurred,
contact the SCCMHA Compliance Department.

- Fraud or misconduct related to Medicare or Medicaid Services.
- HIPAA Privacy Violations
- HIPAA Security Concerns

Contact:

SCCMHA Hotline

Toll Free: (855) 797-3417 | Local Phone: (989) 797-3574

SCCMHA Compliance Office

500 Hancock Street

Saginaw, MI 48602

AmyLou Douglas

Chief Compliance Officer

HIPAA Security Officer

(989) 797-3506

adouglas@sccmha.org

Michelle Vasquez

Compliance Officer

HIPAA Privacy Officer

(989) 272-7360

michelle.vasquez@sccmha.org

SCCMHA HAS A NO RETALIATION POLICY.

Provider Manual Update - June 2026
Included are the updated policies and procedures since the FY26 January Provider Manual Update

				Licensed Residential/Crisis Residential Enhanced Health Services/Autism (speech, behavioral, ot) Inpatient Crisis/CAI/MU/TT Primary Providers (Supports Coordination/Case Management/Primary/ACT/Autism/ICC- Wraparound/Integrated Care) Community Living Supports/CLS Per Diem/Respite Services Skill Build/Supported Employment/Clubhouse/Drop-In Fiscal Intermediaries/Pharmacy/LEP											
11 Tab 1-Introduction to SCCMHA															
00.01.02	A History of CMH and Genesis of SCCMHA	General Review	11/11/2025	x	x	x	x	x							
01.01.07	Community Needs Assessment	Removed complete list of participants in policy section-added as Exhibit C. Made it Correlate with the MDHHS Community Needs Assessment contractual requirements.	3/10/2026	x	x	x	x	x							
91 Tab 2-Eligibility Care Management															
03.01.01	Eligibility Criteria	Updated Workflow Attachments (Added modifiers for MichiCANS) Added Waiver Summaries as attachments	1/19/2026	x	x	x	x	x							
05.04.02	Member Enrollment Quality Data and Case Service Status.	Date Change	3/10/2026						x						
Tab 3- Services & Protocol-No Updates															
131 Tab 4-Service Delivery															
02.03.09	Evidence-Based Practices (EBP's)	Updated CCHC link in references, updated job title for an individual role, and added Best Practices.	3/16/2026	x	x	x	x	x							
02.03.09.01	Dual Diagnosis Treatment Capacity	Website links updated. Updated exhibits B and C. General review.	2/13/2026	x	x	x	x	x							
02.03.09.01.01	Practice Guidelines	Updated standards H, P, and V. Updated practice guidelines definition, updated a reference, and updated responsibilities.	2/13/2026	x	x	x	x	x							
02.03.09.02	Assertive Community Treatment (ACT)	Updated team leader/program staff requirements, section D-1. Procedure, responsibility 2.	2/13/2026												
02.03.09.03	Supported Employment Services	Deleted redundant reference. General review.	2/13/2026	x	x	x	x	x							
02.03.09.04	Dialectical Behavior Therapy (DBT)	Eliminated referral form, updated a responsibility.	3/16/2026		x	x	x	x							
02.03.09.05	Family Psychoeducation (FPE)	General Review	2/13/2026		x	x	x	x							
02.03.09.06	Parent Management Training-Oregon Model (PMT0)	Added Best Practices Committee	3/16/2026												
02.03.09.08	Intensive Care Coordination with Wraparound (ICCW)	General Review	3/24/2026												
02.03.09.11	Adult Crisis Residential Services	General Review	3/24/2026	x					x	x					
02.03.09.14	Clubhouse	D-4 changed to a recommendation because it is recommended by Clubhouse International but is not a required standard.	2/13/2026	x	x	x	x	x							
02.03.09.15	Peer Support Services	General Review	3/16/2026	x	x	x	x	x							
02.03.09.16	Cognitive Behavior Therapy	Added clarification for supervisor privileging. General review.	2/13/2026		x	x	x	x							
02.03.09.17	Mental Health First Aid (MHFA)	General Review	3/24/2026	x	x	x	x	x							
02.03.09.18	Child-Parent Psychotherapy	Updated link. General Review	3/16/2026						x	x					

02.03.09.19	Infant Mental Health - Home Visiting (IMH-HV)	General Review	3/16/2026					x	x				
02.03.09.22	Picture Exchange Communication System (PECS)	General Review	2/13/2026	x	x			x	x		x	x	
02.03.09.24	Permanent Supportive housing (PSH)	General Review	2/13/2026		x	x		x	x		x		
02.03.09.25	Seeking Safety	Updated standard E, 1 and 2.	2/13/2026						x				
02.03.09.26	Beyond Trauma: A Healing Journey for Women	General Review	2/13/2026						x				
02.03.09.27	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Removed PECFAS/CAFAS	2/13/2026					x	x				
02.03.09.28	Whole Health Action Management (WHAM)	General Review	2/13/2026		x			x	x			x	
02.03.09.29	NADA Auricular Acupuncture Protocol	Deleted redundant reference and deleted inactive reference link. Deleted reviewer who is no longer with SCCMHA.	2/13/2026						x				
02.03.09.30	Motivational Interviewing (MI)	General Review	3/16/2026	x	x	x		x	x		x	x	
02.03.09.31	5 A's (Tobacco use EBP)	General Review	2/13/2026		x			x	x				
02.03.09.37	Cognitive-Behavior Therapy for Hoarding Disorder	General Review	2/13/2026		x			x	x		x	x	
02.03.09.38	Learning About Healthy Living Tobacco and You (LAHL)	General Review	2/13/2026	x	x	x		x	x		x	x	x
02.03.09.39	Teach-Back	General Review	3/24/2026	x	x	x		x	x		x	x	
02.03.09.40	SBIRT-YSBIRT	Updated link. General Review	3/16/2026	x				x	x				
02.03.09.41	Eye Movement Desensitization and Reprocessing (EMDR)	General Review	2/13/2026						x				
02.03.09.42	Mindfulness	General Review	3/16/2026						x				
02.03.09.45	DECIPHER (IDEAL Goals)	New Policy	12/1/2025		x				x				
02.03.14	Trauma-Informed Services and Supports	Updated reference HH, changed TIC Workgroup to Best Practices.	3/16/2026	x	x	x		x	x		x	x	x
02.03.19	Locus	Updated Exhibit B. Changed 2010 LOCUS manual to 2016	3/16/2026					x	x				
02.03.24	Suicide Prevention	General Review	3/16/2026	x	x	x		x	x		x	x	
03.02.06	Person Served Health and Safety	General Review	3/24/2026	x	x	x		x	x		x	x	
03.02.07	Residential Services	General Review	3/24/2026	x	x	x		x	x		x	x	
03.02.14	Advance Directives	Add HIPAA Privacy Officer to Kentera's title. · Remove "It is the policy of SCCMHA to provide written information to all adult persons served who received 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." Simplify the wording into bullet list. · Changed Application section from consumers to persons or people served. · Summarize the Standards to have a "title" next to each listed number to give the reader an idea of what's held in the standard. · Change the definitions to be listed under SCCMHA Policy 08.05.00.01 Compliance Definitions. · Under References – add Attorney General Opinions to clarify where some of the references come from. · Update dates and remove consumer to replace with person served in Exhibit A.	7/8/2025										
03.02.32	Medication Administration Program for Adults	General Review	3/31/2026	x	x	x		x	x		x	x	
03.02.39	Psychiatric Hospitalisation of Consumers w-IDD Children w-Autism	Exhibit A – Health and Safety Regulation	4/25/2025	x				x	x				
04.01.01	Quality Improvement Program	General Review	3/10/2026	x		x			x				

04.01.02	Incident Reporting and Review	General Review	3/10/2026	x	x		x	x	x	x	
597 Tab 5-Regulatory Management & HIPPA Compliance											
08.01.08	Releasing Consumer Information	General Review	3/10/2026	x	x	x	x	x	x	x	x
08.05.14.02	Employee Ed - Employee Training on Privacy and Security Awareness	Added details of Phishing & Security Awareness training Referenced Staff Security Awareness & Phishing Procedure	3/16/2026	x	x	x	x	x	x	x	x
08.06.10.04	HIPPA Security, Device and Media Controls	Added details regarding Mobile Device Management (MDM) Added section on Lost or Stolen Devices Added section on Mobile Device Security Added definitions – MDM and mobile device Added references to MDM procedure, Lost or Stolen Device Procedure, and NIST guidelines Added Exhibit A – Reporting a Lost or Stolen Device for End user reference Added Lost or Stolen Device procedure for end user to Procedure section	3/16/2026								
09.07.01.55	IT IS HelpDesk Support Policy with On-Call	General Review	3/16/2026	x	x	x	x	x	x	x	x
09.08.01.03	Agency Naming Convention Standardization	General Review	3/16/2026	x			x	x			
				x	x	x	x	x	x	x	x
654 Tab 6- Recipient Rights - Customer Service - Appeals & Grievance											
02.01.01	Enrollee Rights and Accommodations	Updated standard G: Restraint or Seclusion. Eliminates Generalities. Brings Clarity. Rights stated before limitations. Trauma Informed. Updated standard I: to address timeliness under 42 CFR. Added standard J: "Accommodation needs shall be communicated across the care team and incorporated into care coordination and treatment planning." To fill a CCBHC specific gap regarding care coordination. Added Standard BB: "SCCMHA will ensure that all applicants and persons served shall receive written and verbal notice of their rights under the Michigan Mental Health Code, including how to access the Office of Recipient Rights and file a complaint." Corrected lettering for standard (I & J were duplicated)	2/10/2026								
				x	x	x	x	x	x	x	x
02.01.02	Customer Service	Updated the Purpose to include "linguistically" appropriate services to better comply with CCBHC, ADA, and other national accessibility standard language. Added Standard 4: "SCCMHA shall ensure that all customers, prospective customers, family members, and community partners have continuous, 24-hour access to Crisis Intervention and Mobile Response Services. Information about these services will be prominently posted on the SCCMHA Website, in public areas of all service sites, and provided in written and electronic formats upon request at no charge." To satisfy the CCBHC Standard for 24/7 access to services. Added Urgent Care Remove Standard 6 as assisting staff with room reservation is an internal process. Removed an after hours appointment for customer service from Standard 9. Updated Standard 9 to include "printed alternative formats" to improve accessibility. Responsibilities: Updates #3 to CS Supervisor Exhibit A: Updated the Customer Service Standard 5 to reflect our warm transfer process. Added the CCBHC Handbook as a reference.	2/10/2026								
				x	x		x	x	x	x	

Tab 1

Introduction to SCCMHA

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: A History of CMH and the Genesis of SCCMHA	Chapter: 00 – Introduction	Subject No: 00.01.02
Effective Date: 8/12/09	Date of Review/Revision: 8/21/09, 6/12/12, 6/4/14, 5/5/16, 6/13/17, 7/28/17, 4/10/18, 5/20/19, 7/13/21, 9/27/22, 11/14/23, 11/12/24, 11/11/25 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: SCCHMA CEO
		Authored By: Barbara Glassheim Additional Reviewers: SCCMHA Management Team

Purpose:

This policy is to memorialize the history of the public mental health system in Michigan and the county of Saginaw.

Policy:

It shall be the policy of SCCMHA to retain information related to its heritage.

Application:

This policy applies to public mental health services in Michigan and the county of Saginaw.

Standards:

The following information shall be made available to all interested parties.

A. State Mental Health Administration

The public mental health and substance abuse system is administered within the Michigan Department of Health and Human Services (MDHHS, formerly known as the Michigan Department of Community Health or MDCH) which is one of twenty (20) departments of state government. The department was created in 1996 by consolidating the Departments of Public Health and Mental Health; the Medical Services Administration, the state's Medicaid agency. The Office of Drug Control Policy and the Office of Services to the Aging were later consolidated with MDCH. In 2015, the Michigan Department of Human Services (MDHS) and the Michigan Department of Community Health merged to become the MDHHS.

MDHHS carries out responsibilities specified in the Michigan Mental Health Code, the Michigan Public Health Code, and administers Medicaid Waivers for people with developmental disabilities, mental illness, serious emotional disturbance, and substance disorders. Public Act 258 of 1974 codified, revised, consolidated, and

classified the laws relating to mental health. The Public Health Code defines the laws for substance abuse treatment.

MDHHS operates three (3) adult state psychiatric hospitals for adults who have mental illness (Caro Center, Kalamazoo Psychiatric Hospital, and Walter Reuther Psychiatric Hospital) and one (1) children's psychiatric center (Hawthorn Center), as well as the state's Center for Forensic Psychiatry and, under a contractual agreement with the Department of Corrections, the Huron Valley Center which is an inpatient program for prisoners.

B. Public Service Delivery System

Three different types of organizations manage and administer Michigan's publicly funded mental health system: Ten (10) Prepaid Inpatient Health Plans (PIHPs), forty six (46) Community Mental Health Services Programs (CMHs), and sixteen (16) Substance Abuse Coordinating Agencies (CAs). In addition, limited outpatient mental health services are available through Medicaid Health Plans (MHPs).

Unlike Qualified Health plans which provide medical care to Medicaid enrollees, CMHSPs/PHIPs are a single-plan eligibility model under the 1915(b) federal Medicaid Waiver. Medicaid beneficiaries do not enroll in a PHIP but are eligible for services if they have a serious mental illness, serious emotional disturbance, developmental disability, or a substance use disorder *and* require the covered benefits and levels of care available through a PHIP.

1. CMH Operations

The Board of a CMHSP is a policy making body which appoints an Executive Director to carry out its policies, make recommendations to the Board, and oversee day-to-day operations. The Executive Director appoints staff to provide services authorized by the Board and funded by the state and county, and to assist in administering the program of services.

The Executive Director and staff, like the Board itself, must conduct business in accordance with all applicable local, state and federal statutes. The primary state statute is the Michigan Mental Health Code and its Administrative Rules. Also applicable are the policies and procedures issued by the Michigan Department of Health and Human Services, the contract between the Michigan Department of Health and Human Services, and the Saginaw County Community Mental Health Authority Board. Finally, funding sources and the overall budget set parameters within which business is conducted.

a. Statutory Powers and Duties of the Board:

- 1) Evaluation of the mental health service needs of the community. Board deems appropriate.
- 2) Providing services to eligible recipients, either directly or via contract.
- 3) Overseeing the evaluation of all funded services to ensure they meet the needs of the community.
- 4) Working to ensure that all mental health services offered in

- the county are coordinated.
- 5) Appointing an Executive Director.
- 6) Establishing policies, the parameters of which dictate the administration of community mental health services by the Executive Director.
- 7) Preparation of an annual plan of services and a budget request for submission and approval by the Michigan Department of Health and Human Services .
- 8) Holding a public hearing on the annual program plan and budget request.
- 9) Securing funding from other sources, such as grants (both public and private), as the Board deems appropriate.

C. History

1. Background

Public responsibility for the care of people with mental illnesses and other mental disabilities was set forth in Michigan more than one hundred (100) years ago in the 1850 Michigan Constitution. The state's first mental health institution, the Kalamazoo Asylum for the Insane, received its first patients in 1859 and by the turn of the century others in Pontiac (Eastern Michigan Asylum for the Insane, August 1, 1878), Traverse City (Northern Michigan Asylum, November 1885), and Newberry (Michigan State Asylum for the Insane, 1895) were opened. These institutions were viewed as examples of enlightened public policy; care for persons with mental illness and mental disabilities had previously been a family responsibility that was sometimes ineffectively fulfilled.

The most recent state constitution (1963) identifies care for persons with mental disabilities as an explicit responsibility of the state as indicated in Article VIII, section 8 which indicates that "institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise handicapped shall always be fostered and supported".

The state system for mental health care that has evolved over the years was designed to meet the needs of two very different populations: persons with intellectual disabilities (which also includes those with autism, cerebral palsy, or epilepsy) and persons with a mental illness (e.g., schizophrenia, manic-depressive disorder, and serious depression), and children with serious emotional disturbances.

The capacity of state institutions grew dramatically during the first half of the previous century. Yet, even as the capacity of these institutions reached its peak, there were forces at work that would diminish their importance. In 1965 the state operated forty one (41) psychiatric hospitals and centers for persons with developmental disabilities. These facilities housed more than seventeen thousand (17,000) individuals with mental illness and over twelve thousand (12,000) with developmental disabilities. In 1991 there

were twenty nine (29) state hospitals and centers with 3,054 residents. By 1997 the populations of state institutions had dropped to approximately eleven hundred (1,100) and three hundred (300) respectively, about a ninety five (95%) percent decline. General Fund/General Purpose appropriations to state institutions declined by approximately sixty (60) percent in real dollar terms. This decline occurred because of court rulings that limited involuntary commitments, dramatic improvements in treatment, and a significant change in social views regarding the treatment of persons with mental illness and developmental disabilities.

Today there are four (4) state-operated psychiatric hospitals for adults with mental illness are (Caro Center, Kalamazoo Psychiatric Hospital, and Walter Reuther Psychiatric Hospital) and one (1) for children/adolescents with serious emotional disturbance (Hawthorn Center). In addition, the Center for Forensic Psychiatry provides diagnostic services to the criminal justice system and psychiatric treatment for criminal defendants adjudicated incompetent to stand trial and/or acquitted by reason of insanity. This state hospital system is reinforced by a large system of private hospital care.

Since the mid-1960s a general consensus has evolved among practitioners and the public that the needs of most mental health persons served best can be met in community programs located as close to a person's served family as possible. This treatment mode, broadly termed community-based care, was incorporated into the Michigan Mental Health Code in 1974 (P.A. 258), with the intent to allow persons to participate more fully in community life. Public Act 258 established the structure for community mental health boards (CMHBs) throughout the state, and paved the way for local government to play an increasingly important role in mental health care.

The deinstitutionalization of persons with mental illness and developmental disabilities has had a profound effect on the structure of the mental health delivery system. The mental health delivery system in Michigan today is characterized by a greatly diminished state hospital system and a growing community system; responsibility has devolved from the state to the local level.

In 1965 there were twelve (12) CMHs covering sixteen (16) counties in the state. Today, there are ten (10) PIHPs and forty six (46) CMHSPs serving Michigan's eighty three (83) counties which are responsible for coordinating the diagnosis and treatment of persons served and supervising the activities of group and adult foster care homes, as well as offering an array of services and supports developed through individual plans of service using a person/family-centered planning approach.

In 1996 all state mental health functions moved into the newly created Michigan Department of Community Health (MDCH). The new department subsumed health-related functions that were previously in the departments of Mental Health and Public Health as well as the Michigan Medicaid program.

Since 1995 Michigan state government has been embarked on a large-scale managed-care program for Medicaid recipients with mental illness and persons with developmental disabilities. In FY 1996–97 the state employed a new funding formula for CMHSPs that uses sophisticated statistical projections to estimate the number of persons with mental illnesses and developmental disabilities, are uninsured, and Medicaid enrollees in each CMHSP catchment area.

2. Public Act 54 of 1963

The Community Mental Health Act (CMHA), signed into law by President John Kennedy in October 1963, provided federal funding for the establishment of community mental health centers. The CMHA appropriated funds for the construction of CMHs based on population health and financial need of states. It was intended to help states “provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor.” Of note, the CMHA provided the impetus for deinstitutionalization.

In 1963 the Michigan Legislature passed Public Act 54 which permitted counties to establish local, community-based mental health outpatient programs funded equally by the state and the county. As noted previously, public mental health services at that time were primarily provided by the state with the bulk of care delivered in large inpatient institutions. In 1960 there were 19,059 adults with mental illness and 11,261 individuals with developmental disabilities residing in these institutions.

The purpose of P.A. 54 was to transform service delivery so that community-based alternatives to state institutions could be provided for individuals with mental illnesses and developmental disabilities. In addition to moving from institutional to community-based care, P.A. 254 offered the decentralization of service delivery decision-making authority from the state to the local county level so that local community mental health boards could plan for the mental health service needs of their immediate communities. So, the locus of care shifted from institutions to community-based providers of care. This shift occurred when it did for three reasons: (1) the advent of psychotropic medications allowed a large number of individuals who previously would have been institutionalized to function independently; (2) the growth of public assistance provided previously indigent individuals with the financial resources to live independently, thus eliminating the “poor house” role of mental institutions; and (3) large institutions came to be viewed as isolating individuals from accustomed surroundings thereby creating an artificial treatment environment and instilling dependence on the institution and further complicating rehabilitation.

The 1963 Michigan Constitution (which was adopted at the very beginning of the rise of community mental health programs) directed the Legislature to support mental health programs with the addition of language that de-

clares not only “institutions”, but also “programs and services” are to be “fostered and supported”.

Act 54 had a significant impact on the transition from institutional care to community based care. Within nine years after the act was adopted, fifty (50) counties with ninety (90%) percent of the state’s population had established CMH programs. State appropriations under Act 54 rose from \$12.7 million in fiscal year 1964-65 to \$39 million in 1975. Under Act 54, state financial support accounted for seventy-five percent (75%) of CMH funding with counties providing a match of twenty-five percent (25%).

3. The Mental Health Code: Public Act 258 of 1974

In 1974, P.A. 54 was repealed and replaced with Michigan P.A. 258, the Mental Health Code. The Michigan Mental Health Code is the basis for Michigan’s publicly funded mental health system. It allows for the creation of CMH agencies in single counties and CMH organizations in two or more counties. P.A. 258 further defined the role of CMHs and increased state matching funds to 90 percent.

The Code provided the following powers for the Department of Mental Health (now the Department of Community Health):

- a. Provide services to individuals, giving priority to the areas of mental illness and developmental disability.
- b. Administer the CMH program, with the objective of shifting primary responsibility for the direct delivery of public mental health services from the state to a CMH program “whenever the Community Mental Health Program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area”.
- c. Engage in mental health needs assessment.
- d. Coordinate and integrate all public services for the purpose of providing a unified system of statewide mental health care.
- e. Evaluate the relevance, quality, effectiveness and efficiency of mental health services provided by the Department of Mental Health and assure the review and evaluation of CMH services.
- f. Establish training and experience standards for executive directors of CMH programs.
- g. Support research activities.
- h. Support training, consultation, and technical assistance for CMH service providers.

A county or combination of counties could elect to establish a CMH program operated under the auspices of a community mental health board consisting of twelve (12) members appointed by the county commissioners for three (3) year overlapping terms. The statute required each CMH board to submit an annual plan and budget to the Department of Mental Health for approval. The required state financing was changed to ninety percent (90%) of the net cost of CMH services as limited by legislative appropriation with

the counties responsible for the remaining ten percent (10%). CMH boards were also authorized to secure private, federal, and other public funds to support their services.

4. CMH/MDCH Contracts: From Full Management to Managed Care

With the rise of community-based care, the primary responsibility for providing that care shifted from the State to the CMHs. This transition occurred in stages. In 1981 the then Michigan Department of Mental Health (MDMH) began offering CMHs “shared management” contracts whereby CMHs shared responsibility with the state for planning and coordinating public mental health services. Shortly thereafter the MDMH began offering “full management” contracts wherein the entire responsibility for providing public mental health services was shifted to the CMHs. This movement began in 1981 with four (4) full management contracts. Full management offered so-called “trade off” dollars to build the local CMH budget because the funds that were used to support individuals in institutions were transferred to the CMH which could then use any savings from persons served who moved into the community at less cost than the state facility rates. The “trade-off” is thus the difference between the state facility per diem rate and the community-based services rate, the latter typically significantly lower thereby generating savings to redirect for local program expansion. Thus, full management resulted in more funding for CMHs, but also the assumption of more responsibility for mental health care and the allocation of state funding for services at state-run hospitals and centers and community-based organizations.

5. The Revised Mental Health Code: Public Act 290 of 1995

During 1995 the first major revision of the state Mental Health Code in more than twenty (20) years was completed. Public Act 290 of 1995, which took effect March 28, 1995, moved the state’s public mental health system even more strongly in the direction of community-based care, set new treatment priorities, specified important new person served rights, and established new accreditation requirements for CMHs. Community Mental Health Programs became Community Mental Health *Services* Programs and could be organized as:

- a. A county CMH *agency* which is an existing community mental health board that does not elect to convert itself into a community mental health organization or authority; or
- b. A CMH *organization* which is a joint enterprise created by two or more counties under P.A. 7 of 1967, the Urban Cooperation Act, that legally separates the entities from the counties that establish it; or
- c. A CMH *authority* which is a legally separate entity from the county or counties that establish it.

The revised Michigan Mental Health Code also authorizes CMHs to carry forward up to five percent (5%) of the state's share of its operating budget from one fiscal year to the next.

6. Managed Care

The next phase in the devolution of responsibility from the state to the local level occurred in fiscal year 1998-1999 when the state implemented a 1915 (b) waiver obtained from the Health Care Financing Administration (HFCA) for managed care for Medicaid enrollees in Michigan. The state carved out most of the mental health benefits and developmental disabilities services to the CMHs from the health plans delivering medical services. The CMHs signed a new kind of contract with the state for this carve out, known as a Managed Specialty Services and Supports contract, and accepted risk-based capitated funding for this managed care program.

7. Public Act 130

In 2000, Public Act 130 amended P.A. 258 to expand the definition of a CMH organization known as a "CMHSP Organization" under the Urban Cooperation Act. CMH organizations could now be formed between one or more counties and an institution of higher education with a medical school. The organization would still be a governmental entity separate from the bodies that formed it. This amendment was put in place specifically to enable the formation of the Washtenaw Community Health Organization.

8. Public Acts 500 and 501

Public Acts 500 and 501 amended P.A. 258 to require that by October, 2014, all Substance Abuse Coordinating Agencies (CAs)¹ will be merged with PIHPs in the state, reducing the number of CAs in the state to ten (10). CAs do not deliver care directly, but rather, plan for and oversee public services for substance use disorders in the counties they serve. Currently many CAs are co-located with Prepaid Inpatient Health Plans (PIHPs), but others may be located at county, city, state agencies, or private entities.

9. Funding

Medicaid is the primary source of most funding for Michigan's publicly funded mental health system, and care at CMHs is an entitled benefit under Medicaid. Services for non-Medicaid covered individuals are covered by state general fund dollars which are allocated to each CMH based on historical funding formulas that are modified at the state's discretion. More recently, changes to the allocations have related to administrative expenses, previous general fund transfers between CMHs (under Public Act 236), and an effort to bring all CMHs to the same level of funding based on county population. Medicaid funds are allocated monthly to each CMH through PIHPs according to the number of Medicaid beneficiaries in the PIHP's ser-

¹ Public Act 368 of 1978 amended the Public Health Code to create Substance Abuse Coordinating Agencies (CAs) in the state.

vice area. General funds have decreased in recent years, resulting in the provision of services to non-Medicaid persons served with the most severe mental illness or developmental disabilities (“priority populations” under the Michigan Mental Health Code) with the exception of emergency cases which are treated immediately regardless of a person’s ability to pay.

D. SCCMHA’s Organizational Milestones

1. Michigan Department of Mental Health prior to CMH:
1942: The Norm Westlund Child Guidance Clinic is established
1953: The Adult Mental Health clinic is established
1963: The Saginaw Regional Consultation Center is established
2. Saginaw County Community Mental Health:
1966:
 - A CMH Board is formed by Saginaw County under Michigan Public Act 54 of 1963
 - Dr. Victor Kershul is appointed Director (and serves from 1966 – 1970)1970:
 - James O’Brien is appointed Director (and serves from 1970 – 1976)1973:
 - Mr. O’Brien writes a grant for a Community Mental Health Center1974:
 - The Michigan Mental Health Code, Public Act 258, becomes effective August 19751975:
 - Saginaw CMH is awarded an HEW grant for the construction of a Mental Health Center at 500 Hancock1976:
 - Fergus Mann is appointed Director (and serves from 1976 – 1983)1977:
 - Work starts on the Community Mental Health Center Building1979:
 - The Saginaw County Mental Health Center building is completed and opens in December1980:
 - Saginaw CMH enters into a Shared Management contract with the then Michigan Department of Mental Health which required a single line item appropriation of local match from Saginaw County

1984:

- Lee Martin is appointed Director (and serves from 1984 – 1986)

1986:

- Don Miller is appointed Director (and serves from 1986 – 2000)

1987:

- Saginaw CMH obtains Medicaid Type 21 Provider Clinic Services enrollment for the provision of outpatient counseling, crisis intervention, day treatment, day program, client services management and other services (Prior to 1987: SCCMHA began participation as a fee-for-service [FFS] Medicaid provider of outpatient services)
- Community Support Services begin

1989:

- Saginaw CMH obtains Medicaid Type 21 Provider Rehabilitation Services Enrollment (for Assertive Community Treatment [ACT], Home-based services, and Clubhouse [PSR – psychosocial rehabilitation])

1990:

- Saginaw CMH enters into a Full Management Contract with Michigan Department of Mental Health wherein Saginaw CMH assumes responsibility for the redirection of state facility funds into community-based care
- SCCMHA begins to operate an after-hours office at Saginaw General to provide crisis prescreening in January

1994:

- Bayside Lodge is established

1995:

- Phase I Managed Mental Health Services begins October 1; Saginaw CMH signs an Earned Contract with MDCH to provide Preadmission Screening and Utilization Management for four levels of acute psychiatric care: psychiatric inpatient, partial hospitalization, crisis residential and crisis stabilization
- Saginaw CMH begins reporting data to the Michigan Mission Based Performance Indicator System

1996:

- Phase II Managed Mental Health Services begins January 1; Saginaw CMH contracts with MDCH for the management of Inpatient Psychiatric, Partial Hospitalization, Crisis Residential and Crisis Stabilization Services
- Saginaw CMH is enrolled as a Medicaid provider for Crisis Residential services in May

- Saginaw CMH signs a partnership agreement in September with the Mid Michigan Community Mental Health Partnership, an affiliation with Bay-Arenac, Midland-Gladwin, Gratiot, Ionia, Newaygo, Montcalm and Central Michigan CMH; this eight-member affiliation prepares for functioning as a regional managed care entity

1997:

- Saginaw CMH submits its response to MDCH's Request for Information (RFI) with Mid-Michigan Community Mental Health Partnership in July (The RFI described planned regional managed care functions based on the combined number of covered lives of member counties)
- Saginaw County signs an enabling resolution in May granting Saginaw CMH status as a Mental Health Authority and SCCMHA assumes responsibility for personnel, labor, investments, purchasing, asset management, risk management and other operations functions

1998:

- SCCMHA adopts the Carver Model of Governance and its Ends Committee begins addressing quality performance in April
- SCCMHA joins the Access Alliance of Michigan (AAM) for purchasing managed care services from Bay-Arenac Community Mental Health (which was chosen as the lead board for fiduciary responsibility of an affiliation that evolved from the Mid-Michigan Community Mental Health Partnership)
- SCCMHA joins the Information System Alliance (ISA) in April, a program of Bay-Arenac Community Mental Health that supported AAM's implementation of CMHC Information Systems
- Assertive Community Treatment (ACT) services are purchased
- The collaboration for integrated healthcare for children begins with co-location of SCCMHA staff at Partners in Pediatrics

1999:

- SCCMHA exits Saginaw County's Information Services and implements the CMHC Information System (October 1998 – July 1999)
- SCCMHA begins to purchase the managed care functions of Access, Authorization, Utilization Management, and Network management from the Access Alliance of Michigan in July

2000:

- The SCCMHA Board hires its current CEO, Sandra M. Lindsey, in June
- SCCMHA hires Health Care Perspective (HCP) Consulting in October to review SCCMHA's information system readiness for managed care

2001:

- SCCMHA's outpatient provider panel is enhanced in January to allow increased choice from three to six providers for adult and child outpatient services
- SCCMHA adds its Towerline location
- The SCCMHA Crisis Center after-hours prescreening unit is relocated to the new Covenant Emergency Care Center in August.

2002:

- Leaving the Access Alliance of Michigan, SCCMHA submits an Application for Participation as a Prepaid Health Plan with MDCH as standalone PIHP in February
- SCCMHA ends its contract with the Access Alliance of Michigan and begins direct operation of Managed Care functions under new organization including Access, Care Management, Compliance, and Network Services during March – April
- MDCH notifies SCCMHA in May that its AFP has been approved with a plan for a first PHP contract in FY 2003
- Clubhouse/Psychosocial Rehabilitation Services are bid during the summer
- SCCMHA signs PIHP and CMHSP contracts with MDCH in October
- SCCMHA hires its first IS (Information Systems) Director in November

2003:

- SCCMHA implements Uniform Billing converting all claims to HCFA 1500 and UB92 formats and HCPC service codes in April
- SCCMHA completes business-to-business testing with MDCH for professional and institutional encounter reporting
- The first annual Everyday Heroes recognition event is held
- The SCCMHA partnership with Advanced Care Pharmacy begins in December

2004:

- SCCMHA begins to work toward the purchase of its own information system for managed care in January
- New SCCMHA Mission and Vision Statements and Core Operating Principles are developed
- A three-year CARF Accreditation of SCCMHA key service program is awarded
- The Electronic Medical Record & Information System is bid out during the summer
- The Quality of Life Committee convenes to address adult foster care quality issues during the summer

2005:

- SCCMHA undergoes its first HSAG External Quality Review in January
- The First Choice of Saginaw Project is initiated during the summer
- An Evidence-Based Practices/System Transformation kick-off is held with the CEO's appointment of an Improving Practices Leadership Team in June
- The Juvenile Justice Partnership with the 10th Circuit Court, Family Division and Saginaw DHS is initiated
- The first DHS Outstation Worker starts working at SCCMHA
- Molitor International Leadership Training Series and Organizational Survey takes place (2005-2006)

2006:

- SCCMHA changes its eligibility criteria for persons with serious mental illness in April
- The Association of Social Work Boards grants Continuing Education (ACE) Provider status to SCCMHA to issue CEUs for licensed social work continuing education programs in June
- The 'Go Live' of the Encompass Electronic Medical Record occurs in October
- An expansion of Adult Case Management Services occurs October
- The CSS Forensic Team is started

2007:

- A comprehensive SCCMHA Strategic Plan is developed
- The Residential Watch Committee is initiated
- A community-wide kick-off event for a children's System of Care is held in April
- The "One In Five" anti-stigma video is produced
- The First Responder Guide is published in September
- The Crisis Residential Program is expanded to include more beds and moves to a barrier-free facility on Hospital Road in September

2008:

- First Choice of Saginaw is granted not-for-profit status in March
- The Community Ties South redesigned Skill Build Program starts in December
- The Salter (housing resource) Center is opened
- The SCCMHA/Saginaw DHS Foster Care mental health assessment project takes place

2009:

- The Community Ties North redesigned Skill Build Program and opening of the new Lamson service starts in January
- Encompass is converted to Sentri, an SCCMHA-dedicated system, in January

- The ARR (Application for Renewal and Recommitment) is submitted to MDCH in June
- SCCMHA is selected to become the Administrative Service Agency for the Tri-County Michigan Prisoner ReEntry Initiative (MPRI) program, now called Prisoner Reentry, for Saginaw, Bay, and Midland counties
- The MSHDA HUD housing unit is transitioned to SCCMHA
- The MDCH SED Waiver startup occurs

2010:

- MPRI (Michigan Prisoner Re-entry) services are initiated
- The Children's Mobile Urgent Treatment Team (MUTT) is initiated
- SCCMHA is awarded a multiyear, multimillion-dollar grant from SAMHSA to create a System of Care for children and families
- SCCMHA issues a five-year report on evidence-based practices milestones achieved in June
- The SED Waiver partnership with DHS is initiated

2011:

- SCCMHA/HDI (Health Delivery, Inc., now Great Lakes Bay Health Centers) co-location services are initiated
- The SCCMHA Central Admissions and Intake (CAI) unit begins operation
- The SCCMHA person served wellness initiative is begin with a person served recovery conference in September

2012:

- The Saginaw Health Plan begins offering a mental health benefit in April
- A Saginaw Mental Health Court is initiated
- A Saginaw Adult Felony Drug Court is initiated
- SCCMHA assumes HUB and Lead Agency/Fiduciary roles for the Saginaw Pathways to Better Health project under the auspices of a 3-year CMS grant-funded initiative called Michigan Pathways to Better Health (MBPH) secured by MPHI (Michigan Public Health Institute)
- The Albert & Woods Professional Development & Business Center is developed with the purchase of the old Germania Country Club to provide offices for SCCMHA's Care Management, Continuing Education, Contracts and Property Management, Human Resources, Finance, and Provider Network Auditing Departments

2013:

- Saginaw Pathways to Better Health launches the Saginaw Community Care HUB on February 4 and accepts its first referral on February 11

- The Albert & Woods Professional Development & Business Center dedication is held on July 30
- A Family Resource Center is developed at the old Merrill Park Recreation Center under the auspices of Saginaw MAX System of Care (SOC)
- SCCMHA joins with 11 other CMHSPs throughout 21 surrounding counties to create a new regional entity, the Mid-State Health Network (MSHN), for contracting with MDCH to manage the Medicaid Specialty Services benefit starting January 1, 2014
- SCCMHA is awarded a three-year CARF accreditation
- SCCMHA initiates direct contracts with substance use disorder prevention and treatment providers and a 2-year local integration transition plan and related contract with TAPS (Saginaw County Substance Abuse Treatment & Prevention Services)

2014:

- SCCMHA is awarded a Michigan Early Childhood Home Visiting (MIECHV) first year implementation grant for Community HUB development
- Phil Grimaldi & Leola Wilson are named to MSHN Board of Directors
- SCCMHA is named as a pilot site for Specialty Health Home development and partners with HDI to serve adults with behavioral health disorders and chronic health conditions
- SCCMHA ends its contract as the fiduciary with MDOC for the Prisoner ReEntry program
- The Salter Housing Resource Center returns to renovated space
- SCCMHA & SOC fund Cultural & Linguistic Competency Training for Community Groups using the California Brief Multicultural Scale and Multicultural Training program in partnership with 10th Circuit Juvenile Court Disproportionate Minority Contact Initiative (Year 3 – Implementation)
- SCCMHA Commences Mental Health First Aid Training
- SCCMHA hosted the Castle Museum, and the Michigan Humanities Council “Great Michigan Read” book – “Annie’s Ghosts: A Journey into a Family Secret” by Steve Luxenberg on January 28
- SCCMHA opens a new wellness and recovery themed Drop-In Center for adults with serious mental illnesses named Friends for Recovery
- Mid-State Health Network, Region 5 PIHP in Michigan, becomes the regional Coordinating Agency for substance use disorder services on October 1
- Child, Youth and Family Services (formerly the Family Services Unit) moves to new space on Bay Road on July 29 along with Wrap-around Services previously located at Towerline
- SCCMHA is awarded a four-year System of Care expansion grant from SAMHSA

- SCCMHA is awarded a PBHCI (primary and behavioral health care integration) grant from SAMHSA and uses funds from the grant to add certified medical assistants to provide screening, monitoring and support to person served self-management of chronic health conditions and play a key role in assisting nurses and physicians in providing “whole health” services to SCCMHA persons served
- SCCMHA names the Saginaw Community Care HUB which now directs Saginaw Pathways to Better Health (SPBH) and Centralized Access Home Visiting (CAHV) HUB
- On October 9 the Saginaw Community Care HUB is one of 3 HUBs in the country awarded certification as part of a Kresge Foundation funded national HUB certification pilot demonstration project during a ceremony at the annual CJA (Communities Joined in Action) conference (held in Detroit)

2015:

- SCCMHA launches a new web site on January 13
- SCCMHA launches an anti-stigma campaign
- The Med Drop Program is initiated
- Weekly meetings between HDI, SCCMHA Health Home, Med Drop Representative and the SCCMHA Medical Director commence in February
- SCCMHA transitions the electronic health record to a meaningful use certified platform through PCE in March
- Use of GeneSight Testing in medication management starts March
- The Zultys phone system (to track call statistics) is put into place in May
- SCCMHA begins providing mental health consultation in school-based settings as partner in the elementary schools with Pathways to Potential programs
- Great Plains accounting software is upgraded in May
- SENTRI II goes live on May 4
- SCCMHA becomes a rotation site for CMU students
- The Central Access and Intake and Crisis Units move to newly renovated space at 500 Hancock on May 12
- SCCMHA Crisis Services moves to newly renovated space at 500 Hancock
- ReQlogic purchasing is upgraded in June
- New Data Warehouse development continues
- The SCCMHA CEO convenes a Saginaw Hoarding Task Force that includes multiple agencies and stakeholders
- SCCMHA is selected by the community for the implementation of a Children’s Health Access Program (CHAP) which is funded by a two-year grant from the Michigan Health Endowment Fund through the Michigan Association of United Ways

- SCCMHA begins active utilization of the MSHN Zenith Data Analytics program and CC360 (to identify at-risk groups as well as at-risk individuals)
- SCCMHA initiates the Healthy Homes program
- SCCMHA implements a co-located SUD screening service under the MSHN Coordinating Agency (using the CareNet system)
- SCCMHA continues to provide leadership in the Saginaw County Health Improvement Plan Behavioral Health Workgroup
- Health Delivery, Inc. (FQHC) opens primary care clinic inside 500 Hancock
- MAX SOC supports initiative of Open Table model with the Saginaw Faith Community
- SCCMHA makes Accountable System of Care submission to MDHHS SIM Project
- SCCMHA is awarded PA-2 funds for the expansion of prevention funding with the Parents as Teachers home visiting model
- The Supported Employment Unit moves to new office space in the Bayside complex
- The Parenting with Love and Limits graduates the first families to participate
- The Open Table Model is implemented to engage the faith-based community
- SCCMHA provides support to assist Saginaw Psychological Services and Disability Network of Mid-Michigan in acquiring newly expanded treatment space on Hemmeter Road
- SCCMHA initiates the Annual Disability Awareness Celebration in Saginaw in October
- SCCMHA implements the SIS to determine the service needs for persons with intellectual and developmental disabilities
- SCCMHA establishes contracts with Centria Healthcare and ABA Pathways to meet the increasing demand for services for children with ASD
- SCCMHA establishes an annual camp for children 18 months to 6 years diagnosed with Autism Spectrum Disorder (ASD)
- SCCMHA provides Applied Behavior Analysis (ABA Services) to over 50 Children on the Autism Spectrum
- SCCMHA holds an event at the Mid-Michigan Children's Museum for families receiving ASD services
- SCCMHA trains first 1,000 people in Mental Health First Aid as of December

2016:

- SCCMHA initiates planning for the inclusion of CHWs (Community Health Workers) in the service array in order to help address medical co-morbidities

- SCCMHA announces the expansion of specialized mental health services to include enhanced outpatient services for adults with moderate levels of mental health conditions
- SCCMHA launches the Saginaw CHAP (Children's Health Access Program)
- CMS funding for Saginaw Pathways to Better Health ends March 31 following a nine-month extension of the original grant
- The Saginaw Community Care HUB begins direct Medicaid health plan contracting to support CHAP and Saginaw Pathways to Better Health CHW services
- SCCMHA begins to address Veteran and Military Culture and Suicide Prevention and Screening training in April
- SCCMHA's anti-stigma campaign (launched in 2015 on MLive) receives an ADDY award as Best of Show for a Public Service Campaign at the Great Lakes Bay Advertising Federation Awards event
- SCCMHA opens the Health Home and Wellness Center, located in newly renovated space on the first floor of Hancock, which includes psychiatry, nursing, and enhanced health services as well as co-located primary health services which also include pharmacy and lab services in May
- SCCMHA launches Better Together Wellness program for SCCMHA employees in July (who can use BT time for participation)
- SCCMHA is awarded CARF 3-year accreditation in August. Health Home accreditation for CARF was received as well
- SCCMHA celebrates its 50th anniversary in October
- SCCMHA begins LOCUS training for the SCCMHA employee network
- SCCMHA learns that its CCBHC application received one of the highest rating possible in October SCCMHA makes a submission to MDHHS for consideration of CCBHC pilot status. SCCMHA submits application for Certified Community Behavioral Health Clinic in August
- SCCMHA begins to address meaningful use (MU) certification requirements for its EHR; participates as AUI (Adopting, Updating and Implementing)
- SCCMHA implements expansion of ASD service benefit to persons up to 21 years of age
- SCCMHA contracts with and offers persons served and staff access to the myStrength™ app
- SCCMHA expands MUTT to serve adults (who have been reviewed and referred through Clinical Risk Committee)
- SCCMHA began development of transitional age youth (TAY services)
- SCCMHA begins the SOGI (sexual orientation gender identity) initiative

2017:

- SCCMHA begins to offer evidence-based treatment for persons with hoarding conditions in January
- The Saginaw Hoarding Task Force website, hosted by SCCMHA, goes live in May
- SCCMHA creates a Facebook page
- SCCMHA implements same day/next day service in CAI
- SCCMHA is selected by the National Council to join the Cancer Control Community Practice (CoP)
- SCCMHA is selected by the National Council to join the Trauma informed initiative community
- MDHHS awards an Adult Block Grant to SCCMHA for client (health) self-management
- MDHHS converts the multicultural categorical funding to Hispanic Behavioral Block Grant
- SCCMHA begins work with residential and non-residential providers to come into compliance with the Home and Community Based Service Rule
- SCCMHA joins with all of the public mental health system to contain privatization efforts described in section 298 of the 2018 state MDHHS budget
- Advance Care Pharmacy is purchased by Genoa Pharmacy and retains SCCMHA contract
- General Fund revenue restrictions necessitate cost containment strategies
- MDHHS provides Race to the Top funding for mental health consultation to child care providers
- MDHHS provides funding for a bilingual therapist in the SCCMHA Centralized Access and Intake (CAI) unit
- The SCCMHA Medical Director role is restructured and the Medical Leadership Role is contracted
- SCCMHA is selected by MDHHS as one of three implementation sites for the state SAMHSA grant submission; Promoting Integration of Primary and Behavioral Health Care (PIPBHC)
- SCCMHA together with West Michigan CMH submits “CCBHC Plus” model to 298 Steering Team. CCBHC Plus builds off the CCBHC federal pilots but adds persons with intellectual and developmental disabilities as well as whole SCCMHA network orientation and involvement not just the board operated program.
- Survey and compliance activity to the Home and Community Based Service Rule for residential and non-residential providers begins
- SCCMHA is selected by Michigan Public Health Institutes as convener of Neonatal Abstinence Project
- Management Team succession planning begins for leadership retirements (Ginny Reed, Dir. Network Services & Public Policy and Delores Ford Heinrich, CFO)

- Discussion regarding the Home and Community Based Services New Rule (which includes person served choice in where to live, who to live with, and increased integration into the community including employment opportunities that include community based and minimum wage) is initiated

2018:

- SCCMHA conducts surveys of persons served with an Habilitation and Supports Waiver as part of its implementation efforts to comply with the Home and Community Based Services New Rule
- SCCMHA is selected as one of three CMHSP 298 pilot sites for financial integration with Medicaid Health Plans and behavioral health/primary care integration
- MDHHS awards a block grant to SCCMHA for that funds the Saginaw Community Care HUB's activities for SCCMHA's treatment of uninsured/underinsured Saginaw County residents with hoarding disorder
- Standardized Inpatient and Fiscal Intermediary contract language and oversight/auditing process is initiated with MSHN
- The Saginaw Community Care HUB is awarded a 2-year recertification in March by the Rockville Institute Pathways Community HUB Certification Program
- SCCMHA begins implementation of the SAMHSA PIPBHC grant awarded to the State of Michigan to improve healthcare integration for adults with SMI and develop integration efforts for children with SED in conjunction with Great Lakes Bay Health Centers as its primary care partner.
- MDHHS designates SCCMHA as the fiduciary for the Region 5 Perinatal Collaborative (RBC) and SCCMHA engages the Michigan Health Information Alliance (MiHIA) as the Region 5's lead to develop a comprehensive collaborative to reduce infant mortality rates in the region by improving prenatal care through access to care, prevention and screening for behavioral health and substance use disorders and improving birth outcomes
- The Michigan Public Health Institute (MPHI), funded through a Michigan Health Endowment Grant, partners with SCCMHA to coalesce Saginaw County stakeholders for the purpose of reducing the incidence of neonatal abstinence syndrome (NAS) that results from infants exposed to opioids during pregnancy
- SCCMHA continues to work toward achieving performance and quality measures that demonstrate the ability to utilize its electronic health record (EHR) to transmit and accept health information as part of efforts to ensure adherence to meaningful use (MU) standards
- SCCMHA successfully passes a Security Risk Assessment performed by MiCETA without any findings or recommendations

- Security management through the Access and Identity Management becomes chartered SCCMHA quality workgroup
- SCCMHA launches the Access and Stabilization for Children (ASC) pilot in June in order provide timely access to treatment services, with an immediate emphasis on stabilizing youth who present with extreme needs, linking them appropriate treatments, and identifying those who are not responding to currently prescribed treatments
- Site reviews of evidence-based treatments for children and youth are initiated to improve fidelity
- SCCMHA, along with SVRC, begins work on restructuring employment options for persons served attending SVRC facility-based and segregated enclaves to move to competitive, integrated employment at minimum wage pay
- SCCMHA establishes a partnership with the County of Saginaw for a Bond Sale to support capital improvements at Hancock and the Albert and Woods Center
- In April MDHHS approves Intensive Crisis Stabilization Services for Saginaw County children ages 0-21 with SED and/or intellectual/developmental disabilities (I/DD), co-occurring disorders (CODs) or substance use disorders
- An operating cash loan for \$5 million is secured from PNC Bank to replace the MSHN cash advance
- SCCMHA and Linda Schneider, Director of Clinical Services, are awarded the Great Lakes Bay Pride Business Partner Award in recognition of the agency's support and services to the SOGI (sexual orientation and gender identity) community in the Great Lake Bay Region on June 26 at the Great lakes Bay Pride LGBT and Ally Awards Banquet held at the Anderson Enrichment Center in Saginaw
- MDHHS block grant funding allows SCCMHA to become a community sponsor for the sixth annual Person's Energy "Light Up the City" event, a summer-long series of neighborhood walks to improve safety and community organization engagement; SCCMHA persons served participate in a "fun walk" in conjunction with the 5K sponsorship provided by SCCMHA
- SCCMHA contracts with a vendor to complete automatic monthly sanction checks for all SCCMHA employees and Network Providers contract signers in addition to the monthly sanction checks of internal staff and external providers that is initiated using the Streamline Verify system
- All SCCMHA contracts now include a Conflict of Interest Statement based on Managed Care Standards to assure that all individuals working in an agency do not have any conflict of interest as it pertains to the use of Medicaid and Medicare funding

- SCCMHA continues to distribute NARCAN® Nasal Spray kits and offer training regarding proper administration of naloxone via nasal spray to individuals suspected of experiencing an opioid overdose
- SCCMHA along with Mid-State Health Network, Perceptions, Saginaw County Community Mental Health Authority and the Saginaw Sexual Orientation Gender Identity Youth Advocacy Council (SOGI YAC) sponsor the first annual LGBTQ Conference titled “Let’s Get Building Together for Quality Mental Health” at the Four Points Sheraton
- Work is initiated to adapt the current Sentri 2 Training Database to meet the needs of the Continuing Education unit and the provider network
- The SCCMHA annual training renewal process is migrated to an on-line option for board operated and contracted staff
- The original Wraparound team is divided into two teams each comprised of one Supervisor and four Wraparound Coordinators to allow for capacity building and to provide additional support and oversight for team members
- SCCMHA begins grouping similar training content so that staff time in training can be maximized and staff need to attend less days to obtain required training
- Two Health Home clinicians, funded by MSHN, are certified in Auricular Acupuncture (AA), an intervention primarily supporting individuals in recovery from a substance use disorder and SCCMHA continues to encourage staff to seek certification in AA
- SCCMHA is awarded a three-year recertification of services by MDHHS (effective through September 29, 2021)
- SCCMHA receives a two-year grant from the Blue Cross Blue Shield of Michigan Foundation to assist with funding for additional trainers and to offset the cost of Mental Health First Aid (MHFA) books for adults and children (YMHFA/Youth Mental Health First Aid) in November
- The number of Habilitation Support Waivers for persons with I/DD increases from 121 to 148

2019:

- At the request of MDHHS, in response to the outbreak in Michigan, SCCMHA conducts surveillance and screening of persons served for Hepatitis A, particularly targeting those who are known to have a history of injection and non-injection drug use, homelessness or transient housing and incarceration
- GENOA’s onsite pharmacy institutes access to immunization for persons served who are identified as high risk for Hepatitis A
- MDHHS renews the Person Served Self-Management block grant for FY 2019 to provide access to education and improve person engagement in self-management of chronic health conditions and which allows SCCMHA to renew its sponsorship with the “Light

Up the City” (a community partnership between the United Way of Saginaw, Michigan State Police and Persons Energy that promotes community members to create a safer community)

- SCCMHA and SVRC cosponsor “Wellness on the Waterfront” at the SVRC Marketplace (as part of the Persons Served Self-Management block grant) in which persons served and their families or caregivers participate in health-related activities, walking events and enjoy a community experience at the Farmer’s Market
- MDHHS renews a block grant that funds the Saginaw Community Care HUB to allow SCCMHA to provide treatment to Saginaw County residents with hoarding disorder lacking adequate insurance coverage to treat the disorder
- Succession planning continues for Leadership retirements (Linda Schneider, Director of Clinical Services and Programs and Linda Tilot, Director of Care Management and Quality Systems)
- The Michigan Department of Health and Human Services (MDHHS) completes its triennial Office of Recipient Rights (ORR) Audit in March resulting in a score of 176 out of 180 possible points (i.e., Substantial Compliance)
- In March SCCMHA purchases an additional parking lot with 45 spaces for Hancock that is expected to be completed by July 1
- The Management Team is restructured with addition of three population-specific directors reporting to the Executive Clinical Director
- Work continues on Home and Community Based Waiver New Rule: providers on heightened scrutiny are reviewed by Mid-State Health Network and providers continue to work on out-of-compliance areas for any persons served on a Habilitation Supports Waiver; surveys are sent to persons served and providers of B3 services for residential, skill building, supported employment and community living supports
- SCCMHA adds additional providers to its current provider network to provide Applied Behavioral Analysis for persons with Autism Spectrum Disorder
- Long time Board Chair, Phil Grimaldi dies in April; Tracey Raquepaw becomes the new Board Chairperson
- The Zultys phone system installation is completed in May
- SCCMHA begins to transition to a “mobile workforce” in May with the assignment of Microsoft Surface tablets to staff members that are configured in accordance with each department’s needs
- SCCMHA Senior Leadership Participates in a Year of Planning for 298 Pilot Implementation with Medicaid Health Plans and MDHHS
- SCCMHA changes procedures and forms in response to changes to Kevin’s Law
- Conducted survey of staff to determine participation in Community Benefit Activities and community collaboration to inform statewide costing work MDHHS with state actuary Milliman, Inc.

2020:

Milestones / Regular Business

- SCCMHA Transportation Department staff and fleet vehicles moves from Towerline to Albert and Woods Center
- SVRC Industries assumes transportation responsibility from SCCMHA for persons served attending their vocational programs
- Space redesign and renovations at Bay Road Children, Youth and Family Services to make space for a third FSU clinical team. Related renovations at Towerline to accommodate Wraparound and TAY staff
- Expansion of TAY Program at FSU.
- Establishment of Coding Benefit & Integrity Workgroup (CBI) to train cross section of staff on billing code interpretation.
- Reorganized front door operations and transition of Front Desk Associates managed by Finance Department to Customer Services
- Milliman Service Cost Data Collection projects begin
- Implemented MCG Parity tool for Acute Services
- PHQ-9, PHQ-9A, Columbia, AUDIT-C, DAST and GAD Screening tools selected and implementation planning begins.
- Implementation of significant changes to HSW, SED, CW and Autism Medicaid Waivers as well as Medicaid State Plan Services
- SCCMHA funded by MDHHS for Juvenile Urgent Response Treatment (JURT) grant to expand Mobile Urgent Treatment Team (MUTT) service for 2 years.
- Clinical staff, supervisors and others receive mobile devices.
- Renovations to Hancock first floor group rooms and rest rooms on 2nd floor commence.
- Consolidated all Board Operated psychiatry and nursing to Hancock Building
- Provider and Person Served Surveys and plans of correction, continue to determine Home and Community Based Services Rule compliance for persons served under the Medicaid b3 Waiver. Heightened Scrutiny Process begins.
- Community Ties North and South implement new program design to achieve compliance with new federal Home and Community Based Service Rule with focus on individualized integrated community experiences.
- SCCMHA Board of Directors/ Ends Committee requests education on all public policies attached to MDHHS and MSHN Contracts.

- MDHHS revises definitions of Qualified Intellectual Disability Professional (QIDP) and Qualified Mental Health Professional (QMHP), SCCMHA in response defines human services professional to include degrees in social work, psychology and sociology in related minimum academic requirements.
- MDHHS/MSU Heightened Scrutiny Reviews for HCBS completed for all residential sites. Final report can take up to a year. HS for Skill Building and Supported Employment Services shut Down due to COVID.
- MDHHS Releases preliminary system redesign change to move system to regional Special Needs Plan (RSNP) on the first quarter but puts the plan on hold due to COVID 19.
- Implementation of year 2 of Michigan Health Endowment Funding of Mental Health First Aid, both adult and youth curricula
- MI Mental Health Code Changes to Protected Health Information Person Served Consent process to promote Care Coordination.
- DSM-5 Transition Completed
- Annual Report for 2019/20 published “Making Our Communities Less Vulnerable” with safety net services and community collaborations as focus.
- SAMHSA awards two-year funding to SCCMHA for Certified Community Behavioral Health Clinic readiness

Other Milestones / Events

- Major Bayside Lodge Renovation begins
- May 18 Catastrophic Dam failures in Edenville and then Sanford cause major flooding in the Greater Midland region. Result for Saginaw is storm surge down river from flooding. SCCMHA told to expect flooding of lower level of Albert and Woods Building in the dawn of May 22. Staff mobilize and move all furniture and equipment to upper floor of A&W Building and with assistance from skilled trade partners reinforce southern building berm and shut down all serves and utilities. Staff move vehicle fleet away from A & W. Flooding of lower level avoided by mere inches of storm surge held back by berm reinforcement.
- SCCMHA Board supports *Social Justice and Mental Health - A Statement of Affirmation* on June 8th, in response to George Floyd death and social justice protests against police.
- Planning for SCCMHA Fleet Vehicle Replacement Commences

- Planning and consulting work commences for natural gas generator at Hancock Building to keep agency systems running during power outage

County Bond Funded Capitol Projects

- Permanent Repair to southern berm outside Albert and Woods Center
- New tablets for 54 contracted group homes located in Saginaw County to promote telehealth connections
- 7 Vehicles (vans/truck)
- Lamson Building Roof
- Hospital Road Roof Canopy
- A&W Berm repair
- Bayside Apartment Bathroom
- Albert & Woods Building Fencing for Securing Agency Vehicles
- Group Home Patio Furniture Replacement
- New Hancock parking lot to west of building Does this belong in FY 2019
- Albert and Woods Roof and Balcony replacement
- Replacement of Hancock WIFI Locksets on doors
- Badge Reader and Security Upgrades at all SCCMHA Buildings (Is this a dup of item 6?)
- CTN & CTS HVAC Replacements
- WIFI Controller Upgrades to all buildings
- New Vehicle Replacement to fleet (2- 14 passenger vans with lifts, 4- mini-vans, 1 maintenance truck) Note: All buses were planned for auction. Does this belong in 2021?
- 100 new tablets to support mobile workforce

COVID-19 Pandemic

- Personal Protective Equipment (PPE) Purchasing begins March 4th in anticipation of COVID-19 infections in Michigan
- First COVID-19 Executive Orders Issued by Governor Whitmer:
 - o March 10 Governor Declares COVID-19 State of Emergency
 - o March 12 Michigan schools closed for 3 weeks
 - o April 2 Michigan schools close for rest of school year
 - o March 24 First Stay Home Stay Safe Order issued (Numerous other COVID-19 Executive Orders and later Pandemic Orders issued)

- March 13 all SCCMHA Buildings closed to visitors and Emergency Management Team Activated (Note: the EMT met 44 times in 2020)
- All CMHSP Services including SCCMHA deemed “Essential” by MDHHS
- Week of March 20, all SCCMHA Buildings except Hancock close, staff sent home to work remotely where ever possible over Stay Home Stay Safe Order.
- 40% of staff worked remotely during Stay A Home/Stay Safe Executive Orders (Remote and Remote Essential status), 21% of staff classified as Essential workers remained on site at Hancock and Albert and Woods Center to address needs of persons served, staff and the organization. 38% of work force from CTN, CTS, Transportation staff, some peers and some support staff were placed on Paid Furlough and regrettably then placed on layoff as programs could still not as pandemic continued and in-person services could not resume.
- March 26, 2020, MDHHS Commences weekly COVID Meetings virtually with PIHP and CMHSP CEOs.
- At Hancock, Crisis Staff, Health Home, CAI and Select Administration Functions Remain Open.
- All needed pharmacy prescriptions renewals extended electronically
- Communication, infection surveillance and support of network begins
- Masking Mandate, Hygiene Procedures and daily Staff COVID-19 Symptom Screening begins.
- Custodial staff sanitize all closed building and begin new COVID sanitation procedures at Hancock.
- SCCMHA Staff FAQ postings at SCCMHA Website and ADP Commence
- Facilities leadership begin planning for hard building controls. All conference rooms and PC labs closed. Signage controls and prompts for sanitation and furniture and workspace changes made for social distancing.
- Most all standing SCCMHA staff committees initially suspended
- COVID public messaging on SCCMHA Operations in Response to COVID-19 begins
- All network group services close and clinical contracted teams move to telephonic and then telehealth modalities.
- GLBHC temporarily suspends Primary Care Clinic at Hancock
- Genoa Pharmacy remains on Site at Hancock and Med-Drop program scaled back

- SCCMHA Board begins to meet on April 2 remotely under relaxed COVID-19 Open Meetings Act provisions.
- A series of Executive Orders extends flexibility of Open Meetings Act to Allow all public governing bodies to meet virtually through the end of the year. SCCMHA begins and continues Telephonic meetings for the rest of the year and Citizen's Advisory Council does the same.
- SCCMHA Board approves changes to FMLA Policy and established new COVID-19 Sick Bank for staff effective thru 12-31-20 at the April meeting.
- SCCMHA IT rolls out Skype to support virtual meetings and Doxy.me application installed to support clinical staff with telehealth platform
- Tent and later wooden hut set up outside Hancock front door for person served medication injections.
- PPE Procurement continues for SCCMHA staff and network providers, first delivery from State PPE Stockpile arrives in June and then additional shipments in August and September. PPE Supply chain stabilizes later that summer.
- 4/13/20 SCCMHA COVID-19 Residential Contingency Planning commences to include back up staff for Residential Network and alternative care site at CTN for COVID positive staff (alternative site ultimately not opened)
- \$2.00/hour premium pay + 12% admin increase established for direct care staff working in residential settings 4/1/20-2/28/20. Then \$2.25/hour +12% admin increase extended 3/1/21-9/30/21 (plus supported employment codes). 2020 best estimate of Provider Stabilization payment totals executed in provider rate adjustments for the year total \$649,680
- Provider Stabilization Payments and other financial supports to network providers totaled \$649,680. Payments covered reimbursement for staff overtime for residential providers, PPE and other commodities, hotel rooms for asymptomatic COVID positive staff to support residential staffing adequacy and financial assistance to address reductions in financial billing for other providers.
- MDHHS issues Telephonic and Telehealth Billing Codes in March
- MDHHS issues directive that no Medicaid beneficiaries will be disenrolled over the course of the COVID-19 Pandemic
- Person Served COVID Illness Tracking Commences / MONTI COVID Application installed in Sentri II.

- All Summer Respite Camp Planning Cancelled
- SCCMHA Transportation commence assistance to persons served for groceries when public transportation shuts down.
- In the month of March, 31 MH Activity Aids, 19 Vehicle Operators 6 Peers, 4 support staff and one Transportation Supervisor were placed on paid Furlough and then in May laid off indefinitely as a result of the closure of group programs, in-person office care and general inability to perform work remotely.
- Staff recalls of Mental Health Activity Aids began in August for Day Programs (CTN / CTS) in virtual modalities.
- Continuing Education Department
 - Pivots from In Person to Virtual Zoom Trainings 6-24-21
 - Obtains Sanitation Cabinets to sanitize CPR Mannequins to minimize COVID Transmissions- July 2020
 - Application to ACE the certification provider for CEUs for Social Work, to allow CEUs for virtual trainings
- SCCMHA Auditing Department moves to virtual audits of providers.
- SCCMHA Buildings reopened for staff the starting the week of June 1st on staggered schedules thru July 9th with new COVID safety procedures implemented including office pace arrangements to ensure social distancing; closed lunch rooms, conference rooms and waiting rooms. Significant IT Support needed to bring staff members back into the office as all applications needed to be updated. Telehealth contacts continued from worksite with home visiting appointments scheduled for urgent needs of persons served.
- SCCMHA Moves to Extended Hours in November for all Board Operated programs
- The following documents were developed to direct management of staff activity during the pandemic informed by guidance from the Centers for Disease Control (CDC), Michigan Department of Health and Human Services (MDHHS), Saginaw Public Health Department (SPHD) and Michigan Office of Safety and Health Administration (MIOSHA) included:

Published COVID Plans and Policies:

- *SCCMHA COVID-19 Return to Work & Re-opening Plan*
- *Essential Behavioral Health Services Directive: When to Provide in Person Care*
- *SCCMHA COVID-19 Safety and Re-engagement Policy*
- *SCCMHA Teleworking -Working Remote Policy*

- o *SCCMHA COVID-19 Physical Environmental Preparedness Plan*

Staff Guidance Documents:

- o *COVID-19 Return to Work Safely: Welcome Back to Our Buildings*
- o *COVID-19 Return to Work Safely: Information Technology Guide*
- o *COVID-19 Return to Work Safely: Human Resource Guide*
- o *COVID-19 Return to Work Safely: Buildings Facilities Safety Guide*
- o *COVID-19 Return to Work Safely: Text & Email Notification System*
- o (See Emergency Management Team Minutes for the 44 meetings over the timeframe of the pandemic through the end of FY 2020)
- Provider stabilization investment in contracted network of \$913,102 to offset negative financial impact greater than or equal to 10% less revenue than 5 months prior to COVID period/ net of federal PPP & CARES ACT COVID relief. This investment also supported staff OT, PPE and food/supplies delivery to group homes.

2021: (COVID-19 Pandemic Continues as do all 2020 Safety Measures)

- Expert Paul Elam, PhD, contracted to develop Diversity, Equity and Inclusion (DEI) Organizational Climate Assessment in concert with CEO and cross functional staff DEI Team.
- Formation of a new Business Intelligence Governance Committee.
- Restructuring of 13 staff's job descriptions, roles, responsibilities and team membership within the Information Technology, Information Systems and Quality Departments to support Business Intelligence
- Development of iPad systems to increase persons served access to telehealth – DME authorizations, TECH/TECH+, iPads for Group homes
- Increased Information Security Measures: MFA/DUO, KnowBe4 Awareness Training, Email encryption, Barracuda, MS Security Essentials, MSMS
- Saginaw granted status as MDHHS CCBHC Demonstration site as Michigan becomes CCBHC Expansion State. Readiness activities and pre-certification activities begin. Transition from SAMHSA CCBHC Expansion to MDHHS Demo begins.
- MDHHS / Milliman eliminates the MUNC (Medicaid Utilization and Net Cost) Report and introduce the EQI (Encounter Quality Initiative) report
- Hancock Elevators are modernized/rebuilt

- Person Served IT Pilot implemented to loan iPads to persons without access to technology
- Local match dispute with Saginaw County arises
- Third Party Billing EDI switched from Netwerkes to Tri-Zetto
- Legislative Direct Care Wage increase continues (\$2.25 hourly Premium Pay)
- Staffing Crisis begins, particularly hard hit are masters level clinical staff positions in Children's Services and after hours shifts at CIS & MRSS, Nurses, Case Managers. Non-licensed MH techs and Aids at CTS and CTN and transportation and custodial staff.
- Gun violence and overdose suicide attempts prompt the issuance of free gun locks and locking medication bags, no questions asked at CIS, MRSS and other network and community locations.
- \$1,000 Retention payments were provided to all SCCMHA Staff and Provider Network staff working in points of service located in Saginaw County
- Provider Stabilization Payments made to Contracted Provider Network agencies for unusual expenses (PPE, Overtime, 1st shift additional staffing due to day program closures, etc.) not included in the service rates. Total Network Investment of \$2.9 Million.
- Capital Improvements to SCCMHA Facilities of \$661,750 including complete renovation of Bayside Lodge Building, 5 group home bathroom remodels, 4 kitchen remodels, 3 new covered back porches, several driveway repairs, exterior and interior painting, washtubs converted to mop sinks, 7 sites received new garage storage built-ins, 3 sites received new flooring, 31 in-county group homes received 31 fireproof smoker urns. (After two AFC fires, permanently positioned smoking receptacles provided for all in-county homes.)
- AFC homes received equipment upgrades such as kitchen tables, patio tables and other outdoor amenities
- Crisis Connect iPad project for connections between law enforcement agencies and CIS and MRSS initiated through MDHHS MHBG and implementation planning and "use case" development begins
- MDHHS MICAL Platform goes live for processing CMHSP Certifications and for tracking person served complaints and disputes
- Received at MDHHS, PIHP and legislative levels.
- SAMHSA recognizes preliminary MDHHS CCBHC Demo certification in December for Expansion Grant.
- SCCMHA decides not to apply for second CCBHC expansion grant (largely a staffing grant) due to staff shortages and recruitment challenges.
- MDHHS adds new Mediation Service Contractor for interface with PIHPs and CMHSPs for person served dispute resolution.

- SCCMHA offers online trainings to accommodate remote training options to promote access
- SCCMHA PIPBHC Grant funds AZARA Platform development for data sharing between SCCMHA and GLBHCs.
- Through a grant from MDHHS, SCCMHA hires a Veteran and Military Families Navigator
- Expanded Fiscal Intermediary Services to include GT Independence as second provider.
- MRSS Hours of Service Expand to 8:00 a.m. – 10:00 p.m. including, Saturdays and Sundays.
- At MDHHS Request, the Infant and Early Childhood Mental Health Consultation grant was expanded to include Home Visitor Consultation.
- SCCMHA Added two new Assessors to the Autism Provider Network to meet increased demand for eligibility determinations.
- New ABA Provider added to network
- Game Changer, an ABA provider develops first center-based respite program that includes community outings for youth and young adults on the Autism Spectrum.
- Improved lighting for the Towerline parking lot.
- Curb Side Pick Up for Genoa Pharmacy
- Added exterior upgraded security cameras at Albert & Woods Professional Building
- Added a Security Guards:
 - Towerline in the Customer Service Office at—from 6:45 a.m. to 7:30 p.m. M-Th and 6:45 a.m. to 6:30 p.m. F
 - Bay Road from 3:00 p.m. to 7:30 p.m. M-Th and 3:00 p.m. to 6:30 p.m. F
 - Extended Hours for Security Guards for Hancock due to extended hours for the Mobile Response Stabilization Service (MRSS) Team, to work until 10:00 p.m. M-F in the CAI area as well as 4:30 p.m. to 10:00 p.m. Sa-Su and holidays
- Upgraded alarms for:
 - Albert & Woods Professional Building
 - Bay Road
 - Towerline
 - Community Ties North
 - Supported Employment
- Badge Readers Installed Badge Readers on Main Entry at:
 - Hancock
 - Supported Employment
 - Housing Resource Center
- Customer Service staff took over scanning of clinical documents:
 - Hancock

- o Bay Road
 - o Towerline
- DEI Organizational Climate Assessment Complete and Published – Fall 2021
- Established DEI Staff Workgroup – Summer 2021

2022: (COVID-19 Pandemic Continues/ Staff Shortages Continue)

- ⌚ SCCMHA Hires two new Senior Leaders; Jan Histed, Dir. of Finance and Jen Kreiner, Chief of Health Services
- ⌚ DEI Contract with Paul Elam, PhD. renewed for development of DEI Implementation - 3 Year Plan
- Formation of a new BI – Data Integrity Committee.
- Implementation of the AZARA care coordination application. CMHs & FQHCs are able to identify their shared patients to provide a higher level of whole health care.
- CrisisConnect rolled out to Saginaw City Police Department patrols. Program connects law enforcement officers with MRSS staff via an iPad when responding to behavioral health calls for communication with the law enforcement and persons served at the scene.
- MDHHS fully Certifies SCCMHA as CCBHC Demo Site on April 29, 2022
- Increased Information Security Measures: Intune, Defender, 2021 NIST compliance, PhishEr, Secure Text messaging
- Improved Technology Infrastructure: Azure File Sync, Team Dynamix, Inventory Management platform, Installation of Fiber at all agency buildings, Dictation software
- Redesigned the SCCMHA website and updated the content. This redesign improves navigation within the site as well as updates the design to be more in line with current industry standards.
- SCCMHA Relaxes COVID Masking Mandate and Front Door Symptom Check-in procedures on 5-13-22 for visitors to all SCCMHA Buildings except CTN & CTS. Electronic Staff Self-Monitoring for symptoms daily continues.
- Outside Lighting Enhancements at Towerline and Hancock completed.
- New and Updates Building Security Alarms completed for Community Ties North, Towerline, Hancock, Housing Resource Center, Supported Employment, Albert and Woods Center and Bay Road.
- Hancock elevators equipped with elevator badge readers.
- Open Beds Platform launched by MDHHS for hospitals and psychiatric units to enter inpatient bed availability.

- Planning for Third Party Commercial Billing activities outsourced to Yeo & Yeo Medical Billing Division with “go live” in 10/1/23.
- Legislative Direct Care Wage increase continues at \$2.35 hourly Premium Pay. SCCMHA offers additional \$2 hourly for in-county specialized residential programs operating in congregate settings
- Provider Stabilization payments continue for unusual expenses (PPE, Overtime, 1st shift additional staffing due to day program closures, working in residential setting during COVID+ episode, etc.) not included in the service rates
- MSHN rolled out a Staffing Crisis Stabilization Application with 13 category options for reimbursement to assist Network Service Providers
- Retention payments provided to all SCCMHA Staff and regionally assigned Provider Network staff. \$750 May, \$1000 September
- Contracts Dept goes paperless implementing DocuSign electronic contracts management and electronic signature software
- Operations department / BU created shifting contracts, claims processing, purchasing, care mgmt., properties mgmt. under the oversight of new Chief of Network Business Operations position.
- Replacement Plan for 9 agency vehicles at a cost of \$475,630 completed and order for purchase placed. Supply chain challenges likely to delay delivery until FY 2023.
- Billing, claims, person served insurance, pre-authorization modules within Sentri updated by SCCMHA COB workgroup/PCE
- MDHHS announces due to staffing shortages – changes to State Facility Admissions Policy to exclude persons with IDD if their clinical presentation does not include a psychiatric diagnosis and that severe behavioral challenges will no longer be cause for admission. Persons with mental health diagnosis awaiting competency evaluations in local jails and those already in the forensic process are considered admission priorities.
- SAMHSA Extend MDHHS CCBHC Demonstration Period Out to 2027
- CCBHC DCO Agreements signed with TTI for ACT, Bayside Lodge Clubhouse and Friends for Recovery Drop-In.
- SCCMHA CCBHC Personalized Benefit Pathway Design Project Completes first project year including Core Tools Matrix, Episode of Care Framework and Service Recommendations for FY 2023 implementation. Core Tools Matrix Tools (all CCBHC required screening and assessment tools) added to Sentri in alignment with clinical workflows for 2023.
- CCBHC Expansion Grant closeout completed with SAMHSA.
- Purchase planning of new building security cameras and system with 2023 installation target at Hancock and A & W Buildings.

- SCCMHA Crisis Phone Line connects to MDHHS MiCAL which connects to new 988 Federal Telephone Exchange for Crisis Behavioral Health Telephone and Text service.
- Added Speech therapist to SCCMHA Enhanced Health Services.
- SCCMHA adds a Benefit to Work Coach to Supported Employment Team.
- TTI's ACT Team receives a grant to help stabilize staff and allow for some additional incentives for overtime and coverage to persons served.
- Attendant Care and Game Changers McLeod location closed. New ABA Providers: BF Autism, Autism of America and T.R.A.C. were added to network and Autism Systems, Game Changer, and ABA Pathways expanded to additional location.
- Community Ties Day Programs North & South transitioned from virtual only service to both virtual and in-person service.
- SCCMHA has first MiFast Review in September for Individual Placement Services (IPS) EBP Model.
- SCCMHA expands ABA Network of providers to meet referral demand.
- Added badge readers to the Hancock elevators to allow secure use of the Hancock Group Rooms, # 190 and # 191.
- Improved lighting for the Hancock main parking lot.
- Achieved Full Compliance with the MDHHS ORR Triennial Audit.
- Initiated Provider's ability to take ORR Training on-line
- Added web based security cameras to Community Ties North for testing
- Expansion of Medical Director hours and psychiatry coverage through contractor Hospital Psychiatry 8/15/22.
- Added Security Guard to monitor and float between:
 - Albert & Woods Professional Building
 - Supported Employment
 - Housing Resource Center
 - Bay Road
 - Community Ties North
 - Towerline
- Added badge readers to the Hancock elevators to allow secure use of the Hancock Group Rooms, # 190 and # 191.
- Improved lighting for the Hancock main parking lot.
- Added web based security cameras to Community Ties North for testing
- Added Security Guard to monitor and float between:
 - Albert & Woods Professional Building
 - Supported Employment

- o Housing Resource Center
- o Bay Road
- o Community Ties North
- o Towerline
- Added front door and medication room badge readers at CTS (started on 9/14/22)
- Achieved Full Compliance with the MDHHS ORR Triennial Audit in March, 2022
- Initiated Provider's ability to take ORR Training on-line
- Walk A Mile Rally – 25 attendees
- Customer Service Week Celebration – Gift to staff and go to each building to celebrate
- Attended numerous public events 17 activities, examples:
 - o Farmer's Market
 - o Men's Health Fair
 - o Friday Night Live
 - o Great Lakes Collaborative
- Celebrated Pride Month:
 - o Prepared Board Resolution for Pride Month and read at the SCCMHA Board Meeting
 - o Passing out rainbow-colored masks, stickers, and bracelets

2023: (COVID-19 Pandemic Conditions End / Staff Shortages Continue)

- SCCMHA prepares and implements the Public Health Emergency Unwind tasks that start May 12, 2023.
- PHE ended 5/12/23 resulting in changes to Telemedicine coding
- MDHHS establishes new 1915(i)SPA Benefit with requirement for enrollment by 9/30/23. 2023 SCCMHA ISPA enrollment was 539
- Persons Served.

Staffing Crisis Stabilization

- MSHN extends Staffing Crisis Stabilization Application processes for 1st half & second half of FY23 with 13 category options for reimbursement to assist Network Service Providers.
- Direct Care Wage increase continues at \$2.35 hourly Premium Pay. SCCMHA offers additional \$2 hourly for in-county specialized residential programs operating in congregate settings.
- Provider Stabilization payments for unusual staffing expenses due to the pandemic will come to a close on September 30, 2023. These costs are not included in the service rates.

Training & Continuing Education

- SCCMHA trained two staff to be Applied Suicide Intervention Skill Trainers (ASIST) trainers.

- SCCMHA supports trained Mental Health First Aid trainer for Veterans.
- SCCMHA Training unit provides direct care training as face-to-face full time to increase adult learning.

Health Home and Clinic Operations:

- Behavioral Health Home Launched 4-1-23. SCCMHA became one of 3 new CMHSP sites for the MSHN Regional Expansion of Behavioral Health Home (BHH). Year 1 enrollment was 112
- Transfer of SPSI adult psychiatry (Prescriber/RN) services caseload to SCCMHA Hancock OP Clinic effective 4/3/23.
- New Logo. Brochure and Branding

Quality

- Quality Program Redesign launches
- Data Driven-Quality Improvement Program (DD-QIP) – “Operationalizing Metric Report & Dashboard Analysis, Governance & Annual Reporting”. SCCMHA designed and established a new Data Driven Quality Improvement Program. This program utilizes the agency’s metric reports/dashboards for analysis by the applicable workgroups to develop Quality Improvement Plans which are governed by Executive level Teams and accountable to the Quality Governance Committee. These plans will be reported out in the Annual Quality Report & Plan.

Information Technology

- Improved the Information Technology Network by upgrading the main firewall, automating device enrollment, upgrading Supported Employment and CTS from VPN to fiber, and migrating web filtering from Barracuda to Fortigate.
- Added additional Information Security Safeguards such as implementing a change management process, detection of high-risk users and forcing high risk users to change their passwords, and migration from McAfee to Windows Defender.
- Advanced the utilization of technology for additional EHR developments. These include rolling out Behavioral Health Home (BHH), Certified Community Behavioral Health Clinic (CCBHC) and Care Connect 360 integration, revised assessment and document locations to better align with clinician practices and streamline processes, and billing for provider network.
- Redesigned the SCCMHA website and updated the content. This redesign improves navigation within the site as well as updates the design to be more in line with current industry standards.

- Rolled out the CrisisConnect program. This included providing law enforcement with both iPads and iPhones to contact Crisis Services for consultations and potential virtual interventions. Law Enforcement officers have the option to call the dedicated Law Enforcement line or call into a DOXY virtual waiting room.

Finance and Billing Changes:

- Process begins of assuring current staff are registered in various databases for YEO & YEO to complete Medical Billing on behalf of SCCMHA and SCCMH Network Credentialing Expands
- Third Party Commercial Billing activity went on-line in November 2022 with Yeo and Yeo Medical Billing Division. This on-line interface started out slowly but is currently working effectively
- New Insurance Coding & Compliance Position Added to Finance Department
- CCBHC Sliding Fee Scale is developed based upon Federal Poverty Levels (FPL) and implementation plan development underway, replacing the State Mental Health code Ability to Pay rules for CCBHC persons served without Medicaid. Implementation date was 7/1/23
- New Standards Cost Allocation Reporting commences
- New CBHC Cost Reporting commences
- CFO Transition Completed
- Rehman Oversight of SCCMH Financial Oversight Ends and Rehman is engaged in scaled back consulting Contract.
- Last mortgage payments to Chase Bank totaling \$61,443.05 for seven group homes (Gera, St. Charles, Riverfront, Rambo, Geddes, CRTP, Liberty-Bridgeport and Lamson) were made on 7/31/23
- Through the CCBHC Demonstration Year 1 (YF22) program, we were able to generate \$709,411 of supplemental revenue surplus to be redirected to Local funds for future year spending for services for Non-Medicaid, Un-Insured or Under-Insured persons served.

Network Changes

- Two current ABA providers, ABA Pathways and Mercy Plus, add additional sites to persons served.
- Added an additional Self Determination Coordinator for a total of four to serve increased demands of SD arrangements.
- CCBHC-DCOs are implemented for external primary team providers 10/1/22, supported employment 5/1/23, skill building 5/1/23, and respite staffing agencies 7/1/23.

- Added additional Fiscal Intermediary, GT Independence, to Self Determination Services
- Contracts completed with innovaTel and Array Service providers to provide two master's level clinicians (therapist) for 16 hours of outpatient clinical services a week. These contracts were developed to support CCBHC outpatient therapy needs and specifically serve those with mild to moderate needs.

Customer Services Activities:

- Walk A Mile Rally – 25 attendees
- Customer Service Week Celebration – Gift to staff and go to each building to celebrate
- Attended numerous public events 17 activities, examples:
 - Farmer's Market
 - Men's Health Fair
 - Friday Night Live
 - Great Lakes Collaborative
- Celebrated Pride Month:
 - Prepared Board Resolution for Pride Month and read at the SCCMHA Board Meeting
 - Passing out rainbow colored masks, stickers, and bracelets

Succession Planning for ORR, Customer Services and Security & Compliance

- In anticipation of Tim Ninemire's Retirement in October 2023, the functions in his chain of command reorganized with new positions
- Established new Compliance and ORR Officer Position
- Established new ORR Supervisor Position
- Established new Dir. of Environmental Services, Customer Services and Security position title with subordinate reports that include:
 - New Security Coordinator Position
 - CS Supervisor
 - New Facilities Supervisor

CEO Office & SCCMHA Board

- New *Our Services* Publication Developed
- Commenced Implementation of DEI 3-Yr Plan
- Diversity and Workforce Development Position Developed to Advance DEI
- Public Relations Position Developed
- Welcomed new Board members Cheri Long and Kathleen Schachman
- Sandra Lindsey Received *Heart of the City Award*

CCBHC and Other Clinical Operation Changes:

- CCBHC Year 2 continued to build out service capacity and compliance with standards
- CCBHC Condensed Site visit on 5/31/23 with CAP Submitted on 8/17/23
- Great MSHN Full Quality Assurance Review on 7/18/23 – 7/19/23 with CAP to be submitted by 9/7/23
- Administrative Coordinator – Support Coordination and Self Determination position developed and hired to meet the needs of the growth of the Self Determination Program and to assist with Waiver Management.
- Clinical screening tools added to the SENTRI electronic medical record to assist with monitoring and reporting CCBHC required measures.
 - GAD 7 - General Anxiety Disorder 7
 - DAST 10 – Drug Abuse Screening Test 10
 - AUDIT -C – Alcohol Use Disorders Identification Test - Concise
 - C-SSRS - Columbia-Suicide Severity Rating Scale
- SCCMHA develops committee to begin Zero Suicide Implementation (EBP)
- SCCMHA request for check box to be added to the electronic medical record to monitor the utilization of Screening, Brief Intervention and Referral to Treatment (SBIRT)
- CCBHC Enrollment at year end totaled 4999
- Submitted to MDHHS for Court 2 MRSS Funding w/ Approved Submission
- All teams are conducting and documenting SCCMHA Interdisciplinary Treatment Team meetings.
- CTS & CTN transition to in-person service only
- Hired a new Board Operated psychologist.
- Developed Behavior Intervention Coordinator position.
- Developed full-time Mental Health Activity Aide positions (4), three have been hired (2 CTN & 1 CTS)
- Supported Employment achieved “Recognized IPS program” status, per State of Michigan, as a result of State IPS Fidelity review (October 2022).
- Supported Employment became fully staffed with the hiring of a Certified Peer Support Specialist. (October 2022)
- Supported Employment Program facility remodel completed Jan. 2023
- On October 1, 2022, SCCMHA joined in the “one point of entry” initiative with other community agencies that provide service to the homeless population in Saginaw County.

- January 25, 2023, Housing Resource Center Staff in its entirety participated in the Annual PIT Count. (Community counting of sheltered and unsheltered individuals in the community).
- The Path Outreach Worker/Veteran Specialist completed the SOAR training in March of 2023 and has successfully submitted several SOAR applications to SSA.
- May of 2023, the Housing Resource Center began to assist in breaking barriers to services for individuals in shelters. Path Outreach Worker/Veteran Specialist position is now completing eligibility screens in the shelters for individuals seeking mental health services.
- In August 2023, Enhanced Health Services (EHS) department moves from Towerline to Housing Resource Center (HRC) Salter Place site.

Facility Improvements and Capital Projects:

- CSS Break room was renovated.
- New Security Cameras and Software (Hancock & Germania buildings) to be purchased using County bond dollars. RFP concluded with vendor bid award August 2023, installation to be concluded October 2023.
- Currently awaiting delivery of 9 new vehicles from Ford Motor Company; re-ordering 2024 Vehicle models as SCCMHA order did not make it into Ford's 2023 production line.
- Hancock generator installation which was set for Fall of 2023 pushed back due to Caterpillar manufacturer equipment delays. ETA undetermined.
- Modifications were made to HRC Building for Enhanced Health to move to this location

Human Resources and Staff Support:

- Implemented signing bonuses of \$3000, \$6000, and \$10,000 for clinical and other hard to recruit staff.
- Brought back the *American Society of Employers (ASE)* training of two modules...Principles and Practices of Supervision 1 and 2 for sixteen (16) new managers.
- Retention payments provided to all eligible SCCMHA Staff were in a separate payroll dated April 13, 2023, at a total cost of \$240,225.11. A second retention payment on September 29 for the last 6 months of the fiscal year totaled \$514,761.64.
- Established new DEI Questions to be used for new candidate interviews
- SCCMHA Rain Jackets with logo for all staff

DEI Implementation Plan

- DEI Implementation Plan Update to SCCMHA Board – May 2023
- Developed and delivered training to SCCMHA supervisors and directors on how to have DEI conversations with staff
- Provided all Supervisors with resource to assist with DEI conversations titled: *Diversity, Equity and Inclusion – Strategies for Facilitating Conversations on Race*
- Developed new DEI Page to SCCMHA Website under About Us tab
- Began training of staff charged with policy development and review in use of Equity Impact Assessment (EIA)
- Developed new Diversity Workforce Development Officer position with target hire date in Oct 2024
- Developed Standard DEI questions for all levels of new hire candidate interviews, commencing in Qtr 1 2024

2024:

Clinical Services and Program

- October 2023 – Supported Employment Department restarted the SCCMHA Vending Program after a 3-year covid-induced hiatus
- November 2023 – Behavior Intervention Coordinator hired to support the Behavior Services Team
- November 2023 - Self Determination Team hired Administrative Coordinator due to the increase in support needs
- November 2023 - A fourth Self Determination Coordinator added to the team to meet increase needs of persons served
- November 2023 - SCCMHA Autism Program created a position / hired an internal Autism Eligibility Determination Evaluator (LMSW) to complete Autism Evaluations
- 2023 / 2024 – Seventeen new self-determination cases began for the fiscal year – Total SD Cases for the year totals 234
- 2023 / 2024 – Two new Board Op Support Coordination positions added to address the growing number of persons served which is currently 707
- January 2024 – HUD Grant renewal approved with an 11% increase.
- February 2024 -Mobile Response and Stabilization Services fully staffed and available 24 hours a day, 7 days a week, 365 days a year.
- April 2024 – Saginaw SCCMHA chosen as one of the expansion sites for the development of an Early Childhood Court (Baby Court) with partner Saginaw Family Court of the 10th Circuit.
- May 2024 – Early Childhood Court Coordinator hired.
- June 2024 – Started using an IPS Workflow/Module in Sentri. An IPS-specific EHR documentation workflow.
- July 2024 – Applied for and Award Advocates and Leaders for Police and Community Trust (ALPACT) Mission Forward Grant Funded through The Michigan Department of Civil Rights. Funds

Supported 4 “Connect, Protect and Serve Lunches for Persons Served and law enforcement.

- August 2024 – New Director of Services for Persons with MI and SUD hired.
- August 2024 – Saginaw CMHA receives full certification as a CCBHC for the 2025 Fiscal Year.
- September 2024 – All staff serving children and youth begin the MichiCANS Training.
- Spanish language versions of select SCCMHA brochures completed and made available at CAI, Customer Services and clinical departments.

Training & Continuing Education

- SCCMHA engaged MPHI to assist with the development of Diversity Equity and Inclusion (DEI) ELearning training modular for new staff training and refresher training.
- Initiated discussions and competitive procurement about bringing anew electronic Learning Management System (LMS) product to SCCMHA to streamline training processes. Current system not meant to be a training system. We hope the new system will allow providers to pull their own reports and sign staff up for training without the need for Continuing Education to touch all aspects of the training process. SCCMHA chose ABSORB as our new LMS. Work will be begin 10/1/2024 to start transitioning current files to new LMS. Training for continuing education staff will also start 10/1/2024.

Health Home and Psychiatric Clinic Operations:

- Redesigned clinic workflow for efficiency and efficacy
- Updated physical space in clinic to improve workflow
- Integrated RNs into all specialized residential settings with the goal to improve health outcomes.
- RNs assumed responsibility for Medication Training of CLS Staff in Saginaw based Specialized Residential Settings
- Community Health Worker Training commenced for Medical Assistants
- Partnered with Iris Telehealth to secure child/adolescent psychiatric providers.
- Partnered with CMU College of Medicine Child and Adolescent Fellowship program to embed fellows in the outpatient psychiatric clinic in the Health Home.

Quality

- Redesigned the Quality Improvement Program

Information Technology & Information Security

- Network Upgrades.
 - Upgraded network switches.
 - Enhanced firewall protection.
 - Setup auto-device enrollment.
 - VPN upgrades.
- Security Safeguards
 - Established a formal change management process.
 - Implemented high-risk user detection mechanisms.
 - Deployed Microsoft Defender.
 - Enhanced the web filter systems.
 - Conducted an external penetration test.
 - Joined the Health-ISAC network.
 - Leveraged the Security Functionality of MS 365 Security & Purview
 - Implemented Intune Device Management
- Equipment Expansion
 - Provisioned new mobile devices to 80% of clinical staff
 - Upgraded 90 workstations from Surface Pros to Dell Laptops
 - Installed cell boosters at A&W
 - Provided Medical Cart workstations equipped with a laptop, a monitor, a phone and medical equipment for Health Home services.
- Mobile Devices
 - Migrated from Verizon mobile devices to AT&T devices on the FirstNet Network

Information Systems & Business Intelligence

- Electronic Health Record (EHR) system
 - Behavioral Health Homes (BHH) buildout
 - Certified Community Behavioral Health Clinics (CCBHC) buildout
 - Expanded CareConnect 360 functionalities.
 - Added a new Supported Employment Module
 - Added a C-SSRS assessment and integrated it with existing assessments.
 - Restructured Security Roles and Groups for Role-based Security
 - Improved MRSS screenings
 - Completed the rollout of Automatic Appointment Reminders.
 - Overhauled the Taxi Voucher system
 - Implemented EVV (Electronic Visit Verification)

- Website Redesign – Completed a page-by-page review, revision and overhaul of the existing website. Focused on improved user experience, accessibility, and information dissemination.
- CrisisConnect - Expanded the CrisisConnect program to include the Sheriff's Office and Township Police.
- New Software Solutions
 - AlertMedia – Facility alert system
 - Absorb - Learning Management System
 - TDX - Maintenance Ticket System
 - TigerConnect - Secure text messaging
- Data Warehouse Upgrade
 - Upgraded SQL Server Environment
 - Began moving data from On Prem server to AZURE Data Factory
 - Developed a new data warehouse environment
 - Recreated and Optimized the SSIS ETL processes
 - Began developing a PowerBI Dashboard delivery model.
- Developed a Knowledge Base environment within TeamDynamix and a dedicated Microsoft Teams channel which provides staff with access to IT resources and information.
- Expanded the use of Power Automate, Power Apps, and Power BI

Finance and Billing Changes:

- The Billing Module within Sentri was updated to reflect the correct billing process for CCBHC-DCO agencies, COB insurance policies and private pay persons served.
- CCBHC Demonstration Year 3 (FY24) program ended, we had 5,017 persons served receive services though out the year.
- CCBHC Demonstration Year 2 (FY23) program ended, we were able to generate \$1,586,713 of supplemental revenue surplus to be redirected to local funds for services for non-Medicaid, Un-insured and Under Insured persons served.
- At the end of FY24 we had two grant agreements that came to a close. They were the Enhanced Utilization of Health Information Technology (Azara) Grant in the amount of \$35,500 and the Infant & Early Childhood Mental Health Consultation-In Home Visiting Grant in the amount of \$29,887.
- In FY24 the Finance Department started the process of finding a replacement for our agency's financial software package, as our current software Great Plains is no longer being supported.
- Medicaid Redeterminations, after the end of the COVID Pandemic, of persons served were supported to maintain their Medicaid, The Entitlements Office supported on average, 46.33 persons per month. Because we are funded by sub-capitated Medicaid our efforts to help persons served maintain Medicaid enrollment, kept SCCMHA in a

positive Medicaid financial position, as compared to other CMH's within the State.

- The Entitlements Office added two new positions with new hires Entitlements Coordinator and Typist Clerk – Entitlements.
- A new Entitlements Suite was renovated at the Hancock building – lower level, from an area within the Information Technology (IT) Department office space. This will put all of the Entitlements positions in the same location so as to create a cohesive team.
- Cost sharing with SCCMHA on vehicle replacement was offered to contracted providers. 11 providers participated (repairs/upgrades/new) representing 52 vehicles at 50/50 cost sharing up to \$7,500 per vehicle at a total expense to SCCMHA of \$76,326.

Network Changes and Operations

- Implementation of following FY24 CCBHC-DCO agreements:
 - o 11/1/23- Westlund Guidance Clinic School-Based Therapy
 - o 11/17/23- Saginaw Psychological SUD Outpatient
 - o 1/22/24- McDowell Arts Mild-to-Moderate (M2M)
 - o 5/22/24- Saginaw Psychological SUD- MAT (substance use disorder-Medication Assisted Treatment)
 - o 7/1/24- Grounded Therapy Recreation/Music/Art
 - o 9/7/24 - Guided Grace Music Therapy.
- SCCMHA expanded our contract with Aprecotts, to hire a BCBA to review ABA plans and develop medical necessity and efficacy within our ABA network of providers. This position also involved some education of administrative staff at SCCMHA.
- Centria terminated their Applied Behavioral Analysis (ABA) contract with SCCMHA May 2024. All persons transitioned to other providers within SCCMHA ABA network.
- Together with Friends and Bethesda AFC have changed ownership from Able Light corporately located out of state to Wellspring located in Saginaw County as of August 1, 2024.
- Faith and Family ended their SCCMHA contract for CLS services and persons served were transferred to other providers.
- A 60-day contract termination notice was received from Samaritas for CLS and Respite services with termination in November 2024. Persons served will be given a choice of other providers.
- Offered shared expense opportunity to contracted provider for new vehicles for person transports for residential and day services providers.
- Implemented Legislatively Appropriated DCW increases from \$2.35/hr. to \$3.20/hr and 12% Admin. Wage increase of \$.75 was added on top of provider hourly base pay.
- Contracted with video producer to create short videos of eleven ABA provider sites, Community Ties, Supported Employment and

Enhanced Health Services and all videos were posted to the Our Services section of the SCCMHA website.

Customer Services and Security Activities:

- Completed Taxi Voucher process and policy overhaul aiming to reduce late cancellations and no-shows.
- Deployed Alert Media emergency communication software to enhance 8-1-1 system communications.
- Implementation of a concierge guard position at the 500 Hancock location.
- Rewrite of *SCCMHA Appeals and Grievance Brochure*

Succession Planning for ORR, Customer Services and Security & Compliance

- Successfully separated the ORR functions from Customer Service and Security as part of succession planning efforts.

CCBHC and Other Clinical Operation Changes:

- Received re-certification for CCBHC status in 2025
- Started process of evidence-based practice for Zero Suicide.
- Embedded screening tools into the electronic health record such as Columbia suicide screening (C-SSRS), Social Determinants of Health screening tool.
- Worked on workflows for Substance Use disorder and worked to see how we could get persons into services faster.

Facility Improvements and Capital Projects:

- Installation of Hancock Building Natural Gas Generator – 4/13/24 startup
- Construction of HR Suite Expansion & Transportation Supervisor Office – June 2024
- Genoa Pharmacy funded remodel, extended hours, and leased space reduction – 5/28/24
- Procurement/Delivery of 11 new SCCMHA commercial vehicles
- A&W Marquee Sign replacement with illumination
- Procurement of A&W air-cooled chiller replacement – 5/13/24

Human Resources and Staff Support:

- Remodeled the HR office area in order to create additional office space for two additional staff
- Continue a very heavy focus on recruitment with additional resources invested in radio, recruitment firms, along with the continued use of new hire signing bonuses of \$3000, \$6000, and \$10,000 resulting in the hiring and filling of 48 positions in FY 24
- Current employees were recognized for their contributions with retention bonus payments at year-end of \$3,000 for full time staff and

\$1,500 for part time staff prorated for the number of payroll periods worked in FY 2024. Total cost of \$775,442.31.

DEI Implementation Plan

- Implemented the newly developed (late FY23) DEI questions for all employment interviews
- Development of Diversity, Equity and Inclusion (DEI 101) ELearning *Training Module rolled out to all providers in network.*
- Development of new DEI Logo
- Development of Staff Demographic Data Tracking Reports
- Implemented Supervisor and Director Training on Facilitating DEI Conversations
- Began Plan Development to Improve Organizational DEI Culture with Staff Celebrations of Diversity
- Established DEI Email Box Address for staff questions/suggestions
- Established regular staff broadcast Communication on DEI activity

2025:

Finance and Billing Changes:

- Provider incentives came to an end along with the Covid Grants. As many of the pandemic issues are still in existence (staffing challenges) funding is no longer available to help the providers return to pre-pandemic operations.
- At the end of FY25, we had four grant agreements that came to a close. They were 1) MI Kids Now Mobile Reponse II in the amount of \$200,000, 2) Adult Mental Health COVID Supplemental Services \$18,000 3) Children's Mental Health COVID Supplemental Services \$3,500 and 4) Behavioral Health Workforce Stabilization Support \$68,000 for a total reduced funding level of \$289,500.
- CCBHC Demonstration Year 4 (FY25) program ended as of 9/30/25. We had persons served of 5,802, which was an increase of 788 persons served from the previous fiscal year. Due to an unfavorable PPS-1 Rate of \$324.70, we experienced a deficit of (\$7,471,112) in which CCBHC Expenditures exceeded CCBHC Revenue. Fund Balance was used to cover this deficit.
- In late FY25, Finance A/R / Billing staff have resumed responsibility for credentialing clinical staff with third-party payers. This function had previously been contracted out; however, due to delays and the critical nature of the task, Finance has begun addressing the backlog of clinical staff requiring credentialing.
- Finance A/R / Billing staff began preparing for the October 1, 2025 launch of CCBHC Direct Pay, focusing on completing the required

Sentri set-up and developing the internal procedures needed for this new process.

- Finance continued to work with PCE to enhance the Sentri Billing Module, focusing on streamlining the billing process by automating certain steps.
- Finance staff initiated a process to monitor unsigned notes to reduce the time necessary to bill and receive payments.

Clinical Services and Programs:

- Increase in Behavioral Treatment Plans reviewed by SCCMHA BTC: FY 2024 was 34 & FY 2025 is 42
- 279 Self Determination Arrangements
-
- Fully implemented the Supported Employment Sentri module/workflow.
- Worked with IS to get an automatically generated report of the data from the Sentri SE Module for state reporting and Network dissemination.
- Worked with APPRECOTS to get a report correlating clinical outcomes with Supported Employment outcomes.
- Increased Supported Employment outcomes by almost 15% (with two weeks left to go in the FY).
- Improved the Supported IPS Fidelity Score at annual certification review by 8 points.
- Contract implemented with the Saginaw City Police to address the SUD and Mental Health needs of individuals with police contact in the community.
- Connect, Protect & Serve Lunch Grant Funded by the Michigan Department of Civil Rights provided a collaboration between the Saginaw City Police Department and Saginaw CMHA to support activities which promote trust and relationships between law enforcement and those served by Saginaw CMHA. Five events were held with different participants with the Transition Age Youth, Bayside Lodge, CTN, CTS and Friends for Recovery.
- Law enforcement presentation “Building a Partnership between Law Enforcement and Community Mental Health” by various Saginaw CMHA staff. There were 184 Officers, 20 civilians, chiefs from 5 different departments and Undersheriff Gomez attend the training.
- Utilization of updated Petition for Inpatient Treatment.
- Mobile Response and Stabilization Services and Crisis Intervention team share the responsibility of answering 24- hour phone lines. Referral from 988 and 211 directed to this line.
- New Early Childhood Court Coordinator hired. Quarterly meetings are held with the State of Michigan, DHHS and the Juvenile Court

System to prepare for the first participants of New Early Childhood Court.

- Completion of the CSS work area update, providing more meeting space for in-office visits.
- Completion of the new outpatient therapy unit work area, providing individual therapy offices.
- Development and utilization of Power BI Dashboards to assist supervisors and staff with monitoring home visits, productivity and timeliness.

CEO Office & SCCMHA Board

- Welcomed new Board member Susan McCauley, Jaime Huffman and Jacob Kern

Training Unit:

- Initiated contract with and started implementation of new learning management system (LMS) called ABSORB® with training on how to use the new system starting in July.
- Two staff trained as trainers in ASIST training for Zero Suicide evidence-based practice.
- Two staff trained as trainers in ASMR training for Zero Suicide evidence-based practice.

Facility Improvements and Capital Projects:

- Movable wall installed between medium and small training rooms at A & W to allow for larger training and meeting spaces.
- Completion of remodel of Community Support Services suite on second floor of 500 Hancock Building – Completion June 2025
- Creation of individual therapy suite on first floor of 500 Hancock Building – Completion August 2025
- Security Camera system upgrades CTS, CTN, Hancock, Bayside Properties (Clubhouse, Drop-In Center, Bayside Apartments, Housing Resource Center)

Network Changes and Operations

- Disability Network of Mid-Michigan terminated their Supports Coordination contract as of 12/31/2024.
- Initiated contract with Child and Family Services of Saginaw as a DCO to provide therapy for persons with mild to moderate needs.
- Acorn Health of Michigan LLC terminated their contract for Applied Behavioral Analysis Services as of 10/12/2025.

Customer Services and Security Activities:

- Added Transportation Liaison serves as the key point of contact to assist person served with learning how to schedule transportation with their Medicaid Health plan
- Installed a lockdown button at Towerline, enhancing safety and security against outside threats.
- Expanded camera coverage to Salter Place, Supported Employment, CTN, and CTS, strengthening overall monitoring and protection.
- Walk A Mile Rally – 41 attendees: Promoted program advocacy and raised awareness of the PIHP procurement process.
- Customer Service Week Celebration – Nearly 400 gifts of appreciation were distributed by persons served, allowing them to thank employees face-to-face. A new, safer badge holder was also introduced through the Security QIP Committee and included in the gift bag.

Custodial and Transportation:

- Fleet and Transportation Updates: Added 4 new Ford Transits, including the first vehicle assigned to Crisis Intervention Services, and 4 Chrysler Pacifica's. Created and filled the Lead Vehicle Operator position.
- Facilities and Safety Enhancements: Implemented a fungi and bed bug prevention program, partnered with a new custodial uniform and nameplate vendor, and reconfigured MRSS.
- Construction and Staff Coordination: Successfully managed staff relocation during CSS and Therapy Suite construction.
- Committee Engagement: Custodial and transportation staff participated in the Wellness Committee and Quality Improvement Safety Committee.

Quality & Compliance:

- Operationalization of the Quality Improvement Program Committees

Information Technology & Information Security:

- Network Upgrades
 - Upgraded the UPS Power System at Hancock
 - Expanded network infrastructure at Bay Road with the installation of a new IT Server room with racks, switches and networking.
- Security Safeguards
 - Implemented Smart Print technology.
 - Contracted with Rehmann to conduct a Security Risk Assessment.
 - Completed remediation on External Vulnerabilities and Penetration Test assessments by Rehmann.

- o Completed remediation on Infrastructure, Licensing and Microsoft 365 assessments by Rehmann.
 - o Developed process for external users to obtain MS365 guest accounts for access to Teams meetings, channels, and folders.
- Equipment Expansion
 - o Upgraded all enterprise printers to Kyocera by contracting with Boss Business Solutions.
 - o Migrated POTS fax lines to e-fax solution with eGold Fax.
 - o Installed television monitors in all building breakrooms to provide a tool for staff communication.
- Mobile Devices
 - o Switched transportation phones from flip-style to smartphones connected to FirstNet in preparation for a Fleet Management system.

Information Systems & Business Intelligence:

- Electronic Health Record (EHR) system
 - o Relaunched the CEHR portal
 - o GUI overhaul
 - o New Nursing Care Plan Module
 - o New Prescription Drug Module
- CrisisConnect – Expanded the CrisisConnect program to include all law enforcement agencies within Saginaw County.
- InspectEdge Software – Housing Resource Inspection Software
- Expanded Team Dynamix ticket types and workflows
- Data Warehouse Upgrade
 - o Development of a PowerBI Dashboard delivery model.
 - o Implemented a PowerBI Dashboard Dictionary
 - o Contracted with TBD Solutions to optimize the upgraded Data warehouse to support the new Data and Analytics services
 - o Simplified and optimized all scheduled ETL processes
- Restructured Doxy.Me processes to utilize shared access with appointment cards, Outlook calendars, and training materials.
- Expanded the use of Power Automate, Power Apps, and Power BI

Health Home and Psychiatric Clinic Operations:

- Implementation of dual Lead RN model as part of the ongoing evolution of the nursing model. This new leadership structure designated two Lead Registered Nurses (RNs): one responsible for clinic operations and one dedicated to community-based operations. This dual leadership approach enhances coordination, en-

asures specialized oversight in both clinical and community settings, and supports the delivery of high-quality, integrated care.

- Successfully transferred and integrated all psychiatry cases previously managed by Westlund Guidance Center. This transition was completed without interruption of care and demonstrates our commitment to continuity of care.
- The Great Lakes Bay Health Center integrated primary care clinic has expanded its service availability from three days per week to four days per week. This increase in clinic hours reflects our commitment to improving access to integrated primary and behavioral health services for the community, supporting more timely and comprehensive care.
- A community resource vending machine has been installed to enhance public health and harm reduction efforts. This vending machine provides free naloxone to support overdose prevention and also offers essential hygiene products. This initiative increases access to critical resources for individuals in need and demonstrates our ongoing commitment to supporting the well-being and safety of the community.
- Nursing Services completed a comprehensive revision of the nursing assessment and care planning process. This update includes the redesign of documentation in Sentri to align with the Nursing Process and to better address the needs of individuals served in specialized residential settings. These improvements enhance accuracy, consistency, and person-centered focus of care, supporting optimal outcomes.

Definitions:

Community Mental Health Agency: A CMH Agency is formed by one or more counties and is an entity of the county. Employees of a CMH Agency are county employees. CMH Agencies are governed by a twelve (12) member board appointed by county commissioners or county CEO in charter counties.

Community Mental Health Authority: CMH Authorities exist as government entities, independent from the county or counties that founded them and report to a twelve (12) member board appointed by county commissioners. (Initially, all CMHs were county agencies.) Authorities must be certified by the Michigan Department of Health and Human Services (MDHHS) and are afforded powers that are not available to CMH Agencies or CMH Organizations such as acquiring, owning, operating, maintaining, leasing or selling real or personal property; making purchases or contracts; accepting gifts or bequests and determining their use; incurring debts, liabilities, or obligations of the establishing counties; suing and being sued in their own names; creating reserve accounts, using state funds to cover vested employee benefits; developing a different fee schedule for services provided. In addition, employees of a CMH Authority are employees of the CMH Authority itself and not of the county that created it. If the level of state funding increases after a CMH becomes an Authority, the amount of local matching funds required of the Authority cannot

exceed the level provided by the CMH during the year in which the Authority was established.

Community Mental Health Entity (CMHE): A community mental health authority, community mental health organization, community mental health services program, county community mental health agency, or community mental health regional entity designated by the Michigan Department of Health and Human Services (MDHHS) to represent a region of community mental health authorities, community mental health organizations, community mental health services programs, or county community mental health agencies.

Community Mental Health Organization: A CMH Organization is formed by two or more counties or at least one county and an institution of higher education and is legally separate from the bodies that formed it. Organizations may own property and enter into contracts. Employees work directly for Organizations, not for counties.

Community Mental Health Services Program (CMH or CMHSP): CMHs provide direct mental health care or contract with community providers to do so. Although each CMH is affiliated with a PIHP, the structure of each CMH varies throughout the state. Of the forty six (46) CMHs, thirty seven (37) are designated as Authorities, seven (7) as Agencies of county government, and two (2) are designated as Organizations. The two (2) CMH Organizations are the Washtenaw Community Health Organization (WCHO) and the Central Wellness Network in Manistee/Benzie counties. (WCHO was the first CMH to become an organization under the Urban Cooperation Act.)

Prepaid Inpatient Health Plan (PIHP): PIHPs are Medicaid behavioral health managed care organizations that administer capitated funds, bear risk for Medicaid persons served, and manage behavioral health care for persons served with Medicaid. Medicaid funds are allocated to PIHPs based on the number of Medicaid beneficiaries in the PIHP's service area and PIHPs pay providers directly. Providers include the CMHs themselves as well as community-based providers under contract with a CMH or CA. PIHPs receive monthly capitated payments from MDHHS for the Medicaid Managed Mental Health Care Program. PIHPs issue Medicaid payments to doctors, hospitals, other community providers and CMHs as well as perform gatekeeping and authorization services and monitor health outcomes and standards of care. There are currently ten (10) PIHPs in Michigan.

References:

- A. Ederer, D., Baum, N., Udow-Phillips, M. (2013). *Community Mental Health Services: Coverage and Delivery in Michigan*. Center for Healthcare Research & Transformation (CHRT). Ann Arbor MI. [On-line]. Available: http://www.chrt.org/assets/policy-papers/CHRT_Community-Mental-Health-Services-Coverage-and-Delivery-in-Michigan.pdf.
- B. Michigan Mental Health Code: http://www.michigan.gov/documents/mentalhealthcode_113313_7.pdf

Exhibits:

None

Procedure:

None

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: MDHHS Annual Submission and Community Needs Assessment	Chapter: 01 - Leadership	Subject No: 01.01.07
Effective Date: 10/1/2011	Date of Review/Revision: 6/6/13, 8/8/16, 3/14/17, 7/10/17, 5/08/18, 9/10/19, 3/22/22, 3/7/23, 1/22/24, 1/21/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: AmyLou Douglas, Chief Information Officer and Quality & Compliance Officer Authored By: AmyLou Douglas Additional Reviewers: Quality and Medical Rec- ords Supervisor
	Supersedes:	
		

Purpose:

The purpose of this procedure is to describe how the Chief Quality & Compliance Officer coordinates, processes, and submits the MDHHS Annual Submission, which includes the Community Needs Assessment (CNA) by the Michigan Department of Health and Human Services (MDHHS). This procedure ensures compliance with MDHHS contractual requirements, including content, format, review, public hearing, and Board approval elements mandated under the CMHSP Managed Mental Health Supports and Services Contract.

Policy:

- SCCMHA will participate annually in regional and county-wide collaborative CNA activities. The CNA will inform SCCMHA's priorities for behavioral health, physical health integration, resource allocation, and program/service development.
- SCCMHA will collaborate with a broad range of community partners, including but not limited to law enforcement, public health entities, housing organizations, medical systems, educational systems, consumer and advocacy groups, and community-based providers. These partners contribute to shared datasets, priority identification, and the evaluation of systemic needs across Saginaw County. (Note: The complete partner list is included as Exhibit C and retained for internal documentation.)

- SCCMHA will summarize the annual findings from the CNA and identify planned actions to address identified needs. These findings will be incorporated into the MDHHS Annual Submission, reported to the SCCMHA Board of Directors, and submitted to MDHHS using the format required by the Department. SCCMHA will create the complete Annual Submission, the CNA Executive Summary, publication on the SCCMHA website.
- SCCMHA will present the Annual Submission Executive Summary to the Board of Directors consistent with Michigan Mental Health Code requirements.

Application:

This procedure applies to the SCCMHA Quality Department Executive Management, which is responsible for collecting, reviewing, analyzing, and submitting consumer, population health, and community-level data required for the MDHHS Annual Submission. It also applies to other staff needed to complete the Annual Submission and CNA documentation.

Standards:

- 1) SCCMHA will participate in a collaborative CNA process to determine the health needs of the residents of Saginaw County, including access to behavioral health and substance use disorder treatment service needs of Saginaw County residents. The CNA will inform SCCMHA's planning efforts, resource development, and integration strategies.
- 2) SCCMHA will annually prepare and submit a Annual Submission Executive Summary. The format, documentation, attachments, and data elements of the CNA Summary Narrative shall meet MDHHS Annual Submission requirements in accordance with MDHHS specifications.
- 3) SCCMHA will publish a copy of the MDHHS Annual Submission Executive Summary on the SCCMHA website.

Core Values:

SCCMHA adopts the core values established in the *MDHHS TSG Guidelines for Completing MDHHS Community Needs Assessments*, including:

1. Broad stakeholder engagement, ensuring representation from persons served, community members, providers, partners, and other stakeholders.
2. Attention to cultural, racial, age-related, socioeconomic backgrounds, and other diversity considerations, with intentional inclusion of vulnerable populations.
3. A person-centered/participant-friendly assessment process.
4. Sensitivity to current and emerging needs of the community.
5. Cost-effective implementation that maximizes planning, advocacy, and decision-making value.
6. Use of both qualitative and quantitative data.

7. Use of valid, accurate, predictive, and reliable information that supports local planning and statewide aggregation.
8. Reliance on existing, established data sources whenever appropriate to avoid duplication.
9. Data collection at intervals appropriate to detect meaningful change.
10. Public transparency and access to final results.

Definitions:

None

References:

- 1) Michigan Mental Health Code Section 330.1226
- 2) Administrative Rules R 330.2035 and R 330.2038
- 3) MDHHS/CMHSP Managed Mental Health Supports and Services Contract - Section 7.8 and Attachment 7.8.1

Exhibits:

- A. MDHHS Annual Submission Requirements
- B. TSG Guidelines for Completing CHNA
- C. CHNA Survey Recipients

Procedure:

ACTION	RESPONSIBILITY
1) MDHHS will send the Annual Submission requirements and templates to the CEO each December.	1) CEO
2) The CEO will forward the instructions and the template to the CIO/CQCO.	2) CEO
3) The Chief Quality and Compliance Officer shall prepare the annual submission, CAN, priority issues, planned actions and the Executive Summary for the SCCMHA Board of Directors and MDHHS.	3) Chief Quality and Compliance Officer
4) The CNA will be sent to members of the SCCMHA Citizens Advisory Council (CAC) for review.	4) Citizens Advisory Council
5) The Annual Submission shall be submitted to the SCCMHA Ends Committee for review.	5) SCCMHA Board Ends Committee
6) The Mental Health Supervisor - CAI shall monitor the Waiting List to be included in the MDHHS	6) Mental Health Supervisor - CAI

Annual Submission and submit to the CIO/CQCO.	
7) The Entitlement Supervisor shall complete the MDHHS Community Data Set which trends those demographic indicators which are deemed indicative of mental health needs and resources in the community and shall include this trending reporting in data presented to the venues noted above for discussion and analysis and submit to the CIO/CQCO.	7) Entitlement Supervisor
8) The HR Director will complete the Executive Compensation Reporting Template and submit to the CIO/CQCO.	8) The HR Director
9) The CIO/CQCO shall submit the Annual Submission and CNA to the SCCMHA Board of Directors.	9) CIO/CQCO and Board of Directors
10) The CIO/CQCO will submit to MDHHS: a) Attachment A – Waiting List b) Attachment B – Request for Service and Disposition of Requests c) Attachment C – Community Data Set Worksheet d) Attachment E – Priority Needs and Planned Actions e) 904-2i Executive Compensation Reporting Template	10) CIO/CQCO

Exhibit A. MDHHS Annual Submission Requirement Instructions

2025 v.1

Michigan Department of Health and Human Services Annual Submission Requirement Instructions

Due Date – February 28, 2026

General Instructions

The Annual Submission Reporting Requirements are found in both Section 7.8 and Attachment C.6.5.1.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract. The related reporting documents are found on the MDHHS Reporting Requirements website, located here: [Reporting Requirements \(michigan.gov\)](https://www.michigan.gov/mdhhs/0,4570,7-293_7-294_7-295_7-296_7-297_7-298_7-299_7-300_7-301_7-302_7-303_7-304_7-305_7-306_7-307_7-308_7-309_7-310_7-311_7-312_7-313_7-314_7-315_7-316_7-317_7-318_7-319_7-320_7-321_7-322_7-323_7-324_7-325_7-326_7-327_7-328_7-329_7-330_7-331_7-332_7-333_7-334_7-335_7-336_7-337_7-338_7-339_7-340_7-341_7-342_7-343_7-344_7-345_7-346_7-347_7-348_7-349_7-350_7-351_7-352_7-353_7-354_7-355_7-356_7-357_7-358_7-359_7-360_7-361_7-362_7-363_7-364_7-365_7-366_7-367_7-368_7-369_7-370_7-371_7-372_7-373_7-374_7-375_7-376_7-377_7-378_7-379_7-380_7-381_7-382_7-383_7-384_7-385_7-386_7-387_7-388_7-389_7-390_7-391_7-392_7-393_7-394_7-395_7-396_7-397_7-398_7-399_7-400_7-401_7-402_7-403_7-404_7-405_7-406_7-407_7-408_7-409_7-410_7-411_7-412_7-413_7-414_7-415_7-416_7-417_7-418_7-419_7-420_7-421_7-422_7-423_7-424_7-425_7-426_7-427_7-428_7-429_7-430_7-431_7-432_7-433_7-434_7-435_7-436_7-437_7-438_7-439_7-440_7-441_7-442_7-443_7-444_7-445_7-446_7-447_7-448_7-449_7-450_7-451_7-452_7-453_7-454_7-455_7-456_7-457_7-458_7-459_7-460_7-461_7-462_7-463_7-464_7-465_7-466_7-467_7-468_7-469_7-470_7-471_7-472_7-473_7-474_7-475_7-476_7-477_7-478_7-479_7-480_7-481_7-482_7-483_7-484_7-485_7-486_7-487_7-488_7-489_7-490_7-491_7-492_7-493_7-494_7-495_7-496_7-497_7-498_7-499_7-500_7-501_7-502_7-503_7-504_7-505_7-506_7-507_7-508_7-509_7-510_7-511_7-512_7-513_7-514_7-515_7-516_7-517_7-518_7-519_7-520_7-521_7-522_7-523_7-524_7-525_7-526_7-527_7-528_7-529_7-530_7-531_7-532_7-533_7-534_7-535_7-536_7-537_7-538_7-539_7-540_7-541_7-542_7-543_7-544_7-545_7-546_7-547_7-548_7-549_7-550_7-551_7-552_7-553_7-554_7-555_7-556_7-557_7-558_7-559_7-560_7-561_7-562_7-563_7-564_7-565_7-566_7-567_7-568_7-569_7-570_7-571_7-572_7-573_7-574_7-575_7-576_7-577_7-578_7-579_7-580_7-581_7-582_7-583_7-584_7-585_7-586_7-587_7-588_7-589_7-590_7-591_7-592_7-593_7-594_7-595_7-596_7-597_7-598_7-599_7-600_7-601_7-602_7-603_7-604_7-605_7-606_7-607_7-608_7-609_7-610_7-611_7-612_7-613_7-614_7-615_7-616_7-617_7-618_7-619_7-620_7-621_7-622_7-623_7-624_7-625_7-626_7-627_7-628_7-629_7-630_7-631_7-632_7-633_7-634_7-635_7-636_7-637_7-638_7-639_7-640_7-641_7-642_7-643_7-644_7-645_7-646_7-647_7-648_7-649_7-650_7-651_7-652_7-653_7-654_7-655_7-656_7-657_7-658_7-659_7-660_7-661_7-662_7-663_7-664_7-665_7-666_7-667_7-668_7-669_7-670_7-671_7-672_7-673_7-674_7-675_7-676_7-677_7-678_7-679_7-680_7-681_7-682_7-683_7-684_7-685_7-686_7-687_7-688_7-689_7-690_7-691_7-692_7-693_7-694_7-695_7-696_7-697_7-698_7-699_7-700_7-701_7-702_7-703_7-704_7-705_7-706_7-707_7-708_7-709_7-710_7-711_7-712_7-713_7-714_7-715_7-716_7-717_7-718_7-719_7-720_7-721_7-722_7-723_7-724_7-725_7-726_7-727_7-728_7-729_7-730_7-731_7-732_7-733_7-734_7-735_7-736_7-737_7-738_7-739_7-740_7-741_7-742_7-743_7-744_7-745_7-746_7-747_7-748_7-749_7-750_7-751_7-752_7-753_7-754_7-755_7-756_7-757_7-758_7-759_7-760_7-761_7-762_7-763_7-764_7-765_7-766_7-767_7-768_7-769_7-770_7-771_7-772_7-773_7-774_7-775_7-776_7-777_7-778_7-779_7-780_7-781_7-782_7-783_7-784_7-785_7-786_7-787_7-788_7-789_7-790_7-791_7-792_7-793_7-794_7-795_7-796_7-797_7-798_7-799_7-800_7-801_7-802_7-803_7-804_7-805_7-806_7-807_7-808_7-809_7-810_7-811_7-812_7-813_7-814_7-815_7-816_7-817_7-818_7-819_7-820_7-821_7-822_7-823_7-824_7-825_7-826_7-827_7-828_7-829_7-830_7-831_7-832_7-833_7-834_7-835_7-836_7-837_7-838_7-839_7-840_7-841_7-842_7-843_7-844_7-845_7-846_7-847_7-848_7-849_7-850_7-851_7-852_7-853_7-854_7-855_7-856_7-857_7-858_7-859_7-860_7-861_7-862_7-863_7-864_7-865_7-866_7-867_7-868_7-869_7-870_7-871_7-872_7-873_7-874_7-875_7-876_7-877_7-878_7-879_7-880_7-881_7-882_7-883_7-884_7-885_7-886_7-887_7-888_7-889_7-890_7-891_7-892_7-893_7-894_7-895_7-896_7-897_7-898_7-899_7-900_7-901_7-902_7-903_7-904_7-905_7-906_7-907_7-908_7-909_7-910_7-911_7-912_7-913_7-914_7-915_7-916_7-917_7-918_7-919_7-920_7-921_7-922_7-923_7-924_7-925_7-926_7-927_7-928_7-929_7-930_7-931_7-932_7-933_7-934_7-935_7-936_7-937_7-938_7-939_7-940_7-941_7-942_7-943_7-944_7-945_7-946_7-947_7-948_7-949_7-950_7-951_7-952_7-953_7-954_7-955_7-956_7-957_7-958_7-959_7-960_7-961_7-962_7-963_7-964_7-965_7-966_7-967_7-968_7-969_7-970_7-971_7-972_7-973_7-974_7-975_7-976_7-977_7-978_7-979_7-980_7-981_7-982_7-983_7-984_7-985_7-986_7-987_7-988_7-989_7-990_7-991_7-992_7-993_7-994_7-995_7-996_7-997_7-998_7-999_8000)

There are five (5) annual submission reporting requirements for FY2025:

- Attachment A: Waiting List
- Attachment B: Request for Service and Disposition of Requests
- Attachment C: Community Data Set Worksheet
- Attachment D: Stakeholder Survey (Results)
- Attachment E: Needs Assessment – Priority Needs & Planned Actions

Instructions for each Attachment are below.

Additionally, there is a template for Executive Compensation Reporting. The instructions to complete the report are on the reporting form. The title of the document is:

- 2025 Executive Compensation Report

Please submit completed forms to:

MDHHS-BHDDA-Contracts-MGMT@michigan.gov

ATTACHMENT A: Waiting List

Purpose of Form

The Mental Health Code, Section 330.1124 requires that CMHSPs establish and maintain waiting lists if all service needs are not met. The purpose of this form is to gather information about the use of waiting lists by CMHSPs and the people waiting for various types of services.

Definitions

Program Type: Program type/services to report for waiting list activity.

MI Adult: Anyone who is 18 years old or older with a mental illness.

DD: Anyone with a developmental disability.

SED: Anyone who is 17 years or younger with serious emotional disturbance.

Total: Sum of the MI Adult, DD and SED columns.

General Instructions

CMHSP: Fill in the name of the reporting CMHSP.

Contact Person/Email: Fill in the name and email address of the CMHSP staff completing the report.

Reporting Period: The reporting timeframe to be used (previous fiscal year).

Specify all HCPCS and CPT Codes included in This Category: In the row provided (under each category name), please specify all HCPCS and CPT codes associated with that category. The column will expand as you type.

Cells left blank will be returned for resubmission. If the number is zero, please mark with the number zero (0).

Row Instructions

Targeted CSM/Supports Coordination: Services included here are Client Services Management and Supports Coordination.

1. Specify all HCPCS and CPT Codes included in this category in the space provided.
2. Report the number of people requesting Targeted CSM/Supports Coordination Services who were on the waiting list at the beginning of the previous fiscal year for each population. If the number is zero, enter (0).
3. Report the number of people requesting Targeted CSM/Supports Coordination Services who were added to the waitlist during the previous fiscal year for each population. If the number is zero, enter (0).
4. Report the number of people requesting Targeted CSM/Supports Coordination Services who were removed from the waitlist because the service was provided during the previous fiscal year for each population. If the number is zero, enter (0).
5. Report the number of people requesting Targeted CSM/Supports Coordination Services who were removed from the waitlist because of all other reasons during the previous fiscal year for each population. If the number is zero, enter (0).
6. Report the number of people requesting Targeted CSM/Supports Coordination Services who were left on the waiting list at the end of the previous fiscal year for each population (see Reporting Period at top of spreadsheet). If the number is zero, enter (0).

*****NOTE: The number of people on the waitlist at the beginning of the previous fiscal year plus (+) the number of people added to the waitlist during the year, minus (–) the number of people removed from the waitlist during the year because services were provided, minus (–) the number of people removed from the waitlist for all other reasons must equal (=) the number of people left on the waitlist at the end of the fiscal year*****

Intensive Interventions/Intensive Community Services: Services included here are Assertive Community Treatment, Home Based Services, Integrated Dual Disorder Treatment and Dialectical Behavior Therapy.

1. Specify all HCPCS and CPT Codes included in this category in the space provided.
2. Report the number of people requesting Intensive Interventions/Intensive Community Services who were on the waiting list at the beginning of the previous fiscal year for each population. If the number is zero, enter (0).
3. Report the number of people requesting Intensive Interventions/Intensive Community Services who were added to the waitlist during the previous fiscal year for each population. If the number is zero, enter (0).

4. Report the number of people requesting Intensive Interventions/Intensive Community Services who were removed from the waitlist because the service was provided during the previous fiscal year for each population. If the number is zero, enter (0).
5. Report the number of people requesting Intensive Interventions/Intensive Community Services who were removed from the waitlist because of all other reasons during the previous fiscal year for each population. If the number is zero, enter (0).
6. Report the number of people requesting Intensive Interventions/Intensive Community Services who were left on the waiting list at the end of the previous fiscal year for each population. If the number is zero, enter (0).

*****NOTE: The number of people on the waitlist at the beginning of the previous fiscal year plus (+) the number of people added to the waitlist during the year, minus (-) the number of people removed from the waitlist during the year because services were provided, minus (-) the number of people removed from the waitlist for all other reasons must equal (=) the number of people left on the waitlist at the end of the fiscal year*****

Clinic Services: Services included are Assessment/Evaluation, Psychological Services, Education/Medication Monitoring, Nursing, Health Outpatient, Parent Management Therapy Oregon Model, Family Psycho- Education, Occupational Therapy, Physical Therapy and Speech.

1. Specify all HCPCS and CPT Codes included in this category in the space provided.
2. Report the number of people requesting Clinic Services who were on the waiting list at the beginning of the previous fiscal year for each population (see Reporting Period at top of spreadsheet). If the number is zero, enter (0).
3. Report the number of people requesting Clinic Services who were added to the waitlist during the previous fiscal year for each population. If the number is zero, enter (0).
4. Report the number of people requesting Clinic Services who were removed from the waitlist because the service was provided during the previous fiscal year for each population.
5. Report the number of people requesting Clinic Services who were removed from the waitlist because of all other reasons during the previous fiscal year for each population. If the number is zero, enter (0).
6. Report the number of people requesting Clinic Services who were left on the waiting list at the end of the previous fiscal year for each population. If the number is zero, enter (0).

*****NOTE: The number of people on the waitlist at the beginning of the previous fiscal year plus (+) the number of people added to the waitlist during the year, minus (-) the number of people removed from the waitlist during the year because services were provided, minus (-) the number of people removed from the waitlist for all other reasons must equal (=) the number of people left on the waitlist at the end of the fiscal year*****

Supports for Residential Living: Services included here are 24-Hour Support for Residential and Crisis Residential.

1. Specify all HCPCS and CPT Codes included in this category in the space provided.
2. Report the number of people requesting Supports for Residential Living who were on the waiting list at the beginning of the previous fiscal year for each population. If the number is zero, enter (0).
3. Report the number of people requesting Supports for Residential Living who were added to the waitlist during the previous fiscal year for each population. If the number is zero, enter (0).
4. Report the number of people requesting Supports for Residential Living who were removed from the waitlist because the service was provided during the previous fiscal year for each population. If the number is zero, enter (0).
5. Report the number of people requesting Supports for Residential Living who were removed from the waitlist because of all other reasons during the previous fiscal year for each

- population. If the number is zero, enter (0).
6. Report the number of people requesting Supports for Residential Living who were left on the waiting list at the end of the previous fiscal year for each population. If the number is zero, enter (0).

*****NOTE: The number of people on the waitlist at the beginning of the previous fiscal year plus (+) the number of people added to the waitlist during the year, minus (-) the number of people removed from the waitlist during the year because services were provided, minus (-) the number of people removed from the waitlist for all other reasons must equal (=) the number of people left on the waitlist at the end of the fiscal year*****

Supports for Community Living: Services included here are Community Living Supports less than 24 hours, Supported Employment, Skill Building, Clubhouse and Respite.

1. Specify all HCPCS and CPT Codes included in this category in the space provided.
2. Report the number of people requesting Supports for Community Living who were on the waiting list at the beginning of the previous fiscal year for each population. If the number is zero, enter (0).
3. Report the number of people requesting Supports for Community Living who were added to the waitlist during the previous fiscal year for each population. If the number is zero, enter (0).
4. Report the number of people requesting Supports for Community Living who were removed from the waitlist because the service was provided during the previous fiscal year for each population. If the number is zero, enter (0).
5. Report the number of people requesting Supports for Community Living who were removed from the waitlist because of all other reasons during the previous fiscal year for each population. If the number is zero, enter (0).
6. Report the number of people requesting Supports for Community Living who were left on the waiting list at the end of the previous fiscal year for each population. If the number is zero, enter (0).

*****NOTE: The number of people on the waitlist at the beginning of the previous fiscal year plus (+) the number of people added to the waitlist during the year, minus (-) the number of people removed from the waitlist during the year because services were provided, minus (-) the number of people removed from the waitlist for all other reasons must equal (=) the number of people left on the waitlist at the end of the fiscal year*****

Narrative: How do you assure who service needs are met at an individual level as well as from a program capacity level? The column will expand as you type.

ATTACHMENT B: Requests for Services and Disposition of Requests

Purpose of Form

MDHHS will use this report to gather data on requests for services and the disposition of those requests. The reporting categories in the CMHSP Assessment section are consistent with The Standards Group (TSG) established waiting list standards. Additionally, a narrative submission is also being required to assist in understanding the information provided.

Definitions

DD: Anyone with a developmental disability

MI Adult: Anyone who is 18 years old or older with a mental illness

SED: Anyone who is 17 years or younger with serious emotional disturbance

Unknown / All Others: Anyone else who isn't counted in the previous three (3) categories

Total - Sum of the DD, MI Adult, SED, and Unknown/All Other columns.

General Instructions

CMHSP: Fill in the name of the reporting CMHSP.

Contact Person/Email: Fill in the name and email address of the CMHSP staff completing the report.

Reporting Period: The reporting timeframe to be used (previous fiscal year).

Cells left blank will be returned for resubmission. If the number is zero, please mark with the number zero (0).

Row Instructions

CMHSP Point of Entry-Screening: Information collected here includes the total number of people who approached the CMHSP to inquire about services, who were referred out, who requested provided services, who didn't meet eligibility, and who were scheduled for assessment.

Row 1: Report the total number of all people who walked in or called in with any request.

Row 2: Of the # in Row 1 (all people who telephoned or walked in), report the total # of people referred out due to non-mental health needs. For example, if a telephone inquiry is about Food Stamps or another non-mental health need, the CMHSP would then refer the caller to DHS or another community provider for that specific service.

Row 3: Of the # in Row 1 (all people who telephoned or walked in), report the total # of people who requested services the CMHSP provides, irrespective of eligibility.

*****NOTE: The combined totals of Rows 2 and 3 must match the total in Row 1*****

Row 4: Of the # in Row 3 (People requested services the CMHSP provides), report the total # of people who did not meet eligibility through phone or other screening.

Row 5: Of the # in Row 3 (People requested services the CMHSP provides), report the total # of people who met eligibility and were scheduled for intake/biopsychosocial assessment.

Row 6: Of the # in Row 3 (People requested services the CMHSP provides), report the total # of people with other circumstance and describe at designated area on Line 32 of the spreadsheet.

*****NOTE: The combined totals of Rows 4, 5, and 6 must match the total in Row 3*****

Row 7: Is Row 1 (all people who telephoned or walked in) an unduplicated count in each category? Answer Yes or No for each category

CMHSP Assessment: Information collected here includes disposition of people who were scheduled for assessment, people who didn't meet CMHSP non-entitlement eligibility criteria, people who met CMHSP eligibility criteria, people who met emergency/urgent condition criteria, people who met immediate admission criteria, and people who were put on a waiting list.

Row 8: Of the # in Row 5 (Scheduled for Intake/Biopsychosocial Assessment) – report the total # of people who did not receive intake/biopsychosocial assessment (dropped out, no

- show, etc.)
- Row 9:** Of the # in Row 5 (Scheduled for Intake/Biopsychosocial Assessment) – report the total # of people who were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan). These are Medicaid beneficiaries who do not meet specialty services (PIHP) service criteria and would be better served by another Medicaid fee for service provider, but not the health plan, and did not receive CMHSP provided mental health services. "MA" refers to Medicaid.
- Row 10:** Of the # in Row 5 (Scheduled for Intake/Biopsychosocial Assessment) – report the total # of people who were not served because they were MA HP enrolled and referred out to MA health plan. These are Medicaid beneficiaries who do not meet specialty services (PIHP) service criteria and would be better served by the Medicaid Health Plan, and they did not receive CMHSP provided mental health services.
- Row 11:** Of the # in Row 5 (Scheduled for Intake/Biopsychosocial Assessment) – report the total # of people who otherwise did not meet CMHSP non-entitlement (GF) intake/assessment criteria
- Row 12:** Of the # in Row 5 (Scheduled for Intake/Biopsychosocial Assessment) – report the total # of people who met the CMHSP intake criteria

*****NOTE: The combined totals of Rows 8, 9, 10, 11, and 12 must match the total in Row 5*****

- Row 11a:** Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) – report the total # of people who were referred out to other mental health providers
- Row 11b:** Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) – report the total # of people who were not referred out to other mental health providers

*****NOTE: The combined totals of Rows 11a and 11b must match the total in Row 11*****

- Row 13:** Of the # in Row 12 (Met CMHSP intake criteria) – report the total # of people who met emergency/urgent/priority conditions criteria
- Row 14:** Of the # in Row 12 (Met CMHSP intake criteria) – report the total # of people who met regular/routine/usual admission criteria
- Row 15:** Of the # in Row 12 (Met CMHSP intake criteria) – report the total # of people who were put on a waiting list

*****NOTE: The combined totals of Rows 13, 14, and 15 must match the total in Row 12*****

- Row 15a:** Of the # in Row 15 (Put on a waiting list) – report the total # of people who received some CMHSP services, but wait listed for other CMHSP services
- Row 15b:** Of the # in Row 15 (Put on a waiting list) – report the total # of people who were waitlisted for all CMHSP services

*****NOTE: The combined totals of Rows 15a and 15b must match the total in Row 15*****

- Row 16:** Other Requests for Service and Disposition of Requests – Report total # of people in each category and describe at designated area on Line 32 of the spreadsheet.

Narrative: A narrative is also being required to assist in understanding the information provided. The narrative will be written in designated areas within the spreadsheet and includes the following:

1. Provide a brief description of how the CMHSP collects and maintains the data reported on this form.
2. Briefly describe the process by which the CMHSP determines eligibility [e.g., per use of assessment instrument (ID name), per telephone screen, or face-to-face assessment or combination, etc.].

3. Provide a brief but easily understood and clear narrative describing noticeable trends and what the CMHSP response is to these trends. If trends represent an increased demand for services, explain how the CMHSP plans to manage this increased demand moving forward. If changes in eligibility rules result in termination of services to current enrollees, include this information.

ATTACHMENT C: Community Data Sets Instructions:

The Community Data Sets Instructions includes information on how to complete the Community Data Sets worksheet, which is an annual requirement.

ATTACHMENT C: Community Data Sets Worksheet:

The Community Data Sets Worksheet is an annual requirement. It is expected data will be entered and saved into the worksheet year-to-year and used each time the CMHSP conducts a community needs assessment.

ATTACHMENT D: Stakeholder Survey

This form is a template for CMHSPs to use to complete and submit the Stakeholder Survey every two (2) years. A CMHSP may use this template or another of their choosing to obtain answers to the identified survey questions on this Attachment. Stakeholder Survey results are required to be submitted every other year with Attachment E (Needs Assessment – Priority Needs & Planned Actions).

ATTACHMENT E: Needs Assessment - Priority Needs & Planned Actions

This form is a template for CMHSPs to use to identify at least five (5) priority needs following completion of the Stakeholder Survey. This is also completed and submitted every two (2) years. **CMHSPs will need to plan to provide MDHHS an update on efforts in between reporting Cycles as well as an implementation update moving forward.**

Based on feedback received from stakeholder groups and data collected from the stakeholder survey process, the CMHSP must identify the five (5) priority needs. Of these, the CMHSP must identify the areas where it intends to address and what action is being planned in that area.

PLEASE NOTE:

CMHSPs are only required to complete and submit the Stakeholder Survey Results (Attachment D) and Priority Needs & Planned Actions (Attachment E) every two (2) years on odd numbered years. **Starting in 2026, CMHSPs should anticipate providing an update to MDHHS on the efforts to address Priority Needs and the Planned Actions listed out in Attachment E in between reporting cycles. Additionally, CMHSPs should anticipate providing status updates on how the implementation of the planned actions played out.**

CMHSPs are required to complete and submit Attachment D and Attachment E for 2025.

Exhibit B. TSG Guidelines for Completing Community Needs Assessment (CNA)



GUIDELINES FOR COMPLETING COMMUNITY NEEDS ASSESSMENT

INTRODUCTION

The Michigan Mental Health Code, and the administrative rules implementing it, requires that Community Mental Health Service Programs (CMHSPs) complete an annual written assessment of community need. Over the years, this assessment has taken many forms. In an effort to make the process more effective, efficient and meaningful, The Standards Group, in cooperation with the Michigan Department of Community Health, now known as Health Services, developed these guidelines for completing a community needs assessment.

Several important factors influenced these recommended guidelines.

- The greatest value in conducting a needs assessment is its application to a local planning process. This requires that the assessment include key community partners and stakeholders.
- Any needs assessment process must be accomplished within existing resources and avoid undue administrative burden.
- The process should be aimed at identifying emerging and changing needs that are consistent with the goals of the public mental health system. As Michigan experiences economic challenges, and available resources are shrinking, the needs assessment process must not be an exercise that creates unrealistic expectations within the community.
- The needs assessment process must take into account significant system changes related to the integration of primary healthcare and behavioral healthcare. The importance of integration has been highlighted by the National Association of State Mental Health Program Directors, Medical Directors Council report "Integrating Behavioral Health and Primary Care Services, Opportunities and Challenges for State Mental Health Authorities" and the subsequent release of the "Morbidity and Mortality in People with Serious Mental Illness" report. This second report shows that persons with a serious mental illness have a life expectancy 25 years shorter than the general population. Recently enacted national healthcare reform legislation also calls for greater integration of care. Correspondingly, the needs assessment process should be informed by an awareness of trends and the implications of national healthcare reform to assist the CMHSP in their readiness for appropriate action.
- The needs assessment process must be consistent with the Health Services visions and values as articulated in such documents as the Application for Renewal and Re-commitment and the concept paper that preceded it. These documents represent key policy initiatives for the public mental health system.

In approaching its task, the work group reviewed national literature regarding prevalence data, epidemiology, community health assessment principles, and consumer driven needs assessments. The following themes from that literature are reflected in this guideline:

State of New York, Community Health Assessment, Guidance and Format, 2010-2013

- County level data should be compared with state and national data
- Identify 2-3 priorities in collaboration with local partners
- Profile community resources that are available to help meet need

Kansas University, The Community Tool Box

- Key Community Partners are informants to an effective process

National Consumer Supporter Technical Assistance Center – Community Needs Assessment

- Focus on Recovery-oriented mental health system, embracing self-determination, empowering relationships, meaningful role in society, and eliminating stigma and discrimination
- Community Needs Assessment should include the following sections: community demographics, consumer leadership, service gaps, barriers to recovery oriented services, and organization and funding.

These documents identified key themes for the needs assessment, specifically: the need to set priorities, identify community resources and gaps, and for services to support recovery, resiliency and community inclusion.

This guideline is intended to establish a minimum data set and standardized process for the CMHSP to gather input from its community partners. Beyond this, it is intended to provide locally meaningful information that can be used to develop community based plans for addressing service needs and priorities. It is important that this information be used in the context of local events and circumstances. In summary, this process will provide a set of useful data elements crucial to local strategic planning.

SCOPE

As seen in the regulatory citations below, the Mental Health Code establishes requirements for community mental health service programs (CMHSPs). As such, this guideline applies to all CMHSPs. It is intended, however, that the results will be meaningful not only at the local level, but also at the regional/affiliation and state level.

BACKGROUND/REGULATORY OVERVIEW

Mental Health Code

The Michigan Mental Health Code (MHC) provides that each community mental health services program shall annually conduct an assessment of the mental health needs of the residents of the county(ies) served. The particular requirements are found in Section 330.1226.

Administrative Rules

The Administrative Rules further provide for the annual completion of an assessment of community need. Rule 2035 and Rule 2038 provide specific requirements regarding what information is to be submitted.

Much of the information required is currently available through a variety of sources, including encounter data and QI data submitted to Health Services. This document is intended to provide direction on collecting and reporting information that is not already provided to the Department in order to meet the requirements of the MHC and Administrative Rules.

CORE VALUES

This guideline has been developed based on certain core values. These values, or guiding principles, are as follows:

1. The process of needs assessment considers input from a broad variety of sources and diverse populations including, but not limited to: current consumers, members of the community, providers, and other stakeholders
2. Input is solicited from diverse populations with sensitivity to cultural and racial diversity, stigma, age, and socioeconomic backgrounds, and specifically includes vulnerable populations
3. The process is consumer/participant friendly
4. The process is sensitive to both current and future needs of the community
5. The process is intended to be cost-effective and sensitive to limited resources while providing useable results for planning, advocacy and decision-making
6. The needs assessment process includes collection of both qualitative and quantitative data
7. Information obtained is valid, accurate, predictive, reliable, and replicable and can be used for local planning as well as aggregated in a meaningful way for statewide use
8. Existing, established data sources are used whenever appropriate to avoid duplication of effort
9. Data collection is completed at a reasonable frequency that adds value and is sensitive to change
10. Results of the community needs assessment both locally and aggregated are readily available to participants, interested stakeholders, and the community at large

STANDARDS

A. GENERAL STANDARDS

1. Each CMHSP is required to assess the mental health needs of the residents of the county or counties it serves. (MHC, 330.1226, Sec. 226, (1), (a))
2. Each CMHSP is required to identify the public and non-public services necessary to meet this identified need. (MHC, 330.1226, Sec 226, (1), (a))
3. Public and private providers are to be involved in assessing the needs of the residents. (MHC, 330.1226, Sec. 226 (1), (a))
4. School districts providing special education are to be involved in assessing the needs of the residents. (MHC, 330.1226 (1), (a))
5. Waiting list information will be included in the needs assessment. (MHC, 330.1226, Sec 226, (1), (a))

6. The needs assessment is to be completed annually, or, at a minimum, the previous year's assessment must be certified as accurate. (Administrative Rule 2035, (2))

B. STANDARDS FOR CONTENT OF NEEDS ASSESSMENT

1. Need is identified relative to various significant social and health needs within the community, including (Administrative Rule 2035, (1):
 - a. Employment
 - b. Homelessness
 - c. Corrections
 - d. Education
 - e. Poverty
 - f. Health Care
2. Wait List Data
3. Request for Service Data

METHODOLOGIES/PROCESS

Information comprising the needs assessment is gathered through four basic methodologies:

- Data collection relating to requests for service and waiting lists
- Review of existing county, regional, statewide and national data sets
- Stakeholder input via interviews or surveys.
- Summary of next steps and preliminary plans.

Each of these processes and methodologies is intended to provide important information which, when taken in total, identify both need and demand relative to the key priorities of the public mental health system. This information is best used in local planning. This document, however, is not intended to describe or set standards for that local planning process.

1. Data Related to Requests for Service

The first element of the needs assessment is data related to requests for service and waiting list information consistent with other CMHSP contractual requirements. The data to be collected and reported to Health Services is specified in the Waiting List Guideline and reporting requirements and the CMHSP Report on the Requests for Services and Disposition of Requests.

2. Community Data Sets

The CMHSP shall review, compile and submit available county-level data related to key demographics and population factors of the county including:

- population trends
- Medicaid enrollment
- foster care capacity
- homelessness
- employment
- jail diversions
- prison discharges

- Prevalence rates for Serious Mental Illness in Adults, Serious Emotional Disturbance in children, and Developmental Disabilities.
- Students aging out or graduating from Special Education services
- Graduation and dropout rates
- Primary health conditions of persons served
- Primary care and emergency room utilization of persons served
- Private Mental Health and Substance Abuse treatment providers (optional)

This data is necessary in order to identify priorities for service delivery at the local level. Common data sets shall be identified in the Community Data Sets Form Instructions (Attachment C) and some data will be provided directly to the CMHSP by Health Services. The CMHSP is expected to review the data, identify trends in their local communities and consider potential impacts on service needs.

3. **Stakeholder Input**

Seven key community partners have been identified as primary in identifying community needs. These include:

- the justice system
- school systems
- primary health care
- Michigan Department of Human Services
- private mental health and substance abuse providers organizations
- public health
- consumers/advocates.

In addition to the Community Data Sets described above, the CMHSP shall solicit input and feedback from each of these stakeholder groups. The method used to gather input will vary somewhat according to the size and number of stakeholders involved. CMHSPs may choose to use a mailed survey or conduct either phone or face to face interviews to solicit stakeholder input on 1) the most significant mental health needs that are not currently being adequately addressed in the community, 2) trends that have been identified that the CMHSP should be aware of, and 3) feedback on the top three concerns/priorities from their perspective. Specific questions to be included in the survey process or input session are included in the Stakeholder Survey (Attachment D) The information to be gathered from each stakeholder is intended to reflect both system-wide and local priorities.

A. Justice

Considerable resource and effort have been devoted to meeting the needs of those in, or exiting, the corrections system. This represents a significant source of data related to the emerging demand on the public mental health system. In addition to compiling data related to Jail Diversions and number of persons discharging from prison who meet SMI criteria, the CMHSP shall involve representatives from the local justice system in the stakeholder feedback process as described above.

B. Education

Each year, individuals with developmental disabilities and serious emotional disorders exit the education system. This represents a known need within the community. Additionally, each year some number of youth exit the school system

without graduating. Trends in this figure may also represent a community need. Information to be collected and reported on the Community Data Sets Form includes:

- Number aging out of special education programs
- Number of students not graduating, as defined by educational data sets.

In addition, representatives from the local school systems shall be involved in the CMHSP stakeholder input process as described above.

C. Primary Health

Integration with primary health care is a key need for those with a mental illness. Often, those with serious mental illness experience difficulty when attempting to access primary or specialty care. Primary care venues, particularly emergency rooms, primary care clinics, free clinics, and primary care physicians, are critical to this integration and are an important source in identifying mental health needs.

Specific data to be collected includes:

- Percentage of CMHSP consumers with an identified Primary Care Physician.
- Number of Medicaid enrollees seen in the CMHSP that also saw a Primary Care Physician in the past year.
- Number of CMHSP Medicaid enrollees with BOTH and emergency room contact and a primary care contact in past year.
- Number of CMHSP Medicaid enrollees with emergency room contact only and no primary care in past year
- Number/percentage of existing CMHSP consumers identified as having ever been diagnosed with or were treated for the following conditions in the past year:
 - Pneumonia
 - Diabetes
 - Asthma
 - Hypertension
 - Obesity
- In addition to compiling and reviewing this data (some of which will be provided by Health Services), the CMHSP shall include representatives of the local healthcare delivery system to solicit their feedback as described above.

CI. Department of Human Services

The Michigan Department of Human Services, at the local county level, is an important partner to the CMHSP. This is particularly true in relation to serving youth. The following data is to be gathered and reported:

- Number of children in foster care placement, both in county and out of county.
- Number of licensed beds for adults.

The CMHSP shall also include representatives from the local DHS office when soliciting community input as described above.

E. Private Providers and Public SA Providers

The Mental Health Code requires that input from private providers be included in the needs assessment process. Each community has a variety of private providers ranging from not-for-profit mental health clinics to private sole practitioners. It is anticipated that the most relevant information relating to community need will be

gathered from those mental health clinics or group practices, and those providers would be included in this process. The information to be gathered includes:

- Number of existing private providers in the community
- Does the organization utilize a sliding fee scale?
- Is the provider accepting new clients?

In addition to this data, representatives from local private and public providers of mental health and substance abuse treatment shall be included in the stakeholder input process.

F. Public Health

Local public health departments play a key role in identifying community needs related to risk factors and health trends. Public health departments work to promote health, prevent disease and protect communities. By focusing on the community as a whole, public health departments provide services based on community specific needs. Frequently public health departments conduct surveys that include needs related to behavioral health services. The CMHSP shall include representatives from the local public health department in the stakeholder input process and also review results or any surveys or data collection related to behavioral health, mental health, substance use or other factors impacting the CMHSP.

G. Consumers/Advocates

To the extent that there are organized advocacy or consumer groups within the service area, their input is to be sought and included in the stakeholder input process. Although such groups will not necessarily have solid data on local need, they provide exceptional understanding of just what the need is in human terms. Consumers, family members, and advocacy groups shall be included in the CMHSP's process for stakeholder input.

4. List of Priorities and Planned Action

Upon completion of Items 1 – 3 above, the CMHSP has a basic set of data, feedback and comments regarding the needs within their given community. This information does not, however, stand alone. To be useful, this information must be viewed with the context of current community events, changes over time, and emerging community concerns and existing resources. The CMHSP shall compile the information obtained in this process, identify the key issues identified, and prioritize those issues for local action.

This information is most beneficial in a planning context. The information gathered should be:

- Compiled into a single report,
- Compared to previously collected data (after the first year),
- Aggregated to the regional level if appropriate for an affiliation,
- Reported to Health Services for use in meeting the Mental Health Code and Administrative Rules requirements and for planning, and
- Used for a local and/or regional planning process.

Based on feedback received from stakeholder groups and data collected from this process, the CMHSP must identify at least 5 priority needs. Of these, the CMHSP must identify the areas where it intends to address and what action is being planned in that area.

5. Frequency of Assessment

Consistent with the core value that the needs assessment process not create undue burden while providing timely information, the process will be repeated as follows:

- Data sets will be updated annually as appropriate. Those data sets for which updates are available less frequently will be updated as available.
- The stakeholder input portion will be updated every two years. During the "off year" the CMHSP will provide an update to Health Services on efforts to address those priorities listed in Attachment E.

DATA REPORTING REQUIREMENTS

See reporting templates (Attachments A, B, C, D, E for specific reporting requirements and formats for reporting to Health Services. Complete data on all aspects of Community Needs Assessment will be reported to Health Services no less than every three years. Annually, a subset of data shall be submitted by the CMHSP to Health Services, including data related to Waiting Lists and request for Service and Disposition.

REPORTING TEMPLATES

Attachments:

Reporting Templates and Instruction Sets:

- A. Waiting List
- B. Request for Service and Disposition Form
- C. Community Data Sets
- D. Stakeholder Survey
- E. Issues Identified and Prioritized

Exhibit C. Community Needs Survey Recipients

Organization	Contact	Email
Saginaw Bay Underwriters	Peter Ewend	pewend@sbuins.com
The Ezekiel Project	Brenae Arthur Jones	directorbaj@theeezekielproject.com
Parishioners on Patrol	Pastor Larry Camel	ldcwin@aol.com
Saginaw Housing Commission	Jessica Chasnis	jpittman@saginawhousing.org
Hidden Harvest	Samantha McKenzie	smckenzie@hiddenharvestshares.org
NAACP Saginaw	Terry Pruitt	s.naACP@sbcglobal.net
Saginaw County Chamber of Commerce	Eugene Seals	eugene@saginawchamber.org
Consumer Energy	Kyle McCree	Kyle.McCree@cmsenergy.com
Housing Commission	Leslie Foxx	lfoxx@saginawhousing.org
Bridge the Gap	Ayitha Sowah	info@webridgethegap.net
Ezekiel Project	Imani Clark	ezekeleinformation@gmail.com
Public Libraries of Saginaw	Maria McCarville	mmccarville@saginawlibrary.org
Saginaw Chamber of Commerce	Sam Tany	sam@saginawchamber.org
Frankenmuth Chamber of Commerce	Jamie Furbush	ceo@frankenmuth.org
Birch Run/Bridgeport Chamber of Commerce	Marianne Nelson	info@birchrunbridgeportchamber.org
Rotary Club of Saginaw	Janet Boes	saginawrotary@yahoo.com
Saginaw Board of Realtors, Inc.	Diane Bearss	dmbearss054@gmail.com
Saginaw Board of Realtors, Inc.	Lindsey North	lindseydnorth@gmail.com
Freeland Community Chamber of Commerce	Mindy McIntosh	mindy@wealthmichigan.com
Positive Results Downtown Saginaw	Ann Batkoski-Sullivan	info@prideinsaginaw.org
	Brenda Moore, Mayor	bmoore@saginaw-mi.com
	Michael D. Balls	mballs@saginaw-mi.com
	Eric Braddock, Sr.	ebraddock@saginaw-mi.com
	Priscilla Garcia	pgarcia@saginaw-mi.com
	Carly Hammond	chammond@saginaw-mi.com
	Monique Lamar-Silvia	mlamarsilvia@saginaw-mi.com
	Bill Ostash	bostash@saginaw-mi.com
	Jacinta Seals	jseals@saginaw-mi-com
	Heidi Wiggins	hwiggins@saginaw-mi.com
		rjurek@svrcindustries.com
	Rochelle Cotey	rochellecotey@gmail.com
	Hurley Coleman	hcoleman@saginawcac.org
	Ashley L Frank	alfrank@svsu.edu
		kday@partnershiftnetwork.com
		adavis@unitedwaysaginaw.org

Organization	Contact	Email
		dawnofanewdaycoffee-house@gmail.com
		ewilson@communitiesfirstinc.org
		lkubit@lsem-mi.org
		joshuaspraay@gmail.com
	Becky Gaskin	becky.gaskin@redcross.org
	Tom Miller	jamie@hhhofsaginaw.org Chiara@211nemichigan.org tmiller@saginawfuture.com
City of Saginaw	Alexander Shephard	Swanton@saginawfoodclub.org ashephard@saginaw-mi.com
Training and Treatment Innovations, Inc.	Ashley Thornton-Conway	aconway@ttiinc.org
Saginaw Landlords Association	Carrie Birnbaum	saglls@att.net
Saginaw County 9-1-1 Authority	Chris Izworski	cizworski@saginawcounty.com
Saginaw County Public Health Department	Chris Klawuhn	cklawuhn@saginawcounty.com
Hammer Restoration	Maria Bebeau	mbebeau@hammerrestoration.com
Saginaw County Animal Control Department	Rachel Horton	rhorton@saginawcounty.com
Saginaw Charter Township	Rhanya Faulk	rfaulk@saginawtownship.net
ABA Pathways	EHS	abbym@abaways.com
ABA Pathways		briannap@abaways.com
ABA Pathways		ernestp@abaways.com
ABA Pathways	Frances Yeh	francesy@abaways.com
ABA Pathways	Clinical Director	laurah@abaways.com
ABA Pathways	Corporate	legal@abaways.com
ABA Pathways	Linzie Schweitzer	linzies@abaways.com
ABA Pathways		mitzim@abaways.com
ABA Pathways	General	PAC_saginaw@abaways.com
ABA Pathways	Stephanie Dymora	stephanied@abaways.com
ACL		jlockhart@hopenetwork.org
ACL	New Center/Westwood - HM & HN SE Program Director	kferguson@hopenetwork.org
Acorn Health	Alicia (Corp)	alicia@acornhealth.com
Acorn Health	3	apbailey@acornhealth.com
Acorn Health	Jo Milham	jomilham@acornhealth.com
Acorn Health	1	karteaga@acornhealth.com
Acorn Health	2	lvanelia@acornhealth.com
Acorn Health		ragossan@acornhealth.com
Acorn Health	Shelley Liquia	Sliquia@acornhealth.com
Angel's Place	Grimaldi AFC Rosie HM	mbrown@angelsplace.com
Angel's Place	Corporate	Tom.Ski@angelsplace.com

Organization	Contact	Email
APS Employment	Corporate	lisa@apsemp.com
APS Employment	Respite Coordinator	respitem@apsemploymentservices.com
Ascension	Sarah Maher	sarah.maher@ascension.org
Autism of America	Corporate	info@autismofamerica.com
Autism Systems ABA		madison.grifka@autismsys- temsaba.com
Autism Systems ABA		ruchi.bhardwaj@autismsystem- saba.com
Bay Human Services	Reg. Mgr. Kelly Surles - Corporate	btrainer@bayhs.us
Bay Human Services	Cambridge Christine HM	cambridgehomemanager@bayhs.us
Bay Human Services	Autism - Evan	egunden@bayhs.us
Bay Human Services	Glenvale - Tyrisha HM	GlenvaleHomeManager@bayhs.us
Bay Human Services	House of Hope - Rebecca HM	hopehm@bayhs.us
Bay Human Services	Joseph - Corporate	jpilot@bayhs.us
Bay Human Services	Autism Supervisor	mscharich@bayhs.us
Bay Human Services	Slatestone	slatestonehm@bayhs.us
Child & Family Services of Saginaw	Deana Bentley	dbentley@cfs-saginaw.org
Child & Family Services of Saginaw	Gina Latty	glatty@cfs-saginaw.org
Child & Family Services of Saginaw	Jill Hogenson	jhogenson@cfs-saginaw.org
Child & Family Services of Saginaw	Maureen Burns	mburns@cfs-saginaw.org
Child & Family Services of Saginaw	Miranda Medina	mmedina@cfs-saginaw.org
Children's Therapy Corner	Amber Leiferman	leifermana@childrensthera- pycorner.com
Children's Therapy Corner	Office	midlandofficemanager@childrensther- apycorner.com
Children's Therapy Corner	Operations	operations@childrensthera- pycorner.com
Game Changers Therapy	Scott Staszak	scottsg@gamechangertherapy.com
Genoa Pharmacy	Diane Cranston	dcranston@genoahealthcare.com
Genoa Pharmacy	Mariam Sraj	msraj@genoahealthcare.com
HealthSource Saginaw	Corporate	mwilliams@hss-mi.org
Krasinski AFC/Jubeju CLS	Corporate	jubescomet@charter.net
Krasinski AFC/Jubeju CLS	Erin	krasinski.jubeju@charter.net
McDowell Healing Arts Cen- ter	Shana McDowell	admin@mhacenter.com
McDowell Healing Arts Cen- ter	Joe Uhrich	juhrich@mhacenter.com
McDowell Healing Arts Cen- ter	Melvin McDowell	mmcdowell@mhacenter.com
McDowell Healing Arts Cen- ter	Tony Moten	tmoten@mhacenter.com
Saginaw Meadows	CRU Program Manager	CJWhelton@hopenetwork.org
Saginaw Meadows	CRU Main	klisik@hopenetwork.org
Saginaw Psychological	Barbara Goss - Corporate	bgoss@sagpsych.com

Organization	Contact	Email
Saginaw Psychological	Corporate	mark@sagpsych.com
Saginaw Psychological	Melissa Zaroff - Finance	melissa@sagpsych.com
Saginaw Psychological	N Menendez	nmenendes@sagpsych.com
Stuart Wilson	Contracts	elizabeth@stuartwilsonfi.com
Stuart Wilson	Corporate	stuart@stuartwilsonfi.com
TTI	Corporate	jkwilson@ttiinc.org
TTI	Stacy	sdjones@ttiinc.org
Westlund Guidance Center	Raquel Braun	rbraun@svrcindustries.com
Westlund Guidance Center	Yolanda Bellinger	ybellinger@svrcindustries.com
Wellspring Lutheran	Ann Finta	afinta@wellspringlutheran.com
	Amy Roe	amyroe@themustardseedshelter.org
	Chris Brown	christopherbrown1221@gmail.com
	Jane Roberts	jroberts@undergroundrailroadinc.org
	Jayce Ashwill	jashwill@unitedwaysaginaw.org
	Tracey Raquepaw, Chairperson	tl.rawuepaw@icloud.com & Raquepawt@michigan.gov
	Jill Armentrout	jillsarmentrout@gmail.com
	Maria Vela	myraklemom@gmail.com
	Lisa Coney	
	Mike Cierzniewski	mikecierzniewski@yahoo.com
	Jacob Kern	jkern@tricap.net
	Susan McCauley	smc762@hotmail.com
	Robert Woods	
	Cynthia Winiecke	
	Joan Williams	
	John Pugh	ypugh914@aol.com
	Jaime Huffman	jlhuffman@svsu.edu
	Lesia McAfee	mcafeelesia1962@gmail.com
	Bridgett Townsend	Bridgett-townsend98@gmail.com
	Deb Nagel	debraangel80@gmail.com
	Duke Peltier	ernestp@abaways.com
	Maggie Davis	
	Jim Nesbit	jnesbit@ttiinc.org
	Tracey Roat	troat@ttiinc.org
	Vicki Mikolajski	vimik@charter.net
	Lyn Bradfield	lbradfield2009@yahoo.com
	Lisa Sawyer	lisa.birdsong@yahoo.com
	Cheryl Nelson	
	Alicia Swider	alica@acornhealth.com
	Amanda Schoch	amandaschoch6@gmail.com
	Anesha Stanley	keysofhopecfoundation@gmail.com
	Anthony Weidman	anthonycweidman@gmail.com

Organization	Contact	Email
	Ashley Bryce	Ashley.Bryce@sccmha.org
	Aubree Benchley	bisch2a@cmichedu
	Nola Auernhamer	auernha5@msu.com
	Aundrelia Jackson	aundreliajackson@gmail.com
	Bailey Spradlin	bspradlin@acornhealth.com
	Brian Jackson	brian@saginawfoundation.org
	Celia O'Mara	comara@glbhealth.org
	Chad Pocock	chad@mi-fact.org
	Chrystal Segura-Perez	chica21192@gmail.com
	Deb Lively	dlively@svsu.edu
	Debbie Weadock	djw31@sbcglobal.net
	Kathryn Debo	debo1k@cmich.edu
	Denise Berry	dberry@svrcindustries.com
	Amanda Doyle	adoyle@spsd.net
	Maggie Dwan	dwanm@baisd.net
	Ebonisha Kemp	kempebonisha@gmail.com
	Elizabeth Aikin	eaikin@scypcmi.com
	Ericka Taylor	etaylor@sisd.cc
	Erin Senkowski	senkowski@sisd.cc
	Farren Kaczor	fkaczor@sisd.cc
	Hilary Grundas	hgrundas@saginawcounty.com
	Shanna Hensler	shensler@saginawcounty.com
	Michelle Hite	mhite@spsd.net
	Inez Williams	iwilliams@spsd.net
	Jeffrey Collier	jcollier@sisd.cc
	Jennifer Lepeak	jlepeak@hotmail.com
	Jennifer Shores	shoresj@michigan.gov
	Jill Shye	jillshye@hotmail.com
	Whitney Johnson	johnsonw6@michigan.gov
	Julie Bash	bashj@sisd.cc
	Terri June	JuneT@michigan.gov
	Maggie Karbowski	KarbowskiM@michigan.gov
		kshay@spsd.net
	LaMonica Lee	lamonica@211nemichigan.org
	Leann Bauer	lmbauer@spsd.net
	Linda Hawke	lhawke@readsaginaw.org
	Lindsay Riopelle	lriopelle@spsd.net
	Lisa Tran	ltran@spsd.net
	Maggie Muter-Devericks	mdevericks@glbhealth.org
	Marica Reeves	marcia@r3moline.org
	Meghan Gutka	Meghan.Gutka@gmail.com
	Meghan Shepard	mshepard@sisd.cc

Organization	Contact	Email
		melissarohraff@yahoo.com
	Monica Latoski	mccc16@att.net
	Nicole Brookman	nbrookman@chs-mi.com
	Anne O'Rourke-Bean	orourk65@msu.edu
		oritafaries@yahoo.com
	Paige Speer	pspeer@glbhealth.org
	Rachel Slivik	rachel.slivik@sccmha.org
	Rebekah Willard	rwillard@saginawcounty.com
	Renee Johnston	renee@saginawfoundation.org
	Rosa Davis	rdavis@sisd.cc
	Sabrina Jackson	sjackson1@sisd.cc
	Lauren Saj	laurensaj@delta.edu
	Sarah Henicle	shenicle@readsaginaw.org
	Shanell Boos	shanell@peer360recovery.org
	Sharon Norman	snorman@cancouncil.org
	Sandra Lindsey	sandra.lindsey@sccmha.org
	Tamara Tucker	sassae10@yahoo.com
	Tamra Hammon	Tamra@lifeclinic.org
	Tawnya Simon	tsimon@saginawcounty.com
	Teresa Guerra	tguerra@spsd.net
	Terricina Jackson	terricina@mi-fact.org
	Todd Thomasson	thoma3tr@cmich.edu
		harrisonvera820@gmail.com
	Kevin Zoromski	zoromski@anr.msu.edu
Beacon Harbor Homes		regina@beaconharborafc.com
Beacon Specialized Living		mwilliams@beaconspecialized.org
Geddes		geddes@cscsmi.com
Gera Rd.		eking@valleyresidentialservices.org
Hope Network Affiliates		adynet@hopenetwork.org
Kneaded Angels		kneadedangel2006@yahoo.com
Liberty		jlenhart@valleyresidentialservices.org
Navaho Trail AFC		dcarrillo@valleyresidentialservices.org
Riverfront		riverfront@resadvance.com
Roseview		lflores@valleyresidentialservices.org
Saint Charles		kfting@valleyresidentialservices.org
Sloan		sloan@cscsmi.com
Southport		cwilson@valleyresidentialservices.org
St. Vincent		sadamczyk@hccsnet.org
Sunnyside Home		sunnyside_home@yahoo.com
The Prosperity House		rthomas2971@att.net
Valley Res.		sriley@valleyresidentialservices.org

Tab 2

Eligibility & Care Management

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Eligibility Criteria	Chapter: 03 - Continuum of Care	Subject No: 03.01.01
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	Supersedes:	
		Authored By: Barb Glassheim Additional Reviewers: Service Management Team

Purpose:

The purpose of this policy is to establish protocols and processes for the development and administration of admission and continuing stay criteria in order to make objective determinations of eligibility for persons requesting and/or receiving services from SCCMHA.

Policy:

SCCMHA shall provide a comprehensive array of services and supports to persons who meet initial and ongoing eligibility criteria in accordance with the availability of resources.

SCCMHA shall endeavor to ensure that all persons requesting and receiving services are treated in a manner that is person/family-centered, trauma-informed, recovery/resiliency-oriented, developmentally appropriate, and culturally and linguistically sensitive.

Persons requesting services from SCCMHA who meet eligibility criteria shall be referred to the program(s) and/or service(s) that are deemed the best match for meeting their needs. Such service/program matching shall be made in collaboration with the person/family in a manner that supports shared-decision making.

Application:

This policy applies to services and supports provided and funded under the auspices of SCCMHA.

Standards:

- A. All diagnostic criteria shall be defined by the current version of Diagnostic Statistical Manual of Mental Disorders (APA) and the current International Classification of Diseases (WHO).
- B. SCCMHA shall use standardized, validated, reliable, population-specific, developmentally and culturally appropriate screening and assessment instruments to determine needs, supports, and services of persons seeking and receiving services including, but not limited to, the ASAM Criteria, LOCUS, CAFAS, PECFAS, DECA, SCQ, M-Chat, PHQ-9, and MichiCANS.
 - 1. If no standardized assessment tool is used, need shall be assessed with a combination of generally accepted measures of level of functioning such as the ability to live independently, be competitively employed, or have adequate natural supports.
 - 2. The level of functioning may be further defined by the level of acuity.
 - a. Acuity as an indicator must be assessed as an episode of treatment need which meets the severity of illness/intensity of service requirements established by the Michigan Department of Health and Human Services (MDHHS) and incorporated into the Michigan Medicaid Provider Manual, and/or in accordance with the MDHHS Behavioral Health Home (BHH) Manual, and/or MDHHS Certified Community Behavioral Health Clinic (CCBHC) Manual or other applicable funding source (e.g., waiver).
- C. Eligibility shall be determined only through a face-to-face in-person or telehealth interview with the individual conducted by a Qualified Mental Health Professional (QMHP), Qualified Intellectual Disability Professional (QIDP), Qualified Child Mental Health Professional (CMHP), Qualified Behavioral Health Professional (QBHP), or Qualified Substance Abuse Treatment Specialist.
- D. SCCMHA will not discriminate against any person or family because of race, religion, color, national origin, age, sex, cultural or linguistic styles of communication or background, sexual orientation or gender identity, height, weight, familial status, marital status, disability, military history or any other characteristic protected by law.
 - 1. SCCMHA shall not discriminate based on complexity of care or severity of illness outside of the appropriate application of level of care standards.
 - 2. SCCMHA shall not discriminate against Medicaid recipients in enrollment, disenrollment, or re-enrollment based on health status or need for care other than those eligibility criteria established by the MDHHS for the Michigan Medicaid behavioral health carve-out.
- E. SCCMHA shall serve persons who meet eligibility criteria in accordance with the clinical and/or funding requirements of programs or services as follows:
 - 1. SCCMHA BHH Services
 - a. Medicaid beneficiaries with a specific ICD-10 Code for serious mental illness or serious emotional disturbance including: F06: Other mental disorders due to known physiological condition; F20: Schizophrenia; F25: Schizoaffective disorders; F31: Bipolar disorder; F32: Major depressive disorder, single episode; F33: Major depressive disorder, recurrent; F43: Reaction to severe stress, and ad-

- justment disorders; F41: Other anxiety disorders; F90: Attention-deficit hyperactivity disorders; F91: Conduct Disorders; F98: Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence.
2. SCCMHA Certified Community Behavioral Health Clinic (CCBHC) Services
 - a. Any individual with a for mental health diagnosis including the following ICD-10 Codes: F01-F09: Mental disorders due to known physiological conditions; F20-F29: Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders; F30-F39: Mood [affective] disorders; F40-F48: Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders; F50-F59: Behavioral syndromes associated with physiological disturbances and physical factors; F60-F69: Disorders of adult personality and behavior; F90-F98: Behavioral and emotional disorders with onset usually occurring in childhood and adolescence; F99-F99: Unspecified mental disorder.
 - b. Any individual with a substance use disorder including the following ICD-10 Codes: F10: Alcohol related disorders; 11: Opioid related disorders; 12: Cannabis related disorders; F13: Sedative, hypnotic, or anxiolytic related disorders; F14: Cocaine related disorders; F15: Other stimulant related disorders; F16: Hallucinogen related disorders; F17: Nicotine dependence; F18: Inhalant related disorders; F19: Other psychoactive substance related disorders.
 - c. The mental health or SUD diagnosis does not need to be the primary diagnosis; individuals with a dual diagnosis of intellectual disability/developmental disability (I/DD) are eligible for CCBHC services.
 3. SCCMHA services for persons with I/DD shall include, but not be limited to, persons with: Angelman Syndrome (AS), Autism Spectrum Disorders (ASD), Prader-Willi Syndrome (PWS), Down Syndrome, Fetal Alcohol Syndrome (FAS)/Fetal Alcohol Spectrum Disorders (FASD), Fragile X syndrome (FXS), Phenylketonuria (PKU), Hyperphenylalaninemia (HA), Rubinstein Taybi Syndrome, Smith-Magenis syndrome (SMS), Tuberous sclerosis complex (TSC), 22q11.2 deletion syndrome (22qDS), and Williams syndrome (WS).
 - a. Persons with an I/DD shall be defined as eligible according to the Michigan Medicaid Provider Manual and, if they are not enrolled in Medicaid, shall be considered in need of access to specialized supports and services if they require a specialized residential level of care.
 - b. Person with Autism Spectrum disorder (ASD) shall be assessed using MDHHS required assessment instruments (ADOS-2, M-CHAT, SCQ) and found eligible based on MDHHS review of the assessment and certification of the level of care.

- c. Individuals with mild intellectual disability: IQ 50 to 70; slower than typical in all developmental areas; no unusual physical characteristics; able to learn practical life skills; attain reading and math skills up to grade levels 3 to 6; able to blend in socially; function in daily life.
 - d. Individuals with moderate intellectual disability: IQ 35 to 49; noticeable developmental delays (i.e. speech, motor skills); may have physical signs of impairment (i.e. thick tongue); can communicate in basic, simple ways; able to learn basic health and safety skills; can complete self-care activities; can travel alone to nearby, familiar places.
 - e. Individuals with severe intellectual disability: IQ 20 to 34; considerable delays in development; understand speech, but little ability to communicate; able to learn daily routines; may learn very simple self-care; need direct supervision in social situations;
 - f. Individuals with profound intellectual disability: IQ less than 20; significant developmental delays in all areas; obvious physical and congenital abnormalities; require close supervision; require attendant to help in self-care activities; may respond to physical and social activities; incapable of independent living
4. Adults with mental illness shall be deemed eligible for services in accordance with the criteria set forth in the Michigan Medicaid Provider Manual, and the MDHHS CCBHC and BHH Handbooks.
- a. For persons not otherwise Medicaid or Healthy Michigan eligible, SCCMHA will use General Fund dollars to provide crisis stabilization services while a Medicaid application can be completed.
 - b. SCCMHA will consider non-Medicaid (or other designated funding source) covered persons eligible if they have experienced prior psychiatric inpatient admissions ranging from one to four admissions within the past 12 months, and according to medical necessity, and needed access to the specialty behavioral health care system of care based on diagnosis.
 - c. SCCMHA may serve adults with an SPMI (serious persistent mental illness) diagnosis with no recent acuity when the diagnosis is schizophrenia, other chronic thought disorder, or who may require up to four admissions for the treatment of a diagnosed depressive disorder or anxiety disorder using funds from the Michigan Medicaid specialty behavioral health carve-out.
 - 1). The key variable supporting this discretion is the person's needed access to specialized supports and services; if the mental health diagnosis is commonly treated in primary care, and there is no evidence of substantial functional impairment due to the condition, then there is no need for access to the specialized care provided by SCCMHA within the Michigan Medicaid specialty behavioral health carve-out.

- 2). A LOCUS Score of 14 for persons enrolled in Medicaid managed health plans and a LOCUS Score of 28 for persons who are uninsured will be used as a guideline for eligibility based on level of functioning.
- 3). Persons with a mental health or substance use disorder (SUD) diagnosis who are uninsured shall be assessed for eligibility for the BHH and/or CCBHC.
- 4). Individuals deemed ineligible for any program/service funded under the auspices of SCCMHA shall be referred to community resource(s) deemed adequate to meet their needs.
- d. Adults determined by MDHHS as OBRA Level II eligible shall be given the opportunity to review the determination and appeal the decision if they choose.
 - 1) The nursing facility and resident's physician shall also be apprised of the State's determination regarding the resident.
 - 2) SCCMHA shall assist the resident in accessing needed services delineated in the MDHHS determination.
- e. Adults presently incarcerated in a jail are eligible for services while incarcerated only for Medicaid covered psychiatric inpatient care.
- f. Formerly incarcerated adults with SPMI who are re-entering the community from prison as well as adults who are expectant or new parents and their infants shall be prioritized for services.
5. Children with emotional disorders shall be deemed eligible in accordance with the criteria set forth in the Michigan Medicaid Provider Manual and the MDHHS CCBHC and BHH Handbooks, and Home and Community-Based Waiver for children with SED.
 - a. Children with a Child and Family Assessment Scale (CAFAS) composite score of 90 or greater for children ages 7 to 12 or 120 or higher for children 13-18 shall be deemed eligible.
 - b. Priority shall be given to children who are placed out of their homes or in institutional care by MDHHS.
 - c. For children aged 3-6, an elevated subscale score in at least one of the areas of self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others shall be deemed eligible.
 - d. The Level of Functioning CAFAS score is not required for children younger than aged seven.
 - e. The PECFAS and the DECA will be used to inform eligibility decisions for young children even though no threshold score has been established.
 - f. The Michigan Child and Adolescent Needs and Strengths (MichiCANS) shall be used to determine LOC (level of care), youth, and young adults from birth through age 20, including those presenting with SED and/or IDD, including ASD.

- g. Children eligible for the SEDW shall be screened and served in accordance with applicable SCCMHA policies and procedures (see SCCMHA Policies 03.02.40, 03.02.41, and 03.02.42).
- 6. Persons with substance use disorders shall be deemed eligible for services in accordance with the ASAM (American Society of Addiction Medicine) Criteria for level of care.
 - a. Outpatient (less than 9 hours/week) for people with less severe disorders, or as a step-down from more intensive services
 - b. Intensive outpatient (at least 9 and no more than 20 hours/week) with medical care 24 hours/ day by phone or within 72 hours in person
 - c. MAT (medication assisted treatment) including methadone maintenance therapy (MMT) and medications for opioid use disorders
 - d. Subacute withdrawal management on an ambulatory basis or in a medically supervised residential setting
 - e. Recovery supports including recovery coaching and support groups
- F. Any exceptions to the general eligibility criteria shall be published included in all communications and public information.
- G. Residency in the County of Saginaw shall not be used as an eligibility criterion.
 - 1. SCCMHA shall assume the role of “Responsible Mental Health Agency” or “County of Financial Responsibility” when:
 - a. The individual resides in Saginaw County independently or if they live in a dependent care setting and they were placed in that setting by SCCMHA.
 - b. A minor resides in Saginaw County, or resides in another county, but their parents reside in Saginaw County, or a child who is a ward of the court has been placed in Saginaw County.
 - c. The individual’s last independent residence was in Saginaw County and they were placed in a dependent setting by SCCMHA in another county or they require acute mental health care in another county.
 - d. The individual is enrolled in the SCCMHA CCBHC or SCCMHA BHH.
 - 2. SCCMHA shall not assume the role of Responsible Mental Health Agency for persons who reside in dependent care.
 - a. Equivalency to dependent care shall be established when the IPOS (individual plan of services) stipulates the provision of eight (8) or more hours of specialized services and/or supports in the residence each day) settings in Saginaw County when their last independent address was in another county or state.
- H. No person shall be denied needed services due to inability to pay.
 - 1. A sliding fee scale shall be applied, resources permitting, in an effort to serve all individuals who request services from SCCMHA and who are eligible for services.

Definitions:

Behavioral Health Home (BHH): A health delivery model which has a central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop a person-centered Behavioral Health Home care plan (also known as, care plan, throughout this document) to best manage their care. The model also elevates the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this attends to a beneficiary's complete health and social needs. Provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. Core services include: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family Support, and referral to community and social services.

Certified Community Behavioral Health Clinics (CCBHC): A specially-designated clinic that provides a comprehensive range of mental health and substance use services. CCBHCs serve any person with a mental health or SUD ICD-10 diagnosis code¹ who requests services, regardless of their insurance status/ability to pay, or residence. CCBHCs provide nine core services: (1) crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization; (2) screening, assessment, and diagnosis, including risk assessment; (3) patient-centered treatment planning or similar processes, including risk assessment and crisis planning; (4) Outpatient mental health and substance use services; (5) outpatient clinic primary care screening and monitoring of key health indicators and health risk; (6) targeted case management; (7) psychiatric rehabilitation services; (8) peer support and counselor services and family supports; and (9) intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

Child And Adolescent Functional Assessment Scale (CAFAS): An assessment tool used to determine the functional impairment in eight domains of children and youth aged 5 to 19. The CAFAS is used as part of the determination of functional impairment of the child with SED to document that their mental health condition substantially interferes with or limits the minor's role or results in impaired functioning in family, school, or community activities. This is defined as: A total score of 50 (using the eight subscale scores on the CAFAS, or Two 20s on any of the first eight subscales of the CAFAS, or One 30 on any subscale of the CAFAS, except for substance misuse only. The CAFAS is used as a criteria to consider in determining the intensity of services needed, as an outcome measure (pre and post), as an aid to actively manage cases during a course of treatment, and for agency tracking and quality improvement. It 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.

Developmental Disability (DD): A severe, chronic disability of an individual that is attributable to a mental or physical impairment or combination of mental and physical impairments that are manifested before the individual attains age 22 and are likely to continue

¹ The mental health or SUD diagnosis does not need to be the primary diagnosis. Individuals with a dual diagnosis of intellectual disability/developmental disability are eligible for CCBHC services.

indefinitely. Developmental disabilities result in substantial limitations in three or more of the following functional areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.

Developmental Disabilities are a group of conditions that recognize an impairment in a child's physical, learning, language, or behavioral development. These conditions begin to show up during a child's early development stages, and they may impact their day-to-day functioning. Unlike temporary developmental delays in which children may eventually "catch up" with their peers over time, developmental disabilities usually last throughout a person's lifetime and may require life-long support. In the U.S., one in six children are diagnosed with a developmental disability. Some examples of these conditions include: ADHD, Autism Spectrum Disorder (ASD), Cerebral Palsy, Fragile X Syndrome, Intellectual Disability, Language Disorders, Learning Disorders, Tourette Syndrome and others.

According to the Michigan Mental Health Code, Developmental Disability means either of the following:

- (a) If applied to an individual older than 5 years, a severe chronic condition which meets all of the following requirements:
 - i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments
 - ii) Is manifested before the individual is 22 years old
 - iii) Is likely to continue indefinitely.
 - iv) Results in substantial functional limitations in three or more of the following areas:
 - A. Self-Care
 - B. Receptive and Expressive Language
 - C. Learning
 - D. Mobility
 - E. Self-Direction
 - F. Capacity for Independent Living
 - G. Economic Self Sufficiency
 - v) That this condition and its resulting functional limitation 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.
- (b) If applied to a minor from birth to age 5, a substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subsection (a) if services are not provided.

Functional Impairment means both of the following (Michigan Mental Health Code)

- (a) With regard to a serious emotional disturbance, substantial functional limitation of major life activities in two or more of the following areas: self-care at an appropriate developmental level, self-direction, including behavioral control, capacity for living with family or family equivalent, social functioning, learning, or perceptive and expressive language.
- (b) With regard to serious mental illness, substantial disability/functional impairment in three or more primary aspects of daily living such that self-sufficiency is mark-

edly reduced. This includes: -personal hygiene and self-care, self-direction, activities of daily living, learning and recreation, or social transactions and interpersonal relationships.

Intellectual Disability (ID): A neurodevelopmental disorder that emerges before the age of 22 and affects a person's intellectual functioning and adaptive behavior. It can cause individuals to learn and develop at a slower rate than their peers, struggle with basic daily tasks, and experience difficulties in learning. The DSM criteria for intellectual disability take into account three primary elements: deficits in intellectual functions, limitations in adaptive behavior, and the onset of these signs during the developmental period.

According to the Michigan Mental Health Code Intellectual disability means a condition manifesting before the age of 18 years that is characterized by significantly subaverage intellectual functioning and related limitations in 2 or more adaptive skills and that is diagnosed based on the following assumptions:

- (a) Valid assessment considers cultural and linguistic diversity, as well as differences in communication and behavioral factors.
- (b) The existence of limitation in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the individual's particular needs for support.
- (c) Specific adaptive skill limitations often coexist with strengths in other adaptive skills or other personal capabilities.
- (d) With appropriate supports over a sustained period, the life functioning of the individual with an intellectual disability will generally improve.

Level of Care Utilization Services (LOCUS): An assessment tool designed to guide treatment decisions for adults aged 18 and older. The LOCUS assesses six dimensions:

- 1. Risk of Harm: This dimension considers a person's safety towards themselves, and others.
- 2. Functional Status: This dimension considers how a person is able to function in their daily life, and how their illness may stop them from doing the things they need and want to do.
- 3. Medical, Addictive and Psychiatric Co-Morbidity: this dimension considers the different types of conditions that may be impacting a person's life, and how the conditions interact with one another.
- 4. Recovery Environment (Stress and Support in the Environment): this dimension considers the degree of stress a person may be experiencing in their current (or planned) living setting, and the types of support they have available to aid their recovery.
- 5. Treatment and Recovery History: This dimension considers a person's previous experience with receiving behavioral health treatment and how they responded to that treatment.
- 6. Engagement and Recovery Status: This dimension considers a person's interest in and willingness to receive treatment, and their understanding of their need for treatment.

Michigan Child and Adolescent Needs and Strengths (MichiCANS): An information integration tool designed to explore and communicate the needs and strengths of the child/youth and family. This approach allows staff to listen to the experiences of the child

and family. Together, the child, family, and care team can prioritize action steps and track changes. The MichiCANS includes domains that focus on important areas of the child's/youth's life. The MichiCANS also includes ratings that help the provider, child/youth, and family understand: (1) where intensive or immediate action is most needed and (2) where a child/youth has strengths that can become a major part of the treatment or service plan. The MichiCANS consists of two parts: the MichiCANS Screener and the MichiCANS Comprehensive. The Screener is completed at the child/youth's point of access; and the MichiCANS Comprehensive is completed at intake and periodically during the implementation of services to reflect growth, progress, and changes in life events. The information that is collected through the MichiCANS Screener flows into the MichiCANS Comprehensive to avoid requiring the family to share their experiences multiple times. The MichiCANS was incorporated into the access, intake, and service planning processes for children, youth, and their families/caregivers since October 1, 2024.

Modified Checklist for Autism in Toddlers, Revised (M-CHAT): A 20-question screening instrument completed by the parents in order to identify a potential ASD in toddlers between 16 and 30 months of age.

Patient Health Questionnaire (PHQ-9): A nine-item depressive symptom scale and diagnostic tool used to screen adult patients in primary care settings. It assesses for the presence and severity of depressive symptoms and a possible depressive disorder.

Preschool and Early Childhood Assessment Scale (PECFAS): 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. The PECFAS 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. It 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. The PECFAS is required for young children, ages 3 – 4 enrolled in the SED Waiver and Wraparound.

Qualified Behavioral Health Professional (QBHP): An individual with a minimum of a master's degree in a mental health-related field or BACB approved degree category from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. A physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD.

Qualified Child Mental Health Professional (CMHP): An individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the exami-

nation, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families. For the Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) services individuals must be a Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA).

Qualified Intellectual Disability Professional (QIDP): An individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons with intellectual or developmental disabilities as part of that experience) or one year of experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietitian, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree or higher in a human services field.

Qualified Mental Health Professional (QMHP): An individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited-licensed marriage and family therapist, a licensed physician's assistant, or a human services professional with at least a bachelor's degree or higher in a human services field.

Qualified Substance Abuse Treatment Specialist: An individual who has licensure in one of the following areas, and is working within their scope of practice: Clinical Nurse Specialist (CNS), Licensed Bachelor's Social Worker (LBSW); Licensed Marriage and Family Therapist, Licensed Master's Social Worker (LMSW), Licensed Practical Nurse (LPN), Licensed Professional Counselor (LPC), Licensed Psychologist (LP), Limited Licensed Bachelor's Social Worker (LLBSW), Limited Licensed Marriage and Family Therapist, Limited Licensed Master's Social Worker (LLMSW), Limited Licensed Professional Counselor (LLPC), Limited Licensed Psychologist (LLP), Nurse Practitioner (NP), Physician (MD, DO), Physician Assistant (PA), Registered Nurse (RN), Temporary Limited Licensed Psychologist (TLLP) and who has a registered development plan leading to certification and is timely in its implementation (Development Plan – Counselor (DP-C) – approved development plan in place); or who is functioning under a time-limited exception plan approved by the regional PIHP; or an individual who has one of the following Michigan Certification Board of Addiction Professionals (MCBAP) or International Certification and Reciprocity Consortium (IC & RC) credentials: Certified Advanced Alcohol and Drug Counselor – IC & RC (CAADC), Certified Alcohol and Drug Counselor – IC & RC (CADC).

Serious Emotional Disturbance (SED): A diagnosable mental, behavioral or emotional disorder affecting a minor that exists or has existed during the past year for a period of time

sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by American Psychiatric Association and approved by the department that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school or community activities. The following disorders are included only if they occur in conjunction with another diagnosable emotional disorder: (a) substance use disorder, (b) a developmental disorder, (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Serious Emotional Disturbances Waiver (SEDW): The Children's Home and Community-Based Services Waiver for Children with Serious Emotional Disturbance provides services that are enhancements or additions to Medicaid State Plan coverage for children up to age 21 with SED who meet the criteria for admission to an inpatient psychiatric hospital and/or who are at risk of hospitalization without waiver services. Such services may include community living supports (CLS), family home care training, family support and training, respite care, therapeutic overnight camp, wraparound services, and others.

Serious Mental Illness (SMI): A diagnosable mental, behavioral or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria established in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the department that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders are included only if they occur in conjunction with another diagnosable serious mental illness: (a) a substance use disorder, (b) a developmental disorder or (c) a "V" code in the Diagnostic Statistical Manual of Mental Disorders and "Z" code in the ICD-10 (Other Conditions That May Be a Focus of Clinical Attention).

Social Communication Questionnaire (SCQ) for Autism Assessment: An initial screening instrument for ASD designed for individuals aged four and older that is used to help identify individuals who may require further evaluation and potentially benefit from early intervention strategies. The SCQ consists of 40 yes-or-no questions that focus on various aspects of social communication and behavior typically associated with ASD. These questions are carefully crafted to elicit information about an individual's developmental history and current functioning, covering areas such as: reciprocal social interaction, communication skills, and restricted, repetitive, and stereotyped patterns of behavior.

Substance Use Disorder (SUD): A treatable medical condition that is characterized by the inability to control the use of a particular substance (or substances) despite harmful consequences. SUDs can range from mild to severe (addiction).

Suspension: Services temporarily stopped during periods of time when a person served has failed to renew their Medicaid with consideration for essential benefits related to continuity of residential and medication services.

References:

A. Michigan Mental Health Code; Act 258 of the Public Acts of 1974 as amended:

1. Sec. 330.1100a (20), Definition of Intellectual and Developmental Disability
2. Sec. 330.1100b (5), Definition of Functional Impairment
3. Sec. 330.1100d (2), Definition of Serious Emotional Disturbance
4. Sec. 330.1100d (3), Definition of Serious Mental Illness
5. Sec. 330.1208 (3), Priority of Service
- B. Michigan Department of Health and Human Services Community Mental Health Specialty Services Managed Care Contract; Section 4.2 Target Population, Section 4.5(3) Access Assurance, Section 4.4 Services to be Delivered
- C. Michigan Department of Health and Human Services; Medicaid Provider Manual; most current version of Beneficiary Eligibility, Section 2.5 Medical Necessity Criteria
- D. Commission on Accreditation of Rehabilitation Facilities
- E. SCCMHA Policy 05.04.01 – Care Management Services
- F. Balanced Budget Act of 1997 (H.R.2015)
- G. Michigan Department of Health and Human Services: Behavioral Health Home (BHH) Handbook
- H. Michigan Department of Health and Human Services: Michigan Certified Community Behavioral Health Clinic (CCBHC) Handbook
- I. SCCMHA Policy - Behavioral Health Screening and Assessment Standards
- J. SCCMHA Policies 03.02.40, 03.02.41, 03.02.42 – SEDW

Exhibits:

- A. CCBHC Mild/Moderate Flow Chart
- B. Persons with Intellectual/Developmental Disabilities (I/DD) Flow Chart
- C. Persons with ASD Flow Chart
- D. Children’s Waiver Program (CDP) Flow Chart
- E. Persons with Serious Mental Illness (SMI) Flow Chart
- F. Children with Serious Emotional Disturbance Waiver (SEDW) Flow Chart
- G. Substance Use Disorder Outpatient (ASAM 1.0-2.1) Services Flow Chart
- H. Summary of Children’s Home and Community Based Services Waiver Program
- I. Summary of Habilitation Support Waiver
- J. Summary of 1915(i)SPA Waiver
- K. Summary of Seriously Emotional Disturbances Waiver

Procedure:

ACTION	RESPONSIBILITY
1. In accordance with the Mid-State Health Network Specialty Supports and Services Contract, ensures that the service array provided to the eligible persons is adequate and the available general fund resources are allocated to support services to those most severely affected.	1. SCCMHA Board of Directors and Chief Executive Officer (CEO)
2. Monitors the adequacy of the service array through continuous utilization analysis.	2. SCCMHA Services Management Team (SMT)

3. Monitors the comprehensiveness and MDHHS certification of the provider network.	3. Director of NS, PP, CE, OBRA/PASARR, & EHS
4. Establishes policy which adjusts the threshold of severity for eligibility for services for persons not otherwise eligible for Medicaid or Healthy Michigan when funding is deemed inadequate to support the service array with the exception of CCBHC enrollment. NOTE: This threshold of severity may be expressed in a measurable level of functioning or a measurable level of acuity.	4. Chief Executive Officer
5. Ensures eligibility criteria are communicated to community agencies, to Managed Health Plans and to persons requesting services.	5. SCCMHA CEO
6. Ensures that screening, access and assessment services are in place so that all persons requesting services are a) apprised of the eligibility criteria; b) helped with accessing alternative services in the event they do not meet eligibility criteria; and c) offered a face-to-face eligibility assessment in-person or via telehealth when they are dissatisfied with recommendations following screening or the need for crisis intervention services.	6. Executive Director of Clinical Services and Programs
7. Ensures that all levels of functioning assessment instruments or tests used to establish eligibility meet the criteria set forth in Standard B.	7. Executive Director of Clinical Services and Programs
8. Performs face-to-face in-person or telehealth eligibility evaluations in the Central Access and Intake Unit, and co-located behavioral health consultants in schools, physician offices, juvenile detention and jail services.	8. Intake Specialist
9. Completes an Eligibility Certification in the Electronic Medical Record.	9. Intake Specialist
10. Informs persons denied services following a face-to-face assessment of their right to a second opinion.	10. Intake Specialist
11. Document verification of eligibility in the medical record prior to the authorization or provision of services other than initial assessment and engagement or crisis intervention.	11. Manager of Utilization Care Authorizations

12. Ensures that the criteria for continuing eligibility meets the standards established in this policy and reviews continuing eligibility at least annually.	12. SMT
13. Identifies priority populations established by MDHHS/CMHSP contract, those of local concern and those established by program or service type (e.g., BHH, CCBHC). NOTE: Such persons may be deemed eligible for services with less restrictive criteria than for the general population.	13. SCCMHA Board of Directors, CEO, SMT
14. Gives advance notice of suspension of services to persons served who fail to renew their Medicaid and notifies them of their option to re-enter under the criteria for persons who are uninsured or to resume services when Medicaid is reinstated.	14. Entitlement Supervisor
15. Changes the status to General Fund for persons who have a Medicaid Deductible (spend down) which has not been met in three months and reviews their continuing stay in accordance with the criteria set forth in this policy.	15. Entitlement Supervisor
16. Assists persons who are requesting services for the first time, but are not enrolled in Medicaid, with completing a Medicaid Application.	16. CAI Unit and Entitlement Office staff
17. Assists persons with the MiBridges application portal as needed.	17. Entitlement Office staff
18. Ensures that persons in acute need are served with short term crisis stabilization services in the CAI unit until a Medicaid eligibility determination has been made or a program/service the individual is eligible for is available	18. CAI Supervisor

Exhibit A

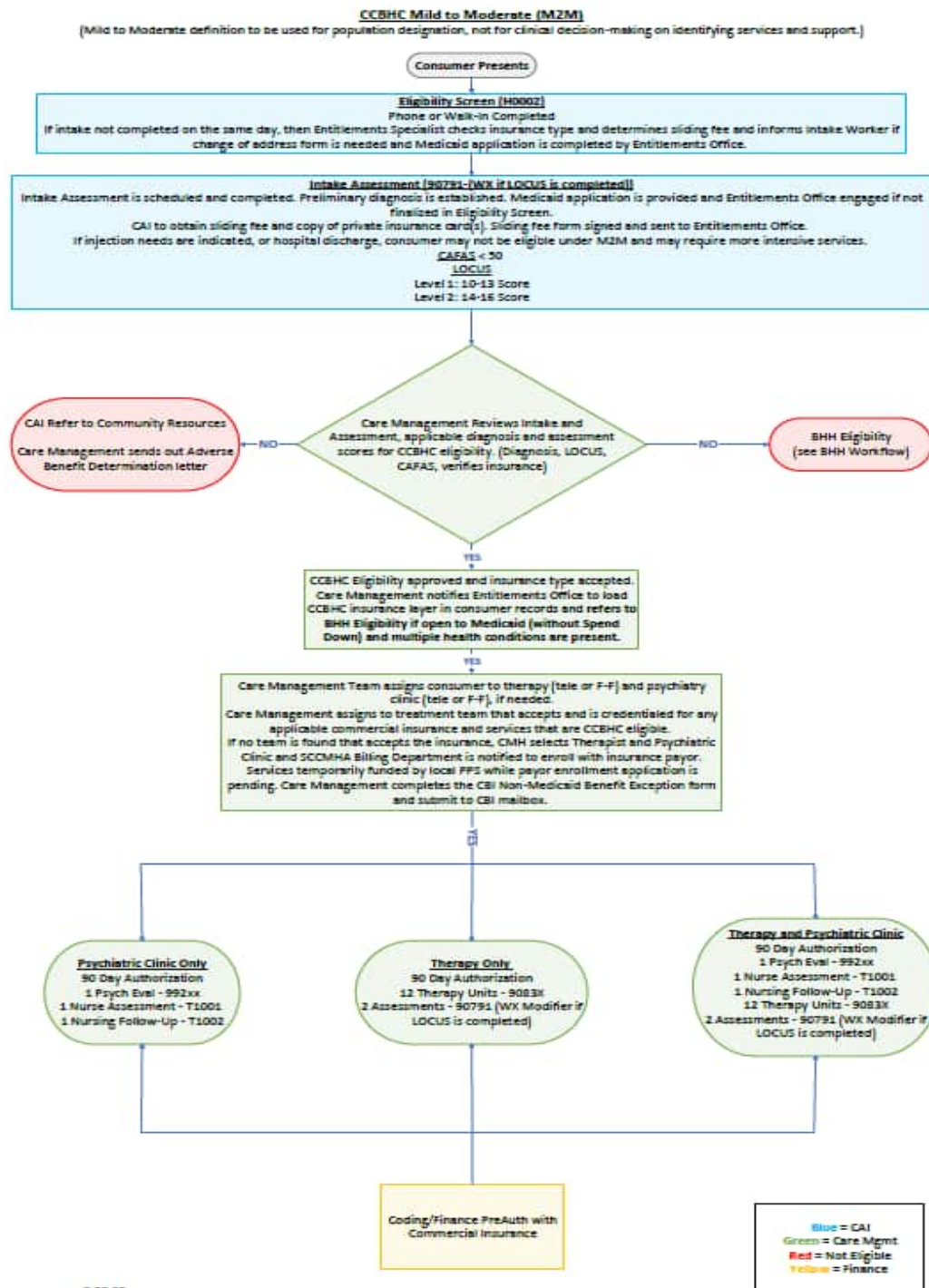


Exhibit B

CMHSP Specialty Benefit - Intellectual/Developmental Disabilities (I/DD) Population

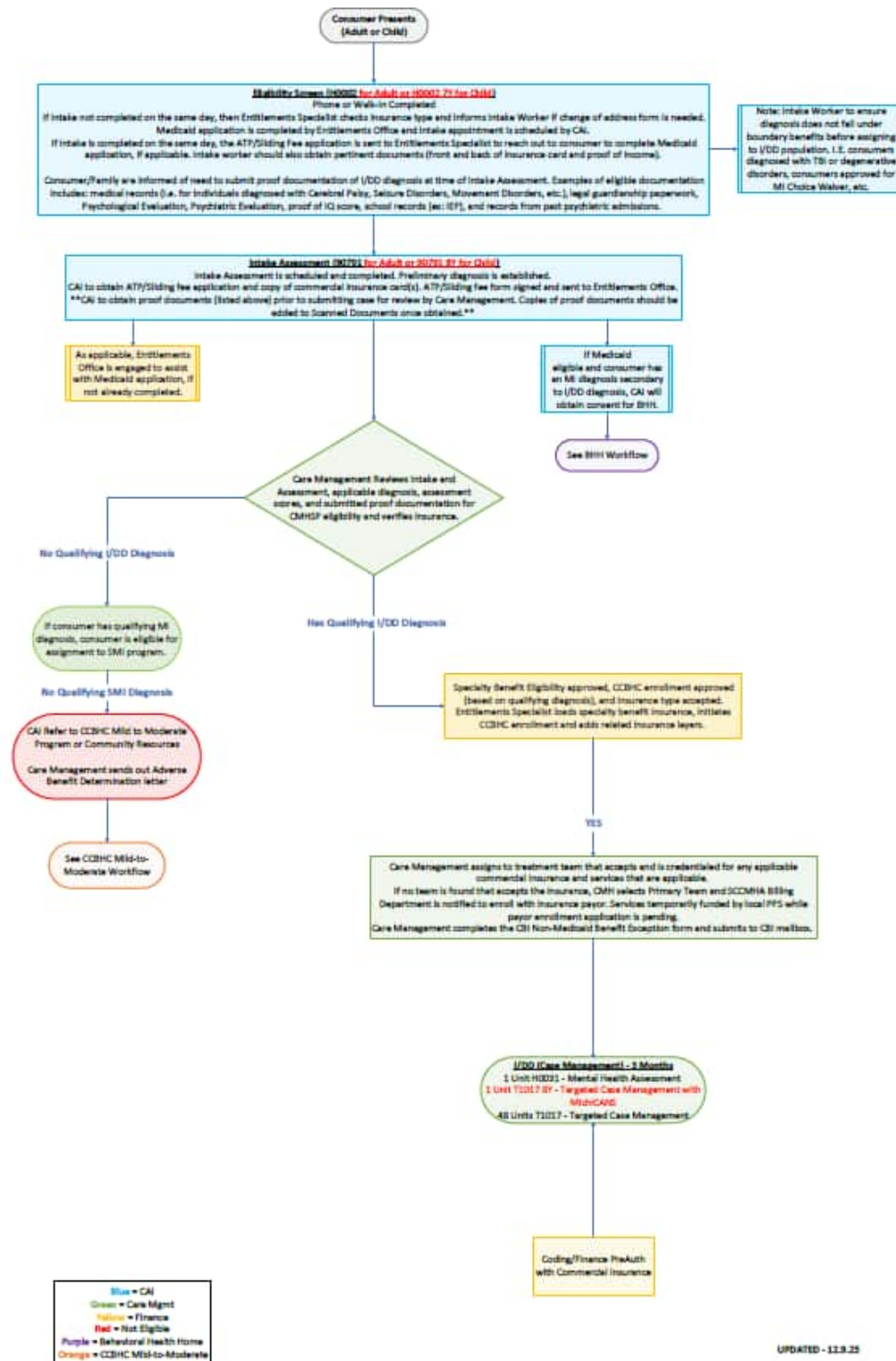


Exhibit C

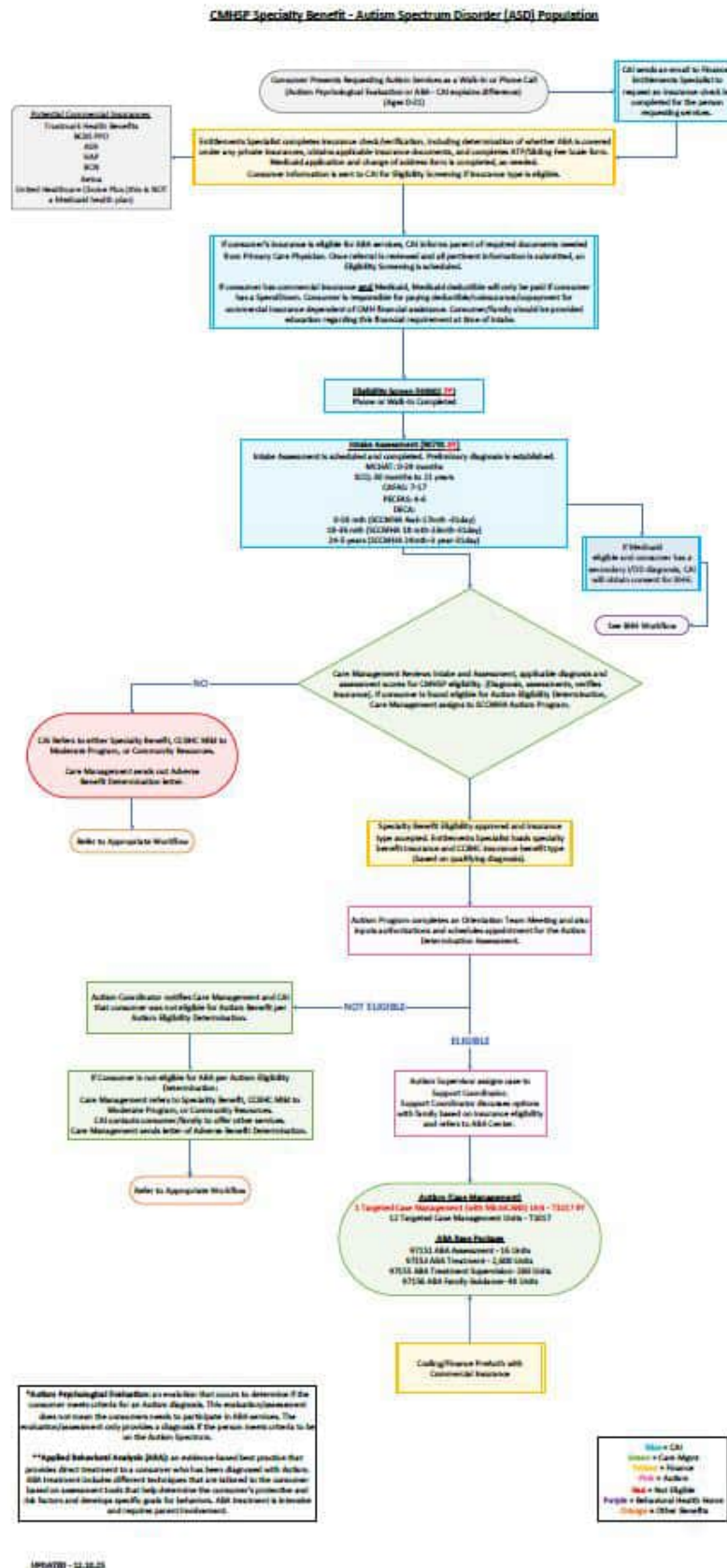


Exhibit D

CMHSP Speciality Benefit - I/DD Child Population - Children's Waiver Program (CWP)

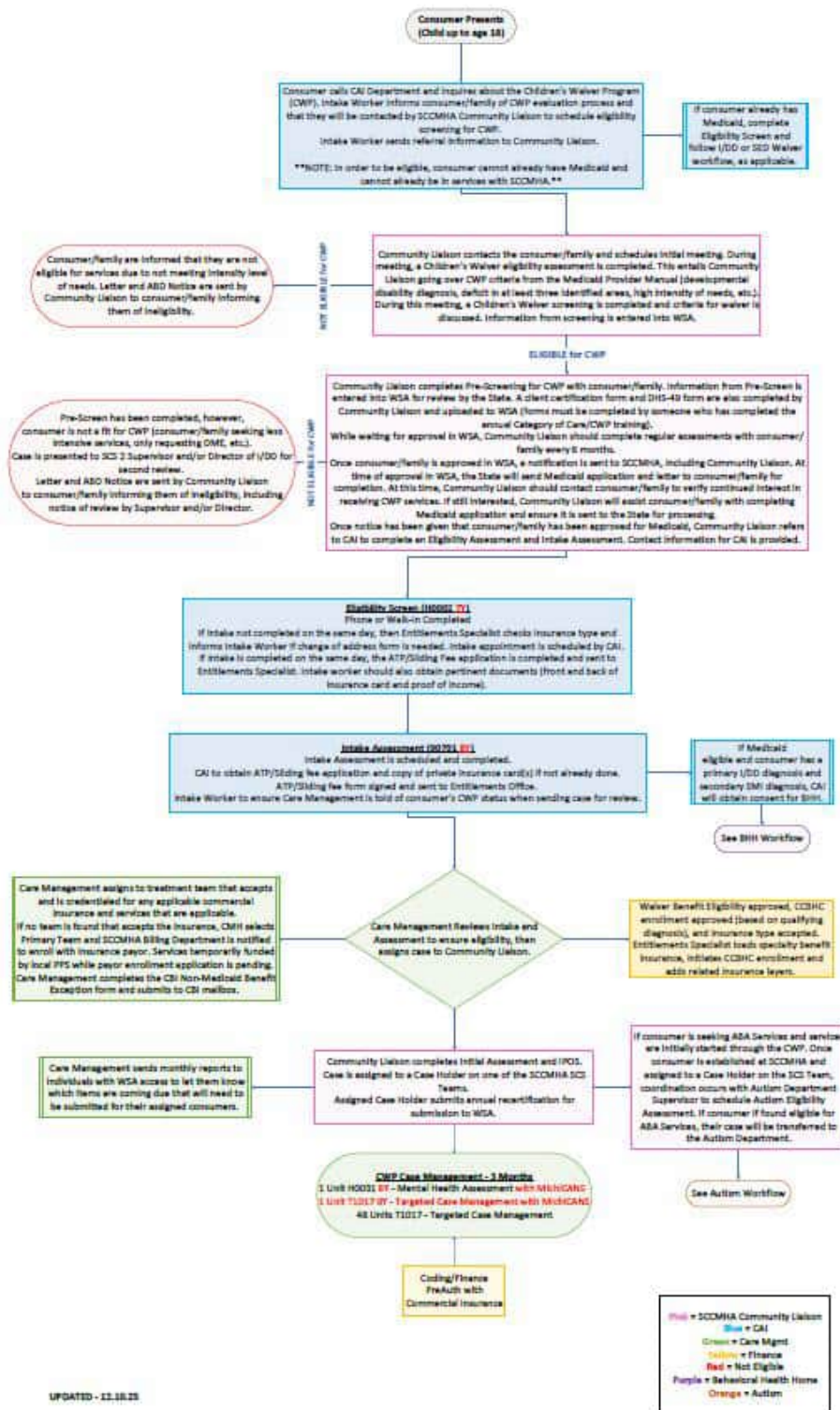
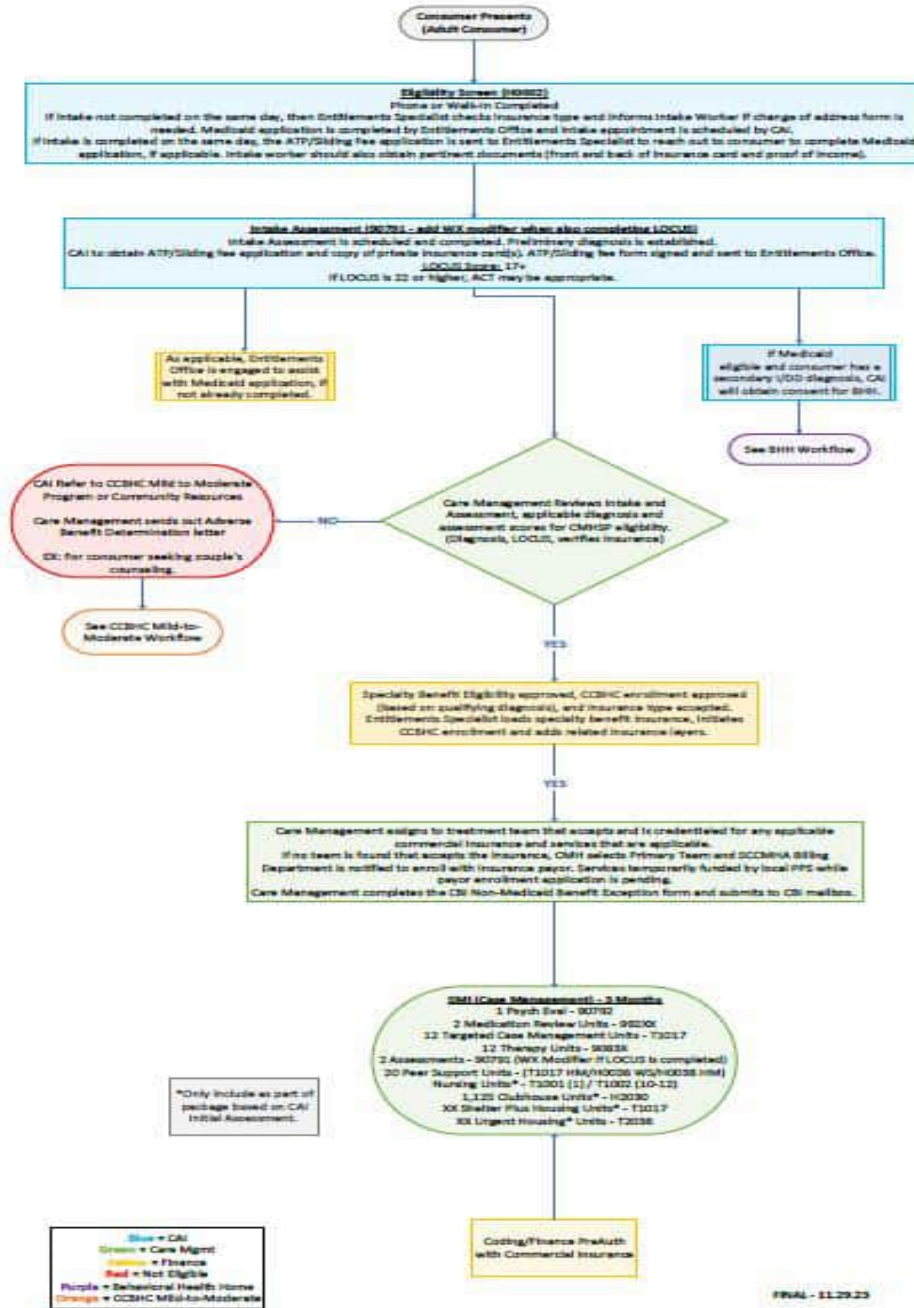


Exhibit E

CMHSP Speciality Benefit - Severe Mental Illness (SMI) Population



CMHSP Specialty Benefit - Children with Serious Emotional Disturbances Waiver (SEDW) Population

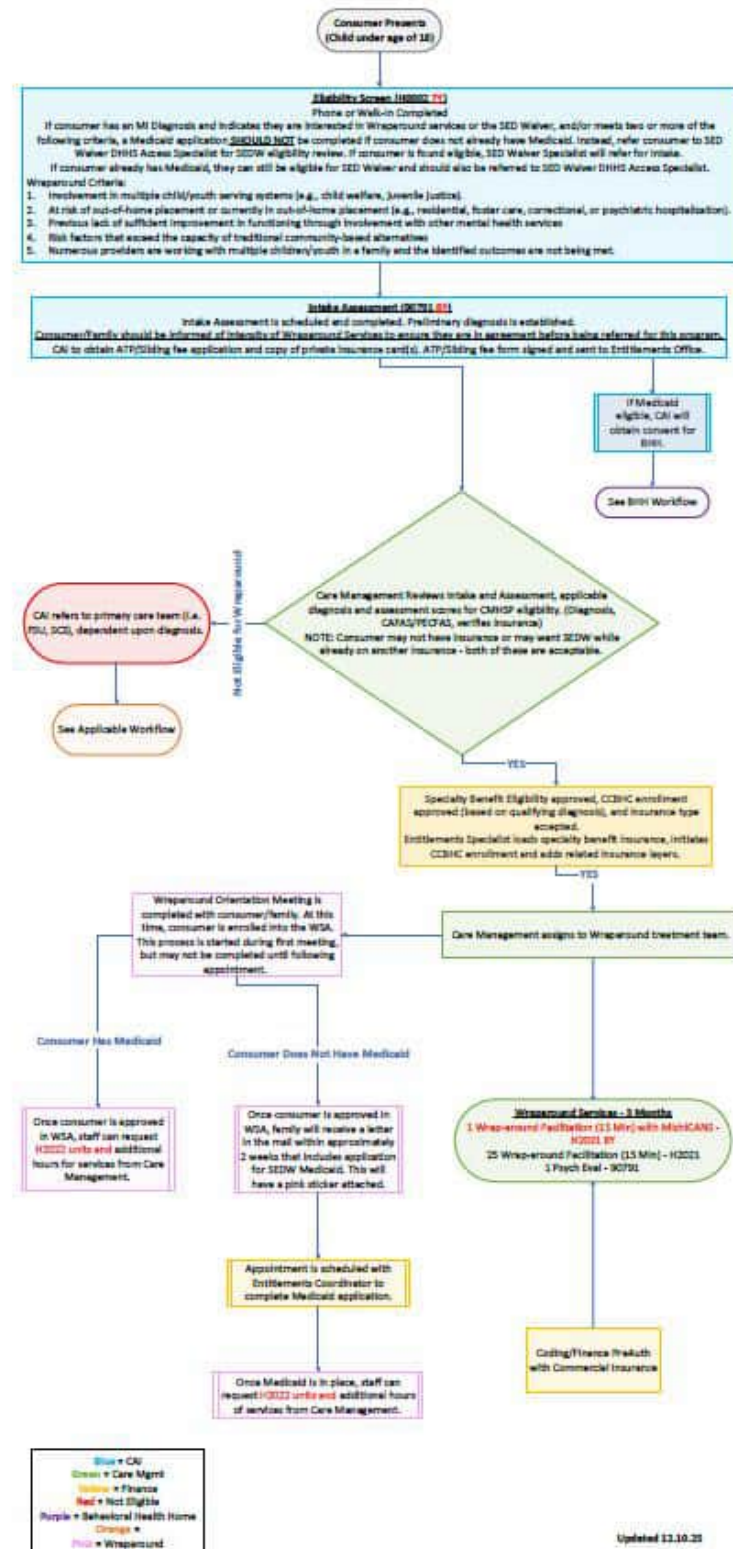


Exhibit G

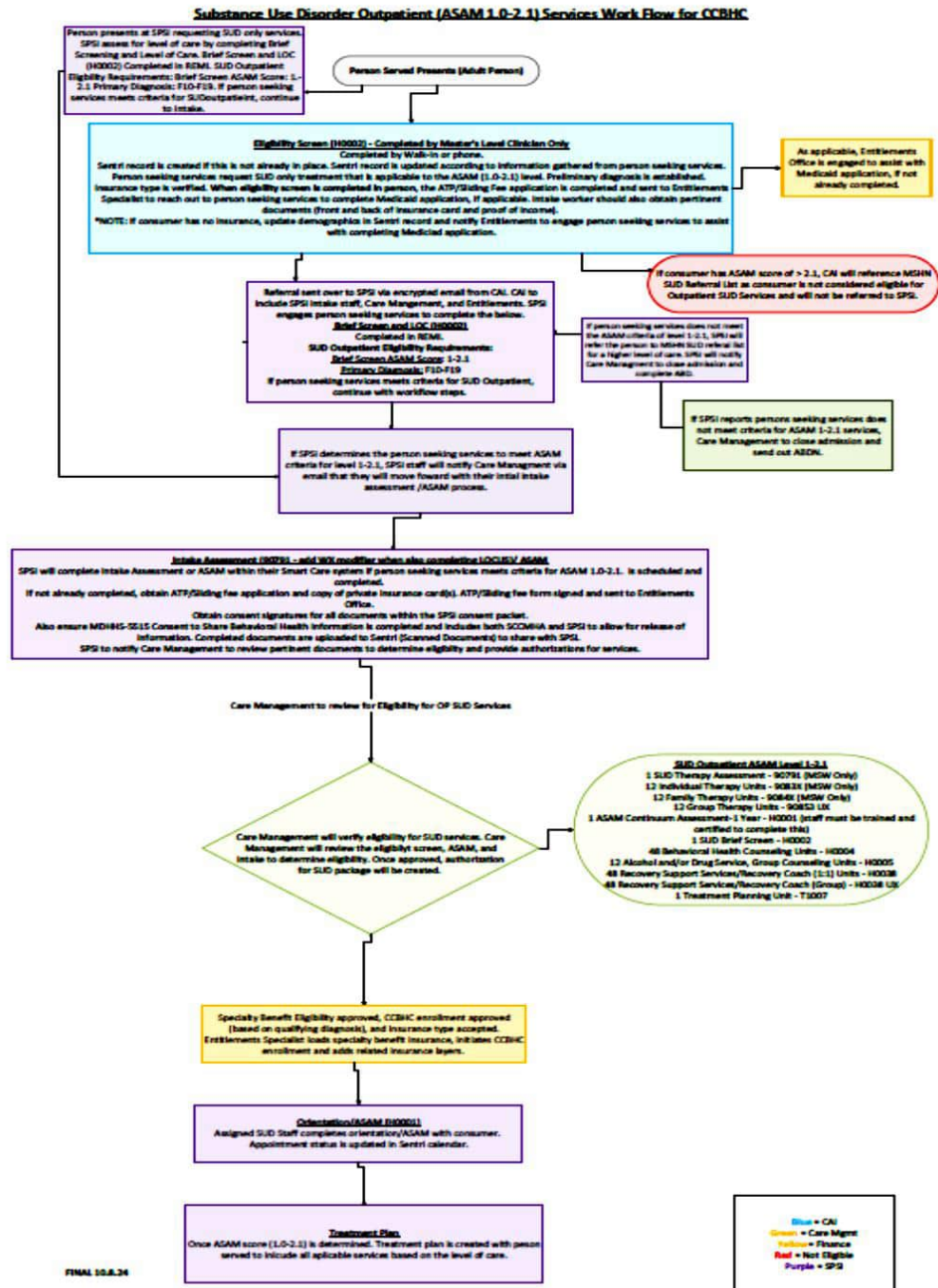


Exhibit H

updated 12/9/2025

Children's Home and Community Based Services Waiver Program (CWP) - Started 10/1/1983

Child Waiver Program Definition = Provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP. The CWP enables Medicaid to fund necessary home and community-based services for children with developmental disabilities who reside 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 MI, regardless of their parent's income.

Eligibility Requirements = 18 years of age, identified developmental disability based on 3 of the 6 defined areas, needs for consistent and aggressive in-home services to promote independence and/or prevent loss of current abilities, live with parent/legal guardian.

Effective 10/1/25- MichiCANS tool is to be used to support eligibility determinations for services.

SCCMHA CWP Lead = Lynn White

SCCMHA CWP beneficiaries = 11 SCCMHA slots out of 469 Statewide slots, MDHHS FY25 waiver approval by CMH added another 100 slots (50 rollout in FY26, 50 in FY27)

PIHP Leads: Tera Harris, Barb Groom

MDHHS HAB/CWP conference reference source =

[Event Details – CMHAM – Community Mental Health Association of Michigan](#)

Child Waiver service requirements = Must receive at least one Child Waiver service monthly (excluding respite & supports coordination).

Reporting Requirements = Critical Incidents, Monthly Encounter Reporting, BH TEDS month reporting - updated annually, Waiver Service Application (WSA)- update demographics, annual client certification with category of care assessment.

Meetings = CMHSP quarterly meetings with PIHP, annual conference, HAB/CWP bi-monthly SCCMHA review workgroup

MDHHS/PIHP Audit of SCCMHA = Annually May-July

CWP Enhancement Service Codes	Service Description	Unit Definition	Place of Service	Unit/\$ Limits	Credential Modifier	Providers
90863	Pharmacological Mgmt. w/Psychotherapy	45 Min		10/month, must be used w/ 90832-90838	Various	SCCMHA, Primary Team Network Clinics
92626	Evaluation of Auditory Rehab Status	1st hour		1 per month	Various	
92627	Eval of Auditory Status Rehab Add-On	each add. 15 min.		12/90 days	Various	
92630	Auditory rehab, prelingual hearing loss	Encounter		8/month	Various	
92633	Auditory rehab, postlingual hearing loss	Encounter		8/month	Various	
97124	Occupational Therapy- therapeutic procedure 1 or more areas	each 15 min DT: 40/day		face to face only	OT Therapist="HO, HP, HN" OT Therapist Assistant="CO"	SCCMHA, Paramount, Game Changer, Mercy+, ABA Pathways, Autism Systems, Flourish
	Physical Therapy-therapeutic procedure 1 or more areas	each 15 min DT: 40/day		face to face only	PT Therapist="HO, HP, HN" PT Therapist Assistant="CQ"	SCCMHA, Paramount, Game Changer
	Massage Therapy	each 15 min		4 sessions/month, face to face only	Licensed Massage Therapist="HM"	
97530	Occupational Therapy	15 min DT:40/day		face to face only	OT Therapist="HO, HP, HN" OT Therapist Assistant="CO"	SCCMHA, Paramount, Game Changer, Mercy+, ABA Pathways, Autism Systems, Flourish
	Physical Therapy	15 min DT:40/day		face to face only	PT Therapist="HO, HP, HN" PT Therapist Assistant="CQ"	SCCMHA, Paramount, Game Changer
97761	Prosthetic Training 1st Encounter	15 min		8 session/month for combined OT & PT procedures	OT Assistant="CO", OT="HO, HN",PT="HN, HO, HP"	SCCMHA, Paramount, Game Changer, Mercy+

E1399	Durable Medical Equipment	item				National Seating & Mobility, Saginaw Medical-Michigan Medical & Rehabilitation Supplies
G0176	Specialty Services, Activity Therapy (music, recreation or art) 45 min or more			4 sessions/month per type	Therapeutic Recreation ="HN", Music Therapist="HN", Art Therapist="HO"	Guided Grace, Grounded Therapy
H2015	Community Living Supports	15 min, 96 units/day	12, 99			SCCMHA, Wellspring, APS Employment Services, SVRC, Flatrock, Genoa Healthcare, Guardian Angel, HOME, Self-Directed, VOICE
K0739	Repair/Service DME non-Oxygen Equipment	15 min				DME vendor
S0215	Transportation	per mile				Taxi-Voucher system
S5111	Family Training	encounter		cannot exceed 1/day. Limit 4/month, limit 12/90 days	Various	SCCMHA, Saginaw Psychological, Westlund
S5116	Home Care Training, Non-Family	Encounter		cannot exceed 1/day. Limit 4/month, limit 12/90 days	Various	SCCMHA, Saginaw Psychological, Westlund
S5165	Environmental Modifications/Accessibility Adaptation-Home modification	service		DT=1,000/day		Specialty Vendor
S5199	Enhanced Medical Equipment & Supplies-Personal Care Item	item		5/quarter, less than \$96 each		DME vendor
T1005	Respite Care	up to 15 min		4,608/fiscal year		APS Employment Services, HOME, First Day Homecare, Guardian Angel, Self-Directed
T2025	Fiscal Intermediary Services	monthly		1/month		Stuart Wilson, GT Independence
T2027	Overnight Health & Safety	15 min		DT=48 unit or 12hr/day		
T2028	Enhanced Medical Equipment & Supplies-Assistive Technology-Special Supply, Nos Waiver	item		5 allergy control/quarter, no greater than \$96 ea		Specialty Vendor
T2029	Enhanced Medical Equipment & Supplies-Assistive Technology-Special Med Equip, Nos Waiver	item				Specialty Vendor
T2039	Enhanced Medical Equipment & Supplies-Assistive Technology-vehicle Mod	item				Specialty Vendor

Misc. Notes:

- * as of 3/31/25, SCCMHA has one case on the CWP statewide waiting list
- * All inquiries are centrally addressed by CWP community liaison whom completes eligibility assessment and pre-screen if deemed appropriate
- * T1017 Supports Coordination code must be rendered monthly face to face with 2 unit minimum
- * CWP applications are submitted through WSA and then receive PIHP level review
- * Provider qualification verification every 3-years

Exhibit I

Updated 12-9-25

HSW (Habilitation Support Waiver) - MDHHS Started this waiver 10/1/87

HSW Waiver Definition = Under Section 1915(c) of the Social Security Act, states may request a waiver of certain federal requirements in order to provide specified home & community based services to designated enrolled participants who would otherwise require institutional services reimbursed through Medicaid. The Habilitation Supports Waiver (HSW) functions as the state's primary vehicle for supporting people in the community by enrolling people who were placed out of the Intermediate Care Facility for the Intellectually Disabled (ICF/ID) and deflecting those who might otherwise require ICF/ID level of services. The purpose of the HSW is to provide community based services to people with intellectual/developmental disabilities who, if not for the availability and provisions of HSW services would otherwise require the level of care services provided in an ICF/ID.

Eligibility Requirements = Monthly HSW recertification submissions. Must have a developmental disability- no age restriction, reside in a community setting (12 beds or less), Medicaid eligible, would otherwise need the level of services similar to an Intermediate Care Facility for Intellectually Disabled (ICF/ID), choose to participate in the HSW in lieu of ICF/ID services.

SCCMHA HSW Lead = Brittany Smith (Care Mgmt. Liaison- Initial submission & renewal certifications) / Char Fondren (Clinical primary contact/BMC)

SCCMHA HSW beneficiaries = as of Feb25, SCCMHA utilizes 153 slots (10%) of MSHN region's 1,577 slots. MDHHS has approximately 7,500 HSW slots statewide approved by CMS

PIHP Leads: Victoria Ellsworth, Kara Hart

MDHHS HSW conference reference source =

[Event Details - CMHAM - Community Mental Health Association of Michigan](#)

HSW Waiver service requirements = Monthly CSM contact face-to-face + qualifying HAB service (CLS, Pre-voc, Out of home non-voc, SE)

Reporting Requirements = HSW signed consent every 3 years, Critical Incidents, Monthly Encounter Reporting, BH TEDS month reporting - updated annually, Waiver Service Application (WSA)- update demographics, annual client certification with "performance of major life activity (PMLA)", RLA code (Type of Residency).

Meetings = CMHSP quarterly meetings with PIHP, annual conference, HAB/CWP bi-monthly SCCMHA review workgroup (HSW forms and meeting minutes stored within MSHN Box shared portal)

MDHHS/PIHP Audit of SCCMHA = Annually May-July

HSW Enhancement Service Codes	Service Description	Unit Definition	Place of Service	Unit/\$ Limits	Credential Modifier	Providers
E1399	Enhanced Medical Equipment & Supplies-Assistive Technology	item				National Seating & Mobility
H0045	Respite Care-includes licensed camp	day				APS Employment Services, Various Camps, ABA providers, Self-Directed
H2014-WZ	Out-of-Home Non-Vocational Habilitation	15 min				
H2015	Community Living Supports	15 min				SCCMHA, AbleLight, APS Employment Services, SVRC, Flatrock, Genoa Healthcare, Guardian Angel, HOME, JubeJu, ABA providers, Self-Directed, VOICE
H2016	Community Living Supports-specialized residential setting	per diem				Various Specialized AFC Homes
H2023	Supported Employment	15 min			"HM, HN"	SCCMHA, SVRC, Shiawassee CMH
H2025	Supported Employment-Job Coaching	15 min			"HM"	SCCMHA, SVRC
S5111	Family Training	encouter		DT=2/day	Various Credentials	SCCMHA, ABA Providers, Saginaw Psychological, Westlund
S5116	Non Family Training	encouter			Various Credentials	SCCMHA, ABA Providers, Saginaw Psychological, Westlund

S5151	Respite Care	per diem				APS Employment Services, Self-Directed
S5160	Personal Emergency Response System (PERS)-installation & testing	encouter				
S5161	Personal Emergency Response System (PERS)-service	month				
S5165	Environment Modifications-Home modification	service		DT=1,00/day		
S5199	Enhanced Medical Equipment & Supplies-Assistive Technology	item				
S9123	Private Duty Nursing-individual nurse (21 years or older)	hour		24/day	"TD"	First Day HomeCare
S9124 rev code: 0582	Private Duty Nursing-private duty agency (21 years or older)	hour			"TD"	First Day HomeCare
T1005	Respite Care	up to 15 min		DT=96/day		APS Employment Services, HOME, Samaritas, First Day Homecare, Guardian Angel, ABA Providers, Self-Directed
T1999	Enhanced Pharmacy	item		DT=1,000/day		
T2015 - Code discontinued 6/1/25	Prevocational Service	hour		DT=8/day		SCCMHA, SVRC
T2025	Fiscal Intermediary	per month				Stuart Wilson, GT Independence
T2027	Overnight Health & Safety	15 min		DT=48 units or 12 hours/day		Self-Directed
T2028	Enhanced Medical Equipment & Supplies-Assistive Technology-Specialized supply	item		DT=1,00/day		
T2029	Enhanced Medical Equipment & Supplies-Assistive Technology-specialized medical equipment	item		DT=1,00/day		
T2039	Enhance Medical Equipment & Supplies-Assistive Technology-	item		DT=1,00/day		
T5999	Goods & Services	item				

Misc. Notes:

- * Each CMHSP within region can only submit 5 initial HSW applications monthly due to region's FY25 reduction of slots
- * Applications where aging off other waiver programs are given higher priority consideration
- * T1017 Supports Coordination code must be rendered monthly face to face
- * HSW applications are submitted through WSA which then receives PIHP level review before final submission to MDHHS
- * Provider qualification verification every 3-years

Exhibit I

1915(i)SPA Waiver

iSPA Waiver Definition = Section 1915(i) of the Social Security Act gives State Medicaid programs the flexibility to cover **home and community-based services (HCBS)** through a Medicaid state plan amendment (SPA) without the need to seek a federal waiver. States can develop the HCBS benefit to meet the specific needs of a population(s) within Federal guidelines, including:

- * Establish a process to ensure that assessments and evaluations are independent and unbiased
- * Ensure that the benefit is available to all eligible individuals within the State
- * Provider adequate and reasonable provider standards to meet the needs of the target population
- * Ensure that HCBS are provided in accordance with a person-centered service plan
- * Establish a quality assurance, monitoring and improvement strategy for the benefit

Eligibility Requirements = Must have a substantial functional limitation in one or more of the following areas of major life activity:

- * Self-care
- * Communication
- * Learning
- * Mobility
- * Self-direction
- * Economic self-sufficiency
- * Capacity for independent living

SCCMHA iSPA Lead = Vurlia Wheeler, Backup- Ann Beeler

SCCMHA iSPA beneficiaries = 942 as of 7/1/25

PIHP Leads: Brianna Elsasser, MSHN State Plan Coordinator

MDHHS iSPA conference reference source = MSHN Leads Mtg- periodic as-needed

iSPA Waiver service requirements = Monthly Supports Coordination monitoring contact and one iSPA eligible service quarterly. SCCMHA Care Mgmt. will enroll all iSPA services on the WSA portal

Reporting Requirements = Initial enrollment in WSA and recertification annually. iSPA loaded in Sentri consumer specific once approved in WSA (Ann Beeler sends list weekly to Kim Hall)

Meetings = 1/4 meeting, July 18, 2025 is next meeting (3rd Friday)

MDHHS/PIHP Audit of SCCMHA = Preparation for annual site visit scheduled 6/24/25 by MDHHS/Belinda Hawks (All waivers)

iSPA Enhancement Service Codes	Service Description	Unit Definition	Place of Service	Unit/\$ Limits	Credential Modifier	Providers
E1399	Enhanced Medical Equipment & Supplies/Misc. (Single Room Air Conditioner)	item				National Seating & Mobility, Saginaw Medical Services, FirstNet/Verizon, Apple
G0177	Family Training	session at least 45 min		DT 1/day	Psychiatrist="AF", Physician="AG", Psychologist="AH, HP" Educator w/education degree="HN", PT="HN, HO", OT="HN, HO", behavioral analyst,="HN", Therapeutic Recreation Spec. ="HN", HS profess. w/BA="HN", Speech-language pathologist="HO", Audiologist="HO", MSW="HO", LPC="HO", Marriage & Family Therapist="HO", LPA="SA-PA, NP, CNS", RN="TD"	No Utilization Found
H0045	Respite Care-including licensed camp	day				APS Employment Services, Various Camps, GT Independence, Spectrum Autism Center, Stuart Wilson, H.O.M.E.
H2014	Skill Building Assistance	15 min				SVRC, Kinney Home, Shiawassee CMH COFR
H2015	Community Living Supports	15 min	12, 99			SCCMHA, AbleLight, APS Employment Services, Bay Human Services, SVRC, Flatrock, Game Changer, Genoa Healthcare, GT Independence, Guardian Angel, HOME, JubeJu, Lutheran Child & Family, Spectrum Autism, Stuart Wilson, VOICE
H2016	Community Living Supports-specialized residential setting	per diem				Various Specialized AFC Homes
H2023	Supported Employment	15 min			"HM, HN"	SCCMHA, SVRC, Shiawassee CMH
H2025	Supported Employment-Job Coaching	15 min			"HM"	SVRC

S5110	Family Training-skills workshop	15 min			Psychiatrist="AF", Physician "AG", Psychologist= "AH, HP", Educator w/education degree="HN", PT= "HN, HO", OT= "HN, HO", Behavior analyst="HN", Therapeutic recreation specialist="HN", HS profess. w/BA="HN", Speech-language pathologist="HO", Audiologist="HO", MSW="HO", LPC="HO", Marriage & Family Therapist="HO", LPA="SA- PA, NP, CNS", RN="TD"	No Utilization Found
S5111	Family Training-home care	encounter		DT=2/day	Various Credentials	SCCMHA, ABA Pathways, Children's Therapy Corner, Saginaw Psychological, Flourish Services, Mercy Plus Healthcare Services
S5151	Respite Care-in home	per diem				APS Employment Services, Game Changer, Stuart Wilson, H.O.M .E
S5160	Personal Emergency Response System(PERS)-install & testing	encounter				
S5161	Personal Emergency Response System(PERS)-service	month				
S5165	Environmental Modification/Accessibility Adaptation- home mod	item				Access Construction
S5199	Enhanced Medical Equipment & Supplies/Assistive Technology (lpads, apps, internet plans)	item				
T1005	Respite Care	up to 15 min		DT=96/day		APS Employment Services, Autism System, Bay Human Services, HOME, Various Camps, First Day Homecare, Game Changer, GT Independence, Guardian Angel, Mercy Plus Healthcare, Spectrum Autism, Stuart Wilson
T1015	Family Training	encounter			Various Credentials	No Utilization Found
T1999	Enhanced Pharmacy	item		DT=1,000		Genoa
T2025	Fiscal Intermediary	month				Stuart Wilson, GT Independence
T2028	Enhanced Medical Equipment & Supplies/NOS (Allergy controlled supplies)	item		DT=1,000		
T2029	Enhanced Medical Equipment & Supplies/NOS (Environmental safety & control devices)	item		DT=1,000		
T2038	Housing Assistance	service			Various Credentials	SCCMHA HRC/Salter Place- No FY25 UM
T2039	Enhanced Medical Equipment & Supplies/Assistive Technology (Vehicle Modification)	item		DT=1,000		

SED (Seriously Emotional Disturbances) Waiver - MDHHS started October 2005, expanded to all counties 2019

SED Waiver Definition = Provides services that are enhancements or additions to Medicaid State Plan services for children/youth under age 21. Statewide managed care title XIX program. Enables Medicaid to fund necessary home and community-based services for eligible children with a serious emotional disturbance who meet admission criteria for psychiatric hospitalization.

Eligibility Requirements = CAFAS score: 90 or greater ages 7 to 12, or 120 or greater ages 13-18; PECFAS subscale scores in one area for ages 3 to 6; DECA ages 2 to 4 with protective T-score 40 or below, and/or elevated score on one or more behavioral concerns 32 scales with T-score 60 or above... and be under age 18 when approved for Waiver
Effective 10/1/25- MichiCANS tool is to be used to support eligibility determinations for services.

SCCMHA SED Lead = Nicholas Kerbleski

SCCMHA SED beneficiaries = 13

PIHP Leads: Tera Harris, Barb Groom

MDHHS Wraparound/SED conference reference source = [Annual Wraparound Conference](#)

SED Waiver service requirements = Must receive at least one SED waiver service, in addition to Wraparound, per month in order to retain eligibility.

Reporting Requirements = Critical Incidents, Monthly Encounter Reporting, BH TEDS month reporting - updated annually, Waiver Service Application (WSA)- update demographics.

Meetings = CMHSP quarterly meetings with PIHP

MDHHS/PIHP Audit of SCCMHA = Annually May-July

SEDW Enhancement Service Codes	Service Description	Unit Definition	Place of Service	Unit/\$ Limits	Credential/Mich iCANS Modifier	Providers
H2015	Community Living Supports - Unlicensed	15-min	12, 99	774 month	DSP= "HM"	SCCMHA, Self-Directed, APS, HOME
G0176	Activity Therapy (Music, Recreation, Art)	Encounter/ Session	11, 12, 99	12 per month	NMTR, NCTRC = "HN", AATCB = "HO"	Guided Grace, Grounded Therapy
H2021- Starts 4/1/25	Intensive Care Coordination with Wraparound	15-min	Various		Various, 8Y = MichiCANS	SCCMHA
H2022- Ends 3/31/25	~~Wraparound - Community Based~~	~~Per Diem~~	~~Various~~		~~Various~~	~~SCCMHA~~
S5111	Family Support and Training	Encounter	Various	1 per day, 4 per month, 12 per 90-day period	Various	SCCMHA, SPSP, Westlund
S5116	Home Care Training, Non-Family	Encounter	12	1 per day, 4 per month, 12 per 90-day period	QMHP, QIDP, CMHP	SCCMHA, SPSP, Westlund
S5145	Therapeutic Family Care, Child Foster Care (Licensed)	Per Diem	12		MDHHS Certified	n/a - MDHHS CFC
T1005	Respite Care	Up to 15-min	12, 99	1,248 per month	DSP= "HM"	Self-Directed, APS, HOME
T2025	Fiscal Intermediary/Financial Management Services	Encounter	n/a	1 per calendar month		Stuart Wilson, GT Independence
T2027	Overnight Health and Safety Supports	15-min	12	48 units daily	DSP= "HM"	Self-Directed
T2036	Overnight Therapeutic Camp	Per Diem	99	\$1,400 per session	DSP= "HM"	Various Camps

Misc. Notes:

- * Must be enrolled in and receiving Intensive CC Wraparound Services (New guidance coming 2025 for TCM T1017 code alternative to Wrap)
- * In-person Child and Family Team meetings are to be provided once per month, at minimum, for children/youth under the SEDW during both Health & Hope phases
- * SEDW applications are submitted through PIHP
- * Provider qualification verification every 3-years
- * SED renewal application required every 3-years by CMHSP into CRM to PIHP

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Member Enrollment, Transfer/ Discharge, BH-TEDS Data and Case Service Status	Chapter: 05 - Organizational Management	Subject No: 05.04.02
Initial Date: November 5, 2002	Date of Review/Revision: 11/5/02, 1/7/08, 6/30/09, 5/8/12 8/3/16, 9/7/16, 3/14/17, 5/8/18, 9/10/19, 3/08/21, 3/16/22, 2/24/23, 1/23/24, 1/30/25, 3/10/26 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: Chief Information Officer and Chief Quality & Compliance Officer Authored By: Holli McGeshick Additional Reviewers: AmyLou Douglas
		

Purpose:

To ensure that Saginaw County Community Mental Health Authority (SCCMHA) will manage consumer membership services in its electronic health record to adequately address the needs of managing treatment, payment and operations including the SCCMHA contractual obligation to the Mid-State Health Network (MSHN) and the Michigan Department of Health and Human Services (MDHHS) for Behavioral Health Treatment Episode Data Set (BH-TEDS) data reporting.

Policy:

SCCMHA shall define required BH-TEDS data elements for compliance with MSHN contract requirements and necessary treatment, payment, and operations functions. The collection and maintenance of this data set shall be directed by this procedure. This BH-TEDS data will be treated as Protected Health Information and all rules of privacy and security shall be adhered to in its maintenance and use. This policy further describes the requirements for member enrollment and for the formation of both a member record and a consumer record in the integrated electronic health record.

Application:

SCCMHA and Primary SCCMHA Network Providers.

Standards:

- All member BH-TEDS data shall be confirmed and updated and complete upon each face-to-face visit.

- SCCMHA shall report the BH-TEDS data set to the Mid-State Health Network according to contractual requirements.

Definitions:

Beneficiary: A person who has applied for and approved for the Medicaid or Healthy Michigan health care benefit provided by the State of Michigan.

Eligibility: Eligibility is defined by the Michigan Department of Health and Human Services, Mid-State Health Network and the Saginaw County Community Mental Health Authority Board Eligibility policy which uses the severity of illness/intensity of service criteria established by the MDHHS contracts for access to this publicly managed behavioral health care service.

Enrollee: A consumer who has applied for and has been accepted by Medicaid or Healthy Michigan health benefit may be required to become an “enrollee” of the qualified health plan of their choice. “Enrollee” designates the relationship between the beneficiary and the qualified health plan. The requirement to enroll in a managed care health plan is limited to certain beneficiaries. Not all Medicaid beneficiaries are required or allowed to enroll.

SCCMHA is not an “enrollment” health plan; however, as the delegated sole source contracted manager for supports and specialty services for Michigan Medicaid and Healthy Michigan plans under MSHN, SCCMHA manages services for Medicaid and Healthy Michigan enrollees and thereby accepts contractually delegated duties from Mid-State Health Network and for the administration of enrollee rights.

Enrollment: Enrollment may be used to describe the process of application and registration for services at the beneficiary level, the managed care level or at the specialty support and services level of a managed care health system. The term is not generally used at the provider level. Enrollment for the Medicaid and the Healthy Michigan programs occurs at the Department of Health and Human Services, enrollment for the Qualified Health Plans occurs through the MDHHS enrollment services provider, Michigan Enrolls. MDHHS provides beneficiary enrollment information to SCCMHA for all capitated contracts. The SCCMHA Care Management Department enrolls members in the specialty benefit managed for Mid-State Health Network PIHP by SCCMHA and the CMHSP managed benefit plans.

Individually Identifiable Health Information: A subset of Health Information that includes demographic information, that is created by a covered entity, that identifies the individual or that, may be used to identify the individual

Protected Health Information: Individually identifiable health information that is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium.

Member: A member is an individual who has requested services from SCCMHA and has been issued a unique identification number (member ID number.) A member may be a

Medicaid and Healthy Michigan under the Mid-State Health Network PIHP contract, or they may be served with the MDHHS general fund allocation under the CMHSP contract. The “member” relationship is between the consumer and Mid-State Health Network as a PIHP and SCCMHA as CMHSP. The term expresses eligibility for services and enrollment in the PIHP and CMHSP service system.

Member Status: A member’s status is expressed as Active or Closed. The function of member status is to ensure the minimum necessary data requirements for SCCMHA claims payment.

Active Member Status: A member record is considered active following an initial request for service. The BH-TEDS data set is initiated at the time of the initial assessment. Claims may be paid for services provided to an active member if the provider has completed the data set (demographics in Sentri) and assessment of consumer’s ability to pay.

Closed/Discharged Member Status: A consumer’s record shall be “closed” upon the planned or unplanned cessation of services. The record status should be changed in Sentri within two weeks of confirmation of the consumer’s intent to terminate service.

Transferred Member: An active consumer is moved to another SCCMHA contracted provider within the SCCMHA network.

BH-TEDS dataset: This set of client demographic and clinical data elements is established by the Michigan Department of Health and Human Services and is reported monthly to MSHN by the SCCMHA Quality Department. This is maintained in the Sentri electronic medical record and administered by the SCCMHA Quality & Medical Records Supervisor.

References:

- Health Insurance Portability and Accountability Act of 1966
- Michigan Department of Health and Human Services Specialty Supports and Service.
- Mid-State Health Network Contract 2026 as updated
- Contracts for PHP’s and CMHSP’s 2026, as amended
- SCCMHA Policy Eligibility Criteria
- Coding Instructions for Michigan Behavioral Health Treatment Episode Data Set (BH-TEDS) FY2025

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
Member Enrollment 1. The SCCMHA Central Access & Intake Department shall enroll members upon elective request for services by the primary consumer or their guardian. Member enrollment services shall be provided by telephone or walk-in request 24/7. 2. Enrollment will not be made for persons upon the request of family or friends other than guardians nor upon the request of agencies. 3. Enrollment requires the voluntary request of the consumer or their guardian unless the person is presented by a police officer who has the individual in protective custody or under the order of the Probate Court. 4. SCCMHA member enrollment procedures will include the verification of the consumer's enrollment status with Medicaid or Healthy Michigan qualified health plans.	1-4 Executive Director of Clinical Services and Programs
Enrollment Non-Discrimination 1. Acceptance of individuals for enrollment shall be open to eligible persons in the order in which they apply without restriction up to the limits set in the MDHHS contract. 2. SCCMHA shall not discriminate on the basis of health status or need for health care services in the enrollment of individuals. 3. SCCMHA shall not discriminate on the basis of race, color, or national origin and will not use any policy or practice which has the effect of discriminating on the basis of race, color or national origin.	1-3 Chief of Network Business Operations
Unique Consumer Identification 1. The SCCMHA Central Access & Intake Department shall issue a unique consumer identification number upon member enrollment. 2. The number shall be issued to the consumer by	1-5. Executive Director of Clinical Services and Programs

legal name. The consumer name shall be recorded in the SCCMHA database as it is in the Medicaid or MiChild enrollee record if such exists. 3. Enrollment shall not be given to persons under an assumed name or alias, although such names may be documented in the record if provided by the consumer. 4. The SCCMHA member enrollment procedure shall establish the uniqueness of the consumer identity with three data points: consumer name, date of birth and social security number. 5. If a second case number is accidentally issued to a consumer, notification shall be made to the Entitlement Supervisor to review and merge the records.	
Case Service Status: 1. Case Service Status shall be expressed as Active (Open) or Closed. "Inactive" status will not be used in the SCCMHA information system. 2. When a consumer is received into any network provider for assessment, the BH-TEDS data set and ability to pay assessment shall be completed and directly entered into the SCCMHA member record or shall be entered into the SCCMHA consumer demographic data collection tool. 3. Each provider shall establish a record status of "Active" (Open) and "Closed". A case status report shall be furnished by the provider upon request for random selection of active and closed cases for review by MSHN and SCCMHA auditors. 4. No service should be provided to a consumer whose case status is Closed. To re-initiate services for a consumer whose case service status has been closed for 90 days or more, Central Access & Intake Department must be notified in order to verify eligibility by completing a new screening. If consumer is found eligible for services, consumer will be re-opened to the appropriate service. Provider must refresh the quality demographic data set and ability to pay	1-7. Executive Director of Clinical Services and Programs and Primary Provider administrators

assessment before providing the requested service. 5. Case status reports may also be requested for utilization management reviews or other quality, compliance or accreditation functions. 6. A case status of Closed shall be entered in the record within two weeks of confirmation of the consumer's intent to terminate services. Supervisors are required to sign off on all discharges within 7 days. 7. Case status designation must be administered or reviewed at a supervisory or administrative level at each provider location. This administrative oversight shall ensure administrative accountability for consumer's eligibility for services and agency adherence to Medicaid Fair Hearing Adequate and Advance Notice requirements.	
Disenrollment: 1. SCCMHA shall not request member dis-enrollment for reasons other than those permitted under the MDHHS Supports and Specialty Services Contract. SCCMHA shall not disenroll any member for reasons related to an adverse change in the enrollee's health status, or because of the enrollee's utilization of services, or their diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. 2. SCCMHA is not a voluntary enrollment program; it is a mandatory enrollment program at the Supports and Specialty Services Contract level. Further, enrollees do not have a plan choice at this level. Change of residency out of the service area is the only reason a member may disenroll from the SCCMHA Specialty Supports and Services program. 3. Enrollee disenrollment rights for the following reasons (with cause) are addressed through Medicaid Fair Hearing, Local Dispute Resolution, Non-Panel provider provisions, Person Centered Plan-	1-4. Chief of Network Business Operations

ning and Self Determination consumer directed purchase of service options. i. Service restriction due to PHP limitation on requested service due to moral or religious objections. ii. Enrollee needs a group of related services, not all of which are available through the SCCMHA network. iii. Other reasons such as poor quality of care, lack of access to covered services under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs. 4. SCCMHA will automatically adjust member fund source based on Medicaid or Healthy Michigan beneficiary status, as SCCMHA is both the delegated manager of the Medicaid Managed Care Supports and Specialty Services for MSHN and the CMHSP Contractor for Saginaw County. Enrollment with SCCMHA does not change based on beneficiary status with Medicaid or Healthy Michigan Assignment: 1. Each consumer whose case service status is Active or Open shall be assigned to a mental health professional who serves as a primary worker. In the SCCMHA provider system, this person's name shall be entered in the case holder field. This designation does not imply the provision of case management services per se, only that the named treatment team member is the lead professional who is responsible for the medical record. 2. The assignment of a consumer to a mental health professional allows the consumer as well as others to have the name of an individual professional who can answer questions about the consumer's record and service status. The assigned worker is the person with primary accountability for the accuracy of the demographic BH-TEDS data. 3. The assigned worker shall periodically review	1-3. Executive Director of Clinical Services and Programs and Primary Provider administrators

1. Primary record holder initiates discharge planning by completing a discharge summary in Sentri and sending appropriate consumer notice. 2. Supervisor reviews and signs off on discharge plan within 7 days of discharge request by Primary record holder. 3. Care Management will monitor all consumers without any contact within 90 days and request reason for no activity from supervisors on a regular basis.	1-3 Executive Director of Clinical Services and Programs and Primary Provider Supervisor
Use of Member BH-TEDS data in Treatment Payment and Operations (TPO) 1. Individual Protected Health Information in the BH-TEDS data set may be used by SCCMHA for treatment, payment and operations as allowed by the Health Insurance Portability and Accountability Act. 2. SCCMHA will contractually require Provider compliance with HIPAA regulations for Privacy in Protected Health Information maintenance, use and transmission.	1-2 Chief Information Officer & Chief Quality and Compliance Officer
BH-TEDS Data Integrity: 1. The Quality Systems department shall make available the Coding Instructions for Michigan Behavioral Health Treatment Episode Data Set (BH-TEDS) for provider training and reference. 2. The Quality Systems and the Information Systems Departments shall ensure that all electronic data base fields in the SCCMHA information system or in data collection tools for the recording of BH-TEDS data elements are consistent with the current MDHHS definitions and coding requirements. 3. The Quality and Information Systems Departments shall monitor data for range errors and omissions and shall initiate needed periodic trainings, system level corrections or requests for correction by the assigned case managers. 4. The Quality & Medical Records Supervisor or the Business Intelligence Coordinator will de-	1-4 Chief Information Officer & Chief Quality and Compliance Officer

velop BH-TEDS data reports for the use in monitoring and editing the BH-TEDS data for consumers. The Provider shall establish a procedure for the periodic review of the BH-TEDS data, case status and assignment to ensure that it is current and accurate.	

Tab 4

Service Delivery

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Evidence-Based Practices (EBPs)	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09
Effective Date: 5/1/06	Date of Review/Revision: 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, 03/28/25, 4/28/25, 03/16/26 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team
		

Purpose:

To promote the use of services and supports for persons served 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 person served.

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 persons served and their families, which, in turn, can promote independence and satisfactory participation as full citizens in community life.
 2. Persons served 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 persons served 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 person served'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/care-giver-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 person served'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 persons served 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-informed 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 persons served and their families to achieve recovery, build resiliency, and foster opportunities for persons served 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; person served 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 person served 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 persons served 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.
 5. Supervisors shall coach EBP practitioners to include answers to the following in their EHR documentation:
 - a. Why are they using this EBP?
 - b. What was addressed?
 - c. What specific technique(s)/intervention(s) was used?
 - d. How did the person served respond?
- E. SCCMHA shall provide support for the implementation and maintenance of EBPs through an EBP Leadership Team and Best Practices Quality Improvement Committee.
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 - MI and Substance Use Disorders - SUD, 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.
 2. Members of the Best Practices Quality Improvement Committee will vary but may include the following: SCCMHA EBP/TIC Coordinator, Director of Network Services, Public Policy, & Continuing Education, SCCMHA Director of Services for Persons with Mental Illness - MI and Substance Use Disorders - SUD, Quality Improvement Program Coordinator, Quality and Medical Records Supervisor, Data Warehouse; Reporting; and Application Analyst, as well as 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 and/or the Best Practices Committee 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, MichiCANS, 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 by the Best Practices Committee.
4. Adaptations to SCCMHA-endorsed EBPs shall be based on person served 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 Best Practices Committee, through the EBP/TIC Coordinator or other supports, shall endeavor to conduct fidelity checks of practices that are not reviewed by other entities (e.g., the Michigan Fidelity Assistance Support Team [MIFAST]).
 - a. Fidelity checks/reviews conducted under the auspices of the Best Practices Committee 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 full fidelity reviews to the leadership of the agency/relevant SCCMHA Director, along with program staff supervisors, prior to conducting a fidelity review.
 - c. Spot checks will not necessarily be notified.
 - d. 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 persons served 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 person served.

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-blind 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 persons served and providers are full partners in the treatment process. Providers are a source of hope, affirmation, and education and collaborate with persons served 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 persons served about the various options available to them to work on their goals and objectives. Persons served 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 non-productive. 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 March 2023, [CCBHC Certified Criteria](#)
- 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 person served 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 person served 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 Best Practices Committee.

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 EBP 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: 1. Program leader 2. Senior staff (e.g., executive director, psychiatrist) 3. Practitioners providing the EBP 4. Clients and / or families receiving EBP 5. Written materials (e.g., brochures)	No more than 1 of the 5 sources shows clear understanding of the program philosophy OR All sources have numerous major areas of discrepancy	2 of the 5 sources show clear understanding of the program philosophy OR All sources have several major areas of discrepancy	3 of the 5 sources show clear understanding of the program philosophy OR 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 OR 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. 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: $\frac{\# \text{ clients receiving EBP}}{\# \text{ clients eligible for EBP}}$	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 where 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 <i>related to the EBP</i> that is consistent with assessment and updated every 3 months.	=20% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i> , updated every 3 months	21%-40% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i> , updated every 3 months	41%-60% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i> , 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, <i>related to the EBP</i> , updated every 3 months	>80% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i> , 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) <i>within 2 months of hiring</i> . 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%-80% 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 <i>specific client situations</i> .	=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 <i>explicitly address the EBP model and its application</i>

	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 OR 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 OR 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 OR Agency fully embraces client choice with one exception	All sources agree that type and frequency of EBP services reflect client choice

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
- Persons served 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 person served 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 persons served rated are those receiving the practice.

- a) Program leader interview, b) Senior staff interview and c) Practitioner interview
d) Person served 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 persons served 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/Person served Identification

Definition:

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

For EBP implemented in a service area: All persons served 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 persons served 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 persons served 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 persons served are invited to receive the service because all are presumed eligible (although the program is intended for persons served 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 person served.
- Screening typically occurs at program admission, but for a program that is newly adopting an EBP, there should be a plan for systematically reviewing persons served already active in the program.

Rationale: Accurate identification of persons served 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 persons served 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 persons served receiving EBP services only. Calculate this percentage and rec-

ord it on the fidelity rating scale in the space provided. If 100% of these persons served receive standardized screening, the item would be coded as a “5.”

G3. Penetration

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

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

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 persons served are actively receiving treatment. As a practical matter, agencies have many conventions for defining “active persons served” 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 persons served are eligible for supported employment (i.e., the community support program has not surveyed the persons served to determine those who are interested). Let’s say the community support program has 120 persons served. Then you would estimate the denominator to be:

$$120 \times .6 = 72$$

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

G4. Assessment

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

Standardization refers to a reporting format that is easily interpreted and consistent across persons served.

High quality refers to assessments that provide concrete, specific information that differentiates between persons served. If most persons served 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 person served'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 persons served receive standardized, high quality, comprehensive, and timely assessments, the item would be coded as a "5".

G5. Individualized Treatment Plan

Definition: For all EBP persons served, 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 person served. Plans that are the same or similar across persons served 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 person served.*

Rationale: Core values of EBP include individualization of services and supporting persons served' 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) Person served interview

e) Team meeting/supervision observation, if available

Item Response Coding: If >80% of EBP persons served 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 persons served 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* person served goals and are unique for each person served. 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 person served 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 person served 3-4 days per week, while the Assertive Community Treatment team only sees the person served 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 person served.

Sources of Information:

- a) Chart review (treatment plan).
- b) Practitioner interview
- c) Person served interview

Item Response Coding: If >80% of EBP persons served 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 person served-centered and explicitly address the EBP model and its application to *specific person served situations*.

Administrative meetings and meetings that are not specifically devoted to the EBP do not fit the criteria for this item. The *person served 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 persons served every 3 months and share the data with EBP practitioners in an effort to improve services. Outcome monitoring involves a standardized approach to assessing persons served.

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:

- o Supported Employment – competitive employment rate
- o Integrated Dual Disorders Treatment – substance use (such as the Stages of Treatment Scale)
- o Illness Management & Recovery – hospitalization rates; relapse prevention plans; medication compliance rates
- o Family Psychoeducation – hospitalization and family burden
- o 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. Person served Choice Regarding Service Provision

Definition: All persons served receiving EBP services are offered a reasonable range of choices consistent with the EBP; the EBP practitioners consider and abide by person served 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 person served 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 persons served rather than prescribing only one or a couple of choices or dictating a fixed sequence or prescribing conditions that a person served must complete before becoming eligible for a service.

Sample of Relevant Choices by EBP:

- o 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
- o Integrated Dual Disorders Treatment
 - Group or individual interventions
 - Frequency of DD treatment
 - Specific self-management goals
- o Family Psychoeducation
 - Person served readiness for involving family
 - Who to involve
 - Choice of problems/issues to work on
- o Illness Management & Recovery
 - Selection of significant others to be involved
 - Specific self- management goals
 - Nature of behavioral tailoring
 - Skills to be taught
- o 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 persons served 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 persons served so that they can become more effective participants in the treatment process.

Sources of Information:

- a) Program leader interview
- b) Practitioner interview
- c) Person served 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 person served choice, the item would be coded as a “5”. If agency embraces person served

choice fully, except in one area (e.g., requiring the agency to assume representative payee-ships for all persons served), 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:				

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Dual Diagnosis Treatment Capacity	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.09.01
Effective Date: 5/7/14	Date of Review/Revision: 4/13/16, 6/13/17, 4/10/18, 4/9/19, 6/9/20, 4/11/21, 10/12/21, 9/27/22, 3/08/23, 3/15/24, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO
	Supersedes: 02.03.09.01 Co-occurring Disorders/Integrated Dual Disorder Treatment	Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
		Authored By: Barbara Glassheim and SCCMHA EBP & TIC Coordinator Additional Reviewers: EBP Leadership Team

Purpose:

To develop and promote a comprehensive, continuous, and integrated system of care for persons with co-occurring substance use disorders and serious mental illnesses, serious emotional disturbances, or intellectual/developmental disabilities who receive SCCMHA-funded services and supports.

Policy:

SCCMHA recognizes that persons with co-occurring psychiatric and substance use disorders generally experience poorer outcomes and incur higher costs for care in multiple clinical and life domains. Local service areas that engage persons with co-occurring disorders (CODs) include the mental health and substance misuse service networks as well as the criminal justice system, primary health care providers, homeless shelters and other housing programs, and the child and adult protective/welfare systems. Further, persons with co-occurring disorders are sufficiently prevalent in all behavioral health settings to be considered an expectation, rather than an exception, in treatment planning and service delivery. It is therefore the policy of SCCMHA that all providers will ensure an integrated scope of practice for clinicians working with persons with co-occurring disorders for persons served and their families to achieve optimal outcomes.

Application:

This policy applies to all SCCMHA-funded providers of mental health and substance use disorder treatment, prevention, and recovery services. Details regarding specific aspects of

the model's applicability to various providers can be found in Exhibit D (SCCMHA Provider Network COD Expectations).

Standards:

- A. The core of treatment success in any setting is the availability of welcoming, empathic, hopeful, integrated, and continuous treatment relationships that support a philosophy of dual recovery.
- B. SCCMHA will screen and assess co-occurring disorders (mental illness, emotional disturbance, or intellectual/developmental disability and a substance use disorder) as well as a history of trauma (e.g., physical abuse, sexual abuse, family, and other environment of violence) and co-occurring trauma-related disorders, cognitive disorders, personality disorders, and medical conditions.
 - 1. Services and supports shall be provided in a person/family-centered, trauma-informed, developmentally appropriate, and culturally and linguistically competent manner.
- C. SCCMHA-funded providers shall conduct integrated, longitudinal, strength-based assessments.
- D. SCCMHA-funded providers shall employ standardized, validated assessment and screening tools.
- E. The four-quadrant national consensus model (found in Exhibit A) will be used to assign responsibility for the provision of service (i.e., primary service delivery program/system), based on the severity of the psychiatric and substance use disorders.
 - 1. The continuum for mental health treatment programs:
 - a. Mental health-only services (MHOS)
 - b. Dual-diagnosis capable (DDC)
 - c. Dual diagnosis enhanced (DDE)
 - 2. The continuum for substance use disorder treatment programs:
 - a. Addiction-only services (AOS)
 - b. Dual-diagnosis capable (DDC)
 - c. Dual diagnosis enhanced (DDE)
- F. Mental illness and substance dependence are both examples of chronic, biopsychosocial disorders that may be understood using a disease and recovery model.
- G. Treatment shall be matched, not only to diagnosis, but also to the phase of recovery, stage of treatment, and stage of change for everyone. Therefore, appropriately matched interventions must be provided at all levels of care; no one correct dual diagnosis program or intervention applies.
- H. At a minimum, clinicians will demonstrate competencies in the provision of an integrated scope of practice that encompasses the following attributes:
 - 1. Convey a welcoming, empathic attitude, supporting a philosophy of dual recovery.
 - 2. Screen for co-morbidity, including trauma history.
 - 3. Assess for acute mental health/detoxification risk and know how to get the person to safety if necessary.
 - 4. Obtain an assessment of the co-morbid condition, either one that has already been done, or, if needed, conduct a new one.
 - 5. Be aware of and understand the diagnosis and treatment plan for each problem (at least as well as the person served understands them).

6. Support treatment adherence, including medication compliance, 12-step program attendance, etc.
 7. Identify the stage of change for each problem.
 8. Provide one-on-one and group interventions for education and motivational enhancement to help persons served move through stages of change.
 9. Provide specific skills training to reduce substance use and/or manage mental health symptoms or mental illness (e.g., help persons served take medications exactly as prescribed).
 10. Help persons served manage feelings, mental health symptoms, and medication side effects without using substances.
 11. Help persons served advocate with other providers regarding mental health treatment needs.
 12. Help persons served advocate with other providers regarding substance misuse/dependence treatment needs.
 - a. Ensure that services are medically necessary.
 - b. Strengthen discharge planning with “warm handoffs.”
 - c. Utilize electronic medical records to improve clinicians’ ability to provide effective integrated care.
 - d. Utilize peer support services to help individuals engage in treatment services.
 13. Collaborate with other providers so persons served receive integrated messages.
 14. Educate persons served about the appropriateness of taking psychiatric medications and participating in mental health treatment while attending 12-step recovery programs and participating in other addiction treatment support systems.
 15. Modify (simplify) skills training for any problem to accommodate each person served’s cognitive or emotional learning impairment or disability, regardless of cause.
 16. Promote dual recovery meeting attendance for persons served when appropriate.
- I. At a minimum, providers will demonstrate a dual diagnosis program capability (DDC) infrastructure designed to provide properly matched integrated services, within the context of its resources and mission, to the individuals and families with co-occurring disorders who are already coming to the door. Programs that are DDC are characterized by the following:
1. Routinely accept persons served with dual diagnoses.
 2. Display welcoming attitudes toward comorbidity.
 3. Substance abuse programs treat individuals whose mental health conditions are stable and can participate in treatment.
 4. Mental health programs coordinate phase-specific interventions for any substance disorder.
 5. Have policies and procedures that routinely look at comorbidity in assessments, medication management plans, diagnostic plans, and programming.
 6. Provide care coordination for medication regimens.

7. Services can be delivered face-to-face, in-person, or via telehealth technology.
- J. SCCMHA shall adopt a comprehensive, continuous, integrated system of care (CCISC) model for individuals who have co-occurring mental illness and substance use disorders that adheres to the following standards (delineated by Kenneth Minkoff, M.D.):
 1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of comorbidity, along with clinical outcome data associating individuals who have co-occurring mental illness and substance use disorders with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.
 2. *All individuals who have co-occurring mental illness and substance use disorders are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (9) can be used as a guide for service planning on the system level.* In this model, individuals who have co-occurring mental illness and substance use disorders can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high CD (Quadrant III), high MH – low CD (Quadrant II), and low-low (Quadrant I). High MH individuals usually have serious persistent mental illness (SPMI) and require continuing integrated care in the MH system. Individuals with High CD are appropriate for receiving episodes of addiction treatment in the CD system, with varying degrees of integration of mental health capability.
 3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence-based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.
 4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each person served, and in each service setting.* Each individual person served may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of commu-

- nity-based reinforcers to make incremental progress within the context of continuing treatment.
5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate persons served within each service setting.
 6. *Both mental illness and addiction can be treated within the philosophical framework of a “disease and recovery model” with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment and demonstrated the value of stage wise treatment [\(6\)](#).
 7. *There is no single correct intervention for individuals who have co-occurring mental illness and substance use disorders; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a “job”: to work with a particular cohort of individuals who have co-occurring mental illness and substance use disorders, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.
 8. *Clinical outcomes for individuals who have co-occurring mental illness and substance use disorders must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long-term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in “harm” (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.
- K. Enhanced Dual Disorders Treatment will be provided by a multi-disciplinary team that includes a psychiatrist, nurse, qualified mental health professional, peer sup-

- port specialist, substance misuse professional, supported employment specialist, and residential/housing services specialist.
- L. Enhanced Dual Disorders Treatment team members will have a training plan that addresses treatment philosophies, motivational interviewing, stage-wise treatment, pharmacological treatment, cognitive behavioral interventions, and substance use treatment. Staff with less than one year of experience must acquire 12 hours of training in integrated treatment specific content and receive supervision from experienced integrated treatment staff.
 - 1. Staff shall be required to acquire at least 6 hours of related training content annually.
 - M. Enhanced Dual Disorders Treatment teams will maintain an Integrated Treatment License issued by Michigan Department of Community Health, Bureau of Health Systems, Division of Licensing & Certification.
 - N. SCCMHA's quality improvement activities shall include fidelity monitoring to ensure adherence to the evidence-based practice model using the SAMHSA DDCMHT and DDCAT Rating Scale scales.
 - 1. All Enhanced Dual Disorder Treatment teams shall undergo a MiFAST fidelity review every 3-5 years.
 - O. The Evidence-Based Practice and Trauma-Informed Care Coordinator will facilitate quarterly meetings for supervisors of teams that provide Integrated Dual Disorder Treatment to discuss fidelity monitoring as needed.
 - P. The Adult Strengths and Needs Assessment (ANSA) will be used as tool to examine outcomes with reports reviewed up to twice per year.

Definitions:

Comprehensive, Continuous, Integrated System of Care (CCISC): A model for organizing services for individuals with co-occurring psychiatric and substance use disorders that is designed to improve treatment capacity by adhering to the above-noted standards.

Co-occurring Disorder (COD): The co-existence of a psychiatric and substance disorder in one person. Each disorder is considered primary and must receive appropriately intensive diagnosis-specific treatment. Adolescents with emotional disturbances as well as individuals with intellectual/developmental disabilities may also experience co-occurring disorders.

Dual diagnosis capable (DDC): Programs that focus on co-occurring mental and substance use-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning. In such programs program staff can address the interaction between mental and substance-related disorders and their effect on the person served's readiness to change as well as relapse and recovery issues through individual and group programmatic content.

Dual diagnosis enhanced (DDE): Programs that have a higher level of integration of substance misuse and mental health treatment services and can provide unified substance misuse and mental health treatment to persons served who have greater symptomatology and/or functional impairment due to their co-occurring mental disorder. Such enhanced services are primarily focused on the integration of services for mental and substance use-related disorders in their staffing, services, and program content.

Integrated Screening, Assessment, and Interventions:

Integrated Screening: Refers to making a determination of the likelihood that an individual has a co-occurring substance use or mental illness. The purpose of integrated screening is to establish the need for an in-depth assessment. Integrated screening is a formal process that typically is brief and occurs soon after the person served presents for services.

Integrated Assessment: Such an assessment is comprised of assembling information and engaging in a process with the person served that allows the practitioner to establish the presence or absence of co-occurring disorders, determine the person served's readiness for change, identify the person served's strengths or problem areas that may affect the processes of treatment and recovery, and engage the person served in the development of an appropriate treatment relationship. The purpose of the assessment is to establish (or rule out) the existence of a clinical disorder or service need and to collaborate with the person served to develop a plan of services and supports.

Integrated Interventions: Specific treatment strategies or therapeutic techniques in which interventions for all COD diagnoses or symptoms are combined in a single contact or in a series of contacts over time. These can be acute interventions to establish safety, as well as ongoing efforts to foster recovery.

Recovery: The process by which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability while for others, recovery implies the reduction or complete remission of symptoms.

Relapse: The return to active substance use in a person with a diagnosed substance use disorder, or the return of disabling psychiatric symptoms after a period of remission related to a non-addictive mental disorder. Relapse is both an anticipated event during recovery and a process in which warning signs appear prior to an individual's actual recurrence of impairment.

Remission: The absence of distress or impairment due to a substance use or mental disorder.

Substance-Induced Disorders: Substance-induced disorders include intoxication, withdrawal, substance induced mental disorders, including substance induced psychosis, substance induced bipolar and related disorders, substance induced depressive disorders, substance induced anxiety disorders, substance induced obsessive-compulsive and related disorders, substance induced sleep disorders, substance induced sexual dysfunctions, substance induced delirium and substance induced neurocognitive disorders..

Substance Use Disorders (SUDs): Patterns of symptoms resulting from use of a substance which the individual continues to take, despite experiencing problems as a result.

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- B. Center for Substance Abuse Treatment. (2005). *Definitions and Terms Relating to Co-Occurring Disorders*. COCE Overview Paper No. 1. Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services. Rockville, MD. [On-line]. Available: <http://www.atforum.com/pdf/DefinitionsandTerms-OP1-4.pdf>.

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- J. SCCMHA Policy 02.03.08 – Welcoming.
- K. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs).
- L. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
- M. Substance Abuse and Mental Health Services Administration. (2011). *Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Toolkit Version 4.0.* Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: [Dual Diagnosis Capability In Mental Health Treatment \(DDCMHT\) Toolkit | Center for Evidence-Based Practices | Case Western Reserve University](#).

Exhibits:

- A. Four Quadrant Model
- B. DDCMHT Index Version 4.1 (Standford)
- C. DDCAT Index Version 4.1 (Standford)
- D. SCCMHA Provider Network COD/Dual Diagnosis Capability Expectations
- E. Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools (MiFAST)

Procedure:

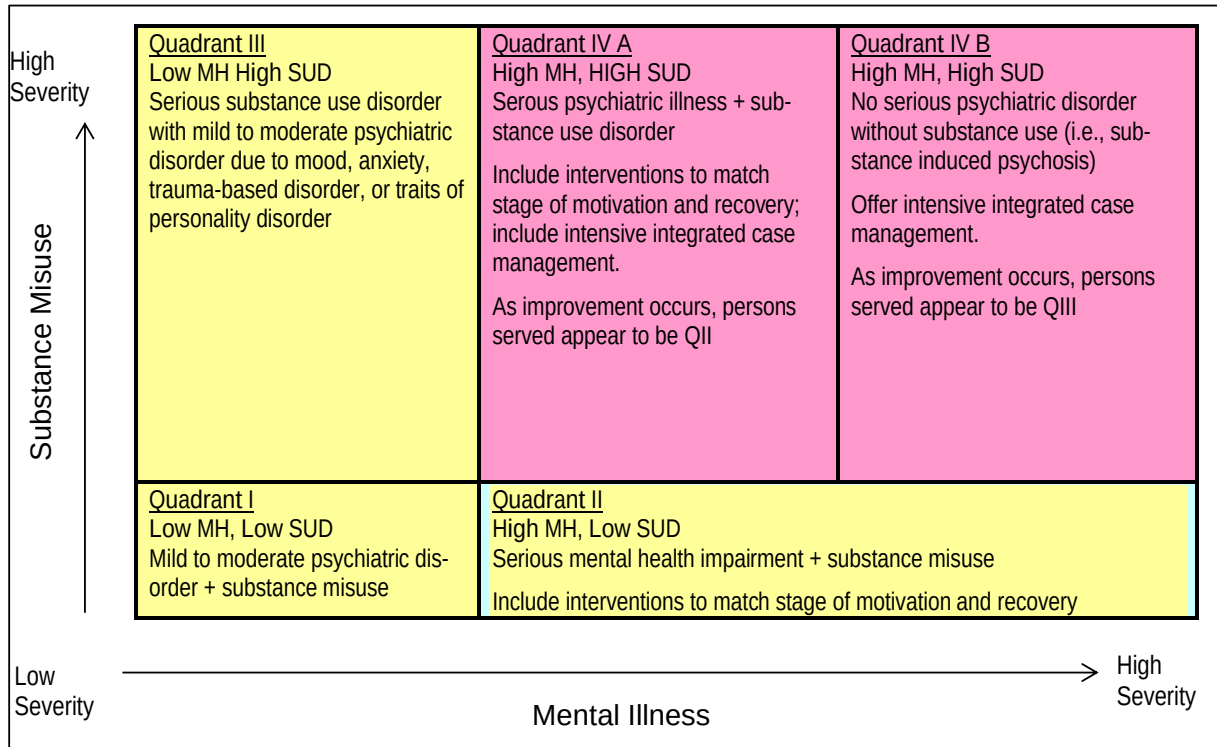
ACTION

RESPONSIBILITY

1. COD treatment services are provided in accordance with the standards of the model to persons served who meet criteria 2. COD treatment services are monitored on a regular basis for fidelity and outcomes	1. IDDT Team Providers 2. MiFAST, SCCMHA EBP Leadership/Fidelity Monitoring Team, IDDT Supervisors

Exhibit A

Four Quadrant Model



DD Capable: Quadrants I, II, and III

DD Enhanced (IDDT): Quadrant IV

Consultation: Quadrant I (both disorders less severe): Informal relationships among providers that ensure both mental disorders and substance misuse problems are addressed, especially regarding identification, engagement, prevention, and early intervention. An example of such consultation might include a telephone request for information or advice regarding the etiology and clinical course of depression in a person abusing alcohol or drugs.

Collaboration: Quadrant II/III (one disorder more severe, the other less severe): More formal relationships among providers that ensure both mental disorders and substance misuse problems are included in the treatment regimen. An example of such collaboration might include interagency staffing conferences where representatives of both substance misuse and mental health agencies specifically contribute to the design of a treatment program for individuals with co-occurring disorders and participate in service delivery.

Integrated Services: Quadrant IV (both disorders more severe): Relationships among mental health and substance misuse providers, in which the contributions of professionals in both fields are merged into a single treatment setting and treatment regimen. Integrated treatment is any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting. Such treatment exists on a continuum that ranges from cross-referral and linkage, through cooperation, consultation, and collaboration, to integration in a single setting or treatment model.

Exhibit B: DDCMHT INDEC 4.1

[DDCMHT_Version4.1_4.6.18.pdf](#)

Exhibit C: DDCAT Rating Scale

[DDCAT_Version4.1_5.10.19.pdf](#)

Exhibit D

SCCMHA PROVIDER NETWORK COD/DUAL DIAGNOSIS CAPABILITY EXPECTATIONS

SCCMHA Network Providers	Fidelity Scale Elements													
	1a	1b	2	3	4	5	6	7	8	9	10	11	12	13
Case Management/ACT Programs (DDE) ¹	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Substance Misuse Providers (DDC)	NA	²	X	X	NA	NA	X	X	NA	X	X	X ³	X	X
Access SCCMHA (DDC)	NA	X	X	X	NA	NA	NA	NA	NA	NA	NA	NA	NA	X
Hospitals Substance Misuse Detox (DDC)	X	X	X	NA	NA	NA	X	X	NA	NA	NA	X	X	X
Hospitals MH (DDC)	X	X	X	X	NA	NA	X	X	X	X	X	X	X	X
Specialized Residential Providers – Community Living Supports & Personal Care Services (DDC)	NA	NA	X	NA	X	NA	X	NA	NA	NA	X	NA	X	X
Crisis Intervention Services (DDC)	X	X	X	X	NA	NA	X	X	NA	X	X	X	X	X
Crisis Residential Services (DDC)	X	X	X	X	NA	NA	X	X	X	X	X	X	X	X
Mobile Response and Stabilization Services (MRSS) (DDC)	X	X	X	X	NA	NA	X	X	NA	X	X	X	X	X
Psychosocial Rehabilitation/Clubhouse (DDC)	NA	NA	X	NA	NA	NA	X	NA	NA	NA	X	NA	X	X
Supports Coordination for Persons with Intellectual and Developmental Disabilities (DDC) ⁴	X	X	X	X	X	NA	X	X	X	X	X	X	X	X
Services for Children, Adolescents & Their Families with Severe Emotional Disturbance ⁵ (DDC)	X	X	X	X	X	X	X	X	NA	X	X	X	X	X

Key:

1a – Multidisciplinary Team

1b – Integrated Substance Misuse Specialist

2 – Stage-Wise Interventions

3 – Access for IDDT Clients to Comprehensive Dual Disorder Services

4 – Time-Unlimited Services

5 – Outreach

6 – Motivational Interventions

7 – Substance Misuse Counseling

8 – Group Dual Disorder Treatment

9 – Family Psychoeducation on Dual Disorders (Note: not FPE EBP model)

10 – Participation in Alcohol & Drug Self-Help Groups

11 – Pharmacological Treatment

12 – Interventions to Promote Health

13 – Secondary Interventions for Substance Misuse Treatment Non-Responders

DDE = Dual Disorder Enhanced

DDC = Dual Disorder Capable

¹ Includes ACT as well as all team related psychiatry and all enhanced health services

² SA providers will have an integrated mental health specialist

³ Applicable whenever psychiatry is available

⁴ Includes all team related psychiatry and enhanced health services.

⁵ Includes all team related psychiatry and enhanced health services; applicable to older children, adolescents and parents of children

Exhibit E: Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools (MiFAST)

Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools Treatment Characteristics and Organizational Characteristics

IDDT FIDELITY DOMAIN	IMPLEMENTATION TIPS, TOOLS, RESOURCES
Tx.1a. Multidisciplinary Team: Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team	Many ACT teams are already constructed in multidisciplinary fashion, and only need enhancement in the direction of co-occurring addictions treatment
Tx.1b. Integrated Substance Abuse Specialist: Substance abuse specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff in IDDT	Certified Addictions Counselor credentialing is recommended, with all pertinent information available at the website of the Michigan Certification Board for Addiction Professionals at www.mcbap.com/ Empower integrated SAP to teach, coach, and clinically consult with team members
Tx.2. Stage-Wise Interventions: Treatment consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)	See Chapter 6 from the Integrated Dual Disorders Treatment Workbook – Stages of Treatment See Chapter 9 from the Integrated Dual Disorders Treatment Workbook – Engagement See the SATS and Modified SATS , and Evaluating Substance Abuse in Persons with Severe Mental Illness tools in the ASSESSMENT section of the CD
Tx.3. Access for IDDT Clients to Comprehensive Dual Disorders Services • Residential services • Supported employment • Family psychoeducation • Illness management • ACT or ICM	Implementing multiple evidence-based practices in an organization poses significant challenges. Those interested in receiving a free copy of the 100-page pdf publication, "Integrating Multiple Evidence-Based Practices in a Public Mental Health Organization: <i>An Implementation Field Guide for Project Managers and Clinical Supervisors</i> " are invited to e-mail a request to wilands@ewashtenaw.org

Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools
Treatment Characteristics and Organizational Characteristics

IDDT FIDELITY DOMAIN	IMPLEMENTATION TIPS, TOOLS, RESOURCES
Tx.4. Time-Unlimited Services • Substance abuse counseling • Residential services • Supported employment • Family psycho-education • Illness management • ACT or ICM	Most ACT teams already operate in this fashion, and are able to “hang in there” over the long haul with ambivalent consumers who may not yet be well-engaged in treatment
Tx.5. Outreach: Program demonstrates consistently well-thought-out strategies and uses outreach whenever appropriate: • Housing assistance • Medical care • Crisis management • Legal aid	Many ACT teams feature a significant amount of outreach activity, especially if maintaining high fidelity to the traditional ACT model
Tx.6. Motivational Interventions: Clinicians who treat IDDT clients use strategies such as: • Express empathy • Develop discrepancy between goals and continued use • Avoid argumentation • Roll with resistance • Instill self-efficacy and hope	See entire TREATMENT: Motivational Enhancement section on CD, which includes 15 handouts &/or tools for use in training staff and engaging consumers, as well as the article, “<i>Enhancing Readiness-to-Change Substance Abuse in Persons with Schizophrenia: A Four-Session Motivation-Based Intervention</i>” See Chapter 10 from the Integrated Dual Disorders Treatment Workbook – Motivational Counseling (Also recommended is a visit to the website www.motivationalinterview.org/ which features additional material for free download and/or purchase, including the useful and affordable <i>Motivational Interviewing: Professional Training Series, 1998</i>, available for only \$100.)

Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools
Treatment Characteristics and Organizational Characteristics

IDDT FIDELITY DOMAIN	IMPLEMENTATION TIPS, TOOLS, RESOURCES
Tx.7. Substance Abuse Counseling: Clients who are in the <i>action</i> stage or <i>relapse prevention</i> stage receive substance abuse counseling that include: • Teaching how to manage cues to use and consequences to use • Teaching relapse prevention strategies • Drug and alcohol refusal skills training • Problem-solving skills training to avoid high-risk situations • Challenging clients' beliefs about s.a. • Coping skills and social skills training	See Chapter 11 from the Integrated Dual Disorders Treatment Workbook – Substance Abuse Counseling for Persons with SMI See Chapter 12 from the Integrated Dual Disorders Treatment Workbook – Relapse Prevention
Tx.8. Group DD Treatment: DD clients are offered group treatment specifically designed to address both mental health and substance abuse problems	See Chapter 13 from the Integrated Dual Disorders Treatment Workbook – Group Treatment for Dual Disorders
Tx.9. Family Psycho-education on DD: Clinicians provide family (or significant others): • Education about DD • Coping skills training • Collaboration with the treatment team • Support	See Chapter 15 from the Integrated Dual Disorders Treatment Workbook – Family Treatment See entire TREATMENT: Educational and Group Materials section on CD, which includes 25 Power Point presentations on various aspects of Dual Disorders recovery, and 57 educational handouts on various substances of abuse.
Tx.10. Participation in Alcohol & Drug Self-Help Groups: Clients in the <i>action</i> stage or <i>relapse prevention</i> stage attend self-help programs in the community	See Chapter 14 from the Integrated Dual Disorders Treatment Workbook – Self-help See Substance Abuse Treatment for Persons With Co-Occurring Disorders. TIP 42, Appendix J

Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools
Treatment Characteristics and Organizational Characteristics

IDDT FIDELITY DOMAIN	IMPLEMENTATION TIPS, TOOLS, RESOURCES
Tx.11. Pharmacological Treatment: Prescribers for IDDT clients: 1. Prescribe psychiatric medications despite active substance use 2. Work closely with team/client 3. Focus on increasing adherence 4. Avoid benzodiazepines and other addictive substances 5. Use clozapine, naltrexone, disulfiram	See Dr. Kenneth Minkoff's Psychopharmacology Practice Guidelines for Individuals with Co-occurring Psychiatric and Substance Use Disorders See Substance Abuse Treatment for Persons With Co-Occurring Disorders. TIP 42, Appendix F
Tx.12. Interventions to Promote Health: Examples include: • Teaching how to avoid infectious diseases • Helping clients avoid high-risk situations and victimization • Securing safe housing • Encouraging clients to pursue work, health, diet, & exercise	See Chapter 16 from the Integrated Dual Disorders Treatment Workbook – Infectious Diseases
Tx.13. Secondary Interventions for Substance Abuse Treatment Non-Responders: Program has a protocol for identifying substance abuse treatment non-responders and offers individualized secondary interventions, such as: • Clozapine/naltrexone/disulfiram • Long-term residential care • Trauma treatment • Intensive family intervention • Intensive monitoring	Information to support trauma-informed services can be found on Lisa Najavits' website (www.seekingsafety.org/), Roger Falloot/Maxine Harris' website's Trauma Services page (www.cdc1.org/trauma_services.htm), Stephanie Covington's website (www.stephaniecovington.com/) or Dusty Miller's website (www.dustymiller.org/) – these feature materials that are viewable, downloadable, or able to be purchased. Another useful point of reference/perspective on the established efficacy of any of these approaches is SAMHSA's NREPP webpage which describes the Seeking Safety and TREM models in additional (and objective) detail, viewable at www.nrepp.samhsa.gov/listofprograms.asp?textsearch=trauma&ShowHide=1&Sort=A1

4

Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools
Treatment Characteristics and Organizational Characteristics

IDDT FIDELITY DOMAIN	IMPLEMENTATION TIPS, TOOLS, RESOURCES
O.1. Program Philosophy. The program is committed to a clearly articulated philosophy consistent with the specific evidence-based model, based on the following 5 sources: • Program leader • Senior staff (e.g., executive director, psychiatrist) • Practitioners providing IDDT services • Clients and/or families receiving IDDT services • Written materials (e.g., brochures)	See the complete set of COCE Overview Papers found in the GENERAL section of the CD See Substance Abuse Treatment for Persons With Co-Occurring Disorders. TIP 42, Chapter 3
O.2. 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 IDDT services using standardized tools or admission criteria consistent with IDDT. Also, the agency tracks the number of eligible clients in a systematic fashion.	Function of tracking/reporting system – may be enhanced with the use of an Electronic Health Record See the entire SCREENING and ASSESSMENT sections of the CD for instruments perspectives See Substance Abuse Treatment for Persons With Co-Occurring Disorders. TIP 42, Chapter 4
O.3. Penetration. The maximum number of eligible clients are provided with IDDT services, as defined by the ratio: $\frac{\# \text{ clients receiving EBP}}{\# \text{ clients eligible for EBP}}$	Function of tracking/reporting system – may be enhanced with the use of an Electronic Health Record

Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools
Treatment Characteristics and Organizational Characteristics

IDDT FIDELITY DOMAIN	IMPLEMENTATION TIPS, TOOLS, RESOURCES
O.4. 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, any existing support network, and evaluation of biopsychosocial risk factors.	See Chapter 7 from the Integrated Dual Disorders Treatment Workbook – Assessment See COCE Overview Paper # 2 - Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders See Substance Abuse Treatment for Persons With Co-Occurring Disorders. TIP 42, Appendix G
O.5. Individualized Treatment Plan. For all EBP clients, there is an explicit, individualized treatment plan <i>related to the EBP</i> that is consistent with assessment and updated every 3 months.	See Chapter 8 from the Integrated Dual Disorders Treatment Workbook – Treatment Planning See COCE Overview Paper # 2 - Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders
O.6. Individualized Treatment. All EBP clients receive individualized treatment meeting the goals of the EBP.	See COCE Overview Paper # 2 - Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders See Substance Abuse Treatment for Persons With Co-Occurring Disorders. TIP 42

Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools
Treatment Characteristics and Organizational Characteristics

IDDT FIDELITY DOMAIN	IMPLEMENTATION TIPS, TOOLS, RESOURCES
O.7. Training. All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) <i>within 2 months of hiring</i>. Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent).	See chapters 1-5 from the Integrated Dual Disorders Treatment Workbook, entitled, Definitions, Alcohol, Cannabis, Stimulants, Opiates and Opioids, as well as the remaining 11 chapters as core curriculum for staff training. See Substance Abuse Treatment for Persons With Co-Occurring Disorders. TIP 42, which serves as an excellent core text / reference for basic IDDT training See entire TREATMENT: Educational and Group Materials section on CD, which includes 25 Power Point presentations on various aspects of Dual Disorders recovery, and 57 educational handouts on various substances of abuse.
O.8. Supervision. IDDT practitioners receive structured, weekly supervision (group or individual format) from a practitioner experienced in IDDT. The supervision should be client-centered and explicitly address the IDDT model and its application <i>to specific client situations</i>.	Ideally this function can be served by the existing Team Leader/Supervisor, who may need significant training in order to be functional in this clinical IDDT supervision role. Other approaches feature delegating this function to the team's Substance Abuse Specialist, or having some other sufficiently experienced & educated individual (Clinical Director, ?) provide "matrix supervision" until Team Leader and/or Substance Abuse Specialist can move along their respective IDDT learning curves.
O.9. 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.	Use of the IDDT Fidelity Scale, for internal review and/or MIFAST Site Review, can be helpful in evaluating the status of implementation, and to inform organizational Action-Planning / Performance Improvement moving forward Minkoff's COMPASS, CODECAT, and COFIT instruments have also been found useful

Integrated Dual Disorders Treatment (IDDT) Fidelity Scale – Tips and Tools
Treatment Characteristics and Organizational Characteristics

IDDT FIDELITY DOMAIN	IMPLEMENTATION TIPS, TOOLS, RESOURCES
O.10. 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 <i>related to the EBP</i>, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.	SAMHSA's National Outcome Measures (NOMs) provides guidance on meaningful outcome indicators to target Each EBP Toolkit (including the IDDT Toolkit), contains a "Client Outcomes – EBP Toolkit Quarterly Report Form" prompting the provider to track the following: 1. EBP eligibility, EBP enrollment (10) 2. Employment status (2), homelessness (4), legal status (3), hospitalization status (7,1) 3. Stage of treatment (~1) 4. Living arrangement (4) 5. Educational status (2)
O.11. 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.	Embed in Clinical Care Committee / Improving Practices Leadership teams at both the provider and PIHP levels
O.12. Client Choice Regarding Service Provision. All clients receiving IDDT services are offered choices; the IDDT practitioners consider and abide by client preferences for treatment when offering and providing services.	Examine and address providers' and community partners' philosophical views on co-occurring addiction as a disease, including attitudes toward harm reduction, "work-first" and "housing first" approaches, "wet" or "damp" housing, etc.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: SCCMHA Practice Guidelines	Chapter: Chapter 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.01.01
Effective Date: 10/1/11	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, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus Additional Reviewers: EBP Leadership Team
	Supersedes: 02.03.16	
		

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 persons served 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 person served 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 persons served 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 person served 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, cognitive behavioral therapy (for psychotherapists), 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 collaborative safety planning with persons served is promoted as part of the overall SCCMHA practice guideline framework; this may include advance directives if desired by the person served.
- 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 and the Best Practices Quality Improvement Committee, in concert with lead practice facilitators, will provide continuous monitoring of the use of practices in the network through a division of responsibilities.
- Q. SCCMHA will provide educational opportunities for persons served in practice areas where feasible, including but not limited to specific evidence-based practice content, person served orientation information provided by providers and dissemination of educational information in any relevant area, such as the SCCMHA Res-

idential Directory which provides guidance on licensed adult foster care home selection.

- R. Active or referred person served 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 person served 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; the Best Practices Quality Improvement Committee; 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 person served needs, training staff capacity and available resources.

Definitions:

Practice Guidelines: Any nationally accepted practices that are recommended by MDHHS 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 person served outcomes.

Evidence-Based Practice: A clinical intervention that has a strongly rooted scientific foundation and produces consistent results in assisting persons served 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).
- *MDHHS Policy Manual* [Current MDHHS Policy Manuals](#)
- 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 ensures 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 person served 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.	Evidence-Based Practices Leadership Team
Reviews data, monitors fidelity reviews and facilitates direct person served leadership oversight and input in practice areas or needs.	Best Practices Quality Improvement Committee

Adhere to practice guidelines of SCCMHA. Seek and maintain credentials to meet requirements and person served 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 person served 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

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Assertive Community Treatment (ACT)	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.09.02
Effective Date: 7/20/06	Date of Review/Revision: 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, 2/12/25, 02/13/26 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team
		

Purpose:

The purpose of this policy is to delineate standards for the provision of Assertive Community Treatment (ACT) services to eligible persons served.

Policy:

- A. SCCMHA shall make ACT services available to eligible persons served 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 persons served of ACT within the team's structure; billing for ACT services shall occur as part of ACT and ser-

- vices 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 persons served in a trauma-informed manner.
 - D. ACT shall be delivered in accordance with the following standards:
 - 1. Resources
 - a. Program Staff: A full-time **team leader** whose experience includes at least two years post-degree clinical work with adults who have a serious mental illness and minimally possesses a master's degree in a relevant discipline, with appropriate licensure to provide clinical supervision to the ACT team staff. The ACT team leader leads the team, provides clinical supervision to team members, and provides direct services to beneficiaries in the community within their individual scope of practice. The ACT team leader also meets the requirements of a MHP and licensing requirements in accordance with Licensing and Regulatory Affairs (LARA) for their position description and provider qualifications. (1.0 FTE with direct service provision 50% of the time), **psychiatrist** (1.0 FTE per 100 persons served), a full-time **RN, Certified Peer Support Specialist** (who must be supervised by a Qualified Mental Health Professional (QMHP) as defined by the MDHHS Health Services), 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**. (For more information on specific team requirements, please see the Medicaid Provider Manual, Section 4.)
 - 1). The ACT team shall address co-occurring substance use disorders (SUDs) of persons served within the team service.
 - a). The ACT team shall provide or obtain co-occurring treatment for persons served 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 persons served who request this service.
- 3). The ACT team shall closely monitor persons served 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 person served'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 persons served in acute need or with emergency conditions.
 - 2). The ACT team will participate in the face-to-face screening of persons served 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 CIS has secured an inpatient bed.
 - 8.) ACT and Crisis Screening staff will coordinate monitoring of all persons served in the emergency department while waiting for bed availability.
 - c. Staff to Person served Ratio: A staff to person served 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 person served 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 persons served to remain in the community, to improve the person served's condition and/or allow the person served to function without more restrictive care.
 3. Persons served 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 person served 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 persons served by the team shall be reviewed.
 - b. Documentation of daily team meetings shall include all persons served discussed, and all staff members present.
 - c. The daily schedule shall be organized, and contacts scheduled.
- G. Service Delivery: Services shall be provided in persons served' 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 person served requires ACT (i.e., meets admission and level of care criteria) in order to maintain community tenure. Persons served who no longer meet criteria shall be transitioned to a less intensive level of supports and services in accordance with need.
1. For persons served 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 person served requests transition to other service(s) because he/she believes maximum benefit has been reached in ACT, consideration for transi-

- tion into less intensive service shall be reviewed using the person- centered planning process.
3. If engaging the person served is not possible using frequent assertive team outreach, discharge will be considered.
 4. If the person served has moved outside the geographic services area, the ACT team will continue to provide care to the person served until services have been established in the new location.
 5. Once it is determined that a person served 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 person served's IPOS.
 - b. The length of transition time shall be specific to the needs of each person served.
 - c. There may be exceptions to transitioning to a lower level of care when a person served 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 person served 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 person served is still in an AFC in order to ensure a smooth transition.
 - f. Persons served 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 person 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 persons served shall also include a concurrent review of ACT services.
 - I. Person served Engagement: Persons served 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 sys-

Exhibit A

ACT Fidelity Scale

Human resources: Structure and composition						
		Ratings / Anchors				
Criterion		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						
		Ratings / Anchors				
Criterion		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						
		Ratings / Anchors				
Criterion		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				

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Supported Employment Services (SE)	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.09.03
Effective Date: 7/20/06	Date of Review/Revision: 8/29/07, 5/18/09, 4/2/12, 5/8/14, 5/9/16, 6/13/17, 4/10/18, 4/9/19, 6/9/20, 3/10/21, 3/9/22, 3/8/23, 03/15/24, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: Rocky Archangeli, Evidence-Based Practice Leadership Team
	Supersedes:	
		

Purpose:

SCCMHA recognizes that most people who live with a serious mental illness and many who have an intellectual/developmental disability want to work and shall therefore provide supported employment (SE) services in order to maximize their opportunities to obtain gainful employment.

Policy:

- A. SCCMHA shall adhere to evidence-based practice standards in the delivery of supported employment services, using the Individual Placement and Support (IPS) model.
- B. SCCMHA or a designated body, shall periodically review supported employment services in order to ascertain their level of fidelity to the IPS model set forth in the *Supported Employment Fidelity Review Manual: A companion guide to the evidence-based IPS Supported Employment Fidelity Scale*.
- C. SCCMHA shall provide supported employment services, as resources permit, to help individuals with serious mental illnesses find and retain jobs at competitive wages in integrated settings in the community based upon the belief that every person with a disability is capable of working competitively in the community if the right kind of job and work environment can be found. Individuals with a developmental disability will be provided employment services contracted through SVRC (Saginaw Valley Rehabilitation Center).

- D. SE services shall be provided in a trauma-informed manner.

Application:

- A. All adult persons served shall be eligible for supported employment based on the following criteria:
1. The person served is unemployed or working non-competitively and desires competitive work.
 2. The person served is working but not receiving employment supports and he/she wants such supports.
 3. The person served wishes to search for other competitive employment.

Standards:

- A. Supported employment shall be guided by eight core principles:
1. Zero exclusion: Eligibility for supported employment is based upon person served choice. No person served is excluded from the opportunity for a competitive job. Persons served are deemed “work ready” when they say they want to work. (Symptomatology, diagnosis, substance abuse, prior hospitalization, education, age, gender, and other person served factors are not strong and consistent predictors of work.)
 2. Integration of vocational rehabilitation and mental health: Supported employment services are integrated with treatment and other related services and supports. The supported employment program is staffed by employment specialists and Certified Peer Support Specialists who function as members of persons served’ treatment teams and participate in team meetings on a regular basis.
 3. Competitive employment: Competitive employment is the goal of supported employment services. Competitive jobs are those that exist in the open labor market that anyone, regardless of disability, could have (rather than those that are set aside for individuals with disabilities), and pay at least minimum wage. The wage should be equal to the standard wage and benefit level paid for the same work performed by individuals who do not have a mental illness.
 4. Rapid job search: A job search commences soon after a person served expresses interest in working and is not postponed by requirements for the completion of extensive pre-employment assessment and training, intermediate work experiences (e.g., transitional employment). Job searches are guided by profiles of persons served’ work experience, job interests and preferences, personal strengths, unique challenges, and input from the treatment team and family members/supporters.
 - a. Components of job finding:
 - 1) Starting the job search soon after entry into the supported employment program
 - 2) Individualizing job finding based on persons served’ strengths, preferences, and experiences
 - 3) Networking to identify job leads

- 4) Involving the treatment team and family/significant others to maintain support
5. Time-unlimited support: Follow-along supports are provided on a continuous basis. Persons served who receive supported employment services are never terminated from such services unless they ~~directly request termination~~.no longer wish for or are no longer receiving employment supports.
6. Attention to person served preferences: Person served preferences are important and play a critical role in determining the type of job sought, the nature of support provided by an employment specialist, and the decision regarding whether to disclose the individual's disability to the employer.
7. Systematic Job Development: Employment specialists systematically visit employers, who are selected based on the job seeker's preferences, to learn about their business needs and hiring preferences.
8. Benefits Planning: The Supported Employment Benefit to Work Coach helps people obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements and how wages from employment will affect those entitlements.
- B. Jobs are seen as transitions; people commonly try several jobs before finding one they want to keep. Employment Specialists help persons served find other jobs when they leave jobs.
- C. Any person on the treatment team, as well as the person served, can make a referral for supported employment services.
- D. By engaging the person served and members of their support system, the Employment Specialist shall focus on developing a working alliance with the person served in the community.
- E. Assessment is ongoing. The Employment Specialist gathers as much information as quickly as possible to start the job search process at the person served's pace. The person served's vocational profile and employment plan are updated with relevant information as the person served looks for employment and works in jobs.
- F. Job supports enable persons served to function successfully in competitive employment and can include assistance with starting a new job, performing in a job over time, dealing with a crisis while at work, ending a job, arranging for workplace accommodations.
- G. Case Holders shall work to ensure that supported employment services are integrated into the person served's plan of service.
 1. Case Holders shall include Employment Specialists in PCP meetings with persons served.
- H. Case Holders shall seek to ensure persons served are actively engaged in SE services.
 1. Case Holders shall hold Interdisciplinary Treatment Team meetings with persons served who are not engaging with the SE team.
 - a. These Interdisciplinary Treatment Team meetings shall include the relevant Employment Specialist(s).
 - b. The IPOS Plan shall be modified, if needed, in accordance with the outcome of the meeting.

9. 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 Supported Employment, to discuss fidelity monitoring.
 - b. The Adult Strengths and Needs Assessment (ANSA) will be used as a tool to examine outcomes for SE participants.
 - c. The SE team(s) shall undergo a DHHS or State IPS or consultant, or internal fidelity review every 1-3 years.

Definitions:

Individual Placement and Support (IPS) is a specific type of supported employment that is an evidence-based practice. The evidence-based practice of IPS is sometimes referred to as IPS and supported employment which may be considered interchangeable when applied to helping people with a serious mental illness who are seeking work in the competitive job market (i.e., in a regular job).

Supported Employment programs assist individuals with serious mental illnesses in finding and maintaining competitive employment.

Customized Employment entails the identification of accommodations and supports that allow an individual to perform the functions of a job. In customized employment, jobs are individually negotiated and developed, based on individualized determinations of persons served' strengths, expressed needs and interests, and designed to meet the specific business needs of employers.

References:

- A. Becker, D., Swanson, S., Reese, S., Bond, G., McLeman, M. (2015). *Supported Employment Fidelity Review Manual: A companion guide to the evidence-based IPS Supported Employment Fidelity Scale*. Dartmouth Psychiatric Research Center. Lebanon, NH. [On-line]. Available: https://ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition_2-4-16.pdf.
- B. Substance Abuse and Mental Health Services Administration. (2009). *Supported Employment 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: <https://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-Kit/SMA08-4364>.
- C. SCCMHA Policy 02.03.07 – Employment of Consumers
- D. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)

Exhibits:

- A. Supported Employment Referral Form
- B. Talking Points for IPOS SE Goal Development
- C. Supported Employment Fidelity Scale (SAMHSA)
- D. Practice Principles of IPS (Individual Placement and Support) Supported Employment (Dartmouth) for persons with a serious mental illness

Procedure:

ACTION	RESPONSIBILITY
SE services are provided to persons served who desire the service.	Employment Specialists
SE services are monitored on a regular basis for fidelity to the model and outcomes.	SCCMHA EBP Leadership/Fidelity Monitoring Team
Referrals for SE are made:	
• Self-refers for SE (via service providers/case holders or via direct contact to the SCCMHA Employment Unit)	Person served
• Contacts the SE Unit to request SE services for persons served.	Case Holder, Physicians, Clinicians, etc.
• Includes the Employment Specialist in the IPOS meeting.	Case Holder
• If the IPOS meeting has already been held, reconvenes the meeting in order to ensure inclusion of the Employment Specialist.	
Provide referral packets to persons served.	
Review the contents of referral packets with persons served.	Case Holder, Physicians, Clinicians, etc.
Reviews the <i>Talking Points for IPOS Goal Development</i> with the person served to ensure their understanding of SE services and supports offered.	Referral source
Reconvenes IPOS meetings for persons served who do not engage with the SE Team and includes SE Team member(s) in the meeting.	Case Holder
Modifies the Plan as needed.	Case Holder
Conducts fidelity reviews and/or Coordinates MIFAST reviews.	SCCMHA EBP Leadership/Fidelity Monitoring Team

Exhibit A



Supported Employment/IPS Referral

Instructions

To obtain Supported Employment Services for a consumer, please complete the following steps:

1. Assure that there is an Outcome related to obtaining employment in the consumer's Individual Plan of Service (IPOS). This outcome is to include how often the Jobseeker/customer and Employment Specialist engage. Feel free to invite Employment Specialist to IPOS meetings! Indicate that the SES (Supported Employment Specialist) will meet with the client "at least monthly, or more often as needed" in the frequency portion of the goal writing.
2. Request authorization for **SE services** (code H2023); 72 units for six months is typical. Request authorization for **Peer Services** (H0038) if client wishes to have ongoing SE Peer Services (36 units for six months recommended).
3. Complete Referral below.
4. Return the referral to the Employment Supervisor by fax (989-791-1464), Senti or inter-office mail. Please contact the Employment Supervisor for any questions about completing this referral: Rocky Archangeli. Phone: 797-3489. Email: Rocky.Archangeli@sccmha.org

IPS (Supported Employment) Referral Form

Referral Date: _____

Customer Name: _____ Senti ID: _____

Customer Cell Phone: _____ Alternate Phone: _____

Employment goal in PCP? ☐ Yes ☐ No; H2023 Auths? ☐ Yes ☐ No; H0038 (Peer) Auths? ☐ Yes ☐ No

Referral completed by: _____ Title: _____

Phone: _____ Email: _____ Agency: _____

Other Notes:

Talking Points for Supported Employment IPOS Goal Development

What is Supported Employment?

The Supported Employment program assists consumers of Saginaw County Community Mental Health with obtaining and maintaining *Competitive Employment*. These are jobs that:

- Are not only for a person with a disability, any person can apply.
- Pays Minimum Wage (or higher).
- Pay is usually based on hours worked but can also be salaried or commission-based.
- The hours of work can be full or part time.
- Are permanent jobs – *not temporary*.
- Located in the community.
- “Competitive employment” means the job duties and job requirements are the same for all applicants.

Supported Employment assists in finding a job using a “person-centered” approach. This is a partnership with you and your case holder and considers your talents, abilities, and desires. Using that information, a plan is developed to help you achieve your career or vocational goals, not just to get you “any” job.

What does the Supported Employment program offer you?

After agreeing to participate, you will be assigned an Employment Specialist and Peer Support Specialist who work closely with you through the *process* of obtaining and keeping employment.

The first step is to gather information about you. This is done by creating a Vocational Profile. This profile gathers your work history as well as your interests, abilities, skills, preferences, supports, personality, strengths, needs, and challenges. Together, you and the Specialist create a Plan to identify a job or industry that best suits you.

Some things you and the Employment Specialist may do in looking for work are:

• Explore vocational and career interests	• Mock Interviews
• Interview Prep- Dress for success Development)	• Visit potential employers (Job
• Create a resume and cover letter	• Benefits Counseling
• Search job listings	• In-depth vocational assistance-
• Peer assistance	
• Fill out job applications	• Learn acceptable Follow-up
techniques	

Supported Employment Services understands concerns regarding working and its affect on your benefits. Our program has a **Benefit to Work Coach** who will work with you and agencies, such as Social Security, MDHHS, MRS, etc., to help identify and manage any impact on your benefits from obtaining work.

Once working, the Employment Specialist will provide **Follow Along** services to help you keep your job. Services provided include *job coaching, task training, employee/employer advocacy and problem solving, and acceptable workplace behaviors-workplace policy review*. There is no time limit on how long or how often this assistance is offered – it depends on what your needs and wishes are.

Supported Employment: What is expected of you?

You really need to want to work - and your participation is vital. We can help you **find** a job, but you are the one that must show up to work every day and **do** the job. Preparing to, and looking for employment can be a demanding activity, and requires a lot of time and energy. Looking for work can be frustrating because you may feel rejected if an employer does not hire you. Looking for work can also cause us to look inward and may require you to change or learn new ways to dress or speak or act.

You should expect to:

- Arrive to appointments on-time.
- Check your email daily. Keep a list of passwords that are kept secret.
- Be actively involved in the search for your job. Remember, this is a partnership.
- Continue your mental health treatment!
- Accept change. Your Employment Specialist may need to address personal concerns that create barriers to your employment - these will only be brought up if they could be a hindrance to finding a job. The Specialist has your best interest in mind in bringing up difficult issues.
- Be serious about wanting a job. You will be personally challenged as you look for work and learn a job. Unemployment can be very difficult at times, but Supported Employment is here to help, encourage, and support you.
- Be patient. Finding the job of your choice will likely take some time.

Job-seeker considerations.

When you are thinking about work, there are many aspects to consider; what is it that appeals to you? Is it the need for income in order to pay bills? Do you want extra spending money for specific things? Is it the human connection and socialization? Is it so you can travel? Other options such as volunteering; joining a club or community group; recreation or sports; taking a class; or other leisure-time activities should be explored if you are looking for socialization. Those should be discussed with your Case Worker.

The Employment Specialist works in conjunction with your other service providers and will be in contact with them regularly. The Employment Specialist does not replace or provide the same services as your therapist, case worker, psychiatrist, nurse, doctor, clergy, or others who support you. The Specialist has one main function – to help you **get** and **keep** the job of your choice.

Supported Employment program staff will work closely with you to help you find employment, but in the end the decision to hire you rests with the employer. No one can force him or her to hire you. Our goal is to convince the employer that you are the right person for the job. Getting a job is quite often a numbers game. The more time invested, and applications submitted the better your chances of being hired. Remember, there are many others out there looking for work just like you. You need to put in the effort. A job is never guaranteed nor promised. The availability of jobs depends upon the local, state, and Federal economy and your personal motivation to find employment. It takes time and patience so please, don't give up!

Program participation is voluntary, and you may stop Supported Employment services at any time. You, the Jobseeker, and your Employment Specialist will notify the Case holder of your decision to change your level of engagement or suspend Supported Employment Services. To satisfy SCCMHA auditing and Network services requirements your Individual Plan of Service (IPOS) will need to be updated to reflect your decision.

Exhibit C: Supported Employment Fidelity Scale (From *The IPS Employment Center at The Rockville Institute, Westat*)

SUPPORTED EMPLOYMENT FIDELITY SCALE*

1/7/08

Rater:

Site:

Date:

Total Score:

Directions: Circle one anchor number for each criterion.

Criterion

Data
Source**

Anchor

STAFFING

1. Caseload size: Employment specialists have individual employment caseloads. The maximum caseload for any full-time employment specialist is 20 or fewer clients.

MIS,
DOC, INT

- 1= Ratio of 41 or more clients per employment specialist.
- 2= Ratio of 31-40 clients per employment specialist.
- 3= Ratio of 26-30 clients per employment specialist.
- 4= Ratio of 21-25 clients per employment specialist.
- 5= Ratio of 20 or fewer clients per employment specialist.

2. Employment services staff: Employment specialists provide only employment services.

MIS, DOC
INT

- 1= Employment specialists provide employment services less than 60% of the time.
- 2= Employment specialists provide employment services 60 - 74% of the time.
- 3= Employment specialists provide employment services 75 - 89% of the time.
- 4= Employment specialists provide employment services 90 - 95% of the time.
- 5= Employment specialists provide employment services 96% or more of the time.

*Formerly called IPS Model Fidelity Scale

3. Vocational generalists: Each employment specialist carries out all phases of employment service, including intake, engagement, assessment, job placement, job coaching, and follow-along supports before step down to less intensive employment support from another MH practitioner. (Note: It is not expected that each employment specialist will provide benefits counseling to their clients. Referrals to a highly trained benefits counselor are in keeping with high fidelity, see Item # 1 in “Services”.)

MIS, DOC,
INT, OBS

- 1= Employment specialist only provides vocational referral service to vendors and other programs.
- 2= Employment specialist maintains caseload but refers clients to other programs for vocational services.
- 3= Employment specialist provides one to four phases of the employment service (e.g. intake, engagement, assessment, job development, job placement, job coaching, and follow along supports).
- 4= Employment specialist provides five phases of employment service but not the entire service.
- 5= Employment specialist carries out all six phases of employment service (e.g. program intake, engagement, assessment, job development/job placement, job coaching, and follow-along supports).

ORGANIZATION

1. Integration of rehabilitation with mental health treatment thru team assignment: Employment specialists are part of up to 2 mental health treatment teams from which at least 90% of the employment specialist’s caseload is comprised.

MIS, DOC,
INT, OBS

- 1= Employment specialists are part of a vocational program that functions separately from the mental health treatment.
- 2= Employment specialists are attached to three or more mental health treatment teams. OR Clients are served by individual mental health practitioners who are not organized into teams. OR Employment specialists are attached to one or two teams from which less than 50% of the employment specialist’s caseload is comprised.
- 3= Employment specialists are attached to one or two mental health treatment teams, from which at least 50 - 74% of the employment specialist’s caseload is comprised.
- 4= Employment specialists are attached to one or two mental health treatment teams, from which at least 75 - 89% of the employment specialist’s caseload is comprised.
- 5= Employment specialists are attached to one or two mental health treatment teams, from which 90 - 100% of the employment specialist’s caseload is comprised.

140

2. Integration of rehabilitation with mental health treatment thru frequent team member contact:

MIS, DOC
INT, OBS

Employment specialists actively participate in weekly mental health treatment team meetings (not replaced by administrative meetings) that discuss individual clients and their employment goals with shared decision-making. Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members. Documentation of mental health treatment and employment services are integrated in a single client chart. Employment specialists help the team think about employment for people who haven't yet been referred to supported employment services.

1= One or none is present.

2= Two are present

3= Three are present.

4= Four are present.

5= Five are present.

All five key components are present.

- Employment specialist attends weekly mental health treatment team meetings.
- Employment specialist participates actively in treatment team meetings with shared decision-making.
- Employment services documentation (i.e., vocational assessment/profile, employment plan, progress notes) is integrated into client's mental health treatment record.
- Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members.
- Employment specialist helps the team think about employment for people who haven't yet been referred to supported employment services.

3. Collaboration between employment specialists and Vocational Rehabilitation counselors: The employment specialists and VR counselors have frequent contact for the purpose of discussing shared clients and identifying potential referrals.

DOC, INT
OBS, ISP

1= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) less than quarterly to discuss shared clients and referrals. OR Employment specialists and VR counselors do not communicate.

2= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) at least quarterly to discuss shared clients and referrals.

3= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in-person) monthly to discuss shared clients and referrals.

4= Employment specialists and VR counselors have scheduled, face-to-face

meetings at least quarterly. OR have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals.

5= Employment specialists and VR counselors have scheduled, face-to-face meetings at least monthly and have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals.

4. Vocational unit: At least 2 full-time employment specialists and a team leader comprise the employment unit. They have weekly client-based group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed.

MIS, INT,
OBS

1= Employment specialists are not part of a vocational unit.

2= Employment specialists have the same supervisor but do not meet as a group. They do not provide back-up services for each other's caseload.

3= Employment specialists have the same supervisor and discuss clients between each other on a weekly basis. They provide back-up services for each other's caseloads as needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times monthly with their supervisor by teleconference.

4= At least 2 employment specialists and a team leader form an employment unit with 2-3 regularly scheduled meetings per month for client-based group supervision in which strategies are identified and job leads are shared and discuss clients between each other. They provide coverage for each other's caseloads when needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times per month with their supervisor in person or by teleconference and mental health practitioners are available to help the employment specialist with activities such as taking someone to work or picking up job applications.

5= At least 2 full-time employment specialists and a team leader form an employment unit with weekly client-based group supervision based on the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseloads when needed.

5. Role of employment supervisor: Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. All five key roles of the employment supervisor are present.

MIS, INT,
DOC, OBS

1= One or none is present.

2= Two are present.

3= Three are present.

4= Four are present.

5= Five are present.

Five key roles of the employment supervisor:

- One full-time equivalent (FTE) supervisor is responsible for no more than 10 employment specialists. The supervisor does not have other supervisory responsibilities. (Program leaders supervising fewer than ten employment specialists may spend a percentage of time on other supervisory activities on a prorated basis. For example, an employment supervisor responsible for 4 employment specialists may be devoted to SE supervision half time.)
- Supervisor conducts weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives.
- Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis.
- Supervisor accompanies employment specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development.
- Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly.

6. <u>Zero exclusion criteria</u>: All clients interested in working have access to supported employment services regardless of job readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation. These apply during supported employment services too. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. If VR has screening criteria, the mental health agency does not use them to exclude anybody. Clients are not screened out formally or informally.	DOC, INT OBS	1= There is a formal policy to exclude clients due to lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.) by employment staff, case managers, or other practitioners. 2= Most clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.). 3= Some clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.). 4= No evidence of exclusion, formal or informal. Referrals are not solicited by a wide variety of sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. 5= All clients interested in working have access to supported employment services. Mental health practitioners encourage clients to consider employment, and referrals for supported employment are solicited by many sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held.
7. <u>Agency focus on competitive employment</u>: Agency promotes competitive work through multiple strategies. Agency intake includes questions about interest in employment. Agency displays written postings (e.g., brochures, bulletin boards, posters) about employment and supported employment services. The focus should be with the agency programs that provide services to adults with severe mental illness. Agency supports ways for clients to share work stories with other clients and staff. Agency measures rate of competitive employment and shares this information with agency leadership and staff.	DOC, INT, OBS	1= One or none is present. 2= Two are present. 3= Three are present. 4= Four are present. 5= Five are present. Agency promotes competitive work through multiple strategies: • Agency intake includes questions about interest in employment. • Agency includes questions about interest in employment on all annual (or semi-annual) assessment or treatment plan reviews.

8. Executive team support for SE: Agency executive team members (e.g., CEO/Executive Director, Chief Operating Officer, QA Director, Chief Financial Officer, Clinical Director, Medical Director, Human Resource Director) assist with supported employment implementation and sustainability. All five key components of executive team support are present.

DOC, INT, OBS

- Agency displays written postings (e.g., brochures, bulletin boards, posters) about working and supported employment services, in lobby and other waiting areas.
- Agency supports ways for clients to share work stories with other clients and staff (e.g., agency-wide employment recognition events, in-service training, peer support groups, agency newsletter articles, invited speakers at client treatment groups, etc.) at least twice a year.
- Agency measures rate of competitive employment on at least a quarterly basis and shares outcomes with agency leadership and staff.

1= One is present.

2= Two are present.

3= Three are present.

4= Four are present.

5= Five are present.

- Executive Director and Clinical Director demonstrate knowledge regarding the principles of evidence-based supported employment.
- Agency QA process includes an explicit review of the SE program, or components of the program, at least every 6 months through the use of the Supported Employment Fidelity Scale or until achieving high fidelity, and at least yearly thereafter. Agency QA process uses the results of the fidelity assessment to improve SE implementation and sustainability.
- At least one member of the executive team actively participates at SE leadership team meetings (steering committee meetings) that occur at least every six months for high fidelity programs and at least quarterly for programs that have not yet achieved high fidelity. Steering committee is defined as a diverse group of stakeholders charged with reviewing fidelity, program implementation, and the service delivery system. Committee develops written action plans aimed at developing or sustaining high fidelity services.

- The agency CEO/Executive Director communicates how SE services support the mission of the agency and articulates clear and specific goals for SE and/or competitive employment to all agency staff during the first six months and at least annually (i.e., SE kickoff, all-agency meetings, agency newsletters, etc.). This item is not delegated to another administrator.
- SE program leader shares information about EBP barriers and facilitators with the executive team (including the CEO) at least twice each year. The executive team helps the program leader identify and implement solutions to barriers.

SERVICES

1. Work incentives planning: All clients are offered assistance DOC, INT in obtaining comprehensive, individualized work incentives planning before starting a new job and assistance OBS, ISP accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits and any other source of income. Clients are provided information and assistance about reporting earnings to SSA, housing programs, VA programs, etc., depending on the person's benefits.

- 1= Work incentives planning is not readily available or easily accessible to most clients served by the agency.
- 2= Employment specialist gives client contact information about where to access information about work incentives planning.
- 3= Employment specialist discusses with each client changes in benefits based on work status.
- 4= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a person trained in work incentives planning prior to client starting a job.
- 5= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a specially trained work incentives planner prior to starting a job. They also facilitate access to work incentives planning when clients need to make decisions about changes in work hours and pay. Clients are provided information and assistance about reporting earnings to SSA, housing programs, etc., depending on the person's benefits.

2. Disclosure: Employment specialists provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a disability.

DOC, INT
OBS

1= None is present.

2= One is present.

3= Two are present.

4= Three are present.

5= Four are present.

- Employment specialists do not require all clients to disclose their psychiatric disability at the work site in order to receive services.
- Employment specialists offer to discuss with clients the possible costs and benefits (pros and cons) of disclosure at the work site in advance of clients disclosing at the work site. Employment specialists describe how disclosure relates to requesting accommodations and the employment specialist's role communicating with the employer.
- Employment specialists discuss specific information to be disclosed (e.g., disclose receiving mental health treatment, or presence of a psychiatric disability, or difficulty with anxiety, or unemployed for a period of time, etc.) and offers examples of what could be said to employers.
- Employment specialists discuss disclosure on more than one occasion (e.g., if clients have not found employment after two months or if clients report difficulties on the job.)

3. Ongoing, work-based vocational assessment: Initial vocational assessment occurs over 2-3 sessions and is updated with information from work experiences in competitive jobs. A vocational profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc, is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with

DOC, INT,
OBS, ISP

1= Vocational evaluation is conducted prior to job placement with emphasis on office-based assessments, standardized tests, intelligence tests, work samples.

2= Vocational assessment may occur through a stepwise approach that includes: prevocational work experiences (e.g., work units in a day program), volunteer jobs, or set aside jobs (e.g., NISH jobs agency-run businesses, sheltered workshop jobs, affirmative businesses, enclaves).

3= Employment specialists assist clients in finding competitive jobs directly without systematically reviewing interests, experiences, strengths,

the client's permission, from family members and previous employers.

etc. and do not routinely analyze job loss (or job problems) for lessons learned.

4= Initial vocational assessment occurs over 2-3 sessions in which interests and strengths are explored. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes. They do not document these lessons learned in the vocational profile, OR The vocational profile is not updated on a regular basis.

5= Initial vocational assessment occurs over 2-3 sessions and information is documented on a vocational profile form that includes preferences, experiences, skills, current adjustment, strengths, personal contacts, etc. The vocational profile form is used to identify job types and work environments. It is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with the client's permission, from family members and previous employers. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes.

4. Rapid job search for competitive job: Initial employment assessment and first face-to-face employer contact by the client or the employment specialist about a competitive job occurs within 30 days (one month) after program entry.

DOC, INT,
OBS, ISP

1= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average 271 days or more (> 9 mos.) after program entry.

2= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 151 and 270 days (5-9 mos.) after program entry.

3= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 61 and 150 days (2-5 mos.) after program entry.

4= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 31 and 60 days (1-2 mos.) after program entry.

5= The program tracks employer contacts and the first face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average within 30 days (one month) after program entry.

5. <u>Individualized job search</u>: Employment specialists make employer contacts aimed at making a good job match based on clients' preferences (relating to what each person enjoys and their personal goals) and needs (including experience, ability, symptomatology, health, etc.) rather than the job market (i.e., those jobs that are readily available). An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.	DOC, INT OBS, ISP	1= Less than 25% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc. rather than the job market. 2= 25-49% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 3= 50-74% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market. 4= 75-89% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market and are consistent with the current employment plan. 5= Employment specialist makes employer contacts based on job choices which reflect client's preferences, strengths, symptoms, lessons learned from previous jobs etc., 90-100% of the time rather than the job market and are consistent with the current employment/job search plan. When clients have limited work experience, employment specialists provide information about a range of job options in the community.
6. <u>Job development - Frequent employer contact</u>: Each employment specialist makes at least 6 face to-face employer contacts per week on behalf of clients looking for work. (Rate for each then calculate average and use the closest scale point.) An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the client is present or not present. Client-specific and generic contacts are included. Employment specialists use a weekly tracking form to document employer contacts.	DOC, INT	1= Employment specialist makes less than 2 face-to-face employer contacts that are client-specific per week. 2= Employment specialist makes 2 face-to-face employer contacts per week that are client-specific, <u>OR</u> Does not have a process for tracking. 3= Employment specialist makes 4 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a monthly basis. 4= Employment specialist makes 5 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a weekly basis.

		5= Employment specialist makes 6 or more face-to-face employer contacts per week that are client specific, or 2 employer contacts times the number of people looking for work when there are less than 3 people looking for work on their caseload (e.g., new program). In addition, employment specialist uses a tracking form that is reviewed by the SE supervisor on a weekly basis.
7. <u>Job development - Quality of employer contact:</u> Employment specialists build relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer. (Rate for each employment specialist, then calculate average and use the closest scale point.)	DOC, INT, OBS	1= Employment specialist meets employer when helping client to turn in job applications, <u>OR</u> Employment specialist rarely makes employer contacts. 2= Employment specialist contacts employers to ask about job openings and then shares these "leads" with clients. 3= Employment specialist follows up on advertised job openings by introducing self, describing program, and asking employer to interview client. 4= Employment specialist meets with employers in person whether or not there is a job opening, advocates for clients by describing strengths and asks employers to interview clients. 5= Employment specialist builds relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer.
8. <u>Diversity of job types:</u> Employment specialists assist clients in obtaining different types of jobs.	DOC, INT, OBS, ISP	1= Employment specialists assist clients obtain different types of jobs less than 50% of the time. 2= Employment specialists assist clients obtain different types of jobs 50-59% of the time. 3= Employment specialists assist clients obtain different types of jobs 60-69% of the time. 4= Employment specialists assist clients obtain different types of jobs 70-84% of the time.

		5= Employment specialists assist clients obtain different types of jobs 85-100% of the time.
9. <u>Diversity of employers</u> : Employment specialists assist clients in obtaining jobs with different employers.	DOC, INT, OBS, ISP	1= Employment specialists assist clients obtain jobs with the different employers less than 50% of the time. 2= Employment specialists assist clients obtain jobs with the same employers 50-59% of the time. 3= Employment specialists assist clients obtain jobs with different employers 60-69% of the time. 4= Employment specialists assist clients obtain jobs with different employers 70-84% of the time. 5= Employment specialists assist clients obtain jobs with different employers 85-100% of the time.
10. <u>Competitive jobs</u> : Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status, e.g., TE (transitional employment positions). Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside for people with disabilities. (Seasonal jobs and jobs from temporary agencies that other community members use are counted as competitive jobs.)	DOC, INT, OBS, ISP	1= Employment specialists provide options for permanent, competitive jobs less than 64% of the time, <u>OR</u> There are fewer than 10 current jobs. 2= Employment specialists provide options for permanent, competitive jobs about 65- 74% of the time. 3= Employment specialists provide options for permanent competitive jobs about 75-84%% of the time. 4= Employment specialists provide options for permanent competitive jobs about 85-94% of the time. 5= 95% or more competitive jobs held by clients are permanent.

11. <u>Individualized follow-along supports:</u> Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Supports are provided by a variety of people, including treatment team members (e.g., medication changes, social skills training, encouragement), family, friends, co-workers (i.e., natural supports), and employment specialist. Employment specialist also provides employer support (e.g., educational information, job, accommodations) at client's request. Employment specialist offers help with career development, i.e., assistance with education, a more desirable job, or more preferred job duties.	DOC, INT, OBS, ISP	1= Most clients do not receive supports after starting a job. 2= About half of the working clients receive a narrow range of supports provided primarily by the employment specialist. 3= Most working clients receive a narrow range of supports that are provided primarily by the employment specialist. 4= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialists provide employer supports at the client's request. 5= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. The employment specialist helps people move onto more preferable jobs and also helps people with school or certified training programs. The site provides examples of different types of support including enhanced supports by treatment team members.
12. <u>Time-unlimited follow-along supports:</u> Employment specialists have face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily, and desired by clients. Clients are transitioned to step down job supports from a mental health worker following steady employment. Employment specialists contact clients within 3 days of learning about the job loss.	DOC, INT, OBS, ISP	1= Employment specialist does not meet face-to-face with the client after the first month of starting a job. 2= Employment specialist has face-to-face contact with less than half of the working clients for at least 4 months after starting a job. 3= Employment specialist has face-to-face contact with at least half of the working clients for at least 4 months after starting a job. 4= Employment specialist has face-to-face contact with working clients weekly for the first month after starting a job, and at least monthly for a year or more, on average, after working steadily, and desired by clients. 5= Employment specialist has face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily and desired by clients. Clients are transitioned to step down job supports, from a mental health worker following steady employment clients. Clients are transitioned to step down job supports from a mental health worker following steady employment.

		Employment specialist contacts clients within 3 days of hearing about the job loss.
13. <u>Community-based services</u> : Employment services such as engagement, job finding and follow-along supports are provided in natural community settings by all employment specialists. (Rate each employment specialist based upon their <u>total</u> weekly scheduled work hours then, calculate the average and use the closest scale point.)	DOC, INT OBS	1= Employment specialist spends 30% time or less in the scheduled work hours in the community. 2= Employment specialist spends 30 - 39% time of total scheduled work hours in the community. 3= Employment specialist spends 40 -49% of total scheduled work hours in the then community. 4= Employment specialist spends 50 - 64% of total scheduled work hours in the community. 5= Employment specialist spends 65% or more of total scheduled work hours in the community.
14. <u>Assertive engagement and outreach by integrated treatment team</u> : Service termination is not based on missed appointments or fixed time limits. Systematic documentation of outreach attempts. Engagement and outreach attempts made by integrated team members. Multiple home/community visits. Coordinated visits by employment specialist with integrated team member. Connect with family, when applicable. Once it is clear that the client no longer wants to work or continue SE services, the team stops outreach.	MIS, DOC, INT, OBS	1= Evidence that 2 or less strategies for engagement and outreach are used. 2= Evidence that 3 strategies for engagement and outreach are used. 3= Evidence that 4 strategies for engagement and outreach are used. 4= Evidence that 5 strategies for engagement and outreach are used. 5= Evidence that all 6 strategies for engagement and outreach are used: i) Service termination is not based on missed appointments or fixed time limits. ii) Systematic documentation of outreach attempts. iii) Engagement and outreach attempts made by integrated team members. iv) Multiple home/community visits. v) Coordinated visits by employment specialist with integrated team member. vi) Connect with family, when applicable.

*Data sources:

MIS	Management Information System
DOC	Document review: clinical records, agency policy and procedures
INT	Interviews with clients, employment specialists, mental health staff, VR counselors, families, employers
OBS	Observation (e.g., team meeting, shadowing employment specialists)
ISP	Individualized Service Plan

2/14/96
6/20/01, Updated
1/7/08, Revised

Supported Employment Fidelity Scale Score Sheet

Staffing		
1.	Caseload size	Score:
2.	Employment services staff	Score:
3.	Vocational generalists	Score:
Organization		
1.	Integration of rehabilitation with mental health thru team assignment	Score:
2.	Integration of rehabilitation with mental health thru frequent team member contact	Score:
3.	Collaboration between employment specialists and Vocational Rehabilitation counselors	Score:
4.	Vocational unit	Score:
5.	Role of employment supervisor	Score:
6.	Zero exclusion criteria	Score:
7.	Agency focus on competitive employment	Score:
8.	Executive team support for SE	Score:
Services		
1.	Work incentives planning	Score:
2.	Disclosure	Score:
3.	Ongoing, work-based vocational assessment	Score:
4.	Rapid search for competitive job	Score:
5.	Individualized job search	Score:
6.	Job development—Frequent employer contact	Score:
7.	Job development—Quality of employer contact	Score:
8.	Diversity of job types	Score:
9.	Diversity of employers	Score:
10.	Competitive jobs	Score:
11.	Individualized follow-along supports	Score:
12.	Time-unlimited follow-along supports	Score:
13.	Community-based services	Score:
14.	Assertive engagement and outreach by integrated treatment team	Score:
Total:		

115 – 125	= Exemplary Fidelity
100 - 114	= Good Fidelity
74 – 99	= Fair Fidelity
73 and below	= Not Supported Employment

Exhibit D

Practice Principles of IPS Supported Employment

Competitive employment is the goal

Employment specialists help clients obtain competitive jobs. Competitive employment is defined: paying at least minimum wage and the wage that others receive performing the same work, based in community settings alongside others without disabilities, and not reserved for people with disabilities. Clients prefer competitive jobs over sheltered work. Working alongside others without psychiatric disabilities helps to reduce stigma and discrimination.

IPS supported employment is integrated with treatment

IPS supported employment services are closely integrated with mental health treatment. Employment specialists are members of multidisciplinary teams that meet regularly to review client progress. Discussions include clinical and rehabilitation information that is relevant to work, such as medication side effects, persistent symptoms, cognitive difficulties, or other rehabilitation needs. They share information and develop ideas to help clients improve their functional recovery.

Zero Exclusion: Eligibility is based on client choice

Every person with severe mental illness who wants to work is eligible for IPS supported employment, regardless of psychiatric diagnosis, symptoms, work history, or other problems, including substance abuse and cognitive impairment. The core philosophy of IPS supported employment is that all persons with a disability can work at competitive jobs in the community without prior training, and that no one should be excluded from this opportunity. Agencies develop a culture of work so all practitioners encourage clients to consider working.

Attention to client preferences

Services are based on clients' preferences and choices, rather than providers' judgments. Client preferences help determine the type of job that is sought, the nature of support provided by the employment specialist and team, and whether to disclose the aspects of a person's psychiatric disability to the employer.

Benefits counseling is important

Employment specialists help clients to access ongoing guidance regarding Social Security, Medicaid, and other government entitlements. Fear of losing benefits is a major reason that clients may not want to seek employment. It is vital that clients obtain accurate information to inform and guide the plan for starting work and over time for making decisions about changes in wages and work hours.

Rapid job search

Employment specialists help clients seek jobs directly, rather than providing extensive pre-employment assessment and training, or intermediate work experiences. Beginning the job search process early (i.e., within 30 days) demonstrates to clients that their desire to work is taken seriously, and conveys optimism that there are multiple opportunities available in the community for clients to achieve their vocational goals.

Systematic job development

Employment specialists develop relationships with employers, based upon their clients' work preferences, by meeting face-to-face over multiple visits. Employment specialists learn about the work environment and the employers' work needs. They find out about jobs that they may not be aware of at employment sites. They gather information about the nature of job opportunities and assess whether they may be a good job fit. Employment specialists continue to make periodic visits because networking is how people find jobs.

Time-unlimited support

Follow-along supports are individualized and continued for as long as the client wants and needs the support. IPS specialists and other members of the treatment team provide work support. In addition they look for natural supports (e.g., family member, co-worker) that would be available over time. The goal is to help the client become as independent as possible in his or her vocational role, while providing support and assistance as needed. Once a person has worked steadily (e.g., one year), they discuss transitioning from IPS.

IPS stands for Individual Placement and Support, which is the evidence-based practice of supported employment for people with severe mental illnesses.

Dartmouth Psychiatric Research Center, 10/11/2011

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Dialectical Behavior Therapy (DBT)	Chapter: 02 - Customer Services and Recipient Rights	Subject No: 02.03.09.04
Effective Date: 7/20/06	Date of Review/Revision: 11/29/07, 5/18/09, 6/10/10, 4/2/12, 5/8/14, 4/5/16, 6/13/17, 4/10/18, 4/9/19, 8/26/19, 6/1/20, 3/10/21, 1/12/22, 1/10/23, 9/22/23, 3/15/24, 04/29/25, 03/16/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
	Supersedes:	
		Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team

Purpose:

The purpose of this policy is to delineate a framework for the provision and monitoring of Dialectical Behavior Therapy (DBT), Dialectical Behavior Therapy for Adolescents (DBT-A), and DBT-Informed interventions such as Skills System.

Policy:

- A. SCCMHA shall make DBT available to eligible consumers as resources permit.
- B. Providers who offer DBT shall adhere as closely as possible to the evidence-based practice model of DBT.
- C. Adaptations to the model for local community needs may be made with the authorization of SCCMHA.
- D. DBT shall be delivered in a trauma-informed manner.
- E. DBT can be delivered face-to-face, in-person, or via telehealth technology.

Application:

This policy applies to all SCCMHA-funded providers of mental health and substance use disorder treatment services who offer DBT.

Standards:

- A. Only clinicians who have received SCCMHA-approved DBT/DBT-A training and have been privileged to do so shall be permitted to conduct this treatment.
- B. DBT/DBT-A shall be provided in accordance with the model which includes:

1. The five primary modes of treatment of DBT:
 - a. Individual therapy
 - b. Group skills training
 - c. Telephone contact/Phone Coaching
 - d. Therapist weekly consultation group (in which the DBT team of individual therapists and skills trainers meet to review the program and their practice using the dialectical style that characterizes the practice of DBT within this peer supervision group).
 - e. Ancillary Treatments (e.g., pharmacotherapy, employment services, clubhouse, hospitalization, and other evidence-based practices)
2. The four groups of skills that are taught:
 - a. Core Mindfulness Skills which are derived from Buddhist meditation techniques and are designed to enable the person served to become aware of the different aspects of experience and develop the ability to stay with that experience in the present moment.
 - b. Interpersonal Effectiveness Skills which focus on effective ways of achieving one's objectives with other people (e.g., asking for what one wants effectively, saying no, being taken seriously) in order to maintain relationships and self-esteem in interactions with other people.
 - c. Emotion Regulation/Modulation Skills are ways of coping with intense emotional experiences and their causes. They also allow for an adaptive experience and expression of intense emotions. These skills include:
 - 1). Identifying and labeling emotions
 - 2). Identifying obstacles to changing emotions
 - 3). Reducing vulnerability to *emotion mind*
 - 4). Increasing positive emotional events
 - 5). Increasing mindfulness to current emotions
 - 6). Taking opposite action
 - 7). Applying distress tolerance techniques
 - d. Distress Tolerance Skills include techniques for putting up with, finding meaning for, and accepting distressing situations if there is no conceivable solution at present.
 - e. DBT-A also includes Walking the Middle Path which entails helping with adolescent-family issues. It focuses on teaching adolescents and their parents the concepts of dialectics, validation, and behavioral therapy. Emphasis is placed on the relationship between parents and teens.
3. The four modules in DBT group skills training:
 - a. The pre-treatment stage focuses on assessment, commitment, and orientation to therapy.
 - b. Stage 1 focuses on suicidal behaviors, therapy interfering behaviors and behaviors that interfere with the quality of life, together with developing the necessary skills to resolve these problems.
 - c. Stage 2 deals with posttraumatic stress related problems (PTSD).

- d. Stage 3 focuses on self-esteem and individual treatment goals.
- 4. Dialectical Behavioral Therapy (DBT) consists of:
 - a. Once-weekly individual psychotherapy sessions in which a particular problematic behavior or event from the past week is explored in detail, beginning with the chain of events leading up to it, going through alternative solutions that might have been used, and examining what kept the person served from using more adaptive solutions to the problem. DBT-A, there may also be family sessions.
 - b. Both between and during sessions, the therapist actively teaches and reinforces adaptive behaviors, especially as they occur within the therapeutic relationship. The emphasis is on teaching consumers how to manage emotional trauma rather than reducing or taking them out of crises.
 - c. Weekly 2.5-hour group therapy sessions in which interpersonal effectiveness, distress tolerance/reality acceptance skills, emotion regulation, and mindfulness skills are taught.
 - d. Phone coaching: An aim of DBT phone coaching is to prevent hospitalization during a crisis.
 - 1. During individual therapy sessions, therapists are encouraged to periodically remind the participant(s) to call well before a suicidal crisis emerges. This is intended to use skills (Mindfulness, Emotion Regulation, Interpersonal Effectiveness and Distress Tolerance,) to avert rather than how to manage a crisis.
 - 2. Therapists should also be familiar with Self-Soothing and Improve the Moment techniques. Should the occasion arise where a caller is addressing self-harm including suicidal crisis, DBT therapists should be familiar with the material in the phone coach binder. This material includes Management of Acute Suicidal Behavior, Pocket Notes for Crisis Intervention and Debriefing (end of assessment session) Checklist & Protocol.
 - 3. The use of the C-SSRS assessment can be used to determine high, moderate, low, or no suicide risk.
 - 4. Only as a last resort should the participant be encouraged to call 911 or contact the SCCMHA crisis department.
- 5. DBT targets behaviors in a descending hierarchy:
 - a. Decreasing high-risk suicidal behaviors
 - b. Decreasing responses or behaviors (by either the therapist or consumer) that interfere with therapy
 - c. Decreasing behaviors that interfere with/diminish quality of life
 - d. Decreasing and dealing with post-traumatic stress responses
 - e. Enhancing respect for self
 - f. Acquisition of the behavioral skills taught during group

- g. Additional goals set by the consumer
- 6. The core strategies in DBT are validation and problem-solving. Attempts to facilitate change are surrounded by interventions that validate the consumer's behavior and responses as understandable in relation to their current life situation, and that show an understanding of their difficulties and suffering. Problem-solving focuses on the establishment of necessary skills. To deal with difficulties in using problem-solving skills in particular situations the following techniques may be applied in the course of therapy:
 - a. Contingency management
 - b. Cognitive therapy
 - c. Exposure based therapies
 - d. Pharmacotherapy
- 7. Inclusion Criteria
 - a. Age 18+ for DBT and Skills System. Ages 13-18 for DBT-A. DBT- informed can be applied to ages 13+.
 - b. At least an I.Q. of 70 (except with Skills System, where an individual with I/DD can fall into the mild to moderate IQ range).
 - c. Diagnosis of Borderline Personality Disorder, or substance use, or self-harming behaviors, or extensive hospitalizations or crisis contacts, significant emotional dysregulation, including Bipolar DO, Major Depression, eating DO, impulsivity, suicidal ideation, significant interpersonal difficulties, trauma, or PTSD.
- 8. Exclusion Criteria. The following may be used to assist in the determination of exclusion from DBT:
 - a. Active psychosis
 - b. Significant anger or aggressive behaviors.
 - c. An IQ outside of what is defined above.
 - d. A score of 0-0.07 on the Borderline Symptoms List (BSL-23)
 - e. A score of 126 or lower on the Life Problem Inventory (LPI)
 - f. A score of 0-4 on the Miller-Patton Self-Assessment Test
- 9. 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 DBT, to discuss fidelity monitoring.
 - b. The Adult Strengths and Needs Assessment (ANSA) will be used as a tool to examine outcomes for DBT participants ages 18+. For youth participating in DBT-A who are under the age of 18, the Child and Adolescent Functional Assessment Scale (CAFAS) or Michi-CANS will be used in a similar manner.
 - i. The Borderline Symptom List (BSL-23) or Borderline Evaluation of Severity over Time (BEST) should also be used as addi-

- tional method(s) of evaluating progress and outcomes for adults.
 - c. All active DBT teams shall undergo MiFAST fidelity reviews every 3-5 years.
 - C. DBT-Informed Treatment Options
 - 1. Standard DBT and DBT-A can be provided in an informed manner.
 - a. Informed means using aspects of the practice without necessarily using all the components and it may not follow the same timeline as full DBT implementation. For example, having a condensed skills group only intervention or working with someone individually, without a group component, and integrating DBT concepts into therapy session.
 - b. DBT-Informed can also be the idea of using DBT concepts in individual or an adapted group setting without the existence of a DBT team.
 - c. DBT-Informed interventions do not identify DBT as the EBP for tracking purposes, but because DBT falls under the umbrella of Cognitive Behavior Therapy, CBT should be identified as the intervention in the SENTRI system.
 - 2. DBT-Informed: Skills System
 - a. The Standard DBT skills curricula are not accessible for people with significant learning challenges. Cognitive load demands are too high to allow for learning, free recall, and generalization in the natural environment.
 - b. Skills System uses a DBT-based framework that helps people experience a dialectical synthesis (the ability to be in pain AND be effective at the same time) versus polarization during emotional, cognitive, behavioral, relationship, and self-processes in complex life contexts.
 - c. The Skills System Design
 - 1) Framework breaks complex tasks into component parts – Task Analysis Integrates mindfulness strategies and goal directed thinking that lead the individual to execute goal-directed actions.
 - 2) Provides clear, strategic steps (micro-transitions) to create adaptive chains of behavior.
 - 3) The tools have to be flexible enough to be able to adapt to internal and external changes in the moment.
 - 4) The skills and the “system” function as cognitive scaffolding to help navigation (being present & effective) across the spans of emotions.

Definitions:

Dialectical Behavior Therapy (DBT): A mode of treatment designed for people with borderline personality disorder (BPD), especially those who engage in suicidal behavior. DBT

aims to help people with BPD validate their emotions and behaviors, examine behaviors and emotions that have a negative impact on their lives, and make a conscious effort to bring about positive changes. In validation the therapist helps the individual see that their behavior and responses are understandable in relation to their current life situation. However, these behaviors and responses often create a great deal of distress, suffering, and instability in the person's life. The person served works on building social and personal skills to deal effectively with the problems in life via training in problem-solving skills. Studies have indicated that people with BPD who have had DBT make fewer suicide attempts and are hospitalized less often. DBT was pioneered by Dr. Marsha Linehan at the University of Washington.

Dialectical Behavior Therapy for Adolescents (DBT-A): Dialectical Behavior Therapy (DBT) has been adapted for adolescents aged thirteen to nineteen who are suicidal. It focuses on helping teens and their families master the challenges of the transition from adolescence to adulthood as well as ameliorate problematic behaviors that are sometimes used to deal with extreme emotional intensity. The intervention has been modified for use in outpatient as well as inpatient settings. The first phase of treatment has been shortened from one year to sixteen weeks. The number of skills has been reduced in order to teach them in sixteen weeks. Parents are included in the skills training group in order to enhance generalization and maintenance of skills. Family members are taught to use skills and improve the adolescent's home environment. A new skills training module, Walking the Middle Path, has been added to teach behavioral principles and validation as well as address the dialectical dilemmas inherent in parent-adolescent interactions.

Parents are required to attend a multi-family parents' group where they learn the DBT skills of mindfulness, distress tolerance, interpersonal effectiveness, emotion regulation and Walking the Middle Path. In addition, parents learn to understand and respond to specific adolescent behaviors, encourage the use of skills at home, and receive support from each other within a DBT framework. One of the group skills trainers provides parents with skills coaching for occasions of distress. Parents and/or other family members are included in individual sessions when indicated. The language on the skills handouts has been simplified to make them developmentally and culturally appropriate for adolescents.

In the DBT-A outpatient format the person served attends twice-weekly psychotherapy for sixteen weeks. One of these weekly sessions is for multifamily group skills training, and the other is for individual therapy. The focus is on stabilization and control of the acute behavior that precipitated the intervention. The inpatient format of DBT-A is briefer, more intensive, and even more focused on the behavior that precipitated the hospital admission. Here therapy goals are limited to establishing a commitment to treatment and stabilization of life-threatening behavior.

Skills System: The Skills System is a user-friendly set of emotion regulation skills, designed to help people of various ages and abilities manage emotions. Learning how to regulate emotions enables individuals to be present in the moment and be more effective—even in stressful situations. Over- and under-reacting can cause more stress and problems. The Skills System helps individuals be aware of our current moment, think through the situation, and take goal-directed actions that align with our values.

References:

- A. [Borderline Symptom List \(BSL-23\) – NovoPsych](#)
- B. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- C. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
- D. DBT-Linehan Board of Certification: <https://dbt-lbc.org>
- E. Skills System Resource Center: <https://skillssystem.com>

Exhibits:

- A. SCCMHA DBT cover sheet and Referral Packet

Procedure:

ACTION	RESPONSIBILITY
Initiates referral for DBT by completing the DBT referral form (found on the SCCMHA information system G-drive and Exhibit A).	Clinician
Interviews the consumer. Provides a DBT case formulation and documents it in the Therapist Assessment in Senti Administers diagnostic and Borderline Symptom List 23 (BSL-23).	DBT Team Screening Clinician
Complete Pre-treatment stage checklist Assist person served to complete intake forms	DBT Therapist and Team Leader
Completes assessment or functional analysis of target behavior. Reviews diagnosis with the consumer. Teaches the Biosocial Theory to the person served if the person served has a diagnosis of borderline personality disorder. Reviews the concept of Dialectics. Reviews the modes of DBT and their functions with the consumer Reviews the DBT therapist's clinical style with the person served and what they can expect during certain in-session behavior. Reviews Agreements of person served and therapist stresses that DBT is supportive, behavioral, collaborative, skill-oriented, and balanced between acceptance and change.	
Determines if the person served has the cognitive capacity (at least an I.Q. of 70 except with Skills Sys-	

tem, where an individual with I/DD can fall into the mild to moderate range) when there is a question of whether the person served will be able to benefit from participating in a DBT skills building format. Determines whether any psychological testing is necessary.	Psychologist
Review clinical and psychometric information reviewed along with person served input for eligibility for DBT membership. NOTE: DBT team consultation members agree to apply DBT philosophy when determining person served inclusion and exclusion criteria to DBT comprehensive services. Provides the following DBT sessions to eligible consumers: • 4-8 DBT joining sessions with a DBT therapist for Pre-Treatment and DBT Case Formulation • 52 weeks of individual therapy • 52 weeks of group therapy • 24-hour DBT telephonic consultation • Ancillary services such as psychiatric services and psychological testing Note: Starts the termination phase of treatment at 10 months. Provides optional booster sessions after termination. Provides post DBT services and supports (e.g., case management) in accordance with SCCMHA utilization criteria for continued stay based on severity of symptoms.	DBT Team (DBT therapist, Consultation team members, psychologist, and other ancillary clinicians if needed)
Monitors DBT on a regular basis for adherence to the model and outcomes. Conducts a MIFAST DBT review every 3-5 years.	Best Practices Committee/Designated DBT Fidelity Monitoring Group MIFAST/SCCMHA DBT Team
Help the person served to monitor person served information related to target behaviors at the following designated intervals: 6 months pre DBT • Start of DBT (initial BSL-23) • 6 months (repeat BSL-23) • 1 year of DBT (repeat BSL-23) • 6 months post DBT	DBT Therapist and Case Holder

Record person served demographics and information in the SENTRI II electronic health record including:

1. Number of times person served has committed acts of attempted suicide or reported suicidal ideations.
2. Number of times the person served has committed acts of self-harm.
3. Numbers of times person served has visited the emergency room.
4. Number of times admitted to inpatient treatment/hospitalizations.
5. Total days spent in the inpatient/hospital.
6. Number of times person served has visited the medical floor of hospital.
7. Number of times person served has committed self-destructive or impulsive acts.
8. Number of times person served has contacted crisis center, called 911 and the number of times person served has called the 24/7 DBT phone coaching line.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Family Psychoeducation (FPE)	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.09.05
Effective Date: 2/7/07	Date of Review/Revision: 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, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team
	Supersedes:	
		

Purpose:

The purpose of this policy is to delineate standards for the provision of Family Psychoeducation (FPE) services to persons served who can benefit from this program and desire to participate.

Policy:

- SCCMHA is committed to supporting the recovery process of persons served 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 persons served 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 persons served 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, persons served 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 persons served, 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, persons served. 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 person served 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 persons served who experience schizophrenic disorders
 - 2. Core Components:
 - a. Joining with persons served 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 person served/family
 - b). Define the problem in behavioral terms
 - c). Generate at least eight suggestions for solution to the problem
 - d). Explore with the person served and family pros and cons for each suggestion
 - e). Have person served and family select the best suggestion
 - f). Develop a step-by-step plan with the person served and family
 - 2). Process:
 - Step 1: Socializing for 10-15 minutes before group starts.
 - Step 2: Go around – everyone (person served 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, person served, and practitioners)
 - Step 4: List all possible solutions (all group members)
 - Step 5: Discuss first advantages and then disadvantages of each in turn (family, person served, and practitioners, group members)
 - Step 6: Choose the solution that best fits the situation (person served and family)
 - Step 7: Plan how to carry out this solution by forming a detailed, written action plan (person served, family, and practitioners)
 - Step 8: Review implementation (practitioners in concert with person served and family)
 - Step 9: At the next meeting, the person served 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-month 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 person served 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 person served 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/or 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 by 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 persons served. 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.
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- 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 Persons served 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 persons served 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 persons served who can benefit from the program.	3. SCCMHA Providers
4. SCCMHA secures/develops resources to ensure 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: - Establishes, monitors, and automates family intake and engagement procedures - Assigns potential FPE consumers to FPE practitioners - Monitors and adjusts FPE practitioner caseloads - Arranges for training new FPE practitioners and continuing education of existing FPE staff - Supervises FPE staff	Agency does not have a designated staff member OR 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 OR 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 OR 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 OR 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, OR 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						
		Ratings / Anchors				
Criteria		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: FPE practitioners use a standardized approach to help consumers and families with problem solving, which includes the following: ■ Define the problem; ■ Generate solutions; ■ Discuss the advantages and disadvantages of each solution; ■ Choose the best solution; ■ Form an action plan; and ■ 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: FPE services are provided in the following: ■ Engagement; ■ 3 or more joining sessions; ■ Educational workshop; and ■ 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: 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. 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

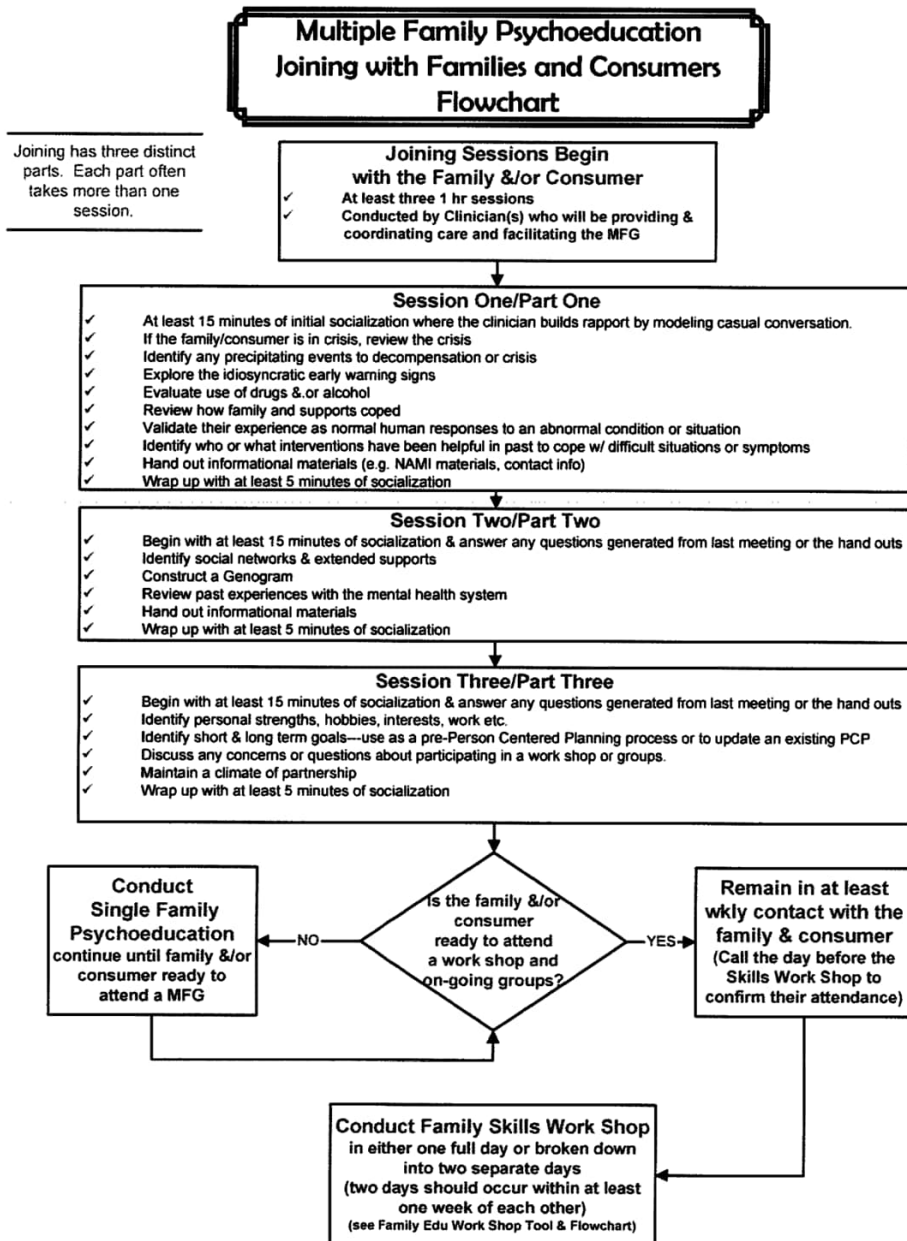


Exhibit E

Single and Multiple Family Psychoeducation Flowchart

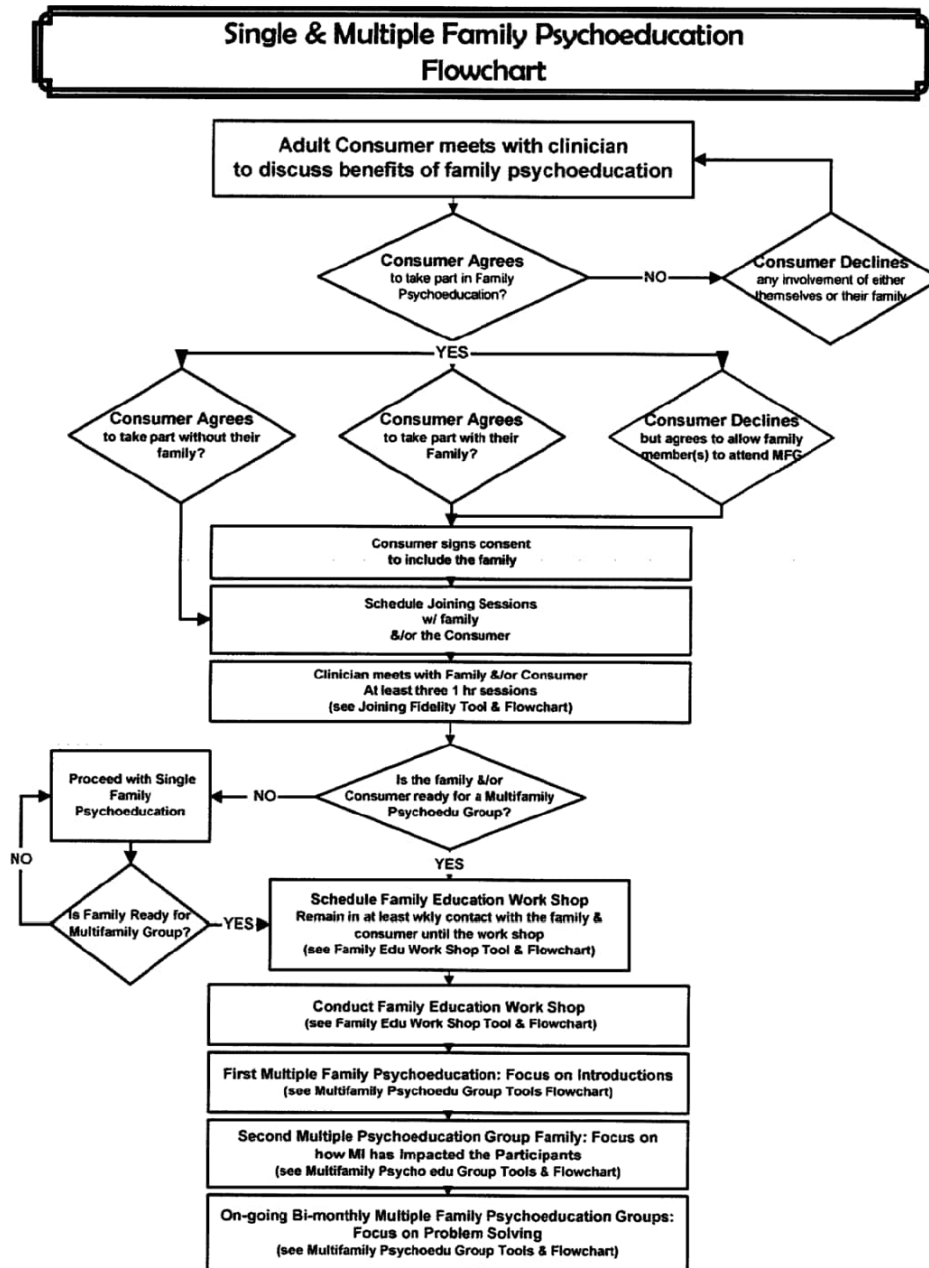


Exhibit F

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 down 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 1

- _____ 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.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Parent Management Training – Oregon Model (PMTO)	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.09.06
Effective Date: 1/25/08	Date of Review/Revision: 5/18/09, 6/10/10, 6/11/12, 5/7/14, 4/19/16, 6/13/17, 4/10/18, 4/9/19, 6/12/20, 3/10/21, 3/9/22, 3/8/23, 3/15/24, 3/28/25, 3/16/26 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: Matthew Linkowski, EBP Leadership Team
		

Purpose:

The purpose of this policy is to delineate a framework for the provision and monitoring of Parent Management Training – Oregon Model (PMTO) as well as Parenting Through Change (PTC) and Parenting through Change Reunification (PTC-R).

Policy:

- A. Providers shall adhere to the practice standards of PMTO as delineated in the PMTO FIMP (Fidelity Implementation Rating System) of the Oregon Social Learning Center (OSLC).
- B. SCCMHA shall offer PMTO, PTC, and PTC-R to eligible persons served as resources permit.
- C. PMTO shall be delivered in a trauma-informed manner.
- D. PMTO can be delivered face-to-face, in-person, or via telehealth technology.

Application:

This policy applies to all providers who have received appropriate training, certification and have been privileged to provide PMTO, PTC, or PTC-R.

Standards:

- A. PMTO shall be delivered in accordance with the following standards:
 - 1. Target population:

- a. Youth from preschool through adolescence who display serious behavior problems including:
 - 1). Overt antisocial behavior (e.g., aggression, defiance, hyperactivity, fighting)
 - 2). Covert antisocial behavior (e.g., lying, stealing, truancy, fire setting)
 - 3). Internalizing problems (e.g., depressed mood, peer relationship problems, deviant peer associations)
 - 4). Delinquency
 - 5). Substance abuse
 - 6). School Failure
 - b. Families experiencing multiple problems including:
 - 1). Parents with mental health problems (e.g., depression, anxiety, antisocial personality traits/disorder)
 - 2). Family contextual problems (e.g., poverty, residing in an economically challenged neighborhood)
 - 3). Family structure transitions (e.g., divorce, re-partnering)
 - 4). Marital conflict
 - 2. Parental empowerment:
 - a. Parents function as primary treatment/change agents
 - b. Identifying and building on families' strengths
 - c. Skills training in five core effective parenting practices for parents:
 - 1). Encouragement: Teaching new behavior through positive contingencies (i.e., praise, incentives)
 - 2). Limit Setting: Responding to problem behavior with negative, non-corporal nonphysical consequences
 - 3). Monitoring and Supervision: Attending to children's behavior at home and away from home
 - 4). Family Problem Solving: An organized method of making decisions with family input that includes interpersonal planning, troubleshooting, contingency agreements
 - 5). Positive Parental Involvement: Parents demonstrating interest, attention, and caring
 - 3. Interventions with family members and subsystems (e.g., couples, youngsters, siblings) as needed.
 - 4. Intensive training of PMTO therapists:
 - a. Workshops
 - b. Biweekly group consultation based on direct observation of family treatment
 - c. Fidelity assessed from observation of family treatment
 - d. Certification in method
- B. Birth parents/caregivers of children with a serious emotional disturbance (SED) whose child welfare plan calls for reunification with their children shall be considered candidates for PTC-R.
- NOTE: PTC-R shall be limited to parents whose children have been removed by MDHHS's (Michigan Department of Health and Human

Service) CPS (Children's Protective Services) and are seeking and actively working toward reunification.

1. PTC/PTC-R shall be delivered in accordance with the model's standards as follows:
 - a. The provision of tools related to five core positive parenting practices listed above in Standard A.2.c.
 - b. The provision of a mixture of education and support in a once weekly group-based format for ninety minutes to eight to ten participants (i.e., birth parents) for a period of ten weeks.
 - c. Adherence to the curriculum for the practice which includes the following topics:
 - 1). Creating Change
 - 2). Encouraging Cooperation
 - 3). Teaching Positive Behavior
 - 4). Observing Emotions
 - 5). Regulating Emotions
 - 6). Setting Limits
 - 7). Following Through
 - 8). Active Communication
 - 9). Problem-Solving
 - 10). Putting It All Together
 - d. Weekly observation utilizing the PTC-R checklist provided shall be provided by the case holder during the parent's visit with their child to encourage the parent to incorporate topics covered in the group session during their visit.
 - 1). PTC-R therapists shall review the results on the portal and incorporate extra help during the group sessions as needed.
 - e. Group attendance and checklist forms shall be entered into the persons served's electronic health record.
 - f. Birth parents shall participate in a six-session aftercare program, Parenting Through Change–Return Home (PTC-RH) program subsequent to reunification with their child.
 - g. Monthly refreshers shall be made available to parents who have not been reunified with their children subsequent to the ten-week PTC-R program.
2. Case holders and supervisors shall receive training to learn the PTC curriculum in order to facilitate PTC groups.
 - a). Two-day PTC-R trainings shall be offered to MDHHS, foster care and other staff in order to inform them of the process the parents go through and provide training regarding the PMTO Portal.
3. Fidelity to the model shall be monitored by SCCMHA.
4. The MichiCANS will be used to examine outcomes by the Best Practices Committee.
5. The Strength and Growth Areas (SAGA) is an additional assessment for outcomes used by the clinician. A pre and posttest are completed with the individuals/families served.

Definitions:

Fidelity of Implementation Rating System (FIMP) evaluates five dimensions of competent adherence to PMTO (i.e., knowledge, structure, teaching skill, clinical skill, and overall effectiveness) specified in the model as well as competent clinical and teaching processes observed during intervention. Objectivity is achieved through the use of observation of video recordings of sessions that deal with core content material.

Parent Management Training-Oregon Model (PMTO™) is an evidence-based, structured, family-based, behavioral intervention program designed by Dr. Gerald Patterson and his colleagues at the [Oregon Social Learning Center \(OSLC\)](#) to help parents and caregivers manage the behavior of their children. It is designed to promote prosocial skills and cooperation and to prevent, reduce and reverse the development and maintenance of mild to moderate to severe conduct problems in children aged 4 – 12. PMTO empowers parents as primary treatment agents to promote and sustain positive change in families and emphasizes, identifies, and builds upon strengths already present in parents, children, and their environment. Professionals shape parents to shape their children's behavior with the use of positive and negative contingencies.

Parenting Through Change (PTC): A group-based birth parent engagement model that teaches core intervention components in order to reduce coercive and inconsistent parenting practices through the empowerment of parents and increasing effective parenting practices while reducing child behavioral and emotional problems; and increase positive and pro-social behaviors in the parent and child.

Parenting Through Change Reunification (PTC-R): An evidenced-based adaptation of Parent Management Training – Oregon Model (PMTO) which is a hands-on, strength-based and skill building oriented practice that is delivered to groups of birth parents with children in foster care who wish to reunify with their children over the course of ten weeks.

Parenting Through Change Return Home (PTC-RH): As part of PTC-R, individual sessions are provided to parents as reunification approaches or upon the child's return home. The family is seen individually for at least six weeks and the worker reviews relevant strategies and materials. Families learn additional skills to support and assist them in dealing with the changes and challenges that arise during the time of reunification. These skills focus on the strength of the parents and rebuilding the family.

References:

- A. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- B. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

Exhibits:

- A. FIMP Categories Rating Form (2019)
- B. Strength and Growth Areas (SAGA)

Procedure:

ACTION	RESPONSIBILITY
PMTO/PTC/PTC-R is offered to eligible persons served and families by certified PMTO therapists.	Therapists/case holders
10-week PTC-R group sessions are delivered to parents who are in the process of reunification	PTC-R Therapists
PTC-RH is delivered to parents who have been reunified with their children	PTC-RH Therapists
10-week PTC sessions are delivered to eligible parents	PTC Therapists
Refresher sessions are delivered to eligible parents who have not been successful in reunifying with their children	PTC-R Therapists
PMTO/PTC/PTC-R programs are monitored for adherence to the model on an ongoing basis using the FIMP.	PMTO instructors/SCCMHA
Family member participation in PMTO/PTC/PTC-R shall be recorded within the active youth persons served's Functional Assessment Systems (FAS) record.	Case Holder
Outcomes will be monitored.	Best Practices Committee

Exhibit A

FIMP Categories Rating Form

Knutson, Forgatch, Rains, Sigmarsson, & Domenech Rodríguez, 2019

Interventionist _____ Family # _____ Session # _____ Session Date _____ Rater _____ Content _____ Phase _____ Date Coded _____

Time(s) Coded: : : - : : : : - : : : : : - : :

				Good Work	Acceptable	Needs Work
Knowledge				9 8 7	6 5 4	3 2 1
• Applies principles and model • Understands core/supporting parenting practices		• Uses correct technical details/procedures • Integrates GenerationPMTO tools as relevant				
Structure				9 8 7	6 5 4	3 2 1
• Follows an agenda • Includes appropriate sections • Manages orderly flow • Appropriate attention to relevant categories		• Responsive to family • Maintains leadership • Leads without dominating		• Good transitions • Sensitive pacing • Good timing • Sums up		
Teaching				9 8 7	6 5 4	3 2 1
Verbal Teaching • Gives information/ instructions • Provides rationales • Good GenerationPMTO raps • Pinpoints • Provides sufficient information		Active Teaching (cont.) • Problem solves / brain storms • Integrates/weaves information • Guides review of material • Assesses skills and fills in gaps • Pre-corrects • Breaks into teachable units • Balances encouragement/ correction • Predicts problems • Leads parents to pinpoint (LQ) • Adjusts GenerationPMTO tools to family • Punctuates		Use of Role Play • Capitalizes on opportunities • Conducts sufficient number/range <u>Sets up:</u> • Models/demonstrates • Provides enough information • Directs what to do <u>Conducts/Coaches:</u> • Engages family • Models/prompts/coaches • Breaks into appropriate steps/chunks • Theatrical/Uses movement <u>Debriefs:</u> • Balances encouragement/ correction • Weaves instructional material • Differentiates		
Active Teaching • Uses variety of activities • Balances verbal Teaching/active teaching • Elicits goal behavior • Engages family						
Process Skills				9 8 7	6 5 4	3 2 1
• Uses questioning process • Prevents/manages resistance • Prevents/manages conflict • Maintains balance • Promotes united approach • Encourages/supports/emphasizes strengths • Reinforces		• Promotes perspective taking • Connects with storyline • Uses variety of tools • Normalizes • Interprets/reframes		• Metaphors • Mirrors/matches • Strategic warning • Takes responsibility • Paraphrases/summarizes • Humor	• Paradox • Reflects • Supportive interrupts • Keeps contact • Movement • Quality of Questioning Process	
Overall Development				9 8 7	6 5 4	3 2 1
• Application of Generation PMTO/SIL model • Adjusts for context/situation/needs • Apparent relationship with Specialist		• Family making progress • Likelihood family will use • Likelihood family will come back		• Family's satisfaction • Difficulty of family/situation • Growth occurred		

Exhibit B

Region:	Therapist:	Type: ☐ PTC ☐ PTC-R ☐ PMTO	Time: ☐ Pre ☐ Post ☐ Follow-Up



Parent First Name: Last Name Initial: Date:

Family Strengths and Growth Areas Survey (SAGA 2.0)

We would like to start by gathering some information about you and your family in order to learn more about families in Michigan participating in PMTO.

Please answer this first set of questions about yourself:

1. What is your age?
 - ☐ 17 or younger
 - ☐ 18-20
 - ☐ 21-29
 - ☐ 30-39
 - ☐ 40-49
 - ☐ 50-59
 - ☐ 60 or older
2. What is your gender?
 - ☐ Male
 - ☐ Female
 - ☐ Prefer not to disclose
3. What is the highest level of school you have completed?
 - ☐ Less than a high school degree
 - ☐ High school degree or equivalent (e.g., GED)
 - ☐ Some college but no degree
 - ☐ Associate degree
 - ☐ Bachelor degree
 - ☐ Graduate degree
4. What is your race/ethnicity? Please select all that apply.
 - ☐ White/Caucasian
 - ☐ Spanish, Hispanic, or Latino
 - ☐ Black or African American
 - ☐ Asian
 - ☐ American Indian or Alaskan Native
 - ☐ Native Hawaiian or other Pacific Islander
 - ☐ Other (please specify): _____
 - ☐ Prefer not to disclose
5. What is your current marital status?
 - ☐ Married
 - ☐ Widowed
 - ☐ Divorced
 - ☐ Separated
 - ☐ Never Married
 - ☐ Other (please specify): _____
6. Are any other caregivers attending PMTO services with you?
 - ☐ No, I am attending PMTO by myself
 - ☐ Yes, I am attending PMTO with a spouse/partner
 - ☐ Yes, I am attending PMTO with another caregiver who is not my spouse/partner (Please specify): _____

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Michigan PMTO Version 2.0

Please answer this next set of questions about your child. (If you have more than one child, tell us about the child receiving services at this time. If more than one child is receiving services, tell us about your oldest child.)

7. What is the date of birth of the child receiving services?

___/___/___

8. What is the gender of the child receiving services?

- ☐ Male
☐ Female
☐ Prefer not to disclose

9. What is your relationship to the child receiving services? Please select all that apply.

- ☐ Mother
☐ Father
☐ Step-mother
☐ Step-father
☐ Grandparent
☐ Foster caregiver
☐ Other family member (please specify): _____
☐ Other (please specify): _____

A. Please indicate **how often** each behavior occurs with your child receiving services.

	Never	Sometimes	Often	
1. Complains of aches/pains	0	1	2	
2. Spends more time alone	0	1	2	
3. Tires easily, has little energy	0	1	2	
4. Fidgety, unable to sit still	0	1	2	
5. Has trouble with a teacher	0	1	2	☐ Does not apply, child not in school
6. Less interested in school	0	1	2	☐ Does not apply, child not in school
7. Acts as if driven by a motor	0	1	2	
8. Daydreams too much	0	1	2	
9. Distracted easily	0	1	2	
10. Is afraid of new situations	0	1	2	
11. Feels sad, unhappy	0	1	2	
12. Is irritable, angry	0	1	2	
13. Feels hopeless	0	1	2	
14. Has trouble concentrating	0	1	2	
15. Less interest in friends	0	1	2	
16. Fights with others	0	1	2	
17. Absent from school	0	1	2	☐ Does not apply, child not in school
18. School grades dropping	0	1	2	☐ Does not apply, child not in school
19. Is down on him or herself	0	1	2	
20. Visits doctor with doctor finding nothing wrong	0	1	2	
21. Has trouble sleeping	0	1	2	
22. Worries a lot	0	1	2	
23. Wants to be with you more than before	0	1	2	
24. Feels he or she is bad	0	1	2	
25. Takes unnecessary risks	0	1	2	
26. Gets hurt frequently	0	1	2	
27. Seems to be having less fun	0	1	2	
28. Acts younger than his or her age	0	1	2	

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<i>(continued from prior page)</i>		Never	Sometimes	Often
29.	Does not listen to rules	0	1	2
30.	Does not show feelings	0	1	2
31.	Does not understand other people's feelings	0	1	2
32.	Teases others	0	1	2
33.	Blames others for his or her troubles	0	1	2
34.	Takes things that do not belong to him or her	0	1	2
35.	Refuses to share	0	1	2

B. Parenting is hard work. Sometimes you might feel good about how things are going. Other times you might feel discouraged. How much do you agree or disagree with the following statements?

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
37. What I do has little effect on my child's behavior	1	2	3	4	5
38. When something goes wrong between me and my child, there is little I can do to correct it	1	2	3	4	5
39. Sometimes I feel that my child's behavior is hopeless	1	2	3	4	5

C. Below are some statements about parents and families. All families are different, and this will help us learn about your family. There are no right or wrong answers. Please circle the number indicating how often each one typically occurs in your family.

	Never	Rarely	Sometimes	Often	Always
40. You praise or compliment your child when they do something well	1	2	3	4	5
41. The kind of punishment you give your child depends on your mood	1	2	3	4	5
42. You know what your child is doing when they are not with you	1	2	3	4	5
43. When solving a problem as a family, you get input from all family members	1	2	3	4	5
44. You make time in your day to play games or do other fun things with your child	1	2	3	4	5
45. You give your child a small reward for behaving well (like a treat or extra privilege)	1	2	3	4	5
46. You give your child a small negative consequence when they misbehave (like time out, privilege removal, or a work chore)	1	2	3	4	5
47. You know where your child is when they are away from your direct supervision	1	2	3	4	5
48. You begin solving a problem by stating a goal to work toward	1	2	3	4	5
49. You give your child a hug, kiss, high five, or fist bump when you spend time together	1	2	3	4	5
50. You feel frustrated when dealing with child misbehavior	1	2	3	4	5
51. You tell your child in advance how you want them to behave in a situation (like telling them to "use an inside voice" before going to a restaurant)	1	2	3	4	5
52. Your child is successful at getting around the rules you have set	1	2	3	4	5
53. You encourage your child to participate in supervised, positive activities (like school programs or clubs) when away from home	1	2	3	4	5
54. When faced with a problem, you come up with many possible solutions	1	2	3	4	5
55. You have friendly conversations with your child on a regular basis	1	2	3	4	5
56. You teach your child step-by-step how to do new behaviors (like showing them how to make their bed)	1	2	3	4	5
57. You give your child a spanking when they do something wrong	1	2	3	4	5
58. You know who your child spends time with when they are not with you	1	2	3	4	5
59. You consider the pros and cons of different ideas when solving a problem	1	2	3	4	5
60. You and your child enjoy laughing together	1	2	3	4	5
61. You check to see if your child does what you tell them to do	1	2	3	4	5
62. When you need to discipline your child, you follow through with a consequence	1	2	3	4	5
63. You pay attention to your child's activities on social media (like on the phone or computer)	1	2	3	4	5
64. When problems come up in your family, you are able to solve them successfully	1	2	3	4	5
65. You attend activities your child is involved in (like school events or sports)	1	2	3	4	5
66. You find parenting to be an easy task	1	2	3	4	5

Please Turn Over To Complete Next Page

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D. We also want to know about any difficulties you might be having so we can make sure parents receive the support they need. Over the **past 2 weeks**, how often have you been bothered by any of the following issues?

	Not at all	Several days	More than half the days	Nearly every day
67. Little interest or pleasure in doing things	0	1	2	3
68. Feeling down, depressed or hopeless	0	1	2	3
69. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
70. Feeling tired or having little energy	0	1	2	3
71. Poor appetite or overeating	0	1	2	3
72. Feeling bad about yourself, or that you're a failure or have let yourself or your family down	0	1	2	3
73. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
74. Moving or speaking so slowly that other people have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
75. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Thank you for completing this survey

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Intensive Care Coordination with Wraparound (ICCW/Wraparound)	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.09.08
Effective Date: 4/29/08	Date of Review/Revision: 6/10/09, 6/10/10, 4/4/12, 6/5/13, 6/24/15, 4/19/16, 8/12/16, 6/13/17, 4/10/18, 4/9/19, 6/12/20, 3/10/21, 3/9/22, 3/8/23, 3/15/24, 3/24/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, & Continuing Education
	Supersedes:	
		Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: Hannah Rousseau, Wardene Talley, EBP Leadership Team

Purpose:

The purpose of this policy is to delineate a framework for the provision of Intensive care coordination with Wraparound (ICCW) services and supports to children and adolescents with serious emotional and/or behavioral disturbances and their families.

Policy:

SCCMHA recognizes that it is essential to design and deliver services and supports for children and adolescents with severe emotional and/or behavioral disturbances that are individualized, strength-based, family-focused, and community-based. As resources permit, SCCMHA shall maintain an MDHHS-enrolled Wraparound (ICCW) services program to provide community-based services to children and adolescents that are individualized, strength-based, trauma-informed, and family-focused.

Application:

This policy applies to Wraparound (ICCW) program service providers.

Standards:

- A. Wraparound (ICCW) services shall be targeted to children/youth and families who meet SCCMHA admission requirements as well as all of the following criteria (as stipulated in the Michigan Medicaid Provider Manual):

- Serious Emotional Disturbance, Serious Mental Illness, and/or Intellectual/Developmental Disability;
- Presenting with complex behavioral needs; and
- Have an identified community.

AND two or more criteria listed below:

- Involvement in two or more child/youth serving systems including but not limited to: Mental/Behavioral Health, Juvenile or Adult Criminal Justice, Child Welfare, Adult Protective Services, Education (special education or other support services at school).
- Has received other case management or case management-like services and higher intensity is required to meet needs.
- Lack of an identified support system.
- Presenting with complex medical needs and stabilization has not been reached.
- Has a functional impairment related to school activities, attendance, or performance. This includes but is not limited to multiple suspensions and/or expulsions.

Displays significant physical or emotional distress after experiencing a traumatic event. Traumatic events may include, but are not limited to, natural disasters, acts of violence, abuse, neglect. B. Wraparound (ICCW) services shall adhere to the thirteen principles of Michigan's Wraparound model which are enumerated in Exhibit A and compared to the national model which has ten principles.

- C. Families shall be involved in the development and implementation of Wraparound (ICCW) services and supports for their children.
- D. Wraparound (ICCW) services and supports shall build on child and family strengths, increase the individual's choice, foster family independence and self-care.
- E. Wraparound (ICCW) shall adhere to the following values:
 - Voice and choice for the child and family
 - o Choice: Families and youth shall be actively involved in the decision-making process.
 - o Voice: Families and youth shall be heard and listened to during all planning and implementation stages, especially with respect to cultural and linguistic background (i.e., communication styles).
 - o Ownership: Plans are made in concert with parents and children; their commitment and agreement with plans is essential.
 - Integration of services and systems
 - Compassion for children and families
 - A focus on safety, success, and permanency in the home, school, and community
 - Care that is:
 - o Unconditional
 - o Individualized
 - o Strengths-based
 - o Family-centered

- o Youth-guided
 - o Culturally and linguistically competent
 - o Community-based (with services close to home in natural settings)
- F. A relationship with the child and family characterized by:
 - A lack of blame
 - A lack of shame
 - Dignity
 - Respect
 - Empathy
 - Active listening
 - Support
 - Meaningful options
 - Self-determination
- G. The following core elements of Wraparound (ICCW) shall be adhered to:
 - Community-based services and supports. Wraparound (ICCW) will be provided in accordance with the premise upon which it is based: children belong in their natural environments.
 - Individualized and strength-focused planning. Individualized and strength-focused planning for services and supports in all life domains that fit the child (as opposed to fitting the child into a pre-existing program), focus on positives, and build on strengths rather than problems, diagnoses, or deficits.
 - Culturally and linguistically competent. Culturally competent services/supports that demonstrate respect for unique family cultures and recognition that every family has its own culture and style of communication.
 - Family-driven. Families shall be full and active partners at every level of the process and responsible for decisions and allocation of resources (with input from the professionals on the team), rather than passive consumers of care. Family choices shall be adhered to and prioritized in accordance with needs based on the premise that families possess the most knowledge regarding how services and supports should enter into their lives. The process shall be structured to give families voice, choice, and ownership. Success shall be defined from the perspectives of the *family* and provider.
 - Team-based. The Wraparound process shall be team-based and include the child, family, natural supports, agencies, and community services. Team members shall be selected on the basis of their connection or attachment to the family rather than their roles. Teams shall include professionals and natural supporters (e.g., friends, co-workers, and family) who are equal partners in the planning process. Teams change over time with respect to roles and membership. The ideal composition of a team includes less than fifty percent professional membership.
 - o The required organizational structure of Wraparound/ICCW must include a Child and Family Team, ICCW Care Coordinator, ICCW supervisor, and Community Team.
 - o The caseload ratio shall not exceed a ratio of one facilitator to twelve child/youth and family teams with the exception of a maximum of fifteen when two child/youth and family teams are transitioning from Wraparound.

- o ICCW Care Coordinators shall:
 - Possess a minimum of a bachelor's degree in any field.
 - Receive certification in ICCW through MDHHS provided training or have been granted provisional approval prior to provision.
 - Maintain certification in ICCW:
 - Complete one annual ICCW booster.
 - Complete at least two MDHHS-provided trainings related to ICCW.
 - Complete an additional 16 hours of training (annually) related to provision of support to children, youth, or young adults and their families when providing ICCW to those served under SEDW.
 - Participate in and complete MDHHS-required evaluation and fidelity measurements.
 - Provide full scope of ICCW and facilitate the Wraparound Planning Process to model fidelity to develop a Wraparound Plan.
 - Participate in the Person-entered Process Training, including Self-Determination.
 - Facilitate the Person-Centered Process in alignment with family driven-and youth guided guidelines in adherence to applicable policy to develop an Individual Plan of Service (IPOS).
 - Obtain certification in MichiCANS if responsible for completion of the annual MichiCANS.
 - Demonstrate knowledge of State Plan and SEDW service array and community resources and programs.
 - Attend Community Team Meetings as needed to support their Wraparound teams.
 - Care Coordinators may not have more than one provider role with a family. If Care Coordinators are providing other mental health services, including crisis response, they may not provide ICCW to the same child, youth, or young adult and their family.
 - If coordinators are assigned to other programs as well as ICCW, the number child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation.
 - o Wraparound supervisors shall:
 - Oversee ICCW, including evaluation.
 - Receive/process referrals and assign children, youth, or young adults and their families to Care Coordinators.
 - Adhere to policies and procedures that align with ICCW.
 - Organize and facilitate Community Team Meetings quarterly, at a minimum.
 - Be designated as a Child Mental Health Professional (CMHP) (when overseeing SED youth) and/or Qualified Intellectual Disabilities Professional (QIDP) (when overseeing provision to Intellectual/Developmental Disabilities (IDD) youth.)
 - Participate in Person-Centered Planning Process training, including Self-Determination.
 - Obtain certification in MichiCANS if providing supervision to a Care Coordinator who is responsible for completion of the annual MichiCANS.
 - Receive certification in ICCW through MDHHS-provided training prior to supervision of Care Coordinators.

- Maintain certification in ICCW:
- Complete one annual ICCW booster.
- Complete at least two MDHHS provided trainings related to ICCW, one of which must be supervisor specific.
- Complete an additional 16 hours of annual training related to provision of support to children, youth, or young adults and their families when supervising the provision of ICCW to those served under the SEDW.
- Provide weekly, individualized supervision and coaching to Care Coordinators and maintain a supervision log.
- Maintain partnership with child, youth, or young adult and family community programs, systems, and partners.
- Ensure Care Coordinators have knowledge of State Plan and SEDW service array and community resources and programs.
- Ensure families and staff have access to a directory of community resources, systems, and programs.

o Community Team shall:

- Include children, youth and young adults and parents/caregivers with lived experience and local system and community partners.
- Work collaboratively to address barriers, provide support, and identify available community services and programs for children, youth and families.
- Balanced between conventional and natural supports. Natural supports are a source of culturally relevant caring and support for families. Ideally, conventional clinical services shall be gradually replaced with natural ones (e.g., extended family members, friends, neighbors, members of the faith-based community, volunteers, local service organizations, teachers, and coaches) that are self-sustaining, culturally relevant, and nurturing.
- Unconditional commitment. A “no reject, no eject” policy and a mindset of doing whatever it takes to meet the needs of the child and family are maintained. When difficulties arise, services and supports are changed, but never eliminated. An attitude of *doing whatever it takes* to meet the needs of children and their families and overcoming barriers and obstacles shall be adopted.
- Collaboration. Interagency/community/neighborhood collaboration shall be used to develop individualized support and service plans. The approach is: *How can we as a group get this accomplished and funded?*
- Accountability for outcomes. Accountability for outcomes shall be based on family, child, and team priorities. Outcomes shall be identified, documented, and progress shall be measured. Goals will often include achieving success, safety, and permanence in the home, school, and community. All team members equally share accountability for, and ownership of, outcomes.

H. Wraparound shall be provided in accordance with the steps of the Wraparound process:

Step 1:	Engagement of the Child and Family
Step 2:	Immediate Crisis Stabilization, Safety and Support Planning
Step 3:	Strengths Assessment and Needs Assessment.

- Step 4: Child and Family Team Formation and Nurturing
- Step 5: Child and Family Team Preparing for the Meeting
- Facilitating the Meeting
 - The Wraparound Plan
 - The Individual Plan of Service (IPOS)
- Step 6: Ongoing Crisis, Safety and Support Planning
- Step 7: Tracking and Adapting (the Wraparound Plan/IPOS)
- Step 8: Transition (Out of Formal Services)
- I. Wraparound teams shall adhere to the Outcome Measurement section in the Wrap-around Framework.
- J. The enrolled provider will comply with the State of Michigan ICCW evaluation requirements. Current evaluation requirements are:
- The enrolled ICCW provider will comply with MDHHS ICCW evaluation requirements as determined by the department.
 - Additional evaluation tools will be completed as identified and requested by MDHHS.
 - Adherence to ICCW model fidelity may be reviewed at enrollment, re-enrollment, and at technical assistance visits through file review, family interviews, and evaluation and fidelity tools.
- K. The SCCMHA-funded Wraparound Program (ICCW) shall be enrolled with MDHHS in accordance with State policy.
- L. The Child and Adolescent Functional Assessment Scale (CAFAS), the Preschool and Early Childhood Functional Assessment Scale (PECFAS), or the Devereux Early Childhood Assessment (DECA) shall be completed at intake, and then annually thereafter.
- M. Wraparound plans shall adhere to the following standards:
- Evidence that the child/youth and family team completed each step/phase of the Wraparound (ICCW) process, including completion of the strengths narrative, needs assessments, collaborative Safety Plan, support plans, Wraparound plans, IPOS, outcomes, and the development of the team mission statement and Family Vision Statement.
 - Individualized child/youth and family outcomes that are developed and measured by each child/youth and family team.
 - A strength-based, needs-driven, and culturally relevant Wraparound plan/IPOS that is stated in the language of the child/youth and family.
 - Evidence of regular updates (quarterly reviews within the IPOS) as the needs of the child/youth and family change (annual updates alone are not sufficient).
 - Any services, supports, and interventions that are provided to the family. A mixture of formal and informal support and services.
 - An individualized support plan that reflects the child's/youth's and family's strengths and culture and seeks to build skills/competencies that reduce risk.
 - Measurement of outcomes identifying when transition plans should be developed. Transition plans will address any barriers to graduation and identify how services and supports will be maintained after Wraparound has ended.

- Evidence that the child/youth and family team review and measure outcomes at least monthly.
- N. Documentation standards shall be adhered to including:
- All Wraparound team meetings shall be documented in the form of minutes.
 - All collateral contacts shall be documented in the form of contact/progress notes.
- O. Meeting frequency is guided by the family's needs and level of risk.
- Wraparound Teams shall meet once per week, at a minimum, during the Hello and Help phases.
 - Wraparound Teams shall meet twice monthly, at a minimum, during the Heal phase. The Heal phase begins once the plan has been developed and the Team agrees stabilization has been achieved.
 - Wraparound Teams shall meet monthly, at minimum, during the Hope phase. The Hope phase begins when the Team agrees that the child, youth, or young adult is ready to graduate from the Wraparound Planning Process and no longer shows a need for ICCW.
 - When a child, youth, or young adult is in placement and the Care Coordinator is facilitating transition planning back into the home and community, the meeting frequency may reflect the needs of the child, youth or young adult. Only upon Wraparound Plan development or adjustment may the frequency of Team meetings decrease.
 - Upon discharge, frequency of meetings should align with the phase that the Wraparound team is in. The Care Coordinator must review services at intervals defined in the IPOS. A formal review of the IPOS shall not occur less often than annually to review progress towards goals and objectives and to assess beneficiary satisfaction.
 - Frequency and scope (face to face and telephone) of other ICCW monitoring activities must reflect the intensity of the child, youth, or young adult's health and welfare needs.
 - Exceptions to Wraparound model expectations regarding the frequency of meetings can occur to fit the family's need and availability and must be documented in the case file.
 - Wraparound child/youth and family teams begin to transition from the formal process when the outcomes identified by child/youth and family teams are met and shall not exceed three months in duration. Monthly meetings may occur during the transition phase.

Definitions:

Blended funds: Funds that come from various sources that are merged and used interchangeably. (This is above my pay grade, but I am not sure we are using these funds this way any longer since SOC ended....)

Braided funding: Funding that uses monies from different sources but accounts for the different sources separately. . (This is above my pay grade, but I am not sure we are using these funds this way any longer since SOC ended....)

CAFAS (Child And Adolescent Functional Assessment Scale): An instrument that is designed to provide an assessment of day-to-day functioning, track outcomes and inform

decisions regarding treatment and level of care for youth aged 7 and above. The CAFAS consists of eight subscales that correspond with functional domains in the child or youth's daily life: School, Home, Community, Behavior Toward Others, Moods and Emotions, Self-Harmful Behavior, Substance Use, and Thinking. Two additional scales are used to rate the child or youth's caregiver(s) - the Material Needs and the Social Support subscales.

MichiCANS: a standardized assessment tool that is designed to explore and communicate the needs and strengths of the child/youth and family. This allows the family and care team to prioritize action steps and track changes. MichiCANS includes domains that focus on important areas of the child/youth's life. It helps the treatment team and family understand where intensive or immediate action is most needed, as well as where a child/youth has strengths that can become a major part of the treatment plan. It consists of a Screener, completed at the point of access, and the Comprehensive, completed with the Biopsychosocial assessment and updated at least annually and when it is necessary to reflect growth, progress, and changes in life events. The information that is collected through the Screener flows into the Comprehensive to avoid having the family share their experiences multiple times.

Wraparound Team: Wraparound utilizes a Wraparound Team, with team members determined by the family often representing multiple agencies and informal supports. The Wraparound Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services, and supports covered by the Medicaid mental health state plan and other community services and supports.

Community Team: The Community Team consists of parents, guardians, and/or legal representatives, agency representatives, and other relevant community members. The Community Team provides support to Wraparound teams to ensure elimination of barriers to treatment and service provision.

Cultural and linguistic 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, physical disability, or style of communication. They also adapt their skills to fit a family's values and customs.

Devereux Early Childhood Assessment (DECA): A suite of age-based assessment instruments for infants and toddlers. All instruments assess protective factors of Initiative and Attachment, additional factors of Self-Regulation, and concerns of Withdrawal/Depression, Emotional Control Problems, Attention Problems, and Aggression are assessed for toddlers and very young children.

Preschool and Early Childhood Functional Assessment Scale (PECFAS): An instrument that is designed to provide an assessment of day-to-day functioning, track outcomes and inform decisions regarding treatment and level of care for preschool-age youth. Medicaid provider contracts require completion for youth ages 4-, 5-, and 6-years-old who receive services. The PECFAS consists of seven subscales that correspond with functional domains in the child's daily life: School, Home, Community, Behavior Toward Others, Moods and Emotions, Self-Harmful Behavior, and Thinking. Two additional scales are used to rate the child's caregiver(s) - the Material Needs and the Social Support subscales.

RedCap: A secure web application for building and managing online surveys and databases.

Wraparound process: A team-based, collaborative process for developing and implementing individualized care plans for children and adolescents with severe emotional and/or behavioral disorders and their families.

References:

- A. Michigan Medicaid Provider Manual: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87572--,00.html
- B. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- C. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

Exhibits:

- A. Wraparound Principles – Michigan (excerpted from SCCMHA’s Wraparound Manual)
- B. Wraparound Evaluation Protocol
- C. Michigan Wraparound Fidelity Tool (2024)

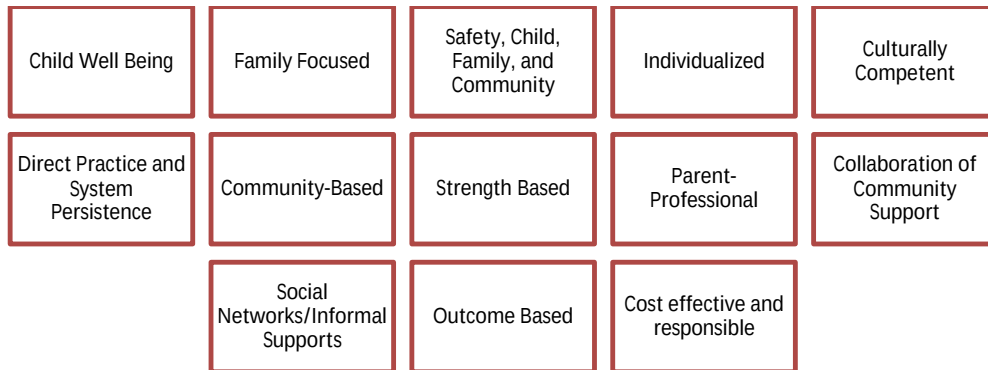
Procedure:

ACTION	RESPONSIBILITY
1. Engage the child and family	Wraparound Coordinator
2. Develop an immediate support plan and complete the Collaborative Safety Plan.	
3. Complete Strengths Assessment and Needs Assessment.	
4. Form and nurture the Wraparound team	Wraparound Coordinator/Team
5. Oversee the child and family team process:	
a. Prepare for the meeting	
b. Facilitate the meeting	Wraparound Team members/Parents/Youth
c. Develop the Wraparound plan	
6. Continue ongoing crisis, safety, and support planning	
7. Track and adapt the Wraparound plan and IPOS to meet changing needs	Wraparound Team members/Parents/Youth
8. Transition out of formal services	
9. Monitor Wraparound services for fidelity using the quarterly reviews within the IPOS.	
10. Monitor person served satisfaction with Wraparound	Wraparound Coordinator

Exhibit A

Wraparound Principles

Michigan utilizes 13 principles as the foundation of Wraparound services.



1. Child Well Being

The best interest of the child is always the paramount concern. When looking at the best interest of the child, the team is looking at all areas: safety, housing, food, clothing, emotional, social, school, interpersonal, transportation, etc. The hope is to minimize disruptions/transitions and create permanency for the family/child and to focus on strengthening their relationships. Focus is on the child's strengths and what the child has to bring to the table. Similar to the national principle of Family Voice and Choice, the child's perspective, beliefs, and values are important to the entire wraparound process. Planning and decision-making consider the child's perspective, preferences, desires, and choices. Options are elicited from the child, and any ideas recommended from the team need to also reflect the child's perspective.

2. Family Focused

Besides having the best interest of the child, the family is central to the Wraparound process. This principle considers the strengths, needs, and outcomes for the entire family. They need to have their voices heard to be able to have ownership in the process. They need access to any necessary resources. The family's perspective/beliefs/values/traditions are a primary and important focus throughout the entire wraparound process. This principle recognizes that families come in many different forms and that the people who have had long-term relationships with the child and the child need to have their voices heard. This value recognizes that the family is interdependent of each other, and that strengthening/improving family relationships are vital. The family needs to be fully involved where their values/perspectives/desires are elicited, and they need to influence the planning and the outcomes of the process. Planning is focused on the family/child's values, preferences, and choices. Any decision-making is a collaborative effort where the family/child's choices are paramount. Options are elicited from the family/child, and any ideas recommended from the team need to reflect the family/child's values/perspectives. This principle recognizes that the likelihood of successful outcomes for the entire family are increased when the wraparound process reflects the priorities of the family.

3. Safety, Child, Family and Community

First and foremost, the priority is safety for everyone, the child, the family, and the community. Throughout the process, any safety concerns will be addressed immediately through honest, open discussions. It is the team's responsibility to address safety concerns, and any team member can address any safety issues at any time. The team will then develop a plan to ensure the safety of the child, family, and/or community. The team will also explore and develop a plan to address any safety concerns within the community. Just as the community needs to be safe, the child and/or family need to feel safe in their community environment.

4. Individualized

To achieve the goals laid out in the Wraparound plan, the team develops and implements a customized set of strategies, supports, and services that represent the family/child's perspectives, beliefs, strengths, and choices. The plan is unique to the family and is not a one size fits all. There should not be any plans that look the same or offer the same set of options. Each family/child is unique, complex, and the plan should reflect what is important and needed by each family/child. Flex funds should be available to assist in meeting the needs of each individualized plan.

5. Cultural Competence

The wraparound process has respect for and builds on the values, preferences, traditions, beliefs, identity, ethnicity, and culture of the family/child and their community. Cultural competence asks that team members also look at their own cultural dynamics and the impact it plays on them and this process. This principle also recognizes the strengths in the family/child's culture and that their cultural identity can be essential to supports and resources that will help the family/child/team meet their goals and to sustain them once wraparound services have ended.

6. Direct Practice and System Persistence

Despite challenges, the team is committed to working toward the goals developed in the wraparound plan until the team reaches an agreement that a formal wraparound process is no longer needed. Thus, the family/child cannot be "ejected or rejected" from the program due to behavior, events, lack of progress, etc. The team does not ever give up and does not place "blame or shame." The wraparound process is committed to working through issues that arise and providing the supports and services necessary for success. The team is responsible to break through barriers, fill any gaps in service delivery, and utilizing the strengths of the family/child to address system issues. The team will continue to work on changing, creating a plan that reflects the wraparound principles and goals of family/child/team until the team decides that services are no longer necessary.

7. Community –Based

The wraparound team implements services and supports that are the least restrictive, most inclusive, most responsive, and most accessible settings where the family/child can participate safely, fully in family and community life. It is important for the family/child to be involved in the community where they choose to live and have access to all the resources/activities that are

available to any other family/child within the community. The family/child needs to learn and apply coping/problem-solving skills to manage life stressors while living within the community. Plans need to work on reducing isolation and on utilizing natural/community supports to the fullest extent.

8. Strength-based

Wraparound is a strengths-based approach. The wraparound process and plan identify, build upon, and enhance the knowledge, skills, and capabilities of the family, the child, the community, and the team. Meetings start and end with discussing strengths, the positives, and with celebrating successes. The interactions of team members should demonstrate mutual respect and recognize the value, skills, capabilities that each person brings to the team. Wraparound seeks not only to identify strengths but utilize them throughout every aspect of the plan and throughout each intervention.

9. Parent – Professional

The parent and professional relationships represent a relationship of equals. Everyone is on the same playing field, and on the same team. It is not a process of “blaming and shaming.” Both the parent/family and professionals are on the same team and working toward the same overall goal. All decisions are made together, and all information is shared. There are not any secrets or behind-the-scenes decisions. The family is a part of every process, including quality improvement and any part of the system infrastructure.

10. Collaboration and Community Support

The wraparound process embraces the philosophy of “Community Children.” The belief that we are all in this together and have equal responsibility to work for the good of the family/child. The focus is on collaboration and utilizing the strengths/resources that each community organization has to offer. This is a time to put aside any differences and share resources/information and to work with the family/child to offer them every opportunity to be a part of the community. This principle focuses on thinking outside of the box and doing what makes sense.

11. Social Networks / Informal Supports

The team actively, intentionally seeks out and encourages the full participation of team members from the family/child’s network of interpersonal and community relationships. This includes re-engaging supports that have disconnected from the family/child and expanding new supports. The team works to empower the family to develop/maintain supports that are going to stay with the family/child long after formal services have ended. Natural supports can include family, friends, neighbors, co-workers, and community organizations such as: church, clubs, school, extracurricular activities, etc. The wraparound plan reflects activities and interventions that utilize the natural support system.

12. Outcome based

The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress, and revises as needed. Outcomes look in concrete terms at what the family wants from the process and what the system wants from the process. This principle holds the team accountable and assesses whether the plan is effective or if it needs to be adjusted. Keeping track of progress helps the family/child identify changes. Monitoring is a way to demonstrate success and a way of maintaining/gaining support/resources.

13. Cost effective and Responsible

The wraparound process utilizes every community resource available that is consistent with the overall family/child goal. The team strives to be fiscally responsible and considers the long-term effects of any decision to use flex funds. Flex funds are only used as last resort.

COMPARISON: NATIONAL PRINCIPLES

The national Wraparound model utilizes ten similar principles. Since they are often referenced in research and best practice materials, Wraparound coordinators should be familiar with them and understand how they correlate to the Michigan principles.

Family Voice and Choice

The family and the youth/child's perspectives/beliefs/values are a primary and important focus throughout the entire wraparound process. This principle recognizes that families come in many different forms and that the people who have had long-term relationships with the child and the child need to have their voices heard. The family and the youth need to be fully involved where their values/perspectives are elicited, and they need to influence the planning and the outcomes of the process. Planning is focused on the family/child's values, preferences, and choices. Any decision-making is a collaborative effort where the family/child's choices are paramount. Options are elicited from the family/child, and any ideas recommended from the team need to reflect the family/child's values/perspectives. This principle recognizes that the likelihood of successful outcomes are increased when the wraparound process reflects the priorities of the family/child.

Team Based

The wraparound team consists of individuals who are committed to the well-being of the family/child. The members may be involved with the family formally, informally, and may consist of multiple members from the community. Choices about who is involved on the team should be driven by the family. It is important to provide support to the family to make informed decisions about who is a member of the team to make sure that the family/child has opportunity to have access to all available resources/supports.

Natural Supports

The team actively, intentionally, seeks out and encourages the full participation of team members from the family/child's network of interpersonal and community relationships. This principle focuses on supports that are going to stay with the family/child long after formal services have ended. Natural supports can include family, friends, neighbors, co-workers, and community organizations such as: church, clubs, school, etc. The wraparound plan reflects activities and interventions that utilize the natural support system.
Collaboration Team members work together and share responsibility for developing, implementing, monitoring, and evaluating the wraparound plan. The team works cooperatively to develop mutually agreed upon decisions about the goals to pursue, how to reach those goals, and whether the team is making progress towards the goals, and/or if adjustments need to be made. The plan reflects a blending of the team members' perspectives and guides each team member's work toward meeting the team goals. This area is focused on the team, and there needs to be a balance of the principle of collaboration and the principle of Family Voice and Choice.
Community Based The wraparound team implements services and supports that are the least restrictive, most inclusive, most responsive, and most accessible settings where the family/child can participate safely, fully in family and community life. It is important for the family/child to be involved in the community where they choose to live and have access to all the resources/activities that are available to any other family/child within the community.
Culturally Competent The wraparound process has respect for and builds on the values, preferences, traditions, beliefs, identity, and culture of the family/child and their community. This principle also recognizes the strengths in the family/child's culture and that their cultural identity can be essential to supports and resources that will help the family/child/team meet their goals and to sustain them once wraparound services have ended.
Individualized To achieve the goals laid out in the Wraparound plan, the team develops and implements a customized set of strategies, supports, and services that represent the family/child's perspectives, beliefs, strengths, and choices. The plan is unique to the family and is not a one size fits all.

Strengths based

Wraparound is a strengths-based approach. The wraparound process and plan identify, build upon, and enhance the knowledge, skills, and capabilities of the family, the child, the community, and of the team. The interactions of the team should demonstrate mutual respect and recognize the value, skills, capabilities that each person brings to the team. Wraparound seeks not only to identify strengths but utilize them throughout the course of the plan.

Persistence

Despite challenges, the team is committed to working toward the goals developed in the wraparound plan until the team reaches an agreement that a formal wraparound process is no longer needed. Thus, the family/child cannot be “ejected or rejected” from the program due to behavior, events, lack of progress, etc. The wraparound process is committed to working through issues that arise and providing the supports and services necessary for success. The team will work on changing, creating a plan that reflects the wraparound principles and goals of family/child/team until the team decides that services are no longer necessary.

Outcome Based

The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress, and revises as needed. This principle holds the team accountable and assesses whether the plan is effective or if it needs to be adjusted. Keeping track of progress helps the family/child identify changes. Monitoring is a way to demonstrate success and a way of maintaining/gaining support/resources.

Exhibit B

Wraparound Evaluation Protocol

Describe the method used to assure ICCW evaluation requirements are met. Identify process for Caregiver/Child Feedback Forms and Care Coordinator Fidelity forms compliance within REDCap.

CMHSP will participate in the evaluation and outcomes measurement policy requirement known as the ICCW Evaluation Project (WEP). As part of this initiative, all ICCW providers must complete data entry for every child, youth, young adult, and family receiving ICCW services. The MSU ICCW Continuous Improvement Team evaluates ICCW data and submits an annual report to the State of Michigan. This data helps measure outcomes, assess adherence to the Wraparound model, and guides ongoing efforts to enhance and strengthen ICCW services across the state.

Data collection for ICCW will include five forms collected at assigned timepoints/intervals during ICCW service provision. All forms are survey links sent directly from the REDCap system:

- 1. Intake Form: This form will collect information about the child/youth/young adult's demographics, primary caregivers, residential living, housing, education, and experience with prior services.*
- 2. Care Coordinator Fidelity Form: This form will gather details about service delivery for each child, youth, or young adult and their support team on phase engagement during the past quarter. This measure is distributed to care coordinators every three months.*
- 3. Caregiver Feedback Form: This form will be emailed to caregivers at 6 and 12 months into ICCW services to provide feedback about their experiences with ICCW services. Providing feedback is optional.*
- 4. Child Feedback Form: This form is an online survey and provides children, youth, or young adults with the opportunity to share feedback regarding their experiences with ICCW services at 6 and 12 months of services. Providing feedback on services is optional.*
- 5. Exit Data Form: This form gathers information about the child, youth, or young adult at the time they exit ICCW services.*

Exhibit C

MICHIGAN INTENSIVE CARE COORDINATION WITH WRAPAROUND FIDELITY TOOL

Indicator / Evidence	Degree to Which Standard is Met			Findings/Comment
	Full	Partial	Inadequate	
Did the coordinator meet with the family within 14 days of intake assessment/approval for ICCW? (evidence: date of intake assessment and date of initial meeting in the record)				
Did the coordinator facilitate the development of and/or review the existing safety plan at the initial meeting with the youth and family? (evidence: the safety plan is completed and maintained in the record)				
Did the coordinator, in partnership with the youth and family, facilitate the identification of functional strengths for each member of the family, and the family as a whole? (evidence: the strengths are completed and maintained in the record)				
Did the coordinator, in partnership with the youth and family, facilitate the identification of needs for each member of the family, and the family as a whole? (evidence: the needs assessment is completed and maintained in the record)				
Did the coordinator record the family's vision statement? (evidence: the vision statement is completed and maintained in the record)				
Did the coordinator record the Wraparound Family Team's mission statement? (evidence: the mission statement is completed and maintained in the record)				

Does the Wraparound Family Team consist of the youth, primary caregivers, adoptive/biological parents, siblings, household members, natural supports and professional supports? Did the youth and family have primary decision-making in the development of their team? (evidence: meeting minutes reflect presence of balance)				
Were community resources and natural supports further developed throughout the planning process? (evidence: meeting minutes)				

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Adult Crisis Residential Services	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.09.11
Effective Date: 4/17/09	Date of Review/Revision: 6/10/10, 4/4/12, 7/30/13, 1/23/14, 5/5/14, 6/7/16, 6/13/17, 4/10/18, 4/9/19, 7/9/21, 9/27/22, 6/6/23, 3/11/25, 3/24/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & EHS Authored By: Barbara Glassheim Additional Reviewers: None
	Supersedes:	
		

Purpose:

The purpose of this policy is to delineate a framework for the provision of crisis residential services and supports to adults with mental illnesses and co-occurring substance use disorders.

Policy:

Saginaw County Community Mental Health Authority (SCCMHA)-funded adult crisis residential services shall adhere to established standards set forth for the provision of crisis residential programs.

Application:

- A. Providers: This policy applies to all SCCMHA-funded adult crisis residential services and supports.
- B. Persons: Services are designed for adult people who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital.

Standards:

- A. Crisis residential services shall be made available, as resources permitted, by SCCMHA to provide a short-term alternative to inpatient psychiatric care for adult persons experiencing an acute psychiatric crisis who meet criteria for inpatient psychiatric hospitalization (per the Michigan Medicaid Provider Manual).

- B. Crisis residential services shall be targeted to adult individuals who meet psychiatric inpatient admission criteria or are at risk for hospitalization but can receive care in a less intensive setting. Individuals who have a mental illness or a mental illness and a concomitant disorder (e.g., a substance use disorder or intellectual/developmental disability) can be served by the CRTP (crisis residential treatment program) if the primary reason for admission is due to a mental illness.
- C. Crisis residential services shall be used to avert an inpatient psychiatric admission (i.e., as a diversion) or to reduce the length of an inpatient stay (i.e., as a step-down).
- D. Crisis residential services can be provided for a period up to 14 calendar days per episode. This length of stay may be extended with clinical justification and SCCMHA approval.
- E. Crisis residential services and supports shall include:
 - 1. Psychiatric supervision
 - 2. Nursing services
 - 3. Therapeutic support services
 - 4. Medication management/stabilization and education
 - a. Medication reviews performed at the crisis residential home must be performed by a physician, physician's assistant, or a nurse practitioner under the clinical supervision of the psychiatrist.
 - 5. Behavioral services
 - a. Individual and group sessions as well as other types of activities that promote wellness and recovery shall be available to people.
 - b. Motivational Interviewing techniques shall be used to engage persons in the process of positive change.
 - 6. Milieu Therapy
- F. Admission shall be predicated upon the person served signing a voluntary consent to treatment.
- G. Individuals who express a desire to leave prior to completion of the program shall be referred to clinical staff or a peer support staff to discuss the benefits of remaining with the program.
 - 1. Transportation shall be arranged for individuals who still wish to leave the facility.
 - 2. Crisis Intervention Services (CIS) and the Case Holder shall be notified of the individual(s) AMA discharge from the CRTP.
- H. MDHHS approval and State of Michigan Adult Foster Care licensing shall be secured and maintained by the SCCMHA-funded CRTP.
- I. SCCMHA's CRTP shall focus on resolving the immediate precipitating crisis and enhancing individuals' abilities to return to their community residences.
 - a. Individuals shall be assisted to develop and implement illness management and coping skills, a relapse prevention plan, and linkages to community resources in accordance with each individual's person-centered plan in a recovery/resiliency-oriented approach.
 - b. Exploration of issues related to crises, substance use/abuse/misuse, identity, values, choices, and choice-making, recovery and recovery planning will be offered.
 - c. Services and supports shall be delivered in a trauma-informed manner.

- J. Individualized plans of service based on a persons needs shall be developed within 48 hours of admission and signed by the individual (if possible), parent or guardian if applicable, attending psychiatrist and other professionals involved in treatment planning. A subsequent plan based on comprehensive assessments must be developed if the length of stay exceeds 14 days. Individualized plans shall consist of:
 - 1. Clearly stated goals and measurable objectives that are derived from the assessment of immediate need with specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis documented.
 - 2. Identification of specific procedures designed to assist the person in attaining their goals and objectives.
 - 3. Discharge plans that include aftercare and follow-up services as well as functions of any assigned case holder.
- K. The SCCMHA-funded CRTP will support and coordinate the physical health care needs of residents including any medical medications.
- L. SCCMHA's CRTP shall adhere to established staffing standards and Michigan Medicaid regulations:
 - 1. Nursing services (i.e., an RN, or LPN under appropriate supervision) provided on site for a minimum of 8 hours per day.
 - 2. A psychiatrist who provides clinical supervision of treatment services available by telephone at all times (24/7) at a minimum, and who must provide psychiatric evaluation/assessments and medication reviews on site.
 - 3. A supervisor who is a master's degree prepared mental health professional with one year of experience providing services to individuals with serious mental illness, or has a bachelor's degree in human services and at least two years of experience providing services to persons with serious mental illnesses, and is on site a minimum of eight hours a day, Monday through Friday, and on call at all other times.
 - 4. Paraprofessional staff members with at least one year of satisfactory work experience providing services to individuals with mental illness, or who have successfully completed a PIHP/MDHHS-approved training program for working with individuals with mental illnesses.
 - 5. Peer support specialists can be part of the multidisciplinary CRTP team and facilitate peer support groups, assist in transitioning people to less intensive services, and provide recovery-oriented mentoring.
- M. Each person's multidisciplinary treatment team shall be comprised of the following disciplines at a minimum:
 - 1. The person served
 - 2. The person's parent or guardian, if applicable
 - 3. The attending psychiatrist
 - 4. The Case Holder assigned to the person served
 - 5. Other professionals relevant to the needs of the individual including their ACT team and outpatient treatment provider
- N. The CRTP shall adhere to following administrative protocols:
 - 1. The CRTP shall fax a bed vacancy summary (or otherwise provide written bed vacancy update per CIS request) that is gender-specific to the

- SCCMHA Crisis Intervention Services (CIS) Unit every morning by 8:30 am. If for any reason this notice is delayed, CRTP will advise CIS and when the update will be provided.
2. The CRTP shall immediately notify CIS Unit by telephone whenever the last available bed of either gender is being requested.
 3. Staff of the CRTP shall wear employee identification badges at all times while on duty and in all venues in which they are assigned to work (e.g., at the CRTP and when transporting individuals from other facilities).
 4. The CRTP shall maintain a separate office telephone number which is only answered by staff members who shall formally identify themselves when answering the office telephone (e.g., “Hello, thank you for calling the CRU. This is [full name of person] speaking. How can I help you?”). An additional telephone/line shall be made available for use by persons served.
 5. Transportation of individuals to the CRTP will be provided by CRTP and shall generally occur within sixty minutes of the request. The CRTP shall notify SCCMHA of any delays in transportation along with a timeframe for the pick-up.
 - a. Upon referral, CRTP will ask CIS when the person will be ready for pickup and arrange pick up based on anticipated time of readiness. CRTP and CIS staff will stay in contact with each other regarding any delays on transportation readiness or pick up times to promote reduction of either person or staff waiting time.
 - b. Transportation exceptions will be made with notice to the CRTP for identified Case Holders only, who may wish to transport individuals. At no time should family, friends, or AFC providers transport individuals to CRTP directly.
 6. Psychiatry services shall be accessible telephonically to the program on a 24-hour basis. Psychiatric consultation will occur for all admissions. Psychiatry face to face services shall occur within 48 hours of admission and a minimum of daily program consultation will occur with the program psychiatrist, and more often whenever indicated.
 7. Therapeutic intervention shall commence upon admission and continue daily for the duration of a person’s stay in accordance with the person’s mental health status.
 8. Pharmacotherapy regimens shall be continuous from the time of admission through discharge with no gaps in treatment.
 - a. A medication evaluation shall be conducted within 24 or less hours of admission or by the end of the nursing day shift.
 9. Discharge planning shall commence upon admission.
 - a. CRTP shall ensure that each person served has a follow-up appointment with a mental health provider scheduled within seven days of discharge from the CRTP.
 - 1). An appointment shall be scheduled with the existing treatment team at SCCMHA or SCCMHA network provider or Designated Coordinating Agency (DCO).

- 2). The SCCMHA Central Access & Intake (CAI) Unit will assist in arranging a seven-day follow-up appointment if the service will be provided by an agency other than SCCMHA or an SCCMHA network provider.
10. CRTP shall check each person's Medicaid status upon admission.
 - a. Medicaid status verification shall include county of residence.
 - 1). CRTP shall assist people whose Medicaid is from a different county to transfer that county of residence to Saginaw County.
 - 2). All county of residence changes shall be communicated to the SCCMHA Entitlement's office (which will then notify Saginaw DHHS).
 - b. An application for Medicaid shall be initiated by CRTP for all people who do not have active Medicaid.
 - 1). When a non-Medicaid person is admitted to the CRTP, CRTP shall contact the SCCMHA Entitlement Coordinator to determine whether a Medicaid application is required.
 - 2). Medicaid applications are to be completed by the CRTP electronically through MI Bridges or submitted to SCCMHA on paper.
 - a.) The SCCMHA Entitlement Coordinator is to be notified of the person's name and date of electronic application.
11. CIS will provide a copy of the preliminary prescreen to CRTP upon admission to CRTP; the prescreen will be entered or scanned into the electronic health record within 24 hours.
- O. Assigned Case Holders of individuals admitted to crisis residential shall be involved as soon as possible following admission and in the arrangement and provision of follow-up services.
 1. Any individual whose stay exceeds 14 days and who does not have a Case Holder prior to admission, shall be assigned a Case Holder for treatment involvement and follow-up care.
 NOTE: Case Holders can be assigned prior to the 14 days in accordance with individual need.
- P. The Program Manager of CRTP shall ensure integrity of the physical plant is maintained in accordance with licensing and general safety standards to ensure the health and safety of individuals served and staff.
 1. CRTP shall assign staff to monitor the facility and act immediately to address any identified structural problems with the plant and/or its furnishings as well as expired products that need to be replaced.
 2. SCCMHA Contracts Unit will be notified of any structural maintenance that is the responsibility of the landlord if the CRTP is owned by SCCMHA.
- Q. Bed checks shall be conducted every 15 minutes at a minimum; this frequency may be enhanced at the discretion of the Program Manager or clinical staff of the CRTP based on the individual's clinical status/needs.
 1. When an individual is found missing from the CRTP facility staff shall:

- a. Conduct a grounds and local area search.
- b. Notify the Program Manager or on-call staff as well as the police, CIS, and the individual's assigned Case Holder.

Definitions:

Crisis Residential Treatment Program services are intended to provide a short-term alternative to inpatient psychiatric services for persons experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that led to a crisis residential admission through a person-centered, recovery-oriented, and resiliency-building approach.

References:

- A. Michigan Medicaid Provider Manual:
<https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/policyforms/medicaid-provider-manual>
- B. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

Exhibits:

Exhibit A: Crisis Residential Continuing Stay Reviews Protocol

Procedure:**ACTION****RESPONSIBILITY**

1. Makes an eligibility determination.	1. Crisis Intervention Services (CIS)
2. If the person is eligible for CRTP, determines CRTP vacancy.	2. CIS staff
3. If an appropriate bed is available, contacts the CRTP to transport the person.	3. CIS staff
4. If the person does not meet criteria or the CRTP does not have a bed an alternative; arranges for an alternative that will meet the person's need.	4. CIS staff
5. Transports the person to the CRTP within 60 minutes of the transport request.	5. CRTP/CaseHolder/AFC/Family/ Primary Health Plan/Taxi
6. Provides crisis residential services (including discharge planning) in accordance with the psychopharmacological intervention, milieu/programming and personnel standards delineated above.	6. CRTP treatment team
7. Conducts continued stay reviews conducted authorizes or denies continued stays in accordance with SCCMHA policy.. If approved for additional days notifies SCCMHA Care Management of need for additional authorization.	7. SCCMHA Crisis Intervention Services staff
8. Reviews Crisis Intervention Services Continuing Stay Review Notifies.	8. SCCMHA Care Management staff
9. Notifies CRTP of approval or denial of continuing stay.	9. CIS staff
10. Maintains the CRTP in accordance with Standard N.	10. CRTP Program Manager
11. Conducts bed checks in accordance with Standard P and addresses person absences in accordance with this standard.	11. CRTP staff



Exhibit A:

Crisis Residential Continuing Stay Reviews Protocol

What is required for an extension for a individual to stay beyond the initial days authorized by SCCMHA.

- 1) CRTP should always know when authorizations are set to expire.
- 2) All requests for extensions should be made Monday through Friday 8:00 am to 4:00 pm in order to obtain an extension of the current authorization. Please make sure to check authorizations two days prior to a weekend or over a holiday to assure an authorization is in place for the person served.
- 3) There are three SCCMHA utilization management staff and any of these can be contacted to discuss a continuing stay review and authorization extension.
Ayanna Allen – 989-498-4202
Adrienne Frisch- 989-793-3123
Jarviona Hart- 989-498-2271
Nancy Johnson is a backup for the three persons above 989-797-3546.
- 4) Information necessary and should have available when calling for a continuing stay review:
 - a. Why is the person in need of the extension?
 - i. What groups has the person participated in?
 - ii. When was the first and last time the person saw the psychiatrist?
 - iii. What medications were prescribed (dosages and timeframe). Any concerns with medications?
 - iv. Any medication changes? What has changed (type, dosages, and timeframes)? Why were medications changed (side effects? not responding to the medications that were prescribed? etc.)
 - v. Please note the start and stop dates of any medications.
 - vi. What other reason are you asking for an additional stay?

NOTE: Please do not leave any continuing stay reviews on answering machines.

- 5) Crisis staff will then use the continued stay review located in Sentri to document who they spoke to and the information above. Once the continuing stay review is completed any extension days of stay is needed, crisis utilization staff will approve and submit/process the continuing stay review to Care management.

- 6) Care management will review the continuing stay review from Crisis utilization staff and either approve additional days or support the denial of additional days by crisis utilization staff. Care management will adjust the authorization.
- 7) Once Care Management has approved the authorization, the crisis staff will send Crisis Residential the approved form along with an email letting them know the authorization has been approved.

Continued Stay Review	
Document Date 03/07/2024	Reviewer 1030384 Miranda Croucher
General Information	
Admission Date 03/01/2024	Discharge Date 03/06/2024
County of Residence Saginaw	Attending Physician Dr. Saheed
Legal Status Denied	Living Situation Home
Comments/Instructions for Provider Discharge approved - Adrienne Frisch, LMSW	

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Clubhouse: Psychosocial Rehabilitation	Chapter: 02 – Customer Service & Recipient Rights	Subject No: 02.03.09.14
Effective Date: 10/2/08	Date of Review/Revision: 6/10/09, 6/10/10, 4/4/12, 5/8/14, 4/13/16, 6/13/17, 4/10/18, 4/9/19, 10/7/19, 6/1/20, 3/10/21, 3/9/22, 3/8/23, 3/15/24, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
	Supersedes: 02.03.13	
		Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: Jim Nesbit, EBP Leadership Team

Purpose:

The purpose of this policy is to delineate a framework for the provision of a Clubhouse model of psychosocial rehabilitation services and supports.

Policy:

SCCMHA-funded Clubhouse programs shall adhere to established standards set for the provision of Clubhouse programs as well as applicable SCCMHA policies including but not limited to trauma-informed services and supports.

Application:

This policy applies to all SCCMHA-funded Clubhouse services and supports.

Standards:

SCCMHA-funded Clubhouse providers shall adhere to the following standards which are derived from the Michigan Medicaid Provider Manual and Clubhouse International:

A. Eligibility:

1. Clubhouse Services are intended for beneficiaries with a primary diagnosis of serious mental illness. Clubhouse is not an appropriate service for beneficiaries with a primary Developmental Disability diagnosis. Clubhouse services are not appropriate for beneficiaries who exhibit:

- Behaviors that would threaten or pose a current health and safety risk to themselves or others.
 - A severity of symptoms requiring a more intensive level of treatment
 - Behaviors that disrupt the daily work of the Clubhouse
 - Behaviors that require excessive redirection and/or monitoring
2. The Clubhouse director has the responsibility to ensure the safety of the Clubhouse. All changes to a member's service provision must follow due process and all policies and procedures at local, state, and federal levels. Discharge criteria are only met if the member moves on voluntarily or if one or more of the above criteria are met. Cessation or control of symptoms alone is not sufficient criteria for discharge from the Clubhouse.
 3. Members must be able to participate in and benefit from activities necessary to support the Clubhouse and its members and are ineligible if they experience behavioral/safety or health issues that cannot be adequately addressed in a program with a low staff-to-member ratio.
- B. Program approval standards:
1. Program approval from the Michigan Department of Health and Human Services Community Health (MDHHS) Behavioral Health Developmental Disabilities Administration (BHDDA) is required for Prepaid Inpatient Health Plans' (PIHPs) providers of psychosocial rehabilitation Clubhouse services. (MDHHS approval is based on adherence to the requirements set forth in the Michigan Medicaid Provider Manual.)
 2. Clubhouses must acquire and maintain Clubhouse International Accreditation in order to ensure fidelity to the model of the evidence-based practice of Psychosocial Rehabilitation.
- C. Core components standards:
1. Member choice and involvement are hallmarks of the program.
 2. All members have access to Clubhouse services/supports and resources without differentiation based upon diagnosis or level of functioning.
 3. Members establish their own schedules of attendance and select a unit that they participate in on a regular basis during the ordered day.
 4. Clubhouse staff members actively engage and provide support to members on a regular basis in the activities and tasks that they have selected.
 5. Membership and access to services is based on each person served's preferences and needs established through individualized person-centered planning processes.
 6. Members have formal and informal decision-making opportunities in all Clubhouse units and program structures in order to influence and shape program operations.
 7. Staff and members work side-by-side to generate and accomplish individual and team-based tasks and activities necessary for the development, support, and maintenance of the Clubhouse.
 8. Members have access to the Clubhouse during times other than the ordered day including evenings, weekends, and all holidays (i.e., New Year's Day, Memorial Day, Independence Day, Thanksgiving Day, and Christmas Day). Members determine how this standard will be met and if even only one

- member wants access on a holiday, services/supports will be provided, although not necessarily at the Clubhouse facility itself.
9. The structure and schedule of the Clubhouse identifies when the various program components occur (e.g., ordered day, vocational, and educational activities). Other activities (e.g., self-help groups and social activities) are scheduled prior to and following the ordered day.
 10. Services directly related to employment, including transitional employment, supported employment, on-the-job training, community volunteer opportunities, completion or initiation of education or training, and other vocational assistance are available to members.
 11. Supports for members, including opportunities for them to provide and receive support in the community (e.g., outreach, warm lines, self-help groups, housing supports, entitlements, food, clothing, basic necessities, or assistance in locating community resources), are available.
 12. Social supports that involve opportunities for members to develop a sense of community through planning and organizing Clubhouse social activities and exploration of recreational resources and activities in the community are based on the interests and desires of the membership; the membership determines both spontaneous and planned activities.
 13. Symptom identification and care including:
 - a. Identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of relapses.
 - b. Gaining competence regarding how to respond to a psychiatric crisis.
 - c. Gaining competence in understanding the role psychotropic medication plays in the stabilization of well-being.
 - d. Working in partnership with members who express a desire to develop a crisis plan.
 14. Competency building standards:
 - a. Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment).
 - b. Social and interpersonal abilities (e.g., conversational competency, developing and/or maintaining a positive self-image, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships).
 - c. Personal adjustment abilities to reduce dependency on professional caregivers and to enhance independence (e.g., developing and enhancing personal abilities in handling everyday experiences and crises, such as stress management, leisure time management, coping with symptoms of mental illness).
 - d. Cognitive and adult role competency including task-oriented activities to develop and maintain cognitive abilities and maximize adult role functioning (e.g., increased attention, improved concentration, and improved memory to enhance the ability to learn and establish the ability to develop empathy).
 15. Environmental supports standards:

- a. Identification of existing natural supports for addressing personal needs (e.g., families, employers, and friends).
 - b. Identification and development of organizational support including sustaining personal entitlements and locating and using community resources or other supportive programs.
- D. Staffing standards:
 - 1. Staff shall be of sufficient capacity to effectively administer the program but allow the members sufficient latitude to participate meaningfully in it. Clubhouse staff shall include:
 - a. One full-time on-site Clubhouse director who has a minimum of a bachelor's degree in a health or human service field and is licensed, certified or registered by the State of Michigan or a national organization to provide health care services with two years' experience working at a Clubhouse accredited by Clubhouse International; or a master's degree in a health or human service field with appropriate licensure and one-year experience working at a Clubhouse.
 - 1). The Clubhouse manager is responsible for all aspects of Clubhouse operations, staff supervision and the coordination of Clubhouse services with case management and ACT. Central to this responsibility is the engagement of members and staff in all aspects of the Clubhouse's operations.
 - b. Other experienced professional staff who are licensed, certified, or registered by the State of Michigan or a national organization to provide health care services.
 - c. Other staff members who are not licensed, certified, or registered by the State of Michigan to provide health care services may be part of the program but shall operate under the supervision of a qualified professional. This supervision must be documented.
 - 2. Clubhouse staff shall not include clinical staff (e.g., nurses, psychiatrists, or therapists); the Clubhouse is not a clinical setting and therefore does not offer psychotherapy or pharmacotherapy.
 - 3. Clubhouse staff members have generalist roles; all staff members share employment-related and other activities, evening, and weekend, holiday, and unit responsibilities; they shall not divide their time between the Clubhouse and other major work responsibilities.
 - 4. All Clubhouse staff must have a basic knowledge of the Clubhouse Model acquired through MDHHS approved Clubhouse-specific training within six months of hire, and then at least one MDHHS approved Clubhouse specific training annually.
 - a. As part of the accreditation process the Clubhouse director, members, and staff shall participate in a comprehensive training program in the Clubhouse Model conducted at an accredited Training Base Clubhouse.
 - b. A six-month follow-up site visit shall be scheduled with the Training Base Clubhouse.

- c. This training requires the development of an action plan for developing the Clubhouse and upon returning from training all Clubhouses will submit their action plan to MDHHS.
- E. Membership standards:
 - 1. Membership is voluntary and without time limits.
 - 2. The Clubhouse maintains control over its acceptance of new members.
 - 3. Membership is open to anyone with a history of mental illness unless that person poses a significant and current threat to the general safety of the Clubhouse community.
 - 4. Members select the ways they utilize the Clubhouse and staff with whom they work; agreements, contracts, schedules, or rules intended to enforce the participation of members shall not be put into effect.
 - 5. All members shall have equal access to every Clubhouse opportunity without differentiation based on diagnosis or level of functioning.
 - 6. Members, at their choice, shall be involved in the documentation of all records reflecting their participation in the Clubhouse; all such records are to be signed by both the member and staff.
 - 7. Members shall have a right to immediate re-entry into the Clubhouse community subsequent to any length of absence unless their return poses a threat to the Clubhouse.
 - 8. The Clubhouse shall provide outreach to members who are not attending, are becoming isolated in the community, or who have been hospitalized.
 - 9. All Clubhouse meetings shall be open to both members and staff; no formal member-only meetings or formal staff-only meetings where program decisions and member issues are discussed shall be held.
- F. Space standards:
 - 1. The Clubhouse shall maintain its own identity, including its own name, mailing address, and telephone number.
 - 2. The Clubhouse shall be located in its own physical space separate from any mental health or institutional settings and shall be impermeable to other programs.
 - 3. The Clubhouse will be designed to facilitate the ordered day as well as be attractive, adequate in size, and convey a sense of respect and dignity.
 - 4. All Clubhouse spaces shall be accessible to members and staff; no staff-only or member-only spaces shall be designated.
 - 5. The Clubhouse will be located in an area where access to local transportation can be assured for getting to and from the program as well as accessing transitional employment (TE) opportunities.
 - a. The Clubhouse shall provide or arrange for effective alternatives whenever access to public transportation is limited.
- G. Ordered Day standards:
 - 1. The ordered day shall function to engage members and staff together, side-by-side, in the day-to-day Clubhouse operations in manner that focuses on strengths, talents and abilities; the ordered day shall not include medication clinics, day treatment, or therapy programs within the Clubhouse.

2. The work conducted in the Clubhouse shall be exclusively work generated by the Clubhouse for its operation and enhancement; work for outside individuals or organizations, whether for pay or not, shall not be conducted within the program.
 - a. Members shall not be paid for Clubhouse work and no artificial reward systems will be put in place to benefit the members.
 - b. The Clubhouse shall provide an ordered day at least five days a week, analogous to typical working hours.
 - c. The Clubhouse shall be organized into one or more work units, each of which has sufficient staff, members, and meaningful work to sustain a full and engaging ordered day.
 - a. Unit meetings will be held to foster relationships as well as to organize and plan the work of the day.
 - b. All work in the Clubhouse shall be designed to help members regain self-worth, purpose, and confidence; work in the Clubhouse is not intended to be job-specific training.
 - c. Members shall have the opportunity to participate in all work of the Clubhouse, including administration, research, intake and orientation, outreach, hiring, training and evaluation of staff, public relations, as well as advocacy and evaluation of the Clubhouse's effectiveness.
- H. Employment and education standards:
 1. The Clubhouse shall enable its members to return to paid work through Transitional Employment (TE), Supported Employment (SE), and Independent Employment (IE); the Clubhouse does not provide employment to members through in-house businesses, segregated Clubhouse enterprises, or sheltered workshops.
 - a. Coordination with the SCCMHA Supported Employment Unit shall occur in order to provide access to SE and independent employment opportunities (e.g., microenterprises) for members.
 2. The Clubhouse shall offer its own Transitional Employment (TE) program as a right of membership to provide opportunities for members to work in job placements in business and industry.
 - a. The Clubhouse shall guarantee coverage on all placements during member absences.
 - b. The Transitional Employment program shall meet the following criteria.
 - 1). The desire to work is the single most important factor determining placement opportunities.
 - 2). Placement opportunities will continue to be available regardless of success or failure in previous placements.
 - 3). Members work at employers' places of business.
 - 4). Members are paid the prevailing wage rate, but at least minimum wage, directly by employers.
 - 5). TE placements are drawn from a wide variety of job opportunities.

- 6). TE placements are part-time and time-limited (generally fifteen to twenty hours per week for six to nine months).
 - 7). The selection and training of members in TE is conducted by the Clubhouse rather than employers.
 - 8). Clubhouse members and staff shall prepare reports on TE placements for SCCMHA and other agencies dealing with members' benefits.
 - 9). TE placements are managed by Clubhouse staff and members rather than TE specialists.
 - 10). No TE placements shall be provided within the Clubhouse; such placements are off-site and meet the above criteria.
 - 11). The Clubhouse will assist and support members to secure, sustain, and subsequently achieve improved employment opportunities.
 - 12). Members who are working independently will continue to have all Clubhouse supports and opportunities (including advocacy for entitlements, and assistance with housing, clinical, legal, financial, and personal issues) as well as participation in evening and weekend programs available to them.
 - 13). The Clubhouse shall assist members to further their vocational and educational goals by helping them take advantage of adult education opportunities in the community including General Education Development (GED) resources and local institutions of higher education (e.g., community colleges).
 - a). Members shall also receive help with admission and applying for financial aid.
 - b). When the Clubhouse provides an in-house educational program, it will utilize the teaching and tutoring skills of members.
 - 14). The Clubhouse shall be committed to securing a range of choices of safe, decent, and affordable housing for all members and shall have access to the SCCMHA Housing Resource Unit.
 - 15). Community support services/activities will be provided by members and staff and be centered in the work unit structure of the Clubhouse. These shall include assistance with entitlements, housing, and advocacy, as well as assistance in finding quality medical, psychological, pharmacological, and substance abuse treatment services in the community.
3. The Clubhouse shall provide its members with assistance in benefits planning.
- I. Wellness supports standards:
 1. The Clubhouse shall support enhanced physical wellness through programming that may include exercise, tobacco cessation, health nutrition, weight loss and other wellness activities that may include the use of community resources (e.g., memberships in the local YMCA).

- J. Recovery support standards:
1. Each member's goals for participation in the Clubhouse are based upon their Individual Plan of Service and developed through a person-centered planning process. Such goals may include:
 - a. Improved community living skills including self-care, grooming, cooking, money management, etc.
 - b. Improved personal and interpersonal skills including interpersonal problem-solving, relationship skills including empathy and conversational competency, developing a positive self-image, effective stress management skills, leisure time management skills, coping with symptoms of a mental illness, and others.
 - c. Improved symptom and illness management skills including the identification and management of triggers and prodromal symptoms, effective management of psychiatric crises, the role of pharmacotherapy, and others.
 - d. Educational/vocational/career opportunity development including learning how to apply for a job, job interview skills, managing co-worker relationships, and others.
 - e. Social support network development including the development of natural supports.
 - f. Linkages with various community resources that support community inclusion.
 - g. Increased independence including improved self-efficacy and enhanced decision-making capacity.
 - h. Enhanced overall psychosocial functioning.
- K. Funding, governance, and administrative standards:
1. The Clubhouse shall maintain an independent advisory board comprised of individuals that can provide fiscal, legal, legislative, person served, and community support and advocacy.
 2. The Clubhouse shall maintain its own operating budget, which is approved prior to the beginning of the fiscal year and is routinely monitored.
 3. The Clubhouse shall be provided with support by SCCMHA.
 4. The Clubhouse shall maintain MDHHS certification.
 5. The Clubhouse will collaborate with individuals and organizations that can increase its effectiveness in the broader community.
 6. The Clubhouse will enable members and staff to actively participate in decision-making, generally by consensus, regarding governance, policy-making, and future directions and development of the Clubhouse.
 7. The Clubhouse will conduct an objective evaluation of its effectiveness on a regular basis.
 8. The Clubhouse director, members, staff, and other appropriate persons will participate in relevant training related to the Clubhouse psychosocial rehabilitation program model.
 9. The Clubhouse will offer recreational and social programs during evenings and on weekends, and holidays will be celebrated on the actual day they are observed.

- L. Documentation standards:
1. Members' progress shall be documented on a monthly basis at a minimum
 2. Progress notes shall be integrated into unit work whenever possible
 3. Members shall have the opportunity to document their own progress in the record

Definitions:

Clubhouse: Programs that provide a wide range of services and supports that are designed to help people living with severe psychiatric disorders recover, achieve, and maintain community integration. Clubhouses are organized around the ordered day and participants (i.e., members) work with a small number of professional staff to operate the program. The ordered day enables individuals experiencing unemployment due to a mental illness to go to work each day side-by-side supportive peers and helpful professionals. Traditional mental health services that tend to focus on treating illnesses are not provided; the focus is almost entirely on the strengths of the membership rather than the problems caused by mental illnesses.

The first psychosocial rehabilitation Clubhouse was started in 1947 by a group of people with a mental illness who realized they could help each other in their recovery. The original group, called WANA (We Are Not Alone) became Fountain House in New York City which was established in 1948. Professional staff members were hired by the clients and a partnership between staff and members developed to create opportunities for people with mental illnesses to function as respected members of society.

Clubhouses use an ordered day which parallels traditional hours of work. Members come to the Clubhouse and have an opportunity to contribute to the completion of its daily functions (e.g., reception, orientation of new members, data entry, creation of newsletters and mailings, public relations, devising menus, food preparation, and clean-up). A critical component is job placement for persons who are either ready to work in a TEP (Transitional Employment Position) or are ready to start competitive employment. Clubhouses help members secure and maintain employment that fits their talents and capabilities. Clubhouses provide the following services:

- An organization (a place) to which a person can belong, contribute, and experience feelings of ownership. In such a work-like setting, people acquire real coping and life skills that make successful community integration possible.
- Peer Support Services: The Clubhouse community functions as a support group for persons who have struggled with mental illness in isolation. Members help other members resolve crises, obtain resources, and pursue rehabilitation goals.
- Crisis Intervention: Clubhouse programs have been shown to reduce the use of more expensive mental health crisis services (e.g., crisis clinics, emergency rooms, and hospital beds). Members can turn to their Clubhouse community for help in times of crisis.
- Prevocational Services: Research has demonstrated that Clubhouse programs, through the structure and activity provided in the Clubhouse work units, help individuals with severe psychiatric disorders who are not interested in employment when they join the Clubhouse become interested in and obtain employment.
- Vocational Rehabilitation Services are designed specifically for the unique needs of persons who live with mental illnesses.

- Supported Education Services: Clubhouses assist members to further their vocational and educational goals by helping them take advantage of adult education opportunities in the community. In addition, Clubhouses provide in-house educational programs that significantly utilize the teaching and tutoring skills of members.
- Case Management Services: Other members and Clubhouse staff provide a full range of community support services and assist members with resource acquisition.

Ordered Day (also referred to as work-ordered day): A basic component of the Clubhouse program that provides opportunities for members to regain a sense of self-worth, purpose, and confidence. It is comprised of tasks and activities essential to the operation of the Clubhouse, usually taking place during traditional work hours, and conducted in organizational units determined by the Clubhouse to accomplish work necessary for its operation and meet the needs of its members. Participation in the ordered day provides opportunities for developing a variety of interpersonal and vocationally related skills but is not intended to be job-specific training. Members' participation in the ordered day provides experiences that support their recovery and is designed to assist them in the acquisition of personal, community, and social competencies as well as establish and navigate environmental support systems.

Transitional Employment (TEP): a vocational strategy for integrating adults with mental illness into the paid labor force. TEPs are part-time, time limited (generally fifteen to twenty hours per week for six to nine months), job placements at minimum wage or higher, drawn from a wide variety of business or work settings in the community. Transitional Employment was created in the early 1960s at Fountain House in New York City to specifically address the needs of persons with severe mental illnesses.

References:

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 2. Standards and Guidelines: http://www.iccd.org/images/employment_guidelines_2012.pdf
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- D. SAMHSA's (Substance Abuse and Mental Health Services Administration) NREPP (National Registry of Evidence-based Programs and Practices). ICCD (International Center for Clubhouse Development) Clubhouse Model
- E. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- F. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

Exhibits:

None

Procedure:

None

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Peer Support Services	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.09.15
Effective Date: 6/4/14	Date of Review/Revision: 4/27/15, 6/8/16, 8/11/16, 6/13/17, 9/27/17, 4/10/18, 4/9/19, 10/21/19, 3/10/21, 1/12/22, 3/31/22, 3/8/23, 3/15/24, 3/28/25, 3/16/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
	Supersedes: 02.03.19	
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team

Purpose:

The purpose of this policy is to delineate a framework for the provision of peer support services.

Policy:

- A. The promotion of a peer culture and peer support (i.e., people helping people) throughout the SCCMHA system is a critical element of a recovery-oriented, resiliency-building, trauma-informed behavioral health care system. SCCMHA will promote and support a vibrant peer culture in recognition of the experience of consumers of mental health and substance use disorder treatment services, youth with serious emotional disturbances, families, and persons with intellectual/developmental disabilities as an important component of effective service and support delivery.
- B. Peers will offer assistance by using their personal and practical experience, knowledge, and first-hand insight on recovery from a mental illness and/or co-occurring substance use disorder, and community inclusion, and independence, and peer mentoring for adults with an intellectual/developmental disability. They will offer support to consumers to help them discover their hopes and dreams, strengths and challenges, and develop plans that facilitate progress toward independence, resiliency, and/or recovery. Peers will also support staff in maintaining recovery/resiliency and trauma-informed orientation by modeling the principles of inclusion, cultural competence, trustworthiness, empowerment, and independence.

Application:

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

Standards:

- A. SCCMHA shall promote SAMHSA's core principles and values for behavioral health services peers:
 - 1. Recovery-oriented: Peer support provides a hopeful framework for the person to envision a meaningful and purposeful life, recognizing that there are multiple pathways to recovery.
 - 2. Person-centered: Peer support is directed by the person participating in peer support service. Peer support is personalized to meet the specific hopes, needs and goals of an individual.
 - 3. Non-coercive: Peer support never involves force and participation in peer support is always voluntary.
 - 4. Relationship-focused: Peer support centers on the affiliation between peers. Characteristics of the relationship are: respectful, empathetic, and mutual.
 - 5. Trauma-informed care: Peer support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.
- B. SCCMHA shall promote SAMHSA's core competencies for behavioral health services peers which include:
 - 1. Engaging peers in collaborative and caring relationships:
 - a. Listening to peers with careful attention to the content and emotion being communicated
 - b. Reaching out to engage peers across the whole continuum of the recovery process
 - c. Demonstrating genuine acceptance and respect
 - d. Demonstrating understanding of peers' experiences and feelings
 - 2. Providing support:
 - a. Validating peers' experiences and feelings
 - b. Encouraging the exploration and pursuit of community roles Conveying hope to peers about their own recovery
 - c. Celebrating peers' efforts and accomplishments
 - d. Providing concrete assistance to help peers accomplish tasks and goals
 - 3. Sharing lived experiences of recovery:
 - a. Relating their own and others' personal recovery stories to peers to inspire hope
 - b. Discussing ongoing personal efforts to enhance health, wellness, and recovery
 - c. Recognizing when to share experiences and when to listen
 - d. Describing personal recovery practices and helping peers discover recovery practices that work for them
 - 4. Personalizing peer support:

- a. Understanding his/her own personal values and culture and how these may contribute to biases, judgments and beliefs
 - b. Appreciating and respecting the cultural and spiritual beliefs and practices of peers and their families
 - c. Recognizing and responding to the complexities and uniqueness of each peer's process of recovery
 - d. Tailoring services and support to meet the preferences and unique needs of peers and their families
- 5. Recovery planning:
 - a. Assisting and supporting peers to set goals and to dream of future possibilities
 - b. Proposing strategies to help a peer accomplish tasks or goals
 - c. Supporting peers to use decision-making strategies when choosing services and supports
 - d. Helping peers to function as a member of their treatment/recovery support team
 - e. Researching and identifying credible information and options on the Internet and through other resources
- 6. Linking to resources, services, and supports:
 - a. Developing and maintaining up-to-date information about community resources and services, both indigenous and formal
 - b. Assisting peers to investigate, select, and use needed and desired resources and services, both indigenous and formal
 - c. Helping peers to find and use health services and support
 - d. Accompanying peers to community activities and appointments
 - e. Participating in community activities with peers
- 7. Teaching information and skills:
 - a. Educating peers about health, wellness, recovery, and recovery supports
 - b. Participating with peers in discovery or co-learning to enhance recovery experiences
 - c. Coaching peers about how to access services and navigate systems of services
 - d. Coaching peers in desired skills and strategies
 - e. Educating family members and other supportive individuals about recovery and recovery supports
 - f. Using teaching strategies that match the preferences and needs of individual peers
- 8. Helping peers to manage crises by:
 - a. Recognizing signs of distress and threats to safety among peers and in their environments
 - b. Providing reassurance to peers who are in distress
 - c. Striving to create safe spaces when meeting with peers
 - d. Taking action to address distress or a crisis by using knowledge of local resources and service and support preferences of individual peers

- e. Assisting peers in developing advance directives and other crisis prevention tools
- 9. Communication skills that include:
 - a. Using respectful, person-centered, recovery-oriented language in written and verbal interactions with peers, family members, community members, and others
 - b. Using active listening skills
 - c. Clarifying their understanding of information when in doubt of the meaning
 - d. Conveys their point of view when working with colleagues
 - e. Documenting information as required by program policies and procedures
 - f. Following laws and rules concerning confidentiality and respects others' rights for privacy
- 10. Collaboration and teamwork:
 - a. Works together with other colleagues to enhance the provision of services and supports
 - b. Assertively engages providers from mental health services, addiction services, and physical medicine to meet the needs of peers
 - c. Coordinates efforts with health care providers to enhance the health and wellness of peers
 - d. Coordinates efforts with peers' family members and other natural supports
 - e. Partners with community members and organizations to strengthen opportunities for peers
 - f. Strives to resolve conflicts in relationships with peers and others in their support network
- 11. Leadership and advocacy:
 - a. Using knowledge of relevant rights and laws (ADA, HIPAA, 42 CFR, Olmstead, etc.) to ensure that peer's rights are respected
 - b. Advocating for the needs and desires of peers in treatment team meetings, community services, living situations, and with family
 - c. Using knowledge of legal resources and advocacy organization to build an advocacy plan
 - d. Participating in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families
 - e. Educating colleagues about the process of recovery and the use of recovery support services
 - f. Actively participating in efforts to improve the organization
 - g. Maintaining a positive reputation in peer/professional communities
- 12. Growth and development:
 - a. Recognizing the limits of their knowledge and seeks assistance from others when needed
 - b. Using supervision (mentoring, reflection) effectively by monitoring self and relationships, preparing for meetings and engaging in problem-solving strategies with the supervisor (mentor, peer)

- c. Reflecting and examining own personal motivations, judgments, and feelings that may be activated by the peer work, recognizing signs of distress, and knowing when to seek support
 - d. Seeking opportunities to increase knowledge and skills of peer support
- C. Peer Support Specialists shall be present or past consumers of mental health services who are assigned to participate as full-fledged members of multidisciplinary teams and work with consumers in a range of settings, including treatment offices, consumers' homes, hospitals, community settings, and transport vehicles.
- D. Peer Support Specialists shall provide a wide range of peer support services to consumers to assist them in gaining/regaining control over their lives and the recovery process as well as attain personal goals of community membership, independence, and productivity.
- E. Peer Support Specialists will assist in the development and maintenance of a recovery-oriented environment by providing any of the following services to consumers:
 - 1. Modeling and teaching effective communication, recovery-oriented living, and effective coping/problem-solving skills, as well as self-help strategies.
 - 2. Assisting consumers in developing self-empowerment skills via self-advocacy and stigma-busting.
 - 3. Assisting consumers in identifying their personal recovery goals, setting objectives for each goal, and determining interventions to be used based on consumers' recovery/life goals; peer support specialists will be actively involved in developing consumers' person-centered recovery plans.
 - 4. Orienting new consumers to SCCMHA-delivered services and supports.
 - 5. Providing input to traditional treatment staff colleagues during staff and person-centered planning meetings.
 - 6. Functioning as liaisons to community resources and assisting consumers in accessing and using such resources.
 - 7. Advocating for the full integration of consumers into communities of their choice and promoting the inherent value of those individuals to those communities.
- F. Veteran Peer Support Specialists may serve in all the same capacities as a Peer Support Specialist with the specification that they serve the Veteran population.
- G. Peer Mentors shall:
 - 1. Help people with disabilities advocate for their own goals
 - 2. Assist consumers in building their own independent lives
 - 3. Assist consumers with person-centered planning goals
 - 4. Help build bridges to people and resources within the community
 - 5. Involve the consumer's circle of support
 - 6. Are guided by the principle of self-determination for all
- H. Parent-to-Parent Support shall be made available to support parents/families of children with serious emotional disturbance (SED) or intellectual/developmental disabilities in order to help them to become empowered, confident and acquire skills that will enable them to assist their child to improve in functioning.
 - 1. Parents who provide parent-to-parent support shall have the lived experience of raising a child with special mental health needs.

2. Parents providing support services to other parents/families shall receive SCCMHA/MDHHS approved training.
 3. Parent-to-Parent services shall include the provision of:
 - a. Education
 - b. Training
 - c. Support
 - d. Enhancement of the assessment and mental health treatment process
 4. Parent support activities shall be provided in the home and in the community.
- I. Peer Health & Wellness Specialists shall work as part of the consumer's Health Home & Wellness team and focus on helping to remove personal and environmental obstacles to health care access for SCCMHA adult consumers with a serious mental illness by offering support to individuals, their family members, and caregivers.
1. Peer Health & Wellness Specialists shall provide the following services and supports:
 - a. Connect consumers to education programs that promote prevention and understanding of chronic health conditions
 - b. Assist in the coordination of care with physical health providers and serve as a person served advocate
 - c. Provide individualized health coaching to consumers to achieve their health objectives and wellness goals.
 - d. Share their knowledge to help coach others about managing their mental and physical health.
 - e. Support consumers in learning how to make good choices for themselves
 - f. Seek input from consumers to create and adapt wellness goals to overcome barriers to good mental and physical health based on the needs of consumers
 - g. Co-facilitate groups or classes to support improved health outcomes for adults with severe mental illness such as PATH (Personal Action Toward Health) classes
 - h. Promote person served engagement with: primary care, therapy with clinicians, engagement with psychiatric appointments, and wellness services
- J. Peer Recovery Coaches shall provide the following to help consumers establish self-sustaining recovery from substance use disorders:
1. Recovery Planning: An opportunity for the recovery coach and person served to assess what services are needed and to develop a plan. Recovery planning can involve, but be not limited to identifying triggers for use, developing a relapse prevention plan, and building a support network.
 2. Relationship Building: A recovery coach can assist the person served in developing social skills needed to maintain healthily relationships or establish new ones. This often requires assisting the person served with repairing, or rebuilding new support network to achieve lasting recovery.

3. Leisure Activity Planning: Consumers can benefit from recovery support services when they learn new ways to have fun without drugs and alcohol. The coach can assist skill building efforts such as time management and positive social activities
 4. Behavior Education: Research shows that addiction is a chronic, relapsing disease. The recovery coach can educate the person served regarding relapse prevention and identify relapse indicators as part of the recovery plan.
- K. Youth Peer Support (YPS) services shall be made available to support youth with severe emotional disturbances, particularly those who may be involved in multiple systems (behavioral health, child welfare, juvenile justice, special education, etc.).
1. The goals of Youth Peer Support services shall be included in the consumer's individualized plan of service and mutually identified in active collaboration with the person served receiving services.
 2. Youth Peer Support Specialist shall meet the following qualifications:
 - a. Aged 18 through 28, with the lived experience of having received mental health services as a youth
 - b. Willing and able to self-identify as a person who has or is receiving behavioral health services use that experience in helping others
 - c. Experience receiving services as a youth in complex, child serving systems preferred (behavioral health, child welfare, juvenile justice, special education, etc.).
 - d. Participation in the MDHHS approved curriculum and ongoing training model
- L. Consumers shall be given a choice, where possible, of peer support service providers.
- M. Supervision shall be provided to peers.
1. Peer Support Specialists shall be provided with supervision by qualified mental health professionals.
 2. Peer Mentors shall be provided with supervision by qualified intellectual/developmental disability professionals.
 3. Parent Support Partners shall be provided with supervision by qualified mental health and/or intellectual/developmental disability professionals.
 4. Recovery Coaches shall receive weekly supervision from designated agency staff.
 5. Professional staff shall supervise Youth Peer Support.
- N. Peers shall receive appropriate training for their roles.
1. Support Specialists shall receive standardized and accredited training and meet MDHHS' (Michigan Department of Health and Human Services) specialized training and certification requirements.
 2. Peer Mentors shall attend the Michigan Developmental Disabilities Council's Peer Mentoring 101 training.
 3. Peer Recovery Associates must receive training that includes:
 - a. Gaining knowledge of community resources
 - b. Listening skills

- c. Taking a non-judgmental stance (the ability to respond positively and provide assistance to an individual regardless of personal opinions, experiences, and choices)
 - d. Understanding of confidentiality
 - e. Establishing boundaries
 - f. Possessing an attitude that there are many paths to recovery (none are any better than another)
- 4. Peer Recovery Coaches must successfully complete the MDHHS Peer Recovery Coach training for certification.
- 5. Youth Peer Support Specialists complete the MDHHS-approved training curriculum.
- 6. Peer Mentors shall attend the Michigan Developmental Disabilities Council's Peer Mentor 101 training and complete a supervised 90-120 hour internship at an SCCMHA-funded agency and receive certification from the Michigan Developmental Disabilities Council.
- 7. Parent Support Partners (peer-parents) who provide family support and training to parents of children with SED must complete MDHHS-endorsed training and receive a Certificate of Completion of the initial three (3)-day training curriculum.
- O. Each SCCMHA-funded adult case management/ACT team must include at least one PSS position. Programs providing services and supports for persons with intellectual/developmental disabilities shall also provide PSS services.
- P. Peer Recovery Support Services will recognize core values in an individual's recovery, their families, and their community allies are critical resources that can effectively extend, and enhance formal treatment services.
 - 1. SAMSHA recognizes the following core competencies, principles and values:
 - a. RECOVERY-ORIENTED: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.
 - b. PERSON-CENTERED: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker.
 - c. VOLUNTARY: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.
 - d. RELATIONSHIP-FOCUSED: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the

- peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.
- e. **TRAUMA-INFORMED:** Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Definitions:

Certified Peer Recovery Mentor (CPRM-M) is an individual who has been successful in their own recovery and is prepared to share their experience and knowledge with others at an earlier stage of recovery from alcohol and/or drug dependency. The Certified Peer Recovery Mentor credential is for peer recovery mentors working within licensed substance abuse service provider organizations, with a minimum of 500 hours of working experience, 25 or more hours documented supervision, and completion of a minimal set of education requirements. (*Michigan Certification Board for Addiction Professionals [MCBAP], 2013*)

Certified Peer Support Specialist (CPSS) is an individual with a lived experience and journey in receiving public mental health services and supports. Certified Peer Support Specialists are employed in a variety of settings including consumer-run organizations, employment, psychosocial rehabilitation programs, housing outreach, supports coordination and integrated behavioral health and primary care. They provide direct services to support others with health navigation, accessing resources, and supporting a person-centered recovery journey to achieve community inclusion and participation, independence, recovery and resiliency. (*Michigan Developmental Disabilities Council*)

Parent-to-Parent Support is designed to support the parents/families of children with a serious emotional disturbance or intellectual/developmental disability as part of the treatment process to be empowered, confident and possess skills that will enable them to assist their child to improve in functioning. The trained parent support partner currently has or previously had a child with special mental health needs. Parent support partners provide education, training, and support, and augment the assessment and mental health treatment process. A parent support partner provides these services to the parents and their family in the home and in the community. Parent support partners receive regular supervision and team consultation by the treating professionals. [Adapted from the *MDHHS Medicaid Provider Manual*]

Parent Support Partners serve as equal members of treatment teams and assist in identifying goals within the Person Centered/Family Centered Plan that will support parents to develop skills, knowledge, resources, and confidence in parenting a child with serious emotional disturbance (SED) and/or an intellectual/developmental disability (I/DD). This service is provided by another parent who has first-hand experience navigating the public child serving agencies and raising a child with mental health challenges. Services focus on increasing confidence and competence in parenting skills, increasing the parent's knowledge to better navigate systems and partner with service providers, and empower the parent to develop sustainable, natural support networks after formal service delivery has ended. [Adapted from the *MDHHS Medicaid Provider Manual*]

Peer is a person who has lived experience with a psychiatric, traumatic, and/or addiction condition, and may benefit from peer recovery support in the context of peer recovery support. (*International Association of Peer Supporters [iNAPS], 2013*)

A peer is a person in a journey of recovery who identifies with an individual based on a shared background and life experience. (*Michigan DCHODCP, 2012*)

Peer Mentor is a person with an intellectual/developmental disability who has learned problem solving strategies, how to be a self-advocate, how to live a self-determined life, and knows how to access services and resources in the community. Peer Mentors offer the benefit of their experiences, passing along encouragement and support to help others construct their own advocacy to bring about the changes they want for their lives. (*MDDHHS*)

Peer Recovery Associate is an individual who assists a peer recovery coach by engaging in designated peer support activities. Peer recovery associates receive an orientation and brief training in the functional aspect of their role by the entity that will utilize them to provide supports. These individuals are not trained to the same degree as peer recovery coaches. A peer recovery associate must have a minimum of six (6) months in recovery (*Michigan DCHODCP, 2012*)

Peer Recovery Coach is a peer specifically trained to provide advanced peer recovery support services in Michigan. A peer recovery coach works with individuals during their recovery journey by linking them to the community and its resources. A peer recovery coach serves as a personal guide or mentor, helping the individual overcome personal and environmental obstacles to recovery. Peer recovery coaches must have two continuous years in recovery at some point in time after the age of 18. (*From MDHHS Peer Recovery Coach application, 2022*)

Peer Recovery Support is the process of giving and receiving non-clinical assistance to achieve long-term recovery from severe psychiatric, traumatic, or addiction challenges. This support is provided by peer recovery supporters – i.e., people who have “lived experience” – and have been trained to assist others in initiating and maintaining long-term recovery and enhancing the quality of life for individuals and their families Peer recovery support services are inherently designed, developed, delivered, evaluated, and supervised by Substance Abuse Treatment Specialists (SATS) or Substance Abuse Treatment Practitioner (SATP) when in a setting that receives Medicaid reimbursement. Programs funded by the Substance Abuse Block Grant (SABG) and/or Public Act 2 (PA2) funding shall receive ongoing supervision by a case manager, treatment practitioner, prevention staff, or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports. (*From MDHHS Bulletin MSA 22-01, 2022 and the International Association of Peer Supporters [iNAPS], 2013*)

Peer Recovery Support Services may include peer mentoring, peer-led support groups, parenting classes, job readiness training, wellness seminars, childcare, transportation, help with accessing community health and social services, recovery centers, sports league participation, and alcohol- and drug-free socialization opportunities. (*SAMHSA, 2009*)

Peer Recovery Supporter is someone who has experienced the healing process of recovery and, as a result, can offer assistance and support to promote another peer’s own personal recovery journey. (*International Association of Peer Supporters [iNAPS], 2013*)

Peer Services include Medicaid Managed Care 1915 (b) (3) waiver services which promote community inclusion and participation, independence and productivity, of which two broad categories found in the Michigan Medicaid Provider Manual: peer-delivered and operated support services (e.g., peer support specialists, peer mentors, etc.), and peer run drop-in centers.

Peer Support Relationship: The qualities that make an effective peer supporter are best defined by the individual receiving support, rather than by an organization or provider of care. Matching peer recovery supporters with peers often encompasses shared cultural characteristics, such as age, gender, ethnicity, language, sexual orientation, co-occurring conditions, experience in the military or with the criminal justice system, or other identity-shaping life experiences that increase common language, mutual understanding, trust, confidence, and safety. (*International Association of Peer Supporters [iNAPS], 2013*)

Peer Support Services consist of activities that focus on helping consumers assume control over their lives and recovery and/or resilience building process. Peer support can include peer mentoring or coaching, helping consumers find and access resources, advocating for consumers, and facilitating and leading recovery, support or educational groups. Peer support is provided by persons with lived experience.

Peer Support Specialist (PSS) is a person with a mental illness and/or co-occurring substance use disorder and/or intellectual/developmental disability who has been trained to help her/his peers identify and achieve specific life goals. Peer Support Specialists cultivate the ability of those they assist to make informed, independent choices and set goals, and gain information and support from the community to achieve those goals. They promote personal responsibility, empowerment, and self-determination inherent in self-directed recovery and resiliency, and assist people with mental illnesses and intellectual/developmental disabilities in gaining/regaining control over their own lives and their own recovery process and achievement of independence. Peer Support Specialists model competency in recovery/resiliency and maintaining ongoing wellness. It should be noted that the role of peer support specialists is not interchangeable with that of traditional staff members who typically operate from the perspectives of their training and/or licensure. Peer Support Specialists operate from the perspective of "having been there" and lend unique insight into mental illnesses, substance use disorders, and intellectual/developmental disabilities and factors that make recovery and the achievement of community integration possible.

Recovery is defined as the process in which people are able to live, work, learn, and fully participate in their communities. For some individuals, recovery entails being able to live a fulfilling and productive life despite a disability. For others, recovery signifies the reduction or complete remission of symptoms of an illness.

Recovery Community includes individuals with 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)

Resiliency is defined as the ability of an individual to function competently in the face of adversity or stress.

Veteran Peer Support may be defined as the help and support given by veterans to veterans through shared experiences and/ or an experience of a mental health illness related to

their military life. It may be social, emotional, or practical support but importantly this support is mutually offered and reciprocal, allowing peers to benefit from the support whether they are giving or receiving it.

Veteran Peer Support Specialist is an individual who has served in the U.S. Military and has a mental health and/or co-occurring condition, who has been trained to help others identify and achieve specific life and recovery goals. They help fellow Veterans navigate the VA system, facilitate support groups, and provide information on community resources while actively being engaged in their own recovery.

Youth Peer Support (YPS) are designed to support youth with a serious emotional disturbance through shared activities and interventions. The goals of Youth Peer Support include supporting youth empowerment, assisting youth in developing skills to improve their overall functioning and quality of life, and working collaboratively with others involved in delivering the youth's care. Youth Peer Support services can be in the form of direct support, information sharing and skill building.

Youth Peer Support Services are provided by trained youth peer support specialists, one-on-one or in a group, for youth with a serious emotional disturbance who are resolving conflicts, enhancing skills to improve their overall functioning, integrating with community, school and family and/or transitioning into adulthood. Services provide support and assistance for youth in accordance with the goals in their plan of service to assist the youth with community integration, improving family relationships and resolving conflicts, and making a transition to adulthood, including achieving successful independent living options, obtaining employment, and navigating the public human services system. Youth Peer Support activities are identified as part of the assessment and the person-centered/family-driven, youth-guided planning process.

Youth Peer Support Specialists are young adults aged 18 through 28 who have lived experience navigating behavioral health systems and must participate in and complete the approved MDHHS curriculum and ongoing training. A Youth Peer Support Specialist is willing and able to self-identify as a person who is receiving or has been the recipient of behavioral health services and is prepared to use that experience to help others. Youth Peer Support Specialists shall receive regular supervision by a child mental health professional and shall participate as an active member of the treatment team.

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- O. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- P. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
- Q. Social Security Act Section 1915 (b) (3) Waiver

- A. Michigan Certified Peer Support Specialist Code of Ethics, updated 2021
- B. Michigan Certified Peer Recovery Coach Code of Ethics, updated 2022
- C. Core Competencies for Peer Workers in Behavioral Health Services (SAMHSA)
- D. Peer Related Medicaid Services Guidance

None

Exhibit A

Michigan Certified Peer Support Specialists Code of Ethics

Certified Peer Support Specialists will maintain high standards of professional conduct in a manner that fosters hope and recovery while practicing self-care.

Certified Peer Support Specialists will advocate and support for the full integration of individuals into the communities of their choice.

Certified Peer Support Specialists will improve their knowledge and skills through on-going education and share that knowledge with colleagues and individuals they serve.

Certified Peer Support Specialists will value diversity, equity and inclusion and will not practice, condone, facilitate, or collaborate in any form of discrimination based on ethnicity, race, sex, sexual orientation, gender identity, age, religion, national origin, marital status, political belief, disability, or any other preference or personal characteristic, condition, or state.

Certified Peer Support Specialists will respect the privacy of those they serve and will abide by State and Federal privacy and confidentiality laws.

Certified Peer Support Specialists will inform supervisor(s) or other members of the treatment team/agency immediately of any reported or suspected intent of serious harm to self or others or abuse from caregivers with those they serve.

Certified Peer Support Specialists will respect the rights and dignity of those they serve and shall not force any values or beliefs onto the person engaging in services.

Certified Peer Support Specialists will not engage in sexual or intimate relationships with individuals they serve, their relatives or others with whom they maintain a close personal relationship with.

Certified Peer Support Specialists will avoid relationships that conflict or create risk of harm in the best interest of individuals they serve. When dual relationships are unavoidable, it is the responsibility of the Certified Peer Support Specialist to seek supervisory consultation.

Certified Peer Support Specialists will not give, lend, borrow and/or accept gifts, of significant value, including financial transactions, from persons they serve.

Certified Peer Support Specialists will conduct themselves in a manner that fosters their own recovery and recognize the many ways in which they may influence peers and others in the community, as they serve as a role model.

Certified Peer Support Specialists will share relevant parts of their recovery story to provide hope at a time when it is beneficial to the person served.

Certified Peer Support Specialists will provide strength-based services acknowledging that every person has skills, gifts, and talents they can use to better their lives.

Certified Peer Support Specialists will provide support for those they serve through all stages of recovery.

Updated 2021

Exhibit B

Michigan Certified Peer Recovery Coach Code of Ethics

March 2022

Certified Peer Recovery Coaches (CPRC), as professionals, who are credentialed by the State of Michigan acknowledge and agree to follow the code of ethics. The standards listed below will direct CPRCs as they function in their roles in providing recovery support services with the persons they serve.

1. **Peer Recovery Coaches** will actively pursue recovery in their own lives as well as role model recovery for others.
2. **Peer Recovery Coaches** will assist and advocate for the persons they serve in achieving their needs, personal pursuits, and self-directed goals.
3. **Peer Recovery Coaches** will advocate for and support all pathways to and of recovery.
4. **Peer Recovery Coaches** will intentionally value and actively implement diversity, equity, and inclusion.
5. **Peer Recovery Coaches** will not practice, condone, facilitate, or collaborate in any form of discrimination based on ethnicity, race, sex, sexual orientation, gender identity, age, religion, national origin, marital status, political belief, disability, or any other preference or personal characteristic, or condition.
6. **Peer Recovery Coaches** will not pursue or engage in sexual or intimate relationships through the use of technology or in-person with individuals they serve, their relatives or others with whom they maintain a close personal relationship with.
7. **Peer Recovery Coaches** will respect the privacy of those they serve and will abide by confidentiality as required by state and federal law.
8. **Peer Recovery Coaches** will not give, lend, borrow and/or accept gifts, of significant value, or personal favors of any kind, from persons they serve.
9. **Peer Recovery Coaches** will improve their knowledge and skills of recovery services through ongoing education and trainings.
10. **Peer Recovery Coaches** will share their lived experiences to inspire hope, encourage change, and assist to identify resources and supports that promote recovery.

CORE COMPETENCIES FOR PEER WORKERS IN BEHAVIORAL HEALTH SERVICES

Category I: Engages peers in collaborative and caring relationships

This category of competencies emphasized peer workers' ability to initiate and develop ongoing relationships with people who have behavioral health condition and/or family members. These competencies include interpersonal skills, knowledge about recovery from behavioral health conditions and attitudes consistent with a recovery orientation.

1. Initiates contact with peers
2. Listens to peers with careful attention to the content and emotion being communicated
3. Reaches out to engage peers across the whole continuum of the recovery process
4. Demonstrates genuine acceptance and respect
5. Demonstrates understanding of peers' experiences and feelings

Category II: Provides support

The competencies in this category are critical for the peer worker to be able to provide the mutual support people living with behavioral health conditions may want.

1. Validates peers' experiences and feelings
2. Encourages the exploration and pursuit of community roles
3. Conveys hope to peers about their own recovery
4. Celebrates peers' efforts and accomplishments
5. Provides concrete assistance to help peers accomplish tasks and goals

Category III: Shares lived experiences of recovery

These competencies are unique to peer support, as most roles in behavioral health services do not emphasize or even prohibit the sharing of lived experiences. Peer workers need to be skillful in telling their recovery stories and using their lived experiences as a way of inspiring and supporting a person living with behavioral health conditions. Family peer support worker likewise share their personal experiences of self-care and supporting a family-member who is living with behavioral health conditions.

1. Relates their own recovery stories, and with permission, the recovery stories of others' to inspire hope
2. Discusses ongoing personal efforts to enhance health, wellness, and recovery
3. Recognizes when to share experiences and when to listen
4. Describes personal recovery practices and helps peers discover recovery practices that work for them

Category IV: Personalizes peer support

These competencies help peer workers to tailor or individualize the support services provided to and with a peer. By personalizing peer support, the peer worker operationalizes the notion that there are multiple pathways to recovery.

1. Understands his/her own personal values and culture and how these may contribute to biases, judgments and beliefs
2. Appreciates and respects the cultural and spiritual beliefs and practices of peers and their families
3. Recognizes and responds to the complexities and uniqueness of each peer's process of recovery
4. Tailors services and support to meet the preferences and unique needs of peers and their families

Category V: Supports recovery planning

These competencies enable peer workers to support other peers to take charge of their lives. Recovery often leads people to want to make changes in their lives. Recovery planning assists people to set and accomplish goals related to home, work, community and health.

1. Assists and supports peers to set goals and to dream of future possibilities
2. Proposes strategies to help a peer accomplish tasks or goals
3. Supports peers to use decision-making strategies when choosing services and supports
4. Helps peers to function as a member of their treatment/recovery support team
5. Researches and identifies credible information and options from various resources

Category VI: Links to resources, services, and supports

These competencies assist peer workers to help other peers acquire the resources, services, and supports they need to enhance their recovery. Peer workers apply these competencies to assist other peers to link to resources or services both within behavioral health settings and in the community. It is critical that peer workers have knowledge of resources within their communities as well as on-line resources.

1. Develops and maintains up-to-date information about community resources and services
2. Assists peers to investigate, select, and use needed and desired resources and services
3. Helps peers to find and use health services and supports
4. Accompanies peers to community activities and appointments when requested
5. Participates in community activities with peers when requested

Category VII: Provides information about skills related to health, wellness, and recovery

These competencies describe how peer workers coach, model or provide information about skills that enhance recovery. These competencies recognize that peer workers have knowledge, skills and experiences to offer others in recovery and that the recovery process often involves learning and growth.

1. Educates peers about health, wellness, recovery and recovery supports
2. Participates with peers in discovery or co-learning to enhance recovery experiences
3. Coaches peers about how to access treatment and services and navigate systems of care
4. Coaches peers in desired skills and strategies
5. Educates family members and other supportive individuals about recovery and recovery supports
6. Uses approaches that match the preferences and needs of peers

Category VIII: Helps peers to manage crises

These competencies assist peer workers to identify potential risks and to use procedures that reduce risks to peers and others. Peer workers may have to manage situations, in which there is intense distress and work to ensure the safety and well-being of themselves and other peers.

1. Recognizes signs of distress and threats to safety among peers and in their environments
2. Provides reassurance to peers in distress
3. Strives to create safe spaces when meeting with peers
4. Takes action to address distress or a crisis by using knowledge of local resources, treatment, services, and support preferences of peers
5. Assists peers in developing advance directives and other crisis prevention tools

Category IX: Values communication

These competencies provide guidance on how peer workers interact verbally and in writing with colleagues and others. These competencies suggest language and processes used to communicate and reflect the value of respect.

1. Uses respectful, person-centered, recovery-oriented language in written and verbal interactions with peers, family members, community members, and others
2. Uses active listening skills
3. Clarifies their understanding of information when in doubt of the meaning
4. Conveys their point of view when working with colleagues
5. Documents information as required by program policies and procedures

6. Follows laws and rules concerning confidentiality and respects others' rights for privacy

Category X: Supports collaboration and teamwork

These competencies provide direction on how peer workers can develop and maintain effective relationships with colleagues and others to enhance the peer support provided. These competencies involve not only interpersonal skills but also organizational skills.

1. Works together with other colleagues to enhance the provision of services and supports
2. Assertively engages providers from mental health services, addiction services, and physical medicine to meet the needs of peers
3. Coordinates efforts with health care providers to enhance the health and wellness of peers
4. Coordinates efforts with peers' family members and other natural supports
5. Partners with community members and organizations to strengthen opportunities for peers
6. Strives to resolve conflicts in relationships with peers and others in their support network

Category XI: Promotes leadership and advocacy

These competencies describe actions that peer workers use to provide leadership within behavioral health programs to advance a recovery-oriented mission of the services. They also guide peer workers on how to advocate for the legal and human rights of other peers.

1. Uses knowledge of relevant rights and laws (ADA, HIPAA, Olmstead, etc.) to ensure that peer's rights are respected
2. Advocates for the needs and desires of peers in treatment team meetings, community services, living situations, and with family
3. Uses knowledge of legal resources and advocacy organization to build an advocacy plan
4. Participates in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families
5. Educates colleagues about the process of recovery and the use of recovery support services
6. Actively participates in efforts to improve the organization
7. Maintains a positive reputation in peer/professional communities

Category XII: Promotes growth and development

These competencies describe how peer workers become more reflective and competent in their practice. The competencies recommend specific actions that may serve to increase

peer workers' success and satisfaction in their current roles and contribute to career advancement.

1. Recognizes the limits of their knowledge and seeks assistance from others when needed
2. Uses supervision (mentoring, reflection) effectively by monitoring self and relationships, preparing for meetings and engaging in problem-solving strategies with the supervisor (mentor, peer)
3. Reflects and examines own personal motivations, judgments, and feelings that may be activated by the peer work, recognizing signs of distress, and knowing when to seek support
4. Seeks opportunities to increase knowledge and skills of peer support

Exhibit D

Name of Peer Service	Youth Peer Support	Parent Support Partner	Mental Health Peer Specialist	Peer Recovery Coach	Peer Mentor (provided by a DD mentor)
Target Population	Youth with a Serious Emotional Disturbance	Parents or caregivers of a child with a Serious Emotional Disturbance or Intellectual or Developmental Disability	Individuals receiving mental health services and supports	Individuals receiving substance use services or co-occurring services	Individuals with intellectual/developmental disabilities
Training Requirements and Certification process	Youth Peer Support provided by a trained youth peer using the MDHHS-endorsed curriculum (can report after completion of initial 3 days of core training but must continue certification process)	Parent-to-parent support provided by a trained parent using the MDHHS-endorsed curriculum (can report after completion of initial 3 days of core training but must continue certification process)	Outlined in Medicaid provider manual. Person must be working at least 10 hours a week in a position described as peer support. Training is 5 days. Once successfully completes the requirements can use the H0038 code with an HE modifier for different codes based on description of activity/description in Medicaid	Outlined in MSA Bulletin 22-01. Peer Recovery Coach certification training provided by MDHHS including passing a certification exam.	There is no training requirement/certification to use the H0046 code. The DD Council's Peer Mentor program requires individuals to attend Peer Mentoring 101, complete a 90-120 hour internship at a CMHSP, and complete an exit interview for certification. Once certified, the H0046 code can be used.

Name of Peer Service	Youth Peer Support	Parent Support Partner	Mental Health Peer Specialist	Peer Recovery Coach	Peer Mentor (provided by a DD mentor)
			provider manual		
Training Structure	Statewide Coordinator and Lead Trainer – MDHHS contract with ACMH	Statewide Coordinator and Lead Trainer – MDHHS contract with ACMH	Overseen by MDHHS and National peer trainers provide training	Statewide Coordinator and Lead Trainer – MDHHS contract with CMHAM	Michigan Developmental Disabilities curriculum and training lead by Certified Peer Mentors

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Cognitive-Behavior Therapy (CBT)	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.03.09.16
Effective Date: 6/4/14	Date of Review/Revision: 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, 2/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team
	Supersedes: 02.03.20	
		

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 persons served 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.
 - ii. For supervisors who do not presently have an active caseload, additional CBT training will be accepted.
 - d. All clinicians who provide psychotherapy to individuals aged 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 persons served' problems and an individual conceptualization of each person served 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 person served to be his or her own therapist and emphasizes relapse prevention that includes teaching the person served 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 persons served to identify, evaluate, and respond to their dysfunctional thoughts and beliefs.
 - 7. CBT is goal-oriented and problem-focused – the person served is helped to enumerate his or her problems and set specific behavioral goals; both the therapist and person served have a shared understanding of what the person served is working toward.
 - 8. CBT places emphasis on collaboration and active participation; therapy is teamwork and includes homework assignments for the person served.
 - 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

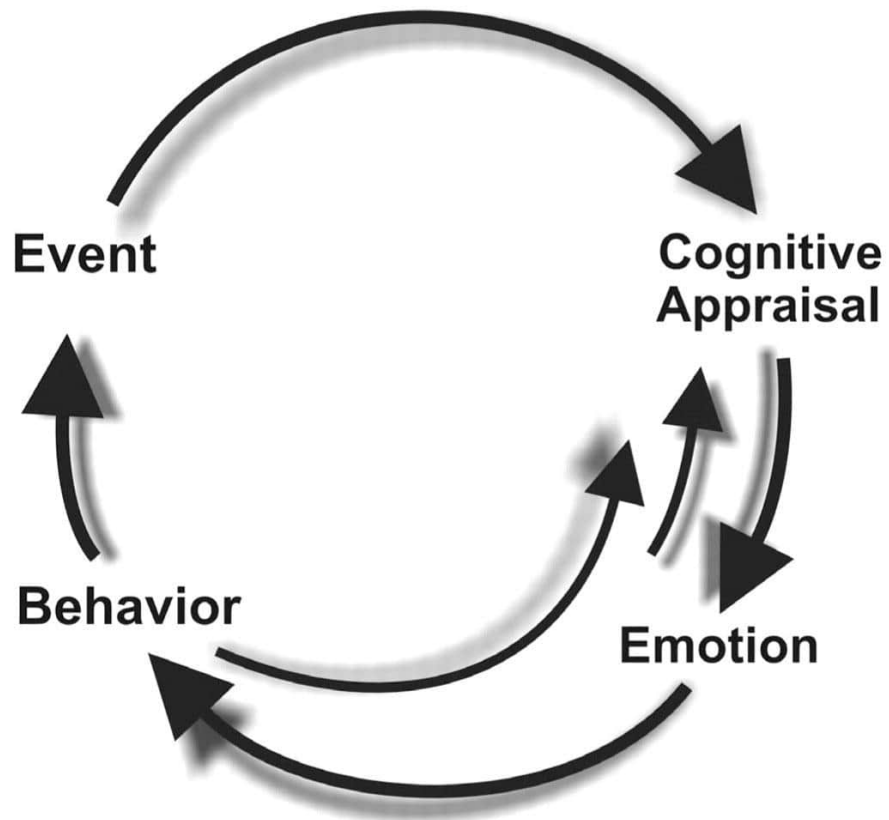
Exhibit A

Examples of CBT Methods
Socratic Questioning: Questioning that allows the therapist to stimulate the person served's self-awareness, focus in on the problem definition, expose the person served's belief system, and challenge irrational beliefs while revealing the person served's cognitive processes.
Guided Discovery: A technique is to help persons served 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. Persons served are offered the necessary assistance and guidance to understand how they process information. It allows persons served to alter the way they process information to change the person served's perception and outlook. A change in perception enables the person served 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 person served become aware of their automatic thoughts and resulting emotions the therapist may role play different situations with the person served, 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 persons served to effectively acquire novel behaviors through observation, especially if they can try out the target behavior. In cognitive rehearsal, the person served imagines a difficult situation and the therapist guides them through the step-by-step process of facing and successfully dealing with it. The person served then works on practicing, or rehearsing, these steps mentally.
Activity and pleasant event scheduling: Commonly used to help persons served 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 step-wise management plan is developed, are used to assist persons served 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:

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Mental Health First Aid (MHFA)	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.17
Effective Date: 1/1/14	Date of Review/Revision: 6/9/17, 6/1/18, 5/23/19, 10/21/19, 5/26/20, 4/14/21, 1/12/22, 6/11/24, 3/24/25, 3/24/26	Approved By: Sandra M. Lindsey, CEO
	Supersedes: 02.03.22	Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services
		Authored By: Jennifer Keilitz Additional Reviewers: Alecia Schabel, EBP Leadership Team

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) 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 training.

Standards:

SCCMHA shall sponsor virtual MHFA 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. SCCMHA can also sponsor blended, in-person MHFA training upon request.

- A. As long as SCCMHA has certified instructors, SCCMHA will promote 4 different modules of MHFA training: Adult, Youth, Military, Veterans and Their Families and Public Safety.
- 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 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 \$1,000 group rate for private MHFA training of 15 minimum and up to to 30 max 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 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 to identify 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
 - 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 separately for the different modules: adult, youth courses, Veterans and Public Safety. Instructors who want to teach an additional 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 annually (3) as well as any additional trainings at the request of SCCMHA Leadership.
 - a. Instructors agree to provide training dates to Continuing Education Unit (CEU) as requested.
 - b. Courses are encouraged to be taught by 2 instructors, but MHFA allows 1 instructor to teach on their own. 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. If an in-person training is requested, in-person training will be taught as a blended format: Instructors/coordinator is to ensure each participant completes modules 1 in the MHFA Connect database 48 business before the instructor-led training starts. The sign in/sign out must be submitted to CEU front office in order for participants to receive their MHFA credit.
 - i. Live Training Only: Ensuring participants review the MHFA Connect Instructions – AFTER TRAINING document within the packet: This is how participants will complete their MHFA quiz, evaluation (the one directly from National MHFA), and this is also how they receive their certificate. (on the website here: [Log in | MHFA \(mentalhealthfirstaid.org\)](https://www.mentalhealthfirstaid.org))

- ii. The trainer is responsible for supporting participants with any follow up needed.
 - c. Virtual Training: instructors will maintain communication with the MHFA Coordinator regarding any First Aiders who have not completed their pre-work 48 business hours prior to the start of the instructor led virtual course.
 - d. Virtual Training: instructors will complete and pass First Aiders within the MHFA Connect System upon successful completion, within 24 hours business hours. However, recommended to be completed same day immediately upon course completion.
 - e. Instructors will support First Aiders with training follow up if needed: quiz, evaluation completion, and certificate.
- J. MHFA participants will successfully complete a 5.5-6.5 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 48 business hours 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 a 5.5-6.5 hour 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	SCCMHA Service Management Team & Director of Network Services, Public Policy, Continuing Education, OBRA/ PASARR, & Enhanced Health Services

health first aid, including youth and adult curriculums.	
SCCMHA Website and Facebook Marketing: CEU maintain an electronic distribution list and will ensure the appropriate contacts have material for community marketing.	SCCMHA Public Relations Specialist and SCCMHA Continuing Education Supervisor
Registration Management: SCCMHA CEU ensures proper First Aider registration and ensures collection of participant fees for MHFA Training.	SCCMHA Continuing Education Unit Staff
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 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: 6/10/2020	Date of Review/Revision: 3/10/21, 1/12/22, 1/10/23, 1/31/24, 3/28/25, 3/16/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus Additional Reviewers: Jennifer Stanuszek, EBP Leadership Team
	Supersedes:	
		

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 person served 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://child-parentpsychotherapy.com/>
- C. CPP Fidelity Forms. [Fidelity – Child-Parent Psychotherapy](#)
- 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



CPP SUPERVISION FIDELITY

v.07.2023
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	☐	☐	☐	☐

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Page 1 of 3

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) 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):

Date	# supervisees in supervision (Individual-1)	Minutes	% time clinical versus administrative	Counter	Optional Notes

[illegible]

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Infant Mental Health- Home Visiting (IMH-HV)	Chapter: 02.03 – Philosophy of Care	Subject No: 02.03.09.19
Effective Date: April 10, 2024	Date of Review/Revision: 03/28/25, 03/16/26	Approved By: Sandra M. Lindsey, CEO
	Supersedes:	
		Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus Additional Reviewers: EBP Leadership Team, Jennifer Stanuszek

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 \(cebc4cw.org\)](https://cebc4cw.org/Program/TheMichiganModelOfInfantMentalHealthHomeVisiting)
- B. Michigan Association for Infant Mental Health, [Michigan Association for Infant Mental Health \(mi-aimh.org\)](https://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

Policy and Procedure Manual 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, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team
	Supersedes: 02.03.30	
		

Purpose:

The purpose of this policy is to specify and promote the use of Picture Exchange Communication System (PECS) for persons served 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 persons served 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 persons served 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 persons served 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 person served.
 - a. As the person served reaches for the desired object, the facilitator shall provide assistance in picking up a picture for the desired object or food item.
 - b. The person served shall be given physical assistance to give the picture to the message receiver who must be within close physical proximity to the person served.
 - 1). Two trainers shall be utilized, one of whom shall function as the person served's communicative partner, and the other as the physical prompter, who will prompt the person served 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 person served's independence. The person served 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 person served shall be encouraged to be responsible for carrying their own communication book.
 - 4. Phase III – Discrimination Between Symbols (Picture Discrimination): During this phase, the person served 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 person served 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 person served 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 person served 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 person served 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 persons served 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 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: 6/13/17	Date of Review/Revision: 4/10/18, 4/9/19, 3/4/20, 07/29/20, 3/10/21, 1/12/22, 1/10/23, 1/31/24, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team, Debbie Jones-Burt
	Supersedes: 02.03.32 and 02.03.06 – Housing Best Practice	
		

Purpose:

The purpose of this policy is to articulate standards for the provision of housing-related services and supports to persons 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 persons served 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 persons served 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 persons served to live in the most integrated setting possible with accessible, individualized supports.
- B. persons served' 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 person served-directed.
 - 2. Case holders and others who are working with the person served shall strive to elicit the person served'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. persons served shall be offered choice of housing that adheres to the following principles:
 - 1. Functional separation of housing and services¹.
 - a. persons served shall have rights of tenancy.
 - 1). persons served 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). persons served 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. persons served 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. persons served 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.

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.)

5. Flexible, voluntary, and recovery-focused services.
 - a. persons served 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 person served 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. person served 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 \(HUD\)](https://www.hud.gov/ud/section8/hqs)
- 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](https://www.dmh.mo.gov/achieving-the-promise)
- 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	$\frac{1.1.a + 1.1.b + 1.1.c + 1.2.a}{4 \text{ items}} = \text{average score for dimension}$	
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	$\frac{2.1.a + 2.1.b + 2.1.c}{3 \text{ items}} = \text{average score for dimension}$	
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	$\frac{3.1.a + 3.2.a}{2 \text{ items}} = \text{average score for dimension}$	
4. Housing integration	4.1: Housing Integration		
	4.1.a: Integration		
	Dimension Subtotal	4.1.a. 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	$\frac{5.1.a + 5.1.b}{2 \text{ items}} = \text{average score for dimension}$	

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	$\frac{6.1.a + 6.1.b + 6.2.a}{3 \text{ items}} = \text{average score for dimension}$	
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	$\frac{7.1.a + 7.1.b + 7.2.a + 7.2.b + 7.3.a + 7.4.a + 7.4.b + 7.4.c}{8 \text{ items}} = \text{average score for dimension}$	

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 spaces. 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. (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?		

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Seeking Safety	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.25
Effective Date: 6/13/17	Date of Review/Revision: 4/10/18, 4/9/19, 3/4/20, 4/14/21, 1/12/22, 1/10/23, 1/31/24, 2/12/25, 2/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
	Supersedes: 02.03.33	
		Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team

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 persons served 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 persons served 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 person served(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 person served's treatment.
- D. Providers shall also focus on engaging persons served 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/or 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 MichiCANS 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 This topic covers: (a) Introduction to the treatment; (b) Getting to know the patient; and (c) Assessment of case management needs.
(2) Safety (combination) 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 <i>Safe Coping Skills</i> is provided, and patients explore what safety means to them.
(3) PTSD: Taking Back Your Power (cognitive) 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) 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) 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) 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) 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) 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) 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 <i>Safety Plan</i> is developed to identify what to do in situations of mild, moderate, and severe relapse danger.
(10) Honesty (interpersonal) 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) 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 <i>List Your</i>

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 <i>(cognitive)</i> 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 <i>(behavioral)</i> 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 <i>(cognitive)</i> Meaning systems are discussed with a focus on assumptions specific to PTSD and substance abuse, such as <i>Deprivation Reasoning</i> , <i>Actions Speak Louder Than Words</i> , and <i>Time Warp</i> . Meanings that are harmful versus healing in recovery are contrasted.
(15) Community Resources <i>(interpersonal)</i> 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 <i>(interpersonal)</i> 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 <i>(cognitive)</i> 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 <i>Ask Others</i> , <i>Try It and See</i> , <i>Predict</i> , and <i>Act "As If"</i> . Suggestions for coping with negative feedback are provided.
(18) Getting Others to Support Your Recovery <i>(interpersonal)</i> 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 <i>(behavioral)</i> Patients are encouraged to actively fight triggers of PTSD and substance abuse. A simple three-step model is offered: change <i>who</i> you are with, <i>what</i> you are doing, and <i>where</i> you are (similar to "change people, places, and things" in AA).
(20) Respecting Your Time <i>(behavioral)</i> 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 <i>(interpersonal)</i> 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 (<i>behavioral</i>) 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 (<i>interpersonal</i>) 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 (<i>combination</i>) 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 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])

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Beyond Trauma: A Healing Journey for Women	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.26
Effective Date: 8/29/2024	Date of Review/Revision: 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO
	Supersedes:	
		Responsible Director: Director of Network Ser- vices, Public Policy, Con- tinuing Education, OBRA/PASARR and En- hanced Health Services Authored By: Mary Baukus Additional Reviewers: Brittany Burton, EBP Leadership Team

Purpose:

The purpose of this policy is to specify the use of Beyond Trauma: A Healing Journey for Women.

Policy:

- A. SCCMHA recognizes that the experience of trauma is the rule rather than the exception among persons served by the public mental health system.
- B. Persons served 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 Beyond Trauma: A Healing Journey for Women for women or nonbinary individuals who have experienced trauma and are being served by SCCMHA-funded providers.
- D. Beyond Trauma: A Healing Journey for Women can be delivered face-to-face, in-person, or via telehealth technology.

Application:

This policy applies to the SCCMHA-funded provider network.

Standards:

- A. Beyond Trauma: A Healing Journey for Women groups shall be offered to women or nonbinary person served 18+ who have a history of sexual, physical, and/or emotional abuse.

- B. Beyond Trauma shall be provided by female clinical members of the SCCMHA provider network who have completed SCCMHA-approved training and have been privileged to provide Beyond Trauma in accordance with SCCMHA policy.
- C. Beyond Trauma shall be delivered by one or more facilitators who meet the following qualifications:
 - a. A master's degree or higher in the mental health field
 - b. Professional licensure (limited or full licensure)
 - c. One two-day training of in-person Beyond Trauma: A Healing Journey for Women (or the live virtual equivalent).
 - d. Annual clinical training on topics such as a specific *Beyond Trauma* refresher, or more general clinical training in trauma, cognitive behavioral therapy, relational therapy, and/or mindfulness of at least six hours in total.
- D. Beyond Trauma: A Healing Journey for Women shall be delivered in accordance with fidelity to the model.
- 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/or the Director of Network Services, Public Policy, & Continuing Education will facilitate quarterly meetings for Supervisors of EBP Teams, including Beyond Trauma: A Healing Journey for Women when appropriate, to discuss fidelity monitoring.
- F. When Beyond Trauma: A Healing Journey for Women is actively being offered, the Adult Strengths and Needs Assessment (ANSA) will be used as a tool to examine outcomes with reports reviewed up to twice per year (or as is appropriate for how frequently Beyond Trauma: A Healing Journey for Women is occurring) for Beyond Trauma: A Healing Journey for Women participants.
- G. Beyond Trauma: A Healing Journey for Women is conducted in the following manner:
 - 1. Beyond Trauma: A Healing Journey for Women shall be conducted by one female leader or two female co-leaders, in once weekly 90-minute group sessions for twelve weeks.
 - 2. It is manual based with a facilitator's guide and participant workbook.
 - 3. The group consists of the following session topics:
 - a) Introduction to the program
 - b) The Connections between violence, abuse, and trauma
 - c) Power and abuse
 - d) The process of trauma and reactions to trauma
 - e) How trauma affects our lives
 - f) Abuse and the family
 - g) The connection between trauma and addiction: Spirals of Recovery and healing
 - h) Grounding and self-soothing
 - i) The mind and the body connection
 - j) Our feelings
 - k) Healthy relationships
 - l) Endings and beginnings

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.

Beyond Trauma: A Healing Journey for Women: An evidence-based treatment for women who have experienced trauma. It consists of twelve sessions using cognitive-behavioral techniques, mindfulness, body-focused exercises, expressive arts, and the principles of relational therapy which are integrated in this strengths-based approach. The curriculum also has a psychoeducation component that teaches women what trauma is, its process, and its impact on both the inner self (thoughts, beliefs, values) and the outer self (behavior and relationships, including parenting). (*Stephanie S. Covington, PhD, 2024*)

References:

- A. Covington, S. S. (2016). Beyond Trauma Facilitator Guide. Hazelden Information & Educational Services.
- B. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- C. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
- D. SCCMHA Policy 04.01.04 – Trauma Screening, Assessment, and Treatment Services

Exhibits:

None

Procedure:

Refer to Evidence-Based Practices procedure.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.27
Effective Date: 6/13/17	Date of Review/Revision: 4/10/18, 4/9/19, 2/7/20, 6/14/20, 4/14/21, 1/12/22, 1/10/23, 1/31/24, 3/28/25, 3/16/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
	Supersedes: 02.03.37	
		Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team

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 persons served 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 (until 19th birthday) 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 person served during the course of twelve to twenty-five sessions and inclusive of the core components (which are summarized by the acronym PRAC-TICE) 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 Person served 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. MichiCANS comprehensive- Organizations will complete this tool without additional notes or descriptions of specific traumas.

ii. UCLA PTSD assessment (or YCPC for younger children under 7)- All TF-CBT clinicians will submit for scanning: pre, mid and post UCLA PTSD Symptom Analysis (stop-light 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/or 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. Age specific trauma assessments (UCLA, YCPC), and/or the Mich-iCANS will be used as tools 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: ([How to Implement Trauma-Focused Cognitive Behavioral Therapy \(TF-CBT Implementation Manual\) | The National Child Traumatic Stress Network](#))
- B. Feldman & Dorsey. (2010). *TF-CBT PRACTICE Checklist* (University of Washington): [TF-CBT Brief Practice Checklist - TF-CBT Certification Program](#)
- 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 – Person served 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

Organizational Readiness and Capacity Assessment^{1,2}						
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 <u>true</u> 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

	Not at all	To a slight extent	To a moderate extent	To a large extent	Consistently
Circle the number that corresponds to how <u>true</u> each statement is with respect to current conditions and practices at your agency.					
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., Putham, 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 <u>symptoms</u> and trauma reminders GE: Identify trauma triggers; use proper words for traumas and body parts											
P: Provide parenting skills (praise, selective attention, time out, contingency reinforcement) GE: connect parental response and youth's behavior problems to trauma											
R: Provide individualized relaxation skills GE: Connect use of relaxation skills to youth's trauma reminders											
A: Provide affect identification and modulation skills GE: Connect use of skills to youth's trauma reminders											
C: Introduce cognitive triangle; encourage more accurate/helpful thoughts GE: Help PARENT use cognitive coping for trauma related maladaptive thoughts											
T: Develop youth's trauma narrative in calibrated increments with thoughts, <u>feelings</u> and worst moments. Cognitively process maladaptive cognitions. Share with parent as TN is developed GE: Re-read the TN at the beginning of <i>each</i> 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 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 GE: Address safety skills related to youth's trauma											
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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 <u>symptoms</u> and trauma reminders GE: identify trauma triggers, use proper words for traumas and body parts											
P: Provide parenting skills (praise, selective attention, time out, contingency Reinforcement) GE: connect parental response and youth's behavior problems to trauma											
R: Provide individualized relaxation skills GE: Connect use of relaxation skills to youth's trauma reminders											
A: Provide affect identification and modulation skills GE: Connect use of skills to youth's trauma reminders											
C: Introduce cognitive triangle; encourage more accurate/helpful thoughts 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 GE: Re-read the TN at the beginning of <i>each</i> session											
I: GE: Develop in-vivo desensitization plan for generalized avoidant behaviors											
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E: Address personal safety skills and assertive communication; increase awareness of problem-solving skills and/or social skills GE: Address safety skills related to youth's trauma											
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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])

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Whole Health Action Management (WHAM)	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.28
Effective Date: 6/13/17	Date of Review/Revision: 4/10/18, 4/9/19, 3/11/20, 4/14/21, 1/12/22, 1/10/23, 1/31/24, 2/12/25, 2/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
	Supersedes: 02.03.39	
		Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team

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 persons served 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 persons served 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 persons served' 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 persons served 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 SAM-HSA-HRSA Center for Integrated Health Solutions (CIHS). WHAM is an integrated health approach that is designed to help persons served 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_for-mat_research_intervention_facilitator_manual_uic_study.pdf
WHAM Peer Support Training Participant Guide (SAMHSA-HRSA, 2015):
[wham_participant_guide.pdf \(kff.org\)](https://www.kff.org/wham/participant-guide/)

Exhibits:

None

Procedure:

None

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: NADA Auricular Acupuncture Protocol	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.29
Effective Date: 4/10/18	Date of Review/Revision: 3/12/20, 4/14/21, 3/9/22, 3/8/2, 3/15/24, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
	Supersedes: 03.02.36	
		Authored By: Mary Baukus Additional Reviewers: SCCMHA Evidence-Based Practices Leadership Team

Purpose:

The purpose of this policy is to delineate a framework for the use of the National Acupuncture Detoxification Association (NADA) auricular acupuncture protocol.

Application:

This policy applies to SCCMHA-funded providers who are privileged to deliver auricular acupuncture. NADA is based on the utilization of both East Asian medicine and Western substance misuse and behavioral health models to bring significant benefit to persons in recovery from substance misuse and a variety of mental disorders. The NADA protocol is a simplified, standardized ear needling technique derived from medical acupuncture. The NADA adaptation has been meticulously developed and tested to assist consumers in their recovery for both severe trauma and substance misuse when talk therapy is limited.

Policy:

SCCMHA shall make the NADA auricular acupuncture protocol available to eligible consumers as resources permit.

Standards:

- A. NADA auricular acupuncture shall be applied to consenting adult consumers with a mental health and/or co-occurring substance use disorder by providers who have received SCCMHA-approved training and have been privileged to use this protocol.

- B. NADA auricular acupuncture shall be incorporated as part of an integrated program rather than as a stand-alone intervention.
 - 1. NADA auricular acupuncture shall be utilized to help consumers with relaxation, stress management and craving or desire for addictive substances. NADA auricular acupuncture opens possibilities on the body, mind, and spiritual levels. The effects of NADA auricular protocol are immediate and tangible and tends to increase the consumer's motivation and readiness to be involved in the recovery process.
- C. NADA auricular acupuncture can be administered in a small or a large group format in a quiet, comfortable room.
- D. NADA auricular acupuncture shall be provided in accordance with the standard protocol to maintain fidelity to the model.
 - 1. One to five acupuncture needles shall be inserted bilaterally into predetermined points on each ear (auricle) for 30 to 45 minutes per session.
 - a. These predetermined points (sympathetic, Shen Men, kidney, liver, and lung) have been shown to produce neurophysiologic, biochemical, endocrine, emotional, and cognitive effects. (See Exhibit A)

Definitions:

National Acupuncture Detoxification Association (NADA) Acupuncture Protocol is a non-verbal approach to healing. NADA involves the gentle placement of up to five, small, sterilized disposable needles into specific sites on each ear. It is a standardized 1- to 5-point auricular needling protocol that is delivered in a group setting as part of a treatment program for substance misuse as well as other behavioral health conditions (e.g., PTSD, depression, stress). The recipients sit quietly in a group setting for 30-45 minutes allowing the treatment to take effect. It can be applied in an individual setting as well. NADA ear acupuncture is an adjunct therapy which is clinically effective, cost-efficient, drug-free, and compatible cross-culturally. The combined application of acupuncture with counseling, education, medical support, and self-help groups such as AA and NA enhance opportunities for success.

References:

- A. Programs. National Acupuncture Detoxification Association. (n.d.-a). <https://acudetox.com/programs/>
- B. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- C. Training. National Acupuncture Detoxification Association. (n.d.-b). <https://acudetox.com/nada-training/?type=trainer&location=1620%2BHan-cock%2BSt%2C%2BSaginaw%2C%2BMI%2B48602%2C%2BUSA%3B43.42572%2C-83.97210%2C100&sort=nearby%2843.42572%2C-83.97210%29>

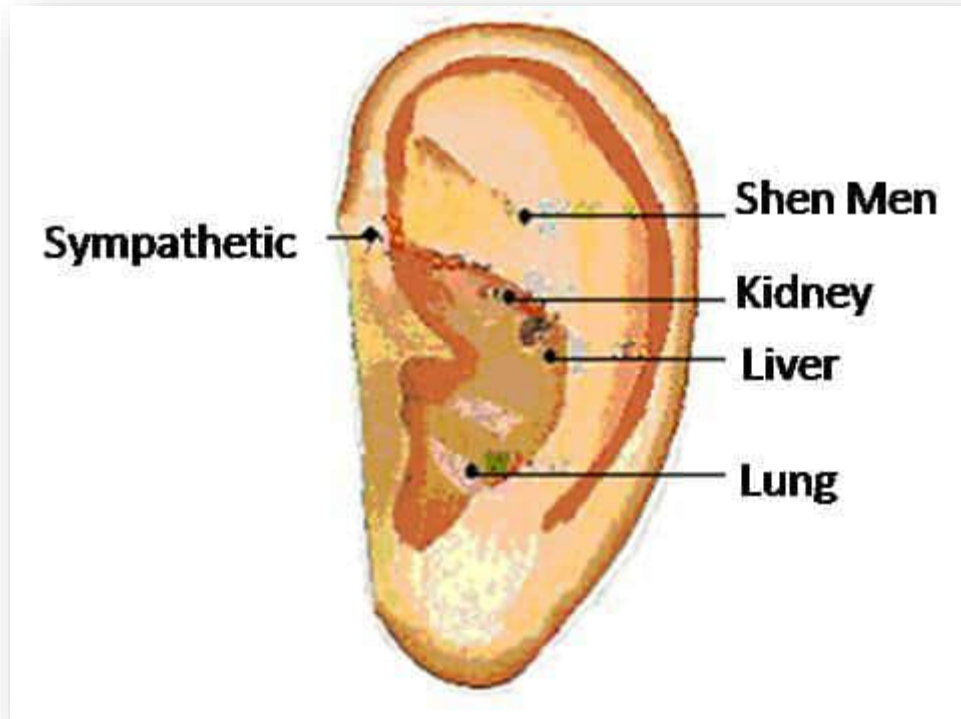
Exhibits:

A: NADA Auricular Acupuncture Protocol's Five Needle Points

Procedure:

None

Exhibit A



Number 1 — Sympathetic: Related to disruption in both sympathetic and parasympathetic nervous systems. It has a strong analgesic and relaxant effect on internal organs as it dilates blood vessels.

Number 2 — Shen Men: Regulates excitation and inhibition of the cerebral cortex and can produce sedation.

Number 3 — Kidney: Strengthening point that can relieve mental weariness, fatigue, and headaches.

Number 4 — Liver: Addresses symptoms associated with poor liver functioning and inflammation.

Number 5 — Lung: Associated with analgesia, sweating, and various respiratory conditions.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Motivational Interviewing (MI)	Chapter: 02 – Customer Service and Recipient Rights	Subject No: 02.03.09.30
Effective Date: 8/16/10	Date of Review/Revision: 4/2/12, 5/8/14, 4/19/16, 6/13/17, 4/10/18, 4/9/19, 7/2/20, 4/14/21, 3/9/22, 3/8/23, 3/15/24, 04/08/25, 03/16/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services Public Policy & Continuing Education
	Supersedes: 03.02.23	
		Authored By: Mary Baukus, Heidi Wale Knizacky Additional Reviewers: EBP Leadership Team

Purpose:

The purpose of this policy is to delineate a framework for the use of Motivational Interviewing (MI). With the use of MI, the aim is to improve the engagement of persons served and improve clinical outcomes.

Policy:

SCCMHA recognizes that behavioral changes are an integral part of health interventions and that ambivalence about committing to behavioral change is both typical and normal. SCCMHA is committed to providing welcoming, engaging, collaborative, empowering, and non-judgmental service environments and recognizes that Motivational Interviewing is an evidence-based approach to conversations that actualize these values. SCCMHA also recognizes that use of Motivational Interviewing increases effectiveness of collaboratively identifying behavioral change targets, eliciting, and strengthening commitment to healthy behaviors, and developing person-centered plans for change. It is therefore the policy of SCCMHA that Motivational Interviewing be used to guide conversations when engagement has not been established or is disrupted, and when the individual and/or their natural support system is in a pre-contemplative, contemplative, or preparatory stage of change relative to person-centered behavior changes. Motivational Interviewing (MI) is considered a core competency requirement for all staff who provide direct services to consumers within the SCCMHA network. MI shall be provided in a trauma informed manner.

Application:

This policy applies to all SCCMHA-funded providers.

Standards:

- A. SCCMHA-funded providers shall use Motivational Interviewing when:
 - 1. Screening and assessment information indicates that the individual receiving services engages in high-risk behaviors, including behaviors known to lead to the development of health problems or prevent optimal management of a chronic condition;
 - 2. The individual/family receiving services is uncertain about what their goals are, or are not confident they can achieve their goals;
 - 3. The individual/family persists with behavior that interferes with their own stated goals;
 - 4. There is poor engagement between the individual receiving services and the provider of the services (as evidenced by cancellations or otherwise being absent from service appointments (i.e., “no shows”), expressing dissatisfaction with services, failing to disclose relevant information, reduction in spontaneous communication, etc.); or
 - 5. Individuals identified within the IPOS as a support (paid or unpaid) to the individual receiving services are ambivalent about their role and commitment to the IPOS goals.
- B. To promote skillful integration of Motivational Interviewing into service delivery, direct-care staff must commit to the goal of accurately performing MI. Two foundational learning activities are minimum training requirements:
 - 1. Within the first three months of employment, complete a Motivational Interviewing introductory training from a training resource approved by the SCCMHA training department (minimum 13.5 hours).
 - a. SCCMHA shall, subject to available resources, offer a *Motivational Interviewing Basics* workshop.
 - 2. Complete the Virtual Assessment of Simulated Encounters – Revised (VASE-R), or other reliable basic skills assessment approved by the Evidence-Based Practices Leadership Team, within 10 days of completing introductory MI training and demonstrate at least ‘Beginning Proficiency’ (a total score of 70% or above).
 - a. If a minimum score of 70% is not achieved, staff must retake the assessment within 10 days of receiving their results.
 - b. If minimum proficiency is not demonstrated with the second assessment, staff must complete additional training and assessment. The training format may be either:
 - i. Re-take the introductory training course; or
 - ii. Take a one-day MI Refresher workshop.
 - 3. The exception to this requirement is mild to moderate outpatient psychotherapy providers for whom the two-step training is recommended but not required. In lieu of the two-step training for mild to moderate outpatient psychotherapy providers, they may take Motivational Interviewing modules 1-4 through Improving MI Practices.
- C. Network supervisors are expected to offer Motivational Interviewing coaching and support to the direct-care staff they supervise.

1. Supervisors of direct-care staff must themselves complete the foundational MI learning activities.
 2. Supervisors are expected to monitor and track staff completion of minimum MI training requirements.
 3. Supervisors will assist staff with identifying and addressing individual MI learning targets, including by directly providing or facilitating individual or group skill coaching.
 4. During consultations, supervisors will identify clinical situations for which Motivational Interviewing is the best-evidence intervention.
 5. Supervisors will be offered additional specialized support training and resources by SCCMHA.
- E. Motivational Interviewing shall be used with fidelity to the most current edition of the manual (i.e., Motivational Interviewing—4th edition: Helping People Change and Grow).
- F. Motivational Interviewing may be used concurrently with other evidence-based practices.

References:

- A. Miller, William R. & Rollnick, Stephen (2023). *Motivational Interviewing – 4th edition: Helping People Change and Grow*. Guilford Press. New York, NY.
- B. SCCMHA Policy 02.03.05 – Recovery
- C. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- D. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

Exhibits:

- A. SCCMHA Motivational Interviewing: Core Competency Expectations (and Attachment)

Procedure:

ACTION	RESPONSIBILITY
1. Motivational Interviewing is used to guide conversations with consumers when engagement has not been established or is disrupted, and when the consumer and/or their natural support system is in a pre-contemplative, contemplative, or preparatory stage of change relative to person-centered behavior changes.	1. SCCMHA Providers
2. Direct-service staff will complete Introduction to Motivational Interviewing training within 3 months of hire date.	2-4. SCCMHA Providers, SCCMHA Training Department, designated trainers
3. Direct-service staff will complete a basic skills assessment within 10 days of completing Introductory MI training.	

4. Direct-service staff who do not demonstrate minimum competency through standardized assessment will complete additional assessment and training until competency is demonstrated.	
5. Supervisors of direct-service staff will complete minimum MI training requirements.	5. SCCMHA Network Supervisors, SCCMHA Training Department, designated trainers
6. Supervisors will support staff with increasing MI skillfulness.	
7. Application of Motivational Interviewing will be coached during clinical consultations when appropriate.	6-7. SCCMHA Network Supervisors
8. Specialized supervisor training shall be offered through the SCCMHA Training Department.	8. SCCMHA Training Department

SCCMHA Motivational Interviewing: Core Competency Expectations

What does it mean that Motivational Interviewing is a ‘Core Competency Expectation’?

Motivational Interviewing (MI) is a skill set that translates the SCCMHA vision, “A belief in potential. A right to dream. An opportunity to achieve,” into action. Unlike the evidence-based practices (EBPs) used exclusively by therapists, MI is not used to diagnose or teach new skills. Instead, MI is a way of guiding a conversation to help a person who has not fully decided if they are ready and able to make a healthy change in their life.

Being listened to by someone who skillfully provides empathic responses that evoke further exploration of values, preferences, and abilities often increases the desire for—and strengthens commitment to—change. Empowering individuals to visualize their ideal future and offering support as a partner (not a director) in their change process is essential to delivering person-centered planning. Therefore, Motivational Interviewing is a fundamental job skill for all staff who provide direct care services within the SCCMHA Network.¹

How does one become competent in Motivational Interviewing?

A common adage describes Motivational Interviewing as “simple but not easy.” Although MI uses familiar techniques (such as reflections and open-ended questions), providing Motivational Interviewing is a complex skill. Becoming proficient in any complex skill—pickleball, playing the piano, driving a car—requires ongoing, disciplined practice guided by feedback and coaching. Each staff member is encouraged to work with their supervisor to build a personal learning plan to become proficient in MI.

To ensure minimum standards are met, direct care providers are required to accomplish two core learning activities:

1. Complete Motivational Interviewing basic training.
2. Demonstrate proficiency on the standardized skills assessment.

Some actions and resources that staff may wish to consider incorporating into their

¹ The exception is mild/moderate outpatient psychotherapy providers, for whom MI training is recommended but not required.

individual learning plan are:

- Review feedback reports from their VASE-R skills assessment and implement the coaching suggestions;
- Read the manual *Motivational Interviewing, Fourth Edition: Helping People Change and Grow* (Miller & Rollnick, 2023);
- Participate in group learning activities during team meetings (<https://www.apprecots.com/mi-sos-archive>);
- Attend advanced training and skills workshops offered by the SCCMHA training department;
- Review demonstration videos (<https://go.changecompanies.net/mi-samples#additionalvideos>);
- Complete virtual training modules (<https://improvingmipractices.org/>);
- Request 1:1 or team coaching sessions with an MI trainer (MI@apprecots.com);
- Complete a standardized patient demonstration/fidelity assessment (information at the end of this document);
and, especially,
- Practice Motivational Interviewing methods (such as talking less than the individual who is receiving services, avoiding the 'fix-it response,' using reflections as the primary response method, demonstrating empathy, proceeding in partnership, honing focus, and eliciting change talk) during every service conversation.

Completing the skills assessment

A basic understanding of Motivational Interviewing is assessed with the Virtual Assessment of Simulated Encounters – Revised (VASE-R), a standardized practice exercise that introduces the participant to characters who are experiencing ambivalence about making changes. Participants alternate between viewing recorded character statements and writing a response to the character. The exercise takes about 35 minutes and can be completed in person or virtually.

The VASE-R is an evidence-based assessment developed and revised through research methods; it has demonstrated acceptable validity and inter-rater reliability. After reviewing each response, a trainer creates a coaching report with feedback about proficiency levels, notes about demonstrated strengths, and suggestions for what to focus on for continued skill growth.

The VASE-R is included as an activity within the Motivational Interviewing basics workshop. If a staff member does not complete the VASE-R within their introduc-

tory training workshop, they must complete it within 10 business days of their training. The assessment may also be completed individually through survey-monkey.com/r/MI_Assessment. Other group administrations are offered through the SCCMHA training department or during team meetings (by the supervisor submitting a request to mi@apprecots.com).

A score of 70% or above indicates that basic proficiency in skills was demonstrated. If proficiency is not met, staff are encouraged to review the custom feedback, incorporate it into practice, and then continue measuring skill growth by attempting the assessment again. If proficiency is not reached after two attempts, an MI Refresher training must be completed. The Refresher training will identify challenges and assist with areas of improvement. The VASE-R will be offered again as part of the Refresher training.

How can you know if you are doing Motivational Interviewing correctly?

Competency in Motivational Interviewing means conversing in a way that adheres to the form and methods detailed in the Motivational Interviewing manual (known as ‘fidelity’). Unlike a test of general knowledge, a fidelity assessment measures how accurately someone shows what the practice looks like in action.

SCCMHA employees are encouraged (but not required) to practice and demonstrate their MI skills by scheduling a standardized patient conversation. To complete a demonstration, participants must choose a scenario from the options in Appendix A. They may then book a time to engage in a role-play with an MI training team member (via <https://calendar.app.google/rAiQUx5QpVAeaUQG6>).

Upon logging in to the appointment, participants will be greeted by an actor (an MI training team member) and invited to ask questions. When the participant is ready, the role-play will begin. The actor will portray the chosen client, and participants will use Motivational Interviewing to assist the “client” in increasing readiness and confidence for a healthful behavior change. The conversation will be recorded and used to generate a transcript.

Participants will have up to twenty minutes for the MI conversation. The actor will keep track of the time and announce when 2 minutes remain. The Planning task does not need to be demonstrated within the allotted time.

Afterward, the recording will be shared with the MI trainers, who will use the Motivational Interviewing Competency Assessment (MICA) to review the conversation for MI consistency. A trainer will score how consistently the participant met the criteria for MI proficiency in each of these essential MI skill areas:

- Strategically Responding to Sustain Talk,
- Strategically Responding to Change Talk,
- Partnership,
- Evoking,
- Guiding,
- Expressing Empathy, and
- Supporting Autonomy & Activation.

These areas are grouped into two categories (Strategies and Intentions), and an average score is generated for each. The category averages are added to create the Total MI Score; Total MI Scores of 7.5 (75%) or above indicate that the participant demonstrated Motivational Interviewing with sufficient fidelity. While these scores help illustrate a practitioner's understanding of MI, the narrative feedback provided by the trainer will give individual guidance to assist practitioners with better incorporating MI into their daily practice.

SCCMHA network members may use this practice/fidelity demonstration process as often as they wish and are encouraged to do so at least every two years to maintain skill levels.

Attachment A

Standardized Client Scenarios for Motivational Interviewing Practice

Note: Gender-neutral/non-binary personal pronouns are used in these descriptions to allow a variety of people to portray the same client. You are welcome to inquire about the actor's actual pronouns.

{1} Chris

Chris is an adult who suffers from severe depression and anxiety. They have not held a job in several years, although they have indicated they would like to have a part-time job someday. They spend most of their time alone in their apartment. Chris does not have a set schedule or routines and often misses appointments because (as Chris later reports) they were sleeping after being awake for most of the night. Chris's psychiatrist has advised that they practice good sleep hygiene habits and stick to a daily routine and schedule. You are about to meet with Chris.

{2} Xander's parent

The designated individual service recipient that you work with, Xander, is 4 years old and has a diagnosis of ASD (autism spectrum disorder). Xander doesn't have any func-

tional speech as he primarily moans, cries, and grunts. He is not successful with independent toileting tasks, and he spends hours each day lining his toys up into rows on his bedroom floor. He sleeps very little, and, on several occasions, he has left the house and wandered the neighborhood in the middle of the night. Xander is always “on the go” and will often hit, kick, or scream at adults who attempt to restrain or deny him. One of Xander’s parents works full-time, and the other is a homemaker who takes care of him, his 6-year-old sister, and his 2-year-old brother. Xander has qualified for the Autism Benefit with a recommendation of 20 hours each week of ABA services.

Xander’s parents have said they only want to sign up for three hours each week because they have too many other things to do with their time and have barriers to getting to the ABA program. Evidence-based research protocols suggest that this suboptimal dose (three hours instead of 20) is unlikely to be effective. You are about to meet with Xander’s parents.

{3} Pat

Pat has been participating in a skills group to learn how to control their impulsive behaviors when angry. You know that the group facilitator is very qualified and receives high satisfaction ratings from group participants. Participants tend to have good outcome changes (such as fewer conflicts in relationships) after they complete the group. Pat has told you that they think the group wastes their time and that all going does is make them angry. You are about to meet with Pat.

{4} Sally’s Guardian

The individual you work with, Sally, is a 24-year-old woman with an intellectual disability. Sally has told you that she would like to move out of her highly supervised adult foster-care home and into an apartment with a roommate. She has identified that another consumer at the AFC home where she currently lives would like to do this with her. This is a financially plausible arrangement, and, if she were to participate in Self Determination services, she and her roommate would be able to hire community living support (CLS) staff to assist with activities of daily living (ADL’s). This living arrangement would help Sally achieve her goals related to increasing independence.

Sally’s legal guardian is her parent. Her parent likes the AFC home where Sally lives. When she was younger and in school, Sally was eager to make friends and was often taken advantage of by peers (such as by giving away possessions to get people to like

her). Sally's parent credits the strict structure and supervision of the AFC home with protecting her from being exploited. You are about to meet with Sally's parent.

{5} Alex

Alex is a 47-year-old who was diagnosed with type 2 diabetes 6 months ago. Alex's doctor prescribed Metformin 500mg twice daily with meals and 2.5 mg Glipizide each morning, half an hour before breakfast. A year ago, Alex was prescribed Lisinopril 20mg once each day for high blood pressure. Four months ago, Alex was also prescribed Fluoxetine 20mg for depression, to be taken once each day with a recommendation to take it in the morning to avoid sleep disruption.

Alex's care team is concerned because there has been little change in Alex's A1c readings and no self-report of improved mood. Even though there was initially significant improvement after first starting Lisinopril, Alex's blood pressure has increased over the past few months. You are about to meet with Alex.

{6} Sam

Sam recently received an eviction notice from their apartment due to non-payment of rent. They were working part-time until they were fired from their job last month after a progressive discipline history. Their final infraction was falling asleep while driving a forklift. Sam acknowledges that they often take extra doses of their prescription painkiller, as well as taking other pain-killers not prescribed to them. They also sometimes use heroin. A couple of years ago, Sam experienced a back injury from falling off a ladder while helping to fix a friend's roof. Now, Sam says they are just doing what is needed to manage their pain. You are about to meet with Sam.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: 5 A's (Tobacco use EBP)	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.31
Effective Date: 4/10/18	Date of Review/Revision: 4/9/19, 3/11/20, 4/14/21, 3/9/22, 3/8/23, 3/15/24, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO
	Supersedes: 02.03.40	Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
		Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team,

Purpose:

The purpose of this policy is to promote the use of 5 A's as an expeditious intervention aimed at harm reduction by helping persons served who use tobacco to quit.

Application:

This policy applies to SCCMHA-funded providers of services and supports to adults with a mental illness as well those with primary and co-occurring substance use disorders who use tobacco or have a recent history of tobacco use.

Policy:

SCCMHA recognizes the prevalence of tobacco use among adult persons served with serious mental illness and the deleterious impact it has on health and wellbeing of smokers and those around them (via secondhand smoke). SCCMHA also recognizes the many immediate and long-term health benefits of quitting. Therefore, SCCMHA encourages providers to become familiar with the 5 A's Intervention and use it, in a trauma-informed manner, to promote healthy behaviors and reduce the use of tobacco among persons served. SCCMHA shall provide training and support for the use of this intervention as resources permit.

Standards:

- A. The 5 A's Intervention shall be utilized with every person served who currently smokes or has recently quit smoking.
- B. Providers shall deliver The 5 A's in accordance with the model:

1. **ASK:** At each visit/encounter, ask persons served about their tobacco use.
2. **ADVISE:** Urge persons served who are using tobacco to quit.
 - a. Advice should be clear, strong, and personalized.
3. **ASSESS:** Determine the person served's willingness to make a quit attempt (Stage of change).
 - a. Assessment shall include a readiness ruler (i.e., "On a scale of 1 to 10, where 10 is very ready, how ready are you to quit smoking?") or a Stages of Change assessment
4. **ASSIST:** Provide help to move persons served toward a successful quit attempt and develop a quit plan.
 - a. Provide brief counseling and medication (if appropriate).
 - b. Refer persons served to complementary support resources (e.g., quitlines, Smokefree.gov, SmokefreeTXT, BeTobaccoFree.gov, group counseling)
 - c. Use the 5R's for persons served who are unwilling to quit in an effort to enhance motivation to quit:
 - 1). **RELEVANCE:** Discuss why and how quitting is relevant to the person served; encourage the person served to indicate how quitting is personally relevant to him/her
 - 2). **RISKS:** Discuss the risks the person served is taking by smoking; encourage the person served to identify the potential negative consequences of tobacco use that are relevant to him/her
 - 3). **REWARDS:** Identify the rewards the person served would benefit from by quitting; ask the person served to identify the potential benefits of quitting
 - 4). **ROADBLOCKS:** Address the roadblocks the person served will face and help find a way around them; ask the person served to identify barriers or impediments to quitting and provide or arrange for treatment (problem-solving counseling, medication) that could address barriers
 - 5). **REPETITION:** Review the 5 A's at every visit; repeat the assessment of readiness to quit as long as needed.
5. **ARRANGE:** Follow-up contact with the person served.
 - a. Arrange for additional support services as needed.

Definitions:

The 5 A's (ask, advise, assess, assist, arrange) is a brief, goal-directed, evidence-based intervention to address tobacco use with persons served that aims to meet tobacco users' needs in terms of readiness to quit. Altogether, the 5 A's may take 1 to 5 minutes, depending on a provider's clinical setting and roles. The 5 A's do not need to be applied in a rigid manner, and an entire office/clinical staff may be involved to support tobacco users. The 5 A's has been adapted for other conditions including alcohol use, obesity and physical activity counseling.

References:

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

- B. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
- C. World Health Organization. (2014). *Toolkit for delivering the 5A's and 5R's brief tobacco interventions in primary care*. [Toolkit for delivering the 5A's and 5R's brief tobacco interventions in primary care](#)

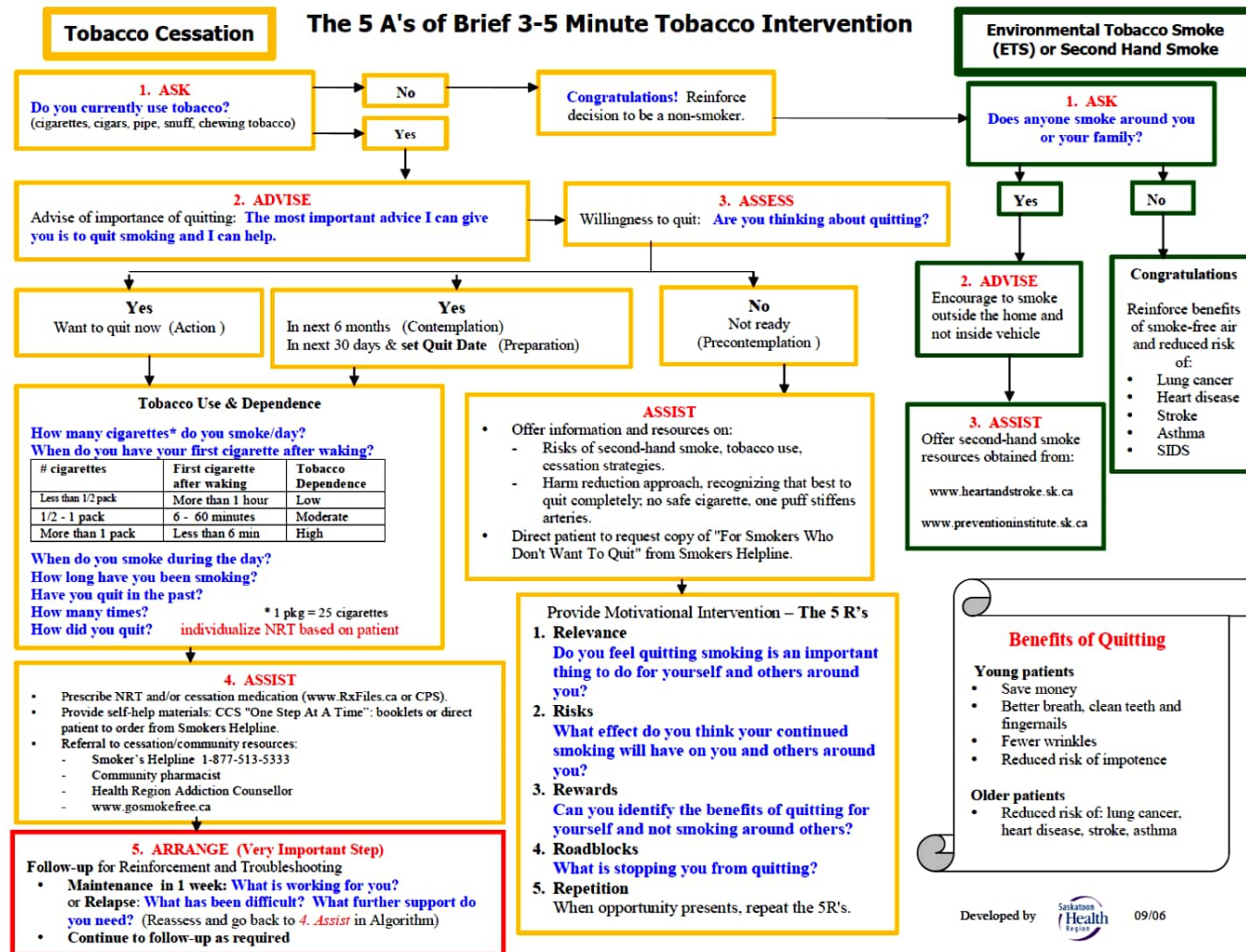
Exhibits:

- A. The 5 A's of Brief 3–5 Minute Tobacco Intervention Flow Chart (Saskatoon Health Region, 09/06)

Procedure:

None

Exhibit A



Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Cognitive-Behavior Therapy for Hoarding Disorder (CBT for HD)	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.37
Effective Date: 6/13/17	Date of Review/Revision: 4/10/18, 4/9/19, 4/14/21, 3/9/22, 3/8/23, 3/15/24, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team
	Supersedes: 02.03.27	
		

Purpose:

The purpose of this policy is to delineate a framework for the use of Cognitive-Behavior Therapy for Hoarding Disorder (CBT for HD).

Policy:

- A. Providers who have been trained and privileged to provide CBT for HD model shall use this intervention for persons served with HD.
- B. CBT for HD shall be made available to persons served as resources permit.
- C. CBT for HD shall be provided in a trauma-informed manner with empathy, compassion, hopefulness, and positive regard for each person served with HD.

Application:

This policy applies to all SCCMHA-funded providers.

Standards:

- A. Clinicians and peers, including CHWs (Community Health Workers) who provide CBT for HD shall receive SCCMHA-approved training prior to the provision of treatment to persons served.
- B. CBT for HD shall be provided inclusive of the following components in order to maintain fidelity to the model.
 1. Assessment, using a validated instrument (e.g., Clutter Image Rating Scale).
 - a. The assessment shall include pictures of the home.

- (1). Said photos shall be made part of the person served's electronic health record.
2. Case formulation to develop an individualized model that explains the function (i.e., the how and why) of hoarding for the persons served (e.g., personal and family vulnerabilities, information-processing difficulties, beliefs about and attachment to possessions, emotional reactions, and reinforcement of the behavior)
3. Goal setting: Treatment goals shall be developed collaboratively with the person served and may include:
 - a. Increasing the person served's understanding of hoarding
 - b. Creating living space
 - c. Expanding the appropriate use of space
 - d. Organizing items in order to make them more accessible
 - e. Improving decision-making skills
 - f. Reducing acquiring
 - g. Evaluating beliefs about possessions
 - h. Reducing clutter
 - i. Learning problem-solving skills
 - j. Preventing hoarding in the future
4. Psychoeducation about hoarding and the cognitive-behavioral model of HD shall be provided to the person served along with a discussion about treatment and its effects.
 - a. An individualized model of the disorder shall be formulated.
5. Motivational interviewing shall be provided to enhance motivation for change by helping persons served deal with ambivalence, recognize problems, self-motivate for change, make a plan, and take immediate steps to be effective in their new intentions.
6. Cognitive therapy that includes treatment for organization problems, helping the person served to reduce the number of categories and locations for saved items as well as categories for unwanted items shall be provided.
 - a. Cognitive therapy shall include cognitive restructuring to help persons served recognize, challenge, and ultimately change patterns of faulty thinking including beliefs about possessions.
7. Skills training sessions shall be provided and include organizing, decision-making, as well as problem-solving skills that incorporates the following steps:
 - a. Defining the problem
 - b. Generating as many solutions to the problem as possible
 - c. Evaluating the solutions and choosing one or two that seem likely to work.
 - d. Breaking the solution into manageable steps
 - e. Implementing the steps
 - f. Evaluating the results
 - g. Starting the process again if the problem is not resolved.

8. Exposure and practice sorting, discarding, and non-acquisition (e.g., “non-shopping” trips to the store) shall be provided including Exposure and Response Prevention (ERP) treatment.
 9. Relapse prevention shall include a collaborative review of the treatment process, symptoms, and interventions with the person served who will be prompted to identify strategies that have been effective, and they will continue to use to prevent relapse.
 10. Booster sessions following the cessation of treatment may be provided to help persons served maintain gains and to cope with specific setbacks.
- C. CBT for HD may be provided in a group format or on an individual basis.
 - D. Family members/natural support systems and relevant community agencies shall be engaged when feasible and appropriate in the treatment of persons served with HD.
 1. Privacy and confidentiality laws and regulations shall be adhered to when sharing person served information with others.

Definitions:

Cognitive Behavior Therapy for Hoarding Disorder (CBT for HD) is a manualized, multi-component twenty-six session evidence-based intervention that is conducted over the course of six to twelve months and includes office and home visits. It incorporates: motivational interviewing to address low insight and limited motivation; decision-making training to improve cognitive processing; exposure to reduce negative emotions associated with discarding and resisting acquiring; and cognitive restructuring to alter distorted beliefs.

Exposure and Response Prevention (ERP) is an evidence-based treatment that consists of controlled and prolonged exposure to the objects or situations that trigger an anxiety while preventing the habitual response.

Hoarding Disorder is characterized by the acquisition of and failure to discard or part with possessions regardless of the value attributed to those possessions by others, even those that appear to be useless or of limited value, resulting in cluttered living spaces and significant distress and impairment in functioning.

References:

- A. *Saginaw County First Responder’s Guide for Behavioral Interventions, 4th Edition.* (February 2018). 5.4 Saginaw Hoarding Task Force, pp.120-122: <https://www.sccmha.org/userfiles/filemanager/12403/>
- B. Saginaw Hoarding Task Force: <http://hoardingtaskforcesaginaw.org/index.html>
- C. SCCMHA. (2016). *Hoarding Disorder: A Guide to Effective Interventions*: <http://hoardingtaskforcesaginaw.org/>
- D. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EBPs)
- E. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

Exhibits:

- A. HD Treatment Components (from SCCMHA’s *Guide to Effective Interventions for HD*)
- B. Saginaw County Community Mental Health Clinical Protocol for Working with Individuals with Hoarding Disorder
- C. Saginaw Community Care HUB Hoarding Disorder Referral Flow Chart

D. SCCMHA/Saginaw Hoarding Task Force HOARDING SERVICES FLOW CHART

Procedure:

CTION	RESPONSIBILITY
Screen the person served for HD. Assess the person served's motivation to address the hoarding. Offer CBT for HD to the person served if they are receptive. Request authorization for CBT for HD if the person served is amenable to treatment. Address motivation for treatment if the person served is not amenable and offer treatment every 6 months if person served declines. Conduct CBT for HD in accordance with the model. Monitor fidelity to the CBT for HD treatment protocol.	Case Holder/Treatment Team Members CBT for HD Clinician/CHW SCCMHA EBP Leadership Fidelity Review Team

HD Treatment Components

- ▣ Assessment and Case Conceptualization
 - ▣ Start with client's explanation
 - ▣ Add features based on interview and experimentation
 - ▣ Identify feelings, beliefs, core beliefs
 - ▣ Connect these to acquiring and saving behavior and clutter
 - ▣ Link vulnerabilities to feelings, beliefs, and behaviors
 - ▣ Do functional analyses of individual features
- ▣ Establishment of Personal Goals and Values
 - ▣ Values
 - What does the client care most about? (e.g., family, friends, honesty, achievements, etc.)
 - ▣ Personal goals
 - What does the client most want to do in the remainder of his/her life?
 - Refer to personal goals and values throughout treatment to clarify ambivalence and increase motivation
- ▣ Psychoeducation
 - ▣ Education about cognitive-behavioral model of hoarding
 - ▣ Discussion of treatment and its effects
 - ▣ Personalized model-building
- ▣ Motivational Interviewing/Motivational Enhancement
 - ▣ Recognize ambivalence
 - ▣ Enhance ambivalence
 - ▣ Resolve ambivalence
 - ▣ Reinforce change talk and action
- ▣ Skills Training for Organizing and Problem-Solving (Cognitive Rehabilitation)
 - ▣ Manage attention/distraction
 - ▣ Teach problem-solving skills:
 - Problem-solving steps:
 1. Identify/define the problem
 2. Generate as many solutions as possible
 3. Evaluate solutions & select one or two that seem feasible
 4. Divide solutions into manageable steps
 5. Implement the steps
 6. Evaluate the outcome
 7. Repeat the process until a good solution is found
- ▣ Cognitive Therapy

- ▣ Identify common thinking errors
 - All-or-nothing thinking (e.g., Most, everything, nothing)
 - Overgeneralization (e.g., Always, never)
 - Jumping to conclusions (e.g., I will need this just as soon as I do not have it anymore)
- ▣ Identify distorted beliefs
 - Listen closely to statements during acquiring and discarding tasks
 - Use the Downward Arrow technique:
 - What would happen if you threw that out?
 - “I’ll never find it again.”
 - Why would that be so bad?
 - “I would lose an opportunity.”
 - What would be so bad about that?
 - “I’d be stupid for not taking advantage of an opportunity.”
 - What’s the worst part about that?
 - “Just that, I’d be a stupid person.”
 - Downward Arrow 2:
 - It sounds like you are worried that if you threw this out, that would mean you were a stupid person. Let’s take a look at that idea.
 - “I guess I never thought about it. I do worry about doing something stupid.”
 - Sounds like you also worry that you might be a stupid person.
 - Does that seem right?
 - “Yeah, I guess so. All through school....”
- ▣ Evaluate and challenge beliefs
 - Standard questions to challenge beliefs (e.g., How many do you already have? Do you have a plan for its use?)
 - Socratic questioning to examine the beliefs (e.g., How well could you cope without having this? How distressing would it be?)
 - Other cognitive strategies (e.g., advantages/disadvantages; taking another perspective: distinguishing need versus want)
 - Behavioral experiments
- ▣ Sorting/discarding/categorizing
 - ▣ Develop a hierarchy of increasingly difficult items for sorting, ranked from easy to hard
 - Remind the client that:
 - ✓ Discomfort is expected
 - ✓ Tolerating discomfort allows progress on clutter
 - ✓ Reduction in anxiety and other negative emotions comes only through confronting them via exposure activities
 - ▣ Select the target area and the type of possession
 - Create categories for this type of possession
 - ▣ Work in easier locations first (with highest motivation)

- ▣ Work on easier objects first; set aside harder objects into box labeled “to be sorted later”
 - Continue cleanout until the target area clear
 - Plan the appropriate use of cleared area
 - Create a plan for preventing new clutter to area
- ▣ Gradually reduce therapist assistance in making decisions
- ▣ Categorizing and Sorting Items:
 - Clients must think aloud when sorting
 - OHIO (Only Handle It Once)
 - Categorize unwanted items:
 - Trash, recycle, donate, sell, and undecided
 - Develop a list of items to be removed
 - Develop an action plan for removing items
 - Define categories for saved objects (non-paper):
 - Keep similar items together (“like with like”)
 - Choose a limited number of locations for each category
 - Help client select final locations for categories of items
 - Categorizing and filing paper:
 - Help the client identify where to store paper
 - Determine the materials needed to organize paper
 - Ensure each paper category is included in the filing system
 - Make categories for mail, newspapers, magazines
- ▣ Establish Personal Rules for Saving and Acquiring:
 - I must have:
 - ✓ an immediate use for it
 - ✓ time to deal with it appropriately
 - ✓ money to afford it comfortably
 - ✓ space to put it
 - ✓ ... [others]
- ▣ Questions to Challenge Acquiring:
 - ✓ Do I need it?
 - ✓ How many do I already have?
 - ✓ Do I have an immediate use for this?
 - ✓ Have I used this in the last year?
 - ✓ Do I have a plan to use this?
 - ✓ Can I manage without it?
 - ✓ Can I get it elsewhere?
 - ✓ Do I want it taking up space in my home?
 - ✓ Does buying/keeping this help meet my personal goals?
 - ✓ Will not buying/getting rid of this help my hoarding problem?

- ✓ Is this truly important or do I want it just because I was looking at it?
- ✓ What are the advantages and disadvantages of acquiring this?

▣ Practice and Homework

- ▣ Collect a box or bag of items from home to bring to the office
- ▣ Work from easier to harder items
- ▣ Sort similar items at home between sessions
- ▣ As skills are gained, bring in only difficult items to sort in office
- ▣ Make sure sorted items are moved to storage locations or out of home

▣ Relapse Prevention

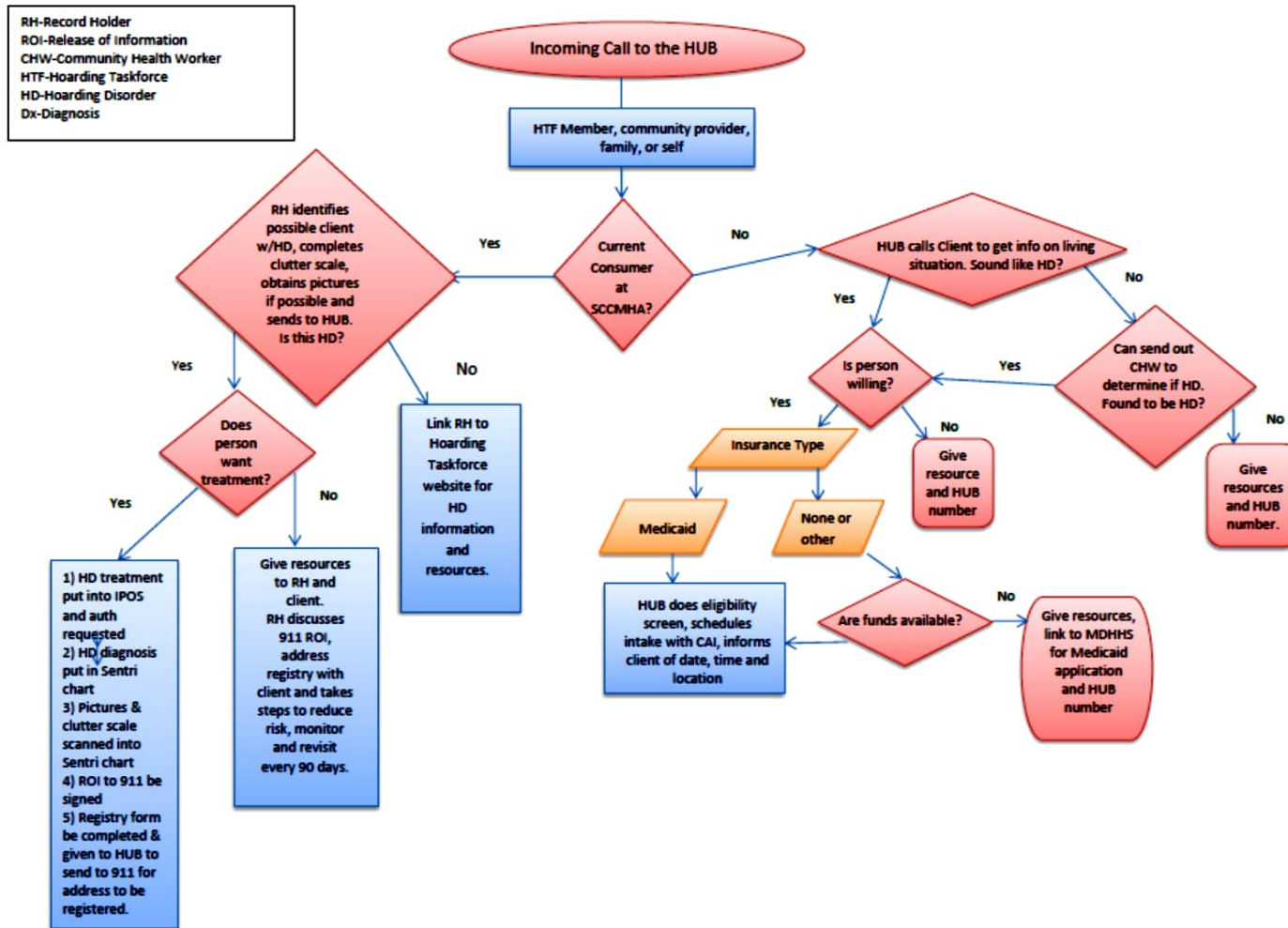
- ▣ Review progress
- ▣ Plan strategies to continue progress
- ▣ Identify therapy methods that worked best
- ▣ Anticipate stressors, setbacks, and lapses
- ▣ Plan strategies to deal with setbacks and determine resources for the future
- ▣ Discuss end-of-treatment concerns
- ▣ Review all skills and techniques
- ▣ Review rules and establish future rules
- ▣ Develop strategies to continue self-work
- ▣ Identify social support and pleasurable maintenance activities
- ▣ Develop strategies for setbacks
- ▣ Schedule booster sessions

Saginaw County Community Mental Health Clinical Protocol for Working with Individuals with Hoarding Disorder

- Treatment for individuals with hoarding disorders will be provided through specifically trained therapists.
- A clinical diagnosis of Hoarding Disorder as outlined in the DSM-V must be present to provide hoarding specific services.
- Before therapy begins, there should be an authorization request made by one of the above-mentioned therapists for hoarding disorder treatment through SCCMHA care management.
 - If there is other individual therapy currently occurring by another provider, the current therapy provider should either transfer the case or step aside from the case until the treatment for the hoarding disorder is completed (having two therapists may be overwhelming or confusing to the person served).
- The Evidence-Based Treatment for individuals with hoarding disorder is CBT for hoarding. The book and workbook Treatment for Hoarding Disorder (Therapist Guide and accompanying workbook) by Gail Steketee and Randy O. Frost is the endorsed treatment model by SCCMHA for the treatment of hoarding disorder. These books should be read by the therapist before beginning treatment.
 - Adjunct books such as: Buried in Treasures (Tolin, Frost, and Steketee) and Stuff (Frost, and Steketee) are also recommended as needed during the treatment process.
- CBT for hoarding (outlined in Treatment for Hoarding Disorder: therapist guide) recommends 26 weekly sessions, spaced over a period of 6 months-this number may vary in some cases.
 - It is also recommended that every 4th session occur in the home with the first home session being recommended to occur by the 2nd session. The in-home sessions may take up to 2 hours to complete.
- Initial hoarding assessment scales should be used, particularly the Clutter Image Rating Scale (CIR), (located on pg. 217 of the Therapist guide and 17 of the person served workbook)
 - There are also scales related to safety, daily living, and home environment that are highly recommended.
 - The hoarding interview may also be a useful tool for clinicians in the initial assessment phase of treatment
 - These forms and assessments are located in the appendix of the therapist guide.
- If pictures are being taken of the persons served house to determine severity and progress, they must be scanned into the Medical Record

- Community Health Workers (CHWs) will be playing an important role in the treatment of persons served with hoarding disorder; acting as a coordinator and a case manager for community services and possible cleanout related to the housing conditions.
 - CHWs should be working closely with the therapist and the person served as a coach (Mentioned in the therapist guide) to help with encouragement in treatment throughout the process of change.
- It is recommended that all therapists and CHW's working with persons with hoarding disorder have a base knowledge in hoarding 101 and motivational interviewing.
 - The clinicians working with persons with hoarding disorder should also have a base knowledge of cognitive behavior therapy (CBT).
- There will be a treatment for hoarding disorder privileging process that all practitioners working with individuals with hoarding disorders will be required to go through.

Exhibit C



Last amended 1/3/19

Exhibit D

SCCMHA/Saginaw Hoarding Task Force
HOARDING SERVICES FLOW CHART

<u>SCREENING & INFORMATION →</u>	<u>→ELIGIBILITY DETERMINATION & ASSESS- MENT →</u>	<u>→TREATMENT PROVISION</u>
●SCCMHA publishes/posts hoarding number/website address for information ●SCCMHA publishes brochure for community on specific services ●SCCMHA HUB Responds to Calls – and takes action depending upon caller/need (family/friend/neighbor, law enforcement/first responder, other) ●Caller given general information ●Clutter tool Screening by Community Health Worker or other if/when appropriate – HUB will deploy CHW as appropriate – CHW may use other contacts to gain access, “Officer asked me to call.” ●Notice to Central Dispatch for property registry if/when appropriate – real or potential issue, check is address is on the list or put on the list ●Notice to municipality/police if/when appropriate/serious situation ●Referral to Crisis Intervention Services if appropriate ●Referrals for other services? ●HUB to track calls/referrals/services (number, referral sources, disposition, etc.)	●Crisis Intervention Services Screening for Urgent/Petition Status ●SCCMHA screening for Enhanced Outpatient services eligibility ●Since Enhanced Outpatient providers can do decentralized intake, referrals to the HUB may come from any of the four providers ●SCCMHA Central Access & Intake – oversees SCCMHA service eligibility, early intervention, and screening/assessment ●SCCMHA Care Management – oversees assignment of provider and authorization for services ●Determination of other service providers/home visitor involvement/history of contact (MDHHS/APS/CPS, first responders, etc.) ●Existing SCCMHA persons served can be referred for hoarding treatment with Care Management Authorization ●Revisit of services offered if first declined – every 90 days ●Serious hoarding conditions require municipality contact and coordination	●Referrals made to Saginaw Psychological Services or Training and Treatment Innovations for clinical services under SCCMHA Enhanced Outpatient benefit ●Non-Medicaid/Healthy MI covered by special funds as available ●Services may include Community Health Worker supports or other to assist with clean out (and other social determinants of health needs) ●Arrangements with DHHS and/or municipality for clean out funds/contracts and monitoring ●Services will be authorized for 6+months ●Evidence-based practice therapy and in-home interventions will be provided ●Plan of service will denote progress in behavior/home conditions ●Use of photos to depict progress, scan pictures into health record on progress ●Post treatment follow up in 6 months

June 2016

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Learning About Healthy Living Tobacco and You (LAHL)	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.38
Effective Date: 6/13/17	Date of Review/Revision: 4/10/18, 4/9/19, 4/14/21, 3/9/22, 3/8/23, 3/15/24, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
	Supersedes: 02.03.28	
		Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team

Purpose:

SCCMHA recognizes the multiple adverse impacts of tobacco use on persons served and therefore supports and promotes the utilization of interventions that aim to reduce and eliminate tobacco use among persons served as part of the organization's health and wellness programming.

Policy:

- A. Persons served who use tobacco shall, in a trauma-informed manner, be routinely asked about their desire to reduce or stop using tobacco and shall be encouraged to engage in harm reduction activities including eliminating or reducing their use of tobacco products.
- B. Adult mental health persons served shall be routinely offered the opportunity to participate in the Learning About Healthy Living Tobacco and You (LAHL) program when it is available at the SCCMHA-funded drop-in center.
- C. Adult mental health persons served shall also be offered combination treatment that includes pharmacotherapy (e.g., nicotine replacement medications, bupropion SR, and varenicline) and counseling (e.g., the 5 As, which is described below).

Application:

This policy applies to SCCMHA-funded providers of services and supports to adult persons served with a serious mental illness who use tobacco.

Standards:

- A. persons served will be screened for tobacco use.
- B. Case Holders are encouraged to educate persons served about the hazards of tobacco use.
 - 1. Case Holders are encouraged to use motivational interventions such as the 5 As for Brief Intervention (ask, advise, assess, assist, arrange follow-up), when discussing tobacco use with persons served. (See Exhibit B)
- C. persons served shall be provided with an opportunity to complete a self-report tobacco use assessment prior to starting LAHL.
 - 1. persons served may also complete other health-oriented assessments at the discretion of SCCMHA and/or the LAHL facilitator.
- D. persons served who are referred to LAHL should be psychiatrically stable, not currently experiencing a crisis and, ideally, not actively abusing substances other than tobacco.
 - 1. Persistent symptoms (e.g., depression, mood instability, or psychosis) shall not preclude participation when the person served is in a stable psychiatric state.
- E. LAHL groups shall be made available to persons served in accordance with their stage of change.
 - 1. Group I: Learning about Healthy Living, an educational and motivational based intervention, shall be targeted to all persons served who smoke.
 - a. The focus shall be on helping persons served to gain knowledge and insight as part of an effort to help them consider moving toward a tobacco-free lifestyle.
 - b. This group shall cover other issues related to healthy living including, but not limited to, nutrition, physical activity, and stress management.
 - c. This group will provide persons served with detailed information regarding the risks associated with smoking, what is in cigarettes, the benefits of quitting smoking, ways to quit smoking, and general healthy lifestyle behaviors that can assist them in quitting smoking.
 - d. This group shall be provided in an open-ended format with rolling admission and shall not be time limited.
 - 1). persons served may continue attending Group I as long as they desire and will only advance to Group II when they have decided they are ready to take action to quit smoking.
 - 2). Group I membership may have mixed membership and, as such, include members who are ambivalent about quitting as well as those who may not even express a desire to quit.
 - 2. Group II: Quitting Smoking, an action-based treatment which emphasizes techniques for quitting in an effort to improve success and minimize the risk of relapse, shall be targeted to persons served who are ready to try to quit smoking.
 - a. Group II shall be provided in a closed group format.
 - b. Group II shall be conducted once a week for eight to ten weeks.
 - c. This group must be comprised of a minimum of four participants who are committed to quitting.

- d. Although most persons served will have completed Group I as a prerequisite to participating in Group II, those who are ready to quit may begin LAHL with Group II.
- F. Facilitators shall adhere to the LAHL curriculum as explicated in the program manual (referenced below) when conducting LAHL groups in order to maintain fidelity to the program model.

Definitions:

Learning About Healthy Living Tobacco and You (LAHL) is a manualized, facilitator-led, group-based intervention for persons served with mental health problems who use tobacco.

References:

- A. Learning about Healthy Living: Tobacco and You Program Manual: [2012_lahl.pdf](#)
- B. SCCMHA. *A Guide to Evidence-Based Wellness Practices*. 2016
- C. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- D. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
- E. SCCMHA Policy 02.03.25 – Wellness
- F. SCCMHA Policy 02.03.09.31 – 5 A’s

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
Screen the person served for tobacco use. Assess the person served’s motivation to quit using tobacco. Inform the person served about the hazards of tobacco use. Offer LAHL to the person served if they use tobacco. Refer the person served to the drop-in center for LAHL.	Case Holder/Treatment Team Members
Conduct LAHL groups in accordance with the goals, objectives, and suggested approaches as specified in in the Learning about Healthy Living: Tobacco and You Program Manual	Friends for Recovery Center staff

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Teach-Back	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.39
Effective Date: 6/13/17	Date of Review/Revision: 4/10/18, 4/9/19, 4/14/21, 3/9/22, 3/8/23, 3/15/24, 02/12/25, 3/24/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services Authored By: Mary Baukus, Barbara Glassheim Additional Reviewers: EBP Leadership Team
	Supersedes: 02.03.36	
		

Purpose:

The purpose of this policy is to encourage the use of Teach-Back in order to help persons served and families derive maximum benefit from the services and supports available to them as well as ensure informed consent to interventions or treatment regimens.

Policy:

Studies have shown that forty to eighty percent of the medical information received during office visits is forgotten immediately and nearly half of the information retained is incorrect. Providers shall use Teach-Back, in a trauma-informed manner, with persons served and families in an effort to improve person served and family understanding of diagnoses, treatments, and interventions in order to enhance adherence to treatment regimens and maximize opportunities for beneficial outcomes.

Application:

This policy applies to all SCCMHA-funded providers.

Standards:

- A. SCCMHA shall offer training in the Teach-Back method to its provider network as resources permit.
 1. Teach-Back shall be deemed a foundational practice.
 - a. Providers shall work to become proficient in the use of the Teach-Back method.

- B. Providers shall use Teach-Back when explaining an important concept (e.g., treatment options, medications, adherence to a treatment plan) or demonstrating how to perform a healthcare related activity.
- C. Providers shall adhere to the core elements of Teach-Back:
 - 1. Speaking slowing and using eye contact as well as a caring tone of voice and attitude
 - 2. Displaying comfortable body language and making eye contact
 - 3. Explaining things clearly and in plain language (i.e., avoiding the use of medical jargon and vague directions)
 - 4. Asking the person served to explain what they heard from the provider using their own words (rather than asking whether they understood what was said or having them parrot what they heard)
 - 5. Using open-ended questions that start with “what” or “how” and avoiding questions that can be answered with a simple “yes” or “no”
 - 6. Emphasizing that the responsibility to explain rests clearly with the provider (rather than the person served)
 - 7. Explaining the information again and re-checking in all instances when the person served is unable to teach the material back correctly
 - a. Rephrasing what was told to the person served/family or re-teaching the material in a different manner and asking them to repeat back what was stated to them in order to increase comprehension
 - 8. Using reader-friendly print materials to support learning
 - 9. When appropriate, asking persons served to demonstrate how to do something (e.g., check their blood pressure or take their medications) – the **show-me method**.
 - 10. Documenting the use of and the person served’s response to Teach-Back in the person served’s electronic health record
- D. Providers who wish to evaluate their Teach-Back skills can use the Conviction and Confidence Scale (Exhibit A) and the Teach-Back Observation Tool (Exhibit B) to assess how they are implementing it in everyday practice.

Definitions:

Health Literacy: The ability to receive, understand, and act on health information to make informed health care decisions. Health literacy includes: reading/comprehension, writing, listening, speaking, numeracy, communication/interaction, and problem-solving skills.

Teach-Back: A research-based health literacy intervention that has been found to improve patient-provider communication and patient health outcomes that is a communication technique designed to help persons served remember and understand important information regarding their diagnosis, treatment, or medication. It entails asking persons served to recall and then explain or demonstrate the important information discussed during an interaction with their health care team.

References:

- A. Agency for Healthcare Research and Quality (AHRQ). *Teach-Back: Implementation Quick Start Guide*:

<https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/TeachBack-QuickStart-Guide.pdf>

- B. Merck & Company, Inc. (2014). *The Teach-Back Technique: Communicating Effectively With Patients*: <https://berkslancasterlebanonlink.files.wordpress.com/2014/07/hl-teachback-brochure.pdf>
- C. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- D. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

Exhibits:

- A. Conviction and Confidence Scale
- B. Teach-Back Observation Tool

Procedure:

ACTION	RESPONSIBILITY
1. Teach new concept or activity to the person served	1. Provider
2. Use own words to describe what was learned or demonstrates what was learned	2. Person served/Family
3. Clarify or correct misinformation Re-teach the concept or activity	3. Provider
4. Restate understanding or demonstrates learned behavior/activity Asks questions	4. Person served
5. Repeat steps 3 and 4 until sure the person served/family understand the concept or has the ability to perform the activity safely and accurately	5. Provider/Person served/Family



Conviction and Confidence Scale

Fill this out before you start using teach-back, and 1 and 3 months later.

Name: _____

Check one: ☐ Before - Date: _____

☐ 1 month - Date: _____

☐ 3 months - Date: _____

1. On a scale from 1 to 10, how **convinced** are you that it is important to use teach-back (ask patients to explain key information back in their own words)?

Not at all important

Very Important

1 2 3 4 5 6 7 8 9 10

2. On a scale from 1 to 10, how **confident** are you in your ability to use teach-back (ask patients to explain key information back in their own words)?

Not at all confident

Very Confident

1 2 3 4 5 6 7 8 9 10

3. How often do you ask patients to explain back, in their own words, what they need to know or do to take care of themselves?

- ☐ I have been doing this for 6 months or more.
- ☐ I have been doing this for less than 6 months.
- ☐ I do not do it now, but plan to do this in the next month.
- ☐ I do not do it now, but plan to do this in the next 2 to 6 months.
- ☐ I do not do it now and do not plan to do this.

1



Conviction and Confidence Scale continued

4. Check all the elements of effective teach-back you have used **more than half the time in the past work week**.

- ☐ Use a caring tone of voice and attitude.
- ☐ Display comfortable body language, make eye contact, and sit down.
- ☐ Use plain language.
- ☐ Ask the patient to explain, in their own words, what they were told.
- ☐ Use non-shaming, open-ended questions.
- ☐ Avoid asking questions that can be answered with a yes or no.
- ☐ Take responsibility for making sure you were clear.
- ☐ Explain and check again if the patient is unable to teach back.
- ☐ Use reader-friendly print materials to support learning.
- ☐ Document use of and patient's response to teach-back.
- ☐ Include family members/caregivers if they were present.

Notes: _____



Teach-back Observation Tool

Care Team Member: _____ Date: _____

Observer: _____ Time: _____

Did the care team member...	Yes	No	N/A	Comments
Use a caring tone of voice and attitude?				
Display comfortable body language, make eye contact, and sit down?				
Use plain language?				
Ask the patient to explain in their own words what they were told to do about: • Signs and symptoms they should call the doctor for? • Key medicines? • Critical self-care activities? • Follow-up appointments?				
Use non-shaming, open-ended questions?				
Avoid asking questions that can be answered with a yes or no?				
Take responsibility for making sure they were clear?				
Explain and check again if the patient is unable to use teach-back?				
Use reader-friendly print materials to support learning?				
Document use of and patient's response to teach-back?				
Include family members/caregivers if they were present?				

1



Teach-back Observation Tool continued

Notes: _____

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: SBIRT/YSBIRT	Chapter: 02 - Customer Services & Re- cipient 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, 03/28/25, 03/16/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Ser- vices, Public Policy, Con- tinuing Education, OBRA/PASARR and En- hanced Health Services Authored By: Mary Bau- kus, Barbara Glassheim Additional Reviewers: SCCMHA EBP Leader- ship Team
	Supersedes:	
		

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 persons served with substance use issues and providing intervention in order to reduce risk and successfully engage persons served 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 persons served and to the enhancement of opportunities for person served recovery.
- B. SCCMHA shall conduct universal screening to help identify the appropriate level of services needed based on the person served's level of risk.
 1. Universal screening and brief intervention shall be delivered to persons served 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 persons served 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. Persons served with SUDs shall have access to a coordinated approach to chronic disease management.
- D. Persons served shall be given tools to maximize the use of proven self-management techniques to improve their health status outcomes.
- E. Persons served 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. Person served participation in SBIRT/YSBIRT shall be deemed voluntary and can be terminated by the person served at any time with no consequence to the person served.
- 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. Screening to identify a person served's place on a spectrum from non-use to substance use in order to deliver an appropriate response.
 2. Brief Intervention (BI) to raise person served awareness of risks, elicit internal motivation for change, and help set behavior-change goals.
 3. Referral to Treatment to facilitate access to and engagement in specialized services and coordinated care for persons served 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 person served to promote behavior change in order to reduce substance use. BI (see Exhibit F) is designed to educate persons served 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 individual's 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 persons served 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 person served 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://www.mass.gov/doc/drug-abuse-screening-test-dast10-8-28-2017-pdf>
- 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: SBIRT: A Step by Step Guide for Screening and Intervening for Unhealthy Alcohol and Other Drug Use: Massachusetts Health Promotion Clearinghouse*
- F. National Council for Behavioral Health. (Undated). *Improving Adolescent Health: Facilitating Change for Excellence in SBIRT: Improving Adolescent Health SBIRT Change Package*
- 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: How many times in the past year have you had 5 (male) or 4 (female) or more drinks in a day? How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? 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). 3. Conducts screening administering and scoring the DAST, AUDIT or CRAFFT+N. 4. Provides Brief Intervention (BI): Establish rapport – understand the person served's views of use. Elicit thoughts and provide information/feedback. Enhance motivation to change. Give advice and negotiate a plan. 5. Conducts brief treatment using CBT and Motivational Enhancement techniques. 6. Provides a referral to treatment using educational, motivational interviewing and feedback about the person served's substance use.	CAI/CIS/MRSS/Nurse/Case Holder

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)	☐ cocaine
☐ cannabis (marijuana, pot)	☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ inhalants (paint thinner, aerosol, glue)	☐ hallucinogens (LSD, mushrooms)
☐ tranquilizers (valium)	☐ 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 No risk of related health problems	None
1 - 2, plus the following criteria: 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 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 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 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.

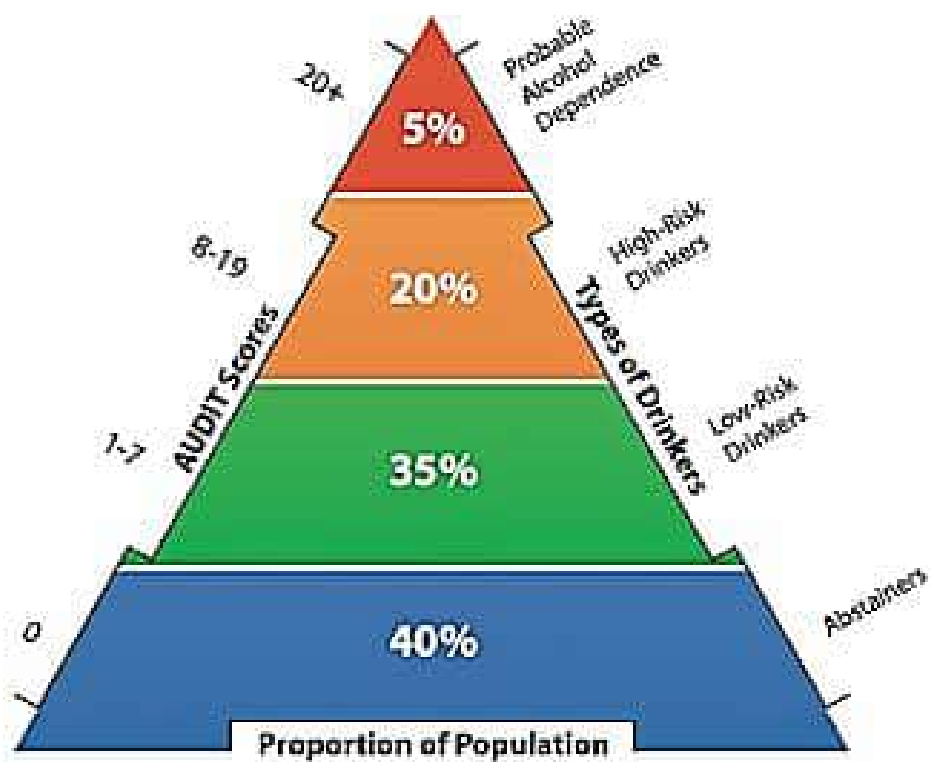
More resources: www.sbirtoregon.org

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
SOURCES OF RESEARCH TOOLS, INC.

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."

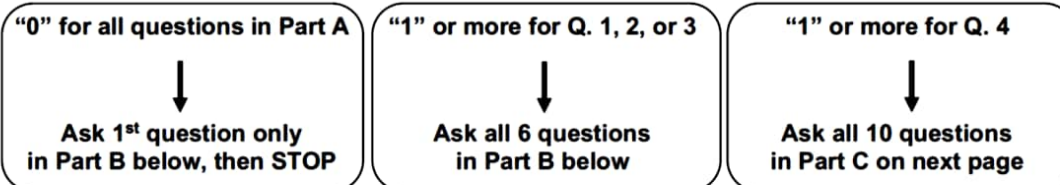
Part A

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...



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. →

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.

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	
	Yes	No
1. Have you ever tried to QUIT using, but couldn't?		
2. Do you vape or use tobacco NOW because it is really hard to quit?		
3. Have you ever felt like you were ADDICTED to vaping or tobacco?		
4. Do you ever have strong CRAVINGS to vape or use tobacco?		
5. Have you ever felt like you really NEEDED to vape or use tobacco?		
6. Is it hard to keep from vaping or using tobacco in PLACES where you are not supposed to, like school?		
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?		
b. did you feel more IRRITABLE because you couldn't vape or use tobacco?		
c. did you feel a strong NEED or urge to vape or use tobacco?		
d. did you feel NERVOUS , restless, or anxious because you couldn't vape or use tobacco?		

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;

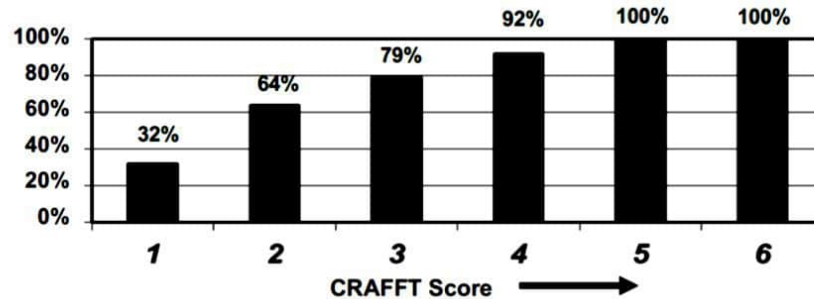
McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and Young Adults' Use and Perceptions of Pod-Based Electronic Cigarettes. *JAMA Network Open*, 1(6), e183535.

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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

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Boston Children's Hospital.

crafft@childrens.harvard.edu www.crafft.org

For more information and versions in other languages, see www.crafft.org.

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.

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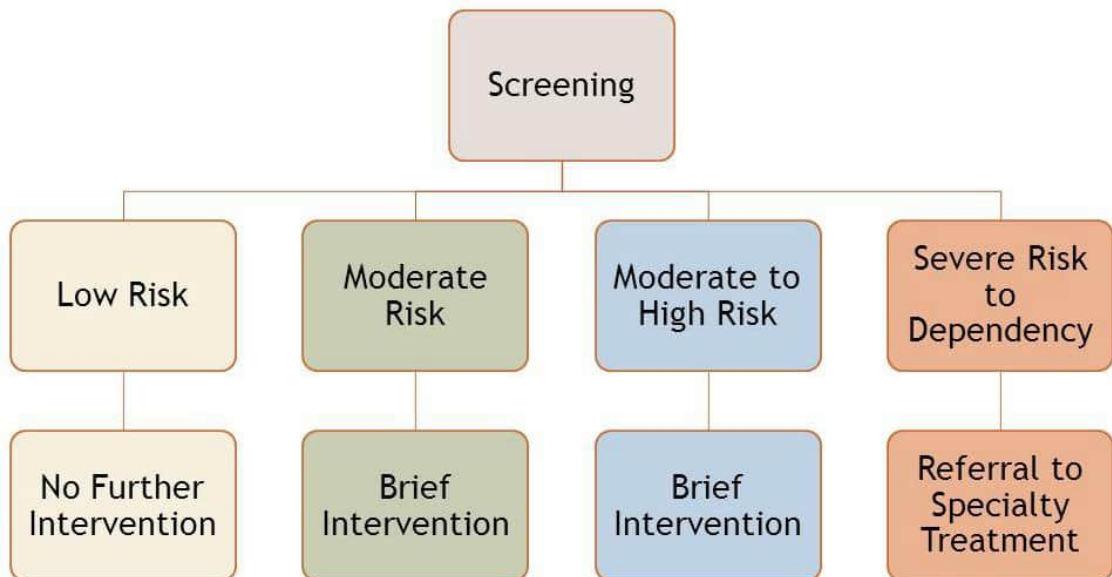
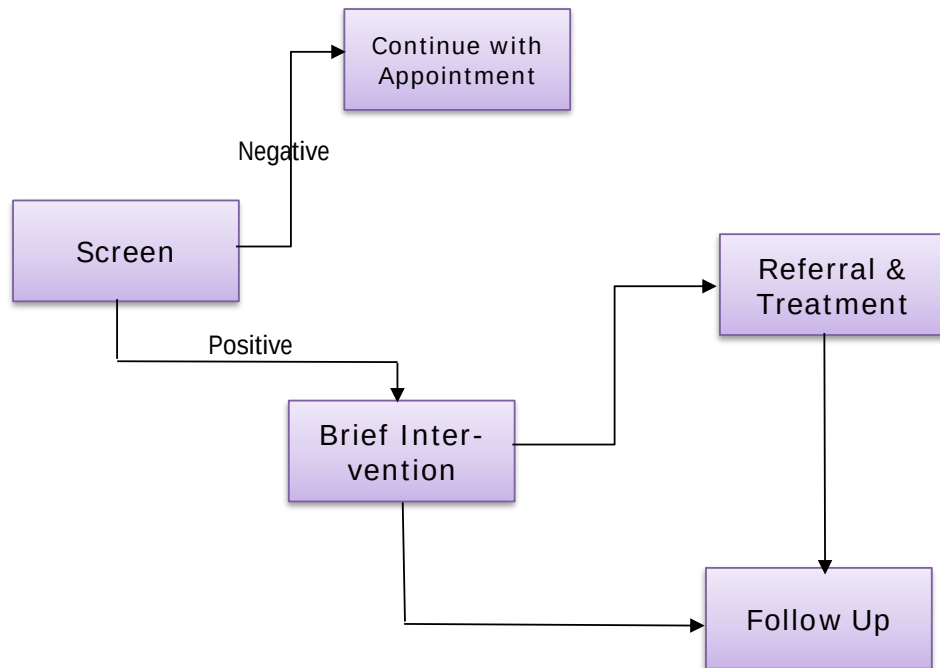
For more information and versions in other languages, see www.ceasar.org

Exhibit F

BI STEPS	DIALOGUE/PROCEDURES
1. Understand the patient's views of use • Develop discrepancy between patient's goals and values and actual behavior	Ask Pros and Cons <i>"I'd like to know more about your use of [X]. Help me to understand what you enjoy about using [X]? What else?"</i> <i>"What do you enjoy less about using [X] or regret about your use".</i> Summarize Pros and Cons <i>"So, on the one hand you say you enjoy X because..."</i> <i>"And on the other hand you said..." reiterate negative consequences, as stated by patient.</i>
2. Give information/feedback • Ask permission to give feedback • Use reflective listening,	Review Health Risks <i>"Is it OK if we review some of the health risks of using X?"</i> <i>"Are you aware of health risks related to your use of X?"</i> If YES: Which ones are you aware of? If NO: Indicate problems. Refer to NIDA Commonly Abused Drugs chart for drug consequences, as needed on p. 18. If focus is on risky alcohol use and abstinence is not indicated: <i>"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."</i>

3. Enhance motivation to change • Ask readiness and confidence scales	Readiness Scale <i>"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."</i> Then, Ask: <i>"Why did you choose that number and not a lower one like a 1 or a 2?"</i> Patient will indicate reasons to change. You also ask the patient for other reasons for change. <i>"How does this fit with where you see yourself in the future? If you make these changes what would be different in your life?"</i> If the patient, answers "0" ask, <i>"What would need to happen to be at a higher number?"</i> Confidence Scale <i>"On a scale from 0-10, how confident do you feel to make these changes?"</i> <i>"A 10 would mean total confidence and a 0 means no confidence at all."</i> <i>"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?"</i>
4. Give advice and negotiate goal	Give Advice Review concerns, as discussed with patient. Advise abstinence or decrease in use, according to screening and assessment. Give referrals for further assessment, if appropriate. Negotiate Goal <i>"What can you do to stay healthy & safe? Where do you go from here?"</i> SUMMARIZE: <i>"Let me summarize what we've been discussing... Is that accurate? Is there anything I missed or you want to add?"</i> Suggest discussing progress of plan at next appointment.
Close: Thank Patient	<i>"Thank you for taking the time to discuss this with me and being so open."</i>

Exhibit G



Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Eye Movement Desensitization and Reprocessing (EMDR)	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.41
Effective Date: 09/08/21	Date of Review/Revision: 3/9/22, 3/8/23, 3/15/24, 02/12/25, 02/13/26	Approved By: Sandra M. Lindsey, CEO
	Supersedes:	
		Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus Additional Reviewers: EBP Leadership Team

Purpose:

The purpose of this policy is to specify the use of Eye Movement Desensitization and Reprocessing (EMDR).

Policy:

SCCMHA recognizes that the experience of trauma is the rule rather than the exception among consumers served by the public mental health system. Therefore, consumers who have been found to have experienced trauma shall be offered opportunities to participate in trauma-specific, evidence-based, interventions including EMDR.

Application:

This policy applies to the entire SCCMHA provider network.

Standards:

- A. SCCMHA shall, resources permitting, offer Eye Movement Desensitization and Reprocessing (EMDR) for individuals who have experienced trauma and are being served by SCCMHA-funded providers.
- B. Providers who deliver EMDR shall receive SCCMHA-approved training and must be privileged to provide EMDR in accordance with SCCMHA policy.
- C. EMDR shall be delivered with fidelity to the model.
 1. SCCMHA's quality improvement activities shall include fidelity monitoring to ensure adherence to the evidence-based practice model using the GOI (General Organizational 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 EMDR, to discuss fidelity monitoring.
- b. When EMDR 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 yearly (or as appropriate for the frequency with which EMDR is occurring) for EMDR participants.

D. Treatment Description:

- 1. EMDR therapy¹ combines different elements to maximize treatment effects.
- 2. EMDR therapy involves attention to three time periods: the past, the present, and the future.
 - a. Focus is given to past disturbing memories and related events, current situations that cause distress, and to developing the skills and attitudes needed for positive future actions.
 - b. The time periods are addressed using an eight-phase treatment approach (see Exhibit A).
 - 1). **Phase 1:** History-taking session(s) and treatment plan development.
 - a). The therapist assesses the consumer's readiness and works with the consumers to develop a treatment plan.
 - b). The person served and therapist identify possible targets for EMDR processing, including distressing memories and current situations that cause emotional distress and related incidents in the past.
 - (1). Emphasis is placed on the development of specific skills and behaviors that will be needed by the person served in future situations.

NOTE: Initial EMDR processing may be directed to childhood events rather than to adult-onset stressors or the identified critical incident if the person served had a problematic childhood. Consumers generally gain insight into their situations, the emotional distress resolves, and they start to change their behaviors. The length of treatment depends upon the number of traumas and the age of the onset of PTSD. Generally, individuals with single event adult-onset trauma can be successfully treated in under 5 hours, while individuals who have experienced multiple traumas may require a longer treatment timeframe.

¹ A full description of the theory, sequence of treatment, and research on protocols and active mechanisms can be found in F. Shapiro (2001) *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures (2nd edition)* New York: Guilford Press.

2). **Phase 2:** Developing ways of handling emotional distress.

- a). The therapist may teach the person served a variety of imagery and stress reduction techniques the person served can use during and between sessions.

NOTE: A goal of EMDR therapy is to produce rapid and effective change while the person served maintains equilibrium during and between sessions.

3). **Phases 3-6:** Identification and processing of a target using EMDR procedures.

- a). The person served identifies three items:
 - (1). The vivid visual image related to the memory.
 - (2). A negative belief about oneself.
 - (3). Related emotions and body sensations.
- b). The person served also identifies a positive belief.

- (1). The therapist helps the person served rate the positive belief as well as the intensity of the negative emotions.
- (2). The person served is then instructed to focus on the image, negative thought, and bodily sensations while simultaneously engaging in EMDR processing using sets of bilateral stimulation.

- (a). These sets may include eye movements, taps, or tones.

NOTE: The type and length of these sets are different for each consumer.

- (b). At this point, the EMDR person served is instructed to just notice whatever spontaneously happens.
- (c). After each set of stimulation, the clinician instructs the person served to let their mind go blank and to notice whatever thought, feeling, image, memory, or sensation comes to mind.
- (d). Depending upon the consumer's report, the clinician will choose the next focus of attention.

NOTE: These repeated sets with directed focused attention occur numerous times throughout the session. If the person served becomes distressed or has difficulty in progressing, the therapist follows established procedures to help the person served get back on track.

(c). When the person served reports no distress related to the targeted memory, they are asked to think of the preferred positive belief that was identified at the beginning of the session. At this time, the person served may adjust the positive belief if necessary, and then focus on it during the next set of distressing events.

4). **Phase 7:** Person served log.

a). The therapist asks the person served to keep a log during the week.

NOTE: The log should document any related material that may arise. It serves to remind the person served of the self-calming activities that were mastered in phase two.

5). **Phase 8:** Examination of progress to date.

NOTE: The EMDR treatment processes all related historical events, current incidents that elicit distress, and future events that will require different responses

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.

EMDR (Eye Movement Desensitization and Reprocessing): A psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences. Repeated studies show that by using EMDR therapy people can experience the benefits of psychotherapy that once took years to make a difference. It is widely assumed that severe emotional pain requires a long time to heal. EMDR therapy shows that the mind can in fact heal from psychological trauma much as the body recovers from physical trauma. The brain's information processing system naturally moves toward mental health. If the system is blocked or imbalanced by the impact of a disturbing event, the

emotional wound festers and can cause intense suffering. Once the block is removed, healing resumes. Using the detailed protocols and procedures learned in EMDR therapy training sessions, clinicians help clients activate their natural healing processes. (EMDR Institute, Inc.)

References:

- A. EMDR Institute, Inc. [What is EMDR? - EMDR Institute - EYE MOVEMENT DESENSITIZATION AND REPROCESSING THERAPY](#)
- B. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- C. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports

Exhibits:

- A. EMDR Session Notes

Procedure:

None

Exhibit A

EMDR Session Notes

Clinician: _____

Client Initials: _____ Date: ____/____/____

Presenting symptom: _____

Treatment Session: (circle one): First Reevaluation

Session # _____

EMDR Treatment:

Target: (circle one): Past Present Future _____

Negative Cognition/Belief: _____

Positive Cognition/Belief: _____

VoC: (circle one) 1 2 3 4 5 6 7

Emotions: _____

SUD: (circle one) 0 1 2 3 4 5 6 7 8 9 10

Body Location: _____

Session Outcome/Target Memory Status: (circle one) Completed Unfinished

SUD: (circle one) 0 1 2 3 4 5 6 7 8 9 10

VoC: (circle one) 1 2 3 4 5 6 7

Closure: If needed (check)

[] Grounding/Breathing [] Secure Place [] Container [] EMD

Client Stability when leaving session: Poor Fair Good Excellent

Treatment Notes:

Additional Interventions Planned:

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Mindfulness	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.42
Effective Date: 12/09/2021	Date of Review/Revision: 1/10/23, 1/31/24, 02/12/25, 04/28/25, 03/16/26	Approved By: Sandra M. Lindsey, CEO
	Supersedes:	
		Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services Authored By: Mary Baukus Additional Reviewers: EBP Leadership Team

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.
- F. When Mindfulness is used in a session/appointment, the EBP practitioner shall include answers to the following in their EHR documentation:
 - a. Why are they using Mindfulness?
 - b. What was addressed with the use of Mindfulness?
 - c. What specific type of Mindfulness was used?
 - d. How did the person served respond to Mindfulness?

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 Saginaw County Community Mental Health Authority		
Subject: DECIPHeR (IDEAL Goals)	Chapter: 02 – Customer Services & Recipient Rights	Subject No: 02.03.09.45
Effective Date: 12/01/2025	Date of Review/Revision:	Approved By: Sandra M. Lindsey, CEO
	Supersedes:	
		Responsible Director: Jen Kreiner Authored By: Jen Kreiner, Tammie Gillespie, Samantha Tenut Additional Reviewers: Taylor Crosby, EBP Leadership Team

Purpose:

The Disparities Elimination through Coordinated Interventions to Prevent and Control Heart and Lung Disease Risk (DECIPHeR) program is a research study designed to reduce disparities in heart disease among persons with serious mental illness by combining two evidence-based practices—Life Goals Collaborative Care and Reach Your Ideal Health Trial—into a single, final evidence-based practice, known as IDEAL Goals. This initiative is supported by the National Heart, Lung, and Blood Institute (NHLBI) and involves a collaborative effort between the University of Michigan and Johns Hopkins University. The program is implemented at outpatient community mental health program sites that are adopting behavioral health homes.

This initiative is supported by the National Heart, Lung, and Blood Institute (NHLBI). It involves a collaborative effort between the University of Michigan and Johns Hopkins University to study the efficacy of training and support on implementation fidelity. Outpatient community mental health program sites that are adopting behavioral health homes are invited to contribute to this research as a study site in exchange for program licensing permissions, training, and technical support. The study is conducted under the oversight of an Institutional Review Board (IRB) to ensure ethical standards are maintained.

Application:

This policy applies to all participating outpatient community mental health program sites involved in the DECIPHeR program.

Policy:

It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) to outline the framework for participating in and incorporating the DECIPHeR program into clinical practices. This policy ensures that participants receive standardized education and resources, while allowing for variation in implementation support to optimize outcomes.

Standards:

1. Evidence-Based Interventions: Combine Life Goals Collaborative Care and Reach Your Ideal Health Trial to create the IDEAL Goals practice.
2. SCCMHA will receive varying levels of support, including training, coaching, and facilitation.
3. Implementation Phases:
 - o Phase 1 (2-3 years): Gather provider and person served input.
 - o Phase 2 (4 years): Train staff and implement IDEAL Goals.

Definitions:

- Persons Served: Individuals receiving services at the participating sites.
- IDEAL Goals: The final evidence-based practice combining Life Goals Collaborative Care and IDEAL practices aimed at reducing heart disease risk.

References:

1. National Heart, Lung, and Blood Institute (NHLBI). [Advancing Heart, Lung, Blood, and Sleep Research & Innovation | NHLBI, NIH](#)
2. University of Michigan Life Goals Collaborative at [Life Goals Collaborative Care | Proven to improve medical and psychiatric outcomes.](#)
3. Johns Hopkins University IDEAL Goals at <https://publichealth.jhu.edu/alacrity-center-for-health-and-longevity-in-mental-illness/research/completed-projects/cardiovascular-risk-reduction-trial-in-serious-mental-illness-ideal>.
4. Kilbourne, A.M., Goodrich, D. E., Lai Z., et al. Randomized controlled trial to assess reduction of cardiovascular disease risk in patients with bipolar disorder: The self-management addressing heart risk trial (SMAHRT). J Clin Psychiatry 2013;74:e655-62.

5. Kilbourne, A.M., Barbarasso, M.M., Lai Z., et al. Improving Physical Help in Patients with Chronic Mental Disorders: 12-1 Results from a Randomized Control Collaborative Care Trial. J Clin Psychiatry 2017;78:129-37.
6. Daumit G., Dalcin A.T., Dickerson f., et al. Comprehensive cardiovascular risk reduction intervention in persons with serious mental illness: A randomized clinical trial. JAMA Network Open 2020. [Effect of a Comprehensive Cardiovascular Risk Reduction Intervention in Persons With Serious Mental Illness: A Randomized Clinical Trial - PMC.](#)

Exhibits:

- A. Training materials and Person served workbook
- B. Technical assistance resources
- C. SENTRI IDEAL Goals Progress Note How-to

Procedure:

ACTION	RESPONSIBILITY
Identify providers and persons served for input.	Chief of Health Services and Integrated Care
Establish Community Working Groups groups/individuals to tailor IDEAL Goals.	Chief of Health Services and Integrated Care
Train staff in IDEAL Goals and provide ongoing assistance.	DECIPHeR Program Team (Training provided by University of Michigan and Johns Hopkins University, ongoing support and assistance provided by IDEAL-GoalsHelp@jh.edu)
Identify and recruit persons served to participate in IDEAL goals.	SCCMHA IDEAL Goals clinical team
Implement IDEAL Goals as part of routine care.	SCCMHA IDEAL Goals Clinical Team
Collect outcomes data.	Quality/Data Team in collaboration with UM and JHU.

Gather and analyze feedback for continuous policy, procedure, and workflow improvement.

SCCMHA IDEAL Goals Clinical Team

Exhibit A

Please log into the <https://idealgoals.org/resources/> to obtain all training materials and participant workbooks.

Exhibit B

Resources are available throughout the study to help with program uptake and delivery.

Resource	Description	Where to Find
Program Specialist	Offers technical assistance and program support.	Email:idealgoalshelp@jh.edu
IDEAL Goals Website	Describes the IDEAL Goals programs and includes program materials, online training videos	idealgoals.org
Avatar simulations for patient-centered counseling skills practice	Provides an opportunity to practice patient-centered counseling skills when talking to clients about weight management, tobacco smoking cessation, or dyslipidemia	https://learning.kognito.com/diweb/institution/guid/985aa662-4846-4038-9ad1-bf5d049c19c6
Care Management Evidence Bundle	Provides guideline-concordant treatment recommendations for each physical health cardiovascular disease risk factor	idealgoals.org or the Delivery Team Binder
Care Management Treatment Workflows for CVD Risk Factors	Describes guideline concordant treatment workflows for physical health risk factors	idealgoals.org or the Care Management Evidence Bundle
Online Training Modules	Provide an opportunity for new staff to complete the IDEAL Goals Program Training and serve as a resource for staff who completed the live training	idealgoals.org

Obtained from “Delivery Team Binder.”

Exhibit C

1. Open a progress note.
2. Complete progress note as any other note – date, time, location (where IDEAL Goals were completed).
3. Add EBP – DECIPHer.

1. Progress Note: Narrative

☐ Flag this note as critical information for prescriber to view during medical review

Service Date and Time

Date: 11/5/2025  Begin Time: 12 PM End Time: 1230 PM Staff: Samantha Tenut

[Use Current Date](#)

Location

Location: Specialized AFC

If Other, Explain:

For this encounter, did you use an Evidence Based Practice (EBP) to fidelity that is included in the drop-down menu below? (Please do not select "Yes" if you have not met the necessary requirements, i.e. been privileged, to be a provider of the EBP.)

☒ Yes ☐ No

The contact documented by this note involved the following evidence based practice(s)

[Show / Hide EBP Descriptions](#)

[Add Evidence Based Practice](#)

Evidence Based Practice

DECIPHer 

4. Add information to “Notes or Other Information.”
5. Complete C-SSRS as required.

6. Go to “DECIPHer” tab and complete section as appropriate to session completed.

5. Progress Note: DECIPHer

IDEAL Goals or care coordination activities completed (Select all that apply)

☐ IDEAL Goals session delivered

☐ Exchanged information with provider

☐ Advocated for care with provider

☐ Supported client self-management (tracking, self-advocacy, attainment of goals)

☐ Coordination with family or support team at organization

Conditions addressed in the IDEAL Goals or care coordination activities (Select all that apply)

☐ Dyslipidemia

☐ Hypertension

☐ Diabetes mellitus

☐ Weight management

☐ Tobacco smoking

☐ Mental health condition

☐ Other condition:

IDEAL Goal Status

☐ Initiating ☐ Active/In-Progress ☐ Pausing ☐ Declined

IDEAL Goals Notes

characters left: 8000

- a. Copy information from step 4 into “IdealGoal notes” on DECIPHer tab.
See above.

7. Sign note using billing code S0280.

1 Service Activity Log Add Service Activity Log

Staff 1026292 Samantha Tenut
Consumer 000000012 Janet W. Doe
Provider [lookup](#) [clear](#)
 SCCMHA Health Home
Address
 500 Hancock
City Saginaw **State** MI **Zip** 48602-4224

Date: 11/05/2025
Begin: 12:00PM
End: 12:30PM
☐ SAL Spans Midnight

Contact Type: Face to Face
Attendance: Client Present
Place of Service: Specialized AFC

☐ Integrated Service (HH) ☐ Follow Up Visit (TS)
☐ Incarcerated Individual (QJ) ☐ IDDT (Y4)
☐ Trained Parent Support Partner (WP) ☐ SE/IPS Service (Y5)
☐ Certified Peer Specialist (WS) ☐ PMTO (Y3)
☐ TF-CBT/CPD Service (ST) ☐ MRSS (HT)
☐ DBT for Adolescents (Y2) ☐ Youth Peer Specialist (WT)
☐ Prolonged Exposure Therapy (Y1) ☐ Family Psychoeducation (FPE) - ACT (WV)

Diagnosis
 Select the primary diagnosis that is being treated for during this treatment event. Enhanced Health Services should ensure the first (primary) diagnosis is updated to reflect the diagnosis that is being treated for during this treatment event.

1) F25.0 [lookup](#) [clear](#)
 2) E11.01 [lookup](#) [clear](#)
 3) F41.1 [lookup](#) [clear](#)
 4) Z91.51 [lookup](#) [clear](#)

Authorization **HCPCS/CPT® Code** [lookup](#) [clear](#)
 S0280

Service Address
 Consumer Address

Was MD/DO/NP/PA general supervision available? ☐ Yes ☐ No

Who was the MD/DO/NP/PA general supervision available during the service? [lookup](#) [clear](#)

Please use the LOOKUP button to find an authorization and CPT® code for the service provided

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Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Trauma-Informed Services and Supports	Chapter: 02 – Customer Service and Recipient Rights	Subject No: 02.03.14
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	Supersedes: 02.01.10	
		

Purpose:

The purpose of this policy is the importance of the recognition of trauma as a foundational concept across the service array in the provision of all services and supports, embed trauma-informed principles of care within the SCCMHA service system and Saginaw community, promote a strength-based focus on resilience that endorses respect for persons served/families in all situations, as well as to delineate organizational efforts to address secondary trauma among staff. SCCMHA recognizes the idea of universal trauma precautions. This approach always presumes the possibility that an individual one encounters, whether a person served, visitor, or staff member, may have a trauma history.

Policy:

- A. SCCMHA recognizes that trauma is pervasive among children, youth, adults, and families who are involved in public systems. Additionally, trauma may be significant amongst staff members. Trauma exposure among children and youth is associated with lifelong health, mental health, and related problems. High percentages of individuals with mental illness, substance use disorders, co-occurring psychiatric and substance use disorders, and intellectual/developmental disabilities have experienced childhood neglect or abuse, sexual assault, and other traumatizing experiences. Trauma can challenge a person's capacity for recovery. The impact of trauma exposure can be mitigated by developing a service delivery and support system that is trauma-informed, prevention-oriented, and focused on

improving mental health functioning for children, youth, adults, and their families. Therefore, SCCMHA supports strategies that are designed to prevent and eliminate treatment practices that cause trauma or re-traumatization as well as those that reduce the adverse impact of trauma exposure on persons served.

- B. SCCMHA administers an organizational trauma-informed culture initiative across the network of service providers and in the local community, which incorporates leadership input of provider and person served members to inform a system trauma-informed practices plan, train and integrate knowledge about violence and abuse and fully account for person served experiences.
- C. SCCMHA recognizes that staff may experience secondary trauma pursuant to working with persons served who have experienced trauma and shall make every effort to address secondary trauma among staff members and shall make resources designed to mitigate its impact available to staff.

Application:

This policy applies to all providers that receive funding from SCCMHA as well as all staff of the SCCMHA organization.

Standards:

- A. Persons served shall be screened for trauma exposure and related symptoms at initial intake and annually with the completion of the psychosocial assessment.
 - 1. Screening instruments for children and youth
 - a. The trauma section of the MichiCANS comprehensive for children and adolescents.
 - b. CTAC Trauma Screening Checklist 0-5 years
 - c. CTAC Trauma Screening Checklist 6-18 years
 - 2. Screening instrument for adults
 - a. CTAC Adult Trauma Screen Self-Report
- B. SCCMHA supports the core principles of a trauma-informed system of care:
 - 1. Safety: ensuring physical and emotional safety of persons served by providing a safe, calm, and secure environment with supportive care to ensure the physical and emotional safety of persons served
 - 2. Trustworthiness: maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries
 - 3. Choice: prioritizing person served voice, choice, and control as well as self-advocacy
 - 4. Collaboration: maximizing collaboration and sharing of power with persons served through the development of healing, hopeful, honest, and trustworthy relationships
 - 5. Empowerment: prioritizing person served empowerment and skill-building through recovery-oriented, person served-driven, trauma-specific services and supports
 - 6. System-wide understanding of the prevalence and impact of trauma on persons served
 - 7. Cultural competence
- C. SCCMHA shall create and maintain a trauma-informed system of care for children and their families that:

1. Makes resources on trauma exposure, its impact, and available treatments available to children, families, and providers
 2. Focuses on strengthening the resilience and protective factors of children and families who have been impacted by and are vulnerable to trauma
 3. Addresses parent and caregiver trauma and its impact on the family system
 4. Emphasizes continuity of care and collaboration across child-service systems
 5. Maintains an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and increases staff resilience
- D. SCCMHA shall ensure that trauma-informed services and supports incorporate the following components:
1. Trauma-informed screening upon admission, and annually with the psychosocial assessment, to identify persons served who are at high risk. (See A-1 and A-2 in this section.)
 2. When a Trauma-informed screening indicates that the person served has experienced trauma, the person served is given the choice to have an assessment of their experiences with trauma, after admission or continued services, is completed using validated instruments and techniques.
 - a. Assessment for adults
 - i. PTSD Checklist for DSM-5 (PCL-5)
 - b. Assessments for children and youth
 - i. Young Child PTSD Checklist Version 5 (YCPC-5) 1-6 years
 - ii. UCLA PTSD Reaction Index for Children/Adolescents DSM 5, 7-18 years
 3. The assessments will:
 - a. Provide a context for current symptoms and guide clinical approaches and recovery progress.
 - b. Inform the treatment culture to minimize potential for re-traumatization.
 4. Treatment planning that facilitates person served choice, control, and participation in treatment, program/policy development, and evaluation.
 5. An environment that is physically and practically designed to avoid re-traumatization.
 6. An environment that is safe and nurturing.
 7. An environment that is empowering.
 8. An environment that is culturally competent.
 9. An environment that is therapeutic.
 - a. This therapeutic environment is demonstrated by:
 - i. Waiting rooms and group rooms that are accessible, clean, neat, and decorated with comfortable furnishings and tasteful wall decorations.
 - ii. Chairs in waiting rooms, group rooms and offices should be sturdy and able to accommodate all persons regardless of size.
 - iii. In spaces where children receive services there should be age-appropriate activities available to make waiting easier. These materials should be kept clean and replenished on a regular basis.

- iv. The front desk where persons served check in should be designed in a way that makes the staff person accessible to the person served while also protecting personal health information.
 - v. Careful consideration should be given to lighting, assuring that it allows for a calm comfortable atmosphere but is not too dim which can result in a dreary, depressing environment.
 - vi. Reading materials, signage, and other educational materials and televisions should be available in waiting rooms for the comfort of the person served and those who may be transporting them.
 - vii. Programs shown on television should be of general interest and reflect, as possible, the values of Saginaw County Community Mental Health Authority.
 - viii. Care should be given to assure that the temperature is comfortable for most persons served.
 - ix. Spaces used for therapeutic purposes must be accessible, clean, and neat with comfortable furnishings and tasteful wall decorations.
 - x. Spaces used for therapeutic purposes must be free of controversial decorations such as religious symbols, political commentary, inflammatory or prurient materials, or other decorative or personal items that might hinder or interfere with the therapeutic environment by causing a conflict with the personal values or beliefs of the persons served in that space.
 - xi. Spaces used for therapeutic purposes as well as general person served waiting rooms should feel safe for most persons served, they should be well lit and private.
 - xii. When meeting with a person served for therapeutic purposes, care should be taken to ensure full person served choice; including but not limited to choice of where to sit in the room, whether to have the door open or closed, and choice of who is in the room with them.
- b. For persons served in residential homes this is demonstrated by:
- i. Homes that are well maintained both inside and outside
 - ii. The main living areas of the home have a warm and homelike feel.
 - iii. Persons served are encouraged and supported to decorate their own personal space with bedding and decorations of their own choosing.
 - iv. Dining areas are large enough for persons served to dine family style.
 - v. Furniture and furnishings are sturdy and in good repair and fixed and/or replaced as needed.
 - vi. Health and safety inspections will occur on a regular basis but at least on an annual basis in all facilities operated by, or under contract with, SCCMHA. The results of these inspections will be documented, identifying the areas inspected and the recommendations for improvement, as well as the action taken to respond to the recommendations.

- c. Welcoming and Recovery are not just about the physical environment but also evidenced through the attitude of the staff working within each environment. Steps should be taken to assure that:
 - i. Persons answering the phone at the main switchboard are pleasant, respectful and have a welcoming trauma-informed attitude.
 - ii. Those assigned front desk responsibility have the personality needed to greet persons served, making them feel comfortable, safe, and welcomed.
 - iii. Staff serving persons served demonstrate respect for persons served, an understanding of recovery, trauma-informed care, and a welcoming attitude.
 - iv. Staff working in residential settings acknowledge that the residence is the person served's home, and the person served is the focus of the services being provided.
 - d. In addition, a therapeutic environment includes:
 - i. Consistently assigned personnel
 - ii. Scheduled activities
 - e. Sufficient professional staff to:
 - i. Conduct clinical assessments
 - ii. Develop appropriate individual plans
 - iii. Provide therapeutic interventions
 - iv. Review goals/objectives on a regular basis
 - f. Recovery is the expectation for persons with mental illness and/or substance use disorders. This should be evident within the environment through posters and materials in the waiting room and through the attitudes of all staff working with persons with mental illness and/or substance use disorders.
10. Staff training regarding trauma and related issues as well as how to provide treatment and care to individuals who have experienced trauma including:
- a. Staff orientation, training, support, job competencies, and standards related to trauma including an understanding of the dynamics of trauma and recognition that some practices (e.g., the use of seclusion and restraint and forcing intramuscular shot medications) are re-traumatizing.
 - b. Staff development activities that reflect understanding of and sensitivity to issues of violence, trauma, and coercion; incorporate relevant skill sets and job standards; and address prevalence and impact of traumatic events.
 - c. Administrative policy that stipulates that all employees receive orientation and basic education about the prevalence and traumatic impacts of sexual and physical abuse and other overwhelming adverse experiences in the lives of persons served.
 - d. Curriculums used for orientation and basic training that cover the dynamics of re-traumatization and how practices can mimic original

sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person in order to ensure safety and reduction of harm.

- e. All employees receive education regarding the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status on individuals' experiences and perceptions of trauma and their unique ways of coping or healing.
- f. Education of direct service and clinical staff that fosters a trauma-informed understanding of unusual or difficult behaviors, the maintenance of personal and professional boundaries, trauma dynamics and avoidance of iatrogenic re-traumatization, relationships between trauma, mental health symptoms and other problems and life difficulties, vicarious traumatization, and self-care.
- g. The application of trauma-informed issues and approaches and trauma-specific techniques such as grounding and teaching trauma recovery skills to persons served.
- h. Input from and involvement of persons (persons served and staff) with the lived experience of trauma shall be a part of trauma trainings.
- i. The implementation evidence-based and promising practices for the treatment of trauma by practitioners whose clinical work includes assessment and treatment, including those involved in critical incident response.
- j. Critical incident planning, policy and curriculums shall include trauma issues and trauma-informed processes shall be incorporated into initial assessments and intervention processes.

E. SCCMHA shall endeavor to address secondary trauma among staff in accordance with the following standards:

- 1. SCCMHA shall provide education regarding trauma and secondary trauma to staff in order to increase self-awareness and recognition which shall include:
 - a. The risk factors for secondary trauma.
 - b. The signs and symptoms of secondary trauma.
- 2. SCCMHA shall promote a supportive culture and safe environment that promotes self-care.
- 3. SCCMHA shall provide information on self-care to staff during orientation and during ongoing continuing education/in-service training.
 - a. Self-care strategies may include: exercise, meditation/mindfulness, healthy eating, increasing positive coping and time management skills, and engaging in supportive relationships, such as reflective supervision, peer consultation and support.
- 4. SCCMHA shall provide opportunities for debriefing following the occurrence of critical incidents.

5. Efforts should be made to assure that each building where staff members are located includes a quiet space that can be used by staff during break periods to separate themselves from the stress of the day.
6. Supervisors shall address secondary trauma during individual and group staff meetings.
7. Staff shall have access to EAP (employee assistance program) services for counseling regarding secondary trauma.

Definitions:

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse (SAMHSA).

Compassion Fatigue which is also known as **secondary traumatic stress (STS)**, is a condition characterized by a gradual lessening of compassion (i.e., the response to the suffering of others that motivates a desire to help) over time.

Individual Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being (SAMHSA).

Recovery is process of change through which individuals improve their health and well-being, live a self-directed life, and strive to reach their full potential.

Re-traumatization entails replication of the event(s) or dynamics of an original trauma which triggers a response associated with the original trauma. Examples include subjecting a person with a history of abuse to restraints and seclusion in a treatment facility or a person exposed to domestic violence who is harshly interrogated in a shelter.

Secondary Trauma which is also known as **vicarious trauma (VT)** is defined as indirect exposure to trauma through a firsthand account or narrative of a traumatic event. SAMHSA (2014) defines secondary trauma as trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all settings and among all professionals who provide services to people who have experienced trauma such as healthcare providers, peer counselors, first responders, clergy, and intake workers.

Therapeutic Environment promotes the ability of each person served to meet the goals and objectives jointly agreed upon in the development of his or her plan. It is free of unnecessary interruptions and distractions

Trauma is defined as 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-Informed Care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives (SAMHSA). This term refers to an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of traumas and seeking to employ practices that do not traumatize or re-traumatize. Trauma-informed care also emphasizes physical, psychological, and emotional safety; trustworthiness and transparency; collaboration and mutuality; empowerment; and cultural sensitivity and responsiveness.

Trauma-Informed Service Systems/Organizations are those in which all components of the system/organization have been reconsidered and evaluated in the light of a basic understanding of the role that trauma plays in the lives of people seeking mental health and substance use disorder treatment services. A trauma-informed organizational environment is capable of supporting and sustaining trauma-specific services. A trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor's life over the lifespan, and therefore coordinates and integrates trauma-related activities and trainings with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics, including that caused by childhood or adult sexual and/or physical abuse shown to be prevalent in the histories of mental health persons served, should be held by all staff and used to design systems of services and supports in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid re-traumatization and facilitate person served participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children who have been traumatically impacted by any of a range of overwhelming adverse experiences, both those that are interpersonal in nature and those caused by natural events and disasters. Written plans and procedures as well as methods to identify and monitor progress in developing a trauma-informed service system and/or trauma-informed organization should be developed and implemented.

Trauma-Informed Services are designed to avoid re-traumatizing persons served as well as staff working in service settings.

Trauma-Specific Services are designed to treat the long-term effects of past sexual, physical, or emotional trauma. Trauma-specific treatments include:

- **Grounding** techniques which help trauma survivors manage dissociative symptoms.
- **Desensitization** therapies which help to render painful images more tolerable.
- **Behavioral therapies** which teach skills for the modulation of strong emotions.

Welcome: to greet hospitably and with courtesy or cordiality

References:

- A. Adverse Childhood Experiences Study ([About the CDC-Kaiser ACE Study |Violence Prevention|Injury Center|CDC](#))
- B. American Academy of Experts in Traumatic Stress (www.aaets.org)
- C. Association of Traumatic Stress Specialists (www.atss.info)
- D. CARF Behavioral Health Standards
- E. David Baldwin's Trauma Information (www.trauma-pages.com)

- F. International Society for the Study of Trauma and Dissociation (<https://www.isst-d.org/>)
- G. Michigan Department of Health and Human Services/Behavioral Health and Developmental Disabilities Administration Trauma Policy, [Trauma-Policy_704460_7.pdf \(michigan.gov\)](#)
- H. National Assn. of State Mental Health Program Directors (www.nasmhpd.org)
- I. National Center for Children Exposed to Violence (www.nccev.org)
- J. National Center for Post-Traumatic Stress Disorder (<https://www.ptsd.va.gov/>)
- K. National Center for Trauma Informed Care (originally from SAMHSA, no longer active)
- L. National Center for Victims of Crime <https://victimsofcrime.org/>
- M. National Child Traumatic Stress Network ([The National Child Traumatic Stress Network |](#))
- N. National Child Traumatic Stress Network. (Undated). *Glossary of Terms Related to Trauma-Informed, Integrated Healthcare*. http://www.nctsn.org/sites/default/files/assets/pdfs/glossary_of_terms_related_to_trauma-informed_integrated_healthcare.pdf
- O. National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (2011). *Secondary traumatic stress: A fact sheet for child-serving professionals*: <https://www.nctsn.org/resources/secondary-traumatic-stress-fact-sheet-child-serving-professionals>
- P. National Trauma Consortium
- Q. Pittsburgh Action Against Rape (www.paar.net)
- R. Rape, Abuse and Incest National Network (www.rainn.org)
- S. Ritual Abuse, Ritual Crime and Healing (www.ra-info.org)
- T. Trauma Services Associates Treatment and Training Institute (www.traumaservices.com)
- U. Sidran Institute (www.sidran.org)
- V. SCCMHA Policy 02.03.05 - Recovery
- W. SCCMHA Policy 02.03.08 – Welcoming
- X. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
- Y. SCCMHA Policy 04.01.04 – Trauma Screening, Assessment and Treatment Services
- Z. SCCMHA Trauma Informed Community Plan
- AA. Stamm, B.H., Varra, E.M., Pearlman, L.A., Giller, F. *Vicarious Traumatization*: [VT Handout 3.2018.pdf \(wsimg.com\)](#)
- BB. Substance Abuse Mental Health Services Administration (SAMHSA)
- CC. Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57*: <https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>
- DD. Vietnam Veterans
- EE. Witness Justice
- FF. Women, Co-Occurring Disorders and Violence Study: <https://www.ncbi.nlm.nih.gov/pubmed/15780539>

- GG. Fallot, R., Harris, M. (2009). *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*: <https://children.wi.gov/Documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf>
- HH. National Council for Mental Wellbeing. Trauma-Informed Care Checklist. [Trauma Informed Care Checklist - National Council](#)

Exhibits:

- A. Person served-Centered, Trauma-Informed, Welcoming Tips and Reminders (Dawn Heje, 9.29.16)
- B. SCCMHA Secondary Traumatic Stress Checklist
- C. Michigan Department of Health and Human Services/Behavioral Health and Developmental Disabilities Administration Trauma Policy

Procedure:

ACTION	RESPONSIBILITY
1. SCCMHA will assign Trauma-Informed Care oversight duties to the Best Practices Quality Assurance Committee, which includes ongoing organizational self-assessment to evaluate the extent to which current policies are trauma-informed, identify organizational strengths and barriers, and any needed corrective action, as well as approaches that address secondary trauma of staff.	1. SCCMHA CEO, Executive Director of Clinical Services and appointed trauma team and Evidence-Based Practice and Trauma-Informed Care Coordinator
2. SCCMHA will provide ongoing training and educational programs to support a trauma-informed culture.	2. Continuing Education Supervisor and EBP & TIC Coordinator
3. SCCMHA will provide oversight of trauma-informed activities which will be reported in relevant community venues.	3. Best Practices Quality Assurance Committee & SCCMHA Service Management Team
4. SCCMHA will provide methods of soliciting person served and provider input and offer resources to support special events, visible communications, and appropriate modifications to highlight, broaden and improve trauma-informed foundational knowledge and inform all practices and procedures through-	4. Service Management Team and Trauma-Informed/Evidence Based Practice and Trauma Informed Care Coordinator and Continuing Education Supervisor

out the network and in the local community.

5. Trauma team members work in collaboration with SCCMHA leadership will include key staff, and trauma survivors such as trauma group participation graduates, who serve in an active advocacy role for service planning, implementation, and evaluation. 6. Persons served are screened for trauma using culturally competent, standardized, and validated instruments appropriate for each population. 7. Persons served are assessed for trauma using culturally competent, standardized, and validated instruments appropriate for each population to identify past or current trauma, violence, abuse, and assess related sequelae that minimally includes: a. Type of trauma (e.g., sexual, physical, emotional abuse or neglect, exposure to disaster) b. Age when the trauma occurred c. Who/what perpetrated the trauma? d. Assessment of symptoms (e.g., dissociation, flashbacks, hyper-vigilance, numbness, self-injury, anxiety, depression, poor school/work performance, conduct problems, eating problems, etc.) e. History of seclusion/restraint, involuntary IM medication experiences f. Individual experiences in inpatient settings (e.g., fear, dissociation, anger, powerlessness)	5. Best Practices Quality Assurance Committee 6. SCCMHA Board Operated and Network Providers 7. SCCMHA Board Operated and Network Providers

g. Homelessness, substance use disorder, domestic violence h. What happened when the trauma was disclosed in the past?	
8. Clinical practice guidelines are used for working with persons served with trauma histories that include services that mitigate the effects of risk factors, minimize any trauma potential, and eliminate any further trauma or re-traumatization.	8. SCCMHA Board Operated and Network Providers
9. Persons served are helped to develop safety plans, crisis plans, advance directives	9. SCCMHA Board Operated and Network Providers
10. Trauma-specific services tailored to the population served are provided when indicated.	10. SCCMHA Board Operated and Network Providers
11. Staff education, training and resources are provided to minimize secondary trauma to staff	11. Service Management Team and Trauma Team Leader/Specialist and Continuing Education Supervisor
12. Sets the expectation that persons served served by SCCMHA receive services in an environment that is accessible, clean, safe, and welcoming.	12. CEO, Executive Director of Clinical Services
13. Reviews the environment on at least an annual basis to assure that the environment meets the standards identified through this policy.	13. Provider and SCCMHA Auditing Department
14. Acts related to the recommendations from the above referenced reviews.	14. Provider

Exhibit A

Person served-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 and telephone assistance that is provided in a warm, welcoming, non-judgmental, person served-centered, trauma-informed, recovery-oriented manner. It is our job to give the person and their loved ones hope for recovery.

Do	Don't/Avoid
During face-to-face contacts sit beside or at a right angle to the person whenever possible.	Sit across from the person with a desk or table between you.
- Ask the person if it would be okay to take notes while you talk. Take notes in a way that the person can see what you are writing. Transfer the notes into the EMR after the face-to-face contact. - If you must enter directly into the EMR when you are with the person, acknowledge the limited eye contact and let them know what you are typing as you type.	- Type into a computer as you talk with the person. If you are entering information into the EMR you are not fully engaged with the person. - Sit or stand with your back to the person at any time.
Use non-verbal and para-verbal communication to let the person know you are listening and that you care. The way you listen, look, move and react is going to tell the person how well you are listening. Examples include eye contact as appropriate for the person's culture; nodding; "um-hmm", leaning in toward the person, facial expression.	- Look at your watch or phone, enter information into the EMR while the person is talking, fidget, stare out the window, doodle or use facial expressions that convey anything but care, concern or respect. - Use sarcasm or an angry tone of voice.
Truly listen. If you are planning what you're going to say next, daydreaming, or thinking about something else, you are probably going to miss nonverbal cues and other subtleties in the conversation. Stay focused on the person and the conversation in order to fully understand what's going on.	- Interrupt, daydream, plan your response, focus on your notes, check your phone, or show signs of impatience or disinterest. - Finish the person's sentence.
- Convey verbally and non-verbally that no matter what the person is facing, there is hope and acknowledge the big step the person took by asking for help. - Each contact should offer explanations and clarifications, and resources and support, 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. • Force them to ask where restrooms are located. • Insist the person answer questions.
• Listen without judgement, artfully ask questions for clarification, provide accurate information, offer assistance, and support the person in their recovery journey by starting in the place they are at to ensure that the person will come back for services.	• Offer advice, assume you know what is best for the person, or judge the person's decisions or situation.
• Remember that asking people to reveal personal information can be re-traumatizing, embarrassing, or frightening. Fully explain about confidentiality before starting every contact. • Acknowledge that some questions can be difficult to answer and that the person is doing a great job with a difficult task.	• Hand the person confidentiality material to read and expect they fully understand about confidentiality. • Neglect the person's signs of discomfort or embarrassment.
• Keep in mind that if a person becomes upset during the interview, it is not recommended to probe for more information. The clinician should stop, take care of the person's needs and help the person regain a sense of safety.	• Ignore signs of distress. • Continue with the interview while the person is crying or showing other signs of emotional distress. • Neglect to offer follow-up services before the person leaves.
• Be extra sensitive to questions about gender identity, sexual orientation, sexual activity, military experience, homelessness or near homelessness, family situation, abuse and trauma, and suicidality.	• While any question could trigger re-traumatization, don't forget that some questions are more likely to bring to mind painful memories, shame, or guilt.
• Look for signs of distress or agitation at the end of the session and help the person regain control over their feelings. Once the clinician is sure the person is okay, end with a warm sendoff or warm handoff.	• End the interview or session with the person distressed or disassociated. • Neglect to spend a few minutes engaging with the person before gently handing 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:

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

[Military Sexual Trauma: Effects & Veteran Resources - Mental Health](#)

Suicide Prevention Resource Center: [Suicide Prevention Resource Center](#)

[Addiction & Mental Health Resources for the LGBTQ+ Community](#)

SCCMHA SECONDARY TRAUMATIC STRESS CHECKLIST

- ☐ Providers shall provide education regarding trauma and secondary trauma to staff in order to increase self-awareness and recognition which shall include:
 - ☐ The risk factors for secondary trauma
 - ☐ The signs and symptoms of secondary trauma
- ☐ Providers shall promote a supportive culture and safe environment that promotes self-care.
- ☐ Providers shall provide information on self-care to staff during orientation and during ongoing continuing education/in-service training.
 - ☐ Self-care strategies may include: exercise, meditation/mindfulness, healthy eating, increasing positive coping and time management skills, and engaging in supportive relationships, such as reflective supervision, peer consultation and support.
- ☐ Providers shall provide opportunities for debriefing following the occurrence of critical incidences.
- ☐ Efforts should be made to assure that each building, where staff members are located, includes a quiet space that can be used by staff during break periods to separate themselves from the stress of the day.
- ☐ Supervisors shall address secondary trauma during individual and group staff meetings.
- ☐ Supervisors should make every effort to promote trustworthiness between supervisors and staff. Supervisors should create an open environment for communication with clear boundaries and expectations.
- ☐ A balance between staff autonomy and clear guidelines should be present in performing job duties.
 - ☐ Staff are encouraged to make meaningful input into affecting their work (i.e. caseload size and diversity, hours and flex time, when to take leave, kinds of training offered, approaches to clinical care, location and décor of office space).
- ☐ All staff are encouraged to collaborate with each other and provide meaningful feedback and feel they are listened to

- o Directors communicate with direct line staff and listen to opinions even if they are not implemented.
- Staff are routinely empowered and skill building is a priority
 - o Each staff member's strengths and skills are utilized to provide the best quality care to persons served/clients
 - o Staff members express a high degree of job satisfaction
 - o Staff members receive annual training in areas related to trauma and workplace stressors
 - o There is appropriate attention to staff accountability and shared responsibility not a blame others mentality.
 - o Supervisory feedback is constructive even when critical.
- Staff shall have access to EAP (Employee assistance program) services for counseling regarding secondary trauma.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

TRAUMA POLICY

The purpose of this policy is to address the trauma in the lives of the individuals served by the community mental health system. This policy is promulgated to promote the understanding of trauma and its impact, ensure the development of a trauma-informed system, and the availability of trauma specific services for all populations served. Trauma is defined as:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.¹

Policy

It is the policy of the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) that Prepaid Inpatient Health Plans (PIHPs), through their direct service operations and their network providers, shall develop a trauma-informed system for all ages across the services spectrum and shall ensure that the following essential elements are provided:

- I. Adoption of trauma-informed culture: values, principles, and development of a trauma-informed system of care ensuring safety and preventing re-traumatization.
- II. Engagement in organizational self-assessment of trauma informed care.
- III. Adoption of approaches that prevent and address secondary trauma of staff (See Exhibit A).
- IV. Screening for trauma exposure and related symptoms for each population.
- V. Trauma-specific assessment for each population.
- VI. Trauma-specific services for each population using evidence-based practice(s) (EBPs), or evidence-informed practice(s) are provided in addition to EBPs.
- VII. The PIHP shall, through its direct service operations and its network providers, join with other community organizations to support the development of a trauma-informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders.^{2, 3}

¹Substance Abuse Mental Health Services Administration (SAMHSA),
<http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx>

²Substance Abuse and Mental Health Services Administration, Leading Change: SAMHSA's Role and Actions 2011-2012.

³SAMHSA's Initiatives, Preventing Substance Abuse and Mental Illness, 2010.

Standards

To ensure a trauma informed behavioral health system, the following standards are required to meet the stated policy.

Policy

- I. Adoption of trauma-informed culture: values, principles, and development of a trauma-informed system of care ensuring safety and preventing re-traumatization.

Standards – Requirements

- a.) The PIHP shall, through its direct service operations and its network providers, develop and support a Quality Improvement committee with representatives from children, adult, SUD, I/DD services, and individuals. The committee's primary focus is to ensure the building and maintaining of trauma informed care within the PIHPs direct service operations and its network providers.
- b.) The PIHP shall, through its direct service operations and its network providers, ensure that all staff, including direct care staff, are trained and has ongoing training in trauma-informed care. An online module is available for use in training, but other curriculums can be utilized if they address the points delineated in the next paragraph. (Online Module: *Creating Cultures of Trauma-Informed Care* with Roger Fallot, Ph.D. of Community Connections, Washington, DC. This online module is available at <http://improvingmipractice.org>).

Training needs to be updated on a regular basis due to changes in the research and/or evidence-based approaches. Staff trained in trauma-informed care should (1.) understand what trauma is and the principles of trauma-informed care; (2.) know the impact of trauma on a child's and/or adult's life; (3.) know strategies to mitigate the impact of the trauma(s);

- (4) understand re-traumatization and its impact; and (5) understand traumatic loss which may include the loss of a therapeutic, direct care or service relationship.
 - c.) Policies and procedures shall ensure a trauma-informed system of care is supported and the policies address trauma issues, re-traumatization, and secondary trauma of staff.
- II. Engagement in organizational self-assessment of trauma-informed care.
 - a.) The PIHP Quality Improvement committee conducts an organizational self-assessment to evaluate the extent to which current agency's policies are trauma-informed and to identify organizational strengths and barriers, including an environmental scan to ensure that the environment/building(s) do(es) not re-traumatize. An online module is available to assist the committee in their self-assessment. No specific self-assessment tool is recommended, but it is recommended that the tool being used is comprehensive and ensures that all aspects of the organization is assessed (administration, clinical services, staff capacity, environment, etc.). (Online module: *Creating Cultures of Trauma-Informed Care: Assessing your Agency* with Roger Fallot, Ph.D. & Lori L. Beyer, LICSW, of Community Connections, Washington, DC. This online module is available at <http://improvingmipractice.org>).
 - The self-assessment is updated every three (3) years.

- III. Adoption of approaches that prevent and address secondary trauma of staff. (See Exhibit A)
 - a.) The PIHP shall, through its direct service operations and its network providers, adopt approaches that prevent and address secondary traumatic stress of all staff, including, but not limited to:
 - Opportunity for supervision
 - Trauma-specific incident debriefing
 - Training
 - Self-care
 - Other organizational support (e.g., employee assistance program)
- IV. Screening for trauma exposure and related symptoms for each population.
 - a.) The PIHP shall, through its direct service operations and its network providers, use a culturally competent, standardized, and validated screening tool appropriate for each population during the intake process and other points as clinically appropriate.^{1, 2}
- V. Trauma-specific assessment for each population.
 - a.) The PIHP shall, through its direct service operations and its provider network, use a culturally competent, standardized, and validated assessment instrument appropriate for each population. Trauma assessment is administered based on the outcome of the trauma screening.³
- VI. Trauma-specific services for each population using evidence-based practice(s) (EBPs). Evidence-informed practice(s) are provided in addition to EBPs.
 - a.) The PIHP shall, through its direct service operations and its network providers, use evidence-based trauma specific services for each population in sufficient capacity to meet the need. The services are delivered within a trauma-informed environment.⁴

¹ACE tool is a population screen and does not screen for related symptoms.

²Examples of standardized, validated screening tools are provided in the trauma section of the website, www.improvingMIpractices.org.

³Examples of standardized, validated assessment tools are provided in the trauma section of the website, www.improvingMIpractices.org.

⁴Examples of trauma-specific services are provided in the trauma section of the website, www.improvingMIpractices.org

- VII. The PIHP shall, through its direct service operations and its network providers, join with other community organizations to support the development of a trauma-informed community that promotes behavioral health and reduces the likelihood of mental illness and SUD.
- a.) The PIHP and its network providers shall join with community organizations, agencies, community collaboratives (i.e., MPCBs), and community coalitions (i.e., Substance Abuse Coalitions, Child Abuse and Neglect Councils, Great Start Collaboratives, neighborhood coalitions, etc.) to support the development of a trauma-informed community that promotes healthy environments for adults, children, and their families.
 - b.) Education on recovery and the reduction of stigma are approaches supported in a trauma-informed community.
 - c.) Substance abuse prevention programs are provided using a SAMHSA approved, evidence-based, and trauma-informed approach.

Exhibit A

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary Traumatic Stress refers to the presence of post-traumatic stress disorder (PTSD) symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

Compassion fatigue is a less stigmatizing way to describe secondary traumatic stress and has been used interchangeably with the term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another individual's traumatic material.

Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues and the conviction that one's work makes a meaningful contribution to clients and society.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops because of general occupational stress. The term is not used to describe the effects of indirect trauma exposure specifically.

Source: The National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. Los Angeles, CA, and Durham, NC. National Center for Child Traumatic Stress.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Person Served Health & Safety	Chapter: 03 - Continuum of Care	Subject No: 03.02.06
Effective Date: 6/1/07	Date of Review/Revision: 6/22/09, 7/15/10, 6/11/12, 1/4/13, 5/6/16, 6/13/17, 6/1/18, 6/17/19, 6/8/20, 4/27/21, 6/26/23, 10/25/24, 3/24/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & EHS
	Supersedes:	
		Authored By: Jennifer Keilitz Additional Reviewers: None

Purpose:

The purpose of this policy is to define a proactive process for identifying and addressing potential health and safety concerns and risk for and with persons served, through the person-centered planning process, and to define a responsive intervention process for all providers to follow in the event that an individual person's health or safety is compromised.

Policy:

It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) to actively engage persons served in defining and identifying health and safety concerns and developing solutions based upon a reasonable community standard. Further, it is the policy of SCCMHA that health and safety concerns, while they may be a consideration, will not be an unnecessary barrier to the achievement of a person's desired outcomes as expressed through the person-centered planning process. In all situations, health and safety concerns will not negate the ability of an individual to pursue a self-determined life and/or seek personal recovery. SCCMHA will promote a wellness focus in the provision of services and supports for individuals served throughout the network. It is the policy of SCCMHA to promote healthy and safe living situations for all persons served.

Application:

This policy applies to all service providers throughout the SCCMHA service network.

Standards:

1. SCCMHA policies and procedures will consistently seek to promote the health and wellness, as well as assure the safety of persons served.

2. All SCCMHA Providers and staff members have a responsibility to observe, monitor, support, document, report and/or address health and safety conditions and risk with persons served who are receiving services.
3. Primary health care coordination will be promoted and documented by SCCMHA network providers.
4. Adverse and allergic reactions to medications or other medical treatments will be reported to the prescribing physician by the appropriate provider and highlighted in the individual's electronic health record.
5. Suspected allergies should be addressed and confirmed by a treating physician prior to notation in the persons electronic health record as a standing allergy.
6. All SCCMHA programs and sites are required to be latex-free, in order to protect both persons served and providers who may have existing or be susceptible to the development of latex allergies and reactions.
7. Any situation that occurs that compromises a person's health and/or safety, or any newly diagnosed condition, will prompt a re-assessment of the person's plan and increased monitoring as appropriate by the treatment team.
8. Treatments for acute or chronic health conditions will be directed by the primary treating physician, including current patient education materials and treatment instructions. Treatment team members will properly note details in the record, and update physician treatment instructions for any condition on a regular basis as appropriate, noting any changes to the physician. Secondary providers will be briefed by treatment team members on person specific conditions and related instructions prior to service provision.
9. Treatment team providers will ensure that residential or other community living services staff, when applicable, receive assessment and treatment information relative to general and specific health, safety and wellness of individual persons served; secondary providers will be given specific instructions by enhanced health team members for individual client treatments as needed. Secondary providers will report health and safety concerns promptly to appropriate treatment team members.
10. Treatment team providers are expected to develop a plan of action or solution to address any health or safety concern, which includes the identification and mobilization of resources, including but not limited to physical changes in the environment, changes in current health practices or behaviors, etc.
11. In all situations of life threatening or potentially life-threatening emergencies, emergency responders should be immediately contacted first, regardless of what immediate simultaneous measures those on the scene must initiate, or what site-specific procedures must be followed.
12. All treatment team members will understand basic first aid; assistance measures as appropriate will be taken by those on the scene of an incident whenever appropriate.
13. Primary prevention, including wellness physicals, and patient education should always be promoted.
14. Good hygiene practices should always be promoted and demonstrated by treatment team members.
15. Documentation on health conditions will be specific to each individual as needed.

16. All treatment team members are expected to be observant regarding any health change for all individual persons, 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.
17. Secondary providers, such as residential, skill build or community living supports, have a direct responsibility to assist persons served with daily health care needs and take steps to decrease health and safety risk factors, as well as communicate to primary case holders about individual health related issues and to coordinate care.
18. Attention to health and safety includes monitoring of physical living settings and spaces, and appropriate alerts, referrals, or interventions, according to healthy home standards including but not limited to mold, fire and pest prevention.

Definitions:

Adverse Reactions - Any harmful effect on the body of therapeutic drugs, drugs of abuse or the interaction of two or more pharmacologically active agents within a short time span; drugs most likely to create adverse reactions include hypnotics, central nervous system stimulants, antidepressants, tranquilizers, and muscle relaxants. Any adverse reaction is any harmful, unintended effect of the medication, diagnostic test or therapeutic intervention.

Allergy or Allergic Reaction – Allergy is defined as a hypersensitive state acquired through exposure to a particular allergen, re-exposure bringing to light an altered capacity to react; allergies may be classified as immediate and delayed. Allergic reaction is defined as an unfavorable physiologic response to an allergen to which a person has previously been exposed; the response may be characterized by a variety of symptoms and may be immediate or delayed.

Body Mass Index or BMI – A calculation using a person's weight and height, resulting in an easily determined number that is a fairly reliable indicator of body fat for most persons; while BMI does not measure body fat directly, it has been shown through research to correlate directly with body fat measurement. For children and teens, BMI is age and sex specific and may be referred to as BMI-for-age. For adults BMI may be used as a screening tool for possible weight related health problems risk in identifying overweight and obese conditions.

Health or Safety Concern – any situation or circumstance that causes an individual or other involved individuals to express a need to change a current pattern of behavior or health practice, based upon their observation that the person has evidenced specific risk.

Health Risk Condition – conditions that potentially compromise the individual's personal safety or health, if not addressed.

Hygiene – the principles and science of the preservation of health and prevention of disease.

Primary Prevention – a program of activities directed to improving general well-being while also involving specific protection for selected diseases, such as immunizations.

Case Holders - Case Managers, Supports Coordinators, Therapists, Wraparound Coordinators and other staff who are noted in the persons electronic health record (E.H.R) as the case holder and are responsible for case coordination and implementation and authorship of the persons individual plan of service (IPOS).

Secondary Providers – Those staff or contract staff that provide services to persons served but are not noted as the case holder in the persons electronic health record (E.H.R.), these persons are typically, skill building, residential, physical therapist, occupational therapist, nurse, dietitian, psychiatrist, peer support, parent support, community living supports staff, etc.

Wellness – proactive approach to health promotion that encourages positive health behaviors and increases awareness of potential health risks through education. *According to SAMHSA, wellness includes at least eight (8) dimensions: emotional, environmental, intellectual, financial, spiritual, social, occupational, and physical.*

References:

Internal: SCCMHA Policies – *Environment of Care Program; Person-Centered Planning; Health Care Integration; Infection Control; Pest Prevention, Identification & Management*

External:

Substance Abuse & Mental Health Services Administration – wellness information

Exhibits:

- Exhibit A – BMI Chart for Adults
- Exhibit B - BMI Chart for Children
- Exhibit C – Healthy Homes 8 Tips
- Exhibit D - Maintenance Checklist

Procedure:

ACTION	RESPONSIBILITY
Provide medical interventions and relevant treatment directives for individuals.	Treating Physicians
Document health and safety issues and responses and develop plans to address; routinely monitor and educate individuals and secondary providers regarding person specific needs or changes.	Case Holders
Document health and safety concerns; assist persons served with needs; observe and report risk concerns to appropriate treat-	Secondary Providers

ment team members; notify primary team contact(s) about health concerns/issues/questions.	
Monitor individuals living arrangement for any health and safety concerns.	Case Holders
Documents Allergy or Allergic Reactions in person served record under Alerts.	Case Holders
Documents individual health care conditions in the individual's diagnosis area of the chart.	Nurses, Physicians Assistants, and Psychiatrists,
Monitors individuals follow up with primary care physician at least annually. This is especially true for persons with Intellectual and Developmental Disabilities.	Care Holders

Exhibit A



Adult Body Mass Index (B M I)



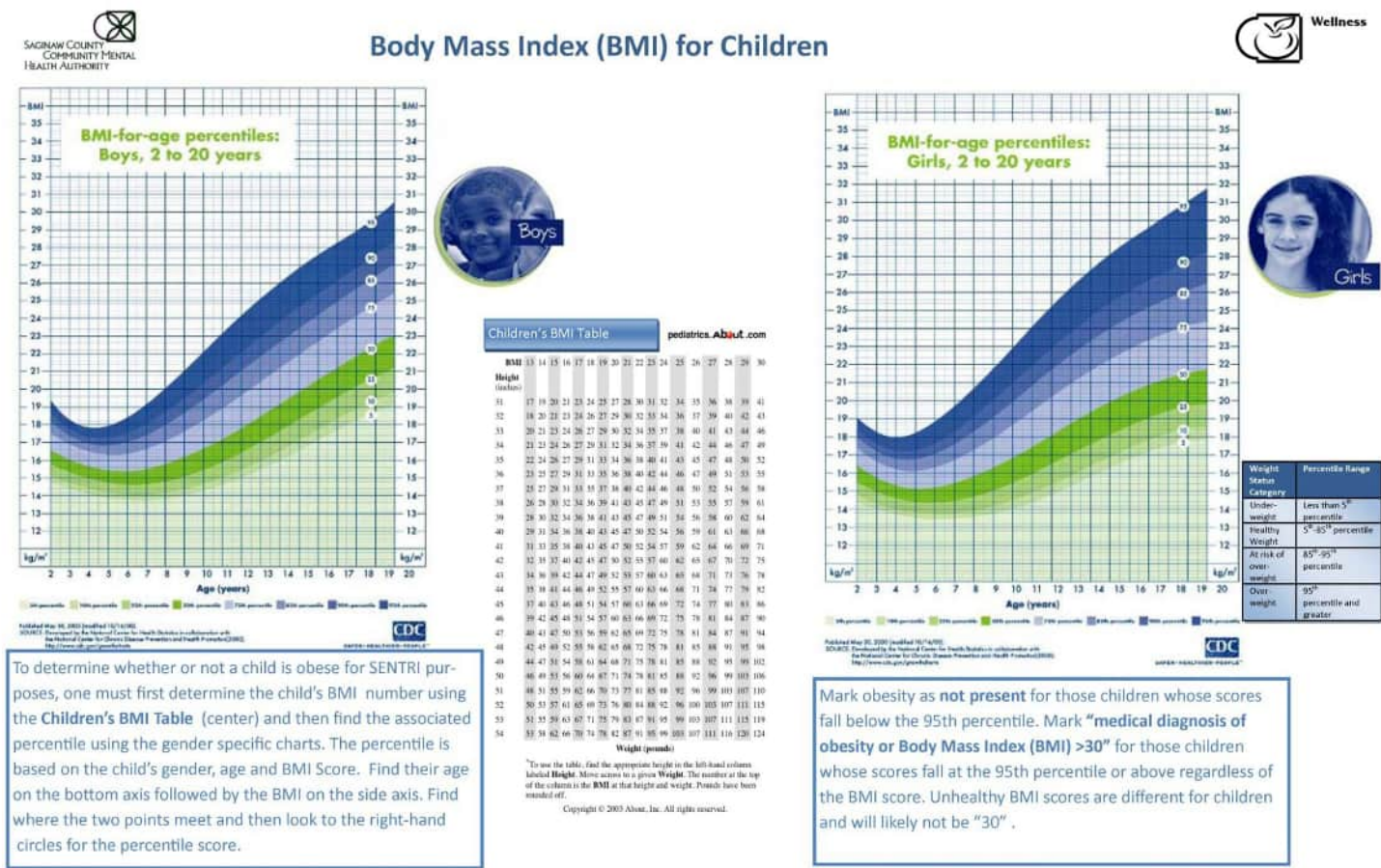
	Healthy Weight							Overweight					Obese															
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38								
Height	Weight (in pounds)																											
4'10"	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181								
4'11"	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188								
5'0"	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194								
5'1"	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201								
5'2"	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207								
5'3"	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214								
5'4"	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221								
5'5"	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228								
5'6"	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235								
5'7"	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242								
5'8"	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249								
5'9"	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257								
5'10"	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264								
5'11"	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272								
6'0"	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	256	265	272	279								
6'1"	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288								
6'2"	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295								
6'3"	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303								
6'4"	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312								

http://www.nhlbi.nih.gov/health/public/heart/other/amer-indian_risk/sec5/lose_weight.htm

Use this table to help you complete the consumer demographic section of SENTRI.

- First find consumer height, then weight.
- Then find the BMI above.
- Those whose score falls into the first two sections should be marked as "not present" under the section regarding obesity.
- Those who have a score of "30" or above should be marked as "medical diagnosis of obesity or Body Mass Index (BMI) >30."

Exhibit B







U.S. Department of Housing and Urban Development
Office of Lead Hazard Control and Healthy Homes



HEALTHY HOMES

Eight Tips for Keeping a Healthy Home

1. **Keep it Dry:** Prevent water from entering your home through leaks in roofing systems, rain water from entering the home due to poor drainage, and check your interior plumbing for any leaking.
2. **Keep it Clean:** Control the source of dust and contaminants, creating smooth and cleanable surfaces, reducing clutter, and using effective wet-cleaning methods.
3. **Keep it Safe:** Store poisons out of the reach of children and properly label. Secure loose rugs and keep children's play areas free from hard or sharp surfaces. Install smoke and carbon monoxide detectors and keep fire extinguishers on hand.
4. **Keep it Well-Ventilated:** Ventilate bathrooms and kitchens and use whole house ventilation for supplying fresh air to reduce the concentration of contaminants in the home.
5. **Keep it Pest-free:** All pests look for food, water and shelter. Seal cracks and openings throughout the home; store food in pest-resistant containers. If needed, use sticky-traps and baits in closed containers, along with least toxic pesticides such as boric acid powder.
6. **Keep it Contaminant-free:** Reduce lead-related hazards in pre-1978 homes by fixing deteriorated paint, and keeping floors and window areas clean using a wet-cleaning approach. Test your home for radon, a naturally occurring dangerous gas that enters homes through soil, crawlspaces, and foundation cracks. Install a radon removal system if levels above the EPA action-level are detected.
7. **Keep it Well-Maintained:** Inspect, clean and repair your home routinely. Take care of minor repairs and problems before they become large repairs and problems.
8. **Thermally Controlled:** Houses that do not maintain adequate temperatures may place the safety of residents at increased risk from exposure to extreme cold or heat.

www.hud.gov/healthyhomes

Exhibit D




National Healthy Homes Training Center and Network

Healthy Homes Maintenance Checklist

The following checklist was developed for the Healthy Homes Training Center and Network as a tool for healthy home maintenance. A healthy home is one that is constructed, maintained, and rehabilitated in a manner that is conducive to good occupant health.

To maintain a healthy home, occupants should keep it dry, clean, well-ventilated, free from contaminants, pest-free, safe and well-maintained. Good home maintenance can act to

reduce allergens, prevent illness, and reduce injury from accidents. This checklist provides basic guidelines; items may need to be checked more often depending on local conditions and manufacturer suggestions.

Developed for the National Healthy Homes Training Center by Terry Brennan and Ellen Tohn, technical advisors to the National Center for Healthy Housing.

Yard & Exterior

	Spring	Fall	Annual	As Needed	Pro Needed?
Water drains away from house	☒				
No trip, fall, choking, sharp edge hazards	☒	☒			
Fence around pool intact	☒	☒			
Check for signs of rodents, bats, roaches, termites	☒	☒			
Drain outdoor faucets and hoses		☒			
Clean window wells and check drainage	☒	☒			
Clean gutters and downspouts	☒	☒			

Exterior Roof, Walls, Windows

	Spring	Fall	Annual	As Needed	Pro Needed?
Shingles in good condition	☒				
Check chimney, valley, plumbing vent, skylight flashing	☒				
Make sure gutters discharge water away from building	☒				
Check attic vents		☒			
Check attic for signs of roof leaks	☒				
Check for icicles and ice dams			winter		
Look for peeling paint	☒				
Look for signs of leaks where deck attaches to house	☒				
Check below window & door that flashing intact	☒				
Repair broken, cracked glass		☒			
Look for signs of leaks at window and door sills	☒				
Clean dryer vent	☒	☒			
Check exhaust ducts are clear	☒	☒			

Basement & Crawlpace

	Spring	Fall	Annual	As Needed	Pro Needed?
No wet surfaces, puddles	☒	☒			
Sump pump and check valve working	☒	☒			
Floor drain working	☒				
Vacuum basement surfaces	☒				
Check for signs of rodents, bats, roaches, termites		☒			

Maintenance Checklist continued on next page.

Building a lead-safe and healthy home environment for all children • 10227 Winocoin Circle, Suite 100, Columbia, MD 21044 • www.centerforhealthyhousing.org



Maintenance Checklist (continued)

	Spring	Fall	Annual	As Needed	Pro Needed?
Interior Walls, Ceilings, Windows, Doors					
Check for signs of water damage			●		
Check operation of windows and doors	●				
Lubricate and repair windows and doors				●	

	Spring	Fall	Annual	As Needed	Pro Needed?
Plumbing, Fixtures and Appliances					
Check washer hoses-connections			●		
Check dishwasher hoses for leaks			●		
Check toilet supply/shut-off valve			●		
Clean & check refrigerator drip pan/icemaker connections			●		
Check shower-tub surrounds for signs of damage			●		
Check traps and drains under sinks, tubs, showers for leaks			●		
Check hot water heater for leaks		●			
Check boiler for leaks		●			
Check water main/meter or well pump for leaks or sweating		●			
Check water main/meter or well pump for leaks or sweating		●			
Clean septic tank			2 yrs		
Check drain and supply time for leaks	●	●			
Check bath and kitchen fans operation	●	●			

	Spring	Fall	Annual	As Needed	Pro Needed?
HVAC Equipment - Replace filters					
Warm air furnace (merv 8)		●			
Air conditioner (central air merv 8)	●				
Dehumidifier	●				
Outdoor air to return to heat recovery ventilation		●			

	Spring	Fall	Annual	As Needed	Pro Needed?
Appliances					
Clean kitchen range hood screens			●		
Clean dryer vents and screens	●				
Clean exhaust fan outlets and screens	●				
Clean outdoor air intakes and screens		●			
Clean air conditioning coils, drain pans	●				●
Clean dehumidifier coils, check operation	●				
Clean and tune furnaces, boilers, hot water heaters		●			●
Clean and tune ovens and ranges		●			●

	Spring	Fall	Annual	As Needed	Pro Needed?
Electrical Equipment					
Check for damaged cords	●	●			
Test ground fault interrupters	●				
Test outlets for proper hot, neutral and ground			once		
Check smoke and CO alarms	●	●			

	Spring	Fall	Annual	As Needed	Pro Needed?
Garage					
Ensure storage of fuel cans	●	●			
Proper operation of garage door safety shut-off	●	●			
Check for signs of water damage	●				
Check for signs of rodents, bats, roaches, termites	●	●			

	Spring	Fall	Annual	As Needed	Pro Needed?
Attic					
Check for signs of rodents, bats, roaches, termites		●			
Check for water damage		●			
Ensure insulation in place		●			
Check that fans still exhaust to outdoors (check ductwork connections)			●		

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Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Residential Services	Chapter: 03 - Continuum of Care	Subject No: 03.02.07
Effective Date: 6/16/05	Date of Review/Revision: 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, 4/4/25, 3/24/26 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Network Ser- vices, Public Policy, Continuing Education, OBRA/PASARR & En- hanced Health Services Authored By: Jennifer Keilitz Reviewed By: Residential Watch Com- mittee, Quality of Life Committee, Provider Network Auditors, Michelle Vance
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		

Purpose:

To identify and clarify residential options available for Saginaw County Community Mental Health Authority (SCCMHA) Persons Served.

Policy:

SCCMHA providers of service are in a position, on a regular basis, to assist persons served/guardians with decisions about the most appropriate residential option for the person served. Though there are many options available, those decisions should be based on some guiding principles.

The guiding principles for helping a person served/guardian make decisions about the most appropriate residential option should include:

The residential option chosen should be based upon the person's served choice.

It should be the least restrictive setting to meet the person's served needs.

The person's served health and safety needs must be able to be met within the residential option chosen.

It should allow the person served to be integrated into their home in the community when at all possible.

The setting must be safe and habitable.

The setting chosen must afford the person served 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 persons served, 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.)

When Case holders are looking for a specialized residential setting for a person or just need some assistance with an appropriate housing setting based on need of the individual, case holders should send a message inside Sentri II to the residential placement committee.

When moving someone into an AFC home SCCMHA has developed a checklist to assist case holders in assuring all aspects of the placement are attended to.

Application:

The Network of SCCMHA Providers.

Standards:

There are a range of options for individuals to live independently. Persons can live with family, in their own apartment with or without supports. These supports called community living supports, can be provided by a provider or some individuals may choose to hire their own staff with a self-determination arrangement. See SCCMHA Policy 02.03.04 Self Determination. Others may need someone available all day and night in a General AFC home, others may need a specialized residential where there are additional staff to support the needs of all individuals in the home and staff are awake 24/7 to check on individuals and engage them in activities. The type of living arrangement should be based on need and person's choice.

- Residential providers have a two to three-day supply of fresh, perishable foods are available in contracted homes. Examples may include but are not limited to: Eggs, milk, cheese, fruit, vegetables, bread. The residential provider will post menus that follow the MyPlate guidelines, including fruits and vegetables offered each meal and proper portions of fruits, vegetables, grains, protein, and dairy. Please refer to

www.myplate.gov for more information regarding healthy meal choices. (See SCCMHA Policy 03.02.07.08 Nutrition Standards for Specialized Residential)

- To assure food safety for all individuals living in the home, 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.
- The residential 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. (See SCCMHA Policy 03.02.07.07 Adult Foster Care Maintenance of Physical Plant.
- Provider will ensure all individuals served are being treated with dignity and respect, to which they are entitled (See SCCMHA Policy 02.02.28 Recipient Rights – Dignity and Respect)
- The provider agrees to pay for three meals a day, laundry detergent, and basic personal care items out of the room and board payments. The residential provider will maintain a resident funds log for any individual they hold funds for safe keeping in the home and will maintain any receipts or obtain signatures for any funds dispersed to the individuals living in the home. See SCCMHA Policy 03.02.07.11 Management of Consumer Funds.

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 (MDHHS) 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 persons served not associated with an agency, although many users of adult foster care services are persons served 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 person served demand hours such as mornings, late afternoons, and evenings. The number of beds in each home varies and is regulated by the local Bureau of Children and Adult Licensing (BCAL) 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 person served 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 person's served personal money where the person served plan indicates

the need for assistance with money management by AFC staff. (See SCCMHA Policy 03.02.07.11 Management of Consumer Funds). These homes are not required to have 24-hour awake staff.

Considerations: Potential participants/ persons served 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 person served and those assisting the person served in choosing an AFC that will meet their wants and needs. (www.sccmha.org). SCCMHA reserves the right to not publish homes on the website that do not take persons served by SCCMHA and their network providers.

Adult Foster Care (AFC) with Michigan Adult Integrated Management System now known as (MiAIMS). formerly known as Model Payments or Adult Services Authorized Payments (ASAP)(See SCCMHA Procedure 03.02.07.05 Michigan Adult Integrated Management System (MiAIMS).)

Under this type of care all of the same requirements pertain as with Adult Foster Care (AFC), but the person served may need some additional assistance with bathing, dressing, or other area that requires more assistance than just reminders to the person served. Under this level of care the provider may ask for additional funding for personal care for a person served Utilizing the MiAIMS application for claims entry system for personal care services authorized through The Michigan Department of Health and Human Services (MDHHS) or Community Mental Health (CMH) 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 home 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 person served Personal Care and Community Living Support Log form DCH 3803. They may also need to initial the medication sheets, and the person served resident funds if the person served 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. These homes are not required to have 24-hour awake staff.

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 Medicaid funds from community mental health to provide specialized mental health services to provide additional staffing to care for individuals.

There are three types of Specialized Residential Settings:

One type is adult foster care homes that accept a mixture of persons served some of which are funded through a contract from community mental health and some that are not. Such homes may have one or several persons served 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 person served is designated in the provider contract, based on the specialized mental health needs of the persons served 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 with requires 24-hour awake staff.

The second type of home is where SCCMHA 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 (full time equivalent) FTE's being utilized to meet the needs of persons served. These homes 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 person served specific treatment plan developed through the person-centered planning process.

The third type are homes in which SCCMHA 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 (full time equivalent) FTE's being utilized to meet the needs of persons served. SCCMHA owns these homes and contracts with a company to provide staffing and general maintenance of the homes. These homes 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 person served specific treatment plan developed through the person-centered planning process.

Considerations for specialized residential settings: The needs of the person served 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 person served 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. Housing assistance can also help to provide some money to help with basic set up of a home. Again, all other resources must be exhausted and proof of such documented in the person's electronic health record. (See SCCMHA Procedure 09.09.05.08 Specialized Medical Equipment and Supplies, Assistive Technology, Enhanced Pharmacy, and Environmental Modifications)

Enhanced Staffing is additional staffing hours exceeding a contracted amount, and is subject to the following conditions:

- o Is provided to avoid hospitalization
- o Is provided to address medical or behavioral conditions that threaten placement or safety of the person served, 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.
- o 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.
- o 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 person served 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 person's served 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 person served 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 person served 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 person served 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 person served 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 persons served of mental health services.	Saginaw County Community Mental Health Authority
Participates in a person-centered planning process to discuss the person's served needs and desires particularly as it relates to residential options.	Person served, guardian, case holder, others as identified by the person served/guardian.
Reviews the residential option desired to determine if it can meet the needs of the person served with special attention to the health and safety needs of the person served.	Person served, guardian, case holder, and others as identified by the person served/guardian.
Develops an individual plan of service (IPOs) which addresses the specific needs of the person served, 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.	Person served, guardian, case holder, and others as identified by the person served/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 persons served into Licensed Res-	Case Holder Clinical Supervisor Care Management Specialist Residential Provider

idential Settings (See Exhibit C in SCCMHA Policy 03.02.07.01). Referral to the Residential Placement Committee for any possible out of county placements or moves from a less restrictive setting into a more restrictive setting. A review of the 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 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.) Monitors the person served in the residential option at intervals agreed to in the individual's plan of service. Monthly home visits are required by SCCMHA to assure that the needs of the person served are being met in the residential setting and that the person served is satisfied with the services provided. If the individual is in specialized residential, a monthly visit is required at minimum. If the individual is living in rental property or own home monitoring should include checking that appliances are in working condition, they have water, food, etc. Follows the Guidelines for Specialized Residential Service Providers as written in Exhibit B. Attends residential facility staff meetings as needed to provide in-services on person served plans, help resolve issues, clarify concerns, etc.	Case Holder/Chair of the Residential Placement Committee Case Holder Case Holder and guardian when one is appointed. Residential Provider Case Holder

Initial and any additional in services on person served plans are scanned into the record.	Case Holder

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.

Guidelines for Specialized Residential Service Providers

Revised: 1/5/07; 12/2014; 04/2023, 12/2024

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 persons served 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 person served by:

- **assuring that** medical providers are aware of person served insurance, Medicare and Medicaid coverage and any other relevant coverage or benefits which the person served holds.
- securing medical care for the person served only through medical providers who are enrolled in the person's served Health Plan or to whom the person's served 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 person served 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 person's served 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 person served 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 person served. In addition, residential providers will assist SCCMHA in maximizing person served use of natural community resources, such as church, human service agency and/or family assistance, in order to avoid unnecessary depletion of person served resources.

Additional funding for personal care via (which is now through (MiAIMS) Michigan Adult Integrated Management System 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 person served if the person served 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 person served by the provider will be pro-rated by day.

Authorization of Services:

All providers must have authorization through the persons served 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 person served plan and based on the person served 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 person served 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 person served 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 person served requires emergency medical treatment. This should include any important medical or health changes that have occurred. If person served 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 person served is receiving nursing services, Provider should also inform person's served team members (i.e. nurse, OT, PT, , Speech, Dietitian, 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 person's served 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.) Persons served are to be group supervised, (i.e., staff are typically in visual contact with persons served, but at a minimum within hearing range) at all times, unless otherwise specified in the person's served individual plan of service (IPOs). The provider is required to provide overnight staffing at a level which meets person served needs and assures person served safety and complies with requirements related to foster care licensure and provider contract. *(Please see sample "Staff Schedule" Attachment 1)* In some cases, persons served 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 person served IPOs specifies the need for 1:1 staffing and how the staff providing 1:1 will interact with the person served. This interaction includes activities to engage in, how close the staff person will be in proximity to the person served 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 person served IPOs as well as reviewed and approved through the Behavioral Treatment Committee (BTC)

Providers are not authorized to provide staffing beyond normal visitation and support to the person served 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 would provide staff for persons served in their rooms to assist if the person served is a fall risk or is exhibiting challenging behaviors. However, there are circumstances when persons served 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 person served to assist in the hospital. The need for these services should be spelled out in the IPOs 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. mealtimes, medication administration times, etc.) based on the person's served needs for this service. When requesting these services, the role of staff providing the 1:1 service/s should be detailed as to what assistance will be provided to the person served 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 person served has 1:1 staffing in the home, person's served 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 person served 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 persons served 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 includes Documentation Training
- 2) Person Centered Planning (annual renewal)
- 3) Recipient Rights (annual renewal)
- 4) Working with People (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) CPI Physical Intervention for Protection/Verbal De-Escalation

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 (Annual Renewal)
- 19) Trauma Training
- 20) Orientation to Training, online training require prior to the start of any in-person or live virtual 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 person served 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 and it should be specific in the

IPOs 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 managers, support coordinators, OT's, Psychologists, nurses, etc.) will provide training, at a minimum, to the home manager/lead staff on the implementation of a person's served individual 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 person's served plan of service when substantial changes in staffing have occurred. The provider's home management staff are required to review all person served plans of service with new staff before they are allowed to work directly with person served.

Direct in-service by qualified individuals is required before any provider staff implement high risk procedures, including but not limited to;; 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 person served plan of service will specify those procedures which require in-service by author of the specific plan and who will perform the in-service to include any addendums to the IPOs which will require in-service as well.

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 person served 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, persons served, staff, persons served 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 person served 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 person served 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 1 business day 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 persons served and their SCCMHA Sentri II I.D. If the incident involves a person served or a person served from another county, it is best practice to code the other person's name and write any additional incident reports.
- 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 for ensuring 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.
- 14) Incident Report forms and supporting documentation, handwritten or otherwise should not be placed or referenced in the consumer's Electronic Health Record (EHR). The Quality Department will create an electronic Incident Report that will be kept separate from the consumer's EHR.

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 person served 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 person served 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	o Gloves
▪ Disposable gown	o Eye shields
▪ Disposable apron	o Body fluid pick up guard
▪ Disposable mouth/nose cover	o Absorbent packs
▪ Antiseptic cleansing wipes	o Bio-hazard bags
▪ Germicidal wipes	o Disposable clean-up towels
▪ <u>Spill Kit (including the following)</u>	o Germicidal floor wipes
o Scooper	o Biohazard identification
o Sealable scoop bag	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:

Persons served will be encouraged to maintain their own personal living quarters. SCCMHA encourages persons served 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 person served 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 i.e., Bleach, Chlorine, Ammonia solutions, liquid plumber, and other items that contain sodium hydroxide, potassium hydroxide, etc.

Provider will comply with the Home and Community Based Services (HCBS) Rules which are a set of rules established by the Center for Medicare and Medicaid Services (CMS) detailing the rights an individual has in their home. The goal is for individuals living in group settings to have the same rights they would have in their own homes such as having access to the laundry room and supplies as needed.

Admissions/Discharges:

The provider shall have the right to reject a request from the SCCMHA for placement of persons served or to terminate an existing placement, providing such action occurs in consultation with the persons served, SCCMHA, and with the person's served legal representative where applicable. Provider must give SCCMHA & the person served/ guardian 60-day written notice of any person served placement terminations.

In situations where SCCMHA is contracting all beds in the home, SCCMHA reserves the right to select persons served 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 person served. However, SCCMHA reserves the right to re-evaluate providers who reject persons served without good reason or lack the capability or flexibility to meet the residential service needs of those persons served 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 persons served 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 person served on a leave of absence of any health and safety precautions in the person's served individual plan of service. For persons served with guardians, the provider will obtain prior authorization from the guardian before allowing any individual, other than the guardian, to remove the person served 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 person served and/or community has been identified, the restriction is included in the person's served individual 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 person served 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 person served accepted for care in accordance with the person's served 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 person served. The provider will ensure that all caregivers are updated routinely of any changes in a person's served IPOs. If the IPOs is unclear, the provider will request clarification immediately from the person's served Case Holder. Person served individual plans of service are to be implemented within 24 hours of receipt by the provider. If the provider is unable to implement a IPOs for any reason, they will notify the SCCMHA Case Holder immediately. Please note that all providers have access to person IPOs , for which they are authorized, on SCCMHA electronic medical record called Senti.

The provider agrees to complete daily documentation on each shift reflecting person served 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 persons served 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 persons served IPOS , 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 person served will be maintained at the office of the person's served primary provider.

Medical Appointments:

Providers will monitor the health status of persons served and will ensure that scheduled medical and clinical appointments are made in a timely manner, that the person served 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 person's served 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 persons served 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 person served by SCCMHA as needed and desired by person served. If a person served 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 person's served IPOs.

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 persons served. Please reference SCCMHA Policy 03.02.14-Advanced Directives for more information on this topic.

Personal Care:

Providers shall provide persons served with a basic supply of personal care items such as shampoo, toothpaste and brush, and deodorant as required by licensing as part of the room and board payment. Person served 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 persons served. If equipment is in disrepair, the provider will immediately assist the person served with securing repair or purchasing a replacement. Providers will make every effort to ensure persons served 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.myplate.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

persons served 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 person served as ordered by the person's served physician and identified in the person's served IPOs 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 persons served 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 person's served case holder. Any adaptive equipment should be noted as an 1915 (i) SPA (State Plan Amendment). Please note Medicaid mental health coverage is payor of last resort, all primary commercial insurances including applicable Medicaid Health Plan and Children's Special Health Care coverages are to be ruled out as primary payors (based on appropriate habilitative vs re-habilitative OT, PT, ST, RD coverage diagnosing) by the assigned case holder/physician by obtaining written auth/service request denials from such primary payors prior to requesting through SCCMHA care mgmt. to review/approve Health Service. This means that SCCMHA is payor of last resort but may assist with appropriate referrals and provide guidance to navigate through insurance.

Personal Possessions and Funds:

Providers will maintain an inventory list of all persons served 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 person served into the facility. Providers will ensure person served clothing is kept in good repair and replaced, as needed. Providers will ensure SCCMHA persons served choose their own clothing and have proper clothing for a variety of activities, occasions, and seasons and appropriate for their size, age, and preferences. Persons served must be able to secure and store their belongings away from others. *(Please see attached sample "Consumer Inventory List", Attachment 2)*. Providers will maintain person served funds according to SCCMHA policy 03.02.07.11 Management of Consumer Funds.

Individuality/Lifestyle:

Persons served will be able to maintain their own personal lifestyles while respecting other persons served in the home. Persons served will be allowed to personalize their living quarters within reason. To include recognizing, respecting, and affirming sexual orientation, and gender identity. Providers will encourage and support persons served 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 persons served.

Activities/Recreation:

The provider will offer persons served frequent opportunities for home and community activities and recreation. Providers will allow persons served to choose their own activities, within any limitations defined in the person's served IPOs , , and where the person served has not expressed a preference, the provider will plan activities that are age appropriate so as to maintain the dignity

of each person served and should be as meaningful to the person served as possible. Activities will be community integrated and offer the person served 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 persons served 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 persons served from the residence in case of an emergency. The provider will provide barrier free transportation as required for persons served 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 persons served if the need for emergency medical treatment arises. If person served is attending a day program and a medical emergency occurs, staff currently responsible for the person served will be required to ensure person served is given transportation to the medical facility. This may or may not involve the responsible staff transporting the individual. If a person served requires transportation to a medical facility while at program, person's served home staff should be notified immediately. If at all possible, home staff should meet the person served to provide transportation to the medical facility as necessary. If time does not allow for home staff to transport person served, it is expected that a staff from the home will meet the person served 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 person served while at a medical facility.

Services:

SCCMHA agrees to provide additional mental health services as defined in the individual plan of service as appropriate for the person served, given their needs and available community resources. SCCMHA will assign a Case Holder for each person served in the home to help coordinate their care.

Attachments to this Guideline:

1. Staff Schedule
2. Individual Inventory List
3. Individual Inventory Disposal Record

Staff Schedule

Attachment 1

Home Name: _____

Home Address: _____

Month: _____ Year: _____

[illegible]

Total Hours _____

Two Week Total Hours_____

Number of Home Manager Administrative Hours: _____

Individual Inventory List

Individual's Name:		Case #:	Home Name:
Date	Quantity	Inventory Item	Condition of Item(s)

Staff Signature: _____ Date: _____

Individual/Guardian Signature: _____ Date: _____

SCCMHA

Attachment 3

Individual Inventory Disposal Record

Individual's Name:	Case #	Home Name:
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Date Purchased	Date Disposed	Inventory Item	Staff Initials	Supervisor Initials	Individual &/or Guardian Initials

Staff Signature: _____ Date: _____
 Individual/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. Participates in Social Activities	☐	☐	
N. Smokes	☐	☐	
O. Appropriately Uses Alcohol/Drugs	☐	☐	

See Page 4 for Non-discrimination and ADA statement

Continued on Next Page

II. SELF CARE SKILL ASSESSMENT**PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Needs Help		IF YES, Describe Needs and How The Will Be Met
	Yes	No	
A. Eating/Feeding	☐	☐	
B. Toileting	☐	☐	
C. Bathing	☐	☐	
D. Grooming (hair care, teeth, nails, etc.)	☐	☐	
E. Dressing	☐	☐	
F. Personal Hygiene	☐	☐	
G. Walking/Mobility	☐	☐	
H. Stair climbing	☐	☐	
I. Use of Prosthesis (Dentures, Artificial limbs, etc.)	☐	☐	
J. Use of Assistive Devices (explain)	☐	☐	
K. Other (explain)	☐	☐	

III. HEALTH CARE ASSESSMENT**PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Yes	No	IF YES, Describe Needs and How They Will Be Met
A. Taking medication	☐	☐	
B. Special Diets	☐	☐	
C. Physical Limitations	☐	☐	
D. Special Equipment Used (Wheel chair, Walker, Cane, etc.)	☐	☐	
E. Other Difficulties (Vision, Weight, Allergies, etc.)	☐	☐	
F. Susceptible to Hypothermia or Hyperthermia	☐	☐	

Continued on Next Page

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 individual if the need arises during an absence and to assure medications are available for an individual/resident-while on leave.

Name of Person Served: _____ 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 individual while on leave:

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Cell phone: _____

If individual has a guardian, has guardian given consent for this individual 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 Individual	
Are medications being sent with individual?	
Yes ☐ No ☐	
(If yes list below)	
Name of medication/strength	Amount Sent
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Employee releasing medication(s):	
Signature: _____	
Title: _____	
Date: _____ Time: _____	

Return of Individual
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)

SCCMHA 911 Guidelines

SCCMHA understands that there may be situations when 911 must be called in a home setting. Even with the best efforts of SCCMHA and home staff, not all situations can be anticipated. A good example of this is if a weapon is identified, or if there is eminent and reasonable belief that someone will be seriously harmed. If staff or visitors are exhibiting suspected criminal behavior - regardless of whether there is an immediate threat to any person's safety - would also be an example to call 911. Another obvious situation is if there is an intruder in the home or eminent threat outside the home. An additional example of course is always when the home is in need of immediate medical response. (police vs. ambulance or fire) SCCMHA will not second guess or penalize homes for contacting 911, if in their best situational judgment, such intervention is needed to prevent serious harm.

However, SCCMHA as well as MDHHS do emphasis prevention and planning as an effective tool in managing residents' behavior and ensuring the safety and welfare of all in the home, residents and staff. It is expected that staff will have a basic knowledge of protocols to follow when an escalating incident occurs. SCCMHA recommends that home staff discuss possible or even probable scenarios or situations and make plans for how such would be managed in advance of any situation. Such planning also serves to help staff stay calm in situations as they understand what the plan is to be and can execute such as discussed prior to the actual situation. Staff are less likely to act in any inappropriate manner if they have a plan at their ready availability. Staff should be familiar with specific residents' 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 residents and staff whenever possible, which will also result in property protection.

It is also the expectation of SCCMHA that if 911 must be contacted for a situation, a debriefing will occur to plan for a second similar occurrence, with an emphasis on prevention of a similar occurrence wherever possible. For residents where it might be anticipated that a behavior might occur, either a crisis plan developed with a resident and/or a behavioral treatment plan should be pursued. Giving residents ownership of how staff can assist them to prevent situations where feasible is highly recommended, although it is recognized that this may not always be feasible with all persons, but this should always be the preferred goal. Emphasis on the development of positive relationships and interactions with residents, at the times when a negative behavior is not present, is also recommended. Prevention assists residents to avoid being in a situation or getting to the point where they feel their only resort is to act out or face negative consequences, including 911 calls and/or police at the setting. Under no circumstances should be calling 911 be used as a routine or periodic threat or consequence of any kind for resident behavior.

Along with physical management techniques, to be used as a last resort, redirection, de-escalation and other calming techniques should be used, even if 911 is being contacted simultaneously. One plan could involve the ability to dispatch extra staff if the distance is reasonable. If a resident 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 residents as well as staff to avoid potential 911 and/or other higher risk situations.

March 2012 revised December 2024

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Advance Directives	Chapter: 03 - Continuum of Care	Subject No: 03.02.14
Effective Date: 9/1/05	Date of Review/Revision: 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, 7/8/25 Supersedes:	Approved By: Sandra M. Lindsey, Chief Executive Officer Responsible Director: AmyLou Douglas, Chief In- formation Officer Chief Quality and Compliance Officer Authored By: Kentera Patterson, Officer of Recipient Rights and Compliance / HIPAA Pri- vacy Officer Additional Reviewers:
		

Purpose:

To ensure Saginaw County Community Mental Health Authority (SCCMHA) is in 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 and the person's right to make their own healthcare decisions, including mental health care. 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.

SCCMHA will:

- Document the person served the decision to accept or decline the opportunity to prepare advance directives, as well as the existence of such advanced 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.

Application:

This policy applies to all Board Operated Programs as well as the SCCMHA Network Providers who provide services to SCCMHA people served.

While residential providers are not responsible for providing information about advanced directives to people served, the providers should:

- Have a working knowledge about advanced directives and how the subject may affect the residents of their respective homes.
- Be aware of the individual decisions of their residents regarding advance directives to ensure appropriate response.

Standards:

1. **Timing:** SCCMHA provides all adult beneficiaries with written information on advance directives at the time of their intake with SCCMHA.
2. **When a Person Can't Decide Yet:** In the event an individual is temporarily unable to give 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. **What's included:** The written information provided to adult beneficiaries will include a description of Michigan law and their applicable rights under Michigan law.
4. **Keeping Beneficiaries Up to Date:** 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. **Rights Explained:** In addition, the written information provided by SCCMHA will include items such as the persons served right to make decisions concerning their mental health care as well as their medical care, including:
 - a. The right to accept or refuse treatment
 - b. The right to formulate, at the person served option, advance directives.
6. **Documentation:** The person served has the choice whether to execute an advanced 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. **Equal Treatment:** 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. **Staff Training:** SCCMHA will provide for the education of staff concerning the policies and procedures related to advance directives.
9. **Public Information:** SCCMHA will provide community information regarding advance directives.
10. **Complaints:** The person served will be informed that complaints concerning non-compliance with the advance directive may be filed with:

- a. The SCCMHA Office of Recipient Rights
- b. The SCCMHA Office of Regulatory Compliance.

Definitions:

See SCCMHA Policy 08.05.00.01 – *Compliance Definitions* for definitions of:

Advance Directive:

- Crisis Plan:
- Do-Not-Resuscitate Order (DNRO):



- Durable Power of Attorney for Health Care (DPAHC):
- Living will:
- Patient Advocate:
- Psychiatric Advance Directive (PAD):

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 PSDA 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 advanced directives.

Attorney General Opinions:

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 resuscitates 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	3. Intake Staff/ Primary Worker

	consent, or unable to receive the above referenced information, arrangements will be made to provide the information to the individual when the circumstances change.	
4.	The written information provided to adult beneficiaries will include a description of Michigan law and their rights under Michigan law.	4. Compliance Officer/ Supervisor of Customer Service
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 persons served 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



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 person served 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 person served 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 person served 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 person served 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>

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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

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Genoa Healthcare Company Medication Administration Program for Adults	Chapter: 03 – Continuum of Care	Subject No: 03.02.32
Effective Date: 5/26/16	Date of Review/Revision: 8/1/18, 5/31/19, 6/1/20, 9/23/22, 6/6/23, 3/19/25, 3/31/26	Approved By: Sandra M. Lindsey, CEO
	Supersedes:	Responsible Director: Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & EHS
		Authored By: Allison Kalmes, Monique Taylor-Whitson, Diane Cranston - (Genoa Healthcare) Reviewed By: None

Purpose:

The purpose of this policy is to discuss the uses, benefits, and requirements for the Medication Administration Program (MAP) offered by Genoa Healthcare Company located in Saginaw, Michigan.

The goal of the Medication Administration program offered by Genoa Healthcare is to improve medication adherence through the observation related to a client's self-administration of his/her medication leading to the person served being able to take their medications independently, as prescribed. This goal is achieved by the MAP staff educating the person served about their medications; and assisting the person served to identify and implement organizational strategies to remember to take their medications as prescribed. Thus, resulting in a decrease in the person served's symptoms and an improved quality of life.

Application:

This policy shall apply to all persons served of the SCCMHA network.

Policy:

The Medication Administration Program (MAP) offered by Genoa Healthcare Company, located in Saginaw, Michigan is meant to provide persons served with a history of medi-

cation non-adherence the practice and skills to be able to take their medication independently, as prescribed. Thus, resulting in decreased symptoms, improved quality of life, and the ability to live independently in the community. These skills include learning how and when to take the medications, the names and purposes of the medications, and side effects of the medications including a reaction to environmental factors such as foods or sunlight.

This policy applies to persons served who have been diagnosed with a serious mental illness or a developmental disability.

The goal is achieved by the Medication Administration Program (MAP) Treatment Team (person served, Medication Administration Program staff, Medication Administration Program Coordinator, Genoa Pharmacist, Primary Case Holder, Treating Prescriber and Guardian) helping the person served to identify and implement organizational strategies to take their medications as prescribed on a consistent basis.

The program consists of four (4) components: Program Orientation Session (Intake) conducted by the Medication Administration Program Coordinator employed by Genoa. Medication administration (medication delivery) provided by the Medication Administration Program Staff. Medication and organizational strategy education provided by the Medication administration program staff and Genoa Pharmacist Care coordination provided by the medication administration program Coordinator employed by Genoa.

The medication drop component consists of the MAP staff dropping medications to a person served at an agreed upon time and location. MAP staff will drop medications at the frequency determined by the MAP Treatment Team and approved by the Treating Prescriber, but no more than two times per day. With the approval of the Treating Prescriber, dosages which are to be taken midday and bedtime will be left with the person served. Medication drop times are typically from 8:00am to 11:30 AM and 5:00 PM to 8:30 PM 365 days per year. MAP staff are to observe the person served self-administering their medications; ask how the person served is feeling, if the person served is experiencing any side effects, and if the person served has any medication concerns. The MAP staff will also observe and note if there are any changes in the person served's speech, physical appearance, or mood. During the drop, the MAP staff will provide medication education and discuss organizational strategies that the person served can use to remember to take medications that are left with them. Daily medication drops will be documented by MAP staff in the Sentri 2 electronic system detailing the above information.

Standards:

- The MAP shall be used to assist persons served with the transition from daily medication deliveries to taking their medication independently.
- The option to participate in the MAP will be based upon the person served's acceptance to do so.
- The use of the MAP should be considered the least restrictive means of ensuring medication adherence for persons served participating in the program.

- Only persons served meeting the requirements determined by Genoa Healthcare will be eligible to receive services through the MAP. Individuals who may be eligible for the MAP include persons served who:
 - are exiting an inpatient hospital or crisis home setting,
 - have an Alternative Outpatient Treatment (AOT) Order mandating medication compliance,
 - have been recommended for long-acting injectable medications, but have declined and prefer oral medications instead.
 - are transitioning from a supervised setting (such as a general Adult Foster Care (AFC) Home or Licensed Specialized Residential Home) to an independent living setting,
 - are living independently with a history of medication non-adherence, and/or
 - are participating in Saginaw County's Mental Health Court.
- In order to receive services through the Medication Administration Program, a referral form must be completed, an authorization must be in place, and the referral source and MAP Coordinator complete the Assessment of Client's Medication Assistance Needs (Exhibit F).
- Within one business day of receiving a completed referral and current authorization for services, the MAP Coordinator will contact the referral source to complete the *Assessment of Client's Medication Assistance Needs (Exhibit F)*. After the completion of the *Assessment of the Client's Medication Assistance Needs*, the Primary Case holder, typically the case manager, will contact the person served to schedule the Program Orientation Session with the MAP Coordinator. Within one business day of completion of the Assessment of Client's Medication Assistance Needs, the MAP Coordinator will contact the person served regarding the completion of the Program Orientation Session, which will include the following:
 - explanation of the program,
 - completion of program consents, medication reconciliation activities, and *Genoa Healthcare Medication Adherence Questionnaire* (Exhibit D), which is the person served's self-report of his/her medication adherence strengthening and risk factors
 - development of treatment goal, objectives, and interventions for the Medication Administration Program, which are then forwarded to the primary case holder within 14 calendar days of the Program Orientation Session
 - provide the initial medication education to the person served including classification of clients by their medication assistance/medication assistance needs (see exhibits F and G)
 - determine the start date of the medication drops.
- Once an authorization has been put into place, the person served's primary case holder will update the individual plan of service to reflect the person served's participation in the MAP, including the benefits and desired outcome from utilizing the program services.

- In order to participate in the program, a person served must agree to utilize the Genoa Pharmacy located in SCCMHA 500 Hancock Facility for all their behavioral health medication and physical healthcare medication, if applicable.
- For persons served participating in the Medication Administration Program Services, the MAP Coordinator, with input from the MAP staff, will complete the Genoa Healthcare *MDP™ Monthly Treatment Review Form (Exhibit C)* which is located under the “MDS™ Monthly Review Forms” section in Sentri 2. This completed document is forwarded to the treating prescriber and primary case holder. This document represents a monthly progress report on the person served’s progress in the Med Drop Program. The document contains the following information:
 - number of months the person served has been in the program
 - number of days the person served was in the psychiatric hospital, medical hospital, jail, or crisis home during the month
 - person served’s adherence rate for the month and how this compares to the prior month
 - person served’s medication adherence strengthening and risk factors; person served’s medication knowledge; and the organizational strategies that the person served is implementing to remember to take his/her medications
 - person served’s progress on their MAP Treatment Goal
 - person served’s readiness to decrease the frequency of his/her medication drops and move toward taking his medications independently
- A person served may remain in the program for an extended period of time, depending on their progress. This will be determined by adherence in the program which is defined as:
 - Full adherence – person served taking his/her medications 80% or more of the available days while in the program.
 - Partial Adherence – person served taking his/her medications 60% to 79% of the available days while in the program.
 - Non-Adherence – person served taking his/her medications 59% or less of the available days while in the program.
- A person served may remain in the program for an extended period of time, depending on their medication assistance need factors that include:
 - Co-occurring Disorder /Substance Use
 - Risk for Adult Foster Care Placement
 - Active Clinical Symptoms
 - Large Volume of Medications
 - Reading or Writing Deficits
 - Intellectual/ Developmental Disorder
 - Physical Challenges such as vision loss and hearing loss
 - Memory Problems

- A person served will be discharged from the program based upon their progress and readiness to take medications independently, as prescribed.

Definitions:

Independent Living with Community Living Supports (CLS): the least restrictive residential setting for persons served of SCCMHA, other than living alone without any supports, intended to assist persons served with gaining skills needed in order to live independently.

References:

None.

Exhibits:

- Exhibit A: Genoa Healthcare Company – MD™ Program Overview
 Exhibit B: Genoa Healthcare Company – MD™ Program Goal and Objectives
 Exhibit C: Genoa Healthcare Company – MDP™ Monthly Review/MDP™ Treatment Team Review Form
 Exhibit D: Genoa Healthcare Company - Medication Adherence Questionnaire
 Exhibit E: Genoa Healthcare Company – MD™ Program Referral Form
 Exhibit F: Genoa Assessment of Client's Medication Assistance Needs
 Exhibit G: Genoa Healthcare Company – Classification of Clients by their Medication Assistance Needs

Procedure:

ACTION	RESPONSIBILITY
Determine the least restrictive means of ensuring medication adherence for persons served living independently, in a Supported Independent Living Placement, or at home alone or with family.	Primary Case Holder
Complete authorization for Medication Assistance Program and attaches to completed Med Drop™ Program referral form (Exhibit E) for persons served who meet eligibility requirements and submit to MAP Coordinator.	Primary Case Holder Care Management
Update person served's individual plan of service to reflect person served's participation in the MAP including the benefits and desired outcome from utilizing the program services.	Primary Case Holder
Complete Assessment of Client's Medication Assistance Needs (Exhibit F) with referral source and Program Orientation Session with persons served who are starting the Med Drop™ Program. Contact to the referral source should occur within one business day of the	MDP Coordinator

initial referral and authorization being submitted. Contact with person served should occur within one business day of completion of Classification of Clients by their Medication Assistance Needs (Exhibit G). The orientation will include the following: explanation of the program; completion of program consents, a Medication Adherence Questionnaire (Exhibit D), and medication reconciliation activities; development of treatment goal, objectives, and interventions for the MAP; providing initial medication education to the person served and determining the start date of the medication drops. A Copy of the completed MAP Treatment Plan shall be forwarded to the primary case holder within 14 calendar days of the Program Orientation Session.	
Complete monthly treatment review form (Exhibit C) available under the “MD™ Monthly Review Forms” area in Sentri 2 for all persons served participating in the Med Drop™ Program. The Med Drop™ Program Coordinator completes the review form with input from the MAP Staff. The completed review is forwarded to the person served’s primary case holder (via Sentri II’s “send copy to” functionality) and treating prescriber. This form contains the person served’s medication adherence rate and readiness to decrease his/her drop frequency.	Med Drop™ Program Coordinator
Complete daily documentation in Sentri 2 system for all medication drop services that occur. This requires completing the Med Drop™ Progress Note in Sentri 2 which includes the success of the medication drop, person served’s orientation, mood, SI/HI/Psychosis Risk Factors, any health and safety concerns, and the provision of education; as well as, any concerns that the person served shares with the MAP staff.	Medication Assistance Program Staff
Monitor adherence to the MAP at least monthly and document by creating a Progress Note in the Sentri 2 system.	Primary Case Holder
Attend medication reviews for persons served of the Med Drop™ Program whenever possible. Attendance should be documented on the MAP Monthly Review/MAS Treatment Review Form (Exhibit C) and forwarded to person served’s primary case holder.	Med Drop™ Program Coordinator



**MED DROP™ PROGRAM
PROGRAM OVERVIEW**

Program Philosophy:

The Med Drop™ Program is a Community Living Supports (CLS) based intervention that focuses on improving medication adherence through the observation related to a client's self-administration of his/her medication¹. The Med Drop Program was designed to fill "a gap" in the service array for all clients. This program assists clients in identifying and implementing strategies and skills to take their behavioral health medications as prescribed. If the client chooses, his/her physical health care medications can also be included in the program. This service is expected to improve the clients' overall mental health and daily functioning by improving the symptoms treated by their medications.

Target Population:

This program is designed for individuals who have chronic problems taking their medications in the prescribed manner. This non-adherence often results in more clinical symptoms, a more restrictive level of care, and a lesser quality of life.

The program can also be used for individuals who have never had the opportunity to demonstrate medication compliance due to their living situation (i.e. adult foster care) and there has been an assessed need for assistance in this domain. Participation and skill acquisition in this program can allow these individuals to move to a less restrictive setting if medications can be closely monitored until adherence and improved clinical response can be demonstrated.

Eligibility:

The following individuals are eligible for this service:

Adults diagnosed with a serious mental illness who reside in the designated service area; who currently receive psychiatric services from the designated Community Mental Health Provider and its Network of Providers; are chronically medication non-adherent, and one of the following are applicable:

- Are exiting an inpatient hospital setting
- Are exiting a crisis home setting
- Have an Alternative Outpatient Treatment (AOT) Order mandating medication compliance
- Are currently in an Assertive Community Treatment (ACT) or Integrated Dual Disorder Treatment (IDDT) Program but could benefit from a less restrictive service model
- Have been recommended for a long acting injectable, but has declined
- Are eligible or participate in a Supported Independent Living Program

- Are transitioning from a supervised setting to an independent living arrangement never having the opportunity to demonstrate medication compliance
- Are participating in the designated service area's Mental Health Court Program

In order to participate in this program, the individual must agree to utilize Genoa Healthcare Pharmacy for all of their behavioral health medications. If physical health care medications are included in the program, the individual must agree to use Genoa Healthcare Pharmacy for their physical health medications. Once the medications are dispensed by Genoa Healthcare Pharmacy, the Med Drop Pharm Tech is responsible for contacting the client's prescribers to obtain needed refills. Discussion of the program, its requirements, and the client's agreement with participation, should occur in the context of a person centered planning meeting process that involves other members of the client's treatment team, minimally the client's primary case manager or supports coordinator.

Program Description:

The goal of the Med Drop Program is to increase a client's skills so that he/she can become independent in taking his/her medications and have an improved quality of life. To assist a client clients in becoming independent in taking his/her medications, the program includes educating the client on the names of his/her medications, how and when to take the medications, the purpose of the medications, the side effects of the medications and possible interactions with other medications, or foods to avoid when taking the medications. The program also assists the client by helping him/her identify and implement organizational strategies to take his/her medications consistently. These strategies might include specialized packaging-DISPILL or Auto Med, using a medication box, setting alarms, etc.

It is the program's intent to move a client receiving daily medication drops to taking his/her medication independently on his/her own within 18 months. However, it is recognized that some clients may need to be in the program longer than 18 months. The recommendation for the length of time a client participates in the program will be made during the course of a person centered planning process, taking into account recommendations by the Medication Drop Program (MDP) Treatment Team which includes the treating prescriber, case manager/supports coordinator, MDP Staff, and MDP Coordinator. In order for this to be accomplished, the MDP Coordinator works in a coordinated manner with the case manager/supports coordinator and/or treating prescriber. This care coordination includes the Pharmacist, MDS Staff, MDP Coordinator, and case manager /supports coordinator working together to identify reasons for the client's medication non-adherence and communicating this information to the treating prescriber, especially if it has to do with side effects from the prescribed medications.

How quickly the client moves from Point A (daily med drop services) to Point B (independent, self-administration of their medication) is determined based upon the client's engagement in the med drop service and his/her other psychiatric/behavioral services as well as his/her clinical stability and day to day functioning.

The Med Drop Program consists of 4 components: Program Orientation Session, Medication Drop (Delivery) Service Component, Medication Education, and Care Coordination (Treatment Planning) Services Component.

Program Orientation Component

If the client is determined to be eligible for the program, within one (1) business day after the discussion with the client's case manager/support coordinator will contact the client to schedule the Med Drop Program Orientation Session. This session is scheduled at a date and time that is convenient for the client, client's case manager/supports coordinator (who is required to attend the session) and the MDP Coordinator. Based upon the client's preference/convenience, the program orientation session can occur at a location in the community or at the Genoa Healthcare Pharmacy.

At the program orientation session, the MDP Coordinator will explain the program, complete the program consents, complete the Medication Adherence Questionnaire (MAQ), review the Assessment of the Client's Medication Assistance Needs, review current demographic information, discuss the client's drop frequency, days and times of the drop, and drop start date. The MDP Coordinator will also perform medication reconciliation activities, and if necessary, contact the Med Drop Pharm Tech/Pharmacist from the field for medication reconciliation assistance. The MDP Coordinator will collaborate with the client on the development of a treatment goal, objectives, and interventions for the Med Drop Program. The MDP Coordinator will bill this session as a Program Orientation Session or the Initial Treatment Planning Session.

During the program orientation session, the MDP Coordinator will also offer the initial education regarding the client's medications that includes medication information sheets; information sheets for questions for the client to ask his/her treating prescriber, and a booklet on mental health medications in general.

Medication Drop (Delivery) Service Component

"Dropped" medications are prescribed by the client's Network Provider's Treating Prescriber. If the client chooses, his/her physical health medications can be included in the Med Drop. These medications are prescribed by the client's Primary Care Provider or Specialty Care Provider.

The MDP Staff provides the medication drop (delivery) service component. This component consists of dropping behavioral health medications, and physical medications if included in the program, to the client's residence/location in the designated service area at a regularly scheduled time. This time is based upon the client's address and where the address is placed on the route. There is an AM route which typically runs from 8:00 AM to 11:30 AM and a PM route which typically runs from 5:00 PM to 8:30 PM. The routes run 365 days per year. These home/community based drops can occur up to twice a day. If a client is prescribed medications that are to be taken three (3) or more times a day, the MDP Staff will leave dosages with the client to self-administer and the Treating Prescriber is notified.

The client's drop frequency is determined by the client's progress, client choice (unless a court order specifies a frequency and duration), treating prescriber, case manager and MDP Coordinator's input. Ultimately, the client's Treating Prescriber approves the drop frequency and any permanent changes in the client's drop frequency. Most clients will begin the Med Drop Program at one drop a day; however, a client can begin the program at a lower frequency such as 1 drop per week. It is expected that the client "step down" to lower drop frequencies as he/she moves through the program. How quickly the client "steps down" depends upon the client's engagement in the med drop program and his/her other psychiatric/behavioral services, his/her clinical stability, and day to day

functioning. The Treating Prescribe must approve “step downs.” In turn, the MDP Coordinator coordinates “step down” dates with the MDP Staff.

If the client is not going to be available for a scheduled drop, the client is expected to contact the MDP Staff to arrange for an Leave of Absence (LOA). A LOA is a situation where the client requests that his/her medications be dropped at a prior drop because he/she is not going to be available at the scheduled drop time. Examples of LOA situations are the client has a doctor appointment, is going on vacation, or is going to be visiting family/friends outside of the designated drop area. Many clients ask for LOAs during the Holiday Seasons. Case Managers/Supports Coordinators can approve LOAs without the Treating Prescriber's approval.

The MDP Staff will do their best to arrive at the scheduled drop time; however, based upon clients' needs, this is not always possible. If the MDP Staff is going to be more than 30 minutes late for the scheduled drop, the MDP Staff will contact the client.

If the client is not present for the scheduled drop, depending upon the route schedule, the MDP Staff may make a second attempt on that day, but it is not required. If the client is not present for a scheduled drop, the client is considered “unavailable” for that day and the MDP Staff will indicate this on the MDP Progress Note. If the client is “unavailable” or “refuses” all dosages on a given day, the client is considered “non-adherent” for that day.

If a client is “non-adherent” two (2) consecutive days, the MDP Coordinator will notify the treating prescriber and case manager/supports coordinator. This notification is important because missing two (2) consecutive days may impact the client's clinical response to his or her medication. The treating prescriber and case manager/treating prescriber will decide the action to take to address the client's non adherence.

During the drop, the MDP Staff will observe the client self-administering the medication, ask how the client is feeling, ask about any side effects, and observe the client's physical appearance, behavior and speech. The MDP Staff will also regularly provide education to the client on his/her medications, and review organizational strategies to help the client take his/her medications as prescribed.

If the client's physical appearance, behavior or speech is unusual for the client, or the client expresses concerns/issues, the MDP Staff shall do the following:

- Contact the MDP Coordinator or MDP Pharm Tech/Pharmacist, who in turn will attempt to reach the client's case manager/supports coordinator
- If after business hours, the MDP Staff will contact the CMH's Crisis Center
- Depending upon the nature and urgency of the situation, the MDP Staff will contact 9-1-1

If the situation is severe/urgent, the MDP Staff MUST speak to a “live person” regarding the situation.

If the client reports experiencing any side effects to the medications, the MDP Staff will call the pharmacist/on-call pharmacist during the drop to advise. The MDP Staff will share the pharmacist's comments with the client or have the client speak directly with the pharmacist. This conversation will be noted on the MDP Progress Note and forwarded the note to the MDP Coordinator, who will follow up on discussion of the side effect concern with the Genoa Pharmacist and/or forward the note to the treating prescriber. If there are concerns about the side effects, the Genoa Pharmacist will decide

on the next steps which may include contacting the client's Primary Care Provider or Treating Prescriber.

The MDS Staff complete the following documentation:

- Medication Administration Record (MAR) on a daily basis
The MAR is completed by the MDP Staff and submitted to the Med Drop Program Manager on a monthly basis for billing verification.
- MDP Progress Note on a daily basis
The MDP Progress Notes are completed by the MDP Staff within one (1) business day of the drop. These are completed in the CMH's Electronic Health Record (EHR). Non-routine progress notes are immediately forwarded to the MDP Coordinator for follow up.
- Chart/Contact Note, as needed
The Chart/Contact Note is completed by MDP Coordinator for any contact with the client/guardian outside of the medication drop; contact with members of the MDP Treatment Team; and to record significant information such as admission/discharge to an out of home setting and discharge from the program. This Note is completed in the CMH's EHR.
- Medication Adherence Questionnaire every 6 months
The MDP Coordinator completes this document initially at the Program Orientation Session. The Med Drop Program Staff complete this document with the client every 6 months.
- MDP Monthly Review Form every month
The MDP Coordinator completes this document, with input from the MDP Staff. The completed document is forwarded to the client's case manager/supports coordinator and treating prescriber.

Education Component

During the drop, the MDP Staff will regularly review with the client the name of the medications, the medication's physical appearance and how and when to take the medications. The MDP Staff will also ask about any side effects concerns. If these are reported, the MDP staff will connect the client with Genoa's Pharmacist or on-call Pharmacist. Medication Information Guides will be provided to the client at least on a monthly basis. Also available to the client/guardian are medication information sheets developed by the National Alliance on Mental Illness (NAMI); information sheets with questions to ask his/her treating prescriber, and booklet on mental health medications in general. The MDP Staff will also assist the client in identifying and implementing an organizational strategy that includes where the client is storing medication that is left with him/her and what strategy he/she is using to remember to take the medication.

Care Coordination/Treatment Planning Service Component

Genoa's MDP Coordinator will work collaboratively with the client's case manager/supports coordinator in addressing client concerns that arise during the drop visits. In general, if the client's

concerns focus on medication issues, the MDP Coordinator will follow up. If the client's concerns focus on non-medication issues, the case manager/supports coordinator will follow up.

The MDP Coordinator will complete and forward the Monthly Review Form to the client's case manager/supports coordinator and treating prescriber. The Monthly Review Form is completed with input from the MDP Coordinator and MDP Staff that are interacting with the client; as well as, information that is provided by the case manager/other treatment team members over the course of the reporting month. The Monthly Review Form identifies the client's medication adherence rate, identifies the client's medication adherence strength and risk factors, summarizes the client's progress including using his/her chosen organizational strategy effectively, and contains recommendations regarding the frequency of the medication drops.

Also as part of care coordination, the MDP Coordinator will participate in the client's treatment planning. Treatment Planning consists of the MDP Coordinator, client, guardian (if applicable), and any other members of the treatment team the client wishes to have present, including the case manager/supports coordinator, when developing the goal, objectives and interventions for the MDP Program during the program orientation session. Within 14 calendar days of the program orientation session, the Med Drop Program goal, objectives and interventions are forwarded to the case manager/supports coordinator for inclusion in the client's person centered plan. This goal will be reviewed at the ongoing MDP Treatment Team planning sessions, which will typically occur at the time of the client's medication review appointment. If the MDP Coordinator participates in the Treatment Team planning session, the MDP Coordinator will complete the MDP Treatment Team Review Form (the same form as the MDP Monthly Review Form) which summarizes the client's progress, medication adherence strength and risk factors for the client, and recommendations regarding the frequency of the medication drops. The MDP Coordinator forwards this form to the case manager/supports coordinator, if he/she did not attend the MDP Treatment Team planning session (Med Review). When applicable, the MDP Coordinator will also share the recommendations from the MDP Treatment Team planning session (Med Review) with the MDP Staff.

Outcome Measurements:

Individual Outcomes:

1. Medication Adherence

Adherence is defined as the client ingests ALL prescribed dosages of his/her medications on an "available day". An "available day" is defined as the client is in the community and in the MDP designated service area.

Monthly Adherence is defined as the following:

- Full Adherence is defined as the client taking his/her medications 80% or more of the available days in a month.
- Partial Adherence is defined as the client taking his/her medications 60-79% of the available days in a month

Non-Adherence is defined as the client taking his/her medications 59% or less of the available days in a month,

Program Adherence is defined as the following:

- Full Adherence is defined as the client taking his/her medications 80% or more of the available days while in the program.
- Partial Adherence is defined as the client taking his/her medications 60% to 79% of the available days while in the program.
- Non-Adherence is defined as the client taking his/her medications 59% or less of the available days while in the program.

80% of the clients who participate in the program shall attain Full Adherence while in the program.

2. Reduction in Psychiatric Inpatient Admissions

70% reduction in psychiatric inpatient hospital admissions by clients who have a history of psychiatric inpatient hospital usage as measured by a comparison of psychiatric inpatient hospital admissions in the 12 months prior to program admission to psychiatric inpatient hospital admissions while in the program. The 12 months prior data will be obtained from the CMH's EHR.

70% reduction in psychiatric inpatient hospital days used by clients who have a history of psychiatric inpatient hospital usage as measured by a comparison of inpatient hospital days used in the 12 months prior to program admission to days used while in the program. The 12 months prior data will be obtained from the CMH's EHR.

3. Reduction in Crisis Home Admissions

75% reduction in crisis home admissions by clients who have a history of crisis home usage as measured by a comparison of crisis home admissions in the 12 months prior to program admission to crisis home admissions while in the program. The 12 months prior data will be obtained from the CMH's EHR.

75% reduction in crisis home days used by clients who have a history of crisis home usage as measured by a comparison of crisis home days used in the 12 months prior to program admission to days used while in the program. The 12 months prior data will be obtained from the CMH's EHR.

Other Individual Data Measures:

1. Indicators related to Medication Adherence Strengthening and Risk Factors

An increase in medication adherence strengthening factors self-reported by the clients as measured by their first completion of the Medication Adherence Questionnaire (MAQ) compared to their second/last completion of the Medication Adherence Questionnaire. The client MUST have at least 2 completed MAQs to be included in "second/last" data set.

A decrease in medication adherence risk factors self-reported by the clients as measured by their first completion of the Medication Adherence Questionnaire compared to their second/last completion of the Medication Adherence Questionnaire. The client MUST have at least 2 completed MAQs to be included in the "second/last" data set.

The number of clients who discharge from the program that are able to independently adhere to his or her medication regimen without assistance or with assistance.

2. Indicators related to Medical Admissions

The number of clients who self-report a history of medical hospital usage shall reduce their medical hospital usage while in the program.

A decrease in the number of medical hospital admissions by clients who self-report a history of medical hospital admissions as measured by a comparison of medical hospital admissions in the 12 months prior to program admission to medical hospital admissions while in the program. The 12 months prior data represents client's self-report at the time of the Program Orientation Session.

A decrease in the number of medical hospital days used by clients who have a history of medical hospital days as measured by a comparison of the medical hospital days used in the 12 months prior to program admission to days used while in the program. The 12 months prior data represents client's self-report at the time of the Program Orientation Session.

3. Indicators related to client incarceration

The number of clients who self-report a history of jail usage shall reduce their jail usage while in the program.

A decrease in the number of jail admissions by clients who have a history of jail admissions as measured by a comparison of jail admissions in the 12 months prior to program admission to jail admissions while in the program. The 12 months prior data represents client's self-report at the time of the Program Orientation Session.

A decrease in the number of jail days used by clients who have a history of jail days as measured by a comparison of days in jail in the 12 months prior to program admission to days in jail while in the program. The 12 months prior data represents client's self-report at the time of the Program Orientation Session.

System Outcomes:

A reduction in psychiatric hospital admissions as measured by a comparison of the number of psychiatric hospital admissions for the MDS clients in the 12 months prior to program admission to admissions while in the program. The 12 months prior data will be obtained from the CMH's EHR.

A reduction in psychiatric hospital days as measured by a comparison of the number of psychiatric hospital days used for the MDS clients in the 12 months prior to program admission compared to

psychiatric hospital days used while in the program. The 12 months prior data will be obtained from the CMH's EHR.

A reduction in crisis home admissions as measured by a comparison of the number of crisis home admissions for the MDP clients in the 12 months prior to program admission to admissions while in the program. The 12 months prior data will be obtained from the CMH's EHR.

A reduction in crisis home days as measured by a comparison of the number of crisis home days used for the MDP clients in the 12 months prior to program admission compared to crisis home days used while in the program. The 12 months prior data will be obtained from the CMH's EHR.

The Med Drop Program Manager will complete a quarterly program evaluation report. The reporting dates are January 30th, April 30th, July 30th and October 30th. The Med Drop Program Manager will complete an annual program outcome report. This reporting date is October 30th. In order for the Med Drop Program Manager to complete these reports in a timely manner, the 12 month prior data for psychiatric inpatient hospital admissions, psychiatric inpatient days usage, crisis home admissions, and crisis home days usage needs to be obtainable from the CMH's EHR.

Referral Process:

Individuals will be identified for this program by the CMH/CMH's Provider Network staff. The referring staff member, in most cases this person is the case manager/supports coordinator, will complete the Program Referral Form and concurrently submit the initial authorization for 90 days of medication drop services. This authorization will consist of submission for one (1) assessment session-H0031, three (3) Treatment Planning Sessions-H0032, and 90 days of medication drop services (H2015).

Eligibility Determination and Program Acceptance

The MDP Coordinator receives the referral and checks the CMH's EHR to see that the initial authorization has been approved. When these two (2) items are in place, within two (2) business days, the MDP Coordinator contacts the individual's case manager/supports coordinator to complete the Assessment of Client's Medication Assistance Need. The Assessment of Client's Medication Assistance Need assists in determining the client's appropriateness for the Med Drop Program as well as the client's initial drop frequency. At the end of this conversation, the MDP Coordinator and case manager/supports coordinator identify a date and time for the Program Orientation Session. It is the case manager/supports coordinator's responsibility to contact the referred individual and schedule the Program Orientation Session.

Authorization:

The CMH will generate an initial authorization for 90 days of medication drop services-H2015, one (1) assessment- H0031 and three (3) treatment planning sessions-H0032.

At the end of each authorization period, one (1) of the following is expected to have occurred:

1. The client is able to independently adhere to his or her medication regimen. The client no longer needs the MDP Staff to coach him/her on how to organize his/her medications or prompt him/her to ingest medications and is ready for the program to

- end. As the client is preparing for discharge, he/she can choose to have Genoa Pharmacy continue to dispense his/her medications in Auto Med/Dispill. If the client chooses this option, Genoa Pharmacy will continue to contact the client's providers for medication refills and prepare the client's medication on a monthly basis for pick up or to be mailed.
2. The client has made progress and can continue to benefit from the Med Drop Program. In some cases, the client may be ready to have his/her drop frequency reduced. For this reason, the Med Drop Program is expected to continue per the recommendation of the MDP Treatment Team and a continued authorization request will be submitted by the client's case manager/supports coordinator.
 3. The client has made no progress and the MDP Treatment Team makes a recommendation regarding a different level of care outside of the Med Drop Program. Within the context of the person centered planning process, this recommendation is discussed with the client. If the client agrees, the case manager/supports coordinator will facilitate a referral to the recommended level of care.

The MDP Coordinator will collaborate with the case manager/supports coordinator to submit ongoing authorization requests in 90 day increments.

When the client exits the program, the MDP Coordinator will complete a discharge note in the CMH's EHR. This note will be forwarded to the case manager/supports coordinator and treating prescriber.

Reimbursement:

Service Description	Code	Unit	Rate
Community Living Supports (CLS)	H2015	Per 15 minute face to face	TBD
Assessment by Non-Professional	H0031	Encounter	TBD
Treatment Planning	H0032	Encounter	TBD

The MDP program will use the following codes: H0031- 1 Assessment per year; H0032- 1 per quarter; and H2015 per drop based upon client's clinical needs. The codes are only reimbursable if the client is present. In addition, to bill the H0032, another member of the client's Treatment Team (treating prescriber, case manager/supports coordinator, nursing staff, etc) must be present.

Staff Qualifications:

The Med Drop Program administration consists of the Genoa Healthcare Pharmacist, who supervises the Med Drop Pharm Tech; Med Drop Program Manager- LMSW who ensures the Med Drop Program Services are implemented as described and supervises the MDP Coordinator; and a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who works with the Med Drop Program (MDP) Staff and ensures the medications are properly stored, accounted for and dropped as prescribed.

The MDP Staff will possess the following minimum qualifications:

- At least 18 years old
- High School Diploma or GED equivalent
- At least 1 year of experience working with adults with a serious mental illness or co-occurring mental illness and substance use disorder; individuals with a developmental disability; or medically fragile older adults, preferred
- Must have reliable transportation
- Able to practice prevention techniques to reduce transmission of any communicable disease
- Able to follow/implement the client's Medication Drop Program (MDP) Treatment Goal, Objectives and Interventions.
- Able to perform basic first aid and emergency procedures
- Eligible to work in the United States
- Be of good moral character
- Be trained in Recipient Rights
- Be able to use good judgment/follow procedures in addressing client concerns/issues
- Demonstrate the ability to work independently and as a part of a coordinated team.
- Excellent interpersonal, verbal and written communication, time management and organizational skills

Quality Assurance:

Genoa's Med Drop Program Manager will conduct an annual internal and external review of the Med Drop Program utilizing the MDP Program Review forms.

MDS Program Contact Information:

CMH/Funding Source

TBD

Genoa Healthcare

Diane Cranston
Med Drop Program Manager
517-945-3863
dcranston@genoahealthcare.com

References:

¹MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual & Developmental Disability Supports and Services p.133, Jan 1. 2020

Medication Drop Program
MED DROP™ Program Goal and Objectives

Program Philosophy:

The Med Drop Program (MDP) is a Community Living Supports (CLS) based intervention that focuses on improving medication adherence through the observation related to a client's self-administration of his/her medication. The Med Drop Program was designed to fill "a gap" in the service array for all clients. This program assists clients in identifying and implementing strategies and skills to take their behavioral health medications as prescribed. If the client chooses, his/her physical health care medications can also be included in the program. This service is expected to improve the clients' overall mental health and daily functioning by improving the symptoms treated by their medications.

Program Goal:

The client will be able to take his/her medications independently, as prescribed

Program Objectives:

Objective 1: The MDP Staff will educate the client about his/her specific medications.

This education will include teaching the client the answers to the following questions:

- What is the name of the medication
- How and when the medication is to be taken

The MDP Staff will ask the client about any side effects or medication concerns

- The MDP Staff will call the Genoa Pharmacist/Genoa On-Call Pharmacist from the drop to address questions about side effects or medication concerns.

Objective 2: The MDP Staff will help the client to identify and implement organizational strategies to take his/her medications consistently.

This will include assisting the client in identifying a place to store the medication and a strategy to remember to go and take the medication. These strategies might include: Medication Trays, Color coded Medication Trays for those clients that can't read, Special Packaging- DISPILL or Auto Med, setting alarms, text messages, or phone calls. There are also medication calendars and possibly dispensing machines.



Medication Drop Program

Monthly Review / MDP Treatment Team Review

Client Name: _____ DOB: _____ Review Date: _____

Period Covered by Review: _____ # of Months in Program: _____

Current Med Drop Frequency: _____ Start Time: _____ End Time: _____

Individuals participating in Review: _____

Reporting Month:

of Days in Psych Hospital: ____ # of Days in Medical Hospital: ____ # of Days in Crisis Home: ____ # of Days in Jail: ____

Adherence Rate:

In the past month, the client 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 client has the following Medication Adherence Strengthening Factors: (check all that apply):

- ☐ Accepts psychiatric diagnosis
- ☐ Understands he/she has a mental illness
- ☐ Believes mental illness symptoms will/are improving with the medications
- ☐ Likes prescriber, primary clinician or case manager
- ☐ Believes the benefits outweigh the risks for taking medications
- ☐ Feels better when taking medications
- ☐ Believes the medications improve his/her functioning and quality of life
- ☐ Is able to tolerate the side effects
- ☐ Has a significant other, family or friends that support and encourage the use of medications
- ☐ Does not use alcohol or drugs regularly
- ☐ Sleeps well

The client has the following Medication Non-Adherence Risk Factors: (check all that apply):

- ☐ Does not believe he/she has a mental illness
- ☐ Active co-occurring substance use disorder/Using alcohol or drugs regularly
- ☐ Participates in a 12 Step Recovery program that criticizes use of any medications
- ☐ Does not like prescriber, primary clinician or case manager
- ☐ Reports medications are not working, symptoms are not improving
- ☐ Not able to tolerate the side effects
- ☐ Significant other, family or friends do not support or encourage client to take medications
- ☐ Stigma- client is ashamed to take medications, feels judged by others for taking medications
- ☐ Has a history of feeling better and then stops taking the medications
- ☐ Has a diagnosis of schizophrenia, psychosis, or bi-polar disorder
- ☐ Has an active Alternative Treatment Order (ATO)
- ☐ Does not sleep well
- ☐ Has tried medications in past and reports they have not worked
- ☐ Does not have transportation to pick up medications
- ☐ Does not have money to pay for medications
- ☐ Forgets to take medications

Medication Knowledge Areas: (check all that apply) The client can state the following:

- ☐ Names of his/her medications
- ☐ How and when to take the medications

Organizational Strategies:

The client is: ☐ Working on this ☐ Not working on this ☐ Completed

MDP Treatment Goal:

The client is: ☐ Working on this ☐ Not working on this ☐ Completed

Readiness for Taking Medications Independently:

The client is ready to decrease the frequency of the medication drops

☐ Yes ☐ No Provide Rationale: _____



MED DROP™ Program
Medication Adherence Questionnaire (MAQ)

Client Name: _____ Client DOB: _____

Questionnaire Completion Date: _____ Person Completing Questionnaire: _____

Your MDP Staff Member and MDP Coordinator would like to work with you 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 some questions to get a sense of how you think, feel and act when it comes to your mental health medications.

1. What is your mental health diagnosis? Do you think this is true for you¹?
2. What are your current mental health medications? What symptoms are they prescribed for?
3. Have you taken mental health medications in the past? Do you remember their names? Did they work for you¹?
4. Do you like your Psychiatrist/Nurse Practitioner¹?
5. Are you having side effects to your medications? If so, do the side effects bother you as you go about your daily activities²?
6. Do your family members, friends and/or significant other support you in taking your taking your mental health medications¹ ?
7. Is this a true statement for you "I do not want anyone to know that I take mental health medications because they would judge me, think less of me, make fun of me, or criticize me"²?

1*	2	3
(None)		

- 1* 2 3
(Not at All)

1 (Not at All)	2	3

- 1* 2 3
(Not True at All)

- 1 2 3
(Worse)

genOa
healthcare
MED DROP™ Program
Program Referral Form

Date: _____

Client Information:

Name: _____ DOB: _____ SS #: _____

Address (Street, City, State, and Zip): _____

Phone Number(s): H: _____ C: _____

Insurance Type (Ex: Medicaid, Medicare, Commercial, and Uninsured): _____

Guardian's Name***: _____

Guardian's Phone Number(s) ***: H: _____ C: _____

*** Client's Guardian will be required to sign the consent forms prior to the Med Drop Program beginning, ideally this will occur at the Program Orientation/Intake Session***

List the client's current behavioral health medications and current name and address of pharmacy:

Does the Client want his/her physical health medications included in the MED DROP™ Program? ☐ Yes* ☐ No
If Yes, list the medications and current name and address of pharmacy:

Can the Med Drop Staff safely deliver daily medications to the Client's Address between the hours of 8 AM and 8 PM? ☐ Yes ☐ No* If No, is the client willing to meet the Med Drop Staff at a different location (indicate address)? _____

Additional Comments regarding Client's Address: _____

Has the MED DROP™ Program been explained to the Client? ☐ Yes ☐ No

Is the Client willing to participate in the MED DROP™ Program? ☐ Yes ☐ No

Is the Case Manager/Supports Coordinator willing to participate in the Med Drop Program Orientation Session? ☐ Yes ☐ No

SCCMHA Services Information:

Case Manager Name: _____

Case Manager's Phone Number: W: _____ C: _____

Case Manager's Email Address: _____

Treating Prescriber Name: _____

Client is receiving the following SCCMHA Services: _____

Eligibility Criteria that the client meets: (Check all that apply):

- ☐ Client is exiting an inpatient behavioral health hospital setting
- ☐ Client is exiting a crisis home setting
- ☐ Client is currently on an ATO mandating medication adherence
- ☐ Client is currently receiving ACT/IDDT services, but could benefit from a lesser restrictive setting
- ☐ Client has declined recommendation for Long Acting Injectable medication
- ☐ Client could participate/continue participating in a Supported Independent Living Program (SIP) through participation in the Med Drop Program
- ☐ Client could transition from a supervised/dependent setting in a supported or independent setting, never having the opportunity to demonstrate medication adherence, through participation in the Med Drop Program
- ☐ Client is participating in Saginaw County's Mental Health Court Program
- ☐ Other: (Explain): _____

Referring SCCMHA Staff Member's Signature

Date

Referring Provider Staff Member's Phone Number and Email Address if not included above:

******The Initial Authorization for the Med Drop Program MUST be entered into the SENTRI System******

AFTER entering the Initial Authorization into SENTRI, Forward completed Referral Form, to Genoa Healthcare Pharmacy located in the SCCMHA Building. If you have questions, feel free to contact the Med Drop Coordinator at 989-793-3130.



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 client who he/she is referring to the Med Drop Program?

Does the person expect the client 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?

Does the person think the client will be in the program for a long period of time? If so, why?

2. Review the following "Need Factors" with the Referral Source & Client/Guardian:

- a. Does the client have a co-occurring disorder?

Does the client have a history of abusing/misusing prescription medications?

Can medications be left in the client's possession?

- b. Is the client coming out of an AFC placement?

Is the client at risk for going into an AFC Placement?

Does the client already have In Home CLS services?

- a. Is the client 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 client's clinical baseline?

- b. Does the client have chronic medical conditions that are of concern?
- c. How many medications is the client taking including psychiatric and physical health?
- d. Can the client read and write?
- e. Does the client have cognitive/learning challenges including an Intellectual Developmental Disorder?
- f. Does the client 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 have memory issues that are Not related to a cognitive/learning challenge or Intellectual Developmental Disorder?

3. Is someone helping the client with his/her 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 client? Or is it intermittently asking the client if he/she is taking her medications with no further oversight?

Does the client 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 client? Does the Treating Prescriber support his/her recommended frequency.



Classification of Clients by their Medication Assistance/Medication Supervision Needs

Low Need

These clients can be transitioned to closure without any significant clinical concerns.

Low to Medium Need

These clients can be transitioned to closure without any significant clinical concerns.

Medium Need

Some of these clients can be transitioned to closure without any significant clinical concerns. For the remaining, there are some concerns and it would be safer to move the client to 1 drop a week.

Medium to High Need

These clients need continued medication assistance/medication supervision at or slightly below their current frequency level. There are significant clinical/safety concerns for these clients.

Medium to High Need Clients have at least 1 of the following factors:

- COD/SA
- At risk for placement in an AFC
- Active Symptoms
- Large Volumes of Medications
- Reading or Writing Deficits
- Intellectual Developmental Disorder
- Physical Challenges
- Memory Problems

High Need

These clients need continued medication assistance/medication supervision at their current frequency level. There are significant clinical/safety concerns for these clients.

High Need Clients have at least 3 of the following factors:

- COD/SA
- At risk for placement in an AFC
- Active Symptoms
- Large Volumes of Medications
- Reading or Writing Deficits
- Intellectual Developmental Disorder
- Physical Challenges
- Memory Problems

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Psychiatric Hospitalization of Consumers with Intellectual and Developmental Disabilities and Children with Autism	Chapter: 03 – Continuum of Care-Integrated Service System	Subject No: 03.02.39
Effective Date: 10/1/2019	Date of Review/Revision: 6/1/20, 3/19/21, 4/27/22, 3/2/23, 4/4/24, 4/25/25 Supersedes:	Approved By: Sandra M. Lindsey, CEO
		Responsible Director: Executive Director of Clinical Services Authored By: Director of Network Services, Public Policy and Continuing Education & Director of Services for Persons with Intellectual and Developmental Disabilities Additional Reviewers: Charlotte Fondren

Purpose:

The purpose of this policy is to provide guidance to those staff that work with persons who are diagnosed with Intellectual and Developmental Disabilities (I/DD). The ultimate goal is to reduce the need for person served 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 individuals 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 persons served to the emergency room in order to address consumer maladaptive behaviors.

Standards:

1. Individuals 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 individual, home staff, family and/or guardian to determine how individual presents on a good day, how individual presents when not feeling well, how individual presents when becoming worried or anxious, and how individual presents when angry or agitated. Knowing whether a person served 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 Plan or request a formal behavior plan through a psychologist or Behavior Intervention Coordinator

****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 individual 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 the individual 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 person saw a dentist?
 8. Increase in symptoms for a known health concern?
 9. Has there been any indication the person could be experiencing a new health concern?
 10. Could the individual 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 individual had a bowel movement?
- iii. Environmental change:
1. Has there been a change in the individual 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 Adult 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 the person does present in the emergency room due to behavioral concerns/issues that staff are unable to address in the home, be aware that individuals 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 person with an I/DD diagnosis to be psychiatrically hospitalized can include the following:

- a. Individual 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. Individual is a threat to him/herself
 - c. Individual is a threat to others beyond the normal functional behaviors displayed; i.e. If individual is known to have aggression toward other persons 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 individual has changed (meaning new symptoms or behavior is being displayed that is not typical).
10. If an individual 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 person's file.
 - b. Crisis Intervention Services staff will notify the supervisor of the team to discuss the individual.
 - 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 person?
 - 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 individual's's psychiatrist or the Medical Director can be consulted.

Please note: Residential Settings in the community are unable to accept individuals who require restraints. If an individual 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 person, provide resources and avoid trauma triggers, also including the psychiatrist/nurse practitioner who has been working with the individual to provide consultation in regards to possible medication changes or other recommended options for the person.

If the case holder is new or less familiar with the individual, they can serve as the liaison to others in the person'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 person in their home, AFC, or CLS staffed living situation.

Case Holder- the person noted in Sentri as the case holder and also coordinates services for the person served.

Behavior Champions- staff that have a particular interest in person serves behavior and how it influences individuals interactions 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 person serve with continued placement in their community.

References:

Michigan Mental Health Code Chapter 5[http://www.legislature.mi.gov/\(S\(52rtq3x5nvnms1out3fv1uaa\)\)/mileg.aspx?page=GetObject&objectname=mcl-Act-258-of-1974](http://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 individual so that they can live their best life, which may include remaining in the community in the least restrictive setting. Continuously evaluates for changes in functional behavior through monitoring and periodic reviews.	1. Person Serve Treatment Team and Case Holder

2. Consults with behavior champions as needed.	2. Case Holder
3. Interdisciplinary meeting is requested to discuss the individual 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 the individual behavior.	5. Residential Staff
6. Addresses functional behavior challenges/concerns in the person serve'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 individual ; on the individual 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 person serve.	9. Case Holder
10. Works with Crisis Intervention Services Staff as needed to assure that individual receives appropriate monitoring and care when brought to Crisis Unit or Emergency Care Center.	10. Unit Supervisor and Case Holder

Exhibit A



Emotional and Health Regulation Intensity Rating Scale

If ABC or other behavioral tracking sheets in place, include an intensity number for events. Thank you!

Person Served: _____ ID: _____

Intensity of Emotional & Health Regulation	Observations at each level (e.g. You may comment on facial expressions, eye contact, pacing, rocking, type of words/verbalizations used, volume of speech, proximity to others, actions towards others or property, and other observations unique to the individual.)	Specify actions needed (e.g. Aside from baseline or "0", you could indicate to document on ABC sheet or tally sheet. You might also write specific proactive or reactive strategies to use – which may include PRN medication if prescribed.)
3 – Severe How I feel when I am upset/angry/mad/annoyed/outraged (Too late for proactive strategies; reactive and possibly emergency strategies needed as specified.) **full behavior has occurred		
2 – Moderate How I feel when I am bothered/anxious/worried/frustrated (Action needed; proactive strategies needed as specified.) ***increase in behavior If has PRN – give if have not given at #1		
1 – Low How I feel when I am feeling ill/sick/sad/lonely (Likely minimal specific action needed; documentation on ABC sheet or comparable still needed.) **change in behavior is occurring		
0 – Baseline How I feel when having a good day. (What things look like during a "good" or "normal" day; No need to document on ABC or elsewhere at this level.)		

Thank you for taking the time to provide great information! Date of scale development: _____ Authors: _____

Revised 04/25/2025

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Quality Improvement Program	Chapter: 04 - Improving Organizational Performance	Subject No: 04.01.01
Effective Date: August 5, 2002	Date of Review/Revision: 8/29/03, 6/8/07, 2/3/09, 6/8/12, 3/21/17, 5/8/18, 9/10/19, 3/8/21, 2/25/22, 2/24/23, 1/22/24, 2/11/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Chief Information Officer & Chief Quality and Compliance Officer
	Supersedes:	
		Authored By: AmyLou Douglas Additional Reviewers: Holli McGeshick

Purpose:

- A. To provide an organized, thoughtful, comprehensive, and integrated approach to system-wide quality assurance and quality improvement for SCCMHA.
- B. To clarify the components of a comprehensive quality plan for SCCMHA.
- C. To ensure a responsive and data-driven organizational culture of performance management.
- D. To fulfill SCCMHA contractual obligations with the Michigan Department of Health and Human Services (MDHHS), Certified Community Behavioral Health Clinic (CCBHC), and with Mid State Health Network (MSHN) PIHP for quality improvement.
- E. To continuously reinforce and promote best value and quality in SCCMHA service delivery, customer service and business operations.
- F. To outline the roles and obligations of various SCCMHA segments - board, management, staff, providers, consumers, and other community stakeholders – in a quality improvement program and plan.
- G. To ensure compliance measurements are determined, implemented, and addressed where appropriate throughout SCCMHA.
- H. To ensure SCCMHA quality planning and implementation for both MSHN delegated managed care functions and board-operated programs/service delivery.
- I. To ensure that SCCMHA responds to changing outcomes, information, technology, risk factors, quality obstacles and customer preference and satisfaction through a comprehensive effort.
- J. To promote quality service, supports and care, as well as satisfaction, dignity and respect for individuals served by SCCMHA.

Policy:

Saginaw County Community Mental Health Authority (SCCMHA) is committed to a structured and accountable Quality Improvement Program (QIP) that ensures continuous enhancement of service delivery and system operations. As a Community Mental Health Services Program contracted with MDHHS and a member of the Mid-State Health Network PIHP, SCCMHA is required to maintain a QIP that meets established standards.

The Saginaw QIP is designed to emphasize a clear organizational structure, accountability to a governing body, and a senior official responsible for overseeing the program. Active participation from providers and persons served is integral to the program, incorporating standardized performance indicators and maintaining minimum performance levels. Thorough documentation and regular reporting to stakeholders ensure continuous improvement and better health outcomes for individuals served.

The scope of the QIP is comprehensive and inclusive, addressing the needs of adults with Severe Mental Illness (SMI), children with Serious Emotional Disturbance (SED), individuals with Intellectual and Developmental Disabilities (I/DD), youth and adults with Substance Use Disorders (SUD), Mild to Moderate (M/M) mental health issues, Co-Occurring Disorders (COD), and individuals with co-morbid conditions. The program covers all care settings, including residential, outpatient, inpatient, and community-based services, and spans both clinical and non-clinical areas.

Quality measurement and performance improvement occur through regular data review and reporting. The Quality Improvement Committees analyze aggregated data to identify trends and areas for enhancement.

SCCMHA's QIP is designed to ensure compliance with regulatory requirements while promoting the highest level of effectiveness in behavioral health service delivery. All components of the SCCMHA behavioral health system are expected to engage in ongoing quality measurement and improvement efforts as part of this structured program.

Application:

This policy applies to all divisions, departments, and units of the SCCMHA system, including board-operated programs, provider network members, and all SCCMHA personnel.

Standards:

- A. Quality improvement program will be a priority of the SCCMHA leadership and system.
- B. The SCCMHA CEO designates the Chief Quality & Compliance Officer and identified resources and functions dedicated to the system oversight of the quality program.
- C. An annual Quality Improvement Plan (QIP) will be developed by SCCMHA for the SCCMHA system.

- D. The SCCMHA Quality Improvement Plan will fully meet the organization's contractual obligations from funding sources or regulatory bodies.
- E. The quality program will be based upon standardized indicators and the systematic, ongoing collection, analysis, and interpretation of valid and reliable data.
- F. SCCMHA will utilize established performance measures as a part of the plan, including but not limited to MDHHS required reporting areas of access, efficiency, and outcome, to measure minimum standards of performance and will initiate any performance improvement goals as indicated or desired.
- G. Performance, quality, and/or process improvement projects will be part of the SCCMHA plan and incorporate both clinical and non-clinical areas.
- H. The SCCMHA QIP will include both periodic quantitative and qualitative assessments, representative of persons served and the SCCMHA service array, and addressing service quality, sufficiency, and accessibility.
- I. The QIP will include expectations for monitoring and evaluating adherence to MDHHS and Regional Practice Guidelines.
- J. Licensed and non-licensed staff and contractors will be qualified based on criteria and credentialing procedures included in the QIP program.
- K. Staff and provider network training programs will demonstrate relevance to the QIP.
- L. The SCCMHA QIP will include a provider auditing system to ensure fraud prevention and protection for proper use of funds.
- M. SCCMHA QIP plan and oversight will occur through a Quality Governance Council, as appointed by the CEO and led by the CQCO.
- N. The Quality Governance Council facilitates staff, provider, and person served input for the QIP and provides leadership for SCCMHA implementation of quality plan and initiatives.
- O. Quality program inputs include both Quality Assurance and Quality Improvement metric reports addressing a comprehensive array of functions including state reporting, PIHP indicators, consumer services indicators, network service indicators, annual report content, regulatory requirements, and regulatory reports as appropriate.
- P. The Citizens Advisory Council (CAC) of SCCMHA will receive routine quality progress and outcome reports and have regular input on quality planning.
- Q. Semiannual meetings of provider and person served stakeholders shall be convened to collect input response to performance reports.

Definitions:

Risk Management Plan: A strategy for monitoring eight domains of risk, with elements established under the OIG Sentencing Guidelines

Key Performance Indicators: This is a select set of metrics which are monitored at a dashboard level. The KPI set can be selected by state, regional PIHP or locally. KPI's may include both outcome and process measures.

Quality Assessment and Performance Improvement Program (QAPIP): CMS Medicaid Managed Care rules for Quality Management.

Quality Assurance: The process of meeting quality standards and assuring that care reaches an acceptable level.

Quality (Performance or Process) Improvement; continuously analyzing your performance and developing systematic efforts to improve it.

Quality Improvement Program (QIP): Michigan Department of Health and Human Services term for CMHSP contractual program requirements.

References:

- MDHHS CMHSP Contract – “Quality Improvement Programs for CMHSP’s”
- CMS Medicaid Managed Care Final Rule 2016
- CARF Standards for Behavioral Health (current version)
- Performance Measurement and Management/Performance Improvement
- CMS
- Agency for Healthcare Research and Quality (AHRQ) National Quality Strategy
- Institute for Health Improvement (IHI)
- MDHHS Quality Training Plan-Public Health Administration
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

Exhibits:

- Exhibit A: QIP Domains
- Exhibit B: QIP Life Cycle
- Exhibit C: QIP RACI Model of Quality Improvement
- Exhibit D: QIP System Structure
- Exhibit E: Quality Governance Council Responsibilities
- Exhibit F: Quality Committee Responsibilities
- Exhibit G: Quality Committees
- Exhibit H: Quality Governance Council
- Exhibit I: Quality Improvement Program
- Exhibit J: QIP RACI Process Assignment

Procedure:

ACTION	RESPONSIBILITY
1. Assigns Administrator responsible for oversight of QIP plan development and implementation, as well as leadership for Quality Governance Council; approves QAPIP policy, program, and annual plan. Facilitates any SCCMHA Board of Directors involvement with QIP as required for oversight including program or plan review and reporting. Submits to Board of Directors and/or	CEO

Board Ends Committee summary data as required or indicated. Publishes quality reports for the community. Ensures stakeholder involvement in QIP policy, plan, and program; reports quality information to the CAC on behalf of SCCMHA.	
2. Serves as assigned Administrator for QIP for SCCMHA. Provides primary leadership for the development of the system QIP plan and recommends policy revisions. Designs the system quality plan to fully address components of SCCMHA compliance, risk and need. Chairs SCCMHA Quality Governance Council and oversees system implementation of QIP. Ensures integrity of quality reporting and related data collections. Publishes quality reports internal to the SCCMHA network and system. Directs or recommend quality related training as indicated. Ensures MDHHS reporting on process improvement and quality reporting as required.	Chief Information Officer & Chief Quality and Compliance Officer
3. Serve as members of the SCCMHA Quality Governance Council appointed by the CEO. Develop and monitor the annual quality plan for SCCMHA. Meet quarterly at minimum to provide quality leadership. Review and approve the Charters for Quality Improvement committees , review, and monitor Quality Reports.	CEO, Chief Information Officer & Chief Quality and Compliance Officer, Director of Finance, Director of Network Services, Public Policy & Continuing Education, Executive Director of Clinical Services and Programs, Chief of Health Services & Integrated Care, Director of Human Resources, Director or Environmental Services; Customer Service and Security, Quality & Medical Records Supervisor, Supervisor of Business Practices, QIP Coordinator,

	Administrative Assistant to Executive Clinical Director, Compliance Officer & Administrative Assistant to CIO/CQCO
4. Contribute to QIP leadership and implementation for respective areas of scope of responsibility. Ensure respective areas of supervision implement quality plan components. Ensure program staff and provider network member involvement in QIP development. Direct board-operated program staff, administrative staff and provider activities for contribution and compliance. Ensure qualifications and competency of persons providing service to individuals; recommend and ensure needed training and corrective action or performance improvement plans. Facilitate consumer and community individuals' involvement in QIP. May direct or delegate and oversee staff leadership in process improvement work groups or projects. Ensure proper documentation of quality activities and accomplishments.	All Management Team Members
5. Provides leadership to the overall quality program, represents SCCMHA at the MSHN Quality Council. Provides leadership to a team of staff who perform technical support and direct data analytics including publication of metric reports for quality workgroups. Provides quality curriculum training for workforce and skill development in quality leadership.	Quality & Medical Records Supervisor
6. Provides coordination of regulatory compliance information and analysis for quality planning and implementation.	Compliance Officer
7. Provide program oversight for quality of services. Meets with program supervisors to implement continuous program level quality improvement activities, review goal progress, and recommend new initiatives. Systematically gather data to evaluate and improve effectiveness, quality, and cost of provided services. Review and address suggestions from staff and consum-	Executive Director of Clinical Services Programs and Director of Network Services, Public Policy & Continuing Education

ers. Provide input on staff development needs of the network.	
8. Program leadership and front-line staff carry out improvement initiatives in their daily work, provide insights and data on the effectiveness of changes, participate in training, and contribute to a culture of continuous improvement. Program leadership from subcontracting agencies or designated collaborating organizations (DCO) are enlisted as subject matter experts as needed.	SCCMHA Supervisors and other Staff
9. Serve as members of the Stakeholder focus groups; provide input through varied mechanisms throughout SCCMHA system, including provider network members and CAC.	SCCMHA Persons Served & Stakeholders
10. Provide system quality improvement input, and comply with quality requirements including training, reporting and documentation. Establish measurable quality improvement initiatives appropriate for provider service type and organizational scope. Provide service in keeping with QIP requirements and principles.	SCCMHA Provider Network Members and Employees
Specific QIP Responsibilities:	
11. The Governing Body that approves the overall QIP and the annual quality improvement plan, as noted in the meeting minutes. The governing body regularly receives written reports from the QIP, describing actions taken, progress in meeting objectives, and improvements made. They also ensure the QIP aligns with Saginaw's mission and vision. Annually, the Governing Body formally reviews a written report on the QIP, which includes: studies undertaken, results, subsequent actions, and aggregate data on service utilization and quality. This review assesses the QIP's continuity, effectiveness, and current relevance. The Governing Body ensures that the CEO acts when appropriate and directs that the operational QIP be modified to address findings and concerns within the Community Mental Health Service Program (CMHSP).	Board of Directors

12. Provides overall direction and support for the QIP. The CEO ensures necessary resources, such as staff and budget, are available and keeps the governing body informed about QIP progress and challenges.	Chief Executive Officer
13. The QGC provides oversight of the activities of the QI Committees. They identify the annual goals of the QIP, ensure the progress of the goals through the work of the QI Committees and receive regular reports from the QI Committees regarding the measures the QIP is responsible for monitoring.	Quality Governance Council
14. Ensures quality and safety standards are met and provides expertise and guidance on clinical issues and improvement strategies.	Medical Director and Clinical Leaders
15. Designated senior official responsible for implementing the QIP. This person will also chair the QGC.	CIO / Chief Quality & Compliance Officer
16. Responsible for the operations of the QIP Committee. Selects the Chair & Co-Chair of the committee. Provides representation of the Management Team to the committee. Possesses the authority to tentatively approve process changes on behalf of leadership. Requests nominations for membership from the various agency department's leadership members.	Executive Sponsor
17. Program leadership and front-line staff carry out improvement initiatives in their daily work, provide insights and data on the effectiveness of changes, participate in training, and contribute to a culture of continuous improvement. Program leadership from subcontracting agencies or designated collaborating organizations (DCO) are enlisted as subject matter experts as needed.	Program Leadership and Front-Line Care Teams
18. Provides valuable insights based on personal experiences with services and represents the perspectives of service users. They contribute to the development and evaluation of improvement	Individuals with Lived Experience

initiatives to ensure that changes meet client needs.	

Exhibit A: QIP Domains

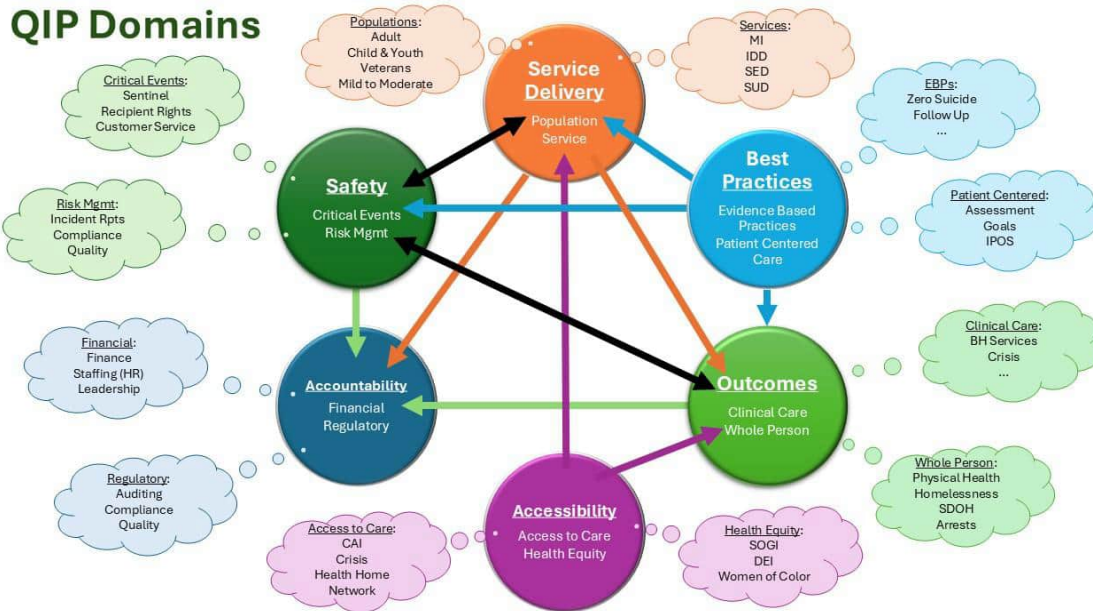


Exhibit B: QIP Life Cycle

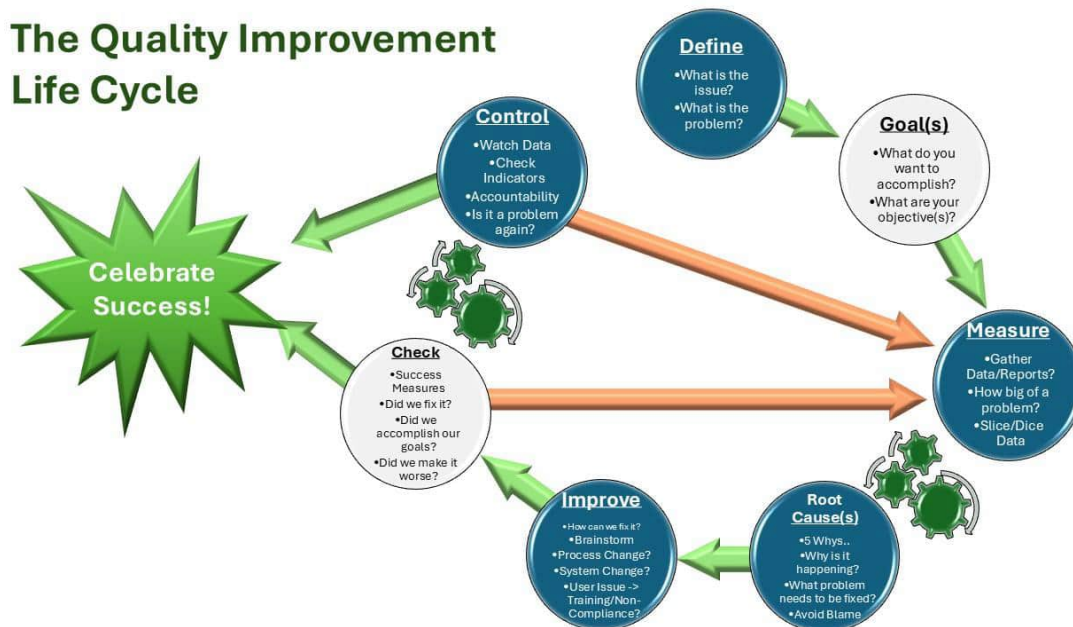


Exhibit C: QIP RACI Model of Quality Improvement

SCCMHA’s RACI Model of Quality Improvement

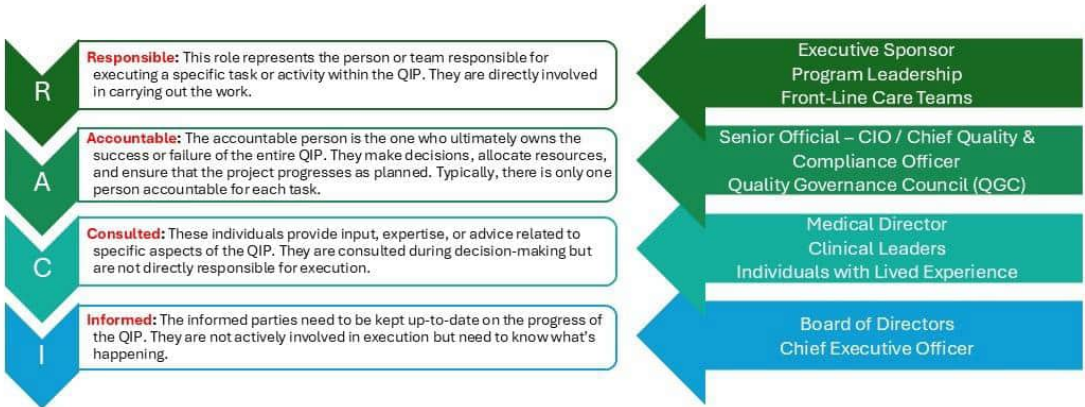


Exhibit D: QIP System Structure

QIP System Structure



Exhibit E: Quality Governance Council Responsibilities

Quality Governance Council



Exhibit F: Quality Committee Responsibilities

Quality Committee Responsibilities

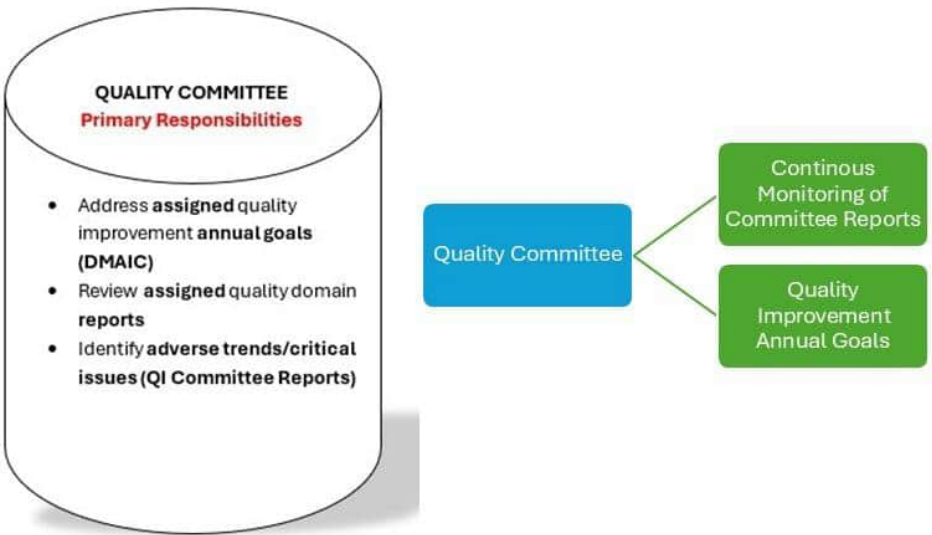


Exhibit G: Quality Committees

Quality Committees

-  Focuses on the overall quality of care provided by the organization
-  Develops and monitors quality improvement initiatives.
-  Reviews performance metrics and outcomes.
-  Ensures compliance with regulatory standards and accreditation requirements.
-  Identifies areas for improvement and implements strategies to enhance care quality.
-  Reviews Non-Identifiable PHI
-  Reviews Aggregate Data
-  Protections for quality improvement and peer review activities

Exhibit H: Quality Governance Council

Quality Governance Council



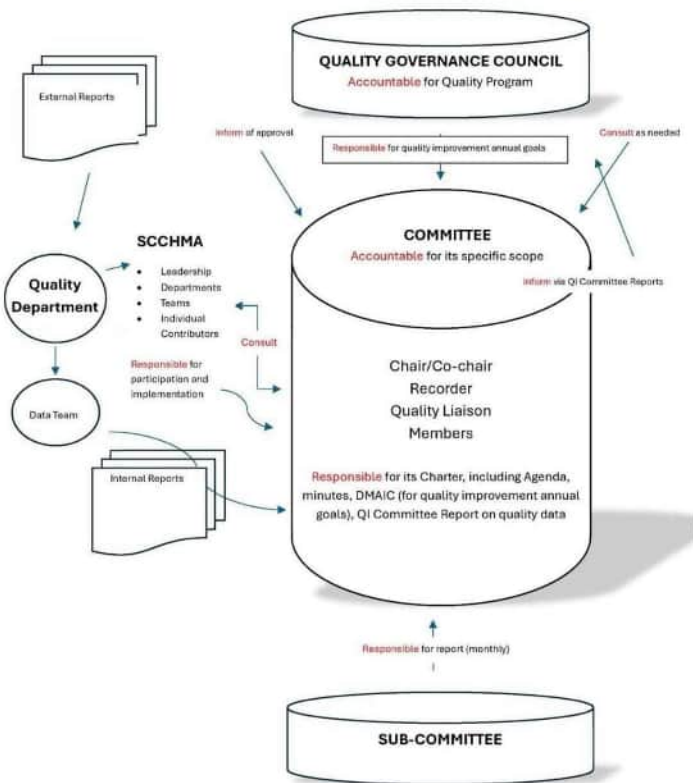
Exhibit I: Quality Improvement Program

Quality Improvement Program



Exhibit J: QIP RACI Process Assignment

QIP RACI Process Assignment



Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Incident Reporting and Review	Chapter: 04 – Improving Organizational Performance	Subject No: 04.01.02
Effective Date: 9/23/15	Date of Review/Revision: 9/23/15, 5/12/16, 3/14/17, 4/30/18, 1/17/19, 9/10/19, 7/14/20, 3/08/21, 2/25/22, 2/24/23, 1/23/24, 1/30/25, 7/31/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Chief Information Officer & Chief Quality and Compliance Officer
	Supersedes: Replaces 02.02.10, 02.02.27, and 04.01.03	
		Authored By: Holli McGeshick Additional Reviewers: Ashley Wilcox

Purpose:

To provide clear guidance and standards for the reporting and review of all deaths and unusual or unexpected events (“Incidents”) of persons served.

Application:

It is the policy of SCCMHA that all deaths and unusual or unexpected events (“Incidents”) involving a person served be recorded on the forms outlined in this policy.

It is also the policy of SCCMHA to identify, track, report and, when necessary, take further action on *Critical Incidents* and *Sentinel Events*.

This policy is intended to assure the quality and appropriateness of care and the treatment, comfort and protection of persons served. It is also intended to comply with various reporting requirements connected to SCCMHA’s contractual arrangements with the Mid-State Health Network (MSHN) as the regional PIHP and with CARF accreditation standards.

Policy:

This policy applies to SCCMHA and its provider network.

Standards:

- 1) Unusual or unexpected events that occur in the life of a person served 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 person served 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 1 business day 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 (BCHS-4607) Rev 6-23 or 11-25 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 person served should be reported on the SCCMHA Report of Person Served Death form (exhibit 3).
- 6) Use of any Physical Intervention will be documented on the Incident Report form. In addition, the SCCMHA CPI Disengagement Skills 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 and may use more than one sheet of paper. 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 full first and last name of the involved persons served and their SCCMHA Senti ID. If the incident involves another person served or a person served from another county; it is best practice to code the other person's name and write any additional incident reports.
- 10) Incidents involving emergency medical treatment and/or hospitalization must include the name of the treatment facility. Please submit discharge paperwork with the incident report.
- 11) Incidents involving medication errors or refused medications must include the name of the medication, the dosage, and the name of involved staff.
 - a. If a physician or pharmacy is contacted regarding medications, staff should annotate on the incident report the date(s) of contact with the prescriber and whom they spoke with.
 - b. Any medication error caused by a staff error that results in an emergency

medical treatment or hospitalization will require remediation for staff including re-taking medication training via the SCCMHA training department and proof of passing score is required.

- c. When medication is refused, staff are to document how many times they offered the medication(s) and in what timeframe it was offered, i.e. every 15 minutes, etc. For example, Medication was offered 3 times in 15-minute intervals.
- 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 EBP and Trauma Informed Care Coordinator.
 - 14) Critical Incidents and Sentinel Events will be reviewed by the Critical Incident Review Committee.
 - 15) Critical Incidents that put individuals at risk of harm to themselves or to others will be analyzed to determine what action needs to be taken to solve the problem and reduce the risk of re-occurrence.
 - 16) A Root Cause Analysis or investigation will take place for all Critical Incidents determined to be a Sentinel Event as defined in this policy. Based on the outcome of analysis or investigation, a plan of correction will be developed and implemented to reduce the risk of re-occurrence.
 - 17) Critical Incidents that involve a person's served death will be reviewed by the SCCMHA Medical Director.
 - 18) Sentinel Events must be identified, and a Root Cause Analysis requested within three (3) business days of the incident occur date. The Root Cause Analysis must commence within two (2) subsequent business days.
 - 19) The Incident Reporting and Critical Incident review process is a retrospective peer review process to improve services or enhance treatment for persons served. Any records, data and knowledge collected in this process are confidential; therefore, this information is not available under the Freedom of Information Act (FOIA) or by court subpoena.
 - 20) Incident Report forms and supporting documentation, handwritten or otherwise should not be placed or referenced in the person's served Electronic Health Record (EHR). The Quality Department will create an electronic Incident Report that will be kept separate from the person's served EHR.
 - 21) Critical Incidents, Risk Events, and Sentinel Events will be reported according to contractual requirements with Mid-State Health Network (MSHN) as the regional PIHP.

- 22) MSHN as the regional PIHP will be notified immediately of any high risk or high-profile critical events (i.e. Immediately Reportable Events).
- 23) The regional PIHP (MSHN) will submit to MDHHS, within **60 days** after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within **the previous 12 months** of the individual's discharge from a State-operated service.
- 24) In the event of a COFR case, a Critical Incident involving a person served by SCCMHA will be reported to the CMH representing the County of Financial Responsibility.
- 25) Aggregated Incident Report data will be reviewed quarterly by the SCCMHA Quality Governance Council.

Critical Incident Reporting Standards:

PIHPs will report the following events, except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on person served ID, event date, and event type:

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If ninety calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- **Non-suicide death** for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver, Children's Waiver services or 1915 iSPA Services. If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.
- **Emergency Medical Treatment due to Injury or Medication Error** for individuals who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services, Children's Waiver services or 1915 iSPA Services. Reporting must specify whether the injury was due to a fall or a result of physical management. The PIHP must report incidents resulting in emergency medical treat-

ment due to injury or medication error within 60 days after the end of the month in which the emergency medical treatment began. Remediation: Remediations are required for critical incidents that are not reported in a timely manner, for emergency medical treatment due to medication errors, falls, are a result of physical management or requested by MDDHS upon review of the critical incident. Remediations are due within 30 days of the reported date to MSHN, or the date requested by MDHHS.

- **Hospitalization due to Injury or Medication Error** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, Children’s Waiver services or 1915 iSPA Services. Reporting must specify whether the injury was due to a fall or a result of physical management. The PIHP must report incidents resulting in emergency medical treatment due to injury or medication error within 60 days after the end of the month in which the emergency medical treatment began. Remediation: Remediations are required for critical incidents that are not reported in a timely manner, for emergency medical treatment due to medication errors, falls, are a result of physical management or requested by MDDHS upon review of the critical incident. Remediations are due within 30 days of the reported date to MSHN, or the date requested by MDHHS.
- **Arrest of Person Served** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children’s Waiver services.

Reference: Medicaid Managed Specialty Supports and Services Program: Attachment P7.7.1.1

Submission Guidelines

TYPE OF INCIDENT	FORM	WHEN AND WHERE TO REPORT
Incident	<i>Licensed Residential Settings:</i> <u>MDLARA AFC Licensing Division – Incident/Accident Report (BCAL-4607) Rev 1-16 or 6-23</u> (exhibit 1) <i>Other Programs and Outpatient Settings:</i> <u>MDCH Incident Report (DCH-0044)</u> (exhibit 2)	Written report to the Quality Department within one (1) business day of the incident
Physical Intervention	<u>SCCMHA CPI Disengagement Skills Form</u> (exhibit 4) <i>(Include with Incident Report Form)</i>	

Death	<i>Licensed Residential Settings:</i> <u>MDLARA AFC Licensing Division – Incident/Accident Report (BCHS-4607) Rev 6-23 or 11-25</u> (exhibit 1) <i>Other Programs and Outpatient Settings:</i> <u>SCCMHA Report of Person Served Death</u> (exhibit 3)	Immediate verbal report to the Office of Recipient Rights AND
Suspected Abuse or Neglect	<u>SCCMHA Staff Action on Regarding Alleged Abuse/Neglect/Exploitation</u> (exhibit 5) <i>Reference SCCMHA Policy 02.02.11 - Abuse and Neglect</i>	Written report to the Quality Department within (1) business day of the incident

Definitions:

Critical Incident: an event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of person served including but not limited to:

- 1) Suicide Death
- 2) Non-Suicide Death
- 3) Emergency Medical Treatment due to Injury or Medication Error
- 4) Hospitalization due to Injury or Medication Error
- 5) Arrest

Incident: an unusual or unexpected event or situation which adversely affects the course of treatment or represents actual or potential serious harm or risk to persons served. Such incidents shall include but are not limited to:

- 1) **Challenging Behavior** – verbal or physical aggression, property damage, self-injurious behavior, sexual behavior, suicide attempt, elopement, medication, or medical treatment refusal, use or possession of weapon or legal or illegal substances, theft
- 2) **Death** – any expected or unexpected death
- 3) **Hospitalization** – admission to a medical or treatment facility due to injury, medication error, illness, or psychiatric issue
- 4) **Emergency Medical Treatment** – face-to-face emergency treatment being provided by medical staff at any treatment facility, including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms due to an injury, medication error, illness, or psychiatric issue
- 5) **Law Enforcement** – police call by residential or provider agency staff for assistance with an individual during a behavioral crisis, suspected abuse or neglect, arrest, or conviction
- 6) **Health & Safety** – injury such as bruise (except those due to illness), contusion, muscle sprain, and broken bone; ingestion; seizure; adverse reaction to medication; choking; fall; communicable disease; infection; physical, emotional, or sexual

assault; use of physical intervention; fire; biohazard; pest infestation (e.g., bed bugs); issue with medical supplies or equipment, or vehicular accident

- 7) **Medication Error** – person served did not take/receive medication as prescribed (e.g., missed med, wrong med, wrong dose)
- 8) **Other** – person served has received a prescribed PRN medication for behavior, eviction, or otherwise not categorized.

Risk Event: additional critical events defined by MDHHS that put individuals at risk of harm. These events require analysis, and reporting to MDHHS occurs upon MDHHS request. They include:

- 1) **Harm to Self** – actions taken by an individual that cause harm to themselves (e.g., pica, head banging, biting, suicide attempt) that resulted in an injury requiring Emergency Medical Treatment or hospitalization
- 2) **Harm to Others** – actions taken by an individual that causes harm to others (family, friend, staff, peer, public, etc.) that resulted in an injury requiring Emergency Medical Treatment or hospitalization of the other individual
- 3) **Police Calls** – police call by residential or provider agency staff for assistance with an individual during a behavioral crisis situation
- 4) **Emergency Use of Physical Management** – physical intervention by staff in response to a behavioral crisis
- 5) **Hospitalizations** – two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness) within a 12-month period

Root Cause Analysis: A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Critical Incident Review Committee: An executive level venue including the Executive Director of Clinical Services, Director of Network Services, Public Policy & Continuing Ed, Chief of Health Services & Integrated Care, the Medical Director and their Physician Assistant, Director of Services for Persons with Intellectual & Development, Director of Services for Persons with Mental Illness, Director of Services for Persons with Mental Illness (MI) & Substance Use Disorders (SUD), the Quality & Medical Records Supervisor, a Registered Nurse, and the Mental Health Supervisor of Health Services (EHS) organized for the purpose of reviewing critical incidents and determining sentinel event status. This is a retrospective peer review process using a case specific analysis to improve services or enhance treatment for persons served through the quality improvement process.

Sentinel Event: Is a Patient Safety Event that reaches a patient and results in any of the following: death, permanent harm, severe temporary harm and intervention required to

sustain life. An event can also be considered sentinel even if the outcome was not death, permanent harm, severe temporary harm and intervention required to sustain life. n “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome. (JCAHO, 1998) (The Joint Commission 2022). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. (Medicaid Managed Specialty Supports and Services Program Contract)

- Unexpected Deaths- All unexpected deaths are sentinel events. This includes critical incidents that have been reported as a non-suicide accidental death, non-suicide-homicide, and/or a suicide death, result of an undiagnosed condition, were suspicious of abuse or neglect.

References:

SCCMHA Policy 03.02.08 Behavioral Interventions

SCCMHA Policy 02.02.11 Recipient Rights – Abuse and Neglect

Medicaid Managed Specialty Supports and Services Program: Attachment P7.7.1.1

Exhibits:

Exhibit 1 – MDLARA AFC Licensing Division – Incident/Accident Report (BCHS-4607)

Exhibit 2 – MDCH Incident Report (DCH-0044)

Exhibit 3 – SCCMHA Report of Person Served Death

Exhibit 4 – SCCMHA CPI Disengagement Skills Form 07-2025

Exhibit 5 – SCCMHA Staff Action Regarding Alleged Abuse/Neglect/Exploitation

Exhibit 6 – SCCMHA Root Cause Analysis

Exhibit 7 – A Framework for Conducting a Root Cause Analysis

Exhibit 8 – Incident Report Processing & Review Flowchart

Procedures:

ACTION	RESPONSIBILITY
1) When an unusual or unexpected incident occurs involving a person served, complete the appropriate Incident Report form(s) according to the standards and guidelines described in this policy.	1) Involved or observing staff person
2) Sign, date and forward the form to the designated Supervisor as soon as possible, but no later than the end of the shift/day during which the incident occurred.	2) Involved or observing staff person
3) Review the Incident Report to ensure the incident is thoroughly described	3) Home Manager/Program Supervisor of the involved or observing staff person

and the form is completed in its entirety and includes actions taken by staff/treatment given. Add corrective measures taken to remedy and/or prevent recurrence of the incident. Sign and date the form. <i>NOTE: A copy of the form(s) should be kept in the home/program records, not in the person's served home record.</i> 4) Within one (1) business day of the incident submit Incident Report form(s) and supporting documentation to the SCCMHA Quality Department by one of the following methods: a. <u>Quality Department Fax</u> (989) 272-0290 b. <u>Drop Box</u> 500 Hancock (outside bldg.) in an envelope addressed to the Quality Department c. <u>Customer Service Office</u> 500 Hancock during regular business hours, Monday - Friday from 8:00 a.m. to 5:00 p.m. in an envelope addressed to the Quality Department 5) All Incident Reports will be reviewed to ensure the incident is thoroughly described and the form(s) is completed in its entirety. Incidents will be coded, processed, and entered in the Senti Incident Report module. 6) All Incident Reports will be reviewed by the Office of Recipient Rights, the Clinical Services Department, and the Network Services Department. 7) Incident Reports will systematically be delivered to the person's served assigned Case Holder, their supervisor,	4) Home Manager/Program Supervisor of the involved or observing staff person 5) Quality/Medical Records Dept. 6) Office of Recipient Rights Clinical Services Department Network Services Department 7) Case Holder Program Supervisor Office of Recipient Rights

the Office of Recipient Rights, and the Evidence-Based Practice and Trauma-Informed Care Coordinator for review, action if necessary, and electronic signoff.	Evidence-Based Practice and Trauma-Informed Care Coordinator
8) If the incident involves a recipient rights issue, the Office of Recipient Rights will investigate it further.	8) Office of Recipient Rights
9) If the incident is determined to be a <i>Critical Incident</i> , it will be brought before the Critical Incident Review Committee.	9) Critical Incident Review Committee
10) If the incident is determined to be a <i>Sentinel Event</i> , a <u>Root Cause Analysis (RCA)</u> will be requested within 3 business days of the incident occur date. The RCA must commence within 2 subsequent business days. A <u>summary</u> of the RCA will be returned to the Quality Department within 12 business days. The incident will then be brought before the Critical Incident Review Committee.	10) Home Manager/Program Supervisor
11) If the incident is a death, the <u>Report of Person Served Death</u> will be routed for review and signatures then will be taken to the Critical Incident Review Committee.	11) Critical Incident Review Committee
12) Risk Events, Critical Incidents, and Sentinel Events will be reported according to contractual requirements with MSHN as the regional PIHP.	12) Quality & Medical Records Supervisor
13) Aggregate Incident Report Data will be reviewed by the SCCMHA Services Management Team and/or the Quality Governance Council.	13) QIP Safety Committee Quality Governance Council
Exhibit 1 – MDLARA AFC Licensing Division – Incident/Accident Report (BCAL-4607)	

AFC LICENSING DIVISION - INCIDENT / ACCIDENT REPORT

Michigan Department of Licensing and Regulatory Affairs

Name of Facility/Home	License Number	Name of Person Directly Involved	☐ Resident ☐ Employee ☐ Visitor
Facility Address		Address	
Facility Phone		City/State/Zip Code	
Licensee Name		Phone	Case Number (if applicable)

OTHER PERSON(S) INVOLVED / WITNESSES:

Name	☐ Resident ☐ Employee ☐ Visitor	Name	☐ Resident ☐ Employee ☐ Visitor
Name	☐ Resident ☐ Employee ☐ Visitor	Name	☐ Resident ☐ Employee ☐ Visitor

FACTS OF THE INCIDENT (ATTACH ADDITIONAL PAGES AS NEEDED):

Date of Incident	Time: 	Name of Employee Assigned to Resident (If Applicable)	Location of Incident (Kitchen, Yard, etc.)
Explain What Happened / Describe Injury (If any) (Attach separate sheet if necessary):			
Action taken by Staff / Treatment Given (Attach separate sheet if necessary):			
Corrective Measures Taken to Remedy and/or Prevent Recurrence (Attach separate sheet if necessary):			
Name of Treating Physician / Health Care / Medical Facility / Hospital	Phone Number	Date Care Given	Time: 
Physician's Diagnosis of Injury, Illness or Cause of Death, if known			

PERSON(S) NOTIFIED:

Adult Protective Services (if applicable)	Notification Date / Time Written Notice / Date	Office of Recipient Rights (if applicable)	Notification Date / Time
Physician or RN (if applicable)	Notification Date / Time	Law Enforcement Agency (if applicable)	Notification Date / Time
Responsible Agency	Notification Date / Time Written Notice / Date	Other (please specify)	Notification Date / Time
Designated Representative / Legal Guardian	Notification Date / Time Written Notice / Date		Notification Date / Time

SIGNATURE(S):

Signature of Person Completing Report	Print Name and Title	Date
Signature of Licensee / Licensee Designee / Administrator	Print Name and Title	Date

BCAL-4607 (Rev. 6-23)

COPY DISTRIBUTION: Resident Record, Licensing Consultant,
Responsible agency (if required by rule) and Designated representative

AFC LICENSING DIVISION - INCIDENT / ACCIDENT REPORT
Michigan Department of Licensing and Regulatory Affairs

Name of Facility/Home	License Number	Name of Person Directly Involved	Resident Employee Visitor
Facility Address		Address	
Facility Phone		City/State/Zip Code	
Licensee Name		Phone	Case Number (if applicable)

OTHER PERSON(S) INVOLVED / WITNESSES:

Name	Resident Employee Visitor	Name	Resident Employee Visitor
Name	Resident Employee Visitor	Name	Resident Employee Visitor

FACTS OF THE INCIDENT (ATTACH ADDITIONAL PAGES AS NEEDED):

Date of Incident	Time: AM PM	Name of Employee Assigned to Resident (if Applicable)	Location of Incident (Kitchen, Yard, etc.)
Explain What Happened / Describe Injury (if any) (Attach separate sheet if necessary):			
Action taken by Staff / Treatment Given (Attach separate sheet if necessary):			
Corrective Measures Taken to Remedy and/or Prevent Recurrence (Attach separate sheet if necessary):			
Name of Treating Physician / Health Care / Medical Facility / Hospital		Phone Number	Date Care Given
			Time: AM PM
Physician's Diagnosis of Injury, Illness or Cause of Death, if known			

PERSON(S) NOTIFIED:

Adult Protective Services (if applicable)	Notification Date / Time Written Notice / Date	Office of Recipient Rights (if applicable)	Notification Date / Time
Physician or RN (if applicable)	Notification Date / Time	Law Enforcement Agency (if applicable)	Notification Date / Time
Responsible Agency	Notification Date / Time Written Notice / Date	Other (please specify)	Notification Date / Time
Designated Representative / Legal Guardian	Notification Date / Time Written Notice / Date		Notification Date / Time

SIGNATURE(S):

Signature of Person Completing Report	Print Name and Title	Date
Signature of Licensee / Licensee Designee / Administrator	Print Name and Title	Date

BCHS-4607 (Rev. 11-25)

COPY DISTRIBUTION: Resident Record, Licensing Consultant,
Responsible agency (if required by rule) and Designated representative

Exhibit 2 - MDCH Incident Report (DCH-0044)

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH INCIDENT REPORT			
AGENCY INFORMATION			
Agency Name		Unit Name	
RECIPIENT INFORMATION			
Recipient Name		Case Number	
☐ Male ☐ Female		DOB	
Age			
INCIDENT INFORMATION			
When did you discover incident? (date and time)		When did incident happen? (date and time)	
☐ AM ☐ PM		☐ AM ☐ PM	
Where did incident happen?			
Other Employees Involved and/or Present:			
Recipient(s) involved:		Other recipient(s) present:	
Explain what happened:			
Action taken by staff:			
Reporting Person's Signature		Date and Time of Report:	
		☐ AM ☐ PM	
THIS SECTION MUST BE COMPLETED BY PHYSICIAN OR R.N. WHEN PHYSICAL INJURY TO THE RECIPIENT IS APPARENT			
Description of injury:			
Description of treatment or care given:			
Date and time care given:		Extent of injury at time care given:	
☐ AM ☐ PM		☐ SERIOUS* ☐ NON-SERIOUS	
		Physician/R.N. Signature	
		Date	
*Serious physical harm means physical damage suffered by a recipient 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.			
REPORTING INFORMATION			
If serious injury Director/Designee Notified: (date/time)		If serious injury Rights Advisor Notified: (date/time)	
☐ AM ☐ PM		☐ AM ☐ PM	
Notification made by (print name):			
TO BE COMPLETED BY DESIGNATED SUPERVISOR			
1. Name of employee assigned to recipient at time of incident: _____			
2. Indicate program or administrative action taken, including disciplinary action, to remedy and/or prevent recurrence of incident:			
Designated Supervisor Signature		Date	
DCH-0044 (W) 05/08		DISTRIBUTION: WITHIN 24 HOURS 1.SEND ORIGINAL TO DIRECTOR 2. MAKE COPIES AND SEND TO: ORR & AGENCY	

Exhibit 3 - SCCMHA Report of Person Served Death

 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		SCCMHA REPORT OF PERSON SERVED DEATH	
INSTRUCTIONS: This form must be completed by the Primary Worker within 24 hours of notification of the person's served death.			
PRIMARY WORKER'S SECTION - <i>complete this section, sign, date and forward to your Supervisor</i>			
PERSON'S SERVED LAST NAME		PERSON'S SERVED FIRST NAME	
DATE OF BIRTH		AGE	
DATE OF DEATH		LIVING ARRANGEMENT PRIOR TO DEATH (i.e., name of home, apartment)	
TIME OF DEATH		LOCATION OF DEATH (i.e., name of home, facility, hospital)	
		☐ am ☐ pm	
CIRCUMSTANCES SURROUNDING DEATH (e.g., accident, illness)			
THE CAUSE OF DEATH IS BELIEVED TO BE		NOTIFICATION OF DEATH WAS RECEIVED FROM (name and relationship)	
NOTIFICATION OF DEATH HAS BEEN GIVEN TO THE FOLLOWING INDIVIDUALS/DISCIPLINES			
☐ FAMILY/GUARDIAN ☐ ORR ☐ PT ☐ OT ☐ SPEECH ☐ PSYCHIATRIST ☐ RN ☐ DIETICIAN ☐ OTHER			
AUTOPSY REQUESTED?		POLICE INVOLVEMENT?	
☐ YES ☐ NO ☐ UNKNOWN		☐ YES ☐ NO	
DATE OF PERSON'S SERVED LAST CONTACT WITH PRIMARY WORKER			
PRIMARY WORKER'S COMMENTS (optional)			
PRIMARY WORKER'S SIGNATURE		DATE OF SIGNATURE	
SUPERVISOR'S SECTION - <i>review, sign, date and forward to the SCCMHA Quality Projects & Reporting Specialist</i>			
I HAVE REVIEWED AND VERIFIED THAT THE ITEMS ABOVE HAVE BEEN COMPLETED ACCURATELY.			
☐ YES ☐ NO			
I HAVE VERIFIED THAT THE PERSON'S SERVED CASE HAS BEEN CLOSED IN THE ELECTRONIC MEDICAL RECORD.			
☐ YES ☐ NO			
SUPERVISOR'S COMMENTS (optional)			
SUPERVISOR'S SIGNATURE		DATE OF SIGNATURE	
DIRECTOR'S SECTION - <i>review, sign, date and forward to the SCCMHA Quality Projects & Reporting Specialist</i>			
EXECUTIVE DIRECTOR OF CLINICAL SERVICES AND PROGRAMS SIGNATURE		DATE OF SIGNATURE	
DIRECTOR OF NETWORK SERVICES, PUBLIC POLICY, AND CONTINUING ED SIGNATURE		DATE OF SIGNATURE	
CHIEF OF HEALTH SERVICES AND INTEGRATED CARE SIGNATURE		DATE OF SIGNATURE	
OFFICER OF RECIPIENT RIGHTS		DATE OF SIGNATURE	
MEDICAL DIRECTOR SIGNATURE		DATE OF SIGNATURE	

SCCMHA REPORT OF PERSON SERVED DEATH 1-2026

Exhibit 4 – SCCMHA CPI Disengagement Skills Form (page 1)



CPI Disengagement Skills Report

Attach this form to an Incident Report when an Emergency
Physical Intervention is used during a behavioral crisis

Person Served Name: _____ Sentri ID: _____

Date of Incident: _____

Setting where physical intervention occurred: ☐ Group Home ☐ Program ☐ Residence ☐ Community

CPI – Nonrestrictive Disengagement Skills Used	
Hold & Stabilize (Low Level):	
☐ Wrist	☐ Clothing ☐ Hair ☐ Neck ☐ Body ☐ Bite ☐ Turning Away
Pull / Push (Medium Level):	
☐ Wrist	☐ Clothing ☐ Hair ☐ Neck ☐ Body ☐ Bite ☐ Turning Away
Lever (High Level):	
☐ Wrist	☐ Clothing ☐ Hair ☐ Neck ☐ Body ☐ Turning Away ☐ Strike Block
CPI – Restrictive Disengagement Skills Used	
Seated Hold (Advanced Level):	
☐ Low-Level Restriction	☐ Medium-Level Restriction ☐ High-Level Restriction
Standing Hold (Advanced Level):	
☐ Low-Level Restriction	☐ Medium-Level Restriction ☐ High-Level Restriction ☐ Team Control Position
Other: _____	
Length of time disengagement lasted:	
☐ 0 – 5 minutes	☐ 6 – 10 minutes ☐ 11 – 15 minutes
Behaviors that initiated the disengagement:	
☐ Imminent Harm to Self	☐ Imminent Harm to Others ☐ Imminent Harm to Self and Others
Positive behavioral supports used immediately prior to and/or during disengagement:	
☐ Coached Use of Skills	☐ Decreased/Removed Demand
☐ Offered Choices	☐ Clarified Expectations
☐ Verbal Redirection/Discussion	☐ Problem Solved with Person Served
☐ Active Listening and Support	☐ Changed Environment
☐ Other (describe): _____	

Exhibit 4 – SCCMHA CPI Disengagement Skills Form (page 2)

Event that resulted in termination of the disengagement:
☐ Person Served regained control of own behavior ☐ Maximum time of intervention was reached (not to exceed 15 minutes) ☐ Other (describe):
Describe the persons served behavior prior to nonrestrictive disengagement, including observations about any events, settings, or factors that may have triggered the behavior:
Additional Comments (optional):

Completed by: _____ Date: _____
signature

Supervisor: _____ Date: _____
signature

Exhibit 5 - SCCMHA Staff Action Regarding Alleged Abuse/Neglect/Exploitation (page 1)



Staff Action Regarding Alleged Abuse/Neglect/Exploitation

Based on the "Summary of Abuse and Neglect Reporting Requirements" a report has been made or filed with the following:

Agency	Officer or Person Contacted	Date Contacted	How Contacted		
☐ Law Enforcement			☐ phone	☐ faxed	☐ mailed
☐ Child Protective Services ☐ form 3200 sent (required)			☐ phone	☐ faxed	☐ mailed
☐ Adult Protective Services			☐ phone	☐ faxed	☐ mailed
☐ AFC Licensing			☐ phone	☐ faxed	☐ mailed
☐ Office of Recipient Rights			☐ phone	☐ faxed	☐ mailed
☐ Other:			☐ phone	☐ faxed	☐ mailed

Alleged victim(s):

Alleged victim(s) identifiers: (indicate the following if known: BD - Birth date, ID - CMH ID#, SS - Social Security Number)

IF Alleged Victim is a minor

Mother: _____ ☐ married ☐ single ☐ divorced ☐ separated

Father: _____ ☐ married ☐ single ☐ divorced ☐ separated

Alleged victim address/residence and phone number:

Alleged perpetrator(s) name:

Alleged perpetrator address or location:

Alleged incident occurred at:

Approximate date(s) or time frames of alleged incident (be as specific as possible):

Details of Allegation: (use second sheet if necessary; attach copy of Form 3200 and/or other related documents)

Signature and Title of Person Making this report

Date

Submit this form to Quality by faxing to 989-272-0290, Executive Director of Clinical Services, & Direct Supervisor

DO NOT copy to Consumer Records: If this report becomes a part of the consumer's clinical record, the name of the alleged perpetrator must not be removed from this report as required by Section 723 (3) of Public Act of 1986. It is a misdemeanor to intentionally file a false report of abuse or to violate Section 723.

G:\Agency Forms\ Clinical Forms\ Report on Alleged Recipient Abuse DO NOT SCAN INTO CONSUMER RECORD

4/11/22

Exhibit 5 - SCCMHA Staff Action Regarding Alleged Abuse/Neglect/Exploitation (page 2)

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES REQUIREMENTS FOR REPORTING ABUSE AND NEGLECT					
WHERE is the report made?	Section 723, Public Act 258 of 1974 as amended (Mental Health Code-Recipient Abuse) To the OFFICE OF RECIPIENT RIGHTS (ORR) at your Hospital or Community Mental Health Services Program (CMHSP) A list of local rights offices can be found at: http://tinyurl.com/orroffices	Public Act 238 of 1975 (Child Protection Law) To the MDHHS Office of Childrens Protective Services (CPS)	Public Act 519 of 1982 (Adult Protective Services Law) To the MDHHS Office of Adult Protective Services (APS)	Section 723, Public Act 258 of 1974 as amended (Mental Health Code-Criminal Abuse) To the Michigan State Police (MSP) or Local Sheriff or Local Police Department	
WHAT must be reported?	Sexual, Physical, Emotional or Verbal Abuse, Neglect, Serious Injury, Death, Retaliation or Harassment	Sexual, Physical or Mental Abuse, Neglect, Sexual Exploitation	Sexual, Physical or Mental Abuse, Neglect, Maltreatment, Exploitation	Assault (other than patient's assault/battery), Criminal Sexual Abuse, Homicide, Vulnerable Adult Abuse, Child Abuse	MSP 517-3332-2521
WHO is required to report?	All employees, contract employees, or volunteers of Michigan Department of Health and Human Services, Community Health Services Programs, Licensed Private Psychiatric Hospitals	Physicians, nurses, coroners, medical examiners, dentists, licensed emergency care personnel, audiologists, psychologists, social workers, school administrators, teachers, counselors, law enforcement officers, and child care providers.	Any person employed by an agency licensed to provide services who is licensed, registered, or certified to provide health care, education, social, or other human services, law enforcement officers, and child care providers.	All employees, contract employees of Michigan Department of Health and Human Services, Community Mental Health Services Programs, Licensed Private Psychiatric Hospitals; All mental health professionals.	
WHAT is the CRITERIA for reporting?	You must report if you: Suspect a recipient has been abused or neglected or any allegations of abuse or neglect made by a recipient.	You must report if you: Have reasonable cause to suspect a child has been abused, neglected, or sexually exploited.	You must report if you: Have reasonable cause to suspect or believe an adult has been abused, neglected, exploited or maltreated.	You must report if you: Suspect a recipient or vulnerable adult has been abused or neglected, sexually assaulted, or if you suspect a homicide has occurred. You do not have to report if the incident occurred more than one year before your knowledge of it.	
WHEN must the report be made and in what format?	A verbal report must be made immediately. A written report on an incident report form must be made before the end of your shift.	A verbal report must be made immediately. A written report on DHS form 3200 must be made within 72 hours.	A verbal report must be made immediately. A written report at the discretion of the reporting person.	A verbal report must be made immediately. A written report must be made within 72 hours of the oral report.	
TO WHOM are reports made?	To your immediate supervisor and to the Recipient Rights Office at your agency or hospital	Report to Protective Services Reporting Hotline 855-444-3911	Report to Protective Services Reporting Hotline 855-444-3911	The law enforcement agency for the county or city in which the alleged violation occurred or the State Police. A copy of the written report goes to the chief administrator of the agency responsible for the recipient.	
If there is more than one person with knowledge must all of them make a report?	Not necessarily. Reporting should comply with the policies and procedures set up by each agency.	Someone who has knowledge must report or cause a report to be made in the case of a school, hospital or agency, one report is adequate.	Everyone who has knowledge of a violation or an alleged violation must make a report. MDHHS has typically accepted one report from agencies.	Someone who has knowledge must report or cause a report to be made.	
Is there a penalty for failure to report?	Disciplinary action may be taken and you may be held liable.	Failure to report is also a criminal misdemeanor.	You may be held liable and have to pay a \$500 fine.	The law states that failure to report or false reporting is a criminal misdemeanor.	
Is it necessary to report to more than one agency?	Each of these laws requires that the designated agency be contacted. If an allegation is suspected to have occurred, which falls under its specific jurisdiction, there are several references in each law indicating that reporting to one agency does not absolve the reporting person from the responsibility of having to report to other agencies, as statutorily required.				
Are there other agencies to which a report can be made?	The Bureau of Community and Health Systems (LARA) is responsible for investigating abuse and neglect in Nursing Homes, Hospitals and Home Health Care. Call the NURSING HOME ABUSE HOTLINE 1-800-882-6066 The Michigan Attorney General's Office has an Abuse Investigation Unit which may also investigate abuse in Nursing Homes. Call the ATTORNEY GENERAL HEALTH CARE FRAUD HOTLINE 1-800-242-2873 The LARA Adult Foster Care (AFC) Division is responsible for investigating abuse or neglect in a licensed foster care home. Call The Bureau of Community and Health Systems. COMPLAINT INTAKE UNIT 1-866-855-0226				
YES					



Exhibit 6 – Root Cause Analysis Summary



Root Cause Analysis Summary for Critical Incidents & Sentinel Events

INSTRUCTIONS: 1) A Root Cause Analysis (RCA) will be requested within 3 business days of the incident occur date. 2) An RCA must commence within 2 business days of the request and be completed within 10 subsequent business days. 3) The provider will file all related documentation and assure it is kept confidential . 4) The provider will return <u>ONLY this Root Cause Analysis Summary</u> to the SCCMHA Quality Department within 12 business days of the request.				
PERSON SERVED LAST NAME		PERSON SERVED FIRST NAME		SENTRI I.D.
DATE OF EVENT	PROVIDER'S NAME		DATE OF REQUEST FOR RCA	DATE OF RCA START
BRIEF DESCRIPTION OF EVENT (attach separate sheet if necessary)				
INDIVIDUALS THAT PARTICIPATED IN THE RCA				
NAME:		TITLE:		
NAME:		TITLE:		
NAME:		TITLE:		
NAME:		TITLE:		
NAME:		TITLE:		
DESCRIBE THE FACTORS (e.g. PROCEDURE, STAFF, ENVIRONMENT, EQUIPMENT) THAT CONTRIBUTED TO THE EVENT (attach separate sheet if necessary)				
THE FOLLOWING PLAN OF CORRECTION WILL BE IMPLEMENTED TO PREVENT FURTHER OCCURRENCE OF THE EVENT (attach separate sheet if necessary)				
TARGET DATE OF IMPLEMENTATION	INDIVIDUAL(S) THAT THE INTERVENTION WILL BE IMPLEMENTED BY			
SIGNATURE OF INDIVIDUAL COMPLETING THE RCA SUMMARY			DATE COMPLETED	
FOR SCCMHA CIRC USE ONLY				
SIGNATURE OF QUALITY & MEDICAL RECORDS SUPERVISOR/CIRC CHAIRPERSON			DATE OF CIRC REVIEW	

SCCMHA ROOT CAUSE ANALYSIS SUMMARY 7-2025

Exhibit 7 – A Framework for Conducting a Root Cause Analysis (page 1)



Sentinel Events

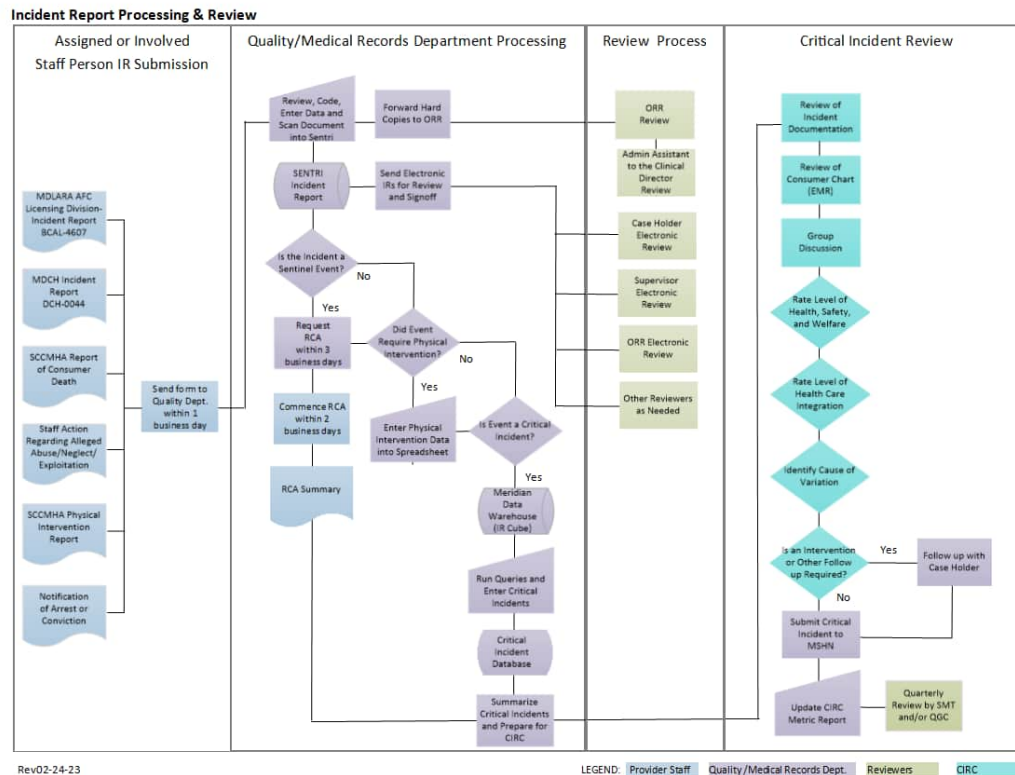
**A Framework for Conducting a Root Cause
In Response to a Sentinel Event**

Level of Analysis	Possibilities	Questions	Findings	Risk Reduction Strategies	Measurement Strategies
What Happened? ↓	Sentinel Event	What are the details of the event?			
Why did it happen? What factors were closest to the event?	Human Factors	What area/service was impacted?			
	Process Factors	What human factors were relevant to the outcome?			
	Equipment Factors	What steps(s) in the process were involved?			
	Controllable environmental factors	How did the equipment performance affect the outcome?			
	Uncontrollable external factors	What environmental factors directly affected the outcome?			
	Other	Are they truly beyond the organization's control?			
		To prevent?			
		Are there any other factors that have directly influenced this outcome?			
Why did that happen? What were the processes involved? (May involve "special cause" variation, "common cause" variation, or both)	Patient care process(es) (Specify)	What are the steps in the Process? (intended and actual) What steps were most directly involved in the event?	Flow chart Cause-effect; change analysis; Failure Mode & effect analysis		
		What can be done to prevent failure at this step?	Fault tree analysis	Eg, amplification, redundancy	
		What can be done to protect against a bad outcome if there is a failure at this step?	Barrier analysis	Eg, "fail safe" design, redundancy	
		What other areas or services are impacted? Where else should improvements be made to reduce risk of this type of event?	Failure mode & effect analysis	(generalize improvements to all applicable areas)	

Exhibit 7 – A Framework for Conducting a Root Cause Analysis (page 2)

Level of Analysis	Possibilities	Questions	Findings	Risk Reduction Strategies	Measurement Strategies
Why did that happen? What systems underlie these processes? Common cause variation here may lead to special cause variation in dependent processes → Why did that happen? What systems underlie these processes? Common cause variation here may lead to special cause variation in dependent processes	Human resource issues	How well do staff qualifications and current competence match their responsibilities in the relevant process(es)? How did actual staffing compare with ideal levels? What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?			
	Information management issues	To what degree is staff performance in the relevant process(es) addressed?			
		How can orientation & in-service training be improved?			
		To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?			
		How can communication among participants be improved?			
	Environmental management issues	To what degree is the physical environment appropriate for the processes being carried out?			
		What systems are in place to identify environmental risks?			
		What emergency and failure-mode responses have been planned and tested?			
	Leadership issues: Corporate culture	How might the culture better support risk identification & reduction?			
	Encouragement of communication	What are the barriers to communication of potential risk factors?			
	Clear communication of priorities	To what degree is the prevention of adverse outcomes communicated as a high priority?			
	Uncontrollable Factors	How can we protect against these?	Barrier analysis		

Exhibit 8 – Incident Report Processing & Review Flowchart



Tab 5

Regulatory Management/ HIPAA Compliance

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Releasing Consumer Information	Chapter: 08 – Management of Information	Subject No: 08.01.08
Effective Date: 5/9/16	Date of Review/Revision: 3/8/17, 3/1/18, 2/25/19, 3/20/20, 3/11/21, 8/30/22, 2/27/23, 1/23/24, 1/21/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: AmyLou Douglas, Chief Information Officer Chief Quality and Compliance Officer Author: Holli McGeshick Additional Reviewers: LaDonna Presley
	Supersedes:	
		

Purpose:

The Purpose of this policy is to delineate the process for the releasing of information from the electronic health record with Saginaw County Community Mental Health Authority.

Application:

The entire Saginaw County Community Mental Health Authority network.

Policy:

It is the policy of Saginaw County Community Mental Health Authority that ownership and control of the electronic record (SENTRI) rests with Saginaw County Community Mental Health Authority.

It is the policy of Saginaw County Community Mental Health Authority that information released or otherwise conveyed from SENTRI will be done only in accordance with Federal and State law, and policies of Saginaw County Community Mental Health Authority.

It is the policy of Saginaw County Community Mental Health Authority that contracted Primary Providers (Providers) shall release information from SENTRI only within the confines of policy.

Standards:

The sharing or provision of information and/or documents will be done in a systematic way that conforms to any applicable law, regulation, or Saginaw County Community Mental Health Authority policies.

The sharing of information and/or documents will be implemented in a manner that assures person served confidentiality.

There will be written guidelines and procedures for the sharing of confidential person served record information or documents by providers that have been approved by the Executive Director of Clinical Services, Quality & Medical Records Supervisor and Chief Quality and Compliance Officer

There will be documentation in the electronic health record that indicates what records or information was shared, when shared, for what purpose, and by whom. This can be in the form of a cover letter sent with documents and scanned into a placeholder document or written as a Clinical Note in SENTRI.

Release requests will be scanned into SENTRI as an attachment to a SENTRI form. If such form is created in error, the function used in SENTRI is to either make the form 'Expired' by using the current date or to indicate that the form is "Invalid." "Revoke" should not be used.

Definitions:

None

References:

08.02.03 – Information Protection

08.04.09 – Ownership & Retention of Hard Copy Consumer Records

08.05.09.01 – Authorizations – Obtaining an Authorization for Use or Disclose PHI

Exhibits:

Exhibit A: Guidelines for providing copies of documents from person served records

Exhibit B: Releasing Information from SENTRI II by Contracted Primary Providers

Exhibit C: Releasing Information Workflow

Exhibit D: Release Letters Sample

Procedure:

ACTION	RESPONSIBILITY
See relevant Protocol	

Guidelines for providing copies of documents from person served records

State and Federal laws, as well as SCCMHA policy, allow for the providing of copies of documents from the Electronic Health Record. The purpose of this guideline is to clarify the process for the sending of these copies.

Documents from the Electronic Health Record can be provided by:

- The Records Department
- The assigned Case Holder (Case Manager, Support Coordinator, Therapist, Care Management)
- Medical Services (primarily Nurses)
- Emergency Services

Copies of documents for entities other than the Person Served or Guardian require an active and proper Consent to Release Information in the Record unless allowed by law:

- Documents may only be provided within the constraints and limitations as indicated on the Release.
- Typically, documents are sent to entities through the Records Department.
 - Single documents may be provided to entities by the Case Holder – primarily the person served or guardian or for emergent circumstances to a third party with the approval of the Case Holder's Supervisor
 - Medical Services may send copies of Medication Reviews, Prescriptions, Lab Results (if requested by SCCMHA), and lists of medications.
 - Emergency Services may send coordination documents
- Requests for documents from law enforcement, lawyers, or required by a subpoena or court order should be referred to the Records Department.
- A Clinical Note should be written and include the names and dates of documents sent. If sent by fax, only the fax cover sheet will be scanned into SENTRI.
- Copies of records obtained from other entities should be sent only through Records as there may be legal constraints on the resending of these documents.

Persons Served, or the legal guardian/parent of a minor, have the right to view the record and/or obtain copies of documents from their record.

- Some documents are provided as part of the course of service such as the Individual Plan of Service.
- Active person serveds should make requests for document copies through the currently assigned Case Holder.
 - The Case Holder will indicate in a Case Note the name and date of any document copies provided to the person served/guardian.
 - If the number of documents requested is excessive, or the documents are not available directly to the Case Holder, the request should be referred to Records Department for processing.
 - A Consent to Share PHI is not required for documents provided by the Case Holder to a person served/guardian. Note: when Records provides copies, a Consent is requested to be signed as proof document.
 - The Quality & Medical Records Supervisor should be contacted regarding any concerns or issues regarding the provision of documents to a person served/guardian.
- Persons Served not currently active with SCCMHA should be referred to the Records Department.

By law and practice, SCCMHA does not charge fees to a Person Served/guardian for the initial copy of any document. SCCMHA may charge a copy fee for any additional copies, as determined by the Quality and Medical Records Supervisor.

Fees for research and copying may be charged to other individuals or entities as determined by the Quality and Medical Records Supervisor. Entities that are typically not charged include: Medical services (physician offices, pharmacy, therapists, counselors, laboratories, etc.), Residential Services, Law Enforcement (including Protective Services), and some other governmental agencies (such as other CMHs, DCH, MRS, etc.). Fees will only be charged through the Records Department.

SCCMHA attempts to provide copies in a timely manner. Copies of documents requested through Records usually cannot be provided on the same day, will be provided within fifteen calendar days (15) days of receipt of the request. If additional time is required, SCCMHA may extend the deadline once for an additional fifteen (15) calendar days with written notification to the individual explaining the delay.

For additional information or questions on releasing information or documents please contact SCCMHA's Records Department at (989) 797-3492 or SCCMHA's Customer Service Department at (989) 797-3452/1-800-258-8678.

Releasing Information from SENTRI II by Contracted Primary Providers

These guidelines are to clarify the releasing of information from SENTRI by the contracted Primary Providers.

1. The Primary Providers should include SCCMHA as a party on all Consents to release or share documents or information from SENTRI II.
2. Requests for documents or information for persons served who are now closed to the Primary Provider should be referred to SCCMHA's Records Department.
3. For persons served open to the Primary Provider:
 - a. Single or small amounts of documents from SENTRI can be given to the person served and/or guardian directly by the Case Holder or provider staff.
 - i. The provision of documents should be documented in a Chart Note in SENTRI II
 - ii. If the person served/guardian is requesting all or a large number of records, then the person served should be referred to SCCMHA's Records Department.
 - b. Documents to third parties for the coordination of care can be released by the Primary Provider so long as what was released is documented either in a Chart Note or as a scanned list for the placeholder 'Attachments' (see 6 below)
4. There is no limitation on the verbal sharing of information from SENTRI II with the person served or guardian or third parties who have consent.
5. When a third-party requests document that will involve sending copies from SENTRI:
 - a. The party should typically be referred to send a release to SCCMHA's Records Department.
 - b. If giving copies, Providers may only provide documents created by their agency
 - c. If the request is a Subpoena, please contact SCCMHA's Compliance Officer for assistance and guidance
6. Provider Releases need to be scanned in the Regional Release section of SENTRI and not in the general scanning, using a SENTRI PHI Exchange Page as a placeholder. This can be done as follows:
 - a. Complete the appropriate fields
 - b. Placing the Provider Name and then the name of the third party in the "Release to and Obtain From" field. For example: SVRC & Social Security; TTI & Dan Fobbs, Atty; SPSI – John Doe
 - c. Sign the template
 - d. Scan the signed document into the "Attachments"
 - e. Complete the 'Consumer signed' or obtain person served signature electronically (if applicable)
 - f. If documents were given to the third party from this release, then a listing of those documents would also be scanned into the placeholder "Attachments." SCCMHA

has 'template' documents for responding to requests available for use by Providers upon request.

If there are any questions regarding the releasing of information from SENTRI II, please contact SCCMHA's Typist/Clerk (Medical Records and Release of Information) at (989) 797-3492 , Quality and Medical Records Supervisor at (989-272-7235) or the Chief Quality and Compliance Officer at (989-797-3539).

Releasing Information Workflow

1. Request to Release form is received
 - a. Review Release
 - i. Compliance to regulations
 1. Completeness
 - a. All required areas filled
 - ii. Signature
 1. Verify the signer is legally authorized to consent to disclose
 2. May check signatures on-file
 3. If Release is from trusted source (SSI, Court, etc.) then can assume accurate
 - iii. Clarify requested information
 1. Check date ranges requested
 2. Terminology for documents varies
 3. Typically require items determining clinical status such as Medication Review, Psychiatric, Emergency Notes, Assessments
 4. May contact the requestor for further clarification
 - b. Log in the Release date on the Medical Release Tracking spreadsheet
 - c. Compile information
 - i. SENTRI
 1. Documents created in Harmony were transferred to either Historical Documents or as Progress Notes
 2. Use Print function: can print for fax or mail, save to file for e-submission
 - ii. May contact requestor for clarification
 - iii. Compile documents in a “packet” or pile.
 1. If faxing, then do not staple
 2. If mailing, may staple but not required
 - d. Send
 - i. Complete Invoice (if charging)
 1. Place after the Document form on packet (save to file for e-submission)
 - ii. Complete Document form
 1. Place on top of document packet (save to file for e-submission)
 - iii. Mail, fax, or e-submit
 - e. Log date sent on Medical Release Tracking spreadsheet
 - f. Release in SENTRI
 - i. Create Release if form from outside agency
 - ii. Scan
 1. Release
 2. Document Form
 3. Invoice
 4. Fax confirmation



To Whom It May Concern

The Michigan Mental Health Code **MCL 330.1748** requires that legally signed Consent to Release, or a statutory exception, is required to provide any requested information. Other applicable Federal and State laws that safeguard confidentiality are:

- The Alcohol and Other Drug (AOD) Confidentiality Rule **42 CFR Part 2**
- Health Insurance Portability and Accountability Act **HIPAA 45 CFR Part 160 and Part 164**
- Family Education Rights and Privacy Act **FERPA**

Your request for information was received but does not meet the requirements for a legally signed Consent to Release, so it is being returned without response.

If you have any questions, please feel free to contact either:

{Name}, Quality and Medical Records Supervisor - 989-272-7235

{Name}, Chief Quality and Compliance Officer – 989-797-3539

Saginaw County Community Mental Health Authority Copies of Files to Persons Served

As a person served of Mental Health Services, you are entitled to receive copies of Saginaw County Community Mental Health Authority (SCCMHA) created documents in your Medical Record by law (laws). Documents from other agencies or organizations cannot be released to you. You will need to go to that agency and request any copies.

Also, by law, SCCMHA can charge a reasonable fee for gathering and making these copies (laws).

However, to serve you better, realizing that many of the persons served of SCCMHA services have fixed or limited incomes, the agency will provide, upon your request a copy of documents in your file without charge. Additional copies of documents already provided may require a fee, payable in advance, if directed by the Quality & Medical Records Supervisor and as applicable to current standards and practices.

Documents released directly on your behalf to other individuals, organizations, or entities such as Department of Human Services, attorneys, physicians, Social Security, etc. may be billed, if applicable, a research and copy fee.

If you are currently an active SCCMHA person served, please request your copies of documents from your current Case Holder. If the number of documents is excessive, or the documents are not available to the Case Holder, then you will be referred to the Medical Records Department for assistance. You will be requested to sign a Release Form to show you requested this information. Record copies may take up to fifteen (15) calendar days to process, though the time is typically much less.

If you are not a current person served of Saginaw County Community Mental Health Authority, the agency requires a Release of Information form signed by you. SCCMHA will only release the information as designated on this form. Please indicate on the form who will be retrieving the documents or the address for where the documents need to be sent. The Medical Records Department staff or the Customer Service Department can assist you in filling out the form.

Copies of documents requested through the Medical Records Department usually are not able to be provided on the same day. SCCMHA attempts to provide copies in a timely manner but no longer than fifteen (15) calendar days. If additional time is required, SCCMHA may extend the deadline once for an additional fifteen (15) calendar days with written notification to the individual explaining the delay.



If you have any questions about this process, please contact SCCMHA's, Typist/Clerk (Medical Records and Release of Information) at (989) 797-3492 or the Customer Service Department at 797-3452 or 1-800-258-8678.500 Hancock Street, Saginaw MI 48602-4292
Phone (989) 797-3400 Fax (989) 799-0597

DOCUMENT DISCLOSURE

DATE OF RELEASE:

RELEASED TO:

Documents Pertaining To:

DOB:

SSN: (last 4 digits)

Notes or Comments

NOTICE OF FEDERAL AND STATE LAWS REGARDING CONFIDENTIALITY AND FURTHER DISCLOSURE

The following document(s) are released under one or more of the applicable laws and regulations indicated below which limits or prohibits disclosure of these records to third parties as indicated in that applicable law or regulation.

45 CFR 160, 164 (Health Information Protection and Portability Act)

Michigan Mental Health Code MCL 330.1748

The following may also apply to these records:

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 CFR 2.32

Document(s) Released

Document Date

Note: documents with the SENTRI logo are electronically signed



500 Hancock Street, Saginaw MI 48602-4292 • Phone (989) 797-3400 Fax(989) 799-0597

Invoice
Fees for disclosed documents

DATE:

Payor:

Address:

RE:

DOB:

SSN: (last 4 digits)

Flat Fee: **\$ 6.50**

Due Date: **Please remit within 30 days**

Pay To: **FE#: 38-3192817**
SCCMHA
Attn: Financial Services
500 Hancock St.
Saginaw, MI 48602

Staff Contact:
Phone:
Email:



500 Hancock Street, Saginaw MI 48602-4292 • Phone (989) 797-3400 Fax (989) 799-0597

No Charge

DATE OF REQUEST:

REQUESTED BY:

Documents Pertaining To:

DOB:

SSN: (last 4 digits)

No charge is being assessed to the requesting party for the research and provision of documents from the records of the above referenced individual.

Records released directly to the person served or guardian are not assessed a charge for the first copy of documents within a time frame. Additional copies of documents within that same time frame will be assessed a research and processing fee at the current rate.

Please feel free to contact Saginaw County Community Mental Health Authority's Medical Records Department with any questions.

Sincerely,

Medical Records Typist Clerk
Phone:



500 Hancock Street, Saginaw MI 48602-4292 • Phone (989) 797-3400 Fax (989) 799-0597

No Records Found

DATE OF REQUEST:

TO:

Documents Pertaining To:

DOB:

SSN: (last 4 digits)

No Records were found that matched the criteria of the Request to Disclose or Re-lease Information for the above referenced individual.

Please feel free to contact Saginaw County Community Mental Health Authority's Medical Records Department with any further questions.

Sincerely,

Medical Records Typist Clerk
Phone:

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject HIPAA Privacy Set: Employee Education and Training - Employee Training on Privacy & Security Awareness	Chapter: 08 - Management of Information	Subject No: 08.05.14.02
Effective Date: April 14, 2003	Date of Review/Revision: 3/5/03, 6/30/09, 6/4/14, 5/12/16, 3/15/17, 6/1/18, 6/11/19, 8/1/21, 10/26/22, 6/27/23, 9/9/24, 10/14/25, 3/16/26 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: AmyLou Douglas, Chief Information Officer Chief Quality and Compliance Officer Authored By: Christina Saunders Additional Reviewers: Holli McGeshick, Quality and Medical Records Supervisor Alecia Schabel, Continuing Education Supervisor Jennifer Keilitz, Director of Network Services, Public Policy, CE, EHS and OBRA
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		

Purpose:

Saginaw County Community Mental Health Authority (SCCMHA) is committed to ensuring the privacy and security of a person served health information in compliance with the HIPAA Privacy Rule (45 CFR §164.530(b)), Security Rule (45 CFR §164.308(a)(5)), the Michigan Mental Health Code (MCL 330.1748), and other applicable laws. To support our commitment to person served confidentiality, all employee of SCCMHA – including interns, volunteers, contractors, and applicable network providers - will receive appropriate training, regarding the policies and procedures for ensuring the secure and confidential receipt, transmission, storage, use and/or disclosure of protected health information.

Policy:

1. Initial Training Requirement:

- a. All new members of SCCMHA's workforce will receive HIPAA Privacy and Security training within 10 calendar days of initial employment or prior to being granted access to systems containing PHI.
 - b. Training shall cover that HIPAA Privacy and Security Rules, SCCMHA privacy practices, and confidentiality under the Michigan Mental Health Code regarding the proper use and disclosure of protected health information.
- 2. **Ongoing and Refresher Training:**
 - a. Training will occur upon initial employment, and at least annually or more frequently in response to:
 - i. Significant updates to regulations, policies, or procedures.
 - ii. Finding from internal audits or incidents involving PHI breaches.
 - iii. Role changes involving new access to PHI or electronic systems.
 - iv. Identified cybersecurity threats or trends (e.g., phishing campaigns, social engineering risks)
 - b. SCCMHA may supplement annual training with targeted modules or real-time alerts as needed.
- 3. **Role-Based Training Content:**
 - a. Training will be tailored to the workforce member's role and job functions, ensuring understanding of:
 - i. Proper use and disclosure of PHI,
 - ii. Access limitations based on minimum necessary standards,
 - iii. Incident reporting requirements,
 - iv. Safeguards for electronic or paper-based PHI,
 - v. Individual rights under HIPAA and the Michigan Mental Health Code.
- 4. **Security Awareness and Phishing Training**
 - a. SCCMHA will provide ongoing security awareness training to all workforce members to reduce cybersecurity risk and protect electronic protected health information (ePHI).
 - b. Workforce members are required to:
 - i. Complete security awareness training upon hire and at least annually thereafter
 - ii. Participate in periodic security awareness activities, including phishing simulations
 - iii. Complete additional training as required based on identified risks, incidents, or trends
 - c. Security awareness training will include, at a minimum:
 - i. Phishing and social engineering awareness
 - ii. Password security and multi-factor authentication (MFA)
 - iii. Protection of electronic data and secure handling practices
 - iv. Incident reporting responsibilities
 - v. Secure use of remote access and mobile devices

- d. SCCMHA may conduct simulated phishing exercises to evaluate workforce awareness and identify areas for additional training.
- e. Results of training and simulations will be reviewed by Information Security and Compliance Departments to support risk management and continuous improvement.

5. Documentation and Retention:

- a. Completion of all training will be documented and tracked by the Continuing Education Department or the designated office.
- b. Records will be retained for a minimum of 6 years in compliance with 45 CFR §164.530(j).
- c. Security awareness training completion and phishing simulation metrics will be tracked and reviewed.

6. Enforcement and Sanctions:

- a. Failure to complete required training within the designated timeframes may result in disciplinary action, up to suspension or termination of access to PHI.
- b. Workforce members are expected to maintain ongoing awareness of PHI confidentiality and must report potential violations to the Chief Compliance Officer immediately.

Application:

All SCCMHA Board operated programs, employees, interns, volunteers, contracted personnel, and applicable Network Providers.

Standards:

- 1. New employees will receive training within 10 days of initial employment.
- 2. Refresher training is required annually, or more frequently as needed based on changes or incidents.

Definitions:

Refer to SCCMHA Policy 08.05.00.01 – *Compliance Definitions* for:

- Protected Health Information (PHI)
- Disclosure
- Use
- Workforce

References:

- HIPAA Privacy Rule, 45 CFR §164.530(b) – Training Requirements
- HIPAA Security Rule, 45 CFR §164.308(a)(5) – Security Awareness and Training
- Michigan Mental Health Code, MCL 330.1748
- SCCMHA Human Resources - Temporary Employee Orientation checklist
- SCCMHA Policy 05.06.03 - Competency Requirements for the SCCMHA Provider Network
- SCCMHA Procedure: Training & Awareness – Staff Security Awareness & Phishing Training Procedure (KnowBe4)

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1. All new employees will receive training regarding the privacy and confidentiality of a person served health information within ten days of initial employment.	HIPAA Privacy Officer
2. Training will be provided to all employees whose functions are affected by a material change in the policies or procedures, within a reasonable period after the material change becomes effective.	HIPAA Privacy Officer
3. Training regarding the privacy and confidentiality of a person served health information will include the following: a. Uses and disclosures of protected health information for treatment, payment, and health care operations. b. Uses and disclosures of protected health information pursuant to person served consent. c. Uses and disclosure of protected health information pursuant to the person served opportunity to agree or disagree with the use or disclosure. d. Uses and disclosure of protected health information that do not require person served consent, or opportunity to agree or disagree. e. People served rights concerning their protected health information. f. Any other information as necessary for the respective members of the workforce to carry out their duties and responsibilities with respect to the proper use or disclosure of protected health information.	HIPAA Privacy Officer
4. HIPAA Cybersecurity awareness training will be provided to all employees upon hire and at least annually thereafter.	HIPAA Security Officer
5. Documentation regarding training for SCCMHA's workforce will be retained 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.	SCCMHA Continuing Education Department

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: HIPAA Security: Device and Media Transport & Disposal	Chapter: 08 – Management of Information	Subject No: 08.06.10.04
Effective Date: October 01, 2020	Date of Review/Revision: 9/15/22, 8/4/23, 9/9/24, 11/12/25, 3/16/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: AmyLou Douglas, Chief Information Officer Chief Quality and Compliance Officer
	Supersedes: 08.01.07 08.06.37 08.06.39	
		Authored By: AmyLou Douglas, Chief Information Officer Chief Quality and Compliance Officer, Security Officer Additional Reviewers: Mark Suave, Senior Systems & Desktop Support Administrator Chad Revell, Inventory Management and Mobile Device Specialist

Purpose:

To ensure compliance with the HIPAA Security Rule, §164.310(d) – Workstation Use, and to protect electronic protected health information (EPHI), this policy governs the receipt, removal, and movement of hardware and electronic media containing EPHI within and outside SCCMHA facilities.

Policy:

SCCMHA will implement comprehensive policies and procedures that govern the inventory, movement, receipt, storage, transport, removal, and disposal of hardware and electronic media that contain electronic protected health information (ePHI). All activities involving these items will be tracked, logged, encrypted when in transport, and managed under chain-of-custody controls to ensure the confidentiality, integrity, availability, protection, and security of ePHI.

SCCMHA-issued mobile devices that access, store, or transmit electronic protected health information (ePHI) must be managed through an approved Mobile Device Management (MDM) system. The MDM system will enforce security controls including device authentication, encryption, application management, remote lock/wipe capability, and compliance monitoring to protect the confidentiality, integrity, and availability of ePHI.

Application:

The HIPAA Security Rule and this Policy apply to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policies and Procedures which comply with the applicable section of the HIPAA Security Rule. Personal or Bring Your Own Device (BYOD) devices are not permitted to access SCCMHA systems containing ePHI unless explicitly authorized through an approved exception process.

Standards:

1. Tracking & Logging:
 - **Movement Tracking:** All movements of SCCMHA hardware, including mobile devices, laptops, removable media, and electronic storage containing ePHI into, within, or out of its facilities must be tracked and logged. Logs must include chain-of-custody records, timestamps, device serial numbers, encryption status, and responsible personnel. Those responsible for such movement must take appropriate and reasonable actions to protect EPHI. This includes both EPHI received by SCCMHA and created within SCCMHA.
2. Authorization and Documentation:
 - **Authorization Requirement:** all uses or movement of information system or electronic media containing EPHI outside SCCMHA's premises must be authorized by appropriate SCCMHA management (Manager of Information Technology, CIO|CQCO). Such authorization must be tracked and logged.
 - **Documentation Details:** At a minimum, such tracking and logging must provide the following information:
 - Date and time of movement of system or media.
 - Device or media identifier (serial number)
 - Identity of individual moving the media
 - Destination and intended use.
 - Identity of approving authority
 - Encryption or security status during transport
 - Verification signature upon receipt
3. Protection and Responsibility:
 - **Employee Responsibility:** employees and associates must ensure that electronic media or information systems containing EPHI are protected

against damage, theft, and unauthorized access during movement. This includes securing the items physically and logically (i.e., tamper-resistant containers, locked cases, or containers) or two-person handoff/transport. Lost or stolen media must be immediately reported and investigated under the Incident Response policy.

- ePHI must only be accessed through SCCMHA-approved applications.
- Workforce members must not transmit ePHI using personal messaging platforms, personal email accounts, or unapproved applications.
- SCCMHA data may not be backed up to personal cloud storage services.

4. Lost or Stolen Devices:

- Lost or stolen devices containing or capable of accessing ePHI must be reported immediately in accordance with SCCMHA Incident Reporting requirements.
- SCCMHA will take immediate action to secure such devices, which may include disabling access, remote lock, or remote wipe.

Incidents involving possible exposure of ePHI will be reviewed under SCCMHA's Security Incident Response and Breach Notification policies.

5. Data Backup and Storage:

- **Pre-Movement Backup:** Before moving equipment containing PHI, ensure that a retrievable, exact copy of electronic protected health information will be created and stored securely.
- **Backup Validation:** Backup integrity must be assessed to confirm no corruption prior to movement.
- **Backup Security:** backups must be encrypted and stored in a secure, access-controlled location that meets SCCMHA's security requirements or encrypted cloud storage.

6. Disposal Procedures:

- **Final Disposition:** Implementation of procedures for the secure disposal of ePHI and any hardware or electronic media that stored ePHI. This includes data wiping, physical destruction, or other secure methods of disposal. Dispose of hardware/media containing ePHI using methods that render data unrecoverable, such as DoD 5220.22-M wiping, degaussing (where applicable), or physical destruction (shredding, crushing).
- **Certification:** The individual overseeing disposal must certify in writing that destruction or overwriting is complete and irrecoverable.
- **Vendor Disposal:** When using a third-party disposal vendor, it requires a formal contract, proof-of-destruction, and chain-of-custody documentation. SCCMHA currently contracts with Shred Experts who are authorized to dispose of hardware/media through their contract.
- **Documentation:** Document the disposal process, including details of the destruction and individual responsible for overseeing it.

7. Media Reuse:

- **Data Removal:** Before electronic media is made available for reuse, ensure that EPHI is completely removed using approved methods such as

data wiping or physical destruction. Acceptable methods include cryptographic wipe, secure erase commands, or multiple pass overwrites, depending on media type.

- **Verification:** Verify that no recoverable EPHI remains in the media before it is repurposed.
- **Logging:** Record reuse actions with who performed wipe, method, date/time, and verification results.

8. Encryption and Security Measures:

- **Encryption Standards:** Implement encryption for EPHI stored on electronic media, both in transit and at rest, to protect against unauthorized access.
 - i. All portable devices (e.g., laptops, USB drives, removable media) carrying ePHI must use full-disk encryption or file-level encryption.
 - ii. Encrypt media prior to movement or transport.
 - iii. Use secure transfer protocols (e.g., SFTP, TLS) if data is moved digitally via media.
 - iv. Disable or physically block unused ports (USB, SD card slots) to reduce risk of unauthorized copying.
- **Security Protocols:** Follow industry best practices for securing electronic media during transport and while stored. Devices containing ePHI must be configured to support remote security actions, including remote lock and remote wipe capabilities.

9. Accountability and Record Keeping:

- **Movement Records:** A record will be maintained of the movements of hardware and electronic media and the identity of responsible individuals.
- **Access to Records:** Ensure that records are accessible to authorized personnel for review and auditing purposes.
- **Retention:** All logs and records related to media movement, reuse, disposal, and authorization must be retained for at least **six (6) years**, per HIPAA documentation requirements (45 CFR §164.316(b)(2)).
- **Auditability:** Logs must be tamper-resistant (write-once or cryptographically protected) and accessible only by designated personnel.
- All lost or stolen device incidents must be documented, including device details, actions taken, and final disposition.

10. Training & Awareness:

- **Employee Training:** Provide regular training to SCCMHA workforce members on the procedures for handling, moving, and disposing of EPHI-containing hardware and electronic media.
- **Media Handling Module:** Training must include modules on device/media handling, disposal, encryption, chain-of-custody, and transport protocols. Training must also address secure use of mobile devices, protection

of mobile applications containing ePHI, and reporting procedures for lost or stolen devices.

- **Awareness Programs:** Implement awareness programs to reinforce the importance of data protection and adherence to policies.
- **Training Frequency:** At minimum, during onboarding and annually thereafter.
- **Acknowledgment:** Workforce must sign an acknowledgment of understanding and compliance with this policy after each training.

11. Compliance Monitoring:

- **Audits:** Conduct periodic audits to ensure compliance with this policy and identify any areas for improvement. Random audits or spot checks of device movement/disposal practices will be performed by CIO|CQCO or Manager of Information Technology to ensure compliance.
- **Reporting:** Establish a reporting mechanism for any incidents or deviations from policy and address them promptly.
- SCCMHA reserves the right to monitor and audit organization-issued devices used to access SCCMHA systems or data to ensure compliance with security policies and procedures.

12. Mobile Device Security

- Use authentication controls such as PIN, password, or biometric authentication.
- Use full-device encryption to protect data stored on the device.
- Be configured and monitored through an approved device management platform.
- Maintain current operating system updates and security patches.
- Use only approved applications when accessing SCCMHA systems or data.
- Permit remote lock or remote wipe if the device is lost, stolen, or compromised.

Responsibilities:

- **IT Department:** Oversees the implementation of encryption, backup procedures, logging, inventory registry, movement coordination, and secure storage.
- **Inventory Management & Mobile Device Specialist:** maintain registry, tag devices, coordinate transport/disposal.
- **HIPAA Security Officer:** Ensures oversight and adherence to HIPAA regulations and SCCMHA's policies. Reviews and validates logs and audits compliance.
- **Chief Information Officer (CIO)** – final approval authority for removal/transport, review of logs, oversight escalations
- **All Employees:** Follow procedures for handling, moving, and disposing of hardware and electronic media containing EPHI. Participate in training and adhere to security measures.

- **Mobile Device:** A portable computing device such as a smartphone or tablet that can store, process, or transmit SCCMHA data.
- **Mobile Device Management (MDM)** – A centralized platform used to configure, secure, monitor, and manage organization-issued mobile devices.

Definitions:

See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:

- The HIPAA Security Rule §164.310(d) - *Device and Media Controls*
- 45 CFR §164.310(b) – *Workstation Use*
- 45 CFR §164.312(a)–(e) – *Technical Safeguards*
- 45 CFR §164.316(b)(2) – *Documentation Retention*
- 45 CFR §164.308(a)(1) & (a)(3) – *Administrative Safeguards*
- NIST SP 800-111 – *Guide to Storage Encryption Technologies for End User Devices*
- NIST SP 800-88 Rev.1 – *Guidelines for Media Sanitization*
- NIST SP 800-53 Rev. 5 – *Security and Privacy Controls for Information Systems* (CM-8, MP-2, MP-4, MP-6)
- FIPS 140-3 – *Security Requirements for Cryptographic Modules*
- HITECH Act §13402 – *Breach Notification Requirements*
- SCCMHA Policy 08.06.08.06 – *HIPAA Security, Security Incident Procedures*
- SCCMHA Policy 08.05.03.03 – *HITECH Breach Notification PHI*
- SCCMHA 08.06.40 – *HIPAA Security, Data Backup and Storage*
- SCCMHA 08.06.08.05 – *HIPAA Security, Security Awareness & Training*
- SCCMHA 08.06.16.01 – *HIPAA Security, Policies, Procedures, and Documentation*
- SCCMHA 08.06.08.04 – *HIPAA Security, Information Access Management*
- SCCMHA Procedure – *Device & Endpoint Security - Mobile Device Management (MDM) Procedure*
- SCCMHA Procedure – *Device & Endpoint Security – Lost or Stolen Device Procedure*
- NIST SP 800-124 Rev. 2 – *Guidelines for Managing the Security of Mobile Devices*
- NIST SP 800-61 – *Incident Handling*

Exhibits:

Exhibit A: Reporting a Lost or Stolen Device

Procedure:

ACTION	RESPONSIBILITY
Implement Methods for Final Disposal of EPHI	

1. Implement policies and procedures to address the final disposition of EPHI and/or the hardware or electronic media on which it is stored. 2. Determine and document the appropriate methods to dispose of hardware, software, and the data itself. 3. Assure the EPHI is properly destroyed and cannot be recreated. Develop and Implement Procedures for Reuse of Electronic Media 4. Implement procedures for removal of EPHI from electronic media before the media are made available for reuse. 5. Ensure that EPHI previously stored on electronic media cannot be accessed and reused. 6. Identify removable media and their use. 7. Ensure that EPHI is removed from reusable media before they are used to record new information. Maintain Accountability for Hardware and Electronic Media 8. Maintain an inventory and record of the movements of hardware and electronic media and any person responsible for such movement.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist • Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist • Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support. • Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist. • Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support. • Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support. • Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support. • Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.

9. Ensure that EPHI is not inadvertently released or shared with any unauthorized party. 10. Ensure that an individual is responsible for, and records the receipt and removal of, hardware and software which contains EPHI. Develop Data Backup and Storage Procedures 11. Ensure that a retrievable exact copy of EPHI is created when needed before movement of equipment. 12. Ensure that an exact retrievable copy of the data is retained and protected to protect the integrity of EPHI during equipment relocation. Lost or Stolen Device Procedure 13. Once a device is lost/stolen then end user MUST put in a ticket stating “lost [type of device]” in the subject. With the issue type Lost/Stolen 14. Request Form - SCCMHA Hardware Support - Select Lost/Stolen in issue type - Add any helpful information in the description (last known location) - Add phone number. - Submit Ticket 15. The ticket will send approvals to the users’ direct supervisor and the CIO for approval.	- Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support. - Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support. - Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support. - Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support. - End User - End User or Supervisor - Supervisors

a. If approved, it will send a task to the inventory and mobile device specialist. b. If not approved, it will send a task to the inventory and mobile device specialist stating that it has not been approved and to close the ticket. c. If the device cannot be located within 48 hours or is in an “untrusted location” confirmed by the end user, the device must be WIPED. 16. NOTE: if the phone can be located and retrieved in a timely manner SCCMHA and its employees must make the best effort to retrieve as to not be considered “wasteful”.	

Exhibit A: Reporting a Lost or Stolen Device

1. Once a device is lost/stolen then end user MUST put in a ticket stating “lost [type of device]” in the subject. With the issue type Lost/Stolen
2. [Request Form - SCCMHA Hardware Support](#)
 - a. Select Lost/Stolen in issue type
 - b. Add any helpful information in the description (last known location)
 - c. Add phone number.
 - d. Submit Ticket

[Service Catalog](#) / [Technical Support](#) / [Hardware Support](#)

Hardware Support

[+ Show Help](#) [- Hide Help](#)

General Hardware Support

All fields marked with an asterisk (*) are required.

Requestor * 

Requestor is required.

Acct/Dept * 

Acct/Dept is required.

Subject * 

Description * 

Format  Font  Size       

Last known location:
Any other pertinent information:

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: IT/IS HelpDesk Support with 24/7 On-Call Services	Chapter: 09 - Departmental Procedures	Subject No: 09.07.01.55
Effective Date: 1/1/2025	Date of Review/Revision: 1/1/25, 3/16/26	Approved By: AmyLou Douglas, CIO/CQCO Authored By: AmyLou Douglas, CIO/CQCO Additional Reviewers: Fred Stahl, Director of Human Resources
	Supersedes: 09.07.01.54	
		

Purpose:

The 24-hour IT/IS HelpDesk procedure ensures continuous support for critical IT services to minimize downtime and maintain operational efficiency and to establish a framework for delivering reliable and responsive IT support.

1. **Ensure Round-the-Clock Availability:** Provide IT support is available 24 hours a day, 7 days a week, to address any urgent technical issues or emergencies that may arise.
2. **Minimize Downtime:** Provide timely and effective IT issue resolution, thus minimizing downtime and disruptions to services provided by the agency.
3. **Improve Incident Response & Resolution Time:** Set specific targets for responding to and resolving incidents within defined timeframes to minimize the impact of technical issues.
4. **Enhance Service Quality:** Provide efficient assistance to users, addressing their needs promptly, and ensuring a positive customer experience.
5. **Ensure Compliance and Security:** Adhere to relevant compliance standards, regulations, and security protocols to safeguard sensitive data and ensure the integrity and confidentiality of IT systems and information.

6. **Documentation:** To create a process by which Saginaw County Community Mental Health Authority Information Systems and Technologies Services can be requested, tracked, and documented.

Policy:

1. We recognize the critical role that IT services play in supporting our operations and providing services. We are committed to delivering uninterrupted IT support to ensure the continuous availability, reliability, and security of our systems, services, and data.
2. We understand that any disruption to IT services can have a significant impact on our business operations, productivity, and service delivery. Our commitment is to maintain robust IT support mechanisms and procedures to minimize downtime and swiftly address any technical issues or emergencies that may arise.
3. Our commitment to providing uninterrupted IT support is underpinned by the following principles:
 - a) **Proactive Monitoring and Maintenance:**
 - i) We continuously monitor our IT infrastructure to detect and address potential issues before they escalate into critical problems.
 - ii) Through proactive maintenance and optimization, we strive to prevent service disruptions and ensure the smooth functioning of our systems.
 - b) **24/7 Availability:**
 - i) We maintain a dedicated team of IT professionals who are available 24 hours a day, 7 days a week, to provide support and assistance per the Service Catalog & Service Level Agreements.
 - ii) Whether during business hours or after hours, our on-call staff are ready to respond promptly to incidents and ensure the continuity of IT services.
 - c) **Rapid Incident Response:**
 - i) In the event of an IT incident or emergency, we are committed to responding swiftly and effectively to minimize the impact on our agency operations per the Service Catalog & Service Level Agreements.
 - d) **Continuous Improvement:**
 - i) We are committed to continuously improving our IT support processes, procedures, and infrastructure to enhance reliability, efficiency, and resilience.
 - ii) Through regular reviews, assessments, and feedback mechanisms, we identify opportunities for optimization and implement proactive measures to prevent future disruptions.
 - e) **Compliance and Security:**

- i) We adhere to relevant laws, regulations, and industry standards to ensure the security and confidentiality of our systems and data.
 - ii) Our IT support practices prioritize compliance with data protection regulations and cybersecurity best practices to safeguard our assets and maintain the trust of our stakeholders.
- f) **Documentation:**
- i) We ensure that all Information Technology, Information Systems, Business Intelligence and EHR Sentri, Data Requests and Reporting Services are documented and tracked with a HelpDesk request through the ticketing system.
 - ii) This Policy will ensure requests are properly documented and routed to the appropriate team member(s).

Application:

1. Applies to all IT systems, services, and departments requiring support during and outside regular business hours as listed in the per the Service Catalog.
2. Defines the criteria for HelpDesk standard support, emergencies and critical issues that warrant IT/IS services.
3. Defines the Service Catalog and their applicable Service Level Agreement. This includes their expected response and resolution times.
4. Applies to:
 - a. All IT/IS staff who are required to support the HelpDesk during regular business hours.
 - b. All IT/IS staff who are required to support the HelpDesk while on an On-Call rotation.
 - c. All agency employees who require IT/IS support and services to complete their job duties and provide services to our persons served.
 - d. All Sentri users who need password resets, accounts unlocked and DUO support.

Standards:

1. The SCCMHA IT/IS Department provides 24-hour HelpDesk Support.
2. Users contact the HelpDesk for Support
 - a. If a HelpDesk call is received, the HelpDesk staff must create a ticket to accommodate and track the request.
 - b. HelpDesk staff will either reply to the ticket, email the user, MS Teams message the user or call the user to arrange for a time to assist and provide them with an estimated resolution time and next steps.
 - c. If the request is a break/fix, HelpDesk staff will attempt to fix/repair the issue using remote assistance or TeamViewer.
 - d. If the issue needs on-site assistance, the request will either be handled by the staff who received the call or assigned to a team member who can assist.

- e. In the event of an escalation, the HelpDesk Team will route the request to the appropriate team or team member.
 - f. The HelpDesk staff person will continuously update the HelpDesk ticket.
 - g. The team or staff person responsible for the support request will update the request with any troubleshooting steps taken to resolve the issue. All steps in the process must be recorded.
 - h. When the request is considered complete, the assigned staff person will confirm with the user that the request is resolved prior to closing the ticket.
 - i. HelpDesk will add closing notes and change the status to complete.
 - j. HelpDesk will consider if a TDX Knowledge Base article exists or should be created to assist users in the future.
 - k. IT/IS Teams will discuss at their regular meetings any tickets that are notable, need discussion, have a delayed SLA, or need additional assistance.
3. When users contact the HelpDesk for Support - In order of preferred method:
- a. During Regular Business Hours
 - i. TDX Ticket System:
 - <https://sccmha.teamdynamix.com/TDClient/63/Portal/Home/>
 - ii. HelpDesk Email Address:
 - HelpDesk@Sccmha.org
 - cc: All agency staff who should receive regular request updates.
 - iii. HelpDesk Phone Number:
 - 989-[797](tel:989-797-3577)-3577
 - o Press 1 – HelpDesk Support
 - o Press 2 – Sentri Support
 - iv. IT/IS Staff Desk Phones, Cell Phones, Voicemails and Microsoft Teams Messages:
 - For urgent matters as a follow-up if needed. Only after a voicemail has been left on the HelpDesk line AND a HelpDesk ticket has been submitted.
 - While all IT/IS staff have their own desk phones, cell phones, voicemails, and Microsoft Teams messaging, it's required to contact the MAIN HelpDesk phone number for IT/IS support.
 - Reaching out directly to an individual staff member may not ensure that others are aware of your request for assistance. The staff member you contact may be out for the day, away from their desk or unavailable.
 - b. During On-Call Hours
 - i. HelpDesk Phone Number:
 - 989-[797](tel:989-797-3577)-3577
 - o Press 5 – After Hours Support
 - ii. IT/IS Staff Agency Cell Phones:

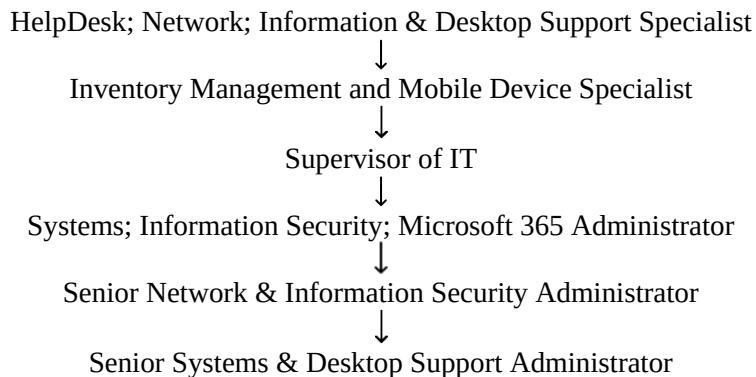
- The Outlook Address Book can be found on the Outlook On-Call calendar and has the On-Call staff person's cell phone number as well.
 - If the need is urgent and no one answers the HelpDesk line after you press 5, please call this person directly or send them a text message.
- iii. If the staff person is in need of urgent support and has been unsuccessful in reaching the On-Call staff person after 30 minutes:
- The Director may contact an IT/IS Senior Staff Member directly.
 - The Director may contact the IT/IS Supervisor directly.
 - The Director may contact the CIO directly (Text Message is most effective.).
4. Responsibilities **of a User Seeking HelpDesk Support:**
- a. Initiate Contact Promptly: Users should promptly report any technical issues or concerns to the HelpDesk through the designated channels, such as phone, email, or ticketing system, providing sufficient details to facilitate diagnosis and resolution.
 - b. Provide Accurate Information: Users are responsible for providing accurate and detailed information about the issue they are experiencing, including error messages, symptoms, and steps taken before encountering the problem.
 - c. Cooperate with Helpdesk & IT Staff: Users must cooperate during troubleshooting sessions, following their instructions, and providing access to the affected device or system as needed to facilitate diagnosis and resolution.
 - d. Adhere to Security Protocols: Users must adhere to established security protocols and procedures when interacting with HelpDesk technicians, including verifying the identity of IT staff before granting remote access and safeguarding sensitive information.
 - e. Follow Policies and Guidelines: Users are expected to adhere to company policies and guidelines related to IT usage and support, including acceptable use policies, data protection regulations, and procedures for requesting assistance.
 - f. Be Available for Communication: Users should be available for communication with HelpDesk technicians during the support process, responding promptly to inquiries, providing additional information as requested, and acknowledging resolution status updates.
 - g. Exercise Patience and Respect: Users should exercise patience and respect when interacting with HelpDesk technicians, understanding that resolving technical issues may take time and require multiple steps to achieve a satisfactory resolution.
 - h. Take Preventive Measures: Users should take proactive measures to prevent future incidents by following best practices for IT usage.
 - i. Participate in Training and Awareness Programs: Users must participate in training and awareness programs to enhance their knowledge and skills in

IT usage and security practices, reducing the likelihood of future support issues.

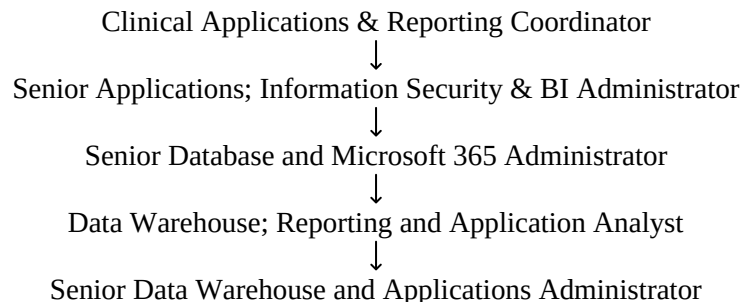
5. HelpDesk Phone Support Order of Responsibility:

- a. When the HelpDesk line rings, IT staff will ensure that every call is answered by a member of the IT/IS department.
- b. If a staff person is away from their desk, on the phone or in the middle of a task, the next person in line (or another staff member) will answer the phone.
- c. Under no circumstance should a call go unanswered.
- d. Every IT staff member must be logged into MXIE or Zac on their agency phone to ensure this does not occur.

HelpDesk Line (when option 1 if pressed)



Sentri Line (when option 2 if pressed))



6. Mandatory usage of the Team Dynamics Ticket System (TDX)

- a. All requests for Information Technology, Information Systems, Business Intelligence and EMR Services work will be documented in the SCCMHA Ticketing System. A ticket will be created for all user requests, telephone calls and emails by a SCCMHA IS/IT Staff Member.
- b. The HelpDesk will act as the triaging agent for incoming requests. If the request requires escalation the HelpDesk Team will assign the request to the appropriate team.
- c. Urgent requests will be identified as Critical in the request system, routed to the appropriate team, taking priority, and acted upon and followed up on immediately.
- d. The assigned IT/IS staff member or team will be responsible to follow-up on the status of all open requests assigned to them and provide regular updates to the requestor.
- e. If an end user contacts the HelpDesk to follow up on a request it is the HelpDesk's responsibility to note the end user contact in the ticket and notify the assigned staff person via a phone call. If there is no assigned staff, the HelpDesk will contact the assigned team. Any updates to the ticket are automatically sent out via TDX.
- f. All outstanding requests will be reviewed during team meetings. Open requests will be discussed, and plans will be put in place for resolution. Closed requests will be reviewed.

7. HelpDesk staff will attempt to remotely assist the user via TeamViewer.

- a. This allows HelpDesk staff to leverage TeamViewer to deliver efficient and secure remote support services to users.
- b. TeamViewer is a remote access and support software that enables HelpDesk technicians to remotely connect to users' computers or devices to provide assistance, troubleshoot issues, and perform maintenance tasks. It offers a range of features designed to facilitate efficient and secure remote support, including:
 - i. Remote Control: Technicians can take control of users' screens to diagnose and resolve issues directly, providing a seamless support experience without the need for physical presence.
 - ii. File Transfer: TeamViewer allows for the transfer of files between the technician's and user's devices, facilitating the exchange of troubleshooting tools, software patches, or configuration files.
 - iii. Chat and VoIP Communication: Built-in chat and VoIP (Voice over Internet Protocol) capabilities enable real-time communication between technicians and users during remote support sessions, enhancing collaboration and problem-solving.
 - iv. Security Features: TeamViewer employs advanced encryption and security protocols to protect remote connections and data transmissions, ensuring the confidentiality and integrity of sensitive information.

- c. Guidelines and procedures for using TeamViewer as a remote support tool for HelpDesk technicians to assist users with technical issues and provide IT support.
 - i. Authorized Users: TeamViewer access is restricted to authorized HelpDesk technicians employed by SCCMHA for the sole purpose of providing IT support to users within the agency.
 - ii. Use of TeamViewer: TeamViewer may only be used for legitimate business purposes, including troubleshooting, maintenance, and configuration of IT systems and devices.
 - iii. Security and Confidentiality: Technicians must ensure the security and confidentiality of remote support sessions by following established security protocols and encryption standards. Users' consent must be obtained before initiating remote control sessions, and technicians must obtain explicit permission for any actions performed on users' devices.
 - iv. Recording and Documentation: Remote support sessions may be recorded for documentation and training purposes with the consent of the user.
 - v. Compliance: Technicians must comply with all applicable laws, regulations, and company policies when using TeamViewer for remote support, including data protection and privacy regulations.
 - vi. Accountability: HelpDesk technicians must adhere to established procedures and guidelines. Technicians are accountable for their actions during remote support sessions and must always act responsibly and ethically.
 - vii. Violations: Violations of this policy may result in disciplinary action, up to and including termination of employment, depending on the severity of the violation and its impact on the organization's security and operations.

8. Mileage:

- a. When Off-Site Support is needed, mileage will be paid to the HelpDesk staff person if they did not travel via Agency vehicle.
- b. See policy 05.02.07 - Travel Expense Reimbursement for additional details

9. Response Time Expectations:

- a. A user will receive an email or a phone call indicating when they can expect support.
- b. The service catalog response time expectations:
 - i. are estimates only and are subject to change.
 - ii. are subject to change due to staff shortages, PTO, etc.
 - iii. are dependent on accurate and complete entry into the ticket system.
 - i.e.: Correct ticket type / categorization.
 - iv. will be delayed when sent to the general HelpDesk email and not the ticket system.
 - v. are dependent on user's following this procedure and processes.

- vi. are dependent on the user following proper agency procedures and processes.
 - i.e.: HelpDesk cannot activate or deactivate without approval from HR or notification on the activation / deactivation sheet.

10. Resolution Time Expectations:

- a. Although HelpDesk staff will work to resolve issues as timely as possible, the time it takes to resolve an issue could be a few minutes, a few hours, a few days or longer depending on the urgency, the priority, the other support requests, and the staff available.
- b. The service catalog resolution time expectations:
 - i. will be estimated during the HelpDesk staff's initial response.
 - This time may be different than the initial expectations.
 - ii. are estimates only and are subject to change.
 - iii. are subject to change due to staff shortages, PTO, etc.
 - iv. will be delayed during third shift hours.
 - v. for support that includes new equipment may be delayed due to back ordered items, or other supply chain issues.
 - vi. will be affected when support request can only performed by certain staff members, and they are off on PTO or otherwise unavailable.
 - vii. can be extended if a temporary solution is put in place.
 - i.e.: Staff is provided with a temporary loaner or another temporary "work-around" is provided.)
 - viii. are dependent on accurate and complete entry into the ticket system.
 - ix. are dependent on timely responses from users when the HelpDesk requests a reply with additional details or other questions.
 - x. can change if it is reliant on an image or other software install is needed due to the installation time.
 - xi. can change if it requires HelpDesk to be dispatched to another location, or to come on-site while HelpDesk staff is On-Call.
 - xii. will be affected if an approval is required. Timely approvals are required.
 - xiii. may change if the support request is lengthy in time required.
 - xiv. may be extended if support needs to be scheduled with a staff member.
 - xv. can change if it is dependent on the response time of a vendor or other contractor.
- c. The HelpDesk ticket *must* be updated with the reason that the Resolution Time Expectations needs to be extended.

11. The HelpDesk utilizes an On-Call Rotation to ensure 24-hour support.

- a. CIO will set the On-Call Rotation.
- b. The CIO will determine which department staff will be On-Call staff.
- c. Staff may "swap" days or weeks with each other, with approval of the CIO.

- d. On-Call staff must be in the On-Call Outlook Calendar with Name & Agency Cell Phone noted. If “swaps” have been arranged, they must also be noted in the calendar.
- e. On-Call Outlook Calendar will be available for all Agency Staff to View Only

12. After-hours Network Support

- a. On-Call staff are also responsible for supporting the maintenance of the Network after-hours.
- b. An example would be network equipment installation and maintenance.

13. On-Call Staff Equipment Needs

- a. Agency Cell Phone
 - i. On-Call staff will always have their Agency Cell Phone on them during their On-Call rotation
- b. Laptop
 - i. On-Call staff will always have their Laptop immediately accessible to them during their On-Call rotation.

14. On-Call Staff Expectations

- a. On-Call IT staff are expected to be available and responsive during their designated On-Call periods, promptly addressing any issues that are supported in the scope of the SLA.
- b. On-Call Staff will be expected to have the access and the training to support the On-Call supported services. They will possess the knowledge and expertise necessary to troubleshoot and resolve technical issues efficiently, either independently or by escalating to appropriate resources if needed. If they have not yet received the proper training and working experience to perform the tasks, they will not be given the On-Call job classification until they have.
- c. At times, the support may need to be escalated to another member of the Team. The On-Call staff will contact and reassign the request to the SME. The SLA times will still be expected from the SME.
- d. On-Call staff will adhere to any established protocols, procedures, and service level agreements to ensure timely resolution of incidents and minimize disruption to business operations.
- e. Regular communication and coordination with other team members will be required to ensure seamless support coverage and handovers.
- f. Professionalism, accountability, and a commitment to maintaining system availability and performance are key expectations for On-Call staff.

Definitions:

- See 08.06.00.01 - Information Technology Definitions Policy

References:

- 05.02.07 - Travel Expense Reimbursement

- HelpDesk Support Schedule:
 - o Regular Business Hours (includes lunches): 7:00am - 5:30pm
- Means of contacting the HelpDesk
 - o TDX Ticket System:
 - <https://sccmha.teamdynamix.com/TDClient/63/Portal/Home/>
 - o HelpDesk Phone Number:
 - 989-797-3577 or Ext. 3577
 - Press 1 – HelpDesk Support
 - Press 2 – Senti Support
 - Press 5 – On-Call Support
 - o HelpDesk Email Address:
 - HelpDesk@Sccmha.org
 - cc: All agency staff who should receive regular request updates.

Exhibits:

Exhibit A: Service Catalog & Service Level Agreements with Response & Resolution Time Expectations

Procedure:

ACTION	RESPONSIBILITY
1) When users need support, they will contact the HelpDesk to open a ticket.	SCCMHA Staff Member
2) If a HelpDesk call is received, the HelpDesk staff must create a ticket to accommodate and track the request.	HelpDesk Team Member (IT/IS Department Staff)
3) HelpDesk staff will either reply to the ticket, email the user, MS Teams message the user or call the user to arrange for a time to assist and provide them with an estimated resolution time and next steps.	HelpDesk Team Member (IT/IS Department Staff)
4) If the request is a break/fix, HelpDesk staff will attempt to fix/repair the issue using remote assistance or TeamViewer.	HelpDesk Team Member (IT/IS Department Staff)
5) If the issue needs on-site assistance, the request will either be handled by the agent who received the call or assigned to a team member who can accommodate.	HelpDesk Team Member (IT/IS Department Staff)
6) In the event of an escalation, the HelpDesk Team will route the request to the appropriate team or team member.	HelpDesk Team Member (IT/IS Department Staff)
7) The HelpDesk staff person will continuously update the HelpDesk ticket.	HelpDesk Team Member (IT/IS Department Staff)
8) The team or staff person responsible for the support request will update the request with any troubleshoot steps taken to resolve the issue. All steps in the process must be recorded.	HelpDesk Team Member (IT/IS Department Staff)
9) When the request is considered complete, the assigned staff person will	HelpDesk Team Member (IT/IS Department Staff)

confirm with the user that the request is resolved.	
10) The user will confirm via the ticket that the issue has been resolved.	SCCMHA Staff Member
11) Te HelpDesk will add closing notes and change the status to complete.	HelpDesk Team Member (IT/IS Department Staff)
12) HelpDesk will consider if a TDX Knowledge Base article should be created to assist users in the future.	HelpDesk Team Member (IT/IS Department Staff)
13) IT/IS Teams will discuss at their regular meetings any tickets that are notable, need discussion, delayed SLA, or need assistance.	IT/IS Teams
14) The Supervisor of Information Technology will ensure the Initial Response Time Expectations and Resolution Time Expectations	Supervisor of Information Technology
15) The Supervisor of IT will ensure that all Standards as listed above are fully complied with.	Supervisor of Information Technology

Exhibit A: Service Catalog & Service Level Agreements with Response & Resolution Time Expectations

Service Catalog Type	Service	Initial Response Time Expectations	Resolution Time Expectations	Urgent / Non-Urgent	On-Call Support?	Primary IT/IS Team Responsible - Primary	Single Staff SME?
Application Development	New Application Request	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Application Development Team	
Application Development	Update Existing Application Request	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Application Development Team	
Application Development	Website Updates	1 Business Day	3 Business Days	Non-Urgent	No	BI Application Development Team	
Application Development	Website Updates - HR Urgent Request	1 Business Day	1 Business Day	Urgent	No	BI Application Development Team	
Data Integrity Support	Data Integrity Issue	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Reporting Team	
Data Integrity Support	Request Integrity Report, Email or Alert	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Reporting Team	
EHR Support	Claims & Billing Issues / Errors	1 Business Day	14 Business Days	Non-Urgent	No	BI Clinical Applications Team	
EHR Support	Enhancement Requests, New Functionality & New ITRs	7 Business Days	Prioritized accordingly	Non-Urgent	No	BI Clinical Applications Team	
EHR Support	General Support	1 Business Day	1 Business Day	Non-Urgent	No	BI Clinical Applications Team	
EHR Support	IT Request Delete	1 Business Day	3 Business Days	Non-Urgent	No	BI Clinical Applications Team	
EHR Support	Locked Sentri Account & DUO Support	30 minutes	2 hours	Urgent	Yes	BI Clinical Applications Team	
EHR Support	Reporting Request	7 Business Days	Prioritized accordingly	Non-Urgent	No	BI Reporting Team	
EHR Support	Sentri Add / Activate Staff	1 Business Day	7 Business Days	Non-Urgent	No	BI Clinical Applications Team	
EHR Support	Sentri Address Book	1 Business Day	3 Business Days	Non-Urgent	No	BI Clinical Applications Team	Clerk Typist - Records

Exhibit A: Service Catalog & Service Level Agreements with Response & Resolution Time Expectations

Service Catalog Type	Service	Initial Response Time Expectations	Resolution Time Expectations	Urgent / Non-Urgent	On-Call Support?	Primary IT/IS Team Responsible - Primary	Single Staff SME?
EHR Support	Sentri Delete / Deactivate Staff	30 minutes	1 Business Day	Urgent	Yes	BI Clinical Applications Team	
EHR Support	Sentri Error Message	1 Business Day	5 Business Days	Non-Urgent	No	BI Clinical Applications Team	
EHR Support	Sentri Login & DUO Issues	30 minutes	2 hours	Urgent	Yes	BI Clinical Applications Team	
EHR Support	Sentri Missing Access/Security Groups	1 Business Day	2 Business Days	Non-Urgent	No	BI Clinical Applications Team	
Hardware Support	New Staff Setup	3 Business Days	14 Business Days	Non-Urgent	No	IT Systems and Desktop Support	
Hardware Support	Purchasing	1 Business Day	30 Business Days	Non-Urgent	No	IT Inventory Management Team	Inventory Management and Mobile Device Specialist
Hardware Support	Staff Move / Transfer	3 Business Days	7 Business Days	Non-Urgent	No	IT Systems and Desktop Support	
Hardware Support	Unique Hardware Request	1 Business Day	30 Business Days	Non-Urgent	No	IT Inventory Management Team	Inventory Management and Mobile Device Specialist
Information Security	Phishing Alerts	1 Business Day	3 Business Days	Non-Urgent	Yes	Information and Network Security Team	
Information Systems	Activation (request from HR)	1 Business Day	5 Business Days	Non-Urgent	No	IT HelpDesk Team	
Information Systems	Deactivation (request from HR)	30 minutes	2 hours	Urgent	Yes	IT HelpDesk Team	
Information Systems	IS Software Support - (Account Lockout, OS issue/Standstill)	30 minutes	2 hours	Urgent	Yes	IT HelpDesk Team	
Information Systems	IS Software Support - (Software install, Config issue, etc.)	1 Business Day	5 Business Days	Non-Urgent	Yes	IT HelpDesk Team	

Exhibit A: Service Catalog & Service Level Agreements with Response & Resolution Time Expectations

Service Catalog Type	Service	Initial Response Time Expectations	Resolution Time Expectations	Urgent / Non-Urgent	On-Call Support?	Primary IT/IS Team Responsible - Primary	Single Staff SME?
Information Systems	New IS System Request - Req Gathering, Discovery, Vetting & Implementation	7 Business Days	Prioritized accordingly	Non-Urgent	No	CIO Office	CIO
Information Systems	TigerConnect Access	1 Business Day	3 Business Days	Non-Urgent	No	IT HelpDesk Team	Systems, Information Security, & Microsoft 365 Administrator
Mobile Device Support	DME iPad Requests	1 Business Day	30 Business Days	Non-Urgent	No	IT Inventory Management Team	Inventory Management and Mobile Device Specialist
Mobile Device Support	MiFi/Hotspot Support	1 Business Day	10 Business Days	Non-Urgent	Yes	IT Inventory Management Team	
Mobile Device Support	SCCMHA Mobile Phones (Existing)	1 Business Day	10 Business Days	Non-Urgent	Yes	IT Inventory Management Team	Inventory Management and Mobile Device Specialist
Mobile Device Support	Tablet Support	1 Business Day	3 Business Days	Non-Urgent	No	IT Inventory Management Team	
Printer/Fax Support	Fax Machine Support	1 Business Day	3 Business Days	Non-Urgent	No	IT HelpDesk Team	
Printer/Fax Support	Printer/Copier Support	1 Business Day	3 Business Days	Non-Urgent	No	IT HelpDesk Team	
Reporting	Auto generate report or other data transfer Request / Change	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Reporting Team	
Reporting	Data Request - Ad Hoc (External)	5 Business Days	30 Business Days	Non-Urgent	No	BI Reporting Team	
Reporting	Data Request - Ad Hoc (Internal)	5 Business Days	30 Business Days	Non-Urgent	No	BI Reporting Team	
Reporting	External Vendors & Contractors Support	5 Business Days	30 Business Days	Non-Urgent	No	BI Reporting Team	

Exhibit A: Service Catalog & Service Level Agreements with Response & Resolution Time Expectations

Service Catalog Type	Service	Initial Response Time Expectations	Resolution Time Expectations	Urgent / Non-Urgent	On-Call Support?	Primary IT/IS Team Responsible - Primary	Single Staff SME?
Reporting	New Pivot Table Request / Change	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Reporting Team	
Reporting	New SSRS Report Request / Change	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Reporting Team	
Reporting	PowerBI Dashboard Request / Change	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Reporting Team	
Reporting	Provider Report	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Reporting Team	
Reporting	Report Request / Change	5 Business Days	Prioritized accordingly	Non-Urgent	No	BI Reporting Team	
Reporting	State Reporting / Submission Issues	5 Business Days	30 Business Days	Non-Urgent	No	BI Reporting Team	
Reporting	State reporting/submissions Request / Change	5 Business Days	30 Business Days	Non-Urgent	No	BI Reporting Team	
Technical Support	Broadcast Access (Needs approval)	1 Business Day	3 Business Days	Non-Urgent	No	IT Networking Team	
Technical Support	Camera System Support	1 Business Day	3 Business Days	Non-Urgent	No	IT HelpDesk Team	
Technical Support	File Restoration	1 Business Day	5 Business Days	Non-Urgent	No	IT Networking Team	Senior Network & Information Security Administrator
Technical Support	Folder Access (Needs approval)	1 Business Day	5 Business Days	Non-Urgent	No	IT Networking Team	Senior Network & Information Security Administrator
Technical Support	Hardware Support - Normal	1 Business Day	3 Business Days	Non-Urgent	Yes	IT Systems and Desktop Support	
Technical Support	Hardware Support - Work Stoppage	30 minutes	12 hours	Urgent	Yes	IT Systems and Desktop Support	

Exhibit A: Service Catalog & Service Level Agreements with Response & Resolution Time Expectations

Service Catalog Type	Service	Initial Response Time Expectations	Resolution Time Expectations	Urgent / Non-Urgent	On-Call Support?	Primary IT/IS Team Responsible - Primary	Single Staff SME?
Technical Support	Loss of Power / Network Support	30 minutes	12 hours	Urgent	Yes	IT Networking Team	Senior Network & Information Security Administrator
Technical Support	Microsoft Teams & Channel Access (Needs approval)	1 Business Day	3 Business Days	Non-Urgent	No	BI Quality Team	
Technical Support	Network / Internet Outage	30 minutes	12 hours	Urgent	Yes	IT Networking Team	Senior Network & Information Security Administrator
Technical Support	Network Account Lockout / DUO Support	30 minutes	2 hours	Urgent	Yes	IT HelpDesk Team	
Technical Support	Network Account Not Active (Needs HR)	1 Business Day	2 Business Days	Urgent	Yes	IT HelpDesk Team	
Technical Support	Network Maintenance & Upgrade Support	5 Business Days	30 Business Days	Non-Urgent	No	IT Networking Team	Senior Network & Information Security Administrator
Technical Support	Phone System Outage	30 minutes	12 hours	Urgent	Yes	IT Systems and Desktop Support	Senior Systems & Desktop Support Administrator
Technical Support	Safe/Block Websites	1 Business Day	1 Business Day	Non-Urgent	No	IT Networking Team	Senior Network & Information Security Administrator
TeleCom Support	MXIE/Zac	30 minutes	2 hours	Urgent	Yes	IT Systems and Desktop Support	Senior Systems & Desktop Support Administrator
TeleCom Support	Zultys Desk Phone	1 Business Day	3 Business Days	Non-Urgent	Yes	IT Systems and Desktop Support	Senior Systems & Desktop Support Administrator

Exhibit A: Service Catalog & Service Level Agreements with Response & Resolution Time Expectations

Quality Systems Procedure or Plan Manual Saginaw County Community Mental Health Authority		
Subject: Agency Naming Convention Standardization	Chapter: 09 - Department Procedures	Subject No: 09.08.01.03
 Quality Assurance		
Effective Date: April 20, 2023	Date of Review/Revision: 7/30/2024, 5/29/2025, 3/16/2026	Approved By: AmyLou Douglas, Chief Information Officer, Chief Quality and Compliance Officer Authored By: Holli McGeshick Additional Reviewers: LaDonna Presley
	Supersedes: 09.03.05.03	

Purpose:

To ensure that all Saginaw County Community Mental Health Authority (SCCMHA) Sentri 2 Users are using standard naming conventions for data entry within the Sentri Electronic Health Record (EHR) and Consumer Demographics.

Policy:

This policy serves as the SCCMHA standard for consistent naming convention guidelines for all Sentri users keeping information within Sentri organized and easy to process while assisting in analyzing large volumes of data for reporting purposes and correction of errors.

Data Integrity principles are designed to support and maintain data that is:

- Accurate
- Complete
- Secure
- Consistent
- Timely

Application:

All Sentri users must be familiar with the policy and demonstrate competence in the requirements of the policy.

Standards:

All Senti users will learn the proper naming conventions and consistently apply these standards.

USPS Postal Addressing Standards are to be used for all addresses.

Consumer Demographic Data:

A. Data entry for the following fields should be consistent for every entry.

- a. First Name
 - i. Title case
 - ii. If two first names, use title case with one space between.
 - iii. Use an apostrophe when applicable (A'niilah).
 - iv. If using a hyphenated first name, separate using “-” without spaces in between (Carter-James).
 - v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
 - vi. Do not enter nickname with first name; use “Aliases” field .
- b. Middle Name
 - i. Title case
 - ii. If there are two middle names, use title case with one space between.
 - iii. Use an apostrophe when applicable (A'niilah).
 - iv. If using a hyphenated middle name, separate using “-” without spaces in between (Carter-James).
 - v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
 - vi. Do not enter nickname with first name; use “Aliases” field.
- c. Last Name
 - i. Title case
 - ii. Capitalize appropriately for letters after the initial capital letter (MacDonald, DeWitt, etc.).
 - iii. Use an apostrophe when applicable (O'Donnell).
 - iv. If using a hyphenated last name, separate using “-” without spaces in between (Smith-Jones).
- d. Suffix
 - i. Jr, Sr, I, II, III, IV (no periods)
- e. Maiden Name
 - i. See A.c.
- f. Aliases
 - i. Enter an additional name that the consumer uses.
- g. Other Identifying Information
 - i. Enter any additional information if needed. This is a free text box.
- h. SSN
 - i. Include dashes: 999-99-9999
- i. Address
 - i. No punctuation (commas, periods, number sign, or other non-alphanumeric characters).

- ii. No identifiers other than address , do not enter “n/a”, “none”, apartment number, complex name, AFC home name, notes, or an alias.
 - a. If a person served is homeless, use 500 Hancock as the address.
 - iii. Follow abbreviations for standard usage: **See Exhibit A**
 - j. Address 2 (second line in address)
 - i. See A.f.i. & A.f.iii.
 - ii. Enter “Apartment “, “Suite “, or “Building” followed by the number or name (if applicable).
 - iii. Enter “PO Box” (no periods) followed by the box number (if applicable).
 - k. City
 - i. Title Case
 - ii. No periods (i.e., St Louis)
 - iii. Use hyphens when it is part of the city name
 - l. State
 - i. Two-character standard abbreviation, capitalized
 - m. Zip
 - i. 5-digit Zip Code followed by the 4-digit extension, separated by a “-” with no spaces: 99999-9999.
 - ii. Zip Code lookup website: <https://tools.usps.com/go/ZipLookupAction!input.action>
 - iii. If no 4-digit extension populates on the Zip Code lookup website, change the house number by a few digits in the lookup to see if that generates the +4. Remember if changing, odd number must remain odd number and even number must remain an even number.
 - iv. In the event that the 4-digit extension cannot be found, use 0000. This is to be used sparingly.
 - n. Phone
 - i. (999) 123-4567 Encapsulate the area code with parenthesis followed by a space between the area code and the exchange code.
 - ii. (999) 123-4567 999 For numbers with an extension, add the extension at the end, prefaced by a space.
 - o. Alternate Phone
 - i. See A.m.
 - p. Email
 - i. someone@host.com
 - q. Date of Birth
 - i. 01/01/2001 Sentri requires this format
 - r. Consumer Mailing Address (if different from Home Address)
 - i. See A.f. - A.j., and Exhibit A
 - s. Consumer Contacts
 - i. See A.a. - A.d.
 - ii. If First Name and Middle Name are used, put both in First Name field with one space between.
 - iii. If suffix applies, put last name, followed by the suffix in the Last Name field with one space between.

- t. School: Name/Address
 - i. Name: follow official name of school as listed; use Title Case
 - ii. Address: See A.h. - A.l., and Exhibit A

Staff Demographics:

- B. Data entry for the following fields should be consistent for every entry.
 - a. Staff legal names must be entered, no aliases or nicknames may be used.
 - b. First Name
 - i. Title case
 - ii. If two first names, use title case with one space between.
 - iii. Use an apostrophe when applicable (A'niilah).
 - iv. If using a hyphenated first name, separate using “-” without spaces in between (Carter-James).
 - v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
 - vi. Do not enter nickname with first name; use “Aliases” field.
 - c. Middle Name
 - i. Title case
 - ii. If there are two middle names, use title case with one space between.
 - iii. Use an apostrophe when applicable (A'niilah).
 - iv. If using a hyphenated middle name, separate using “-” without spaces in between (Carter-James).
 - v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
 - vi. Do not enter nickname with first name; use “Aliases” field.
 - d. Last Name
 - i. Title case
 - ii. Capitalize appropriately for letters after the initial capital letter (MacDonald, DeWitt, etc.).
 - iii. Use an apostrophe when applicable (O'Donnell).
 - iv. If using a hyphenated last name, separate using “-” without spaces in between (Smith-Jones).
 - e. Suffix
 - i. Jr, Sr, I, II, III, IV (no periods)
 - f. SSN
 - i. Include dashes: 999-99-9999
 - g. Address
 - i. No punctuation (commas, periods, number sign, or other non-alphanumeric characters).
 - ii. No identifiers other than address or “homeless”, do not enter “n/a”, “none”, apartment number, complex name, notes, or an alias.
 - iii. Follow abbreviations for standard usage: **See Exhibit A**
 - h. Address 2 (second line in address)
 - i. See A.f.i. & A.f.iii.

- ii. Enter “Apartment “, “Suite “, or “Building” followed by the number or name (if applicable).
 - iii. Enter “PO Box” (no periods) followed by the box number (if applicable).
- i. City
 - i. Title Case
 - ii. No periods (i.e., St Louis)
 - iii. Use hyphens when it is part of the city name
- j. State
 - i. Two-character standard abbreviation, capitalized
- k. Zip
 - i. 5-digit Zip Code followed by the 4-digit extension, separated by a “-” with no spaces: 99999-9999.
 - ii. Zip Code lookup website: <https://tools.usps.com/go/ZipLookupAction!input.action>
 - iii. If no 4-digit extension populates on the Zip Code lookup website, change the house number by a few digits in the lookup to see if that generates the +4. Remember if changing, odd number must remain odd number and even number must remain an even number.
 - iv. In the event that the 4-digit extension cannot be found, use 0000. This is to be used sparingly.
- l. Phone
 - i. (999) 123-4567 Encapsulate the area code with parenthesis followed by a space between the area code and the exchange code.
 - ii. (999) 123-4567 999 For numbers with an extension, add the extension at the end, prefaced by a space.
- m. Alternate Phone
 - i. See A.m.
- n. Email
 - i. someone@host.com
- o. Date of Birth
 - i. 01/01/2001 Senti requires this format

Provider Address Demographics:

- a. Provider: Name/Address
 - ii. Name: follow official name of school as listed; use Title Case
 - iii. Address: See A.h. - A.l., and Exhibit A

Provider Contracts Demographics:

C. Data entry for the following fields should be consistent for every entry.

- a. First Name
 - i. Title case
 - ii. If two first names, use title case with one space between.
 - iii. Use an apostrophe when applicable (A'niilah).
 - iv. If using a hyphenated first name, separate using “-” without spaces in between (Carter-James).

- v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
 - vi. Do not enter nickname with first name; use “Aliases” field.
- b. Last Name
 - i. Title case
 - ii. Capitalize appropriately for letters after the initial capital letter (MacDonald, DeWitt, etc.).
 - iii. Use an apostrophe when applicable (O’Donnell).
 - iv. If using a hyphenated last name, separate using “-” without spaces in between (Smith-Jones).
- c. Suffix
 - i. Jr, Sr, I, II, III, IV (no periods)
- d. SSN
 - i. Include dashes: 999-99-9999
- e. Address
 - i. No punctuation (commas, periods, number sign, or other non-alphanumeric characters).
 - ii. No identifiers other than address or “homeless”, do not enter “n/a”, “none”, apartment number, complex name, notes, or an alias.
 - iii. Follow abbreviations for standard usage: **See Exhibit A**
- f. Address 2 (second line in address)
 - i. See A.f.i. & A.f.iii.
 - ii. Enter “Apartment “, “Suite “, or “Building” followed by the number or name (if applicable).
 - iii. Enter “PO Box” (no periods) followed by the box number (if applicable).
- g. City
 - i. Title Case
 - ii. No periods (i.e., St Louis)
 - iii. Use hyphens when it is part of the city name
- h. State
 - i. Two-character standard abbreviation, capitalized
- i. Zip
 - i. 5-digit Zip Code followed by the 4-digit extension, separated by a “-” with no spaces: 99999-9999.
 - ii. Zip Code lookup website: <https://tools.usps.com/go/ZipLookupAction!input.action>
 - iii. If no 4-digit extension populates on the Zip Code lookup website, change the house number by a few digits in the lookup to see if that generates the +4. Remember if changing, odd number must remain odd number and even number must remain an even number.
 - iv. In the event that the 4-digit extension cannot be found, use 0000. This is to be used sparingly.
- j. Phone
 - i. (999) 123-4567 Encapsulate the area code with parenthesis followed by a space between the area code and the exchange code.

- ii. (999) 123-4567 999 For numbers with an extension, add the extension at the end, prefaced by a space.
- k. Alternate Phone
 - i. See A.m.
- l. Email
 - i. someone@host.com

Definitions:

- A. **Data Integrity:** the overall accuracy, completeness, and consistency of data maintained by processes, rules, and standards developed by the SCCMHA Business Intelligence Data Integrity Workgroup.
- B. **Sentri EHR:** The Electronic Health Record system used by SCCMHA and their contracted provider network.
- C. **Sentri Users:** Users who access the Sentri EHR through a login and password
- D. **Naming Convention:** a convention for filling in fields to ensure consistency throughout the system to assist with keeping information organized and searchable in the Sentri 2 EHR.
- E. **Title Case:** Major words are capitalized, and most minor words are lowercase. For names, the first letter of each name is capitalized, with special exceptions given to names that contain more than one capital letter, such as McDonald, DeSoto, MacIntosh, O'Brien, etc. For these situations, follow the direction given by the responsible party.
- F. **USPS:** United States Postal Service

References:

<https://apastyle.apa.org/style-grammar-guidelines/capitalization/title-case>

Sentri -Help / Resources: Address Entry Instructions and Guideline

https://pe.usps.com/text/pub28/28apc_002.htm

https://pe.usps.com/text/pub28/28apc_003.htm

<https://pe.usps.com/text/pub28/28apf.htm>

Exhibits:

Exhibit A – Address Standardization Guide

Exhibit B – Secondary Unit Designators

Procedure:

None

Exhibit A –

Address Standardization (No Commas, No Periods)	
<i>Possible Variation</i>	<i>Standard Usage</i>
Street	St
Road	Rd
Avenue	Ave
Drive	Dr
Boulevard	Blvd
Court	Ct
P.O. Box	PO Box
Parkway	Pkwy
Suite	Ste
Place	Pl
Highway	Hwy
North	N
South	S
East	E
West	W
Center	Ctr

Exhibit B –

Secondary Unit Designators	
<i>Possible Variation</i>	<i>Standard Usage</i>
Apartment	Apt
Building	Bldg
Department	Dept
Floor	Fl
Lot	Lot
Penthouse	Ph
Room	Rm
Space	Spc
Stop	Stop
Suite	Ste
Trailer	Trlr
Unit	Unit

Tab 6

Recipient Rights, Customer Service, Appeals & Grievance

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Enrollee Rights and Accommodations	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.01.01
Effective Date: May 2002	Date of Review/Revision: 6/7/02, 6/13/10, 5/14/12, 6/3/14, 9/22/14, 5/6/16, 6/13/17, 6/10/18, 1/8/19, 2/11/20, 2/9/21, 6/7/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Service & Security
	Supersedes:	
		Authored By: Director of Customer Service, Recipient Rights, & Security Reviewed By:

Purpose:

To ensure the rights and protections of all recipients receiving community mental health services authorized and/or delivered by SCCMHA board operated or contracted providers, while accommodating access, ensuring each individual's ability for full participation, maximizing benefit from services, and adding customer value and satisfaction by recognizing and addressing differences between and uniqueness of individuals and their needs

Policy:

It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) to ensure that applicants and recipients of services, as well as the staff and provider network members, and the community and public, receive any necessary and appropriate accommodations throughout the local SCCMHA mental health system in order to provide satisfactory and effective consumer service and ensure meaningful participation for all individuals in the service area.

All SCCMHA staff and all contracted network provider staff must adhere to relevant Federal and State laws concerning enrollee rights protections. Enrollees are guaranteed the right to receive information, respect, participation in healthcare decisions, freedom from coercion or seclusion, and access to medical records. They also have the right to receive healthcare services as outlined by Federal regulations. SCCMHA ensures enrollees are free to exercise their rights without negative repercussions and mandates compliance with additional Federal and State laws to protect against discrimination and ensure accessibility. Assessment and accommodation of individual needs are prioritized to enhance system access and service quality.

Application:

This policy applies to all provider network members, including contracted, board operated and contract or direct operated affiliations that provide purchased services to persons served by SCCMHA. This policy addresses individual – person serviced or applicant and related family, advocate, and stakeholder - and community/public accommodations. This policy does not address relevant employee/staff accommodations.

Standards:

- A. Barriers to person served accommodations will be routinely identified and addressed by SCCMHA on an individual and systemic basis.
- B. Guarantee enrollee rights to be treated with respect and with due consideration for his or her dignity and privacy.
- C. SCCMHA will assure access and accommodation of persons with Limited-English proficiency (LEP).
- D. SCCMHA will assure system sensitivity and accommodation of diverse ethnic and cultural backgrounds.
- E. SCCMHA will ensure accommodation of individuals with communication impairments (including persons who do not use verbal language to communicate or who use alternative forms of communication).
- F. SCCMHA will ensure persons who are deaf, blind, or hard of hearing or have other accommodation needs are accommodated throughout the system.
- G. SCCMHA will ensure that enrollees have the right to be free from restraint or seclusion. Any use of restraint or seclusion is governed by applicable state and federal regulations and is never used as a means of coercion, discipline, convenience, or retaliation.
- H. Accommodation for staff/employees to promote their performance with job roles is the responsibility of the Human Resources Department and not covered by this policy.
- I. Accommodations for persons served will be individually addressed, and implemented in a timely manner consistent with the urgency of the individual's needs and applicable federal access standards, but collectively will reflect the cultural context and diversity of the SCCMHA geographical service delivery area and community needs.
- J. Accommodation needs shall be communicated across the care team and incorporated into care coordination and treatment planning.
- K. SCCMHA will provide materials to applicants for services in varied formats that consider the individual differences of each person's communication or access needs and in a format that is easily understood.
- L. SCCMHA will secure interpreter services or bilingual staff as needed for persons served or others.
- M. SCCMHA will routinely assess and respond to community cultural diversity needs.
- N. SCCMHA will assess the organizational and provider network system accessibility to meet person served and service applicant needs.
- O. SCCMHA will ensure staff and provider network orientation and training in all aspects of accommodations to ensure competency and full system access in the community.

- P. SCCMHA will offer electronic, telephonic, or audio communication means to meet person served and community needs where appropriate.
- Q. SCCMHA will periodically measure system sensitivity to person served accommodations and will implement any indicated improvements in a timely manner.
- R. Staff and provider performance assessment will include cultural diversity and communication/accommodation sensitivity and responsiveness.
- S. SCCMHA outreach activities will specifically include individual accommodation response whenever indicated.
- T. Intake, screening, assessment, and treatment, as well as customer service will receive specific orientation to person served accommodation, and will ensure accurate language identification, assessment and planning for each individual served.
- U. An Accommodation Plan for the SCCMHA system will be prepared by the Director of Environmental Services, Customer Service, and Security, at a minimum on an annual basis.
- V. Examples of person served accommodations include facilitating use of client communication adaptive devices or service animals, Braille and Spanish language written materials and building signage, and availability of an augmentative communication specialist.
- W. SCCMHA will review materials provided to applicants, persons served, and the community to ensure that written information is provided at appropriate reading levels for each audience.
- X. SCCMHA announces changes to the Primary Provider Network by posting notice throughout the SCCMHA Provider Network and will inform persons served and the public the updated information may be viewed by visiting the SCCMHA web site or by contacting the Customer Service Office at 1-800-258-8678. Changes will be made and kept up to date to the SCCMHA Primary Provider Contact Information document on www.sccmha.org.
- Y. For routine or planned person served and/or family contacts, interpreter services when needed are to be made available; for crisis or urgent situations, bilingual staff should be utilized if an interpreter cannot be immediately made available.
- Z. Staff of SCCMHA or a provider agency will be trained to follow proper procedures to both identify, and to respond with appropriate steps once identification is made of a non-English speaking person served or other SCCMHA customer.
- AA. Primary teams will track what language assistance options are available directly from staff members to assist persons served.
- BB. SCCMHA will ensure that all applicants and persons served shall receive written and verbal notice of their rights under the Michigan Mental Health Code, including how to access the Office of Recipient Rights and file a complaint.

Definitions of Accommodation Needs:

Limited-English Proficiency: Persons who cannot speak, write, read, or understand the English language in a manner that permits them to interact effectively with health care providers and social services agencies.

Linguistically Appropriate Services: Provided in the language best understood by the person served through bi-lingual staff and the use of qualified interpreters, including Amer-

ican Sign Language, to individuals with limited-English proficiency. These services are a core element of cultural competency and reflect an understanding, acceptance, and respect for the cultural values, beliefs, and practices of the community of individuals with limited-English proficiency. Linguistically appropriate services must be available at the point of entry into the system and throughout the course of treatment and must be available at no cost to the person served.

Cultural Competency: An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of the minority populations. The cultural competency of an organization is demonstrated by its policies and practices. PIHP (Prepaid Inpatient Health Plan) components of cultural competence include: 1) a method of community assessment; 2) sufficient policy and procedure to reflect the PIHP's value and practice expectations; 3) a method of service assessment and monitoring; and 4) ongoing training to assure that staff are aware of, and able to effectively implement policy.

Basic Reading Level: The reading level at which an individual can understand the overall meaning of what they read.

Reading Level: For marketing materials intended to be distributed through written or other media to the community that describe the availability of covered services and supports and how to access those supports and services, all such materials shall be written at or below the 6.9 grade reading level when possible.

Individual: Persons with mental illness, developmental disabilities, or substance abuse disorders (or a combination), including persons who are Medicaid-eligible, as well as other mental health and substance use disorder specialty services recipients who may be indigent, are self-pay or have private insurance coverage.

Outreach: Efforts to extend services to those persons who are under-served or hard-to-reach that often require seeking individuals in places where they are most likely to be found, including hospital emergency rooms, homeless shelters, women's shelters, senior centers, nursing homes, primary care clinics and similar locations.

Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. 42 CFR 438.2.

Provider Network: Refers to services and supports provided directly by both SCCMHA staff and individuals and private agencies operating under a professional service contract with SCCMHA.

References:

Internal - SCCMHA Customer Service Department description; SCCMHA Competency & Performance Evaluation Checklist

External - Michigan Department of Health and Human Services (MDHHS) contract, including attachment and reference documents; MDHHS Person-Centered Planning Revised Practice Guideline (most current version), Americans with Disabilities Act 1990; Title VI of Civil Rights Act 1964; Rehabilitation Act 1973

Exhibits:

None

Procedure:

Action	Responsibility
1) Approves and authorizes SCCMHA accommodation policy and plan.	1) CEO
2) Provides leadership through policies, practices, and system response to complaints/requests regarding person served and service accommodations. Prepares and oversees system accommodation improvement plans, including assuring person served input.	2) Director of Environmental Services, Customer Service, & Security
3) Reviews accommodations compliance in Office of Recipient Rights (ORR) system and provider reviews	3) Officer of Recipient Rights & Compliance
4) Ensures provider network compliance with accommodation policy requirements and system improvement plans.	4) Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services
5) Oversees accommodation for persons served and families in clinical service programs.	5) Executive Director of Clinical Services and Programs
6) Respond to individual person served accommodation needs whenever indicated.	6) SCCMHA departments/units and provider network members
7) Provide initial and routine input on accommodation policies and procedures; provide stakeholder feedback to SCCMHA on accommodation performance in the community.	7) Representative persons served/families/stakeholders

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Customer Service	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.01.02
Effective Date: August 8, 2002	Date of Review/Revision: 7/30/02, 4/21/06, 6/29/09, 5/14/12, 6/22/14, 11/27/16, 5/29/18, 3/12/19, 2/11/20, 2/9/21, 6/7/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Service, & Security Authored By: Director of Customer Service, Recipient Rights, & Security Additional Reviewers: Customer Service Supervisor
		

Purpose:

The purpose of this policy is to establish standards in assisting customers and their family members with needs that arise in dealing with mental health services, ensuring they receive timely, accurate, understandable, and culturally and linguistically appropriate services.

Policy:

The Customer Service staff shall handle customer concerns and questions in an effective, efficient, and timely manner to produce customer satisfaction. Customer concerns and questions may include, but are not limited to: Medicaid and other Insurance benefits, Community Mental Health (CMH) covered services, appeals and grievance procedures, second opinion procedures, assisting with filling out Recipient Rights complaints and forwarding the complaints to the Office of Recipient Rights, Medicaid Fair Hearing requests, etc. The SCCMHA and the Provider Network shall convey an atmosphere that is welcoming, helpful, and informative for its customers.

Application:

This policy applies to all Saginaw County Community Mental Health Authority (SCCMHA) board operated programs. The SCCMHA Provider Network is required to follow this policy or have its own policy that is submitted and approved by SCCMHA.

Standards:

- 1) All SCCMHA Board Operated Programs and Provider Network will be responsible for dealing with the customers of SCCMHA in a dignified and respectful manner.

- 2) The Customer Service Office will provide effective and appropriate assistance to staff and customers as requested or needed as evidenced by improved results of Customer Satisfaction Surveys.
- 3) Customer Service Office staff are always available during regular business hours (Mon. – Fri. 8 a.m. to 5 p.m. except for holidays and during emergency closures) to assist customers with questions or complaints.
- 4) SCCMHA shall ensure that all customers, prospective customers, family members, and community partners have continuous, 24-hour access to Crisis Intervention, Mobile Response & Stabilization Services (MRSS) and Urgent Care. Information about these services will be prominently posted on the SCCMHA website, in public areas of all service sites, and provided in written and electronic formats upon request at no charge.
- 5) Provide information about how to access benefits, including authorization requirements, for mental health, primary healthcare, substance use disorder treatment and prevention, and other community-based services as well as other units of SCCMHA.
- 6) Customers in need of special accommodations will receive any assistance they need through the Customer Service Office.
- 7) Voice mail messages will be returned within one (1) business day.
- 8) SCCMHA customers will be able to access Customer Service staff after hours by leaving a message on the Customer Service phone line of (989) 797-3452 or Toll Free 1-800-258-8678
- 9) When providing information electronically, it must be in a form that is readily accessible; it must be on the website in a location that is prominent and readily accessible; it must be in an electronic form that can be electronically retained and printed; Customer/Person Served must be informed that the information is available in paper form and printed alternative formats without charge and provided within five (5) business days upon request.
- 10) Provide information on available treatment options and alternatives. Provide information on the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure beneficiaries understand the benefits to which they are entitled and the extent to which, and how, after-hours crisis services are provided.
- 11) Provide information on Ability to Pay/Sliding Fee Scale, as appropriate, how to access the various recipient rights processes.
- 12) Upon request, assist customers with problems and inquiries regarding benefits, the local complaint and grievance processes, and local appeal and Medicaid Fair Hearing processes, including expected timelines.
- 13) The Customer Service Office shall track and report patterns of potential problem areas for the organization and ensure that material does not contain false, confusing, and/or misleading information.

Definitions:

Customer Service Office staff activity is defined by job titles: Job titles within this unit are Customer Services Specialist, Customer Service Advocate, Administrative Assistant to the Director of Environmental Services, Customer Service and Security, Supervisor of the

Customer Service Office, and the Director of the Environmental Services, Customer Service and Security.

Agency phones: The agency switchboard, Toll Free phone number, Customer Service number, Centralized Access, and Intake (CAI), and Crisis Intervention Services (CIS).

Appeals Coordinator: Responsible for educating SCCMHA staff regarding proper procedures in appeals and grievances. Also responsible for obtaining needed records, consulting with other departments, and reviewing relevant information in order to make an informed decision on appeals and grievances.

SUD Provider Network: Refers to a Substance Use Disorder Provider that is directly operated by SCCMHA or is under contract with SCCMHA to provide services and/or supports.

References:

Internal: None

External: Michigan Department of Health and Human Services (MDHHS) contract

External: Michigan Certified Community Behavioral Health Clinic (CCBHC)

Handbook Newest Version Published

Exhibits:

Exhibit A - SCCMHA Customer Service Standards

Procedure:

ACTION	RESPONSIBILITY
1) Agency phones will be answered by a live voice within three rings or 30 seconds and in a customer-friendly tone. These staff will be knowledgeable of the service array for SCCMHA and will display the ability to refer customers to the area they need to speak to in a timely manner.	1) Customer Service, CAI, and CIS staff
2) Train SCCMHA and Network Provider staff in Appeals and Grievances and assist staff to be aware of their responsibilities when involved in a Hearing.	2) Customer Service Supervisor (Appeals Coordinator)
3) Customers will receive any assistance they need to initiate the process of requesting a Medicaid Fair Hearing and local complaint processes.	3) Customer Service Supervisor (Appeals Coordinator)

4) Customers will be greeted when they approach the Customer Service Office in a warm and friendly manner.	4) Customer Service staff
5) Customers will be directed to the area they need to get to and will be provided an escort as necessary to assist them.	5) Customer Service staff
6) Customers in need of any accommodation will be able to find assistance through the Customer Service Office. This could include an interpreter, assistance with a physical disability, inability to read, etc.	6) Customer Service staff
7) Customer Service staff have access to information about the organization, including annual reports; current organizational chart; SCCMHA board member list, meeting schedule, and minutes that are available to be provided in a timely manner to the person requesting the information.	7) Customer Service staff

Exhibit A

Customer Service Standards

1	The phone will be answered by a live voice promptly (within three rings).
2	Their calls will be answered in a courteous manner (with a smile).
3	There will always be telephone coverage during business hours.
4	All incoming phone calls coming from external sources will be answered with a consistent greeting such as "Saginaw Community Mental Health."
5	When customers call requesting a specific department or staff member, Customer Service staff will complete a warm transfer by first confirming the appropriate contact point, speaking with the receiving staff or department when possible, and then connecting the caller directly. Direct extensions will only be provided if the staff member has given prior permission for their extension to be shared.
6	In the event a caller is requesting a number outside of SCCMHA. The Customer Service Specialist answering the call will make a reasonable effort to provide the number for them.
7	When multiple calls are received, calls will be answered in order; callers will be asked if their call may be put on hold; the first caller will be returned to first; and the employee will continue to answer the lines in the order of the calls received.
8	When a person is at the window, a timely and courteous acknowledgement, such as eye contact or a positive indication that the CS specialist knows they are there, will be made.
9	If there is a person at a counter and the phone rings, the employee will acknowledge the customer at the counter, answer the telephone, tell the caller that a customer is waiting, and give the caller the option of being put on hold or having their call returned.
10	The outgoing voicemail message will be kept current, and the voicemail message at the main switchboard will be changed on days SCCMHA is closed for a holiday.
11	The voicemail message gives an optional phone number to call in the event of a crisis.
12	Any messages left on the general SCCMHA voicemail system will receive acknowledgements of their voicemail messages within 1 business day.
13	The Customer Service Specialists will assist with support for all departments within SCCMHA and attend to their requests within 1 business day whenever possible.
14	SCCMHA customers will be able to access Customer Service staff after hours by leaving a message on the Customer Service phone line of (989) 797-3452 or Toll Free 1-800-258-8678 or by making arrangements for an afterhours appointment. Messages will be returned within one (1) business day.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Person Served Involvement and Leadership Opportunities	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.01.03
Effective Date: August 8, 2002	Date of Review/Revision: 7/30/02, 7/21/09, 6/17/12, 6/22/14, 5/28/18, 6/11/18, 3/12/19, 2/11/20, 2/9/21, 6/8/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Service and Security
	Supersedes: Previously Named: Consumer Involvement and Leadership Opportunities	
		Authored By: Director of Customer Service, Recipient Rights, & Security Additional Reviewers: Consumer Leadership Group, Administrative Assistant to the Director of Environmental Services, Customer Service and Security

Purpose:

The purpose of this policy is structured to empower meaningful participation of persons served by fostering leadership skills and providing opportunities to provide input on agency functions, including service quality. SCCMHA enhances and refines person-centered care by incorporating the diverse perspectives, abilities, and potential of persons served through the Consumer Leadership Group.

Policy:

It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) to include persons served of this agency in areas that affect services. The input sought from the persons served will be obtained through involvement with committee membership, customer satisfaction surveys, orientation to SCCMHA services, Evidence Based Practices, the Request for Proposal process, implementation as well as through regular invitations to attend board meetings a opportunities to speak directly to the board.

The involvement of persons served in SCCMHA is promoted wherever and whenever possible. The development of leadership skills for persons served as well as improving services

provided by SCCMHA are the primary building blocks for including persons served in our work.

Application:

This policy applies to all persons served, previous persons served, guardians, advocates, and families of SCCMHA persons served and is applicable to the provider network as appropriate.

Standards:

The SCCMHA Centralized Access and Intake (CAI) are responsible for informing new persons served of all necessary information by meeting with them and providing a copy of the SCCMHA Service Orientation folder.

- 1) Persons served will be given the opportunity to be involved in the Consumer Leadership Group. Membership of the Consumer Leadership Group will be offered to any interested persons served but will be limited to 20 members.
- 2) Participation in the Consumer Leadership Group (CLG) will include development of an Individual Plan of Leadership (IPOL) for each member. The IPOL serves as the CLG's method of providing leadership training, allowing each participant to identify personal leadership goals and objectives for a two-year period that reflect how they view leadership and their growth in leadership skills. CLG facilitators will review the IPOL periodically to provide guidance, support progress, and ensure ongoing leadership development.
- 3) Persons served and their family members, guardians, and advocates participating in SCCMHA committees will complete a Stipend Request form for each meeting they attend. There are some committees where a stipend is not paid.
- 4) Participation in most committees will be compensated by payment of a stipend as outlined in the Stipend Request Form.
- 5) The form (Stipend Request Form) will be signed and forwarded on through the routing process for signatures.
- 6) Persons served will be given information about opportunities to serve as members of committees and encouraged to be involved in committees and other areas of the agency.
- 7) The SCCMHA Provider Network will offer opportunities of person served leadership within their services.
- 8) Election of Officers within the Consumer Leadership Group will be completed every other year:
 - a) Chair
 - b) Vice-Chair
 - c) Secretary
 - d) Treasurer
- 9) Officers will not serve more than two consecutive two-year terms in the same position
- 10) Feedback, recommendations, and input received from the CLG will be formally reviewed on a monthly basis by the Quality Governance Council. The Council will document discussions, actions taken, and follow-up plans to ensure that the per-

spectives of persons served are considered in agency governance, service development, and quality improvement activities.

Definitions:

Consumer Leadership Group: A committee of persons served, previous persons served, guardians, advocates, and families that provides diverse perspectives and input on agency functions and support leadership development.

Quality Governance Council: A leadership body within SCCMHA responsible for reviewing quality improvement initiatives and monitoring agency performance.

References:

None

Exhibits:

Exhibit A: Stipend Request Form

Procedure:

None

Exhibit A



STIPEND REQUEST FORM

NAME: _____

PHONE: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

MEETING DATE(S):

_____ Consumer Leadership Group
_____ Self Determination
_____ Person Centered Planning
_____ Citizen's Advisory Council (CAC)
_____ Recipient Rights Committee
_____ Learning Links Committee
_____ RFP Review Committee: _____
_____ Other: _____

- ☐ I decline to accept the Stipend payment and am volunteering my time to SCCMHA
☐ I accept the Stipend payment and choose to donate the payment to: _____

_____ Total Meetings/Participation Attended
_____ Meeting Stipend Payment: **See Payment Guideline on bottom*
_____ Other Payment (Describe): _____
_____ TOTAL PAYMENT

CEO SIGNATURE

PERSON SERVED SIGNATURE

STAFF LIAISON

*Payment Guideline		
1 – 3 hours = \$30.00	3 – 6 hours = \$40.00	6 hours/over = \$60.00

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Input from Persons Served	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.01.04
Effective Date: August 8, 2002	Date of Review/Revision: 7/30/02, 6/29/09, 6/17/12, 6/22/14, 1/27/16, 5/29/18, 3/12/19, 2/11/20, 2/9/21, 6/8/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Services, & Security Authored By: Director of Customer Services, Recipient Rights, & Security Additional Reviewers: Customer Service Supervisor, Administrative Assistant to the Director of Environmental Services, Customer Service and Security
	Supersedes:	
		

Purpose:

To establish mechanisms to ensure that the Saginaw County Community Mental Health Authority (SCCMHA) has systems in place that solicit person served input for utilization in program decision making, evaluation, and development.

Policy:

It is the policy of SCCMHA to create and maintain systems to obtain information and feedback from persons served, on an ongoing basis, regarding the quality of services provided.

Application:

This policy applies to all 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.

Standards:

- 1) SCCMHA will regularly seek input from persons served regarding the quality of services provided.
- 2) Input regarding the quality of services provided by SCCMHA obtained from persons served and stakeholders will be formally reviewed on a monthly basis by the

Quality Governance Council and have an impact on the decisions made regarding improvement in the quality of services.

- 3) Persons served and stakeholders will voice their sense of empowerment as a result of increased input through written and electronic Suggestion Box Forms, input on committees, and through Satisfaction Surveys.
- 4) Suggestions are welcomed by having a Suggestion Box available at every SCCMHA service site.

Definitions:

Service sites: Any SCCMHA building designed or used to provide services to persons served found eligible for service and those applicants requesting services from SCCMHA.

Quality Governance Council: A leadership body within SCCMHA responsible for reviewing quality improvement initiatives and monitoring agency performance.

References:

Person Served Involvement and Leadership Policy 02.01.03.00

Quality Assessment and Performance improvement Program for SCCMHA 04.01.01.00

Exhibits:

Exhibit A: Suggestion Box Form

Exhibit B: Suggestion Box Location

Exhibit C: Suggestion Box Sign with QR to Electronic Form

Procedure:

ACTION	RESPONSIBILITY
1) Person Served Satisfaction questionnaires will be mailed out on an ongoing basis to give persons served and stakeholders the opportunity to give input on their view of services provided by SCCMHA.	1) Chief Information Officer & Chief Quality & Compliance Officer
2) The Customer Satisfaction Surveys will be developed through a collaborative effort that includes the Citizen's Advisory Committee (CAC). The surveys will have input from persons served and stakeholders as that is part of the membership of the CAC.	2) Chief Information Officer & Chief Quality & Compliance Officer
3) In between the ongoing surveys, persons served and stakeholders will be given the opportunity to give their input on a regular basis in two ways. The input gathered will be obtained through: The Suggestion Box forms available at every	3) Coordinated between the Director of Environmental Services, Customer Services, & Security, Chief Information Officer & Chief Quality & Compliance Officer, and the Executive Director of Clinical Services and Programs

SCCMHA service site and through the Consumer Leadership Group

4) Persons served will also be invited to participate in short-term work groups.	4) Chief Information Officer & Chief Quality & Compliance Officer, Executive Director of Clinical Services and Programs, and Director of Network Services, Public Policy, & Continuing Education

Exhibit A

Your comments are welcome!

Please use the back of this form if you need more space.



Process Improvement Suggestion

What do we do well? Was there anything about your visit that you did not like? What do we need to do, or where do we need to make improvements?

(OPTIONAL)

Write your name and telephone number below if you would like us to get in touch with you.

Name: _____ Phone: _____

We empty these boxes monthly, so if you need immediate assistance, feel free to call our Customer Services at (989) 797-3452, or the CEO at (989) 797-3501.

Exhibit B

Suggestion Box Locations



Exhibit C

We're here for you! Let us know how we can help!



SCCMHA is here for you!

We want to make sure you get the best care possible!

Please share your questions, concerns and comments with us!

Scan the QR code below to complete a survey to inform us of what we can do to help!



SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Service Orientation	Chapter: 02 - Customer Service & Recipient Rights	Subject No: 02.01.05
Effective Date: 6/7/04	Date of Review/Revision: 4/13/04, 2/9/09, 6/29/09, 7/20/12, 6/22/14, 9/22/14, 12/18/16, 5/29/18, 3/12/19, 2/11/20, 2/9/21, 6/8/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Service and Security Authored By: Director of Customer Services, Recipient Rights, & Security Additional Reviewers: Customer Service Supervisor
	Supersedes: Previously Named: Consumer Orientation	
		

Purpose:

The purpose of this policy is to establish and set forth guidelines to ensure that new persons served receiving services from Saginaw County Community Mental Health Authority (SCCMHA) or the SCCMHA Provider Network are educated regarding available services, as well as dispute resolution and assistance with issues related to services. This will take place when they meet with Centralized Access and Intake (CAI) to establish an introduction to services. The Primary Support Staff with the assigned provider will complete a second orientation specific to the services provided and their location.

Policy:

It is the policy of SCCMHA to provide orientation to new persons served of SCCMHA and the SCCMHA Provider Network. Information regarding services and general information will also be given to persons served on an annual basis.

Application:

This policy applies to new and current persons served of SCCMHA and the SCCMHA Provider Network.

Standards:

- 1) CAI staff will review SCCMHA materials with new and current persons served contained in the Orientation Folder upon their initial meeting.

- 2) Primary Support Staff or their supervisors of the assigned provider will provide a second orientation for their location for initial services.
- 3) Primary Support Staff will provide information to persons served on an annual basis. Items such as the Recipient Rights booklet and the SCCMHA Customer Service Handbook are given annually, usually during the Person-Centered Planning (PCP) process. A full list of items to be given to persons served annually is listed in Standard # 5.
- 4) Initial Orientation Folders are regularly prepared by Customer Service staff and distributed to CAI and the Provider Network upon request. These folders contain the:
 - a) Welcome to Services! Sheet
 - b) Your Rights Booklet
 - c) Customer Service Handbook
 - d) Notice of Privacy Practices Packet
 - e) Notice of Privacy Practices Acknowledgement
 - f) SCCMHA Primary Provider Contact Information Sheet
 - g) MDHHS-CONSENT 5515 document
 - h) Advance Directive Acknowledgment Sheet
 - i) Advance Directive Brochure
 - j) An Overview of Evidence Based Practices Flyer
 - k) Self Determination (SD) Brochure
 - l) Appeals and Grievances Brochure
 - m) Person Centered Planning Process Checklist
 - n) Customer Services Complaint Form
 - o) A Resource Guide for Families Dealing with Mental Illness Booklet
 - p) SCCMHA SOGI Flyer
 - q) No Wrong Door Flyer
 - r) CEHR Brochure
 - s) PCP Brochure
 - t) Behavioral Health Mediation Services Program Flyer (2-Sided)
 - u) SCCMHA Our Services Information Sheet (2-Sided)
 - v) The Arc of Bay County Information Sheet
 - w) Consent to Share Behavioral Health Information Form
 - x) Individual Placement & Support (IPS) Supported Employment
 - y) Veteran and Military Family Navigator Program Brochure
 - z) Ability to Pay/Sliding Fee Scale Application Packet
 - aa) MRSS Flyer
- 5) Annual Orientation Folders are regularly prepared by Customer Service Staff and distributed to Primary Support Staff and the Provider Network upon request. These folders contain:
 - a) Crisis Planning for Psychiatric and Medical Hospitalizations
 - b) Advance Directive Acknowledgement Form
 - c) SCCMHA Fact Page (Advance Directive)

- d) SCCMHA Primary Provider Contact Information Sheet
 - e) Self Determination Information Brochure
 - f) Person Centered Planning Brochure
 - g) Appeals & Grievance Brochure
 - h) Your Rights Booklet
 - i) Customer Service Handbook
 - j) Notice of Privacy Practices Acknowledgement
- 6) Interpretation services and translated orientation materials will be made available to anyone needing assistance with understanding information or services provided to them at no cost.
 - 7) SCCMHA Staff working in the Customer Service Office will be available for questions of persons served and other visitors to SCCMHA buildings.
 - 8) SCCMHA Staff working in the Recipient Rights Office will be available for questions of persons served and other visitors to SCCMHA buildings.

Definitions:

Current Persons Served: A person receiving services through SCCMHA or the SCCMHA Provider Network on an ongoing basis.

New Persons Served: Defined as a person applying for and receiving services from SCCMHA or the SCCMHA Provider Network. This can be a person receiving services for the first time, or someone returning to services after being discharged.

Natural Supports: A person or person supporting a person served that is not paid for their support to the person served.

Primary Support Staff: The Case Manager, Support Coordinator, or Primary Therapist assigned to a person served.

References:

National Committee for Quality Assurance (NCQA) Managed Behavioral Healthcare Organizations Standards & Guidelines RR1: Statement of Members' Rights and Responsibilities

Exhibits:

None

Procedure:

None

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Service Accessibility for Persons Served	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.01.06
Effective Date: August 8, 2002	Date of Review/Revision: 7/30/02, 8/10/09, 5/14/12, 6/22/14, 8/12/16, 5/29/18, 3/12/19, 2/11/20, 2/9/21, 6/8/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Services, & Security
	Supersedes: Previously named: Service Accessibility for Consumers	
		Authored By: Director of Customer Services, Recipient Rights, & Security Additional Reviewers: Customer Service Supervisor

Purpose:

The purpose of this policy is to maximize both actual (physical) and perceived accessibility of the Saginaw County Community Mental Health Authority (SCCMHA) services for all persons served and applicants for service; and to create a work environment in which employees are sensitive to the needs of persons served with physical, developmental, and psychiatric disabilities. To accommodate access and assure each individual's full participation and receipt of maximum benefit from services being offered. To add customer value and satisfaction to services being offered by recognizing and addressing differences between individuals.

Policy:

It is the policy of SCCMHA to ensure that applicants and recipients of services, as well as the staff and provider network members, and the community and public, receive any necessary and appropriate accommodations throughout the SCCMHA system to provide satisfactory and effective service and ensure meaningful participation for all individuals in the service area. Assessment of accommodation needs shall commence and be documented upon initial contact with the SCCMHA system and shall be reviewed and updated as needed throughout service delivery to ensure continued meaningful access. SCCMHA recognizes that individual differences can directly impair system access, receipt of services and the quality, effectiveness, and satisfaction with the SCCMHA service delivery.

Application:

This policy applies to all SCCMHA provider network members, including contracted, board operated and contract or direct operated affiliations that provide purchased services to persons served by SCCMHA. This policy addresses individual person served or applicant and related family, advocate and stakeholder and community/public accommodations.

Standards:

- a) SCCMHA service site buildings will be assessed to determine accessibility to services for persons served with disabilities on an individual and systemic basis.
- b) SCCMHA will assure access and accommodation of persons with Limited English Proficiency (LEP). This includes the provision of auxiliary aids and services such as interpreters and translated materials, as needed.
- c) SCCMHA will assure persons with visual, hearing, or other physical and mobility challenges are accommodated throughout the system.
- d) Persons served will be able to receive the services designated as necessary and appropriate through the Person-Centered Planning process without worry about accessibility to those services.
- e) Accommodations for persons served will be individually addressed, but collectively will reflect the cultural context and diversity of the SCCMHA geographical service delivery area and community needs.
- f) The Customer Services Office will assist persons served with meeting initial accommodation needs they have, which prevents them from receiving necessary and appropriate services.
- g) Materials intended for distribution to persons served, their guardians, and families will be written at a 6.9 grade level, to the best ability of SCCMHA. This takes into consideration some state and federal guidelines required to be in writing may not be written at this level.
- h) When possible, all persons served are seen face to face by a Psychiatrist, Physician Assistant, or Nurse Practitioner. In areas where there is a shortage of Psychiatry, Tele-Psychiatry may be used.
- i) When Tele-Psychiatry is used the RN or a Care Coordinator assigned to the clinic will confirm prior to the start of each session that all necessary technology and/or equipment:
 - 1) Is available at:
 - o the originating site and
 - o the remote site
 - 2) Functions properly at:
 - o the originating site and
 - o the remote site

Definitions:

- **Accessibility:** Defined by the ease of which someone with a disability would be able to reach their intended destination.
- **Limited English Proficiency (LEP):** A person with Limited English Proficiency or “LEP” is not able to speak, read or understand the English language well enough to allow them to interact effectively with health and social service or other providers.
- **Necessary and appropriate services:** Those services found necessary and appropriate for the person served to meet the goals, dreams, or desires identified through their Person-Centered Planning meeting.
- **Service sites:** Any building designed or used to provide services to persons served found eligible for service and those applicants requesting services from SCCMHA.

References:

None

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Site assessments for all SCCMHA service sites will be completed to determine accessibility to service sites for persons served with disabilities.	1) Occupational Therapist
2) Recommendations from the completed assessments of SCCMHA service sites will be given to the Director of Environmental Services, Customer Service and Security.	2) Occupational Therapist
3) Persons served will receive the services needed for them to achieve their goals, dreams, and desires as expressed through the Person-Centered Planning process.	3) Case Manager, Supports Coordinator, or Primary Therapist
4) Persons served in need of accommodations will have a central location to receive assistance with finding needed resources.	4) Customer Service Office
5) Awareness and training for SCCMHA staff will be provided so that the assigned staff	5) Director of Network Services, Public Policy, & Continuing Education,

person will be able to evaluate and accommodate the needs of persons served.

OBRA/PASARR and Enhanced Health Services, and Director of Environmental Services, Customer Services, & Security.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Telephone Access Services	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.01.08
Effective Date: August 8, 2002	Date of Review/Revision: 7/30/02, 6/29/09, 6/17/12, 6/22/14, 12/8/16, 5/29/18, 3/12/19, 2/11/20, 2/9/21, 6/10/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Services, & Security Authored By: Director of Customer Services, Recipient Rights, & Security Additional Reviewers:
	Supersedes:	
		

Purpose:

The purpose of this policy is to create and maintain a system that enables persons served, private citizens, and stakeholders to contact Saginaw County Community Mental Health Authority (SCCMHA) for assistance in a manner that does not limit their ability to speak with the SCCMHA staff that they request. It is also important to maintain a system that offers individuals with limited resources a means in which to contact SCCMHA without incurring any expense for such contact.

Policy:

It is the policy of SCCMHA to make telephone access for mental health services available at no cost to citizens who require services or assistance and who lack resources to pay for such calls.

Application:

This policy applies to all board operated programs. The SCCMHA Provider Network is required to follow this policy or have their own policy that is submitted and approved by SCCMHA.

Standards:

- 1) Persons served, private citizens, and stakeholders will be able to contact SCCMHA without incurring a cost when completing the call.
- 2) Persons served who are deaf or hard of hearing, private citizens and stakeholders will be able to contact SCCMHA by using the Michigan Relay Service (711), without incurring any cost for the call. SCCMHA will ensure telephone systems are

accessible to persons with disabilities, including TTY/TDD and other alternative communication methods, in accordance with federal and state accessibility requirements.

- 3) SCCMHA will offer a main toll-free number for anyone to call for any reason.
- 4) SCCMHA will offer a crisis toll free number for anyone experiencing a mental health emergency.
- 5) Toll free numbers will be published in regularly viewed documents within the Saginaw community, on magnets, and published on Customer Service Handbooks produced by SCCMHA.
- 6) Persons served and stakeholders will have access to interpreter services for limited English proficiency at no cost.
- 7) SCCMHA will provide 24-hour toll-free access to crisis services, including Mobile Response and Stabilization Services (MRSS), Crisis Intervention Services and Urgent Care.

Definitions:

Michigan Relay Service: A communications system that allows hearing persons and persons who are deaf, hard of hearing, or speech-impaired to communicate by telephone.

“Toll free”: A special telephone number that is free for the person calling, the cost of the call is charged to the called party.

References:

None

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) SCCMHA will maintain a toll-free number to be available for persons served, private citizens, and stakeholders, which will ensure they incur no cost while contacting SCCMHA. This number will be published in regularly viewed documents within the Saginaw community, on magnets, and published in Customer Service Handbooks produced by SCCMHA, and on the SCCMHA web site. The Handbook and the magnets will be made readily available for persons served, private citizens, and stakeholders.	1) Director of Environmental Services, Customer Services, & Security

2) SCCMHA will maintain a toll-free number for crisis calls so that persons served, private citizens, and stakeholders will incur no cost when calling the Crisis Intervention Services (CIS) of SCCMHA in a mental health emergency. This number will be published in the same areas as the agency's toll free number.	2) Customer Service
3) The toll-free number used by persons served, private citizens, and stakeholders will be available for persons who are deaf or hard of hearing by using the Michigan Relay Service. The Michigan Relay Service contact information will be published in the SCCMHA Customer Service Handbook (711). People who are deaf or hard of hearing can access this service to communicate with staff at SCCMHA.	3) Customer Service
4) SCCMHA can use the Michigan Relay Service for anyone calling SCCMHA phone numbers who is deaf or hard of hearing.	4) All SCCMHA staff
5) The SCCMHA main switchboard will be staffed during regular business hours. The staff responsible for answering the phone will answer the phone in a friendly, cordial manner and will politely transfer calls to the appropriate location.	5) Customer Service
6) SCCMHA maintains 24-hour crisis telephone access through Mobile Response and Stabilization Services and Crisis Intervention Services, including toll-free crisis numbers. Crisis contact information is published on the SCCMHA website and in agency materials.	6) Director of Environmental Services, Customer Service, and Security

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Person Served and Family Education Materials and Activities	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.01.09
Effective Date: August 8, 2002	Date of Review/Revision: 7/30/02, 6/29/09, 6/17/12, 6/22/14, 12/8/16, 5/29/18, 3/12/19, 3/9/20 4/22/20, 2/9/21, 6/10/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Services, & Security
	Supersedes: Consumer and Family Education Materials and Activities	
		Authored By: Director of Customer Services, Recipient Rights, & Security Additional Reviewers:

Purpose:

The purpose of this policy is to ensure that person served education material regarding services and eligibility is updated as new programs or services are created. Educational materials about mental health intellectual and developmental disability and substance use disorder conditions will be available and Saginaw County Community Mental Health Authority (SCCMHA) will keep accurate and complete information available to persons served, private citizens, and stakeholders.

Policy:

It is the policy of SCCMHA to maintain up to date, accurate information on the services provided to persons served and to the public. SCCMHA is dedicated to keeping the local community informed regarding mental health information and the services provided to this community. MSHN shall create, publish, and maintain a Customer Handbook/Guide to Services for distribution to persons served, their families, and any other interested persons and audiences.

Application:

This policy applies to all 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.

Standards:

- 1) Up-to-date brochures regarding services will be kept in the main lobbies of the 500 Hancock, 1040 Towerline, and the 3875 Bay Road facilities.

- 2) Educational material regarding mental health will be located in the main lobby or will be available upon request at the SCCMHA 500 Hancock, 1040 Towerline, and the 3875 Bay Road facilities for anyone that is interested. Additional copies of material specific to the populations served by SCCMHA service departments will be available in the waiting rooms.
- 3) Persons served and their family members will be able to participate in regular, ongoing training opportunities offered by SCCMHA, such as Person-Centered Planning, Self Determination, Natural Supports, and others as they become available. These training opportunities are available through the Learning Links programs once a month.
- 4) Ensure that all customers that are served by SCCMHA and the Provider Network are provided a Regional Customer Handbook/Guide to Services that includes federal, and state of Michigan information required for mental health and substance use disorder services.
- 5) If/when MDHHS contractual requirement updates are made to the Customer Handbook, the SCCMHA and the SCCMHA Provider Network shall provide supplemental materials (inserts, stickers, addendum, or companion guide) to customers receiving services to reflect the changes. To the extent possible, customers will be provided at least 30 days' notice before the intended effective date of any change that the State defines as significant in the information specified in 42 CFR 438.10(g)(2).
- 6) Although the Customer Handbook is standardized to include the MDHHS and MSHN required content, SCCMHA may tailor approved portions of the Customer Handbook to include local content.

Definitions:

Customer: Refers to individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of this policy, these terms are used interchangeably.

Customer Handbook: The handbook is a required set of information that must be provided to Medicaid beneficiaries at the start of treatment and at least annually.

MDHHS: Michigan Department of Health and Human Services

MSHN: Mid-State Health Network

Provider Network: Refers to a Provider that is directly under contract with SCCMHA to provide services and/or supports.

References:

42 CFR 438.10 Information requirements

State of Michigan/PIHP Contract: Schedule A: Statement of Work, Section 1. General Requirements, B. Customer Services Standards, 4. Customer Services Handbook Requirements

Michigan Certified Community Behavioral Health Clinic (CCBHC) Handbook or most current published version Section 2.C.6

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Educational material relating to mental health will be available to persons served and visitors at the SCCMHA 500 Hancock, 1040 Towerline, and 3875 Bay Road facilities. This material will be reevaluated on an annual basis to ensure that the educational material being given out to persons served, private citizens, and stakeholders is relevant and up to date.	1) Customer Service Office
2) SCCMHA information and brochures relating to services and eligibility of SCCMHA will be available to persons served and visitors at the SCCMHA 500 Hancock, 1040 Towerline, and 3875 Bay Road facilities. The material will be reevaluated on an ongoing basis.	2) Customer Service Office

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Medicaid Appeals	Chapter: 02 - Customer Service & Recipient Rights	Subject No: 02.01.11
Effective Date: October 1, 1998	Date of Review/Revision: 12/30/03, 4/18/06, 12/12/06, 8/10/09, 5/14/12, 6/22/14, 11/10/14, 12/8/16, 6/6/18, 2/11/20, 4/20/21, 6/10/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Services, & Security
	Supersedes: 06.02.02.00	
		Authored By: Director of Customer Services, Recipient Rights, & Security Additional Reviewers: Appeals Coordinator

Purpose:

The purpose of this policy is to establish guidelines for a uniform process for Medicaid recipients receiving mental health services from Saginaw County Community Mental Health Authority (SCCMHA).

Policy:

It is the policy of SCCMHA that all persons served have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by SCCMHA and the provider network. This policy is written specifically for Medicaid recipients receiving services from SCCMHA.

Application:

This policy applies to all Medicaid recipients of SCCMHA including the Provider Network.

Standards:

- 1) Adverse Benefit Determination Notice is not required under the following circumstances:
 - a) Confirmation of the death of a person served;
 - b) Written confirmation from the person served indicating they no longer wish to receive services.
 - c) The person served has been admitted to an institution where they are ineligible under Medicaid for further services.

- d) The persons served whereabouts are unknown and the post office has returned agency mail directed to them.
 - e) The agency establishes the fact that the person served has been accepted for Medicaid services by another entity.
 - f) A change in the level of medical care is prescribed by the persons served physician.
 - g) If the scheduled action will occur in less than 10 days.
- 2) An applicant for, or a person served of, public mental health or substance use disorder may access several options simultaneously to pursue the resolution of complaints.
- 3) During the initial contact with SCCMHA, the applicant will be notified of their rights, the grievance and appeals process, and the right to access the appropriate process. (The Recipient Rights process is not available to an applicant for initial services unless they are denied their request to a second opinion.)
- 4) If an individual requests inpatient treatment, or a specific mental health or substance use disorder support or service for which appropriate alternatives for the individual exist that are of equal or greater effectiveness and equal or lower cost, the clinician will:
 - a) Identify and discuss the underlying reasons for request/preference;
 - b) Identify and discuss alternatives with the person served; and
 - c) Negotiate toward a mutually acceptable support, service and/or treatment
- 5) If a person served is not satisfied with their Individual Plan of Service, the Michigan Mental Health Code allows the individual to make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days.
- 6) Medicaid persons served will be notified of their right to request an Administrative Hearing through the receipt of an Adverse Benefit Determination Notice when an action by SCCMHA calls for such a notice. A copy of the Adverse Benefit Determination Notice will be kept in the persons served records.
- 7) Medicaid persons served may simultaneously request a Local Appeal (addressed in the Local Appeal Policy) and file a complaint with the Recipient Rights Office (if the person served is a current SCCMHA person served, or has been denied their right to a second opinion for initial services or hospitalization.).
- 8) Expedited (Quickened) Appeals must be conducted in 72 hours. If a quickened review is denied, oral notice of the denial must be given and followed up by a written notice within two calendar days. This is the responsibility of the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Medicaid Fair Hearing.

- 9) Persons served who wish to file a complaint may do so independently or with the assistance of Customer Service or Support Staff.
- 10) Providers in the SCCMHA Provider Network will assist a person served who needs help in creating a complaint or appeal and submitting that complaint or appeal for resolution or will direct persons served to the SCCMHA Customer Service Office to assist them.
- 11) Medicaid persons served receiving non-Medicaid services are required to exhaust the Local Appeal process before they can access the Michigan Department of Health and Human Services (MDHHS) Alternative Dispute Resolution process.
- 12) If a person served involved in this process has Limited English Proficiency (LEP), SCCMHA and its Provider Network will take necessary and reasonable steps to accommodate this need. This includes obtaining an interpreter that can assist the person served understand the process and assist in completing complaints or appeals. The Network Provider may contact Customer Service to arrange an interpreter.
- 13) The Fair Hearing Officer will track information relating to the Appeals process for the purpose of reporting to the SCCMHA Quality Governance Committee. Upon request, this information will also be reported to MDHHS and the contracted External Quality Review Organization.
- 14) The Fair Hearing Officer will inform the Executive Director of Clinical Services and Programs or the Chief Information Officer/Chief Quality and Compliance Officer or both, as appropriate, of a Medicaid Fair Hearing.
- 15) Customer Service staff, Appeals Coordinator, Fair Hearing Officer, and the Office of Recipient Rights coordinates as necessary to provide the best resolution for the person served filing the Medicaid Appeal.
- 16) For persons served who receive services through the Wraparound Program, given the intensity and frequency of the review of services, the following variation for the providing of notices shall occur:
 - a) At the initial **Child & Family Team Meeting (CFT)** where the **Plan of Care (POC)** is developed, at least annually thereafter, the Adverse Benefit Determination Notice will be provided along with obtaining signatures on the Signature Page. Only the Signature Page will be copied into Senti.
 - b) Since most of the contact with the family is a subsequent CFT, because the POC is reviewed and tweaked as needed, if there is a denial/reduction/termination of a service, then Adverse Benefit Determination Notice will be offered. This will be documented in the Progress Note regarding the CFT. If there is no change in service, but a change in a goal or objective, then an Adequate Notice or Adverse Benefit Determination Notice is not required.

- c) If there is a denial/reduction/elimination of a service (or services) outside the CFT, for example, termination from program, the Adverse Benefit Determination Notice will be given. The Adverse Benefit Determination Notice will be copied into Sentri.

Definitions:

Action:

- Denial, reduction, suspension, or termination of mental health or substance abuse service(s).
- Denial or limited authorization of a requested service, including the type or level of service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within 3 working days from the date of receipt of a request for an expedited service authorization.
- Failure to provide services within 14 calendar days of the start date agreed upon during the Person Centered Plan and as authorized by the PIHP (SCCMHA).
- Failure of SCCMHA to act within 30 calendar days from the date of a request for a standard appeal.
- Failure of SCCMHA to act within 72 hours from the date of a request for an expedited appeal.
- SCCMHA fails to provide notice of disposition of a local grievance within 90 calendar days of the date of the request.

Adverse Benefit Determination Notice: A written notice mailed or directly provided to a Medicaid person served or his/her guardian or legal representative no later than the date of action each time service is denied, during the development or change of the Person Centered Plan, or when a Grievance or Local Appeal is not completed within the appropriate time frame.

Medicaid Fair Hearing: An evidentiary hearing for a Medicaid person served conducted by an Administrative Law Judge with the MOAHR regarding an action, as defined above, regarding a Medicaid covered service, by SCCMHA or one of its Service Providers.

Administrative Hearing Team: The Chief Information Officer/Chief Quality and Compliance Officer, Executive Director of Clinical Services and Programs, Director of Network Services, Public Policy, & Continuing Education, and the Fair Hearing Officer.

Advance Notice: A written notice mailed or directly provided to a Medicaid person served or his/her guardian or legal representative at least 10 calendar days before the date of an action involving a termination, suspension or reduction in a Medicaid covered service.

Appeals Coordinator: Staff assigned to coordinate all grievances and local appeals (currently the Customer Service Supervisor).

Applicant: An individual, or their guardian, who makes a request for entrance into services with SCCMHA or one of their Service Providers.

Expedited (Quickened) Review: The review of a Medicaid or non-Medicaid persons served appeal in three or less business days when following the time necessary for the normal appeal review process could seriously jeopardize the persons served life or health or ability to attain, maintain, or regain maximum function.

Fair Hearing Officer: Staff person assigned to conduct the Administrative Fair Hearing, representing SCCMHA or the Service Provider (currently the Chief Information Officer/Chief Quality and Compliance Officer).

Intake Evaluation Specialist: Master's level clinician designated to assess/evaluate applicants for public mental health services.

Mediation: A private informal dispute resolution process in which an impartial, neutral person, in a confidential setting, assists parties in reaching their own settlement of issues in a dispute. A mediator does not have authoritative, decision-making power but relies on persuasion and reason to solve problems.

Notice: A written announcement given to a non-Medicaid person served or a Medicaid persons served when related to a Medicaid covered service when the service is terminated, suspended, or reduced.

Second Opinion: The process by which the decision made by the Clinician evaluating an applicant for services is reviewed to determine public funding eligibility for an applicant of a requested service(s). A second opinion may be requested at the time of a denial to enter the SCCMHA system or when admission for inpatient psychiatric services has been denied.

sentri II: The SCCMHA electronic clinical record, maintained by the SCCMHA Information Systems Unit.

Support Staff: Support Coordinator, Case Manager, or Primary Therapist from a SCCMHA Board Operated program or from the SCCMHA Provider Network.

Utilization Review: A process in which established criteria are used to recommend or evaluate services provided in terms of cost-effectiveness, necessity, and effective use of resources.

References:

- MDHHS Administrative Hearings Policy and Procedure
- Title 42 Code of Federal Regulations Part 438, Subpart F (Grievance and Appeal System)
- Care Management Services Policy 05.04.00, Customer Service Complaint (Grievance) Policy 02.01.11.01, and the Local Appeal Policy 02.01.11.02

- The Mental Health/Substance Abuse Chapter of the Michigan Medicaid Provider Manual

Exhibits:

Exhibit A – Adverse Benefit Determination Notice

Exhibit C – MDHHS Request for an Administrative Hearing Instructions

DCH- 0092-MOHR (Rev. 9-19)

Exhibit D – Customer Service Complaint Form

Procedure:

ACTION	RESPONSIBILITY
1) Evaluates/assesses applicants for public mental health services.	1) Intake Specialist
2) If found ineligible for public mental health services, the applicant will be informed of their right to request a Second Opinion and be given an Adequate Action Notice.	2) Care Management
3) Contacts Care Management to request a Second Opinion.	3) Applicant or Representative
4) Second Opinion is scheduled with an Intake Specialist.	4) Care Management
5) Decides based upon the clinical information available to: a) Support the initial decision that eligibility is not met and deny services, Or b) Direct that clinically suitable services be provided.	5) Intake Specialist
6) Logs in data related to the Second Opinion event.	6) Care Management
7) Evaluates/assesses applicants for psychiatric hospitalization.	7) Crisis Intervention Staff
8) If found ineligible for psychiatric hospitalization, the applicant will be informed of their right to request a Second Opinion.	8) Crisis Intervention Staff
9) Requests a Second Opinion.	9) Applicant or Representative
10) Secures a Second Opinion within 72 hours (excluding weekends and holidays) with a Psychiatrist, Medical Doctor, or Licensed Psychologist.	10) Chief Executive Officer or designee

11) Decides based upon the clinical information available to: a) Support the initial decision that eligibility is not met and deny services, Or b) Directs that psychiatric hospitalization be arranged Non-Medicaid Notice, Adverse Benefit Determination Notice: 12) The Adverse Benefit Determination Notice form will be provided to any Medicaid recipient receiving non-Medicaid services when: a) Any action is taken regarding services as described in the “Action” definition described above. b) Adverse Benefit Determination Notice is required when services currently being provided are reduced, suspended, or terminated (to be sent at least 10 days prior to the date the action is to take place. Medicaid: 13) The Adverse Benefit Determination Notice form will be provided to any Medicaid person served when: a) Any action is taken regarding services as described in the “Action” definition described above. b) Adverse Benefit Determination Notice is required when services currently being provided are reduced, suspended, or terminated (to be sent at least 10 days prior to the date the action is to take place. Medicaid Adverse Benefit Determination Notice and - Wraparound 14) These notices will be provided to persons served receiving services from the Wraparound program as follows: a) At the initial Child & Family Team Meeting (CFT) where the Plan of Care (POC) is developed, at least annually thereafter, the Adverse Benefit Determination Notice will be provided along with obtaining signatures	11) Psychiatrist, Medical Doctor, or Licensed Psychologist providing Second Opinion 12) Care Management Staff 13) Care Management staff 14) Wraparound staff

on the Signature Page. Only the Signature Page will be copied into Sentri II. b) Since most of the contact with the family is a subsequent CFT, because the POC is reviewed and tweaked as needed, if there is a denial/reduction/termination of a service, then an Adverse Benefit Determination Notice will be offered. This will be documented in the Progress Note regarding the CFT. If there is no change in service, but a change in a goal or objective, then an Adverse Benefit Determination Notice is not required. c) If there is a denial/reduction/elimination of a service (or services) outside the CFT, for example, termination from program, the Adverse Benefit Determination Notice will be given. 15) Services are continued when a Request for an Administrative Hearing is filed and SCCMHA receives a request from the person served or representative to continue the services, and the request for a hearing is done before the expressed date of action is to take place, and the appeal involves a reduction, suspension or termination of services, and the services were ordered by an authorized provider, and the original period of the authorization has not expired. 16) If a Medicaid person served disagrees with their IPOS or an action taken by SCCMHA or one of their Service Providers, they can do one or all of the following: a) Ask for a review by their assigned Support Staff or their Supervisor. b) Request the Local Appeal through the Customer Services Office. c) File a Recipient Rights complaint, only if they are a current person served or have been denied their right to a second opinion. 17) Upon receipt of a request to review the Person-Centered Plan, a review will be completed within 30 days.	15) Appeals coordinator or Hearings Officer will notify the Support Staff or Supervisor 16) Person Served or Representative 17) Assigned Support Staff or their Supervisor

18) If the decision of the Support Staff or their Supervisor is unsatisfactory, a request for a Local Appeal may be made by using the Customer Services Complaint Form (Attached to the Local Appeals Policy) or requesting help from Customer Services or a Support Staff. Note: Persons served or their Representative have 60 days to request a Local Appeal from the date of the action being disputed.	18) Person Served or Representative
19) The decision of the Local Appeal will be made within 30 days of the receipt of the Customer Services Complaint Form and will be in writing.	19) Appeals coordinator
20) Medicaid persons served may file a written Request for a Medicaid Fair Hearing within 120 days after receipt of the Notice and Hearing Rights.	20) Medicaid Person Served or Representative
21) Provides a copy of the Notice of Hearing to the Hearings Officer.	21) Manager of the Office of the Chief Executive Officer
22) Provides copies of the Notice of Hearing to the Administrative Hearing Team, and invites them to the hearing as needed.	22) Fair Hearing Officer
23) Upon receipt of the Notice of Hearing, reserves a room for the Medicaid Fair Hearing and notifies the Hearings Officer of the location.	23) Appeals Coordinator
24) Contacts the Person Served or Representative to attempt to resolve the complaint prior to the Medicaid Fair Hearing.	24) Appeals Coordinator
25) If a resolution of the complaint is not achieved, prepares SCCMHA information and invites needed SCCMHA staff to the scheduled Administrative Fair Hearing.	25) Fair Hearing Officer
26) Tracks the time frames of Medicaid State Fair Hearings.	26) Fair Hearing Officer
27) Keeps and files completed Medicaid State Fair Hearings information.	27) Fair Hearing Officer



LETTER OF ADVERSE BENEFIT DETERMINATION
Saginaw County Community Mental Health Authority (SCCMHA)

Janet W. Doe
 500 Hancock
 SAGINAW, MI 48602-4224

Adverse Benefit Determination is a decision made by a health plan that:

- denies a request for a service(s);
- denies payment;
- reduces or stops a benefit; or
- does not provide services in time

Appeal is a request you can make to ask that a decision that you do not agree with is looked at again.

Important: The letter explains your Appeal rights. Read this letter carefully. If you need help with this letter or disagree with the decision that was made, you can call one of the numbers listed on the last page under "Get help & more information".

Provided/Mailed Date: 01/31/2025

Member ID: 000000012

Name: Janet W. Doe

Beneficiary ID: 000123456789

This is to tell you about our decision:

Your current service(s) will be: Reduced.

Effective: 02/11/2025

This decision is based on the following:

Residency: you live outside of the Saginaw service area so we cannot authorize services for you.

There is a law [42 CFR §440.230(d)] that allows us to place appropriate limits on service requests based on the reason for the medical need.

You can share a copy of this letter with your provider so you and your provider can discuss next steps. If your provider asked for these services to be provided to you, we have sent a copy of this letter to your provider.

If you do not agree with our decision, you have the right to an Appeal.

You must ask Saginaw for an appeal within **60 days** of the date of this letter. You can name a relative, friend, attorney, provider, or another person to speak for you with your permission. If you already have a person approved to make legal health care decisions for you, you do not have to do anything else. The Appeal can be requested either verbally or in writing.

There are two (2) types of Appeals:

Standard Appeal:

You will be provided with a written decision on a Standard Appeal within **30 days** after your Appeal is received. Our decision might take longer than 30 days if you ask for more time, or if we need more information about your case. We will tell you if we are taking extra time and we will explain why more time is needed.

Fast Appeal:

You will be provided with a decision on a Fast Appeal within **72 hours** after your Appeal is received. You or your provider can ask for a Fast Appeal if you or your provider believe your health could be seriously harmed by waiting up to 30 days for a decision. Saginaw will decide if your request is considered a Fast Appeal. If you are not provided a Fast Appeal, you will be called as soon as possible to tell you and then you will be given a decision within **30 days**. To ask for a Fast Appeal, you must call: **(989) 797-3452 TTY: 711** right away.

Next steps if you want to file an appeal:

When asking for an appeal, you must tell us the following:

- Your Name.
- Your Address.
- Your Member Number.
- Your Reason for the Appeal.
- Whether you want a Standard or Fast Appeal.
- If you want someone to speak for you. Both you and the person you want to speak for you must sign and date a letter saying this is what you want.
- Any proof you want us to review, such as medical records, letters from your providers, or other information that explains why you need the item or service. [Note: There is a limited time available if you are asking for a Fast Appeal].
- If your services were stopped or reduced, if you want your services to continue.

If you would like to continue the services that you are currently receiving, you must follow the below:

If you ask for an Appeal within **10 days** of this letter, in some cases, you may continue to receive your services while your Appeal is being looked at. Your request to continue services can be sent at the same time with your Appeal request.

If your services are continued during your Appeal, you can keep getting the service(s) until one of the following happens: 1) you cancel the Appeal; or 2) all individuals that receive and review your Appeal decide to say "no" to your request; or 3) the original approval request for your services has ended. You may be asked to pay for some of the services you received during the Appeal process if the Appeal is not approved. This is not always the case, but if you need to pay, you will be notified of the amount.

Access to Documents:

You and/or your approved individual are allowed access to and a free copy of all documents that relate to your appeal any time before or during the appeal. You can ask for these documents either by requesting in writing or by calling Customer Services at the number below or if you have any questions or concerns about this decision.

What happens next:

- If you ask for an Appeal, Saginaw will review information about the Appeal request and send you a letter with the decision. If Saginaw does not support your Appeal, the letter will explain why Saginaw did not approve your request.

- You can ask for a Medicaid State Fair Hearing. The State Fair Hearing process can only be used after Saginaw does not approve your Appeal. The letter that will be sent to you will give you more information about the State Fair Hearings process and how to file the request.
- If Saginaw approves your Appeal, you will receive a letter that explains the steps you and Saginaw will follow to approve the services that are now allowed.
- If you do not receive a letter or decision about your Appeal within **30 days** of the Standard Appeal **or 72 hours** of your Fast Appeal, your appeal is considered finished, and you may file a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR). Please call us to get this information.

Get help and more information:

- If you need help or more information about our decision and the Appeals process, call Customer Services at: (989) 797-3452; TTY 711 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).

There is a law that does not allow Saginaw to judge or exclude a person based on race, color, where they are from, gender, age, or different ability.

Saginaw provides help to people with different abilities so that they are able to communicate with us, such as:

- Qualified sign language interpreters for those who are deaf or hard of hearing.
- Written information in other formats (such as large print, audio, and braille).
- Free language services to people whose main language is not English, such as:
 - Someone who speaks your language.
 - Information written in another language.

If you need these services, you can call Customer Services at one of the numbers listed above under "Get help and more information."

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (989) 797-3452 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (989) 797-3452 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث أذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. (رقم هاتف الصم والبكم اتصل برقم 1- (989) 797-3452 (TTY: 711).

Bengali: লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ (989) 797-3452 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電。(989) 797-3452 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (989) 797-3452 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (989) 797-3452 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。まで、お電話にてご連絡ください。
(989) 797-3452 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오.
(989) 797-3452 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (989) 797-3452 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (989) 797-3452 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (989) 797-3452 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (989) 797-3452 (TTY: 711).

Syriac: ܩܪܝܬܐ ܕܡܫܟܝܢ ܕܥܠܝܗ ܕܡܫܚܝܢ ܕܥܠܝܗ ܕܡܫܚܝܢ ܕܥܠܝܗ ܕܡܫܚܝܢ
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(989) 797-3452 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (989) 797-3452 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (989) 797-3452 (TTY: 711).

REQUEST FOR HEARING FOR MEDICAID ENROLLEES, PACE ENROLLEES OR WAIVER APPLICANTS

Michigan Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services
PO Box 30763, Lansing, MI 48909
Telephone Number: 800-648-3397 Fax: 517-763-0146

SECTION 1: TO BE COMPLETED BY THE PERSON REQUESTING A HEARING

Client Name [REDACTED]			Client Telephone No. [REDACTED]	Client Social Security No. [REDACTED]
Client Address (No. and Street, Apt. No.) [REDACTED]			Medicaid ID No. [REDACTED]	
City [REDACTED]	State [REDACTED]	Zip Code [REDACTED]	Client or Legal Guardian Signature [REDACTED]	Date [REDACTED]
What agency took the action or made the decision that you are appealing? Make sure to attach a copy of the letter from the agency that told the client about their decision. [REDACTED]				Client MDHHS Case No. [REDACTED]
I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. Use additional sheets if needed. [REDACTED] [REDACTED] [REDACTED] [REDACTED]				
Do you have a physical disability or other condition requiring special arrangements for you to attend or participate in a hearing? ☐ No ☐ Yes (If yes, please explain here.) [REDACTED]				
Will you need an interpreter? ☐ No ☐ Yes (If yes, language needed:) [REDACTED]				

SECTION 2: HAVE YOU CHOSEN SOMEONE TO REPRESENT YOU AT THE HEARING?

Has someone agreed to represent you at this hearing? ☐ No ☐ Yes (If Yes, have the representative complete and sign Section 3.)

SECTION 3: AUTHORIZED HEARING REPRESENTATIVE INFORMATION

Name of Representative (please print) [REDACTED]	Representative Telephone No. [REDACTED]	Relationship to Enrollee [REDACTED]	
Address (No. and Street, Apt. No.) [REDACTED]	City [REDACTED]	State [REDACTED]	Zip Code [REDACTED]
Representative Signature [REDACTED]		Date Signed [REDACTED]	

SECTION 4: AGENCY INVOLVED IN THE ACTION BEING DISPUTED BY THE CLIENT

Name of Agency [REDACTED]			Agency Contact Person Name [REDACTED]
Agency Address (No. and Street, Apt. No.) [REDACTED]			Agency Telephone Number [REDACTED]
City [REDACTED]	State [REDACTED]	Zip Code [REDACTED]	State Program or Service being provided to this client [REDACTED]

REQUEST FOR HEARING FOR MEDICAID ENROLLEES, PACE ENROLLEES OR WAIVER APPLICANTS INSTRUCTIONS

A hearing is an impartial review of a decision made by the Michigan Department of Health and Human Services or one of its contract agencies that a client believes is wrong.

This form is to ask for a hearing if you are a Medicaid enrollee, or a PACE enrollee, or a Medicaid waiver applicant when the action has been taken by MDHHS or one of its contract agencies. You can also send in your signed hearing request in writing on any paper. This form is also available online at: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Office of Administrative Hearings and Rules for the Department of Health and Human Services or www.michigan.gov/LARA >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings.

Do not use this form to appeal an action

- Taken by a Medicaid, Healthy Michigan Plan or MI Health Link health plan, Community Mental Health Services Program / Prepaid Inpatient Hospital Plan (CMHSP/PIHP), Healthy Kids Dental health plan, or MI Choice Waiver Agency. You must go through their internal appeals process first before you ask for a MDHHS-5617-MOHR, Request for State Fair Hearing form. This form is also available online at the links above.
- Related to program eligibility, cash assistance, food assistance, or other assistance programs. Use the DHS-18, Request for Hearing form available online at www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Forms and Applications >> Other, or go to www.michigan.gov/documents/FIA-Pub18_14356_7.pdf to download the form.

GENERAL INSTRUCTIONS

- Read ALL instructions before completing the attached form.
- Complete Section 1 using the name of the client (even if the client has a guardian or is a minor).
- Complete Sections 2 & 3 only if the client wants someone to represent them at the hearing.
- Complete Section 4 if the agency who took the action you are appealing did not fill this out.
- Attach a copy of the notice or letter from the Agency that told the client about the change that is being appealed.
- Please make a copy for your records.
- Questions can be answered by calling toll free: 800-648-3397.
- After the form is completed, mail or fax page 1 to:

**MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 30763
LANSING MI 48909
Fax 517-763-0146**

- The client may choose to have another person represent them at a hearing.
 - This person can be anyone the client chooses but must be at least 18 years of age.
 - The client must give this person written permission to represent them.
 - The client may give written permission by checking yes in Section 2 and having the person who is representing them complete Section 3. The client must still complete and sign Section 1.
 - The client's guardian or conservator may represent them. A copy of the court order naming the guardian or conservator must be included with this request.

Completion: Is Voluntary.

Michigan Department of Health and Human Services (MDHHS)
Please note if needed, free language assistance services are available.
Call 877-833-0870 (TTY users call TY: 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877-833-0870 (TTY 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 877-833-0870 (رقم هاتف الصم والبكم: TTY 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 877-833-0870 (TTY 711)
Syriac (Assyrian)	تەنبێ: ئەگەر تۆ هێشتا بە ئینگلیزی قسڵێ، ئەوە بۆ تۆ بەبێ پارە خزمەتی یارمەتی زمانی دەستگیر دەکات. ٨٧٧-٨٣٣-٠٨٧٠ (٧١١ تەلەفۆن) بۆ زانیاری زیاتر.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877-833-0870 (TTY 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 877-833-0870 (TTY 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877-833-0870 (TTY 711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৭৭-৮৩৩-০৮৭০ (TTY 711)
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 877-833-0870 (TTY 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 877-833-0870 (TTY 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 877-833-0870 (TTY 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。877-833-0870（TTY 711）まで、お電話にてご連絡ください。
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 877-833-0870 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 877-833-0870 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 877-833-0870 (TTY 711).

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, 4th Floor
P.O. Box 30195
Lansing, MI 48909

517-284-1018 (Main), TTY 711, 517-335-6146 (Fax)

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.

REQUEST FOR HEARING FOR MEDICAID ENROLLEES, PACE ENROLLEES OR WAIVER APPLICANTS

Michigan Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services
PO Box 30763, Lansing, MI 48909
Telephone Number: 800-648-3397 Fax: 517-763-0146

SECTION 1: TO BE COMPLETED BY THE PERSON REQUESTING A HEARING

Client Name			Client Telephone No.		Client Social Security No.	
Client Address (No. and Street, Apt. No.)					Medicaid ID No.	
City	State	Zip Code	Client or Legal Guardian Signature		Date	
What agency took the action or made the decision that you are appealing? Make sure to attach a copy of the letter from the agency that told the client about their decision.						Client MDHHS Case No.
I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. Use additional sheets if needed. 						
Do you have a physical disability or other condition requiring special arrangements for you to attend or participate in a hearing? ☐ No ☐ Yes (If yes, please explain here.)						
Will you need an interpreter? ☐ No ☐ Yes (If yes, language needed.)						

SECTION 2: HAVE YOU CHOSEN SOMEONE TO REPRESENT YOU AT THE HEARING?

Has someone agreed to represent you at this hearing? ☐ No ☐ Yes (If Yes, have the representative complete and sign Section 3.)

SECTION 3: AUTHORIZED HEARING REPRESENTATIVE INFORMATION

Name of Representative (please print)		Representative Telephone No.		Relationship to Enrollee	
Address (No. and Street, Apt. No.)		City		State	Zip Code
Representative Signature				Date Signed	

SECTION 4: AGENCY INVOLVED IN THE ACTION BEING DISPUTED BY THE CLIENT

Name of Agency			Agency Contact Person Name		
Agency Address (No. and Street, Apt. No.)			Agency Telephone Number		
City	State	Zip Code	State Program or Service being provided to this client		

REQUEST FOR HEARING FOR MEDICAID ENROLLEES, PACE ENROLLEES OR WAIVER APPLICANTS INSTRUCTIONS

A hearing is an impartial review of a decision made by the Michigan Department of Health and Human Services or one of its contract agencies that a client believes is wrong.

This form is to ask for a hearing if you are a Medicaid enrollee, or a PACE enrollee, or a Medicaid waiver applicant when the action has been taken by MDHHS or one of its contract agencies. You can also send in your signed hearing request in writing on any paper. This form is also available online at www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Office of Administrative Hearings and Rules for the Department of Health and Human Services or www.michigan.gov/LARA >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings.

Do not use this form to appeal an action

- Taken by a Medicaid, Healthy Michigan Plan or MI Health Link health plan, Community Mental Health Services Program / Prepaid Inpatient Hospital Plan (CMHSP/PIHP), Healthy Kids Dental health plan, or MI Choice Waiver Agency. You must go through their internal appeals process first before you ask for a MDHHS-5617-MOAH, Request for State Fair Hearing form. This form is also available online at the links above.
- Related to program eligibility, cash assistance, food assistance, or other assistance programs. Use the DHS-18, Request for Hearing form available online at www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Forms and Applications >> Other, or go to www.michigan.gov/documents/FIA-Pub18_14356_7.pdf to download the form.

GENERAL INSTRUCTIONS

- Read ALL instructions before completing the attached form.
- Complete Section 1 using the name of the client (even if the client has a guardian or is a minor).
- Complete Sections 2 & 3 only if the client wants someone to represent them at the hearing.
- Complete Section 4 if the agency who took the action you are appealing did not fill this out.
- Attach a copy of the notice or letter from the Agency that told the client about the change that is being appealed.
- Please make a copy for your records.
- Questions can be answered by calling toll free: **800-648-3397**.
- After the form is completed, mail or fax page 1 to:

**MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 30763
LANSING MI 48909
Fax 517-763-0146**

- The client may choose to have another person represent them at a hearing.
 - This person can be anyone the client chooses but must be at least 18 years of age.
 - The client must give this person written permission to represent them.
 - The client may give written permission by checking yes in Section 2 and having the person who is representing them complete Section 3. The client must still complete and sign Section 1.
 - The client's guardian or conservator may represent them. A copy of the court order naming the guardian or conservator must be included with this request.

Completion: Is Voluntary.

Please note if needed, free language assistance services are available.
Call 877-833-0870 (TTY users call TY: 711).

[illegible]

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 - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
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 - Information written in other languages

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If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

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Compliance Office, 4th Floor
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Lansing, MI 48909

517-284-1018 (Main), TTY 711, 517-335-6146 (Fax)

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MDHHS is an equal opportunity provider.



Customer Service Complaint Form

(Customer Service-Grievance or Local
Appeal)

**Instructions:**

Our goal is to provide the best service to the persons we serve. There are some state and federal regulations that SCCMHA must be in compliance with as well. In an effort to provide better service for all those we serve; we have developed a way to have your concerns heard and dealt with. If you have a complaint about anything related to Saginaw County Community Mental Health Authority, please let us know. We can receive your complaint verbally or in writing, anyone in Customer Services will be happy to help you. Please call the number below or send your questions or complaints to the Customer Services department at the address below.

(989) 797-3452 or Toll Free 1-800-258-8678 or Michigan Relay Service 7-1-1

Saginaw County Community Mental Health Authority

**500 Hancock
Saginaw, MI 48602**

Complainant's Name	Person Served Name (if different from complainant)	
Complainant's Address	What Department does this involve?	
	Phone Number	
Describe what happened: 		
Do you have any recommendations on how to resolve this complaint? 		
Complainant's Signature	Date	Name of Person Assisting Complainant

For Office Use Only:

Date received:	Received by:
Complaint Number:	Category:

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Person(s) Served Grievance	Chapter: 02 - Customer Services	Subject No: 02.01.11.01
Effective Date: 1/31/06	Date of Review/Revision: 11/13/05, 2/9/09, 6/29/09, 5/14/12, 7/22/13, 6/22/14, 9/22/14, 6/7/18, 2/11/20, 2/9/21, 6/10/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26 Supersedes: Previously Named: Con- sumer Grievance	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Ser- vices, & Security Authored By: Director of Customer Services, Reci- pient Rights, & Security Additional Reviewers: Appeals Coordinator
		

Purpose:

The purpose of this policy is to establish guidelines to allow persons served access to a local grievance process for issues that are not “actions.”

Policy:

It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) to provide maximum protection of persons served rights. SCCMHA will provide information to persons served in relation to grievance procedures and time frames for filing and when they can expect a decision relating to a Customer Service Grievance.

Application:

This policy applies to SCCMHA and the provider network.

Standards:

- 1) Persons receiving services from SCCMHA and the provider network will be provided the following information:
 - a) The right for persons served to file a Grievance
 - b) Requirements and time frames to file a Grievance
 - c) Availability of assistance in filing a Grievance
 - d) Toll free number the persons served may use to file a Grievance
 - e) The right to file a Grievance orally or in writing
- 2) All Grievances will be logged into the Appeal/Grievance database.

- 3) The staff making the determination on the Grievance will not be involved in the original review or decision-making process and have the authority to require Corrective Action.
- 4) The Customer Service Supervisor will report Grievances to the Compliance and Policy Team (CPT).
- 5) An acknowledgement letter accepting the Grievance will be sent to the person served within ten (10) business days.
- 6) The staff person completing the work on the Grievance will have the clinical experience necessary to make decisions regarding clinical issues. Grievances best suited for a different person to decide other than the Supervisor of Recipient Rights Office will be forwarded to the SCCMHA Executive Director of Clinical Services and Programs, Chief of Health Services and Integrated Care, or the Chief Information Officer & Chief Quality and Compliance Officer. The determination of which individual will receive the Grievance will be based on which department and their staff was involved in the original decision or issue.
- 7) The Grievance will be resolved within 90 calendar days of receipt and a written notice of disposition will be sent to the person served, guardian, their authorized representative, or parent of a minor or his or her legal representative. The date on the Final Letter sent to the person served or their representative is the Resolution Date unless otherwise noted.
- 8) Grievances not completed within 90 days will constitute an action and gives access to the Medicaid Fair Hearings process for Medicaid beneficiaries.
- 9) A Grievance may be filed by a person served, guardian, their authorized representative, or a parent of a minor child or his or her legal representative, or by a member of the SCCMHA Provider Network.
- 10) The date of the receipt of the Grievance will be recorded as the earliest date when SCCMHA became aware of the request for a Grievance.
- 11) The notice of disposition must include (**Medicaid beneficiaries only**):
 - a) The result of the Grievance process
 - b) The date the Grievance was concluded
 - c) The right of the person filing the Grievance to request a Medicaid Fair Hearing if the notice of disposition is more than 90 days of receipt
 - d) How to access the fair hearing process if the notice of disposition is more than 90 days from receipt
- 12) Persons served without Medicaid insurance who disagree with the disposition of the Grievance will be informed of their right to request an Alternative Dispute Res-

olution Process through Michigan Department of Health and Human Services (MDHHS) and will be given assistance with this process upon request. The mailing address for this process will be included in the letter of disposition. The mailing address is:

ATTN: Request for MDHHS Level Dispute Resolution
Lewis Cass Building, 5th Floor
320 South Walnut
Lansing, MI 48913

- 13) SCCMHA will offer a main toll-free number for anyone to call for any reason.
- 14) The SCCMHA toll-free phone number and the Michigan Relay Service phone number will be published in regularly viewed documents within the Saginaw community, on magnets, and published in Customer Service Handbooks produced by SCCMHA.
- 15) For Grievances where the complaint is better suited for a Recipient Rights investigation, the complaint will be forwarded to a Recipient Rights Investigator. However, the complaint may be completed through both processes.
- 16) Customer Service staff, Appeals Coordinator, and the Office of Recipient Rights coordinates as necessary to provide the best resolution for the person served filing the Grievance.
- 17) Members of the SCCMHA Provider Network are encouraged to share their satisfaction or dissatisfaction with the Grievance process by contacting the Customer Service Supervisor. Any information obtained from the Provider Network regarding satisfaction with the process will be shared with the Quality Governance Committee.
- 18) Persons served may file a grievance without fear of retaliation or reprisal. The grievance process will be person-centered, culturally and linguistically appropriate, and trauma-informed.

Definitions:

Action: A decision by SCCMHA to reduce, suspend, or terminate services currently being provided to a person served receiving services from SCCMHA.

Person Served Grievance: A process set up to allow persons served of SCCMHA services to file a complaint due to a dissatisfaction with services not relating to an action taken by SCCMHA. This process meets all requirements of the federal and state regulations regarding grievances.

Michigan Relay Service: A communications system that allows hearing persons and persons who are deaf, hard of hearing, or speech-impaired to communicate by telephone.

References:

Grievance and Appeal Technical Requirement Prepaid Inpatient Health Plan (PIHP) Grievance System for Medicaid Beneficiaries.

42 CFR 438, Subpart F and 42 CFR 438.10(g)(1)

Exhibits:

Exhibit A - Customer Service Complaint Form

Procedure:

ACTION	RESPONSIBILITY
1) Grievance is filed with the Customer Service Office.	1) Person served, guardian, their authorized representative, or parent of a minor child or his or her legal representative
2) Grievance is logged into the Appeal and Grievance database. The log includes the Fiscal Year, Date Received, Complaint Number, Provider Name, Description of Appeal Type, Timely Resolution (Yes or No), Category, Number of Days to Complete, and the Date Completed.	2) Customer Service Supervisor
3) Acknowledgment Letter confirming receipt of the Grievance is sent to the person filing within ten (10) business days	3) Customer Service Supervisor
4) Reviews all information and interviews those necessary to make a determination	4) Customer Service Supervisor
5) When it is determined a Grievance is better suited to be reviewed through the Recipient Rights investigation, the complaint will be forwarded to a Recipient Rights Investigator.	5) Customer Service Supervisor
6) When a Grievance is determined to need a different reviewer due to clinical issues, the Grievance will be forwarded to the SCCMHA Executive Director of Clinical Services and Programs, Chief of Health Services	6) Customer Service Supervisor

and Integrated Care, or the Chief Information Officer & Chief Quality and Compliance Officer based on the standards above. 7) When a Grievance is referred to the SCCMHA Executive Director of Clinical Services and Programs, Chief of Health Services and Integrated Care, or the Chief Information Officer & Chief Quality and Compliance Officer, the review of the Grievance will be completed, and the decision will be forwarded back to the Customer Service Supervisor Office for the determination to be sent out to the person who filed the Grievance. 8) Provides notice of disposition to the person who filed the Grievance within 90 days of receipt	7) Executive Director of Clinical Services and Programs, Chief of Health Services and Integrated Care, or the Chief Information Officer & Chief Quality and Compliance Officer 8) Customer Service Supervisor



Customer Service Complaint Form

(Customer Service-Grievance or Local
Appeal)

**Instructions:**

Our goal is to provide the best service to the persons we serve. There are some state and federal regulations that SCCMHA must be in compliance with as well. In an effort to provide better service for all those we serve; we have developed a way to have your concerns heard and dealt with. If you have a complaint about anything related to Saginaw County Community Mental Health Authority, please let us know. We can receive your complaint verbally or in writing, anyone in Customer Services will be happy to help you. Please call the number below or send your questions or complaints to the Customer Services department at the address below.

(989) 797-3452 or Toll Free 1-800-258-8678 or Michigan Relay Service 7-1-1

Saginaw County Community Mental Health Authority

**500 Hancock
Saginaw, MI 48602**

Complainant's Name	Person Served Name (if different from complainant)	
Complainant's Address	What Department does this involve?	
	Phone Number	
Describe what happened: 		
Do you have any recommendations on how to resolve this complaint? 		
Complainant's Signature	Date	Name of Person Assisting Complainant

For Office Use Only:

Date received:	Received by:
Complaint Number:	Category:

1/31/25 MG

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Local Appeal	Chapter: 02 - Customer Services & Re- cipient Rights	Subject No: 02.01.11.02
Effective Date: 1/31/06	Date of Review/Revision: 11/13/05, 1/12/07, 3/11/09, 6/29/09, 5/14/12, 7/22/13, 6/22/14, 9/22/14, 6/7/18, 2/11/20, 2/9/21, 6/10/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Ser- vices, & Security
	Supersedes:	
		Authored By: Director of Customer Services, Recipi- ent Rights, & Security Additional Reviewers: Appeals Coordinator

Purpose:

The purpose of this policy is to establish guidelines to allow persons served of Saginaw County Community Mental Health Authority (SCCMHA) access to a local appeal process for actions taken relating to their services.

Policy:

It is the policy of SCCMHA to provide maximum protection of person served rights and to comply with state and federal guidelines. This local appeal process is in place to fulfil this obligation regarding all persons served of SCCMHA services.

Application:

This policy applies to SCCMHA and the provider network.

Standards:

- 1) Federal regulations require that Medicaid beneficiaries have access to a local appeal process of actions taken by SCCMHA relating to services being provided.
- 2) State regulations require that all persons served by SCCMHA have access to a local process for resolving disputes of services.
- 3) Persons served of SCCMHA services have 60 calendar days from the date of the notice of action to request a local appeal.

- 4) Local appeals may be accepted orally or in writing.
- 5) Local appeals must be regarding an “Action” such as termination of services, reduction of services, authorizing a service in an amount less than requested, not initiating services within 14 days as agreed to in the Person-Centered Plan, etc.
- 6) The date of the receipt of the Local Appeal will be recorded as the earliest date when SCCMHA became aware of the request for an appeal.
- 7) Persons served filing a local appeal will be sent a letter acknowledging receipt of the appeal within ten (10) business days unless an expedited resolution is requested.
- 8) If a Medicaid beneficiary requests the local appeal or their authorized representative requests a local appeal no more than 10 calendar days from the date of the notice of action and request services be continued, and the authorization for the services through the Person-Centered Plan has not run out, SCCMHA will reinstate the Medicaid services until the disposition of the appeal.
- 9) SCCMHA Customer Service will give persons served any assistance necessary for them to file the local appeal, including arranging interpreter services if necessary and toll-free numbers that have adequate Michigan Relay Service and interpreter capability.
- 10) Customer Service staff, Appeals Coordinator, Fair Hearing Officer, and the Office of Recipient Rights coordinates as necessary to provide the best resolution for the person served filing the Appeal.
- 11) Local appeals information will be tracked and reported to the Compliance and Policy Team (CPT) and forwarded to the Quality Governance Committee.
- 12) Members of the SCCMHA Provider Network are encouraged to share their satisfaction or dissatisfaction with the Local Appeal process by contacting the Customer Service Supervisor. Any information obtained from the Provider Network regarding satisfaction with the process will be shared with the Quality Governance Committee.
- 13) The person responsible in the previous level review or decision making will not be involved in making the decision of the local appeal.
- 14) The individual making the decisions on the local appeal will have appropriate clinical experience in treating the persons served condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues.
- 15) When SCCMHA makes a denial of services, the person served or the person served authorized representative and the provider will be sent an Adverse Benefit Determination Notice for the denied services.

- 16) Local Appeals regarding termination of Autism Services when annual Re-Evaluations are completed will be resolved by having a Second Re-Evaluation completed by a clinician with appropriate credentials
 - a) The Local Appeal will use the results from that evaluation for the opinion of the Local Appeal
 - b) As long as the appeal is received within 60 days of the Adverse Benefit Determination Notice, a Second Re-Evaluation will be completed
- 17) The person served or their representative will be provided with:
 - a) Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing
 - b) Opportunity, before and during the appeal process, to examine the persons served case file, including medical records and any other documents or records considered during the appeal process.
 - c) Information regarding the right to a fair hearing (Medicaid beneficiaries only and only after a local appeal has been completed) and the process to be used to request the Medicaid Fair Hearing
- 18) Standard resolution of a local appeal must be completed within 30 calendar days or within 72 hours for an expedited resolution.
- 19) The notice of disposition to the person served or their representative will be made in writing. The date on the Final Letter sent to the person served or their representative is the Resolution Date unless otherwise noted.
- 20) Every effort will be made to provide oral notice of an expedited appeal.
- 21) The notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- 22) When the appeal is not resolved in favor of the person served, the notice of disposition must include (**Medicaid beneficiaries only**):
 - a) The right to request a Medicaid Fair Hearing, and how to do so
 - b) The right to request to receive benefits while the Medicaid Fair Hearing is pending, if requested within 10 calendar days of the mailing of the notice of disposition, and how to make the request
 - c) That the person served may be held liable for the cost of the benefits if the hearing decision upholds the previous decision
- 23) Person served without Medicaid insurance who disagree with the disposition of the local appeal will be informed of their right to request an Alternative Dispute Resolution Process through Michigan Department of Health and Human Services (MDHHS) and will be given assistance with this process upon request. The mailing address for this process will be included in the letter of disposition. The mailing address is:

ATTN: Request for MDHHS Level Dispute Resolution
Lewis Cass Building, 5th Floor
320 South Walnut
Lansing, MI 48913

- 24) Persons served may file local appeals without fear of retaliation or reprisal. The appeal process will be person-centered, culturally and linguistically appropriate, and trauma-informed.

Definitions:

Action: A decision that adversely impacts a persons served claim for services.

Expedited Resolution: SCCMHA must resolve the appeal and provide notice of disposition to the effected parties no longer than 72 hours after the request for an expedited resolution. An expedited resolution is required when SCCMHA determines (for a request from the person served) or the provider indicates (in making the request on behalf of or in support of the persons served request) that taking the time for a standard resolution could seriously jeopardize the persons served life or health or ability to attain, maintain or regain maximum function.

- SCCMHA may extend the notice of disposition timeframe by up to 14 calendar days if the beneficiary requests an extension, or if SCCMHA shows to the satisfaction of the state that there is a need for additional information and how the delay is in the persons served best interest.
- If SCCMHA denies a request for an expedited resolution of an appeal, they must:
 - Transfer the appeal to the timeframe for standard resolution or no longer than 30 calendar days from the date the appeal is received
 - Make reasonable efforts to give the person served prompt oral notice of the denial
 - Give the person served follow up written notice within 2 calendar days

MDHHS Alternative Dispute Resolution Process is described as follows:

- **MDHHS** shall review all requests within 2 business days of receipt
- If the **MDHHS** representative, using a “reasonable person” standard believes that the denial, suspension, termination, or reduction of services and/or supports will pose an immediate and adverse impact upon the individual’s health and safety, the issue is referred within 1 business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the **MDHHS** /CMHSP contract.
- In all other cases, the **MDHHS** representative shall attempt to resolve the issue with the individual and the CMHSP within 15 business days. The recommendations of the **MDHHS** representative are non-binding in those cases where the decision poses no immediate impact to the health and safety of the individual

Michigan Relay Service: A communications system that allows hearing persons and persons who are deaf, hard of hearing, or speech-impaired to communicate by telephone.

Standard Resolution: SCCMHA must resolve the appeal and provide notice of disposition to the effected parties as expeditiously as the persons served health requires, but not to exceed 30 calendar days from the day the appeal is received.

References:

Grievance and Appeal Technical Requirement Prepaid Inpatient Health Plan (PIHP) Grievance System for Medicaid Beneficiaries

Exhibits:

Exhibit A –Customer Service Complaint Form

Procedure:

ACTION	RESPONSIBILITY
1) Local appeal request is filed with the Customer Service Office	1) Person served or their representative
2) The local appeal is logged into the Appeals and Grievance database when received. The log includes the Fiscal Year, Date Received, Complaint Number, Provider Name, Description of Appeal Type, Timely Resolution (Yes or No), Category, Number of Days to Complete, and the Date Completed.	2) Customer Service Supervisor or designee
3) An acknowledgement letter is sent to the person served and/or their representative letting them know the appeal has been received within ten (10) business days	3) Customer Service Supervisor or designee
4) If an expedited resolution is requested, the person served or their representative will be notified of approval or disapproval of the request orally and in writing within two calendar days	4) Customer Service Supervisor
5) If the appeal is requested within 10 calendar days from the date of the notice of action and the person served or their representative requests services be continued, Medicaid services will be reinstated (<u>Medicaid beneficiaries only</u>)	5) Customer Service Supervisor in cooperation with the Director overseeing the services
6) Information is gathered and reviewed and necessary interviews are conducted	6) Customer Service Supervisor

7) Time before reaching a decision will be scheduled for the person served and/or their representative to review all the relevant information if requested by the person served. 8) Notice of disposition is sent to the person served and/or their representative within 30 calendar days of the receipt of the appeal, 72 hours days if expedited resolution has been accepted (time frame for expedited resolution may be extended up to 14 days if the specific standards listed above are met.)	7) Customer Service Supervisor or designee 8) Customer Service Supervisor

Exhibit A



Customer Service Complaint Form

(Customer Service-Grievance or Local
Appeal)



Instructions: Our goal is to provide the best service to the persons we serve. There are some state and federal regulations that SCCMHA must be in compliance with as well. In an effort to provide better service for all those we serve, we have developed a way to have your concerns heard and dealt with. If you have a complaint about anything related to Saginaw County Community Mental Health Authority, please let us know. We can receive your complaint verbally or in writing, anyone in Customer Services will be happy to help you. Please call the number below or send your questions or complaints to the Customer Services department at the address below. (989) 797-3452 or Toll Free 1-800-258-8678 or Michigan Relay Service 7-1-1 Saginaw County Community Mental Health Authority 500 Hancock Saginaw, MI 48602		
Complainant's Name	Person Served Name (if different from complainant)	
Complainant's Address	What Department does this involve?	
	Phone Number	
Describe what happened:		
Do you have any recommendations on how to resolve this complaint?		
Complainant's Signature	Date	Name of Person Assisting Complainant

For Office Use Only:

Date received:	Received by:
Complaint Number:	Category:

1/31/25 MG

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Limited English Proficiency	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.01.13
Effective Date: 10/21/08	Date of Review/Revision: 6/17/12, 6/22/14, 12/8/16, 5/28/18, 3/12/19, 2/11/20, 2/9/21, 6/10/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Services, & Security Authored By: Director of Customer Services, Recipient Rights, & Security Additional Reviewers: Administrative Assistant to the Director of Environmental Services, Customer Service & Security
	Supersedes:	
		

Purpose:

The purpose of this policy is to ensure persons served of Saginaw County Community Mental Health Authority (SCCMHA) have access to program information and services although they may be limited in their English language proficiency. SCCMHA is committed to this plan as the appropriate response to meeting the needs of the persons we serve.

Policy:

It is the policy of SCCMHA to provide for effective communication between persons served with Limited English Proficiency (LEP) and SCCMHA staff by making appropriate language assistance services available when persons served need these services. This policy was developed to service SCCMHA persons served, prospective persons served, their family members, or other eligible members of the service area who do not speak, read, write, or understand English or who do so on a limited basis.

Application:

All SCCMHA Programs and Network Providers.

Standards:

- 1) The policy of SCCMHA regarding LEP will be consistent with federal requirements.

- 2) All agencies that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS) must take adequate steps to ensure that persons with limited English proficiency receive the language assistance necessary to allow meaningful access to services, free of charge.
- 3) No person will be denied access to SCCMHA program information or programs because they do not speak English or communicates in English on a limited basis.
- 4) SCCMHA staff will initiate an offer for language assistance to persons served who have difficulty communicating in English.
- 5) SCCMHA will provide persons served with difficulty communicating in English with meaningful access to programs and services in a timely manner and at no cost to the persons served.
- 6) Free interpretation and/or translation service is provided in a language the person considered to have LEP understands, in a way that preserves confidentiality, and in a timely manner.
- 7) SCCMHA will provide effective services to persons with LEP, by using competent interpreters.
- 8) Persons used to provide interpretation must be competent, meaning they demonstrate proficiency in both English and the target language, are trained in interpretation ethics and confidentiality, and are able to accurately and effectively convey information. State certification or nationally recognized credentials may be used when available but are not required.
- 9) SCCMHA Customer Service Unit will request additional translation service or interpretation services contracts through the Network Services and Public Policy Unit if necessary to meet the current need for services for persons served in the service area.
- 10) SCCMHA provides access for people who are deaf or hard of hearing to communicate with SCCMHA using the Michigan Relay Service. Information related to the Michigan Relay Service (711) will be published in the SCCMHA Customer Service Handbook.
- 11) Major SCCMHA publications are translated into Spanish.
- 12) Interpretation for languages other than English may be provided by phone when a live interpreter is not available. This service is provided to persons served of SCCMHA using one of three SCCMHA contracted translation service providers.

Definitions:

- **Effective Communication:** In a human service setting, effective communication occurs when provider staff have taken the necessary steps to make sure that a person with LEP is given adequate information to understand the services and benefits available and receives the benefits for which he/she is eligible. Effective communication also means that a person with limited English proficiency can communicate the relevant circumstances of their situation to the provider.
- **Interpretation:** Interpretation means the oral or spoken transfer of a message from one language into another language.
- **Limited English Proficiency (LEP):** A person with limited English proficiency or “LEP” is not able to speak, read or understand the English language well enough to allow them to interact effectively with health and social service or other providers.
- **Meaningful Access:** Meaningful access to programs and services is the standard of access required of federally funded entities to comply with Title VI’s language access requirements. To ensure meaningful access for people with limited English proficiency, service providers must make available to persons served free language assistance that result in accurate and effective communication.
- **Michigan Relay Service** – A communications system that allows hearing persons and persons who are deaf, hard of hearing, or speech-impaired to communicate by telephone.
- **Office for Civil Rights (OCR):** The Office for Civil Rights is the civil rights enforcement agency of the U.S. Department of Health and Human Services. OCR Region V is the regional office that enforces Title VI in Michigan for health and human services agencies/providers.
- **Principal Languages:** Principal languages refer to the languages other than English that are most spoken by SCCMHA persons served. Currently there is 1 in Saginaw County: Spanish.
- **Translation:** Translation means the written transfer of a message from one language into another language.
- **Competent Interpreter:** Interpreters that have demonstrated proficiency in both English and the intended language; training that includes the skills and ethics of interpreting (e.g., issues of confidentiality); fundamental knowledge in both languages of any specialized terms or concepts; and sensitivity to the persons served’s culture.

References:

- **Title VI of the Civil Rights Act of 1964**, 42 U.S.C. §2000 et seq.; 45 CFR §80, Nondiscrimination Under Programs Receiving Federal Financial Assistance through the U.S Department of Health and Human Services Effectuation of Title VI of the Civil Rights Act of 1964
- **Office for Civil Rights Policy Guidance**, 65 Fed. Reg. 52762 (2000), Department of health and Human Services, Office for Civil Rights, Policy Guidance on the Prohibitions Against National Origin Discrimination as It Affects Persons with Limited English Proficiency (August 30, 2000); OCR Website: www.hhs.gov/ocr/lep/
- **Department of Justice Regulation**, 28 CFR §42.405(d)(1), Department of Justice, Coordination for Enforcement of Non-discrimination in Federally Assisted Programs, Requirements for Translation

- **Bilingual Requirements in the Food Stamp Program**, 7 CFR §272.4 U.S. Department of Agriculture, Food and Consumer Service

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Persons receiving services from SCCMHA or the SCCMHA Provider Network will be assessed for their ability to communicate by English at the time of their intake.	1) Central Access and Intake (CAI) Staff
2) Enter into the Senti record under Demographics the individual persons served Primary Language.	2) Central Access and Intake (CAI) Staff
3) Those persons identified to have LEP will be provided an interpreter and information translated into their language free of charge.	3) Support Coordinator, Client Service Manager, Therapist, all Clinical staff or Intake Specialist with assistance from the SCCMHA Customer Service Unit

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Transportation to SCCMHA Appointments – Taxi Cab Voucher	Chapter: 02 – Customer and Member Services	Subject No: 02.01.16
Effective Date: 4/1/14	Date of Review/Revision: 12/1/17, 5/28/18, 3/12/19, 11/15/19, 2/11/20, 2/9/21, 6/10/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Services, & Security Authored By: Director of Customer Services, Recipient Rights, & Security Additional Reviewers: Customer Service Supervisor
	Supersedes:	
		

Purpose:

The purpose of this policy is to assist persons served by the Saginaw County Community Mental Health Authority (SCCMHA) Provider Network in obtaining transportation to SCCMHA or other mental health related appointments.

Application:

This policy applies to the SCCMHA Provider Network.

Policy:

It is the policy of SCCMHA to assist people receiving services through the SCCMHA Provider Network in obtaining transportation to and from SCCMHA and related mental health appointments.

Standards:

(Standards # 1-4 are directly from the Michigan Medicaid Provider Manual – Chapter: Behavioral Health and Intellectual and Developmental Disability Supports and Services; Section: # 3.29 – Transportation; Page: # 37)

- 1) Pre-Paid Inpatient Health Plans (PIHPs) and hence Community Mental Health Service Providers (CMHSPs) are responsible for transportation to and from the beneficiary's place of residence when provided so a beneficiary may participate in a state plan, Habilitation Support Waiver (HSW) or additional/1915(i) State Plan

Amendment (SPA) service at an approved day program site or in a clubhouse psychosocial rehabilitation program.

- 2) Medicaid Health Plans (MHPs) are responsible for assuring their enrollees' transportation to the primary health care services provided by the MHPs, and to (non-mental health) specialists and out-of-state medical providers.
- 3) Michigan Department of Health and Human Services (MDHHS) is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to Health Kids Dental, substance use, and mental health services (except those noted above and in the HSW program described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries. (Refer to the local MDHHS office or MHP for additional information, and to the Ambulance Chapter of this manual for information on medical emergency transportation.)
- 4) PIHP's payment for transportation should be authorized only after it is determined that it is not otherwise available (e.g., MDHHS, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.
- 5) The following travel circumstances apply for minor (under age 18 years of age) beneficiaries: Children under 12 years of age must be escorted to medically necessary appointments by a parent, foster parent, caregiver or legal guardian. For children between the ages of 12 and 18 years, a consent letter signed by a parent, foster parent, caregiver or legal guardian is required for a child to be transported without accompaniment unless access to the service does not require parental consent by the Medicaid program.
- 6) It is the requestor's responsibility to determine whether other less expensive means of transportation are available before requesting a Taxi Cab be provided by SCCMHA.
- 7) Incomplete Taxi Cab Vouchers will be returned to the Requestor to finalize request.
- 8) Natural Supports will be pursued to assist with transportation needs.
- 9) SCCMHA pays for transportation by taxi for the following SCCMHA services:
 - 1) Orientation Appointment
 - 2) SCCMHA Provider Network Health Care Appointment (Psychiatrist / RN)
 - 3) Court / Circuit Court / Family Court / District Court
 - 4) Hospital Admission
 - 5) Hospital Discharge
 - 6) Therapy Appointment (Ind / Group / Family)
 - 7) Return to Residence from SCCMHA
 - 8) Other* Refer to standard 13)

- 10) Transportation to groups such as the Consumer Leadership Group are not paid for by SCCMHA as the Stipend paid for participation is expected to cover the transportation costs.
- 11) SCCMHA does not pay for transportation to medical appointments for physical health care when it is the responsibility of the MHP or MDHHS.
- 12) SCCMHA may pay for transportation to Case Management appointments in the office (Only approved on a limited basis when specifically requested by the person served and this choice is documented in the IPOS). SCCMHA requires Case Management/Support Coordination to visit persons served in their home settings, generally at a minimum of once a month to help ensure welfare and well-being oversight.
- 13) There may be **exceptions** to the transportation to non-SCCMHA appointments when requested by any SCCMHA provider network clinical team supervisor and they may request approval by the Customer Service Supervisor for the following appointments:
 - a) Medical appointments for persons served with Fee for Service Medicaid
 - b) SSA Hearing to gain or remain with benefits
 - c) Housing related appointments – section 8
 - d) DHHS- Medicaid related issues
 - e) Social security related issues
 - f) Minimal supported employment related issues
 - g) Selective urgent medical situations:
 - I) For a same day appointment with a person's primary care physician or an Urgent Care visit (Purpose: to avoid Emergency Room (ER))
 - a) Persons served with Great Lakes Bay Health Center (GLBHC) as their primary care provider should arrange transportation with GLBHC
 - i) SCCMHA would transport in instances where a patient of GLBHC cannot be transported for a same day appointment by GLBHC
 - II) For transport to ER for a non-acute emergency when a primary care physician does not offer a same day appointment (Purpose: to avoid an ambulance transport)
 - III) For medical conditions that are evaluated by a primary care physician, urgent care facility or ER where a prescription is written that needs to be filled and taken after the visit. (Purpose: need to begin taking a medication immediately)
- 14) For an acute medical situation call for an ambulance, do not call and/or wait for a cab.
- 15) After Hours Taxi Vouchers are requested and approved by Crisis Intervention Services staff.

- 16) SCCMHA provides front door screening for SUD services. SCCMHA may provide non-urgent transportation to service sites. This requires an SCCMHA Administrative sign off.
- 17) Licensed Residential Adult Foster Care (AFC) Homes are responsible for providing transportation to medical appointments **(site AFC Licensing Rules)**.
- 18) Using the SCCMHA Taxi Voucher process requires Transportation to be the last resort for transportation according to the Michigan Medicaid Provider Manual.
- 19) Failure to accept a ride (no show) when a Taxi is arranged for an SCCMHA Network appointment will be dealt with on an individual basis. This may include the Support Coordinator or Case Manager checking on the individual and reviewing their plan to make adjustments to the individual needs.
- 20) All requests for a Taxi Cabs to take persons served to SCCMHA and Provider Network appointments will be completed in the sentri system attached to the appointment once you select “Consumer needs transportation” and click “Create taxi voucher.”

Definitions:

Prepaid Inpatient Health Plan (PIHP): a term contained in federal regulations from the Centers for Medicare & Medicaid Services. It means an entity that 1) provides medical services to enrollees under contract with the state Medicaid agency on the basis of prepaid capitation payments, 2) includes responsibility for arranging inpatient hospital care, and 3) does not have a comprehensive risk contract.

Requestor: SCCMHA Provider Network Staff requesting a Taxi be used for transporting to and/or from an SCCMHA Provider Network appointment.

References:

Michigan Medicaid Provider Manual Standard 3.29 – Transportation
 SCCMHA Customer Service Procedure # 09.05.01.07 for sentri Taxi Cab Vouchers

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Schedule SCCMHA or related mental health appointment and select “Consumer needs transportation.”	1) Support Coordinator, Case Manager, or administrative personnel (Requestor)

2) Click the MHP Instructions and schedule transportation through the MHP until MHP transportation is exhausted.	2) Support Coordinator, Case Manager, or administrative personnel (Requestor)
3) For urgent taxi vouchers or if the MHP is exhausted complete Taxi Voucher within sentri, ensuring all required fields are completed	3) Support Coordinator, Case Manager, or administrative personnel (Requestor)
4) Inside sentri, fax a completed copy of the Taxi Voucher form to the Taxi Vendor as available in sentri.	4) Customer Service Specialist

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Housing Local Appeal	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.01.17
Effective Date: 7/14/20	Date of Review/Revision: 2/9/21, 6/10/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO
	Supersedes:	
		Responsible Director: Director of Environmental Services, Customer Services, & Security Authored By: Director of Customer Services, Recipient Rights, & Security Additional Reviewers: Appeals Coordinator

Purpose:

The purpose of this policy is to establish guidelines to allow persons served of the Saginaw County Community Mental Health Authority (SCCMHA) Housing Resource Center (HRC) access to a local appeal process for actions taken relating to their housing services.

Policy:

It is the policy of SCCMHA to provide maximum protection of person served rights and to comply with state and federal guidelines. This local housing appeal process is in place to fulfill this obligation regarding persons served of SCCMHA housing services.

Application:

This policy applies to SCCMHA Housing Resource Center, Recipient Rights, and Customer Service Unit.

Standards:

- 1) State and Federal regulations require that HRC beneficiaries have access to a housing local appeal process of actions taken by SCCMHA Housing Resource Center relating to services being provided.
- 2) When violations are evident to HRC or land lord, notice will be sent with a requirement to correct the violations within 30 days, or the termination process will begin.
- 3) Persons served of SCCMHA housing services have 30 calendar days from the date of the notice of action to request a housing local appeal.

- 4) Housing Local Appeals (HLA) must be received in writing.
- 5) HLAs must be regarding an “Action” such as a reduction, or termination of housing services.
- 6) The date of the receipt of the HLA will be recorded when the request has been received in writing.
- 7) Persons served filing an HLA will be sent a letter acknowledging the receipt of the appeal within five (5) business days.
- 8) SCCMHA Customer Service will give persons served any assistance necessary for them to file the HLA, including arranging interpreter services if necessary and toll-free numbers that have adequate Michigan Relay Service and interpreter capability.
- 9) HLA information will be tracked and reported to the Compliance and Policy Team and forwarded to the Quality Governance Committee.
- 10) The person responsible in the previous level review or decision making will not be involved in making the decision of the local appeal.
- 11) The individual making the decisions on the HLA will be the same staff completing other Local Appeals.
- 12) When the SCCMHA HRC decides to terminate services, the person served or the person served representative will receive a Notice.
- 13) The person served or their representative will be provided with:
 - a) Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing
 - b) Opportunity, before and during the appeal process, to examine information being considered during the appeal process.
- 14) Standard resolution of a local appeal must be completed within 30 calendar days.
- 15) The Final Letter to the person served or their representative will be written. The date on the Final Letter sent to the person served or their representative is the Resolution Date unless otherwise noted.
- 16) The Final Letter will include the final decision and the process used to reach this decision.
- 17) The Final Letter must include an explanation of the results of the resolution and the date it was completed.

Definitions:

Action: A decision that adversely impacts a persons served claim for services.

Michigan Relay Service: A communications system that allows hearing persons and persons who are deaf, hard of hearing, or speech-impaired to communicate by telephone.

References:

Code of Federal Regulations (CFR) 578.91 Termination of Assistance to Program Participants

Exhibits:

Exhibit A - Customer Service Complaint Form

Exhibit B – Housing Resource Center (HRC) Letter

Procedure:

ACTION	RESPONSIBILITY
1) The Customer Service Office can assist with HLA requests.	1) Person served or their representative
2) The HLA is logged into a separate log than other SCCMHA Local Appeals. The log includes the Fiscal Year, Date Received, Complaint Number, Provider Name, Description of Appeal Type, Timely Resolution (Yes or No), Category, Number of Days to Complete, and the Date Completed.	2) Customer Service Supervisor
3) An acknowledgement letter is sent to the person served and/or their representative letting them know the appeal has been received within five (5) business days	3) Customer Service Supervisor
4) Information is gathered and reviewed and necessary interviews are conducted	4) Customer Service Supervisor
5) Appeal meeting may be scheduled with the person served and/or their representative and necessary clinical staff and the Supervisor or Director responsible for the services to meet the time frame for standard	5) Customer Service Supervisor
6) Time before reaching a decision will be scheduled for the person served and/or their representative	6) Customer Service Supervisor

sentative to review all the relevant information if requested by the person served	
7) The Final Letter is sent to the person served and/or their representative within 30 calendar days of the receipt of the appeal	7) Customer Service Supervisor

Exhibit A



Customer Service Complaint Form

(Customer Service-Grievance or Local
Appeal)



Instructions: Our goal is to provide the best service to the persons we serve. There are some state and federal regulations that SCCMHA must be in compliance with as well. In an effort to provide better service for all those we serve, we have developed a way to have your concerns heard and dealt with. If you have a complaint about anything related to Saginaw County Community Mental Health Authority, please let us know. We can receive your complaint verbally or in writing, anyone in Customer Services will be happy to help you. Please call the number below or send your questions or complaints to the Customer Services department at the address below. (989) 797-3452 or Toll Free 1-800-258-8678 or Michigan Relay Service 7-1-1 Saginaw County Community Mental Health Authority 500 Hancock Saginaw, MI 48602		
Complainant's Name	Person Served Name (if different from complainant)	
Complainant's Address	What Department does this involve?	
	Phone Number	
Describe what happened: _____ _____ _____ _____		
Do you have any recommendations on how to resolve this complaint? _____		
Complainant's Signature	Date	Name of Person Assisting Complainant

For Office Use Only:

Date received:	Received by:
Complaint Number:	Category:

1/31/25 MG

Exhibit B



CONTRACT TERMINATION NOTICE

Landlord Name and address:

Date:

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This notice serves as written verification of the termination of the Housing Assistance Payment Contract.

The contract (and lease agreement) will be terminated effective _____
Date

If the tenant continues occupancy beyond the termination date, the tenant will be responsible for paying the full amount of the contract rent. The Landlord is responsible for executing a new lease agreement with the tenant.

Tenant Name and address:

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Reason for Termination

Tenant move from unit	Contract violation by owner
Program violation by tenant	30-day notice by tenant
Tenant-caused housing quality standards (HQS) damages	Recertification paperwork not completed by tenant
Tenant evicted from unit	Tenant deceased
Lease termination by landlord	Other (Describe below):

If you have any questions or need further assistance, please contact:
Cathy Williams at 989-272-7215 or Supervisor Debbie Jones-Burt at 989-498-2263.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Complaint and Appeal Process	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.01
Effective Date: September 8, 1987	Date of Review/Revision: 2/19/03, 4/21/06, 7/25/07, 1/25/08, 6/29/09, 6/22/12, 6/13/14, 11/27/16, 6/1/18, 1/17/19, 2/11/20, 3/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
	Supersedes: 06.02.00.00, 02.02.02, 02.02.13 and 02.02.15	
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		

Purpose:

The purpose of this policy is to ensure the rights of the person served of Public Mental Health Services are protected according to P.A. 258, 1974, and the Michigan Mental Health Code, Chapters 7 and 7A.

Policy:

It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) to protect the rights of person served of mental health services, in addition to the rights, benefits, and privileges guaranteed by other provisions of the law, the Constitution of 1963, and the Constitution of the United States. The SCCMHA Recipient Rights Office shall provide a system for determining whether in fact violations have occurred and shall ensure that firm and fair disciplinary and appropriate remedial action is taken in the event of a violation. SCCMHA intends to protect the rights of all people served and to have a process in place for complainants (listed on a Recipient Rights Complaints), person served, the parent of a minor person served, or the person served guardian; if any, to appeal decisions made by the SCCMHA Office of Recipient Rights (ORR), they disagree with.

Application:

This policy applies to the Recipient Rights Office of SCCMHA to protect the rights of the person served receiving public mental health services from SCCMHA and its Network Providers. The Substance Use Disorder Coordinating Agency is responsible for developing policies specific to the Public Health Code related to Recipient Rights.

Standards:

- 1) The Your Rights booklet, a summary of rights, will be placed in all Orientation Folders given to SCCMHA person served during the intake process. The Your Rights booklet and a summary of rights will be given to the person served periodically during the time services are provided.
- 2) Recipient Rights information will be explained to all SCCMHA people served in an understandable manner during the intake process. If alternative methods, such as an interpreter for a different language are needed, documentation of the alternative methods as well as the interpreter's name used will be documented in the clinical record.
- 3) The SCCMHA Recipient Rights Office assures that person served, parents of minors, guardians, and others have ready access to Recipient Rights Complaint Forms.
- 4) Each Recipient Rights Complaint is recorded upon receipt in the SCCMHA Recipient Rights Complaint Module of Sentri II (database designed for the tracking of complaints).
- 5) Rights complaints filed by the person served or anyone on their behalf will be provided to SCCMHA ORR in a timely manner.
- 6) Acknowledgment of the complaint (recording) is sent along with a copy of the complaint to the complainant within five business days.
- 7) SCCMHA ORR notifies the complainant within five business days after receiving the complaint if it was determined that no investigation of the complaint was warranted.
- 8) SCCMHA ORR aids any person served or other individual with the complaint process, as necessary.
- 9) SCCMHA ORR advises people served or other individuals that there are advocacy organizations available to assist in preparation of written rights complaint and offers to make the referral.
- 10) In the absence of assistance from an advocacy organization, SCCMHA ORR will assist in preparing a written complaint which contains a statement of the allegation, the right allegedly violated, and the outcome desired by the complainant.
- 11) If a rights complaint had been filed regarding the conduct of the Chief Executive Officer, the rights investigation would be conducted by the ORR of another Community Mental Health Service Program (CMHSP) or by the MDHHS ORR as determined by the SCCMHA Board of Directors.

- 12) Investigations will be immediately initiated in cases involving alleged abuse, neglect, severe injury, or death of a person served when a rights violation was apparent or suspected.
- 13) SCCMHA ORR initiates investigations of apparent or suspected rights violations in a timely and efficient manner.
- 14) SCCMHA ORR issues a written status report every thirty calendar days during the investigation to the complainant, respondent, and the Responsible Mental Health Agency (RMHA) and that the Status Report will contain the following:
 - a) Statement of the allegations
 - b) Citations
 - c) Statement of the issues
 - d) Investigative progress to date and
 - e) Expected date of completion
- 15) SCCMHA ORR will complete investigations no later than ninety calendar days following the receipt of all complaints, unless awaiting action by external agencies (MDHHS, law enforcement, etc.).
- 16) A rights investigation may be reopened or reinvestigated by the rights office if there is new evidence that was not presented at the time of the investigation.
- 17) SCCMHA ORR will conduct investigations in a manner that does not violate the rights of any employee.
- 18) Investigation activities for each rights complaint will be accurately recorded by the SCCMHA ORR in Sentri II.
- 19) SCCMHA ORR uses a preponderance of the evidence as its standard of proof in determining whether a right was violated.
- 20) Upon completion of the investigation, the SCCMHA ORR will submit a written investigative report to the respondent and to the Chief Executive Officer of SCCMHA (Issuance of the written investigative report may be delayed pending completion of investigations that involve external agencies).
- 21) The written investigative report will include the following:
 - a) Statement of the allegations
 - b) Citations to relevant provisions of the law, rules, policies, and guidelines
 - c) Statement of the issues involved.
 - d) Investigative findings
 - e) Conclusions
 - f) Recommendations, if any

- 22) On substantiated rights violations, the RMHA and/or respondent will take appropriate remedial action that meets all the following requirements:
 - a) Corrects or provides remedy for the rights violation.
 - b) It is implemented in a timely manner.
 - c) Attempts to prevent a recurrence of the rights violation.
- 23) The remedial action taken on substantiated violations is documented and made part of the record maintained by SCCMHA ORR.
- 24) The Chief Executive Officer will submit a written summary report to the complainant and the person served, if different than the complainant, parent of a minor, or guardian, within ten business days after the Chief Executive Officer receives a copy of the investigative report from SCCMHA ORR.
- 25) The written summary report will contain all the following:
 - a) Statement of the allegations
 - b) Citations to relevant provisions of the law rules, policies, and guidelines
 - c) Statement of the issues involved.
 - d) Summary of investigative findings of SCCMHA ORR
 - e) Conclusions of SCCMHA ORR
 - f) Recommendations made by SCCMHA ORR, if any
 - g) Action taken, or plan of action proposed, by the respondent.
 - h) A statement describing the complainant's right to appeal, time limit, the grounds for making the appeal, and the process for filing an appeal.
- 26) SCCMHA and each service provider ensure that appropriate disciplinary action is taken against those who have engaged in abuse or neglect or retaliation and harassment including official reprimand, demotion, suspension, reassignment, or dismissal.
- 27) Information in the summary report will be provided within the constraints of the confidentiality/privileged communications sections (1748, 1750) of the Mental Health Code.
- 28) The SCCMHA ORR will ensure that information in the summary report will not violate the rights of any employee (ex. Bullard-Plawecki Employee Right to Know Act, (Act 397 of the Public Acts of 1978).
- 29) When either SCCMHA or service provider personnel fail to report suspected violations of rights, appropriate administrative action will be taken.
- 30) If the summary report contains a plan of action the director must send a letter indicating when the action was completed.
- 31) If the plan of action was proposed by the respondent at the time of the issuance of the original summary report, the Chief Executive Officer must submit an amended

summary report to the complainant, recipient, parent of a minor recipient, and/or guardian if one has been appointed once confirmation of final action was received by the rights office from the respondent. The amended summary report must indicate what final action was taken by the respondent and include notice of appeal rights.

- 32) The SCCMHA Board of Directors will appoint an Appeals Committee consisting of seven individuals or designate the Recipient Rights Advisory Committee (RRAC) as the Appeals Committee. A committee designated separately from the RRAC will have at least three members from the RRAC, at least two members of the Board of Directors and at least two primary persons served. Members can represent more than one of these categories. None of the members shall be employed by SCCMHA or MDHHS.
- 33) The Appeals Committee may request consultation and technical assistance from MDHHS ORR.
- 34) A member of the Appeals Committee who has a personal or professional relationship with an individual involved in the appeal will abstain from participating in that appeal as a member of the committee.
- 35) The complainant, person served (if different than the complainant), guardian or parent of a minor, in the summary report from the Chief Executive Officer, will be informed of the following: An appeal may be filed no later than 45 days after receipt of the summary report.
- 36) The grounds for the appeal are:
 - a) The investigative findings of the rights office are not consistent with the facts, law, rules, policies, or guidelines.
 - b) The action taken or plan of action proposed by the respondent does not provide an adequate remedy.
 - c) An investigation was not initiated or completed on a timely basis.
- 37) If the appeal concerns the timeliness of the investigation and the Appeals Committee confirms that the investigation was not initiated or completed in a timely manner, the committee must recommend that the Chief Executive Officer take remedial action to address the lack of timeliness with the rights office.
- 38) SCCMHA ORR will advise the complainant that there are advocacy organizations available to assist in preparing the written appeal and will offer to make a referral.
- 39) In the absence of assistance from an advocacy organization, SCCMHA ORR will assist the complainant in meeting the procedural requirements of a written appeal.
- 40) Within 5 business days after a written appeal, at least two members of the Appeals committee will review the appeal to determine whether the appeal meets the required criteria listed within this policy.

- 41) The results of the review and a copy of the appeal request will be provided, in writing, to the appellant, within five business days.
- 42) If the appeal is accepted, a copy of the appeal will be provided to the respondent and SCCMHA within five business days.
- 42a) If the appeal is accepted, no later than 30 calendar days after receipt of a written appeal the appeals committee must meet in closed session to review the facts as stated in complaint investigation documents in light of the reason for appeal. The appeals committee must not consider allegations that were not part of the original complaint but must inform appellant of their right to file a new complaint with the office.
- 42b) The Appeals Committee will do one of the following in deciding upon an appeal:
 - a) Uphold the findings of the rights office and the action taken or plan of action proposed by the respondent.
 - b) Return the investigation to the rights office with a request that it be reopened or reinvestigated.
 - c) Uphold the investigative findings of the rights office but recommend that the respondent take additional or different action to remedy the violation.
 - d) Recommend that the SCCMHA Board of Directors request an external investigation by MDHHS ORR.
- 43) The Appeals Committee will document its decision and justification for the decision in writing.
- 44) Within 10 days after reaching its decision, the Appeals Committee will provide copies of the decision to the respondent, appellant, person served (if different than the appellant), person served guardian if one has been appointed, SCCMHA, and the SCCMHA ORR.
- 45) Copies of the Appeals Committee decision will include a statement of the appellant's right to appeal to MDHHS (Level 2), the time frame for appeal (45 days from the receipt of the decision) and the grounds (reason) for the appeal (investigative findings of the rights office are inconsistent with the law facts, rules, policies, or guidelines).
- 46) If an investigation is returned to SCCMHA by an Appeals Committee for reinvestigation, the office will complete the reinvestigation within 45 days following the standards established in 330.1778.
- 47) If an investigation is returned to SCCMHA by an Appeals Committee for reinvestigation, upon receipt of the investigative report, the respondent will take the appropriate remedial action and SCCMHA ORR will submit a written summary report to the complainant, person served, if different than the complainant, parent or guardian, and the Appeals Committee within 10 business days.

- 48) If a request for additional or different action is sent to the respondent , a response will be sent within 30 days as to the action taken or justification as to why it was not taken. The response will be sent to the complainant, person served, if different than the complainant, parent of a minor, or guardian, and the Appeals Committee.
- 49) If the committee notifies the SCCMHA Board chair of a recommendation to seek an external investigation from MDHHS ORR, the board will send a letter of request to the director of MDHHS ORR within five business days of receipt of the request from the Appeals Committee. An external investigation must be conducted within the timeframes outlined under Sec.778. The MDHHS rights office must submit an amended investigative report to the Chief Executive Officer and board directors. Within 10 business days of receipt of the amended report the Chief Executive Officer must issue an amended summary report in compliance with sec.782. The amended summary report must be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the parent of a minor recipient, rights office and the Appeals Committee. If the appellant still disagrees with the conclusion of the rights investigation or asserts that the investigative findings of the rights office are not consistent with the facts or with law, rules, policies, or guidelines they may file an appeal with MDHHS (Level 2) Appeals Committee. .
- 50) It is the standard of SCCMHA that all services are available to all individuals regardless of any disability, race, color, ethnicity, national origin, religion, gender identity status, veteran status, age, sex, sexual orientation, or any other characteristic protected by law. SCCMHA will provide services in accessible locations. Any individual who alleges a violation of section 504 and grievances related to the Americans with Disability Act may file a complaint with the SCCMHA Rights Office.
- 51) The Recipient Rights Officer and Investigator/Advisor will have unimpeded access to all SCCMHA programs as well as all SCCMHA Network Provider locations, all staff employed by or under contract, and all evidence necessary to conduct a thorough investigation or to fulfill its monitoring function.
- 52) SCCMHA ORR will maintain a neutral stance on all complaints until which time the investigative findings reveal the facts about the complaint.
- 53) SCCMHA Board shall empower the Recipient Rights Office with authority to intervene as necessary to protect the person served rights within the SCCMHA system.
- 54) The Chief Executive Officer shall ensure adequate Recipient Rights coverage. In the absence of both the Recipient Rights Officer and the Rights Investigator/Advisor, the Chief Executive Officer shall appoint a designee with non-clinical responsibilities to receive and initiate investigation of alleged persons served rights violations.
- 55) To maintain the confidentiality of the Recipient Rights process, the offices of the Recipient Rights Officer and the Recipient Rights Investigators/Advisors will be kept

locked when not occupied and only SCCMHA ORR staff will have electronic access and keys assigned to them to enter these offices.

- 56) A person served rights complaint may be written or verbal or based on a determination that an incident report represents an alleged violation of the Michigan Mental Health Code.
- 57) All rights complainants, rights staff, and other advocates shall not be harassed or retaliated against due to the investigation or determination of a rights complaint. Any action construed to be harassment or retaliation shall be reported immediately to the Chief Executive Officer, and appropriate disciplinary action shall be taken.

Definitions:

Code Protected Right: A right as defined by the Michigan Mental Health Code.

Sentri II Recipient Rights Complaint Module: The database designed for the tracking of complaints.

Preponderance of Evidence: Black's Law Dictionary (Sixth Edition) defines a preponderance of the evidence as: "Evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it...Preponderance of evidence may not be determined by the number of witnesses, but by the greater weight of all evidence, which does not necessarily mean the greater number of witnesses, but the opportunity for knowledge, information possessed, and manner of testifying determines the weight of testimony."

Recipient Rights Complaint: An allegation that a Code Protected Right has been violated.

References:

Michigan Administrative Rules 7035
Michigan Administrative Rules 7011
American Disabilities Act
Bullard Plawecki Act
Job Descriptions of the Recipient Rights Officer and the Recipient Rights Investigator/Advisor
MDHHS/CMH Contract Attachment C6.3.2.4
Michigan Mental Health Code 330.1152
Michigan Mental Health Code 330.1706
Michigan Mental Health Code 330.1722
Michigan Mental Health Code 330.1755
Michigan Mental Health Code 330.1774
Michigan Mental Health Code 330.1776
Michigan Mental Health Code 330.1778
Michigan Mental Health Code 330.1780
Michigan Mental Health Code 330.1782
Michigan Mental Health Code 330.1784

Michigan Mental Health Code 330.1786
SCCMHA Policy 02.01.13 Limited English Proficiency

Exhibits:

None

Procedure:

ACTIONS	RESPONSIBLE
General Recipient Rights	
1) The rights of people served receiving mental health services will be protected.	1) Recipient Rights Officer
2) Person served, parents of minors, and guardians or other legal representatives will have access to Recipient Rights Booklets titled "Your Rights," which summarizes Chapter 7 & 7A of the Mental Health Code. The receipt shall be documented in the case record. The person served rights system shall be verbally explained. If the person served or guardian is unable to read or understand the material or is considered to have Limited English Proficiency, every effort shall be made to assist in that explanation and will be noted in the case record.	2) Supports Coordinator, Case Manager, or Primary Therapist.
3) The name, address, and phone number of the Rights Officer or Investigator/Advisor shall be conspicuously posted at all SCCMHA service sites including the SCCMHA contracted Provider Network.	3) Recipient Rights Office
4) All incident reports will be reviewed to determine if they involve rights violations.	4) Recipient Rights Advisor/Investigator
5) When an allegation is outside of the agency's jurisdiction, the complainant or person served will be informed of how to contact the appropriate agency.	5) Recipient Rights Advisor/Investigator
6) Records of investigating alleged violations are maintained independent of person served case records, and subject to all applicable confidentiality safeguards. All investigative documents and evidence shall be secured.	6) Recipient Rights Advisor/Investigator
7) All SCCMHA sites and the Provider Network service sites where the SCCMHA has responsibility to	7) Recipient Rights Advisor/Investigator

provide direct services will be visited on an annual basis.	
8) All individuals employed by SCCMHA or the Provider Network of SCCMHA shall receive training related to the person served rights protection before or within 30 days after being employed and annually thereafter.	8) Recipient Rights Office staff or Auditors from Network Services and Public Policy
9) Recipient Rights policies of SCCMHA will be followed by all SCCMHA programs as well as the SCCMHA contracted Provider Network.	9) Recipient Rights Officer
10) The Recipient Rights Officer or Advisor shall attend the Behavior Treatment Committee meetings, Continuous Quality Improvement meetings, Management Team meetings, Board meetings, and individual case meetings when rights-related matters are discussed.	10) Recipient Rights Officer or designee
11) Both staff and the people served are aware of their due process rights, specifically: a) The nature of the complaint / investigation. b) The opportunity to provide evidence on their behalf.	11) Recipient Rights Advisor/Investigator
12) The Office of Recipient Rights shall function as a consultant to the Chief Executive Officer and staff to ensure compliance in rights manners.	12) Recipient Rights Officer
13) A Recipient Rights Advisory Committee that meets regularly reviews aggregate data and information from Recipient Rights investigations will be established in accordance with Michigan Mental Health Code Section 330.1757.	13) SCCMHA Board
14) The Recipient Rights Office will complete regular reports (at least quarterly) to present to the Recipient Rights Advisory Committee. These reports will be an aggregate review of the investigations completed by the Recipient Rights Office.	14) Recipient Rights Officer
15) An annual budget that assures adequate provision of person served rights services to SCCMHA person served will be reviewed and approved annually by Recipient Rights Advisory Committee.	15) Chief Executive Officer

16) Submit to the board of the SCCMHA & MDHHS an annual and semi-annual report prepared by the Recipient Rights Office on the status of recipient rights and a review of the operations of the Recipient Rights Office.	16) Chief Executive Officer
Complaint Process	
17) Complaints received or initiated by SCCMHA ORR will be logged into the Sentri II Recipient Rights Complaint Module upon receipt.	17) Recipient Rights Advisor/Investigator
18) When a complaint is received from the Customer Service Office, the complaints will be recorded in the Sentri II database and indicate in the database the complaint is a referral from Customer Service staff.	18) Recipient Rights Advisor/Investigator
19) Assist in the filing of a rights complaint when requested and/or file a rights complaint when they are aware of a violation of a person served rights.	19) Recipient Rights Advisor/Investigator
20) Assist in filling out Recipient Rights complaint forms and turning them over to the Recipient Rights Office for investigation.	20) Customer Service staff
21) Complaints will be investigated in a fair and timely manner (timely as defined by the Michigan Mental Health Code requires that investigations be completed within 90 days of receipt of a complaint) by the Recipient Rights Officer or Advisor. There may be an exception to this time limit for the reason of waiting for an external investigative process such as through MDHHS, law enforcement, or another appropriate external agency.	21) Recipient Rights Advisor/Investigator
22) The office shall issue a written status report every 30-calendar day during the investigation.	22) Recipient Rights Advisor/Investigator
23) Complaints brought to the Recipient Rights Office that are not investigated due to being out of the jurisdiction of the Recipient Rights Office or determined not to be a Code Protected Right will be documented in accordance with Chapter 7A.	23) Recipient Rights Advisor/Investigator

24) An independent determination will be completed as to whether each allegation is substantiated or not substantiated and recommend to the Chief Executive Officer appropriate remedial action when an allegation is substantiated. The preponderance of evidence standards shall be used in making this determination.	24) Recipient Rights Officer
25) A Report of Investigative Findings will be completed and sent to the appropriate parties with a decision to substantiate or not substantiate the alleged violation.	25) Recipient Rights Advisor/Investigator
26) Upon the receipt of the Investigative Findings Report, a summary report will be sent to the complainant within 10 days.	26) Chief Executive Officer
27) Appropriate remedial action will be taken when a complaint is substantiated. The action will be implemented in a timely manner and recorded in the Sentri II database. a) If the Summary report contains a plan of action to be completed in the future, the Chief Executive Officer shall assure that the complainant, person served if different that the complainant, his/her legal guardian, if any, and the office are provided with written notice of the completion of the plan. b) The notice shall include specific information as to the action that was taken and the date that it occurred, if it is different than that proposed. c) The complainant, the person served, if different that the complainant and his/her legal guardian, shall have 45 days from the mailing date of the notice to appeal. d) The Appeal may be sent to the Appeals Committee on the grounds of inadequate action taken to remedy a rights violation.	27) Recipient Rights Advisor/Investigator
28) Written consent will be obtained from the person served or guardian when the complainant is not the person served or guardian, prior to disclosure of confidential information.	28) Recipient Rights Advisor/Investigator

29) When an Investigative Summary includes information involving disciplinary action to a SCCMHA employee or an employee of a SCCMHA contracted Provider Network, Human Resources, or the contracted agency will be notified so that they may notify the employee the information is being sent to a third party in accordance with the Bullard Plawecki Act.	29) Chief Executive Officer
Appeal Process	
30) In the summary report from the Chief Executive Officer, the complainant listed on Recipient Rights Complaint, person served, the parent of a minor person served, or the person served guardian, if any shall be informed of their right to appeal.	30) Chief Executive Officer
31) Within five business days after receipt of a written appeal, two members of the Recipient Rights Appeals Committee shall review the appeal to determine whether it meets the criteria for an appeal.	31) Recipient Rights Appeals Committee
32) The appellant will be notified in writing within five business days of the decision of the Recipient Rights Appeals Committee, as to whether or not the appeal will be reviewed.	32) Recipient Rights Appeals Committee
33) Within 30 days after receipt of an accepted written appeal, the appeals committee shall meet and review the facts as stated in all complaint investigation documents; and shall decide based on the Standards Section above.	33) Recipient Rights Appeals Committee Members
34) Any member of the Recipient Rights Appeal Committee who has a personal or professional relationship with an individual involved in an appeal, shall abstain from participating in that appeal as a member of the committee.	34) Recipient Rights Appeals Committee
35) The Recipient Rights Appeals Committee shall document its decision in writing, within ten working days of reaching its decision.	35) Recipient Rights Appeals Committee
36) The committee shall provide copies of the decision to the respondent, SCCMHA, and the appellant or the person served, parent of a minor person served,	36) Recipient Rights Appeals Committee

or the guardian of a person served; if any, if different from the appellant, and the Rights Office.	
37) Included in this written decision shall be described, the appellant's right to a second level appeal to MDHHS—State Office of Administrative Hearings and Rules.	37) Recipient Rights Appeals Committee
38) If the Recipient Rights Appeals Committee directs the Office of Recipient Rights to reopen or reinvestigate the complaint, the Office shall submit another investigative report in compliance with MHC section: 778 (5), within 45 days of receiving the written decision of the Recipient Rights Appeals Committee. The 45-day time limit may be extended to no longer than 90 days by the Recipient Rights Appeals Committee upon showing good cause by the Office.	38) Recipient Rights Officer
39) Within ten days of receipt of the investigative report, the Chief Executive Officer must issue another summary report in compliance with MHC section: 1782. The summary report shall be submitted to the appellant, complainant, person served, recipient's legal guardian; if any, parent of a minor person served, the Recipient Rights Office, and the Appeals Committee. a) In the event that the investigative findings of the Office remain the same as those originally appealed, the appellant, complainant, person served, person served legal guardian, or parent of a minor person served may file a second level appeal to MDHHS. b) The summary report shall contain information regarding the right to further appeal, the time limit for appeal, and the ground for appeal. c) The summary report shall also advise advocacy organizations available to assist in filing a written appeal or offer the assistance from the Office of Recipient Rights in the absence of assistance from an advocacy organization. d) In the event that the Appeals Committee upholds the findings of the Office of Re-	39) Chief Executive Officer

ipient Rights and directs the respondent to take additional action, that direction shall be based upon the fact that appropriate remedial action was not taken in compliance with Michigan Mental Health Code section 330.1780.	
40) Within 30 days of receipt of the determination by the Appeals Committee the respondent shall provide written notice that action has been taken, or justification as to why it has not. This written notice shall be sent to the appellant, person served, person served guardian, parent of a minor person served, SCCMHA, and the Office of Recipient Rights.	40) Respondent
41) If the Appeals Committee and/or appellant, person served, person served guardian, or parent of a minor person served determines that the action taken by the respondent is still inadequate, the appellant, person served, person served guardian, or parent of a minor person served shall be informed of his or her right to file a complaint against the SCCMHA Chief Executive Officer for violation of Michigan Mental Health Code section 330.1755 (3), (b).	41) Appellant

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Confidentiality	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.05
Effective Date: March 7, 2000	Date of Review/Revision: 3/19/03, 1/25/08, 6/29/09, 2/22/10, 6/22/12, 6/13/14, 11/27/16, 6/6/18, 1/8/19, 2/21/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights
	Supersedes: 06.02.04.00	
		Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights

Purpose:

The purpose of this policy is to protect the information in the record of a recipient, and other information acquired while providing public mental health services to a recipient.

Policy:

Information obtained through the course of public mental health treatment shall be kept confidential unless the person served has signed an Authorization to Release Medical Information or is otherwise specified by law.

Application:

This Policy applies to all Saginaw County Community Mental Health Authority (SCCMHA) direct operated programs as well as all SCCMHA Service Provider Network programs.

Standards:

- 1) As stated in the Policy Section, all information in the clinical record and other information obtained while providing services is confidential.
- 2) A summary of the Michigan Mental Health Code section 330.1748 is made a part of every person served record.
- 3) For case records made following March 28, 1996; information made confidential by Section 330.748 of the Michigan Mental Health Code, shall be disclosed to a competent adult person served upon the recipient's request. Release will be done as expedient.

tiously as possible, but in no event, later than the 30 days of the request, or prior to release from treatment.

- 4) Except as otherwise provided in 1748 (4), if consent has been obtained from:
 - a) The recipient,
 - b) The recipient's guardian who has the authority to consent,
 - c) A parent with legal custody of a minor recipient, or
 - d) Court appointed personal representative or executor of the estate of a deceased recipient, information made confidential by 1748 may be disclosed to:
 - 1) a provider of mental health services to the recipient, or
 - 2) the recipient, his or her guardian, the parent of a minor, or another individual or agency unless, in the written judgement of the holder {of the record} the disclosure would be detrimental to the person served or others.
- 5) When requested, information shall be disclosed only under one or more of the following circumstances:
 - a) Pursuant to order or subpoenas of a court of record or legislature for non-privileged information unless the information is privileged by law.
 - b) To a prosecuting attorney as necessary for the prosecutor to participate in a proceeding governed by the Mental Health Code.
 - c) To an attorney for the person served with consent of the recipient, the recipient's guardian with authority to consent, or the parent with legal and physical custody of a minor recipient.
 - d) To the Auditor General.
 - e) When necessary, to comply with another provision of the law.
 - f) To MDHHS when information is necessary for the department to discharge a responsibility placed upon it by law.
 - g) To a surviving spouse, or if not, closest relative of the recipient, to apply for and receive benefits, but only if the spouse or closest relative has been designated the personal representative or has a court order.
- 6) For requests made for confidential information by a person or agency not covered under 1748(4) the following steps will be followed.
 - a) The holder of the record shall not decline to disclose information whether a person served, or other empowered representative has consented, except for a documented reason.
 - b) If a holder declines to disclose, there shall be a determination whether part of the information can be released without detriment.
 - c) Once the decision has been made to not release information based on determination, the Chief Executive Officer (CEO) will review the information and determine if a part of the information requested may be released without detriment and will provide the decision in writing.
- 7) This review shall not exceed three business days if the record is on-site, or ten business days if the record is off-site.

- 8) The requester of the information may file a complaint with the SCCMHA ORR if he or she disagrees with the decision of the CEO.
- 9) Attorneys representing recipients may review records only upon presentation of identification and the recipient's consent or a release executed by the parent or guardian shall be permitted to review the record on the provider's premises.
- 10) An attorney who has been retained or appointed to represent a minor pursuant to an objection to hospitalization of a minor shall be allowed to review the records.
- 11) Attorneys who are not representing recipients may review records only if the attorney presents a certified copy of an order from a court directing disclosure of information concerning the person served to the attorney.
- 12) Attorneys shall be refused information by phone or in writing without the consent or release from the person served, or the request is accompanied or preceded by a certified copy of an order from a court ordering disclosure of information to that attorney.
- 13) A private physician or psychologist appointed by the court, or retained for testimony in civil, criminal, or administrative proceedings shall, upon presentation of identification and a certified copy of a court order, be permitted to review the records of the person served on SCCMHA premises. Before the review, notification shall be provided to the reviewer and to the court if the records contain privileged communication which cannot be disclosed in court, unless disclosure is permitted because of an express waiver of privilege or because of other conditions that, by law permit or require disclosure.
- 14) A prosecutor may be given non-privileged information or privileged information which may be disclosed if it contains information relating to names of witnesses to acts which support the criteria for involuntary admission, information relevant to alternatives, to admission to a hospital or facility and other information designated in policies of SCCMHA.
- 15) Information shall be provided as necessary for treatment, coordination of care, or payment for the delivery of mental health services, in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191.
- 16) The holder of a record may disclose information that enables a person served to apply for or receive benefits without the consent of the person served or legally authorized representative only if the benefits shall accrue to the provider or shall be subject to collection for liability for mental health service.

- 17) SCCMHA shall grant a representative of the Disability Rights of Michigan access to the records of all of the following:
 - a) A recipient, if the recipient, the recipient's guardian with authority to consent, or a minor's parents with physical and legal custody of the recipient, have consent to the access.
 - b) A recipient, including a person served who has died, or whose whereabouts are unknown, if, all of the following apply:
 - i) Because of mental or physical condition, the person served is unable to consent to access.
 - ii) The person served does not have a guardian or other legal representative, or the recipient's guardian is the State.
 - iii) Disability Rights of Michigan has received a complaint on behalf of the recipient, or has probable cause to believe, based on monitoring or other evidence, that the person served has been subject to abuse or neglect.
 - c) A person served who has a guardian or other legal representative if all of the following apply:
 - i) A complaint has been received by the protection and advocacy system or there is probable cause to believe the health or safety of the person served is in serious and immediate jeopardy.
 - ii) Upon receipt of the name and address of the recipient's legal representative, Disability Rights of Michigan contacted the representative and helped in resolving the situation.
 - iii) The representative has failed or refused to act on behalf of the recipient.
- 18) The records, data, and knowledge collected for or by individuals or committees assigned a peer review function including the review function under section 143a (1) of the Mental Health Code are confidential, are used only for the purpose of peer review, are not public records, and are not subject to court subpoena.
- 19) SCCMHA, when authorized to release information for clinical purposes by the recipient, their guardian, or a parent of a minor, releases a copy of the entire medical and clinical record to the provider of mental health services.
- 20) Upon receipt of a written request from the Department of Health and Human Services and/or Child Protective Services, every effort will be made to provide the requested records or information by the next business day. However, compliance with the request will not exceed 14 days from the receipt of the request.
- 21) 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 factual information in the recipient's record; the person served or other empowered representative will be allowed to insert into the record a statement correcting or amending the information at issue; the statement will become part of the record.
- 22) A record is kept of disclosures including:
 - a) Information released

- b) To whom it is released
 - c) Purpose stated by person requesting the information
 - d) Statement indicating how disclosed information is appropriate to the state purpose
 - e) The part of law under which disclosure is made
 - f) Statement that the people receiving the disclosed information could only further disclose consistently with the authorized purpose for which it was released.
- 23) Any person receiving information made confidential by this policy shall disclose the information to others to an extent consistent with the authorized purpose for which the information was obtained. A record shall be kept of all disclosures including:
- a) Information released
 - b) To whom it is released
 - c) Purpose stated by the person requesting the information
 - d) Statement indicating how disclosure information is appropriate to the stated purpose.
 - e) The part of law by which disclosure is made
 - f) Statement that the people receiving the disclosed information could only further disclose consistently with the authorized purpose for which it was released.
- 24) Information may be disclosed at the discretion of the holder of the record:
- a) As necessary for the purpose of, outside research, evaluation, accreditation, or statistical compilation, provided that the person who is the subject of the information be identified from the disclosed information, only when such identification is essential in order to achieve the purpose for which the information is sought or when preventing such identification would clearly be impractical. But, in no event when the subject of the information is likely to be harmed by such identification.
 - b) To providers of mental or other health services or a public agency when there is a compelling need for disclosure based upon a substantial probability of harm to another person.
- 25) Unless 330.748(4) applies, if a request for information has been delayed, the CEO shall review the request.

Definitions:

Holder of the record: The agency given charge over a record which contains confidential information obtained through the course of mental health treatment.

References:

Mental Health Code: 330.1748
 Mental Health Code: 330.1749
 Mental Health Code: 330.1776
 Administrative Rules: 330.7051
 45 Code of Federal Regulations 164.502(g)(4)

Health Insurance Portability and Accountability act of 1996
Public Law 104-19

Exhibits:

Exhibit A - Saginaw County Community Mental Health Authority Release of Information

Procedure:

ACTIONS	RESPONSIBLE
1) Any requests for information contained in person served medical records are directed at the Medical Records Unit.	1) People requesting medical records
2) Any individual requesting medical records, including recipients, will be required to sign the appropriate release to receive the requested information.	2) Medical Records staff
3) Requests for medical records are processed in accordance with the Standards contained in this policy.	3) Medical Records staff

Saginaw County Community Mental Health Authority
Michigan Department of Health and Human Services (MDHHS)
(Revised 9-25)

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

Why This Form is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

To give consent, fill out Sections 1, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3, and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it to your health care provider. They can make a copy for you.

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last)
Janet W. Doe

Date of Birth
07/04/1988

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

- ☐ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.

This consent expires (optional)
03/12/2027

When providing a consent for treatment, payment, and health care operations there is the potential for records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected under 42 CFR Part 2.



A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

Pre-paid Inpatient Health Plan (PIHP)
Mid-State Health Network

- 500 Hancock Street Saginaw, MI 48602-4224
Phone: 989-797-3400 Fax: 989-799-0206

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

☒ Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 3a

- ☐ Do not share my information through the organizations listed below.
- ☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

1. PCE Systems

- ## 2. Michigan Health Information Network

Choose one option:

- ☒ Share all of my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."
- ☐ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.

Date, event, or condition

<ONE YEAR FROM SIGNATURE DATE>

Read the statements below, then sign and date the form.

By signing this form, I understand:



- I am giving consent to share my behavioral health and/or substance use disorder records. This includes referrals and services for alcohol and substance use disorders and/or other information may also be shared.
- My records may be shared with the people or organizations as described above.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes and/or with substance use disorder counseling notes."
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.

Electronically Signed By:

Kentera Patterson BS

03/17/2026

STAFF SIGNATURE / CREDENTIALS

DATE

CONSUMER SIGNATURE

PRINTED NAME

DATE

PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE
SIGNATURE

PRINTED NAME

DATE

WITNESS SIGNATURE

PRINTED NAME

DATE

SECTION 6 - TAKE AWAY YOUR CONSENT, WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed above. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

- ☐ Self
- ☐ Parent (Print Name)
- ☐ Guardian (Print Name)
- ☐ Authorized Representative (Print Name)

Signature

Date

SECTION 7 - FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdraw of Consent

☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

- ☐ Individual listed in Section 1
☐ Parent (Print Name)
☐ Guardian (Print Name)
☐ Authorized Representative (Print Name)

Print name of person who received the verbal withdrawal

Signature

Date

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent

Additional Identifiers (Optional)

Medicaid	Last 4 of the Social Security Number	Case #
000123456789	*****9998	000000012

Form Copy (choose one option)

- ☒ The individual in Section 1 **received** a copy of this form.
☐ The individual in Section 1 **declined** a copy of this form.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, national origin, color, sex, disability, religion, age, height, weight, family status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: This form is acceptable to MDHHS as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.

COMPLETION: Voluntary but required of disclosure is requested.



Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Reporting Complaints and Alleged Violations	Chapter: 02 - Customer Services and Recipient Rights	Subject No: 02.02.06
Effective Date: 9/1/15	Date of Review/Revision: 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights
	Supersedes:	
		Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights

Purpose:

The purpose of this policy is to establish standards for the reporting of recipient rights complaints and alleged violations to the Saginaw County Community Mental Health Authority (SCCMHA) Office Recipient Rights (ORR).

Policy:

It is the policy of SCCMHA for staff to report recipient rights complaints and alleged violations to SCCMHA ORR.

Application:

This policy applies to all SCCMHA personnel and the service sites within the Service Provider Network.

Standards:

- 1) Recipient Rights complaints and alleged violations occurring in the lives of person served while receiving services from SCCMHA and the Provider Network will be reported to the SCCMHA ORR within 24 hours.
- 2) All Recipient Rights complaints and alleged violations must be reported by completing a Recipient Rights Complaint Form or by other forms of communication including telephone and email.
- 3) Incidents involving a death, or significant physical or psychological injury or serious rights complaint (Abuse & Neglect) should be immediately reported by phone to SCCMHA ORR.

- 4) All individuals shall have unimpeded access to SCCMHA ORR.
- 5) Staff are to directly report Abuse or Neglect or any potential Rights complaints to the ORR and to all applicable agencies as required by law.

Staff's submission of an Incident Report does not satisfy reporting requirements to directly report to the ORR.

Definitions:

Staff: Individuals working within SCCMHA Board Operation Programs and SCCMHA provider network. This includes paid staff, interns, volunteers, and Self-Determination.

Complaints or Alleged Violations: A statement of the alleged right that may have been violated. The rights of the recipient as defined in the Michigan Mental Health Code. Such occurrences shall include but are not limited to:

- 1) Death (any death of a person served of SCCMHA services, including a death occurring in a private residence)
- 2) Any injury of a person served, explained or unexplained
- 3) Suspected abuse or neglect of a person served
- 4) Suspected sexual abuse
- 5) Exploitation
- 6) Unreasonable Force
- 7) Medication Errors
- 8) Confidentiality
- 9) Dignity and Respect
- 10) Treatment Suited to Condition
- 11) Safe, Sanitary, Humane treatment environment
- 12) Personal property
- 13) Freedom of Movement
- 14) Communication by mail, phone, visits

References:

None

Exhibits:

Exhibit A - Recipient Rights Complaint Form

Procedure:

ACTION	RESPONSIBILITY
1) Any time a complaint or alleged violation occurs it shall be reported to the Office of Recipient Rights within 24 hours. A) Immediately report to the Recipient Rights Office by calling (989) 797-3462, (989) 797-3583, or (989) 272-7606.	1) Any individual working for SCCMHA and within SCCMHA Provider Network with knowledge of a potential Rights violation

B) Forward completed Recipient Rights Complaint Form to SCCMHA ORR Recipient Rights Office by: Fax to (989) 797-3595, Drop box located outside the 500 Hancock facility; or Delivered to the Customer Service Office located in the 500 Hancock lobby during regular business hours; Monday through Friday from 8:00 a.m. to 5:00 p.m.

**Saginaw County Community Mental Health Au-
thority Recipient Rights Com-
plaint Form**

Complaint Number	Category

Instructions:

If you believe that one of your rights has been violated you (or someone on your behalf) may use this form to make a complaint. A Rights Officer/Advisor will review the complaint and follow up with you. Send your complaint to:

**Saginaw County Community Mental Health Authority
Office of Recipient Rights
500 Hancock
Saginaw, MI 48602**

Complainant's Name	Recipient's Name (if different from complainant)	
Complainant's Address	Phone Number	
Where did the alleged violation happen?	When did it happen? (Date & Time)	
What right was violated?		
Describe what happened		
What do you want to have happen in order to correct the problem?		
Complainant's Signature	Date	Name of Person Assisting Complainant

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Services Suited to Condition	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.02.07
Effective Date: September 16, 1998	Date of Review/Revision: 1/10/03, 4/27/06, 1/25/08, 6/29/09, 6/22/12, 6/13/14, 11/27/16, 6/1/17, 1/1/18, 1/8/19, 2/11/20, 3/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
	Supersedes: 06.02.06.00, 06.02.06.01, 06.02.08	
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		

Purpose:

The purpose of this policy is to ensure people served of mental health services receive appropriate/suitable services, in a suitable treatment environment, and in a suitable setting.

Policy:

It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) that all people served receiving mental health services from SCCMHA, and the Service Provider Network have the right to receive services suited to their condition.

Application:

This policy applies to all staff of SCCMHA as well as the Service Provider Network.

Standards:

- 1) SCCMHA will notify the applicant, their guardian, parent of a minor, or loco parentis that a second opinion to determine if the applicant has a serious mental illness, serious emotional disturbance, or a developmental disability, or is experiencing an emergency or urgent situation may be requested if denied services.
- 2) SCCMHA ensures a person-centered planning process is used to develop a written Individual Plan of Service (IPOS) in partnership with the person served.
- 3) The IPOS will include an assessment of the person served need for food, shelter, clothing, health care, employment opportunities where appropriate, educational opportunities where appropriate, legal services and recreation.

- 4) The IPOS will identify any restrictions or limitations of the person's served rights and will include documentation describing attempts to avoid such restrictions as well as what action will be taken as part of the plan to mitigate or eliminate the need for the restrictions in the future.
- 5) Restrictions, limitations, or any intrusive behavior treatment techniques are reviewed by a formally constituted committee of mental health professionals with specific knowledge, training, and expertise in applied behavioral analysis.
- 6) The justification for the exclusion of individuals chosen by the person served to participate in the IPOS process will be documented in the case record.
- 7) SCCMHA and/or the service provider will ensure a person served is given a choice of physician or mental health professional within the limits of available staff. If the decision under this policy is to deny a change in mental health professionally, the person served may have the decision reconsidered six months after the decision has been made. The only acceptable reason a person served will be denied a request for a change of physician or other mental health professionals will be:
 - a) Clinical reason the change should not be made, the Clinical Risk Management Committee can only make this decision.
 - b) If there is not an available alternative, documentation as to the reason no alternative is available will be required.
 - c) If services received by a recipient are in a specialty category, SCCMHA will not be required to offer a choice of a mental health professional that is not already trained in the specialty area.A recipient will be informed orally and in writing of their clinical status and progress at reasonable intervals established in the individual plan of service in a manner appropriate to their clinical condition.
- 8) SCCMHA will ensure a person served may request a second opinion, if the pre-admission screening unit (Crisis Intervention Services) denied hospitalization and that:
 - a) The Chief Executive Officer arranges the second opinion to be performed within three days: excluding Sundays and holidays.
 - b) The Chief Executive Officer in conjunction with the Medical Director reviews the second opinion if this differs from the opinion of Crisis Intervention Services
 - c) The Chief Executive Officer's decision to uphold or reject the findings of the second opinion is confirmed in writing to the requestor; this writing contains the signatures of the Chief Executive Officer and Medical Director or verification that the decision was made in conjunction with the Medical Director
- 9) For people served needing a Behavior Treatment Plan, a comprehensive assessment/analysis of a recipient's challenging behaviors will be conducted prior to the implementation of the Behavior Treatment Plan.

- 10) The Behavior Treatment Committee will meet regularly to develop, review, and approve plans to address challenging behaviors.
- 11) Any behavior treatment plan that proposes aversive, restrictive, or intrusive techniques, or psycho-active medications for behavior control purposes and where the target behavior is not due to an active substantiated psychotic process, must be reviewed and approved by the Behavior Treatment Committee.
- 12) If an applicant for community mental health services has been denied mental health services, the applicant, their guardian if one has been appointed, or the applicant's parent or parents if the applicant is a minor may request a second opinion of the SCCMHA Executive Director. The Executive Director will secure the second opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker, or master's level psychologist.
- 13) A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release.
- 14) A Person served shall receive mental health services suited to his or her condition.
- 15) Mental health services shall be provided in a safe, sanitary, and humane treatment environment.

Services shall be provided in accordance with all applicable standards of care or treatment required by any of the following:

- 16) All state or federal laws, rules or regulations governing the provision of community mental health services; and
- 17) Obligations of a provider established under the terms of a contract of employment agreement with SCCMHA; and
- 18) SCCMHA policies and procedures; and
- 19) Written guidelines or protocols of a provider; and
- 20) Written directives from a supervisor consistent with any of the above; and
- 21) A recipient's Individual Plan of Service

Definitions:

Behavior Treatment Committee: Section 3.3 Behavioral Treatment Review of the Mental Health/Substance Abuse Medicaid Provider Manual defines the Behavior Treatment

Committee as a specially constituted body comprised of at least three individuals, one of whom shall be a fully- or limited-licensed psychologist with the formal training or experience in applied behavior analysis; and one of whom shall be a licensed physician/psychiatrist.

Behavior Treatment Plan: A behavior treatment plan that proposes aversive, restrictive, or intrusive techniques or psycho-active medications for behavior control purposes where the target behavior is not due to an active substantiated psychotic process.

Support Staff: Case Manager, Supports Coordinator, or Therapist

References:

Michigan Mental Health Code 330.1409.
 Michigan Mental Health Code 330.1705.
 Michigan Mental Health Code 330.1708(4).
 Michigan Mental Health Code 330.1711.
 Michigan Mental Health Code 330.1712.
 Michigan Mental Health Code 330.1713.
 Administrative Rules 330.7199.
 SCCMHA Policy regarding Person served Choice and Service Management-03.01.03.
 Section 3.3 Behavioral Treatment Review of the Mental Health/Substance Abuse Medicaid Provider Manual

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Applicants requesting initial services or inpatient psychiatric hospitalizations will be evaluated for their appropriateness of requested services.	1) Crisis Intervention Services for inpatient hospitalization requests and Central Access and Intake staff for initial services
2) Applicants, their guardian, parent of a minor or loco parentis, will be informed of their right to a second opinion.	2) Crisis Intervention Services for inpatient hospitalization requests and Central Access and Intake staff for initial services

3) Second opinions will be provided to applicants according to Standards above.	3) Chief Executive Officer or designee
4) Mental health services shall be provided in a safe, sanitary, and humane treatment environment.	4) All SCCMHA staff and Service Provider Network staff
5) The worth, dignity, and uniqueness of all person's served as well as their rights and opportunities, shall be respected and promoted.	5) All SCCMHA staff and Service Provider Network staff
6) The people served shall be given a choice of physician or other mental health professionals as described in the standard above.	6) Support Staff or their supervisor
7) Upon receiving a request to change physician or other mental health professional, the clinical supervisor will respond to the person requesting the change within two weeks of the request.	7) Clinical Supervisor
8) If the request for a change of physician or other mental health professional is not granted, a written response with the reason the request is denied will be provided to the person who made the request with support of the Clinical Risk Management Committee.	8) Clinical Supervisor
9) Lack of response to a request for a change of physician or other mental health professional will result in a Recipient Rights complaint being filed.	9) SCCMHA ORR
10) People served in need of a Behavior Treatment Plan will be referred to the Behavior Treatment Committee or the Positive Behavioral Support Champion in their unit.	10) Support Staff

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Consent for Treatment	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.08
Effective Date: September 8, 1997	Date of Review/Revision: 3/19/03, 1/25/08, 6/29/09, 6/22/12, 6/13/14, 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/14, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights
	Supersedes: 06.02.07.00	
		Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights, and Jen Kreiner, Chief of Health Services and Integrated Care

Purpose:

The purpose of this policy is to establish a means for people served of mental health services to consent to treatment with Saginaw County Community Mental Health Authority (SCCMHA).

Policy:

It is the policy of SCCMHA that all people served receiving mental health services with SCCMHA will consent to treatment and provide legally valid informed consent prior to initiation of treatment, except as otherwise permitted by law (e.g., emergency services or court-ordered treatment).

Application:

This policy applies to all persons served of SCCMHA including the Service Provider Network.

Standards:

- 1) All individuals consenting to treatment shall be made aware of the purpose of the procedure, risks and benefits, alternative procedures available, other consequences and

relevant information, and offered an opportunity to ask and receive answers to questions, using the informed consent process

- 2) Persons served, their guardians, parents of a minor or loco parentis will be made aware that consent can be withdrawn at any time without prejudice to them. Consent withdrawal is limited only to the extent treatment is mandated by court order.
- 3) All people served of SCCMHA services shall be assumed to be competent and able to comprehend the purpose of treatment, except as described below.
- 4) A legal representative may consent only within the scope and duration of authority granted by the court (written in guardianship documents). Individuals remain legally competent regarding matters outside the scope of the guardianship.
- 5) An evaluation of the ability to give consent shall precede any guardianship proceedings.
- 6) Informed consent will be reobtained if changes in circumstances change the risks, other consequences or benefits that were previously expected.
- 7) A minor 14 years of age or older may request and receive mental health services and a mental health professional may provide services on an out-patient basis (excluding pregnancy termination referral services and use of psychotropic drugs) without the consent or knowledge of the minor's parent, guardian, or loco parentis, unless the treating mental health professional determines a compelling need for disclosure based upon substantial probability of harm to minor or another and if the minor is notified of the treating professional's intent to inform.
- 8) All minors under 14 years of age and those who have a guardian must have a parent, or their guardian, or loco parentis sign authorization for services before any services may be provided, except in the case of an emancipated minor who may authorize services.
- 9) Services provided to the minor as described in the standard below are limited to not more than 12 sessions or 4 months per request and after these expire, the mental health professional terminates the services or, with the consent of the minor, notifies the parent, their guardian, or loco parentis to obtain consent to provide further out-patient services.
- 10) Services provided to the minor will, to the extent possible, promote the minor's relationship to the parent, guardian, or person in loco parentis, and will not undermine the values that the parent, guardian, or parent loco parentis has sought to instill in the minor.
- 11) Psychotropic medications may not be prescribed to minors without parental, guardian, or court authorization
- 12) All recipients of mental health services consent will be available in the medical record.

13) The minor's parent, guardian, or parent loco parentis is not liable for the cost of services that are received by a minor.

14) If a person served refuses to sign the consent, but there is court ordered treatment, and SCCMHA does provide the service, a copy of the consent will be kept in the chart or record with documentation of the refusal of the person served to sign the consent.

Definitions:

Assigned Support Staff: Case Manager, Support Coordinator, or Therapist assigned to work with a SCCMHA person served. The Case Manager, Support Coordinator, or Therapist may be a SCCMHA staff person or a member of the SCCMHA Service Provider Network.

Consent: Per Mental Health Code 330.1100(a)(19) means a written agreement executed by a person served, the parent of a minor, a person acting in Loco Parentis, or a legally appointed representative acting within the scope of authority granted by the court, or a verbal agreement of a person served that is witnessed and documented by an individual other than the individual providing treatment.

Informed Consent: is defined by the Administrative Rules 330.7003

(1) All of the following are elements of informed consent:

- (a) Legal competency- An individual shall be presumed to be legally competent. This presumption may be rebutted only by a court appointment of a guardian or exercised by a court of guardianship powers and only to the extent of the scope and duration of the guardianship. An individual shall be presumed legally competent regarding matters that are not within the scope and authority of the guardianship.
- (b) Knowledge - To consent, a person served, or legal representative must have basic information about the procedure, risks, other related consequences, and other relevant information. The standard governing required disclosure by a doctor is what a reasonable patient needs to know in order to make an informed decision. Other relevant information includes all of the following:
 - (i) The purpose of the procedures.
 - (ii) A description of the attendant discomforts, risks, and benefits that can be expected.
 - (iii) A disclosure of appropriate alternatives advantageous to the person served.
 - (iv) An offer to answer further inquiries.
- (c) Comprehension - An individual must be able to understand what the personal implications of providing consent will be based upon the information provided under subdivision (b) of this subrule.
- (d) Voluntariness - There shall be free power of choice without the intervention of an element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion, including promises or assurances of privileges or freedom. There shall be

an instruction that an individual is free to withdraw consent and to discontinue participation or activity at any time without prejudice to the person served.

Court ordered treatment: Mental health treatment is ordered by the Saginaw Probate Court, or another county's Probate Court, and must be offered or monitored by SCCMHA.

Loco Parentis: A person or institution that assumes parental rights and duties for a minor.

References:

Administrative Rules 330.7003 (1)(a) -(d); (2)

Michigan Mental Health Code 330.1100

Michigan Mental Health Code 330.1707

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) All people served of mental health services with SCCMHA, their empowered guardian, parent of a minor or loco parentis will be offered Consent to Treatment form upon intake. Thereafter, the consent to treatment will be as indicated on the individual plan of service (IPOS) signature page. Note: A separate consent may be required for prescribed medications.	1) Assigned Support Staff
2) An adult person served, and a minor if emancipated, shall be presumed legally competent. This presumption may be rebutted only by a court appointment of a guardian or exercised by a court of guardianship powers and only to the extent of the scope and duration of a guardianship. An evaluation of the ability to give consent shall precede any guardianship proceedings. When guardianship is being considered, a formal capacity evaluation shall be completed by a licensed psychologist not directly involved in the individual's treatment.	2) Assigned Support Staff
3) In emergency or crisis situations, the person served will be requested to sign consent to treatment in order to receive mental health	3) Crisis Intervention Services (CIS) Staff person

services. If the person served lacks capacity and no legal representative is immediately available, services may be provided consistently with Michigan law under emergency treatment procedures.	
4) Before consenting to receive mental health services, each person served shall be informed of their rights.	4) Assigned Support Staff or CIS Staff person
5) Staff should be available to answer any questions of the person served.	5) Assigned Support Staff or CIS Staff person
6) Individuals under court order shall be offered services and given the opportunity to give consent. If a person served under a court order refuses to sign consent to treatment, the appropriate staff person will notify the probate court of the person's served refusal of services. If the person served under a court order refuse to sign the consent to treatment form but continues to keep appointments for mental health treatment, a copy of the consent to treatment with "Refused to sign" written on the person's served signature line, date form was offered, and a witness signature will be kept in the chart or record. Notification to the probate court shall occur within the timeframe of court requirements.	6) Assigned Support Staff or CIS Staff person

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Change in Type of Treatment	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.09
Effective Date: September 16, 1998	Date of Review/Revision: 1/10/03, 1/25/08, 6/29/09, 6/22/12, 6/13/14, 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26 Supersedes: 06.02.09.00	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
		

Purpose:

The purpose of this policy is to establish a discharge policy for people served by mental health services when a maximum benefit from services has been established as well as establishing standards for reviewing changes in treatment.

Policy:

It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) to provide people served with progressive treatment and care until sufficiently rehabilitated or as required by laws, rules, policies, or guidelines, or until the person served has received the maximum benefit from the program.

Application:

This policy applies to all people served by SCCMHA including the Service Provider Network.

Standards:

- 1) This policy requires that the written Individual Plan of Service (IPOS) has a specific date(s) when the plan and any of its sub-components will be formally reviewed for modification or revision.
- 2) A recipient will be given a choice of physician or other mental health professional in accordance with the policies of the CMHSP or service provider and within the limits of available staff.
- 3) A written IPOS will be developed and revised as necessary, but in no case longer than

annually. The written IPOS will be kept in the clinical record and will be modified, as necessary.

- 4) The person served will be informed orally and in writing of his or her clinical status and progress at reasonable intervals established in the IPOS in a manner appropriate to his or her clinical condition.
- 5) If a person served is not satisfied with their IPOS, the person served, their guardian, parent of a minor, or loco parentis may make a request for the review of their plan. This request will begin with the request to the assigned support staff. If not satisfied with the review of the plan, they may request a review from the assigned support staff's supervisor.
- 6) The requested review of the plan will be completed within 30 days. The request for review of the plan may be made verbally or in writing. The person requesting the review may file a Recipient Rights Complaint if they are dissatisfied with the review.
- 7) SCCMHA will provide mental health treatment suited to conditions for all Saginaw County people found eligible for services.
- 8) Upon benefit or completion of appropriate services, people served will be discharged from treatment of SCCMHA.
- 9) When people served are discharged from services, appropriate notices of available appeal rights will be given to the people served.

Definitions:

Assigned Support Staff: Case Manager, Support Coordinator, or Therapist assigned to work with a SCCMHA person served. The Case Manager, Support Coordinator, or Therapist may be a SCCMHA staff person or a member of the SCCMHA Service Provider Network.

Loco Parentis: A person or institution that assumes parental rights and duties for a minor.

References:

Michigan Mental Health Code 330.1752.

Michigan Mental Health Code 330.1712.

Michigan Mental Health Code 330.1714.

Administrative Rules 330.7199.

SCCMHA Policy and Procedures regarding Transition/Discharge Services 03.02.13

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) A written Individual Plan of Service using a Person-Centered Planning process will be developed in partnership with the person served. The plan of service will have a specific date(s) when the plan and any of its subcomponents will be formally reviewed for modification or revision.	1) Assigned Support Staff
2) Justification for a change from one type of treatment to another within the program shall be noted in the person's served treatment plan. Appropriate notices and appeal rights will be given to the recipient of mental health services.	2) Assigned Support Staff
3) The person served shall be informed of a change in treatment, when ready for change, release, discharge, or when maximum benefit is received.	3) Assigned Support Staff
4) A person served, parent of a minor, their guardian, or loco parentis may request and shall receive a review of the determination and/or appropriateness of the type of treatment a person served is receiving. The review shall be completed within thirty (30) days or less. The request and subsequent review are to be documented in the person served clinical record.	4) Assigned Support Staff
5) Person's served , parents of minor, guardians, or loco parentis have the right to appeal decisions concerning a change in the type of treatment, either verbally or in writing, to the Customer Service Department, file a Recipient Rights Complaint, file a Local Appeal, or complete a Request for a Medicaid Fair Hearing (Medicaid beneficiaries only) and only after a Local Appeal has been completed.	5) Assigned Support Staff

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Abuse and Neglect	Chapter: 02 - Customer Services and Recipient Rights	Subject No: 02.02.11
Effective Date: March 7, 2000	Date of Review/Revision: 2/19/03, 7/25/07, 1/25/08, 6/29/09, 5/24/10, 7/20/12, 11/1/12, 6/13/14, 11/27/16, 6/6/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
	Supersedes: 06.02.17.00	
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		

Purpose:

The purpose of this policy is to protect the people served by Saginaw County Community Mental Health Authority services from abuse and neglect and to ensure that suspected abuse and neglect is reported to the proper authorities.

Policy:

It is the policy of SCCMHA that suspected abuse or neglect of recipients receiving public mental health services will be addressed immediately.

Application:

This policy applies to all SCCMHA direct operated programs as well as all SCCMHA Service Provider Network programs.

Standards:

- 1) A person served of SCCMHA shall not be subjected to abuse or neglect.
- 2) All SCCMHA and SCCMHA Service Provider Network program staff are required to report any suspected abuse, neglect, exploitation, or humiliation to the appropriate authorities immediately.
- 3) The SCCMHA ORR will investigate all allegations of suspected abuse, neglect, exploitation, or humiliation and will initiate the investigation (in areas where ORR has jurisdiction) immediately (within 24 hours of the notification). The SCCMHA ORR will have access to all information necessary to complete a thorough investigation.

- 4) When suspected allegations of abuse, neglect, exploitation, or humiliation are substantiated, remedial action and firm and appropriate disciplinary action will be taken. When suspected allegations are reported, the staff who are suspected of committing abuse, neglect, exploitation, or humiliation toward a person served will be suspended until the SCCMHA ORR has enough information to ensure the safety of the person(s) served involved. This determination is made on a case-by-case basis by the SCCMHA ORR.
- 5) As stated, below, it is the responsibility of the staff person who has the knowledge of the suspected allegation of abuse, neglect, exploitation, or humiliation to report this information to the appropriate authorities immediately.
- 6) All SCCMHA and SCCMHA Service Provider Network programs staff are required to report suspected criminal abuse including vulnerable adult abuse and child abuse to local law enforcement immediately as described below
- 7) The written report to law enforcement referenced below will be made using the Report on Alleged Recipient Abuse-Neglect-Exploitation. This form is not required by the SCCMHA Provider Network but is available to them upon request. This report will be made by SCCMHA or SCCMHA Service Provider Network staff who are aware of the suspected allegation of abuse or neglect.
- 8) The worth, dignity, and uniqueness of all people served, as well as their rights and opportunities, shall be respected and promoted.
- 9) Any instance of physical, psychological, sexual, or other types of abuse or neglect of people served will not be acceptable and staff members responsible for these types of actions will be considered for disciplinary action up to and including discharge.
- 10) A person served who is abused or neglected has the right to pursue injunction and other appropriate civil relief.
- 11) People served who feel they have been abused or neglected should follow reporting procedures and complete a Recipient Rights Complaint Form with assistance from the Office of Recipient Rights if requested.
- 12) Any individual who makes a report under Section 330.1722 of the Michigan Mental Health Code shall not be dismissed or otherwise penalized by an employer or contractor for making the report.

Definitions:

Abuse -: "Abuse" means non-accidental physical or emotional harm to a person served , or sexual contact with or without sexual penetration of a person served as those terms are defined in section 520a of the Michigan Penal Code, 1931 PA 328, MCL 750.520a, that is committed by an employee or volunteer of the department, a community mental health services program, or a licensed hospital or by an employee or volunteer of a service provider under contract with the department, community mental health services program, or licensed hospital.

- (a) Abuse Class I – A non-accidental act or provocation of another act by an employee, volunteer, or agent of a provider that caused or contributed to death, serious physical harm, or sexual abuse of a person served.
- (b) Abuse Class II – means any of the following:
 - i) A non-accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to non-serious physical harm to a person served.
 - ii) The use of unreasonable force on a person served by an employee, volunteer, or agent of a provider with or without apparent harm.
 - iii) An action or provocation of another to act by an employee, volunteer, or agent of a provider that causes or contributes to emotional harm to a person served.
 - iv) An action taken on behalf of a person served by assuming incompetence, although a guardian has not been appointed or sought, that results in substantial economic, material, or emotional harm to the person served.
 - v) Exploitation of a person served by an employee, contract employee or volunteer.
- (c) Abuse Class III – The use of language or other means of communication by an employee, volunteer, or agent of a provider to degrade, threaten, or sexually harass a person served.

Neglect-: "Neglect" means an act or failure to act committed by an employee or volunteer of the department, a community mental health services program, or a licensed hospital; a service provider under contract with the department, community mental health services program, or licensed hospital; or an employee or volunteer of a service provider under contract with the department, community mental health services program, or licensed hospital, that denies a person served the standard of care or treatment to which he or she is entitled under this act(330.1100b).

- (i) Neglect Class I – means any of the following:
 - (i) Acts of commission or omission by an employee, volunteer, or agent of a provider that results from non-compliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plans of service and causes or contributes to the death, or sexual abuse of, or serious physical harm to a person served.
 - (ii) The failure to report abuse or neglect of a person served when the abuse or neglect results in death or serious physical harm to the person served.
- (j) Neglect Class II – means any of the following:

- (i) Acts of commission or omission by an employee, volunteer, or agent of a provider that result from non-compliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plans of service and that cause or contribute to non-serious physical harm or emotional harm to a person served.
- (ii) The failure to report abuse or neglect of a person served when the abuse or neglect results in non-serious harm to the person served.
- (k) Neglect Class III - means any of the following:
 - (i) Acts of commission or omission by an employee, volunteer, or agent of a provider that results from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service that either placed or could have placed a recipient at risk of physical harm or sexual abuse.
 - (ii) The failure to report apparent or suspected abuse Class III or neglect Class III of a recipient.

Criminal Abuse:

- (1) An assault that is a violation or an attempt or conspiracy to commit a violation of sections 81 to 90 of the Michigan Penal Code, Act No. 328 of the Public Acts of 1931, being sections 750.81 to 750.90 of the Michigan Compiled Laws. Criminal abuse does not include an assault or an assault and battery that is a violation of section 81 of Act No. 328 of the Public Acts of 1939, being section 750.81 of the Michigan Compiled Laws, and that is committed by a person served against another person served.
- (2) A criminal homicide that is a violation or an attempt or conspiracy to commit a violation of section 316, 317, or 321 of Act No. 328 of the Public Acts of 1931, being sections 750.316, 750.317, and 750.321 of the Michigan Compiled Laws.
- (3) Criminal sexual conduct is a violation or an attempt or conspiracy to commit a violation of sections 520b to 520e or 520g of Act No. 328 of the Public Acts of 1931, sections 750.520b to 750.520e and 750.520g of the Michigan Compiled Laws involving an employee, volunteer, or agent of a provider and a person served.
- (4) Vulnerable adult abuse that is a violation or an attempt or conspiracy to commit a violation of section 145n of the Michigan Penal Code, Act No. 328 of the Public Acts of 1931, being section 750.145n of the Michigan Compiled Laws.
- (5) Child abuse that is a violation or an attempt or conspiracy to commit a violation of section 136b of Act No. 328 of the Public Acts of 1931, being section 750.136b of the Michigan Compiled Laws.

Degrade: means any of the following:

- (i) To cause a humiliating loss of status or reputation.
- (ii) To cause the person to feel that they or other people are worthless and do not have the respect or good opinion of others.
- (iii) To deprive of self-esteem or self-worth, to shame or disgrace.
- (iv) Language of captions that insult the person's heritage, mental status, race sexual orientation, gender, intelligence; etc.

Examples of behavior that is degrading and must be reported as abuse include but is not limited to:

- a. Swearing at a person served
- b. Using foul language towards a person served
- c. Using racial or ethnic slurs towards a person served
- d. Causing or prompting others to commit the actions listed above.

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.

Exploitation: An action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a person served 's property or funds for the benefit of an individual or individuals other than the person served.

Humiliation: To reduce to a lower position in one's own eyes or others' eyes; extremely destructive to one's self-respect or dignity.

Sexual Abuse: means any of the following:

- (i) as described in section (3) above under Criminal abuse
- (ii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a person served
- (iii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and person served for whom the employee or agent provides direct services

Sexual Contact: means the intentional touching of the person served or employee's intimate parts or the touching of the clothing covering the immediate area of the person served or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following:

- (i) Revenge
- (ii) To inflict humiliation
- (iii) Out of anger

Sexual Harassment: means sexual advances to a person served, requests for sexual favors from a person served, or conduct or communication of a sexual nature toward a person served.

Sexual Penetration: means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, or any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

Threaten: means either of the following:

- (i) To utter intentions of injury or punishment against.

- (ii) To express a deliberate intention to deny the well-being, safety, or happiness of somebody unless the person does what is being demanded.

Unreasonable Force: means physical management or force that is applied by an employee, volunteer, or agent of a provider to a person served in one or more of the following circumstances:

- (i) There is no imminent risk of serious or non-serious physical harm to the person served, staff, or others.
- (ii) The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
- (iii) The physical management used is not in compliance with the emergency interventions authorized in the person served individual plan of service.
- (iv) 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:

Administrative Rules 330.7001

Administrative Rules 330.7035

Michigan Mental Health Code 330.1722

Michigan Mental Health Code 330.1723

Michigan Mental Health Code 330.1778

Exhibits:

Exhibit A - Staff Action Regarding Alleged Abuse/Neglect/Exploitation Form

Exhibit B - Summary of Abuse and Neglect Reporting Requirements, Rev. 3/2024

Procedure:

ACTION	RESPONSIBILITY
1) SCCMHA and Provider Network staff along with the Recipient Rights Office will work to protect the people served of mental health services from abuse and neglect.	1) SCCMHA, Provider Network staff, and the SCCMHA Recipient Rights Office
2) Whenever an injury is suffered regarding suspected abuse or neglect, staff are responsible for ensuring that the people served receive immediate proper treatment, comfort, and protection as necessary, and that action taken by staff sufficiently addresses the urgency of the injury.	2) Staff responsible for supervision of people served

3) In all cases of abuse, neglect, and/or mistreatment, it is the assigned duty and responsibility of the staff who has knowledge of or reasonable cause to suspect person served abuse, neglect or mistreatment to immediately report it to their immediate supervisor, the Recipient Rights Office, administration, law enforcement, Protective Services, and the Department of Licensing and Regulatory Affairs (LARA), and other agencies as required by law. 4) Appropriate disciplinary action will be taken against anyone proven to have engaged in abuse or neglect. Proof will come through a Recipient Rights Office investigation, or a criminal investigation completed by a law enforcement agency or recognized court of law. 5) Any mental health professional employed by SCCMHA or any of its Provider Network, who has reasonable cause to suspect the criminal abuse including vulnerable adult abuse and child abuse will immediately make a call or cause a call to be made, by telephone or otherwise to the law enforcement agency for the county or city in which the criminal abuse is suspected to have occurred or to the state police. 6) Within 72 hours after making the oral report, the reporting individual shall file a written report (using the attached form – Report on Alleged Recipient Abuse-Neglect-Exploitation) with the law enforcement agency to which the oral report was made and with the chief administrator of the facility or agency responsible for the person served. This report will also be made to the Recipient Rights Office of SCCMHA.	3) Staff or Supervisor with the knowledge of abuse or neglect 4) SCCMHA Chief Executive Officer and Administrative staff of the SCCMHA Service Provider Network 5) Mental health professionals employed or contracted with SCCMHA or any of its Provider Network. 6) The mental health professional making the report of suspected abuse or neglect

7) The written report required in #6 of these procedures will contain the name of the person served and a description of the criminal abuse and the manner in which it occurred. The report will become a part of the Sentri Incident Report Module.	7) The mental health professional making the report of suspected abuse or neglect will send the report to the SCCMHA ORR
8) The identity of an individual who makes a report is confidential and is not subject to disclosure without the consent of that individual or subpoena of a court of record. An individual acting in good faith who makes a report of criminal abuse against a person served is immune from civil or criminal liability that might otherwise be incurred.	8) SCCMHA and its Provider Network will protect the individual making the good faith report
9) Reporting the suspected abuse or neglect to the legal authorities will not preclude nor hinder the Recipient Rights Office of the department, a licensed facility, SCCMHA or any of its Provider Network from investigating the report of suspected abuse or neglect and from taking appropriate disciplinary action against its employees based upon that investigation.	9) Recipient Rights Office

Exhibit A



Staff Action Regarding Alleged Abuse/Neglect/Exploitation

Based on the "Summary of Abuse and Neglect Reporting Requirements" a report has been made or filed with the following:

Agency	Officer or Person Contacted	Date Contacted	How Contacted		
☐ Law Enforcement			☐ phone	☐ faxed	☐ mailed
☐ Child Protective Services form 3200 sent (required)			☐ phone	☐ faxed	☐ mailed
☐ Adult Protective Services			☐ phone	☐ faxed	☐ mailed
☐ AFC Licensing			☐ phone	☐ faxed	☐ mailed
☐ Office of Recipient Rights			☐ phone	☐ faxed	☐ mailed
☐ Other:			☐ phone	☐ faxed	☐ mailed

Alleged victim(s):

Alleged victim(s) identifiers: (indicate the following if known: BD - Birth date, ID - CHS ID#, SS - Social Security Number)

IF Alleged Victim is a minor

Mother: _____ ☐ married ☐ single ☐ divorced ☐ separated

Father: _____ ☐ married ☐ single ☐ divorced ☐ separated

Alleged victim address/residence and phone number:

Alleged perpetrator(s) name:

Alleged perpetrator address or location:

Alleged incident occurred at:

Approximate date(s) or time frames of alleged incident (be as specific as possible):

Details of Allegation: (use second sheet if necessary; attach copy of Form 3200 and/or other related documents)

Signature and Title of Person Making this report

Date

Submit this form to Quality by faxing to 989-272-0290, Executive Director of Clinical Services, & Direct Supervisor

DO NOT copy to Consumer Records: If this report becomes a part of the consumer's clinical record, the name of the alleged perpetrator must not be removed from this report as required by Section 723 (j) of Public Act of 1996. It is a misdemeanor to intentionally file a false report of abuse or to violate Section 723.

Q: Agency Form/ Clinical Form/ Report on Alleged Recipient Abuse DO NOT SCAN INTO CONSUMER RECORD

m 4/11/23

Exhibit B

REQUIREMENTS FOR REPORTING ABUSE AND NEGLECT				
	Section 723, Public Act 258 of 1974 as amended (Mental Health Code-Recipient Abuse)	Public Act 238 of 1975 (Child Protection Law)	Public Act 519 of 1982 (Adult Protective Services Law)	Section 723, Public Act 258 of 1974 as amended (Mental Health Code-Criminal Abuse)
WHERE is the report made?	To the MDHHS, CMHSP, or Hospital OFFICE OF RECIPIENT RIGHTS A list of local rights offices can be found at: https://tinyurl.com/CALL-ORR	To the MDHHS Office of Childrens Protective Services ADULT OR CHILDRENS PROTECTIVE SERVICES HOTLINE 855-444-3911	To the MDHHS Office of Adult Protective Services	To the Michigan State Police, Local Sheriff or Local Police Department Contact your local police or sheriff department
WHAT must be reported?	Sexual, Physical, Emotional or Verbal Abuse, Neglect, Serious Injury, Death, Retaliation or Harassment	Sexual, Physical or Mental Abuse, Neglect, Sexual Exploitation	Sexual, Physical or Mental Abuse, Neglect, Maltreatment, Exploitation	Assault (other than patient-patient assault/battery), Criminal Sexual Abuse, Homicide, Vulnerable Adult Abuse, Child Abuse
WHO is required to report?	All employees, contract employees, or volunteers of Michigan Department of Health and Human Services, Community Health Services Programs, Licensed Private Psychiatric Hospitals	Physicians, nurses, coroners, medical examiners, dentists, licensed emergency care personnel, audiologists, psychologists, social workers, school administrators, teachers, counselors, law enforcement officers, and child care providers.	Any person employed by an agency licensed to provide, anyone who is licensed, registered, or certified to provide health care, education, social, or other human services, law enforcement officers and child care providers.	All employees, contract employees of: Michigan Department of Health and Human Services, Community Mental Health Services Programs, Licensed Private Psychiatric Hospitals; All mental health professionals.
WHAT is the CRITERIA for reporting?	You must report if you: Suspect a recipient has been abused or neglected or any allegations of abuse or neglect made by a recipient.	You must report if you: Have reasonable cause to suspect a child has been abused, neglected, or sexually exploited.	You must report if you: Have reasonable cause to suspect or believe an adult has been abused, neglected, exploited or maltreated.	You must report if you: Suspect a recipient or vulnerable adult has been abused or neglected, sexually assaulted, or if you suspect a homicide has occurred. You do not have to report if the incident occurred more than one year before your knowledge of it.
WHEN must the report be made and in what format?	A verbal report must be made immediately. A written report on an incident report form must be made before the end of your shift.	A verbal report must be made immediately. A written report on DHS form 3200 must be made within 72 hours.	A verbal report must be made immediately. A written report at the discretion of the reporting person.	A verbal report must be made immediately. A written report must be made within 72 hours of the oral report (330.1723)
TO WHOM are reports made?	To your immediate supervisor and to the Recipient Rights Office at your agency or hospital	Report to Protective Services Reporting Hotline 855-444-3911	Report to Protective Services Reporting Hotline 855-444-3911	The law enforcement agency for the county or city in which the alleged violation occurred or the State Police. A copy of the written report goes to the chief administrator of the agency responsible for the recipient.
If there is more than one person with knowledge must all of them make a report?	Not necessarily. Reporting should comply with the policies and procedures set up by each agency.	Someone who has knowledge must report or cause a report to be made in the case of a school, hospital or agency, one report is adequate.	Everyone who has knowledge of a violation or an alleged violation must make a report. MDHHS has typically accepted one report from agencies.	Someone who has knowledge must report or cause a report to be made.
Is there a penalty for failure to report? YES	Disciplinary action may be taken and you may be held civilly liable.	You may be held civilly liable. Failure to report is also a criminal misdemeanor.	You may be held civilly liable and have to pay a \$500 fine.	The law states that failure to report or false reporting is a criminal misdemeanor.
Is it necessary to report to more than one agency? YES	Each of these laws requires that the designated agency be contacted, if an allegation is suspected to have occurred which falls under its specific jurisdiction. There are several references in each law indicating that reporting to one agency does not absolve the reporting person from the responsibility of having to report to other agencies, as statutorily required.			
Are there other agencies to which a report can be made? YES	The Bureau of Community and Health Systems (LARA) is responsible for investigating abuse and neglect in Nursing Homes, Hospitals and Home Health Care. Call the NURSING HOME ABUSE HOTLINE 800-882-6006 The Michigan Attorney General's Office has an Abuse Investigation Unit which may also investigate abuse in Nursing Homes. Call the ATTORNEY GENERAL 24 hour HEALTH CARE FRAUD HOTLINE 800-24-ABUSE/ 800-242-2873 The LARA-BCHS Adult Foster Care and Camps Licensing Division is responsible for investigating abuse or neglect in a licensed foster care home. Call The Bureau of Community and Health Systems (LARA) COMPLAINT INTAKE UNIT 866-856-0126			



DCH-0727

03/2024

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Restraint and Seclusion	Chapter: 02 - Customer Services and Recipient Rights	Subject No: 02.02.14
Effective Date: March 7, 2000	Date of Review/Revision: 2/19/03, 1/25/08, 7/13/09, 6/22/12, 6/13/14, 11/27/16, 6/6/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26 Supersedes: 06.02.15.00	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
		

Purpose:

The purpose of this policy is to protect people served by Saginaw County Community Mental Health Authority from abuse through the use of restraint and/or seclusion.

Policy:

It is the policy of SCCMHA to protect the safety of people served receiving mental health services. The use of restraints and/or seclusion will not be used in a community setting due to the unavailability of specialized personnel in such settings.

Application:

This policy applies to all SCCMHA direct operated programs as well as all of the Service Provider Network.

Standards:

- 1) People served of mental health services of SCCMHA will be free from the use of restraints in all treatment programs, except as outlined in the standard below.
- 2) SCCMHA Office of Recipient Rights prohibits the use of restraint in all programs or sites directly operated or under contract where it is not permitted by statute and agency policy. SCCMHA ORR will review the restraint policies and practices of contracted inpatient settings and child caring institutions for compliance with Attachment B from the MDHHS ORR. Seclusion shall be used only in a hospital or

center or in a child caring institution licensed under Act No. 116 of the Public Acts of 1973, sections 722.111 to 722.128 of the Michigan Compiled Laws.

- 3) The use of physical management is prohibited except in situations when a recipient is presenting an imminent risk of serious or non-serious harm to himself, herself or others, and less restrictive interventions have not reduced or eliminated the risk of harm.
- 4) Physical management shall not be included as a component of the Behavior Treatment Plans.
- 5) Prone Immobilization is prohibited unless other techniques are medically contraindicated and documented in the record.
- 6) The use of seclusion is prohibited in all agency programs, directly operated sites, or contractual service locations unless permitted by statute and agency policy.
- 7) Incidents where physical intervention is used will be documented in an Incident Report and sent to the SCCMHA ORR.
- 8) A recipient will not be placed in restraint except in the circumstances and the conditions set forth in Sec. 740 or in other law.

Definitions:

Behavior Treatment Committee: Section 3.3 Behavioral Treatment Review of the Mental Health/Substance Abuse Medicaid Provider Manual defines the Behavior Treatment Committee as a specially constituted body comprised of at least three individuals, one of whom shall be a fully- or limited-licensed psychologist with formal training or experience in applied behavior analysis; and one of whom shall be a licensed physician/psychiatrist.

Behavior Plan: A behavior management or treatment plan that proposes aversive, restrictive, or intrusive techniques or psycho-active medications for behavior control purposes where the target behavior is not due to an active substantiated psychotic process.

Community Setting: Any location where treatment for mental health people served takes place in the community.

Timeout: Defined as a person served voluntarily removing him/herself from a stressful situation as a response to a therapeutic suggestion to prevent a potentially hazardous outcome.

Physical Management: Technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical

harm. To ensure the safety of each person served and staff, each agency shall designate emergency physical management techniques to be utilized during emergency situations. The term “physical management” does not include briefly holding an individual in order to comfort him or her or to demonstrate affection or holding his/her hand. The following are examples to further clarify the definition of physical management:

- Manually guiding down the hand/fists of an individual who is striking his or her own face repeatedly causing risk of harm is considered physical management if he or she resists the physical contact and continues to try and strike him or herself. However, it is not physical management if the individual stops the behavior without resistance.
- When a caregiver places his hands on an individual’s biceps to prevent him or her from running out the door and the individual resists and continues to try and get out the door, it is considered physical management. However, if the individual no longer attempts to run out the door, it is not considered physical management.

Physical management involving prone immobilization of an individual, as well as any physical management that restricts a person’s respiratory process, for behavioral control purposes is prohibited under any circumstances. Prone immobilization is extended physical management of an individual in a prone (face down) 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.

Restraint: The use of a physical device to restrain an individual’s movement. Restraint does not include the use of a device primarily intended to provide anatomical support.

Seclusion: A temporary placement of a person served in a room alone, where egress is prevented by any means. “By any means” includes the egress being blocked by a staff person to prevent the person served from leaving the room.

Support Staff: Case Manager, Supports Coordinator, or Therapist, etc.

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 recipient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

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 person served.

References:

Mental Health Code 330.1755 (5)(a)(g)
Mental Health Code 330.1700
Mental Health Code 330.1742
Mental Health Code 330.1740
Administrative Rules R 330.7001

Administrative Rules R 330.7243

Health Care Financing Administration 42 Code of Federal Regulations Part 482.13

Act 116 of the Public Acts of 1973 sections 722.111 to 722.128

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) SCCMHA requires the use of non-restrictive techniques to address challenging behaviors.	1) Staff responsible for providing care for people served
2) People served in need of a Behavior Plan due to challenging behaviors will be referred to a Behavioral Psychologist for a comprehensive assessment/analysis.	2) Support Staff
3) Physical intervention may be utilized on a limited basis when less restrictive techniques have been unsuccessful and there is a risk of severe injury to the person served or others in the absence of intervention.	3) Staff responsible for providing care for people served.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Medication and the use of Psychotropic Drugs	Chapter: 02 - Customer Services and Recipient Rights	Subject No: 02.02.16
Effective Date: September 16, 1998	Date of Review/Revision: 2/19/03, 1/25/08, 7/13/09, 6/22/12, 1/28/13, 6/4/13, 6/14/14, 11/27/16, 6/1/18, 1/22/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
	Supersedes: 06.02.18.00, 06.02.18.01, and 06.02.19.00	
		

Purpose:

The purpose of this policy is to establish standards and practices for the use of medications, including psychotropic medications for the purpose of treatment of mental health related issues.

Policy:

It is the policy of Saginaw County Community Mental Health Authority to follow strict guidelines, which will be established by this policy, when administering medication to people served of mental health services from SCCMHA or any of its Service Provider Network.

Application:

This policy applies to all SCCMHA direct operated programs as well as all Provider Network programs.

Standards:

- 1) Medications shall only be ordered by a physician. The physician's order for medication may come from or through a Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner. A provider will only administer medication at the order of a physician.
- 2) Medication should not be used as punishment, for the convenience of staff or as a substitute for other appropriate treatment.

- 3) Medications shall be reviewed as specified in the plan of service and based on the person served clinical status, to determine the appropriateness of continued use.
- 4) Medication shall be prepared and administered by qualified and trained staff.
- 5) At the time the Physician/Psychiatrist/Nurse Practitioner writes the prescription, the documentation will go into the person served record and specify the purpose of the medication. Informed Consent from the person served, their guardian, parent of a minor or loco parentis prior to the administration of the medication is required.
- 6) Medication errors and adverse drug reactions are immediately reported to the RN or physician and documented in the clinical record.
- 7) A provider will record the administration of all medication in the recipient's clinical record.
- 8) Only medications authorized by a physician are to be given at discharge or leave and enough medication will be made available to ensure the person served has an adequate supply until he or she can become established with another provider.
- 9) Medication use shall conform to standards of the medical community.
- 10) When a medication is used for behavioral reasons and not to treat a psychiatric condition, this is considered an intrusive technique and needs to be reviewed and approved by the Behavior Treatment Committee (BTC).
- 11) Agency personnel shall comply with the orders of a physician in administering and/or stopping medications, and shall comply with other relevant regulations, such as Licensing Regulations regarding storing/securing resident medication within the facility. Medication shall be kept in a locked cabinet.
- 12) Telephone orders for medication shall be accepted only in specific situations set forth by this policy. A nurse may accept these orders. The orders must be signed by the Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner within 24 hours. Orders may be faxed to a residential setting if a Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner have signed the order.
- 13) Orders for medication shall be effective only for the specific number of days indicated by the prescribing Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner. Orders for Schedule 2 controlled substances shall expire after 60 days.
- 14) Medication that is given to recipients shall follow state rules and federal regulations pertaining to labeling and packaging.

- 15) Before initiating a course of psychotropic drug treatment for a recipient, the prescriber, or a licensed health professional acting under the delegated authority of the prescriber shall do both of the following:
 - a) Explain the specific risks and most common adverse side effects associated with that drug, and
 - b) Provide the individual with a written summary of those common adverse side effects.
- 16) Psychotropic medication shall not be administered unless the individual gives informed consent, or the administration is necessary to prevent physical injury to the person or another, or with a court order.
- 17) The administration of psychotropic medication to prevent physical harm or injury occurs:
 - a) ONLY when the actions of a recipient, or other objective criteria, clearly demonstrate to a physician that the recipient poses a risk of harm to himself, herself, or others, and
 - b) ONLY after signed documentation of the physician is placed in the recipient's clinical record
- 18) The initial administration of psychotropic medication under 7158(8)(b) is limited to a maximum of 48 hours unless there is consent.
- 19) The initial administration of psychotropic medication will be as short as possible and at the lowest possible dosage that is therapeutically effective. The medication will be terminated as soon as there is little likelihood that the recipient will pose a risk of harm to himself, herself, or others.
- 20) At the time the Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner writes the prescription, the documentation will go into the person served record and specify the purpose of the medication.
- 21) Psychotropic medications will not be given without a signed Informed Consent Form.
- 22) A person served, their guardian, parent of a minor, or loco parentis shall have the right to accept or refuse psychotropic medications treatment, except when a court order is in place.

Definitions:

Assigned Support Staff: Case Manager, Support Coordinator, or Therapist assigned to work with a SCCMHA recipient. The Case Manager, Support Coordinator, or Therapist

may be a SCCMHA staff member or a member of the SCCMHA Service Provider Network.

Informed Consent: is defined by the Administrative Rules 330.7003

(1) All of the following are elements of informed consent:

- (a) Legal competency. An individual shall be presumed to be legally competent. This presumption may be rebutted only by a court appointment of a guardian or exercise by a court of guardianship powers and only to the extent of the scope and duration of the guardianship. An individual shall be presumed legally competent regarding matters that are not within the scope and authority of the guardianship.
- (b) Knowledge to consent, a person served, or legal representative must have basic information about the procedure, risks, other related consequences, and other relevant information. The standard governing required disclosure by a Physician is what a reasonable patient needs to know to make an informed decision. Other relevant information includes all of the following:
 - (i) The purpose of the procedures.
 - (ii) A description of the attendant discomforts, risks, and benefits that can be expected.
 - (iii) A disclosure of appropriate alternatives advantageous to the recipient.
 - (iv) An offer to answer further inquiries.
- (c) Comprehension. An individual must be able to understand what the personal implications of providing consent will be based upon the information provided under subdivision of this subrule.
- (d) Voluntariness. There shall be free power of choice without the intervention of an element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion, including promises or assurances of privileges or freedom. There shall be an instruction that an individual is free to withdraw consent and to discontinue participation or activity at any time without prejudice to the recipient.

Loco Parentis: A person or institution that assumes parental rights and duties for a minor.

Psychotropic drug: Any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior. In this policy, Psychotropic drug or medication is used interchangeably with Psychotropic Chemotherapy.

References:

Michigan Mental Health Code 330.1719

Michigan Mental Health Code 330.1752

Administrative rules 330.7158

Administrative rules 330.7001

Michigan Department of Health and Human Services (MDHHS) Behavioral Health & Developmental Disabilities Administration Standards for Behavior Treatment Plan Review Committees Revision FY24

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) When a person served by mental health treatment is seen by a Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner, an evaluation will be completed to determine whether or not that person served would benefit from the use of prescription psychotropic medication.	1) Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner evaluating the person served
2) If the Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner determines the person served would benefit from the use of psychotropic medication, a prescription will be written and given to the person served, their guardian, or licensed Foster Care Provider.	2) Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner writing the prescription
3) At the time the Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner writes the prescription, the documentation will go into the person served record and specify the purpose of the medication.	3) Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner writing the prescription
4) If psychotropic medication is being used for the purpose of behavior management, the Behavior Treatment Committee will review the use of the medication.	4) Behavior Treatment Committee
5) The Behavior Treatment Committee will review, on a quarterly basis, those records of recipients who receive psychotropic medication for behavior treatment purposes.	5) Behavior Treatment Committee
6) Use of medication in conjunction with a behavioral modification plan must be reviewed monthly by qualified staff (R.N., psychologist or QMRP/QMHP, as defined in the individual program plan, and quarterly by the recipient's physician).	6) Assigned Support Staff
7) When it is not possible to receive an order written by a Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner, a Nurse may take a phone order. This may only be done in situations where the person served, or others are put in danger by a person served not receiving the medications or that the Service Plan agreed on by the treat-	7) Assigned Support Staff or the Licensed Foster Care Provider responsible for the care of the person served

ment team and the person served or their guardian cannot be followed if the person served does not receive the medication. The phone order must be signed within 24 hours. 8) Administration of medications shall be recorded in the person served clinical record. 9) The use of psychotropic medications must be a part of the individual's program service plan and must be a recommendation of the Treatment Planning Team or the psychiatrist/nurse practitioner. 10) On a quarterly basis, AIMS testing will be conducted for those people served that are receiving psychotropic medications, unless specified otherwise in the Individual Plan of Service.	8) The trained staff administering the medication 9) Assigned Support Staff 10) The Nurse working with the Medical or Osteopathic Physician/Psychiatrist, Physician Assistant, or Nurse Practitioner writing the prescription for psychotropic medications

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Sterilization, Abortion, and Contraception	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.17
Effective Date: March 7, 2000	Date of Review/Revision: 2/19/03, 1/25/08, 7/13/09, 6/22/12, 6/14/14, 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26 Supersedes: 06.02.20.00	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
		

Purpose:

The purpose of this policy is to establish boundaries for the responsibilities for Saginaw County Community Mental Health Authority as it relates to sterilization, abortion, and contraception.

Policy:

It is the policy of SCCMHA not to provide any direct services relating to sterilization, abortion, or contraception, but not to discriminate against any person served, their guardian, parent of a minor, or loco parentis for any decision made regarding sterilization, abortion, or contraception.

Application:

This policy applies to all SCCMHA direct operated programs as well as all SCCMHA Service Provider Network programs.

Standards:

- 1) The Support Staff responsible for the person served written plan of service shall provide notice to the person served, their guardian, parent of a minor or loco parentis of the availability of family planning and health information.
- 2) The Support Staff responsible for the person served written plan of service shall provide referral assistance to providers of family planning and health information services upon request of the person served, their guardian, parent of a minor, loco parentis.

- 3) Notice shall be given to the person served, their guardian, parent of a minor or loco parentis, indicating that the receipt of mental health services, release, or discharge, is in no way dependent upon the request or decision to act on the family planning information.
- 4) Neither SCCMHA staff members nor members of the SCCMHA Service Provider Network shall make recommendations regarding sterilization or abortion.

Definitions:

Loco Parentis: A person or institution that assumes parental rights and duties for a minor.

Assigned Support Staff: Case Manager, Support Coordinator, or Therapist assigned to work with a SCCMHA person served. The Case Manager, Support Coordinator, or Therapist may be a SCCMHA staff person or a member of the SCCMHA Service Provider Network.

References:

Michigan Mental Health Code 330.1752
Administrative Rule 330.7029

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) While SCCMHA does not provide direct services related to sterilization, abortion, or contraception, a person served, their guardian, parent of a minor or loco parentis may request information regarding these subjects.	1) Support Staff
2) Upon request from a person served, their guardian, parent of a minor or loco parentis, SCCMHA staff or staff of the SCCMHA Service Provider Network may provide information on family planning and health.	2) Support Staff
3) The person served, their guardian, parent of a minor or loco parentis will be directed to the appropriate county or private agency available to provide more information.	3) Support Staff

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights - Voice Recording, Photography, Fingerprinting, and the use of One-Way Glass	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.18
Effective Date: March 7, 2000	Date of Review/Revision: 2/19/03, 1/25/08, 6/29/09, 6/22/12, 6/14/14, 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26 Supersedes: 06.02.21.00	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights

Purpose:

The purpose of this policy is to set limits and guidelines for the use of voice recording, fingerprinting, and the use of one-way glass in the treatment of people served receiving mental health services from Saginaw County Community Mental Health Authority (SCCMHA) or any of its Service Provider Network.

Policy:

It is the policy of SCCMHA that the use of voice recording, fingerprinting, and one-way glass will not be used without the expressed written consent of the person served, their guardian, parent of a minor or loco parentis.

Application:

This policy applies to all SCCMHA direct operated programs as well as all Provider Network programs.

Standards:

- 1) Written consent is required for the use of fingerprints, photographs, audiotapes, or one-way glass. Fingerprints, photographs, or audiotapes may be taken, and one-way glass may be used only when prior expressed written consent is obtained from the person served, their guardian, parent of a minor or loco parentis.
- 2) Fingerprints, photographs, or audiotapes may be taken, and one-way glass may be used to determine the identification of the person served as set forth within this policy.
- 3) Consent for the use of fingerprints, photographs, audiotapes, or one-way glass may be withdrawn at any time.
- 4) Photographs (videos are excluded) may be taken for pure personal or social purposes. However, photographs taken will not be posted on social media or for any public viewing without prior expressed written consent. A photograph of a person served shall not be taken or used if the person served has indicated his or her objection.
- 5) The safekeeping of fingerprints, photographs, or audiotapes is described in the procedure section of this policy.
- 6) Fingerprints, photographs, or audiotapes in the record of a person served, and any copies of them, shall be given to the person served, or destroyed when they are no longer essential to achieve one of the objectives set forth within this policy , or upon discharge of the person served , whichever occurs first.
- 7) The consent for the use of fingerprints, photographs, audiotapes, or one-way glass will be considered valid for one year from the date of the initial signature. However, the assigned support staff will make known to the person served, their guardian, parent of a minor or loco parentis each time any of these methods are being used and the consent can be withdrawn at any time.
- 8) This policy prohibits video surveillance when recording is occurring and in non-public areas.
- 9) All persons served consents related to fingerprints, photographs, audiotapes, one-way glass, or written information for SCCMHA publications will be completed by using the MDHHS-5515 - Consent to Share Behavioral Health Information link in Sentri II.
- 10) Fingerprints, photographs, or audiotapes may be taken and used and one-way glass may be used in order to provide services, including research, to a person served or in order to determine the name of the person served only when prior written consent is obtained.

Definitions:

Assigned Support Staff: Case Manager, Support Coordinator, or Therapist assigned to work with a SCCMHA person served. The Case Manager, Support Coordinator, or Therapist may be a SCCMHA staff member or a member of the SCCMHA Service Provider Network.

Loco Parentis: A person or institution that assumes parental rights and duties for a minor.

Photography: Still pictures, motion pictures, and videotapes.

Social media: Social interaction among people in which they create, share or exchange information and ideas in virtual communities and networks.

References:

Administrative Rules 7003

Michigan Mental Health Code 330.1724

Exhibits:

Exhibit A - SCCMHA - Consent to Share Behavioral Health Information

Procedure:

ACTION	RESPONSIBILITY
1) The rights of people served receiving mental health services are clearly protected under the Michigan Mental Health Code in specific regard to fingerprints, photographs, use of one-way glass, and audiotapes. It is the duty of the SCCMHA Recipient Rights Office to ensure these rights are upheld.	1) Recipient Rights Office
2) Any use of fingerprints, photographs, audiotapes, or of one-way glass without the expressed written consent of the person served, (if 18 years of age or over and competent to consent), their guardian, the parent of a minor, or loco parentis is expressly prohibited.	2) Recipient Rights Office
3) If fingerprints, photographs, or audiotapes are taken in order to provide services to a person served, all copies of them shall be kept as part of the record of the person served.	3) Assigned Support Staff
4) If fingerprints, photographs, or audiotapes are necessary for determining the name of a person served, these will be kept as part of the	4) Assigned Support Staff in conjunction with the Officer of Recipient Rights

record. If necessary, fingerprints, photographs, or audiotapes may be delivered to others for assistance in determining the identity of the person served. Upon completion the use of the fingerprints, photographs, or audiotapes, together with copies, will be kept as part of the record of the person served.	
5) Fingerprints, photographs, or audiotapes in the record of a person served, and any copies of them, will be given to the person served or destroyed when it is no longer essential in order to achieve one of the objectives set forth within this policy or upon discharge of the person served, whichever occurs first.	5) Assigned Support Staff in conjunction with their Supervisor and the Medical Records Unit

Saginaw County Community Mental Health Authority
Michigan Department of Health and Human Services (MDHHS)
(Revised 9-25)

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

Why This Form is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

To give consent, fill out Sections 1, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3, and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it to your health care provider. They can make a copy for you.

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last)	Date of Birth
Janet W. Doe	07/04/1988

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

- ☐ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.

This consent expires (optional)
03/12/2027

When providing a consent for treatment, payment, and health care operations there is the potential for records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected under 42 CFR Part 2.

If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any, are

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

Health Plan

Pre-paid Inpatient Health Plan (PIHP)

Mid-State Health Network

1. Saginaw

500 Hancock Street Saginaw, MI 48602-4224

Phone: 989-797-3400 Fax: 989-799-0206

B. Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

☒ Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 3a

☐ Do not share my information through the organizations listed below.

☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only. List all health information exchanges or networks:

1. PCE Systems

2. Michigan Health Information Network

SECTION 4 - WHAT INFORMATION YOU WANT TO SHARE

Choose one option:

☒ Share all of my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."

☐ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

The expiration date, event, or condition for Sections 3 and 4

This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.

Date, event, or condition

<ONE YEAR FROM SIGNATURE DATE>

SECTION 5 - YOUR CONSENT AND SIGNATURE

Read the statements below, then sign and date the form.

By signing this form, I understand:



- I am giving consent to share my behavioral health and/or substance use disorder records. This includes referrals and services for alcohol and substance use disorders and/or other information may also be shared.
- My records may be shared with the people or organizations as described above.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes and/or with substance use disorder counseling notes."
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.

Electronically Signed By:

Kentera Patterson BS

03/17/2026

STAFF SIGNATURE / CREDENTIALS

DATE

CONSUMER SIGNATURE

PRINTED NAME

DATE

PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE
SIGNATURE

PRINTED NAME

DATE

WITNESS SIGNATURE

PRINTED NAME

DATE

SECTION 6 - TAKE AWAY YOUR CONSENT, WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed above. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

- ☐ Self
- ☐ Parent (Print Name)
- ☐ Guardian (Print Name)
- ☐ Authorized Representative (Print Name)

Signature

Date

SECTION 7 - FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY



Verbal Withdraw of Consent

☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

☐ Individual listed in Section 1

☐ Parent (Print Name)

☐ Guardian (Print Name)

☐ Authorized Representative (Print Name)

Print name of person who received the verbal withdrawal

Signature

Date

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent

Additional Identifiers (Optional)

Medicaid

000123456789

Last 4 of the Social Security Number Case #

****9998

000000012

Form Copy (choose one option)

☒ The individual in Section 1 **received** a copy of this form.

☐ The individual in Section 1 **declined** a copy of this form.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, national origin, color, sex, disability, religion, age, height, weight, family status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: This form is acceptable to MDHHS as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.

COMPLETION: Voluntary but required of disclosure is requested.



Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Treatment by Spiritual Means	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.20
Effective Date: March 7, 2000	Date of Review/Revision: 3/19/03, 1/25/08, 7/13/09, 6/22/12, 6/14/14, 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights
	Supersedes: 06.02.22.00	
		Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights

Purpose:

The purpose of this policy is to ensure the rights of people served who are receiving public mental health services from Saginaw County Community Mental Health Authority (SCCMHA) can obtain treatment by spiritual means.

Policy:

It is the policy of SCCMHA to assist interested persons served of public mental health services in obtaining treatment by spiritual means.

Application:

This policy applies to all persons served of SCCMHA including the SCCMHA Service Provider Network.

Standards:

- 1) Person served shall be permitted treatment by spiritual means upon request of the person served, their guardian, or parent of a minor or loco parentis.
- 2) Requests for printed, recorded, or visual material essential or related to treatment by spiritual means, and for a symbolic object of similar significance, which shall be honored and made available at the recipient's expense.

- 3) If a minor, parent of a minor, or loco parentis refuse medication or other treatment based on spiritual grounds, SCCMHA ORR will assist in working with the court in determining the most appropriate method of treatment.
- 4) Person served, their guardian, parent of a minor or loco parentis will be informed of the reason for a denial of treatment by spiritual means.
- 5) Person served, their guardian, parent of a minor or loco parentis will be informed of their right to the Local Appeal Process upon a denial of treatment by spiritual means.
- 6) Opportunity for contact with agencies providing treatment by spiritual means shall be provided in the same manner as person served are permitted to see private mental health professionals.
- 7) The right to treatment by spiritual means includes the right of the person served their guardians, parents of a minor, or loco parentis to refuse medication or other treatment on spiritual grounds if:
 - a) Spiritual treatment predates the current allegations of mental illness or disability
 - b) No court order empowering guardian or facility to make those decisions
 - c) The person served is not imminently dangerous to self or others and treatment is essential to prevent physical injury.
- 8) The right to treatment by spiritual means does not include the right:
 - a) To use mechanical devices or chemical or organic compounds which are physically harmful
 - b) To engage in activity prohibited by law
 - c) To engage in activity that physically harms the person served or others
 - d) To engage in activity which is inconsistent with court ordered custody or voluntary placement by a person other than the person served

Definitions:

Assigned Support Staff: Case Manager, Support Coordinator, or Therapist assigned to work with a SCCMHA person served. The Case Manager, Support Coordinator, or Therapist may be a SCCMHA staff member or a member of the SCCMHA Service Provider Network.

Loco Parentis: A person or institution that assumes parental rights and duties for a minor.

Treatment by spiritual means: Spiritual discipline or school of thought upon which a person served wishes to rely to aid physical or mental recovery.

References:

Michigan Mental Health Code 330.1704

Administrative Rules 330.7001

Administrative Rules 330.7135

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Receipt of a request to receive treatment by spiritual means will be documented in the person served record.	1) Assigned Support Staff
2) When the request to receive treatment by spiritual means is received from a guardian or the parent of a minor, the person served will be asked if they consent to the treatment requested. If an agreement cannot be reached between the guardian and the person served, the person served will be able to decline the treatment.	2) Assigned Support Staff
3) Upon request to receive treatment by spiritual means, agencies providing treatment by spiritual means will be contacted to make a referral for treatment.	3) Assigned Support Staff
4) In the event that the staff member receiving the request believes there is a clinical reason for denying the request, the staff making the denial will send the person served, their guardian, parent of a minor, or loco parentis a letter stating the reason for denial.	4) Assigned Support Staff
5) The person served, their guardian, parent of a minor, or loco parentis receiving the written refusal of treatment by spiritual means will be notified of the ability to appeal the decision through the SCCMHA Local Appeal process. This request to access the Local Appeal process will be filed through the SCCMHA Customer Service Department.	5) Assigned Support Staff, and the Customer Service Department

6) If the person served, their guardian, parent of a minor or loco parentis refuse treatment ordered by a court based on spiritual grounds, the court originating the order will be consulted.	6) Assigned Support Staff
7) The court's decision based on this refusal of treatment will be followed by SCCMHA.	7) Assigned Support Staff

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Comprehensive Examination	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.21
Effective Date: September 7, 1997	Date of Review/Revision: 3/19/03, 1/25/08, 7/13/09, 6/22/12, 6/14/14, 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
	Supersedes: 06.02.23.00	
		

Purpose:

The purpose of this policy is to ensure people served by mental health services from Saginaw County Community Mental Health Authority (SCCMHA) receive a comprehensive physical and mental examination when admitted into a psychiatric hospital.

Policy:

It is the policy of SCCMHA to reach an agreement with contractual providers of psychiatric inpatient facilities that ensure comprehensive examinations are completed when a person served is admitted into their facility.

Application:

This policy applies to all people served of inpatient psychiatric facilities holding a contract with SCCMHA.

Standards:

- 1) The people served admitted to inpatient psychiatric facilities will receive a comprehensive physical and mental examination within 24 hours of admission.

Definitions:

Inpatient psychiatric facility: A unit or a hospital designated to treat mental and emotional disorders.

References:

Michigan Mental Health Code 330.1710

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) People served admitted to a psychiatric inpatient facility will receive a comprehensive physical and mental examination within 24 hours of admission.	1) Inpatient psychiatric facility
2) Upon completion of a comprehensive physical and mental examination, an Individual Plan of Service will be developed using the information obtained during the comprehensive examinations.	2) Inpatient psychiatric facility
3) The Individual Plan of Service will be developed through the Person-Centered Planning process.	3) Inpatient psychiatric facility
4) Each person served remaining in the facility will be periodically re-examined no less than annually.	4) Inpatient psychiatric facility

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights - Entertainment Material, Information, and News	Chapter: 02 - Customer Service and Re- cipient Rights	Subject No: 02.02.22
Effective Date: September 7, 1997	Date of Review/Revision: 3/19/03, 1/25/08, 7/13/09, 6/19/12, 6/14/14, 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26 Supersedes: 06.02.24.00	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
		

Purpose:

The purpose of this policy is to ensure the rights of people served receiving mental health services from Saginaw County Community Mental Health Authority (SCCMHA) to have access to entertainment material, information, and news.

Policy:

It is the policy of SCCMHA to assure people served of mental health services are not discriminated against in having access to entertainment material, information, and news unless specified in their Individual Plan of Service.

Application:

This policy applies to all people served of SCCMHA including the Service Provider Network.

Standards:

- 1) Person served shall not be prevented, at their own expense, from acquiring reading, written or printed material, or from viewing or listening to television, radio, recordings, or movies for reasons of, or similar to, censorship except under circumstances outlined in this policy.
- 2) A provider may limit access to entertainment materials, information, or news only if such a limitation is specifically approved in the person served Individualized Plan of Service. A provider shall document each instance when a limitation is imposed in the person served record.

- 3) The limitations/restrictions will be removed when they are no longer clinically justified.
- 4) Minors served have the right to access material not prohibited by law unless the legal guardian of a minor or Loco Parentis objects to this access.
- 5) There may be general program restrictions to access material by a provider, but in no circumstances when it conflicts with an individual's rights as defined in the Constitution of the United States or the Bill of Rights.
- 6) This policy provides a process addressing a person served interest in a daily Newspaper.
- 7) This policy allows the person in charge of the plan of service to attempt to encourage the parent/guardian of a minor to withdraw their objections as referenced within this policy.
- 8) The policy describes the process for persons served to appeal the denial of their right to have access to entertainment material, information, and news.
- 9) Restrictions on access to entertainment material, information, and news for the benefit of a group are not allowed and must be addressed in each Individual Plan of Service.

Definitions:

Assigned Support Staff: Case Manager, Support Coordinator, or Therapist assigned to work with a SCCMHA person served. The Case Manager, Support Coordinator, or Therapist may be a SCCMHA staff person or a member of the SCCMHA Service Provider Network.

Loco Parentis: A person or institution that assumes parental rights and duties for a minor.

Entertainment material, information, and news: Printed material, viewing or listening to television, radio, recordings, or movies

References:

Michigan Mental Health Code 330.1708
Administrative Rules 330.7139

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Limitations may be imposed upon a person served right to access entertainment material, information, or news if the need to do so is indicated in the assessment during the Person-Centered Planning process. The limitations(s) will be documented in the clinical record. Restrictions for the benefit of a group are not allowed and must be addressed in each Individual Plan of Service.	1) Assigned Support Staff
2) Limitations will be removed when they are no longer essential to achieving objectives which justify the restrictions or limitations. The removal of restrictions or limitations will be documented in the clinical record.	2) Assigned Support Staff
3) The person served, their guardian, parent of a minor, or loco parentis will be notified they may file a Recipient Rights complaint if they feel the restrictions or limitations are not justified.	3) Assigned Support Staff
4) A person served interest in and for the provision of a daily newspaper will be assessed.	4) Assigned Support Staff
5) Attempts will be made to encourage a guardian, parent of a minor, or loco parentis to withdraw objections to material desired by the minor, when appropriate.	5) Assigned Support Staff

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Communication, Mail, Telephone & Visiting Rights	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.23
Effective Date: March 7, 2000	Date of Review/Revision: 3/19/03, 1/25/08, 7/13/09, 6/19/12, 6/14/14, 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26 Supersedes: 06.02.25.00	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		

Purpose:

The purpose of this policy is to ensure the rights of people served receiving mental health services from Saginaw County Community Mental Health Authority (SCCMHA) to have access to mail, telephone, and to visit with people of their choice.

Policy:

It is the policy of SCCMHA to assure people served of mental health services are not discriminated against in having access to mail, telephone, and to visit with people of their choice.

Application:

This policy applies to all people served of SCCMHA services living in residential settings.

Standards:

- 1) Telephones will be made accessible, and a reasonable amount of funds will be made available to the person served for the purpose of phone use if necessary.
- 2) Correspondence can be conveniently and confidentially received and mailed and writing materials and postage will be provided in reasonable amounts.
- 3) Space will be made available for visits.
- 4) In residential settings, telephone, mail, and receiving visitors shall not be further limited except as authorized in the Individual Plan of Service (IPOS).

- 5) No limitation of communication by mail, telephone, or visit may be imposed on any person served if that communication is between person served and the Recipient Rights Office, clergy, the court, attorney, or other individual when the communication involved matters, which are or may be in the subject of legal inquiry.
- 6) A person served who is able to secure the services of a mental health professional shall be allowed to see that person at any reasonable time.
- 7) A postal box or daily pickup and deposit of mail is required in order for the person served to be able to easily send and receive communication by mail.
- 8) Person served shall be entitled to unimpeded, private, and uncensored communication with others by mail and telephone, and to visit with persons of their choice, except under circumstances where the limitation is clearly documented in the individual plan of service per Michigan Mental Health Code (MMHC).
- 9) Writing materials and postage shall be provided to the person served, in reasonable amounts, if the person served is unable to procure such items.
- 10) Mail for a person served shall not be opened unless a person served, their guardian, the parent of a minor or loco parentis has consented that a designated person may open an article of mail, or there is reasonable belief that the mail is a violation of a law.
- 11) Outgoing and incoming mail shall not be opened or destroyed without the written consent of a person served, their guardian, parent of a minor or loco parentis. Instances of opening or destruction of mail by staff shall be recorded and placed in the person served record.

Definitions:

Support Staff: Case Manager, Supports Coordinator, or Therapist

References:

Michigan Mental Health Code 330.1715

Michigan Mental Health Code 330.1726

Administrative rules 330.7199

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Limitations may be imposed upon a person served the right to access communication, telephone, and visiting rights only if it is clearly documented in the individual plan of service per Michigan Mental Health Code (MMHC).	1) Support Staff
2) Limitations will be removed when they are no longer essential to achieving objectives which justify the restrictions or limitations. The removal of the restrictions or limitations will be documented in the clinical record.	2) Support Staff
3) The person served or guardian will be notified they may file a Recipient Rights complaint if they feel the restrictions or limitations are not justified.	3) Support Staff

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Freedom of Movement	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.24
Effective Date: September 8, 1997	Date of Review/Revision: 3/19/03, 1/25/08, 7/13/09, 6/19/12, 6/14/14, 11/27/16, 6/2/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights
	Supersedes: 06.02.26.00	
		Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights

Purpose:

The purpose of this policy is to ensure the rights of people served receiving mental health services from Saginaw County Community Mental Health Authority (SCCMHA) will be allowed freedom of movement to the greatest extent possible.

Policy:

It is the policy of SCCMHA to ensure that people served of mental health services are not discriminated against in order to allow freedom of movement.

Application:

This policy applies to all people served by SCCMHA including the Service Provider Network.

Standards:

- 1) SCCMHA and its Service Provider Network shall treat all people served in the least restrictive environment suitable to their individual plan of service.
- 2) Freedom of movement of a person served shall not be restricted more than necessary to:
 - a) Provide mental health services to the person served
 - b) Prevent injury to the person served or others
 - c) Prevent substantial property damage except that security precautions are appropriate to the condition and circumstances of an individual admitted by order of a criminal court, or a person transferred from a penal institution

- 3) A person served right to freedom of movement will only be limited as authorized by the person served Individual Plan of Service. The reasons for any limitation(s) must be clearly documented in the Individual Plan of Service. Any limitation placed on the person served will be time limited per Michigan Mental Health Code (MMHC).
- 4) Limitations on freedom of movement will be removed when the circumstances that justified its adoption cease to exist.
- 5) Person served shall be entitled access to areas designated for recreational, vocational, social activities where age, sex, physical illness/handicap, or maintenance of security is appropriate for access.
- 6) The residential agency shall provide for a rational and fair manner in which a person served, their guardian, parent of a minor, or loco parentis may request leaves and appeal denial of requests. If dissatisfied, the person served may seek assistance from the SCCMHA ORR.
- 7) Substantial limitations shall be reported to the guardian, parent of a minor or loco parentis and the court during any hearing process.
- 8) Service plans for person served involved in the legal or criminal justice system will identify any security precaution necessary to ensure safety to comply with an existing court order.
- 9) Person served placed in adult foster care homes are able to have complete freedom of movement unless specified differently in their Individual Plan of Service.

Definitions:

Support Staff: Case Manager, Supports Coordinator, or Therapist

References:

Michigan Mental Health Code 330.1708

Michigan Mental Health Code 330.1744

Administrative rules 330.7199

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Limitations may be imposed upon a person served right to freedom of movement if the need to do so is indicated in the person served individual plan of service and will be time limited per Michigan Mental Health Code (MMHC).	1) Support Staff
2) Limitations will be removed when they are no longer essential to achieving objectives which justify the restrictions or limitations. The removal of the restrictions or limitations will be documented in the clinical record.	2) Support Staff

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Personal Property & Funds	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.25
Effective Date: March 7, 2000	Date of Review/Revision: 3/19/03, 12/19/06, 1/25/08, 7/13/09, 6/19/12, 6/14/14, 11/27/16, 6/6/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
	Supersedes: 06.02.27.00	
		

Purpose:

The purpose of this policy is to ensure the rights of people served receiving mental health services from Saginaw County Community Mental Health Authority (SCCMHA) to have access to personal property and their own funds.

Policy:

It is the policy of SCCMHA to ensure that all people served of mental health services are not discriminated against in having access to their personal property and their own funds.

Application:

This policy applies to all people served of SCCMHA including the Service Provider Network.

Standards:

- 1) A person served property or living area shall not be subject to search by a provider except in the following circumstances:
 - a) Search is authorized in the person served plan of service.
 - b) There is reasonable cause to believe the person served is in possession of contraband or property excluded by written policies or procedures of the provider.
- 2) Documentation will be made in the record of the circumstances surrounding the search which includes: (i) the reason for initiating the search, (ii) the names of the individuals performing and witnessing the search, (iii) the results of the search, including a description of the property seized.

- 3) Any property taken into possession by the residence/facility must be given to the person served at the time the person served leaves.
- 4) Person served will be allowed to inspect personal property at reasonable times.
- 5) Each facility will provide a reasonable amount of storage space to each resident for their clothing and other personal property.
- 6) The Support Staff responsible for the Individual Plan of Service may limit property to prevent the person served from physically harming himself, herself, or others, or to prevent the destruction of property. This may include limiting property to reduce the likelihood of theft or loss unless the person served signs a waiver. A limitation adopted by the individual in charge of the plan of service, the date it expires, and justification for its adoption will be promptly noted in the record of the person served.
- 7) A receipt shall be given to the person served and a person designated by the person served, for any personal property taken into possession by the home provider.
- 8) All limitations of property will be justified and documented in the Individual Plan of Service per Michigan Mental Health Code (MMHC).
- 9) Circumstances surrounding the search including:
 - (i) The reason for initiating the search
 - (ii) Names of the individuals performing and witnessing the search
 - (iii) Results of the search, including a description of property seized, shall be entered into the person served clinical record.
- 10) All of the people served money will be logged into their Resident Funds Log, and every time money is taken out of their account, it will be documented, initially by both the person served and staff, and a reason for the withdrawal will be recorded by staff. A person served is entitled to easy access to the money in his or her account and to spend or otherwise use the money as he or she chooses, except as stated previously under limitations.
- 11) The limitation will be removed when the circumstances that justified its adoption cease to exist.
- 12) A person served is entitled to receive, possess, and use all personal property, including clothing, except in the circumstances and under the conditions set forth in the MMHC.
- 13) A facility may exclude kinds of personal property from the facility. Any exclusions will be officially adopted and will be in writing and posted in each residential unit.

14) A search of a persons served living area or property will occur in the presence of a witness. The person served will also be present unless they decline to be present.

Definitions:

Support Staff: Case Manager, Supports Coordinator, or Therapist

References:

Michigan Mental Health Code 330.1728

Michigan Mental Health Code 330.1730

Michigan Mental Health Code 330.1732

Administrative Rules 330.7009

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Restrictions or limitations may be imposed upon a person served right to personal property if the need to do so is indicated in the assessment during the person-centered planning process. The restrictions or limitations will be documented in the clinical record.	1) Support Staff
2) The person served or guardian will be informed of any restrictions on access to personal property and funds at the time of the person-centered plan.	2) Support Staff
3) Restrictions or limitations will be removed when they are no longer essential to achieve objectives which justify the restrictions or limitations. The removal of the restrictions or limitations will be documented in the clinical record.	3) Support Staff
4) At the time the person served moves, their property shall be returned.	4) Adult Foster Care Home Provider
5) The person served may file a Recipient Rights complaint if they or their guardian believes all of their belongings have not been returned to them.	5) Person served or their guardian

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Recipient Labor	Chapter: 02 - Customer Service and Recipient Rights	Subject No: 02.02.26
Effective Date: March 7, 2000	Date of Review/Revision: 3/19/03, 1/25/08, 7/13/09, 6/19/12, 6/14/14, 11/27/16, 6/2/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights
	Supersedes: 06.02.28.00	
		Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights

Purpose:

The purpose of this policy is to set standards for appropriate compensation for work performed by people served of mental health services from Saginaw County Community Mental Health Authority (SCCMHA).

Policy:

It is the policy of SCCMHA to ensure appropriate payment is rendered for work completed by people served.

Application:

This policy applies to all people served by SCCMHA including the Service Provider Network.

Standards:

- 1) A person served may perform labor which contributes to the operation and maintenance of the residence for which the residential agency would otherwise employ someone only if:
 - a) The person served voluntarily agrees to perform the labor
 - b) Engaging in the labor would not be inconsistent with the Individual Plan of Service for the person served
 - c) The amount of time or effort necessary to perform the labor would not be excessive
 - d) In no event shall discharge or privileges be conditioned upon the performance of such labor

- 2) Person served will be compensated appropriately for the performance of work which the agency would otherwise employ someone. This includes complying with applicable federal and state labor laws, including minimum wage and minimum reduction provisions.
- 3) Person served will be compensated for performing labor which benefits another person/agency.
- 4) A person served need not be compensated for personal self-care and personal housekeeping.
- 5) One-half of any compensation paid to a person served under this section is exempt from collection under the Mental Health Code, as payment for mental health services is rendered.
- 6) Person served with open and active cases who have vocational/employment goals as part of their treatment plan will be compensated for work performed commensurate with current applicable state and local laws.
- 7) Work activities considered inappropriate are those which:
 - a) Lack appropriate planning and supervision
 - b) Are supervisory in nature
 - c) Are hazardous either as defined under federal, state, or local law, or in light of an individual person served functional capacity
 - d) Are not performed in accordance with an individualized treatment plan
- 8) Person served who are under the legal working age as defined in applicable federal and state child labor laws may not engage in work.
- 9) More than six hours of work per day must be approved by the agency Clinical Risk Management Committee.
- 10) The Americans with Disabilities Act, Policy #7105, will be followed for people served with active or inactive cases who do not have vocational/employment goals as part of their treatment plan, and who seek employment or who are employed by SCCMHA.

Definitions:

Compensation: As used in this policy it refers to financially compensating a person served to perform labor. In other words, compensation is not to be considered giving person served a token compensation such as a ticket to a concert or other event.

Support Staff: Case Manager, Supports Coordinator, or Therapist

References:

American with Disabilities Act, Policy #7105

Michigan Mental Health Code 330.1736

Administrative Rules 330.7229

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) Participation in occupational training and/or work experience shall be documented as part of the individual Plan of service.	1) Support Staff
2) Participation in vocational/employment training shall be clearly documented in the person served individual plan of services.	2) Support Staff
3) SCCMHA staff will collaborate with the employer to ensure appropriate payment for work is made to the person served.	3) Support Staff

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Dignity and Respect	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.02.28
Effective Date: January 25, 2008	Date of Review/Revision: 1/25/08, 7/13/09, 9/20/10, 6/19/12, 6/14/14, 11/27/16, 6/6/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights
	Supersedes:	
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		

Purpose:

The purpose of this policy is to ensure people served mental health services and their families are treated with dignity and respect, to which they are entitled.

Policy:

It is the policy of SCCMHA that all people served and their families are treated with dignity and respect.

Application:

This policy applies to all staff of SCCMHA as well as the Service Provider Network.

Standards:

- 1) SCCMHA staff and the Service Provider Network protect and promote the dignity and respect to which all people served of services are entitled.
- 2) Family members of the people served are treated with dignity and respect.
- 3) Family members are given an opportunity to provide information about treating professionals.
- 4) Family members will be provided with an opportunity to request and receive general educational information about the nature of disorders, medications, and their side

effects, available support services, advocacy, and support groups, financial assistance, and coping strategies.

Definitions:

Respect: To show deferential regard for; to be treated with esteem, concern, consideration, or appreciation; to protect an individual's privacy; to be sensitive to cultural differences; to allow an individual to make choices.

Dignity: To be treated with esteem, honor, politeness; to be addressed in a manner that is not patronizing or condescending; to be treated as an equal; to be treated the way any individual would like to be treated.

- Examples of treating a person with dignity and respect include, but are not limited to: calling a person by his or her preferred name; knocking on a closed door before entering; using positive language; encouraging a person to make choices instead of making assumptions about their preferences; taking a person's opinion seriously; including a person in conversations; allowing a person to do things independently or to try new things.

Support Staff: Case Manager, Supports Coordinator, or Therapist

References:

Michigan Mental Health Code 330.1704

Michigan Mental Health Code 330.1708

Michigan Mental Health Code 330.1711

Michigan Mental Health Code 330.1752

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) The worth, dignity, and uniqueness of all people served as well as their rights and opportunities, shall be respected and promoted.	1) All SCCMHA staff and Service Provider Network staff
2) Family members of the people served shall also be treated with dignity and respect.	2) All SCCMHA staff and Service Provider Network
3) Complaints regarding the dignity and respect of people served or their family members will be investigated or an intervention on behalf of the person served, or family member will be completed.	3) Office of Recipient Rights

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Least Restrictive Setting	Chapter: 02 - Customer Services & Re- cipient Rights	Subject No: 02.02.29
Effective Date: January 25, 2008	Date of Review/Revision: 1/25/08, 7/13/09, 6/19/12, 6/14/14, 11/27/16, 6/6/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22, 3/14/23, 3/12/24, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights
	Supersedes:	
		Authored By: Kentera Patterson, Officer of Recipient Rights Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights

Purpose:

The purpose of this policy is to ensure all people served of mental health services receive their treatment in the least restrictive setting possible.

Policy:

It is the policy of SCCMHA that all people served are afforded the treatment necessary for them to achieve recovery in the least restrictive setting.

Application:

This policy applies to all staff of SCCMHA as well as the Service Provider Network.

Standards:

- 1) SCCMHA offers mental health services in the least restrictive setting that is appropriate and available.
- 2) A person served shall receive mental health services suited to his or her condition.

Definitions:

Least Restrictive Setting: The setting where appropriate treatment can be provided with the least number of restrictions placed upon the person served. An example of this would be a person served may meet the criteria for inpatient hospitalization, but if the services can be provided to the person served in a crisis residential placement, this option should be offered to them if it is appropriate to the circumstances. A crisis residential placement offers the person served more freedom than an inpatient hospitalization.

Support Staff: Case Manager, Supports Coordinator, or Therapist

References:

Michigan Mental Health Code 330.1708.

Michigan Mental Health Code 330.1752

Exhibits:

None

Procedure:

ACTION	RESPONSIBILITY
1) People served of mental health services shall receive services in the least restrictive setting possible. This is determined by diagnosis, symptoms, and the person-centered planning process.	1) Support Staff
2) Complaints regarding the least restrictive setting will be investigated or an intervention will be completed on behalf of the person served.	2) Recipient Rights Office

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Recipient Rights – Substance Use	Chapter: 02 - Customer Services & Recipient Rights	Subject No: 02.02.30
Effective Date: September 15, 2008	Date of Review/Revision: 9/15/08; 7/31/09; 6/19/12; 12/10/12; 6/14/14; 11/27/16; 6/10/18; 2/11/20, 4/8/25, 3/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Kentera Patterson, Officer of Recipient Rights Authored By: Kentera Patterson Additional Reviewers: Judy Sausedo, Supervisor of Recipient Rights, and Jen Kreiner, Chief of Health Services and Integrated Care
	Supersedes:	
		

Purpose:

The purpose of this policy is to establish a Recipient Rights process for the purpose of protecting the rights of individuals receiving substance use (SUD) services from Saginaw County Community Mental Health Authority (SCCMHA).

Policy:

SCCMHA is committed to protecting, promoting, and safeguarding the rights of individuals receiving SUD services through a clearly defined Recipient Rights process. This policy is established to ensure full compliance with the Michigan Administrative Rules for Substance Abuse Programs (1981), as amended, and all other applicable state and federal laws governing SUD services.

Application:

This policy applies to services provided for persons served receiving SUD services within the provider network.

Standards:

- 1) This process was adopted and maintained by the SCCMHA ORR Advisory Committee in compliance with the Michigan Administrative Rules for Substance Abuse Service Programs and are reviewed at least annually.

- 2) A person served as defined in the 1981 Administrative Rules for Substance Abuse Service Programs in Michigan shall not be denied appropriate service based on race, color, national origin, religion, sex, age, mental or physical handicap, marital status, sexual preference, or political beliefs.
- 3) The admission of a person served to this program, or the provisions of prevention services, shall not result in the person served being deprived of any rights, privileges, or benefits which are guaranteed to individuals by state or federal law or by the state or federal constitution.
- 4) A person served may present grievances or suggested changes in program policies and services to the program staff, to governmental officials, or to another person within or outside the program. In this process, the program shall not in any way restrain the person served .
- 5) A person served has the right to review, copy, or receive a summary of his or her program records, unless in the judgment of the Program Director, such actions will be detrimental to the person served or to others for either of the following reasons:
 - (a) Granting the request for disclosure will cause substantial harm to the relationship between the person served and the program or to the program's capacity to provide services in general.
 - (b) Granting the request for disclosure will cause substantial harm to the person served. If the Program Director determines that such action will be detrimental, the person served is allowed to review non-detrimental portions of the record or a summary of the record. If a person served is denied the right to review all or part of his or her record, the reason for the denial shall be stated to the person served . An explanation of what portions of the record are detrimental and for what reasons, should be stated in the person served record and should be signed by the Program Director.
 - (c) Any denial of access to records shall be documented in writing, including the clinical basis for denial, and the person served shall be informed of their right to request review of the decision.
- 6) A program staff member should not physically or mentally abuse, neglect, or sexually abuse a person served as the terms "abuse" and "neglect" are defined in the Substance Abuse Licensing Section of the Administrative Rules. If an individual suspect's abuse and/or neglect of a person served, the individual is required to report the allegations to the appropriate authorities.
- 7) A person served has the right to review SCCMHA written fee schedule. Any revisions of fees will be approved by the governing authority.
- 8) A person served is entitled to receive an explanation of his or her bill upon request, regardless of the source of payment.

- 9) Should this program engage in any experimental or research procedure, any or all persons served will be advised as to the procedures to be used and have the right to refuse participation in the experiment or research without jeopardizing their continuing services. State and federal rules and regulations concerning research involving human subjects will be reviewed and followed.
- 10) A person served shall participate in the development of his or her treatment plan. Counseling staff will inform persons served that development of a treatment plan is a cooperative effort between counselor and the person served. It is the policy of this program that both the person served and counselor sign the treatment plan and any major revisions of that plan.
- 11) A person served has the right to refuse treatment and to be informed of the consequences of that refusal. When a refusal of treatment prevents this program from providing services according to ethical and professional standards, the relationship with the person served may be terminated. Reasons for termination will be recorded in the person served case file in the discharge summary, and the proper Appeals and Grievance Notices will be given to the person served. Relapses or continued substance use alone shall not constitute grounds for automatic discharge. Discharge decisions shall be clinically justified, documented, and communicated in writing with appeal rights provided.
- 12) All medications used to treat SUD must be prescribed and/or administered under the Informed Consent process. Informed consent for medication shall include an explanation of the purpose of the medication, expected benefits, potential risks and side effects, alternatives (including no treatment), and the right to refuse. Consent shall be documented in the clinical record.
- 13) A person served has the right to give prior informed consent, consistent with federal confidentiality regulations, for the use and future disposition of products of special observation and audiovisual techniques, such as one-way vision mirrors, tape recorders, television, movies, or photographs.
- 14) Fingerprints may be taken and used in connection with treatment or research or to determine the name of a person served only if expressed written consent has been obtained from the person served. Fingerprints shall be kept as a separate part of the person served record and shall be destroyed or returned to the person served when the fingerprints are no longer essential to treatment or research.
- 15) This policy and procedure shall be provided to each member of the program staff. Each staff member shall review this material and shall sign a form which indicates that he or she understands and shall abide by this program's recipient rights policy and procedures. It is the responsibility of the program director to ensure that each

staff member fully comprehends the intent of the policies and procedures. A copy of the signed form will be maintained in the staff member's personnel file; a second copy will be retained by the staff member.

- 16) The program director shall designate one staff member to function as the program rights advisor. The rights advisor shall:
 - (a) Attend all the Substance Abuse Licensing training pertaining to recipient rights.
 - (b) Receive and investigate all recipients' rights complaints independent of interference or reprisal from program administration.
 - (c) Communicate directly with the Coordinating Agency Rights Consultant when necessary.
- 17) The staff member designated as rights advisor shall not be a provider of counseling services where staffing permits.
- 18) The rights of recipients shall be displayed in a public place on a poster to be provided by the Bureau of Substance Abuse Standards (BSAS). The poster will indicate the designated rights advisor's name and telephone number.
- 19) As part of the intake admission process, each person served will receive a brochure which summarizes recipient rights for both substance abuse and mental health programs. The brochure must either have been provided by BSAS or been approved by BSAS.
- 20) It is the responsibility of the intake worker or counselor to explain each right listed on the brochure to the person served. The recipient will then be requested to sign the rights acknowledgment form to indicate understanding of the rights. If he or she refused to sign, then the refusal and reason given is noted in the person served file by the intake worker.
- 21) If a person served is temporarily unable to comprehend or acknowledge receipt of the Recipient Rights information at admission due to their clinical condition, the brochure and explanation of rights shall be provided as soon as the recipient is able to participate meaningfully. Documentation of the reason for delay provided shall be entered in the record.
- 22) The procedure to be followed when the rights advisor receives a formal complaint is described in detail in the January 1982 Recipient Rights Procedure Manual. It is this program's policy that the Program Rights Advisor follows the procedures outlined in that manual.
- 23) All information related to substance use disorder services shall be maintained in accordance with 42 CFR Part 2, the Health Insurance Portability and Accountability Act (HIPAA), and applicable Michigan law. No information shall be disclosed without proper written consent except as permitted or required by law as outlined in SCCMHA Notice of Privacy Practices.

Definitions:

None

References:

1981 Administrative Rules for Substance Abuse Programs in Michigan R 325.14302
1981 Administrative Rules for Substance Abuse Programs in Michigan R 325.14301 to R325.14306 of the Administrative Rules for Substance Abuse Service Programs in Michigan
SCCMHA - Notice of Privacy Practices

Exhibits:

Exhibit A - SCCMHA - Consent to Share Behavioral Health Information

Procedure:

ACTION	RESPONSIBILITY
1) Upon admission, each persons served is provided with program rules, which are also posted in public places in the program. These program rules inform new persons served of the infractions which can lead to discharge. The rules also describe the mechanism for appealing a discharge decision and which staff has authority to discharge. The person served signs a form that documents that a written copy of program rules has been received and questions about it answered. This form is maintained in the person served file.	Central Access and Intake Specialist
2) A person served shall have the benefits, side effects, and risks associated with the use of any drugs fully explained in language which is understood by the person served. The medical program director is responsible for providing this explanation or for designating staff to do so.	Medical Program Director or designated staff

Saginaw County Community Mental Health Authority
Michigan Department of Health and Human Services (MDHHS)
(Revised 9-25)

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

Why This Form is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

To give consent, fill out Sections 1, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3, and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it to your health care provider. They can make a copy for you.

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last)	Date of Birth
Janet W. Doe	07/04/1988

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

- ☐ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.

This consent expires (optional)
03/12/2027

When providing a consent for treatment, payment, and health care operations there is the potential for records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected under 42 CFR Part 2.



If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any, are

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

Health Plan

Pre-paid Inpatient Health Plan (PIHP)

Mid-State Health Network

1. Saginaw

500 Hancock Street Saginaw, MI 48602-4224

Phone: 989-797-3400 Fax: 989-799-0206

B. Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

☒ Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 3a

☐ Do not share my information through the organizations listed below.

☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only. List all health information exchanges or networks:

1. PCE Systems

2. Michigan Health Information Network

SECTION 4 - WHAT INFORMATION YOU WANT TO SHARE

Choose one option:

☒ Share all of my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."

☐ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

The expiration date, event, or condition for Sections 3 and 4

This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.

Date, event, or condition

<ONE YEAR FROM SIGNATURE DATE>

SECTION 5 - YOUR CONSENT AND SIGNATURE

Read the statements below, then sign and date the form.

By signing this form, I understand:



- I am giving consent to share my behavioral health and/or substance use disorder records. This includes referrals and services for alcohol and substance use disorders and/or other information may also be shared.
- My records may be shared with the people or organizations as described above.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes and/or with substance use disorder counseling notes."
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.

Electronically Signed By:

Kentera Patterson BS

03/17/2026

STAFF SIGNATURE / CREDENTIALS

DATE

CONSUMER SIGNATURE

PRINTED NAME

DATE

PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE
SIGNATURE

PRINTED NAME

DATE

WITNESS SIGNATURE

PRINTED NAME

DATE

SECTION 6 - TAKE AWAY YOUR CONSENT, WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed above. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

- ☐ Self
- ☐ Parent (Print Name)
- ☐ Guardian (Print Name)
- ☐ Authorized Representative (Print Name)

Signature

Date

SECTION 7 - FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY



Verbal Withdraw of Consent

☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

☐ Individual listed in Section 1

☐ Parent (Print Name)

☐ Guardian (Print Name)

☐ Authorized Representative (Print Name)

Print name of person who received the verbal withdrawal

Signature

Date

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent

Additional Identifiers (Optional)

Medicaid

000123456789

Last 4 of the Social Security Number Case #

****9998

000000012

Form Copy (choose one option)

☒ The individual in Section 1 **received** a copy of this form.

☐ The individual in Section 1 **declined** a copy of this form.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, national origin, color, sex, disability, religion, age, height, weight, family status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: This form is acceptable to MDHHS as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.

COMPLETION: Voluntary but required of disclosure is requested.



Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Service Animals	Chapter: 02 - Customer Services & Re- cipient Rights	Subject No: 02.02.31
Effective Date: 6/10/18	Date of Review/Revision: 1/8/19, 2/11/20, 3/9/21, 6/10/22, 2/14/23, 2/13/24, 2/11/25, 2/10/26	Approved By: Sandra M. Lindsey, CEO Responsible Director: Director of Environmental Services, Customer Ser- vice, & Security Authored By: Director of Customer Ser- vice, Recipient Rights, & Security Additional Reviewers:
	Supersedes:	
		

Purpose:

To provide guidelines for the safe introduction of service animals into the Saginaw County Community Mental Health Authority (SCCMHA) and the SCCMHA Provider Network environment. SCCMHA abides by the rights of persons with disabilities accompanied by a service animal in accordance with applicable Federal, State and Local law.

Application:

This policy applies to SCCMHA as well as the SCCMHA Service Provider Network.

Policy:

It is the policy of SCCMHA to provide a warm and welcoming environment for its employees, persons served, and visitors, which includes service animals assisting individuals with disabilities while in or on agency premises unless otherwise indicated.

Standards:

- A. Dogs: It is the standard of SCCMHA that individuals with a disability will be allowed to bring their individually trained service animal (dog) into all areas of the facility where persons served are normally allowed to go in accordance with the following:
 - 1. The individual may be asked, by SCCMHA Staff responsible for maintaining a safe and secure environment, if the animal is a service animal and what tasks the service animal has been trained to perform;

2. There will be no requirement for special ID cards for the service animal;
 3. There will be no requirement for a certificate or license of training for the service animal;
 4. There will be no inquiries of the individual regarding the individual's disability;
 5. The individual who uses a service animal, hereafter simply referred to as the individual will not be charged extra fees, isolated from other persons served, or treated less favorably than other persons served;
 6. The agency will not provide care or food for a service animal; nor will the agency be required to provide a special location for the animal to relieve itself;
 7. A service animal must be under the control of its handler. Under the ADA, service animals must be harnessed, leashed, or tethered, unless the individual's disability prevents using these devices or these devices interfere with the service animal's safe, effective performance of tasks. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.
 8. If the individual does not maintain control of the service animal, e.g., the animal continually barks, wanders around, damages property; or if the animal becomes a threat to the health and safety of others; or the dog is not housebroken, the individual will be asked to remove the service animal from the premises;
 9. If the condition exists wherein the individual is asked to remove the service animal from the premises, reasonable accommodations will be offered to insure continued services without having the service animal on the premises;
 10. If the service animal damages property, the individual will be responsible for payment for such damages in accordance with policies and procedure which require other individuals to pay for damages to the facility's property;
 11. Service animals will not be allowed entrance into areas of the facility where their presence would "fundamentally alter" the function of the specific service area.
- B. Miniature Horses: (Miniature horses generally range in height from 24 inches to 35 inches measured to the shoulders and generally weigh between 70 and 100 pounds.) It is the standard of SCCMHA that individuals with a disability, will be allowed to bring their trained service animal (miniature horse) into all areas of the facility

where persons served are normally allowed to go in accordance with the above standards and additionally the following;

1. the miniature horse is housebroken;
2. the miniature horse is under the owner's control at all times;
3. the facility can accommodate the miniature horse's type, size, and weight, and;
4. the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

C. If there is a question about whether or not a dog or miniature horse brought into an SCCMHA facility is a service animal, the following procedures should be followed:

1. Staff responsible for maintaining a safe and secure environment may ask:
 - a. Is the animal a Service Animal required because of a disability, and
 - b. What work or task has the animal been trained to perform?

If the animal is determined not to be a service animal, according to the definition in this policy, the individual will be asked to remove the animal from the SCCMHA facility.

Definitions:

Service Animal: Is defined as dogs that are individually trained to perform tasks for people with disabilities. (Americans with Disabilities Act of 1990 (ADA) – Title III Regulation 28 CFR Part 36 – Sec.36.104) In addition, the ADA recognizes miniature horses which are trained to provide assistance to an individual with a disability as a service animal.

The miniature horse is not included in the definition of service animal, which is limited to dogs. However, ADA regulations contain a specific provision which covers miniature horses.

Staff responsible for maintaining a safe and secure environment: Customer Service Staff, Front Desk Associate, Security Guard or other SCCMHA staff given this responsibility.

References:

American with Disabilities Act of 1990 (ADA) – Title III Regulation 28 CFR Part 36

Exhibits:

Exhibit A - Michigan Department of Civil Rights Service Animal Poster

Procedure:

None

Did you know:

If you're open to the public, you **must be** accessible to service animals.

It's not only the right thing to do, **it's the law.**



Learn more at michigan.gov/serviceanimals



Tab 8

Network Services

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: SCCMHA Continuing Education Program	Chapter: 05 - Organizational Management	Subject No: 05.06.06
Effective Date: 9/1/03	Date of Review/Revision: 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, 4/1/26 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services Authored By: Jennifer Keilitz Additional Reviewers: Alecia Schabel
		

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 inservices, 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 re-	SCCMHA Management, Senior Clinical Leaders Teams, & Continuing Education Committee (as documented in minutes)

quirements for SCCMHA network and staff. Approve and develop ad hoc courses and in-services to meet needs; ensure qualifications of instructors. Ensure staff and self-schedule of attendance/completion of required courses and monitor staff adherence to minimum education requirements. 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. Oversee Continuing Education Unit functions and development of continuing education schedules, protocols and resources. Chairs Continuing Education Committee 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. Meets on a quarterly and ad hoc basis as needed to review and provide feedback on SCCMHA continuing education program structure and goals. Provides input on continuing education issues and needs for the SCCMHA system and makes suggestions for improvement.	SCCMHA Continuing Education Supervisor Supervisors and Directors Staff and Supervisors SCCMHA Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services SCCMHA Continuing Education Supervisor SCCMHA Continuing Education Supervisor Continuing Education Committee Quality Governance Committee SCCMHA Supervisors SCCMHA Provider Network Members Continuing Education Committee

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: SCCMHA Training for General AFC Licensees, Licensee Designees, and Direct Care Staff	Chapter: 05 - Organizational Management	Subject No: 05.06.06.02
Effective Date: 3/27/07	Date of Review/Revision: 6/6/12, 5/15/14, 4/3/16, 6/13/17, 6/13/18, 5/23/19, 9/10/19, 6/8/20, 5/4/23, 4/1/26 Supersedes:	Approved By: Sandra M. Lindsey, CEO Responsible Director: Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services Authored By: Jennifer Keilitz Additional Reviewers: Continuing Education Supervisor, Alecia Schabel
 SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		

Purpose:

It is required by Adult Foster Care Licensing that Adult Foster Care Home licensees, administrators and direct care staff complete educational requirements as specified in R 400.14201, R 400.14203 and R 400.14204 of the Department of Human Services *Licensing Rules for Adult Foster Care Small Group Homes for 12 or Less* effective May 24, 1994. Areas of required staff education include: personal care, supervision, and protection of residents; handling emergency situations; reporting requirements; first aid; cardiopulmonary resuscitation; resident rights; safety and fire prevention; prevention and containment of communicable diseases. In addition, the licensee and administrator must annually complete no less than 16 hours of Department of Human Services approved training that is relevant to the licensee's admission policy and program statement.

OCAL or the Department of Health and Human Services & Office of Children & Adult Licensing does not directly provide training for licensees. However, education and training for homes licensed for persons who have a mental illness, developmental disability, physical disability or the aged must be designated or approved by the Department of Human Services. OCAL offers a web site where licensees may purchase approved training in limited geographical areas. MDHHS Group Home Curriculum Training is considered one of the Department approved training curricula.

SCCMHA core values indicate support of all citizens with disabilities in the community regardless of service provider's contractual affiliation with SCCMHA. SCCMHA intends to ensure some level of resources are made available to general AFC licensees at no cost, as room in the classroom is available.

Policy:

It is the policy of SCCMHA to offer a continuing education and training program that meets Federal and State requirements and provides opportunities for general adult foster care licensees, licensee designees and direct care staff to gain professional skills that will contribute to a safe, humane environment and will promote hope, recovery and a life like everyone else.

It is also the policy of SCCMHA that providers of service to people with mental health disorders, developmental disabilities and co-occurring disorders in Saginaw County have access to quality education and training opportunities. Providers of service with a contractual agreement with SCCMHA will be given priority in situation where training resources are limited. Providers of service with no contractual agreement with SCCMHA will be offered education and training opportunities when openings are available.

Application:

This policy applies to general Adult Foster Care Small Group Homes in Saginaw County who serve individuals diagnosed with a mental illness, developmental disability or co-occurring disorder. This policy pertains only to ongoing training and education; it does not address employee orientation, resident-specific in-services or home policies and procedures.

Standards:

- A. SCCMHA will prioritize education and training opportunities for network service providers in obligation to the contractual agreement with the Michigan Department of Mental Health as a PIHP for the Managed Specialty Supports & Services Program.
- B. Priority level for education and training opportunities will be as follows:
 - 1. First priority will be given to network providers holding a valid contract with SCCMHA.
 - 2. The second priority level will include Saginaw County AFC providers serving individuals enrolled in an SCCMHA services program but not holding a valid contract with SCCMHA.
 - 3. The third priority level will include Saginaw County providers serving individuals with a developmental disability, mental illness or co-occurring disorder but not enrolled in an SCCMHA services program nor holding a valid contract with SCCMHA.
 - 4. Fourth priority will be given to Out of County AFC providers.
- C. SCCMHA will limit education and training opportunities to Saginaw County licensees and licensee designees holding a valid Adult Foster Care license. Individuals applying for an Adult Foster Care license or waiting on a license approval will not be eligible for SCCMHA education and training until a license is granted by OCAL- DHS.

- D. SCCMHA will provide training and education that have published education protocols that 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, and educator/trainer qualifications.
- E. SCCMHA provided courses will adhere to an established, published education plan and calendar. The education plan will be developed by the SCCMHA Continuing Education Committee and approved by the SCCMHA Management Team.
- F. SCCMHA provided courses will adhere to written education protocols for all continuing education courses routinely conducted.
- G. 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.
- H. Routine Courses will include core competencies required by State of Michigan Department of Human Service Office of Children and Adult Licensing as well as core competencies required by SCCMHA contractual agreement for specialized residential care. These routine competencies will include:
 - a) Rights of Recipients
 - b) Cardiopulmonary resuscitation and First Aid (offered together only)
 - c) Introduction to Residential Services: Reporting Requirements, Personal Care, Supervision and Protection
 - d) Environmental Emergencies and Fire Safety
 - e) Basic Health: vital signs, Prevention and containment of communicable disease (offered together only)
 - f) Basic Medications
 - g) Nutrition and Food Safety
 - h) Working with people Culture of Gentleness and Crisis Response
- I. Education protocols will be kept current by SCCMHA staff and will be adopted by SCCMHA through Management Team and Continuing Education Committee review.
- J. Ad hoc courses sponsored or provided by SCCMHA must have an established protocol; approval for ad hoc courses must come from the designated SCCMHA Management Team member.
- 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. Ad hoc courses will be evaluated for possible insertion into standing education programs.
- M. SCCMHA will establish a periodic continuing education committee - composed of the Continuing Education Supervisor, Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR and Enhanced Health Services; SCCMHA Human Resources, Network Services Provider Auditing Supervisor, Provider/Clinical program representatives, consumer representative(s), and Social Work Consultant and others as applicable. to review continuing education procedures, coordination and standards.

- N. As determined and approved by the SCCMHA Continuing Education Supervisor on an individual basis, providers may be offered the opportunity for some course offerings to be “self-study” with a comprehensive test as proof of competency in lieu of face-to-face attendance at an education session. If a “self-study” course may be substituted due to limited calendar availability, providers should note live training follow up may be required with the next available course.
- O. Providers are to complete each training course and pass a competency test with a score of 80% or higher. Providers are able to re-test up to 2 additional times with some testing room accommodations, if necessary. If the test is failed a 3rd time, staff will need to wait 6 months and re-take the course.
**staff will not be able to work alone with consumers if they fail one or more of these courses: Rights of Recipients; Cardiopulmonary resuscitation and First Aid; Reporting Requirements; Environmental Emergencies and Fire Safety; Care and Supervision; Prevention and containment of communicable disease; Health and vital signs; Medications; Nutrition; and Working with people with disabilities.*
- P. All providers are required to take SCCMHA Orientation to Training prior to registering for any other courses. Trainees not following the SCCMHA rules and expectation may be asked to leave at the trainer’s discretion.
- Q. SCCMHA will record trainee involvement in SCCMHA training and education courses including course title, date of attendance, competency test score, pass/fail, and credit hours of course.
- R. SCCMHA will provide the licensee with routine monthly and quarterly reports of individual course completion. For providers who may need immediate proof of attendance, trainees are to be given a training tracker form. Trainees will be responsible for giving the training tracker form to the trainer for a signature at the end of each training. The signature does not verify a passed training.
- S. For classroom-based courses, SCCMHA reserves the right to limit class audience size for optimal learning.

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.

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 facility policies and practices.

Service Provider – Department of Human Services Office of Children & Adult Licensing (DHS – OCAL) Adult Foster Care licensee or in the case of corporations, licensee designee.

References:

SCCMHA Education Protocols Manual (most current version)
 SCCMHA Continuing Education Program Policy and Procedure
 Licensing Rules for Adult Foster Care Small Group Homes

Exhibits:

Exhibit A: Registration Form
 Exhibit B: Program Guidelines for All Training Attendees

Procedure:

ACTION	RESPONSIBILITY
Approve SCCMHA annual continuing education program/plan, standing education protocols and minimum education requirements for SCCMHA network and staff.	SCCMHA Management, Services 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 Committee SCCMHA Directors and Supervisors
Oversee Continuing Education Unit functions and development of continuing education schedules, protocols, and resources.	SCCMHA Director of Network Services & Continuing Education
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. Chairs Continuing Education Committee.	SCCMHA Continuing Education Supervisor and Trainers
Meets on ad hoc basis as needed to review and provide feedback on SCCMHA continuing education program structure and goals.	Continuing Education Committee SCCMHA Supervisors

Provides input on continuing education issues and needs for the SCCMHA system and makes suggestions for improvement.	SCCMHA Provider Network Members Continuing Education Committee

Exhibit A

Direct Care Registration Form

If Not LR Direct Care, Please Indicate Staff Type:					Provider Name:	
Autism	CLS	RESPIRE	SIP	SD	Supervisor / Home Manager Name:	
☐	☐	☐	☐	☐	Date Requested:	
Staff Information					For accurate transcript records, please be sure spelling is correct.	
Last Name					For SCCMHA Use Only	
First Name						
Hire Date						
Termination Date						
Has staff worked for other SCCMHA providers?						
If yes, please list other provider(s)/other home name(s)						
Name of Class					Date Of Class	
Orientation						
Cultural Awareness						
Recipient Rights						
Blood Borne Pathogens					Covered in Basic Health	
Working with People 1						
Working with People 2						
Verbal De-Escalation/Physical Intervention for Protection						
Basic Health with Blood Borne Pathogens						
Basic Medications						
Introduction To Residential Services and PCP						
First Aid & CPR						
Person Centered Planning					Covered in Intro to Res.	
Safety & Communication Class (NFS, EE/FS, EOT, LEP)						
Basic Meds Renewals					Renewals Only	

9/2019

Exhibit B

PROGRAM GUIDELINES FOR ALL TRAINING ATTENDEES

1. I understand that class begins at 9:00 a.m. If I come in after 9:10 a.m., I will not be able to attend that class.
2. I understand that if I return to class late from **break** or **lunch**, the door will be locked and I will not be able to re-join the class.
3. I understand that class runs until the times indicated on the training schedule. If I need to leave early for any reason I will have to make the entire class up in a future training cycle.
4. I understand that there is no smoking on any Saginaw County Community Mental Health Authority (SCCMHA) property. I agree to smoke only in my vehicle with the windows rolled up and the doors closed or off the premises.
5. I agree to conduct myself in a professional manner while in SCCMHA buildings /on SCCMHA property. This includes but is not limited to:
 - a. Keeping my voice at a low volume when in the public areas of the building including the front lobby;
 - b. Showing respect to staff and others using SCCMHA services;
 - c. Showing respect to instructors and fellow students.
 - d. Not playing excessively loud music in the parking lot.
6. I understand that no form of intimidation is allowed or tolerated in the classroom or SCCMHA property. Any display of verbal or physical intimidation toward anyone while attending group home training will result in immediate expulsion from classes.
7. I understand that I may not use my personal mobile phone during class. Use includes but not limited to: checking/reading texts, sending texts, checking and sending emails and voice mails, making phone calls, playing games, accessing the web or having the phone out. Use includes holding the phone in one's lap, in an open purse or bag so that it can be viewed or concealed in books, papers or any other items. Please note, that phone use in the bathroom or hallway during class is also prohibited.
8. I understand that if there is a personal emergency situation that must be monitored during class hours, I will talk to the trainer(s) before class starts to make arrangements for SCCMHA Continuing Education Department (CE) clerical staff or supervisor to be contacted to deliver messages.
9. I understand that sleeping during class is not allowed. Sleeping is defined as eyes closed and/or head down **or** a hat or hood covering the eyes to prevent trainers from determining if eyes are closed. Sleeping in class will result in being asked to leave the class.
10. I agree to return all training materials on the day they are due.
11. I understand that everyone learns at a different pace and will be tolerant and supportive of each other's needs.
12. I understand I must pass all aspects of the training including any hands-on requirements as directed by the trainer(s) in order to pass the training in full, modification of the training will not be allowed.
13. Students may not bring children or pets with them during classes that they are scheduled to attend at SCCMHA facilities. At no time are children or pets permitted to be left unattended, in the building or in a vehicle on SCCMHA property. NO EXCEPTIONS.

By signing this document, I acknowledge that I have read and understood the program rules and expectations presented in the above information. I understand that failure to comply with program guidelines may result in expulsion from this training program.

Printed Name

Signature of Trainee

Date

Revised September 2019 (all other versions of this document are void)

Network Services & Public Policy Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Quality of Life Visits	Chapter: 09.04.01 - Auditing	Subject No: 09.04.01.04
 Provider Network Auditing		
Effective Date: 9/10/09	Date of Review/Revision: 9/10/09, 7/30/10, 7/3/12, 6/2/14, 5/2/16, 5/19/17, 6/13/18, 1/2/20, 2/3/22, 6/1/23, 2/13/26	Approved By: Jennifer Keilitz, Director of Network Services, Public Policy, Continuing Educa- tion, OBRA/PASARR & Enhanced Health Services Authored By: Jennifer Keilitz Reviewed By:
	Supersedes:	

Purpose:

To ensure the safety and well being of consumers who reside in licensed residential settings as well as other community living settings. As part of Saginaw County Community Mental Health Authority (SCCMHA) Residential Watch program, SCCMHA auditing unit, with the assistance of consumers, will conduct Quality of Life visits in settings funded by SCCMHA.

Policy:

It is the policy of SCCMHA to visit service providers offering residential services at least once each year, twice each year, when able. The intent is to improve the quality of life for residents being served in settings funded by SCCMHA.

Application:

This procedure applies to all licensed residential and community living supports provider programs under contract with SCCMHA.

Standards:

- A. It is the belief of SCCMHA that on-site visitation and monitoring to detect early identification of key risk factors may prevent more serious provider noncompliance as well as reduce any compromise in the well-being of residents who are placed in residential settings.

- B. SCCMHA intends to provide systematic support to providers and persons associated with residential settings with emphasis on settings under contract with SCCMHA.
- C. For General AFC homes we would offer as an option as a means of quality improvement.
- D. Quality of Life visits will be conducted as needed for each home as assigned by Residential Watch Committee. In lieu of Quality of Life Visits, SCCMHA may conduct Home and Community Based (HCBS) Waiver Reviews to assure compliance in these areas.
- E. Quality of Life visits will be conducted using a standard format to document findings.
- F. It is the intent that Quality of Life visits will be conducted primarily by persons served.
- G. Individuals involved with Quality of Life visits will be subject to the same orientation process as SCCMHA volunteers. This process includes the need for a TB test, background check and orientation.

Definitions:

Licensed Residential Providers/Contractors: are those that hold an Adult Foster Care License with special certification with the Michigan Department of Health and Human Services and are currently serving individuals who are persons served by SCCMHA services or their contracted network as part of a Specialized Residential Contract.

General AFC Providers: are those that hold an Adult Foster Care License with the Michigan Department of Health and Human Services and are currently serving individuals who are receiving services through SCCMHA but do not have a contract with SCCMHA for Specialized Services.

Community Living Supports settings- Housing options where the provider and the land lord are the same.

References:

SCCMHA Policy 09.04.03.07 Residential Provider Watch Program

Exhibits:

Exhibit A - Quality of Life Visit form

Procedure:

ACTION	RESPONSIBILITY
1. SCCMHA will solicit persons served to assist with Quality-of-Life visits.	1. SCCMHA Provider Network Auditing Supervisor or Designee
2. Will screen and discuss the importance of confidentiality of residents and any findings at the provider site.	2. SCCMHA Provider Network Auditing Supervisor or Designee
3. Persons Served that perform Quality of Life Visits will go through the SCCMHA volunteer orientation process.	3. SCCMHA Provider Network Auditing Supervisor or Designee

4. SCCMHA will train persons served on how to conduct Quality of Life visits.	4. SCCMHA Provider Network Auditing Supervisor or Designee
5. Will work with persons served until they feel comfortable with what they are doing for the Quality-of-Life visits.	5. SCCMHA Provider Network Auditing Supervisor or Designee
6. Will review all Quality of Life visits for any concerns.	6. SCCMHA Provider Network Auditing Supervisor or Designee and Residential Watch Committee
7. Will forward a copy of completed Quality of Life visit forms to the provider affiliated with the facility, including Home Manager, Program Director, and other applicable Supervisory staff.	7. SCCMHA Provider Network Auditing Supervisor or Designee
8. Will forward a copy of the completed Quality of Life visit forms to the case holders affiliated with consumers residing at the facility.	8. SCCMHA Provider Network Auditing Supervisor or Designee
9. Will make necessary changes as noted in the quality of life reports.	9. Licensed Residential Providers/Contractors and General AFC Providers
10. Will report any concerns from the Quality of Life visits to Residential Watch Committee or other entities as needed for follow up such as Recipient Rights, Contracts, or Clinical.	10. SCCMHA Provider Network Auditing Supervisor or Designee
11. Any follow up completed will be reported at the Residential Watch Committee.	11. SCCMHA Provider Network Auditing Supervisor or Designee
12. Residential Watch Committee will make recommendations as to actions or further steps that need to be taken based on the findings.	12. SCCMHA Provider Network Auditing Supervisor, Residential Watch Committee members
13. Quality of Life reports are filed in the SCCMHA Auditing files.	13. SCCMHA Provider Network Auditing Supervisor or Designee
14. Will review Quality of Life reports as part of auditing process to assure provider is addressing any concerns noted.	14. SCCMHA Provider Network Auditors

15. Will complete HCBS reviews in lieu of Quality of Life Visits as necessary.	15. Residential Coordinator and Provider Network Auditor

Exhibit A



Quality of Life Home Visit Report

Date of Visit: _____ Time of Visit: _____ QOL Auditor Name(s): _____

Group Home Name: _____ Address: _____

Service Provider: _____ Number of Staff Present: _____

Names of Staff on Duty: _____

Number of Residents Living at this home: ____ Men ____ Women ____ Other _____

Name of Resident Interviewed: _____ Staff Assisting Interview: _____

Review of Exterior of Home

1. Does the exterior of the home appear to be clean and well kept? (Does it need to be repainted or resided? Is there trash or litter in the front or back yard?)

2. Are the grass, plants, flowers, etc. being maintained?

3. Are egress locations (doors, windows, walkways, etc.) clear from obstructions?

Resident Feedback

1. What were the residents doing when you arrived?

2. How does the resident interviewed make meaningful choices in his/her life (large and small)?

3. How does the resident decide when to go to bed and get up?

4. Does the consumer that you're talking to have at least one activity of his/her choice outside the home per week? Examples of the activity? If no what would they like to do?

5. Are there residents that stay home during the day (do not attend a skill build program, supported employment program or clubhouse)? What things do they do when they stay home all day? Do they go anywhere?

6. Does the resident connect with friends and relatives outside of the group home setting? If so, what kind of activities do they do?

7. Does the individual participate in activities with other group home residents? List examples.

8. Does the individual like where he/she lives? What are likes & dislikes of the group home setting?

9. Does the home do any type of exercise? What types?

10. How often does the home eat fast food or got out to a restaurant a week?

11. How does the individual gain access to his/her money?

12. What were the staff doing when you arrived?

Volunteer Feedback

13. Do consumers in this home participate in Day Activity Programming? ☐ Yes ☐ No

If yes, do you see an activity calendar posted specifically for Day Activity Programming activities?

☐ Yes ☐ No

If yes, do you see additional outings occurring not as part of the Day Activity Programming? ☐ Yes ☐ No

14. Is the dietary menu posted, and did it match the account of what consumers ate? ☐ Yes ☐ No

15. Is consumer input being given for menu choices and options? ☐ Yes ☐ No

16. What snacks are being offered by the home? Are healthy choices included? Where are snacks listed?

17. Does the home have information about healthy eating posted, such as MyPlate? Do the menus appear to be offering healthy choices, including fruits and vegetables with each meal?

18. Are there grocery items to match menu for the next two days? ☐ Yes ☐ No

19. Is there fresh milk (not powdered) in the refrigerator? ☐ Yes ☐ No

20. Are there thermometers placed in all of the refrigerators and freezers in the home? Do they appear to be within the correct amounts? (Below 40 degrees for refrigerators; below 0 for freezers so that food is frozen solid) ☐ Yes ☐ No

21. Are there fresh fruits and vegetables available? ☐ Yes ☐ No

22. Are there sheets, mattress pads, pillows, and blankets on the beds? ☐ Yes ☐ No

23. Are there soap, towels, and toilet paper available in the bathroom? ☐ Yes ☐ No

24. Where are personal care items being stored? Are they properly labeled with consumer initials?
☐ Yes ☐ No

25. Is the medication cupboard locked? ☐ Yes ☐ No

26. Are medications being stored separately? (Orals and topicals should not be in the same drawer) ☐ Yes ☐ No

27. Is there a communication book for staff, and is it up to date? ☐ Yes ☐ No

28. Are there current copies of each consumer's plan easily available for staff to review?

☐ Yes ☐ No

29. Is the living area free from health and safety hazards? ☐ Yes ☐ No

30. Are hallways clear and free of health and safety risks? ☐ Yes ☐ No

31. Is the kitchen area free of health and safety risks? ☐ Yes ☐ No

32. Is the residence a “home”? ☐ Yes ☐ No

33. Does the overall residence appear clean, well maintained, and organized? ☐ Yes ☐ No

34. What is the diversity of consumers in the home?

35. Are there any additional comments or issues that need to be addressed?

Quality of Life Auditor Signature: _____

Distribution: 1 Copy SCCMHA, 1 Copy Owner/Administrator
2/07, revised JRM 2012, AK 2016, MS 2023

Network Services & Public Policy Procedure or Plan Manual Saginaw County Community Mental Health Authority		
Subject: Consumer Access to Network Service Provider Information	Chapter: 09 - Department Procedures	Subject No: 09.04.03.06
Network Services & Public Policy		
Effective Date: 1/1/06	Date of Review/Revision: 6/12/12, 6/3/14, 5/6/16, 6/1/17, 6/13/18, 3/1/19, 2/4/22, 6/6/23, 2/13/26	Approved By: Jennifer Keilitz, Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services Authored By: Jennifer Keilitz Reviewed By: None
	Supersedes:	

Purpose:

Michigan Department of Health and Human Services (MDHHS) contractual requirements of Pre-Paid Inpatient Health Plans (PIHPs), including federal external quality review standards, indicate the need for a written procedure on how Saginaw County Community Mental Health Authority (SCCMHA) as a Community Mental Health Service Provider (CMHSP) with delegated responsibilities will provide persons served access to provider information.

Policy:

SCCMHA individuals of services and supports from the provider network have a right to have access to provider performance and contact information.

Application:

This procedure applies to all SCCMHA Network Service Providers, contractual and SCCMHA operated programs.

Standards:

- A. SCCMHA routinely publishes provider performance information through the issuance of provider audit score summaries in newsletters and other public reports.
- B. SCCMHA maintains a provider network database through the Network Services & Public Policy Department. This database includes the contact information, languages spoken, and whether or not they are accepting new referrals.
- C. SCCMHA publishes routine provider directories made available to the public.

- D. The Customer Services Department of SCCMHA is the contact location for consumers seeking service provider related information.
- E. SCCMHA will provide new consumers of services with contact information for the provider network upon admission to SCCMHA services.
- F. SCCMHA will make specific provider performance available on the SCCMHA Website.
- G. SCCMHA updates provider information through an annual provider application process.
- H. SCCMHA will issue annual surveys to network providers on limited English resources within the network.

Definitions:

None

References:

SCCMHA Network Management & Development Policy
 SCCMHA Customer Service Policy
 MDHHS PIHP and CMHSP contract requirements

Exhibits

None

Procedure:

ACTION	RESPONSIBILITY
Publishes provider information and maintains provider database information. Updates provider application and Limited English information annually. Provides specific provider data or information to persons served, through Customer Service Department when requested or indicated. Updates SCCMHA Provider information routinely with Mid-State Health Network PIHP for regional consumer access.	Network Services & Public Policy Department
Assist persons served to access provider network information upon admission to SCCMHA services and upon their request. Includes provider information access notice in persons served publications. Receives quarterly reports on provider data by service type.	Customer Service Department

Network Services & Public Policy Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Persons Served Leadership Roles	Chapter: 09 - Department Procedures	Subject No: 09.04.03.11
Network Services & Public Policy		
Effective Date: August 1, 2010	Date of Review/Revision: 6/13/17, 3/1/19, 2/4/22, 6/6/23, 3/13/26	Approved By: Jennifer Keilitz, Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services Authored By: Jennifer Keilitz Reviewed By: Tim Ninemire
	Supersedes:	

Purpose:

The purpose of this procedure is to 1) define the leadership roles for persons served and opportunities, 2) establish this expectation throughout the service delivery network, 3) clarify the method of performance measurement, and 4) promote the continual expansion of meaningful opportunities for persons served in leadership roles and experiences.

Policy:

As part of the goal to acquire true community membership for persons with disabilities and partnership with key stakeholders, Saginaw County Community Mental Health Authority (SCCMHA) network of provider programs and service sites are expected to define, develop, and encourage regular leadership roles of persons served within their organizations and operations.

Application:

This procedure applies to all SCCMHA services programs and sites including purchased, contracted services in the provider network. This procedure does not apply to individual contractors of SCCMHA.

Standards:

- A. Leadership roles of persons served may include primary and secondary persons served.

- B. All providers who operate program sites are expected to make leadership opportunities available to primary and/or secondary people who receive services at the program level.
- C. Leadership roles may be unpaid/voluntary time or may or may not include a specific stipend for time spent involved in the leadership opportunity, especially if others are paid for such roles, however, these are not employment roles.
- D. Roles may be a regular, ongoing involvement, or they may be an annual or ad hoc opportunity, and may vary from several or numerous hours per year.
- E. Examples of roles for persons served are not limited to, but could include: 1) serving on an advisory or governing board or committee of the organization or program; 2) participation in program quality reviews or quality improvement projects; 3) involvement in the interviewing of job candidates for staff positions; 4) facilitating or assisting to facilitate regular resident home meetings; or 5) family member or alumni resident involvement in operations, such as facilitating an activity of interest for the site; 6) consultation or participation in a specific project or problem-solving activity of the program site.
- F. Participation in satisfaction surveys or individual or panel interviews relative to their individual service experience, including through external audits (SCCMHA, MDHHS or other surveyors) is not included in this definition or process.
- G. Persons served leadership involvement should be reflective of the diversity and populations of the service program or site.
- H. Programs will integrate primary and secondary person served leadership feedback in quality improvement plans and processes.
- I. The volume of opportunities should be reflective of the size of the program; for example, larger programs or organizations should have more than one role available to primary or secondary persons served for meaningful involvement.
- J. While direct operated programs of SCCMHA are under the organizational operation of SCCMHA, they are encouraged to develop program specific leadership or advisory roles.
- K. SCCMHA will seek to collect data and review performance of provider programs in keeping with this expectation of providers.

Definitions:

Primary Person Served: An individual who is a current or past direct recipient of SCCMHA services and supports.

Secondary Person Served: An individual who is a family member or guardian of a primary person served.

Ad Hoc: Roles that may be short-term or time limited and deal with a specific purpose, subject, project or goal/outcome.

References:

SCCMHA Policy: 02.01.03 Persons Served Involvement & Leadership Opportunities
MDCH Application for Renewal & Recommitment 2009

Exhibits

None

Procedure:

ACTION	RESPONSIBILITY
Establish policy and procedure.	Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services and Director of Environmental Services, Customer Service and Security
Communicate expectations to providers.	Director of Network Services, Public Policy, Continuing Education, OBRA/PASARR & Enhanced Health Services and Supervisor of Provider Network Auditing
Collect data and measure provider performance through audits.	Provider Network Auditors