

**WEST MICHIGAN COMMUNITY MENTAL HEALTH
ADMINISTRATIVE MANUAL**

		Chapter: 2	Section: 2	Subject: 1
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SECTION: Assessment, Care Planning and Documentation				
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- I. **PURPOSE:** To establish procedures for assessment, planning of care and support, coordination and documentation of these functions, and to ensure customer involvement to the fullest extent possible in the assessment, service planning and delivery of care and supports.
- II. **APPLICATION:** All programs and services operated by or contracted with the West Michigan Community Mental Health.
- III. **REQUIRED BY:** Michigan Department of Health and Human Services (MDHHS) Contract for Managed Behavioral Healthcare Services, and Accrediting Bodies.
- IV. **DEFINITIONS:**
 1. **Responsible Clinician:** A professional staff member of WMCMH who is primarily responsible, along with the consumer, for the completion of clinical documentation (assessment, individual plan of service, reviews, changes and annual paperwork) in a team environment such as ACT and Home Based Services. There are multiple other team members who may fulfill the other responsibilities of targeted case management.
 2. **Care Manager (Targeted Case Management, TCM):** A professional staff member of West Michigan Community Mental Health who has the primary responsibility, together with the consumer, for assessment, care planning, advocacy, coordination and monitoring. The care manager is responsible for consumer's access to needed health and dental services, financial assistance, housing, employment, education, social services, mental health services, habilitation, employment, preferences and other services and natural supports developed through the person-centered planning process. Care is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes. Care Management is provided to consumers who have multiple service needs, have a high level of vulnerability, and/or are unable to independently access and sustain involvement with needed services. The care manager is responsible for ensuring the implementation of the individual plan of service. The care manager is responsible for what is in the consumer's clinical record for those consumers assigned.
 3. **Supports Coordinator:** A professional staff member of WMCMH who has the primary responsibility, together with the consumer, for planning and/or facilitating person centered planning meetings, developing the individual plan of service , linking, coordinating, advocacy and monitoring of specialty services and supports,

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brokering, assistance with access to entitlements and coordination with Medicaid Health plans or other health care providers.

4. Supports Coordinator Assistant: A professional staff member of WMCMH who has the primary responsibility, together with the consumer, for planning and/or facilitating person centered planning meetings, developing the individual plan of service , linking, coordinating, advocacy and monitoring of specialty services and supports, brokering, assistance with access to entitlements and coordination with Medicaid Health plans or other health care providers. This position must be supervised by a person with case management experience.
5. The Clinical Record: The clinical record is a tool that helps the clinician with the consumer's treatment. It includes a summary of all the services the individual has received from the agency and other outside providers. The clinician can read the history of the person, find out what worked and what did not work in treatment. The clinical record tells the reader where the consumer has been, whom they worked with, what their hopes and dreams were in the past and how they have changed. Each contact we have with the consumer is documented in the record according to established standards outlined in this policy, procedure and attachments. The documents belong to the agency; however, all the information entered into the clinical record belongs to the consumer.
6. CCBHC: The Certified Community Behavioral Health Clinic is a designation earned by West Michigan Community Mental Health granted by the federal government based on the agency's ability to provide required services and report on specific data elements. The CCBHC designation has its own set of requirements which are referenced in this policy.
7. Electronic Health Record (EHR): WMCMH uses an EHR developed by PCE Systems, named R3. All internal staff use this system to record consumer case information. Some external providers have been given access to R3 to enter progress notes and billings. This is a web access system with all data kept on servers by PCE.
8. Support Team (Interdisciplinary Team): A support team consists of the consumer, consumer-identified support systems/individuals/advocates as well as professional staff of WMCMH and/or contracted consultants representing different disciplines or service areas relevant to the consumers identified choices and assessed needs. Along with the individual and trusted supports, the supports team is responsible for

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directing, coordinating and managing the care and services. It is the responsibility of the support team to work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of the individual. The care manager is responsible to ensure that treatment recommendations are consistent across interdisciplinary team members. The individual, trusted supports, care manager and support team members (as invited by the individual/family) are present during the person centered planning process so that needs, outcomes and preferences of the individual/family are addressed in all life domains and treatment areas. WMCMH uses the following criteria to determine whether an interdisciplinary team is needed for the individual. The criteria includes: degree of functional impairment, severity of medical or behavior health support needs and diagnosis.

9. **Screening:** The purpose of the Screening Document is to record why the person is contacting WMCMH. It functions as a clinical screening tool, collects required data elements and demonstrates to the reader the rationale for the clinical decision that was made. The screening documents if the consumer is eligible for a CMH Assessment. It includes a clear description of the consumer's presenting problem, urgency of request, determination of care eligibility for an assessment, identifies any specific referral source, if applicable, information about the individual's personal representative, guardian, payee, and a confirmation of insurance benefits if any.
10. **Initial Assessment:** The Initial Assessment is the starting point for helping an individual along the recovery path by gathering information about their reason for seeking services. The assessment contains important and relevant information for the development of clear desired changes and outcomes for successful support and/or treatment. Assessment begins at Service Entry and is continuous throughout treatment. Because the time spent with the Service Entry staff is short, the Service Entry Assessment document is to provide a snapshot of the consumer at the time of the request. It is assumed this document will not contain all the information about the consumer. It is expected the document will show if the consumer meets eligibility determination for community mental health services, what population and assigned level of care, initial diagnosis, the completion of functional tools such as CAFAS, PECFAS, LOCUS, SNAP, DECA, etc. An important component of the initial assessment is the expectation that the Service Entry Clinician obtain medication information from all sources. The clinician cannot rely only on self-report from the individual. It is also the expectation that from this

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document, the Care Manager, consumer and family would be able to complete an initial Individual Plan of Service.

11. Annual Assessment: Annually the assigned clinician will complete an Assessment of the consumer's status/needs. It is expected the annual assessment will contain updated information about the consumer from the past year, establish medical necessity for ongoing service and to identify service and treatment needs to be addressed in the Individual Plan of Service. An important component of the annual assessment is the expectation that the completing clinician obtain medication information from all sources. The clinician cannot rely on self-report from the individual.
12. Other Assessments: Valid and standardized accepted professional screening tools, assessments or tests, other than psychological tests, that are conducted by a mental health care professional within their scope of practice for the purposes of determining eligibility for specialty services and supports, and the treatment needs of the individual. This also includes a Nursing Assessment by the on staff NP who completes a Screening and Assessment of all CCBHC consumers' key health indicators and other health conditions that impact recovery.
13. Preliminary Plan of Service: The Preliminary Plan of Service is developed prior to the Individual Plan of Service. This plan outlines what the next step of treatment will be as the team prepares for the Individual Plan of Service. It guides the consumer through the program orientation and it leads the consumer through the Person Centered planning process by educating the consumer in the PCP philosophy. This pre-plan will expire within 30 days of completion. The Preliminary Plan may request services for other assessments needed by the individual as determined by the annual assessment (OT, PT, dietary, etc.). The preliminary plan also contains the consumer's wishes for where and when the IPOS meeting will be held, who will be in attendance, hopes, dreams, desires and preferences, and other required information.
14. Consumer Orientation: The goal of consumer orientation is to assist the consumer in understanding the services provided at West Michigan Community Mental Health. Consumers will be re-oriented to CMH services minimally on an annual basis or any time there is a level of care change.
15. Authorizations: Authorizations are a billing/finance function. Specific services are identified through the Person Centered Plan process. The authorizations in the

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IPOS are recommended by the care manager based on the complexity/severity of the service needs and preferences of the individual. Authorizations that are within the benefit and service packages do not require prior approval of the UM system.

16. Person Centered Planning (PCP): PCP is a process and philosophy for planning and supporting the individual receiving services that builds upon the individual's capacity and strengths to engage in activities that promote community life and that honors the individual's preferences, choices and abilities. The person centered planning process involves families, friends and professionals as the individual desires or requires. The resulting individual plan of service is based on the assessment of the consumer needs.
17. Amount, Scope and Duration: Amount, scope and duration are required content elements of the individual plan of service document to inform the individual/family of how much, how long and how the needed services will be provided, and by who. These elements are entitlements and are subject to the Grievance and Appeal Process.
 - Amount: The number of services/units to be provided per day, week or month as identified in the person-centered plan.
 - Scope; The parameters within which the service will be provided as stated in the person-centered plan. This is the who, how and where the service is provided.
 - Duration: The length of time it is expected that the service identified in the person-centered plan will be provided.
18. Periodic Review: A review has two functions. First, it functions as a means to summarize all services that were provided in the specified review period and to assess the consumer's response to treatment/support interventions. It is an assessment of how the services are working and to determine if services need to change. The review summarizes ALL the progress notes and summarizes the care managers monitoring notes.

Secondly, the review amends the PCP with revised outcomes, interventions/ supports and transition criteria as necessary to meet the consumer's assessed service need. If there was no progress toward treatment, the review indicates why and the individual plan of service is amended to assist the consumer in making progress toward recovery/care. The review assures that the services that were

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provided in the review period were medically necessary and therapeutically appropriate and the services for the next period are medically necessary/therapeutically appropriate.

19. Addendum: An addendum is completed to update the individual plan of service. Changes include: adding/deleting/changing outcomes, and interventions/services AND/OR extending time frames or authorizing additional units of a particular service. This is accomplished by having the clinician complete the Addendum inside of R3 in collaboration with the consumer. This document is then concurrently printed and signed by the consumer, along with the necessary Advanced and/or Adequate Notice documents.
20. Discharge Summary: The Discharge Summary is completed for all consumers who have achieved their desired change, outcome/transition criteria and are no longer in need of provider care/support or if the consumer drops out of care. The responsible clinician is to summarize a consumer's achievement or lack thereof for all active outcomes, services/ supports rendered, transition criteria and the need for linkage arrangements when follow up care is needed.
21. Clinical Progress Notes: Progress notes document what happened in a contact. They are to be completed within 24 hours of the provision of service.
22. Level of Care Guidelines: Level of Care Guidelines provide direction to the clinician when aligning the assigned level of care and the required functional impairment score (LOCUS, CAFAS PECFAS, SNAP) to the intensity of service needed by the consumer.
23. Support Plans: A support plan is developed at any time during the planning process. It assists the consumer in planning for needs and support during a crisis. The support plan is completed at the time of the preliminary plan.
24. Referral Process (transition): The referral process is used when referring consumers to a supportive service or transferring a consumer from one population to another or to a different LOC outside of a department. Clinicians engage in a follow up contact with the individual to ensure that he/she has been successfully linked to the resource.
25. Grievance and Appeals: A Grievance is an expression of dissatisfaction about services other than an "action." An Action is a decision that adversely impacts a

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consumer's claim for services due to denial, reduction, suspension, termination or limited authorization of a service. An Appeal is a challenge to an action. For process of Grievance and Appeals, please see policy 2.6.5.

- V. **POLICY:** It is the policy of West Michigan Community Mental Health to ensure the implementation of specific procedures for the assessment, care planning, supports coordination, documentation, transition and referral for all customers receiving care.

VI. **PROCEDURES for Clinical Work Flow:**

1. Screening

- A. A screening is completed by a Service Entry Clinician either in person or over the phone. See Appendix 2-2-1 B for the contents of the screening document.
- B. Based on the clinical and eligibility information gathered at the time of the screening, the individual is referred to a community resource or referred internally for an Initial Assessment to determine eligibility for either traditional mental health services, SUD services or outpatient counseling services.
 - a. The individual is referred to a community resource when the individual did not meet eligibility criteria for traditional Medicaid Provider Manual mental health services.
 - b. The Service Entry Clinician completes a warm hand-off by assisting the individual in making contact with the referred provider and scheduling an appointment when appropriate or requested by the consumer.
 - c. The Service Entry Clinician will follow up with the individual within 7-14 business days. The Service Entry Clinician documents the follow up contact in a progress note.
 - d. If the individual is referred for an Initial Assessment, the Service Entry Clinician schedules an appointment with a Service Entry Clinician within 14 calendar days of the screening document date per MDHHS criteria. CCBHC requires that the appointment be scheduled within 10 working days.

2. Initial Assessment

- A. The individual arrives 30 minutes prior to their initial assessment appointment to complete the check in process with the assigned support services staff to complete the required paperwork and consumer education/orientation, which includes the Universal Release of Information, financial determination, Consent

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and Ability to pay for Treatment, HIPAA, confidentiality and rights information, Grievance and Appeal information, Advance Directive information, consumer guide to services, emergency services information and other required documents. This is the first level of orientation.

- B. Please see Appendix 2-2-1C for required content of the Initial Assessment (Violence Assessment, Columbia Suicide Risk Assessment, ANSA, CANS, AUDIT, DAST, Trauma Assessment, as examples).
- a. Part of the diagnostic formulation includes the completion of the functional assessment tools. The age of the consumer and primary diagnosis determines which tool is to be administered.
 - CAFAS-children ages 7 and older
 - LOCUS-adults with mental illness
 - SNAP-adults and children with developmental disabilities
 - PECFAS-children ages 3-7
 - GAIN/ASAM-substance use disorders.
 - b. Recovery Recommendation Section: The Service Entry Clinician is to use the Level of Care Guidelines (Appendix 2-2-1E), Eligibility Checklists (Appendix 2-2-1D) and the Medicaid Provider manual in determining the service need of the individual.
 - c. Traditional Mental Health Services: For those individuals who meet the eligibility criteria for adults with severe and persistent mental illness, children with severe emotional disorder and adults and children with developmental disabilities; and whose functional tool score indicates eligibility. The LOC guidelines, the functional tool score and clinical judgment assist the clinician in assigning the individual to the correct level of care and team. The Service Entry Clinician completes the preliminary plan with the individual and obtains their signature on the document. The Service Entry Clinician schedules an appointment with the assigned staff person and team within 14 calendar days of the initial assessment date. This is the MDHHS standard. The CCBHC standard is 10 work days. If possible, the Service Entry Clinician will attempt a meet and greet with the assigned team staff person, at the time of the initial assessment.
 - d. Mild to Moderate Outpatient Therapy: Individuals who do not meet eligibility for traditional mental health services but still require formal intervention and treatment are referred to the Outpatient Therapy program funded by the Medicaid Health Plans (MHP) for brief, solution focused therapy, psychiatric services, and assessment/screening primary care

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services. These services are available at WMCMH. Other community resources are available for the brief solution focused therapy only in each of the 3 counties. Service Entry Clinicians provide choice of providers to individuals based on consumer preference and the type of Medicaid Health Plan.

- e. Substance Use Disorder Services: Individuals who do not meet eligibility for traditional mental health services but have an identified substance use disorder and require formal intervention and treatment are referred to the SUD Outpatient program funded by Medicaid, Healthy Michigan, state allocated block grant funds, and commercial insurance. Services offered in this program include: assessment, individual therapy, group therapy, peer recovery coaching, care management, psychiatric services, assessment/screening primary care services, ambulatory detoxification, and referral to other needed services that include medication assisted treatment, withdrawal management, residential treatment (short and long term), and placement at recovery residences. These services are available at WMCMH in the Counseling Services Program or other providers in each of the 3 counties. The Service Entry Clinician provides choice of providers to individuals based on the type of Medicaid Health Plan.
- f. Private Insurance Track (PIT): For individuals who meet criteria for traditional mental health services who have commercial insurance or Medicare, but no Medicaid and choose to get treatment from WMCMH. Services are limited to those covered by the insurance of the individual, however the CCBHC allows access to all medically necessary traditional mental health services. Medicare covered services are provided by Master Level clinicians who are credentialed based on insurance coverage.
- g. Refer Out: The individual may be eligible for traditional mental health services and chooses to receive services from a different provider or after the initial assessment, it is determined the individual is not eligible for traditional mental health services. The Service Entry Clinician makes a warm hand-off by assisting the individual in making contact with the referred provider and scheduling an appointment. Assistance in keeping the appointment with the outside provider will be offered. The Service Entry Clinician will follow up with the individual in 7-14 business days, documenting contact. When the individual is referred out, is not eligible for traditional mental health services and is a Medicaid recipient, a second opinion must be offered.

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- h. Catchment Area: Services will not be denied to those who are not residents of the Lake, Mason and Oceana county catchment area. The consumer's preference of treatment location is taken into consideration. Consumers who are willing to receive services in their home catchment area will be referred to the appropriate service provider. WMCMH will attempt to obtain reimbursement for needed routine, ongoing services for those who do not live in the catchment area and prefer services from WMCMH. No one will be denied access to Mobile Crisis or Crisis Stabilization services regardless of residency.
 - i. BH TEDs: Behavioral Health Treatment Episode Data Set: This data set is required by MDHHS. At the start of care, at the time of a service entry assessment, a "New" BH TEDS record must be opened and completed by the Service Entry Clinician. The clinician will not be able to mark the initial assessment complete (signed with electronic signature) until the BH TEDS record is complete. When there is a significant change in consumer care (PAS, crisis intervention, or level of care change), an "Updated" BH TEDS record is required. At the time of the annual assessment, an updated BH TEDS record is required. When the consumer leaves care (the case is closed), an "End" BH TEDS record is required. In all circumstances, the clinical document cannot be marked complete with the electronic signature until the BH TEDS record is marked complete.
3. Annual Assessment: The annual assessment is completed at the team level by the assigned clinician. The assessment determines ongoing eligibility for traditional mental health services for adults with severe and persistent mental illness, children with severe emotional disturbance, adults and children with developmental disabilities and persons with substance use disorders. The assessment identifies the life domains and needs of the individual that will be addressed in the individual plan of service. This assessment is updated annually or more often if there is a change in need for the consumer. The functional assessment (CAFAS, PECFAS, SNAP or LOCUS) associated with the designated population is required.
4. Preliminary Plan: The preliminary plan begins the person centered planning process. The preliminary plan identifies who is invited to the PCP, the date, time and location of the planning meeting. The preliminary plan details the preferences and choices of the individual plus the hopes and dreams of the life they wish to live. The plan also identifies who the individual chooses to facilitate the person centered planning meeting. See Appendix 2-2-1F for the prelim plan template.

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- a. Orientation: The second level of program orientation begins at the preliminary planning meeting. See Appendix 2-2-1G for Orientation to Services Process. This level of orientation addresses the navigation of the mental health system. There are three levels of orientation. Orientation is repeated annually or when an individual is assigned to a new level of care.
 - b. The consumer has a choice as to who will facilitate their individual plan of service meeting to develop their person centered plan. The options are discussed during preliminary planning for the PCP. One option is an independent facilitator. An independent facilitator is not employed by WMCMH. The independent facilitator is conflict free from any agency or service provider, thus is better able to advocate for the consumer and facilitate the plan without bias. If the consumer selects the independent facilitator, the service entry clinician/care manager is responsible for making the necessary connections and linking the consumer to this service and choice of provider.
5. Individual Plan of Service: Once the consumer is assigned to a Level of Care within a specific population served, the consumer, the care manager and others who the consumer invites develop the individual plan of service. Routine service must start with the consumer within 14 calendar days of the initial assessment per MDHHS standards. CCBHC requires that routine services must start within 10 business days of the assessment date.
 - a. The 3rd level of the orientation process is completed at this time. See Appendix 2.2.1F.
 - b. Summarize the results of any additional assessments or outside information that was gathered between the initial/annual assessment and the person centered planning meeting. This includes OT assessments, PT assessments, psychiatric evaluations, etc.
 - c. Develop goals in the words of the consumer.
 - d. Develop achievable and measurable objectives based on the needs (including co-occurring disorders) and life domains outlined in the assessment, from the additional assessments or outside information, from treatment team input and from the consumer.
 - e. Interventions: Those actions that the consumer will do, what others will do to support the consumer and what CMH will do (services). CMH services must describe the intensity, scope and duration of the service.
 - f. The consumer is given choice as to who will provide the identified services/interventions. For all clinical services the provider must meet

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qualification and licensing regulations outlined in the Medicaid Provider Manual.

- g. Identify when the plan will be reviewed and at what frequency including the consumer in the review process.
 - h. The support plan is developed/updated as a part of the person centered planning process. The plan identifies triggers, warning signs, coping skills, action items specific to the consumer, emergency contacts and advance directives when appropriate.
 - i. Any unmet needs not addressed in the plan are identified with an explanation as to why they are not being addressed.
 - j. Referrals to community resources are identified when applicable.
 - k. Discharge criteria are listed, specific to the consumer
 - l. Diagnosis, co-occurring information and diagnostic summary are reviewed for accuracy.
 - m. The list of authorized services for encounter reporting and UM review.
 - n. The consumer is given a copy of their plan within 15 business days of the completion date. R3 has the capacity to obtain signatures electronically. All signatures will be obtained electronically in the office and in the field. In the case of a guardian, the plan is mailed with a letter to the guardian, requesting the return of the signature page as proof that a copy of the plan was provided.
6. Internal/External Referral Process: The referral process is used when referring the consumer to a supportive service that is medically necessary as identified by the assessment, a member of the treatment team, or when the consumer requests the service and meets medical necessity for the service.
- a. Internal Referral Process: Use the discussion feature in R3 to begin the referral process for a supportive service. The clinical process to determine whether the service/assessment is needed is handled as a discussion. The case holder talks with her/his supervision about the need for a supportive service. After getting the okay to proceed from immediate supervisor, the case holder, using the discussion feature of R3 contacts the referring supervisor to discuss the referral for the supportive service. If the referring supervisor agrees with the referral, proceed to step 5. If the referring supervisor does not agree with the need for the supportive service; the situation becomes a conversation between the immediate and referring supervisor for resolution. The case holder requesting the supportive service on behalf of the consumer creates an addendum to add the

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requested service/assessment and the needed authorizations for the service.

- b. The internal referral process for routine needs meeting medical necessity is to be completed with 10 business days.
 - c. External referral process: Use form CR#161, External Referral Form. This form is used when the needed service is from a contract provider or Licensed Independent Practitioner (LIP). The clinician/care manager completes the form and mails it to the LIP (submits a copy to clinical records for scanning into R3), requesting an assessment for service with clinical rational and medical necessity identified. The clinician/care manager follows up with the LIP within 7 days to find out when the assessment is scheduled and to create the needed authorization for the service. The clinician will assist the consumer in obtaining and keeping this appointment if needed. The LIP schedules the assessment with the parent/home/consumer and completes the assessment. The written assessment along with any recommendations for treatment are sent by the LIP to the CMH care manager/clinician and to the home/consumer/family. The clinician creates an Addendum to add the objective, interventions and authorizations to the plan. The LIP trains the home staff or family/self-determination staff in the completion of the interventions.
7. Integrated Care/Coordination of Care with Primary Care Physician: All health care and medical care needs revealed by the consumer are documented in the initial and annual assessment. Health care needs that impact a consumer's behavioral health care needs are identified in the assessment and the individual plan of service as goals and objectives. This is an example of integrated care. Consumers sign a release of information authorizing WMCMH to exchange/release information to their primary care physician and Medicaid Health Plan to coordinate their physical and behavioral health care needs. Examples of coordination include:
 - a. Sharing psychiatric evaluations and medication review results with the primary care physician. The physician has knowledge of medications prescribed by CMH and CMH can in turn obtain information about medications prescribed by the primary care physician.
 - b. A clinical service aide (CSA) attends a health care appointment with the consumer. The CSA is then able to communicate information from the physician to the primary care giver, assist the consumer in following through on lab orders or other tests, and understanding doctor's recommendations.

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- c. WMCMH ordered labs and test results are copied to the primary care physician.
 - d. Coordination of care assists the consumer in addressing both behavioral health and physical health care in a coordinated fashion, leading to better outcomes for the individual and a more quick recovery.
 - e. For individuals who do not have a primary care provider to coordinate care, WMCMH has a NP who can assess/screen for key health indicators, follow up and monitor with the consumer so that health care needs do not go unmet.

- 8. Periodic Review: The MDHHS standard requires that the individual plan of service must be reviewed at least annually or more often as determined by consumer and the person centered plan. There are certain programs where 90 day reviews are required by MDHHS (ACT, Home Based, Children's Waiver and the Autism program). Any team that provides services to a consumer enrolled in the CCBHC must provide a 90 day assessment. The ANSA/CANS is used at 90 days and 270 days to the assessment. The periodic review, which contains the ANSA and CANS, is used at the 180 day mark.
 - a. The periodic review serves as a means to review and summarize services that were provided in the specified review period to assess the consumer's response to service and support interventions. The review also summarizes and updates any significant changes that may have occurred during the review period. It is an assessment of how the services are working and determine if services need to change. The periodic review summarizes all the progress notes of the services provided in the review period.
 - b. The periodic review serves as an update to the individual plan of service with revised objectives (outcomes), interventions/supports and transition criteria as necessary to meet the consumer's need. If there was no progress towards service objectives, the periodic review indicates why and the plan is updated to assist the consumer in making progress towards recovery. The review assures that services/supports provided were medically necessary and that services in the next review period are also medically necessary.

- 9. Addendum: The Addendum document is a process that allows the care manager or designated internal supportive service clinician (see internal referral) to make modifications to an existing individual plan of service. Changes include adding/changing/deleting objectives (outcomes) and interventions, adding

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authorizations, and/or extending timeframes of a particular service. The clinician/care manager completes the Addendum in collaboration with the consumer. The changes made on the Addendum will electronically modify and integrate into the existing individual plan of service document. The new/revised Addendum is printed and signed by the consumer concurrently with the appropriate Adequate and Advance Notification.

10. Level Of Care transfer (**transition**): There are times when a consumer requires a change in Level of Care and services (child with SED from children's services ages to adult with mental illness services or a child with SED transfers to children with developmental disabilities services, there is a significant change in condition involving the functional assessment or a home based case transfers to traditional children's case management) to better meet their care needs as clinically appropriate or the outcomes have been achieved in the more intensive level of care. The LOC transfer is completed with the active participation of the consumer/family/guardian and other supports.
- a. Level of Care transfer within the same population: When the level of care change is within the same population, a review is created, indicating in the documentation that this is a level of care change. This may or may not require a change in care managers. If a new care manager is assigned, a warm hand off with the old and new care manager and consumer occurs for introduction, continuity of care and to facilitate on the ongoing recovery process. A new assessment, preliminary plan, and Person Centered Plan are not required. This process must occur within 10 days of the functional assessment and/or request of the consumer.
 - b. Level of Care transfer to a new population:
 - 1. When the responsible clinician identifies the need for a change in population for a consumer, the case holder speaks to his or her immediate supervisor. This starts the **30 day time frame** to complete the population change.
 - 2. The immediate supervisor contacts the supervisor of the receiving team.
 - 3. If there is agreement for the change in population, the receiving supervisor makes the change in population and LOC in the admission tab in R3.
 - 4. The current case holder arranges a warm hand off between the consumer and the new case holder in the population and LOC.

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5. The receiving case holder is responsible for creation of the new assessment and IPOS with the population and level of care change.
 6. There is a yes/no question in the IPOS document. When the response is yes, this is a population, a list of all levels of care appears, and the case holder selects the new LOC within the new population. Based on the selection of the new population and LOC, all services that are available in the new population and LOC are available for authorization purposes and the new population and level of care prints on documents and changes inside R3.
 7. The new responsible clinician must change any future appointments (med reviews) to their schedule
 8. If there is not agreement between the immediate and receiving supervisors, the discussion is brought to the deputy director of clinical services for resolution; this may include the CoC.
11. WMCMH Psychiatric Inpatient/Crisis Residential Discharge Planning Process: It is important for consumers to know there is a plan for their discharge and what is going to happen next. It is the responsibility of the Service Entry Team to coordinate inpatient/crisis residential discharge when the consumer is new to WMCMH. With an open, existing consumer, the assigned team and responsible clinician coordinates the discharge. The discharge plan uses the Discharge Planning Form inside of R3 to plan with the inpatient psychiatric unit/crisis residential and the consumer. Some items that may need to be addressed in the discharge plan include:
- a. Transportation for the service entry appointment or appointment with responsible clinician.
 - b. Medications prescribed at discharge
 - c. Connection to alcohol or drug treatment programs and support groups.
 - d. Application for benefit programs including Medicaid.
 - e. Housing referrals due to homelessness
 - f. The hospital will fax any/all Legal documentation, , information about ATOs or AOTs as the CMH is the legal monitoring entity no matter where the consumer receives services.
 - g. Needed medical treatment and referral to a primary care physician if needed.
 - h. There must be face-to-face clinical contact with the consumer within 7 days of discharge per MDHHS standards.

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12. Transition (**Discharge**): For all consumers leaving services a discharge Summary is completed to describe the course of services provided and the response of the consumer. This process is used to bring closure to the WMCMH episode of care whether planned or unplanned. The transition process includes the active participation of the consumer and other natural or community supports when a planned discharge occurs.

- a. The discharge summary for both planned and unplanned transitions contains the following:
 1. Date of admission and date of discharge from WMCMH services.
 2. Describes all services provided and the course of care.
 3. Identifies the present condition and reason for leaving services.
 4. Describes the extent to which goals and objectives were achieved.
 5. The status of the person at last contact
 6. Recommendations for all community and natural services and supports with contact information of the identified referral sources.
 7. Includes information on medications prescribed when applicable and referral source for medication prescribing and management.
- b. Unplanned discharge process:
 1. The care manager/clinician attempts to reach the consumer by phone, documenting the attempts in an indirect progress note.
 2. If the consumer cannot be reached by phone a not kept (NK) appointment letter is sent to the consumer requesting they contact the agency to schedule an appointment.
 3. The care manager/clinician continues to attempt to reach the consumer by phone and/or schedules an attempted appointment.
 4. If the consumer does not contact the agency as a result of the first letter, a second letter is sent two weeks following the first letter.
 5. If there is no word from the consumer and attempted appointments were also unsuccessful, complete the discharge summary as outlined above and include the reason for the unplanned discharge.
 6. The discharge summary must be completed within 45 days after the date of the first NK letter. A copy of the discharge is mailed to the last known address of the consumer along with Advance and Adequate Notice.
- c. Planned discharge process:
 1. The consumer signs a release of information to the referral sources so that records are released and coordination of care

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occurs. The care manager/clinician is responsible for care coordination and any needed follow up.

2. Start the discharge plan with the consumer at the second to last appointment. Review it with the consumer, having them sign it and give the consumer a copy at the final appointment.
3. If the discharge plan was not completed at the last appointment, the document must be completed within 10 days of the final appointment. The document is mailed to the consumer within 15 business days of the document date with a signature page and Advance and Adequate notice.

13. Documentation of the clinical Process

- a. **Electronic Health Record** – All clinical documentation is completed in R3. Clinicians have access to information and data about individuals assigned to them for care. No staff person should access consumer information if they are not involved with the particular consumer.
- b. **Scheduling** – All consumer appointments are scheduled through the agency's electronic scheduling system. No person should access consumer information if they are not involved with the particular consumer.
- c. **Reportable Encounters:** All services provided must be documented in a progress note with the SAL (service activity log) completed. See [Appendix 2-2-1J](#) for the service to be reported as an encounter. Reportable encounters are those services that are provided face to face with the identified consumer as defined in the Medicaid provider manual. These encounters can be provided in the office, community, consumer's home, school or through videoconferencing. If videoconferencing is used, please see the procedures on videoconferencing for more details in policy 7.1.1.
- d. **Indirect Services** – There are services such as linking, coordinating, phone contacts and consultation that are not reported as encounters. These are important services provided on behalf of the consumer and are documented in an indirect note in R3.
- e. **Confidentiality** – When using equipment for documentation, scheduling, videoconferencing, or supervision, the clinician must ensure that confidentiality is maintained.
- f. **Outside information** – When outside information is received, Records scans the information into R3 and then notifies the responsible clinician that information is available for review. It is the responsibility of the responsible clinician to review this information. If the care manager feels

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others on the treatment team need to review the information, the care manager will notify others via email.

14. Care Planning Impasses

- a. Care impasses with Adults: If an impasse should occur between an adult consumer, his or her guardian and the assigned care manager regarding the assessment, Individual plan of service, and/or discharge planning, the appropriate program supervisor will review the impasse. The supervisor will review all clinical recommendations and attempt to resolve the impasse with a compromise using the LOC guidelines, agency policy and procedures, and resources available at WMCMH. If a compromise cannot be reached, the case will be referred to the Clinical Oversight Committee for review and recommendations. The Clinical Oversight Committee will provide a written recommendation within 30 days of the request for review. Consumers have a right to appeal the decisions through the process and procedures outlined in the Advanced/Adequate Notice policy, Chapter 2, Section 6, Subject 5.
- b. Care impasses between Children/Adolescents and parents: Care, supports, and interventions for children and adolescents are always designed and provided using the family centered practice approach, except when family centered interventions are not practical due to legal circumstances or when such interventions would place the child at emotional or physical risk. The child/adolescent and custodial parent or guardian shall be involved in the development of the person/family-centered plan. If the child/adolescent or parent/guardian is in disagreement with his/her referral to WMCMH for assessment or the person/family centered plan, the care manager will review the impasse with the custodial parent/guardian providing consultation as to other possible sources of assistance as determined by the presenting problem and the level of risk to the child/adolescent.
If during the course of services there develops a disagreement as to the focus of or participation with the family centered plan, the care manager will do one of the following:
 - i. Determine to the extent possible the needs and desires of the child and family, as compared to the child's verbalized desires and those stated by the custodial parent or guardian.
 - ii. Determine to the extent possible the best interest of the child and custodial parent or guardian. Present these to both in a family and/or individual session. If an appropriate clinical compromise can be

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made, modifications are made to the Family Centered Plan to achieve the compromise.

- iii. If in the opinion of the care manager action taken by the child/adolescent places a minor at risk of physical harm, the care manager should initiate procedures to assist the family in protecting the minor to the extent possible under state/federal statutes.
- iv. If in the opinion of the care manager actions taken by the custodial parent or guardian places the child/adolescent at emotional/physical risk, or represents parental/custodian neglect or abuse, the care manager will call the 1 800 CPS report line and file a written 3200 report with Department of Health and Human Services within 24 hours.
- v. If the child/adolescent and custodial parent/guardian both desire to continue to remain in services, but remain opposed to the focus, the impasse will be referred to the program supervisor for review and action. If the impasse cannot be resolved, then a referral will be made to the Clinical Oversight Committee for review and recommendation.
- vi. The Clinical Oversight Committee will review all the data and reach a consensus within 30 days of the request for review as to what changes can be proposed to the Family Centered Plan that will continue to meet the interests of the family. The compromise will be presented to the family in a way that is agreeable to all parties involved. The family may choose to continue with services or terminate the services. Consumers have a right to appeal the decisions through the process and procedures outlines in the Advanced/Adequate Notice policy, Chapter 2, Section 6, Subject 5.

15. Providing Education Materials to Consumers and Family Members: Consumers and family members are provided with information and education that is relevant to the needs of the consumer. Information and education is provided in a variety of formats and variety of topics. Topics included:

- a. housing
- b. medication
- c. medical needs (metabolic syndrome, smoking cessation, etc.)
- d. mental health
- e. alcohol and drug issues
- f. relationships
- g. life skills
- h. coping skills.

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Format for providing education and information include:

- a. Individual sessions
- b. Group sessions, including Family Psycho-Education Group, SUD group, and coping skills group.
- c. Psychiatric Medication facts hand outs
- d. Nurse teaching groups on medical issues
- e. Community partners such as schools, health department and other community agencies.

16. Utilization Management and Concurrent Reviews: The agency's Utilization Management plan specifically outlines the monitoring process and the peer review standards as part of the agency's performance improvement process. The Utilization Management/Utilization Review group reviews a sample of all clinical documents on a scheduled and routine basis. Please see the UM and Performance Improvement Plan for additional information. Concurrent review of clinical documentation are completed by Clinical Team Leads and Supervisors as part of the supervision process. This review provides supervision as well as performance improvement opportunities. Standards for timeliness for concurrent reviews and Rules for documents that require supervisor signature are outlined in Appendix 2-2-1M.

VII. SUPPORTING DOCUMENTS:

- Appendix 2-2-1A: Paperwork Flow Chart
- Appendix 2-2-1B: Screening Process
- Appendix 2-2-1C: Initial Assessment Expectations
- Appendix 2-2-1D: Eligibility Checklist
- Appendix 2-2-1E: LOC Guidelines
- Appendix 2-2-1F: Orientation to Services Process Documentation
- Appendix 2-2-1G: Person Centered Plan (PCP)
- Appendix 2-2-1H: Person Centered Plan Review (PCP-R)
- Appendix 2-2-1I: PCP-C Virtual Team Process
- Appendix 2-2-1J: Transition Plans
- Appendix 2-2-1K: Progress Notes
- Appendix 2-2-1L: Referral Process
- Appendix 2-2-1M: Time Frame Definitions
- Appendix 2-2-1N: Routing Rules for Supervision Signature
- Appendix 2-2-1O: Psychiatric Services
- Appendix 2-2-1P: SUD Resource Management Flowchart
- Appendix 2-2-1Q: SUD Resource Management Narrative

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Appendix 2-2-1R BH TEDS Flow Chart

2-2-1 Service Planning

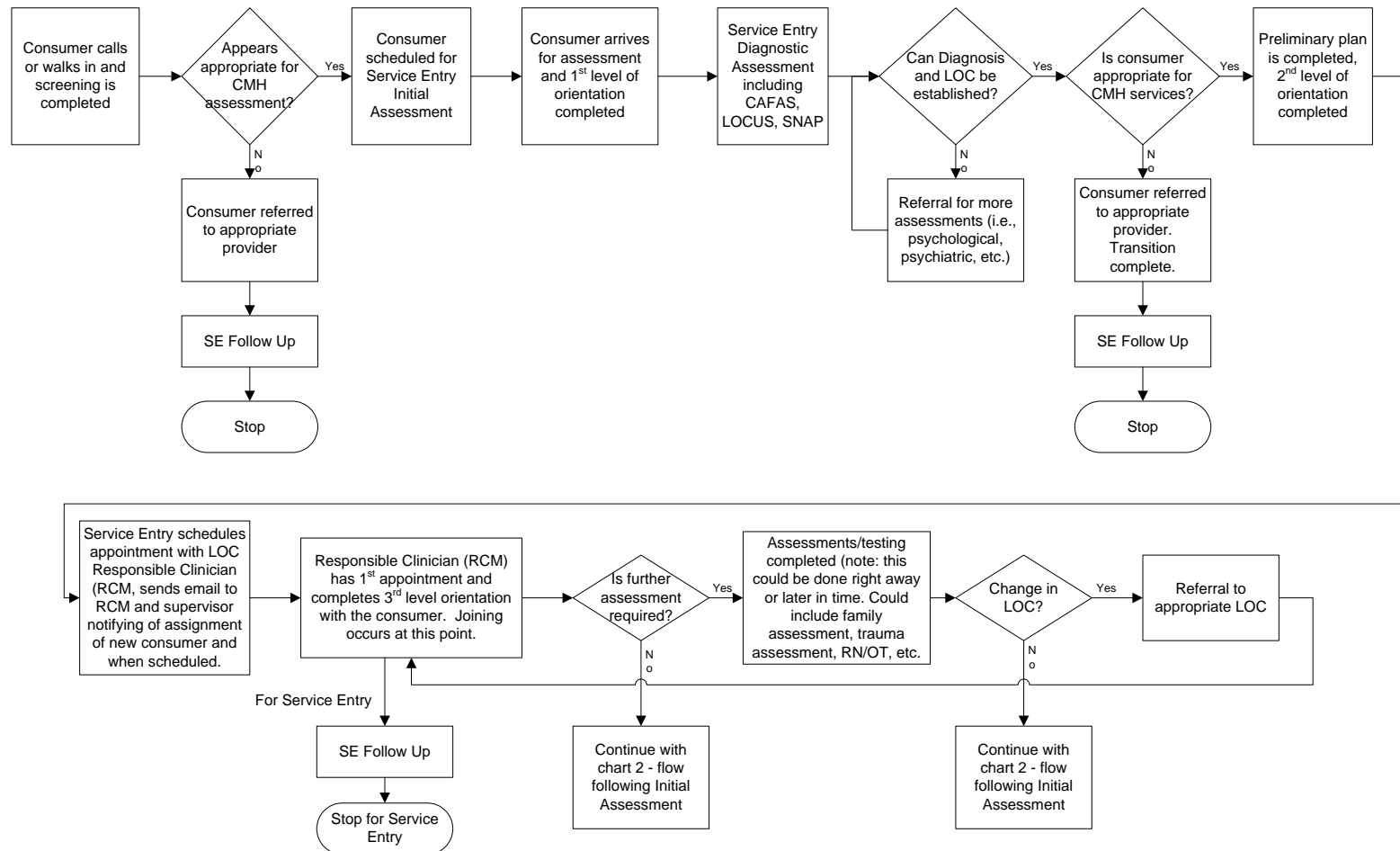
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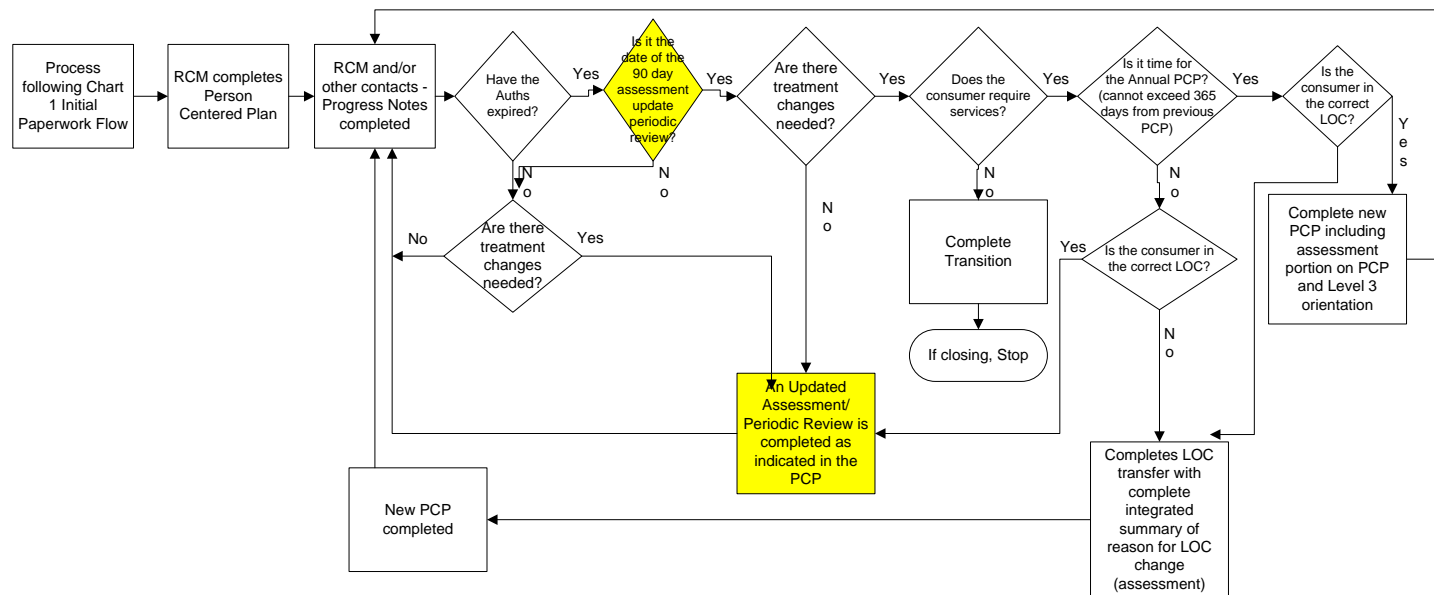
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Paperwork Flow



Paperwork Flow Following Initial Assessment



Screening

Purpose of the Screening Document is to record why the person is contacting WMCMH and documentation as to where the person was directed. The screening collects required data elements and outlines the clinical decision making process and why. Although this is a short form, it is a very important part of the clinical record. The screening determines if the consumer is eligible for a WMCMH Assessment. It includes a clear description of the consumer's presenting problem, urgency of request, determination of care eligibility for an assessment, identifies any specific referral source, if applicable, information about the individual's personal representative, guardian, payee, and a confirmation of insurance benefits if any.

Information Tab:

Name:

Maiden Name: Please complete. This will assist in finding any old records the person may have had.

Contact type: Please select the method in which the contact was made. Choices include:

- ☐ Phone
- ☐ Walk in
- ☐ Jail
- ☐ OBRA
- ☐ Hospital
- ☐ Court Referral

Screening Date/Time: There are timeliness standards that must be followed in certain areas such as time of request, type of urgency of the request, when the person is seen, how long it takes for them to have an assessment completed, and the time between assessment and start of care. As a result, the clock starts at the request date or the date of screen.

Contact Start Date/time: This is the date/time the actual face to face or telephone contact started with the individual. It may be different from the screening date/time or it may be the same.

Proto Call request: This is third party information obtained from support staff Proto Call, or a nonclinical information request.

Demographic Tab:

Demographics: This data is important for reporting and figuring out where the person is right now. Please obtain the most recent information of where they live and/or confirm the information.

Most of the data is self-explanatory, however:

Phone number: Please put primary if they have one, secondary phone number to contact the person.

Guardian Name and address: Need to put the address in here. Do not answer the same as this will not pull forward in e records.

Phone number: This is the phone number of the guardian.

Service Entry Person: This is the clinician doing the actual phone or face to face screening.

Screening Tab:

Please get a copy of the Medicaid and/or Medicare number.

Other insurance Comments: Current and accurate insurance information is very important. Those who have Medicare or commercial insurance are referred to the Private Insurance Track (PIT). The individual must be linked to the appropriately credentialed internal provider for proper reimbursement for the service provided. Please find out as much as possible about the person's insurance, find out if there are prior authorizations needed and put this information in the Overall Insurance comments. The individual may have multiple insurance coverage, please gather information about all insurances.
Need name of insured, date of birth, contract number if not Medicaid.

Insurance code: This is the listing of other insurances the person may have. Select the primary insurance.

Presenting Problem: This starts the clinical part of the screening. Please identify the **presenting problem** or complaint, or reason for seeking services. This is a simple statement that answers the question of why the consumer is here. What does the consumer want to achieve from WCMH services. The reader should very quickly be able to discern why the consumer contacted WCMH. Again, this is where clinical skills come in.

Emergency type:

Routine = needs to be completed within 14 days of request

Urgent = needs to be completed in 3 hours

Emergent = need to be completed immediately

Inquiry type: Please remember, the screening is what we use as our single point of entry. People come in for a number of reasons. When the screening is completed, choose one:

- Request for Services – the majority will be this
- Request for IA Second Opinion
- Records Entry
- Emergency Contact – EOCs are tracked here
- SE Follow up - We follow up if we are referring someone out of SE. Use this code when doing a follow up.
- Managed Care PAS – this is the preadmission screening
- Managed Care PAS Second Opinion
- OBRA PAS
- OBRA Annual Resident Review – these are completed by a contracted agency and scanned into the ECR by the records department.
- Retro review – mainly outside providers or inpatient retro reviews for payment completed by SE clinicians.

- SUD Court Ordered IA - a number of folks who are coming in for SUD assessment as part of their court sentencing.

Substance Use questions: These are questions that must be answered for SUD consumers. This information must be reported to the state.

Assessment Appointment Timeliness: This is for MMBPIS (Michigan Mission-Based Performance Information System) reporting. At least three appointments within 14 days of the screening for the assessment to be completed must be offered. If the individual needs an appointment after 14 days, this must be documented on the screening form. If the appointment options are not documented WMCMH may be out of compliance with the MMBPIS contact performance measures.

Final Disposition: What is the final clinical impression and recommendation thus far? Do not use abbreviations and remember, this is a clinical document that may be sent to court. Trying to contact the individual is not documented in this section.

Population: What is the primary (can only be one):

- MIA
- MIC
- DDA
- DDC
- SUDA
- SUDC
- Unknown A Not able to bill for this population
- Unknown C Not able to bill for this population
- No condition A Not able to bill for this population
- No condition C Not able to bill for this population
- Prevention

If referred out, notice provided: If the individual is not coming in for an initial assessment, and/or they are referred out, Adequate and Advance notices is given. Document this in this section.

Referral date: Date screening and referral were complete.

Referral source from: Where did the referral come from?

Referral from Level Of Care: Were they already in a LOC? Was the individual in mild to moderate services and is being referred for a case management level of care.

Referral source to: Where and to what services was the individual referred?

Referral to Level of Care: Can this be determined at this point? If an EOC, you may because they are already in a LOC.

INITIAL ASSESSMENT EXPECTATIONS

The Initial Assessment is the starting point for helping an individual along the recovery path by gathering information about their reason for seeking services. The assessment contains important and relevant information for the development of clear goals and objectives for successful treatment. Assessment begins at Service Entry and is continuous throughout treatment. Because the time spent with the Service Entry staff is short, the Service Entry document is to provide a snapshot of the consumer at the time of the request. It is assumed this document will not contain all the information on the consumer. It is expected the document will demonstrate eligibility for community mental health services, what population and level of care the consumer should be in, what initial diagnosis the consumer has, and the completion of functional tools such as CAFAS, LOCUS, or SNAP. It is also the expectation that from this document, the new Care Manager should be able to complete an initial Person Centered Plan with life domains identified by the Service Entry Clinician.

The Service Entry Initial Assessment format is built on the assumptions that:

- 1) The consumer brings important strengths that are critical to their recovery;
- 2) Causes of problems are multidimensional;
- 3) Problems need to be viewed operationally or concretely;
- 4) Problems occur in a social context and are affected by internal and external circumstances that are functionally related and that influence the problem in various ways, and;
- 5) Pieces of the problem and consequences of the problem can be affective, somatic, behavioral, cognitive, contextual, and relational.

The Initial Service Entry Assessment is built in a way that the clinician follows a path of evidence gathering to support or reject a diagnosis and/or functional impairments. The sections included contain clinically relevant material that leads to a decision of where an individual can best receive treatment for his problem. This decision takes into account the person's county of residence, insurance, diagnosis, and functional impairment.

WMCMH's priority population continues to be persons eligible for publically funded behavioral health services who also have a developmental disability, serious mental illness, serious emotional disturbance and/or substance use disorder. Definitions can be found in the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services and the Medicaid Provider Manual.

The first section of the Assessment is the **presenting problem** or complaint section or reason for seeking services. This is a simple statement that answers the question of why the consumer has requested services from WMCMH. The reader should very quickly be able to discern why the consumer came in.

The second section of the assessment is the **clarification of the presenting problem**. This section is where the reader will discover:

- 1) When did the problem or concern begin?
- 2) How often the problem or concern occurs?
- 3) What thoughts, feelings, and behaviors are associated with the problem?
- 4) When the problem occurs?
- 5) Where the problem occurs?

- 6) When and where the problem occurs most?
- 7) When and where the problem occurs least?
- 8) What the precipitating factors are for the problem.
- 9) What makes the problem better?
- 10) What makes the problem worse?
- 11) How much does the problem interfere with the person's life and functioning?
- 12) What caused the person to seek help at this time and/or what influenced the referral source to refer at this time?
- 13) Identify who was in attendance at the service entry assessment besides the individual requesting services.

The **Mental Status** Section is where the reader is introduced to the current mental status of the person being assessed.

- 1) How does he look? Is he disheveled or neatly groomed?
- 2) Does he have any obvious physical signs or symptoms?
- 3) Does he have any perceptual difficulties, hallucinations?
- 4) What are his thoughts, are they permeated with delusion thinking?
- 5) What is his stated mood and does it match with his affect?
- 6) Does he currently struggle with guilt, shame, fear, apathy?
- 7) Is he calm or anxious?
- 8) Does he exhibit forgetfulness, trouble concentrating, poor memory?
- 9) Is his attention span adequate?
- 10) How does he feel about himself?
- 11) How is his judgment?
- 12) What is his current risk level? Is he suicidal or homicidal?
- 13) Were any agency approved screening tools used that helped identify objective signs of symptoms. (The approved screening tools are in the common folder in the U drive, folder labeled, Clinical Processes. If in doubt, use a tool.

Brief Psychiatric History is the section where the reader will discover whether or not the person being assessed:

- 1) Has the individual ever requested services before and if so, what did they come here for and did they view it as helpful?
- 2) Did the person receive any other psychiatric treatment, for what, and was it helpful?
- 3) Was the person ever psychiatrically hospitalized in residential psychiatric care or in a facility placement for persons with a developmental disability, why, what was the result?
- 4) Does this episode match what they have been treated for in the past or is this new?
- 5) Does the universal release to previous service providers need to be obtained?

Education and Job History is where the reader is introduced to some developmental and relational aspects of the individual's education and employment.

- 1) Did the person being assessed have trouble in school? How did he get along with teachers and peers?
- 2) Did he attend any special classes for the learning disabled?
- 3) What was the last grade completed?
- 4) Is he currently employed, on Disability?
- 5) Does he like his current work?
- 6) Has he switched jobs a lot, why?
- 7) Has he been fired or laid off?
- 8) Is there evidence of military service? What?
- 9) Did he attend any center based (ISD) classes?

- 10) What level of cognitive impairment was identified (if any)? If a child, gather specific information about school, where they attend, what grade, special education status, current grades, most and least favorite classes, subject strengths and weaknesses, any behavior problems in school, and involvement in school activities.

The **Current Health and Medical History** section is where the reader will be able to view this person's current medical status.

- 1) Is there any medical problem that could be impacting and appearing as if it is a mental health condition? 1a) If yes, have they sought treatment for this problem?
- 2) Is there any history of head injury, concussion, or serious accident?
- 3) Is the person taking any medications that could impact his current life situation?
- 4) Allergies?
- 5) Are there any physical limitations that could impact the person's ability to receive care?
- 6) What are the person's sleep patterns?
- 7) Appetite, weight?
- 8) Does the person smoke?
- 9) Does the individual have health insurance?
- 10) Also provide a list of all current medication (from all prescribers) and efficacy of medications. Also list historical and current psychiatric medications and efficacy. The service entry clinician cannot accept just the verbal information provided by the individual. The clinician must obtain verification via MAPS, Zenith ICDP, and/or pharmacies regarding all medications that may be prescribed.
- 11) Inquire as to whether the individual is using illegal or street medications. Does the individual have a medical marijuana card?
- 12) Does the person have a physician?

The **Substance Use Assessment** section describes the current and/or historical patterns of use of substances and related information.

- 1) What substances are/were used?
- 2) How frequently and in what amounts?
- 3) What is the consumer's perception of his/her use?
- 4) Have there been previous consequences to use in any/all life areas?
- 5) Have there been previous treatment episodes for substance use?
- 6) Any periods of sobriety?
- 7) Is there a history of withdrawal symptoms or tolerance?
- 8) Information learned from the Substance Use Assessment Screening (ASAM) is helpful here.

The **Family History** section is where the reader will discover whether or not there is family history pertaining to the individual's current problem.

- 1) Is there any evidence of familial mental illness?
- 2) Substance abuse?
- 3) Domestic Violence?
- 4) Neglect?
- 5) Abuse?
- 6) Suicide

The **Social Assessment** describes the current life situation of the individual. The reader will find the answer to the question of what the person's current family structure is:

- 1) What is his current living arrangement?
- 2) Is he married, single, divorced?

- 3) Multiple times?
- 4) Children?
- 5) Who/what are the individual's natural supports?
- 6) Is he religious?
- 7) Are there culturally relevant issues?
- 8) What is his current legal status?
- 9) What are his hobbies/interests? Does he engage in them? If not why?
- 10) Does he engage in his community? Why not?
- 11) Are his basic needs being met? Shelter? Food? Clothing? Transportation? Ask some further in depth questions.
- 12) What does your typical week look like?
 - 12a) How does the consumer spend his time?
 - 12b) Is he connected to his community? How? Who, what?
- 13) For Children, we need information about family structure, involvement of parents (including non-custodial parents), and siblings.
 - 13a) Housing, interests, any barriers the family has about involvement in child activities?
 - 13b) Parent information should include feelings towards the child, any parenting information/classes, what works and what does not.
 - 13c) Whether their parenting style has become coercive over time, and how coercive.
 - 13d) Are there extended family resources or family friends that the family could rely upon for support?

The next section of the assessment is for those consumers who may have a **developmental disability**. This information must be collected for MDHHS reporting purposes. If it does not appear the person has a developmental disability, please skip this section. This is for any population who may have a co-occurring developmental disability, not just those who are in the DDA or DDC population. If the person has a co-occurring diagnosis of MI and DD and are in the MI population, the data must be gathered and reported.

Strengths and Abilities: provide a list of strengths and abilities as identified by the individual, family/caregiver or guardian. From the clinical perspective and as a part of the assessment, the clinician identifies strengths and abilities discovered during the assessment process.

Trauma Assessment: The clinician inquires about any trauma history the individual may have experienced including current and by history. If there is a positive response, the clinician completes the appropriate Trauma history assessment by population. These assessments are located in the U drive, Forms New file, CR#365 and 364 for children, CR#364 for MI adult and CR# 362 and 363 for adults and children with developmental disabilities.

Diagnostic Summary is where the reader will discover what elements of the Assessment were diagnostically relevant. This is not simply a regurgitation of diagnostic criteria, but the individual's unique presentation of diagnostic criteria. For example: a Diagnostic criterion for major depression is the presence of at least one major depressive episode. The reader will not only discover that there is evidence but also what that evidence is such as, "Tom appears to have had one distinct major depressive episode when he returned from Iraq and for the following three week period experienced feeling sad and empty every day, spending much of his time sleeping. He also reported that he didn't eat and had lost 30 pounds during that time period, which is slightly more than 5% of his total body weight. He struggled with feelings of worthlessness and inability to concentrate on anything, which he continues to deal with. There is no evidence of psychosis, mania or substance abuse, which leads me to the diagnosis of

Major Depressive Disorder, single episode, moderate.” The reader will also discover the functional impairment here that would suggest service with CMH. Were any screening tools used that helped identify outcome signs you saw? If in doubt, use a tool. See list of screening/assessment tools approved by the Clinical Oversight Committee.

Diagnosis - If the consumer has a deferred diagnosis, this means there is insufficient information to make a diagnosis or condition at this time. One should not carry this type of diagnosis for long and WMCMH should not discharge someone from care with a deferred diagnosis. The diagnosis must be reviewed to determine if it is still accurate at each Service entry episode. Also consider what others who are treating the consumer feel what the diagnosis should be. If there is significant disagreement, the treatment team needs to come up with a preliminary treating diagnosis. Each time a diagnosis is given, all three components need to be examined. There are drop down pick lists for each of the above tabs. This allows the clinician to quickly find the classification (Diagnostic categories such as depression, schizophrenia, etc.) then determine the Diagnostic code. If there is a qualifier, specify this as well.

There are five sections in the diagnosis tab:

Behavioral Health Diagnosis – DSM 5 Diagnosis rules apply. Please note there is a separate section if you are using DC 0-3 diagnosis codes in this section.

Primarily we are looking at the following:

- Principle Diagnosis here. There can only be one Principle Diagnosis and needs to coincide with the population.
- Provisional diagnosis
- Rule out diagnosis (you suspect this diagnosis but are not sure they meet all the criteria)
- Diagnosis by history (there is a history of the diagnosis however you do not see all the criteria)
- Diagnosis that requires treatment.

Substance Use Diagnosis – Same above, however these categories deal just with SUD.

Medical Diagnosis – Look at what Medical conditions the consumer has. Please note once you choose select a diagnosis in this category, a life domain of Medical/health will go into the cockpit of the PCP.

Other Conditions – These are non-billable codes and will not go into the cockpit. This is important information for treatment and gives the reader a better understanding of what is happening in the person’s life; however, the individual is not eligible for WMCMH with only the other conditions present.

Functional Tools – In the Diagnosis section, record the functional Tools administered. Document the scores when completing the functional tool as well as the date the tool was completed. The choices are:

- CAFAS
- LOCUS
- SNAP
- PECAFAS

The Staging/COD Tab in E-clinical requires several COD related designations. I. Quadrant Model. II. Stage of Change for Each Disorder. III. The SUD Designation for reporting. See below:

I. COD Quadrant Model

SA Treatment System	CMH Treatment System
Quadrant I: Low-Moderate Psych/ Low - Moderate Substance	Quadrant II: High Psych/Low-Moderate Substance
Quadrant III: Low-Moderate Psych/High Substance	Quadrant IV: High Psych/High Substance

- _____ Quadrant I: Low-Moderate Psych/ Low-Moderate Substance
- _____ Quadrant II: High Psych/Low-Moderate Substance
- _____ Quadrant III: Low-Moderate Psych/High Substance
- _____ Quadrant IV: High Psych/High Substance
- _____ Not Applicable

II. Preliminary Stage of Change

	Mental Illness	Substance Use
1. Pre-Contemplation	_____	_____
2. Contemplation	_____	_____
3. Preparation/Determination	_____	_____
4. Action	_____	_____
5. Maintenance	_____	_____
6. Relapse	_____	_____
7. Unable to Determine	_____	_____
8. Not Applicable	_____	_____

SUD Designation

- 1 = No, individual does not have a SUD
- 2 = Not evaluated for SUD (e.g., person is an infant, in crisis situation, etc.).
- 3 = Individual has one or more DSM substance use disorder(s), with at least one disorder either active or in partial remission (use within past year)
- 4 = Individual has one or more DSM substance use disorder(s), and all coded substance use (no use in the past year).
- 5 = Results from a screening or assessment suggest substance use disorder. This includes indications, provisional diagnoses or "rule-out" diagnoses.

Guidelines for Completion are:

- a. It is not required for consumers with a diagnosis of DD because COD and Stage of Change don't often apply. It can be completed when applicable.
- b. All sections are required at each Initial Assessment.
- c. Designations given at the Assessment are automatically carried forward to the Initial PCP Document. Therefore, completion is not required at the Initial PCP, but clinicians are able to "override" if necessary.
- d. At each Periodic Review, the clinician is required to re-stage the individual for each issue that is present, both the SUD and the MI issue. The Quadrant and SUD Reporting Designations do not required re-completion at this time, but can be changed, if necessary.
- e. At the Annual Assessment/Review, the clinician is required to re-designate all 3 sections.

Diagnostic Summary and Narrative: The clinician is to summarize all the diagnostic information into a paragraph that describes the conclusions, symptoms and functional impairments that led to the diagnosis given.

Identified Risk and Safety Concerns is an area of the Assessment that the reader can quickly determine:

- 1) What high risk behaviors the individual is currently engaged in;
- 2) Whether there are safety concerns;
- 3) The summary of the Columbia suicide risk assessment (chronic/acute risk);
- 4) The risk of violence; and
- 5) Homicide/physical assault.

Recommendation/Recovery Plan section. This is where the reader will discover the initial elements of person centered planning.

- i. What are the agreed upon treatment needs?
- ii. Were additional services needed? Where? With whom? What time is the appointment?
- iii. Can the reader tell that the consumer had choices and that accommodations were thought about and addressed?
- iv. How do they want their PCP appointment to occur and who would they like there?
- v. What other options are available to the consumer?

Needs and Preferences: The clinician documents any specific needs and preferences expressed by the individual and/or discovered during the initial assessment interview. Examples include: preference for a male or female therapist/care manager; appointment times, appointment locations, group or individual therapy, trauma history awareness/experiences or any specific treatment preferences.

Eligibility For Services Check List for Medicaid Consumers

To assist in determining eligibility for services, the attached checklists have been developed as a tool. There are 5 tools:

- Children age 0-3 with SED
- Children age 4-6 with SED
- Children age 7-17 with SED
- Adults with a Mental Illness
- Persons with a Developmental Disability
- SUD eligibility guidelines.

Eligibility for Services Check List For Children age 0-3 with SED
Initial Clinical Medicaid Services

NAME:	DOB:	CASE #
DOCUMENT DATE:	PROVIDER:	

Question 1: Diagnosis	Does the infant or toddler have a mental, behavioral, or emotional disturbance sufficient to meet the diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders consistent with the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC 0-3 R)?	Yes:	No:
Question 2: Degree of Disability/Functional Impairment	Does the infant or toddler have interference with, or limitation of proficiency in performing developmentally appropriate skills as demonstrated by at least one indicator drawn from two of the following three functional impairment areas: (check all that are applicable)		
	AREA I: <i>General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems such as:</i> <ul style="list-style-type: none"> <input type="checkbox"/> Uncontrollable crying or screaming <input type="checkbox"/> Sleeping and eating disturbances <input type="checkbox"/> Disturbance (over or under expression) of affect, such as pleasure, displeasure, joy, anger, fear, curiosity, apathy toward environment and caregiver. <input type="checkbox"/> Toddler has difficulty with impulsivity and/or sustaining attention <input type="checkbox"/> Developmentally inappropriate aggressiveness toward others and/or toward self <input type="checkbox"/> Reckless behavior(s) <input type="checkbox"/> Regression as a consequence of a trauma <input type="checkbox"/> Sexualized behaviors inappropriate for developmental age 	Yes:	No:
	AREA II: <i>Behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibit the infant or toddler's daily adaptation and relationships such as:</i> <ul style="list-style-type: none"> <input type="checkbox"/> A restrictive range of exploration and assertiveness <input type="checkbox"/> Severe reaction to changes in routines <input type="checkbox"/> Tendency to be frightened and clinging in new situations <input type="checkbox"/> Lack of interest in interacting with objects, activities in their environment, to relating to others, and infant or toddler appears to have one of the following reactions to sensory stimulation: <ul style="list-style-type: none"> <input type="checkbox"/> Hypersensitivity <input type="checkbox"/> Hypo-sensitive/under responsive <input type="checkbox"/> Sensory stimulating-seeking /impulsive 		

Question 2: Degree of Disability/Functional Impairment (CONTINUED)	<p>AREA III: <i>Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of infant/toddler, parent /caregiver and environmental characteristics such as:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Does not meet developmental milestones (i.e., delayed motor, cognitive, social/emotional speech and language) due to lack of critical nurturing <input type="checkbox"/> Has severe difficulty in relating and communicating <input type="checkbox"/> Disorganized behaviors or play <input type="checkbox"/> Directs attachment behaviors non-selectively <input type="checkbox"/> Resists and avoids the caregiver(s) which may include childcare providers <input type="checkbox"/> Developmentally inappropriate ability to comply with adult requests, disturbed intensity of emotional expressiveness (anger, blandness or is apathetic) in the presence of a parent/caregiver who often interferes with infant's goals and desires, dominates the infant or toddler through over-control, does not reciprocate to the infant or toddler's gestures, and/or whose anger, depression or anxiety results in inconsistent parenting. The parent/caregiver may be unable to provide critical nurturing and/or be unresponsive to the infant or toddler's needs due to diagnosed or undiagnosed perinatal depression, other mental illness, etc. 	<u>Yes:</u>	<u>No:</u>
Question 3: Duration/History	<p>The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endure without intervention, include one or more of the following: (check</p> <ul style="list-style-type: none"> <input type="checkbox"/> The infant or toddler's disorder(s) is affected by persistent multiple barriers to normal development (inconsistent parenting or care giving, chaotic environment, etc.); or <input type="checkbox"/> The infant or toddler has been observed to exhibit the functional impairments for more days that not for a minimum of two weeks (see areas I-III above); or <input type="checkbox"/> An infant or toddler has experienced a traumatic event involving actual or threatened death or serious injury or threat to the physical or psychological integrity of the child, parent or caregiver, such as abuse physical, emotional, sexual abuse, medical trauma and/or domestic violence. 	<u>Yes:</u>	<u>No:</u>

If answered yes to question 1 and 3 *AND* at least 1 item from 2 of the 3 areas in question 2, then eligible for initial clinical Medicaid services

Eligibility for Services Check List For Children age 4-6 with SED
Initial Clinical Medicaid Services

NAME:		DOB:	CASE #		
DOCUMENT DATE:		PROVIDER:			
Question 1: Diagnosis	Does the child have a diagnosable mental, behavioral or emotional disorder sufficient to meet diagnostic criteria specified in the most recent DSM (excluding a primary substance abuse disorder, developmental disorder or "V" codes)?			<u>Yes:</u>	<u>No:</u>
Question 2: Degree of Disability/Functional Impairment	Does the child have interference with, or limitation of proficiency in performing developmentally appropriate tasks, when compared to other children of the same age, across life domain areas and/or consistently within specific domains as demonstrated by at least one indicator drawn from at least three of the following areas: (check all that are applicable)				
	AREA I: <i>Limited capacity for self-regulation, inability to control impulses, or modulate emotions as indicated by:</i> <u>Internalized behaviors:</u> <ul style="list-style-type: none"> • Prolonged listlessness or sadness • Inability to cope with separation from primary caregiver • Shows inappropriate emotions for situation • Anxious or fearful • Cries a lot and cannot be consoled • Frequent nightmares • Makes negative self statements that may indicate suicidal thoughts <u>Externalized behaviors:</u> <ul style="list-style-type: none"> • Frequent tantrums or aggressiveness toward others, self and animals • Inflexibility and low frustration tolerance • Severe reaction to changes in routine • Disorganized behaviors or play • Shows inappropriate emotions for situations • Reckless behavior • Danger to self including self-mutilation • Need for constant supervision • Impulsive or danger seeking • Sexualized behaviors inappropriate for developmental age • Developmentally inappropriate ability to comply with adult requests • Refuses to attend child care and/or school • Deliberately damaged property • Fire starting • Stealing 			<u>Yes:</u>	<u>No:</u>

Question 2: Degree of Disability/ Functional Impairment ^(CONTINUED)	AREA II: <i>Physical symptoms, as indicated by behaviors that are not the result of a medical condition, include:</i> <ul style="list-style-type: none"> • Bed wetting • Sleep disorders • Eating disorders • Encopresis • Somatic complaints 	<u>Yes:</u>	<u>No:</u>
	AREA III: <i>Disturbance of thought, as indicated by the following behaviors:</i> <ul style="list-style-type: none"> • Inability to distinguish between real and pretend • Difficulty with transitioning from self-centered to more reality based thinking • Communication is disordered or bizarre • Repeats thoughts, ideas or actions over and over • Absence of imaginative play or verbalizations commonly used by preschoolers to reduce anxiety or assert order/control on their environment 		
	AREA IV: <i>Difficulty with social relationships as indicated by:</i> <ul style="list-style-type: none"> • Inability to engage in interactive play with peers • Inability to maintain placements in child care or other organized groups • Frequent suspensions from school • Failure to display social values or empathy toward others • Threatens or intimidates others • Inability to engage in reciprocal communications • Directs attachment behaviors non-selectively 		
	AREA V: <i>Care giving factors which reinforce the severity or intractability of the childhood disorder and the need for intervention strategies such as:</i> <ul style="list-style-type: none"> • A chaotic household/constantly changing care giving environments • Parental expectations are inappropriate considering the developmental age of the young child • Inconsistent parenting • Subjection to others' violent or otherwise harmful behavior • Over protection of the young child • Parent/caregiver is insensitive, angry and/or resentful to the young child • Impairment in parental judgment or functioning (mental illness, domestic violence, substance abuse, etc.) • Failure to provide emotional support to a young child who has been abused or traumatized 		
Question 3: Duration/History	<p>The young age and rapid transition of young children through developmental stages makes consistent symptomatology over a long period of time unlikely. However, indicators that a disorder is not transitory and will endure without intervention, could include one or more of the following:</p> <ol style="list-style-type: none"> 1) Evidence of three continuous months of illness; or 2) Three (3) months of symptomatology/dysfunction in a six (6)-month period: or 3) Conditions that are persistent in their expression and are not likely to change without intervention; or 4) A young child has experienced a traumatic event involving actual or threatened death or serious injury or threat to the physical or psychological integrity of the child, parent or caregiver, such as abuse (physical, emotional, sexual), medical trauma and/or domestic violence. 	<u>Yes:</u>	<u>No:</u>

If answered yes to question 1 and 3 **AND** must meet 1 indicator in at least 3 of 5 areas in question 2 then eligible for initial clinical Medicaid services

Eligibility for Services Check List For Children age 7-17 with SED
Initial Clinical Medicaid Services

NAME:	DOB:	CASE #
DOCUMENT DATE:	PROVIDER:	

Question 1: Diagnosis	Does the youth have a diagnosable mental, behavioral or emotional disorder sufficient to meet diagnostic criteria specified in the most current DSM (excluding a primary substance abuse disorder, developmental disorder or “V” codes)?	<u>Yes:</u>	<u>No:</u>
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Question 2: Degree of Disability/Functional Impairment	Diagnosis substantially interferes with or limits the youth’s ability to function as evidenced by at least one of the following 8 categories. (if substance abuse then youth must also meet at least one additional category) Rate the Degree of disability/functional impairment using the following scale: 0 = No Impairment, 1 = Mild Impairment, 2 = Moderate Impairment, 3 = Severe Impairment		
	<ul style="list-style-type: none"> • School/Work (absent greater than 10% of the time, failing at least half of classes or grade avg lower than C, repeated consistent disruption of class, well known to school officials, school believes an IEP is needed or in place, in a special program due to behavior problems, school has referred for mental health evaluation due to inability to manage.) 	<u>Rating</u>	0 1 2 3
	<ul style="list-style-type: none"> • Home (persistent lack of compliance with rules and expectations, deliberate damage to home or belongings, repeated irresponsible behavior that is potentially dangerous, running away overnight, persistent use of profanity toward household members when this is not typical in the home and there is no indication of abuse.) 	<u>Rating</u>	0 1 2 3
	<ul style="list-style-type: none"> • Community (stealing without confronting a victim, shoplifting, vandalism, defacing property, taking car for joyride without permission, on probation or court supervision, repeated intentional fire setting, inappropriate sexual behavior.) 	<u>Rating</u>	0 1 2 3
	<ul style="list-style-type: none"> • Behavior toward others (frequently sexually inappropriate, frequently mean to animals or other people, frequently exploits or cons others, bullying or intimidating others, spiteful, vindictive, belligerent, behavior that could people at risk.) 	<u>Rating</u>	0 1 2 3
	<ul style="list-style-type: none"> • Mood/Emotions <ul style="list-style-type: none"> ○ Persistent sad or depressed mood –with trouble concentrating OR trouble sleeping OR trouble eating OR significant decrease in energy level OR inability to enjoy normal activities, OR irritability AND at least two of the above symptoms. ○ Persistent and excessive worry – at least half of the time with sleep problems OR tiredness OR poor concentration OR irritability OR muscle tension OR feeling “on edge” (not hyperactive). 	<u>Rating</u>	0 1 2 3
	<ul style="list-style-type: none"> • Self-Harmful Behavior <ul style="list-style-type: none"> ○ Engaging in at least non-threatening cutting, burning or other self-mutilative behavior. ○ Repeated talk or thoughts of wanting to die or to harm themselves 	<u>Rating</u>	0 1 2 3

	<ul style="list-style-type: none"> • Substance Use (cannot be only criteria) that is associated with the youth getting into trouble with others, having negative effects on responsibilities or obligations, endangering the youth or others, recent change in friendships to mostly substance users or gets high or intoxicated at least once per week. 	<u>Rating</u> 0 1 2 3			
	<ul style="list-style-type: none"> • Thinking (disorganized communication, hallucinations, frequent suspicions or obsessions, recurrent preoccupying thoughts that are disturbing) 	<u>Rating</u> 0 1 2 3			
Question 3: Duration/History	Evidence that the disorder exists or has existed during the past for a period of time to meet diagnostic criteria specified in the DSM.	<u>Yes:</u>	<u>No:</u>		

If answered yes to question 1 and 3 and a cumulative score of 3 or more in question number 2 (if substance abuse then must have at least one additional area), then eligible for initial clinical Medicaid services.

Eligibility Recommendations To Be Considered Regarding Adults ages 18-21 with SED
Initial Clinical Medicaid Services

NAME:	DOB:	CASE #
DOCUMENT DATE:	PROVIDER:	

Question 1: Meet SED Criteria <i>(Diagnosis, Degree of Disability/Functional Impairment, & Duration/History)</i>	<p>A. Does the young adult have a diagnosable mental, behavioral or emotional disorder sufficient to meet diagnostic criteria specified in the most current DSM (excluding a primary substance abuse disorder, developmental disorder or “V” codes)?</p> <p>B. The diagnosis substantially interferes with or limits the young adult’s ability to function in the following categories: School/Work Home Community Behavior Toward Others Moods/Emotions Self-harmful Behavior Substance Use Thinking <i>(qualifying CAFAS score is total of 50 or two 20s or one 30 (except for substance use only))</i></p> <p>C. Evidence that the disorder exists or has existed during the past for a period of time to meet diagnostic criteria specified in the DSM.</p>	<u>Yes:</u>	<u>No:</u>
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Question 2: Other Functional Considerations	<p>Is the young adult:</p> <ul style="list-style-type: none"> Still involved in other child serving systems (foster care, juvenile justice, special education, alternative education and/or vocation rehabilitation services) Not able to live independently or requires special accommodations to live independently In need of intensive family support to maintain their level of functioning In need of intensive community support and services to maintain their level of functioning 	<u>Yes:</u>	<u>No:</u>
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Question 3: Additional Considerations	<ul style="list-style-type: none"> • Service utilization history: are there current or previous episodes of care in children's SED services? • Which services best meet the young adult's needs based on an individualized plan of service • Will the young adult require long-term behavioral health services • The young adult's employment status • Is the young adult a parent – what best meets their service needs (for themselves and their infant/toddler) • Is another adult legally appointed to make decisions for the young adult • What are the young adult's preferences, expectations, and/or needs 	<u>Yes:</u>	<u>No:</u>
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Eligibility for Services Check List For Adults with a Mental Illness
Initial Clinical Medicaid Services

CONSUMER NAME:		DOB:	CASE #	
DOCUMENT DATE:		PROVIDER:		
Question 1: Diagnosis	Is the individual displaying signs and symptoms of a psychiatric disorder and does the individual have a psychiatric diagnosis as identified in the most current DSM?	<u>Yes:</u>	<u>No:</u>	
Question 2: Degree of Disability/Functional Impairment	Rate the Degree of disability/functional impairment using the following scale: 1 = No limitations – (Daily Functioning not Impeded) 2 = Mild limitations – (Most Useful Functioning Retained) 3 = Moderate limitations/dysfunction – (Some Useful Function Retained) 4 = Marked limitations/dysfunction – (Significantly Impeded Useful Function) 5 = Extreme limitations/dysfunction – (Precludes Useful Functioning)			
	Risk of Harm This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner. For the purposes of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as; past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past.	<u>Rating</u> 1 2 3 4 5		
	Functional Status This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care. This ability should be compared against an ideal level of functioning given an individual's limitations, or may be compared to a baseline functional level as determined for an adequate period of time prior to onset of this episode of illness. Persons with ongoing, longstanding deficits who do not experience any acute changes in their status are the only exception to this rule and are given a rating of three. If such deficits are severe enough that they place the client at risk of harm, they will be considered when rating Dimension I in accord with the criteria elaborated there. For the purpose of this document, sources of impairment should be limited to those directly related to psychiatric and/or addiction problems that the individual may be experiencing. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining the placement of a given individual in the behavioral treatment continuum.	<u>Rating</u> 1 2 3 4 5		

	Medical, Addictive, and Psychiatric Co-Morbidity This dimension measures potential complications in the course of illness related to co-existing medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent (here referred to as the presenting disorder). Co-existing disorders may prolong the course of illness in some cases, or may necessitate availability of more intensive or more closely monitored services in other cases. Unless otherwise indicated, historical existence of potentially interacting disorders should not be considered in this parameter unless current circumstances would make reactivation of those disorders likely. For patients who present with substance use disorders, physiologic withdrawal states should be considered to be medical co-morbidity for scoring purposes.	<u>Rating</u> 1 2 3 4 5	
	Recovery Environment This dimension considers factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a person's efforts to achieve or maintain mental health and/or abstinence. Stressful circumstances may originate from multiple sources and include interpersonal conflict or torment, life transitions, losses, worries relating to health and safety, and ability to maintain role responsibilities. Supportive elements in the environment are resources which enable persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members. The availability of friends, employers or teachers, clergy and professionals, and other community members that provide caring attention and emotional comfort, are also sources of support. For persons being treated in locked or otherwise protected residential settings, ratings should be based on the conditions that would be encountered upon transitioning to a new or returning to the usual environment, whichever is most appropriate to the circumstances.	<u>Level of Stress Rating</u> 1 2 3 4 5 <u>Level of Support Rating</u> 1 2 3 4 5	
	Treatment and Recovery History This dimension of the assessment recognizes that a person's past experience provides some indication of how that person is likely to respond to similar circumstances in the future. While it is not possible to codify or predict how an individual person may respond to any given situation, this scale uses past trends in responsiveness to treatment exposure and past experience in managing recovery as its primary indicators. Although the recovery process is a complex concept, for the purposes of rating in this parameter, recovery is defined as a period of stability with good control of symptoms. While it is important to recognize that some persons will respond well to some treatment situations and poorly to others, and that this may in some cases be unrelated to level of intensity, but rather to the characteristics and attractiveness of the treatment provided, the usefulness of past experience as one predictor of future response to treatment must be taken into account in determining service needs. Most recent experiences in treatment and recovery should take precedence over more remote experiences in determining the proper rating.	<u>Rating</u> 1 2 3 4 5	
	Engagement and Recovery Status This dimension of the assessment considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process. Factors such as acceptance of illness, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in defining the measures for this dimension. These factors will likewise impact a person's ability to be successful at a given level of care.	<u>Rating</u> 1 2 3 4 5	
Question 3: Duration/History	Has there been a period of at least 12 months of disability, per same four areas in Question #2 (if the course was variable, rating should characterize the severity during at least 6 of 12 months)? AND Has the person been receiving at least one mental health service (or taken psychotropic medications) since then? or Has the person been disabled during the past 12 months, per same four areas?	Yes:	No:

If answered yes to question 1 and 3 and the total of number 2 equals at least 19, then eligible for Medicaid services. If there is a clinical reason to place someone at a more intensive level than the number indicates, please thoroughly document in the screening/assessment.

Eligibility for Services Check List For Medicaid Consumers

For Persons with a Developmental Disability

	If applied to an individual older than five years, a severe, chronic condition that meets all of the following requirements:	Yes:		No:	
Question 1:	<p>A. Is attributed to mental or physical impairment or a combination of mental and physical impairments.</p> <p>Exception: Cognitive specifier is not applied to persons with autism. If diagnosed with autism still need to meet the functional criteria in question 4 below to be in the DD population</p>	Yes:		No:	
Question 2:	B. Is manifested before the individual is 22 years old.	Yes:		No:	
Question 3:	C. Is likely to continue indefinitely.	Yes:		No:	
Question 4:	<p>D. Results in substantial functional limitation in three or more of the following areas of major life activities. "Substantial Limitation" is defined by ADA as <u>unable to perform or is significantly restricted</u>. (does not mean there is no motivation to complete tasks, it means cannot do)</p> <ul style="list-style-type: none"> a. Self care b. Receptive and expressive language c. Learning d. Mobility e. Self-Direction f. Capacity for independent living g. Economic self-sufficiency 	Yes:		No:	
	E. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.	Yes:		No:	
Question 5:	If applied to minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in item (A) if services are not provided.	Yes:		No:	

If answered yes to question 1, 2, 3 and 4, or: yes to question 5 then eligible for Medicaid services

**West Michigan Community Mental Health
MI Adult Level of Care Guidelines**

August 2016

Inpatient Psychiatric or Crisis Residential (Medically Managed Residential)	Specialized Residential/ Emergency Respite (Medically Monitored Residential)	ACT (Medically Monitored non-residential services)	CSM (High Intensity Community Based Services)	Mild/Moderate (Low Intensity Community Based Services)	No Treatment Services (Recovery Maintenance and Health Management)
LOCUS Score 28 + High Acuity Level of Care	LOCUS Score 23 to 27 Level 4 or 5	LOCUS Score 20 to 22 Level 5	LOCUS Score 17 to 19 Level 3 and 4	LOCUS Score 14 to 16 Level 1 and 2	LOCUS Score 10-13 No level of care assigned
Services Inpatient or Secure Facility	Services Provision of services in a non-hospital freestanding residential facility in the community. Access to clinical Care at all times Reasonable protection of personal safety and property. Free of seclusion and restraint Provision of skill learning opportunities. Supervision of Personal Care and ADLs	Services Provided to people capable of residing in the community either in supportive (AFC) or in independent settings, but whose treatment needs required intensive management by a multidisciplinary team. Services are available to people throughout the day. Psychiatric services are available on a daily basis as necessary Nursing services are available at least 40 hours a week.	Services People need intensive support and treatment but are living independently or with minimal support in the community. Services needs do not require daily or weekly contact.	Services Treatment is provided to people needing ongoing treatment but who are living independently or with minimal support in the community. Supervision or frequent contact is not needed.	Services May provide up to two hours of service per month, but no less than one hour every three months.

	Facilitates treatment aimed at facilitating a return to community functioning in a less restrictive setting.	Medications are carefully monitored Rehabilitation services are an integral part of the treatment program Access to crisis services provided by the team on 24/7 basis.			
LOCUS Criteria Provide Secure Care Involuntary Care 24 hour clinical services 5 on risk of harm is automatic qualification. 5 on Functional Status is automatic qualification 5 on Medical and psychiatric Comorbidity is automatic qualification	LOCUS Criteria 4 on Risk of Harm is automatic qualification 4 on Function Status is automatic qualification 4 on Medical and Psychiatric Comorbidity is automatic qualification with exception of people who score 1 on Level of Stress domain and 1 on Level of Support domain	LOCUS Criteria 3 or Less on Risk of Harm. A score of higher than 3 should not be managed in this level. 3 on Functional Status is most appropriate at this level except a 4 may be managed by the ACT program if the person has a 1 on the Level of Stress domain and being in ACT automatically is a 2 on Level of Support domain. 3 on Comorbidity is most appropriate for this level of care with the exception that a 4 is appropriate if the person is rated as a 2 on Level Stress Domain and being served by ACT automatically is scored as a 2 on Level of Support domain.	LOCUS Criteria 3 or less on Risk of Harm. 3 or less on Functional Status 3 or less on comorbidity 3 or less on each scale in Recovery Environment and a combined score of no more than 5 in Level of Stress and Level of Support Domain. A rating of 2 or 3 on Treatment and Recovery History A 3 or less on Engagement and Recovery A score of 4 or more on any domain excludes the person from placement at this level of care.	LOCUS Criteria No CSM services are needed. 2 or less on Risk of Harm. A score of 3 on Risk of Harm may be appropriate depending on the overall composite score. 3 or less on Functional Status 3 or less on each scale under Recovery Environment, and a combined score of no more than 5 on Level of Stress and Level of Support Domain 2 or less on Treatment and Recovery History.	LOCUS Criteria A score of 2 or less on Risk of Harm A score of 2 or less on Functional Status A score of 2 or less on comorbidity. A combined score of no more than 3 on Recovery Environment, Level of Stress and Level of Support. A score of 2 or less on Treatment and Recovery History. A score of 2 or less on Engagement and Recovery History. A composite score of more than 10 but less than 14.

MI Child Level of Care Guidelines

Inpatient Psychiatric or Crisis Residential	Homebased/Infant Mental Health Wraparound & SED Waiver	Case Management	Case Management	Mild to Moderate	Community Resources with No Treatment
CAFAS Score High Acuity	CAFAS Score 80* to 240 Level 5	CAFAS Score 70-140 Level 4	CAFAS Score 50+ Level 3	CAFAS Score, less than 50 Level 1 or 2	CAFAS Score No Level of Care Assigned
Services Inpatient hospitalization or secure facility	Services History of non- compliance to care History of multiple hospitalizations Multiple service needs High need for structure, support and monitoring Clear compromise of ability to care adequately for oneself, to be adequately aware of his/her environment, or lack of ability of the care-taking environment to meet and manage the needs of the child/youth. Significant difficulties with interpersonal interactions Not able to perform academic tasks or occupational responsibilities Current SI/HI with expressed intentions and/or history of carrying out threats	Services History of non- compliance and/or multiple hospitalizations. Parents unable to access services on their own. Requires regular monitoring to reduce decompensation. Some evidence of self- neglect and/or decrease ability to care for oneself. Significant disturbance in physical functioning (sleep, eating, activity level, etc.), unable to fulfill education responsibilities. Significant risk of SI/HI History of chronic, impulsive high risk, suicidal/homicidal behavior or threats but current expressions do not represent significant	Services Supportive resources are limited and not capable of providing support in times of need. At least one prior hospitalization. Moderate disturbance in physical functioning (sleep, activity level, eating, etc.) Moderate struggles fulfilling educational responsibilities History of moderate thoughts of SI/HI and /or previous passive suicidal/homicidal behavior.	Services Supportive resources are not abundant, but are capable and willing to provide support in times of need. Developing minor yet consistent difficulties in social role functioning but able to maintain academic status, etc. May have transient or passive thoughts of SI/HI.	Services Refer to community resources, such as Pastor, youth group, volunteer opportunities, school guidance counselor.

	<p>WRAP/SED Referral to and approval by community team required. Must staff with MIC team leader and/or supervisor regarding possible Wraparound services.</p>	change from usual behavior.			
<p>CAFAS Criteria</p> <ul style="list-style-type: none"> 	<p>CAFAS Criteria Ages 7-17</p> <ul style="list-style-type: none"> Score of 20 or greater on at least 2 elements of the CAFAS <u>or</u> Score of 20 or greater on one element of CAFAS combined with a 20 or greater score involving Caregiver/Caregiving resources <u>or</u> A score of 80 or more on the CAFAS. <p>PECFAS (ages 4-6 years) Specific scores have not been identified for use as part of the determination of functional impairment at this time</p>	<p>CAFAS Criteria</p> <ul style="list-style-type: none"> Score of 70 (using the 8 subscales scores on the CAFAS), <u>or</u> Two 20s on any of the first 8 subscales <u>or</u> One 30 on any subscale of the CAFAS, except for substance use only. <p>PECFAS Specific scores have not been identified for use as part of the determination of functional impairment at this time.</p>	<p>CAFAS Criteria</p> <ul style="list-style-type: none"> Score of 50 (using the 8 subscale scores on the CAFAS), <u>or</u> Two 20s on any of the first 8 subscales <u>or</u> One 30 on any subscale of the CAFAS, except for substance abuse. <p>PECFAS Specific scores have not been identified for use as part of the determination of functional impairment at this time.</p>	<p>CAFAS Criteria</p> <ul style="list-style-type: none"> Score of less than 50 (using the 8 subscales <p>PECFAS Specific scores have not been identified for use as part of the determination of functional impairment at this time.</p>	CAFAS Criteria

Persons with Developmental Disabilities Level of Care Guidelines

Inpatient Psychiatric or Crisis Residential	Level 5	Level 4	Level 3	Level 2	Level 1
High Acuity with Axis 1 diagnosis	NC SNAP Score 5	NC SNAP Score 4	NC SNAP Score 3	NC SNAP Score 2	NC SNAP Score 1 (community referral, on rare occasion would open for short term assistance)
Services Inpatient psychiatric hospitalization or secure facility.	Services Private Duty Nursing- 24 hours per day. Needs total assistance with personal care. Coordination and linking are required due to multiple health and behavioral needs. Requires 1:1 staffing or greater 24 hours per day due to behavior challenges. Skill building and/or CLS supports may be present. Dietary, OT, PT, SLP may be needed. Specialized equipment and technology needs.	Services Specialized residential with 24-hour awake staff. Skill building and CLS supports needed. Coordination and linking are required for community participation and access to needed services. Behavioral concerns can be self-harming, unsafe and disruptive requiring intervention by a licensed mental health professional. Needs hands on assistance for personal care but may be able to assist with some tasks. Needs total help with complex tasks such as health care and money management.	Services Specialized residential needs for CLS or personal care may be present, but does not need 24-hour awake staff. Skill building and CLS supports needed. Coordination and linking are required for community participation and access to needed services. Behavioral challenges are mildly disruptive and non-self harming, may require guidelines rather than formal behavior plan. Requires mostly verbal prompts and gestures for personal care, with occasional hands on assistance. Needs total help with complex tasks such	Services General AFC, living at home with parents or family. May be in independent living or Supported Living with supports for CLS. Skill building and CLS supports needed, which may lead to supported employment. Coordination and linking are required for community participation and access to service needs. Behavior challenges require redirection and brief interventions. May be independent in some personal care but needs verbal prompts and gestures for some skills. Needs some	Services Lives independently or with family, friends or relatives. May needed assistance with obtaining supported or independent employment. May needs some training for independent living skills related to cooking, cleaning, laundry, etc. Time limited coordination and linking for community participate and access to service needs. No behavioral challenges or need for mental health interventions. Mostly independent in all areas of self-care. May need some assistance with

		Dietary, OT, PT, SLP may be needed.	as health care and money management. Dietary, OT, PT, SLP may be needed.	assistance with complex task such as decision making and money management.	complex decision making and money management.
SNAP Criteria	<p>SNAP Criteria Extreme need for 24-hour continuous, non-stop monitoring by awake person specifically trained to meet the individual's particular needs. All tasks must be done for the individual with no participation from the individual whatsoever in any task.</p> <p>Extreme need for a chronic medical condition that requires immediate availability of a physician and frequent monitoring.</p> <p>Extreme need for behavior treatment by a specialized team with advanced experience with extreme behavior problems.</p> <p>Intervention procedures require continuous 24-hour, 1:1 or greater staffing.</p>	<p>SNAP Criteria 24-hour awake staffing required for supervision. Individual can assist in some person care tasks, but requires hands on to complete assistance to accomplish all tasks associated with self-help, daily living, decision making, and complex skills.</p> <p>More than quarterly physician visits for consultation or treatment of chronic health care needs.</p> <p>Licensed or certified mental health professional with expertise in the treatment of extreme behavior challenges needed to develop and provide direct oversight of a comprehensive intervention plan based on analysis and frequent assessment.</p>	<p>SNAP Criteria Requires 24 hour supervision, with sleep staff. Hands on assistance needed to accomplish most self-help and daily living skills, and typically, will require complete assistance for some basic skills and all complex skills.</p> <p>Requires weekly nursing interventions for chronic medical condition.</p> <p>Licensed or certified mental health professional may be needed to develop and monitor a formal behavior intervention program.</p>	<p>SNAP Criteria 9-16 hours of supervision during day-time, can be left unattended at night. May be independent in some skills, but verbal prompts or gestures are needed to accomplish many self-help and daily living skills, and may require hands-on or complete assistance for some basic skills and all complex skills.</p> <p>Up to quarterly consultation or treatment with a physician for chronic health care needs.</p> <p>Consultation to develop/monitor individual behavior guidelines or reinforcement procedures and/or ongoing counseling with a mental health professional.</p>	<p>SNAP Criteria Requires less than 8 hours per day of supervision. No assistance needed for most self-help and daily living skills (independent), however, some verbal prompts or gestures may be needed for some skills and complete assistance may be needed for complex skills such as financial and health planning. None or periodic behavioral interventions are needed.</p>

Adults and Children Substance Use Level of Care Guidelines

Substance Use grid Adults and Children									
	<u>Level VI</u>	<u>LEVEL III</u> Residential				<u>LEVEL II</u>	<u>Level I</u> Includes individual therapy, Care Management, methadone OP treatment		<u>LEVEL 0.5</u> Prevention
Levels of Care	Level VI Sub –Acute Detox	Level III. 7D	Level III.5	Level III.3	Level III.1	<u>LEVEL II</u> Intensive Outpatient	<u>LEVEL I</u> MATP	<u>LEVEL I</u> Outpatient	<u>LEVEL 0.5</u> Early Intervention
Criteria Dimensions	Withdrawal screening scores are severe (CIWA COWS,).	Meets DSM-IV criteria for substance abuse or dependence. Dimension 1 of minimal or no risk of withdrawal or detox has already been completed for this episode of care. Dimensions 2 and/or 3 do not indicate the need for medically monitored services. Meets criteria for level of residential treatment on any of Dimensions 4, 5 or 6.				Meets DSM-IV criteria for substance abuse or dependence. Meets specifications in Dimension 2 and in Dimension 3 as well as in at least one of dimensions 4, 5 or 6. Dimensions 4 - 6 do not indicate need for a more intensive level of treatment with 24-hour supervised care	Meets DSM-IV criteria for substance abuse or dependence. Meets criteria for OMT on all 6 dimensions. Must also meet the MDCH and Federal requirements for admission or readmission into OMT/MATP and be approved by program physician. MATP Cannot be used for Pain management	Meets DSM-IV criteria for substance abuse or dependence. Dim.1, 2 &3 minimal to stable. At least one of Dim. 4, 5 or 6 meets ASAM Level I criteria and none meet criteria for Levels II - IV.	
		Level III. 7D	Level III.5	Level III.3	Level III.1				

Substance Use grid Adults and Children

	<u>Level VI</u>	<u>LEVEL III</u> Residential				<u>LEVEL II</u>	<u>Level I</u> Includes individual therapy, Care Management, methadone OP treatment	<u>LEVEL 0.5</u> Prevention
1. WITHDRAWAL	The client is experiencing signs and symptoms of severe withdraw or there is evidence based on history of substance intake, age, gender, previous withdrawal, physical conditions, and/or emotional/behavioral/cognitive condition.	Significant withdrawal at based on the previous history, amount and frequency	Minimum risk of severe withdrawal is present	Not at risk of severe withdrawal, or moderate withdrawal is manageable	No withdrawal risk or minimal withdrawal	Minimal to moderate withdrawal risk	Physiologically dependent on opiates and requires OMT to prevent withdrawal None to minimal risk	No significant risk
2. BIOMEDICAL		Stable or current physical illness that could be exacerbated by withdrawal		None or stable or receiving concurrent medical monitoring		Mildly distracting from treatment but manageable in IOP	None or manageable with outpatient medical monitoring None or very stable	None or very stable
3. EMOTIONAL/ BEHAVIORAL/ COGNITIVE	The individual has a SPMI or cognitive disorder that would complicate treatment and thus required 24 hour monitoring.	Co-morbid emotional behavior or cognitive condition, if any, is manageable in this setting but increases the clinical severity of the	Demonstrated repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require 24 hour setting to reach coping	Mild to Moderate severity needs structure to focus on recovery. If stable a dual dx setting is appropriate. If not stable then dual dx enhanced program is require. Treatment should be	None or minimal; not distracting to recovery. If stable then dual dx capable program is appropriate. If not then dual dx enhanced program require.	Mild to moderate severity with potential to distract from recovery	None or manageable in an outpatient structured environment None to mild severity, but very stable	None or very stable

Substance Use grid Adults and Children

	<u>Level VI</u>	<u>LEVEL III</u> Residential				<u>LEVEL II</u>	<u>Level I</u> Includes individual therapy, Care Management, methadone OP treatment		<u>LEVEL 0.5</u> Prevention
		withdra wal.	skills. A dual diagnosis enhanced setting is require for SPMI consumer	designed to respond to patient's cognitive deficits					
4. READINESS TO CHANGE			Resistanc e high & impulse control poor despite negative consequ ences Needs motivatin g strategies in a 24- hour structure d setting	Has little awarenes s and needs interventi ons available to engage in treatmen t	Open to recovery but needs a structure d environm ent to maintain therapeut ic gains	Poor engagement in treatment, significant ambivalence, or lack of awareness of problems, requiring intensive structured program	Ready to change the negative effects of opiate use, but not ready for total abstinence	Ready but needs additional motivating/monitoring strategies; or high severity in this dimension but not in other dimensions	Willing to explore how current alcohol/drug use may affect personal goals
5. RELAPSE/ CONTINUED USE/ CONT. PROBLEM			Unable to control use, with imminent ly dangerou s consequ ences needing 24-hr monitorin g and	Has little awarenes s and needs interventi on to prevent continued use, with imminent dangerou s consequ ences because	Understa nds relapse but needs structure to maintain therapeut ic gains	High likelihood of relapse or continued use or continued problems without near- daily monitoring and support	At high risk of relapse/ continued use without OMT and structured therapy to promote treatment progress	Able to maintain abstinence or control use and pursue recovery or motivational goals with minimal support	Needs understanding of, or skills to change, current alcohol/drug use patterns

Substance Use grid Adults and Children

	<u>Level VI</u>	<u>LEVEL III</u> Residential				<u>LEVEL II</u>	<u>Level I</u> Includes individual therapy, Care Management, methadone OP treatment		<u>LEVEL 0.5</u> Prevention
			structure d support	of cognitive deficits or comparab le dysfuncti on.					
6. RECOVERY/LIVING ENVIRONMENT	The individual has minimal or no supports to assist in non-residential detoxification	Minimal or lacking supportive environment	Environm ent is dangerou s and lacks skill to cope outside of structure d 24-hr setting	Environm ent is dangerou s and client needs 24 hour structure to cope	Environm ent is dangerou s but recovery is achievabl e if 24 hour structure is available	Unsupportive recovery environment, but with structure and support, the patient can cope	Has supportive recovery environment and/or skills to cope	Supportive recovery environment and/or patient has skills to cope	Social support system abuses or condones alcohol/ drugs and increases risk of personal conflict about alcohol/drug use
		detox	6 months to a year LOS	30,60 or 90 day LOS	Short term residenti al 7-10 day LOS				

Services include the following:

- Recovery principles are used.
- Evidenced/researched based interventions will be utilized including motivational interviewing techniques.
- Provide co-occurring capable services in a welcoming environment
- Provide services and/or interventions that are stage matched with ongoing evaluation to meet changing needs and abilities, including referrals to alternative services as needed.
- Person/family centered planning/individualized treatment planning is required.
- Treatment needs will be coordinated with the primary health care provider and other community resources when clinically appropriate. Coordination with primary health care provider will include documentation of diagnosis and medications if applicable. Coordination will occur ongoing as needed.
- If the child is in foster care, the provider must coordinate with the foster care agency a minimum of once monthly
- If using an evidenced based practice, must comply with those guidelines.
- Services must meet all applicable regulations and requirements set forth in the Mental Health/Substance Abuse chapter of the Michigan Medicaid provider Manual.
- Professional staff must possess certification or license appropriate to the service they provide.
- Ensure language interpreter, translation services, and hearing interpreter services are provided as needed.
- Gentle teaching principles will be utilized.
- Family focused care will be utilized for children and adolescents.
- Trauma Informed Care will be utilized.

Orientation to Services Process Documentation

Orientation to services is important so the consumer knows what to expect from the mental health system. There are three levels of orientation. This is repeated each time the consumer is assigned to a new level of care and at least annually.

A. Level One – Complete an overall orientation to CMH. This would be similar to the orientation you get at the hospital. The following is completed by a support staff and/or the Service Entry Clinician:

- Consent and Ability to Pay for Services
- Ability to Pay Worksheet
- Review of the Consumer Guide to Services Handbook
- Review the Rights Handbook
- Review Grievance and Appeal process
- Complete the Health & Safety Form
- Universal Release MDHHS Form: If the consumer refused to sign the release of information, please inform the care manager/clinician so they can engage with the consumer in attempt to obtain the release of information. It is the responsibility of the service entry clinician to request records from previous providers of service (schools, psychiatric hospital, previous mental health providers, primary care physician, etc.)
- Person Centered Planning Description and review of the Recovery philosophy
- Advanced Directive Overview: if the consumer refuses to participate in an Advance Directive, the service entry clinician will inform the care manager/clinician. The care manager will engage the consumer in further discussion regarding the Advance Directive
- HIPAA and Confidentiality Acknowledgement

B. Level Two – If the consumer is eligible for WMCMH services, then Level Two orientation is completed by the Service Entry Clinician. The following will be completed at this point:

- Treatment Program Description
 - Brief description of the program to which the consumer is referred
 - Identify the clinician responsible for coordination and service delivery, including the person's qualifications
 - What the consumer can expect when they meet with the program clinician
- Preliminary Plan of Service
 - Person Centered Planning Description
 - Provide a brief description of PCP , hours of operation and emergency numbers
 - PCP Preplanning occurs
 - Support Plan begins at this point. If the consume refuses to complete a safety/support plan, the service entry clinician is responsible for notifying the care manager/clinician. The care manager/clinician is responsible to engage the consumer to consider a safety/support plan.

Items that need to be available for the Service Entry clinician to use as needed:

- Adequate Notice / Denial of Services
- Columbia Suicide Risk Assessment
- Pre-Admission Screening
- Consent for Emergency Off-Site Evaluation

C. Level Three – The consumer is referred to the program where Level Three orientation is completed. At this point the following will be completed:

- Orientation Meeting – First contact with the program clinician.
 - Rights, Grievance and Appeal, and informal conflict resolution process questions are answered.
 - Introduction to the program, its purpose and capacity, including an explanation of the recovery model, hours of operation, agency evidenced based interventions or preferred practice, etc.
 - What the consumer can expect from the clinician, i.e., core functions of the clinician. For example, if this is a CSM consumer, provide a description of the monitoring, linking and coordination functions of the program.
 - Expectation the program has of the consumer. This includes active participation by completing homework, keeping appointments, participating in groups and following through on interventions identified in the plan of service.
 - Referral Process and form
 - Accessing after hours services.
 - Support Plan continues here
 - PCP Preplanning Documents
 - Explain the purpose of the next meeting that may be the treatment plan meeting.
 - Complete the PCP preplanning document with the consumer (annual).
- Annual Orientation
 - The consumer will be reoriented to the service annually or when referred to another department. At this point they will go through all the levels of orientation and complete an assessment.
 - The care manager will schedule and complete a preplanning meeting.
- If a consumer is moving from one level of care to another before their annual PCP, then Level 2 and 3 will be completed by the receiving care manager and an assessment will be completed.

Directions for Completing the Preliminary Plan

The Preliminary Plan is used at three different points in care: Initial Preliminary Plan, Annual Preliminary Plan, and Discharge from Inpatient Preliminary Plan.

Initial Preliminary Plan:

Consumer demographics – Tells us whose prelim plan it is and what date it was completed Choose if this is a Preplan from Service Entry or if the Annual Preplan. If Preplan is from Service Entry, the SE clinician chooses life domains that were assessed to be part of the PCP. SE Clinician then indicates why these were chosen.

Also for Service Entry, if the consumer is to remain with the Service Entry program for any reason, the reason for this is listed in the preplan and indicates what they would be meeting for:

What will be addressed.

Who attended the meeting – List names here.

Short plan – gives the consumer the direction they will be going and what the next steps are.

The clinician checks off what is appropriate.

Orientation and planning – This section assists us in what the consumer wants/need from us and what they can expect from CMH. We explain the PCP process, find out who the consumer wants at the meeting, what time, what place, etc. We help find out what they want their life to look like in the future so we can help plan for this. If there is someone who they want to help with their plan, this is identified here. There are a lot of prompts to help the clinician to remember to go through with the consumer. These are requirements and need to be completed at least annually. All questions on the Preliminary Plan form must be answered.

Authorized Services – identify the services needed by the consumer prior to the person centered planning meeting in their assigned level of care.

The consumer receives a copy of the signed plan so they are aware of the next steps in service at WCMCMH.

Annual Preliminary Plan

The Annual Preliminary Plan must be completed prior to the Person Centered Plan (usually at the time of the annual assessment). Level 3 Orientation is completed with the consumer no less than annually. All questions must be answered on the preliminary plan. The HSW and Autism questions are specific to the DD population. The preliminary plan is important as it is the start of the person centered planning process. The plan documents the hopes, dreams, desires and preferences of the consumer. It identifies who the important people are in the person's life. The consumer receives a copy of the signed plan so they are aware of the date, time and place of their PCP meeting as well as any additional authorized services needed prior to the PCP meeting.

Discharge from Inpatient Preliminary Plan:

This preliminary plan requires some additional information. The goal is to assist a new consumer to CMH who has been hospitalized in a psychiatric inpatient unit and will be coming to WCMCMH for services. The plan assists in helping the consumer to know what the plan is between discharge from the unit and their Service Entry Assessment or meeting with a care manager. The information gathered is:

Discharge Diagnosis from inpatient unit:

Assistance Needed Upon Transfer Of Care From Inpatient To CMH:

- ☐ Transportation for Service Entry Appointment
Create or Update Safety/Support Plan prior to discharge
- ☐ Medication Prescribed at Discharge
- ☐ Connection to Alcohol or Drug Treatment Programs and Support Groups
- ☐ Application for Benefit Programs
- ☐ Application to Indigent Medication Programs
- ☐ Housing Due to Homelessness
- ☐ Legal Issues, i.e., Guardianship and/or Conservatorship
- ☐ Medical Treatment Including Locating a Primary Care Doctor

Person Centered Plan (PCP)

A Person Centered Plan (PCP) is developed using a person-centered/family centered planning process and is based on the assessment of consumer and input from the consumer. The consumer's Person Centered Plan is a document that clearly states the behavioral definition of the problem; the consumer's goals in their words and measurable objectives that reflect consumer identified preferences and needs in areas of skill development or behavioral change. The consumer strengths identified in the plan are the building blocks to help the consumer achieve success when writing the goals and objectives. The outcomes are stated positively in terms of specific and observable changes in behavior, skills, attitudes, or circumstances and are described in terms of attaining a more satisfactory state and skill level. Each outcome (objective) has a time frame for attainment (duration), the identification of who, how, when and where the intervention is to take place and the frequency of the service (amount). Interventions clearly delineate the strategies to be used to assist the consumer in achieving their stated goals. The PCP is to be completed within 30 days of assessment start date.

The completed/typed plan may not be ready for review at the end of the person centered planning meeting. The care manager or facilitator will review the contents of the plan with the consumer/family/caregiver for agreement on objectives, interventions and intensity, scope and duration of services. The consumer/family will receive a copy of the plan in the mail within 15 days of the date of the PCP meeting.

Annual person Centered plans must be completed within 364 days of the previous person centered plan. This is a MDHHS technical requirement.

Behavior is defined as something we can see or hear someone doing it, and if people agree upon whether it is being done. When goals and objectives are written, we are not concerned with how well it is being done, just whether or not it could be measured objectively.

Often consumers/families feel most vulnerable because they are unable to achieve their hopes and dreams. They feel overwhelmed, frightened and defeated by their needs and challenges. Identifying the consumer goals is a means of showing respect, understanding, hope and empathy by the provider. By acknowledging this with the consumer and having a written outcome statement, one can go a long way toward recovery and success.

Some of the specific fields in E clinical –

- **Document Date** – this is the date of the PCP meeting with the consumer
- **Plan Type** – your choices on the PCP include:
 - Initial
 - Annual
- **Provider** – this is the author of the document
- **Admission** – This is the date the consumer started service at WMCMH. There is a drop down menu to choose from.
- **Next Review Date** – the time you are projecting to review the plan with a PCP-R document. There are minimum standards per program; however, this could as frequently as the consumer needs change. A PCP-R must be completed prior to the review date documented on the PDP

- **Who Attended the Meeting** – list who was at the meeting and how they are “related” to the consumer.
- **Strengths** – Plans are to be developed based on the consumer/families strengths. List those strengths here.
- **Transition Plan Criteria:** I / My family will be ready to bring CMH services to a close when: (Transition/Discharge)
 - Must be specific to each individual
 - Need detail
 - Connected to goal – why I am here in first place
 - Action to take for crisis – a “crisis plan”
 - Must be realistic
 - Must be achievable
 - Must be in consumer’s words
- **Support Plan Tab**
 The Support Plan is an ongoing document. Normally it is started at the beginning of services and is updated as the consumer finds supports, learns new skills and is something the consumer should have posted so they can easily find it in an emergency. If the consumer has previously refused to create a support plan, this is a time when the facilitator of the plan will engage with the consumer in an attempt to create a support plan. The emergency worker can refer to this document to assist someone in crisis. The support plan has three sections:
 - **What are the signs I am in crisis** – What are the consumers’ specific prodromals, rapid heart rate, thoughts of harming themselves, frequent crying? This needs to be specific to the consumer and something that the consumer understands.
 - **What Steps can I take** – the consumer may have learned skills to deal with a crisis situation and these skills may be very specific to the consumer. For example, maybe holding an ice cube instead of cutting on themselves or going outside for walk instead of getting angry. What are some ideas? Also remember this should be updated on a regular basis because skills are being updated.
 - **Identify people and phone numbers of people I can call in case of an emergency** – who are some people (including natural supports) that the consumer can call if the steps listed above do not work. It is important to have the phone number or a way to contact the person because in a crisis situation, it is hard to find the numbers and is more frustrating to the consumer. CMH can be listed here but we want to identify natural supports first.

Other places in the community that I/my family may need to consider connecting with are: (External Community Services)

- Focus on what supports the consumer can use in the community, where they will be after sessions/services and try to link the consumer to those services as quickly as possible. Outlining this in the Person Centered Plan helps the consumer to be more self-reliant and promotes the recovery process. What supports are out there for the consumer to use? Some examples are support groups, educational groups, etc. There should always be something out there!
- External supports we are collaborating with now and possible future considerations

**Other changes that I/my family may need to consider making now or in the future:
(Unmet needs)**

- What are the identified needs the consumer has that are not part of the consumer's Plan? For example, there may be a need for the consumer to have employment yet they are not ready to have a job, or they may need help finding a church to go to but they are not sure which community they will be living in. If there are life domains not addressed in the plan, these are listed here with rationale as to why the life domain was not addressed in the plan.
- Be cautious in how question is asked – asking for future may be challenging when a consumer first comes in. This may be a big leap at the beginning of services.

Diagnosis- See Appendix 2-2-1C for details on completing the diagnosis section of the person centered plan.

Signatures

The author of the document signs the completed plan electronically. Depending on the insurance type, provisional status of the staff member and random route process, the plan may be routed to the supervisor for signature. Some plans require the physician signature, e clinical is programmed to know which plans are routed to the physician for signature. Once the author electronically signs the plan, the plan is archived in the ECR overnight. The plan is printed by records on the next business day and a copy of the plan along with Adequate and Advance Notice is mailed to the consumer. The consumer is asked to return the signature sheet to WMCMH as proof they received a copy of their plan.

PERIODIC REVIEW (PCP-R)

Items specific to a Person Centered Plan Review:

1. Summarize any significant events that occurred in the review period, i.e., hospitalizations, moving, etc. For children and families, structure this by indicating what is happening in the community, in the home, and in the school. This is a summary of information that would not be listed in any other part of the document.
2. There are times when a service is needed by the consumer yet a document is not required. This may be an emergency psychiatric evaluation or an additional CSM contact. Please recall that a PCP-R must summarize all services that were provided to the consumer during the previous reporting period. The service without an authorization would need to be summarized in the updated summary.
3. Summarize any outside information received, if any.
4. An overall assessment of the consumer is documented. This helps support the medical necessity of services.
5. Information as to why a diagnosis may have – if it was. If the consumer has a deferred diagnosis, consult with physician or therapist as to whether a more firm diagnosis is needed.
6. Any prodromals the consumer has; how one will know when the consumer is decompensating.
7. A new goal or objective may be needed by the consumer. Provide the rationale and medical necessity for the new outcome in the updated summary of the PCP-R document.
8. If the consumer has previously refused to sign a release of information, or complete a support plan, the care manager will re-engage the consumer in an attempt to have the consumer sign the release and create a support plan.

For a PCP Review: Summary of Progress and Evidence of Need for Continued Service

Document why the consumer needs to continue with services. What is the medical necessity here? Use the Medicaid Provider Manual as a guide.

For a PCP Review: Please tell me how well CMH services are helping you make the change you want to see in your life

Consumer satisfaction is documented in this section. Use the words of the person and how they think things are going.

Signatures: Follow the same procedures outlined in the person centered planning process, Appendix 2-2-1G

PCP- C Process (Virtual Team PCP)

PCP-C Process allows both the care manager and designated Internal Supportive Service Clinicians to make modifications to an existing PCP. Changes include: adding/deleting/ changing desired changes, outcomes, and interventions/services AND/OR extending time frames or authorizing additional units of a particular service. This is accomplished by having the clinician complete the Person Centered Plan Change (PCPC) form in collaboration with the consumer. The modifications made on the PCPC will automatically modify the PCP itself accordingly and integrates the changes into a new PCP. This document becomes the consumer's new PCP. This document is then concurrently printed and signed by the consumer along with the necessary Advanced and/or Adequate Notice documents.

Transition Plan

The Transition Plan is the vehicle used to bring closure to an authorized episode of care. The care manager is to summarize a consumer's achievement or lack thereof for all active goals and objectives, services/supports rendered, transition criteria and the need for linkage arrangements when follow up care is needed.

The Transition (Discharge) Plan is similar to the PCP document, it does have a couple of additional sections.

1. In the transition plan section, please indicated the status of each of the transition/discharge criteria listed. Did the consumer achieve each of the discharge criteria?
2. If there is still a deferred diagnosis at the time of discharge, please explain in the updated summary why the diagnosis continues as deferred at the time of discharge.
3. Each of the outcome (objective) statements needs to be reconciled, i.e, they need to be marked achieved, cancelled, etc. No active objectives remain in the plan at the time of transition.
4. List all medications (both internal and external) and state the name and phone number of the physician who will be taking over prescribing responsibility.
5. External Supports: Identify the external supports with all contact information so the consumer is able to use the transition plan to contact needed supports.
6. Update the support plan if needed.
7. There should be no services identified in the transition document in the authorization section.

Progress Note Explanation of Required Documentation

Each provider shall utilize an approved standardized progress note to document the provision of direct/indirect care provided to or on behalf of a consumer. Clinical care providers are required to submit a progress note for each service contact (direct/indirect). If the contact, attempted contact or consultation is not documented in a progress note, then there is no evidence of it happening.

Progress Note Documentation Standards for Clinical Programs: The progress note is designed to capture all relevant and required clinical information documenting the provision of program care/support services.

Clinical Progress Notes Submission Standard: Clinical progress notes are to be completed on the E-Clinical electronic record system within 24 hours of the provision of service.

E clinical has 5 types of progress notes. The Clinical Services note (direct) Indirect/Cancelled note, Crisis note, Psychiatric notes and the Group Note. All the notes have some required fields. These include those marked with **. Completing these will be mandatory in order to mark the progress note complete. There are sub note types for data collection purposes. The choices for sub notes include the following:

- ACT
- CSM
- Direct Individual
- Home Based
- Community Support
- Community Support Aide
- Therapy
- Ending Therapy
- Crisis
- Health Services
- Prevention
- Indirect

The headings of the progress note include:

The Clinical Services Direct Progress Note

- **Consumer Name and Number**** pre populated
- **Records Comments** - On the top of the Progress Note form the user will see a text box labeled "Records Comment." This is there to display comments that a Records Team member enters as to why this note was unlocked. This box therefore is something that the eClinical user can read but cannot change. These comments will also be displayed, if text exists, on the top of the Progress Note report. **Start and Stop time and Date**** pre populated and may be edited by the author
- **Units** – pre populated
- **Level of Care** – pre populated
- **Cost Center** – pre populated
- **Service Provided**** – pre populated from the appointed created in scheduler.

- **Activity Code:** This is a pick list of codes that allows the author to describe the type of service provided. For example, there are many types of community living support services; the activity code describes the type of CLS service (attendance at medical apt, legal, grocery shopping, skill group, etc.).
- **Provider** – pre populated, author of the note.
- **Number in Group/ Others Present** – If you had a group of consumers you were working with, you would add this here. This is not when you have 4 other family members present. It is the number of other consumers present.
- **Population** – pre-populated.
- **Diagnosis**/Stage of Change** – pre populated **Location**** - We need to know where the service was provided. We cannot report some encounters with some insurances when they are provided in certain locations. For example, we cannot bill CSM services in a nursing home. The per diem (daily rate) a consumer is paying to the nursing home includes care management. Thank goodness we have a billing department that sorts this out for us because there is a lot to keep track of.
- **Modality**** – How the service was provided.
- **Others Present During the session** – Please use initials of the other consumers only here. Other consumer name cannot be in someone else's clinical record.
- **Select Therapy** – this helps track selected therapies like evidence based practices.
- **For Children's Services Only** – Parent Contact following Face-to Face Contact - Face to Face, Phone, Mail – indicate how you communicated with the parents after you have seen their child
- **Law Enforcement/Jail Diversion** –
 - Was Law Enforcement involved? (Yes/No)
 - If yes, what law enforcement agency was involved?
 - Sheriff
 - Police
 - State Police
 - Court Magistrate
 - What was the charge? Text box
 - Was the individual diverted from possible incarceration? Yes/No
- **Risk Assessment Needed Yes /No** – If yes, the Columbia Suicide Risk Assessment is completed. The paper risk assessment is scanned in and connected to the progress note.
 - Overall Violence Risk Rating
 - Not addressed
 - Low
 - Moderate
 - High
 - Requires the initiation of Mandatory Duty to warn process Yes No
- **Appropriate for Transport**** – Each time before you transport a consumer you must assess them to ensure they are in a state of mind that s/he can be safely transported. We have policy on this.
- **Mental Status** – What is your assessment of the consumer today? The mental status will help you with this. We developed a check box to make this easier for you. Now there are some times you do not need to do the mental status. I would say when I am working with the DD population I would not use this as often. However, with the MI population I would use this each time I saw a person; especially ACT consumers. I would also use this in each Crisis note when I saw the person face to face.
- **The Desired Changes and Outcomes**** – The Outcomes (goals and objectives) will populate from the consumer's Person Centered Plan. Select the one that you are working

on during the session or you are monitoring. Rate how the consumer reports how they are doing on this, if the clinician agrees or disagrees and what stage of change they are in at the time of the progress note. If you have to write more information on this, you have the space below to comment on the plan. You are to write the progress/status of the outcomes. In other words, what happened? Each face-to-face session should be related to the Plan of Service.

- **Consumer involvement****– This is the consumer’s satisfaction. Addressing this will help determine if the consumer is happy with the treatment. Being proactive here will help reduce any complaints consumers may have. This is also a MDHHS requirement. The services are meeting the expectation of the consumer (Yes, No, NA)
- **Additional information** – This is where other important information, which may not relate to the Person Centered Plan is documented.
- **Referrals/Information** – Document if the consumer was given a referral and to where.
- **Homework for the Consumer** - what did you assign the consumer to do before the next time you see them? Indicate this here.
- **Follow up Appointment (Schedule next appointment)** – the progress note links you to the scheduler so you can schedule the next appointment.
- **Finally you need to sign and date the progress note.** After this is completed, the copy of the note will go to the ECR.

Indirect/Cancelled Note – This Progress note is completed when an indirect service such as conferencing with the schools, if you cancel an appointment or the consumer cancels the appointment. Once again remember, if it is not written down it did not happen.

Crisis (EOC Note) – This is similar to the “regular progress note” however; the difference is the addition of the consumer information. We want to make sure we are getting the most up to date demographic data. We want you to change demographic data when necessary. If there is a change, then will indicate such and this will flag Records to make the change. Clinicians have a new required field to indicate change or no change here.

Group Progress Note – Group notes are to be used when you are seeing multiple consumers at the same time. This is scheduled in Scheduler and thus much of the information is generated from the Scheduler. If you put the topic of the group in Scheduler, this will pre-populate into all the consumers’ notes for that group. Other fields that are individual to the consumer include the following:

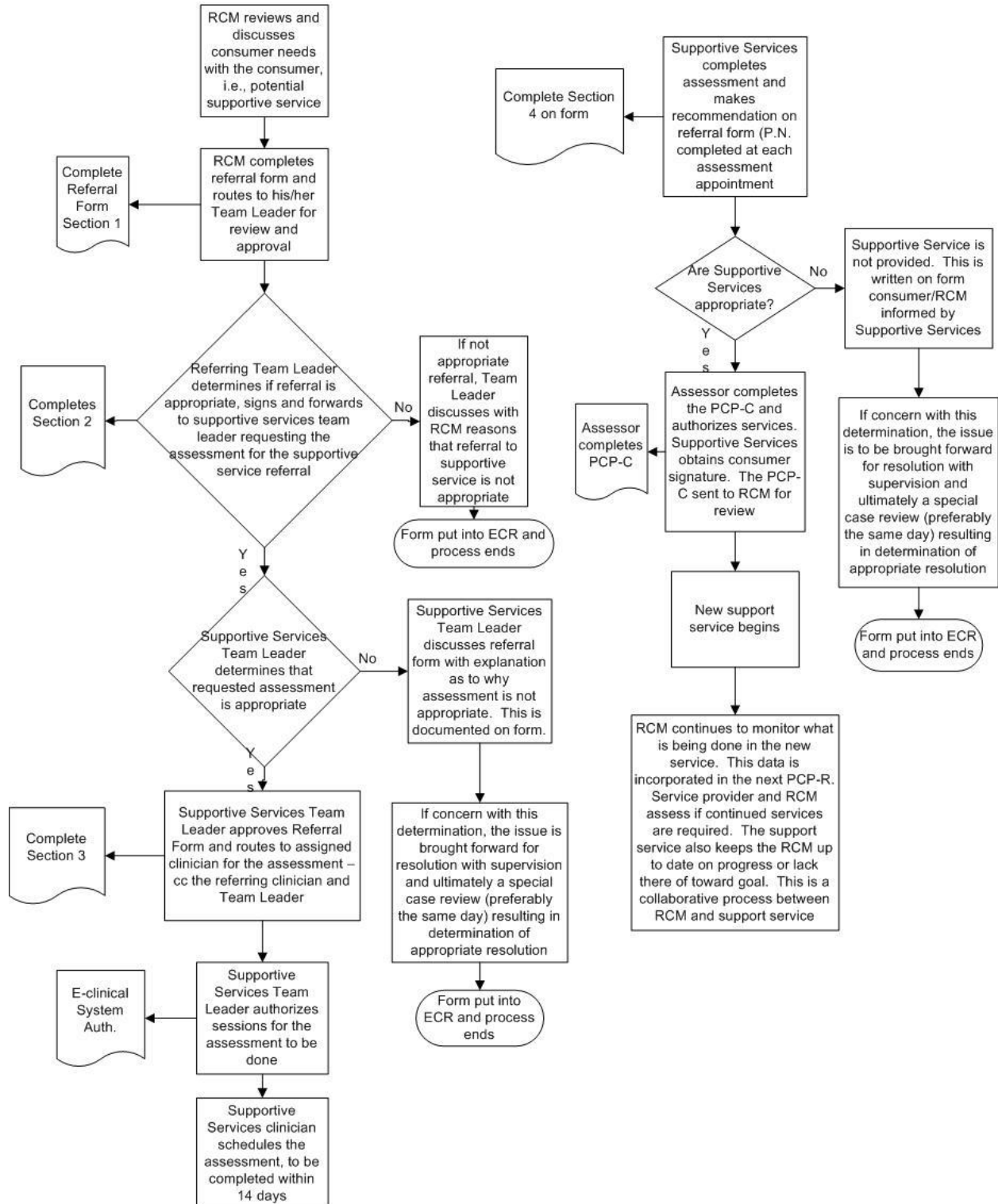
- | | |
|-----------------------------------------------------|--------|
| • Seemed interested in the group/activity | Yes No |
| • positive interaction in the group/activity | Yes No |
| • Shared relevant experiences to topic/activity | Yes No |
| • Understood the group topic | Yes No |
| • Participated in group/activity topic | Yes No |
| • Showed listening skills | Yes No |
| • Offered opinions, suggestions, feedback | Yes No |
| • Individual Redirection required in group/activity | Yes No |

Progress Notes for Assessments/PCPs Etc.

Progress notes are required for assessments, treatment plans, pre plans, and PCP-Rs. The clinical document itself does not create an encounter, thus the reason for the progress note. The progress note also documents that a direct service was provided by the clinician/care manager.

Appendix 2.2.1L Referral Process Flow Chart

Referral Process



Time Frame Definitions

Person Centered Plan

1. Start Date Definition
 - a. **Definition:** Date of face-to-face appointment with the consumer to complete PCP
 - b. **Standard:** Within 30 days of Preplan start date (see above for definition) and on an annual basis as long as this does not exceed 364 days of the previous PCP.
2. Completion definition
 - a. **Definition:** Date a copy of the Person Centered Plan is sent/given to the consumer and signature is obtained. A copy of the plan must be received by the consumer within 15 business days of the date of the face to face meeting of the person centered plan.
 - Date completed in E-clinical (date the last supervisors signature)

Periodic Review

1. Start Date Definition
 - a. **Definition:** Date of face-to-face appointment with the consumer to review progress
 - b. **Standard:** prior to the review date documented on the PCP.
2. Completion definition
 - a. **Definition:** Date the consumer signs the Periodic Review – we also want to keep track of:
 1. Date completed in E-clinical (date of the last supervisor's signature)
 2. Date a copy of the Periodic Summary is sent/given to consumer for signature. This must be within 15 business dates of the date of the PCP-R document.
 - b. **Standard:**

Completed Care Transition Summary

1. Start Date Definition
 - a. **Definition:** Date of the last planned contact
 - b. **Standard:** Within 15 days of the last planned contact with the consumer
2. Completion definition
 - a. **Definition:** Date completed in E-clinical (which is the date of the last supervisor's signature) – we want to also keep track of:
 1. Date the copy of the transition is sent/given to the consumer for signature. This must occur within 15 days of the planned transition meeting.
 2. Date the consumer signs the discharge (MDHHS Definition)
 - b. **Standard:** Within 30 days of the last planned contact with the consumer

Incomplete Care Transition

1. Start date definition
 - a. **Definition:** Date of 2nd NK Letter
 - b. **Standard:** Within 2 weeks of the 2nd NK letter date
2. Completion Definition
 - a. **Definition:** Date completed in E-clinical (which is the date of the last supervisor's signature) we also want to keep track of:

1. Date copy of the D/C is sent to the consumer for signature
2. Date the consumer signs the discharge (DCH Definition)
- b. **Standard:** Within 15 days of the 2nd NK letter date

Progress Note

1. Start Date Definition
 - a. **Definition:** Date of the service
 - b. **Standard:** Within 24 hours of scheduled contact
2. Completion Definition
 - a. **Definition:** Date completed in E-clinical (date which is the date of the last supervisor's signature)
 - b. **Standard:** Within 24 hours of scheduled contact

Concurrent Reviews Standards

Supervisor/Team Leader

1. Start Date Definition
 - a. **Definition:** Date the document is authenticated by the author and routed to the supervisor.
2. Completion Definition
 - a. **Definition:** Date the document is authenticated by the supervisor.
 - b. **Standard:** Within 4 business days of document arriving on the supervisor's to sign list.

Physician Signatures

1. Start Date Definition
 - a. **Definition:** Date the document is authenticated by the supervisor and routed to the physician.
2. Completion Definition
 - a. **Definition:** Date the document is authenticated by the physician.
 - b. **Standard:** Within 4 business days of document arriving on the physician's to sign list.

Referral Documentation Standards

1. Start Date Definition
 - a. **Definition:** Date the referral was completed by the referring clinician.
2. Completion Definition
 - a. **Definition:** Date the determination was made and assessment was completed with changed to the PCP.
 - b. **Standard:** Within 14 business days of referral to the service. Please note there are standards with which the supervisors must make a determination See above attachment for these dates.

Health Services Staffing Standards

1. Start Date Definition
 - a. **Definition:** Date the consumer is scheduled for a med review or psych eval.
2. Completion Definition
 1. **Definition:** Date the clinician completed the staffing for the particular med review or psych eval.

2. **Standard:** Completion is to be done within 24 hours before the scheduled med review or psych eval.

Preplan – Expires 30 days after completion

Urgent/Emergent Requests for Services – Determination is completed within 3 hours of request

Routine Requests for Services – Determination is completed within 14 days of request

Care impasses – COC shall come to a determination within 30 days of request for review.

Routing Rules for Supervision Signature

1. There are two sets of Routing Rules for Supervisors Review and Signature on clinical documentations.

- a. **Option #1: All documents require signature in the following situations:**

- i. All New Clinicians until off probation.
 - ii. A clinician has a Plan of Correction in effect that the supervisor believes warrants all Documentation to be reviewed.
 - iii. All Clinicians who are not fully privileged for any reason.
 - iv. All Insurances other than Medicaid that require Supervisor and Dr. Signature.

- b. **Option #2: A Selected sample of Clinician document are sent to the Supervisor for review according to the following rules:**

- i. Routing Frequency Rule: Each document type once per month per clinician w/o repeat consumers (this negates the high or low volume issue).
 - ii. Place the statement "A PCP Change Recommendation was made for this document" on the Supervisor Signature page when one is requested.
 - iii. Always send a PCP Change form back to the Supervisor when it was added to the "To Do List" of the clinician by the Supervisor.
 - iv. Until the Virtual PCP Team model is implemented, the PCP Change takes the form of a PCP Review on the occasions when it is necessary to do one.
 - v. In the Typical Authorization Package, when there is a range of service units allowed, leave the # blank to require the clinician to complete it.

2. Documents included in this process include:

- i. Initial Assessment (Service Entry)
 - ii. Annual Assessment
 - iii. PCP Initial (PCP-I)
 - iv. PCP Annual (PCP-A)
 - v. PCP Change Form (PCP-C)
 - vi. PCP Review Form (PCP-R)
 - vii. Transition/Discharge Summary

3. Documents that do not follow the Routing Rules:

- i. Department Transfer Form
 - ii. Transition/Discharge Summary
 - iii. Internal Referral for Supportive Service Assessment Form
 - iv. Progress note
 - v. Pre-plans
 - vi. Health and Safety

Psychiatric Services

The Psychiatric Assessment and Medication Review Progress notes are made up of a number of tabs in the Health Services. This is where the HST Team primary works in. It has a number of tabs that we track information including medication consents, HST staffing notes, medications record, vitals, and medication reconciliation.

The prescriber will choose if they are doing a Psychiatric Assessment or a Medication review.

1. Vitals – port into the progress notes completed by the prescriber. Vitals are primary completed by the medical assistant however any HST provider can complete this. The vitals include the following:
 - a. Blood pressure
 - b. Pulse
 - c. Repertory
 - d. Weight
 - e. Height
 - f. BMI
 - g. Any health changes since last Medication Review
 - h. Dietary Complications
 - i. Sleep patterns
 - j. Pain issues (on a scale of 1-10 (10 is high) what is your pain?
 - k. Medical follow up or ER visits
 - l. Physical issues
2. Subjective Objective
 - a. Reason for visit
 - b. History of Present Illness
 - i. Mental Health services/providers
 - ii. Substance Use
 - iii. Trauma
 - c. Past History
 - i. Family history
 - ii. Psychosocial history
 - d. Review of Symptoms
3. Mental Status
4. Assessment
 - a. Impression
5. Diagnosis

There are five sections in the diagnosis tab:

Behavioral Health Diagnosis – DSM 5 Diagnosis rules apply. Please note there is a section if you are using DC 0-3 diagnosis codes in this section. Primarily we are looking at the following:

- Principle Diagnosis here. There can only be one Principle Diagnosis and needs to coincide with the population.

- Provisional diagnosis,
- Rule out diagnosis (you suspect this diagnosis but are not sure they meet all the criteria),
- Diagnosis by history (there is a history of the diagnosis however you do not see all the criteria)
- Diagnosis that requires treatment.

Substance Use Diagnosis – same as above; however, these categories deal just with SUD.

Medical Diagnosis - look at what medical conditions the consumer has. Please note once you choose something in this category, a life domain of Medical/health will go into the cockpit of the PCP.

Other Conditions – these are non-billable codes and they will not go into the cockpit. This is important information for treatment and gives the reader a better understanding of what is happening in the person's life; however, we cannot treat someone with only the other conditions present.

Functional Tools - In the Diagnosis section, you will find the place to record the functional Tools administered. You are to write the scores that you came up with when completing the functional tool as well as the date you completed the tool. Right now here are your choices:

- CAFAS
- LOCUS
- SNAP
- PECAFAS
- SIS

The Staging/COD Tab in E-clinical requires several COD related designations be given. I. Quadrant Model. II. Stage of Change for Each Disorders. III. The SUD Designation for reporting. See below

I. COD Quadrant Model

SA Treatment System	CMH Treatment System
Quadrant I: Low-Moderate Psych/ Low - Moderate Substance	Quadrant II: High Psych/Low-Moderate Substance
Quadrant III: Low-Moderate Psych/High Substance	Quadrant IV: High Psych/High Substance

- _____ Quadrant I: Low-Moderate Psych/ Low-Moderate Substance
- _____ Quadrant II: High Psych/Low-Moderate Substance
- _____ Quadrant III: Low-Moderate Psych/High Substance
- _____ Quadrant IV: High Psych/High Substance
- _____ Not Applicable

II. Preliminary Stage of Change

1. Pre-Contemplation
2. Contemplation
3. Preparation/Determination
4. Action
5. Maintenance

Mental Illness

Substance Use

- | | | |
|------------------------|-------|-------|
| 6. Relapse | _____ | _____ |
| 7. Unable to Determine | _____ | _____ |
| 8. Not Applicable | _____ | _____ |

I. SUD Designation

- 1 = No, individual does not have a SUD
- 2 = Not evaluated for SUD (e.g., person is an infant, in crisis situation, etc).
- 3 = Individual has one or more DSM substance use disorder(s), with at least one disorder either active or in partial remission (use within past year)
- 4 = Individual has one or more DSM substance use disorder(s), and all coded substance use (no use in the past year).
- 5 = Results from a screening or assessment suggest substance use disorder. This includes indications, provisional diagnoses or "rule-out" diagnoses.

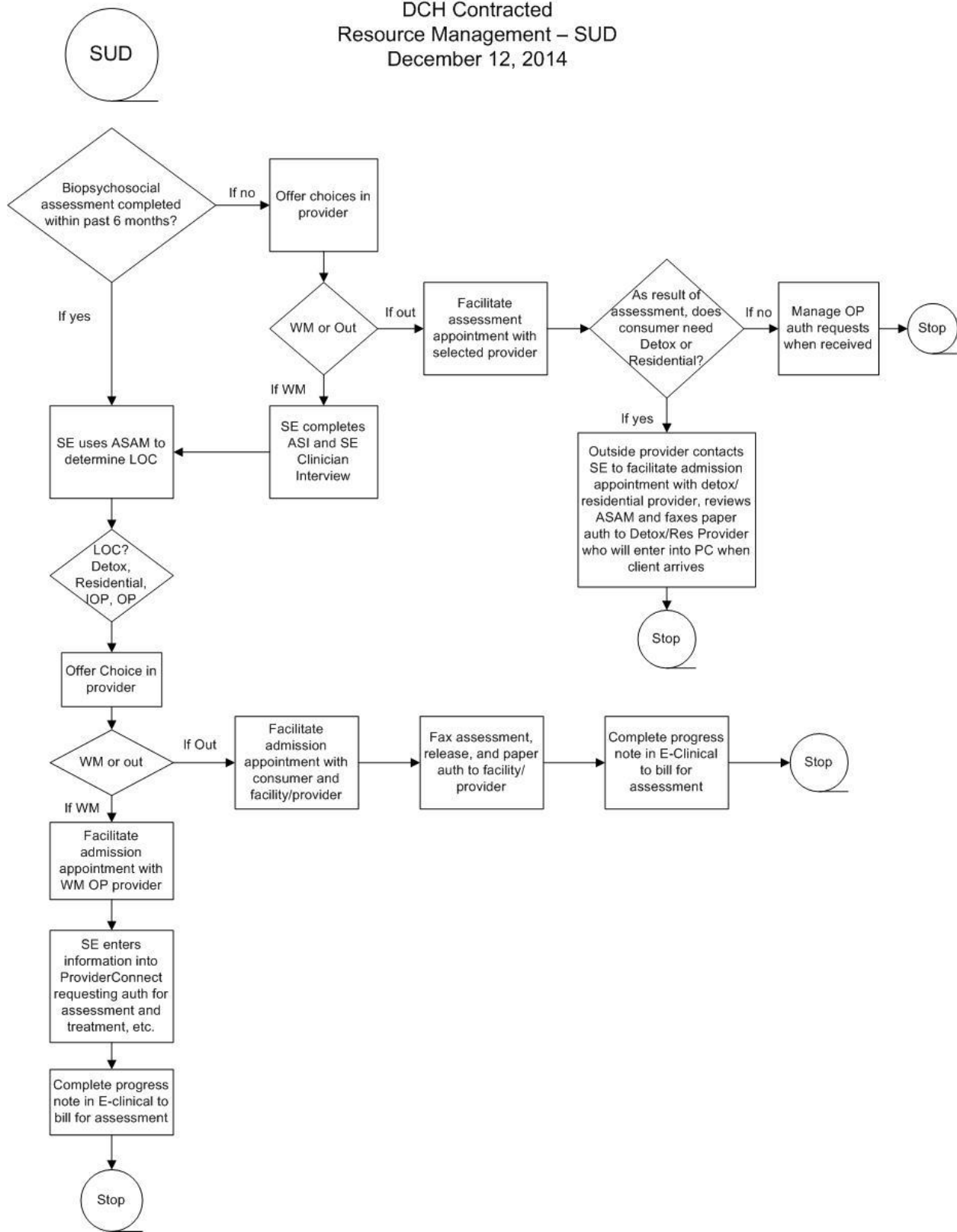
Guidelines for Completion are:

- a. It is not required for consumers with a DD diagnosis because COD and Stage of Change don't often apply. It can be completed when applicable.
- b. All sections are required at each Initial Assessment.
- c. Designations given at the Assessment are automatically carried forward to the Initial PCP Document. Therefore, completion is not required at the Initial PCP, but clinicians are able to "override" if necessary.
- d. At each Periodic Review, the clinician is required to re-stage the individual for each issue that is present, both the SUD and the MI issue. The Quadrant and SUD Reporting Designations do not required re-completion at this time, but can be changed, if necessary.
- e. At the Annual Assessment/Review, the clinician is required to re-designate all 3 sections.

6. Plan

- Labs ordered
- Medications prescribed (please note WMCMHS does have an active medication formulary)
- Known medications from outside provider
- Medication box required
- Follow up recommendation

DCH Contracted
Resource Management – SUD
December 12, 2014



WEST MICHIGAN COMMUNITY MENTAL HEALTH

Service Entry SUD CA Work-Flow

I. SUD REQUESTS FOR SERVICES

1. SE receives call/walk-in from individual.
 - Walk-ins complete regular CMH packet given at screening.
2. Completes regular CMH Screening in E-clinical as normal to determine appropriate referral for individual.
3. Based on screening and ASAM/SSGSs, if determined to be appropriate for a SUD Service, also, gather the following:
 - Assessment done in past 6 months?
 - SUD Priority Population?
4. For all Levels of Care (OP, Detox, Residential), facilitate a referral for full ASI Assessment to an Outpatient Provider of their choice in our region (currently either FHC or WMCMH).
 - If client chooses external provider, client to call and schedule appointment.
 - If client chooses WMCMH, SE worker can schedule client or set them up immediately.
5. After completing the ASI, the OP Provider does the following depending on LOC disposition:
 1. For Outpatient LOC:
 - a. Completes TEDS in ProviderConnect (PC)
 - b. Completes Auth request in PC.
 - c. Schedules for OP appointment.
 2. For Detox or Residential LOC:

Note: These steps are completed internally if WMCMH SE completed the ASI themselves.

Note: SE will accept SE CMH Mental Health Assessment completed in past 6 months if referral coming from WMCMH CSM rather than putting client through ASI.

- a. OP Provider contacts WMCMH SE to discuss appropriateness for detox/residential services and make final decision on authorization and location of detox/residential based on ASAM/SSG's.
- b. WMCMH SE will identify available bed and does/faxes the paper approval/referral auth to the provider chosen.
- c. The facility calls client and connect with chosen detox/residential by calling and scheduling intake appointment.
- d. OP Provider complete Auth request in PC for the Assessment and also projected step-down OP auths for after detox/residential treatment (per the

Authorization Matrix in Provider Manual). NOTE: The detox/residential provider will enter all required PC info for detox/residential auth once client actually arrives for treatment.

e. OP Provider obtains all ROIs for providers that will be involved.

6. Detox/Residential Provider Responsibility:

- a. Completes Admission in ProviderConnect.
- b. Completes initial auth request in PC, and any reauth, if needed.
- c. Facilitates the next clinically necessary treatment service (residential, OP, IOP, etc.).
- d. Completes Discharge in PC after discharge.

II. Authorizing Service Requests in Avatar

1. Assigned SE Clinician runs the Auth Request Report each day in Avatar. This report shows all authorization requests submitted for residents of our 3 counties.
2. Ottawa CMH will daily auto-auth all that can be. Assigned CMH SE clinician will manually review all that require it.

Note: Auths that require manual review are OP auths that are outside of auto-auth parameters that get kicked back, and all higher levels of care requests (IOP, detox, methadone, residential).

III. After-Hours SUD Requests

1. Protocall manages all after-hours calls as usual and EOC clinician manages all emergent requests per established CMH procedures.
2. Emergent SUD admissions are the exception, therefore situations that require an SUD referral will normally be managed the next business day per the established SUD Requests for Services procedures.
3. Detox facilities are the only SUD services that provide 24/7 admissions. Therefore, when a detox admission is urgent, the EOC clinician may facilitate an admission into detox services and ensure that the authorization for the service in Avatar is completed at the next business day.

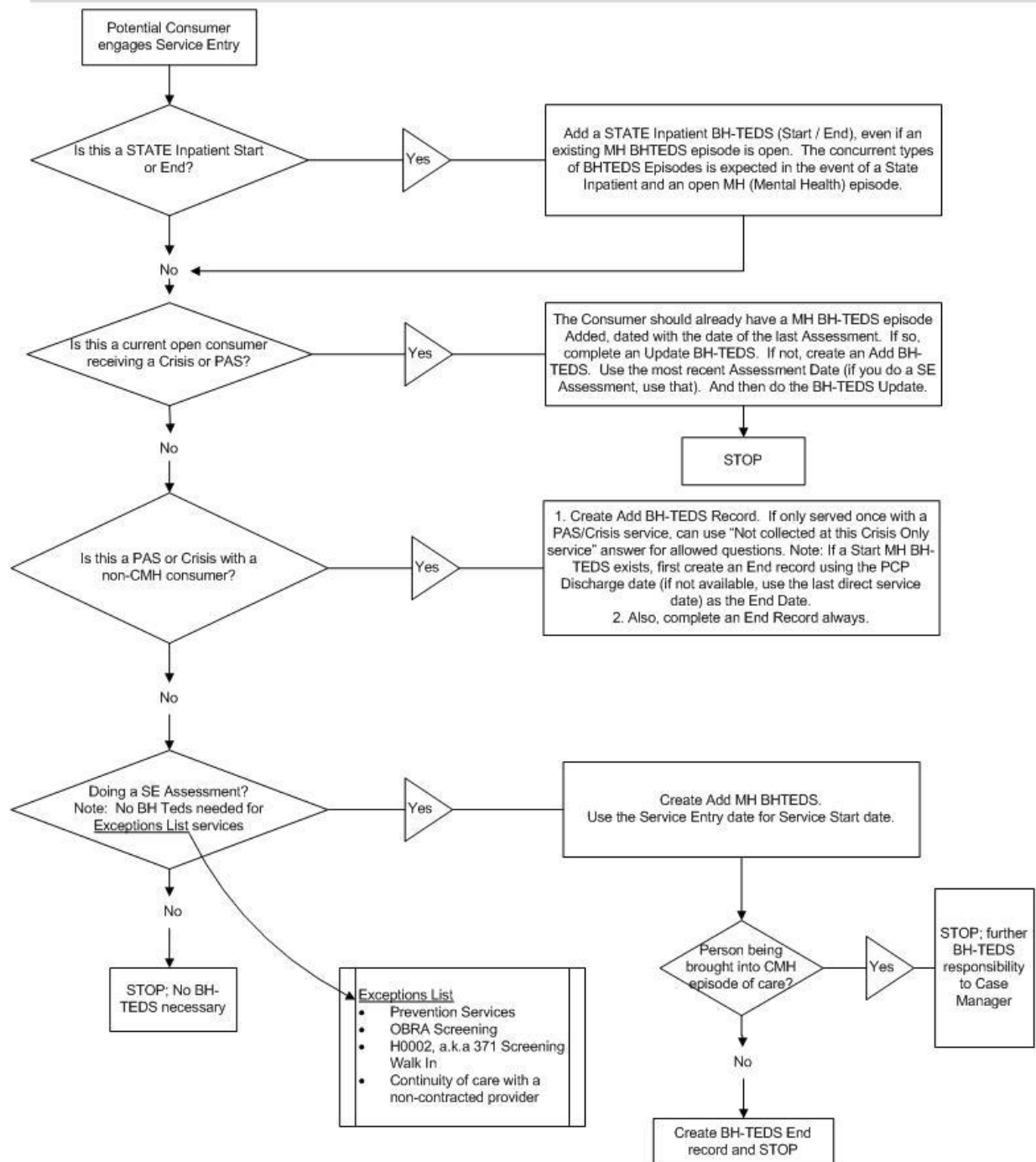
IV. Miscellaneous CA Calls/Requests

1. Service Entry staff will continue to function in their role of managing phone calls from the community as they do now.
2. In the event where the call falls into the area of CA responsibility, they will either manage the situation themselves or forward the call to the appropriate CMH staff person for that issue. Expected topics of calls include:
 - Calls from SUD Providers on Provider Manual, ProviderConnect Technical Support, Finance, etc.
 - Calls from loved ones on how to access SUD Services.
 - Calls from community stakeholders (DHS, Courts, jails, schools, etc.) on how to manage SUD situations.

V. Step Downs to OP Services from Residential Services

1. To WMCMH: Residential facility contact SE to facilitate step down to OP following existing procedures of scheduling client with SUD Program clinician for appointment after discharge from Residential. SE creates authorization (if not already completed) in PC. After 1st session, OP SUD Program clinician completes admission TEDS in PC.
3. To external OP Provider: As CA, SE may be contacted by residential provider to help facilitate placement for step down.

BH-TEDS Service Entry and Emergency Services Workflow Last Revised: 10/11/2016



MH/SU OVERRIDE: IF the existing BH-TEDS episode's Start record has a non-Integrated MH/SA designation, and the clinician writes an Integrated Treatment Plan (or vice versa, changing from Integrated to non-Integrated), the current BH-TEDS Episode needs to be Ended and a New one Started. This probably pertains more to Case Management, but would be necessary for a SE worker to follow if the MH/SA Integration status changes from non-Integrated to Integrated, or vice versa.