ACCESS
Community Health & Research Center

Policy Name: Policy Section/ Number:	Created By:	Initial Date:	Current Date:	Pages:
Member Grievance Policy Section __/# ____	Ana Dutcher Quality Assurance Manager	9/9/19	9/9/19	Page 1 of 6

Approved By: Mohamad Khraizat	Title: Health Operations Manager
Signature: Mohamad Khraizat	Date: 9-20-19

I. POLICY:

It is the policy of ACCESS Community Health and Research Center (ACCESS CHRC) that Enrollee/Members receiving behavioral health services have access to the grievance process consistent with the Michigan Department of Health and Human Services, (MDHHS) and Center for Medicare and Medicaid Services (CMS) requirements, contracts, policy guidelines and technical advisories. This protocol ensures that all recipients have access to grievance rights, options that are timely, objective, fair, accessible and understandable.

II. PURPOSE:

The purpose of this policy is to promote a standardized process for the resolution of consumer disputes, to increase knowledge of grievance options and to support the goal of improving services.

III. APPLICATION

This policy applies to ACCESS, its employees, direct contractors and volunteers.

IV. PROCEDURES:

1. ACCESS will ensure that the grievance process is in alignment with DWMHA directives and is
    a. Timely
    b. Fair to all parties, which includes
        i. Enrollee/Member
        ii. Enrollee/Member's authorized or legal representative
        iii. Provider and provider's staff
    c. Administratively simple
    d. Objective and credible
    e. Accessible and understandable to Enrollees/Members and providers
    f. Subject to quality improvement review
    g. Ensures that the individual staff who assist Enrollee/Member with the grievance process shall be free from discrimination and/or punitive action
    h. Ensures that the grievance process does not interfere with the delivery of the Enrollee/Member's services
    i. Ensures that an Enrollee/Member who files a grievance shall be free from discrimination and/or retaliation
    j. Promotes the resolution of Enrollee/Member's concerns about services
2. ACCESS CHRC will ensure that staff and providers are compliant with the grievance requirements as evidenced by ensuring:

a. All employees are trained on the grievance process, including rights and responsibilities, procedures and time frames, within thirty (30) days of hire and annually thereafter
b. Grievance forms, posters and brochures are available in the waiting room
c. All Enrollee/Members are informed of their right to designate an authorized representative to act on their behalf as long as the representative is at least 18 years of age and the member has provided written permission by completing and forwarding the Appointment of Representative form to DWMHA
d. ACCESS CHRC staff may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so
e. The grievance process is a separate process and is not utilized in lieu of an Enrollee/Member's ability to file a Recipient Rights Complaint
f. Enrollees/Members are informed that they have a Right to concurrently file an Appeal of an Adverse benefit Determination and a Grievance regarding other service complaints
g. All necessary language in contracts is compliant with State and Federal requirements
h. Standardized documents related to this Grievance Policy are the customizable templates provided by DWMHA
i. Documentation of the substance of the grievance and action(s) taken in MH-WIN
j. Investigation of the substance of grievance and action(s) taken, including any aspects of clinical care involved
k. All operational and/or policy changes, including reference materials and documents, is communicated with subcontractors
    i. ACCESS CHRC provides technical assistance and training on the grievance process to promote the resolution of concerns as well as to support and enhance services
    ii. ACCESS CHRC engages subcontractors in consultative meetings to provide information and guidance in establishing and implementing grievance process policies

3. Enrollees/Members have access to one or more of the following dispute resolution options. They may be utilized concurrently:
    1. Grievance
    2. Appeal
    3. Recipient Rights Complaint
4. Enrollees/Members may access the State Fair Hearing process only if the resolution of the grievance is not resolved within ninety (90) calendar days of the receipt of the grievance unless a fourteen (14) day extension was granted
5. Enrollee/Member and/or his/her authorized/legal representative will be:
    a. Informed at the time of initial enrollment, intake, annually, upon request, and at the time he/she expresses dissatisfaction, of the internal grievance procedures, including the right to file a grievance, the resolution process, and the time frames for standard and expedited resolutions.
    b. Informed orally and in writing of the grievance process available and methods to file a grievance;
    c. Informed of the right to file an expedited or standard grievance;
    d. Informed of the right to file an internal grievance orally or in writing at any time with his/her provider at the provider location, assigned MCPN or with DWMHA by calling 1.888.490.9698,

TTY: 1.800.630.1044, or in writing to: DWMHA Customer Service Department at 707 West Milwaukee, Detroit, MI 48202 or email to the appropriate address as noted below:

i. MI Health Link Enrollee/Members at MIHealthLinkGrievances@dwmha.com
ii. Or by contacting Medicare to file an external grievance at 1-800-MEDICARE (1-800-633-4227), or through the DWMHA's website at: www.DWMHA.com under the Customer Service tab.
iii. Medicaid/Healthy Michigan and Non-Medicaid Enrollee/Members at PIHPGrievances@dwmha.com

e. Informed that filing a grievance will not affect eligibility of service;
f. Offered reasonable assistance in completing grievance forms and in taking other procedural steps which shall include but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability
g. Allowed to file a grievance on behalf of the Enrollee/Member to the extent allowed under applicable Federal or State law
h. Informed that with written consent, they have the right to have a provider or other authorized representative, acting on their behalf, file a Grievance to DWMHA
i. Informed that a provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so
j. Provided information regarding grievance rights in a format provided or approved by DWMHA at the time of initial enrollment, upon request, and/or at least annually thereafter
k. Informed there is no time limit on filing a Grievance

6. ACCESS CHRC ensures all grievances are processed timely by:
   a. ACCESS CHRC staff coordinates as appropriate with Fair Hearing Officers and the local Office of Recipient Rights
   b. Being initiated at the time an Enrollee/Member/legal representative or an authorized representative expresses dissatisfaction with services and/or experience in receiving services;
   c. Acknowledging upon receipt;
      iv. Within three (3) days for MI Health Link Enrollees/Members;
      v. Within five (5) days for Medicaid and uninsured or under insured Beneficiaries
      vi. Responding orally or in writing within twenty-four (24) hours to an expedited grievance for MI Health Link Enrollees/Members when:
         4. DWMHA extends the appeals time frame, or
         5. DWMHA refuses to grant a request for an expedited appeal.
7. ACCESS CHRC ensures the grievance is submitted to the appropriate staff including an administrator with the authority to require corrective action, none of whom shall have been involved in the previous review or decision-making, nor a subordinate of any such individual
8. ACCESS CHRC ensures that the individuals who make decisions on the grievance are individuals who have clinical expertise, as determined by the State, in treating the Enrollee/Member's condition or disease if the grievance involves:
   a. Clinical issues
   b. The denial of an expedited resolution of an appeal (of an action)
9. ACCESS CHRC ensures the completion and forwarding of the Status Letter to an Enrollee/Member, authorized or legal representative for a grievance pending resolution beyond thirty (30) days

10. ACCESS CHRC ensures will be processing, investigating, and resolving a grievance as expeditiously as the Enrollee/Member's health requires and in no event later than ninety (90) calendar days
    a. The ninety (90) day time frame may be extended up to fourteen (14) days should the Enrollee/ Member/authorized or legal representative request the extension, or if the provider justifies the need for additional information and documents how the delay is in the interest of the Enrollee/Member
    b. If ACCESS CHRC extends the time frame for response to a grievance and it is not at the Enrollee/Member's request, ACCESS CHRC must make reasonable efforts to give the Enrollee/Member prompt oral notice of the delay
    c. ACCESS CHRC must give the Enrollee/Member written notice of the reason for the extended time frame within two (2) business days and inform the Enrollee/Member of the right to file a grievance if he or she disagrees with that decision
11. ACCESS CHRC will be taking into account all comments, documents, records, and other information submitted by the Enrollee/ Member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination. Providing accessibility and availability of Customer Service Grievance staff and Customer Service Representatives to discuss and provide assistance with resolving an Enrollee/Member's grievance
12. ACCESS CHRC ensures that subcontractors provide the Enrollee/Member/authorized or legal representative the opportunity before, during, and after the grievance process to examine, free of charge, their case file, medical records and any other documents and records being considered. Further, the Enrollee/Member/ authorized or legal representative may present any additional information in person as well as in writing for the decision-making process
13. ACCESS CHRC ensures the maintenance of an electronic tracking system (Evolv) to register, track and report to DWMHA's Quality Department the following:
    a. Number of grievances
    b. Time frames and disposition of grievances
    c. Substance/reason for, and the number of grievance requests by category
    d. The number of Standard and Expedited Grievance requests
    e. Resolution times of grievances; and
    f. Grievance records
14. ACCESS CHRC ensures the notification of the Enrollee/Member, authorized or legal representative in writing of the disposition and the right to appeal the resolution of his/her grievance upon case closure and no later than ninety (90) calendar days from the date of receipt of the grievance
    a. The notice of Grievance resolution must include
        i. The results of the grievance process
        ii. The date the grievance process was concluded
        iii. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than 90-days from the date of the Grievance
        iv. Instructions on how to access the State Fair Hearing process, if applicable.
15. ACCESS CHRC ensures that all forms and Enrollee/Member materials related to grievances are available and easily accessible, in understandable and linguistically appropriate format, via DWMHA website, IPOS meetings and at provider locations
16. As required, ACCESS CHRC materials are compliant with all contractual, regulatory, and accreditation requirements in regards to reading level (at or below 4th grade level), font, type size, format, and language. ACCESS CHRC will meet reasonable accommodations as required by the American

Disabilities Act (ADA), Limited English Proficiency (LEP), and Cultural Competency guidelines. These services are provided at no cost to the Enrollee/Member

a. The availability of vital written information in the prevalent non-English languages in the service area in accordance with the LEP guidelines, Center for Medicare and Medicaid Services (CMS) and/or DWMHA's contract with the Michigan Department of Health and Human Services (MDHHS). Materials will meet the most stringent guideline
b. Upon request, ACCESS CHRC will provide materials in alternate formats to meet the needs of vision and/or hearing impaired Enrollee/Members, including large font (at least 16 point font), Braille, oral interpretation service, ASL, audio and visual formats
c. Translation services will be made available to the Enrollee/Member, upon request
d. Interpreter services and toll-free numbers that have adequate TTY and interpreter capability

17. Enrollee/Member Grievance Timeframes and Procedural Steps
    a. Time frame for filing a grievance:
        i. There is no time limit for filing a grievance
        ii. The standard time frame of resolution is ninety (90) calendar days
    b. Response to a Grievance:
        i. All grievances, whether they are received verbally or in writing, will be responded to in writing, including quality of care grievances.
        ii. Acknowledgment of the receipt MI Health Link grievances is required within three (3) calendar days.
        iii. Acknowledgment of the receipt of a Medicaid and Non-Medicaid grievance is required within five (5) calendar days.
        iv. A Combination Letter (Acknowledgement/Resolution Letter) is required for Medicaid and NonMedicaid grievances resolved within five (5) calendar days.
    c. MI Health Link grievances requiring a response within twenty-four (24) hours of receipt are:
        i. Expedited grievances
        ii. Grievances where DWMHA extends the appeals time frame or DWMHA refuses to grant a request for an expedited appeal

V. QUALITY ASSURANCE/IMPROVEMENT:

ACCESS' Quality Manager shall review the adherence to this policy as an element of its Contractor Performance Review program. Results of this review will become part of the database used to monitor the performance. The QAPIP must include measures for the monitoring of and the continuous improvement in quality of the program and process described in this policy.

VI. COMPLIANCE WITH ALL APPLICABLE LAWS:

ACCESS staff are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives in effect, or as amended.

VII. REOURCES

DWMHA Policies and Forms: All DWMHA policies refer to the most recent policy at the time of writing.

1. Customer Service Enrollee/Member Appeal Policy
2. Recipient Rights Policies
3. Limited English Proficiency (LEP)
4. Cultural Competency
5. Substance Use Disorder – Recipient Rights

https://www.dwmha.com/files/5115/3209/4424/Member_Grievance.pdf

ACCESS

Community Health & Research Center

Policy Name: Policy Section/ Number:	Created By:	Initial Date:	Current Date:	Pages:
Customer Service (CS) Member Appeals Policy Section __/# ____	Ana Dutcher Quality Assurance Manager	3/14/2012	9/9/2019	Page 1 of 14

Approved By: Mohamad Khraizat	Title: Manager of Health Operations
Signature: Mohamad Khraizat	Date: 9-20-19

I. POLICY

It is the policy of ACCESS CHRC that members receiving and requesting behavioral health services have access to an appeal process consistent with the Michigan Department of Health and Human Services (MDHHS) and Center for Medicare and Medicaid Services (CMS)

II. PURPOSE

To provide guidance regarding the development and consistent processing of member appeals

III. APPLICATION:

This is a policy that applies to ACCESS employees, interns and volunteers who provide support and treatment on behalf of the agency.

IV. KEY WORDS:

1. Adequate Notice of Adverse Benefit Determination
2. Administrative Appeal
3. Advance Notice of Adverse Benefit Determination
4. Adverse Benefit Determination
5. Appeal
6. Behavioral Health Supports and Services
7. Expedited Appeal (Fast)
8. Fair Hearing
9. Grievance
10. Individual Plan of Service (IPOS)
11. Independent Review Entity (IRE)
12. Integrated Care Organization (ICO)
13. Legal Representative
14. Medicaid
15. Medicare
16. Michigan Department of Health and Human Service (MDHHS)

17. Prepaid Inpatient Health Plan (DWMHA)
18. Provider
19. Provider Network
20. Reconsideration
21. Re-determination
22. Similar Specialist
23. State Fair Hearings

V. PROCEDURES

ACCESS will

1. Ensure that all appeal processes are
    a. Timely
    b. Fair to all parties;
        i. Member
        ii. Member's Authorized or Legal Representative
        iii. Estate Representative of a Deceased Member
        iv. Agency
    c. Administratively simple
    d. Objective and credible
    e. Accessible and understandable to members/members and providers
    f. Subject to quality improvement review
    g. Developed in a manner to assure that members/members who participate in the appeal process are free from discrimination or retaliation
    h. Developed in a manner to assure that they do not interfere with communication between member and the receipt of services
2. Ensure compliance with the appeal requirements as evidenced by:
    a. Including all necessary language in contracts and requiring contractor's language follows state and federal requirements
    b. Structuring the appeal process that promotes the resolution of the member's concerns about services
    c. Documenting the substance of the appeal and actions recorded in MH-WIN
    d. Asks DWMHA providing technical assistance and training on the appeal processes to promote the resolution of concerns as well as support and enhance services

e. Participate in consultative meetings to provide information and guidance in implementing appeal policies
f. Providing standardized documents related to the appeals policy in the form of templates to give providers the ability to customize with their specific identifying information;
g. Ensuring that staff reviewers are licensed practitioners of the healing arts with same or similar clinical expertise in treating the member's condition or disease when the appeal is denied based on medical necessity or involves other clinical issues;
h. Ensuring the staff who reviews the appeal will not be the same person who was involved in making the initial decision that is the subject of the appeal nor be the subordinate of the previous reviewer;
i. Ensuring access to all forms related to appeal actions (i.e. Appeal bookmarks, Appeal Request forms, Member Handbooks and Request for Hearing forms with envelopes) are available, easily accessible, understandable and linguistically appropriate to members/members and providers via websites, Individual Plan of Service meetings and at provider sites;
j. Incorporating a written process in operational manuals consistent and compliant with this appeal policy;
k. Ensuring that ACCESS' appeal materials are compliant with all contractual, regulatory and accreditation requirements regarding reading level (at or below a fourth (4th) grade reading level), font, type size, medium and language. Upon request, ACCESS will provide material in alternative formats to meet the needs of vision and/or hearing-impaired member upon request. These services are provided at no cost to the member.
    i. The availability of vital written information in the prevalent non-English languages in the service area in accordance with the LEP guidelines, Center for Medicare and Medicaid Services (CMS) and/or DWMHA's contract with the Michigan Department of Health and Human Services (MDHHS). Materials will meet the most stringent guideline.
    ii. Upon request, ACCESS will obtain materials from DWMHA and provide them in alternate formats to meet the needs of vision and/or hearing-impaired members, including large font (at least 18-point), Braille, oral interpretation service, ASL, audio and visual formats.
    iii. Translation services will be made available to the member, upon request.

iv. Interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

l. Provide access to one or more of the following dispute resolution options that may be utilized simultaneously;
   i. Grievance
   ii. Local Appeal
   iii. Recipient Rights Complaint

3. Provide in writing to the member the appropriate standardized notice in the event of an adverse action. The form(s) shall include:
   a. A statement of what action is being taken in easy, understandable language which does not include:
      i. abbreviations or acronyms that are not defined; and
      ii. is culturally and linguistically sensitive to the members' needs; and iii. health care procedure codes that are not explained
   b. An explanation of the action including the denial of services in amount, scope and duration if less than what is requested;
   c. The specific jurisdiction that supports or the change in the federal or state law that requires the action including a reference to the benefit provision, guideline, protocol or other similar criterion on which the action is based and the option of the member to have a copy of the benefit provision, guidelines or protocol, upon request;
   d. If the Enrollee's services were reduced, terminated or suspended without an advance notice, ACCESS CHRC must reinstate services to the level before the action.
   e. A statement that the member has the right to appeal and a description of the expedited and standard appeal process including time frames
      i. Unless the Enrollee requests an expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal
      ii. Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal)
   f. A statement that the member has a right to continue receiving Medicaid covered services if a request is made within ten (10) calendar days from the date of the notice when applicable (per MDHHS and DWMHA contract effective October 1, 2017); and an explanation of the procedures of how to request such services be continued to the end of the currently approved treatment authorization or final decision whichever comes first .

g. A statement that the member may have to pay for the continuation of services if the result of the internal appeal or external State Fair Hearing is to uphold the denial;
h. A statement that if the decision is found in favor of the member made by either the DWMHA or State Fair Hearing and services have been previously discontinued, the DWMHA and/or service provider must reinstate services within 72 hours
i. A statement that the member, his/her legal guardian or authorized representative has 14 calendar days from the initiation of the appeal request to present evidence, testimony, and allegations of fact or law in person and/or in writing
j. A statement that the member can request copies of all documents relevant to the appeal, free of charge
k. A statement that informs the member of their right, with the written consent from the Enrollee, to designate an authorized representative to act on their behalf to file an appeal, as long as the member has provided written permission by submitting the request in writing
l. Include a list of titles and qualifications, including specialties of the individuals participating in the appeal review.

4. For all pre service, post service and standard local appeals:
   a. ACCESS and their staff are prohibited from taking any punitive or retaliatory actions towards a member, authorized representative, legal guardian or provider who requests an appeal.
   b. Appeals for service for which Medicaid and Medicare overlap, the member can file an appeal through either the Medicaid or Medicare process or both. Any determination that overturns the denial will be binding
5. Will adhere to the Customer Service Appeal Process for Medicaid Standard, Pre-Service or Post Service Appeals which include:
   a. Local/Internal Appeals (First Level) 1
      i. Identifying and verifying the individual requesting to appeal an Adverse Benefit Determination (Medicaid) or Denial of Medical Coverage (MI Health Link) decision is legally able to do so in order to ensure and protect the member's rights and information.
      ii. Sending the member 10 calendar days prior to the effective date of the action the standardized adverse benefit determination (Adequate or Advance) notice or Denial of Medical Coverage notice to inform the member of a denial, reduction, suspension or termination of services.

iii. Aiding the member, legal guardian or authorized representative in completing the needed paperwork to file and submit an internal/local appeal.

iv. They can request an appeal be resolved in an expedited or standard timeframe. An expedited request requires a 72 hour decision be rendered on the adverse benefit determination as the individual appealing feels a delay in decision making might seriously jeopardize an member's life, health or ability to attain, maintain or regain maximum function. If a decision is made to deny the request for an expedited appeal, an attempt is made to provide the member/ guardian/authorized representative prompt oral notice of the denial as soon as the decision is rendered. Written correspondence is sent to the member/guardian/authorized representative within two (2) calendar days of the denial. A standard resolution of an appeal acknowledges that a decision on the issue will take place no later than 30 calendar days from the date of the appeal request.

v. DWMHA may extend the resolution timeframe by no more than 14 calendar days provided that either the member/guardian/authorized representative requests an extension or DWMHA shows to the satisfaction of the State there is a need for additional information and how the delay is in the best interest of the member. If the extension is granted, DWMHA will provide the member written notice within two (2) calendar days of the decision to extend the timeframe as well as inform the member of their right to file a grievance if they disagree with the extension.

vi. Timely processing and distribution of the standardized acknowledgement letters (Notice of Receipt of Appeal) to the member, legal guardian or authorized representative to indicate the receipt of the appeal request.

vii. Accurately documenting in MHWIN all contacts with members/members, guardians and authorized representatives.

viii. Providing timely resolution to the appealing party and provide detailed explanation of the appeal decision via the Notice of Appeal Approval or Appeal Denial for Medicaid and Notice of Appeal Decision for MI Health Link members. Resolution and investigation of appeals completed for standard appeals within 30 calendar days and 72 hours for fast/expedited appeals. The appeal decision letters are mailed within two (2) calendar days of the decision.

Included with the Notice of Appeal Decision and the Notice of Appeal Denial are instructions to pursue next level review options.

b. Second Level/External Appeal Review for Pre-Service, Standard and Post-Service Appeals:
   i. The member's request for a Medicaid second level/external appeal must be in writing to the Michigan Administrative Hearing Systems in Lansing. There is a form, Request for State Fair Hearing, that is provided to the member with the receipt of the Notice of Appeal Denial (MI Health Link) or Notice of Appeal Decision form (Medicaid).
   ii. The member's request for a Medicaid second level external appeal can be standard or expedited. An expedited appeal is a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay or other behavioral healthcare services for an member who has received urgent services but has not been discharged from a facility or when a delay in decision-making might seriously jeopardize an member's life, health or ability to attain, maintain or regain maximum function. The member has 120 calendar days from the date of the Adequate or Advance Notice of Appeal Denial or Notice of Appeal Decision to request a Medicaid second level/external appeal.
   iii. An Administrative Law Judge (ALJ) from the Michigan Administrative Hearing system will conduct/facilitate the hearing between the appellant (member, authorized representative, legal guardian) and the respondent (DWMHA and/or Service Provider) to determine if proper protocol was adhered to while obeying all federal, state and local rules and regulations.
   iv. The Administrative Law Judge will hear the case and a ruling will be made based upon the information presented by the appellant and the respondent. The ruling is issued to the appellant and/or the appellant's authorized representative and/or legal guardian, respondent and state officials in the form of the Order and Decision notification within 90 days of the hearing.
   v. If the decision is in favor of the member and services were not continued during the appeal process, services must be restored within 72 hours of receiving the decision.
   vi. The member, authorized representative and/or legal guardian is then given the opportunity to appeal the decision within 30 days to the Third Judicial Circuit

Court. Instructions are provided in the Order and Decision notification that is disseminated to the member and/or their representative.

c. Will adhere to the Customer Service Appeal Process for MI Health Link Pre-Service, Standard and Post-Service:
    i. First Level/External Appeal Review:
        1. The member is given a Notice of Denial of Medical Coverage. Such notice shall be provided at least ten (10) calendar days in advance of the date of notice of Denial of Medical Coverage for ongoing services.
        2. The member has up to 60 calendar days from the receipt of the Notice of Denial of Medical Coverage to request a first level internal/local appeal for MI Health Link covered services.
        3. The member's request for first level internal/local appeal for MI Health Link covered services can be verbally or in writing. Unless the request is an expedited request, the appeal request must be followed up in writing.
        4. The request for a MI Health Link first level internal/local appeal can be standard or expedited. An expedited appeal is a request to review a decision concerning eligibility, benefit, screening, admission, continued/concurrent stay or urgent services but has not been discharged from a facility or when a delay in decision-making might seriously jeopardize an member's life, health or ability to attain, maintain or regain maximum function.
        5. DWMHA shall send a Notice of Appeal Receipt within three (3) calendar days of a non expedited MI Health Link first level appeal request and within 24 hours of an expedited MI Health Link first level appeal request.
        6. DWMHA has 72 hours from the receipt of the expedited MI Health Link first level request to review and decide and within 30 calendar days from receipt of the non-expedited MI Health Link first level internal/local appeal request to the member.
        7. If DWMHA needs to extend the time frame for an appeal, the member must receive prompt oral notice of the delay and in addition provide written notice of the reason for extension. It can be extended up to the

14 calendar days. If the member disagrees with this decision, the Member has the right to file a grievance.

8. A MI Health Link first level internal/local appeal request that results in upholding part or all the initial denial is communicated verbally to the provider. Written notification using the standardized Notice of Appeal Decision MHL is sent for partial or full denial of services appealed and the Notice of Decision Approval (MHL) letter is sent to the member for fully approved services.
9. The Notice of Appeal Decision must include an explanation that the case is automatically forwarded to Maximus for a second level appeal if the determination is to uphold, all or in part, the non-authorization of eligibility, screening admission, continued/concurrent stay or other behavioral healthcare services.

6. Second Level Appeal Review for MI Health Link Covered Services:
   a. For services that are Medicare approved, these appeals will be sent directly to Maximus for review. Maximus will respond with a decision within 30 calendar days. For an expedited MI Health link external appeal, the resolution will be made within 72 hours unless a 14-day extension had been granted.
   b. For services that are Medicaid covered, the member has the opportunity to file a State Fair Hearing through Michigan Administrative Hearing Systems 120 days from the date on the Notice of Appeal Decision. MAHS has up to 72 hours to make a decision on an expedited appeal and up to 90 days to provide a written decision and order on a non-expedited state fair hearing request.
   c. For services that are covered by both Medicare and Medicaid, (in which services overlap), members may file an appeal through either or both processes. DWMHA will automatically forward the information to Maximus however, the member can request for a State Fair Hearing. Any determination that is in favor of the Member will be binding and DWMHA is to enforce the decision as expeditiously as possible.
7. Third Level Medical Necessity Appeal Review for MI Health Link Covered Services:
   a. The third level of appeal is the Administrative Law Judge (ALJ) hearing. This hearing allows the member to present the appeal to a new person who will review the facts independently and listen to testimony before making a new and impartial decision. An ALJ hearing is usually held by phone, video-conference or in some cases, in person. To secure an ALJ hearing, the minimum amount of the case must be $150. All

requests for an ALJ hearing must be written and forwarded to the Office of Medicare Hearing and Appeals (OMHA). The address is documented in MAXIMUS' decision notice.

b. In most cases, the ALJ will review a case, decide and notify DWMHA, the provider and the member within ninety (90) days of the request.
c. If the ALJ upholds part or all of the second level decision by MAXIMUS, they provide written notification of their decision to DWMHA and the member. The Notice also includes an explanation of the next (fourth) level appeal process.
d. If the ALJ overturns part or all of the second level decision by MAXIMUS, DWMHA will inform the servicing provider to reinstate the services and submit the services for payment no later than thirty (30) calendar days from the ALJ's decision.

8. Fourth Level Appeal Review for MI Health Link Covered Services:
    a. The fourth level of appeals is with the Medicare Appeals Council (MAC). The request for a review by MAC must be submitted in writing, must be within 60 calendar days of the ALJ decision and must specify the issues and finding that are being contested.
    b. In most cases, MAC will review a case, make a decision and notify DWMHA and the member/ member within 90 days of receipt of the request. However, that time frame may be extended for various reasons including but not limited to the case being escalated from an ALJ hearing. If MAC does not issue a decision within the applicable time frame, the member can ask MAC to escalate the case to the next (fifth) level review, the Judicial Review.
    c. If MAC overturns part or all of the third level decision by the ALJ, DWMHA will inform the servicing provider to reinstate services and submit the claim no later than 30 calendar days from MAC's decision.
9. Fifth Level Medical Necessity Appeal Review for MI Health Link Covered Services:
    a. If at least $1,460 or more is still in controversy following the MAC decision, a judicial review before a U.S. District Court judge can be requested. This is the fifth and final level of appeal. The request must be submitted in writing and must be within 60 calendar days of MAC's decision.
    b. There is no statutory time frame for the Federal Court decision.
    c. If the Federal Court upholds part or all of MAC's decision, they provide written notification of their decision to DWMHA and the member. The Notice also includes an explanation that this is the final level for appeal.

d. If the Federal Court overturns part or all of MAC's decision, DWMHA will notify the servicing provider to re-instate services and submit claims for payment no later than thirty (30) calendar days from the Federal Court decision.

10. Will adhere to the Customer Service Appeal Process for Services provided to the Uninsured/Underinsured population (Pre Service, Post Service and/or Standard):
    a. First Level Appeal Review for Uninsured/Underinsured Services:
        i. The member, authorized representative or legal guardian has up to 30 calendar days (per the MDHHS CMHSP contract effective October 1, 2017) from the date of the Adequate or Advance Notice of Adverse Benefit Determination to request a first level internal/ local dispute resolution review. DWMHA and/or the service provider must provide written notification 30 calendar days in advance of any changes to services that are currently being provided.
        ii. The member's request for a first level internal/ local dispute resolution review can be verbal or in writing to DWMHA.
        iii. The member's request for a first level internal local dispute resolution can be standard or expedited. An expedited appeal is a request to review a decision concerning eligibility, benefit coverage, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an member who has received urgent services but has not been discharged from a facility or when a delay in decision-making might seriously jeopardize an member's life, health or ability to attain, maintain or regain maximum function. The member can request an expedited first level local dispute resolution based on the information from the Adequate or Advance Notice of Adverse Benefit Determination.
        iv. DWMHA shall send a standardized Notice of Local Dispute Resolution Review Request within 24 hours of an expedited first level local dispute resolution request and within five (5) calendar days of a non-expedited internal first level/ local dispute resolution review request to the member.
        v. DWMHA has 72 hours from the receipt of the expedited internal first level/ local dispute resolution request to review and make a determination and 30 calendar days from receipt of the non-expedited internal, first level/ local dispute resolution request to review and make a determination.

vi. An internal, first level/ local dispute resolution request that results in upholding part or all of the initial denial is communicated verbally to the member and/or their representative. If it is an expedited local dispute resolution request, the Notice of Local Dispute Resolution Denial will be sent within 72 hours. If the first level local dispute resolution request is found in favor of the member, Notice of Local Dispute Resolution Approval is sent. If it is a non-expedited appeal request and the request is partially or fully denied, the standardized Notice of Local Dispute Resolution Denial will be sent. For approved appeals, the Notice of Local Dispute Resolution Approval is sent. The resolution letters are sent within 2 calendar days of the decision.

vii. The Notice of Local Dispute Resolution Denial must include an explanation of how to file a second level external/alternate dispute resolution.

b. Second Level Review for Uninsured/Underinsured Services

i. After the exhaustion of the local dispute resolution process, the member, guardian or authorized representative may request an alternate dispute resolution within ten (10) days from the date on the Notice of Adequate Benefit Determination or Notice of Advance Adverse Benefit Determination. This request must be in writing and submitted to: Department of Health and Human Services, Division of Program Development, Consultation and Contracts, Bureau of Community Mental Health Services. Attn: Request for MDHHS Level Dispute Resolution, Lewis Cass Building-5th Floor, Lansing, MI 48913

ii. MDHHS shall review all requests within two (2) business days of receipt.

iii. If MDHHS determines that the denial, suspension, termination or reduction of services/supports will pose an immediate or adverse impact upon the consumer's health and safety, the issue is referred within one (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.

11. Independent Review Organization (IRO)

a. ACCESS will advise members at least annually of the availability and right to an external appeal of the final internal determination for Medicare and Medicaid covered services by an independent review organization (IRO) including their contact information. Under federal and state law ACCESS is responsible to forward to

DWMHA and the IRO all relevant medical records and any supporting documentation that was used in the adverse action determination such:

i. A summary of applicable issues;
ii. The final decision;
iii. Relevant portions of the criteria used to make the decision;
iv. For medical necessity decisions, the clinical reasons for the decision;
v. Communications from the provider and member to DWMHA, the Access Center, Mobile Crisis Stabilization Unit and/or service provider; and
vi. Any new information related to the case that became available after the final internal appeal decision.

12. ACCESS do not influence the IRO review process and must adhere to and implement the IRO's decision within the time frame specified by the IRO. The IRO decision is final and binding.
13. Written notification of the IRO decision will be given to the member and provider by the DWMHA and if the IRO overturns any part of the denial decision, the written notification includes the time and procedure for claim payment or approval of services. The DWMHA will maintain data and track all IRO requests and review findings on each appeal case and forward the information to the ICOs for the MI Health Link population. The DWMHA will also use this information in evaluating and revising its medical necessity decision-making process.
14. ACCESS CHRC is expected to develop their policies in alignment with DWMHA directives.

VI. QUALITY ASSURANCE/ IMPROVEMENT

ACCESS will monitor contractor adherence to this policy as one element in its network management program, and as one element of the Quality Assurance Performance Improvement Program (QAPIP) Goals and Objectives. The quality improvement programs of contracted service providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy

VII. COMPLIANCE WITH ALL APPLICABLE LAWS

ACCESS, its affiliates, service providers, and other contracted and subcontracted employees are bound by all applicable local, state and federal laws, rules, regulations, all Federal waiver requirements, and state and county contractual requirements, policies and administrative directives in effect, or as amended.

VIII. LEGAL AUTHORITY AND REFERENCES

Federal Regulation 42 CFR: Sections 431.200 et seq., 435.911-920, 438.400 et seq;

Michigan Department of Community Health (Administrative Hearings, Policies and Procedures)

Michigan Mental Health Code, PA 258 of 1974, as amended;

Contract between United States Department of Health and Human Services, Center for Medicare and Medicaid Services in Partnership with the State of Michigan and the Integrated Care Organizations, current or as amended (The Three-Way Contract)

Agreement between Michigan Department of Health and Human Services and DWMHA for the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Programs, Healthy Michigan Programs, and Substance Use Disorder Community Grant Programs, Attachment 6.3.1.1 Revised Judiciary Act of 1961, P.A. 236 of 1961 as amended, MCL 600.5851.

IX. EXHIBITS

DWMHA Customer Service (CS) Member Appeals Policy and attachments

https://www.dwmha.com/files/5215/5743/0824/Cusotmer_Service_CS_Member_Member_Appeals_Policy.pdf

ACCESS

Community Health & Research Center

Policy Name: Policy Section/ Number:	Created By:	Initial Date:	Current Date:	Pages:
SUD/MH Enrollee and Recipient Rights, Treatment with Dignity and Respect Section /#	Ana Dutcher Quality Assurance Manager	7/29/2013	7/29/19	Page 1 of 5

Reviewed By: Mohamad Khraizat	**Title: Health Operations Manager**
Signature:	**Date:** 9-20-19
Approved By:	**ACCESS Board**
Signature(s):	**Date:**

I. POLICY

It is the policy of the ACCESS Community Health and Research Center (ACCESS) to ensure that all recipients of mental health services and their family members shall be treated with dignity and respect. All rights complaints and/or other reports of alleged rights violations shall be reviewed resolved by the Regional Recipient Rights Consultant and remediated if substantiated. All service providers are also required to utilize the recipient rights procedure in the Michigan Public Health Code Act 368 of 1978, Article 6, Substance Abuse.

II. PURPOSE

The purpose of this policy is to provide direction for ACCESS staff to protect and promote the dignity and respect to which all recipients of mental health services, and family members of those recipients, are entitled. All applicants have access to the recipient rights procedure and internal grievance procedure. Medicaid recipients also have access to the Michigan Department of Health and Human Services Administrative Hearing Procedure established by federal law and departmental policy.

The Recipient Rights process does not replace a Medicaid beneficiary's right to file a hearing request with the Michigan Department of Health and Human Services, and both processes may possibly occur simultaneously.

III. APPLICATIONS

This policy applies to all ACCESS Community Health and Research Center (CHRC) employees, interns and volunteers who provide support and treatment on behalf of the ACCESS to any Mental Health and Substance Use Disorder (SUD) Prevention, Treatment and Recovery consumers as required in the Administrative Rules for Substance Abuse Programs in Michigan, Section 6231, Part

3, under P. A. 368. It applies to all funding sources under Medicaid, Healthy MI, Block Grant, MI CHILD, PA 2, and MI Health Link.

IV. DEFINITIONS

A. **Dignity** - to be treated with esteem, honor, politeness; to be addressed in a manner that is not patronizing, condescending or demeaning; to be treated as an equal; to be treated the way any individual would like to be treated.

B. **Family member** - A parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer, or an individual upon whom a primary consumer is dependent for at least 50% of his or her financial support.

C. **MCPN** - Manager of Comprehensive Provider Network

D. **Respect** - To show deferential regard for; to be treated with esteem, concern, consideration or appreciation; to protect the individual's privacy; to be sensitive to cultural differences; to allow an individual to make choices

E. **Key Words**

- Administrative Hearing (AH)
- Administrative Law Judge (ALJ)
- Authorized Hearing Representative (AHR)
- Administrative Tribunal (AT)
- Departmental Review
- Hearings Coordinator
- Staff Coordinator

V. PROCEDURES

A. ACCESS Staff will inform enrollees of their Rights and protections as described in the Screening and Access to Services Policy Orientation Section

a. Receive information about ACCESS CHRC, its Services, its Practitioners, and Providers, and Your Rights and Responsibilities
b. Be treated with respect and recognition of your dignity and the right to privacy
c. Participate with Practitioners in making decisions about your health care
d. A candid discussion of appropriate or medically necessary treatment options for your conditions regardless of cost or benefit coverage and to freely communicate with your providers without restriction on any information regarding care
e. Voice complaints or appeals about ACCESS CHRC or the care provided
f. Make recommendations regarding DWMHA's Members' Rights and Responsibilities policy

B. ACCESS CHRC will provide enrollees information within a reasonable time after enrollment

a. Grievance, appeal, and fair hearing procedures and timeframes that include

i. The right to a State Fair Hearing;
ii. The method for obtaining a hearing
iii. The rules that govern representation at the hearing
iv. The right to file grievances and appeals
v. The requirements and timeframes for filing a grievance or appeal;
vi. The availability of assistance in the filing process
vii. The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone
viii. The fact that when requested by the beneficiary, benefits will continue if the beneficiary files an appeal or a request for State Fair Hearing within the timeframes specified and that the beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary
ix. Any appeal rights that the State chooses to make

C. The Quality Assurance Manager and Office of Recipient Rights shall assure that training is provided to the ACCESS staff

D. Treatment with dignity and respect shall be defined by the recipient or family member, and considered in light of the specific incident, treatment goals, safety concerns, laws and standards, and what a reasonable person would expect under similar circumstances

E. 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 the person to make choices instead of making assumptions about what he or she wants, taking the person's opinion seriously, including the person in conversations, allowing the person to do things independently or to try new things

F. ACCES CHRC will provide the enrollee the right to participate in decisions regarding his or her health care, including the right to refuse treatment

G. All staff, volunteers, agents and subcontractors, of ACCESS, shall treat recipients and their family members with dignity and respect, being sensitive to conduct that is or may be deemed offensive to the other person

H. In addition to the above, treating family members with dignity and respect shall include:

a. Giving family members an opportunity to provide information to the treating professionals

b. Providing family members 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.

I. Information shall be received from or provided to family members within the confidentiality constraints of Section 748 of the Mental Health Code (MCL 330.1748).

J. If ACCESS CHRC is electing not to provide, reimburse for, or provide coverage of, a counseling or referral service based on objections to the service on moral or religious grounds must furnish information about the services it does not cover as follows

a. To the State, with its application for a Medicaid contract, and whenever it adopts the policy during the term of the contract

b. To potential enrollees, before and during enrollment

c. To enrollees, within 90 days after adopting the policy with respect to any particular service, with the overriding rule to furnish the information at least 30 days before the effective date of the policy

K. All recipient rights communications shall comply with state and federal regulation.

L. The process of investigating a recipient rights complaint shall be in accordance with the Administrative Rules for Substance Abuse Service Programs in Michigan. Promulgated pursuant to section 6231 (1) of Michigan Public Act 368 of 1978 by the Michigan Department of Public Health; which includes:

M. Providing simple mechanisms for notifying recipients of their rights, reporting apparent rights violations, determining whether in fact violations have occurred, and for ensuring that firm, consistent, and fair remedial action is taken in the event of a violation of these rules.

N. Recipient rights complaints shall be distributed to the client, the program, the coordinating agency, and the office on a form provided by the office.

O. Reporting: ACCESS CHRC will report recipient rights complaints as required. The information provided will be for demographics purposes only and will not infringed upon the client(s) confidentiality.

P. Retention: ACCESS CHRC will retain recipient rights complaints records for six (6) years following a final decision. If any litigation, claim negotiation, audit or other action involving the records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the regular five-year period, whichever is later.

Q. ACCESS CHRC will comply with the State's required SUD procedures for Recipient Rights (see attached procedure).

VI. QUALITY ASSURANCE / IMPROVEMENT:

A. The ACCESS Quality Assurance Manager

a. Will monitor adherence to this policy as one element of its site review process.

B. ACCESS' Quality Assessment and Performance Improvement Program (QAPIP) must include measures for both monitoring of and for the continuous improvement in quality of the program or process described in this policy.

VII. COMPLIANCE WITH ALL APPLICABLE LAWS:

ACCESS staff are all bound by all applicable counties, state, and federal laws; rules; regulations and policies; all federal waiver requirements; state and county contractual requirements; and administrative directives in effect at the time of the writing of this policy, or as amended.

VIII. LEGAL AUTHORITY AND REFERENCES:

DWMHA Recipient Rights Complaint Resolution Policy
DWMHA Recipient Rights Appeals Policy
Michigan Public Health Code Act 368 of 1978, Article 6, Substance Abuse
Michigan Public Health Code Act 258 of 1974, Chapter 2A, Substance Use Disorder Services Michigan Mental Health Code, P.A. 258 of 1974, as amended MCL 330.1704; MCL 330.1708; MCL 330.1711; MCL 330.1748
Authority Policies (All Authority Policies refer to the most recent policy at the time of writing):

- Disclosure of Confidential or Privileged Information
- Services Suited to Condition in the Least Restrictive Environment

IX. EXHIBITS:

Know Your Rights Brochure
Rights Poster
SUD Recipient Rights Form 504
SUD Recipient Rights Form 505
SUD Recipient Rights Form 506
SUD Recipient Rights Form 507
SUD SOP for SUD Recipient Rights

ACCESS
Community Health & Research Center

Policy Name: Policy Section/ Number:	Created By:	Initial Date:	Current Date:	Pages:
Person Centered Planning and Individual Plan of Service Policy Section __/# ____	Ana Dutcher Quality Assurance Manager	7/29/2013	7/2/18	Page 1 of 13

Approved By: Mohamad Khraizat	Title: Health Operations Manager
Signature:	Date: 9-20-19

I. POLICY

The policy of the ACCESS Community Health and Research Center (CHRC) ensures that a comprehensive and integrated array of services/supports which inspires hope and promotes recovery will be given to Wayne and Macomb County residents and their families. Individuals with co-occurring mental health, substance abuse and physical health conditions are expected to receive services within a system of care that is welcoming, recovery oriented and capable of delivering integrated services to meet their needs and preferences. The provision of an Individualized Plan of Service (IPOS) developed through the Person-Centered Planning (PCP) process, shall be given to each individual and family being served.

II. PURPOSE

The purpose of this policy is to delineate the development, implementation and monitoring of policies and procedures, for meeting the requirements of the Michigan Department of Community Health (MDCH), Michigan Mental Health Code (Code), Detroit Wayne County Community Mental Health (DWCCMHA) Victims of Crime Act (VOCA) and Office of Refugee Resettlement Torture Survival Program (ORR-TSP) for an IPOS, for each individual governed by PCP principles.

III. APPLICATIONS

This policy applies to all ACCESS employees, interns and volunteers who provide support and treatment on behalf of the ACCESS Community Health and Research Center.

IV. DEFINITIONS

Adequate Notice: A written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services requested. Notice is to be provided to the Medicaid beneficiary on the same date the action takes effect (Action Notice Exhibit), or at the time of the signing of the Individual Plan of Services/supports.
Advance Notice: A written statement advising the beneficiary of a decision to reduce, suspend, or terminate Medicaid services currently provided. Notice is to be provided/mailed at least 12 calendar days prior to the proposed date the action is to take effect (Advance Notice Exhibit).
Advance Directives: A legal document, signed by a competent adult that gives direction to healthcare providers about the individual's treatment choices in specific circumstances, including but not limited, to medical or psychiatric conditions, should the individual become unable to make or communicate healthcare decisions
Administrative (Fair) Hearing (also known as Medicaid Fair Hearing): An impartial review process maintained by the Michigan Department of Community Health Administrative Tribunal (MDHHS/AT) that insures Medicaid beneficiaries or their legal representatives involved in a Community Mental Health Services Program Managed Care Plan have the opportunity to appeal decisions of the agency or its

contractors to deny, suspend, reduce or terminate Medicaid-covered or MDHHS-defined services. A Medicaid beneficiary may request a hearing at any point during the rendering of mental health services or supports by contacting:

State Office of Administrative Hearings and Rules
For the Department of Community Health
PO BOX 30763
Lansing, MI 48909- 9951

Alternate Dispute Resolution Process (ADRP): A mechanism developed by MDHHS that is accessible to persons without Medicaid coverage but only after internal, local mechanisms of dispute resolution have been exhausted (i.e., clinical Second Opinion/ Reconsideration Review and agency appeal; Recipient Rights (RR) investigation and appeal mechanisms), and only in those instances where it is alleged that the investigative findings of the Office of Recipient Rights (ORR) are not consistent with the facts or with law, rules, policies, or guidelines. ADRP may be pursued through traditional review or through mediation. The RR advisor at the contractor/subcontractor site is available to provide assistance in accessing this process, if desired by the individual.

Comprehensive Examination: Refers to a thorough, face-to-face exploration of a person's biological, psychological/mental and social condition that is strength-based and developed based upon principles and discipline-specific professional standards, by credentialed professionals. The examination emphasizes strengths and abilities and identifies problems/needs/disabilities and appropriate recommended measures to address identified conditions with the appropriate services and supports. It concludes with a summary of significant findings, interpretations, and discipline-specific recommendation, and serves as the clinical database in the development of an IPOS.

Crisis Plan: A written document used for periods of crisis when the mental health of a individual deteriorates, which specifies the choices and preferences of the individual when in a period of decompensation; the crisis situation may or may not include periods of legal incompetence.

Developmental Disability (DD): As defined by the Michigan Mental Health Code means either of the following:

- If applied to a person older than five years of age, a severe chronic condition that is attributable to a mental or physical impairment or both, and is manifested before the age of 22 years, is likely to continue indefinitely and results in substantial functional limitations in three or more areas of the following major life activities:
- Self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration;

If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in a developmental disability.

Independent Facilitation: The option of selecting a neutral person to facilitate the PCP process. The person

must be willing to provide services at the minimum recommend rate of sixty (60) dollars per plan of service, and meet the following criteria:

- Has successfully completed training in the PCP process through the agency, the Michigan Department of Community Health, or an established community advocacy organization.
- Represents no conflict of interest. The person is not employed at the requesting individual's provider agency.

Individualized Plan of Service/Treatment Plan (IPOS): A written comprehensive plan of treatment/services/supports developed through a person-centered planning process, in partnership between the individual and one or more qualified professionals (e.g., mental health professional (MHP), child mental health professional, (CMHP), or mental retardation professional (QMRP) to address identified desires and needs and to establish meaningful and measurable goals that are prioritized by the individual. The IPOS is the fundamental document in the individual's record and must be authenticated by the dated legible signatures of the recipient/authorized representative and the person chosen by the recipient and named in the plan to be responsible for its implementation. The IPOS consists of a treatment plan, and a support plan, or both, and may be further characterized as follows:

- It must satisfy guidelines demonstrating adherence to Person-Centered Planning process and principles (Person-Centered Planning Best Practice Guideline Exhibit).
- It includes pertinent information from assessments necessary to address the expressed desires and needs prioritized by the recipient, and may include general physical, psychiatric (i.e., mental/psychological, emotional and behavioral) and social examinations. For persons under 26 years of age who have developmental disabilities, the mental examination includes psychometric and educational evaluations as well as assessment of adaptive behavior.
- It addresses as either desired or required by the individual/family, his or her need for housing, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation.
- It is reviewed and updated at intervals specified in the plan which reflect the level of care and intensity of service needs, and when requested by the individual, or required as a result of identified health and safety conditions, but no less than annually for adults, and every 90 days for Children and individuals up to 21 years old. The documented reviews shall contain an analysis of progress regarding objectives and goals that were developed using the PCP process. Updates and the indicated changes are authenticated by the signature of the individual/authorized representative and the dated legible signature of the person named in the plan as responsible for managing it.
- It includes any restrictions or limitations of rights placed on the recipient only when these limitations or restrictions are essential to safeguarding the health and safety needs of the individual. All clinically appropriate attempts shall be made to limit or avoid such restrictions or limitations. Actions taken as a part of the plan to ameliorate or eliminate the need for the restrictions in the future shall be documented and include specific intermediate and long-range goals, developed with the individual/authorized representative that specify the manner in which the facility can improve the individual's condition and the projected timetable for attainment of such goals.

- The person/authorized representative shall receive a copy within 15 business days of the IPOS meeting.
- Includes, but is not limited to core demographic and clinical elements (Person- Centered Planning Best Practice Guideline Exhibit)

Interdisciplinary Treatment Team (ITT): A group of clinical professionals (e.g., mental health or child mental health, mental retardation professionals, etc) of different disciplines (e.g., social work, nursing, psychology, etc) that collaboratively produce an IPOS in equal partnership with the person receiving treatment services or his/her authorized representative, after carrying out assessments appropriate for the desires and needs of the individual, and to the discipline. The ITT may include persons chosen

by the individual or authorized representative who are not clinical professionals (e.g., parents/guardian of a minor, significant other, friends, families, paid staff).

- **Medical Necessity:** As defined by the Michigan Department of Community Health, refers to mental health (and/or substance (use) disorder) services that are:
- Necessary for screening and assessing the presence of a mental illness or substance (use) disorder; as defined by standard diagnostic nomenclature of the American Psychiatric Association (i.e., current DSM or its successor)
- Required to identify and evaluate a mental illness or substance (use) disorder that is inferred or suspected
- Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness (or substance use disorder) and to prevent or delay relapse
- Expected to prevent, arrest or delay the development or progression of a mental illness (or substance use disorder) and to prevent or delay relapse
- Designed to provide rehabilitation for the recipient to attain or maintain an optimal level of functioning according to his or her potential (including functioning in important life domains, such as daily activities, social relationships, independent living, and employment pursuits)
- Delivered consistent with national professional standards of practice in community psychiatry, psychiatric rehabilitation and in substance abuse, and/or empirical professional experience
- Provided in the least restrictive setting appropriate and available

Office of Recipient Rights (ORR): A division of the agency established in accordance with the Michigan Mental Health Code in order to ensure a uniformly high standard of protection of the rights of recipients throughout Wayne County

Person Centered Planning (PCP)/Family Centered Planning: A process for planning and supporting the individual receiving services that builds on the individual's/family's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. It is comprehensively described in the Michigan Department of Community Health (MDHHS) Best Practice Guideline (Exhibit A)

Peer Support Specialist Services: The Michigan Department of Community Health has described peer support services as services which provide individuals with opportunities to support, mentor, and assist beneficiaries to achieve community inclusion, participation, independence, recovery, resiliency and/or productivity. Peers are individuals who have a unique background and skill level from their experience in utilizing services and supports to achieve personal goals of community membership, independence, and

productivity. Peers have a special ability to gain trust and respect of other beneficiaries based on shared experience and perspectives with disabilities and with planning and negotiating human service systems.
Psychiatric Evaluation: A comprehensive examination performed by a psychiatric physician that explores mental, emotional and behavioral functioning by investigating the patient's chief compliant (i.e., the reason for the request for care by or on behalf of the recipient); history of the present illness; previous psychiatric history; history of significant general medical illnesses and treatment; psychoactive medication history; relevant personal, social, alcohol and substance use and family histories; and by performing an appraisal of the immediate mental status. It concludes with an inventory of strengths and assets, a summary of pertinent positive and negative findings; an estimate of risk factors; a multi-axial diagnosis using the current Diagnostic and Statistical Manual (DSM) classification system of the American Psychiatric Association; special other examination recommendations; an initial treatment plan and criteria for discharge.
Psychosocial Assessment: An investigation of psychological and social factors relevant to the adaptive health status of a person seeking or receiving agency services, performed by professionals who are trained, licensed and credentialed as capable of performing this clinical function. It includes but is not limited to the following:

- The circumstances surrounding the request for services, including the recipient's expressed desires and needs
- Past psychiatric/medical history
- Exploration of natural supports and formal and informal support systems, including family, significant others and other concerned parties and organizations chosen by the individual, and the identification of a procedure for their involvement in the evaluation, treatment and referral and ongoing support of the individual seeking services
- Appraisal of the person's strengths and supports to address any barriers, including those to health and safety issues
- Housing situations, desires and needs
- Employment status, including recipient's desires and needs
- Legal status
- Formulation of proposed discipline-specific services reflecting recipient's desires and needs that are to be incorporated into an IPOS

Recovery: A journey of healing and change allowing a person to live a meaningful life in a community of their choice, while working toward their full potential
Restraint: is the use of physical force or mechanical means to temporarily limit a person's freedom of movement; chemical restraint is the involuntary emergency administration of medication, in immediate response to a dangerous behavior. Restraints used as an assistive device for persons with physical or medical needs are not considered restraints for purposes of this section. Briefly holding a person served, without undue force, for the purpose of comforting him or her or to prevent self- injurious behavior or injury to self or holding a person's hand or arm to safely guide him or her from one area to another, is not a

restraint. Separating individuals threatening to harm one another, without implementing restraints, is not considered restraint.

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

Serious Mental Illness: A diagnosable mental, behavioral, or emotional disorder affecting an adult, that exists or has existed within the past year for period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and approved by the MDCH and 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 also are included only if they occur in conjunction with another diagnosable mental illness: (a) a substance abuse disorder; (b) a developmental disorder; (c) a "V" code in the Diagnostic and Statistical Manual of Mental Disorders.

Welcoming: The process of providing available and accessible services to individuals and families which conveys empathy, demonstrates excellent listening skills, and expresses the message of "How may I help you?" in a nonjudgmental way.

V. PROCEDURES

1. ACCESS promotes the principles of welcoming, recovery, self-determination, choice, community inclusion, and productivity.

2. ACCESS **does not utilize seclusion or restraint**. If a person served is in need of seclusion, physical or chemical restraint, a referral to another provide is made.

3. For each individual there shall be one integrated IPOS/PCP, which addresses physical health care needs, and relevant co-occurring, mental illness and substance abuse services, even if multiple providers are involved in the provision of services and supports.

4. The IPOS/PCP shall reflect strength-based assessments, which address health and safety needs for families of children and adolescents with serious emotional disturbances, individuals with both serious mental illness/co-occurring substance abuse disorders, and individuals with developmental disabilities. Identified activities related to protecting health and safety shall be

developed in partnership with the individual/guardian and family.

5. A **preliminary plan of service**, which addresses immediate needs, shall be developed within seven (7) days of the commencement of services at outpatient community mental health provider agencies.

6. Before the IPOS/PCP meeting is initiated, a **pre-planning meeting** shall occur. In the preplanning meeting the individual chooses:

    a. Topics about which he/she would like to discuss, including dreams, goals, and desires
    b. Topics he/she does not want discussed.
    c. Who to invite
    d. Where and when the meeting will be held
    e. Who will facilitate
    f. Who will record
    g. The option of completing a crisis plan
    h. The option of completing an advance directive
    i. The IPOS/PCP shall describe the specific peer support services as needed to achieve the goals of community inclusion and participation, independence and productivity. These activities shall be provided in partnership with the individual and may include:

        i. vocational assistance
        ii. housing assistance
        iii. assist with employment opportunities
        iv. sharing stories of recovery/or advocacy
        v. assisting with entitlements
        vi. assistance with developing wellness plans
        vii. assistance with advance directives
        viii. assist with learning about alternatives to guardianship
        ix. providing supportive services during a crisis
        x. overall assistance in the process of recovery and self-determination

7. The comprehensive IPOS/PCP shall be developed in partnership with the individual/guardian and family, within thirty (30) days of commencement of services at outpatient community mental health agencies.

8. The IPOS/PCP shall clearly identify the following:

    a. The amount of service: number of units (i.e. 15-25 minutes)
    b. Scope of service: parameters within which the services will be provided.
    c. How the service will be rendered: (e.g. face-to-face, telephone, group, individual, etc.)
    d. How frequently the service will be provided: (i.e. weekly, monthly, etc.)
    e. Where the service will be rendered: (e.g. community setting, office, home, etc.)
    f. Duration of service: the length of time (e.g., 3 weeks, 6 months, etc.) it is expected that an identified service will be provided

9. Individuals shall be afforded the option and encouraged to complete a **crisis plan** and an advance directive during the PCP process.

    a. The crisis plan provides direction regarding the care to be provided on his/her behalf during a crisis situation. The crisis plan has multiple components which must minimally include:

    b. Specific designated persons who will be involved in making decisions for the individual (name, relationship, phone number, and assigned tasks)

    c. Current medications and allergies Physicians/psychiatrist involved in care and treatment
    d. Preference for hospitals/treatment facilities
    e. Hospitals or treatment facilities that the individual does not wish to be utilized
    f. Any specific interventions or activities that can be used to help the individual during the crisis reduce anxiety and regain control.

10. The option of an **independent facilitator** for PCP who meets the qualifications established by the state shall be provided to each individual/guardian.
11. Individuals, guardians, and family shall be made aware of the option of independent facilitator services prior to the scheduled planning meeting.

12. The purpose and advantages of having an **advance directive** shall be explained to each individual which includes expression of individual preference for doctors, hospitals and medications; expression of other specific wishes or individual choices during a time when he/she is unable to make decisions; and the possibility that a commitment hearing in probate court can be avoided in some circumstances.

13. ACCESS ensures full access to complaint/grievance/appeal processes which enforce each

individual's PCP/IPOS rights.

14. ACCESS ensures that staff receives updated information on policies and guidelines which impact the PCP process at least annually, and that these training sessions are documented on staff training logs.
15. ACCESS staff is expected to access or provide supports such as environmental supports, verbal prompts, written expectations, clarity of rules and expectations, or praise and encouragement if those supports are wanted and needed by the individual. Staff members are trained to recognize signs fear, anger, or pain, which may lead to aggression or agitation and respond through de-escalation, changes to the physical environmental, implementation of meaningful and engaging activities, redirection, active listening, etc. Seclusion and restraint are never considered treatment interventions; they are always considered actions of last resort. If such interventions are needed, a referral is made to another agency, provider, hospital or the police.

16. Individuals shall be informed of the option of receiving **peer supports** services during the PCP process. For individuals to receive peer supports, the IPOS/PCP shall include one or more of the goals of community inclusion and participation; independence and productivity based upon individual choice and medical necessity criteria. (Peer Delivered and Operated Supports DWCCMHA Policy Exhibit)

17. Service needs can be divided and recognized and its important to respond appropriately to the possibility of **co-occurring disorders**, evaluating the interrelationship between them and prioritize accordingly. ACCESS staff shall work with the individual on removing barriers to goal attainment. Clarification of goals and quality of life can determine how the services can help in the individual and family's journey to attaining and keeping the dreams.

18. ACCESS staff shall adhere to the following values and principles, as required within the Person-Centered Planning Best Practice Guidelines (Person-Centered Planning Best Practice Guideline Exhibit)

19. Each individual/family has strengths and the ability to express preferences and to make choices.
20. The PCP process shall be family centered for children and adolescents
21. Families shall be provided information regarding respite services and other community resources during the pre-planning meeting
22. The individual's choices and preferences shall always be considered, if not always granted.
23. Professionally trained staff will play a role in the planning and delivery of treatment and may play

a role in the planning and delivery of supports. Their involvement occurs if the individual has expressed or demonstrated a need that could be met by professional intervention.

24. Treatment and supports identified through the PCP process shall be provided in environments that promote maximum independence, community connections and quality of life
25. A person's cultural background shall be recognized and valued in the decision-making process.
26. It is understood be all staff and clients that the organization does not use seclusion or restraint during treatment and it teaches the client and families methods of addressing threatening behaviors, such as engagement to one-on- one attention, meditation, de-escalation, active listening. Staff is trained in such modalities of treatment and promote those methods.
27. The PCP process shall include the active participation of natural supports, family, friends, and allies to participate in the PCP process. Those will be the individuals who can assist in keeping the individual's dreams after transition to a lesser level of care or discharge from services.
28. ACCESS staff will use the PCP process to assist the individual link their goals and anticipated transition or discharge from services. Goals will reflect the resolution to the problems and will be used to measure readiness for transition from services.
29. Priorities will be taken in consideration when setting goals and ACCESS staff must give priority to protecting and preserving the basic health and safety needs of the individual, family and community. Although at times the individual may not agree on those priorities, tactful approach of the subject will assist in maintaining a positive relationship between the individual and staff. Unless those basic needs are tended to, other goal attainment may not be obtained, but a trusting relationship between the clinician and the individual will assist in creating a safe environment while planning for a safe recovery process.
30. Individuals shall be provided with opportunities to provide feedback on how they feel about the service, support and/or treatment they are receiving and their progress toward attaining valued outcomes.
31. Information regarding individual feedback shall be collected and changes made in response to the individual's feedback.
32. Each individual shall be provided with a copy of his/her person-centered plan within 15 business days after the meeting.
33. Informational brochures and reading materials which describe the option of independent facilitation and advance directives shall be made available to persons and families during the intake process

34. PCP/IPOS Status Review

    a. The IPPOS/PCP is reviewed and updated at intervals specified in the plan which reflect the level of care and intensity of service needs, and when requested by the individual, or required as a result of identified health and safety conditions, but no less than annually for adults, and every 90 days for Children and individuals up to 21 years old.
    b. The documented reviews shall contain an analysis of progress regarding objectives and goals that were developed using the PCP process.
    c. Updates and the indicated changes are authenticated by the signature of the individual/authorized representative and the dated legible signature of the person named in the plan as responsible for managing it.

35. Closure of case records:

    a. Setting discharge criteria is a straight forward task and it is addressed at admission. ACCESS staff will ask the individual and family about the changes that need to happen in order to manage on their own and not be in need of mental health services. The answer of this question holds the criteria for transition and discharge, as well as the basic elements to the treatment goals.

    b. In addition, ACCESS ensures Transition/Discharge planning is explained to the individual and family from the beginning and that it could also be related to the closure of case records when there has been no contact with an individual for 90 calendar days or more, which includes the following:

        i. Documentation of written and telephone attempts to contact the individual/family to offer services during the 90-day period.
        ii. Notification provided to the individual/family regarding his/her right to local or informal dispute resolution and recipient rights process at the time of case closure.
        iii. Documentation of the provision of an Adequate Notice form to Medicaid beneficiaries, to inform the individual of his/her right to appeal accompanied by a Request for an Administrative Hearing Form and an MDCH Administrative Tribunal postage paid envelope.

VI. QUALITY ASSURANCE/IMPROVEMENT

ACCESS Quality Assessment and Performance Improvement Program (QAPIP) must include measures for both monitoring of and for the continuous improvement in quality of the program or process described in this policy.

VII. COMPLIANCE WITH ALL APPLICABLE LAWS

ACCESS Employees, interns and volunteers are bound by all applicable local, state, and federal laws, rules, regulations, and policies, all federal waiver requirements, state, and county contractual requirements, policies, and administrative directives in effect and as amended.

VIII. LEGAL AUTHORITY AND REFERENCES

Michigan Mental Health Code Act 258, PA 258 of 1974, as revised. MCL 330.1001 et seq.
MCL 330. 1700-g
MCL 330. 1708 (3
MCL 330. 1712-1-3
MCL 330. 1752.
Department of Community Health Administrative Rules:
R.330.7135
R.330.7199, Revised l998
R.330.7243
R.330.7199, Revised 1998 (Exhibit B)
R. 330.1702 (a)-(f)
R. 330.1703
R. 330.1704
R. 330. 2814

Agency policies refer to the most recent policy at the time of writing:

- Dispute Resolution: Grievance and Appeals Systems
- Medicaid Fair Hearing
- Advance Directives

MDCH/CMHSP Managed Specialty Supports and Services Contract 10/1/98 - 9/30/2001:

- Attachment 4.5.1.1: Person-Centered Planning Best Practice Guidelines (attached)
- Attachment 4.7.4.1: Grievance and Appeal Technical Requirement

IV. EXHIBITS

MDHHS Elements of the Individualized Plan of Service
MDHHS Person-Centered Planning Best Practice Guideline
Policy Peer Delivered and Operated Supports
Notice of Hearing Rights - Individual Plan of Service
State Forms:

- Administrative Fair Hearing Request
- Advance Action Notice: Suspension, Reduction, Termination of Services/Supports
- Adequate Action Notice: Denial of Authorization

ACCESS
Community Health & Research Center

Policy Name: Policy Section/ Number:	Created By:	Initial Date:	Current Date:	Pages:
Treatment Interventions Policy Section __/# ____	Ana Dutcher Quality Assurance Manager	7/29/2013	6/3/19	Page **1** of **15**

Approved By: Mohamad Khraizat	Title: Health Operations Manager
Signature:	Date: 9-20-19

I. POLICY

The policy of the ACCESS Community Health and Research Center (ACCESS CHRC) provides an environment that facilitates recovery for people with mental illness, emotional disturbance, developmental disabilities and substance use disorder. ACCESS expects that recovery principles and practices are integrated in system policies, procedures, language, and documentation at all levels toward a recovery-enhancing environment. Individuals shall receive services suited to his/her condition in the least restrictive setting.

ACCESS ensures that those services shall be determined in partnership with the individual/guardian and family through a person-centered planning process. This shift means new roles and responsibilities for professionals at every level of the organization. Different modalities of treatment will be summoned to provide the most individualized and holistic approach to mental health care. These criteria are delineated in the Michigan Mental Health Code, and the Michigan Department of Health and Human Services (MDHHS) Administrative Rules, the Victims of Crime Act (VOCA) Crime Victim Assistance Grant and the Office of Refugee Resettlement Torture Survival Program (ORR - TSP). The services are based upon available funding.

II. PURPOSE

To provide direction for ACESS, its contractors, and the subcontractors to ensure that the individuals served receive the necessary assessments which lead to appropriate person-centered planning and referrals to other services or community resources as expected in a coordination of care approach.

III. APPLICATIONS

This policy applies to all ACCESS employees, interns and volunteers who provide support and treatment on behalf of the ACCESS CHRC.

IV. DEFINITIONS

Co-occurring Disorder: People who have substance use disorders as well as mental health disorders are diagnosed as having co-occurring disorders, or dual disorders. This is also sometimes called a dual diagnosis.

Conjoint/Collateral Therapy: a type of therapy in which a therapist sees the two spouses, or

parent and child, or other partners together in joint sessions.

Coordination of Care: Collaboration between physicians, other clinical professionals and their designees within the MCPN's array of contractors and sub-contractors, MHP's, and substance abuse providers, in the provision of services to persons mutually served: This coordination of care includes sharing of relevant information such as diagnosis, course of treatment, medication and side effects and recommendations regarding treatment/services/supports for a specific person who is receiving services.

Home Based Services: Mental health home-based services programs are designed to provide intensive services to children and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to support families in meeting their child's developmental needs, to support and preserve families, to reunite families who have been separated, and to provide effective treatment and community supports to address risks that may increase the likelihood of a child being placed outside the home.

Manager of Comprehensive Provider Network (MCPN): A business contracting entity established to develop and manage a comprehensive network of providers that can meet the needs of adults with or at risk of developing severe mental illness; children and adolescents with serious emotional disturbances; persons with developmental disabilities; and persons with severe mental illness and substance abuse disorders.

Peer Services: A Medicaid Managed Care 1915 (b) (3) waiver and Healthy Michigan service which promotes community inclusion and participation, independence and productivity. They include Peer Support Specialists, Peer Mentors, Recovery Coaches, Parent Support Partners and Youth Peer Support Specialists.

Person Centered Planning (PCP): A process for planning and supporting the individual receiving services that builds on the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices and abilities. The process involves family/significant other(s), friend(s) and professional(s) as the individual desires or requires.

Recovery: Abroad life journey that allows individuals to achieve their full potential with services and supports in the community of their choice (modified and adopted by D- WCCMHA, 2008).

Recovery Enhancing Environment (MI-REE) Michigan version: A modified version of a paper and pencil self-report instrument that gathers data on mental health recovery from people who receive mental health services.

Serious Emotional Disturbance: A diagnosable mental, behavioral, or emotional disorder affecting a minor that meets the diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Serious Mental Illness: Diagnosable mental, behavioral or emotional disorder affecting an adult that meets the diagnostic criteria specified in the most current DSM.

Substance Abuse and Mental Health Services Administration (SAMHSA): A branch of the U.S. Department of Health and Human Services. It is charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

Substance Use Disorders: Includes Substance Dependence and Substance Abuse according to selected specific diagnostic criteria specified in the most current DSM.

Support Plan: A written plan that specifies the personal support service, or any other supports that are to be developed with and provided for a recipient.

Treatment plan: A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services that are to be developed with and provided for the recipient.

Individual Plan of Service/Person-Centered Plan/Family-Centered Plan (IPOS/PCP): A written comprehensive plan of treatment/services/supports developed through a person-centered/family-centered planning process, in partnership between the consumer and one or more qualified professional (e.g., Mental Health Professional (MHP), Child Mental Health Professional (CMHP) or Mental Retardation Professional (QMRP), to address identified desires and needs and to establish meaningful and measurable goals that are prioritized by the consumer. The IPOS is the fundamental document in the individual's record and must be authenticated by the dated legible signatures of the recipient/authorized representative and the person chosen by the recipient, and named in the plan to be responsible for its implementation. The IPOS consists of a treatment plan and/or a support plan, and may be further characterized as follows:

Manager of Comprehensive Provider Network (MCPN): A business Entity contracted by DWMHA to develop and manage a comprehensive network of providers which can meet the individual's needs with or at risk of developing serious mental illness, serious emotional disturbance, developmental disabilities and/or substance abuse.

Respite: Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the unpaid caregiver and is provided during those portions of the day when the caregivers are not being paid to provide care. The methods and amounts of respite are decided during the person/family centered planning process

Targeted Case Management: Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process.

Treatment by Spiritual Means: Encompasses a spiritual discipline or school of thought upon which a recipient wishes to rely to aid physical or mental recovery and includes easy access, at the recipient's expense, to printed, recorded or visual material essential or related to treatment by spiritual means and to a symbolic object or similar significance.

V. PROCEDURES

A. Aftercare

Each patient is encouraged to agree to aftercare services after completing the formal treatment program. A patient is eligible for aftercare services after satisfactorily completing any component of treatment via the transition process in order for an individual to move to aftercare treatment modality, a patient meets policy criteria as stated above and agrees to aftercare services.

a. Patient may sign a treatment plan agreeing to participate in aftercare. The therapist assists the patient in formulating aftercare goals which are specific.
b. The individualized aftercare plan may include but is not limited to any of the following:
    i. Alcoholics Anonymous, Narcotics Anonymous, etc. Specific groups and number of groups should be specified.

ii. With length of time committed to using and arrangements for refill
iii. Self Help groups including names of groups, location and number of groups to attend
iv. Other organizations, identified as to name and attendance
v. Vocational/Educational with name and plan for attendance
vi. Self Help: exercise program schedule, books to read, etc

c. Patient may renew or terminate aftercare at any time
d. All aftercare will assure patient confidentiality

B. Behavior Plans

If an individual requires behavior management plan, he/she will be referred to an agency providing this service and that can generate a plan through the interdisciplinary team approach and reviewed by the Behavior Management Committee. Behavior management plans will be completed and monitored by that service provider.

C. Conjoint/Collateral Therapy

Therapist will provide conjoint therapy services for all patients assessed to be appropriate for this therapeutic service.

a. At the time of assessment or at any point in treatment the therapist of patient may request conjoint therapy services.
b. Therapist must include conjoint therapy (frequency, goals, etc.) in the patient's treatment plan.
c. Therapist facilitates appropriate conjoint counseling session focusing on the patient's treatment plan.
d. Therapist must document summation of session on a progress note in the patients' medical record

D. Group Therapy

A therapist assess patient for appropriateness for group therapy sessions. Therapist must include group therapy participation in the treatment plan.

a. Therapists provide orientation to each patient assigned to group therapy.
b. Supply a group sign-in sheet and verify that each patient is signed-in and understands the rules for group therapy.

c. Facilitate patient interaction and group process.
d. Document summation in the patient's medical record.
e. Charge each therapy session on a daily basis per established procedure.
f. Participation of patients in group therapy is limited to a minimum of 4 and a maximum of 12 patients per group.

E. Integrated Treatment for Co-occurring Disorders

ACCESS will use the integrated treatment model which an evidence-based practice and addresses the problem of access by ensuring that one visit, in one setting, is sufficient to receive treatment for both disorders. It addresses the problem of combining messages and philosophies by giving this responsibility clearly to the treatment provider instead of the client. There are several key features of integrated treatment services:

a. Shared Decision Making - Shared decision making is a systematic approach to client-centered care that involves the client explicitly in the treatment process. In this approach, clients with co-occurring disorders decide what goals they want to pursue, how they want to proceed with treatment, and what their path to dual recovery will be.

b. Integration of Services - When both mental health and substance use services are provided by the same person or team, the client has one treatment plan, one set of goals, and one relapse plan. The need for communication across agencies disappears.

c. Comprehensiveness - People with co-occurring disorders typically have multiple needs. Having two illnesses can be demoralizing and can reduce a person's basic psychosocial supports. Co-occurring disorders programs, therefore, must have access to an array of services. These include, among others:

i. Housing
ii. Case management
iii. Supported employment
iv. Family psychoeducation
v. Social skills training
vi. Illness management

vii. Pharmacological treatment

d. Assertive Community Outreach - Many people with co-occurring disorders do not come into mental health centers to seek treatment on their own. They might be on the streets, in homeless shelters, in police custody, or in jail or prison. Assertive community outreach that uses specific engagement strategies is necessary to connect them to the help they need.

e. Reduction of Negative Consequences - Before people are ready to completely stop using substances, they are often willing to take some smaller steps to reduce some of the harmful consequences of their use.

i. When people make progress on some of these [harm reduction] goals, they become more motivated to control their substance and mental health disorders. Some professionals argue that this approach enables an addicted person to continue to use and add that, because of this enabling, addicted persons will never experience the pain of their use and "hit bottom" so they can truly recover. For people with co-occurring disorders, however, not attending to the negative consequences of addiction often leads to death. Taking positive steps often increases motivation for recovery.

f. Long-term Perspective - People with co-occurring disorders recover at varying rates. Research shows that some begin to manage their illnesses in a matter of months. Unfortunately, many people enter recovery gradually, over many years. This long-term perspective means that we must be accepting of different paths. We must never give up. We must accept that recovery can be a life-long journey.

g. Motivation-based Treatment - To effectively address a client's co-occurring disorders, treatment must target the client's stage of motivation for recovery. The idea of stages of treatment means that there are different interventions for different stages. The stages of motivation-based treatment are engagement, persuasion, active treatment, and relapse prevention.

h. Multiple Psychotherapeutic Interventions - People with co-occurring disorders typically have multiple needs. Like everyone, they also have their own unique preferences and values. Needs, preferences, and values all influence their goals. Interventions, therefore, must be highly individualized and tailored to each client. Most clients engage in multiple interventions at the same time. For example, two

young clients with schizophrenia and cocaine abuse could easily have different interventions. Person A might be bothered more by the interaction of schizophrenia and cocaine abuse and require residential dual diagnosis treatment plus attendance in Narcotics Anonymous. Person B might be bothered more by family problems and past trauma and need trauma intervention and family psychoeducation. Both might need supported employment.

F. Individual Therapy

Therapist will provide individual therapy services for all patients assessed to be appropriate for this therapeutic service.

a. At the time of assessment or at any point in treatment the therapist or patient may request plan.
b. Therapist must include individual therapy (frequency, goals, etc) in patient's treatment plan.
c. Therapist facilitates appropriate individual counseling sessions focusing on the patient's treatment plan.
d. Therapist must document summation of session on a progress note in the patient's medical record

G. Services Suited to Condition

a. Mental health services shall be offered in the least restrictive setting that is appropriate and available.
b. ACCESS shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient.
c. A preliminary plan shall be developed within seven days of the commencement of service.
d. Any treatment plan shall establish meaningful and measurable goals with the recipient.
e. The individual plan of service shall contain pertinent information from assessments necessary to address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational

opportunities, legal services, transportation and recreation.

f. The individual plan of service shall identify the needs and goals of the recipient and the medical necessity, amount, duration, and scope of the services and supports to be provided.

g. If a recipient exhibits challenging behaviors, there shall be a comprehensive assessment/analysis of the recipient's challenging behaviors conducted.

h. Restrictions, limitations, or any intrusive behavior treatment techniques shall be reviewed by a formally constituted committee of mental health professionals with specific knowledge, training and expertise in applied behavioral analysis.

i. Any restrictions or limitations of the recipient's rights shall be justified, time- limited, and clearly documented in the individual plan of service.

j. Additionally, a description of attempts to avoid the limitations or restrictions, as well as what actions will be taken as part of the treatment plan to ameliorate or eliminate the need for the restrictions in the future shall be documented in the recipient's record.

k. A recipient shall be given a choice of psychiatrist or other mental health professional within the limits of available staff.

l. If a recipient is not satisfied with his/her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of service, the guardian of the recipient, or the parent with legal custody of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by ACCESS.

m. An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

n. A recipient shall be informed orally and in writing of his/her clinical status and progress