Southwest Michigan
BEHAVIORAL HEALTH

Section: **Provider Network Management**	Policy Name: **Provider Network Monitoring**	Policy Number: **02.13**
Owner: **Director of Provider Network Management**	Reviewed By: **Mila C. Todd**	Total Pages: **5**
Required By: ☒ **BBA** ☒ **MDHHS** ☐ **Other (please specify):** _____	Final Approval By: Mila C. Todd Mila Todd (Mar 31, 2023 05:58 EDT)	Date Approved: Mar 31, 2023
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☐ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** ____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☐ **Other (please specify):** _____	Effective Date: **1/1/2014**

Policy: Southwest Michigan Behavioral Health (SWMBH) and participant Community Mental Health Service Providers (CMHSP) shall monitor the performance, quality, contract compliance and compliance with Federal and State standards and regulations of each entity with whom it contracts to provide mental health and substance use disorder services for customers utilizing Medicaid funds. SWMBH and its participant CMHSPs will monitor their provider network(s) annually at minimum. Monitoring may occur through a variety of mechanisms, such as through the use of shared reviews conducted by external Prepaid Inpatient Health Plans (PIHP), where appropriate. SWMBH will review and follow-up on any provider network monitoring conducted by its participant CMHSPs. SWMBH and its participant CMHSPs will adhere to the Michigan Department of Health and Human Services (MDHHS) Network Management Reciprocity & Efficiency Policy while conducting review activities.

Purpose: The purpose of this policy is to define the methods for monitoring, review, and oversight of contracted providers by SWMBH and participant Community Mental Health Service Providers (CMHSP) to assure the highest quality of services are provided to customers.

Scope: SWMBH; Participant CMHSPs

Responsibilities: SWMBH and its Participant CMHSPs are responsible for annual monitoring of their provider network(s) to ensure compliance with applicable contract provisions, rules, and regulations.

Southwest Michigan
BEHAVIORAL HEALTH

Definitions:

A. **Sanctions:** Penalties triggered when a provider fails to meet specified performance standards or other conditions of the contract. Sanctions include a range of options of varying in severity depending on the seriousness, frequency and/or nature of the contract violation. Sanctions may include, but are not limited to:

1. Letter of guidance, warning or reprimand
2. Impose conditions for continued practice within the SWMBH provider network.
3. Referral moratorium
4. Impose requirements for monitoring or consultation.
5. Recommendation for additional training or education.
6. Contract termination with cause.

Standards and Guidelines:

A. Communication to Providers Regarding Requirements & Expectations

SWMBH and participant CMHSPs will assist providers in understanding contractual requirements and expectations through a variety of means including, but not limited to:

1. New provider orientation of contractual requirements and business practices.
2. Designated provider network staff to address provider questions and concerns.
3. Notification to providers of changes in Federal and State regulations impacting contractual requirements and/or business practices.
4. Notification to contracted providers of changes in SWMBH or CMHSP policy.
5. On-going training.

B. Communication from Providers regarding Negative Action

1. It is the responsibility of providers to communicate negative actions to the entity that holds the contract with the provider. Participant CMHSPs shall report negative actions regarding their provider networks to SWMBH within five (5) business days of becoming aware of an action.
2. Providers are expected to provide immediate notification (within 10 business days) for the following actions:
    a. Loss of accreditation.
    b. Loss of insurance.
    c. Unfavorable financial audit.
    d. Successful litigation claim against the Provider member.
    e. Loss of substance abuse license.
    f. Loss or change in Adult Foster Care or Child Placing Licensing.
    g. Reports of substantiated violations of State or Federal rules or regulations.
    h. Any claim, allegation, financial loss or change in credentialing that may negatively impact the provider.
    i. Loss of professional licensure.
3. Sentinel Events must be reported as soon as possible and in accordance with the MDHHS contract and SWMBH policy.

C. Provider Monitoring Review Elements

1. The monitoring of providers shall consist of a review of the following applicable elements:
    a. Federal regulations, including the Medicaid Managed Care Regulations, Code of Federal Regulations (CFRs), Health Insurance Portability and Accountability Act (HIPAA), Centers for Medicare and Medicaid Services (CMS) protocols for PIHPs, and applicable federal laws pertaining to the Medicaid program and/or health plan.
    b. PIHP managed care administrative delegations to CMHSPs.
    c. Michigan Mental Health Code and Substance Use Disorder Administrative Rules.
    d. Provider contract provisions.
    e. SWMBH policies, standards and procedures.
    f. Michigan Medicaid Provider Manual
2. Reference source(s) for specific monitoring or audit standards will be included on monitoring tools.
3. Monitoring tools will be reviewed annually for necessity, value and efficiency of specific monitoring or audit standards.
4. When adding new monitoring items to review processes, SWMBH and its participant CMHs will review the necessity of existing items, and whenever possible consider reducing or eliminating items of less value.
5. SWMBH and its participant CMHs will utilize the provider review tools attached to this policy for provider reviews.
6. SWMBH and its participant CMHs will incorporate meaningful consumer involvement in the monitoring activities of service providers.
7. SWMBH and its participant CMHSPs will utilize processes and procedures to share provider monitoring results of shared providers within the SWMBH region in order to reduce redundant processes and duplicative site reviews of providers contracting with multiple SWMBH organizations.
8. Monitoring results may be obtained from another Regional Entity/PIHP for shared providers. Results will be reviewed and if found complete and sufficient, may be accepted in the provider file as evidence of provider monitoring.
9. This policy does not usurp the ability of the funding PIHP/CMHSP to conduct ad hoc audits or reviews of provider programs where needed or indicated at any time based on reported performance or as required by external entities

D. Provider Non-compliance and Sanctions

Whenever possible, SWMBH and participant CMHSPs will work toward continuous improvement with providers who are out of compliance with their contract. SWMBH and participant CMHSPs will develop procedures to address contract compliance and the use of sanctions.

1. Sanctions will be used with providers who demonstrate unsatisfactory performance, lack of response, failure to submit plan of correction within required timeframe and/or discovery of significant risks (i.e., health hazard, injury, loss, exposure).

2. Sanctions will be based on the severity and frequency of the contractual violation(s). Typically, sanctions may be progressive in nature, but can begin at any level depending on the severity and frequency of the violation.
3. Under usual circumstances (a non-emergent situation where health and safety is not at risk), sanctions will require providers to satisfactorily remediate/correct violations noted, within a time frame determined by the contracting entity.
4. Under emergent situations where health and safety is a concern, the provider will immediately remediate/correct violations.
5. Ongoing monitoring of the provider will occur to ensure prompt resolution of the issues for which the sanction was applied.

F. Communication to Providers regarding Sanctions

1. SWMBH and participant CMHSPs will send the provider notice outlining the areas of non-compliance. Correspondence will outline the following:
    a. Area(s) of non-compliance
    b. Level and type of sanction
    c. Expected remedy or improvement
    d. Additional monitoring of the provider.
    e. Date the remedy is expected to occur.
    f. Due date for a response from the provider.
    g. Contact person for questions and correspondence.
    h. Statement indicating that continued non-compliance may include termination of the contract.
    i. Notice of grievance and appeal process for non-clinical decisions.
2. Participant CMHSPs shall report contractual sanctions of their provider networks to SWMBH within five (5) business days of the sanction date.

References:

MDHHS-PIHP Contract, Schedule A, Section 1(E)(1)

Attachments:

A. 02.13A Primary & Clinical Providers Administrative Review Tool
B. 02.13B Ancillary Community-Based Services Administrative Review Tool
C. 02.13C Specialized Residential Administrative Review Tool
D. 02.13D Financial Management Services Administrative Review Tool
E. 02.13E SUD Full Administrative Review Tool
F. 02.13F SUD Recovery Housing Review Tool
G. 02.13G SUD Provider Full Clinical Review Tool
H. 02.13H LPH Compliance Standards with Guidance
I. 02.13I Inpatient Staffing Chart
J. 02.13J IPHU Chart Summary
K. 02.13K ABA Administrative Review Tool
L. 02.13L ABA Provider Clinical Quality Review Tool

Southwest Michigan
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Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	7/1/2020	N/A	Moved to new template	Mila C. Todd
1	4/27/2022	References Attachments	Updated MDHHS-PIHP contract reference Updated Attachments list	Mila C. Todd
2	03/23/2023	N/A	Annual review. Provided updated Attachments and updated 02.13D Attachment to "Financial Management Services". Added new 02.13F – Recovery Housing Tool, re-lettered remaining attachments.	Mila C. Todd

02.13 Provider Network Monitoring

Final Audit Report 2023-03-31

Created:	2023-03-29
By:	Megan O'Dea (megan.odea@swmbh.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAe2mRS5et8RJd1rMQho0wrNmNm0cEgwGw

"02.13 Provider Network Monitoring" History

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Review Date: _____

Provider: _____

Service: *Select one or more - ACT, Homebased, Wraparound, Outpatient Therapy, Psychiatry, Targeted Case Management, Autism Services, OT/PT, Speech*

Reviewer: _____

SCORING INSTRUCTIONS

2 = compliance with standard/intent

1 = partial compliance standard/intent

0 = non-compliance or insufficient levels of compliance with standard/intent

N/A = requirement not applicable to this type of review or this provider

Professional Clinical - any provider with professional licensure or certification. Typically will go through formal credentialing; Primary Provider - those responsible for creating and monitoring the IPOS (not necessarily licensed or certified but may be).

		Possible Score	Actual Score	References	Comments	Plan for Improvement
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT						
1.1	The provider has adequate ***physical safeguards*** in place to prevent unauthorized use or disclosure of Protected Health Information (PHI), including, as applicable, both policy and procedures to protect PHI. (If reviewer determines policies and procedures are not applicable, explain reasoning in the "Comments" box) For example, paper records are locked with only appropriate			*HIPAA/HITECH* *42 CFR Part 2* *MH Code 330.1748*		
1.2	The provider has adequate ***technical safeguards*** in place to prevent unauthorized use or disclosure of PHI, including, as applicable, both policy and procedures to protect PHI. (If reviewer determines policies and procedures are not aplicable, explain reasoning in the "Comments" box). For example, password protection is used to access electronic			*HIPAA/HITECH* *42 CFR Part 2* *MH Code 330.1748*		
1.3	The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct (must have written certification that they have received, read, and will abide by SWMBH's Code of Conduct).			*PIHP Policy 10.1*		
1.4	Staff know what to do if they suspect Medicaid fraud or abuse within the organization. (N/A if no hired staff - e.g., Family homes). Compliance training content may be reviewed to assess this item.			*Deficit Reduction Act; Patient Protection & Affordable Care Act of 2010; HealthCare & Education Reconciliation Act of 2010*		**Could be staff interviews (Reviewer should note method of verification)**

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1.5	Plans for Improvement in response to citations/recommendations from the most recent reviews (licensing etc.) or licensing special investigations have been submitted to the appropriate agency, and there is evidence of implementation.					
	Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:			**Percent:**		
SECTION 2 - CUSTOMER SERVICES/ACCESS TO CARE						
2.1	Communication Accommodations: program has developed resources and incorporated features to overcome barriers for persons who have limited ability to communicate in standard English (i.e., LEP resources; bi-lingual staff; communication resources in alternative languages/formats [Braille, Spanish, audio enhancements, sign language communication; TDI; communication enhancement devices; signs; person served-specific communication techniques, etc.); interpreters]).			*PIHP Policy 4.1 Access Management Policy PIHP policy 6.5 (Communication Accommodations for Limited English Proficiency and Visual Impairment)*		
2.2	Taglines in the top 15 languages spoken in the state are posted advising clients of the availability of free language assistance services.			*Affordable Care Act Section 1557*		
2.3	The Notice of Non-Discrimination is posted advising clients they cannot be refused treatment based on race, color, national origin, sex, age or disability.			*Affordable Care Act Section 1557*		
	Section 2 - CUSTOMER SERVICES/ACCESS TO CARE Total:			**Percent:**		

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		Possible Score	Actual Score	References	Comments	Plan for Improvement
SECTION 3 - FACILITY & MAINTENANCE (If applicable - when customers are served at a provider-owned location)						
3.1	Handicapped access to facility, therapy/exam rooms, and restrooms is provided			*ADA Accessibility Guidelines (ADAAG) 4.13, 4.14, 4.23*		
3.2	Exits, corridors, and hallways are free of obstruction.			*ADA Accessibility Guidelines (ADAAG) 4.6*		
3.3	Rooms allow for privacy of conversation (voices of normal volume cannot be heard through walls)			*MHC 330.1261*		
3.4	Facility Grounds & Premises - driveway, surrounding yard areas, detached structures appear well maintained and free of obvious litter, refuse, etc. (note: roof, exterior walls, doors, windows/screens, stairways, sidewalks, attached structure, etc.).			*DHHS Site Review Protocol D.3*		
3.5	Facility Interior/Cleanliness - Sanitary environment is maintained throughout the facility. (furnishings, flooring, walls, smells, cleanliness, housekeeping standards, etc.).			*DHHS Site Review Protocol D.3*		
3.6	Maintenance of Facility - there is evidence that maintenance issues are being appropriately addressed (invoices for repair/inspection/replacement of equipment, utilities, evidence of facility improvements, etc.).			*DHHS Site Review Protocol D.3*		
	Section 3 - FACILITY & MAINTENANCE Total:			**Percent:**		
SECTION 4 - EMERGENCY RESPONSE (If applicable - when customers are served at a provider-owned location)						
4.1	Program has a comprehensive set of written Emergency Response Procedures containing clear instructions in response to fire, severe weather, medical emergencies, and emergencies while transporting individuals served, if applicable.			*DHHS Site Review Protocol D.3*		
4.2	Emergency evacuation maps/routes are displayed in prominent locations at the facility. (when customers are served at a provider-owned location)			*DHHS Site Review Protocol D.3*		
	Section 4 - EMERGENCY RESPONSE Total:			**Percent:**		

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SECTION 5 - MEDICATION MANAGEMENT (For providers who are distributing medication)						
5.1	If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.			*R 330.7158*		
5.2	A provider shall record the administration of all medication in the recipient's clinical record. 1) The dosage. 2) Label instructions for use. 3) Time to be administered. 4) The initials of the person who administers the medication, which shall be entered at the time the medication is given. 5) A resident's refusal to accept prescribed medication or prescribed procedures.			*R 330.7158*		
5.3	A provider shall ensure that medication errors (including refusals) and adverse drug reactions are immediately and properly reported and recorded in Incident Reports.			*R 330.7158*		**Has administrator/licensee provided specific performance improvement to prevent reoccurrence of the incident for each staff member involved, per Incident Report. Are there Incident Reports to explain any irregularities in the MAR?**
5.4	If there are no Incident Reports (any IRs, not limited to med errors) to review, do staff know the process for documenting and reporting applicable incidents?					**Staff interviews - if no IRs, do staff know what to do if one occurs?**
	Section 5 - MEDICATION MANAGEMENT Total:			**Percent:**		
SECTION 6 - STAFF TRAINING REQUIREMENTS						
6.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).			*MH Code: 330.1755(5)(f)*		
6.2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).			*MDHHS Master Contract Section (1)(B)(3)(k)*		
6.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).			MDHHS Master Contract Section (1)(B)(3)(k) 42 CFR 438.206		
6.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			*MIOSHA R 325.70016*		

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6.5	Limited English Proficiency (LEP) (within 6 months of hire).			*MDHHS Master Contract Section (1)(B)(3)(k)* *Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination*		
6.6	HIPAA (within 30 days of hire, annual updates).			*45 CFR 164.308(a)(5)(i) & 45 CFR 164.503.(b)(1)*		
6.7	Corporate Compliance (within 30 days of hire, annual updates).			*Medicaid Integrity Program (MIP)* *Deficit Reduction Act (DRA)*		
6.8	Individuals Plans of Service and Ancillary Plans (there is evidence that staff have been trained in the IPOS and in any applicable Support Plan for Individuals in their care before the provision of direct care [Behavior Treatment Plan, PT, OT, Nursing, etc.]).			*Michigan Mental Health Code* *330.1708*		
6.9	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior- (within 30 days of hire & annual updates, if working with individuals with challenging behavior)			*R 330.1806* *MDHHS BHDDA Technical Requirement for Behavior Treatment Plans*		
6.10	MDHHS-approved CPR (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years).			*R 400.14204*		
6.11	First Aid (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years). Required if providing Aide or Behavior Technician services as defined in Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes.			*Medicaid Provider Manual 2.4*		
6.12	Advance Directives (All in the following roles: Primary clinicians, Access/UM staff, Customer Services, Psychiatrists/nurses, Peer Support Specialists, Service supervisors/directors of the above listed staff)			*42 CFR 422.128* *42 CFR 438.3* *MDHHS Master Contract Section (1)(Q)(5)*		

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6.13	Grievances and Appeals within 30 days of hire and annually for all in the following roles: • Primary clinicians & SUD therapists (including residential/detox) • Access/UM staff, • Customer Services, • Service supervisors/directors of the above listed staff			*42 CFR 438.400-424 MDHHS Master Contract Section (1)(B)(3)(k)*		
6.14	Customer Services within 30 days of hire and annually for all in the following roles: • Psychiatrists/nurses, • Peer support specialists, • Recovery coaches, • Reception staff, • Service supervisors/directors of the above listed staff, • Minimum one person per site for all other services (MH and SUD)			*42 CFR 438.400-424 MDHHS Master Contract Section (1)(B)(3)(k)*		
6.15	Implicit Bias Training (for professional, licensed staff - at license renewal)					
6.16	Trauma Informed Training within 60 days of hire and annually thereafter			*MDHHS Trauma Policy SWMBH 2.15A*		**Consultative for FY23**
6.17	MDHHS three-day Wraparound Facilitator training (within 90 days of hire for Wraparound facilitators, and supervisors who are working with families)			*Medicaid Provider Manual 3.29.B*		
6.18	MDHHS Wraparound trainings (2 within 12 months of hire and 2 per calendar year thereafter for wraparound supervisors and facilitators. Supervisors must include one supervisory training).			*Medicaid Provider Manual 3.29.B*		
6.19	ACT training - MDHHS approved (within six months of hire and annual updates for ACT staff except physicians)			*Medicaid Provider Manual 4.3*		
6.20	ACT physician training - MDHHS approved (within 12 months of hire for ACT physicians)			*Medicaid Provider Manual 4.3*		

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		Possible Score	Actual Score	References	Comments	Plan for Improvement
6.21	Registered Behavior Technician (RBT) training - for Behavior Technicians. Prior to delivering behavioral health treatment services.			*Medicaid Provider Manual 18.12*		
6.22	Child and Family specific training (24 hours annually for Child Mental Health Professionals - CMHPs)			*Children's Diagnostic and Treatment Services Program requirement*		
6.23	LOCUS training (prior to administering and booster as required by MDHHS or SWMBH clinical policy - LOCUS assessors)			*MDHHS Master Contract*		
6.24	ASAM training (prior to administering and booster as required by MDHHS or SWMBH clinical policy - ASAM assessors)			*MDHHS Master Contract*		
6.25	SIS training (prior to administering and booster as required by MDHHS or SWMBH clinical policy - SIS assessors)			*MDHHS Master Contract*		
6.26	CAFAS/PECFAS training (prior to administering and booster every two years - CMHPs)			*Medicaid Provider Manual 7.2.B*		
	Section 6 - STAFF TRAINING REQUIREMENTS Total:			**Percent:**		
SECTION 7 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS						
7.1	The provider has written job descriptions for all positions. Each job description shall specifically identify all of the following: a. Job Title b. Tasks & Responsibilities c. The skills, knowledge, training, education, and experience required for the job d. Recovery-based (as appropriate), person-centered and culturally competent practices.			*PIHP Policy 1.2* *SWMBH-Provider Contracts* *OROSC Recovery Policy Practice Advisory*		

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7.2	Individuals have been credentialed prior to providing services that require credentialing. Re-credentialing occurs at least every 2 years, and includes: -updated attestation to credentialing application questions and any other updates to credentialing application information, -verification of valid and current licensure to practice in the State of Michigan, -verification of current malpractice insurance, -review of any quality concerns, -verification that the practitioner has not be excluded from participation in Medicaid through OIG/SAM check, -verification of licensure limitations or malpractice suits reported through NPDB check.			*MDHHS-PIHP Contract* *MDHHS BPHASA Credentialing Technical Requirement* *PIHP Policy 2.2 & 2.3*		
7.3	Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: A. Educational background (Primary source verification required) B. Relevant work experience C. Certification, registration, and licensure as required by law. (Primary source verification required)			*MDCH Contract attachment P.6.4.3.1* *PIHP Policy 2.2*		
7.4	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the verification protocol required by SWMBH policy 2.16; and subsequent verification of criminal back ground checks of current employees will occur every other year after the initial check. In the event of a positive criminal history screening result, provider follows SWMBH Policy 2.16.			*Contract Requirement; Public Act 59 (PA 218 400.734a); 5) AFC Licensing Rules: R.400.14201.13 (SGH); R.400.1404.6 (FH);* *PIHP Policy 2.16*		

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7.5	Primary source verification of State driving infractions has been conducted prior to hire and annually thereafter, for staff who transport customers. Provider has policies and procedures in place to ensure safe transportation of Customers receiving Supports/Services, including some form of verification of valid vehicle insurance.			*Payor Contract requirement: Transporting Customers*		
7.6	Personnel Performance Management: there is documented evidence that program has an adequate system to support, monitor, and complete at least annual performance evaluations of staff who provide direct care services.			*DHHS Site Visit Protocol B.1.3, 4.4.2(e), 5.4.2, 6.4.2, 7.4.1, 8.3.2*		
7.7	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each unlicensed* employee is to be run through the following databases, prior to hire and at least annually thereafter: 1. OIG exclusions database (https://www.exclusions.oig.hhs.gov/) and 2. The State of Michigan Sanctioned Provider list (https://www.michigan.gov/mdhh/doing-business/providers/providers/billingreimbursement/list-of-sanctioned-providers) and 3. System for Award Management (SAM) (https://www.sam.gov) *Licensed/credentialed staff must be run monthly (consultative for FY23).			*MDHHS Master Contract Section (1)(R)(10)(e) MDHHS-PIHP Contract - Federal Provisions Addendum, Paragraph 7 MDHHS Credentialing Policy PIHP Policy 10.13; 42 CFR 438.602*		**Exclusion screening results (review date); applicable policies/procedures if provider has any.** **Best practice is to run exclusions screenings monthly for any staff who provides Medicaid-funded services.**
	Section 7 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:			**Percent:**		

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Poss-ible Score	Actual Score	References	Comments	Plan for Improvement

Summary and Comments

Positive Observations:

Areas Needed for Improvement:

Other Discussion Points:

Health and safety issues requiring immediate attention will be documented above if not addressed elsewhere.

Scoring Summary	Poss-ible Score	Actual Score	Percent
Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:	0	0	
Section 2 - CUSTOMER SERVICES/ACCESS TO CARE Total:	0	0	
Section 3 - FACILITY & MAINTENANCE Total:	0	0	
Section 4 - EMERGENCY RESPONSE Total:	0	0	
Section 5 - MEDICATION MANAGEMENT Total:	0	0	
Section 6 - STAFF TRAINING REQUIREMENTS Total:	0	0	
Section 7 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:	0	0	
OVERALL	***0***	***0***	

Review Date: _____
Provider: _____
Service: *(Unit based CLS; Skill-building; Respite; Supported Employment; Music Therapy;* _____

Reviewer: _____
Location/Site: _____
Accreditation: _____

SCORING INSTRUCTIONS
2 = compliance with standard/intent
1 = partial compliance standard/intent
0 = non-compliance with standard/intent

		Possible Score	Actual Score	References	Comments	Plan for Improvement	
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT							
1.1	The provider has adequate ***physical safeguards*** in place to prevent unauthorized use or disclosure of Protected Health Information (PHI), including both policy and procedures to protect PHI. For example, paper records are locked with only appropriate staff members having access, and not left in open areas.			HIPPA/HITECH 42 CFR Part 2 MH Code 330.1748			Policy or Procedures
1.2	The provider has adequate ***technical safeguards*** in place to prevent unauthorized use or disclosure of PHI, including both policy and procedures to protect PHI. For example, password protection is used to access electronic records; encryption if PHI is being sent through email.			HIPPA/HITECH 42 CFR Part 2 MH Code 330.1748			Policy or Procedures
1.3	The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct (must have written certification that they have received, read, and will abide by SWMBH's Code of Conduct).			PIHP Policy 10.1			Code of Conduct
1.4	Staff know what to do if they suspect Medicaid fraud or abuse within the organization. (N/A if no hired staff - e.g., Family homes). Compliance training content may be reviewed to assess this item.			Deficit Reduction Act; Patient Protection & Affordable Care Act of 2010; HealthCare & Education Reconciliation Act of 2010			**Suggested Proofs: Compliance Training Content, Staff interviews, Compliance Reporting posting.**
1.5	Plans for improvement in response to citations/recommendations from the most recent reviews (licensing etc.) or licensing special investigations have been submitted to the appropriate agency, and there is evidence of implementation.			Payor Contract requirement: LICENSES, ACCREDITATIONS, AND CERTIFICATIONS; AND, CREDENTIALING AND PRIVILEGING REQUIREMENTS AND QUALIFICATIONS			
	Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:				**Percent:**	*#DIV/0!*	

		Possible Score	Actual Score	References	Comments	Plan for Improvement	
SECTION 2 - MEDICATION MANAGEMENT / HEALTH & SAFETY							
2.1	If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.			AFC Licensing Rules R400.14312 (SGH); R400-1418 (FH) MI Admin Code 330.7158(5)			SKIP IF NO MEDICATIONS ARE ADMINISTERED DURING PROGRAM; if provider answers "yes" then also score the Med Admin Training section
2.2	A provider shall record the administration of all medication in the recipient's clinical record, including 1) The dosage. 2) Label instructions for use. 3) Time to be administered. 4) The initials of the person who administers the medication, which shall be entered at the time the medication is given. 5) A resident's refusal to accept prescribed medication or procedures.			Michigan Mental Health Code R 330.7158			
2.3	A provider shall ensure that medication errors, missed medications, refusals and/or adverse drug reactions are immediately and properly reported and documented in Incident Reports.			Michigan Mental Health Code R 330.7158			
2.3A	If there are no Incident Reports (any IRs, not limited to med errors) to review, do staff know the process for documenting and reporting applicable incidents?						
2.4	If sharps are being used, there is a container on site for disposal which is not overfilled.			OSHA Blood borne Pathogens standard (29 CFR 1910.1030)			Containers should be clearly labeled as biohazards, kept in a secure area or container, and sharps are disposed of promptly once the container is full (policy/procedure/staff interview re: process, is the container currently full?).
2.5	Strategies to prevent the same incident from reoccurring are consistently documented in incident reports. Addendums to the individual plans of service are developed to address trends/concerns identified, as needed.			Payor Contract Requirement: HEALTH AND SAFETY OF CUSTOMERS; RECIPIENT RIGHTS AND CONSUMER GRIEVANCE PROCEDURES			Has administrator/licensee provided specific performance improvement to prevent recurrence of the incident for each staff member involved, per the Incident Report? Look for any incident reports to explain irregularities in the MAR.
2.6	Pets - if an agency has a pet or therapy animal on the premises, vaccination records should be available for review, if applicable.			DHHS site review			Example - dogs & cats should be vaccinated against rabies.
	Section 2 - MEDICATION MANAGEMENT / HEALTH & SAFETY Total:				**Percent:**		
SECTION 3 - EMERGENCY RESPONSE							
3.1	Emergency evacuation maps/routes are displayed in prominent locations at the facility. *Score for facility-based programs.*			AFC Licensing Rules R400.14318 (SGH)			
3.2	Program has a comprehensive set of written Emergency Response Procedures containing clear instructions in response to fire, severe weather, medical emergencies, and emergencies while transporting individuals served, if applicable. *Score for facility-based programs.*			DHHS Recommendation from Site Review			Written Emergency Response Procedures
	Section 3 - EMERGENCY RESPONSE Total:		0		**Percent:**		

		Possible Score	Actual Score	References	Comments	Plan for Improvement	
SECTION 4 - TRAINING	***Guidance: Review that last 365 days; If a new hire, verify "within X days of hire" requirements; if NOT a new hire, check annual.***						
4.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).	2		MCL 330.1755(5)(f) Medicaid Provider Manual			
4.2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).	2		MDHHS Master Contract Section (1)(B)(3)(k)			
4.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).			MDHHS Master Contract Section (1)(B)(3)(k) 42 CFR 438.206			
4.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			MIOSHA R 325.70016 Medicaid Provider Manual 14.5			
4.5	HIPAA (within 30 days of hire, annual updates).			45 CFR 164.530(b)(1) MDHHS Master Contract Section			
4.6	Corporate Compliance (within 30 days of hire, annual updates).			45 CFR 164.308(a)(5)(i) 45 CFR 164.530(b)(1) Deficit Reduction Act			
4.7	Limited English Proficiency (LEP) (within 6 months of hire).			Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination MDHHS Master Contract Section (1)(B)(3)(k) 42 CFR 438.206			
4.8	Individuals Plans of Service and Ancillary Plans (there is evidence that staff have been trained in the IPOS and in any applicable Support Plan for Individuals in their care before the provision of direct care [Behavior Treatment Plan, PT, OT, Nursing, etc.]).			Michigan Mental Health Code 330.1708			

		Possible Score	Actual Score	References	Comments	Plan for Improvement	
4.9	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (within 30 days of hire & annual updates, if working with individuals with challenging behavior)			MDHHS BHDDA Technical Requirement for Behavior Treatment Plans R 330.1806			Regional agreement that all staff providing direct services individually should be trained in MANDT day #1, unless training is needed to implement an approved BTP - then full 2 day training required. If more than one staff providing direct services together, at least one staff must be trained unless needed to implement at BTP.
4.10	MDHHS approved CPR training (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years).			42 CFR 438.400-424 Medicaid Provider Manual			
4.11	First Aid (within 60 days and ongoing as required per the training program - usually every 2 to 3 years. Required if providing Aide or Behavior Technician services as defined in Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes.).			42 CFR 438.400-424 Medicaid Provider Manual			
4.12	Grievances and Appeals (within 30 days of hire and annually for all in the following roles: Primary clinicians & SUD therapists (including residential/detox), Access/UM staff, Customer Services, Service supervisors/directors of the above listed staff)			42 CFR 438.400-424 MDHHS Master Contract Section (1)(B)(3)(k)			Reviewer should ensure review of an applicable staff record to make sure someone is trained on G&A if an applicable staff is not included in the staff sample.
4.13	Customer Services (within 30 days of hire and annually for all in the following roles: Psychiatrists/nurses, Peer support specialists, Recovery coaches, Reception staff, Service supervisors/directors of the above listed staff, minimum one person per site for all other services (MH and SUD))			42 CFR 438.400-424 MDHHS Master Contract Section (1)(B)(3)(k)			Same guidance as above.
4.14	MDHHS approved Clubhouse-specific training (within 6 months of hire and annually thereafter for Clubhouse staff).			42 CFR 438.400-424 Medicaid Provider Manual, BH/IDDSS Section 5.8			
4.15	Trauma Informed Training within 60 days of hire and annually thereafter.			MDHHS Trauma Policy SWMBH 2.15A	**CONSULTATIVE FOR FY23**		https://www.improvingmipractices.org/

Section 4 - TRAINING Total: **Percent:** ***#DIV/0!***

		Possible Score	Actual Score	References	Comments	Plan for Improvement	
SECTION 5 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS							
5.1	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the verification protocol required by SWMBH policy 2.16; and subsequent verification of criminal back ground checks of current employees will occurs every other year after the initial check (if the individual employee is not fingerprinted and enrolled in the Michigan Workforce Background Check system). If an employee is working or has been working with a criminal history exclusion, SWMBH compliance department will be contacted for consultation.			Contract Requirement; Public Act 59 (PA 218 400.734a); 5) AFC Licensing Rules: R.400.14201.13 (SGH); R.400.1404.6 (FH); PIHP Policy 2.16			
5.2	Primary source verification of State driving infractions has been conducted prior to hire and annually thereafter, for staff who transport customers. Provider has policies and procedures in place to ensure safe transportation of Customers receiving Supports/Services.			Payor Contract requirement: Transporting Customers			If reviewer observes significant findings on a driving record, discussion with provider about "driver of last resort" or recommending checking with insurance company. Reviewer checking to see if valid license and verification exist. Provider decision if the person is SAFE to transport. Is ther something in the provider's P&Ps with standards around this?
5.3	Personnel Performance Management: there is documented evidence that program has an adequate system to support, monitor, and complete at least annual performance evaluations of hired staff who provide direct care services.			DHHS Site Visit Protocol B.1.3, 4.4.2(e), 5.4.2, 6.4.2, 7.4.1, 8.3.2			May be an Annual Performance Evaluation document, may be other documentation that shows a pattern of performance feedback.

		Possible Score	Actual Score	References	Comments	Plan for Improvement	
5.4	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each unlicensed* employee is to be run through the following databases, prior to hire and at least annually thereafter: 1. OIG exclusions database (https://www.exclusions.oig.hhs.gov/) and 2. The State of Michigan Sanctioned Provider list (https://www.michigan.gov/mdhh/doing-business/providers/providers/billingreimbursement/list-of-sanctioned-providers) and 3. System for Award Managment (SAM) (https://sam.gov) *Licensed/credentialed staff must be run monthly. (Consultative for FY23)			MDHHS Master Contract Section (1)(R)(10)€ MDHHS Master Contract - Federal Provisions Addendum, Paragraph 7 PIHP Policy 10.13; 42 CFR 438.602			**Exclusion screening results (review date); applicable policies/procedures if provider has any.** **Best practice is to run exclusions screenings monthly for any staff who provides Medicaid-funded services.**

Section 5 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS **Percent:**

Summary and Comments

Positive Observations:

Areas Needed for Improvement:

Other Discussion Points:

Health and safety issues requiring immediate attention will be documented above if not addressed elsewhere.

Scoring Summary	Possible Score	Actual Score	Percent
Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:	0	0	#DIV/0!
Section 2 - MEDICATION MANAGEMENT / HEALTH & SAFETY Total:	0	0	
Section 3 - EMERGENCY RESPONSE Total:	0	0	0.0%
Section 4 - TRAINING Total:	0	0	
Section 5 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:	0	0	0.0%
OVERALL	***0***	***0***	

Possible Score	Actual Score	References	Comments	Plan for Improvement

Review Date: _____
Provider: _____
License #: _____
License Type: _____
Population(s) Certifed: _____

Reviewer:
Location/Site:
Expiration Date:
# of Beds:
Accreditation:

SCORING INSTRUCTIONS
2 = compliance with standard/intent
1 = partial compliance standard/intent
0 = non-compliance with standard/intent
N/A = requirement not applicable to this type of review or this provider

		Possible Score	Actual Score	*References*	Guidance/Evidence
SECTION 2 - MEDICATION MANAGEMENT					
2.1	Medication is properly stored and secured, including controlled substances.			Reciprocity Tool 2.1 AFC Licensing Rules R 400.14312 Rule 312(1); R 400.1418 Rule 18(5)	**Medication is stored in the original pharmacy-supplied and pharmacy-labeled container; Medication is labeled for the specific resident; Medication storage is locked; refrigerated medications are locked/secured; topical and oral medications are separated from each other.**
2.2	Staff are trained on and follow the Rules of passing medications (e.g. correct patient/medication/dose/route/time/documentation/reason/response)			R 400.14312 Rule 312 (1-7)	**Training logs; staff interviews regarding passing meds.**
2.3	Medication errors (***including refusals***), missed medications, and/or adverse drug reactions are immediately and properly documented in Incident Reports.			Reciprocity Tool 2.3 Michigan Mental Health Code R 330.7158	**Has administrator/licensee provided specific performance improvement to prevent reoccurrence of the incident for each staff member involved, per Incident Report. Are there Incident Reports to explain any irregularities in the MAR?**
2.3A	If there are no Incident Reports (any IRs, not limited to med errors) to review, do staff know the process for documenting and reporting applicable incidents?				**Staff interviews - if no IRs, do staff know what to do if one occurs?**

2.4	Strategies to prevent the same incident from reoccurring are consistently documented in incident reports. Addendums to the individual plans of service are developed to address trends/concerns identified, as needed.			Reciprocity Tool 2.3 Payor Contract Requirement: HEALTH AND SAFETY OF CUSTOMERS; RECIPIENT RIGHTS AND CONSUMER GRIEVANCE PROCEDURES	**Has administrator/licensee provided specific performance improvement to prevent recurrence of the incident for each staff member involved, per the Incident Report? Look for any incident reports to explain irregularities in the MAR.**
2.5	Medication Administration Record (MAR) is implemented and used. A provider shall record the administration of all medication in the recipient's clinical record, including 1) The dosage. 2) Label instructions for use. 3) Time to be administered. 4) The initials of the person who administers the medication, which shall be entered at the time the medication is given. 5) A resident's refusal to accept prescribed medication or procedures.			Reciprocity Tool 2.4 R 400.14312 Rule 312(1) R 400.1418 Rule 18(5)	**Medication Administration Record (MAR) is implemented and used.**
	Section 2 - MEDICATION MANAGEMENT Total:			**Percent:**	

SECTION 3 - HEALTH & SAFETY and CONTINGENCY PLANS

3.1	First Aid kit is present in the home.			Reciprocity Tool 3.1 AFC Licensing Rules R400.14318; R 400.14319	
3.2	There is a system in place to ensure individuals can identify their own personal care items (razors, tooth brush, etc.)			Reciprocity Tool 3.2	**Individual bins are labeled and/or stored separately**
3.3	Carbon Monoxide Detectors are present and operational			Reciprocity Tool 3.3 Payor Contract Requirement: HEALTH AND SAFETY OF CUSTOMERS; RECIPIENT RIGHTS AND CONSUMER GRIEVANCE PROCEDURES	**Applicable to homes with gas fireplace(s) or heated with gas. "N/A" for homes without this.**
3.4	Provider has a policy, procedure, or process in place for testing and maintenance of carbon monoxide detectors			Reciprocity Tool 3.4 Manufacturer recommendations	**Ensure log of testing in accordance with Policy/Procedure/Process; maintenance log shows at minimum annual testing.**
3.5	Smoke Detectors are present and operational.			Reciprocity Tool 3.5 R 400.14505 Rule 505 (1-6) R 400.2376 Rule 376 (1-5) R 400.1437 Rule 37 (1-6)	
3.6	Provider has a policy/procedure/process in place for testing and maintenance of smoke detectors			Reciprocity Tool 3.6	**Ensure log of testing in accordance with Policy/Procedure/Process; maintenance log shows at minimum annual testing.**

3.7	Evacuation scores are recorded and present.			Reciprocity Tool 3.7 R400.14318 Rule 318 (5)	**Records of scores. For E-scores that do not meet the threshhold, thus indicating inadequate staff, reviewer should consult with CMH Recipient Rights Officer (or other agency subject matter expert) on remediation plan & monitoring.**
3.8	Fire drills are performed in the home (quarterly on every shift)			Reciprocity Tool 3.8 R 400.14318 Rule 318 (5) R 400.2261 Rule 261	**One daytime, one evening, one sleeping each quarter; Staff interviews; Policy & Procedures; Review of log of drills.**
3.9	Evacuation routes are posted, accurate, and current.			Reciprocity Tool 3.9 R 400.14318 Rule 318 (2) R 400.1438 Rule 38 (2)	**Evacuation route postings; Staff interviews on safety plan.**
3.10	Home has a designated tornado shelter area.			Reciprocity Tool 3.10 R 400.14318 Rule 318 (5)	**Policy/procedure; safety manual; Posting(s)**
3.11	If emergency lights are present, they are in working order			Reciprocity Tool 3.11	
3.12	Emergency numbers are posted, including Poison Control Number (1-800-764-7661), gas company (if applicable), police/non-emergency police #, local CMH Crisis Line, suicide hotline, applicable provider staff #s (example - on-call clinical staff).			Reciprocity Tool 3.12	**Posting.** CONSULTATIVE FOR FY23.
3.13	Material Safety Data Sheet (MSDS) guidelines are present.			Reciprocity Tool 3.13	**MSDS guide sheets - may be electronic or paper format - staff should know how to access and follow guide sheet.**
3.14	If sharps are being used, there is a container on site for disposal, which is not overfilled.			Reciprocity Tool 3.14 OSHA Blood Borne Pathogens standard (29 CFR 1910.1030)	**Containers should be clearly labeled as biohazards, kept in a secure area or container, and sharps are disposed of promptly once the container is full (policy/procedure/staff interview re: process, is the container currently full?).**
	Hazards, such as cleaning supplies, are safeguarded for consumer safety.				**Items are not locked away "just because".**
3.15	Interior of home is free of surveillance/monitoring cameras.			Reciprocity Tool 3.15 MHC 330.1724	**Prohibited under the MHC. Residential Licensee can request a variance from licensing rules for medical reasons - requires a physician order and guardian consent**
3.16	Provider has systems in place to ensure adaptive equipment (i.e. beds, C-PAP, wheelchairs) is maintained.			Reciprocity Tool 3.16 R 400.14306	**Should include evidence that licensee is following the manufacturer's maintenance schedule; Equipment is clean; staff interviews can describe policies and procedures; etc.**
3.17	Blood spill kit is on site with items such as, but not limited to: absorbent Packs, Antiseptic Cleansing Wipes, Biohazard Bags, Body Fluid Pick Up Guide, Disposable Clean-Up Towels, Disposable Gown, Disposable Shoe Covers, Eye Shields, Germicidal Wipes, Gloves, Scooper			Reciprocity Tool 3.17 OSHA 29 CFR 1910.1030(d)(3)(i)	**Evaluate how this is monitored and refilled when used.**
3.18	Fire extinguishers are present, not expired, and accessible			Reciprocity Tool 3.18 R 400.2245 Rule 245	

3.19	Fire, medical, and severe weather drills occur in accordance with a written policy, procedure, or evacuation plan, according to licensure.			Reciprocity Tool 3.19 R 400.14318 Rule 318 (5)	
3.20	Contingency plan is available in the event of a driving accident.			Reciprocity Tool 3.19	**Suggested proofs: policy, procedure, protocol, staff interview to determine if staff know what to do in the event of a car accident with members.**
3.21	Emergency Shelter plan (interim) is documented.			Reciprocity Tool 3.20	**Emergency Shelter example - if the home has a fire, or is without heat or water, where will members go?**
3.22	Contingency plan is available in the event of a power outage.			Reciprocity Tool 3.22	**Food safety, temperature safety, specific needs of the home's residents safety/medical needs (refrigerated medications; CPAP machines; nebulizer; etc.). Does not have to be a stand alone document.**
3.23	If an agency has a pet or therapy animal on the premises, vaccination records should be available for review, if applicable.			DHHS site review	**Example - dogs & cats should be vaccinated against rabies.**
EMERGENCY BAGS					
3.24	Emergency Bags ***in the vehicle*** at minimum contain a basic First Aid Kit and there is a process for monitoring contents.			Reciprocity Tool 3.23 R 400.14319 Resident Transportation	**Process for monitoring Emergency Bags - frequency and responsibility identified and followed. Basic first aid kits required in any vehicle (company or personal) used to transport consumers, AT THE TIME the consumer is being transported. A portable First Aid Kit that is required to be taken each time a consumer is transported, but is otherwise housed in the Spec Res Home is acceptable. Look for policy/procedure/training/staff knowledge on the requirement to take it. First Aid kit may be located in the Vehicle Emergency Bag.**

3.25	Emergency Bags ***in the home*** contain all items listed below and are mobile: Food items and bottled water are labeled with expiration dates Blankets and rain coats: # Portable radio Consumer Profiles (w/meds, physician/allergies) First Aid Kit Flash light Appropriate batteries Keys: vehicle and house Gloves Disposable briefs (as appropriate) Wet wipes/hand sanitizer Telephone numbers of staff, guardians, and a process to contact others are included.			Reciprocity Tool 3.24 FEMA safety practices	**2 = all items present; food/water labeled but may be expired** **1 = less than half of items are missing** **0 = more than half of the items are missing**
3.27	There is a process for monitoring the contents of Emergency Bags in the home and it is implemented. Incorrect Client Profiles result in a score of "0" and a Plan of Correction.			Reciprocity Tool 3.26 R 400.2261 Rule 261 (2)	**Process for monitoring Emergency Bags - frequency and responsibility identified and followed** **Expired food/water items indicate the monitoring process has failed. Score "1" if written policy/process exists but isn't implemented.**
	Section 3 - HEALTH & SAFETY and EMERGENCY RESPONSE Total:			**Percent:**	
SECTION 4: STAFFING					
4.1	Staffing is sufficient to implement programming schedule (document ratio in "Comments")			Reciprocity Tool 4.1 R 400.14206 Rule 206 (1)	**Minimum ratio 1:12; Staff schedules for AM, PM, and Midnight shifts. Repeated finding of ratio below requirement may suggest ineffective plan for short staffing. Staffing must take into consideration e-scores**
4.2	Licensee has an effective plan for short staffing.			Reciprocity Tool 4.2 R 400.14203 Rule 206 (1)	**Interview home manager/staff; review schedules to see if plan occurred as it was supposed to. Short staffing could result from staff absences and vacancies OR resident schedule changes such as a day program being cancelled (i.e. increased # of residents in the home results in a change in staffing need).**
	Section 4 -STAFFING RESPONSE Total:			**Percent:**	
SECTION 5: INCIDENT REPORTING					
	INDICATE NUMBER OF INCIDENT REPORTS REVIEWED:				

	5.1	Incident reports are completed in their entirety and Prevention Strategy was addressed.			Reciprocity Tool 5.1 PIHP/MDHHS Contract 6.1, Critical Incidents; Medicaid Provider Manual Section 10.4; CARF I.H.9, I.H.10.b.(3-5); R 400 14209; R 400 14307	**Request log of incident reports and select a sample to review. Incident Reports are NOT limited to Recipient Rights. Can involve a resident tripping and falling over a hazard in the home or community, suicide attempts, and/or self harm (example - cutting). Must be properly documented, supervisor reviewed, and plan to ensure it does not reoccur if needed (example - loose carpeting repaired).**
	5.2	Are there individuals with specialized care needs in the home and, if so, have staff been trained on how to care for population specific needs? Circle all that are applicable: Feeding tube(s); Diabetes; Wheelchairs; Hypertension; Autistic; Cerebral Palsy; Needs lift; Other (specify):			R 400.14306	**Must be trained on medical protocols, safe lifting, chair transfers, etc.**
		Section 5 - INCIDENT REPORTING Total:			**Percent:**	

SECTION 6 - TRAINING

6A - All Direct Service Staff

6.A.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).			MH Code: 330.1755(5)(f) Medicaid Provider Manual	
6.A.2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).			MDHHS Master Contract Section (1)(B)(3)(k)	
6.A.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).			MDHHS Master Contract Section (1)(B)(3)(k) 42 CFR 438.206	
6.A.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			MIOSHA R 325.70016 Medicaid Provider Manual 14.5	
6.A.5	Limited English Proficiency (LEP) (within 6 months of hire).			MDHHS Master Contract Section (1)(B)(3)(k) Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination	
6.A.6	HIPAA (within 30 days of hire, annual updates).			45 CFR 164.308(a)(5)(i) & 45 CFR 164.530(b)(1)	

6.A.7	Corporate Compliance (within 30 days of hire, annual updates).			Deficit Reduction Act (DRA)	
6.A.8	Individuals Plans of Service and Ancillary Plans (there is evidence that staff have been trained in the IPOS and in any applicable Support Plan for Individuals in their care before the provision of direct care [Behavior Treatment Plan, PT, OT, Nursing, etc.]). Can be reviewed as part of the clinical case review.			Michigan Mental Health Code 330.1708	
6.A.9	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior - (within 30 days of hire & annual updates, if working with individuals with challenging behavior)			R 330.1806 MDHHS BHDDA Technical Requirement for Behavior Treatment Plans	
6.A.10	Customer Services within 30 days of hire and annually for all in the following roles: • Psychiatrists/nurses, • Peer support specialists, • Recovery coaches, • Reception staff, • Service supervisors/directors of the above listed staff, • Minimum one person per site for all other services (MH and SUD)			42 CFR 438.400-424 MDHHS Master Contract Section (1)(B)(3)(k)	
6.A.11	Trauma Informed Training within 60 days of hire and annually thereafter.			MDHHS Trauma Policy SWMBH 2.15A	Consulatative for FY23
	Section 6A - DIRECT CARE STAFF TRAINING REQUIREMENTS Total:			**Percent:**	

SECTION 6 - TRAINING - CONTINUED

6B - Specialized Residential Services					
6.B.1	CPR (within 60 days; ongoing as required per the training program - usually every 2 to 3 years).			R 400.14204	
6.B.2	First Aid (within 60 days; ongoing as required per the training program - usually every 2 to 3 years).			PIHP Policy 2.15 MPM 2.4	
6.B.3	Role of Direct Care Workers/Working with People (prior to working independently with customers or as lead staff; or within 90 days of hire).			Specialized Residential Licensing Rules R 330.1806	
6.B.4	Health Administration (prior to working independently with customers or as lead staff; or within 90 days of hire).			Specialized Residential Licensing Rules R 330.1806	
6.B.5	Medication Administration (prior to working independently with customers or as lead staff; or within 90 days of hire).			Specialized Residential Licensing Rules R 330.1808	

6.8.6	Nutrition (prior to working independently with customers or as lead staff; or within 90 days of hire).			Specialized Residential Licensing Rules R 330.1809	
6.8.7	Emergency Preparedness (prior to working independently with customers or as lead staff; or within 90 days of hire).			Specialized Residential Licensing Rules R 330.1810	
6.8.8	Introduction to Special Needs MI/DD (prior to working independently with customers or as lead staff; or within 90 days of hire).			Specialized Residential Licensing Rules R 330.1811	
	Section 6B - TRAINING REQUIREMENTS FOR SPECIALIZED RESIDENTIAL Total:			**Percent:**	
SECTION 7 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS					
7.1	There is documentation of the date of hire OR the offer letter, included in the personnel file.			Reciprocity Tool MA Manual R 400.14208(1G)	**Provider should maintain a personnel file for each staff member.**
7.2	The current job description is present in the personnel file and is signed and dated by the employee. (Annual)			Reciprocity Tool R 400.14207(3) small	
7.3	There is a copy of a current driver's license or State ID (front and back) in the personnel file.			Reciprocity Tool R 400.14204 (Age) R 400.14208 (transportation)	
7.4	There is an I-9 verification in the personnel file.			Reciprocity Tool Labor law	**Completed I-9 for with copies of applicable sources of identification .**
7.5	The finger printing process provides a State of Michigan Eligibility to Work Letter that is included in the personnel file, establishign that the Direct Care Worker is employed at the AFC Home.			Reciprocity Tool MCL 333.20173a MCL 333.20173b MCL 330.1134a MCL 400.734b/c	**Provider can obtain the Eligibility Determination Letter by logging into their background check account. Letter must contain the name of the specific facility or agency where the DCW is working.**
7.6	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire. All direct care employees are enrolled in the Michigan Workforce Background Check system.			Reciprocity Tool Contract Requirement; Public Act 59 (PA 218 400.734a); 5) AFC Licensing Rules: R.400.14201.13 (SGH); R.400.1404.6 (FH); PIHP Policy 2.17	
7.7	There is evidence that Direct Care Worker(s) are able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed.			Reciprocity Tool MA Manual - Provider Qualifications	***Auditor must use best judgment to determine if provider is taking steps to ensure communication skills.* Evidence may include: Diploma/GED; basic literacy exam; employment interview process/content; employee interview(s); etc.**
7.8	There is evidence in the personnel file that the agency conducted a Recipient Rights Violation Check with the local CMHSP.			Reciprocity Tool Contractual Requirement	**Should be performed annually for all employees.**

7.9	Provider ensures that staff who use their personal vehicle(s) to transport customers or for other business purposes have insurance binder or policy on file.			Reciprocity Tool	**Current policy certification or binder. Verify the policy holder name and effective/expiration date of policy.**
7.10	For staff who transport customers, primary source verification of State driving infractions has been conducted prior to hire and annually thereafter. Provider has policies and procedures in place to ensure safe transportation of Customers receiving Supports/Services.			Payor Contract requirement: Transporting Customers	
7.11	Personnel Performance Management: there is documented evidence that program has an adequate system to support, monitor, and complete at least annual performance evaluations of hired staff who provide direct care services.			DHHS Site Visit Protocol B.1.3, 4.4.2(e), 5.4.2, 6.4.2, 7.4.1, 8.3.2	
7.12	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each unlicensed* employee is to be run through the following databases, prior to hire and at least annually thereafter: 1. OIG exclusions database (https://www.exclusions.oig.hhs.gov/) and 2. The State of Michigan Sanctioned Provider list (https://www.michigan.gov/mdhh/doing-business/providers/providers/billingreimbursement/list-of-sanctioned-providers) and 3. System for Award Management (SAM) (https://www.sam.gov) *Licensed/credentialed staff must be run monthly.			MDHHS-PIHP Contract Section (1)(R)(10)(e) MDHHS-PIHP Contract - Federal Provisions Addendum, Paragraph 7 MDHHS Credentialing Policy PIHP Policy 10.13; 42 CFR 438.602	**Exclusion screening results (review date); applicable policies/procedures if provider has any.** Best practice is to run exclusions screenings monthly for any staff who provides Medicaid-funded services.
	Section 7 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:			**Percent:**	

Summary and Comments

Positive Observations: _____

Areas Needed for Improvement: _____

Other Discussion Points:

_____

Health and safety issues requiring immediate attention will be documented above if not addressed elsewhere.

Scoring Summary	Possible Score	Actual Score	Percent
#REF!	#REF!	#REF!	
Section 2 - MEDICATION MANAGEMENT Total:	0	0	
Section 3 - HEALTH & SAFETY and EMERGENCY RESPONSE Total:	0	0	
Section 5 - TRAINING TOTAL	0	0	
Section 6A - DIRECT CARE STAFF TRAINING REQUIREMENTS Total:	0	0	
Section 6B - TRAINING REQUIREMENTS FOR SPECIALIZED RESIDENTIAL Total:	0	0	
Section 7 - CREDENTIALING AND	0	0	
OVERALL	***#REF!***	***#REF!***	

Review Date: _____
Provider: _____
License #: _____
License Type: _____
Population(s) Certifed: _____

Reviewer: _____
Location/Site: _____
Expiration Date: _____
# of Beds: _____
Accreditation: _____

SCORING INSTRUCTIONS
2 = compliance with standard/intent
1 = partial compliance standard/intent
0 = non-compliance with standard/intent
N/A = requirement not applicable to this type of review or this provider

SECTION 8 - RECIPIENT RIGHTS

The following postings are in a conspicuous location for recipients and staff:

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
8.1	Recipient Rights Poster (List the CMHSPs and name(s) of Rights Staff included on the poster(s))			Reciprocity Tool 6.1 PIHP/MDHHS Contract Requirement G&A Technical Requirement		
8.2	Abuse and Neglect			Reciprocity Tool 6.1 PIHP/MDHHS Contract Requirement G&A Technical Requirement		
8.3	Grievance			Reciprocity Tool 6.1 PIHP/MDHHS Contract Requirement G&A Technical Requirement		
8.4	Appeals			Reciprocity Tool 6.1 PIHP/MDHHS Contract Requirement G&A Technical Requirement		
8.5	Whistleblowers Act			Reciprocity Tool 6.6 R400.14318 Rule 318(3) R400.1438 Rule 38		
8.6	Were complaint forms readily available?			Reciprocity Tool 6.7 State ORR Tool		
8.7	Were recipients aware of how to file a complaint?			Reciprocity Tool 6.8 State ORR Tool		
8.8	Were staff aware of how to file a complaint?			Reciprocioty Tool 6.9 State ORR Tool		
8.9	Were copies of Chapter 7 and 7A available? (Look for print or electronic copies of Recipient Rights section of the MI Mental Health Code that are easilty accessible to staff)			Reciprocioty Tool 6.10 State ORR Tool		
8.1	Were any exclusions to items able to be brought into the site (contraband) posted and visible to consumers and visitors?			Reciprocioty Tool 6.11 State ORR Tool		

8.11	Were records and other confidential information secured and not open for public inspection?			Reciprocioty Tool 6.12 State ORR Tool		
8.12	Were any health or safety concerns identified during the visit?			Reciprocioty Tool 6.13 State ORR Tool		
8.13	Were appropriate accommodations made for persons with physical disabilities?			Reciprocioty Tool 6.14 State ORR Tool		

Section 1 - RECIPIENT RIGHTS Total: **Percent:**

Summary and Comments

Positive Observations:

Areas Needed for Improvement:

Other Discussion Points:

Health and safety issues requiring immediate attention will be documented above if not addressed elsewhere.

Scoring Summary	Possible Score	Actual Score	Percent
Section 1 - RECIPIENT RIGHTS Total:	0	0	
	#REF!	#REF!	#REF!
	#REF!	#REF!	#REF!
Section 5 - TRAINING TOTAL	#REF!	#REF!	
	#REF!	#REF!	#REF!
	#REF!	#REF!	#REF!
	#REF!	#REF!	#REF!
OVERALL	***#REF!***	***#REF!***	

Review Date:	0	**Reviewer:**	0
Provider:	0	**Location/Site:**	0
License #:	0	**Expiration Date:**	0
Liscense Type:	0	**# of Beds:**	0
Popuation(s) Certifed:		**Accreditation:**	

		Poss-ible Score	Actual Score	*References*	Comments	Plan for Improvement
SECTION 1 - NEIGHBORHOOD/HOME EXTERIOR						
1.1	Is the home similar to other residences in the neighborhood and is maintained?			Reciprocity Tool 7.1 MDHHS PCP Policy		
1.2	Is the location accessible to generic services in the community?					
1.3	Is the outside of the home in good condition (Guidance: no safety hazards - broken windows, holes, missing siding, broken/missing deck boards, etc.)?					
	SECTION 1 - NEIGHBORHOOD/HOME EXTERIOR Total:			**Percent:**		
SECTION 2 - HOME INTERIOR						
2.1	Is the living environment comfortable?					
2.2	Are furnishing adequate and in good repair? (Guidance: can furnishing be used according to their intended purpose or are they missing things like a chair or table leg; are furnishing ripped/falling apart; does the condition of furnishings like flooring create a safety hazard such as tripping)					
2.3	Is the home clean and free from odors?					
	SECTION 2 - HOME INTERIOR Total:			**Percent:**		
SECTION 3 - INDIVIDUAL CHOICE						
3.1	Can individuals personalize/decorate their room?					
3.2	Can individuals close and lock their bedroom door? (Guidance: keyed lock is required on bedroom doors and must be non-locking on egress - it can be opened from the inside in one motion)					
3.3	Can individuals close and lock their bathroom door? (Guidance: pop-locks are allowable; locks are not required if the bathroom is located within a single occupancy bedroom (i.e. an en suite))					

3.4	Can individuals choose to come and go from the home when they want?					
3.5	Do individuals have access to food at any time? (Guidance: refrigerators and pantries must be open to residents; one resident's BTP cannot limit access for all the other residents (see 3.6 below))					
3.6	Restrictions are not present in the home OR if restrictions affect other members of the home, the provider has a process for other residents to overcome the restriction.			Reciprocity Tool 7.2 MDHHS PCP Policy HCBS Final Rule		
3.7	A standard set of house rules are not imposed or enforced by the setting.					**House rules are optional for Adult Foster Care and Homes for the Aged, but are not permitted under the HCBS Final Rule for Spec Res.**
	SECTION 3 - INDIVIDUAL CHOICE Total:	**#REF!**	**#REF!**	**Percent:**		

SECTION 4 - COMMUNITY INTEGRATION

4.1	Do individuals have full access to the community? (Guidance: Organized at least 1x per week with non-Medicaid beneficiaries, and independently unless otherwise determined in a resident's BTP)					
4.2	Do individuals live and/or receive services and supports in a setting where there is regular (more than once a week) opportunity for contact with people not receiving services? (Guidance: Residents may choose not to participate, but the opportunity must be available)					
	SECTION 4 - COMMUNITY INTEGRATION Total:			**Percent:**		

Summary and Comments

Positive Observations:

Areas Needed for Improvement:

Other Discussion Points:

Health and safety issues requiring immediate attention will be documented above if not addressed elsewhere.

HCBS Scoring Summary (Consultative)	Possible Score	Actual Score	Percent

SECTION 1 - NEIGHBORHOOD/HOME EXTERIOR Total:	0	0
SECTION 2 - HOME INTERIOR Total:	0	0
SECTION 3 - INDIVIDUAL CHOICE Total:	#REF!	#REF!
#REF!	#REF!	#REF!
SECTION 4 - COMMUNITY INTEGRATION Total:	0	0
HCBS OVERALL	***#REF!***	***#REF!***

STAFF TRAINING		Name
		Hire Date
6.A.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).	
6.A.2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).	
6.A.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).	
6.A.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).	
6.A.5	Limited English Proficiency (LEP) (within 6 months of hire).	
6.A.6	HIPAA (within 30 days of hire, annual updates).	
6.A.7	Corporate Compliance (within 30 days of hire, annual updates).	
6.A.8	Individuals Plans of Service and Ancillary Plans (there is evidence that staff have been trained in the IPOS and in any applicable Support Plan for Individuals in their care before the provision of direct care [Behavior Treatment Plan, PT, OT, Nursing, etc.]).	
6.A.9	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior - (within 30 days of hire & annual updates, if working with individuals with challenging behavior)	
6.A.10	Customer Services within 30 days of hire and annually for all in the following roles: • Psychiatrists/nurses, • Peer support specialists, • Recovery coaches, • Reception staff, • Service supervisors/directors of the above listed staff, • Minimum one person per site for all other services (MH and SUD)	
6.A.11	Trauma Informed Training	
6.B.1	CPR (within 60 days; ongoing as required per the training program - usually every 2 to 3 years).	
6.B.2	First Aid (within 60 days; ongoing as required per the training program - usually every 2 to 3 years).	
6.B.3	Role of Direct Care Workers/Working with People (prior to working independently with customers or as lead staff; or within 90 days of hire).	
6.B.4	Health Administration (prior to working independently with customers or as lead staff; or within 90 days of hire).	
6.B.5	Medication Administration (prior to working independently with customers or as lead staff; or within 90 days of hire).	
6.B.6	Nutrition (prior to working independently with customers or as lead staff; or within 90 days of hire).	
6.B.7	Emergency Preparedness (prior to working independently with customers or as lead staff; or within 90 days of hire).	
6.B.8	Introduction to Special Needs MI/DD (prior to working independently with customers or as lead staff; or within 90 days of hire).	
CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS - FILE REVIEW		
7.1	Documentation of the date of hire OR the offer letter	
7.2	Current job description is present in the personnel file and is signed and dated by the employee.	
7.3	Current copy of employees driver's license or State ID (front and back)	
7.4	I-9 verification	
7.5	State of Michigan Eligibility to Work Letter	

7.6	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire. All direct care employees are enrolled in the Michigan Workforce Background Check system.	
7.8	Recipient Rights Violation Check(s) with local CMHSP (Annual)	
7.10	Primary source verification of State driving infractions has been conducted prior to hire and annually thereafter, for staff who transport customers.	
7.11	Personnel Performance Management: there is documented evidence that program has an adequate system to support, monitor, and complete at least annual performance evaluations of hired staff who provide direct care services.	
7.12	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each unlicensed* employee is to be run through the following databases, prior to hire and at least annually thereafter: 1. OIG Exclusions database 2. State of Michigan Sanctioned Provider List 3. System for Award Management *Licensed/credentialed staff must be run monthly (consultative for FY23)	

Name	Name	Name	Name
Hire Date	Hire Date	Hire Date	Hire Date

Southwest Michigan Behavioral Health ~Fiscal Intermediary Administrative Site Review

Review Date: _____
Provider: _____
Service: *Fiscal Intermediary*
Reviewer: _____

SCORING INSTRUCTIONS
2 = compliance with standard/intent
1 = partial compliance standard/intent
0 = non-compliance or insufficient levels of compliance with standard/intent
N/A = requirement not applicable to this type of review or this provider

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT						
1.1	The provider has adequate ***physical safeguards*** in place to prevent unauthorized use or disclosure of Protected Health Information (PHI), including both policy and procedures to protect PHI. For example, paper records are locked with only appropriate staff members having access, and not left in open areas.			*HIPAA/HITECH* *42 CFR Part 2* *MH Code 330.1748*		
1.2	The provider has adequate ***technical safeguards*** in place to prevent unauthorized use or disclosure of PHI, including both policy and procedures to protect PHI. For example, password protection is used to access electronic records; encryption if PHI is being sent through email.			*HIPAA/HITECH* *42 CFR Part 2* *MH Code 330.1748*		
1.3	The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct (must have written certification that they have received, read, and will abide by SWMBH's Code of Conduct). Applies to employees of the FI, not self-determination employees.			*PIHP Policy 10.1*		

		Possible Score	Actual Score	References	Comments	Plan for Improvement
1.4	The fiscal intermediary meets the requirements of the Deficit Reduction Act of 2005: 1) the FI's written policies provide detailed information about a) The Federal False Claims Act, b)Administrative remedies for false claims and statements established under the Federal False Claims Act, c) the Michigan False Claims Act, d)Whistleblower protections under such laws, with respect to preventing and detecting fraud, waste and abuse; AND 2) the FI's annual compliance training includes a specific discussion of a) the same four elements required in the written policies, b) the rights of employees to be protected as whistleblowers, and c) the entity's policies and procedures for detecting and preventing fraud, waste and abuse.			*Deficit Reduction Act; Patient Protection & Affordable Care Act of 2010; HealthCare & Education Reconciliation Act of 2010*		
1.5	The fiscal intermediary has **a process in place** to collect feedback from individuals utilizing the FI's services and their allies, including experience and satisfaction data and other performance measurements that includes alternate data collection methods (more than mailed surveys).			*Self-Direction Technical Requirement Implementation Guide (aka the Self-Direction Technical Guide) Version 2.2, January 2022 (NOT YET FINAL)*		
1.6	The fiscal intermediary **responds** to feedback from individuals using FI services when areas needing improvement are identified.			*Self-Direction Technical Requirement Implementation Guide (aka the Self-Direction Technical Guide) Version 2.2, January 2022 (NOT YET FINAL)*		
1.7	The FI has policies and procedures in place to: - assure financial accountability for the funds comprising the individual budgets, and - indemnify the PIHP/CMHSP for any amounts paid in excess of the individual budget			*Self-Direction Technical Requirement Implementation Guide (aka the Self-Direction Technical Guide)*		

		Possible Score	Actual Score	References	Comments	Plan for Improvement
1.8	Monitoring for Exclusion from Participation in Federal Healthcare Programs. All managing/controlling employees are to be run through OIG exclusion database on a monthly basis. If SWMBH conducts these screens, the FI has a process to inform SWMBH/the CMH of staff changes (removing employees who are gone and adding new employees).			*PIHP Policy 10.13; 42 CFR 438.602*		

Section 1 - General Administrative Oversight Total: **Percent:**

SECTION 2 - EMPLOYER FILE REVIEW						
2.1	The FI has the following documents on file for each consumer, as required by the contract between the CMH and the FI: • FI Agreement (FI & Customer) • Employment Agreement (Provider & Customer) • Provider Agreement (Provider and CMH if customer specific agreement is applicable) • Self Determination Agreement (if applicable) • Job Description (Appendix of Emp. Agreement) • Back-Up Plan			*Self-Direction Technical Requirement* *CMHSP-FMS Contract Requirement*		
2.2	The FMS has provided monthly financial status (budget) reports to the supports coordinator (and/or anyone else at the CMHSP identified in the contract to receive monthly budget reports) and the individual (or the family of a minor child) by no later than 15 days after the end of month.			*Self-Direction Technical Requirement* *Contract Requirement*		
2.3	There is a record of payments within the record, which correspond with the IPOS and the individual budget, including budget revisions (made through the PCP process) if applicable.			*Self-Direction Technical Requirement* *Contract Requirement*		
2.4	The FMS contacts the supports coordinator and/or CMH-designated staff by phone or e-mail in the case of an over expenditure of 10 percent in one month prior to making payment for that expenditure.			*Self-Direction Technical Requirement* *Contract Requirement*		
2.5	The FMS contacts the supports coordinator and/or CMH-designated staff by phone or e-mail in the case of under expenditure of the pro rata share of the individual budget for the month that indicates that the individual is not receiving the services and supports in the IPOS.			*Self-Direction Technical Requirement* *Contract Requirement*		

Section 2 - Employer File Review Total: **Percent:**

		Possible Score	Actual Score	References	Comments	Plan for Improvement
SECTION 3 - STAFF FILE REVIEW						
3.1	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the verification protocol required by SWMBH policy 2.16; and subsequent verification of criminal back ground checks of current employees occurs every other year after the initial check. FMS follows SWMBH Policy 2.16 in the event of a positive criminal history result.			*Contract Requirement; Public Act 59 (PA 218 400.734a); PIHP Policy 2.16*		
3.2	For any staff members who transport persons served, A) there is documented evidence of verification of status of driver's license at the time of hire; B) annual verification of the status of the staff member's driver's license; and C) documented verification of valid vehicle liability insurance when staff member is using his or her own vehicle to transport persons served.			*SWMBH Contract requirement*		
3.3	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each unlicensed* employee is to be run through the following databases, prior to hire and at least annually thereafter: 1. OIG exclusions database (https://www.exclusions.oig.hhs.gov/) and 2. The State of Michigan Sanctioned Provider list (https://www.michigan.gov/mdhh/doing-business/providers/providers/billingreimbursement/list-of-sanctioned-providers) and 3. System for Award Management (SAM) (https://www.sam.gov) *Licensed/credentialed staff must be run monthly (consultative for FY23).			*MDHHS Master Contract Section (1)(R)(10)€ MDHHS Master Contract - Federal Provisions Addendum, Paragraph 7 MDHHS Credentialing Policy PIHP Policy 10.13 42 CFR 438.602*		Best practice is to run exclusions screenings monthly for any staff who provides Medicaid-funded services.
3.4	Staff file contains W2/W4 forms, I9 form and proof of ID as required by state and federal law.			*Contract requirement*		
3.5	Staff file contains payroll history.			*PIHP Policy 10.13*		
	Section 3 - Staff File Review Total:			**Percent:**		
SECTION 4 - TRAINING Aide Level Service Working with Adults						
4.1	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			*MIOSHA R 325.70016*		

		Possible Score	Actual Score	References	Comments	Plan for Improvement
4.2	Individuals Plans of Service and Ancillary Plans (there is evidence that staff have been trained in the IPOS and in any applicable Support Plan for Individuals in their care before the provision of direct care [Behavior Treatment Plan, PT, OT, Nursing, etc.]). May be reviewed as part of the clinical review.			*Michigan Mental Health Code 330.1708*		
4.3	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (PIHP approved curriculum if restricted interventions included) - (within 60 days of hire & annual updates) Only required as necessary to implement individual person-centered plans.			*R 330.1806 MDHHS BHDDA Technical Requirement for Behavior Treatment Plans*		
4.4	First Aid (within 60 days and ongoing as required per the training program - usually every 2 to 3 years).			*Medicaid Provider Manual 2.4*		
4.5	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual updates.).			*MH Code: 330.1755(5)(f)*		
4.6	Medication Administration. (within 90 days of hire) Only if necessary to implement an individual person-centered plan/member requires					
	Section 4 - Training Total:			**Percent:**		
Section 5 - TRAINING Aide Level Service working with Children on SED and CWP Waivers						
5.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual updates.).			MHC 330.1755(5)(f)		
5.2	Basic First Aid (as evidenced by completion of a first aid trianing course) - within 60 days of hire, updates as required per the training program.			Medicaid Provider Manual 2.4 & 18.12		
5.3	General Emergency Procedures (fire, tornado, etc.) - within 30 days of hire and annually thereafter			MDHHS Provider Qualifications		
5.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			MIOSHA R 325.70016		
5.5	Training in IPOS, including customer-specific emergency procedures (prior to delivery of service)			MPM 15.2.C		
5.6	Medication Administration. (within 90 days of hire) Only if necessary to implement an individual person-centered plan/member requires					

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
5.7	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (PIHP approved curriculum if restricted interventions included) - (within 60 days of hire & annual updates) Only required as necessary to implement individual person-centered plan			R 330.1806 MDHHS BHDDA Technical Requirement for Behavioral Treatment Plans		

Scoring Summary	Poss-ible Score	Actual Score	Percent
Section 1 - General Administrative Oversight Total:	0	0	
Section 2 - Employer File Review Total:	0	0	
Section 3 - Staff File Review Total:	0	0	
Section 4 - Training Total:	0	0	
OVERALL	***0***	***0***	

Review Date:	
Provider:	
Service:	
Reviewer:	

SCORING INSTRUCTIONS
2 = compliance with standard/intent
1 = partial compliance standard/intent
0 = non-compliance or insufficient levels of compliance with standard/intent
N/A = requirement not applicable to this type of review or this provider

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT							
1.1	The provider has adequate policy and/or procedure to protect confidential and individually identifiable information from unauthorized use or disclosure, including: 1. Protections for physical facility access. 2. Protections for electronic access. 3. Media and device controls. 4. Physical safeguards for workstations. 5. Procedures for allowing and removing access according to role-based employment			*HIPPA/HITECH* *42 CFR Part 2* *MH Code 330.1748*			
1.2	The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct (must have written certification that they have received, read, and will abide by SWMBH's Code of Conduct).			*PIHP Policy 10.1*			
1.3	Staff know what to do if they suspect Medicaid fraud or abuse within the organization.			*Deficit Reduction Act; Patient Protection & Affordable Care Act of 2010; HealthCare & Education Reconciliation Act of 2010*			
1.4	Recipients Rights Poster are clearly displayed and identify the internal and PIHP rights officer and their contact information.			*R 325.14302*			
1.5	Verification the organization is disseminating a Notice of Privacy Practices			*Provider Contract requirement*			
	Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:			**Percent:**			
SECTION 2 - QUALITY IMPROVEMENT							
2.1	Plan(s) for Improvement in response to citations/recommendations from the most recent reviews (licensing, MDCH, PIHP or accrediting body, etc.) has been submitted to the appropriate agency.			*Provider Contract requirement*			
2.2	All citations by PIHP, CMH, and MDHHS BH/IDD or licensing divisions have been corrected.			*Provider Contract requirement*			
	Section 2 - QUALITY IMPROVEMENT Total:			**Percent:**			
SECTION 3 - CUSTOMER SERVICES/ACCESS TO CARE							

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
3.1	Communication Accommodations: program has developed resources and incorporated features to overcome barriers for persons who have limited ability to communicate in standard English (i.e., LEP resources; bi-lingual staff; communication resources in alternative languages/formats [Braille, Spanish, audio enhancements, sign language communication; TDI; communication enhancement devices; signs; person served-specific communication techniques, etc.); interpreters]).			*MDHHS Contract Attachment P.4.1.1 Access System Standards; MDHHS Contract Attachment P.6.3.1 Customer Service Requirements; DHHS Site Review Protocol B.4.5.1; PIHP policy 6.5 (Communication Accommodations for Limited English Proficiency and Visual Impairment)*			
3.2	Taglines in the top 15 languages are posted advising clients of the availablity of free langauge assistance services.			*Affordable Care Act Section 1557*			
3.3	The Notice of Non-Discrimination is posted advising clients they cannot be refused treatment based on race, color, natinoal origin, sex, age or disability.			*Affordable Care Act Section 1557*			
3.4	Model Notice for Charitable Choice - As applicable, provider shows that treatment clients and prevention service recipients are notified of their right to request alternative services by providers that are faith-based. Notification must be in the form of the model notice contained in the final regulations, or the PIHP may approve an equivalent notice with MDHHS approval.			*45 CFR part 96 SWMBH-Provider Contract*			
3.5	FASD screening - has the organization referred children for FAS assessment? Do clinicians know where to find FAS screening forms for at-risk children?			*SWMBH Policy 11.9: Fetal Alcohol Spectrum Disorders OROSC Treatment TA #08*			
3.6	Evidence that the provider is providing the SWMBH customer handbook to the customer at intake and annually thereafter (may show documention of refusal)			*SWMBH Provider Contract Section XIV B*			
	Section 3 - CUSTOMER SERVICES Total:			**Percent:**			
SECTION 4 - FACILITY & MAINTENANCE (If applicable - when customers are served at a provider-owned location)							
4.1	Facility Grounds & Premises - driveway, surrounding yard areas, detached structures appear well maintained and free of obvious, litter, refuse, etc. (note: roof, exterior walls, doors, windows/screens, stairways, sidewalks, attached structure, etc.).			*DHHS Site Review Protocol D.3*			
4.2	Exits, corridors, and hallways are free of obstruction.			*DHHS Site Review Protocol D.3*			
4.3	Facility Interior/Cleanliness - Sanitary environment is maintained throughout the facility. (furnishings, flooring, walls, smells, cleanliness, housekeeping standards, etc.).			*DHHS Site Review Protocol D.3*			
4.4	Maintenance of Facility - there is evidence that maintenance issues are being appropriately addressed (invoices for repair/inspection/replacement of equipment, utilities, evidence of facility improvements, etc.).			*DHHS Site Review Protocol D.3*			
	Section 4 - FACILITY & MAINTENANCE Total:			**Percent:**			
SECTION 5 - MEDICATION MANAGEMENT (For providers who are distributing medication)							
5.1	If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.			*R 330.7158*			
5.2	A provider shall record the administration of all medication in the recipient's clinical record.			*R 330.7158*			
5.3	A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported and recorded.			*R 330.7158*			

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
	Section 5 - MEDICATION MANAGEMENT Total:			**Percent:**			
SECTION 6 - EMERGENCY RESPONSE							
6.1	Program has a comprehensive set of written Emergency Response Procedures containing clear instructions in response to fire, severe weather, medical emergencies, and emergencies while transporting individuals served, if applicable.			*DHHS Site Review Protocol D.3*			
6.2	Emergency evacuation maps/routes are displayed in prominent locations at the facility. (when customers are served at a provider-owned location)			*DHHS Site Review Protocol D.3*			
	Section 6 - EMERGENCY RESPONSE Total:			**Percent:**			
SECTION 7 - TRAINING							
7.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).			*MH Code: 330.1755(5)(f)*			
7.2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).			*MDHHS Master Contract Attachment P.4.4.1.1*			
7.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).			MDHHS Master Contract Part II(A); 4.5 *42 CFR 438.206*			
7.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			*MIOSHA R 325.70016*			
7.5	Limited English Proficiency (LEP) (within 6 months of hire).			*MDHHS Master Contract Part I; 18.16* *Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination*			
7.6	HIPAA (within 30 days of hire).			*45 CFR 164.308(a)(5)(i) & 45 CFR 164.503.(b)(1)*			
7.7	Corporate Compliance (within 30 days of hire, annual updates).			*Medicaid Integrity Program (MIP)* *Deficit Reduction Act (DRA)*			
7.8	Advance Directives (All in the following roles: Primary clinicians, Access/UM staff, Customer Services, Psychiatrists/nurses, Peer Support Specialists, Service supervisors/directors of the above listed staff)			*42 CFR 422.128* *42 CFR 438.3* *MDHHS Master Contract Part II(A) 7.10.5*			
7.9	Grievances and Appeals within 30 days of hire and annually for all in the following roles: • Primary clinicians & SUD therapists (including residential/detox) • Access/UM staff, • Customer Services, • Service supervisors/directors of the above listed staff			*42 CFR 438.400-424* *MDHHS Master Contract Attachment P 6.3.1.1*			
7.10	Customer Services within 30 days of hire and annually for all in the following roles: • Psychiatrists/nurses, • Peer support specialists, • Recovery coaches, • Reception staff, • Service supervisors/directors of the above listed staff, • Minimum one person per site for all other services (MH and SUD)			*42 CFR 438.400-424* *MDHHS Master Contract Attachment P 6.3.1.1*			
7.11	ASAM training (prior to administering and booster as required by MDHHS or SWMBH clinical policy - ASAM assessors)			*MDHHS Master Contract Attachment P.II.B.A.*			
7.12	Trauma Informed Systems of Care (Within 60 days of hire)			*MDHHS Master Contract Attachment P.2.7.10.6. and 7.10.6.1*			
	Section 7 - DIRECT SERVICE STAFF TRAINING REQUIREMENTS Total:			**Percent:**			

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
SECTION 8 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS							
8.1	The provider has written job descriptions for all positions. Each job description shall specifically identify all of the following: a. Job Title b. Tasks & Responsibilities c. The skills, knowledge, training, education, and experience required for the job d. Recovery-based (as appropriate), person-centered and culturally competent practices.			*R 325.14112* *PIHP Policy 1.2* *SWMBH-Provider Contracts*			
8.2	Individuals have been credentialed prior to providing services that require credentialing. Re-credentialing occurs at least every 2 years, and includes: -updated attestation to credentialing application questions and any other updates to credentialing application information, -verification of valid and current licensure to practice in the State of Michigan, -verification of current malpractice insurance, -review of any quality concerns (if applicable), -verification that the practitioner has not be excluded from participation in Medicaid through OIG check, -verification of licensure limitations or malpractice suits reported through NPDB check. -QI data was reviewed at recredentialing including: a. Member complaints, adverse events,quality improvement activities related to identified instances of poor quality. b. Compliance any incidences of Medicaid and Medicare Sanctions. c. Any restrictions and/or sanctions on licensure and/or Certification.			*MDCH Contract attachment P.6.4.3.1* *PIHP Policy 2.2 & 2.3*			
8.3	Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: A. Educational background (Primary source verification required) B. Relevant work experience C. Certification, registration, and licensure as required by law. (Primary source verification required)			*MDCH Contract attachment P.6.4.3.1* *PIHP Policy 2.2*			
8.4	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the protocol required by SWMBH policy 2.16, including documentation of approval of waiver for employees with exclusionary convictions.			*Contract Requirement; Public Act 59 (PA 218 400.734b); 5) AFC Licensing Rules: R.400.14201.13 (SGH); R.400.1404.6 (FH); PIHP Policy 2.16*			
8.5	Driver's License: A) there is documented evidence of verification of status of driver's license at the time of hire and B) ongoing monitoring of the status of the driver's license of every staff member who transports persons served.			*SWMBH Contract requirement*			
8.6	Personnel Performance Management: there is documented evidence that program has an adequate system to support, monitor, and complete at least annual performance evaluations of staff who provide direct care services.			*DHHS Site Visit Protocol B.1.3, 4.4.2(e), 5.4.2, 6.4.2, 7.4.1, 8.3.2*			

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
8.7	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each employee is to be run through OIG and SAM exclusion databases prior to hire and annually thereafter.			*PIHP Policy 10.13*			
8.8	The Applicant Rights for Credentialing and Recredentialing form is included in credentialing packet, which includes written notification of, and an appeal process for, adverse credentialing decisions.			*PIHP Policy 2.05 & Credentialing Application Document*			
8.9	The Credentialing Application includes anti-discrimination provisions, attestation and disclosure questions within.			*PIHP Policy 2.05 & Credentialing Application Document*			
8.10	All credentialing files include the following information: Credentialing Start date, Credentialing decision date, and Credentialing completion date.			*PIHP Policy 2.05 & Credentialing Application Document*			
8.11	All practitioner files include documentation that Grievance and Appeal information was reviewed during the recredentialing process			*PIHP Policy 2.02 & Credentialing Application Document*			
	Section 8 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:			**Percent:**			
SECTION 9- EVIDENCE BASED PRACTICE (EBP)							
9.1	Core components of monitoring fidelity for EBPs are being implemented as planned. Typical Methods to monitor fidelity of a program and clinician adherence include: a. Independent observations (audio tape, video, in person, record review) b. Practitioner completed checklists c. Consumer ratings			*EBP Fidelity Plan(s) submitted to SWMBH*			
9.2	The amount and type of supervision being provided for EBP practitioners is consistent with the EBPs in terms of time, frequency, duration, etc.			*EBP Fidelity Plan(s) submitted to SWMBH*			
9.3	The agency has sufficient staff trained so normal attrition doesn't threaten sustainability of EBPs.			*EBP Fidelity Plan(s) submitted to SWMBH*			
9.4	Clinicians have received training to support competence in Evidence Based modality utilized.			*SWMBH-Provider contract*			
9.5	Trauma Informed Policy I. Adoption of trauma-informed culture: values, principles, and development of a trauma-informed system of care ensuring safety and preventing re-traumatization. II. Engagement in organizational self-assessment of trauma informed care. III. Adoption of approaches that prevent and address secondary trauma of staff (See Exhibit A). IV. Screening for trauma exposure and related symptoms for each population. V. Trauma-specific assessment for each population. VI. Trauma-specific services for each population using evidence-based practice(s) (EBPs), or evidence-informed practice(s) are provided in addition to EBPs. VII. The PIHP shall, through its direct service operations and its network providers, join with other community organizations to			*MDHHS Trauma Policy*			
	Section 9- EVIDENCE BASED PRACTICE Total:			**Percent:**			
Section 10 - ABILITY TO PAY							
10.1	Did the provider complete an Ability To Pay (ATP) for the customer if the customer is NOT eligible for Medicaid			*SWMBH Policy 9.12*			

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
10.2	Is the Provider making every effort to collect ATP fees from individuals?			*SWMBH Policy 9.12*			
10.3	Is the Provider completing the ATP in its entirety?			*SWMBH Policy 9.12*			
	Section 10 ABILITY TO PAY total:			**Percent:**			

SECTION 11 - SPECIALTY REQUIREMENTS FOR RESIDENTIAL AND WOMEN'S SPECIALTY (if applicable)

11.1	Residential Service Providers implement treatment schedule / curriculum that meets the requirements of OROSC Treatment Policy #10. ASAM III.1 - minimum 5 hrs clinical services and 5 hours life skills/self care per week. ASAM III.3 - minimum 13 hrs clinical services and 13 hours life skills/self care per week. ASAM III.5 - minimum 20 hrs clinical services and 20 hours life skills/self care per week.			*OROSC Treatment Policy #10*			
11.2	Residential Service Providers have a process in place to assure that, as part of admission to residential treatment, all clients are given a TB test.			*OROSC Prevention Policy #02*			
11.3	Designated Women's Specialty providers only - The program demonstrates that outreach activities are conducted to promote and advertise women's programming and priority population status.			*MDHHS-PIHP contract, Part II, Section 4* *OROSC Treatment Policy #12*			
11.4	Designated Women's Specialty providers only - The program has a Gender-Responsive policy for treating women's specialty population.			*MDHHS-PIHP contract, Part II, Section 4* *OROSC Treatment Policy #12*			
	Section 11 - SPECIALTY REQUIREMENTS Total:			**Percent:**			

SECTION 12 - METHADONE (if applicable)

12.1	The provider shall have a designated medical director who assumes responsibility for the administration of all medical services performed by the program.			Methadone Licensing Rules R 325.14404			
12.2	Dispensing logs are maintained according to the Administrative Rules 421 (2): (Includes date, dosage, where ingested, signature of the individual and the administering professional).			Methadone Licensing Rules R 325.14421			
12.3	Take home medications are labeled with the following information: * Name of the medication * The treatment center's name, address, and phone number *Client name or code number * Medical director's name * Directions for use * Date to be used * A cautionary statement that the drug should be kept out of reach of children			Methadone Licensing Rules R. 325.14415			
12.4	Written documentation of the agency's emergency procedures to be implemented in case of an emergency situation which would stop, or substantially interfere with normal dispensing procedures. To include: • Arrangements with security providers for immediate security of drug stocks. • Written agreements, updated annually for the use of an alternate program, hospital, or other site for dispensing during an emergency.			R. 325.14423 (4)(a-d)			

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
12.5	The provider has a written agreements updated annually with back up medical personnel, such as physician or nurses for the coverage of dispensing and other medical needs if regular personnel are not available.			R. 325. 14423 (4)(b).			
12.6	The provider has a reliable system to confirm the identities of clients before dispensing Methadone.			Methadone Licensing Rules R. 325.14423 (4)(c)			
12.7	The provider shall meet staffing requirements. The program shall employ: * One full-time physician per 300 clients * Two full-time nurses per 300 clients * A physician's assistant to be utilized for up to 30% of physician's hours if supervised by a physician as outlined in (16103 (1)) of the act			R. 325.14403			
	Section 12 - METHADONE Total:			**Percent:**			

Scoring Summary	Possible Score	Actual Score	Percent
Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:	0	0	
Section 2 - QUALITY IMPROVEMENT Total:	0	0	
Section 3 - CUSTOMER SERVICES Total:	0	0	
Section 4 - FACILITY & MAINTENANCE Total:	0	0	
Section 5 - MEDICATION MANAGEMENT Total:	0	0	
Section 6 - EMERGENCY RESPONSE Total:	0	0	
Section 7 - TRAINING TOTAL	0	0	
Section 8 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:	0	0	
Section 9 EVIDENCE BASED PRACTICE (EBP) Total:	0	0	
Section 10 ABILITY TO PAY Total:	0	0	
SECTION 11 - SPECIALTY REQUIREMENTS FOR RESIDENTIAL AND WOMEN'S SPECIALTY	0	0	
SECTION 12 - METHADONE (if applicable)	0	0	
OVERALL	***0***	***0***	

SWMBH Clinical Quality Review Tool

Recovery Residence:			
Date of Review:			
Reviewer:			
		Possible	**Actual**
1	There is proof of MARR membership or application. Results of the most recent MARR site review is available. The recovery residence has obtained at minimum NARR level II.		
2	There is documentation showing that house meetings are held at least once a week and are being facilitated by certified recovery staff or appropriate house staff.		
3	There is documentation that the house utilizes a sign in/sign out tracking form that demonstrates residents are present at the home.		
4	Emergency Exits, Fire Extinguishers, Smoke Detectors and Carbon Monoxide Detectors are clearly marked and in working order.		
5	Resident records are kept in a secure location with access limited to authorized staff.		
6	There is an up to date medication list for each resident and medications are stored in a secure location.		
7	There is evidence that residents are provided with a receipt of any payment made.		
8	Recipient Rights information is clearly posted.		
9	Provider has an orientation process that clearly communicates residents' rights and requirements prior to them signing any agreement; collects demographic and emergency contact information and provides new residents with written instructions on emergency procedures and staff contact information.		
10	Provider posts emergency procedures and staff phone number in conspicuous locations.		
	Comments (Required for any score of 1 or 0):	Average:	

SWMBH Clinical Quality Review Tool

Case #:			
Name:			
Provider:			
Date of Review:			
Reviewer:			
Section A: Coordination of Care		**Possible**	**Actual**
1	Appropriate releases of information are in the resident's file. Releases should include emergency contact, primary SUD treatment provider, SWMBH, primary care and/other health care providers, etc. If client refuses to sign a release of information, the chart contains documentation		
2	Chart includes evidence of initial and on-going care coordination with service providers including SUD treatment provider.		
3	Chart contains documentation of resident's attendance and/or engagement with recovery focused supports such as 12 Step Meetings, Peer Support, Recovery Coaching.		
4	Chart contains documentation of resident's attendance SUD treatment services.		
Section B: Assessment			
1	Resident's file contains a copy of client's most recent assessment that documents medical necessity for recovery housing.		
2	Recovery Residence application and screening are included in the resident's file.		
Section C: Treatment Planning/Recovery Planning			
1	Chart contains a copy of resident's most recent treatment plan that contains a goal/objective related to recovery housing and/or recovery environment.		
2	Chart includes a Recovery Plan developed with the resident and recovery residence staff.		
Section D: Recovery Supports			
1	File includes progress notes or documentation of attendance at house meetings, coaching or other recovery supports provided at the recovery home.		
2	Resident's file includes drug screen results, if applicable.		
Section E: Orientation/Rights			
1	Resident's file includes a signed acknowledgement of an orientation process that ensures the resident understands agreements, policies, procedures and house rules. House rules should include but not be limited to curfew, expectations for outpatient SUD treatment, which medications are allowed and how they are handled/distributed, how meal prep and food storage are handled, how groceries and toiletries are purchased, grounds for discharge, etc.		
2	Resident's file includes a signed acknowledgment that grievance policy and procedure has been reviewed with the resident.		
3	Resident's file contains evidence that income, if applicable, has been reviewed and any payment expectation by the resident is clear and in writing.		

Scoring:

2 = Fully compliant with all requirements
1* = Partially compliant with requirements
0* = Not compliant
NA = Not applicable-put this in the box next to the score box so that it does not interfere with automatic calculations.
**An explanation describing the partially compliant or noncompliant findings will be provided in the "Comments" box within each section of the audit tool.*

	Section A: Coordination of Care	**Scoring Guidance**
1	Appropriate releases of information are in the resident's file. Releases should include emergency contact, primary SUD treatment provider, SWMBH, primary care and/other health care providers, etc. If client refuses to sign a release of information, the chart contains documentation.	2 - File contains all appropriate releases. 1 - File is missing some appropriate releases and/or no documentation as to why release is not present. 0 - No releases in file or lacking documentation as to why releases are missing (ex: refused to sign).
2	Chart includes evidence of initial and on-going care coordination with service providers including SUD treatment provider.	2 - Clear documentation that care coordination with appropriate service providers is present 1 - Care coordination only took place at admission, not all appropriate providers received care coordination, etc. 0 - No evidence of care coordination.
3	Chart contains documentation of resident's attendance and/or engagement with recovery focused supports such as 12 Step Meetings, Peer Support, Recovery Coaching.	2 - Appropriate documentation of resident's attendance at recovery support services 1- Incomplete documentation 0 - No evidence of documentation
4	Chart contains documentation of resident's attendance SUD treatment services.	2 - Appropriate documentation of resident's attendance at SUD treatment services. 1- Incomplete documentation 0 - No evidence of documentation
	Section B: Assessment	**Scoring Guidance**
1	Resident's file contains a copy of client's most recent assessment that documents medical necessity for recovery housing.	2 - Assessment is present 1 - Assessment is present, but no medical necessity noted for recovery housing, the assessment is outdated, etc. 0 - No assessment present.
2	Recovery Residence application and screening are included in the resident's file.	2 - Are present 1 - Present, but incomplete 0 - Not present
Section C: Treatment Planning/Recovery Planning		**Scoring Guidance**
1	Chart contains a copy of resident's most recent treatment plan that contains a goal/objective related to recovery housing and/or recovery environment.	2- Most recent tx plan is present. 1- Tx plan is outdated, no goal/obj re recovery housing, etc. 0 - No tx plan on file
2	Chart includes a Recovery Plan developed with the resident and recovery residence staff.	2 - Recovery plan/updated plan present in file 1 - Plan is present but incomplete or outdated. 0 - No plan present.
Section D: Recovery Supports		**Scoring Guidance**
1	File includes progress notes or documentation of attendance at house meetings, coaching or other recovery supports provided at the recovery home.	2 - Notes are complete and present in file. 1 - Notes are present but incomplete. 0 - No evidence of notes.

2	Resident's file includes drug screen results, if applicable.	2 - Are present 1 - Present, but incomplete 0 - Not present
Section E: Orientation/Rights		**Scoring Guidance**
1	Resident's file includes a signed acknowledgement of an orientation process that ensures the resident understands agreements, policies, procedures and house rules. House rules should include but not be limited to curfew, expectations for outpatient SUD treatment, which medications are allowed and how they are handled/distributed, how meal prep and food storage are handled, how groceries and toiletries are purchased, grounds for discharge, etc.	2 - Are present 1 - Present, but incomplete 0 - Not present
2	Resident's file includes a signed acknowledgment that grievance policy and procedure has been reviewed with the resident.	2 - Are present 1 - Present, but incomplete 0 - Not present
3	Resident's file contains evidence that income, if applicable, has been reviewed and any payment expectation by the resident is clear and in writing.	2 - Are present 1 - Present, but incomplete 0 - Not present

SWMBH SUD Clinical Quality Review Tool 2019

PROVIDER:		Corrective Action Plan Request	Corrective Action Plan Submission	Accepted/Not Accepted (with date)	Comments	SWMBH Follow Up
Section A: Physician Coordination	Average Score %					
File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.						
If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.						
Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.						
In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.						
In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.						
Section B: Assessment	Average Score %					
ASAM Continuum assessment is present and complete in SWMBH's customer file.						
The biopsychosocial assessment clearly identifies the customer 's strengths.						
Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.						
The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and Hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).						
Section C: Treatment Plan/Person-Centered Planning	Average Score %					
Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.						
Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.						
If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.						
Realistic target dates are identified for each goal and objective.						
The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.						
Section D: Consumer Discharge/ BH TEDS	Average Score %					
BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).						
BH TEDS admission is completed.						
Section E: Michigan Department of Corrections (If Applicable)	Average Score %					
There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.						
The discharge plan contains referrals and after care services if applicable.						
The file contains documentation of a completed discharge plan and is signed by the customer.						
On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).						
If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.						
Section G: Women's Specialty Services (If Applicable)						
There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.						
Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.						
Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.						
Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.						
Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.						
Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.						
The file contains a screening for FASD and referral (if applicable).						
The file contains a completed child(ren) needs assessment.						
Section G: Methadone Treatment (If Applicable)						
There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.						
There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis may be performed) Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.						
There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15))						
If the customer has take-home doses: The customer is receiving up to the appropriate number of take-home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15))						
A detailed account of any adverse reactions to medication (FD-3639) is in the file.						
The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)						
The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana) (SWMBH Policy 11.18 & OROSC Tx Policy #5)						
The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.						
Monthly medical progress notes by the dispensing nurse are contained in the file.						
The file contains the initial standing order and renewals of methadone.						
Documentation is in the file of a physician-customer encounter every 60 days.						
Documentation of methadone authority approval of any exception to the application rules and regulations.						
The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.						
Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.						

SWMBH SUD Services Clinical Quality Review Tool

	Summary				
	Provider:				
	Date of Review:				
	Section A: Physician Coordination	**Possible**	**Actual**	**Average**	**FY 2021**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.				
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.				
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.				
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.				
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.				
			Section Average:		
	Section B: Assessment	**Possible**	**Actual**	**Average**	**FY 2021**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.				
2	The biopsychosocial assessment clearly identifies the customer 's strengths.				
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.				
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).				
			Section Average		
	Section C: Treatment Plan/Person-Centered Planning	**Possible**	**Actual**	**Average**	**FY 2021**

SWMBH SUD Services Clinical Quality Review Tool

1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.				
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.				
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.				
4	Realistic target dates are identified for each goal and objective				
5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.				
			Section Average:		
	Section D: Discharge / BH TEDS	Possible	Actual	Average	FY 2021
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).				
2	BH TEDS admission is completed.				
			Section Average:		
	Section E: Michigan Department of Corrections (If Applicable)	Possible	Actual	Average	FY 2021
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.				
2	The discharge plan contains referrals and after care services if applicable.				
3	The file contains documentation of a completed discharge plan and is signed by the customer.				
4	On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).				
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.				
			Section Average:		
	Section G: Women's Speciality Services (If Applicable)	Possible	Actual	Average	FY 2021
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.				
	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.				
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.				

4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.				
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.				
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.				
7	The file contains a screening for FASD and referral (if applicable).				
8	The file contains a completed child(ren) needs assessment.				
				Section Average:	
	Section G: Methadone Treatment (If Applicable)	Possible	Actual	Average	FY 2021
1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.				
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.				
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).				
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).				
5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.				
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)				
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)				
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.				
9	Monthly medical progress notes by the dispensing nurse are contained in the file.				
10	The file contains the initial standing order and renewals of methadone.				

11	Documentation is in the file of a physician-customer encounter every 60 days				
12	Documentation of methadone authority approval of any exception to the application rules and regulations.				
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.				
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.				
			Section Average:		
				Overall Score FY 2022	Overall Score FY 2021

SWMBH SUD Services Clinical Quality Review Tool

Case #:	
Name:	
Provider:	
Date of Review:	
Reviewer:	

	Section A: Physician Coordination	**Possible**	**Actual**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.		
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.		
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section B: Assessment	**Possible**	**Actual**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.		
2	The biopsychosocial assessment clearly identifies the customer 's strengths.		
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.		
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).		

SWMBH SUD Services Clinical Quality Review Tool

	Comments (Required for any score of 1 or 0):	Average:	

	Section C: Treatment Plan/Person-Centered Planning	Possible	Actual
1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.		
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.		
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.		
4	Realistic target dates are identified for each goal and objective		
5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section D: Discharge / TEDS	Possible	Actual
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).		
2	BH TEDS admission is completed.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section E: Michigan Department of Corrections (if Applicable)	Possible	Actual
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.		
2	The discharge plan contains referrals and after care services if applicable.		
3	The file contains documentation of a completed discharge plan and is signed by the customer.		
4	On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).		
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section F: Women's Specialty Services (If Applicable)	Possible	Actual
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.		
	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.		
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.		
4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.		
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.		
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.		
7	The file contains a screening for FASD and referral (if applicable).		
8	The file contains a completed child(ren) needs assessment.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section G: Methadone Treatment (If Applicable)	Possible	Actual
1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.		
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.		
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).		
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).		

SWMBH SUD Services Clinical Quality Review Tool

5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.		
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.		
9	Monthly medical progress notes by the dispensing nurse are contained in the file.		
10	The file contains the initial standing order and renewals of methadone.		
11	Documentation is in the file of a physician-customer encounter every 60 days		
12	Documentation of methadone authority approval of any exception to the application rules and regulations.		
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.		
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.		
	Comments (Required for any score of 1 or 0):	Average:	
		Overall Score:	

SWMBH SUD Services Clinical Quality Review Tool

	Case #:
	Name:
	Provider:
	Date of Review:
	Reviewer:

	Section A: Physician Coordination	**Possible**	**Actual**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.		
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.		
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section B: Assessment	**Possible**	**Actual**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.		
2	The biopsychosocial assessment clearly identifies the customer 's strengths.		
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.		
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).		

	Comments (Required for any score of 1 or 0):	Average:	

	Section C: Treatment Plan/Person-Centered Planning	Possible	Actual
1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.		
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.		
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.		
4	Realistic target dates are identified for each goal and objective		
5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section D: Discharge / TEDS	Possible	Actual
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).		
2	BH TEDS admission is completed.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section E: Michigan Department of Corrections (if Applicable)	Possible	Actual
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.		
2	The discharge plan contains referrals and after care services if applicable.		
3	The file contains documentation of a completed discharge plan and is signed by the customer.		
4	On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).		
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section F: Women's Specialty Services (If Applicable)	Possible	Actual
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.		
	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.		
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.		
4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.		
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.		
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.		
7	The file contains a screening for FASD and referral (if applicable).		
8	The file contains a completed child(ren) needs assessment.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section G: Methadone Treatment (If Applicable)	Possible	Actual
1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.		
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.		
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).		
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).		

SWMBH SUD Services Clinical Quality Review Tool

5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.		
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.		
9	Monthly medical progress notes by the dispensing nurse are contained in the file.		
10	The file contains the initial standing order and renewals of methadone.		
11	Documentation is in the file of a physician-customer encounter every 60 days		
12	Documentation of methadone authority approval of any exception to the application rules and regulations.		
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.		
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.		
	Comments (Required for any score of 1 or 0):	Average:	
		Overall Score:	

SWMBH SUD Services Clinical Quality Review Tool

	Case #:
	Name:
	Provider:
	Date of Review:
	Reviewer:

	Section A: Physician Coordination	**Possible**	**Actual**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.		
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.		
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section B: Assessment	**Possible**	**Actual**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.		
2	The biopsychosocial assessment clearly identifies the customer 's strengths.		
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.		
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).		

SWMBH SUD Services Clinical Quality Review Tool

	Comments (Required for any score of 1 or 0):	Average:	
	Section C: Treatment Plan/Person-Centered Planning	**Possible**	**Actual**
1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.		
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.		
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.		
4	Realistic target dates are identified for each goal and objective		
5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section D: Discharge / TEDS	**Possible**	**Actual**
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).		
2	BH TEDS admission is completed.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section E: Michigan Department of Corrections (if Applicable)	**Possible**	**Actual**
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.		
2	The discharge plan contains referrals and after care services if applicable.		
3	The file contains documentation of a completed discharge plan and is signed by the customer.		
4	On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).		
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section F: Women's Specialty Services (If Applicable)	Possible	Actual
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.		
	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.		
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.		
4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.		
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.		
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.		
7	The file contains a screening for FASD and referral (if applicable).		
8	The file contains a completed child(ren) needs assessment.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section G: Methadone Treatment (If Applicable)	Possible	Actual
1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.		
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.		
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).		
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).		

5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.		
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.		
9	Monthly medical progress notes by the dispensing nurse are contained in the file.		
10	The file contains the initial standing order and renewals of methadone.		
11	Documentation is in the file of a physician-customer encounter every 60 days		
12	Documentation of methadone authority approval of any exception to the application rules and regulations.		
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.		
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.		
	Comments (Required for any score of 1 or 0):	Average:	
		Overall Score:	

SWMBH SUD Services Clinical Quality Review Tool

	Case #:		
	Name:		
	Provider:		
	Date of Review:		
	Reviewer:		
	Section A: Physician Coordination	**Possible**	**Actual**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.		
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.		
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section B: Assessment	**Possible**	**Actual**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.		
2	The biopsychosocial assessment clearly identifies the customer 's strengths.		
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.		
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).		

SWMBH SUD Services Clinical Quality Review Tool

	Comments (Required for any score of 1 or 0):	Average:	

	Section C: Treatment Plan/Person-Centered Planning	Possible	Actual
1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.		
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.		
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.		
4	Realistic target dates are identified for each goal and objective		
5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section D: Discharge / TEDS	Possible	Actual
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).		
2	BH TEDS admission is completed.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section E: Michigan Department of Corrections (if Applicable)	Possible	Actual
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.		
2	The discharge plan contains referrals and after care services if applicable.		
3	The file contains documentation of a completed discharge plan and is signed by the customer.		
4	On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).		
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section F: Women's Specialty Services (If Applicable)	Possible	Actual
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.		
	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.		
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.		
4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.		
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.		
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.		
7	The file contains a screening for FASD and referral (if applicable).		
8	The file contains a completed child(ren) needs assessment.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section G: Methadone Treatment (If Applicable)	Possible	Actual
1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.		
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.		
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).		
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).		

5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.		
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.		
9	Monthly medical progress notes by the dispensing nurse are contained in the file.		
10	The file contains the initial standing order and renewals of methadone.		
11	Documentation is in the file of a physician-customer encounter every 60 days		
12	Documentation of methadone authority approval of any exception to the application rules and regulations.		
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.		
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.		
	Comments (Required for any score of 1 or 0):	Average:	
		Overall Score:	

SWMBH SUD Services Clinical Quality Review Tool

	Case #:		
	Name:		
	Provider:		
	Date of Review:		
	Reviewer:		
	Section A: Physician Coordination	**Possible**	**Actual**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.		
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.		
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section B: Assessment	**Possible**	**Actual**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.		
2	The biopsychosocial assessment clearly identifies the customer 's strengths.		
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.		
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).		

	Comments (Required for any score of 1 or 0):	Average:	

	Section C: Treatment Plan/Person-Centered Planning	Possible	Actual
1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.		
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.		
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.		
4	Realistic target dates are identified for each goal and objective		
5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section D: Discharge / TEDS	Possible	Actual
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).		
2	BH TEDS admission is completed.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section E: Michigan Department of Corrections (if Applicable)	Possible	Actual
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.		
2	The discharge plan contains referrals and after care services if applicable.		
3	The file contains documentation of a completed discharge plan and is signed by the customer.		
4	On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).		
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section F: Women's Specialty Services (If Applicable)	Possible	Actual
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.		
	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.		
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.		
4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.		
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.		
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.		
7	The file contains a screening for FASD and referral (if applicable).		
8	The file contains a completed child(ren) needs assessment.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section G: Methadone Treatment (If Applicable)	Possible	Actual
1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.		
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.		
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).		
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).		

5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.		
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.		
9	Monthly medical progress notes by the dispensing nurse are contained in the file.		
10	The file contains the initial standing order and renewals of methadone.		
11	Documentation is in the file of a physician-customer encounter every 60 days		
12	Documentation of methadone authority approval of any exception to the application rules and regulations.		
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.		
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.		
	Comments (Required for any score of 1 or 0):	Average:	
		Overall Score:	

SWMBH SUD Services Clinical Quality Review Tool

	Case #:		
	Name:		
	Provider:		
	Date of Review:		
	Reviewer:		
	Section A: Physician Coordination	**Possible**	**Actual**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.		
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.		
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section B: Assessment	**Possible**	**Actual**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.		
2	The biopsychosocial assessment clearly identifies the customer 's strengths.		
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.		
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).		

SWMBH SUD Services Clinical Quality Review Tool

	Comments (Required for any score of 1 or 0):	Average:	

	Section C: Treatment Plan/Person-Centered Planning	Possible	Actual
1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.		
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.		
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.		
4	Realistic target dates are identified for each goal and objective		
5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section D: Discharge / TEDS	Possible	Actual
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).		
2	BH TEDS admission is completed.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section E: Michigan Department of Corrections (if Applicable)	Possible	Actual
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.		
2	The discharge plan contains referrals and after care services if applicable.		
3	The file contains documentation of a completed discharge plan and is signed by the customer.		
4	On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).		
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section F: Women's Specialty Services (If Applicable)	Possible	Actual
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.		
	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.		
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.		
4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.		
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.		
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.		
7	The file contains a screening for FASD and referral (if applicable).		
8	The file contains a completed child(ren) needs assessment.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section G: Methadone Treatment (If Applicable)	Possible	Actual
1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.		
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.		
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).		
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).		

5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.		
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.		
9	Monthly medical progress notes by the dispensing nurse are contained in the file.		
10	The file contains the initial standing order and renewals of methadone.		
11	Documentation is in the file of a physician-customer encounter every 60 days		
12	Documentation of methadone authority approval of any exception to the application rules and regulations.		
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.		
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.		
	Comments (Required for any score of 1 or 0):	Average:	
		Overall Score:	

SWMBH SUD Services Clinical Quality Review Tool

	Case #:
	Name:
	Provider:
	Date of Review:
	Reviewer:

	Section A: Physician Coordination	**Possible**	**Actual**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.		
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.		
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section B: Assessment	**Possible**	**Actual**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.		
2	The biopsychosocial assessment clearly identifies the customer 's strengths.		
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.		
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).		

SWMBH SUD Services Clinical Quality Review Tool

	Comments (Required for any score of 1 or 0):	Average:	
	Section C: Treatment Plan/Person-Centered Planning	**Possible**	**Actual**
1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.		
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.		
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.		
4	Realistic target dates are identified for each goal and objective		
5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section D: Discharge / TEDS	**Possible**	**Actual**
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).		
2	BH TEDS admission is completed.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section E: Michigan Department of Corrections (if Applicable)	**Possible**	**Actual**
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.		
2	The discharge plan contains referrals and after care services if applicable.		
3	The file contains documentation of a completed discharge plan and is signed by the customer.		
4	On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).		
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section F: Women's Specialty Services (If Applicable)	Possible	Actual
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.		
	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.		
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.		
4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.		
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.		
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.		
7	The file contains a screening for FASD and referral (if applicable).		
8	The file contains a completed child(ren) needs assessment.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section G: Methadone Treatment (If Applicable)	Possible	Actual
1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.		
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.		
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).		
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).		

5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.		
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.		
9	Monthly medical progress notes by the dispensing nurse are contained in the file.		
10	The file contains the initial standing order and renewals of methadone.		
11	Documentation is in the file of a physician-customer encounter every 60 days		
12	Documentation of methadone authority approval of any exception to the application rules and regulations.		
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.		
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.		
	Comments (Required for any score of 1 or 0):	Average:	
		Overall Score:	

SWMBH SUD Services Clinical Quality Review Tool

	Case #:		
	Name:		
	Provider:		
	Date of Review:		
	Reviewer:		
	Section A: Physician Coordination	**Possible**	**Actual**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the customer has refused to sign a release.		
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.		
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section B: Assessment	**Possible**	**Actual**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.		
2	The biopsychosocial assessment clearly identifies the customer 's strengths.		
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.		
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).		

	Comments (Required for any score of 1 or 0):	Average:	
	Section C: Treatment Plan/Person-Centered Planning	**Possible**	**Actual**
1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.		
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.		
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.		
4	Realistic target dates are identified for each goal and objective		
5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section D: Discharge / TEDS	**Possible**	**Actual**
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).		
2	BH TEDS admission is completed.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section E: Michigan Department of Corrections (if Applicable)	**Possible**	**Actual**
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.		
2	The discharge plan contains referrals and after care services if applicable.		
3	The file contains documentation of a completed discharge plan and is signed by the customer.		
4	On the occasion that customer is receiving MAT the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).		
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.		
	Comments (Required for any score of 1 or 0):	Average:	

	Section F: Women's Specialty Services (If Applicable)	Possible	Actual
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.		
	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.		
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.		
4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.		
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.		
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.		
7	The file contains a screening for FASD and referral (if applicable).		
8	The file contains a completed child(ren) needs assessment.		
	Comments (Required for any score of 1 or 0):	Average:	
	Section G: Methadone Treatment (If Applicable)	**Possible**	**Actual**
1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.		
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.		
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).		
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).		

5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.		
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)		
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.		
9	Monthly medical progress notes by the dispensing nurse are contained in the file.		
10	The file contains the initial standing order and renewals of methadone.		
11	Documentation is in the file of a physician-customer encounter every 60 days		
12	Documentation of methadone authority approval of any exception to the application rules and regulations.		
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.		
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.		
	Comments (Required for any score of 1 or 0):	Average:	
		Overall Score:	

	Scope: **Review Period:** The reviewer will review documentation from the time period between the most recent treatment plan through the current date. If the most recent treatment plan is less than 2 months (60 days) old, then the prior year's treatment plan and associated documentation will be reviewed.
A	**Section A: Physician Coordination**
1	File contains the primary care physician's name and address, and a signed release of information for the PCP or a statement that the client has refused to sign a release.
2	If there is no primary care physician established, a referral to a PCP has been made and is documented. If documentation of refusal is present as outlined above: this item is not applicable.
3	Upon intake, coordination of care has occurred with the Primary Care Physician. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.
4	In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.
5	In the event the case is closed, documentation of coordination of care is present. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate release must be present if SUD information is shared.
B	**Section B: Assessment**
1	ASAM Continuum assessment is present and complete in SWMBH's customer file.

2	The biopsychosocial assessment clearly identifies the customer 's strengths.
3	Documentation shows that service decisions are aligned with results of the level of care determination from the ASAM C. If the service decision is lower than the ASAM C recommendation, justification is present.
4	The record contains documentation that the customer was screened for risk of HIV/AIDS, STDs, TB, and hepatitis, and was provided with basic information about risk. Use of SWMBH's Communicable Disease screening tool meets this requirement (SWMBH Policy 11.5 attachment).
C	**Section C: Treatment Plan/Person-Centered Planning**
	The written treatment plan shall conform to all the following:
1	Contain clear, concise and measurable statements of the objectives the customer will be attempting to achieve.
2	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.
3	If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.
4	Realistic target dates are identified for each goal and objective

5	The customer 's treatment plan shall be reviewed at least once every 120 days by the program director or his/her designee and the review reflects the customer 's progress toward the stated goals and objectives.
D	**Section D: Discharge / BH TEDS**
1	BH TEDS discharge is completed within 45 days of the last date of service (5 business days for residential/detox).
2	BH TEDS admission is completed.
E	**Section E: Michigan Department of Corrections (if Applicable)**
1	There is documentation in the file that monthly reports were sent to the supervising agent by the 5th of each month.
2	The discharge plan contains referrals and after care services if applicable.
3	The file contains documentation of a completed discharge plan and is signed by the customer.
4	On the occasion that customer is receiving MAT, the file contains proof that the supervising agent was informed (the document must include medication type and/or changes on the medication if applicable).
5	If a referral is made for a customer to withdrawal management or residential treatment, but the customer does not show up for treatment, a notification to the supervising agent must be sent (within 1 business day) and be present in the customer's file.
G	**Section F: Women's Specialty Services**
1	There is a Needs Assessment/checklist that demonstrates that the woman/recipient meets at least one criteria: 1) pregnant; 2) has dependent child/children; or 3) attempting to regain custody of child/children.

2	Provider demonstrates services for primary pediatric care for children, including immunizations, are provided for or arranged if needed.
3	Provider demonstrates that gender specific substance use disorder treatment and other therapeutic interventions for women, which may address relationship issues, sexual and physical abuse, parenting and childcare, is provided while women are receiving these services.
4	Provider demonstrates appropriate therapeutic referrals for children in custody of women in treatment, which may among other things address developmental needs, issues of sexual abuse, physical abuse and neglect.
5	Sufficient case management and transportation is provided to ensure that women and their dependent children have access to services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children as well as those who are pregnant.
6	Provider demonstrates that they provide or have arranged primary medical care for women, including prenatal care if pregnant, and child care while women are receiving such treatment.
	The file contains a screening for FASD and referral (if applicable).
	The file contains a completed child(ren) needs assessment.
Section G: Methadone Treatment (If Applicable)	

1	There is documentation in the record that the customer received a physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission.
2	There is documentation (results) of performance of biweekly urinalysis. (If customer has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the customer tests positive for substances other than methadone or other legally prescribed medications.
3	There is documentation that the medical director has approved the customer 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).
4	If the customer has take home doses: The customer is receiving up to the appropriate number of take home dose(s) in a week as outlined in the Administrative rules (R325.1383 (15)).
5	A detailed account of any adverse reactions to medication (FD-1639) is in the file.
6	The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. (SWMBH Policy 11.18 & OROSC Tx Policy #5)
7	The record contains a listing of all the customer 's prescribed medications in the case file. (including medical marijuana). (SWMBH Policy 11.18 & OROSC Tx Policy #5)
8	The termination and readmission evaluation written or endorsed and dated by the program physician is in the file.
9	Monthly medical progress notes by the dispensing nurse are contained in the file.

10	The file contains the initial standing order and renewals of methadone.
11	Documentation is in the file of a physician-customer encounter every 60 days
12	Documentation of methadone authority approval of any exception to the application rules and regulations.
13	The file contains the initial treatment plan and periodic treatment plan review by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days.
14	Documentation that the initial and annual treatment plan are review and signed off by the physician, physician's assistant, or advanced practice registered nurse.

Scoring: 2 = Fully compliant with all requirements 1* = Partially compliant with requirements 0* = Not compliant NA = Not applicable-put this in the box next to the score box so that it does not interfere with automatic calculations. **An explanation describing the partially compliant or noncompliant findings will be provided in the "Comments" box within each section of the audit tool.*
2 - The file contains documentation of PCP or there is documentation to indicate they do not want PCP coordination. 0 - The file contains no documentation regarding a PCP or a refusal for coordination.
NA - If a PCP has been listed 2 - A referral to a PCP has been made. 0 - No primary care doctor referral has been made.
NA If the individual has refused PCP coordination. 2 - Coordination of care has occurred upon intake (within 45-60 days) 1 - Coordination of care has occurred, however it was well past intake period (60+ days) 0- No coordination of care has occurred when there is a PCP named and an appropriate release is present.
2 - The file contains in documentation of health care coordination in every event of a significant change. 1 - Coordination of Care is present, but has not happened for all significant changes. 0 - There is no evidence of ongoing coordination of care for significant events.
2 - The file contains documentation of coordinating health care informing the doctor that they are no longer involved in treatment upon discharge (within 30 days). 1 - The file contains documentation of coordinating health care, however it was late (more than 30 days after discharge). 0 - There is no evidence of coordination of care upon discharge.
2 - ASAM Continuum assessment is present and complete in SWMBH's customer file. NA - There is no ASAM Continuum assessment present and complete in SWMBH's customer file. (Consultative standard this review period).

2 - The client 's strengths have been clearly identified and documented. 1 - The psychosocial assessment is generic or vague when listing out specific strengths of the client /family. 0 - The psychosocial assessment does not contain documentation of the client 's strengths.
2 - Service recommendations are clearly stated, align with the ASAM, along with rationale for eligibility. If a different level of care is recomended there is rationale for the recommendation. 1 - Service recommendations are vaguely stated; or no rationale for service eligibility. If services area outside the ASAM level, there is no rationale for the recommendation. 0 - All of the above are missing.
2 - This document is included in the client file and it was denoted that they were offered basic information about risk, client signature is present. 1 - This document was included in the client file, however it was unclear if basic information was offered to client and/or the document was not filled out completely (i.e. client signature is missing) 0 - There is no documentation that the client was screened for communicable diseases
2 - Goals are clearly measurable in an objective way (goals contain quantifiers that make them clearly measurable.) 1 - Goals are measurable as a matter of the clinician's opinion; subjective. 0 - No apparent way to measure progress.
2 - There are detailed and clear interventions associated with treatment plan objectives 1 - There are broad interventions associated with the treatment plan objectives (i.e. "client will attend individual therapy") 0 - There are no interventions associated with treatment plan objectives
2 - Evidence based practices are clearly identified in the intervention section and details specific practices, modules or interventions from the model. 1 - Evidence based practices identified, but not in detail. 0 - Evidence based practices are not identified in the interventions.
2 - Target dates match the goal and objective well and have varying target dates. 1 - Target dates have all the same end dates. 0 - Target dates do not correlate at all to the goals and objectives they are tied too.

2 - The treatment plan is reviewed quarterly. 1 - The treatment plan is reviewed quarterly for the most part, but there may be plans that occur past their due dates. 0 - Treatment plans are not reviewed at all; or are always completed past their due date.
2 – The BH TEDS discharge documentation is present in the client's file and is done so in the aforementioned timeframe above. 1- The BH TEDS discharge document is present, but is "in progress" or has not been completed. 0 – The BH TEDS document has not been completed accurately or the TEDS discharge documentation was not completed and documented in the required time frame.
2 – A complete BH TEDS admission is present in the SWMBH MCIS. 1 – A BH TEDS admission is "in progress" (not complete). 0 – There is no BH TEDS admission documented.
2 – Monthly reports are in the file and documented as sent by the 5th of each month. 1 – Monthly reports are in the file and documented as sent to supervising agent sometimes, or regularly sent after the 5th of the month. 0 – There are no monthly reports sent.
2 – Discharge plan contains referrals and aftercare services. 0 - Discharge plan does not contain referrals and aftercare services.
2 – File contains discharge plan that is signed by customer. 1 – File contains discharge plan but no customer signature. 0 – No discharge plan present.
2 – File contains proof that the supervising agent was informed of MAT information. 1 – File contains proof that supervising agent was informed about MAT but not medication changes as applicable. 0 – File does not contain proof that the supervising agent was informed of MAT information.
2 – Documentation of supervising agent notified within one business day after customer missing WM/Res is present in file. 1 – Notification to the supervising agent was made beyond one business day. 0 – Supervising agent was not notified of customer missing WM/Res.
2 - The needs assessment check list is present and fully filled out. 1 - The needs assessment check list is present, however it is not filled out completely. 0 - There is no needs assessment check list present.

2 - Documentation of pediatric care arrangement is present in the client file, if applicable. 1 - Documentation shows that pediatric care is needed, however it has not been arranged for. 0 - Documentation of pediatric care arrangement is not present in the client file. NA- If the parent does not have custody of the children.
2 - Gender specific treatment is clearly documented in the progress notes/case notes. 1 - There are some progress notes/case notes indicating gender specific treatment. 0 - Gender specific treatment is not occurring or being documented.
2 – Therapeutic referrals for children, if applicable, are clearly documented in progress notes/case notes. 1 – Therapeutic referrals for children are not clearly documented, but based on the progress notes/case notes, can be discerned by a Clinician. 0 – Therapeutic referrals for children, if applicable, are not occurring or being documented
2 - If applicable, documentation of case management and transportation is present in the client's file. 1 - There are identified transportation and case management needs that have been documented, however, those needs are not being fully met. 0 - If applicable, there is no evidence that case management or transportation is taking place/has been arranged.
2 - There is ample evidence that medical care for women has been provided/arranged and documented in the client's file. 1 - There are medical needs that have been identified, however they are not being fully met. 0 - There is no evidence that this is being addressed in the client's file.
2- If applicable, documentation is present, completed and any referrals needed have been made. 1- If applicable, documentation is present however, either documentation is not completed and/or no referrals were made. 0- If applicable, documentation is present and any referrals have been made.
2 - The Children needs assessment is present and fully filled out. 1 - The Children needs assessment is present, however it is not filled out completely. 0 - There is no needs assessment present.

2- A physical evaluation by a program physician, PCP or an authorized healthcare professional within 14 days following admission. 1-A physical evaluation by a program physician, PCP or an authorized healthcare professional is present but outside of the 14 days following admission. 0-A physical evaluation by a program physician, PCP or an authorized healthcare professional Is not present.
2- Documentation (results) of performance of biweekly urinalysis or Weekly urinalysis if the client tests positive for substances other than methadone or other legally prescribed medications. 1- Documentation (results)of urinalysis is present however outside of the time frames. Biweekly if client has been drug free for 6 months, weekly is client tests positive for substances. 0- Documentation is not present
2- documentation that the medical director has approved the client 's take home privileges are present. 0- Documentation is not present. NA- client has no take home privileges.
2-Documentation of take home dosage per week is in accordance with the administrative rules. 1- Documentation is present but not in accordance with the administrative rules. 0- Documentation is not present. NA- client does not have take home privileges.
2- A detailed account of adverse reactions to medication is present. 0- A detailed account of any adverse reactions to medication is not present despite indication that client s is experiencing adverse reactions.
2- The record contains evidence of coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers. Or client s refusal for coordination of care is documented. 0- There is no evidence of coordination of care.
2- client s file contains a listing of all prescribed medication. 0- The files does not contain a list of all prescribed medication.
2- Termination and readmission evaluation written or endorsed and dated by the program physician is in the file. 0- Termination and readmission evaluation written or endorsed and dated by the program physician is not present. NA- client was not terminated.
2- Monthly medical progress notes by the dispensing nurse are contained in the file. 1- Progress notes by the dispensing nurse are present but outside of the time frame. 0- Progress notes are not present.

2- Initial standing order and renewals of methadone. 1- one of the two is missing (initial or renewals) 0- no orders are present.
2- Documentation of a physician-client encounter every 60 days is present. 1- Documentation of a physician-client encounter is present but outside of the time frame. 0- Documentation is not present.
2- Documentation of methadone authority approval of any exception to the application rules and regulations is present. 0- Documentation of methadone authority approval of any exception to the application rules and regulations is not present.
2- initial treatment plan and periodic treatment plan reviewed by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse at least every 90 days. 1-initial treatment plan and periodic treatment plan reviewed by the program physician medical director, a physician, physician's assistant, or advanced practice registered nurse outside of the time frame. 0- initial treatment plan and periodic treatment plan review is not present.
2- Initial and annual treatment plan are reviewed and signed off by the physician, physician's assistant, or advanced practice registered nurse. 1- Initial and annual treatment plan are reviewed and but they are missing the signature. 0- Initial and annual treatment plan are not present.

Citation	Standard	Section	Max Score	Score	Guidance	Findings

Citation	Standard	Section	Max Score	Score	Guidance	Findings
		SECTION 1 – HOSPITAL RESPONSIBILITIES				
330.1755(1)	1.1.1	The Hospital has an assigned Rights Advisor.	1		Review Job Description of RR Advisor. Interview RR Advisor, Director.	
330.1755(1)	1.1.2	The Hospital has an assigned alternate Rights Advisor.	1		Review Job Description of RR Advisor Alternate. Interview RR Alternate, Director; Request an investigation completed by the alternate (redacted if necessary), request intervention by alternate. The "away message" from the rights officer references contact information for the alternate.	
330.1755(4)	1.1.3	The rights advisor has the education and training required for the office.	1		Review job descriptions of RR Advisor and Alternate. Interview RR Advisor; what were the requirements of the office? What qualified you for the job? Ascertain in interview that the rights staff do not have clinical responsibilities on the psychiatric unit.	
330.1755(1)(2)(c)	1.1.4	The Rights Advisor reports only to Chief Administrative Officer (CAO) of the Hospital.	1		Completed during site review: policy, job description of director, org chart, etc. Name on Annual report letter is the director's? Interview with Director; Has the director seen the annual report? Is the director familiar with the content, goals & recommendations? How often do you meet with the Rights Advisor? Are you their sole supervisor? Interview with the RR Advisor; Do you report only to the director (Chief Administrative Officer)? Is there a person in-between? How often do you meet with the director?	
330.1755(1)(2)(c)	1.2.1	In the absence of the CAO, there is a designee who can perform the duties required of the CAO.	1		Completed during site review by interview with Director, RR Advisor, (check policy, job descriptions, org chart, etc.) Is there a process for appointing the designee in policy? (Is the appointment made in writing?) Is the designee consulted on rights related matters?	
330.1755(2)(d)	1.3.1	The hospital assures that the Rights Advisor has unimpeded access to all information/areas necessary to conduct investigations and perform monitoring functions.	2		Interview RR Advisor, and ask them to explain the process of an investigation they have conducted as well as access to employees, EHR, etc. ☐ programs & services ☐ employees and all others ☐ any other evidence requested	
330.1776(1) Agency Policy	1.4.1	Staff are aware of the policy requiring staff to be knowledgeable of the complaint process, including how to file a complaint on behalf of a recipient and how to assist a recipient in filing a complaint.	1		Staff is interviewed. Staff is able to explain the policy regarding the rights process & can explain how to contact the rights advisor if needed. They can identify where the complaint box and complaint forms are located. They know who the rights advisor is.	
330.1776(1) Agency Policy	1.4.2	Staff are aware of this requirement and the process for carrying it out.	1		Staff can describe ways a complaint can be filed. They are required to list all of the possible ways. Staff are able to explain how to assist recipients in filing complaints.	
		SECTION TOTAL	9	0		

Citation	Standard	Section	Max Score	Score	Guidance	Findings
SECTION 2 – RIGHTS OFFICE OPERATIONS						
330.1776 (5)	2.1.1	As necessary, the office assists recipients or other individuals with the complaint process.	2		Interview with rights advisor, and, if possible, recipients. Rights advisor may provide an example of a complaint with which they assisted.	
330.1776 (4)	2.1.2	Complaints are responded to within 5 business days	2		On site review may include review of ORR log: Log indicates timeframes of response.	
330.1755(5)(d)(i)	2.1.3	There is a mechanism for logging all complaints received by the office.	2		All complaints received by the rights office are dated with a "received date" and logged into a complaint log.	
330.1778	2.2.1	Investigations and interventions are completed within the timeframes required by law and contract.	2		On site review may include review of ORR log: Log indicates timeframes of responses.	
330.1778	2.2.2	Interventions are completed in accordance with the parameters established by contract and the guidelines established in Basic Skills training	2		Complaint information may be solicited from CMHs with contracts with the LPH. RRO provides examples of complaints, acknowledgement, interbvention letter language. At minimum 5 interventions and 2 each of OOJ and "not code protected right" letters and complaint samples to be reviewed.	
330.1778 (5)	2.2.3	Investigations, and resultant reports, are completed in accordance with the parameters established by law, rules, and guidelines established in Basic Skills training.	2		Complaint information may be solicited from CMHs with contracts with the LPH. RRO provides examples of complaints, acknowledgement, status report and RIF language. At minimum 3 RIF files to be reviewed.	
330.1782	2.2.4	Summary Reports are completed in accordance with the parameters established by law, rules, and guidelines established in Basic Skills training.	2		Summary Reports contain the required elements. Summary Reports describe the findings sufficiently to reflect all relevant evidence obtained during the investigation. Summary repotrs contain the required information regarding the accused, outcome, and action. There is evidence that the Director has reviewed the RIF and Summary Report. The Director's signature appears on the Summary Report.	
330.1755(5)(d)	2.3.1	ORR maintains all reports of apparent or suspected rights violations received & evidence collected to support the decision in the investigation. (file)	2		RRO provides examples of complaint file, indicating that the evidence is in the file, as is acknowledgement letters, interventions and investigations. Evidence of action taken is in the folder. (Additionally, Investigative files may be reviewed by the CMH Rights office over the course of the year as part of monitoring).	
330.1755(5)(d)	2.4.2	ORR has established a mechanism for secure storage of all investigative documents and evidence, including files kept in the Rights Office and off site, and electronic files.	2		The complaint log is kept securely by the recipient rights advisor. All complaints received, including evidentiary materials are kept in a case file in a locked cabinet located in the recipient rights advisor's secure office. (Files may be reviewed by the CMH Rights office over the course of the year as part of monitoring). Log and physical files and storage reviewed during site visit.	
330.1755(5)(h)	2.5.1	ORR serves as a consultant to the director and to agency staff in rights related matters.	2		Interview with Director; -- can any outcomes be pointed to as a result of the interactions between the advisor and director? Interview RR Advisor; what are some of the issues that have been discussed with the director – can any outcomes be pointed to as a result of the interactions between the advisor and director? between the advisor and staff?	
330.1755(5)(i)	2.6.1	Ensure that all reports of apparent or suspected violations of rights within the hospital investigated in accordance with section 330.1778.	2		Case files/reports reflect immediate initiation of abuse, neglect, serious injury or death with an apparennt or suspected violation. All other investigations are opened in a timely and efficient manner.	
330.1755(2)(d)	2.7.1	The Rights Advisor is able to access video surveillance for the purposes of investigation.	2		Rights Advisor indicates that all video requested is made available without undo challenge. Policy reflects ORR access rights to video (timeframe as defined by ORR).	
330.1755 (2) (d) 330.1776 (1) 330.1778 (1)	2.7.2	The Rights Advisor is able to access incident reports for the purposes of monitoring and ascertaining if a right may have been violated and, as needed, to conduct an investigation.	2		Rights Advisor indicates that all incident reports are provided to ORR on an ongoing basis. Policy reflects ORR access rights to incident reports.	
330.1776 (1)	2.8.1	Recipients are aware of how to file a complaint.	1		Recipients are interviewed. Recipients can explain how to contact the rights advisor if needed. They can identify where the complaint box and complaint forms are located. They know who the rights advisor is.	
		SECTION TOTAL	**27**	**0**		

SECTION 3 – UNIT/HOSPITAL OPERATIONS

Citation	Standard	Section	Max Score	Score	Guidance	Findings
330.1708(2)	3.1.1	The Unit/Hospital is free of health and safety concerns.	1		Look for (Locked medications, cleaning supplies, etc.), view seclusion room (if applicable) for sanitary conditions, access to toilet facilities and opportunities to sit of lie down; check that ORR has communication with safety committee and QA/Risk Management.	
330.1755(5)(c)	3.1.2	The name of the Rights Advisor, and a method for contact, are conspicuously posted in areas where recipients, family members, guardians, and visitors have access.	2		The posters are on the wall of the unit. The poster should identify the recipient rights advisor's name and contact information.	
330.1755(5)(b)	3.1.3	There is a copy of Chapter 7 and 7a available to recipients.	1		Observation/ Interview Chapter 7&7A are found on the unit/units, or recipients have knowledge of their ability to request a complete copy of chapter 7 and 7A, and are able to identify the process or person to ask.	
330.1706 330.1755(5)(b)	3.2.1	Recipient Rights booklets are provided to recipients, family members, and guardians upon admission.	2		Interview individuals on unit, if they deny receiving one, request unit staff/ ORR show evidence it was provided. (form in record)	
330.1755(5)(c)	3.2.2	Contact information for the Rights Advisor is provided on the rights booklets.	2		Request a booklet from staff – is the contact information on it?	
R 330.7011	3.2.3	The recipient's record identifies the person who provided the explanation of rights, and, when the recipient is unable to read or their understanding is in question, an explanation of the materials used to explain rights.	2		Review (redacted if necessary), forms from recipient records indicating appropriate documentation of alternative communication. (does the blank have a place for documentation?)	
330.1755 (5) (l) 330.1776 (1)	3.3.1	There is unimpeded access to complaint forms.	1		There are complaint forms readily available and recipients do not have to request the form.	
330.1776 (1)	3.3.2	There is a marked secure mechanism for filing complaints (lock box or other confidential method).	1		There is a locked complaint box located on the unit, which is mounted on the wall. The rights advisor and alternate have access to the complaint box. No other staff have access to the complaint box.	
330.1776 (5)	3.3.3	There is a poster advising recipients that there are advocacy organizations available to assist in preparation of a written rights complaint, and an offer to refer recipients to those organizations, or for ORR to assist in creating a complaint.	2		Observe poster meeting the standard or ask for a copy of an actual letter with no PHI or the template letter.	
330.1723(1)	3.3.4	Current posters regarding the reporting of abuse and neglect are present and visible in staff areas.	2		Posters for reporting abuse and neglect are found on the unit/units mounted on the wall. Typically found in area where staff chart or hold team.	
330.1723 (1)	3.4.1	Staff are aware of abuse and neglect reporting requirements.	2		Staff are able to describe when external agencies and ORR must be notified under the reporting requirements.	
330.1726(3) 330.1728(3)	3.5.1	If applicable, Unit Rules (i.e., telephone usage, visitation, etc.), including any exclusions (i.e., weapons, glass, aerosol), are posted.	2		The rules are posted on the unit/units on the wall. (Phone hours, Visiting Hours, other Rules) A copy of the unit rules containing exclusions are provided at the time of admission on the unit. C. The is a "contraband list", separate from the unit rules, is posted on the wall & exterior to the unit and is provided in the admission packet. D. The auditor receives an admission packet to keep, which contains the unit rules and contraband list (if separate from the unit rules).	
330.1726(3) 330.1728(3)	3.5.2	The Rights Advisor has reviewed the Unit rules.	1		Review admission packet, Interview with Advisor: The auditor is provided a copy of the unit rules to keep for the purposes of the audit for review. ATTACH COPY OF RULES	
330.1726(3) 330.1728(3)	3.5.3	The Rights Advisor has determined that the Unit Rules are reasonable and lawful.	1		Review admission packet, Interview with Advisor: Any issues as a result of the review of the unit rules are brought to the attention of the Rights Advisor - Are there any rules that the Auditor determines are not reasonable. Note them. ATTACH COPY OF RULES	
330.1724(9)	3.6.1	When video surveillance is utilized in common areas, recipients are notified of the existence and location of videotaping upon admission and by posted signs.	2		Request notification & observe posted notification. Rights Advisor is aware of the placement of video cameras and notification documents.	
330.1724(9)	3.6.2	When video surveillance is utilized, private areas (bedrooms, bathrooms and showers) are excluded from videotaping or surveillance.	2		Interview with Unit Manager, RRO tour of unit	
330.1406 330.1415 330.1416	3.7.1	Recipients are afforded an opportunity to sign into the hospital on a voluntary basis.	2		Rights Advisor is aware of the process for admissions and can explain how it is carried out on the unit.	

Citation	Standard	Section	Max Score	Score	Guidance	Findings
330.1406 330.1415 330.1416	3.7.2	When applicable, rights pertaining to voluntary admission are explained verbally and in writing.	2		ORR to show evidence explanation was provided. (form in record) Interview recipients on unit, if they deny offering of voluntary, request evidence as to how voluntary is offered by staff upon admission	
330.1406 330.1415 330.1416	3.7.3	There is a mechanism for noting who provided the explanation in 3.7.2 and, when the recipient is unable to read or their understanding is in question, an description of the explanation is in the recipient's record.	2		Review (redacted if necessary), forms from recipient records indicating appropriate documentation of alternative communication.	
		SECTION TOTAL	**32**	**0**		

Citation	Standard	Section	Max Score	Score	Guidance	Findings
SECTION 4 – EDUCATION AND TRAINING						
CMHSP 6.3.2.3A	4.1.1	The primary and alternate rights staff have attended and successfully completed the Basic Skills Training program within 90 days of hire.	2		LPH can provide documented evidence. – certificate, email from MDHHS-ORR	
330.1755(2)(e) CMHSP 6.3.2.3A	4.2.1	The staff of the rights office have complied with the continuing education requirements identified in the contract attachment.	2		Request list of training attended with CEU number as assigned by MDHHS-ORR	
330.1755(2)(e) CMHSP 6.3.2.3A	4.2.2	A minimum of 12 of the required 36 CE hours were approved as either Category I or II.	2		Request list of training attended with CEU number as assigned by MDHHS-ORR - Annual Report breakout is acceptable evidence	
330.1755(2)(e) CMHSP 6.3.2.3A	4.2.3	Both the primary and alternate Rights staff have earned at least 3 continuing education credits during the calendar year.	2		Annual Report Listing, Certificate from training	
330.1755(5)(f)	4.3.1	All persons engaged by the LPH who will have contact with recipients have been trained on basic rights within 30 days of hire.	2		Review New Hire Orientation Topics, training materials, List of Orientees with dates of training (may have brochure for "incidental staff, such as construction workers)	
330.1755(5)(f)	4.3.2	All staff of the LPH (unit/hospital) have been trained on residential rights within 30 days.	2		Review training policy, copy of training materials; evidence provided of new hires, date of hire, date of initial training. Does the hospital HR provide the rights office a list of employees and start dates?	
330.1755(5)(f) CMHSP 6.3.2.3B	4.3.3	Training related to recipient rights protection addressed all training standards identified in the MDHHS ORR Training Standards (all aspects of chapter 4, 7, 7A).	2		Rights Advisor has copy of training standards; Is the requirement for training content in the contract with the CMH? There is evidence provided of new hires, date of hire, date of residential (full) training.	
330.1755(2)(a)	4.4.1	Education and training in recipient rights policies and procedures are provided to the recipient rights advisory committee and appeals committee.	1		Interview Advisory committee chair. Minutes reflect evidence of training in policies. Interview Appeals committee chair. Minutes reflect evidence of training in policies.	
		SECTION TOTAL	**15**	**0**		

SECTION 5 – RIGHTS ADVISORY COMMITTEE						
330.1758	5.1.1	There is a Recipient Rights Advisory Committee in place either 1) by agreement with the local CMHSP or 2) appointment by the hospital.	1		Documentation that the provider has a current agreement for the CMH to provide the RRAC. Documentation that the hospital has an internally appointed RRAC that is made up of 1/3 primary consumers and/or family members, and of that 1/3 at least half of the members are primary consumers. None of the members work on the psychiatric unit, or have a vested interest in the outcome of the committee's actions. There is a list of committee member names? There is a list of committee member types?	
330.1758(a)	5.1.2	RRAC Minutes reflect that meetings are held at least twice per year.	1		Interview committee chair if possible. Review minutes of RRAC to ensure it meets at minimum twice a year.	
330.1758(c)	5.1.3	The committee acts to protect ORR from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions.	1		Interview committee chair. Minutes reflect evidence of issues are brought to the committee for discussion & resolution (if necessary) Also, interview with rights officer – Is the committee responsive to issues?	
330.1755(2)(b)	5.1.4	The committee reviews the funding for the Office at least annually.	1		Minutes reflect evidence of a review of rights office funding at least once a year.	
330.1758(d)	5.1.5	The RRAC reviews the Semi-Annual and Annual reports and provides input for the Board of Directors on the Annual report.	1		Interview committee chair. Minutes reflect evidence of review of the semi-annual report; it is completed and submitted in a timely fashion & it is accurate. Minutes reflect evidence of a review of the annual report and an opportunity for recommendations to the Board; it is completed and submitted in a timely fashion. It is accurate. Also interview with rights advisor that both reports are discussed with the director.	
		SECTION TOTAL	**5**	**0**		

SECTION 6 -- SECLUSION/RESTRAINT

Citation	Standard	Section	Max Score	Score	Guidance	Findings
330.1740 330.1742 R 330.7243 42CFR 482.13	6.1.1	If seclusion or restraint has been utilized within the past 12 months, the usage was compliant with policy (including timeframes as outlined by CMS).	2		Rights advisor is aware of Seclusion & Restraint Policy, and can demonstrate location of requirements: No initiation without evidence that a physician is contacted; Recipient removed from S or R if physician does not respond within 30 minutes; Ordered seclusion not to exceed 4 hours for adults, 2 hours for minors; 1 hour for mino+F80rs 9 or under; physician must see recipient 30 minutes prior to reorder. Rights Advisor is aware of CMS and MHC requirements and can show reviewer where logs are kept	
330.1740 330.1742 R 330.7243 42CFR 482.13	6.1.2	If seclusion or restraint was utilized, the visit at 1 hour was completed by a physician or PA as required by state law.	2		Physician exam occurs within 60 minutes of authorized seclusion or restraint;	
		SECTION TOTAL	**4**	**0**		

SECTION 7 – APPEALS COMMITTEE

330.1774(3)	7.1.1	For recipients who are under the authority of a CMHSP, the governing body of a licensed hospital has designated the appeals committee of the local community mental health services program to hear an appeal of a decision on a recipient rights matter brought by or on behalf of a recipient of that community mental health services program.	2		Contract between CMH & LPH indicates 7.1.1	
330.1774(4)	7.1.2	For recipients who are not under the authority of a CMHSP, the Governing Body (Board) of the Hospital appointed an appeals committee to hear appeals of recipient rights matters OR entered into an agreement with MDHHS to use the MDHHS appeals committee.	2		LPH must present list of members & list of categories of members. The committee must be 7 members. No members can be from MDHHS or the CMHSP. Two of the members shall be primary consumers and 2 shall be community members. *(Michigan Medicine only)* LPH should have a current copy of the agreement that reflects that MDHHS will hear appeals on non-CMH recipients. (Current Director, or within 5 years)	
330.1774(3)	7.1.3	Notices of appeal rights refer recipients to appropriate appeals committee.	2		Review notice of appeals rights for clear referral to appropriate CMH appeals committee or to MDHHS-ORR Appeals Committee.	
330.1774(6)	*7.1.4*	*Committee policy/bylaws require that a member of an appeals committee who has a personal or professional relationship with an individual involved in an appeal shall abstain from participating in that appeal as a member of the committee.*			(Michigan Medicine only) Review bylaws. If none exist, recommend development of minimum documantation for review by committee members.	
330.1784	*7.1.5*	*Appeals heard by the LPH Appeals Committee meet the required timeframes and are based upon the standards established by law and contract.*			(Michigan Medicine only) Review appeal case files. Appeals are heard if the appellant has standing, names grounds and appeals within the designated timeframe. The committee addresses the concerns of the appellant. The committee sends follow up correspondance within the designated timeframe.	
		SECTION TOTAL	**6**	**0**		

SECTION 8 – POLICY

330.1752 (a-p)	8.1.1	The policies of the hospital have been reviewed and accepted.	2		
		SECTION TOTAL	**2**	**0**	

POLICY COMPLIANCE CHECKLIST

	Yes	No
Completed LPH/U Policy review on file?	☐	☐

Date of Last Review: _____
Reviewer Name: _____
ate LPH Notified of Results: _____
Date Corrections Received: _____

	Yes	No
Are there policies altered since last policy review was conducted?	☐	☐

Name(s) of all policies revised since last review:

	Yes	No
Were hospital policies reviewed for compliance by the LPH Rights Advisor?	☐	☐

Date of LPH Review: _____
LPH Reviewer Name: _____

Citation	Standard	Section	Max Score	Score	Guidance	Findings

COMPLAINT CASE REVIEW

Case Number	Case Type
	Investigation
	Investigation
	Investigation
	Intervention
	Intervention
	Intervention
	Intervention
	Intervention
	Intervention
	Outside Jurisdiction
	Outside Jurisdiction
	No Right Involved
	No Right Involved

Date

LPH ASSESSMENT REPORT

Hospital Reviewed: _____

Assessment Date(s): _____

QUALITY SECTION	Maximum	Your Score
9. TRAINING	3	0
10. UNIT FLOOR	4	0
11. CORPORATE CO	5	0
12. SENTINEL EVENT	4	0
SUBTOTAL	16	0

TOTAL SCORE	16	0

Full Compliance:	16
Substantial Complian	15.2
Less Than Substantial Compliance:	?

Citation	Standard	SECTION 9 – TRAINING	Max Score	Score	Findings	Requried Action
	9.1.1	Required Trainings are completed for all staff on unit. (PCP, Grievance, Appeals, ...)	2			
	9.1.2	Corporate Compliance Training includes DRA 2005.	1			
		SECTION TOTAL	**3**			

Citation	Standard	SECTION 10 – UNIT FLOOR	Max Score	Score	Findings	Requried Action
	10.1.1	Provisions for privacy are available. (Note if separate rooms or by Dr. orders)	2			
	10.2.1	Weekly and weekend activities are scheduled and posted for consumers to see.	2			
		SECTION TOTAL	**4**			

Citation	Standard	SECTION 11 –CORPORATE COMPLIANCE	Max Score	Score	Findings	Requried Action
	11.1.1	Sanctioned/excluded providers checklist	1			
	11.1.2	Exclusion checks are being completed on required individuals monthly.	2			
	11.2.1	Disclosure of ownership, controlling interest, and criminal convictions are completed on managing employees, contractors, etc. at times and frequency designated.	2			
		SECTION TOTAL	**5**			

Citation	Standard	SECTION 12 –SENTINEL EVENTS	Max Score	Score	Findings	Requried Action
	12.1.1	Sentinel events that occurred on the unit during the review period were reported to PIHP/CMHSP as required.	2			

	12.1.2	An investigation/root cause analysis occurred for all sentinel events.	2			
		SECTION TOTAL	**4**			

DOCUMENTS OBTAINED

Date on File	Document	Current?	Comments
	License		
	Liability Insurance		
	Workers Comp Insurance		
	Accreditation		

DOCUMENTS NEEDED

QUALITY DISCUSSION

1. Describe the Organization's Quality Improvement process:

2.What ongoing processes are in place for evaluating the effectiveness of ongoing services (Feedback loop, surveys, outcome measures)?

3. How are staff trained on the Organization's Quality Improvement Initiatives?

CUSTOMER SERVICES DISCUSSION

1. Describe the Organization's Customer Services process:

2. Describe any best practices or processes you would like to share:

CLINICAL RECORDS SUMMARY *Number of Records Reviewed:* _____

Reviewer(s) Name(s) Date

Southwest Michigan Behavioral Health ~ Inpatient Psychiatric Administrative Site Review Tool

Review Date: _____
Provider: _____
Service: *Inpatient*
Reviewer: _____

SCORING INSTRUCTIONS
2 = compliance with standard/intent
1 = partial compliance standard/intent
0 = non-compliance or insufficient levels of compliance with standard/intent
N/A = requirement not applicable to this type of review or this provider

		Possible Score	Actual Score	References	Comments	Plan for Improvement
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT						
1	The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct.			PIHP Policy 10.1		
2	Staff know what to do if they suspect Medicaid fraud or abuse within the organization.			Deficit Reduction Act; Patient Protection & Affordable Care Act of 2010; HealthCare & Education Reconciliation Act of 2010		
3	The provider has adequate policy and/or procedure to protect confidential and individually identifiable information from unauthorized use or disclosure, including: 1. Protections for physical facility access. 2. Protections for electronic access. 3. Media and device controls. 4. Physical safeguards for workstations. 5. Procedures for allowing and removing access according to role-based employment			HIPPA/HITECH 42 CFR Part 2 MH Code 330.1748 R 325.14116		
Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:					**Percent:**	
SECTION 2 - QUALITY IMPROVEMENT/CUSTOMER SERVICES						
1	Plan(s) for Improvement in response to citations/recommendations from the most recent reviews (licensing, MDHHS, PIHP or accrediting body, etc.) has been submitted to the appropriate agency.			SWMBH-Provider contract XV 325.14113		
2	Program can demonstrate effort to implement proposed corrective actions of Improvement Plan (document status of implementation).			SWMBH-Provider contract XV 325.14113		
3	The provider submits survey data and other reports (such as financial reports as required, survey data, sentinel event reports) in accordance with SWMBH requirements.			SWMBH-Provider contract XI.G and XV		

		Possible Score	Actual Score	References	Comments	Plan for Improvement
4	Communication Accommodations: program has developed resources and incorporated features to overcome barriers for persons who have limited ability to communicate in standard English (i.e., LEP resources; bi-lingual staff; communication resources in alternative languages/formats [Braille, Spanish, audio enhancements, sign language communication; TDI; communication enhancement devices; signs; person served-specific communication techniques, etc.); interpreters]).			DHHS Site Review Protocol B.4.5.1; PIHP policy 6.5 (Communication Accommodations for Limited English Proficiency and Visual Impairment)		

Section 2 - QUALITY IMPROVEMENT/CUSTOMER SERVICES **Total:** **Percent:**

SECTION 3 - FACILITY & MAINTENANCE

1	Adequate parking is provided, including handicap accessible spaces.			*DHHS Site Review Protocol D.3*		
2	Handicap access to facility, therapy/exam rooms, and restrooms is provided			*DHHS Site Review Protocol D.3*		
3	Exits, corridors, and hallways are free of obstruction.			*DHHS Site Review Protocol D.3*		
4	Safe and sanitary environment is maintained throughout the facility.			*DHHS Site Review Protocol D.3*		
5	Maintenance of Facility - there is evidence that maintenance issues are being appropriately addressed (invoices for repair/inspection/replacement of equipment and fire alarms/extinguishers, elevators, evidence of facility improvements, etc.).			*DHHS Site Review Protocol D.3*		
6	Emergency evacuation maps/routes are displayed in prominent locations at the facility.			*DHHS Site Review Protocol D.3*		

Section 3 - FACILITY & MAINTENANCE: **Percent:**

SECTION 4 - TRAINING REQUIREMENTS

1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30			MH Code: Sec 330.1755(5)(f)		
2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).			MDCH Contract 3.4.1.1.V.A.4		
3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).			BBA 438.206 DCH Contract 3.4.2		
4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			OSHA R325.7000 Administrative Rule R330.2807 (10) MIOSHA R325.70016 (7)(a)		
5	Limited English Proficiency (LEP) (within 6 months of hire).			BBA 438.206 MDCH Contract Part 1, 15.7		
6	HIPAA (within 30 days of hire).			Code of Federal Regulations - 45CFR 164.308(a)(5)(i) and 164.530(b)(1)		
7	Corporate Compliance (within 30 days of hire, annual updates).			Medicaid Integrity Program		

		Possible Score	Actual Score	References	Comments	Plan for Improvement
8	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (MDCH approved curriculum if restricted interventions included) - (within 30 days of hire, annual updates)			*Behavior Management Technical Requirement*		

Section 4 - TRAINING REQUIREMENTS Total: **Percent:**

SECTION 5 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS						
1	Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: A. Educational background (Primary source verification required) B. Relevant work experience C. Certification, registration, and licensure as required by law. (Primary source verification required)			MDCH Contract attachment P.6.4.3.1 PIHP Policy 2.2		
2	Individuals have been credentialed prior to providing services that require credentialing. Re-credentialing occurs at least every 2 years or as required by accreditation, and includes: -updated attestation to credentialing application questions and any other updates to credentialing application information, -verification of valid and current licensure to practice in the State of Michigan, -verification of current malpractice insurance, -review of any quality concerns (if applicable), -verification that the practitioner has not be excluded from participation in Medicaid through OIG check, -verification of licensure limiations through LARA or other issuing state database, or NPDB -verification of malpractice suits reported through NPDB check or malpractice insurance carrier.			MDCH Contract attachment P.6.4.3.1 PIHP Policy 2.2 & 2.3		
3	Criminal Background Checks: there is evidence that provider conducts verification of criminal background prior to hire and on an ongoing basis, using the verification protocol required by MDHHS licensing (Michigan Workforce Background Check System).			MCL 330.1134a, MCL 400.734b PIHP Policy 2.16		
4	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each employee is to be run through OIG exclusion database prior to hire and annually.					

Section 5 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total: **Percent:**

Scoring Summary	Possible Score	Actual Score	Percent
Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:	0	0	

	Possible Score	Actual Score	References	Comments	Plan for Improvement
Section 2 - QUALITY IMPROVEMENT/CUSTOMER SERVICES Total:	0	0			
Section 3 - FACILITY & MAINTENANCE:	0	0			
Section 4 - TRAINING REQUIREMENTS Total:	0	0			
Section 5 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:	0	0			
OVERALL	***0***	***0***			

	Standard	Supporting Evidence and Scoring:
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT		
1	The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct (must have written certification that they have received, read, and will abide by SWMBH's Code of Conduct).	**Supporting Evidence**: A copy of the organization's Code of Conduct or acknowledgement of use of the SWMBH Code of Conduct. For evidence of "adoption" of the code of conduct - training records, policy and/or procedure regarding dissemination of the code, employee handbook with the code, posting of ways to report fraud, waste, and abuse. **Scoring (see note below):** 2 - Code of conduct is in place and evidence supports its adoption in the organization. 1 - Code of conduct has been developed or accepted from SWMBH, but efforts are not being made to make staff aware of its content or purpose. 0 - No code of conduct in place.
2	Staff know what to do if they suspect Medicaid fraud or abuse within the organization.	**Supporting Evidence:** Interviews with staff members. **Scoring:** 2 - Staff consistenly know who to report possible Medicaid fraud and abuse to, various ways to report (phone, email, etc.). 1 - Not all staff interviewed knew who or how to report possible Medicaid fraud and abuse. 0 - Staff appear to be unaware of Medicaid fraud and abuse reporting.
3	The provider has adequate policy and/or procedure to protect confidential and individually identifiable information from unauthorized use or disclosure, including: 1. Protections for physical facility access. 2. Protections for electronic access. 3. Media and device controls. 4. Physical safeguards for workstations. 5. Procedures for allowing and removing access according to role-based employment	**Supporting Evidence:** Computer safeguards (e.g., screen locks, password use, and regular password expiration), paper file safeguards (locking paper files when not in use), IT policies and/or procedures, policies and/or procedures around verbal/written sharing of customer information with others (such as with family members, law enforcement and/or other health professionals). **Scoring:** 2 points - No concerns. Ample precautions to protect confidential information are in place. 1 point - One or two minor suggestions for improvement. 0 points - Improvement needed in several areas; or potential for serious violation of privacy was noted.
SECTION 2 - QUALITY IMPROVEMENT/CUSTOMER SERVICES		
1	Plan(s) for Improvement in response to citations/recommendations from the most recent reviews (licensing, MDCH, PIHP or accrediting body, etc.) has been submitted to the appropriate agency.	**Supporting Evidence:** Plan(s) for improvement submitted to monitoring agencies complete with dates and corrective action plans. **Scoring:** 2 - Plan(s) complete and submitted within time frames, or no recommendations or citations from recent reviews. 1 - Plan(s) does not address all items for correction or not completed within time frames. 0 - No response has been implemented to citations/recommendations from recent reviews.
2	Program can demonstrate effort to implement proposed corrective actions of Improvement Plan (document status of implementation).	**Supporting Evidence:** Documentation of trainings conducted, repairs made, changes made to policies, forms, procedures, etc., as identified in corrective action plan(s). **Scoring:** 2 - Follow up complete and done within time frames, or no recommendations or citations from recent reviews. 1 - Improvements address most, but not all, items cited for correction, or not completed within time frames. 0 - No response or very limited response implemented to address citations/recommendations and due date is past.
3	The provider submits survey data and other reports (such as financial reports as required, survey data, sentinel event reports) in accordance with SWMBH requirements.	

	Standard	Supporting Evidence and Scoring:
4	Communication Accommodations: program has developed resources and incorporated features to overcome barriers for persons who have limited ability to communicate in standard English (i.e., LEP resources; bi-lingual staff; communication resources in alternative languages/formats [Braille, Spanish, audio enhancements, sign language communication; TDI; communication enhancement devices; signs; person served-specific communication techniques, etc.); interpreters]).	**Supporting Evidence:** Contract for interpretation services. Translations of key documents into different languages. Accommodations for individual customers' language styles and abilities. The reviewer(s) will verify through a review of materials, policies, staff training and interviews that there are resources available to assist persons who have limited ability to communicate in standard English. **Scoring:** 2 - Program has appropriate communication accommodations in place to address needs and staff are familiar with accommodations. 1 - Program has a need for communication accommodations and has made some movement toward this, but there is still a gap. 0 - Program has a need for communication accommodations but there has been no movement toward this.
SECTION 3 - FACILITY & MAINTENANCE		
1	Adequate parking is provided, including handicap spaces.	**Supporting Evidence:** The site review team will verify through a tour of the facility. **Scoring:** 2 - Facility and premises are barrier free. 1 - Facility and premises are not barrier free but adequate planning exists to address physical accessibility needs as they arise. 0 - Facility and
2	Handicap access to facility, therapy/exam rooms, and restrooms is provided	**Supporting Evidence:** The site review team will verify through a tour of the facility. **Scoring:** 2 - Facility and premises are barrier free. 1 - Facility and premises are not barrier free but adequate planning exists to address physical accessibility needs as they arise. 0 - Facility and premises are not barrier free and adequate planning does not exist to address physical accessibility needs as they arise.
3	Exits, corridors, and hallways are free of obstruction.	**Supporting Evidence:** The site review team will verify through a tour of the site that exits, corridors, and hallways are free of obstruction to allow for safe ambulation for the occupants and emergency evacuation. **Scoring:** 2 - Exits, corridors, and hallways are free of obstruction. 1 - Exits, corridors, and hallways have an obstruction that can be permanently corrected while review team is on site (example - moving a laundry basket). 0 - Exits, corridors, and hallways have multiple areas of obstruction, or at least one obstruction that requires planning by the facility for permanent correction (example - moving a Hoyer lift to a more practical location).
4	Safe and sanitary environment is maintained throughout the facility.	**Supporting Evidence:** The site review team will verify through a tour of the inside of the site that the facility is structurally sound and maintained in a safe condition for the occupancies. **Scoring:** 2 - The interior is well-maintained and clean. 1 - The interior is in need of minor repairs, maintenance or cleaning (e.g., repairs/maintenance <~$1000, minor cleaning/housekeeping needs that could be alieved in an hour or less). 0 - The interior is in need of major repairs, maintenance or cleaning (e.g., repairs/maintenance >~$1000, cleaning/housekeeping needs that would take more than an hour to accomplish).

	Standard	Supporting Evidence and Scoring:
5	Maintenance of Facility - there is evidence that maintenance issues are being appropriately addressed (invoices for repair/inspection/replacement of equipment and fire alarms/extinguishers, elevators, evidence of facility improvements, etc.).	**Supporting Evidence:** The site review team will verify through a review of maintenance records and site tour that facility and equipment upkeep is being adequately addressed. **Scoring:** 2 - Equipment and appliances on the site are in good repair; fire alarms are tested and batteries replaced bi-annually, fire extinguishers are replaced when expired. 1 - One or two minor maintenance issues identified. 0 - More than two minor maintenance issues were identified, or one or more substantial issue.
6	Emergency evacuation maps/routes are displayed in prominent locations at the facility.	**Supporting Evidence:** The site review team will verify through a tour of the facility. **Scoring:** 2 - Present and prominently displayed. Else - 0.
SECTION 4 - TRAINING REQUIREMENTS		
1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).	**Supporting Evidence:** For all training and personnel items, the review team will verify by a review of staff personnel files or training records. **Scoring:** 2: 95-100% of staff selected completed each required training item within the stated timeframes. 1: 75-94.4% of staff completed the required training item within the stated timeframes. 0 – Less than 75% of staff have completed the training within the stated timeframes.
2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).	
3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).	
4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).	
5	Limited English Proficiency (LEP) (within 6 months of hire).	
6	HIPAA (within 30 days of hire).	
7	Corporate Compliance (within 30 days of hire, annual updates).	
8	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (MDCH approved curriculum if restricted interventions included) - (within 30 days of hire, annual updates)	
SECTION 5 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS		

	Standard	Supporting Evidence and Scoring:
1	Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: A. Educational background (Primary source verification required) B. Relevant work experience C. Certification, registration, and licensure as required by law. (Primary source verification required)	
2	Individuals have been credentialed prior to providing services that require credentialing. Re-credentialing occurs at least every 2 years or as required by accreditation, and includes: -updated attestation to credentialing application questions and any other updates to credentialing application information, -verification of valid and current licensure to practice in the State of Michigan, -verification of current malpractice insurance, -review of any quality concerns (if applicable), -verification that the practitioner has not be excluded from participation in Medicaid through OIG check, -verification of licensure limiations through LARA or other issuing state database, or NPDB -verification of malpractice suits reported through NPDB check or malpractice insurance carrier.	
3	Criminal Background Checks: there is evidence that provider conducts verification of criminal background prior to hire and on an ongoing basis, using the verification protocol required by MDHHS licensing (Michigan Workforce Background Check System).	
4	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each employee is to be run through OIG exclusion database prior to hire and annually.	

STAFF TRAINING		Name	Name	Name	Name	Name	Name
		Hire	Hire Date -	Hire Date	Hire Date	Hire Date	Hire Date
4.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).						
4.2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).						
4.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).						
4.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).						
4.5	Limited English Proficiency (LEP) (within 6 months of hire).						
4.6	HIPAA (within 30 days of hire).						
4.7	Corporate Compliance (within 30 days of hire, annual updates).						
4.8	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (MDCH approved curriculum if restricted interventions included) - (within 30 days of hire, annual updates)						
	STAFF HR FILE REVIEW						
5.1	Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: A. Educational background (Primary source verification required) B. Relevant work experience C. Certification, registration, and licensure as required by law. (Primary source verification required)						

STAFF TRAINING		Name	Name	Name	Name	Name	Name
5.2	Individuals have been credentialed prior to providing services that require credentialing. Re-credentialing occurs at least every 2 years or as required by accreditation, and includes: -updated attestation to credentialing application questions and any other updates to credentialing application information, -verification of valid and current licensure to practice in the State of Michigan, -verification of current malpractice insurance, -review of any quality concerns (if applicable), -verification that the practitioner has not be excluded from participation in Medicaid through OIG check, -verification of licensure limiations through LARA or other issuing state database, or NPDB -verification of malpractice suits reported through NPDB check or malpractice insurance carrier.						
5.3	Criminal Background Checks: there is evidence that provider conducts verification of criminal background prior to hire and on an ongoing basis, using the verification protocol required by MDHHS licensing (Michigan Workforce Background Check System).						
5.4	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each employee is to be run through OIG exclusion database prior to hire and annually.						
6.5	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the verification protocol required by licensing (finger printing); annual verification of the status of criminal back ground of current employees.						

Name
Hire Date

Name

Standard	Consumer ID

Development or Assessment/Diagnostic Data: Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the person is treated in the unit.

The identification data must include the inpatient's legal status. Legal status is defined by state statutes and dictates the circumstances under which the patient was admitted and/or is being treated (i.e. voluntary, involuntary, committed by court).

A provisional or admitting diagnosis must be made on every inpatient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both

The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

H&P completed within 24 hours (History & Physical)

Psychiatric Evaluation

The psychiatric evaluation must include the following components: 1) Chief complaints, reaction to hospitalization, 2) Past history of any psychiatric problems and treatment, including previous precipitating factors, diagnosis, and course of treatment, and 3) Past family, educational, vocational, occupational, and social history.

Be completed within 24 hours of admission

Include a medical history - Does the evaluation include any medical conditions that may impact the patient's recovery/remission?

Contain a record of mental status: does the mental status record describe the appearance, behavior, emotional response, verbalization, thought content, and cognition of the patient?

Note the onset of illness & the circumstances leading to admission: Are the identified problems related to the patient's need for admission?

Describe attitiudes and behavior: does the problem statement describe the behavior(s) which require modification in order for the patient to function in a less restrictive environment?

Estimate intellectual functioning, memory functioning, and orientation

Treatment Plan

Each consumer must have a comprehensive treatment plan that must be based on an inventory of the consumer's strengths and weaknesses: is the treatment plan a result of collaboration between the patient and the treatment team? Is the plan individualized? Is there a primary diagnosis upon which the treatment interventions are based? Are the treatment plan golas written in a manner that allows for changes in the patient's behavior to be measured? If the consumer is a minor, is the plan family-focused?

Must include the specific treatment modalities utilized; the responsibilities of each member of the treatment team. It clearly identifies what the condition/status the consumer should be to discharge to a less restrictive setting. Goals and objectives meet sMART criteria: Does the treatment team encourage the patient's active participation and responsibility for engaging in the treatment regimen? Do completion of goal/objectives identify the desired behavioral outcomes that will reflect readiness to discharge to a less restrictive setting (i.e. - when no longer verbalizing intent to commit self-harm; not acting on persecutory hallucinations; willing to contract for safety; demonstrating orientation to all spheres, etc)

Plan includes all required signatures and evidence that consumer was offered a copy of plan: Consumer has the right to refuse and if so, refusal is documented.

Service delivery Consistent with Plan

Progress notes must be recorded by the psychiatrist responsible for the care of the inpatient, a nurse, social worker and, when appropirate, others significatnly involved in active treatment modalities: Does the content of the treatment notes and progress notes relate to: 1) the treatment plan 2) what the staff is doing to carry out the treatment plan, and 3) the patient's response? Evidence of daily psychiatry progress notes. Progess notes should document progress of lack of progress and any adjustments/changes to the treatment plan

Doctor's orders are followed

There is evidence of discharge planning documented wihtin the record.

Medications

Was medication reconciliation completed at admission and discharge?

Evidence of informed consent for all psychotropic medications: Consents are signed by the consumer/guardian or evidence of refusal. Consent should state explanation of medications and side effects

There is evidence medicatoin is administered as prescribed.

Discharge/Transfers

Include a summary of the patieint's hospitalization, the patient's condition on discharge, and recommendations for follow-up or aftercare: Does the discharge planning process include the participation of the multidisciplinary staff and the patient? Are the details of the discharge plan communicated to the post-hospital treatment entity? Evidence of coordination with CMH on discharge/transition planning. Follow-up appointment is scheduled iwthin 7-days of discharge.

Y = 100 %,
N = 0 %
Totals

Review Date:	
Provider:	
Service:	
Reviewer:	

SCORING INSTRUCTIONS
2 = compliance with standard/intent
1 = partial compliance standard/intent
0 = non-compliance or insufficient levels of compliance with standard/intent
N/A = requirement not applicable to this type of review or this provider

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement	Response to Plan for Improvement
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT							
1.1	The provider has adequate policy and/or procedure to protect confidential and individually identifiable information from unauthorized use or disclosure, including: 1. Protections for physical facility access. 2. Protections for electronic access. 3. Media and device controls. 4. Physical safeguards for workstations. 5. Procedures for allowing and removing access according to role-based employment			*HIPPA/HITECH* *42 CFR Part 2* *MH Code 330.1748*			
1.2	The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct (must have written certification that they have received, read, and will abide by SWMBH's Code of Conduct).			*PIHP Policy 10.1*			
1.3	Staff know what to do if they suspect Medicaid fraud or abuse within the organization.			Deficit Reduction Act; Patient Protection & Affordable Care Act of 2010; HealthCare & Education Reconciliation Act of 2010			
Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:							
SECTION 2 - QUALITY IMPROVEMENT							
2.1	Plan(s) for Improvement in response to citations/recommendations from the most recent reviews (licensing, MDCH, PIHP or accrediting body, etc.) has been submitted to the appropriate agency.			*Provider Contract requirement*			

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement	Response to Plan for Improvement
2.2	All citations by PIHP, CMH, and MDHHS BH/IDD or licensing divisions have been corrected.			*Provider Contract requirement*			
2.3	Documentation is present to support that individuals' choices are implemented, when possible.			*MDHHS Contract Consumerism Attachment P.7.10.2.3 DHHS Site Visit Protocol A.1*			
	Section 2 - QUALITY IMPROVEMENT Total:						
SECTION 3 - CUSTOMER SERVICES							
3.1	Communication Accommodations: program has developed resources and incorporated features to overcome barriers for persons who have limited ability to communicate in standard English (i.e., LEP resources; bi-lingual staff; communication resources in alternative languages/formats [Braille, Spanish, audio enhancements, sign language communication; TDI; communication enhancement devices; signs; person served-specific communication techniques, etc.); interpreters]).			*MDHHS Contract Attachment P.4.1.1 Access System Standards; MDHHS Contract Attachment P.6.3.1 Customer Service Requirements; DHHS Site Review Protocol B.4.5.1; PIHP policy 6.5 (Communication Accommodations for Limited English Proficiency and Visual Impairment)*			
	Section 3 - CUSTOMER SERVICES Total:			**Percent:**			
SECTION 4 - FACILITY & MAINTENANCE (If applicable - when customers are served at a provider-owned location)							
4.1	Facility Grounds & Premises - driveway, surrounding yard areas, detached structures appear well maintained and free of obvious, litter, refuse, etc. (note: roof, exterior walls, doors, windows/screens, stairways, sidewalks, attached structure, etc.).			*DHHS Site Review Protocol D.3*			
4.2	Exits, corridors, and hallways are free of obstruction.			*DHHS Site Review Protocol D.3*			
4.3	Facility Interior/Cleanliness - Sanitary environment is maintained throughout the facility. (furnishings, flooring, walls, smells, cleanliness, housekeeping standards, etc.).			*DHHS Site Review Protocol D.3*			
4.4	Maintenance of Facility - there is evidence that maintenance issues are being appropriately addressed (invoices for repair/inspection/replacement of equipment, utilities, evidence of facility improvements, etc.).			*DHHS Site Review Protocol D.3*			

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement	Response to Plan for Improvement
Section 4 - FACILITY & MAINTENANCE Total:							
SECTION 5 - MEDICATION MANAGEMENT (For providers who are distributing medication)							
5.1	If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.			*R 330.7158*			
5.2	A provider shall record the administration of all medication in the recipient's clinical record.			*R 330.7158*			
5.3	A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's clinical record.			*R 330.7158*			
Section 5 - MEDICATION MANAGEMENT Total:							
SECTION 6 - EMERGENCY RESPONSE							
6.1	Program has a comprehensive set of written Emergency Response Procedures containing clear instructions in response to fire, severe weather, medical emergencies, and emergencies while transporting individuals served, if applicable.			*DHHS Site Review Protocol D.3*			
6.2	Emergency evacuation maps/routes are displayed in prominent locations at the facility. (when customers are served at a provider-owned location)			*DHHS Site Review Protocol D.3*			
Section 6 - EMERGENCY RESPONSE Total:							
SECTION 7 - TRAINING							
7.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).			*DHHS Site Review Protocol E.3.6; MDHHS Code: 330.1755(5)(f); R 325.14302 Rule 302(3)(a)(i)*			
7.2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).			*MDHHS Contract 3.4.1.1.V.A.4*			
7.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).			*BBA 438.206 DHHS Site Review Protocol E.3.6*			
7.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			*OSHA R325.7000 Administrative Rule R330.2807 (10) MIOSHA R325.70016 (7)(a)*			
7.5	Limited English Proficiency (LEP) (within 6 months of hire).			*BBA 438.206; DHHS Site Review Protocol E.3.6*			
7.6	HIPAA (within 30 days of hire).			*Code of Federal Regulations - 45CFR 164.308(a)(5)(i) and 164.530(b)(1); DHHS Site Review Protocols E.3.6*			
7.7	Corporate Compliance (within 30 days of hire, annual updates).			*Medicaid Integrity Program (MIP); Deficit Reduction Act (DRA)*			

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement	Response to Plan for Improvement
7.8	Individuals Plans of Service and Ancillary Plans (there is evidence that staff have been trained in the IPOS and in any applicable Support Plan for Individuals in their care before the provision of direct care [Behavior Treatment Plan, PT, OT, Nursing, etc.]).			*Michigan Mental Health Code 330.1708*			
7.9	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (MDCH approved curriculum if restricted interventions included) - (within 30 days of hire & annual updates, if working with individuals with challenging behavior)			*Behavior Management Technical Requirement and R 330.1806*			
7.1	CPR (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years).			*R 400.14204*			
7.11	First Aid (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years). ABA BHTs must have first aid certifications.			*R 400.14204*			
7.12	ABA BHTs - Principles of behavior, behavior measurement and data collection, function of behaviors, basic concepts of ABA, generalization and it importance in sustainability of learned/acquired skills, and medical conditions/illness that impact behavior.			*Medicaid Provider Manual 18.7*			
7.13	Trauma Informed Systems of Care (Within 60 days of hire)			*MDHHS Master Contract Attachment P.2.7.10.6. and 7.10.6.1*			
Section 7A - DIRECT CARE STAFF TRAINING REQUIREMENTS Total:							
SECTION 8 ~ CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS							
8.1	The provider has written job descriptions for all positions. Each job description shall specifically identify all of the following: a. Job Title b. Tasks & Responsibilities c. The skills, knowledge, training, education, and experience required for the job d. Recovery-based (as appropriate), person-centered and culturally competent practices.			R 325.14112 PIHP Policy 1.2 SWMBH-Provider Contracts			

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement	Response to Plan for Improvement
8.2	Individuals have been credentialed prior to providing services that require credentialing. Re-credentialing occurs at least every 2 years, and includes: -updated attestation to credentialing application questions and any other updates to credentialing application information, -verification of valid and current licensure to practice in the State of Michigan, -verification of current malpractice insurance, -review of any quality concerns (if applicable), -verification that the practitioner has not be excluded from participation in Medicaid through OIG check, -verification of licensure limitations or malpractice suits reported through NPDB check.			MDCH Contract attachment P.6.4.3.1 PIHP Policy 2.2 & 2.3			
8.3	Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: A. Educational background (Primary source verification required) B. Relevant work experience C. Certification, registration, and licensure as required by law. (Primary source verification required)			MDCH Contract attachment P.6.4.3.1 PIHP Policy 2.2			
8.4	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the verification protocol required by SWMBH policy 2.16; bi-annual verification of the status of criminal back ground of current employees.			*Contract Requirement; Public Act 59 (PA 218 400.734a); 5) AFC Licensing Rules: R.400.14201.13 (SGH); R.400.1404.6 (FH); PIHP Policy 2.16*			
8.5	Driver's License: A) there is documented evidence of verification of status of driver's license at the time of hire; B) ongoing monitoring of the status of the driver's license of every staff member who transports persons served (i.e., annual attestation).			*AFC Licensing Rules R400.14319-d, R400.14208-c (SGH)*			
8.6	Personnel Performance Management: there is documented evidence that program has an adequate system to support, monitor, and complete at least annual performance evaluations of staff who provide direct care services.			*DHHS Site Visit Protocol B.1.3, 4.4.2(e), 5.4.2, 6.4.2, 7.4.1, 8.3.2*			
8.7	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each employee is to be run through OIG exclusion database prior to hire and annually thereafter.			*PIHP Policy 10.13*			
8.8	*The Applicant Rights for Credentialing and Recredentialing form is included in credentialing packet, which includes written notification of, and an appeal process for, adverse credentialing decisions.*			*PIHP Policy 2.05 & Credentialing Application Document*			
8.9	*The Credentialing Application includes anti-discrimination provisions, attestation and disclosure questions within.*			*PIHP Policy 2.05 & Credentialing Application Document*			
8.10	*All credentialing files include the following information: Credentialing Start date, Credentialing decision date, and Credentialing completion date.*			*PIHP Policy 2.05 & Credentialing Application Document*			

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement	Response to Plan for Improvement
8.11	*All practitioner files include documentation that Grievance and Appeal information was reviewed during the recredentialing process*			*PIHP Policy 2.02 & Credentialing Application Document*			
Section 8 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:							

Scoring Summary	Poss-ible Score	Actual Score	Percent
Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:	0	0	
Section 2 - QUALITY IMPROVEMENT Total:	0	0	
Section 3 - CUSTOMER SERVICES Total:	0	0	
Section 4 - FACILITY & MAINTENANCE Total:	0	0	
Section 5 - MEDICATION MANAGEMENT Total:	0	0	
Section 6 - EMERGENCY RESPONSE Total:	0	0	
Section 7 - TRAINING TOTAL	0	0	
Section 8 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:	0	0	
OVERALL	***0***	***0***	

STAFF TRAINING STAFF HR FILE REVEW

TRAINING		Name	Name	Name
		Hire Date	Hire Date	Hire Date
7.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).			
7.2	Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).			
7.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).			
7.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			
7.5	Limited English Proficiency (LEP) (within 6 months of hire).			
7.6	HIPAA (within 30 days of hire).			

STAFF TRAINING STAFF HR FILE REVEW

7.7	Corporate Compliance (within 30 days of hire, annual updates).			
7.8	Individuals Plans of Service and Ancillary Plans (there is evidence that staff have been trained in the IPOS and in any applicable Support Plan for Individuals in their care before the provision of direct care [Behavior Treatment Plan, PT, OT, Nursing, etc.]).			
7.9	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (MDCH approved curriculum if restricted interventions included) - (within 30 days of hire & annual updates, if working with individuals with challenging behavior)			
7.10	CPR (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years).			
7.11	First Aid (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years). ABA BHTs must have first aid certifications.			

STAFF TRAINING STAFF HR FILE REVEW

7.12	ABA BHTs - Principles of behavior, behavior measurement and data collection, function of behaviors, basic concepts of ABA, generalization and it importance in sustainability of learned/acquired skills, and medical conditions/illness that impact behavior.			
7.13	Trauma Informed Systems of Care (Within 60 days of hire)			
CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS		**Name**	**Name**	**Name**
		Hire Date	**Hire Date**	**Hire Date**
8.1	The provider has written job descriptions for all positions. Each job description shall specifically identify all of the following: a. Job Title b. Tasks & Responsibilities c. The skills, knowledge, training, education, and experience required for the job d. Recovery-based (as appropriate), person-centered and culturally competent practices.			

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8.2	Individuals have been credentialed prior to providing services that require credentialing. Re-credentialing occurs at least every 2 years, and includes: -updated attestation to credentialing application questions and any other updates to credentialing application information, -verification of valid and current licensure to practice in the State of Michigan, -verification of current malpractice insurance, -review of any quality concerns (if applicable), -verification that the practitioner has not be excluded from participation in Medicaid through OIG check, -verification of licensure limitations or malpractice suits reported through NPDB check.			
8.3	Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: A. Educational background (Primary source verification required) B. Relevant work experience C. Certification, registration, and licensure as required by law. (Primary source verification required)			

STAFF TRAINING STAFF HR FILE REVEW

8.4	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the verification protocol required by SWMBH policy 2.16; bi-annual verification of the status of criminal back ground of current employees.			
8.5	Driver's License: A) there is documented evidence of verification of status of driver's license at the time of hire; B) ongoing monitoring of the status of the driver's license of every staff member who transports persons served (i.e., annual attestation).			
8.6	Personnel Performance Management: there is documented evidence that program has an adequate system to support, monitor, and complete at least annual performance evaluations of staff who provide direct care services.			
8.7	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each employee is to be run through OIG exclusion database prior to hire and annually thereafter.			

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8.8	*The Applicant Rights for Credentialing and Recredentialing form is included in credentialing packet, which includes written notification of, and an appeal process for, adverse credentialing decisions.*			
8.9	*The Credentialing Application includes anti-discrimination provisions, attestation and disclosure questions within.*			
8.10	*All credentialing files include the following information: Credentialing Start date, Credentialing decision date, and Credentialing completion date.*			
8.11	*All practitioner files include documentation that Grievance and Appeal information was reviewed during the recredentialing process*			

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Southwest Michigan BEHAVIORAL HEALTH

SWMBH Behavioral Health Services
ABA Provider Clinical Review Tool 2023
SCORING GUIDE

Scope: Review Period: The reviewer will review documentation from the time period between the most recent treatment plan through the current date.	Scoring: 2 = Fully compliant with all requirements 1* = Partially compliant with requirements 0* = Not compliant NA = Not applicable-put this in the box next to the score box so that it does not interfere with automatic calculations. **An explanation describing the partially compliant or noncompliant findings will be provided in the "Comments" box within each section of the audit tool .*
Section A: Physician Coordination	**Scoring guidelines**
Coordination with the CMHSP case manager is documented.	2 - Evidence of emails and communication with case manager at time of assessment, changes in treatment plan recommendations, updates on progress, etc. 1 - Evidence of submission of assessments/auth requests to case manager, but no other communication 0 - There is no evidence of coordination with CMHSP case manager
Section B: Treatment Planning	**Scoring guidelines**
Comprehensive ABA behavioral treatment plan is present and is updated at minimum annually.	2 - Comprehensive plan is complete and present within the clinical record of the client. 1 - Comprehensive plan is present, but the annual plan was completed after due date, or the plan is lacking in clinical elements to fully encapsulate the requirements 0 - No plan is in place
Plan is individualized based upon assessment of the customer's needs and preferences.	2 - Goals and objectives addressed are relevant to the presenting concerns of the client and any expressed needs of the family. 1 - Goals and objectives are vaguely related to what the customers identified needs are, or do not address all identified needs clearly or have evidence as to why some needs have been deferred. 0 - Treatment plan is unreleated to the identified needs of the consumer
Goals are measurable, achievable and realistic.	2 - 90% of identified objectives are measurable, achievable, and realistic 1 - less than 90% but more than 50% of goals are measurable, achievable and realistic 0 - less than 25% of goals are measurable, achievable and realistic;
Plan addresses risk factors identified for the child and family.	2 - Plan has clear goals related to concerning behaviors regarding health and safety (self harm, propery destruction, physical aggression etc) if applicable, and also contains general information with regards to safety concerns present as part of ABA treatment. Plan also includes safety plan to ensure client and clinician's safety during treatment 1 - No objectives/goals related to presenting concerns regarding safety and behavior in relevant cases but does have information regarding general safety concerns present as part of ABA treatment/plan to ensure safety. 0 - No discussion of risk or safety as part of treatment plan.
Family Training is present within the treatment plan or there is documentation that the family declined.	2 - Evidence of emails and communication with case manager at time of assessment, changes in treatment plan recommendations, updates on progress, etc. 1 - Plan mentions family training though there are no clear goals/objectives related to it 0 - There is no evidence of discussion of family training of parent refusal
Services are provided as specified in the providers IPOS including amount, scope, duration.	2 - Services are provided at at least 80% of prescribed authorizations, or there is information attesting to the family or child causing the lack of services/what is being done to address lack of service provision 1 - Services are provided less than 80% prescribed authorizations and there is no documentation as to what is being done to address the concerns or what is causing the lack of service provision, or the provider is the cause of lack of services 0 - Services are provided at less than 25% of the prescribed authorization
Behavioral Technicians, Occupatoinal Therapists, Physical Theraspists etc. have been trained in the IPOS, any applicable plan Addendums, and any applicable Support Plan (Behavior Treatment Plan, PT/OT/Nursing Plan, etc.) for individuals in their care, before the provision of direct care.	2 - Evidence of training of 90% of employees involved in the case. 1 - Evidence of training of 50-90% of employees involved in the case. 0 - Evidence of training of fewer than 50% of employees involved in the case.
Section C: Progress Notes	**Scoring guidelines**

Southwest Michigan
BEHAVIORAL HEALTH

SWMBH Behavioral Health Services
ABA Provider Clinical Review Tool 2023
SCORING GUIDE

Progress notes reflects which goal(s)/objective(s) were addressed during the contact.	2 - 90% of notes clearly identify specific objectives from the client's treatment plan as being addressed in the session, both in narrative and data driven sections of the note 1 - 25% - 90% Notes identify objectives as being addressed, but narrative makes it unclear as to how those objectives were addressed. 0 - less than 25% of notes provide adequate information as to what objectives were addressed and how during the session.
Progress notes reflect the customer's progress toward goals/objectives.	2 - 90% of supervision notes reviewed discuss clear data driven progress of clients towards identified goals and objectives, rather than overall behavior of the client in the session. 1 - 50%-89% of supervision notes reviewed discuss clear data driven progress of clients towards identified goals and objectives 0 - Less than 49% of notes provide adequate information as to the clients specific clinical progress towards goals/objectives.
If applicable, the record contains evidence of follow up attempts to engage customer after no shows/missed appointments (phone calls, letters, etc.).	2 - Active communication within the clinical record of relevant cases is logged of efforts by clinicians to make up sessions/engage with no-call no shows 1 - No call/no shows are recorded, but there is inconsistent follow up from clinicians to reach out to the family 0 - There is no evidence of follow up after missed appointments, no calls/no shows, etc
Section D: Evaluation/Re-Evaluation	**Scoring guidelines**
Ongoing determination of service level has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB-Mapp. Other documentation of analysis may be accepted (i.e. graphs, assessment, reports, records of service, progress reports etc.)	2 - Assessments are completed as required and timely, including analysis of ABA data and graphs to show progress 1 - Assessments are completed but are not completed timely, or do not include a full analysis/discussion of ABA data. 0 - Assessments are not completed as required
Documentation is present within the file on parent engagement (phone calls, family training, collateral contacts etc.)	2 - Consistent and present documentation of parent communication, involvement in parent training sessions as appropriate, follow ups, etc. 1 - Parent involvement is only documented during assessments. 0 - There is no evidence of parental involvement
Documentation is present within the file to show that ABA services are not supplanting special education services if service hours are during standard school hours (if applicable.)	2 - Documentation of clinical record shows when child is engaged in school hour activities, or if home schooled contains information about when the client is receiving school/education services. Clinical objectives are not built around educational elements. 1 - Documentation of clinical record is unclear as to if and when client is receiving educational services outside of ABA (such as mentioning home school, IEP being present, but there is no supporting documentation or clarifying information about how ABA fits in) 0 - No documentation is present regarding the client's academic engagement
If individual is out of school and attending ABA, a plan/critela is present to return to a traditional school environment.	2 - Plan related to returning child to school contains specific target goals related to reasons for being removed from school, as well as a tentative return to school goal date. 1 - Treatment plan of client is focused on behaviors that are keeping them from engaging in school but does not have a target return to school goal date present. 0 - Treatment is unrelated to concerning behaviors that are keeping the child from engaging in school.
Ongoing progress is documented at minimum every six months.	2 - All required assessments are present and completed timely 1 - Assessments are not completed timely 0 - ongoing progress is not documented within the clinical record
A discharge plan is present.	2 - Discharge plan is related to the presenting abilities of the client, and include a titrated transition plan based on realistic objectives for the client and where they will be transitioning to (decreasing hours, increasing family training, referral to other less intensive providers, etc) 1 - Discharge planning is a generic statement regarding determination of the end of services or does not contain an individualized transition plan. 0 - Discharge planning is not present within the clinical record