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** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Mila C. Todd	Date Approved: **4/27/2022**
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☐ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** **MI Health Link**	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **1/1/2014**

Policy: Southwest Michigan Behavioral Health (SWMBH) and participant Community Mentah 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.

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. <u>Provider Non-compliance and Sanctions</u>

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 Fiscal Intermediary Administrative Review Tool
E. 02.13E SUD Full Administrative Review Tool
F. 02.13F SUD Provider Full Clinical Review Tool
G. 02.13G LPH Compliance Standards with Guidance
H. 02.13H Inpatient Staffing Chart
I. 02.13I IPHU Chart Summary
J. 02.13J ABA Administrative Review Tool
K. 02.13K ABA Provider Clinical Quality Review Tool

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

Review Date:
Provider:
Service: ***Select one or more* - ACT, Homebased, Wraparound, Outpatient Therapy, Psychiatry, Targeted Case Management, Supports Coordination, ABA, 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

		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*		
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*		
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*		

		Possible Score	Actual Score	References	Comments	Plan for Improvement
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:**		
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. ***(consultative FY18)***			*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. ***(consultative FY18)***			*Affordable Care Act Section 1557*		
	Section 2 - CUSTOMER SERVICES/ACCESS TO CARE Total:			**Percent:**		

		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:**		

		Poss-ible Score	Actual Score	References	Comments	Plan for Improvement
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 procedures.			*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*		
	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 Attachment P.4.4.1.1*		
6.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).			MDHHS Master Contract Part II(A); 4.5 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*		
6.5	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*		
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)*		

		Poss-ible Score	Actual Score	References	Comments	Plan for Improvement
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 (MDHHS approved curriculum if restricted interventions included) - (within 30 days of hire & annual updates, if working with individuals with challenging behavior)			*MDHHS Master Contract Attachment P.1.4.1 and R 330.1806*		
6.10	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 Part II(A) 7.10.5*		
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 Attachment P 6.3.1.1*		
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 Attachment P 6.3.1.1*		
6.15	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*		
6.16	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*		

		Possible Score	Actual Score	References	Comments	Plan for Improvement
6.17	ACT training - MDHHS approved (within six months of hire and annual updates for ACT staff except physicians)			*Medicaid Provider Manual 4.3*		
6.18	ACT physician training - MDHHS approved (within 12 months of hire for ACT physicians)			*Medicaid Provider Manual 4.3*		
6.19	Registered Behavior Technician (RBT) training - for Behavior Technicians. Prior to delivering behavioral health treatment services.			*Medicaid Provider Manual 18.12*		
6.20	Child and Family specific training (24 hours annually for Child Mental Health Professionals - CMHPs)			*Children's Diagnostic and Treatment Services Program requirement*		
6.21	LOCUS training (prior to administering and booster as required by MDHHS or SWMBH clinical policy - LOCUS assessors)			*MDHHS Master Contract Part II(A) 7.7.3*		
6.22	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.*		
6.23	SIS training (prior to administering and booster as required by MDHHS or SWMBH clinical policy - SIS assessors)			*MDHHS Master Contract Part II(A) 7.7.3*		
6.24	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.			*R 325.14112* *PIHP Policy 1.2* *SWMBH-Provider Contracts*		

		Poss-ible Score	Actual Score	References	Comments	Plan for Improvement
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.			*MDCH Contract attachment P.6.4.3.1* *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 no more than every 2 years. Employees with a positive criminal history have a completed waiver on file if required by SWMBH Policy 2.16. If an employee is working or has been working with a criminal history exclusion without proper waiver, 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*		
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.			*Payor Contract requirement: Transporting Customers*		

		Poss-ible Score	Actual Score	References	Comments	Plan for Improvement
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 employee is to be run through OIG and SAM exclusion databases prior to hire and annually thereafter.			*PIHP Policy 10.13; 42 CFR 438.602*		
	Section 7 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:			**Percent:**		

	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***	

Southwest Michigan Behavioral Health ~ Administrative Site Review Training Matrix

STAFF TRAINING		Name	Name	Name	Name
		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	HIPAA (within 30 days of hire, annual updates).				
4.6	Corporate Compliance (within 30 days of hire, annual updates).				
4.7	Limited English Proficiency (LEP) (within 6 months of hire).				
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.]).				
4.9	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)				
4.10	CPR (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years).				
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.).				

STAFF TRAINING		Name	Name	Name	Name
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				
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,				
4.14	MDHHS approved Clubhouse-specific training (within 6 months of hire and annually thereafter. Clubhouse staff).				
	STAFF HR FILE REVIEW				
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 occur no more than every 2 years. Employees with a positive criminal history have a completed waiver on file if required by SWMBH 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.				
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.				
5.4	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 at least annually thereafter.				

STAFF TRAINING		Name	Name	Name	Name
		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	HIPAA (within 30 days of hire, annual updates).				
4.6	Corporate Compliance (within 30 days of hire, annual updates).				
4.7	Limited English Proficiency (LEP) (within 6 months of hire).				
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.]).				
4.9	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)				
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STAFF TRAINING		Name	Name	Name	Name
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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.				
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.				
5.4	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 at least annually thereafter.				

STAFF TRAINING

		Name	Name	Name	Name
		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	HIPAA (within 30 days of hire, annual updates).				
4.6	Corporate Compliance (within 30 days of hire, annual updates).				
4.7	Limited English Proficiency (LEP) (within 6 months of hire).				
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.]).				
4.9	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)				
4.10	CPR (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years).				
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.).				

STAFF TRAINING		Name	Name	Name	Name
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				
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,				
4.14	MDHHS approved Clubhouse-specific training (within 6 months of hire and annually thereafter. Clubhouse staff).				
	STAFF HR FILE REVIEW				
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 occur no more than every 2 years. Employees with a positive criminal history have a completed waiver on file if required by SWMBH 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.				
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.				
5.4	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 at least annually thereafter.				

STAFF TRAINING		Name	Name	Name	Name
		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	HIPAA (within 30 days of hire, annual updates).				
4.6	Corporate Compliance (within 30 days of hire, annual updates).				
4.7	Limited English Proficiency (LEP) (within 6 months of hire).				
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.]).				
4.9	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)				
4.10	CPR (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years).				
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.).				

STAFF TRAINING		Name	Name	Name	Name
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				
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,				
4.14	MDHHS approved Clubhouse-specific training (within 6 months of hire and annually thereafter. Clubhouse staff).				
	STAFF HR FILE REVIEW				
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 occur no more than every 2 years. Employees with a positive criminal history have a completed waiver on file if required by SWMBH 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.				
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.				
5.4	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 at least annually thereafter.				

Southwest Michigan Behavioral Health ~ Specialized Residential Administrative Site Review

Review Date:		**Reviewer:**	
Provider:		**Location/Site:**	
License #:		**Expiration Date:**	
License Type:		**# of Beds:**	
Population(s) Certifed:		**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*	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*		
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 acccess electronic records; encryption if PHI is being sent through email.			*HIPPA/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*		
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:**	
SECTION 2 - MEDICATION MANAGEMENT / HEALTH & SAFETY						

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
2.1	Medication supplies are stored in the container received from the pharmacy and stored a locked location.			*AFC Licensing Rules R400.14312 (SGH); R400-1418 (FH)*		
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 and adverse drug reactions are immediately and properly reported and recorded.			*Michigan Mental Health Code R 330.7158*		
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)*		
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*		
2.6	Pets - if an agency has a pet or therapy animal on the premises, vaccination records should be available for review.			*DHHS site review*		

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.			*AFC Licensing Rules R400.14318 (SGH)*		
3.2	Fire drills (various shifts) are conducted per requirements and are properly documented evaluated.			*AFC Licensing Rules R400.14318(5) and Suppl #4 DMH Adm; Rules R330.1803 #3, #5 & #6*		
3.3	Tornado drills (at least once per year) are properly documented and evaluated.			*Historical interpretation of AFC Licensing Rules R400.1438 (SGH); R400.1438 (FH)*		
3.4	First Aid & Spill Kits available and in good condition.			*DHHS Recommendation from Site Review*		
3.5	Carbon monoxide detectors are present and in working order.			*Payor Contract Requirement: HEALTH AND SAFETY OF CUSTOMERS; RECIPIENT RIGHTS AND CONSUMER GRIEVANCE PROCEDURES*		

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
3.6	Emergency Evacuation Bag kept in an accessible area and equipped with items that can be of assistance in case of an emergency evacuation (i.e., emergency contact #s including guardians, water, food, FA supplies, blankets, flashlights, portable radio, batteries, etc., all with current expiration dates).			*DHHS Recommendation from Site Review*		
	Section 3 - EMERGENCY RESPONSE Total:			**Percent:**		
SECTION 4 - TRAINING						
4A - All Direct Service Staff						
4.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)*		
4.A.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*		
4.A.3	Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).			*MDHHS Master Contract Part II(A) 4.5 42 CFR 438.206*		
4.A.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			*MIOSHA R 325.70016*		
4.A.5	Limited English Proficiency (LEP) (within 6 months of hire).			*MDHHS Master Contract Part I18.16 Office of Civil Rights Policy*		
4.A.6	HIPAA (within 30 days of hire, annual updates).			*45 CFR 164.308(a)(5)(i) & 45 CFR 164.503.(b)(1)*		
4.A.7	Corporate Compliance (within 30 days of hire, annual updates).			*Medicaid Integrity Program (MIP) Deficit Reduction Act (DRA)*		
4.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*		
4.A.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)			*MDHHS Master Contract Attachment P.1.4.1 and R 330.1806*		

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
4.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 Attachment P 6.3.1.1*		
	Section 4A - DIRECT CARE STAFF TRAINING REQUIREMENTS Total:			**Percent:**		
SECTION 4 - TRAINING - CONTINUED						
4B - Specialized Residential Services						
4.B.1	CPR (within 60 days; ongoing as required per the training program - usually every 2 to 3 years).			*R 400.14204*		
4.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*		
4.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*		
4.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*		
4.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*		
4.B.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*		
4.B.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*		
4.B.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 4B - TRAINING REQUIREMENTS FOR SPECIALIZED RESIDENTIAL Total:			**Percent:**		
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. All direct care employees are enrolled in the Michigan Workforce Background Check system.			*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*		

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
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*		
5.4	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 at least annually thereafter.			*PIHP Policy 10.13; 42 CFR 438.602*		
	Section 5 - 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	Poss-ible Score	Actual Score	Percent
Section 1 - GENERAL ADMINISTRATIVE OVERSIGHT Total:	0	0	
Section 2 - MEDICATION MANAGEMENT / HEALTH & SAFETY Total:	0	0	
Section 3 - EMERGENCY RESPONSE Total:	0	0	
Section 5 - TRAINING TOTAL	0	0	
Section 4A - DIRECT CARE STAFF TRAINING REQUIREMENTS Total:	0	0	
Section 4B - TRAINING REQUIREMENTS FOR SPECIALIZED RESIDENTIAL Total:	0	0	
Section 5 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS Total:	0	0	
OVERALL	***0***	***0***	

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*		
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*		

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
1.5	The fiscal intermediary has **a process in place** to collect feedback (experience and satisfaction) from individuals using FI services and other FI performance data with alternate methods for collections data from individuals using services (more than mailed surveys).			*Fiscal Intermediary Technical Requirement*		
1.6	The fiscal intermediary **responds** to feedback from individuals using FI services when areas needing improvement are identified.			*Fiscal Intermediary Technical Requirement*		
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 and maintain required insurance for nonperformance or negligent performance of FI functions			*Fiscal Intermediary Technical Requirement*		
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			*FI Technical Requirement*		

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
2.2	The FI has provided monthly financial status (budget) reports to the supports coordinator (and 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.			*FI Technical 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.			*FI Technical Requirement*		
2.4	The FI contacts the supports coordinator 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.			*FI Technical Requirement*		
2.5	The FI contacts the supports coordinator 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 supported in the IPOS.			*FI Technical Requirement*		
	Section 2 - Employer File Review Total:			**Percent:**		
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 will occur no more than every 2 years. Employees with a positive criminal history have a completed waiver on file if required by SWMBH Policy 2.16. If an employee is working or has been working with a criminal history exclusion without proper waiver, SWMBH compliance department will be contacted for consultation.			*Contract Requirement; Public Act 59 (PA 218 400.734a); PIHP Policy 2.16*		
3.2	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*		
3.3	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*		
3.4	Staff file contains W2/W4 forms, I9 form and proof of ID.					

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement
3.5	Staff file contains payroll history.			*PIHP Policy 10.13*		

Section 3 - Staff File Review Total: **Percent:**

SECTION 4 - TRAINING						
4.1	Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).			*MIOSHA R 325.70016*		
4.2	HIPAA (within 30 days of hire, annual updates).			*45 CFR 164.308(a)(5)(i) & 45 CFR 164.503.(b)(1)*		
4.3	Corporate Compliance (within 30 days of hire, annual updates).			*Medicaid Integrity Program (MIP)* *Deficit Reduction Act (DRA)*		
4.4	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*		
4.5	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)			*MDHHS Master Contract Attachment P.1.4.1 and R 330.1806*		
4.6	First Aid (within 60 days and ongoing as required per the training program - usually every 2 to 3 years. 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*		
4.7	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter - as required by contract with CMH)			*MH Code: 330.1755(5)(f)*		

Section 4 - Training Total: **Percent:**

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	

	Possible Score	Actual Score	*References*	Comments	Plan for Improvement
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*			
	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*			
	Section 5 - MEDICATION MANAGEMENT Total:			**Percent:**			

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
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 7A - DIRECT SERVICE STAFF TRAINING REQUIREMENTS Total:			**Percent:**			
SECTION 8 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS							

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
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 218 400.734a); 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 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	2		*MDHHS Trauma Policy*			
	Section 7- EVIDENCE BASED PRACTICE Total:	**2**		**Percent:**	***0.0%***		
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*			
10.2	Is the Provider making every effort to collect ATP fees from individuals?			*SWMBH Policy 9.12*			

		Possible Score	Actual Score	References	Comments	Plan for Improvement	Provider Response to CAP
10.3	Is the Provider completing the ATP in its entirety?			*SWMBH Policy 9.12*			
	Section 9 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 8 - SPECIALTY REQUIREMENTS 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:	2	0	**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	***2***	***0***	**0.0%**

	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	Level of Care is appropriately evaluated using ASAM and is updated for each authorization request.
2	Documentation shows that service decisions are aligned with results of the ASAM. If the service decision is lower than the ASAM recommendation, justification is present.
3	There is clear documentation that the individual meets the identified medical necessity criteria for the services being recommended.
4	The record contains documentation that the client 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).
5	The psychosocial assessment clearly identifies the client 's strengths.

6	Clinical analysis and interpretive summary of the client 's identified needs and priorities, and a professional opinion of service needs and recommendations are recorded.
C	**Section C: Treatment Plan/Person-Centered Planning**
	The written treatment plan shall conform to all the following:
1	> Is individualized based upon the assessment of the client's needs and if applicable, the medical evaluation.
2	> Define the services to be provided to the client including amount, score and duration.
3	> Contain clear, concise and measurable statements of the objectives the client will be attempting to achieve.
4	> Each objective includes interventions that will be used to assist the client in being able to accomplish the objective.
5	> If Evidence-Based Practices are utilized, they are identified in the interventions section of the treatment plan.
6	> Realistic target dates are identified for each goal and objective

7	> The client '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 client 's progress toward the stated goals and objectives.
8	>The treatment plan contains the signatures of at least the client and therapist.
D	**Section D: Progress Notes**
1	The progress note reflects what goal(s)/objective(s) were addressed during the treatment episode and the client 's progress toward the goal.
2	Group progress notes document implementation of Evidence-Based practices if they are documented in the treatment plan.
3	Progress notes (group and individual) are individualized to the client , including participation and current mental status in each session.

4	Documentation shows services were implemented as indicated in the treatment plan (type of service and frequency)
E	**Section E: BH TEDS and client Discharge/Transfer**
1	If applicable, the record contains evidence of follow up attempts to engage client after no shows/missed appointments (phone calls, letters, etc.).
2	BH TEDS discharge documentation was completed fully and accurately and within 45 days of service for unplanned discharges and 5 days for planned discharges.
3	BH TEDS admission is completed.
G	**Section G: 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.
7	The file contains a screening for FASD and referral (if applicable).
8	The file contains a completed children needs assessment.
G	**Section H: Methadone Treatment**
1	There is documentation in the record that the client 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 client has maintained drug-free urines for 6 months monthly urinalysis maybe performed). Weekly urinalysis is required if the client tests positive for substances other than methadone or other legally prescribed medications.
3	There is documentation that the medical director has approved the client 's take home privileges based on the following eligibility as outlined in the Administrative rules (R325.1383 (15)).
4	If the client has take home doses: The client 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 client '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-client 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 - Appropriate level of functioning assessment has been conducted. 1 - The level of functioning/daily living is underdeveloped and/or vague; or assessment tool has not been completed or updated within appropriate timeframe. - There is no documentation of appropriate assessment tool being utilized.	0
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 - Assessment contains clear documentation of how the client meets medical necessity for all services being recommended. 1 - Assessment's documentation of how the client meets medical necessity for services being recommended is vague, or not all services are addressed. 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 - 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 - Clinical analysis is current, Includes clinician's professional opinion, summarizes needs and priorities, indicates what treatment is recommended for the client based on specific signs, symptoms, needs, priorities and client strengths that have been self-identified by the client . (copy paste from other sections of the assessment is not sufficient for a full score.) 1 - Clinical analysis is not current and/or does not fully indicate treatment recommendations based on specific signs, symptoms, needs, priorities or client needs. 0 - Clinical analysis is not current AND fails to establish specific needs, priorities or client needs or fails to establish specific treatment recommendations.
2 - Treatment plan is individualized, and documents the person's strengths/abilities, hopes/plans/interests/preferences, and natural supports. 1 - Documentation of one of the above is missing. 0 - Documentation of more than one of the above is missing.
2 - Service types are clearly outlined and document amount, scope and duration. 1 - Services types are present, however elements are missing (such as amount scope duration). 0 - Service types are not indicated in the treatment plan.
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 treatment plan is signed by at least the therapist and the client. 1- The treatment plan is signed by only one party (ie: therapist or client) and there is no documentation as to why the treatment plan is not signed by both parties 0- The treatment plan is not signed.
2 - Progress notes consistently and clearly identify which goals/objectives were addressed during contacts (about 95-100% of the time). Progress towards goal/objective is also documented. 1 - Most of the time, progress notes clearly identify which goals/objectives were addressed during contacts (about 75-95% of the time). Progress towards the goal/objective are only present sometimes. 0 - Progress notes infrequently clearly identify which goals/objectives were addressed during contacts (less than 75% of the time). Progress towards goas/objectively has not been documented.
2 - Group progress notes clearly identify evidence based practices and tie in how they are used through the session. 1 - Evidence based practices are identified, but there is little to no detail how it was utilized during the session. 0 - Evidence based practices are not identified in the note; however the session is billed as such.
2 - Progress note are detailed and include participation and current mental status. 1 - Progress notes are primary "cut and paste" group notes with a small section about the client at the end/or they are missing one key piece, such as mental status. 0 - Progress notes are not detailed/or are only "cut and paste" group notes with not individualization to the client.

2 - Services are provided to the client completely as outlined in the treatment plan. 1 - Services are mainly occurring as outlined; however some services are not occurring as much (and there is not documented absent note); or type of services is occurring as outlined, but another is not. 0 - Services are not being delivered as outlined with no documented absences/or services being rendered do not correlate to what was authorized in the treatment plan.
2 - There is consistent evidence of follow up efforts to re-engage the client after missed appointments (about 95-100% of the time). 1 - Most of the time, there is evidence of follow up efforts to re-engage the client after missed appointments (about 75-95% of the time). 0 - There is infrequent evidence of follow up efforts to re-engage the client after missed appointments (less than 75% of the time).
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 - 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
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.	

Citation	Standard	Section	Max Score	Score	Guidance	Findings
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

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) (i) 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	

Citation	Standard	Section	Max Score	Score	Guidance	Findings
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.	
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 iof 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

Citation	Standard	Section	Max Score	Score	Guidance	Findings
		Were hospital policies reviewed for compliance by the LPH Rights Advisor?	☐	☐		
		Date of LPH Review: _____				
		LPH Reviewer Name: _____				

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

	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.						

Standard	Consumer ID

Development of 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 cicumstances 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.

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			
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			
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			

		Possible Score	Actual Score	*References*	Comments	Plan for Improvement	Response to Plan for Improvement
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*			
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	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	

	Possible Score	Actual Score	*References*	Comments	Plan for Improvement	Response to Plan for Improvement
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***				

SWMBH Behavioral Health Services
ABA Provider Clinical Review Tool 2022

ABA Provider Name:		Corrective Action Plan Request	Corrective Action Plan Submission	SWMBH Follow Up
Section A: Physician Coordination	Average Score %			
Coordination with the CMHSP case manager is documented.				
Section A: Physician Coordination	Average Score %			
Comprehensive ABA behavioral treatment plan is present and is updated at minimum annually.				
Plan is individualized based upon assessment of the customer's needs and preferences.				
Goals are measurable, achievable and realistic.				
Plan addresses risk factors identified for the child and family.				
Family Training is present within the treatment plan or there is documentation that the family declined.				
Services are provided as specified in the providers IPOS including amount, scope, duration.				
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.				
Section A: Physician Coordination	Average Score %			
Progress notes reflects which goal(s)/objective(s) were addressed during the contact.				
Progress notes reflect the customer's progress toward goals/objectives.				
If applicable, the record contains evidence of follow up attempts to engage customer after no shows/missed appointments (phone calls, letters, etc.).				
Section A: Physician Coordination	Average Score %			
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.)				
Documentation is present within the file on parent engagement (phone calls, family training, collatoral contacts etc.)				
Documentation is present within the file to show that ABA services are not supplanting special education services (if applicable.)				
If individual is out of school and attending ABA, a plan/criteia is present to return to a traditional school enviornment.				
Ongoing progress is documented at minimum every six months.				
A discharge plan is present.				