PIHP SITE REVIEW REPORT

PIHP: Genesee County CMH Services **Survey Date: January 10-26, 2011**

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
A. CONSUMER INVOLVEMENT (Medicaid Managed Specialty Services and Supports Contract, Consumerism Practice Guideline Attachment P 6.8.2.3.)	**2/2**		
B. SERVICES 1. GENERAL (Medicaid Managed Specialty Supports and Services Contract, Part II, Statement of Work, Section 2.0 Supports and Services)	**2/2**		
B.2. PEER DELIVERED & OPERATED DROP IN CENTERS	**10/10**		
B. 3. HOME BASED (Medicaid Provider Manual, Mental Health and Substance Abuse Services, Section 7)	**11/12**	Easter Seals Genesee CMH	
B.3.1. Eligibility/Target population: Family unit with multiple service needs.	2		
B.3.2. Structure/Organization: Home-based program has a centralized structure (identifiable service unit of an organization).	2		
B.3.3. Mechanism for service coordination and integration has been defined and utilized.	1	Ninety-one percent of the home-based records reviewed contained evidence of releases of information for coordination with Schools/ISDs. A break-down resulted in the following percentages: • Easter Seals, 90% • Genesee CMH, 92%	Submit a plan with time frames to ensure that: • Evidence of coordination with the Schools/ISDs occurs and is integrated into the clinical records, as appropriate. • Evidence of coordination with the Schools/ISDs occurs and is integrated into the clinical records, as

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		Ninety-one percent of the home-based records reviewed contained evidence of coordination with the Schools/ISDs occurs and is integrated into the clinical records, as appropriate. A break-down resulted in the following percentages: • Easter Seals, 90% • Genesee CMH, 92% Note: Ninety-six percent of records reviewed contained evidence of coordination with the primary care physicians for those individuals where such coordination is needed. A breakdown resulted in the following percentages: • Easter Seals, 100% • Genesee CMH, 92% Note: The amount of face to face contact was inconsistently recorded in family-centered plans of service. (Easter Seals and Genesee)	appropriate.
B.3.4. Staffing: Full time worker to family ratio does not exceed 1:15.	2		
B.3.5. The home based services worker to family ratio must accommodate the levels of intensity that may vary from two to twenty hours per week based on individual family needs.	2		
B.3.6. Home based services are provided in the family home or community settings which all citizens use.	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
B.4. ASSERTIVE COMMUNITY TREATMENT (Medicaid Provider Manual, Mental Health/Substance Abuse, Section 4 - Assertive Community Treatment Program)	**25/26**	GCCMH Team 1 GCCMH Team 2 New Passages TTI	
B.4.1. The program has been approved by DCH to provide Assertive Community Treatment services.	2		
B.4.2. Eligibility/Target Population: Persons receiving ACT services meet the eligibility requirements established in the Medicaid Provider Manual.	2		
B.4.3. Structure/Organization: ACT services are provided by all members of a: • Mobile • Multi-interdisciplinary team.	2		
B.4.4. Case management services are interwoven with treatment and rehabilitation services and are provided by all members of the team.	2		
B.4.5. ACT crisis response coverage services are available 24 hours a day, 7 days a week. Crisis response coverage includes psychiatric availability.	2		
B.4.6. ACT team meetings are held daily.	2		
B.4.7. Physician meets with the ACT team on a frequent basis. Medicaid Provider Manual, MH/SA, Section 4- Assertive Community Treatment Program – Team Composition and Size.	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
B.4.8. ACT team meetings occur Monday through Friday and are attended by all staff members on duty. Meeting activities and documentation comply with Medicaid Provider Manual Requirements. Medicaid Provider Manual, MH/SA, Section 4.3 – Essential Elements	2		
B.4.9. Team composition is sufficient in number to provide an intensive array of services on a 24-hour/7days a week basis (including capability of multiple daily contacts); and team size is based on a staff (excluding psychiatrist, peers who don't meet the paraprofessional or professional staff criteria and clerical staff) to consumer ratio of not more than 1:10.	2		
B.4.10. Team composition meets Medicaid Provider Manual requirements.	2	Note: Currently the full-time ACT supervisor at TTI is off on family medical leave and they do not have a return to work date determined yet. In the interim the ACT supervisor from TTI Oxford is helping with the supervisory role.	
B.4.11. The ACT program is an individually tailored combination of services and supports that may vary in intensity over time based on the beneficiary's needs and condition.	2		
B.4.12. Discharge is not prompted by cessation or control of symptoms alone, but is based on criteria that includes recovery and preference of consumer.	2		
B.4.13. Majority of ACT services are provided according to the beneficiary's preference and clinical appropriateness in the beneficiary's home or other community locations rather than the team office.	1	There was a lack of evidence that the registered nurse provided service in the beneficiary's home or other community location at a minimum of quarterly contacts. (GCCMH Team 1 and 2)	Submit a plan with time frames for ensuring that the majority of ACT services are provided, according to the beneficiary's preference and clinical appropriateness, in the beneficiary's home or other community locations rather than the team office.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
B.5. CLUBHOUSE PSYCHO-SOCIAL REHABILITATION PROGRAM (Medicaid Provider Manual, Mental Health/Substance Abuse, Section 5.)	**15/16**	Rainbow Connection	
B.5.1. Program is approved by DCH to provide Psycho-Social Rehabilitation Services.	2		
B.5.2. Eligibility: PSR members are adults with a serious mental illness who wish to participate in the PSR program and have identified psychosocial rehabilitation goals that can be achieved.	2	Note: The review team found that individuals with a primary diagnosis of a developmental disability were participating in the clubhouse program. **Consultative Recommendation:** Individuals participating in the clubhouse program should have a serious mental illness with identified psychosocial rehabilitation goals and the ability to participate in and benefit from the program.	
B.5.3. Structure/Organization: Members have access to the clubhouse during times other than the ordered day, including evenings, weekends, and all holidays.	2		
B.5.4. The program must have a schedule that identifies when program components occur.	2		
B.5.5. The program must have an ordered day; vocational & educational support; member supports (outreach, self help groups, sustaining personal entitlements, help locating community resources, and basic necessities); social opportunities that build	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
personal, community and social competencies.			
B.5.6. Services directly relate to employment, including transitional employment, supported employment, on-the-job training, community volunteer opportunities, and supports for the completion of educational and other vocational assistance must be available.	1	There was a lack of evidence to support that clubhouse services directly related to employment. It was reported to the reviewer that supportive employment services were not occurring. Approximately 22 percent of the membership is currently employed.	Submit a plan with time frames for ensuring that clubhouses services directly relate to employment, skill development, and enhancing independence. Show evidence that supported employment/ and traditional employment opportunities are actively recruited and be available to the membership as well as supports in place for education on job readiness and benefit planning.
B.5.7. Members influence and shape program operations.	2		
B.5.8. Staff and members work side by side to generate and accomplish individual/team tasks and activities necessary for the development, support and maintenance of the program.	2		
B.6. CRISIS RESIDENTIAL SERVICES Medicaid Provider Manual, Mental Health/Substance Abuse, Section 6.)	**11/14**	New Passages Crisis Residential Unit (Genesee Regional Home)	
B.6.1. Eligibility: Persons who meet psychiatric inpatient admission criteria, but who have symptoms and risk levels that permit them to be treated in alternative settings.	1	The Crisis Residential unit uses the psychiatric evaluation as their admission notes. One of two evaluations completed by their psychiatrist did not articulate why an individual discharged from an inpatient setting needed the level of care for Crisis Residential program rather than ACT.	Submit a plan with time frames for ensuring that consumers admitted to crisis residential program meet the psychiatric inpatient admission criteria.
B.6.2. Structure/Organization Services must be designed to resolve the immediate crisis and improve the functioning level of the person receiving services to allow them to return to less intensive community living as soon as possible.	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
B.6.3. Covered services include: psychiatric supervision; therapeutic support services; medication management/stabilization and education; behavioral services; and nursing services.	1	Covered services were described in Crisis Residential program. However, reviewer did not observed any active programming occurring during the visit.	Submit a plan with time frames for ensuring that a posted schedule is visible for consumers that delineates when services and supports are being provided to the individual.
B.6.4.(a) Child Crisis Residential Services Settings - Nursing services must be available through regular consultation and must be provided on an individual basis according to the level of need of the child.	N/A	Note: The crisis residential unit does not provide service to children.	
B.6.4.(b) Adult Crisis Residential Settings - On-site nursing for settings of 6 beds or less must be provided at least 1 hour per day, per resident, 7 days per week, with 24 hour availability on-call. OR On-site nursing for settings of 7-16 beds must be provided 8 hours per day, 7 days per week, with 24 hour availability on-call.	2		
B.6.5. Staffing: Treatment services must be provided under supervision of a psychiatrist.	2		
B.6.6. If the individual has an assigned case manager, the case manager must be involved in treatment, as soon as possible, including follow-up services.	2		
B.6.7. If the length of stay in the crisis residential program exceeds 14 days, the interdisciplinary team must develop a subsequent plan based on comprehensive assessments.	1	There was a lack of evidence to support that comprehensive assessments were completed when the consumer's length of stay exceeded 14 days.	Submit a plan with time frames for ensuring that comprehensive assessments are completed when the length of a consumer's stay exceeds 14 days.
B.7. TARGETED CASE MANAGEMENT (Medicaid Provider Manual, Mental Health/Substance	**5/6**	Consumer Services Genesee CMH	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
Abuse, Section 13)		New Passages TTI	
B.7.1. Eligibility: Children with serious emotional disturbance, adults with mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs; have a high level of vulnerability; require access to a continuum of mental health services; or are unable to independently access and sustain involvement with services.	2		
B.7.2. Persons must be provided a choice of available, qualified case management staff upon initial assignment and on an ongoing basis.	2		
B.7.3. Program provides the core elements of case management: assessment, linking/coordination, and monitoring.	1	Note: Ninety-eight percent of the case management records reviewed contained current psychiatric assessments when required. A breakdown resulted in the following percentages: • Consumer Services, 100% • Genesee CMH, 94% • New Passages, 100% • TTI, 100% Ninety-three percent of the case management records reviewed contained evidence of coordination with the primary care physician. A breakdown resulted in the following percentages: • Consumer Services, 92%	Submit a plan with time frames for ensuring that: • Each of the core elements of case management is consistently provided. • Evidence of coordination with the Schools/ISDs occurs and is integrated into the clinical records, as appropriate. • Evidence of coordination with the Schools/ISDs occurs and is integrated into the clinical records, as appropriate. • CAFAS is completed for children receiving case management services. • Psychosocial assessments are

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• Genesee CMH, 84% • New Passages, 96% • TTI, 100% Eighty-seven percent of the child case management records reviewed contained evidence of releases of information for coordination with Schools/ISDs. A break-down resulted in the following percentages: • Consumer Services, 90% • Genesee CMH, 79% • New Passages, N/A • TTI, N/A Eighty-seven percent of the child case management records reviewed contained evidence of coordination with the Schools/ISDs occurs and is integrated into the clinical records, as appropriate. A break-down resulted in the following percentages: • Consumer Services, 90% • Genesee CMH, 79% • New Passages, N/A • TTI, N/A CAFAS was not consistently completed for children receiving case management services. (Consumer Services and New Passages)	completed prior to the Individual Plan of Service meeting. • Clinical documents are signed by legal guardians.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		Psychosocial assessments were completed as much as three months after the individual plan of service. (Genesee) There was a lack of evidence to support that releases of information were obtained for Social Security Administration, Department of Human Service and Michigan Rehabilitation Services when required. (Consumer Services) Guardianship documents were not consistently contained in the clinical record when required. (Consumer Services and New Passages) Medication consents and individual plans of service were signed by a foster parent of a permanent court ward rather than the legal guardian-the Department of Human Service Worker. (Consumer Services and New Passages) Note: The frequency of face to face contact was inconsistently identified in the individual or family-centered plans of service. (Consumer Services, New Passages and Genesee)	
B.8. PERSONAL CARE IN LICENSED RESIDENTIAL SETTINGS (Medicaid Provider Manual, Mental Health/Substance Abuse, Section 11) Administrative Rule R330.1801-09 (as amended in 1995)	**2/2**		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
B.9. INPATIENT PSYCHIATRIC HOSPITAL ADMISSION (Medicaid Provider Manual, Mental Health/Substance Abuse, Section 8; M.C.L. 330.1209(a))	**4/6**		
B.9.1. Inpatient pre-admission screening services must be available 24 hours a day, 7 days a week.	2		
B.9.2. Disposition is completed within three hours.	0	Site review team members were unable to accurately measure the time frame of the disposition. PIHP staff members reported that the Genesee PIHP changed its process for completing prescreening for hospitalization on October 1, 2010. PIHP staff members reported that the PIHP does not require hospitals to record the time the consumer was medically cleared for a prescreening for inpatient hospitalization or the time the evaluation actually began. The PIHP records the time that hospital staff called for authorization of service as the time of request for the prescreening following an evaluation completed by hospital staff. The PIHP staff reported that the PIHP currently does not have the authority to have the hospital staff record the times of the requests, evaluation start or disposition by hospital staff.	Submit a plan with time frames for ensuring that disposition is completed within three hours from the recorded time of the request and the time of the actual evaluation.
B.9.3. The PIHP is responsible for ensuring that discharge planning is completed in conjunction with hospital personnel.	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
B.10. INTENSIVE CRISIS STABILIZATION SERVICES (Medicaid Provider Manual, Mental Health/Substance Abuse, Section 9)	**14/14**	New Passages Crisis Stabilization Service	
B.11. CHILDREN'S WAIVER (Medicaid Provider Manual, Mental Health/Substance Abuse, Section 14 and Appendix)		This area was reviewed by the MDCH Children's Waiver staff.	
B.12. HABILITATION SUPPORTS WAIVER (Medicaid Provider Manual, Mental Health/Substance Abuse, Section 15)	**5/6**	**HSW CMS Selected: 17 cases** Psychosocial assessments were not consistently completed prior to the development of the individual plan of service. For example, in one habilitation waiver record reviewed the plan was dated 8/9/10. However, the assessment that identified the consumer's needs was not completed until over two months later on 10/26/10. (Genesee)	Submit a plan with timeframes for ensuring that assessments are completed prior to the individual plan of service.
B.12.1. If a Waiver enrollee receives Environmental Modifications or Equipment, the PIHP has implemented prior authorizations in accordance with their process.	2		
B.12.2. Individual had an ability to choose among various waiver services. Medicaid Provider Manual, Section 15	1	Individuals had an ability to choose among various waiver services. However, evidence that eligibility for habilitation supports waiver was not regularly present. In one example the individual was involved in supported employment and was independent with activities of daily living. Staff agreed that this individual should be transferred to the services of support coordination or case management.	Submit a plan for ensuring that: • A process is developed to insure that individuals receiving the service of habilitation support waiver meet the eligibility requirements as identified in the Medicaid Provider Manual. • Contact Deb Ziegler, MDCH Specialist, (517) 241-3044 as

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
			questions arise.
B.12.3. Individual had an ability to choose their providers. Medicaid Provider Manual, Section 15	2		
B.13. ADDITIONAL MENTAL HEALTH SERVICES [(B)(3)S] (Medicaid Provider Manual, Mental Health/Substance Abuse, Section 17)	**35/42**		
B.13.1. Presence in the Plan: Services to be provided are documented in the IPOS.	1	Occupational therapy assessments were not regularly completed when identified in the individual plan of service. (New Century)	Submit a plan for ensuring that services and supports are provided when recommended and documentation is present to support that the service was provided.
B.13.1.2. Goals: • Community Inclusion and participation • Independence • Productivity	2		
B.13.2.1. Supports and Services • Assistive Technology	2		
B.13.2.2. Community Living Supports	2		
B.13.2.3. Enhanced Pharmacy	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
B.13.2.4. Environmental Modifications	2		
B.13.2.5. Crisis Observation Care	0	The PIHP did not have the capacity to provide crisis observation care.	Submit a plan of correction that describes how the PIHP will ensure it has the capacity to provide crisis observation care services.
B.13.2.6. Family Support and Training	2		
B.13.2.7. Housing Assistance	2		
B.13.2.8. Peer Delivered Or Operated	2		
B.13.2.9. Peer Specialist Services	2		
B.13.2.10. Drop-in Centers	2		
B.13.2.11. Prevention – Direct Service Models	0	The PIHP did not have the capacity to provide Prevention – Direct Service Models.	Submit a plan of correction that describes how the PIHP will ensure it has the capacity to provide Prevention – Direct Service Models.
B.13.2.12. Respite Care Services	1	The amount of respite services was not consistently documented as being provided as identified in individual plans of service. (Genesee)	Submit a plan with time frames for ensuring covered services are provided to individuals who need them.
B.13.2.13. Skill Building Assistance	2		
B.13.2.14. Support and Service Coordination	2		
B.13.2.15. Supported /Integrated Employment Services	2		
B.13.2.16. Wraparound Services For Children And Adolescents	2		
B.13.2.17. Fiscal Intermediary Services	2		
B.13.3.1. Sub-Acute Detoxification	1	Genesee had one sub-acute detoxification	Submit a plan with time frames for ensuring

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		provider. However, the provider was located outside of the community. The reviewer was advised that the PIHP is seeking a local provider.	that the PIHP has a sub-acute detoxification provider within the community.
B.13.3.2. Residential Treatment	2	Odyssey House, Adolescent Center	
B.14. JAIL DIVERSION Adult Jail Diversion Policy Practice Guideline of February 2005 – Contract Attachment P.6.8.4.1. R 330.2810 Michigan Mental Health Code, 1995, Act 290	**10/12**		
B.14. The PIHP is responsible for ensuring that each CMHSP within its provider network:			
B.14.1. has an interagency agreement that describes the specific pathways of the pre-booking and post-booking jail diversion program with each law enforcement entity on their service area. AFP Section 2.9.3 & 2.9.4	1	The PIHP had an interagency agreement that described the specific pathways of the pre-booking and post-booking jail diversion program. However, there was not an agreement with each law enforcement entity in their service area. • Genesee Co SO • Burton PD • Clio PD • Davidson PD • Fenton PD • Flint PD • Flushing PD	Submit a plan with time frames for ensuring interagency agreements or memorandum of understanding are obtained from each law enforcement entity within the PIHP's service area.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• Grand Blanc PD • Lennon PD • Linden PD • Mount Morris PD • Otisville PD • Swartz Creek PD	
B.14.2. has a post-booking jail diversion program in place that ensures jail detainees are screened for the presence of a serious mental illness, co-occurring substance disorder, or developmental disability within the first 24-48 hours of detention.	1	There was a system in place to screen for serious mental illness, substance use disorders and developmental disability during the work week. However, there was not sufficient evidence that screens occur within 24-48 hours of detention, particularly when detention occurred on weekends, especially Sundays.	Submit a plan with time frames to assure jail diversion screenings occur in a timely manner, with in 24-48 hours of detention.
B.14.3. assigns specific staff to the pre-booking and post-booking program to serve as liaison between the mental health, substance abuse, and criminal justice systems. MDCH/CMHSP Managed Mental Health Supports and Services Amendment #1	2		
B.14.4. establishes regular meetings among the police/sheriffs, court personnel, prosecuting attorney, judges, and CMHSP representatives.	2		
B.14.5. provides cross training for law enforcement and mental health personnel on the pre-booking and post-booking jail diversion program.	2	*Positive Observation:* There was evidence law enforcement agencies within Genesee County took advantage of cross trainings by use of a DVD. This promotes effective use of time, money and convenience.	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		Law enforcement officers have an immediate access phone number to program in their cell phones/phone system to expedite coordination with the CMHSP. **Consultative Recommendation:** Law enforcement agencies throughout the region should be educated regarding the benefits of jail diversion activities, which include: decreased paperwork for officers; decreased overcrowding in jails' and the opportunity to break the cycle of crisis that brings persons diagnosed with a mental illness/developmental disability to the attention of their law enforcement officers. By utilizing the jail diversion option, law enforcement agencies can identify and link individuals to the needed supports and services that can make a positive difference in their lives and keep mental health consumers out of the criminal justice system.	
B.14.6. maintains a management information system that can identify individuals brought or referred to the mental health agency as a result of a pre-booking or post-booking diversion. Medicaid Managed Specialty Supports and Services Contract, Section 6.5.1 & 6.5.2	2	*Positive Observation:* The PIHP collected jail diversion data. A summary report to evaluate the programs effectiveness and to make recommendations for improvement had been developed.	
B.15. SUBSTANCE ABUSE ACCESS & TREATMENT (Medicaid Managed Specialty Supports and Services Contract, Statement of Work, Section 2 Supports and	**12/14**		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
Services, Section 3 Access Assurance)			
B.15.1. The PIHP has adopted common policies and procedures concerning assessment and service provision for individuals with co-occurring mental health and substance use disorders. (AFP 3.8.4.)	2		
B.15.2. The PIHP is responsible for coordination with substance abuse treatment providers when appropriate.	2		
B.15.3. The PIHP ensures that the required continuum of substance abuse rehabilitative services is available.	2		
B.15.4. The PIHP has sufficient capacity to meet demands for substance abuse services.	1	During the course of the review the PHIP staff reported that contracts for substance abuse services were in the process of development.	Submit a plan with time frames to insure there was sufficient capacity to meet substance abuse services needs.
B.15.5. The PIHP meets the requirements to provide 24 hours a day, 7 day a week access to substance abuse screening assessment and referral services.	1	There was a system in place to assure timely assessment for consumers requiring substance use disorder treatment. However, screenings were not consistently occurring on weekends, especially Sundays.	Submit a plan with time frames to insure a substance use disorder screenings are available 24 hours a day, 7 days a week.
B.15.6. The PIHP has effective methods for assuring that substance abuse treatment is based on the development of an individualized treatment plan.	2		
B.15.7. The PIHP has a process for ensuring that substance abuse treatment providers make clinical decisions consistent with the Medical Necessity Criteria for Medicaid Mental Health and Substance Abuse Services requirements as attached to the contract.	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
C.1. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Practice Guideline Attachment 3.11.3 Consumerism Best Practice Guideline. MHC 712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement. MDCH Administrative Hearings Policy and Procedures dated 9/1/99. Technical Requirements in 42CFR on Grievance and Appeals.	**36/38**		
C.1.1. The individual is provided with options of choosing independent facilitation.	2		
C.1.2. The PIHP has integrated person-centered planning processes for individual with co-occurring mental health and substance disorders. (AFP 2.2.2.)	2		
C.1.3. Preplanning meetings occur before a person-centered planning meeting, according to the individual's desires and needs.	2	**HSW CMS Selected: 17/17**	
C.1.4. Person-centered planning addressed: individual's goals, interests and desires.	2	**HSW CMS Selected: 17/17**	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
C.1.5. Person-centered planning used a strength based approach.	2	**HSW CMS Selected: 17/17**	
C.1.6. Person-centered planning addressed community inclusion.	2		
C.1.7. Person-centered planning addressed natural supports.	2		
C.1.8. Person-centered planning addressed health and safety.	2	**HSW CMS Selected: 17/17** Note: Approximately 98 percent of the identified health care concerns were followed-up in the consumer's individual plan of service. A breakdown resulted in the following percentages: • Consumer Services, 92% • Easter Seals, 100% • Genesee, 98% • New Century Support Services, 100% • New Passages, 100% • Training and Treatment Innovations, 100% • Vocational Independence Program, 100% . Reviewers noted that approximately 99 percent of records reviewed both identified and addressed safety issues in the consumer's individual plan of service.	
C.1.9. The plan of service for individuals receiving crisis residential services must contain clearly stated goals and measurable objectives, derived from the	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
assessment of immediate need, stated in terms of specific observable changes in behavior, skills, attitude, or current circumstances structured to resolve the crisis (Children's plan of service must address the child's needs in context with the family's needs and in consultation with school district staff) and identify the activities designed to assist the person receiving services to attain his/her goals and objectives			
C.1.10. The plan of service for individuals receiving crisis residential services must contain discharge planning information and the need for aftercare/follow-up services, including the role and identification of the case manager.	2		
C.1.11. The file for an individual receiving personal care services contains an assessment of their need for personal care. Medicaid Provider Manual, Section 11.3	2		
C.1.12. When there is a need for a behavior treatment plan, it is developed through a person-centered planning process.	2		
C.1.13. Written special consent is obtained before the behavior treatment plan is implemented.	2		
C.1.14. Family driven and youth guided supports and services are provided for minor children.	2		
C.1.15. For beneficiaries with co-occurring substance use disorders, individualized treatment will be integrated by the team as part of the overall treatment approach.	2		
C.1.16. Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are	2	Note: Approximately 96 percent of records reviewed addressed satisfaction with the service array as well as the	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
receiving, and their progress towards attaining valued outcomes.		person-centered planning process. A break-down resulted in the following percentages: • Consumer Services, 100% • Easter Seals, 80% • Genesee, 97% • New Century Support Services, 92% • New Passages, 100% • Training and Treatment Innovations, 88% • Vocational Independence Program, 100% **HSW CMS Selected: 17/17**	
C.1.17. The person-centered planning process includes an identification and prioritization of risks.	2		
C.1.18. Individuals are provided an opportunity to develop a crisis plan.	1	In 88 percent of the records reviewed There was documentation to support that consumers had been offered crisis planning. However, reviewers noted that the content of the crisis plan was more of a safety plan in nature. A breakdown resulted in the following percentages: • Consumer Services, 92% • Easter Seals, 100% • Genesee, 85% • New Century Support Services, 92% • New Passages, 84% • Training and Treatment Innovations, 88% Vocational Independence Program, 92%	Submit a plan with time frames for ensuring that crisis planning is discussed and offered to consumers as part of their individual person-centered planning process

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
C.1.19. Individuals are provided the opportunity and support to develop a psychiatric advanced directive.	1	The PIHP has a policy in place for advanced directives. However, it does not appear to be fully effective. Of the 56 primary consumers interviewed that would qualify for an advanced directive, only 9 individuals or 16 percent stated they had heard of the process.	Submit a plan with time frames for ensuring that individuals are educated on the process for obtaining an advanced directive.
C.2. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS	**25/30**		
C.2.1. Preliminary plans of service are developed within 7 days of commencement of services.	2		
C.2.2. The individual plan of service for individuals receiving crisis residential services must be developed within 48 hours of admission.	2		
C.2.3. The file for individuals receiving personal care services contains an assessment of their need for personal care.	2		
C.2.4. The individual plan of service for individuals receiving Intensive crisis stabilization services treatment plan must be developed within 48 hours.	2		
C.2.5. Specific services and supports to be provided, including the amount, scope, and duration of services, are identified in the plan of service.	1	Approximately 91 percent of individual plans of service contained the date the service was to begin, the specified scope, duration, intensity and who would provide each authorized service. A break-down resulted in the following percentages: • Consumer Services, 88% • Easter Seals, 80% • Genesee, 90%	Submit a plan with time frames for ensuring that the date the service was to begin, the specified scope, duration, intensity and who would provide each authorized service is identified on the consumer's individual plan of service in a way that the consumer will understand the services they will be receiving and how often.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• New Century Support Services, 100% • New Passages, 86% • Training and Treatment Innovations, 100% • Vocational Independence Program, 100% *Positive Observation: New Century Support Services, TTI, and Vocational Independence Program met or exceeded the 95% threshold for full compliance.*	
C.2.6. Presence in Family-Centered Plan: Services provided by home based service assistants must be clearly identified in the family-centered plan of service.	N/A	The PIHP does not utilize home-based assistants.	
C.2.7. The plan of service identifies available conflict resolution processes.	1	Approximately 90 percent of individual plans of service contained an available informal conflict resolution process. A break-down resulted in the following percentages: • Consumer Services, 92% • Easter Seals, 100% • Genesee, 97% • New Century Support Services, 100% • New Passages, 100% • Training and Treatment Innovations, 94% • Vocational Independence Program, 0%	Submit a plan with time frames for ensuring that the consumer's individual plan of service identifies available conflict resolution processes.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		Positive Observation: Easter Seals, Genesee, New Century Support Services, and New Passages met or exceeded the 95% threshold for full compliance.	
C.2.8. Individuals are provided timely Adequate Notice consistent with DCH format.	1	Adequate Notice regarding the right to appeal was given to 77 percent of consumers when new individual plans of service were developed. A break-down resulted in the following percentages: • Consumer Services, 81% • Easter Seals, 100% • Genesee, 65% • New Century Support Services, 100% • New Passages, 79% • Training and Treatment Innovations, 59% • Vocational Independence Program, 100% *Positive Observation: Easter Seals, New Century Support Services, and Vocational Independence program met or exceeded the 95% threshold for full compliance.*	Submit a plan with time frames for ensuring that adequate notice regarding the right to appeal was given to consumer's when a new individual plan of service is developed.
C.2.9. The individual plan of service for individuals enrolled in the HSW is updated within 365 days of their last individual plan of service.	2	**HSW CMS Selected: 17/17**	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
C.2.10. The plan of service identifies the frequency that it will formally be reviewed for effectiveness and reviews of the plan are completed at those intervals.	1	The frequency that individual plans of service were to be formally reviewed was identified in only 89 percent of records reviewed. A break-down resulted in the following percentages : • Consumer Services, 88% • Easter Seals, 100% • Genesee, 93% • New Century Support Services, 100% • New Passages, 86% • Training and Treatment Innovations, 82% *Positive Observation: Easter Seals and New Century Support Services were at full compliance.*	Submit a plan with time frames for ensuring that the frequency the individual plans of service were to be formally reviewed is identified on the individual plans of service.
C.2.11. The services and supports identified in the individual plan of service address the individual's identified needs.	2	**HSW CMS Selected: 17/17**	
C.2.12. The plan of service for individuals receiving crisis residential services is signed by the individual receiving services, his or her parent or guardian if applicable, the psychiatrist and any other professionals involved in treatment planning.	2		
C.2.13. Individuals are provided a copy of their individual plan of service within fifteen business days after the planning meeting.	1	The Person-Centered Planning Practice Guideline attachment to the contract requires that individuals receive a copy of their plan of service within 15 business	Submit a plan with time frames for ensuring that consumers receive copies of their plans of service within 15 business days.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		days after the planning meeting occurs. Approximately 37 percent of the total number of records reviewed had evidence to support that individuals were given a copy of their plan. A breakdown resulted in the following percentages: • Consumer Services, 12% • Easter Seals, 90% • Genesee, 53% • New Century Support Services, 8% • New Passages, 29% • Training and Treatment Innovations, 0% • Vocational Independence Program, 83% During consumer interviews seventy of the seventy-eight individuals or 90 percent who said they received a copy of their plan reported getting it within 15 days. This raises the score of zero for documentation to a one for partial compliance.	
C.2.14. Reviews of the effectiveness of the individual plan of service are completed at the intervals identified in the plan and include a review of the individual's satisfaction with services and/or treatment and a review of progress made towards achieving desired outcomes.	2	Note: Status reviews occurred as stated in 95 percent of records reviewed A breakdown resulted in the following percentages: • Consumer Services, 100% • Easter Seals, 100% • Genesee, 97% • New Century Support Services,	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		100% • New Passages, 92% • Training and Treatment Innovations, 82% • Vocational Independence Program, 100%	
C.2.15. Services and treatment identified in the individual plan of service are provided as specified in the plan.	2	**HSW CMS Selected: 17/17**	
C.2.16. The individual plan of service is modified in response to changes in the individual's needs.	2	**HSW CMS Selected: 17/17**	
C.3. IMPLEMENTATION OF ARRANGEMENTS THAT SUPPORT SELF-DETERMINATION Medicaid Managed Specialty Services and Supports Contract, Attachment 3.4.4 Self-Determination Practice Guideline (SD P&PG). Attachment ________ Choice Voucher System Technical Advisory Medicaid Provider Manual, Provider Assurances & Provider Requirements Attachment 4.7.1 Grievances and Appeals Technical Requirement. MDCH Administrative Hearings Policy and Procedures dated 9/1/99. Technical Requirements in 42CFR on Grievance and Appeals.	**10/12**		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
C.3.1. Adults with developmental disabilities and serious mental illness have opportunities to pursue arrangements that support self-determination in order to control and direct their specialty mental health services and support arrangements. SD P&PG, Purpose § I, Policy § I.	1	CMH had a policy requiring that during the IPOS pre-planning process, consumers would be asked whether or not they would want to participate in self-determination. This did not consistently occur.	Submit a plan with time frames for ensuring that consumers will consistently be asked if they want to participate in self-determination.
C.3.2. Individuals receive information about self-determination and the manner in which it may be accessed and applied is provided to each consumer. SD P&PG, Policy § I.C.	1	The consumer interviews indicated that most consumers were not aware of the opportunity to participate in self-determination.	Submit a plan with time frames for assuring that consumers are aware of their option to participate in self-determination.
C.3.3. The individual budget and the arrangements that support self-determination are included as part of the person-centered planning process. SD P&PG, Policy § II.A	2		
C.3.4. Each individual participating in arrangements that support self-determination has a Self-Determination Agreement that complies with the requirements. SD P&PG, Policy § II.E	2		
C.3.5. Each PIHP has a contract with at least one fiscal intermediary. SD P&PG, Policy § IV.B	2		
C.3.6. Each PIHP has procedures in place for assuring that fiscal intermediaries meet the minimum requirements. SD P&PG, Policy § IV.B, C, D &E; Medicaid Provider Manual, MH/SA, § 17.3.O.	N/A		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
C.3.7. Individuals participating in self-determination shall have assistance to select, employ, and direct his/her support personnel, and to select and retain chosen qualified provider entities. SD P&PG, Policy § IV.	N/A		
C.3.8. Each PIHP, or its designee, has a process for handling both voluntary and involuntary termination of a Self-Determination Agreements that meets the requirements of the Self-Determination Policy and Practice Guideline. SD P&PG, Policy § II.5.	2		
C.3.9. Within prudent purchaser constraints, an individual is able to access any willing and qualified provider. SD P&PG, Policy § III.A.	N/A		
D. ADMINISTRATIVE SERVICE FUNCTIONS **1. PROVIDER NETWORKS** (Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Section 3.8, 4.0)	**9/12**		
D.1.1. The PIHP has adopted common policies and procedures for managing networks, including policies and procedures for use throughout the service area. Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 3.8, 4.0 42 CFR 438.214.	1	The PIHP developed and required common policies, procedures and forms for managing their network. However, policies were not consistently followed. For example, assessments were not consistently completed prior to the individual plan of service. Performance evaluations to judge staff competency were not consistently completed according to the PIHP policy.	Submit a plan with time frames for ensuring that: • Providers consistently comply with the PIHP requirements. • Evidence of staff competency is regularly evaluated as required by the PIHP policy. • Forms developed to increase

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		Forms designed to increase compliance were not consistently utilized. For example, some medication consent forms did not contain the right for the individual to withdraw their consent at any time. Not all required documents were present in "Chip". Hard copies of some documents throughout the review were provided as evidence. *Positive Observation:* *The PIHP utilizes an electronic record system called "Chip". Reviewers found Chip to be easy to navigate and user friendly.*	compliance are used as directed by the PIHP.
D.1.2. The PIHP has policy and business procedures to assure regular monitoring and reporting on each network provider. 42 CFR 438.230(b)(4) 42 CFR 438.810 Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 2.5, 3.8, 3.1.8	2		
D.1.3. The PIHP has documentation that supports that on-site reviews of each provider are completed annually or more often if needed.	1	Quality of care audits were completed at annually, by the PIHP Quality Management Department, of all clinical network providers. The method of	Submit a plan with time frames for ensuring that: • Required staff training consistently

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Section 3.8, Regulatory Oversight and Management		monitoring was a combination of quality assurance report analysis, medical record auditing and site reviews. An annual audit schedule was developed, adhered to and shared with the MDCH site reviewer. However, the process was not fully effective. For example, • Evidence of required staff training was not consistently present in records reviewed. • Concerns identified by the State of Michigan Licensing Department were not resolved. • Performance reports were not consistently present. The nature of review findings regarding the implementation of person-centered planning processes indicates that the PIHP's process for monitoring their contract providers was not fully effective.	occurs. • Compliance with person-centered planning requirements is effectively monitored.
D.1.4. Provider performance reports are available for review by individuals, families, advocates, and the public. Attachment P6.8.2.3 Consumerism Practice Guideline	1	The PIHP network report card was documented in the Annual Report/Calendar. However, evidence that the report was provided to individuals, families, advocates and the public was not present. During consumer interviews only 17 of 98 individuals interviewed stated they had seen the calendar or performance reports. It was not clear that individuals had been advised of how they could obtain a	Submit a plan with time frames for ensuring that: • Individuals are informed of how to obtain agency performance reports. • Provider performance reports are available for review by individuals, families, advocates, and the public. • Individual performance reports of the PIHP/CMHSPs or their respective providers available for review by

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		provider performance report.	individuals, families, advocates and the public.
D.1.5. The PIHP has a process for assuring subcontractors' implementation of and compliance with person-centered planning requirements.	2		
D.1.6. The PIHP takes action to address provider compliance or performance problems. 42 CFR 438.230(b)(4) corrective action 42 CFR 438.240(a)(1) on-going quality Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Section 3.8	2		
D. ADMINISTRATIVE FUNCTIONS **2. QUALITY IMPROVEMENT** (Medicaid Managed Specialty Supports and Services contract, Section 6.7; AFP Section 3.9; Medicaid Provider Manual, Mental Health/Substance Abuse, Section 3.3)	**4/4**		
D. ADMINISTRATIVE FUNCTIONS **3. HEALTH & SAFETY** (Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1; 4c CFR 438.208) Administrative rule Section 3(9) of Act 218 P.A. 1979, as amended	**2/4**		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
D.3.1. The PIHP has organizational processes for addressing health and safety issues. Administrative Rule R 330.2802 Person-centered Planning Best Practice Guideline Attachment 3.4.1.1. to the MDCH Contract AFP Section 2.7	1	**<u>ORGANIZATIONAL PROCESS FOR ADDRESSING HEALTH:</u>** Note: Ninety-eight percent of health care concerns identified were followed-up in the consumer's individual plan of service. A breakdown resulted in the following percentages: • Consumer Services, 92% • Easter Seals, 100% • Genesee, 98% • New Century Support Services, 100% • New Passages, 100% • Training and Treatment Innovations, 100% • Vocational Independence, 100% **<u>HEALTH CARE</u>** A review of consumer clinical records in group homes reflected that individuals who smoked cigarettes were provided some safety directions. However, documentation was not present to support that individuals were provided information about the health care risks associated with smoking cigarettes. At risk health behaviors were identified in	<u>Health:</u> Submit a plan with time frames for ensuring that health issues: • Are comprehensively assessed, identified and addressed in the individual plan of service. • Recommendations by health care professionals are addressed in the planning process. • At risk behaviors when identified are appropriately addressed. • Staff members at group homes consistently have evidence that TB screening occurs as required by policy. • Bathrooms contain liquid soap and paper towels to decrease the spread of infections. • The PIHP conducts monitoring to ensure the effectiveness of corrective action plans submitted to MDCH. • The PIHP maintains documentation for the MDCH follow-up site review visit to support that all identified health concerns were addressed. <u>Safety:</u> Submit a plan with time frames for ensuring that safety issues:

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		assessments. However, the behaviors were not consistently addressed. For example, it was noted in assessments that consumers were smoking cigarettes. There was a lack of documentation to support that individuals were provided education or educational material to address this unhealthy practice. (Easter Seals) Health screens when authorized were not consistently completed. (Consumer Service) Note: Health screens were found in some clinical records reviewed. However, the screens were not provided to the primary care physician. It is recommended that this current information is provided to the primary care physician for coordination activities. **INFECTION CONTROL:** • Personal care items were not regularly labeled with the consumer's name. (Gatti CLF Lochhead, Parkside FAIS Home) • The bar soap in the bathroom was used by all staff and consumers. Community bar soap may promote the spread of communicable diseases. (Andrews & Johnson #3, Thorn AFC) • The PIHP policy requires that	• Are comprehensively assessed, identified and addressed in the individual plan of service. • Home maintenance concerns are resolved. • Policies and procedures are developed, staff receive training, and copies of policies are present in group homes. • The PIHP conducts monitoring to ensure the effectiveness of corrective action plans submitted to MDCH. • The PIHP maintains documentation for the MDCH follow-up site review visit to support that all identified safety concerns were addressed and/or appropriately repaired.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		staff members have TB screening every three years. Staff members at group homes reviewed did not consistently have evidence that TB screening had occurred as required by policy. (Thorn AFC) • The toilet seat in the large bathroom was made of soft material. It was dry and torn presented an infection control concern. (Richfield Corners CLF) • Vents in the homes reviewed were not clean. This could post an infection control concern. **ORGANIZATIONAL PROCESS FOR ADDRESSING SAFETY:** Note: Ninety-nine percent of safety care concerns identified were followed-up in the consumer's individual plan of service. A breakdown resulted in the following percentages: • Consumer Services, 100% • Easter Seals, 100% • Genesee, 98% • New Century Support Services, 100% • New Passages, 100% • Training and Treatment Innovations,	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		100% • Vocational Independence, 100% **<u>AT RISK BEHAVIORS/ACTIVITIES:</u>** • Criminal record background checks prior to hire were not consistently present in records reviewed. (Gatti CLF Lochhead, Genesee Regional Crisis Residential home, Sherwood-Duffield AFC) • Staff driver's <u>license verification</u> were not regularly present. One Thorn AFC staff member's license had expired 2002. (Andrews & Johnson Inc #3, Sherwood-Duffield AFC, Thorn AFC) • Evidence that <u>reviews</u> of driver licenses for violations was not present. (Gatti CLF Lochhead, Parkside FAIS, Richfield Corners CLF) • The dryer filter was completely filled with lint. This practice poses a fire risk. (Gatti CLF Lochhead) **<u>EMERGENCY RESPONSE CAPACITY (E.G., FIRE, DISASTER, MEDICAL EMERGENCY):</u>** • Policies and procedures for	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		contingency plans were not consistently present in homes reviewed. For example, emergency shelter plans, water shortage, and chemical threat policies. (Andrews & Johnson Inc #3, Gatti CLF Lochhead, Parkfield FAIS, Richfield Corners CLF, Sherwood-Duffield AFC, Thorn AFC) • Many policies had not been reviewed since 1995. • E-scores to assess evacuation needs had not been consistently completed. (Andrews & Johnson Inc #3, Richfield Corners CLF, Sherwood-Duffield AFC, Thorn AFC) • Evacuation plans were posted. However, they did not contain accurate information. (Parkside FAIS and Richfield Corners CLF) • Emergency bags for vans and homes were not complete. • Homes did not consistently have a procedure to follow to ensure the safety of consumers in the event of a driving accident. • Homes that did have a procedure to follow in the event of a driving accident were not consistently	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		consumer focused. • The evacuation plan for the home reflected the following "all consumers and staff should be evacuated from the premises' immediately via the **van**". However, the home didn't have a van only a car. Twelve individuals and staff could not be loaded into the car. An appropriate plan needs to be developed to ensure consumer safety. (Sherwood-Duffield AFC) • Evidence to support that tornado drills had taken place was not present. (Gatti CLF Lochhead) **SAFETY OF THE SETTING:** **Andrews & Johnson #3** This was a white aluminum sided two story home with black awnings. It was licensed, with an expiration date of 9/9/2011, for six beds and was at full capacity. The home was located in a subdivision and had a circular driveway. Three residents were present during the visit. The last audit conducted by the CMH was dated 2/24/10. A tour of the facility resulted in the following findings: • Emergency bags were incomplete. • Posted food menus did not	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		include snacks. • Documentation to support that wheelchairs were monitored for cleanliness and safety was not present. • External inspection for plumbing was not completed. • The handrail leading to the second floor was not secure. • The manager had developed a preventive maintenance tool to monitor the home. However, it had not been utilized. • The carpet was gathered in one bedroom and needed to be stretched to prevent a trip and fall hazard. • The bathrooms were in need of fresh chalking. • The heat vent in the living room was detached from the wall. • The kitchen cupboards and shelving was in need of repair. Paint was missing in several areas. **Gatti CLF Lochhead** This was a beige aluminum sided two story home. It was licensed, with an	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		expiration date of 11/19/2011, for six beds and was at full capacity. The home was located in a subdivision. The residents were at another home participating in a "pot luck" activity. The reviewer was advised that this occurs regularly every three weeks to provide a social activity. The homes alternate the location. The last audit conducted by the CMH was dated 5/17/10'. A tour of the facility resulted in the following findings: • The kitchen counter had large spaces where caulk was missing. The thermometer in the refrigerator did not register an accurate reading. Both the inside and outside of the stove exhaust unit was rusted. • Emergency bags were incomplete. • The lower bathroom floor appeared to be water damaged. Large sections of paint on the ceiling were peeling away from the surface. The slab of wood next to the tub had a mold like material around the edges. • In the upper bathroom sections of linoleum were separating from the floor. Many of the tiles in the shower needed grout. The rubber and wood baseboards were not attached to the wall in several	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		areas. • The heat register in the large bedroom was damaged and missing fins. • One of the upstairs bedrooms needed plaster repair to the wall. The wooden floor was discolored and damaged • There was a bird and cat in residence. A policy regarding the care of the pets was not present. Nor was there a policy to ensure consumer safety. For example, if someone was allergic to the pets what steps would be taken to ensure the individuals health and safety. • The handrail leading to the upper level of the home was not sturdy. *Positive Observation:* *An in home programming schedule was posted on a large white post board in the kitchen. It identified each individuals activities and the time that the activity was to occur. The reviewer was advised that the activities were designed to aid in the consumer's independence.* **Parkside FAIS** This was a brick ranch home with white shutters located in a subdivision. It was a	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		former AIS/MR facility and was handicap accessible. The expiration date of the license was 1/22/2011 (two days after this review), and was licensed for six beds and at full capacity. Two residents were present during the visit. The provider was Central State Community. The last audit conducted by the CMH was dated 11/10/10. A tour of the facility resulted in the following findings: • Heat registers and vents were damaged i.e., rusted, chipped and/or missing fins. • The strip of wood in the small bathroom connecting the Kydex protective wall covering to the dry wall was broken. The piece that remained had sharp edges. • The home lacked a preventive maintenance check list. Nor was a process articulated for monitoring the homes maintenance. • Evidence that staff meetings occurred regularly was not present. • The emergency hall light failed when tested. • The thermometers in the refrigerator and refrigerator did not function properly (a temperature was not indicated).	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• One bathroom lacked paper towels. The reviewer was advised that two consumers “stuffed toilets”. A review of the individual’s clinical records revealed a behavior plan for only one of the two persons. • The emergency bag contained hard candy. However, the agency policy stated that no hard candy was to be included in emergency bags. • Tiles were missing or loose in the large bathroom. Grout and caulk needed to be replaced. • The ceiling between the dinning area and hallway was cracked from one end of the wall to the other. **Richfield Corners CLF** This was a brick and vinyl sided ranch home located in a rural area on about an acre of land. It was a former AIS/MR facility and was handicap accessible. The expiration date of the license was 1/4/2012, and was licensed for six beds and was at full capacity. One resident was present during the visit. The provider was Alternative Services. The last audit conducted by the CMH was dated 10/21/10. A tour of the facility resulted in the following findings:	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• The smoke detector in the southwest bedroom was missing the outer cover. This concern was also reflected in the December 1, 2009 Department of Human Services Bureau of Children and Adult Licensing Report. Renewal of the license was contingent upon receipt of a corrective action plan. However, it appears that the plan may not have been implemented. • The freezer, when checked, lacked a thermometer. Reviewer was unable to determine the interior temperature of the refrigerator. However, the manager obtained and placed one in the freezer prior to the reviewer leaving the home. The refrigerator lacked interior door guards to protect food from falling when opening the door. • The return air vents in various areas throughout the home were damaged. • Heat registers and vents were not clean. One was missing completely (leaving a gaping whole) some others were damaged i.e., missing grates, rusted, and/or chipped. • One bedroom contained a	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		portable oxygen tank. However, none of the individuals in the home had an order for oxygen. • The living room inside front door needed to be painted. It was also missing part of the seal which allowed one to see out side. Heat was escaping. The window blinds were broken with missing blinds and the size of the blind did not fit the window. The entrance rug runner was damaged. • The basement stairwell lacked a light. It was reported that standing water was in the basement due to leaks from the main floor. • The Kydex protective wall covering needed to be cleaned. • The small bathroom's dry wall was water damaged. Grout was missing from most of the shower tiles. Most of the metal equipment/fixtures were rusted. • The large bathroom had a light fixture missing. The "Hoyer" lift when tested failed and was not operable. Many areas needed both caulk and grout. Water from the faucet would not shut off. There was a stain in the bottom of the tub under the faucet.	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• The finish was striped from the water jets in the whirlpool. The whirlpool vent was extremely rusted and damaged. • The home had a preventive maintenance check list. However, it was not regularly completed. • Staff meeting minutes were not regularly in place. • One individual's plan of service reflected a "walking" program. Evidence that supported the program had been implemented was not present. **Sherwood-Duffield AFC (Sherwood Care Facilities)** This was a green ranch home and had converted the garage into a sunroom. It was licensed, with an expiration date of 3/21/2012, for twelve beds and was at full capacity. Five of the twelve were contacted with the home by Genesee CMH. The home was located in a rural like setting. Three residents were present during the visit. The last audit conducted by the CMH was dated 4/30/10. A tour of the facility resulted in the following findings: • Emergency bags were incomplete. • The refrigerator, when checked,	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		contained an oven thermometer. Reviewer was unable to determine the interior temperature of the refrigerator. • A review of the shift to shift communication log revealed a trend. Several entries stated that the "girls" room was "cold" or "freezing". • The use of white out was present in several entries in the Communication Log. • The floor in the "girls" room was damaged and presented a trip and fall hazard. • The basement had a large accumulation of water on the floor. Water appeared to be leaking in from a separation in the wall. • The home's heating had been converted from a boiler system to gas forced air. However, the damaged non-functioning registers from the former system remained. • The wooden floors throughout the home were damaged and needed to be refinished. • One male consumer engaged the reviewer and stated that he never	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		gets to go anywhere. This was conveyed to the staff and a request was made to contact the case manager and inform him/her of the consumer's desire. **Thorn AFC** This was a two large brick story home. It was licensed, with an expiration date of 2/9/2011, for twelve beds and had two vacancies. Five of the ten were contacted with the home by Genesee CMH. The home was located in a subdivision on a main road. Four residents were present during the visit. The last audit conducted by the CMH was dated 10/18/10. A tour of the facility resulted in the following findings: • Emergency bags were incomplete. • Food menus were not posted as required. • Hand rails were not secure (leading upstairs to the bedrooms was loose so was the hand rail leading to the basement from the main floor). • There was a lack of evidence that the water temperature was monitored. An oven thermometer was provided when the reviewer asked to check the temperature.	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• The kitchen floor was damaged. • The kitchen door leading to the basement was in need of repainting. The metal was showing in many large areas and the white paint was spotty. • The large heavy radiator covers were not secured. • Chairs in two of the bedrooms were damaged and needed to be replaced or repaired. • The bathroom toilet when flushed continued to run without stopping. • The caulking in the bathrooms needed to be replaced. • The bathtub was severely damaged. The home owner said it was being replaced with a shower. **Vista Drop-in Center** The smoke detector when tested failed. **Consultative Recommendations:** • Many of the homes contained heavy emergency bags. A wheeled emergency bag would increase ease of movement during an emergency.	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• Emergency bags should minimally contain a radio, batteries, first aid kit, consumer profiles, flash light, gloves, keys (van and house), blankets, wet wipes, water and snacks (*with expiration dates clearly labeled*), snacks for other specialty groups as appropriate for example sugar free snacks for diabetics, depends (as appropriate) staff and guardian telephone numbers. • Homes should be provided Bio-terrorism plans. These plans can typically be obtained from the County Health Department. **INCIDENT REPORTS** Only eleven incident reports were present to be reviewed. The reviewer read “Communication Logs” and other documentation that reflected the need for incidents to be reported. Incident reports did not appear to be regularly generated when appropriate. • Documentation was not regularly present to address needed changes to prevent future incidents of the same type. • Reviewer was advised of a medication error. However, documentation of the error (incident report) was not present.	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		(Sherwood-Duffield AFC) • Documentation that consumers had fallen was present in the communication log. However, incident reports were not completed. (Sherwood-Duffield AFC) • It appeared that incident reports were not regularly completed at Andrews & Johnsons #3, Sherwood-Duffield AFC or Thorn AFC. The last incident report was dated 5/04/09 at Andrews and Johnson #3 and only one incident report was present for the last 12 months at Sherwood-Duffield AFC. The reviewer was advised that the last incident report was over 2 years ago at Thorn AFC. • There were no incident reports to review at the Gatti CLF Lochhead home. Reviewer was advised that incidents had occurred and reports were documented. However, the manager was not allowed access to the reports.	
D.3.2. Organizational process for monitoring medications. R 330.1719 R 330.2813 R 330.7158	1	Note: The PIHP had an organizational process for monitoring medications. In those instances where consumers received psychotropic medications ninety-five percent had medication consents. A break-down resulted in the following percentages:	Submit a plan with time frames for ensuring that the PIHP: • Medication administration policy is consistently implemented. • Topical medications are

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• Consumer Services, 100% • Easter Seals, 100% • Genesee, 92% • New Century Support Services, 92% • New Passages, 97% • Training and Treatment Innovations, 100% • Vocational Independence, 100% **MEDICATION ADMINISTRATION:** • Topical medications were not separated from oral medications. (Andrews & Johnson #3, Gatti CLF, Parkside FAIS, Thorn AFC) • Expired medications were present in the medication cabinet. (Andrews & Johnson #3) • The medication cabinet was disorganized. Medications, (oral & topical), injection pens, and other items i.e., tape were not separated. Reviewer suggested that the CMH registered nurse be contacted to update medication training and identify proper medication storage. (Thorn AFC) • There was one container in the	separated from oral medications. • Expired medications are disposed of according to the agency policy. • Medication storage is orderly. • Incident reports are documented when a medication error occurs.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		medication cabinet that contained the medications of various individuals. (Andrews & Johnson #3) • Medication consents reviewed did not consistently contain the right for the individual or guardian to withdraw their consent at anytime. (Spectrum) • Informed medication consents were not consistently signed by the consumer or guardian. (Genesee)	
D. ADMINISTRATIVE FUNCTIONS **4. ACCESS STANDARDS** Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.3.1.1	**37/38**		
D.4.1. The Organization's Access System is available to all Michigan residents and is not restricted to individuals who live in a particular geographic region. Contract, Attachment P 3.3.1.1, Standard I.a.	2		
D.4.2. Access System Services staff members are welcoming, accepting, and helping with all applicants for services, including individuals with co-occurring mental health and substance use disorders. Contract, Attachment P 3.3.1.1, Standard I.a.	2		
D.4.3. Access centers/units in the service area routinely screen and assess for co-occurring disorders.	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
(AFP 3.8.4.)			
D.4.4. The PIHP has formal procedures in place to assure that individuals with a co-occurring mental health and substance use disorder are not inappropriately denied access during screening or initial assessment. (AFP 3.1.3.)	2		
D.4.5. The Access System is available 24 hours a day, seven days per week. Contract, Attachment P 3.3.1.1, Standard I.b.	2		
D.4.6. The Access System's telephone response system is answered by a live voice and demonstrates a welcoming atmosphere. Contract, Attachment P 3.3.1.1, Standard I.b.i.	1	During interviews five consumers reported the crisis line was answered by a recording. One consumer reported that access staff were not welcoming.	Submit a plan with time frames for assuring that the access system is answered by a live voice demonstrating a welcoming atmosphere 24 hours a day, seven days per week.
D.4.7. Access System crisis/emergent telephone calls are immediately transferred to a qualified practitioner without requiring an individual to call back. Contract, Attachment P 3.3.1.1, Standard I.b.ii.	2		
D.4.8. Responses to non-emergent calls are completed in a timely manner. Contract, Attachment P 3.3.1.1, Standard I.b.iii-iv.	2		
D.4.9. Individuals who walk in to an Access System are provided a timely and effective response to their requests for assistance. Contract, Attachment P 3.3.1.1, Standard I.c.	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
D.4.10. The Access System has the capacity to accommodate individuals who have special access needs. Contract, Attachment P 3.3.1.1, Standard I.d.	2		
D.4.11. Access system services do not require prior authorization and are to be provided without charge to the individual being served. Contract, Attachment P 3.3.1.1, Standard I.e.	2		
D.4.12. Access System staff members provide applicants with a summary of their recipient rights, including their rights to a person-centered planning process and timely access to the pre-planning process. Contract, Attachment P 3.3.1.1, Standard I.f.	2		
D.4.13. The PIHP provides notice of rights to a second opinion in the case of denials.	2		
D.4.14. The PIHP provides or refers and links individuals who are denied inpatient psychiatric hospitalization services to alternative services.	2		
D.4.15. The Access System shall inquire as to the existence of any established medical or psychiatric advanced directives relevant to the provision of services. Contract, Attachment P 3.3.1.1, Standard II.c.	2		
D.4.16. Clinical Screening for eligibility results in a written (hard copy or electronic) screening decision which addresses each of the required elements. Contract, Attachment P 3.3.1.1, Standard III.e.	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
D.4.17. The PIHP has a regular and consistent outreach effort to commonly unserved and underserved populations which ensures that outreach occurs regardless of the presence of a co-occurring disorder. Contract, Attachment P 3.3.1.1, Standard VIII.b.ii.	2		
D.4.18. The PIHP's medical director is involved in the review and oversight of Access System policies and clinical practices. Contract, Attachment P 3.3.1.1, Standard VIII.c.i.	2		
D.4.19. The PIHP shall monitor Access Center performance and implement quality improvement measures in response to performance issues. Contract, Attachment P 3.3.1.1, Standard VIII.c.iv.	2		
D. ADMINISTRATIVE FUNCTIONS **5. BEHAVIOR TREATMENT PLAN REVIEW COMMITTEES** Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.-10/1/08	**24/24**		
D.6. COORDINATION (Medicaid Managed Specialty Services and Supports Contract, Part 2 – Statement of Work; 42 CFR 438.208)	**10/10**		
E.1 STAFF QUALIFICATIONS, SUPERVISION & TRAINING REQUIREMENTS	**35/42**		
E.1.1. The PSR program has one full time on-site clubhouse manager who is a qualified professional and has extensive experience with the target population	2		

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
and is licensed, certified, or registered by the State of Michigan or a national organization to provide health care services.			
E.1.2. Non-degreed staff members who carry out treatment activities in crisis residential programs must have at least one year of satisfactory work experience providing services to beneficiaries with mental illness or have successfully completed a PIHP/MDCH approved training program for working with beneficiaries with mental illness.	1	A staff member from the crisis residential program lacked the required work experience.	Submit a plan with time frame for ensuring that non-degreed staff hired at the crisis residential unit has at least one year satisfactory work experience providing care to individual with serious mental illness, according to MDCH requirement.
E.1.3. Primary case manager must be a professional who possesses a bachelor's degree in human services.	2		
E.1.4. Professionals providing intensive crisis stabilization services must be a mental health care professional.	2		
E.1.5. Home-based staff members are child mental health professionals.	2		
E.1.6. Home-based staff members for individuals with a developmental disability must be a QMRP and a child mental health professional.	2		
E.1.7. The PIHP ensures that Waiver service providers meet credentialing standards prior to being formally enrolled as part of the PIHP's provider panel.	2		
E.1.8. The PIHP ensures that Waiver service providers continue to meet credentialing standards after being formally enrolled as part of the PIHP's provider panel.	2		
E.1.9. The PIHP ensures that non-licensed Waiver service providers meet the provider qualifications identified in the Medicaid Provider Manual.	1	The PIHP had a process but it was not fully effective. Reference E.3.8	Submit a plan with time frames for ensuring that the PIHP have an effective monitoring of their non-licensed provider.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
E.2.1. The home-based program is supervised by a QMHP and Child Mental Health professional.	2		
E.2.2. Non-professional staff in the PSR program work under the documented supervision of a qualified professional.	2		
E.2.3. Crisis Residential Treatment services must be provided under the immediate direction of a professional possessing at least a bachelor's degree in a human services field, and who has at least 2 years work experience providing services to beneficiaries with a serious mental illness.	1	The senior home manager who was also assigned as the case manager for the crisis residential unit possessed a bachelor degree in psychology. However, review of her credential and work experience revealed that this staff was not licensed and did not have documentation to support that she had two years experience providing services to individuals with serious mental illness prior to hiring at the crisis residential unit.	Submit a plan with time frames for ensuring that direct supervision of the crisis residential treatment service meets the program requirement.
E.2.4. Supervision of personal care services must be provided by a health care professional that meets the qualifications outlined in the Medicaid Provider Manual. R 330.2805 R 330.2806 Medicaid Provider Manual, Section 11	2		
E.2.5. The intensive crisis stabilization services team may be assisted by trained paraprofessionals under appropriate supervision. The trained paraprofessionals must have at least one year of satisfactory experience providing services to persons with serious mental illness.	2		
E.3.1. All ACT team staff members must have a basic knowledge of ACT programs and principles acquired	1	Evidence to support that ACT staff members had received ACT specific	Submit a plan with time frames for ensuring that all ACT staff members receive ACT

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
through ACT specific training.		training was not consistently present in the personnel records reviewed. Some staff members were recently hired and were registered to attend ACT specific training in March of 2011 (TTI). A peer specialist lacked ACT specific training. (New Passages) An ACT specialist lacked ACT specific training as well as a registered nurse that was filling in temporarily. Team 2 Genesee)	specific training, i.e., ACT 101, as well as all required core trainings.
E.3.2. All access centers/units in the service area have professional staff members who are cross-trained in performing assessments for co-occurring disorders. (AFP 3.8.4.)	2		
E.3.3. Providers must document initial and ongoing training for case managers related to core requirements.	1	There was a lack of evidence to support that case management staff members were consistently trained in co-occurring disorders (Consumer Services) and person-centered planning (Genesee). Note: A case manager that developed an individual plan of services that contained substance use treatment goals lacked a substance abuse treatment provider credential. Additionally, the staff informed the reviewer that the consumer was being referred to another substance abuse treatment provider for treatment. The reviewer questioned why this consumer was being referred to another provider when the case manager worked at an agency that was licensed to provide substance abuse service. This appeared to	Submit a plan with time frames for ensuring that providers document initial and ongoing training for case managers related to core requirements.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		conflict with the Integrated Dual Diagnosis Treatment philosophy of one plan, one team, one location. (Consumer Services)	
E.3.4. Home-based assistants must be trained prior to beginning work with the beneficiary and family.	N/A	The PIPH does not utilize home-based assistants.	
E.3.5. For home-based programs serving infants/toddlers (birth through age three) and their families, staff must be trained in infant mental health interventions.	2		
E.3.6. Staff members are trained in the philosophy and methods of person-centered planning.	1	A staff member lacked person-centered planning training. (Genesee) A temporary registered nurse on the also lacked person-centered planning training. (ACT team 2 Genesee)	Submit a plan with time frames for ensuring that all staff members receive person-centered planning training.
E.3.7. Staff members are trained in the philosophy and methods of self-determination. Medicaid Managed Specialty Supports and Services contract §6.2 (Training, Education, Experience and Licensing Requirements).	2		
E.3.8. The PIHP shall identify staff training needs and provide in-service training, continuing education, and staff development activities that include the topic areas of abuse and neglect (recipient rights), medical emergencies, environmental emergencies, universal precaution, behavior management (applied behavioral sciences); crisis management*;* Person-centered training: cultural diversity, HIPAA, language proficiency; grievance and appeal; and other DHS approved training required for staff members working in specialized residential settings as applicable.	1	Training records lacked documentation to support that required initial and ongoing training consistently occurred at residential sites visited. The outcome of the review resulted in the following findings: **<u>Andrews & Johnson Inc #3</u>** Three staff training records were reviewed.	Submit a plan with time frames for ensuring that: • Staff members receive required training. • Ongoing training occurs, as required. • Job descriptions are maintained in personnel records. • Evidence that staff received copies of

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
Administrative Rule R330.1806 AFP 3.8.3 Person-Centered Planning Guideline		• Three staff lacked annual person centered planning training per Genesee's policy. In one case the last PCP training had occurred 12/11/00. • Evidence of ongoing training was not present. • One individual lacked evidence of basic health training. The two others had not repeated this training since 12/14/99. • Annual performance evaluations were not present in any personnel files. **<u>Gatti CLF- Lochhead</u>** Three staff training records were reviewed. • None of the staff members had evidence that they had received their job description nor were job descriptions maintained in their personnel records. • Staff lacked evidence of training in population specific issues, i.e., diabetes, special diets ... • Evidence of ongoing training was not consistently present. • Required performance appraisals	their job descriptions is present. • Performance evaluations used to gauge staff competence are regularly completed according to policy.

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		were not regularly completed. **<u>Parkside FAIS</u>** Three staff training records were reviewed. • Evidence that basic health and medication training had been updated/repeated was not present. • None of the staff members had evidence of training in population specific issues, i.e., diabetes, lifts, and special diets. • Evidence to support that reviews of staff driver license was not present. *<u>Positive Observation</u>* *The training records were well organized and reviewer friendly. Central State Agency had a training center.* **<u>Thorn AFC</u>** Three staff training records were reviewed. • Evidence that basic health, medication, person-centered planning, and infection control training had been updated/ repeated was not present. One had not been repeated since 9/1/99.	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		• Not all staff had evidence of training in population specific issues, i.e., diabetes. • Performance evaluations were not regularly in place as required by policy. • Required job descriptions were not a part of the personnel record nor was there evidence that staff had received a copy of their job description. • The date of the staff members hire was not consistently contained in personnel records. **Richfield Corners (CLF)** Three staff training records were reviewed. • Basic health training had not repeated in two of the staff records reviewed. One had not been repeated since 3/19/99. • Not all staff had evidence of training in population specific issues, i.e., diabetes, working with the blind, safe lifting. • Performance evaluations were not regularly in place as required by policy.	

DIMENSIONS/INDICATORS	SCORE	FINDINGS	REMEDIAL ACTION
		Positive Observation: *It was reported that the Alternative Services Program Coordinator completes monthly audits in all of their homes. This individual was present and reviewing training records during the MDCH site review.* **Sherwood-Duffield Road Home (Sherwood Care Facilities)** Six staff training records were reviewed. • Basic health training had not been repeated in two of the staff records reviewed. One had not been repeated since 3/4/98, and the other since 12/14/99. • Not all staff had evidence of training in population specific issues, i.e., gentle teaching and food texture. • Performance evaluations were not regularly in place as required by policy.	