Mission: To promote hope, recovery, resilience, quality of life and wellness in Washtenaw County by providing high quality, integrated services to eligible individuals.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH)
BOARD MEETING AGENDA
4135 Washtenaw Ave, Ann Arbor, MI
Learning Resource Center-Michigan Room
April 19, 2019
9:30AM-11:30AM

I. Introductions

II. Audience Participation (see guidelines below) (5 minutes)

III. Board Response to Audience Participation (5 minutes)

IV. Consent Agenda (Attachment #1) (5 minutes) ACTION
   A. WCCMH Board Meeting Minutes and Actions-3/15/19 (Attachment #1A)
   B. WCCMH Budget-Finance Committee Meeting Minutes and Actions-1/14/19 (Attachment #1B)
   C. WCCMH Budget-Finance and Program-Quality Committee Meeting Minutes and Actions-3/11/19 (Attachment #1C)
   D. WCCMH Contracts and Leases (Attachment #1D)
   E. WCCMH Executive Director Authorizations (Attachment #1E)
   F. WCCMH Consumer Advisory Council Meeting Minutes and Actions-1/9/19 (Attachment #1F)
   G. WCCMH Consumer Advisory Council Meeting Minutes and Actions-3/13/19 (Attachment #1G)
   H. CMHPSM Claims Payment and Appeal Policy-Attachment #1H)
   I. CMHPSM Consumer Appeals Policy (Attachment #1I)
   J. CMHPSM Person Centered Planning Policy (Attachment #1J)

V. Treasurer’s Report (5 minutes)
   • Financial Status Report (Attachment #2) ACTION

VI. Executive Director Report- T. Cortes (15 minutes)

VII. CMHPSM Regional Update (10 minutes)
   • March 13, 2019 meeting minutes (Attachment #3)
   • April 10, 2019 meeting update

VIII. Old Business (10 minutes)
   • WCCMH Committee Structure (Attachment #4) ACTION
   • WCCMH Board Officers ACTION

IX. New Business (30 minutes)
   • Recipient Rights Training
   • Consumer Advisory Council Quarterly Update- M. Hershberger
   • FY19 Board Grant List (Attachment #5)- H. Linky

X. Items for Future Discussions (5 minutes)
   • I/DD presentation-June
   • Youth Mapping
   • ABLE Change
   • Housing
   • Funding Crisis
   • Diversion Council (data review)

XI. Adjournment of Public Meeting and move into closed session

XII. Move to closed session to discuss pending litigation (30 minutes)

Audience Participation Guidelines:
   • Three (3) minutes are allowed per speaker
   • Speakers are asked to bring a copy of their concerns/comments in writing
   • Resolutions on issues will be brought to the appropriate committee as necessary
CONSENT AGENDA

A. WCCMH Board Meeting Minutes and Actions-3/15/19
B. WCCMH Budget-Finance Committee Meeting Minutes and Actions-1/14/19
C. WCCMH Budget-Finance and Program-Quality Committee Meeting Minutes and Actions-3/11/19
D. WCCMH Contracts and Leases
E. WCCMH Executive Director Authorizations
F. WCCMH Consumer Advisory Council Meeting Minutes and Actions-1/9/19
G. WCCMH Consumer Advisory Council Meeting Minutes and Actions-3/13/19
H. CMHPSM Claims Payment and Appeal Policy
I. CMHPSM Consumer Appeals Policy
J. CMHPSM Person Centered Planning Policy
J. Martin called the meeting to order at 9:29 am.

I. Introductions
   • None

II. Audience Participation
   • None

III. Board Response to Audience Participation
   • None

IV. Consent Agenda Actions
   • WCCMH Board Minutes and Actions – 2/15/19 (Attachment #1A)
   • WCCMH Budget-Finance Committee Meeting Minutes and Actions 1/14/19 (Attachment #1B)
   • WCCMH Program-Quality Committee Meeting Minutes and Actions 2/15/19 (Attachment #1C)
   • WCCMH Executive Committee Meeting Minutes and Actions 12/10/18 (Attachment #1D)
   • WCCMH Contracts and Leases (Attachment #1E)
   • WCCMH Executive Director Authorizations (Attachment #1F)
   • FY2019 Year End Update (Attachment #1G)
   • CMHPSM Psychotropic Medication Orders and Consents Policy (Attachment #1H)
   • CMHPSM Medication Administration, Medication Storage & Other Medical Treatment Policy (Attachment #1I)

REQUEST TO REMOVE ATTACHMENT #1B WCCMH BUDGET-FINANCE MEETING MINUTES AND ACTIONS FROM 1/14/19 DUE TO BUDGET-FINANCE COMMITTEE NOT HAVING A QUORUM. THESE WILL BE VOTED ON AT THE NEXT BUDGET-FINANCE COMMITTEE MEETING AND BROUGHT TO THE BOARD FOR FUTURE APPROVAL.

REQUEST TO MOVE ATTACHMENT #1E WCCMH CONTRACTS AND LEASES AND ATTACHMENT #1F WCCMH EXECUTIVE DIRECTOR AUTHORIZATIONS TO THE TREASURER'S REPORT DUE TO BUDGET-FINANCE COMMITTEE NOT HAVING A QUORUM.
MOTION BY M. CREEKMORE SUPPORTED A. DUSBIBER TO APPROVE THE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH CONSENT AGENDA DATED MARCH 15, 2019 AS AMENDED.

MOTION CARRIED

V. Financial Status Report
- N. Phelps reviewed the financial status report for the month ending January 31, 2019.
- Medicaid Enrollees were 32,939 in January 2019.
- Healthy Michigan Enrollees in January 2019 were 16,147.
- Medicaid consumers served through January 2019 are 3,051. This is 173 more consumers served than the same period last year.
- ABA Waiver consumers served through January 2019 were 126. This is 10 more consumers served than the same period last year.
- General Fund consumers served through January 2019 are 536. This is 47 more consumers served than the same period last year.
- Healthy Michigan consumers served through January 2019 are 645. This is 9 less consumers served than the same period last year.
- CLS costs to date are $8.3 Million. This is $417,000 under budget.
- Community Inpatient costs to date total $1.9 Million. This is $121,000 over budget.
- Licensed Residential costs to date are $3.7 Million. This is $100,000 under budget.
- Applied Behavior Analysis/Autism service costs to date are $1.0 Million. This is $128,000 over budget.
- Medicaid, Healthy Michigan and Autism revenues are on budget.
- Financial performance by funding source:
  - Medicaid is showing a deficit of $2.5 Million.
  - Healthy Michigan is showing a deficit of $1.2 Million.
  - State General Funds is showing a deficit of $292,000.
  - Local Funds are showing a surplus of $264,000 through January 2019.
- The Fund Balance at the beginning of FY2018 was $2.7 Million. At this time, it is projected that the use of $40,000 will be necessary to close the State General Fund deficit for FY2018.

MOTION BY C. COLLINS SUPPORTED BY N. GRAEBNER TO ACCEPT THE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH TREASURERS REPORT FOR THE PERIOD OF JANUARY 31, 2019.

MOTION CARRIED

- FY2019 Budget Amendment
  - N. Phelps presented the FY2019 Budget amendment to the committee.
MOTION BY N. GRAEBNER SUPPORTED BY C. RICHARDSON TO APPROVE THE WASHTENAW COUNTY COMMUNITY MENTAL FY2019 BUDGET AMENDMENT AS PRESENTED.

MOTION CARRIED

- Contracts and Leases
  - Rainbow Rehabilitation Center, Inc.
    - This contract is to provide Licensed Residential Services from March 1, 2019 through September 30, 2019.
  - Washtenaw County Trial Court
    - This contract will provide a Mental Health Professional to work closely with Trial Court Juvenile Division to engage and provide trauma focused therapeutic services from April 1, 2019 through September 30, 2019.

MOTION BY K. WALKER SUPPORTED BY N. GRAEBNER TO APPROVE THE CONTRACTS AND LEASES AS PRESENTED.

MOTION CARRIED

- Executive Director Contract Authorizations
  - MEND
    - This contract is to provide Telemedicine system from March 1, 2019 through September 30, 2019.

MOTION BY C. RICHARDSON SUPPORTED BY K. WALKER TO APPROVE THE EXECUTIVE DIRECTOR CONTRACTS AUTHORIZATIONS AS PRESENTED.

MOTION CARRIED

VI. Executive Director Report
- T. Cortes presented the Executive Director report to the WCCMH Board.
  - T. Cortes stated that Bob Gordon from the State is open to acknowledging that there is a funding issue regarding eligible. He stated that they were considering a mid-year adjustment. They are currently trying to understand the current situation but it is confirmed that they are looking to make this a priority.
  - T. Cortes stated that she emailed the news to the board members to make sure they received the information, and it includes the proposals.
  - There are MDHHS Budget hearings are coming up and Trish stated that she will be attending to testify on our behalf. Jeff Irwin will also be attending. She stressed that importance of advocacy from all partners and people of interests in our County is critical during this time.
  - T. Cortes mentioned that the WCCMH Administration team is gathering the required information that was requested by the County to discuss options on reducing costs to help cover the deficit.

VII. CMHPSM Regional Update
- March 13, 2019 Regional update
  - C. Richardson provided an update to the Board.
o The meeting was focused on the evaluation of the CEO of the PIHP. The PIHP commissioned a 360 evaluation that included feedback from community partners, local agencies, PIHP employees, and others.

o She stated that the feedback was very low and overall unhappy with her performance. The Board voted to state that this was unsatisfactory evaluation. The decision was to extend her contract for 6 months with a follow up on improvement plan by the end of 30 days, with an additional follow up on the implementation of the improvement plan within 3 months.

o J. Martin stated that K. Scott has agreed to join the PIHP board and he stated he is also looking to have one additional WCCMH Board member on this board.

o The February 13, 2019 CMHPSM meeting minutes were reviewed.

o N. Phelps discussed the revenue trends based on the trend and geographic factors. She discussed an info graphic that showed the trends since FY 2015. The rates were based on trended rates 100% in FY 2015 and currently for FY 2018 are based 100% on geographic factors. There was a discussion regarding Milliman completing a study regarding how the different CMHSPs are developing their rates.

VIII. Old Business

• WCCMH Board Officers
  o J. Martin distributed a revised spreadsheet to the board.
    ▪ Suggested Officers are as follows for the term April 1, 2019 through March 31, 2020:
      ▪ J. Martin-WCCMH Board Chair and Executive Committee Chair
      ▪ K. Walker-WCCMH Vice-Chair and Program-Quality Committee Chair
      ▪ C. Collins-WCCMH Treasurer and Budget-Finance Committee Chair
      ▪ M. Bloom-WCCMH Secretary

THIS HAS BEEN TABLED UNTIL THE WASHTENAW COUNTY BOARD OF COMMISSIONERS APPOINT THE WCCMH BOARD MEMBERS AT THEIR MEETING ON MARCH 20, 2019. THIS WILL COME BACK TO THE WCCMH BOARD IN APRIL FOR APPROVAL.

• WCCMH Committee Structure
  o J. Martin distributed the revised WCCMH Committee Structure to the board.
  o Committees are as follows:
    ▪ WCCMH Executive Committee
      o J. Martin-Chair
      o M. Bloom
      o F. Brabec
      o C. Collins
      o M. Creekmore
      o K. Walker

    ▪ WCCMH Budget-Finance Committee
      o C. Collins-Chair
      o M. Bloom
      o M. Creekmore
      o Dusbiber
      o N. Grabner
      o K. Scott
      o D. Strong (ex-officio member)
- WCCMH Program-Quality Committee
  - K. Walker-Chair
  - S. Antonow
  - M. Creekmore
  - N. Grabner
  - P. Spriggel

- WCCMH CARES Committee
  - F. Brabec
  - C. Collins
  - M. Creekmore
  - A. Dusbiber
  - J. Martin
  - K. Walker
  - F. Brabec

- CMHPSM Regional Committee
  - C. Richardson
  - K. Scott
  - Vacant

THIS HAS BEEN TABLED UNTIL THE WASHTENAW COUNTY BOARD OF COMMISSIONERS APPOINT THE WCCMH BOARD MEMBERS AT THEIR MEETING ON MARCH 20, 2019. THIS WILL COME BACK TO THE WCCMH BOARD IN APRIL FOR APPROVAL.

IX. New Business
   - WCCMH Board Evaluation Results
     - J. Martin presented the Board evaluation results to the committee.
     - Surveys were sent to 11 WCCMH Board members. Out of the 11 surveys, 8 of them were received. 55 questions broken down into 5 areas.
     - Overall the board seems to be happy with the way that the board is functioning.

X. Items for future discussion
   - I/DD presentation-June
   - Youth mapping
   - ABLE Change
   - Housing
   - Funding crisis
   - Diversion council (data review)

MOTION BY M. CREEKMORE SUPPORTED BY K. WALKER TO ADJOURN THE WCCMH BOARD MEETING AT 10:57 AM.

MOTION CARRIED

XI. Meeting adjourned at 10:57 AM
C. Collins called the meeting to order at 2:00 pm.

I. Introductions
   • R. Dornbos introduced Nick Soos. He is an intern from Eastern Michigan University that will be working with Rhonda for about three months.

II. Audience Participation
   • None

III. Board Response to Audience Participation
   • None

IV. Budget-Finance Committee Minutes and Actions from 12/15/18
   • Budget-Finance and Program-Quality combined quarterly committee meeting minutes from 12/15/18 were reviewed.

MOTION BY D. STRONG SUPPORTED BY M. CREEKMORE TO APPROVE THE MINUTES AND ACTIONS FROM THE DECEMBER 15, 2018 BUDGET-FINANCE AND PROGRAM-QUALITY QUARTERLY COMMITTEE MEETING.

MOTION CARRIED

V. Finance Status Reports
   • N. Phelps reviewed the financial status report for the month ending November 30, 2018.
   • The November data for enrolled consumers and consumers served was not available at the time that the report was created. This information will be updated as soon as it is available.
   • CLS costs to date are $4.2 Million. This is $21,000 over budget.
   • Community Inpatient costs to date total $939,000. This is $39,000 over budget.
Licensed Residential costs to date are $1.8 Million. This is $2,000 under budget.

- Applied Behavior Analysis/Autism service costs to date are $515,000. This is $34,000 over budget.
- Medicaid, Healthy Michigan and Autism funds are on budget.
- Financial performance by funding source:
  - Medicaid is showing a deficit of $1.3 Million
  - Healthy Michigan is showing a deficit of $533,000
  - State General Funds is showing a deficit of $68,000
  - Local Funds are showing a surplus of $114,000
- The Fund Balance at the beginning of FY2018 was $2.7 Million. It is projected that the use of $750,000 will be necessary to close the State General Fund.
- D. Strong would like it noted that he would like to see information in the finance reports that shows total expenses and where we are at each month in regards to the overall budget.

MOTION BY M. CREEKMORE SUPPORTED BY D. STRONG TO APPROVE THE FINANCIAL STATUS REPORT THROUGH NOVEMBER 30, 2018.

MOTION CARRIED

VI. Contracts and Leases
- None

- Executive Director Contract Authorizations
  - Policy Research Associates
    - This contract is to provide youth system intercept mapping from January 1, 2019 to September 30, 2019.

MOTION BY D. STRONG SUPPORTED BY M. CREEKMORE TO APPROVE THE EXECUTIVE DIRECTOR CONTRACT AUTHORIZATIONS AS PRESENTED

MOTION CARRIED

VII. Regional Finance Update
- T. Cortes presented the Regional Finance update. The adverse action was submitted before the holidays. The pre-trial is schedule for this month. The regional board approved a budget amendment that will reflect the litigation and that the region intends to bring in more revenue in the FY19 budget. She also stated that MDHHS has named their new Director, Robert Gordon.

VIII. Old Business
- None
IX. New Business
   o M. Harding presented on the Millage /CCBHC Grant/Medicaid Funding. On December 18, 2018 administration received notification that WCCMH was awarded the CCBHC grant in the amount of $1.8 Million. This is a grant from SAMHSA and we are treating the funding as a federal grant. Mike discussed the complication of making sure that funding sources a being used accurately but assured that they are working with the grant officer of CCBHC to make sure that WCCMH receives the guidance that is needed.

X. Items for Future Discussions
   o On-going financial analysis on millage recommendations will be a continued discussion for future meetings

XI. Meeting adjourned at 2:59 pm.
K. Walker called the meeting to order at 2:06 pm.

I. Introductions
   - K. Scott introduced herself to the WCCMH Board as the Board of Commissioners representative to the WCCMH Board.

II. Audience Participation
    - None

III. Budget-Finance Committee Minutes and Actions from 1/14/19
    - Budget-Finance Committee Minutes and Actions of 1/14/19 were reviewed.
    - THERE WAS NOT A QUORUM FOR THE BUDGET-FINANCE COMMITTEE MEETING, SO THE BUDGET-FINANCE COMMITTEE MINUTES AND ACTIONS FROM JANUARY 14, 2019 WILL BE TABLED UNTIL THE NEXT BUDGET-FINANCE COMMITTEE MEETING FOR APPROVAL.

IV. Program-Quality Committee Minutes and Actions from 2/11/19
    - Program-Quality Committee Minutes and Actions of 2/11/19 were reviewed.
    - MOTION BY M. CREEKMORE SUPPORTED BY P. SPRIGGEL TO APPROVE THE MINUTES AND ACTIONS FROM THE FEBRUARY 11, 2019 PROGRAM-QUALITY COMMITTEE MEETING.
    - MOTION CARRIED

V. Finance Status Reports
   - N. Phelps reviewed the financial status report for the month ending January 31, 2019.
   - Medicaid Enrollees were 32,939 in January 2019.
   - Healthy Michigan Enrollees in January 2019 were 16,147.
   - Medicaid consumers served through January 2019 are 3,051. This is 173 more consumers served than the same period last year.
ABA Waiver consumers served through January 2019 were 126. This is 10 more consumers served than the same period last year.

General Fund consumers served through January 2019 are 126. This is 10 more consumer served than the same period last year.

Healthy Michigan consumers served through January 2019 are 645. This is 9 less consumers served than the same period last year.

CLS costs to date are $8.3 Million. This is $417,000 under budget.

Community Inpatient costs to date total $1.9 Million. This is $121,000 over budget.

Licensed Residential costs to date are $3.7 Million. This is $100,000 under budget.

Applied Behavior Analysis/Autism service costs to date are $1.0 Million. This is $128,000 over budget.

Medicaid, Healthy Michigan and Autism funds are on budget.

Financial performance by funding source:

- Medicaid is showing a deficit of $2.5 Million.
- Healthy Michigan is showing a deficit of $1.2 Million.
- State General Funds is showing a deficit of $292,000.
- Local Funds are showing a surplus of $264,000 through January 2019.

The Fund Balance at the beginning of FY2018 was $2.7 Million. At this time, it is projected that the use of $100,000 will be necessary to close the State General Fund deficit for FY2018.

THERE WAS NOT A QUORUM FOR THE BUDGET-FINANCE COMMITTEE MEETING, SO THE FINANCIAL STATUS REPORT THROUGH JANUARY 31, 2019 WILL BE PRESENTED TO THE WCCMH BOARD ON MARCH 15, 2019 FOR APPROVAL.

VI. Contracts and Leases

- Rainbow Rehabilitation Center, Inc.
  - This contract is to provide Licensed Residential Services from March 1, 2019 through September 30, 2019.

- Washtenaw County Trial Court
  - This contract will provide a Mental Health Professional to work closely with Trial Court Juvenile Division to engage and provide trauma focused therapeutic services from April 1, 2019 through September 30, 2019.

THERE WAS NOT A QUORUM FOR THE BUDGET-FINANCE COMMITTEE MEETING, SO THE CONTRACTS AND LEASES WILL BE PRESENTED TO THE WCCMH BOARD ON MARCH 15, 2019 FOR APPROVAL.

VII. Executive Director Contract Authorizations

- MEND
  - This contract is to provide Telemedicine system from March 1, 2019 through September 30, 2019.
THERE WAS NOT A QUORUM FOR THE BUDGET-FINANCE COMMITTEE MEETING, SO THE EXECUTIVE DIRECTOR CONTRACT AUTHORIZATIONS WILL BE PRESENTED TO THE WCCMH BOARD ON MARCH 15, 2019 FOR APPROVAL.

VIII. Regional Finance Update
   • T. Cortes presented the Regional Finance update.
   • FY 18 has been closed for all regional members. The deficit is $18 Million for the region and is what has been reported in the litigation documents.
   • Executive Director evaluation is ongoing for the regional director.
   • PIHP attorney has indicated that the litigation needs to be expedited due to regional budget issues.
   • Suggestion to bring the PIHP attorney to one of the board meetings under closed session soon, along with the County attorney to better understand the process of the litigation.

IX. Old Business
   • FY 2019 Budget Amendment
     o N. Phelps presented the FY2019 Budget Amendment to the committee.
     o A regional FY 2019 Budget amendment was distributed to the committee.

THERE WAS NOT A QUORUM FOR THE BUDGET-FINANCE COMMITTEE MEETING, SO THE FY2019 BUDGET AMENDMENT WILL BE PRESENTED TO THE WCCMH BOARD ON MARCH 15, 2019 FOR APPROVAL.

   • A Community Living Supports (CLS) presentation was presented to the committee by M. Harding and S. Dominique.

   • FY 2018 Year End Update
     o N. Phelps presented the FY 2018 Year End Update to the committee.

X. New Business
   • Annual Performance Improvement Report/End of Year Narrative FY2018.
     o L. Higle presented the Annual Performance Improvement Report/End of Year Narrative FY2018.
     o 4th quarter Data Dashboard will come forward to Program-Quality Committee in April 2019.
     o Question was asked if this data is compared with the overall County data. L. Higle will check and see if there is any public data available for comparison.

MOTION BY M. CREEKMORE, SUPPORTED BY N. GRABNER TO ACCEPT THE ANNUAL PERFORMANCE IMPROVEMENT REPORT/END OF YEAR NARRATIVE FOR FY2018.

MOTION CARRIED

   • Millage/CCBHC presentation
     o K. Bellus presented the Millage (CARES)/CCBHC presentation to the committee.

XI. Items for Future Discussions
   • Data Dashboard-April 2019 Program-Quality Committee
- Budget Amendment

XII. Meeting adjourned at 3:35 pm.
ACTION REQUESTED: To approve the following contract(s):

BACKGROUND:

1. CBI Rehabilitation Services - will provide Licensed Residential Services
2. Washtenaw County Health Department – will create and implement a marketing campaign aimed at reducing stigma (linked to Community Mental Health Advisory Committee investment “Communicate, educate, and engage community”)

Service Contracts

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Funding</th>
<th>Estimated Budget</th>
<th>Contract Term</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CBI Rehabilitation Services</td>
<td>Medicaid</td>
<td>Per consumer authorizations</td>
<td>April 1, 2019- September 30, 2019</td>
<td>Licensed Residential Services</td>
</tr>
<tr>
<td>2. Washtenaw County Health Department</td>
<td>Millage</td>
<td>Not to exceed $300,000</td>
<td>May 1, 2019 – February 28, 2021</td>
<td>Community wide anti-stigma marketing campaign</td>
</tr>
</tbody>
</table>

RECOMMENDATIONS: To approve the contract(s) listed above.
#### Executive Director Contract Authorizations
April 2019 Finance Committee Meeting

**ACTION REQUESTED:** Acceptance of the Executive Director’s signature on contracts with a value of less than $25,000

**Recommendation:** Acceptance

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Amount</th>
<th>Term</th>
<th>Purpose</th>
<th>Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Interactive Services</td>
<td>$7,392</td>
<td>10/1/18 – 9/30/19</td>
<td>Reminder Communications</td>
<td>10/19/2018</td>
</tr>
<tr>
<td>Deborah Kennard</td>
<td>$2,000</td>
<td>10/1/18 – 9/30/19</td>
<td>Eye Movement Desensitization and Reprocessing Training</td>
<td>10/19/2018</td>
</tr>
<tr>
<td>Saline Area Schools</td>
<td>$20,000</td>
<td>10/1/18 – 9/30/19</td>
<td>Respite Services</td>
<td>10/19/2018</td>
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<tr>
<td>UpToDate</td>
<td>$5,850</td>
<td>10/1/18 – 9/30/19</td>
<td>Evidence-based physician-authored clinical decision support resource</td>
<td>10/19/2018</td>
</tr>
<tr>
<td>Policy Research Associates</td>
<td>$22,500</td>
<td>1/1/19 – 9/30/19</td>
<td>Youth System Intercept Mapping</td>
<td>1/18/2019</td>
</tr>
<tr>
<td>MEND</td>
<td>$22,116</td>
<td>3/1/19 – 9/30/19</td>
<td>Telemedicine system</td>
<td>3/15/19</td>
</tr>
<tr>
<td>Washtenaw Alliance for Children &amp; Youth (WACY)</td>
<td>$4,000</td>
<td>7/1/18 – 6/30/19</td>
<td>Become a participating member of Leadership Team, supports increased high school graduation rates</td>
<td></td>
</tr>
</tbody>
</table>
WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)  
WCCMH CONSUMER ADVISORY COUNCIL MEETING MINUTES  
January 9, 2019
MEMBERS PRESENT: Barb Higman, Alayna Manzanares, Lisa Porzondek, Jason Zurawski, Laura Garcia, Ed Howlett  
STAFF PRESENT: Mert Hershberger
MEMBERS ABSENT: Debbie Patterson, Denise Simpson, Kim Vandenburg, Pam Rathbun

I. Called to order at 12:37 pm.

II. Audience Participation: New members Ed Howlett and Laura Garcia were given the opportunity to state what their interests were: Ed is interested in speaking (1/18 @LRC @10AM) and serving as vice chair in preparation for chairing next year. Mert will continue to chair the meetings throughout the duration of 2019, unless he is absent from work on a particular day. Laura is interested in writing about issues relevant to CMH and advocating. They were duly inducted into membership on the council after they shared a little of how WC-CMH had helped each of them.

III. Consent Agenda Actions.

• October and November minutes were approved with minor corrections.

MOTION BY Barb - SUPPORTED BY Laura TO APPROVE THE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) CONSUMER ADVISORY COUNCIL (CAC) CONSENT AGENDA AS REVISED.

MOTION CARRIED

IV. Chairpersons Report: New Members welcomed and all encouraged to participate fully this year.

V. CMHPSM Regional Consumer Advisory Council Update.

• The upcoming meetings of 2/13, 4/10, 6/12, 9/11, 11/13 were mentioned.
• Some discussion was made about what Federal Services impacting CMH services have been shut down during the 2018/9 Budget Crisis.
• Mert will send a note to Monroe for WC-CMH and others in the RCAC.
• Lisa will take Mert’s Place at the table at the RCAC meetings and Laura will be the back-up RCAC representative from CMH. Mert will continue to drive folks from Ellsworth @ 9:15AM.

VI. Old Business

• Articles suggested for the newsletter for February 4, 2019 deadline:
  o Alayna – New clinic off Maple Road – Investigate and write about it.
  o Laura: election results & impact with Barb who will also write on Millage and 298 outcomes.
• Ed may be interested in writing up his personal story; Both Ed and Laura agreed that CMH made a big difference.
• There was some discussion of the outcomes of the millage and how Ann Arbor had discussed using their portion of these funds for climate change.
• Speaker’s Bureau continues to present and have engagements planned at local high schools.
• Laura Suggested contacting WCC program for Nurse’s Aids and Nursing Staff.

VII. New Business

• 5+ peer positions have opened up related to the millage.
• Lisa to share her story 2/13/19; Ed to share his story the following month with 25-30 minutes each to present.
• We need to prepare to get the building of St. Luke reserved for the 3rd Tuesday, Wednesday, or Thursday in October for the Celebration of Success.
• Walk-A-Mile In My Shoes – Thursday, May 9, 2019. – Barb to design a T-Shirt. Possible Mottoes: “Mental Health goes a long way.” “Let’s walk for a better world.” “Let’s walk for better mental health.” “Mental health goes a long way. Let’s walk to make it better.”

VIII. Meeting adjourned at 1:37pm
Next meeting planned for March 13, 2018 at 12:30 a.m. at 2140 E. Ellsworth, Ann Arbor.
[February meeting was cancelled due to weather emergency.]
WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH CONSUMER ADVISORY COUNCIL MEETING MINUTES
March 13, 2019

MEMBERS PRESENT: Barb Higman, Alayna Manzanares, Lisa Porzondek, Jason Zurawski, Laura
Garcia, Ed Howlett, Pam Rathbun
STAFF PRESENT: Mert Hershberger
MEMBERS ABSENT: Debbie Patterson, Denise Simpson, Kim Vandenburg

I. Called to order at 12:35 pm.
II. Audience Participation.
III. Consent Agenda Actions.
   • January minutes were approved as presented.
   MOTION BY Alayna - SUPPORTED BY Barb TO APPROVE THE WASHTENAW COUNTY
   COMMUNITY MENTAL HEALTH (WCCMH) CONSUMER ADVISORY COUNCIL (CAC) CONSENT
   AGENDA AS REVISED.
   MOTION CARRIED
IV. Chairpersons Report: council readied for next month when the chair will be absent and in Europe.
   All wished him well.
V. CMHPSM Regional Consumer Advisory Council Update.
   • The upcoming meetings of 4/10, 6/12, 9/11, 11/13 were mentioned.
   • Mert had sent a note to Monroe CMH-CAC on behalf of RCAC. Lisa, Barb, Alayna, and Pam
     will be the official representatives from Washtenaw County. Kim will transport from WC-CMH.
     Jason and Ed are also interested in going as observers.
VI. Old Business
   • Articles suggested for the newsletter for March 29, 2019 deadline:
     o Alayna – New clinic off Maple Road – Article submitted.
     o Barb & Laura: submitted an article on the millage and plan to resubmit that.
     o Lisa may submit something on her strategies for recovery.
     o Ed is working on his story of recovery.
   • Speaker’s Bureau continues to present and Lisa will present her story in May. Barb talked
     about her plans to speak at EMU later in the month.
   • Lisa to share her story in May or June; Ed to share his story in the May or June meeting.
   • Walk-A-Mile In My Shoes – Thursday, May 9, 2019. – Barb is working on a T-Shirt Design
     that will have Lady Liberty with a brain and footprints and the Motto: Carrying a Torch for
     Mental Illness. – Ed & Jason will carry the Banner. Laura will read the message, “We are
     carrying a torch for mental illness. Let’s make it brighter! Walk a mile in My shoes.”
VII. New Business.
   • We discussed the Tobacco 21 Resolution: A move to raise the age for tobacco sales to age
     21. Lisa was congratulated on 2.5 years free from tobacco. Alayna was congratulated on 8
     months tobacco free. Barb moved to have a vote the motion. Laura seconded the motion. All
     members agreed to forward the measure to the WC-CMH Board to raise the age for legal
     tobacco sales to Age 21. See the following pages for the measure as approved, which will be
     sent to the State of Michigan.
   • Meeting adjourned at 1:25pm

Next meeting planned for April 10, 2018 at 12:30 a.m. at 2140 E. Ellsworth, Ann Arbor.
RAISING THE MINIMUM SALES AGE OF TOBACCO PRODUCTS IN MICHIGAN TO AGE 21 RESOLUTION

“Raising the legal minimum age for cigarette purchaser to 21 could gut our key young adult market (17-20) where we sell about 25 billion cigarettes and enjoy a 70% market share.” Phillip Morris report, 1/21/86

WHEREAS: Each year over 16,200 Michiganders die from tobacco use and 5,200 Michigan children become new regular, daily smokers, of whom a third will die prematurely because of this addiction;

WHEREAS: 95% of adults began smoking before age 21, and 4 out of 5 become regular, daily smokers before age 21. Young people are sensitive to nicotine and can feel dependent earlier than adults, and the brain continues to develop until about age 25. The younger youth are when they start using tobacco, the more likely they will be addicted. Increasing the age at which young people first experiment with tobacco reduces the risk of nicotine addiction;

“If a man has never smoked by age 18, the odds are three-to-one he never will. By age 24, the odds are twenty-to-one.” RJ Reynolds researcher, 1982

WHEREAS: Adolescents are more likely to obtain cigarettes from social sources than through commercial transactions, and youth who reported receiving offers of cigarettes from friends were more likely to initiate smoking and progress to experimentation. Raising the legal age of access to 21 would reduce the likelihood that young people would have access to tobacco products through social sources;

WHEREAS: Over 330 local jurisdictions in 21 states have already raised the minimum age of legal access to tobacco products, and California, Hawaii, Oregon, Massachusetts, Maine, and New Jersey have passed statewide legislation;

WHEREAS: Smoking-caused health costs in Michigan total more than $4.5 billion per year, including more than $1.3 billion in state and federal Medicaid expenditures, and raising the age of legal access to tobacco products to age 21 will likely decrease overall tobacco use rates, which in turn will likely lead to reduced future tobacco-related health care costs;

WHEREAS: Tobacco companies spend an estimated $320 million to market their products in Michigan, and 90.7 percent of middle school students and 92.9 percent of high school students were exposed to pro-tobacco ads in stores, in magazines or on the internet. According to the U.S. Surgeon General, the more young people are exposed to cigarette advertising and promotional activities, the more likely they are to smoke. Nearly 9 out of 10 smokers start smoking by age 18, and more than 80% of underage smokers choose brands from among the top three most heavily advertised;

WHEREAS: The Institute of Medicine concluded that raising the age of legal access to tobacco products to 21 years of age will likely prevent or delay initiation of tobacco use by adolescents and young adults, immediately improve the health of adolescents and young adults, improve maternal, fetal, and infant health outcomes, and substantially reduce smoking prevalence and smoking-related mortality over time, and predicted that raising the age now to 21 nationwide would result in approximately 249,000 fewer premature deaths, 45,000 fewer deaths from lung cancer, and 4.2 million fewer years of life lost for those born between 2000 and 2019;

WHEREAS: Tobacco use is 50% more common among those with substance use, emotional, behavioral and mental health conditions compounding with other existing conditions to reduce longevity and increase morbidity of people with mental health conditions, and since those those with mental health conditions and substance use disorders smoke and vape more intensely; and tobacco related diseases account for 50% of all deaths among people with serious mental illnesses.
BE IT RESOLVED: That the undersigned endorses raising the minimum age of legal access to tobacco products to 21 years of age.

The _____________________________ (name of organization) of ______________________ (location), confirms its support for each and all the above statements. The undersigned authorizes and encourages Tobacco-Free Michigan to use this signed Resolution to promote the above-stated objective.

Organization Name: ___________________________ Number of Members: ______

Title: (Mr./Mrs./Ms./Dr./Other) _____ Contact Person (Print): __________________________

Address: __________________________________________________________________________

Phone, Fax, E-mail: __________________________________________________________________

Authorized Signature: ___________________________ Date: ____________

Please Print Name: ___________________________ Title: __________________________

Please return to: Tobacco-Free Michigan P.O. Box 10231 Lansing, Michigan 48901

BE IT RESOLVED: That the undersigned endorses raising the minimum age of legal access to tobacco products to 21 years of age.

The _____________________________ (name of organization) of ______________________ (location), confirms its support for each and all the above statements. The undersigned authorizes and encourages Tobacco-Free Michigan to use this signed Resolution to promote the above-stated objective.

Organization Name: ___________________________ Number of Members: ______

Title: (Mr./Mrs./Ms./Dr./Other) _____ Contact Person (Print): __________________________

Address: __________________________________________________________________________

Phone, Fax, E-mail: __________________________________________________________________

Authorized Signature: ___________________________ Date: ____________

Please Print Name: ___________________________ Title: __________________________

Please return to: Tobacco-Free Michigan P.O. Box 10231 Lansing, Michigan 48901
I. PURPOSE
To establish the standards by which behavioral health (Mental Health and Substance Use Disorder) service claims, submitted by service providers, are reviewed for accuracy, conformance to authorizations, and paid within the requirements stated in the current contract between the State of Michigan-Department of Health and Human (MDHHS) and the CMHPSM or the regional CMHSPs.

II. REVISION HISTORY

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III. APPLICATION
This policy shall apply to the CMHPSM as the PIHP, the CMHSPs within the CMHPSM region (herein after referred to as CMHPSM payers) and all service providers submitting service claims.

IV. POLICY
It is the policy of the CMHPSM that service claims submitted directly to the CMHPSM, or to one of its regional CMHSPs will be appropriately adjudicated and processed according to this policy, MDHHS rules and all applicable federal regulations. Service providers serving CMHPSM consumers will follow this policy related to claims payment.

V. DEFINITIONS
- Adjudication- claims payment process that involves paying clean claims or denying claims after comparing claim information to payer coverage requirements and system edits.
- Claim- formal request for payment related to mental health or substance use disorder service delivery based upon service rates.
- Clean Claim- a claim that does not contain a defect related to adjudication rules or other CMHPSM claim requirements.
- Denied Claim – a claim that did not meet the CMHPSM adjudication rules and/or claim requirements.
- CMHPSM Payers - The CMHPSM itself as the PIHP, or one of the CMHSP entities within the CMHPSM region that pay service claims to their contracted service providers.
- HIPAA - Health Insurance Portability and Accountability Act, law designed to protect patients' health and treatment information.
- Service Provider – Any entity authorized to provide specialty services on behalf of the CMHPSM payers (PIHP or CMHSP).
- Electronic Health Record (EHR) - a digital version of a patient centered health record.

VI. STANDARDS
A. Claims Payment Process
The CMHPSM payers (CMHPSM and its partner CMHSPs) will adjudicate all claims and pay valid clean claims based on the following standards.

1. Service provider Claim Submission
Claims will be submitted by direct entry into the CMHPSM web-based electronic health record (EHR). Service providers may also submit claims electronically through a CMHPSM approved format, such as an 837 file transfer. Service providers submitting paper claims must use a HIPPA compliant HCFA 1500, CMS 1450 (UB04) or a CMHPSM approved format. Service providers must submit claims within the following prescribed timeframes:
   a. 60 calendar days of providing a service
   b. 60 calendar days from date of discharge for all inpatient hospital stays
   c. 90 calendar days of providing service where the CMHPSM payer is a secondary payer.

2. Adjudication
The CMHPSM payer staff will perform adjudication activities on service claims, included but not limited to: system edits, manual edits, claim documentation reviews, primary insurance validation, and/or Medicaid Service Verification sample audits. Service providers may be required to submit additional information to CMHPSM payers upon request including service documentation, copies of primary insurance EOB’s, etc.

3. Clean Claims
All clean claims submitted electronically to the CMHPSM payer will be paid within 30 calendar days of the adjudication review submission date by the CMHPSM payer. Claims not submitted electronically will be processed within 90 calendar days of receipt.

4. Pended Claims
Claims may be pended for multiple reasons during the claims adjudication process. These claims may be denied or returned to the service provider for correction. Batches that have been returned to service providers must be corrected and resubmitted within 30 calendar days of the date it was returned to the service provider. CMHPSM payers will assist service providers upon request.

4.5. Denied Claims
5. Services that are denied must be re-entered and submitted for payment within 30 days of the CMHPSM payer denial EOB/Check date. A denied claim may be rebilled. A corrected clean claim must be entered and resubmitted for payment within 30 calendar days of the original denial.
or the EOB/Remittance advice date the original claim appeared. If a rebilled claim is denied for a second time, service provider must follow appeal process for final determination.

6. Reconsidered Claims
Previously paid claims may need to be reconsidered by the CMHPSM payer for multiple reasons. The reconsideration process may result in an increase or decrease in the payment to the service provider which would be reconciled in a future payment to the service provider.

7. Claim Data Layout
Service providers follow the current data claim layout, data fields requirements, etc. as prescribed by the CMHPSM to ensure claims meet all CMHPSM, MDHHS, and/or federal field requirements.

8. HIPAA
Service providers must follow all HIPAA regulations when submitting claims.

9. Other Claim Information
Service provider must maintain documentation supporting claims in a format that provides evidence that service was provided as billed. CMHPSM payer may review supporting documentation in its determination of appropriateness of claims.

10. Fiscal Year End Claims Submission
Service provider must submit all claims for the previous fiscal year (October-September) no later than October 15th. Batches received with different fiscal year claims will be denied and no additional Fiscal Year end submission time will be allotted. Due to the end of the year reporting requirements set by MDHHS, the CMHPSM payer may shorten submission days for Pending, Denied and Appealed claims after October 15th. Failure to follow the Fiscal year End Claims Submission process may result in payment denial. Exceptions to the process must be approved by the CMHPSM payer.

If October 15th falls on a Saturday, Sunday or federally recognized holiday, the due date will be the next business date.

B. Service Provider Appeals
1. Service Provider Right to Appeal
Service providers may appeal CMHPSM payer decisions related to service claim payment denials. The CMHPSM payer and service provider should first communicate so each party understands the reason for denial. If communication between the parties does not resolve the situation, service providers shall follow the Service Provider Appeal Process as outlined in this standard.

2. Service Provider Appeal Process
Service providers will utilize the CMHPSM appeal form which can be found on the CMHPSM website www.cmhpsm.org or through your local CMHPSM payer contact.

a. Service provider submits appeal form, with all relevant documentation attached, to the CMHPSM Payer that denied the claim, within 30 calendar days of the initial denial, most recent denial or the EOB/Remittance advice date the original claim appeared.

b. The CMHPSM payer designee reviews the appeal form and attached documentation to make a determination within 15 working business days of receiving the appeal.
c. CMHPSM payer returns will provide the appeal determination to the submitting service provider. Services approved in the appeal must be re-entered in EHR and submitted to CMHPSM payer by the service provider within 15 business days of receiving the appeal determination.

d. If the service provider disagrees with the determination, they have the right to file a second appeal within 15 working business days of receiving the appeal determination.

e. Service provider submits a written appeal and includes any additional information to the CMHPSM payer’s Executive Director or their designee.

f. CMHPSM payer’s Executive Director or their designee makes determination on 2nd appeal and returns final determination to the service provider within 15 working-business days of receiving the appeal. Services approved in the appeal must be re-entered in the EHR and submitted to CMHPSM payer within 15 working-business days of receipt of final determination.

C. Provider Compliance with Medicaid Service Verification Activities
Regional service provider claims are constantly monitored through the adjudication rules and edits described in this policy. Regional service providers may be selected by CMHPSM payers for additional service verification activities related to claims that have been submitted. Additional service verification activities include but are not limited to random or targeted service claim reviews.

VII. EXHIBITS
   A. Attachment #1: HCFA 1500 Form Example
   B. Attachment #2: CMS1450 (UB04) Form Example
   C. Attachment #3: Appeal Form (Form found at www.cmhpsm.org)

VIII. REFERENCES

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<td>Michigan Department of Community Health (MDHHS) Medicaid Contract</td>
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CLAIMS PAYMENT AND APPEAL POLICY

Attachment #1 HCFA 1500 Form

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08/14)
attachment #2 CMS1450 (UB04) Form Example

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Claims Payment and Appeal Policy

Attachment #1H
APRIL 2019
Regional Service Provider Claim Payment Appeal Form

Providers must use this form to appeal service claims denied by Lenawee, Livingston, Monroe, Washtenaw or CMHPSM SUD payers.

| Provider Name: | Appeal Date: |
| Contact Person: | Contact Email: |
| Contact Phone: | Contact Fax: |

### CMHPSM Payer

- [ ] Lenawee
- [ ] Livingston
- [ ] Monroe
- [ ] Washtenaw
- [ ] CMHPSM SUD

#### EHR Claim ID Number(s)

#### EHR Batch Number(s)

#### Denial Date and Reason for Denial

#### Basis of Appeal

#### Resolution Requested

#### Service Provider Authorized Signature

<table>
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Completed appeal form, including supporting documentation, should be faxed or e-mailed directly to the appropriate CMHPSM Payer department (i.e. Appeal of Lenawee CMH denial of payment sent to Lenawee CMH, appeal of CMHPSM-SUD sent to CMHPSM, etc.)

#### Received by CMHPSM Payer

| Date |

#### Determination / Outcome

| Date |

I. PURPOSE

To establish policy and procedures to receive and resolve consumer appeals regarding the denial, suspension, reduction, or termination of services; the timeliness of service provision; family support subsidy appeals; second opinion requests; local level appeals, and state level appeals.

II. REVISION HISTORY

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<td>1/28/19</td>
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III. APPLICATION

All regional staff of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), all Community Mental Health Service Provider (CMHSP) staff, students and volunteers, all Recovery Oriented System of Care (ROSC) Core Providers, and contractual providers.

IV. POLICY

Consumer Appeals Policy
All grievance processes will be initiated at the local Board level and will be handled by the local Customer Services department of each local Board. All policy and procedures for grievance processes can be found in the CMHPSM Customer Services Policy.

All appeal processes will be initiated at the local Board level and will be handled locally. Each CMHSP/ROSC Core Provider shall have a designee to handle internal/local appeals until:

a. A Medicaid consumer requests a State Fair Hearing with the Michigan Administrative Hearing System (MAHS) after receiving notice that an adverse benefit determination (ABD) was upheld by the Local Dispute Resolution Committee (LDRC).
b. A Medicaid consumer initiates a State Fair Hearing with the MAHS, because the PIHP/CMHSP failed to adhere to the notice and timing requirements. (When this occurs, a consumer is deemed to have exhausted the internal appeals processes).
c. A Non-Medicaid consumer completes the Local Dispute Resolution Process and requests a Michigan Department of Health and Human Services (MDHHS) Alternative Dispute Resolution Hearing.

Upon the request of a state level hearing/appeal, the designated Fair Hearings Officer will assume responsibility for the process in collaboration with the local Board. This includes working in conjunction with MAHS on behalf of the local Board, representing the local Board for the State Fair Hearing requests and representing the local Board for MDHHS Alternative Dispute Resolution requests.

All appeal processes will be handled by the PIHP and its region in accordance with the procedures attached to this policy. All appeal processes shall be:

1. Timely
2. Fair to all parties
3. Administratively simple
4. Objective and credible
5. Accessible and understandable to consumers and providers
6. Cost and resource efficient
7. Subject to quality improvement review

These processes shall:
i. Not interfere with communication between consumers and their service providers.

ii. Assure that service providers who participate in an appeal process on behalf of a consumer are free from discrimination or retaliation.

iii. Assure that a consumer/legal representative who files an appeal is free from discrimination or retaliation.

V. DEFINITIONS

Access Staff – Staff designated to provide intake and/or assessment of an applicant’s/consumer’s eligibility and/or medical necessity for requested services. Staff provide screenings and referrals using diagnostic criteria for mental health and substance abuse services. Staff also assess the needs of callers, make appropriate referrals, and provide authorization of mental health and substance use disorder services based on client need, eligibility, and available funding resources.

Action (also referred to as adverse action) – A benefit/service determination related to Non-Medicaid/General Funds by which the CMHSP determines any of the following covered by Non-Medicaid/General Funds:
- Denial of inpatient psychiatric hospitalization or denial of a requested alternate service if inpatient is denied.
- Denial of services where there are rights to a second opinion.
- Suspension, reduction, or termination of reduction of existing supports/services.

Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

Adequate Notice - Written notice to an applicant/consumer/legal representative that a service is being approved or an adverse benefit determination (ABD) has occurred that is not a suspension, reduction or termination.

Administrative Law Judge (ALJ) - A person designated by the state to serve as a judge for the Michigan Administrative Hearing System to conduct Medicaid State Fair Hearings.

Advance Notice - Written notice of an ABD or action to a consumer/legal representative that a service is being suspended, reduced, or terminated. For Medicaid consumers, this notice must be mailed at least 10 days before the effective date of the service change. For Non-Medicaid consumers, this notice must be mailed at least 30 days before the effective date of the service change.
Adverse Benefit Determination (ABD) – A benefit/service determination specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following for Medicaid services:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

2. The reduction, suspension, or termination of a previously authorized service.

3. The denial, in whole or part, of a payment for service.

4. The failure to make a standard service authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard service request.

5. The failure to make an expedited service authorization within 72 hours after receipt of a request for expedited service authorization.

6. The failure to provide services within 14 calendar days of the start date agreed upon during the person centered planning process and as authorized by the PIHP/CMHSP.

7. The failure of a PIHP/CMHSP to resolve grievances and provide notice within 90 calendar days of the date of the request.

8. The failure of a PIHP/CMHSP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal.

9. The failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal.

10. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a consumer’s request to exercise his or her right under 438.52(b)(2)(ii) to obtain services outside the network.

11. The denial of a consumer’s request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other consumer financial liabilities.

Alternative Dispute Resolution Process - A program of the Michigan Department of Health & Human Services with responsibility for conducting an appeal which was not resolved at the local level through the LDRP. This process may occur after the LDRP review has been exhausted and Community Mental Health (CMH) upholds the adverse action at the local appeal.
**Applicant** - An individual, or his/her legal representative, who makes an initial request for mental health or substance use disorder services, including services provided by agencies under contract to the PIHP.

**Authorized Hearing Representative (AHR)** - Any person designated in writing by a consumer (or the consumer’s legal representative) to stand in for or represent the consumer during a local/internal or state level appeal, or a representative/parent of a minor, or the consumer's spouse, widow, or widower, if there is no one else with authority to represent the consumer.

**Community Mental Health Partnership of Southeast Michigan (CMHPSM)** - The Regional Entity that serves as the Pre-Paid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe and Washtenaw for mental health, intellectual/developmental disabilities, and substance use disorder services.

**Community Mental Health Services Program (CMHSP)** - A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

**Consumer** - An individual who is receiving mental health or substance use disorder services, including services provided by entities under contract with the PIHP.

**Core Provider** - A local provider of substance use disorder services utilizing the ROSC model that provides for and/or coordinates all levels of care for clients with substance use disorders.

**Denial** - An action taken by the CMHSP with Non-Medicaid/General Funds services, by which a service is denied in whole, denied in part, or currently authorized services or supports are to be suspended, terminated, or reduced. This is also known as an Action or Adverse Action.

**Expedited Appeal** – The prompt review of an ABD or action, requested by a consumer/legal representative or a provider on behalf of the consumer, when the time necessary for the normal/standard review process could seriously jeopardize the consumer’s life or health or ability to attain, maintain or regain maximum function. If the consumer/legal representative requests the expedited review, the PIHP/CMHSP determines if the request is warranted. If the consumer’s provider makes the request, or supports the consumer’s request, the PIHP/CMHSP must grant the request.

**Fair Hearings Officer (FHO)** – Person assigned by the CMHSP Board for mental health appeals, or by PIHP for Substance Use Disorder (SUD) appeals, to handle state level appeals, maintain appeals-related data, and report this data to the PIHP.
Grievance – An expression of dissatisfaction about any matter related to PIHP/CMHSP service issues, other than an adverse benefit determination or action, which does not involve a Recipient Rights complaint. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the consumer. Grievances not completed according to time frames are also considered a Medicaid ABD and are appealable.

Grievance Process - Impartial local level review of a consumers’ grievance.

Grievance and Appeal System – Processes the PIHP implements to handle appeals, grievances and the collecting and tracking of appeal and grievance information.

Internal Appeal – A request for the PIHP/CMHSP to review a Medicaid ABD at the local level.

Legal Representative – The representative, parent of a minor, or other person authorized by law to represent an applicant/consumer.

Local Appeal – A request for the PIHP/CMHSP to review a denial, suspension, termination or reduction of Non-Medicaid/General Funds services and/or supports at the local level.

Local Dispute Resolution Process (LDRP) - A review of a Non-Medicaid/General Funds local appeal convened by the local entity (either the CMHSP or the ROSC Core Provider). The LDRP for mental health services is chaired by the designee of the CMHSP Director; the LDRP for substance use disorder services is chaired by the SUD Director. The LDRP has the responsibility for reviewing local appeals regarding mental health or substance use disorder services covered with Non-Medicaid/General Funds by the PIHP/Core Provider and those of its contract agencies.

Medicaid Services – Services provided to a consumer under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, 1915(c), Children’s Waiver Program, and/or B3/Additional Service Section 1915(b)(3) of the Social Security Act.

Mediation - An informal dispute resolution process in which an impartial, neutral individual who has no authoritative decision-making power assists parties to reach their own settlement of issues in a confidential setting.

Michigan Administrative Hearing System (MAHS) - The entity charged by the state with responsibility for conducting Medicaid State Fair Hearings.
Notice of Resolution – Written statement of the PIHP/CMHSP resolution of a grievance or appeal, which must be provided to the consumer as described in 42 CFR 438.408.

Recipient Rights Complaint – A written or verbal statement by a consumer or anyone acting on behalf of a consumer alleging a violation of a consumer’s legally protected rights, including rights cited in the Michigan Mental Health Code, Chapter 7, which is resolved through the processes established in Chapter 7A.

Regional Entity - The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, intellectual/developmental disabilities, and substance use disorder needs.

Service Authorization – PIHP/CMHSP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to 42 CFR 438.210.

State Fair Hearing – (Also called a Medicaid Fair Hearing). An Administrative Law Judge (ALJ) from MAHS completes an impartial state level review of a decision made by the PIHP or the local CMHSP, or one of its contract agencies, regarding Medicaid services.

Utilization Review (UR) - Process in which established criteria are used to recommend or evaluate services provided in terms of cost effectiveness, medical necessity, and efficient use of resources.

VI. STANDARDS

A. General Standards

1. Grievance and Appeal System: Processes shall be in place for consumers and promote the resolution of concerns as well as support and enhance the goal of improving the quality of services.

2. Consumers/legal representatives shall be informed of their right to access the grievance and appeal processes, if they are dissatisfied or concerned at any point during the delivery of mental health services or supports.

3. Customer Services and the Office of Recipient Rights (ORR) shall assist applicants/consumers/legal representatives of their legal rights to access all grievance and/or appeal processes which they are eligible.

4. Providers shall be informed of their right to access the appeal process when they are denied or limited authorization for services, or when they wish to file an expedited appeal on behalf of a consumer.
5. Providers, acting on behalf of a consumer/applicant and with the consumer’s/legal representative's written consent, may file an appeal as the consumer’s Authorized Hearing Representative (AHR).

6. If an external/contractual provider makes a service request on behalf of a consumer, and that request results in an adverse benefit determination/action, both the provider and the consumer/guardian will be notified of the adverse benefit determination/action. Notice to the provider can be verbally or in writing. Notice to the consumer/guardian shall follow written notice requirements as outlined in this policy.

7. If the consumer/legal representative is not aware of the provider’s service request, and the matter warrants involving the consumer/legal guardian in the request process (i.e. will warrant a change in the Individual Plan of Service (IPOS) that the consumer/legal representative would need to agree to), CMHSP staff will inform the consumer/legal representative regarding the request.

8. Level of Appeals: The PIHP/CMHSP may only have one level of appeal for consumers.

B. Timeliness of Authorization/Service Decisions

1. State and federal regulations require that specific service decisions shall be made within certain time frames. If these times frames (described below) are not met they are considered denials/Adverse Benefit Determinations and staff shall follow the same processes for providing consumers/legal representatives with notices of their appeal rights as all other denials/Adverse Benefit Determinations.

2. Authorization decisions at the initial request for services, or request for hospitalization shall be made within 14 days of when the consumer, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent.

3. Authorization decisions for Medicaid consumers currently receiving services shall be made within 14 days of when the consumer, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent.

4. A standard service authorization decision may be extended an additional 14 calendar days if the consumer or legal representative requests an extension or if the PIHP/CMHSP/Core Provider justifies a need for
additional information and the extension is in the consumer’s interest. If the PIHP/CMHSP/Core Provider extends the timeframe, it must give the consumer/legal representative written notice of the reason for the decision to extend the timeframe, inform the consumer/legal representative of the right to file a grievance if he/she disagrees with the decision to extend, and make a determination as expeditiously as the consumer’s health condition requires and no later than the date the extension expires.

5. Medicaid covered services shall begin within 14 days from when the authorization was completed, except in cases where the consumer agrees to a start date outside the 14-day timeframe. If services cannot begin within the 14 day time frame and the consumer does not agree to an extension, this shall be considered an ABD and staff shall provide the consumer/legal representative with notice of the denial.

6. Expedited authorization decisions shall be made in urgent cases where the provider indicates, the consumer/legal guardian requests, or the PIHP/CMHSP determines that following the standard timeframe could seriously jeopardize the consumer/applicant’s life or health or ability to attain, maintain, or regain maximum function. In these cases a decision must be made and written/electronic notice provided no later than 72 hours from receipt of the request for service.

7. The PIHP/CMHSP may extend the 72 hour time period by up to 14 calendar days if the consumer/legal representative requests an extension, or if the PIHP/CMHSP justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer’s interest. If the PIHP/CMHSP extends the timeframe, it must give the consumer/legal representative written notice of the reason for the decision to extend the timeframe, inform the consumer/legal representative of the right to file a grievance if he/she disagrees with the decision to extend, and make a determination as expeditiously as the consumer’s health condition requires and no later than the date the extension expires.

8. Consumer requests for an expedited review of an authorization decision can be denied; if it is denied the consumer shall receive notice of denial for an expedited review and standard 14-day timeframes for an authorization decision shall still be met.

9. If a provider requests an expedited review of an authorization decision, such a request from a provider cannot be denied; the review shall follow the expedited process and the provider shall be informed within 72 hours on whether the service request will be approved or denied.
C. Filing and Timeliness Requirements

1. Grievances: A consumer/legal representative may file a grievance at any time.

2. Appeals:
   a) Medicaid Appeals: Following receipt of notification of an Adverse Benefit Determination (ABD) by a PIHP/CMHSP, a consumer/legal representative has 60 calendar days to request an internal appeal with the PIHP/CMHSP. *An internal appeal must be resolved within 30 days of receipt. This timeframe may be extended by up to 14 calendar days if a consumer/legal representative requests an extension or if the CMHSP/PIHP finds that there is a need for additional information that would be in the best interest of the consumer.*

   A consumer/legal representative may request a State Fair Hearing within 120 calendar days after receiving notice that the ABD was upheld by the internal appeal.

   If the PIHP/CMHSP does not meet the notice or internal appeal timing requirements, the consumer has the immediate right to file a State Fair Hearing.

   b) Non-Medicaid/General Fund Appeals: Following receipt of an action by the CMHSP, a consumer/legal representative has 30 calendar days to request a local appeal with the CMHSP. A consumer/legal representative may request an Alternative Dispute Resolution Process with the state within 10 calendar days after receiving notice that the action was upheld by the local appeal/LDRP.

D. Providing Notice of Approved Services

1. State regulation requires that consumers/legal representatives receive notice of their appeal/hearing rights when services are approved at the onset of services and during the person-centered planning process.

E. Second Opinion Process

1. All applicants/consumers/legal representatives may request a second opinion for a denial of access to services and of access to hospitalization within 30 days of the denial. A second opinion will be provided within the PIHP/CMHSP at no extra cost to applicants/consumers by a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist.

2. Non-urgent requests for a second opinion will be completed for applicants/consumers within five (5) business days from the receipt of the request.

3. Urgent requests for a second opinion will be provided within two (2)
business days.

4. Emergent requests for a second opinion will be provided on an immediate basis where applicable, based on clinical judgment of consumer clinical need, and no later than 24 hours of when the service was requested.

5. Upon completion of the second opinion, the applicant/consumer will be provided verbal notification of the outcome within one (1) business day from the completion of the second opinion; this notification will be followed by a written notification within five (5) business days from the completion of the second opinion.

6. If the second opinion upholds the original denial, the notification to the applicant/consumer shall include the next steps available to them, including filing a recipient rights complaint.

7. If the second opinion reverses the original denial, staff (Access, Psychiatric Emergency Services, or the local designee) shall arrange for services to be provided per the appropriate required timeframes for authorization decisions.

F. Timeliness of Providing Notice of an Adverse Benefit Determination/Adverse Action

1. Consumers/legal representatives shall receive written notice of an ABD/action that meets federal and state requirements for timeliness.

2. Timeliness of Notice for Medicaid Beneficiaries:

   a. For a Service Authorization decision that denies or limits services, notice must be provided to the consumer within 14 days following receipt of the request for service for standard authorization decisions, or within 72 hours after receipt of a request for an expedited authorization decision.

   b. The CMHSP/PIHP/ROSC Core Provider may be able to extend the standard Service Authorization timeframe up to 14 additional calendar days, if:

      (i) The consumer, or the provider, requests extension; or

      (ii) The CMHSP/PIHP/ROSC Core Provider justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer's interest.

   c. If a standard service authorization timeframe is extended, the
CMHSP/PIHP/ROSC Core Provider must:

(iii) provide the consumer written notice of the reason for the decision to extend the timeframe and inform the consumer of the right to file a Grievance if he or she disagrees with that decision; and

(vi) issue and carry out its determination as expeditiously as the consumer's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).

d. Advance Notice of Adverse Benefit Determination is required for service authorization decisions that are reductions, suspensions or terminations of previously authorized/currently provided Medicaid Services. Advance Notice of an ABD must be provided to the consumer/legal representative at least ten (10) calendar days prior to the proposed effective date.

e. If Advance Notice of Adverse Benefit Determination is not provided within required timeframes, the CMHSP/PIHP must reinstate services to the level before the action if services have been reduced, terminated, or suspended.

f. Limited Exceptions to Advance Action Notice of an ABD:
The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, if:

i. The CMHSP/PIHP has factual information confirming the death of a consumer/applicant;

ii. The CMHSP/PIHP receives a clear written statement signed by a consumer/legal representative that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the consumer/legal representative understands that this must be the result of supplying that information;

iii. The consumer has been admitted to an institution where he/she is ineligible under the plan for further services;

iv. The consumer's whereabouts are unknown and the post office returns agency mail directed to him/her indicating no forwarding address;

v. The CMHSP/PIHP establishes that the consumer/applicant has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
vi. A change in the level of medical care is prescribed by the consumer's physician;

vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;

viii. The date of action will occur in less than 10 calendar days.

ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the consumer (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

g. If the PIHP/CMHSP does not meet the requirements of providing notice or of internal appeal timing requirements, the consumer has the immediate right to file a State Fair Hearing.

3. Timeliness of Notice for Non-Medicaid/General Funds Consumers Beneficiaries:

a. Whenever a currently authorized service or support or currently authorized services are to be suspended, terminated, or reduced, whether through a utilization review (UR) function, or when the action is taken outside of the person-centered planning process when there is not an identifiable UR unit, the CMHSP/PIHP/ROSC Core Provider must inform the consumer with written notification of the change at least 30 days prior to the effective date of the action.

b. Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

G) Content of Notice

1. Consumers/legal representatives shall receive written notice of an ABD/action with content that meets federal and state requirements.

   a. Content of a Medicaid Notice shall explain the following:

      i. The ABD the PIHP/CMHSP intends to make or has already made.

      ii. The reasons for the ABD.

      iii. The consumer’s right to request an appeal of the
PIHP’s/CMHSP’s ABD, including information on exhausting the PIHP’s/CMHSP’s one level of appeal and the right to request a State Fair Hearing.

iv. The right for consumers/legal representatives to have an AHR and the timeframes for requesting appeals.

v. Before and during the appeal, the right of the consumer/legal representative and/or AHR to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the consumer’s ABD. This shall occur in a timely manner sufficient for preparation of their case for the appeal.

vi. How to submit written comments or information relevant to the appeal.

vii. The procedure for exercising their appeal rights.

viii. The circumstances under which an appeal process can be expedited and how to request it.

ix. The consumer’s right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the consumer may be required to pay the cost of these services. A consumer may be required to pay the cost of the services if:

1) The decision was upheld.

2) The consumer/legal representative/AHR withdraws their appeal request.

3) The consumer/legal representative/AHR does not attend the appeal.

x. Notice of denials given to providers/practitioners shall include information on the opportunity for providers to discuss any denial decision with the reviewer and how to contact the reviewer.

b. Content of a Non-Medicaid/General Funds Notice shall explain the following:

a. A statement of what action the CMHSP intends to take.
b. The reasons for the intended action.

c. The specific justification for the intended action.

d. An explanation of the LDRP.

H) Handling of Appeals:

1. All PIHP/CMHSP entities will:

   a. Ensure that written materials will be provided to consumers, legal representatives and AHRs in a language and format that is easily understood.

   b. If an applicant/consumer requires written materials in alternative formats (i.e. visual/hearing impairments or limited English proficiency), materials will be provided free of charge and in ways to meet their needs. Large print materials must be typed in a font large enough and no less than an 18 point font for the individual to read. (See the Regional Customer Services Policy for further information about written materials).

   c. Give consumers/legal representatives reasonable assistance in completing forms and taking other procedural steps related to an appeal. This includes, but is not limited to auxiliary aids and services upon request, such as providing free interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. This shall occur in accordance with PIHP policies on interpreters and/or limited English proficiency.

2. Any staff/designee handling appeals of ABDs/actions shall:

   a. Acknowledge the receipt of each internal/local appeal in writing within 5 calendar days to the consumer/legal representative and when applicable, the AHR. Requests for internal/local appeals received orally will be treated as a formal appeal request to establish the earliest possible filing date for a local appeal. An oral appeal must be confirmed in writing unless the applicant/consumer, legal representative/provider requests expedited resolution of an appeal.

   b. Ensure that the individuals who make decisions on appeals are individuals who:
      i. Were not involved in any previous level of review or decision making nor a subordinate of any such individual.
      ii. If deciding any of the following, are individuals who have the appropriate clinical expertise in treating the consumer’s condition:
         (i) An appeal of a denial that is based on lack of medical necessity.
         (ii) A grievance regarding denial of expedited resolution of an appeal
         (iii) A grievance or appeal that involves clinical issues.

   c. Take into account all comments, documents, records and other information submitted
by the consumer/legal representative without regard to whether such information was submitted or considered in the initial ABD/action.

d. Provide the consumer/legal representative a reasonable opportunity, in person or in writing, to present evidence and testimony and make legal and factual arguments. The PIHP/CMHSP must inform the consumer/legal representative of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and in the case of expedited resolution.

e. Provide the consumer/legal representative the consumer’s case file, including medical records, other documents, records, and any new or additional evidence considered, relied upon, or generated by the PIHP/CMHSP in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

f. Include, as parties to the appeal, the consumer/legal representative; or the legal representative of a deceased consumer’s estate.

g. Ensure Medicaid consumers with a Medicaid spend down receive Medicaid notices of appeal. MAHS, in conjunction with the designated FHO, will determine whether the consumer had active Medicaid during the time of the decision and is eligible for a State Fair Hearing. If a consumer with a Medicaid spend down is not eligible for a State Fair Hearing, he/she shall be given the rights to Non-Medicaid appeals processes.

h. Ensure services continue to be provided for consumers where applicable during a local/internal or state appeal process without interruption and regardless of the original authorization period, if the consumer requests to continue to receive the services during this process within the required timeframes.

i. Ensure Medicaid consumers may continue services, if the appeal request is received within 10 days of the notice of the ABD and includes a written request to continue services. If the ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP/ROSC Core Provider may recover against the consumer for services provided during the appeal and State Fair Hearing. (Recoupment must be consistently applied). If Advance Notice of Adverse Benefit Determination is not provided within required timeframes, the CMHSP/PIHP must reinstate services to the level before the action if services have been reduced, terminated, or suspended. If the PIHP/CMHSP continues or reinstates the consumer’s benefits, at the consumer’s/legal representative’s request, while the internal Appeal or State Hearing is pending, the PIHP/CMHSP must continue benefits until one of the following occurs:
   i. The consumer/legal representative withdraws the internal appeal or request for State Fair Hearing.
   ii. The consumer/legal representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the PIHP/CMHSP sends the consumer notice of an adverse resolution to the consumer’s/legal representative’s
internal appeal.

iii. A State Fair Hearing office issues a decision adverse to the consumer/legal representative.

j. If the Administrative Law Judge reverses a CMHSP/PIHP decision to deny, limit, or delay services that were not furnished while the appeal was pending the CMHSP/PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee’s health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

k. Ensure Non Medicaid/General Funds may continue at the discretion of the CMHSP until the outcome of the local appeal is completed, if a consumer requests a local appeal of a reduction, suspension, or termination within 30 days of the date of the notice and in that request includes a written request to continue services. If the local appeal is upheld, the PIHP/CMHSP/ROSC Core Provider may recover against the consumer for services provided during the local appeal and MDHHS Alternative Dispute Resolution Process. Recoupment must be consistently applied.

l. Ensure that staff provide notice of appeal rights through the use of/entry into the Consumer Notice Module in the regional electronic record, which will generate the appropriate forms as described in this policy. The only exception to this standard is in cases where staff/providers do not have access to the electronic record. In these cases, staff will provide paper/manual notice.

G. Resolution and Notification: Internal/Local Level Appeal Process:

1. The Internal/Local Appeal Coordinator will follow the receipt process for requests for internal/local appeals.

2. PIHP/CMHSP person(s) reviewing internal/local appeals will follow processes for conducting internal/local appeals.

3. Review of all internal/local appeals will include:

   a. A full investigation of the substance for the appeal and any aspects of clinical care involved.
   b. The opportunity for the consumer/legal representative/Authorized Hearing Representative to be present at the internal/local appeal and bring anyone they wish to testify on their behalf.
   c. The opportunity for the consumer/legal representative to submit written comments, documents, or other information before or during the internal/local appeal meeting.

4. Medicaid internal appeals shall be completed (including the disposition sent out) within 30 calendar days of receipt of the request for an internal appeal with exception of expedited appeals. The 30 day timeframe may be extended by up to 14 calendar days if the consumer/legal representative
request the extension or the PIHP shows that there is need for additional information and the delay is in the consumer’s best interest. If the PIHP extends the timeframe not at the request of the consumer, it must:

a. Make reasonable efforts to give the consumer/legal representative prompt oral notice of the delay,
b. Within 2 calendar days give the consumer/legal representative written notice of the reason for the decision to extend the timeframe and inform the consumer/legal representative of the right to file a grievance if he or she disagrees with that decision, and
c. Resolve the appeal as expeditiously as the consumer’s health condition requires and no later than the date the extension expires.

5. Non-Medicaid/General Fund local appeals shall be completed within 45 days of the receipt of the request for a local appeal with exception of expedited appeals.

6. Expedited resolution of local appeals shall be carried out in cases when, by request from the consumer/legal representative, the PIHP/CMHSP determines or the provider indicates (in making the request on the consumer’s behalf or supporting the consumer’s request) that following the standard timeframe could seriously jeopardize the consumer/applicant’s life, physical or mental health or ability to attain, maintain, or regain maximum function.

7. Medicaid Expedited Appeals: The expedited internal appeals for Medicaid beneficiaries must be resolved and notice of disposition given no later than 72 hours from the request. In emergent situations, the timeframe to make expedited decisions will be made on an immediate basis where applicable, based on clinical judgment of a consumer’s needs. As with appeals of reductions, suspensions or terminations, the consumer’s services will continue until a decision is made, if requested within 10 days of ABD.

8. For expedited resolution of Medicaid internal/local appeals, the PIHP/CMHSP may extend the 72 hour notice of disposition time frame by up to 14 calendar days if the consumer/legal representative requests an extension or, if the PIHP/CMHSP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the consumer’s best interest. (Justification for the extension must be documented).

9. If the request for an expedited resolution of a Medicaid internal appeal is denied, the PIHP/CMHSP must:
a. Transfer the internal appeal to the timeframe for standard resolution or no longer than 30 calendar days from the date the PIHP/CMHSP received the appeal;
b. Make reasonable efforts to give the consumer/legal representative prompt oral notice of the denial for and expedited appeal; send the consumer/legal representative written notice of the denial for an expedited appeal within two (2) calendar days;
c. Inform the consumer/legal representative of their right to file a grievance for denial of an expedited appeal.

10. For Medicaid internal appeals, if the CMHSP/PIHP reverses a decision to deny authorization of services that the consumer received while the appeal was pending, the CMHSP/PIHP must pay for those services.

11. Non-Medicaid/General Fund Expedited Appeal

a. If psychiatric inpatient services are denied for Non-Medicaid/General Fund consumers, the consumer/legal representative must be informed of their right to the LDRP, with the decision from that process to be reached within 3 business days.
b. If the CMHSP does not recommend hospitalization and an alternative service requested by the consumer/legal representative is denied, the CMHSP must inform the consumer/legal representative of his/her ability to access the LDRP. The decision from that process for these persons must be reached within 3 business days.
c. The CMHSP must communicate the decision of the LDRP and inform the consumer/legal representative of the right to access the MDHHS Alternative Dispute Resolution Process, if unsatisfied with the outcome of the LDRP.

12. Medicaid Internal Appeal – Notice of Resolution: A written letter of resolution shall be provided to the consumer/legal representative/AHR within 30 calendar days of the receipt of the request for internal appeal. The written resolution must include:

a. The results of the resolution and the date it was completed.
b. When the appeal is not resolved wholly in favor of the consumer, the notice of disposition must also include notice of the following:
   i. The consumer’s right to request a State Fair Hearing and how to do so.
   ii. The Right to request to receive benefits while the State Fair Hearing is pending and how to make the request.
   iii. The potential liability for the cost of those benefits, if the
hearing decision upholds the PIHP’s ABD.
iv. The right to contact Customer Services or the Office of Recipients Rights.

c. If the consumer/legal representative continues to receive the service pending the appeal, the consumer may have to repay the cost of the service. This may happen if:
i. The proposed suspension, reduction or termination of services is upheld in the appeal decision.
ii. The consumer/legal representative/AHR withdraws their appeal request.
iii. The consumer/legal representative/AHR does not attend the appeal.

13. Non-Medicaid/General Fund – Notice of Resolution: At the completion of a LDRP, the CMHSP must provide the consumer/legal representative written notification of the LDRP decision and subsequent avenues available, if he/she is not satisfied with the result, including the rights of consumers without Medicaid coverage to access the MDHHS Alternative Dispute Resolution Process after exhausting the local dispute resolution procedures.

J. State Level Appeal Process:

1. State level appeal processes for Medicaid and Non-Medicaid/General Fund consumers will be followed in accordance with federal and state requirements, per the current Michigan Administrative Hearing System Pamphlet and the MDHHS contract.

2. Medicaid:

a. After the internal appeal has been exhausted, a Medicaid consumer may request a State Fair Hearing, if the PIHP/CMHSP upholds the ABD. If the PIHP/CMHSP does not adhere to the notice and timing requirements in 42CFR 438.408, the consumer is deemed to have exhausted the internal appeal process and may initiate a State Fair Hearing.

b. A consumer must request a State fair hearing not later than 120 calendar days from the date of the PIHP’s/CMHSP’s notice of resolution.

c. The parties to the State Fair Hearing include the PIHP/CMHSP as well as the consumer/legal representative or the representative of a deceased consumer’s estate.
d. If ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP may recover against the consumer for services provided during the internal appeal and State Fair Hearing.

e. If the Administrative Law Judge at the State Fair Hearing level reverses a CMHSP/PIHP decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CMHSP/PIHP must authorize, pay for, and/or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

3. Non Medicaid/General Fund:

   a. After exhausting the local dispute resolution procedures, a Non Medicaid/General Fund consumer may request the MDHHS Alternative Dispute Resolution Process if the CMHSP upholds the action.

   b. A consumer must request the Local Dispute Resolution Process within 10 days from the written notice of the LDRP outcome.

   c. MDHHS shall review all requests within two business days of receipt.

   d. If MDHHS agrees with the CMHSP, the consumer may be required to pay for the extended services.

K. Family Support Subsidy Appeals

   1. All Family Support Subsidy appeals are handled by the local CMHSP.

   2. If a Family Support Subsidy Application is denied or services are terminated, the CMHSP will send the consumer's parent or legal representative a memorandum stating the reason for ineligibility and timeline for an appeal.

   3. If the parent or representative had an income increase that resulted in the family exceeding the statutory limit, and the parent or representative did not notify the CMH within two weeks of the change, the CMHSP shall send the parent or representative a memorandum explaining that the subsidy will be terminated, and any amount illegally received will be repaid together with interest as provided in Administrative Rule 330.1621. Repayment of these services will be arranged through the state FSS program.

   4. The parent/legal representative has 60 days to file an appeal from the date of the notice of ineligibility or termination. This may be done by letter or by a local Non-Medicaid appeal form available from the local CMHSP.
5. If the parent/legal representative requests an FSS appeal within 60 days, the CMHSP shall conduct an FSS hearing in the manner provided for a contested case hearing under Chapter 4 of the Administrative Procedures Act of 1969.

6. Using a “reasonable person” standard, the CMHSP determines if the denial or termination of the subsidy will pose an immediate and adverse impact upon the consumer’s health and safety. If so, the CMHSP hears the appeal within one business day. If not, the CMHSP follows the steps below.

   a. Sends parent or legal representative notice of receipt of appeal, indicating the following information about the scheduled hearing:

      i. Date, hour, place, and nature of hearing.

      ii. Statement of legal authority and jurisdiction under which the hearing is to be held.

      iii. Reference to statutes and rules involved, and

      iv. Short and plain statement of the matters asserted.

      v. If the timeline for an appeal was exceeded, sends a response indicating that the appeal was not received within two months of the action, and no further appeal rights are warranted.

L. Record Keeping Requirements:

   a. PIHPs shall ensure the maintenance of records for second opinions, local appeals, and copies of State appeals. The PIHP must review the information as part of its ongoing monitoring procedures. The record of each appeal must contain, at a minimum, all of the following information:

      i. A general description of the reason for the appeal.

      ii. The date and time the appeal was received.

      iii. Whether an expedited appeal review was requested

      iv. The date of each review or, if applicable, review meeting.

      v. Evidence that individuals who made the decisions on appeals were not involved in any previous level of review or decision making, nor are subordinates of any such individual.

      vi. Resolution at each level of the appeal, if applicable.

      vii. Date and time of resolution at each level, where applicable.
viii. Name of the covered person for whom the appeal was filed.

b. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.

**M. Performance Improvement**

1. Each local board will maintain a log of second opinion requests, Family Support Subsidy appeals, LDRC requests/resolutions, MAHS Administrative Hearing requests/resolutions, and MDHHS Alternative Dispute Resolution requests/resolutions. This information will be reported and reviewed by the PIHP UM Committee quarterly and provided to the PIHP Director of Quality and Compliance quarterly.

2. Quarterly aggregate reports of appeals data shall be provided by the PIHP Director of Quality and Compliance/PIHP Utilization Management Committee Chair to the PIHP Clinical Performance Team as the PIHP Quality Assurance and Performance Improvement Program (QAPIP) entity for their review and recommendations on any trends or improvement opportunities.

**VII. REFERENCES**

<table>
<thead>
<tr>
<th>Reference:</th>
<th>Check if applies:</th>
<th>Standard Numbers:</th>
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<tbody>
<tr>
<td>Medicaid Managed Care Rule 42 CFR Parts 432, 433, 438 et al.</td>
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<td>Michigan Mental Health Code Act 258 of 1974 as amended</td>
<td>X</td>
<td>Section 100b, 409(4), 705</td>
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<tr>
<td>MDHHS/PIHP Medicaid Contract and Attachments</td>
<td>X</td>
<td>4.4.1.1 Person Centered Planning Practice Guideline; 6.3.1.1 Grievance &amp; Appeal Technical Requirement Process</td>
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<td>MDHHS Medical Services Administration (MSA) Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings.</td>
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<td>MDHHS clarifications</td>
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<td>CMHPSM Office of Recipient Rights Policy</td>
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I. PURPOSE
Establish the service and treatment philosophy of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) is based on the values and principles of the person-centered planning process, establish standards and applications for person-centered planning, and ensure compliance with the requirements governing service delivery established by regulatory and/or funding bodies.

II. REVISION HISTORY

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<tr>
<td>2005</td>
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<td>2011</td>
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<td>Revised to reflect the Quality Improvement Council’s (QIC) quality improvement plan.</td>
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<td>2018</td>
<td>5.0</td>
<td>Regional Review of Policy.</td>
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III. APPLICATION
This policy applies to all staff, students, volunteers and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY
It is the policy of the CMHPSM that all eligible persons are informed of their right to engage in Person Centered Planning at any time. All individuals who receive services shall have a plan outlining the individual outcomes to be achieved through various means of support and or services. The process by which a plan is developed shall be done in a way that is person centered as outlined in the standards of this policy.
V. DEFINITIONS

Assessment: The process for obtaining clinically relevant information about each individual seeking behavioral health care, treatment, or services. The information is used to match an individual’s need with the appropriate setting, service/program, and intervention. The systematic collection and review of data specific to an individual served. Data from assessments is used in the development of the Individual Plan of Service (IPOS).

Client Services Manager/Supports Coordinator: A designated individual responsible for assisting the individual in accessing needed supports and services. Activities include needs assessment, pre-planning, planning, coordinating, monitoring and evaluating the effectiveness of needed supports and services.

Community Mental Health Partnership of Southeast Michigan: The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program: A program operated under Chapter 2 of the Michigan Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Emancipated Minor: The termination of the rights of the parents to the custody, control, services and earnings of a minor which occurs by operation of law or pursuant to a petition filed by a minor with the Probate Court.

Emergency situation: A situation where the individual can reasonably be expected within the near future to physically injure himself, herself, or another person; or is unable to attend to the need for food, clothing, shelter or basic physical activities, and this inability may lead in the near future to harm to the person or to another person; or, the individual’s judgment is impaired, leading to the inability to understand the need for treatment or support which can be expected to result in physical harm to self or others. The sudden disruption of the person’s system of supports may constitute an emergency if s/he is unable meet basic needs and maintain health and safety in the absence of these supports.

Family-Centered Planning Process: An approach that recognizes the importance of the family and the fact that supports, and services impact the entire family. Therefore, in the case of minors, the child/family is the focus of service planning, and family members are integral to the planning process and its success.

Family member: A parent, stepparent, spouse, significant other, sibling, child, or grandparent of a primary recipient, or an individual upon whom a primary recipient is dependent for at least 50 percent of his or her financial support.

Legal Representative: Legal Representative - A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Individual Plan of Services (IPOS): A written individualized plan of supports and services directed by the individual as required by the Mental Health Code. This plan may include both support and treatment elements.
Interim IPOS: A time-limited plan, not to exceed 90 days (best practice within 30 days), that needs to be completed in because an annual re-assessment and/or annual IPOS has not been completed, in order to prevent any gaps of the continuation of services that remain medically necessary until an annual re-assessment and/or annual IPOS can be completed.

**Minor:** A person under the age of 18 years.

**Person-Centered Planning:** A process for planning and supporting the individual receiving services that builds upon the individual’s capacity to engage in activities that promote community life and that honor the individual’s preference, choices, and abilities. The person-centered planning process involves family, friends and professionals as the individual desires or requires. The process is directed by the person and focuses on his or her desires, dreams, strengths and needs for support.

**Reassessment:** Ongoing data collection which begins at initial assessment, comparing the most recent data with the data collected at earlier assessments. Consumer may be reassessed for many reasons. These include: evaluation of his or her response to care, treatment or services; response to a significant change in status and/or diagnosis or conditions; request from the consumer and/or the consumer’s representative for a change in the supports and services authorized in the most current IPOS; as required to satisfy regulatory requirements (i.e. for eligibility determination for a Children’s Waiver, or Habilitation Support Waiver (HSW); as required for the determination of ongoing eligibility for supports and services based on a managed care authorization period. In addition, a reassessment of need shall occur during a routine periodic review or annual review prior to the revision of an existing IPOS.

**Regional Entity:** The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, developmental disabilities, and substance use disorder needs.

**Specialty Assessments:** Assessments and evaluations resulting from referrals following an initial biopsychosocial assessment, a reassessment, or as authorized in an IPOS. Included are psychiatric evaluations, nursing assessments, occupational therapy assessments, physical therapy assessments, speech and language assessments, behavior treatment assessments, nutrition assessments, and psychological testing. Autism-related screens and assessments also are considered Specialty Assessments.

**Significant Change:** A Significant Change occurs when a consumer experiences a change in functioning or circumstances potentially impacting service needs. The assessment update will focus on the consumer’s current need and may result in change to the Individual Plan of Service (IPOS) that may add new outcomes, amend existing authorizations for services or supports, or add authorizations for new supports or services. A Significant Change may be the result of a positive change so that the consumer needs less service or less restrictive care, such as mainstreaming to primary care as a medical home. Or, consumer may be at risk of, or experiencing, a decrease in functional ability or a loss of supports necessary to maintain functioning. A Significant Change in functioning may result from an acute illness or injury or as a result of a chronic condition. Additionally, environmental change may lead to the need for substantial modifications in service delivery.

**Examples of Significant Change that would initiate a reassessment include:**
- A sentinel event
- Change in level of care, treatment, or service need. For example, transition to a less independent service (more restrictive service) or transition to a more independent services (less restrictive service)
- Legal status change (involvement with the law enforcement/court action, being charged with a crime or the victim of a crime, or guardianship awarded or modified)
- Significant health, nutrition, safety change or hospitalization (new diagnosis medical diagnosis, nutritional issues including significant weight loss/gain or new mobility issues).
- Loss of parent, significant other or caretaker that effects treatment
- Introduction of protective devices (including a helmet, gait belts, door/bell alarms, or bed rails)
- Introduction of a behavior plan that includes restrictive or intrusive techniques and/or introduction of medication when prescribed solely for the purpose of behavior control not resultant of a documented diagnosis of a psychotic, mood or anxiety disorder
- Introduction of new medical equipment
- When a consumer has a major change in presenting conditions or disabilities
- When a consumer reaches the age of majority
- If a consumer experiences abuse/neglect or other major trauma
- If a new diagnosis is given.

VII. Standards

A. All persons must have a current Individual Plan of Services (IPOS). An IPOS must be reviewed and completed annually. A completed IPOS means the IPOS goals and objectives are written and agreed upon, the plan is signed by all parties (including the consumer/legal guardian) and the authorization is completed.

B. Consumers who are enrolled in a C waiver program (Habilitation Waiver, Children’s Waiver, Children’s SED Waiver) cannot have an IPOS that exceeds 365 days. Ideally all consumers served by the CMHSP/CMHPSM would have a new plan at least annually. For those consumers not enrolled in a waiver, if a new IPOS cannot begin by the expiration date of the current IPOS, and the continuation of services needs to be ensured, an extension of the current IPOS and current authorization must be completed and submitted for supervisory/UM approval. The reasons for the need of such an extension need to be clearly documented in the consumer record. Depending on the reasons, such an extension would be conducted as an engagement plan or interim plan. The start date of the Interim Plan of Service will be the day after the current IPOS expires, and such an extension cannot exceed more than 90 days.

C. Each individual has the ability to express preferences and to make choices with appropriate supports. The capacity for growth and choice shall be recognized in all persons. Individual choices and preferences shall always be honored, if not always granted.

D. The individual’s perceptions, expressions, thoughts, and experiences are the most valid avenue of relatedness.

E. Only the person him/herself can develop his/her potential. Person centered services and supports create a climate and context for that development.

F. Planning shall be based upon individual strengths and abilities and shall presume competence and assume readiness.
G. A person’s cultural background shall be recognized and valued in the decision-making process.

H. Planning shall promote the provision of services to children within the context of their family and to adults in the home of their choice.

I. Supports and services are provided with the goal of promoting meaningful connections through relationship, work, recreation and community involvement.

J. Services shall promote growth, maximum independence, and interdependence within the context of natural support systems, and community membership and recognition.

K. Community inclusion and participation include choice and control over living arrangements, relationship building, opportunities to contribute and be productive, and leisure and recreation.

L. Community accountability for services includes addressing health and safety concerns, assuring fairness, equity and privacy and assuring quality.

M. Professional services shall be made available to individuals as part of a full array of supports and services and provided based upon individual interest, preference and need. Professional services are offered in the context of providing resources and opportunities and will facilitate a climate of safety for growth.

N. Persons with legal guardians will be included in person centered planning. Wherever possible, guardians shall be educated regarding the values and principles of person centered planning and encouraged to offer the person served maximum input and control over choices and decisions.

O. Parents and significant family member of minors shall participate in the planning process unless:
   1. The minor is fourteen years of age or older and has requested services without the knowledge or consent of parent, guardian, or person in loco parentis within the restriction of the Mental Health Code.
   2. The minor is emancipated.
   3. The inclusion of the parents(s) or significant family members would constitute a substantial risk of physical or emotional harm to the person or substantial disruption of the planning process as defined in the Mental Health Code. Justification of exclusion shall be documented in the clinical record.

P. Persons with emergent or urgent needs, including those which present an imminent danger to self or others, or a health and safety risk, shall receive those immediate services needed to assure the person’s well being and stabilization of the situation. To the extent possible, person centered values and principles will be honored in the provision of emergency services, although the complete Person Centered Process may not be feasible. Limitations of choice and rights will be only those sufficient and necessary to assure the health and safety of the person and others. Following stabilization of the situation, should the person continue in services, the person shall be invited to participate in Person Centered Planning.

Q. An Individual Plan of Service for persons receiving Intensive Crisis stabilization and/or Crisis Residential Services must be developed within 48 hours. The use of interim plans does not apply in these situations.
R. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release.

S. Persons expressing a need or making a request for a single support or service, or short-term services, will be offered services based upon the principles in this policy, assuring maximum choice, control and individualization of services. Persons will be invited to participate in Person Centered Planning, if desired. This may include future planning for children or adults living with family members, particularly when it is anticipated that additional supports will be needed over time.

T. Requests for Interim Plans: In case where an interim plan needs to be completed in order to continue medically necessary services until an annual re-assessment and/or annual IPOS can be completed, the following shall apply:
   A. The reason for the interim plan is clearly stated in the plan. Examples include engagement issues with the consumer, or the need to reschedule a re-assessment/IPOS meeting.
   B. Interim plans need to have a goal, outcomes, and the amount scope and duration of the services provided.
   C. The interim IPOS goals shall state what goal(s) will be accomplished specifically for that interim period of time, and what services will be needed to accomplish that goal. Examples include:
      o Assisting the consumer to re-engage with their CMH clinical team (loss of contact).
      o Interventions staff need to provide or ways they would assist with overcoming barriers to care for the consumer.
      o Goals specific to the consumer they would continue to work on during the interim (such as abilities they are learning through the using of CLS/skill building services that would continue the interim, or their care needing to be maintained in their living setting).

S.U._____

V. All persons expressing complex needs which involve multiple life domains and supports, services or treatment of an extended duration will receive supports and services through the Person Centered Planning Process.

T.W. For consumers receiving only substance use disorder treatment services, a recovery plan will be developed using Person Centered Planning principles.

U.X. Needs Assessment and Pre-Planning
   1. Before a person-centered planning meeting is initiated, an assessment of needs and a pre-planning meeting occurs. The needs assessment can occur on the same day or on a separate day of the pre-planning meeting. The pre-planning meeting cannot occur on the same day of the person-centered planning meeting. Ideally, a pre-planning meeting will occur 30 days prior to the planning meeting so that persons have sufficient time to consider their outcomes and invite those they may wish to attend their planning meeting. Persons are not required to have a 30-day time frame but will be given the choice in the amount of time they need between their pre-planning and planning meetings.
   2. The person is offered the opportunity to express needs, desires and preferences. Any needed accommodations for communication are provided. Pre-planning begins with the person’s initial contact with the local CMHSP. Information gathering
activities include eliciting information with regard to the person’s needs for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation and recreation, as defined by the Mental Health Code.

3. The needs assessment and planning process shall acknowledge that the person and those closest to him/her know the individual best. Information may be gathered from family, friends, co-workers, teachers and current service providers with the permission of the person.

4. Potential issues of health and safety are explored and discussed to determine if there is a role for other professionals to provide additional information, opinions or recommendations for supports and services. Such services are arranged for and provided based upon needs assessment and pre-planning activities.

5. Persons will be offered an opportunity to develop a crisis prevention plan.

6. As a result of health or safety concerns, or court ordered treatment, limitations may exist for individual choice. Within the context of any such limitations the individual will be offered the maximum input and control over decisions.

7. If the individual currently has a legal representative, the level of and/or the appropriateness of the legal restriction such as an Alternative Treatment Order (ATO), shall be reviewed in light of considering the expressed desire for independence. As a result, the IPOS may include steps and activities for the consumer to pursue that could lead to a lessening or removal of the legal restriction.

8. Valued outcomes are identified from the perspective of the individual.

9. Potential sources of services and support, including natural, generic, and specialized supports are explored fully with the person. Initial expectations of the service delivery system are identified. Satisfaction with any current services and supports is explored.

10. Persons are assisted in exploring their support network to identify who they would like involved in the person-centered planning process, and are offered support and assistance in inviting those persons to participate. Persons are also offered the opportunity to identify which professionals or support providers they would like to participate in their planning meeting. Persons will be educated on and offered peer support services where applicable.

11. Within the context of support for communication needs, and education regarding potential options, the person is given ongoing opportunities to express preferences and make meaningful choices. Choice making shall include adequate information regarding options available. Opportunities for exploration, dialogue and experimentation shall be provided. The service system shall provide education, supports and skill development when needed to support the person’s development of the ability to make meaningful choices. The knowledge of those closest to the person regarding the person’s preferences shall also be honored and acknowledged.

12. The person is offered the opportunity to identify what information will be shared and discussed during the planning meeting in the presence of all participants and what information should be discussed privately.

13. The person is also offered the opportunity to select a facilitator who will facilitate the meeting on his/her behalf. Ideally, this will be the person him/herself, an advocate, or a person trained specifically for the task. The option of an external independent facilitator will be included in these choices.

14. Persons are offered the opportunity for self-determination arrangements as an alternative in arranging their supports and services.
established to ensure that the person is the focal point, that the process is not “professionalized” and that the meeting is conducted in the manner the person chooses.

2. The person, and those he or she has selected, explore the desired future and valued outcomes, and determine what resources and supports are needed to support those outcomes. The focus is on strengths, abilities and building on the capacities of the person.

3. The person’s preferences, choices and abilities are honored in the planning process. The role of professionals is to consult and make recommendations and contributions based upon their expertise and their knowledge of the person. The person retains the right and responsibility to make decisions, and to determine who will be a part of his/her decision-making process.

4. The person’s dreams, desires and preferences are captured in short-term and long-term outcomes which are consistent with the person’s values.

5. Exploration of resources and the building of a support plan are to be considered in this order:
   a. The person
   b. Family, friends, guardian, and significant others
   c. Resources in the neighborhood and community
   d. Publicly funded supports and services available to all persons
   e. Publicly funded supports and services available through the CMHSP/CMHPSM

   The development of natural supports (family, friends, and community) shall be an equal responsibility of the CMHSP and the person.

6. A written individualized plan of supports and services shall be developed which includes those supports to be provided by natural supports, generic community supports, and the CMHSP service system. Specialized supports augment enrich and do not necessarily supplant those provided by an existing network of natural and community supports. The plan is specific as to the supports to be provided and who/how those supports will be delivered.

7. The plan or accompanying documentation will specify the rationale for deferring, not addressing or not providing any of the supports and services identified as needed or desired.

8. The plan will specify the CSM/Supports Coordination activities to be provided and the planned frequency.

W.Z. Service Provision and Follow-Up

1. Those implementing a new or changed IPOS, must be in-serviced within 30 days of the effective date. Documentation must occur within 1 business day of the training. The CMHSP and CMHPSM will provide ongoing monitoring to ensure this training occurs.

2. Supports and Services are provided as identified in the person’s plan and delivered by the providers of the individual’s choice wherever possible. Depending upon the preferences of the person and/or family, the CSM/Supports Coordinator will arrange for and coordinate the provision of supports identified.

3. Supports and Services remain focused on the person and his/her needs, rather than on program elements or slots.

4. The IPOS shall include an authorization for the amount, scope, duration, and frequency of the supports and services to be provided.

5. Each individual shall be provided a copy of her/his IPOS no later than 15 business days following the completion of the IPOS. This copy shall include the amount, scope, duration, and frequency of the supports and services that were
authorized for the individual.

6. Persons are provided with opportunities to provide ongoing feedback regarding their individual supports and services. These mechanisms include both informal feedback through persons providing or monitoring supports, formal satisfaction and outcome measurement processes, and problem resolution/complaint processes.

7. Planning is an ongoing process. Consumers may experience significant changes in functioning or circumstances potentially impacting service needs. The assessment update will focus on the consumer’s current need and may result in change to the Individual Plan of Service (IPOS). Services are tailored or adjusted over time based on changes in needs or preferences. The plan shall be updated and amended as frequently as needed. The person will be provided the opportunity for a person-centered planning meeting no less than annually.

8. The IPOS identifies the frequency that it will formally be reviewed for effectiveness and reviews of the plan are completed at those intervals.

9. The CSM/Supports Coordinator reviews the IPOS and monitors the provision of supports and services at a frequency identified in the planning process to assure implementation and to assess the effectiveness of supports in achieving the outcomes identified.

X.AA. Dispute Resolution/Appeal Mechanisms

1. If a person is not satisfied with his or her IPOS, the person, their guardian, or their legal representative may request a review of the IPOS to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

2. Persons have the right to access the local CMH appeals, rights and problem resolutions processes if they believe that:
   a. They have not received the opportunity for person centered planning
   b. They have believe they have been inappropriately denied a requested service
   c. They disagree with limitations that have been placed on choice or preference for health and safety reasons

VIII. EXHIBITS

EXHIBIT A: Process for Person-Centered Planning
EXHIBIT B: Engagement Examples
EXHIBIT C: Person-Centered Process Outcomes Statement Guidelines; Values and Rationale
EXHIBIT D: Outcome Improvement Exercise

IX. REFERENCES

Department of Community Health Person- Centered Planning Guideline –Attachment P.3.4.1.1 to the MDCH/CMHSP Managed Mental Health Supports and Services Contract
Michigan Renewed Habilitation Supports Waiver, Section 7: Person Centered Process, April 1996
MDCH-MDHHS Application for Renewal of the 1915(b) Specialty Supports and Services Managed Care Waiver.
MDCH-MDHHS Policy and Practice Guideline, Attachment P.3.4.4 to the MDCH-MDHHS/CMHSP Managed Mental Health Supports and Services Contract
Notes: PCP Policy Discussion for CPT:

Livingston’s feedback re: the PCP Policy revision:

V. Definitions:
Interim IPOS:

1. We think the interim plan should only be good for 30 days, to resolve the issues that prevented the new IPOS being done on time.

2. We think the interim plan should be NOT ALLOWED for Hab waiver consumers who need a NEW IPOS every 365 days.

Washtenaw’s Feedback:

We do not agree with the interim plan requirements. We would like a reasonable extension (no more than 90 days) to continue previous goals during that 90 days. The thinking behind this is if the family/individual does not want or cannot meet for a new Person Centered Planning meeting we should be allowed to create the interim plan and keep the previous goals in place as we can't change those goals/objectives without the individual/family being a part of the discussion.

Monroe Feedback:

For #1 I’d prefer we not prescribe 30 days for an interim in a regional policy since some of us may have different local practices. Maybe we can say up to 90?

For #2, as long as the interim is not cookie cutter of the previous IPOS (has new goals and services match those goals), the state auditors have accepted the interim as the new IPOS in meeting the 365 day requirements (the next full IPOS to be done would just be another new IPOS post interim), so again I wouldn’t want this to be prescriptive for all CMHs.
COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN

PROCESS FOR PERSON CENTERED PLANNING

I. VISION AND PURPOSE STATEMENT

The Community Mental Health Partnership of Southeastern Michigan (CMHPSM) is committed to ensuring that consumers have a process to develop a plan that moves the consumer along their recovery path that is inclusive of the people of most significance to them (family, guardian, friends, staff, etc...). This process is called Person Centered Planning (PCP) which is a dynamic process that allows for the flexibility to adjust plans as lives change. It is the role of the case manager and/or supports coordinator (CM/SC) to engage with the consumer to identify what is most important them. This will provide key information for establishing the outcomes of the consumer’s Individual Plan of Service (IPOS) which will result in a service authorization. It is with the delivery of these services that directly connect to the consumer’s outcomes that will assist the consumer in accomplishing their recovery plan.

II. DEFINITIONS

**Community Mental Health Partnership of Southeast Michigan:** The Affiliation of Community Mental Health Authorities consisting of Lenawee, Livingston, Monroe and Washtenaw counties.

**Individual Plan of Service (IPOS):** The consumer driven individual plan of service that is created from the Person Centered Planning Process.

**Peer Support Specialists:** A certified employee from one of the CMHPSM Affiliate partners who has or currently is receiving services who can assist consumers in navigating the system and provide personal experience to assist in engaging consumers onto their recovery path.

III. PHASES OF PERSON CENTERED PLANNING

The person centered planning process is a series of phases that shall be followed in order to develop the most comprehensive and meaningful plan for the consumer. The Case Manager/Supports Coordinator (CM/SC) is the staff that will coordinate the process to ensure the inclusion of the consumer. The CMHPSM’s value is that in order to engage and build a relationship with the consumer, the following phases should be addressed face to face and with enough time to provide information and education about the process to achieve the best outcomes.

**a. Engagement & Pre-Planning:** The CMHPSM believes that in order to create a meaningful plan with a consumer, relationships shall be developed with the consumer. Based on direct feedback from consumers this should be done by starting the process where the consumer is at in their recovery. This may be
very different for someone brand new to the system than for someone who has been in the system for a while. See **EXHIBIT B** for examples on engagement.

i. For a new consumer, this phase shall be done face to face and engagement and pre-planning may begin immediately. If a person new to the system is either in crisis, unfamiliar with options or unclear on what to plan for, the CM/SC may consider an interim plan at this time.

ii. For an existing consumer this phase is preferably a Face to Face session that begins a minimum of 3-4 weeks prior to the actual Person Centered Planning (PCP) meeting. Regardless of historical requests from consumers and/or families, they should always be provided the options of how this phase can be completed with the face to face option provided first.

1. For existing consumers where you know the pre-planning takes longer and or there is a possibility the Person Centered Plan will not be completed within the expiration date, the CM/SC shall start this phase earlier. An interim plan is not considered a viable option due to timing.

iii. The Engagement/Pre-Planning phase can be done simultaneously with the Assessment phase that follows.

iv. CM/SC shall give the consumer an opportunity to review the process of person centered planning again and offer a copy of their previous plan if they would like one. This applies to existing consumers.

v. CM/SC shall begin to address the items on the PCP Pre-Mtg page.

vi. CM/SC shall remind and encourage the consumer to invite whomever they would like to their meeting. The more people that know the consumer, the more comprehensive the plan will be.

vii. CM/SC shall ask the consumer if they would like to have an independent facilitator. This can be arranged through a panel of people available.

viii. CM/SC shall provide information about developing a crisis plan and psychiatric advanced directives. The CM/SC shall also inquire about whether or not the consumer already has and advanced directive, and if so, request a copy for the consumer file.

ix. CM/SC shall make available Peer Support Specialists whenever possible at this phase of the process to assist with engaging the consumer. If the consumer is new to the system, this will allow for a more personal interaction from someone who has had to navigate through the system.

b. **Assessment:** This is a critical phase of the PCP process as it determines the consumer needs and supports the CMH will provide for a level of care based on eligibility and medical necessity criteria. These determinations will assist in determining what CMH services to deliver (i.e. specialized residential, community living supports (CLS), supported employment, outpatient treatment, dialectical behavior therapy etc...). It is during the assessment phase that **ALL** applicable
assessments (New or Updated Bio/Psycho/Social, Personal Health Review, CLS, Occupational Therapy, Physical Therapy, Speech etc…) shall be completed. Information from these assessments shall result in recommendations for outcomes to be included in the IPOS. In addition, Health and Safety issues shall be included in the plan if identified.

i. For a new consumer, the assessment shall occur within 14 days of the request for service and be completed in a face to face session.

ii. For existing consumers, assessments shall be completed in a Face to Face session which occurs at a minimum of 3-4 weeks prior to the PCP meeting.

1. Ancillary assessments (OT, PT, Speech etc…) not able to be scheduled prior to the PCP meeting and/or occur right up to the PCP meeting date should not postpone or push back the date of the PCP meeting.

iii. The Assessment Phase may be completed simultaneously with the Engagement/Pre-Planning phase.

iv. CM/SC shall request from the consumer the inclusion of any necessary people (family, direct care staff, friends, nurses etc…) in completing the assessments to ensure all areas of the person’s life are addressed.

c. Getting Ready for the Plan: It is this phase where the CM/SC and the consumer and/or family meet to discuss the results of the assessments and to begin the discussion about the possible outcomes they would like to have developed for their PCP meeting. This could be done with the Independent Facilitator if one is chosen. It is also at this phase where further engagement and relationship building occurs.

i. CM/SC, Independent Facilitator, Consumer and or family may draft preliminary outcomes to provide during the PCP meeting.

ii. CM/SC shall review any possible service needs with the supervisor to obtain preliminary approval.

d. Person Centered Planning Meeting: This is the phase where the past year’s accomplishments are celebrated. A facilitated process (MAPs, PATH etc…), if chosen, is used to determine what the consumer would like to address the next year to move them along their recovery path. There may be long term and/or short term outcomes. Whomever the consumer would like to attend this meeting is welcome and the more people that know the person the more likely it is that a comprehensive plan will result.

i. The PCP shall be a face to face meeting that shall happen no less than annually. It shall happen more frequently when requested by the consumer or when a significant change occurs for the consumer.

ii. Items that have been addressed and/or recommended during the assessment phase shall be discussed.
iii. If there are additional things addressed during the meeting that have not been addressed during the assessment, they shall be documented.

iv. The final result of the meeting shall be to have established outcomes/goals that the consumer would like to achieve. These goals may be either short term or long term. Regardless of short or long term outcomes/goals, they shall be measurable. Measurable outcomes/goal shall be able to inform the consumer when they have achieved the outcome/goal. **EXHIBIT C and D** for tools on developing outcomes.

v. Outcomes shall outline the following for each service that will be authorized.

1. **Amount**: how much of a service will be used (i.e. 30 minute CM/SC contact)

2. **Scope**: what is the purpose of the service (i.e. monitor achievement of the PCP outcome, has the consumer learned a new skill and applied it to gain employment or practiced making a lunch and limited verbal prompts were needed). Was there improvement or regression from the last contact.

3. **Duration**: how long will this service be provided (i.e. one month, 30 days, 90 days, etc…)

vi. Outcomes shall differentiate between the role of natural supports (family, friends, community members), CMH supports (CM/SC, therapist, OT, PT etc…) and Provider Support (Community Living supports, Supported Employment etc…) in helping the consumer achieve their recovery plan.

   1. Outcomes that outline provider supports shall be explicit in the role of the provider staff in the areas of but not limited to self care, transportation, managing of funds, addressing health and safety and or community involvement.

   **On-Going Monitoring**: It is important that consumers know if they are achieving their outcomes. The CM/SC shall routinely review with the consumer and or family the progress they are making on their goals. It is at this time that if there have been changes in a consumer’s life, the IPOS shall be revised to reflect the change. Since consumers’ lives change and are not static so shall the IPOS outcomes. The IPOS shall be adjusted whenever needed. On-going monitoring shall occur routinely to ensure the services and supports being provided are delivering the desired results.

   i. CM/SC shall complete a Periodic Review whenever a significant change occurs with a person’s life or at least every 6 months.

   ii. The Periodic Review shall be the summary of information from the consumer/family, progress notes that demonstrates the consumer’s progression towards achieving their outcomes and any other necessary documentation.
iii. The Periodic Review shall reflect what has changed in the person’s life and if the person has made progress or not made progress on their outcomes. Any additions/deletions or changes to outcomes shall be reflected in the Periodic Review.

iv. Outcomes in the IPOS shall be updated whenever needed throughout the year.

v. Progress Notes shall be the document used to demonstrate that the services authorized are being delivered. The services documented in a progress note shall directly be related to an outcome. Progress on the outcome shall be documented based on the services delivered and the interventions used.
Engagement Examples

The following are examples a CM/SC can use in working on engagement through the Person Centered Planning Process.

a. Based on direct feedback from consumers: Many consumers have been introduced to Community Mental Health (CMH) for the first time when they were in crisis. It was at that time they were asked to develop a plan based on their hopes, dreams and wishes for the future. This may not be the best time to do this given the person may be just trying to get through the day. Developing a plan that addresses the person trying to get through the day may be more appropriate. That outcome may only be applicable for a few weeks, however with the flexible planning process; a new outcome can be established to reflect the new place in the consumer's recovery.

   a. It may be at this time if the person is new to the CMH system that an interim plan be developed that focuses on engagement and/or becoming stable and not in crisis.

   b. Once the person has become stable, the CM/SC can work with the consumer on what would be good short term outcomes. Then build towards long term outcomes.

b. Another example is: A consumer may have been living with their family and not receiving CMH services but are now in need of services. Asking that consumer to go into a meeting to discuss what their plans are when they are not even aware of what is available or what the process is may cause trauma to that consumer and/or family. What may be more appropriate is to begin the process in a phased approach. It may mean that there are several meetings with the consumer and or family. An outcome could be written in the meantime to address where the family and consumer is at in their engagement process. This will work towards engagement and relationship building which allows the CM/SC to have the discussion of what they are looking for in the future.
“Outcome” Defined:
The final consequence of an action or activity, the end result; that which one wants to have take place; an eventuality; the outgrowth of a series of endeavors; the fruits of one’s labors; the impact of a process; the culmination.

1. **Consumer Quotes Plus**
   
   It is essential to use consumer / family quotes when they can be obtained, but it is often necessary for the clinician to augment them with the clarification, elaboration, and/or paraphrasing necessary to meet the guidelines listed below. This usually requires a conversation in which desired outcomes / goals are expanded upon, clarified or narrowed down. Getting to why a consumer desires a particular outcome can facilitate this narrowing down process if done sensitively and patiently.

   **Rationale:** IPOS outcomes provide guidance, context, focus and meaning to service activities, their steps, interventions and content. A consumer is more likely to be energized, fully participate and experience ownership in these services to the extent that they are seen as moving him or her closer to a desired end point that has been personally chosen. The more motivated consumers are to participate in their services, the more likely they will reach their desired results. When consumers reach their desired results, our primary organizational purpose has been achieved.

   To comply with DCH requirements, consumer quotes are to be used.

2. **Consistent**
   
   The outcome should be consistent with the consumer’s expressed desires, with those problematic areas identified in the most recent assessment(s) and with his or her readiness to make changes in those areas.

   **Rationale:** All that consumers may want for their mental health-related improvements / outcomes is not necessarily contained in their responses to our questions about their preferences, desires, dreams and goals. To realize the latter, they may need to advance to a place where, for example, their safety and health are ensured. Thus, it would be a disservice were we not to offer consumers opportunities to obtain support and services in all appropriate areas identified in a comprehensive assessment, outcome areas not already personally identified.

   All of our regulatory and accrediting organizations require that our clinical documents make clear that the plan of service flows logically from the assessment(s).

3. **Clear**

   The outcome / goal statement should be clear with little doubt about its meaning. It should be easily understandable to the consumer as well as to the clinician.

4. **Concrete**
It should be concrete, that is, it should be specific and simple, preferably unique to the individual consumer.

5. **Observable / Measurable**

It should be observable and/or measurable. Future agreement should be able to be reached between the consumer, staff and other observers as to whether it had or hadn’t been achieved.

6. **“As Evidenced By” Statements**

It is often necessary to make outcome statements less vague, more concrete and, most importantly, more observable. This can be achieved by using and completing the phrase, “as evidenced by…” or “We will know the outcome had been achieved by observing that…” One can get at this by asking the consumer (or yourself) what will be different, what will you be able to do again, what will you be able to do more of, what will you be able to do for the first time, what will you continue to be able to do or what change will others notice once you’ve achieved this outcome.

The consumer’s self-report is an acceptable source of the evidence, but it should be the report of something concrete and observable. When assessing progress, it becomes the clinician’s responsibility to ask the consumer for this report if not offered spontaneously.

**Rationale for 3 through 6 above:**

Our primary focus is on helping consumers achieve their outcomes. It is important for consumers and those providing services and supports to have clarity regarding what their specific outcomes are, how close they are to achieving them and whether and when they have actually realized them. Only when outcomes are clear, understandable, specific, concrete and unambiguous can consumers (and their service and support providers) obtain this clarity. Only then can we maximize consumers' motivation to achieve their outcomes as well as their sense of accomplishment when they have been achieved.

7. **Realistic**

The outcome / goal should be realistic; if the consumer’s desired outcome is unrealistic, the clinician is encouraged to help the consumer add a more modest statement that is of a shorter term, more realistic kind, adding something that must first be accomplished as a prerequisite or stepping stone for accomplishing the more ambitious one.

8. **Outcome Achievement Timeframe**

A shorter term outcome / goal statement is better than a longer term one; it is fine if the consumer is interested in achieving a long term outcome / goal, but the statement should be supplemented with a shorter term one, one that is a step in the right direction. The statement should be reasonably achievable before or around the time of the next scheduled Periodic or Annual Review, usually in 6 – 12 months.

**Rationale for 7 and 8 above:**

Although it is important to honor and respect a consumer’s wishes, hopes and dreams, no matter how realistic or unrealistic they are, there are other values that come into play when establishing IPOS outcomes. Consumers can experience serious disappointment
when an outcome is well out of reach, disappointment that can diminish their interest in pursuing other goals, some of which may be well within reach. There is much research to confirm that more satisfaction, and thus, motivation can result from succeeding at a series of short term, less ambitious tasks than can result from many longer term, more ambitious ones.

9. **Positively Stated**

It should be stated in positive terms, as an increase in something, as demonstrating a new skill, as a success at something or as reaching a positive state (as evidenced by….), rather than as a reduction or ending of something undesirable. (See 10. below re maintenance outcomes.

**Rationale:** Striving toward a distinct, rewarding end is often more motivating and sustaining than moving away from something, however undesirable, where the alternative is uncertain, unfocused or ambiguous. Helping someone try to build on strengths is more self-affirming and respectful than helping someone try to overcome a weakness. The former has a positive focus; the latter has a negative one.

DCH requires us to develop service goals that are stated in positive terms.

10. **Maintenance Outcomes**

Maintenance of a consumer's level of self-sufficiency or independence in a specified area is acceptable if a thorough assessment reveals no capacity for improvement. Maintenance outcome / goal statements should otherwise be consistent with these guidelines.

**Rationale:** For an assessment to be truly strength-based, it is necessary to explore all potential areas for growth and improvement before concluding that only maintenance outcomes can be developed. Without this exploration, we may miss an opportunity for helping a consumer move toward greater self-sufficiency and experience its resulting satisfaction.

11. **Service Participation**

A statement about participating in a service, attending a program or having contact with a clinician, although important, is not an acceptable outcome / goal statement in itself; one must include a statement about what desirable outcome / goal / end result / impact is sought by way of this service involvement. (See outcome definition above)

Statements about participating in, having contact with or attending a CMH program or service are more appropriately written in the “Steps” or “Documentation” section rather than the “Outcome” section.

**Rationale:** Outcome statements emphasizing service participation may omit a necessary component of an “outcome” as defined in the guidelines: an end result; the impact of the service.

12. **Meaningful**

The ideal outcome statement will also be individualized, meaningful, real, motivating and even inspiring to the individual consumer or family.
**Rationale:** To have a goal that is uniquely one’s own, that is generated not by impulse or based on what others want for us, but through a thoughtful, inward-looking process, is more likely to be fully embraced and, thus, achieved.
## 20 Outcome Improvement Exercises

### Guide to Life Areas

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<td>25. End of Life</td>
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<td>26. Developmental Skills (mobility, expr. / rec. commun., range of motion, sens. integ.)</td>
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<td>27. Community Inclusion</td>
<td>8,11</td>
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**OUTCOME IMPROVEMENT EXERCISES**

***Current Outcome Example #1:***

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<td>Life Area #3 - Independent Living Skills</td>
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</table>

Rick wants to continue to live independently in his apartment; as evidenced by completing his daily chores, assisting with cooking dinner at least twice per week, taking his medications as prescribed, completing his laundry weekly and grocery shopping with his staff daily.

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed?</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>N</td>
<td>Could be improved if an actual quote from the consumer, parent or guardian was included, e.g., “I’d like to be on my own and stay in my apartment”</td>
</tr>
<tr>
<td>2. Consistent?</td>
<td>Y</td>
<td>(With consumer quote added, the outcome becomes consistent with his expressed desires – The clinician would need to determine if the outcome is also consistent with the most recent assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>Y</td>
<td>(It’s very clear what will serve as evidence that the outcome has been achieved: completing chores daily, cooking dinner twice per week, etc.)</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>(The statement meets the criteria of simple, specific and unique to this consumer – Including the specific daily chores would make it a little more concrete but this could also be stated in the “Steps.”)</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>Y</td>
<td>(It’s quite likely that observers could agree as to whether the consumer had or had not achieved the outcome)</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>Y</td>
<td>(Perfectly consistent with this guideline – The “as evidenced by” statement makes the outcome clear, concrete and observable)</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(It appears likely that the specific outcomes in the statement are within Rick’s reach)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(It appears that the outcome is not only realistic but that goals can be achieved in the short term)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(“completing,” “assisting,” “taking,” etc. are all positive terms)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>(The outcome does not appear to be a maintenance one)</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The outcome puts emphasis on the impact and end result of the services and interventions, not on Rick’s participation in them. Even though the statement includes his taking medication as prescribed, the point is that he will do so independently)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>If the clinician observed some enthusiasm on Rick’s part in relation to achieving this outcome, it could be concluded that it is personally meaningful</td>
</tr>
</tbody>
</table>

**Improved Version**

Rick states that he would “like to continue to be on my own and stay in my apartment.” Outcome achievement will be evidenced by completing his daily chores (making his bed, taking out the trash, straightening up the apartment), assisting with cooking dinner at least twice per week, taking his medications as prescribed, completing his laundry weekly and grocery shopping with his staff daily.
Current Outcome Example #2:

Jenny will develop some of the necessary skills in order to successfully live independently as evidenced by Jenny preparing a meal once per week. Jenny will be able to call in prescriptions, arrange transportation to pick them up and set up her med box for the week.

**Guideline**

Guideline Followed? Possible Improvement / (Explanation of why Y)

1. Consumer Quotes Included? N Could be improved if an actual quote from the consumer, parent or guardian was included, e.g., “I’d like to prepare some meals and handle my medications on my own.”

2. Consistent? Y (With consumer quote added, the outcome becomes consistent with her expressed desires – The clinician would need to determine if the outcome is also consistent with the most recent assessment)

3. Clear? Y (It’s very clear what will serve as evidence that the outcome has been achieved: preparing some meals, calling in prescriptions, etc.)

4. Concrete? Y (The statement meets the criteria of being simple, specific and unique to this consumer)

5. Observable / Measurable? Y (It’s quite likely that observers could agree as to whether the consumer had or had not achieved the outcome)

6. “As Evidenced By” Statement? Y (Perfectly consistent with this guideline – The “as evidenced by” statement makes the outcome clear, concrete and observable)

7. Realistic? Y (It appears likely that the specific outcomes in the statement are within Jenny’s reach)

8. Outcome Achievement Timeframe Y (It appears that the outcome is not only realistic but contains goals that can be achieved in the short term)

9. Positively Stated? Y (“preparing,” “calling in,” “arrange” and “set up” are all positive terms, vs. terms that denote that something will stop happening)

10. Maintenance Outcomes? NA (The outcome does not appear to be a maintenance one)

11. Service Participation? Y (The outcome puts emphasis on the impact and end result of the services and interventions, not on Jenny’s participation in them)

12. Meaningful / Individualized? Y If the clinician observed some enthusiasm on Jenny’s part in relation to achieving this outcome, it could be concluded that it is personally meaningful.

**Improved Version**

Jenny states that she “would love to be able to take care of more things without depending on others, like cooking and dealing with my meds.” This will be evidenced by Jenny preparing a meal once per week. Jenny will be able to call in prescriptions, arrange transportation to pick them up and set up her med box for the week.
Current Outcome Example #3:

**Life Area #4 - Health Care/Medical Issues**

“I will become more active in identifying and taking care of my physical health needs as evidenced by attending annual appointments to see my primary care physician, dentist and eye doctor.”

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed? Y or N</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>Y</td>
<td>Beginning with a quote, as this clinician did, is the best way to set the stage for any clarification or elaboration</td>
</tr>
<tr>
<td>2. Consistent?</td>
<td>Y</td>
<td>(With consumer quote, the outcome clearly becomes consistent with expressed desires – The clinician would need to determine if the outcome is also consistent with the most recent assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>Y</td>
<td>It’s very clear that if the consumer sees his or her primary care physician, dentist and eye doctor annually, a good part of the outcome will have been achieved. What could be made clearer is what is meant by “identifying” health needs and what the consumer will do proactively to follow through when an unexpected medical issue arises.</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>An example of the outcome being more clear and concrete would be to include a statement like, “The consumer will make an appointment with her primary care physician when symptoms of a moderate to serious medical condition arise.”</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>Y</td>
<td>It’s quite likely that observers could agree as to whether the consumer had or had not seen her doctors annually, but, without some clarification as suggested in 4., it would be hard to determine if the consumer had been successful in identifying and taking care of medical problems that arose between annual checkups</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>Y</td>
<td>The “as evidenced by” statement nicely addresses the specific result that is sought regarding annual preventive checkups, but should be extended to include something about how the consumer would be more active in her physical needs at other times.</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(It appears likely that the specific outcomes in the statement are within reach)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(It appears that the outcome is not only realistic but contains goals that can be achieved in the short term)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(“attending” is a positive term)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>(The outcome does not appear to be a maintenance one)</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The outcome puts emphasis on the impact and end result of the mental health services and interventions, not on participation in them.)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>If the clinician observed some strong interest on the consumer’s part in relation to achieving this outcome, it could be concluded that it is personally meaningful.</td>
</tr>
</tbody>
</table>

**Improved Version**

“I will become more active in identifying and taking care of my physical health needs as evidenced by attending annual appointments to see my primary care physician, dentist and eye doctor.” Further evidence of the consumer achieving the outcome will be contacting, making and keeping appointments with her primary care physician after identifying an unexpected physical health problem that is moderate to serious or lingering.
Current Outcome Example #4:

```
Life Area #5 – Finance / Money Management
Life Area #3 - Independent Living Skills
```

“I want to learn how to budget my money so I can earn my checks and pay my bills on my own.” Kelly’s impulse buying has caused her mother/guardian to retain Kelly’s checkbook. Kelly would like CSL support to help her with her budgeting as evidenced by reminding her daily to refrain from impulse buying, prioritize purchase needs weekly and encourage her to deposit checks in her bank account, taking $20 or so out first, if needed. By doing these tasks it will eventually help Kelly regain her checkbook.

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed? Y or N</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>Y</td>
<td>Quote nicely sets the stage for any expansion of the outcome statement</td>
</tr>
<tr>
<td>2. Consistent?</td>
<td>Y</td>
<td>(The consumer’s quote demonstrates that the outcome is consistent with his expressed desires – The clinician would need to determine if the outcome is also consistent with the most recent assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>y</td>
<td>It’s clear what will serve as evidence that the outcome has been achieved, retain her checkbook after demonstrating that she can deposit her check, budget her money, pay her bills, and prioritize her purchases. The outcome itself could be clearer if the CSL interventions were stated in another section</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>(The statement meets the criteria of simple, specific and unique to this consumer –)</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>Y</td>
<td>(It’s quite likely that observers could agree as to whether the consumer had or had not achieved the outcome)</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>y</td>
<td>It’s fairly clear what consumer behavior will serve as indicators that the outcome had or had not been achieved. Removing the CLS interventions (reminding and encouraging) would improve the “as evidenced by” statement.</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>y</td>
<td>The outcome may be within reach, but it’s hard to be certain about this. It may be more realistic to scale the outcome down to one or two of the tasks.</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>y</td>
<td>As with 7, the sought-after accomplishments may not be realistic for the short-term, e.g. six months</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(Obtaining her checkbook, paying bills, budgeting money and prioritizing purchases are all positive statements. The one negative one, refraining from impulse buying, is overshadowed by the positives)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>(The outcome is clearly not a maintenance one)</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>y</td>
<td>(The outcome includes the impact and end result of the services and interventions but blurs the focus by including various interventions)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>(Kelly’s strong interest in achieving this outcome is seen in the quotes, and thus appears personally meaningful)</td>
</tr>
</tbody>
</table>

**Improved Version**

“I want to learn how to budget my money so I can earn my checks and pay my bills on my own.” Kelly’s impulse buying has caused her mother/guardian to retain Kelly’s checkbook. Through CSL support, she will budget her money, deposit her checks, prioritize her purchases and eventually get her checkbook back from her mother.
Current Outcome Example 5:

Alex will increase his focus on academic subjects as evidenced by participating in weekly therapy sessions to focus on improving them and on behavioral control.

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed? Y or N</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>N</td>
<td>Needs a quote like, Alex says, “I want to do better in school but I can’t seem to keep my mind on the work.”</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(With the added quote, the outcome statement would be consistent with his expressed desires. The clinician would need to confirm that the outcome statement is consistent with the assessment results.)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>N</td>
<td>It’s not clear what is meant by “increase his focus,” “focusing on improving them” and “behavioral control.” Hence, the end result is far from clear.</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>N</td>
<td>It would be more clear and concrete if it said something like: “By improving his study and concentration skills, Alex will obtain a 2.5 grade average during the next semester.” The term “behavioral control would need to be made more simple/concrete, e.g., “Alex will be able to take fewer and shorter study breaks.”</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>N</td>
<td>See 4 above</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>N</td>
<td>The “as evidenced by” statement in the current example should contain as observable end result rather than his participation in and the focus of weekly group therapy sessions.  The latter would be more appropriate in the steps.</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(I’ll assume it is realistic to expect improved grades.)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(I’ll assume that the outcome has some likelihood of achievement in 6-12 months)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(Although the example could be clearer and more concrete, it is stated in positive terms, as an increase in something.</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>--</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>N</td>
<td>See 6 above</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>(If the clinician observed or elicited strong interest coming from Alex, the outcome could be considered personally meaningful. If it were imposed by others and Alex was not strongly aligned with it, its meaningfulness may be weak.)</td>
</tr>
</tbody>
</table>

Improved Version

Alex says, “I want to do better in school but I can’t seem to keep my mind on the work.” Alex will improve his grades in the next semester as evidenced by a 2.5 grade point average. He will also show improvement in his ability to concentrate on his school work as evidenced by his reporting that he is completing his homework before dinner and taking fewer and shorter breaks.
Current Outcome Example 6:

```
Life Area #8 - Vocational/Employment/Volunteer Work
```

“*I would like a part time volunteer position at the Humane Society as soon as possible to keep me busy during the week. I like working with animals and taking care of them.*”

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed?</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>Y</td>
<td>(Good quote directly from the consumer)</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(Obviously consistent with the consumer’s desires – We can probably assume consistency with the assessment’s employment section and with the consumer’s readiness to go after the volunteer position)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>Y</td>
<td>(The quote is clear and understandable enough that further clarification is not necessary)</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>(The consumer’s quoted outcome is simple, specific and individualized)</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>Y</td>
<td>(Perfectly observable – There should be no doubt among observers as to whether or not the outcome has been achieved)</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>Y</td>
<td>(In this case the quote is clear, concrete and observable, making it unnecessary to expand it with an “as evidenced by…” statement)</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(The clinician and consumer would need to determine if the outcome could realistically be achieved in the next 6 to 12 months)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(See 7)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(It is clear that the outcome is something the consumer would be moving toward, rather than something undesirable he or she would be avoiding or reducing)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>(The outcome is not related to maintaining a current level of functioning, but moving forward and improving the consumer’s situation)</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The quote focuses exclusively on an end result, not on service involvement as a means to achieve the end result)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>(The inclusion of the consumer’s quoted interest affirms the outcome as something personally meaningful)</td>
</tr>
</tbody>
</table>

Improved Version – No change

```
“I would like a part time volunteer position at the Humane Society as soon as possible to keep me busy during the week. I like working with animals and taking care of them.”
```
Current Outcome Example 7:

Julie will be able to learn, practice and implement PMTO strategies to get her children to cooperate and follow house rules and expectations as evidenced by the children responding positively to Julie’s requests and the family enjoying family relationships that are considerate and caring toward each other.

<table>
<thead>
<tr>
<th>Guideline</th>
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<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>N</td>
<td>Without quotes or evidence of paraphrasing, it raises the question of whether the outcome reflects alignment between Julie and the clinician</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>y</td>
<td>(It’s a bit unclear if the outcome is consistent with the consumer’s expressed desires – Likely but not obvious)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>y</td>
<td>(The outcome is fairly understandable and unambiguous – It would be a bit clearer if Julie’s self report or clinician observation or both were going to be used as evidence of outcome achievement and if an example or two of acting considerate and caring were included.)</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>y</td>
<td>(See 3)</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>y</td>
<td>(See 3)</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>Y</td>
<td>(Except for the improvements suggested in 3, the clinician made a pretty good effort to include something that would serve as evidence that the outcome had been achieved)</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(It’s likely that outcome achievement could realistically occur within 6 to 12 months)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(See 7)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(Everything is stated in positive terms, “will be able,” “cooperate and follow,” “responding positively,” etc.)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>(It’s clear that achieving the outcome will move the family to a new and improved state)</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The statement emphasizes the end result of the acquisition of PMTO skills)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>y</td>
<td>(See 2)</td>
</tr>
</tbody>
</table>

Improved Version

Julie says she is interested in learning how to improve her children’s cooperativeness. “I wish they would respond to my requests more positively and we could get along.” PMTO strategies will lead to more cooperation as well as enjoyable, considerate and caring family relationships as evidenced by an increase in enjoyable activities, an increase is compliments/words of praise/words of affection as reported by Julie.
Current Outcome Example 8:

```
“I would like Dean to participate in activities he enjoys and be part of the community” as evidenced by leaving his apartment at least three times weekly and participating in activities with others.
```

<table>
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<tr>
<th>Guideline</th>
<th>Guideline Followed?</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Quotes Included?</td>
<td>Y</td>
<td>(Parent/guardian quote nicely provides the context for the specifics that follow)</td>
</tr>
<tr>
<td>Consistent</td>
<td>Y</td>
<td>(The outcome follows directly from the quoted desires and likely follows from one of the issues identified in the assessment – What remains somewhat unclear is Dean’s personal interest, motivation and readiness to pursue the outcome)</td>
</tr>
<tr>
<td>Clear?</td>
<td>Y</td>
<td>(There is much clarity as to the meaning of this outcome)</td>
</tr>
<tr>
<td>Concrete?</td>
<td>Y</td>
<td>(There are good specifics that spell out how it will be concluded that the outcome was or was not achieved – A few examples of activities might have made the statement even more concrete.</td>
</tr>
<tr>
<td>Observable / Measurable?</td>
<td>Y</td>
<td>(Quite observable and measurable – As stated in 3, a few examples of activities with others would have made it a bit easier to map out what is sought and thus achieve the outcome)</td>
</tr>
<tr>
<td>“As Evidenced By” Statement?</td>
<td>Y</td>
<td>(See 3-5)</td>
</tr>
<tr>
<td>Realistic?</td>
<td>y</td>
<td>(The clinician would need to assess whether it is realistic to expect that it could be accomplished in 6-12 months)</td>
</tr>
<tr>
<td>Outcome Achievement Timeframe</td>
<td>y</td>
<td>(See 7)</td>
</tr>
<tr>
<td>Positively Stated?</td>
<td>Y</td>
<td>(All terms are positively stated)</td>
</tr>
<tr>
<td>Maintenance Outcomes?</td>
<td>NA</td>
<td>(It seems that improvement is being pursued)</td>
</tr>
<tr>
<td>Service Participation?</td>
<td>Y</td>
<td>(Participation/involvement in CMH services is not included in the outcome statement)</td>
</tr>
<tr>
<td>Meaningful / Individualized?</td>
<td>n</td>
<td>The statement does not appear to capture whether leaving his apartment to engage in activities with others is personally meaningful</td>
</tr>
</tbody>
</table>

Improved Version

```
“I would like Dean to participate in activities he enjoys and be part of the community” as evidenced by leaving his apartment at least three times weekly and participating in activities with others. Dean has indicated that he enjoys bowling, restaurants, movies and an occasional party.
```
Current Outcome Example 9

**Life Area #1 – Personal / Self Care**

Jaime would like to improve her hygiene so she can maintain her part-time job as a greeter at Walmart; as evidenced by showering daily, putting on clean and neat clothes daily, brushing her teeth x2 per day and combing her hair as needed

<table>
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<tr>
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<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>N</td>
<td>Add a consumer quote like, “I’d like to make sure that I keep my job at Walmart”</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(With the added quote, the outcome is consistent with the consumer’s desires and likely with the assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>Y</td>
<td>(What will serve as evidence that the outcome has been achieved is made clear, keeping her job and routine performing the listed personal care tasks)</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>(Specific examples are given)</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>Y</td>
<td>(Observers would likely agree as to whether the outcome had or had not been achieved)</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>Y</td>
<td>(The statements contain both the end result, maintaining the job, and other results like wearing clean clothes, having brushed hair, etc.)</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(Let’s assume its realistic that the consumer will be able to keep her job and perform the personal care tasks mentioned)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(It is probably likely that the outcome could be achieved in a relatively short period of time, e.g., 6-12 months)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(All statements are positive ones)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>--</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(Statements about participating in specified services are not included in the outcome statement)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>(If the clinician had observed a good amount of positive feeling when the consumer was expressing herself about this outcome, it would likely meet the test of being personally meaningful)</td>
</tr>
</tbody>
</table>

**Improved Version**

“I’d really like to keep my job at Walmart so I need to take care of my appearance.” Jaime will maintain her job as a greeter by showering daily, putting on clean and neat clothes daily, brushing her teeth x2 per day and combing her hair as needed.
Current Outcome Example #10

Life Area #6 – Housing
Life Area #5 – Financial

“I want to move out of my house and buy a house with my brother so it will be more financially affordable;” as evidenced by contacting a realtor and a creditor and following through with the necessary paperwork.

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed? Y or N</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>Y</td>
<td>(Beginning with a quote sets the stage for a discussion of some of the actions that will need to occur before the outcome can be fully achieved)</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(Seems consistent with the consumer’s interests, but the clinician will need to ensure that the outcome is consistent with the problem areas identified in the assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>Y</td>
<td>(The words and statement appear clear as to their meaning)</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>(The statements are simple and specific)</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>Y</td>
<td>(Whether or not the consumer moves, buys a house with his brother, contacts a realtor, contacts a creditor and/or completes the necessary paperwork, can be confirmed by an observer)</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>Y</td>
<td>--</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(The clinician would need to assess the achievability of both the long and short term aspects of the outcome statements)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>y</td>
<td>(see 7 above)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(All terms point to doing something positive rather that avoiding something negative)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>--</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The statements emphasize results rather than the CMH services that will facilitate them)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>“The quote seems to demonstrate that the consumer is well motivated to achieve the outcome”</td>
</tr>
</tbody>
</table>

Improved Version – No change

“I want to move out of my house and buy a house with my brother so it will be more financially affordable;” as evidenced by contacting a realtor and a creditor and following through with the necessary paperwork.
Jim would like to maintain his safety regarding ambulation in the community through the use of sighted guide techniques.

**Guideline**

- **Guideline Followed?**
  - Y or N
- **Possible Improvement / (Explanation of why Y)**

1. **Consumer Quotes Included?**
   - N
   - Without a quote from the consumer or his guardian, it leaves it open as to whether this is something that is desirable – Even adding something like his guardian says “he loves to get out of his house and do something,” would improve the outcome statement.

2. **Consistent**
   - Y
   - (With the inclusion of the quote, the outcome would be made clearly consistent with expressed desires -- We can probably assume that safety in the community was identified in the assessment)

3. **Clear?**
   - N
   - It should be made clearer what “safety regarding ambulation” means – Without this clarification, the end result is vague – Does it mean safe from injury from falls, safe from being hit by a car, etc.?

4. **Concrete?**
   - N
   - See 3 above

5. **Observable / Measurable?**
   - N
   - See 3 above

6. **“As Evidenced By” Statement?**
   - N
   - See 3 above

7. **Realistic?**
   - Y
   - (It’s probably safe to say that the consumer will be reasonably able to make progress toward this outcome)

8. **Outcome Achievement Timeframe**
   - Y
   - (I’ll assume the outcome can be achieved in 6-12 months)

9. **Positively Stated?**
   - Y
   - --

10. **Maintenance Outcomes?**
    - Y
    - (Although the word “maintain” is used, it sounds like the outcome may involve some improvement)

11. **Service Participation?**
    - Y
    - (It’s okay to include the step of “sighted guide techniques,” but specifics should be spelled out in the steps section of the outcome page of the PCP)

12. **Meaningful / Individualized?**
    - Y
    - (It depends on the importance the consumer gives this outcome)

---

**Improved Version**

His guardian says “he loves to get out of his house and do something.” Jim will be safe when he walks during a community activity as evidenced by always remaining upright rather than falling and, thus, being free from injuries due to falls.
Current Outcome Example #12

Life Area #11 – Mood/Affect/Feelings

“I want to keep my moods stable so John won’t worry. “I want to stay out of the hospital.” I want to feel better about myself, have a little more self-image.”

<table>
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</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>N</td>
<td>Without a quote from the consumer or his guardian, it leaves it open as to whether this is something that is desirable – Even adding something like his guardian says “he loves to get out of his house and do something,” would improve the outcome statement</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(With the inclusion of the quote, the outcome would be made clearly consistent with expressed desires -- We can probably assume that safety in the community was identified in the assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>N</td>
<td>It should be made clearer what “safety regarding ambulation” means – Without this clarification, the end result is vague – Does it mean safe from injury from falls, safe from being hit by a car, etc.?</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>N</td>
<td>See 3 above</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>N</td>
<td>See 3 above</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>N</td>
<td>See 3 above</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(It’s probably safe to say that the consumer will be reasonably able to make progress toward this outcome)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(I’ll assume the outcome can be achieved in 6-12 months)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>--</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>Y</td>
<td>(Although the word “maintain” is used, it sounds like the outcome may involve some improvement)</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(It’s okay to include the step of “sighted guide techniques,” but specifics should be spelled out in the steps section of the outcome page of the PCP)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>(It depends on the importance the consumer gives this outcome)</td>
</tr>
</tbody>
</table>

Improved Version

His guardian says “he loves to get out of his house and do something.” Jim will be safe when he walks during a community activity as evidenced by always remaining upright rather than falling and, thus, being free from injuries due to falls.
Current Outcome Example #13

Life Area #16 – Legal/Guardianship Issues
Life Area #14 – Safety
Life Area #4 – Health / Medical Issues

Margaret needs help in making appropriate and safe decisions for herself so she can live a stable and healthy lifestyle; as evidence by Supports Coordinator arranging a guardian (contacting OLHSA) as soon as possible and assisting with submitting the necessary paperwork for guardianship.

<table>
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<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>N</td>
<td>No consumer quotes or other indications that the consumer feels a need for this outcome are included. Something like, “The consumer says she ‘would like a lot of help in making decisions about my daily life’ would be an improvement.”</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(It might be consistent with the assessment, but, without a corresponding quote, it might not be consistent with the consumer’s preferences)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>N</td>
<td>It’s not clear what is meant by a “stable and healthy lifestyle” or “making appropriate and safe decisions.” For example, either specific examples of safety issues or, at least, general areas where safety risks are present should be added. The statement could also be made clearer by eliminating the clinician’s activities and responsibilities.</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>N</td>
<td>The statement isn’t simple or specific enough. “The consumer will obtain an OLHSA guardian,” would partially remedy this.</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>N</td>
<td>Obtaining a guardian is observable, but the statement also needs some observable, concrete changes or improvements that would result from a more stable, safe, healthy lifestyle.</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>N</td>
<td>See 3, 4 and 5 above</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(This is probably achievable)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(This is probably achievable in the short term)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>--</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>--</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The statement excludes the consumer’s role in service involvement)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>N</td>
<td>No evidence is given that the consumer wants this for herself</td>
</tr>
</tbody>
</table>

Improved Version

The consumer says she needs “a lot of help in making decisions about my daily life.” Because she puts herself at risk of being taken advantage of by others and risks her health by not obtaining needed medical attention, she will obtain an OLHSA guardian. An increase in medical appointment will be observed as well as an increase in relationships with friends that are not exploitative.
Current Outcome Example #14

“I need help with understanding what my doctor is saying when I go in for my yearly exams. I get confused easily and I have a hard time communicating with my doctor.” Lisa needs assistance from CSL contract staff to attend the medical appointments with her to help communicate Lisa’s concerns to the doctor as well as explaining the doctor’s instructions to Lisa.

Guideline | Guideline Followed? Y or N | Possible Improvement / (Explanation of why Y)
--- | --- | ---
1. Consumer Quotes Included? | Y | 
2. Consistent | N | The issue of consistency is difficult to address since the statement does not include an impact or end result. It only addresses to role of CSL staff in assisting the consumer.
3. Clear? | N | A clear statement about the concrete, observable impact of the staff’s help needs to be included. An example would be, “The consumer will show an improvement in her health as evidenced by an increase in days at work” (or an increase in days when she feels well enough to participate in community activities or an increase in sufficiently pain-free days to report to her supports coordinator that she had a good week, etc.)
4. Concrete? | N | See 3 above
5. Observable / Measurable? | N | See 3 above
6. “As Evidenced By” Statement? | N | The only clarification or expansion of the quote is the support person’s interventions
7. Realistic? | N | Unable to determine
8. Outcome Achievement Timeframe | N | Unable to determine without an outcome statement
9. Positively Stated? | N | Positive result statements are not included
10. Maintenance Outcomes? | NA | The issue appears to be one of improvement, not maintenance
11. Service Participation? | N | The focus is on the responsibilities of the provider and, thus, the consumer’s involvement with the provider’s services
12. Meaningful/Individualized? | N | The quote clearly expresses the consumer’s individual concerns but the additions do not reflect the personal importance of achieving a result

Improved Version

“I need help with understanding what my doctor is saying when I go in for my yearly exams. I get confused easily and I have a hard time communicating with my doctor.” With communication help from her CSL support person during doctor appointments, the consumer with experience an improvement in her health status as evidenced by an increase in days when she feels well enough to participate in community activities and an increase in sufficiently pain-free days to be able to report to her supports coordinator that she had a good week.
Current Outcome Example #15

**Life Area #18 – Child Care**

“I would like to have more stable childcare in my home so I don’t feel so uneasy when I leave my children to go to work;” as evidenced by my kids expressing their happiness and comfort with their sitter each time I return home from work.

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed?</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ConsumerQuotes included?</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(The outcome statement is quite consistent with the consumer’s quoted desire – The clinician would be responsible for ensuring consistency with the most recent assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>Y</td>
<td>The meaning of the end result is clear</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>(The stated outcome is specific and simple)</td>
</tr>
<tr>
<td>5. Observable/ Measurable?</td>
<td>Y</td>
<td>(The kids’ statements of satisfaction are observable)</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>Y</td>
<td>(The ‘as evidenced by’ statement receives appropriate emphasis)</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(Kids’ happiness with their sitter can be a realistic result, although not always easy to attain)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(This outcome seems achievable in 6 to 12 months)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(There’s nothing much more positive than expressions of happiness)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>(“More stable” implies improvement, not the status-quo)</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The way in which the family will be involved in the services was not included in the outcome statement)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>(The content of the quote confirms the importance of the outcome to the consumer)</td>
</tr>
</tbody>
</table>

Improved Version – No change

“I would like to have more stable childcare in my home so I don’t feel so uneasy when I leave my children to go to work;” as evidenced by my kids expressing their happiness and comfort with their sitter each time I return home from work.
Current Outcome Example #16

Life Area #20 -- Transportation

“I’m a good driver. I want to have reliable transportation. I want a gas powered golf-cart. I want a green Corvette.” Leif would like to pursue obtaining his driver’s license; as evidenced by participating in an assessment for driver’s training and going to driver’s education as scheduled.

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed?</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>Y</td>
<td>(The consumer’s quote gives the clinician a good idea of what is desired and provides an opportunity for clarification and developing other, more modest, goals)</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(The clarification and final outcome statement is consistent with the consumer’s initial goal – The obtaining of a driver’s license could have been added to the statement or reserved for the next Periodic Review – I’m assuming there are no inconsistencies with the most recent assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>Y</td>
<td>(There is little doubt about the meaning of the clarified outcome statement)</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>(The statement become specific and simple, not abstract)</td>
</tr>
<tr>
<td>5. Observable/Measurable?</td>
<td>Y</td>
<td>(Agreement could easily be reached as to whether the consumer participated in driver’s education)</td>
</tr>
<tr>
<td>6. &quot;As Evidenced By&quot; Statement?</td>
<td>Y</td>
<td>(The importance of its inclusion is nicely demonstrated in this outcome statement)</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(The consumer’s participation in driver’s education is probably realistic)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(It’s likely that the clinician and consumer judged the outcome to be achievable in the next 6 to 12 months)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(All of the statements reflect movement toward something positive)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>See 9 above</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The CMH services that will facilitate the achievement of the outcome are absent from the statement)</td>
</tr>
<tr>
<td>12. Meaningful/Individualized?</td>
<td>Y</td>
<td>(The quote seems to express the consumers strong interest in achieving the outcome)</td>
</tr>
</tbody>
</table>

Improved Version – No change

“I’m a good driver. I want to have reliable transportation. I want a gas powered golf-cart. I want a green Corvette.” Leif would like to pursue obtaining his driver’s license; as evidenced by participating in an assessment for driver’s training and going to driver’s education as scheduled.
Current Outcome Example #17

Life Area #21 – Substance Abuse

“I need to obtain a sponsor to help me keep sober; especially during the holidays;” as evidenced by client attending AA regularly (x3-x5 per week), getting to know the sponsors, and then selecting one of interest.

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed?</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>Y</td>
<td>(In this quote the consumer provides a clear statement of an outcome, keeping sober during the holidays, and the shorter term goals that need to be accomplished in order to attain it, attending AA and obtaining an AA sponsor.)</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(Clearly consistent with the consumer’s desires and, most likely, with the assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>Y</td>
<td>(The meaning is clear and a positive or negative result would be observable – A designated period of time during which sobriety is maintained would add some concreteness to the statement)</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>(See 3 above)</td>
</tr>
<tr>
<td>5. Observable / Measurable?</td>
<td>Y</td>
<td>(See 3 above)</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>Y</td>
<td>(See 3 above)</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(It appears realistic on the face of it)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(It appears the outcome could be achieved in a relatively short period of time)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(All terms are positively stated)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>(Staying sober sounds like as maintenance goal, but staying sober for a longer-than-usual length of time for this consumer would bring it into the category of improvement)</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The consumer’s sought after outcome is emphasized over participation in CMH services)</td>
</tr>
<tr>
<td>12. Meaningful/ Individualized?</td>
<td>Y</td>
<td>(The quote appear to reflect the consumer’s strong individual desire to pursue this outcome)</td>
</tr>
</tbody>
</table>

Slightly Improved Version

“I need to obtain a sponsor to help me keep sober; especially during the holidays;” as evidenced by client attending AA regularly (x3-x5 per week), getting to know the sponsors, selecting one of interest and staying sober for a minimum of six month period which includes the winter holidays
Current Outcome Example #18

Life Area #24 – Cultural / Spiritual

“I would really like to be able to go back to church again, but I have to be reinstated by the council.” [Successful completion of the Outcome will be evidenced by Ms. J. completing the following in the term of her treatment plan: 1. Contacting her former church. 2. Meeting with the Council. 3. Developing a plan for Reinstatement. 4. Getting approval. 5. Official Reinstatement. 6. Registering at her Church office. 7. Active and regular participation in services. This evidence will be collected and monitored via self-report during interviews at monthly case management contacts. Ms. J. will report on her progress at each contact.

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed?</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>Y</td>
<td>(The consumer quote serves as an excellent jumping off point for specifics and observables)</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(The specifics that were added are clearly consistent with the consumer’s desired outcome – It is also quite likely that there is nothing in the assessment that would make the outcome statements inconsistent with it)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>Y</td>
<td>(Spelled out very clearly – There is negligible ambiguity)</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>Y</td>
<td>(Statement is simple, straightforward and individualized)</td>
</tr>
<tr>
<td>5. Observable/Measurable?</td>
<td>Y</td>
<td>(There should be no difficulty in obtaining agreement about whether the outcome(s) has been achieved)</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>Y</td>
<td>(In this case, adding the steps provides ample evidence about which smaller goals are needed to be achieved before the broader outcome of going back to church, the end result, is achieved – Including some of these shorter term goals in the steps would have also been acceptable)</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(Probably)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(It appears that the outcome(s) can be achieved during the term of the plan – In fact this is nicely added to the statement)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(Everything is stated positively in terms of actions the consumer will take to move toward outcome achievement)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(Only the method of determining whether outcomes have been achieved is related to the service contacts, rather than service participation being stated as an outcome in itself)</td>
</tr>
<tr>
<td>12. Meaningful / Individualized?</td>
<td>Y</td>
<td>(The quote provides evidence that outcome achievement will be important and meaningful to the consumer)</td>
</tr>
</tbody>
</table>

Improved Version – No change

“I would really like to be able to go back to church again, but I have to be reinstated by the council.” [Successful completion of the Outcome will be evidenced by Ms. J. completing the following in the term of her treatment plan: 1. Contacting her former church. 2. Meeting with the Council. 3. Developing a plan for Reinstatement. 4. Getting approval. 5. Official Reinstatement. 6. Registering at her Church office. 7. Active and regular participation in services. This evidence will be collected and monitored via self-report during interviews at monthly case management contacts. Ms. J. will report on her progress at each contact.
Current Outcome Example #19

**Life Area #26: Developmental Skills**

*Frank would like to improve his sensory processing skills (per mom – guardian) in order to be more comfortable in his environment.*

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed?</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>N</td>
<td>Actual quotes would improve the statement</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>Probably consistent with the assessment and the desires of the mom</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>N</td>
<td>There needs to be more clarity about which specific sensory processing skills are needing improvement and about the meaning of being more comfortable in his environment – An example of the latter would be something like, “Frank will show an increase in the frequency of activities in which he appears alert and relaxed”</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>N</td>
<td>Same as 3 above</td>
</tr>
<tr>
<td>5. Observable/Measurable?</td>
<td>N</td>
<td>Same as 3 above – The end result needs to be something that is observable – In this example a way of determining whether the consumer is comfortable or not needs to be spelled out</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>N</td>
<td>See 3 above</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>(Probably)</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>(Probably)</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>Y</td>
<td>(An increase, rather than a decrease, is stated)</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td>An increase in something indicates an improvement as opposed to maintaining a current level of functioning</td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(The focus is on the impact of services, rather than on participating in a service)</td>
</tr>
<tr>
<td>12. Meaningful/Individualized?</td>
<td>N</td>
<td>A fuller quote and additional clarification might produce a statement that is more individualized and personally meaningful</td>
</tr>
</tbody>
</table>

**Improved Version**

*Frank’s mom says that “Frank often appears very frustrated, unhappy and confused when he is in the presence of a moderate or high amount of visual/sound/tactile stimulation” – “I’d like to him to be able to take in these sights and sounds and touches more satisfactorily” – Frank will benefit from sensory integration assistance as evidenced by showing an increase in the frequency of activities in which he appears alert and relatively relaxed – These activities will include ...*
Current Outcome Example #20

Life Area #25: End of Life Needs

“I don’t want to end up dying alone”

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Guideline Followed? Y or N</th>
<th>Possible Improvement / (Explanation of why Y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Quotes Included?</td>
<td>Y</td>
<td>(Clearly states consumer’s concerns and wishes)</td>
</tr>
<tr>
<td>2. Consistent</td>
<td>Y</td>
<td>(The quote is very likely consistent with issues raised in the assessment)</td>
</tr>
<tr>
<td>3. Clear?</td>
<td>N</td>
<td>A more specific picture of the consumer’s desired social, interpersonal environment as she approaches death is lacking -- Something like the following would improve the statement: “Leslie will increase her feelings of belonging as evidenced by developing and maintaining closer relationships with her acquaintances, her church and other community supports such as hospice and reporting feeling accepted and cared for”</td>
</tr>
<tr>
<td>4. Concrete?</td>
<td>N</td>
<td>See 3 above</td>
</tr>
<tr>
<td>5. Observable/Measurable?</td>
<td>N</td>
<td>See 3 above</td>
</tr>
<tr>
<td>6. “As Evidenced By” Statement?</td>
<td>N</td>
<td>See 3 above</td>
</tr>
<tr>
<td>7. Realistic?</td>
<td>Y</td>
<td>Let’s assume the consumer has the capacity to develop meaningful relationships</td>
</tr>
<tr>
<td>8. Outcome Achievement Timeframe</td>
<td>Y</td>
<td>Let’s assume the consumer can do the above within the duration of the PCP</td>
</tr>
<tr>
<td>9. Positively Stated?</td>
<td>N</td>
<td>See 3 above</td>
</tr>
<tr>
<td>10. Maintenance Outcomes?</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>11. Service Participation?</td>
<td>Y</td>
<td>(Service participation / contacts with CMH providers are left for inclusion somewhere else in the plan)</td>
</tr>
<tr>
<td>12. Meaningful/Individualized?</td>
<td>Y</td>
<td>(The quote itself meets the criteria for personal meaningfulness)</td>
</tr>
</tbody>
</table>

Improved Version

“I don’t want to end up dying alone”  Leslie will increase her feelings of belonging as evidenced by developing and maintaining closer relationships with her acquaintances, her church and other community supports such as hospice and reporting feeling accepted and cared for.
1. **Washtenaw County Enrollees**

A summary of FY 2019 Washtenaw County Medicaid and Healthy Michigan Enrollees is shown below:

![Graph showing enrollees comparison between FY 2018 and FY 2019](image1)

Washtenaw County Medicaid Enrollees were 33,884 in February 2019. This is a 1.95% decrease from the same time last year (674 less enrollees than in February 2018). Healthy Michigan enrollment in February was 16,894. This is a 1.68% decrease from the same time last year (289 less enrollees than in February 2018).

2. **WCCMH Consumers Served to Date**

![Graph showing enrollees comparison between FY 2018 and FY 2019](image2)
Medicaid consumers served through February 2019 are 3,216. This is 181 more consumers than the prior year (3,035 consumers were served through February 2018).

ABA Waiver consumers served through February 2019 are 151. This is 25 more consumers than the prior year (126 consumers were served through February 2018).

General fund consumers served through February 2019 are 588. This is 35 more consumers served than the same period last year.

Healthy Michigan consumers served through February 2019 were 737. This is 8 more consumers than the same period last year.
3. **Financial Statement Highlights**

   a. CLS service costs to date are $10.7 Million. The costs year to date are .03% more than last year as of February 2018. This is $285,000 under the budget.

   b. The graph below is presented with actual paid claims for CLS services and does not reflect the general ledger. Figures below have been updated retrospectively back to October in order to incorporate all paid claim amounts from prior periods. In doing so, the graph represents the most accurate and up to date information for this service at the time of report preparation.

   ![Community Living Supports]

   ![Community Inpatient]

   c. Community Inpatient costs to date are $2.4 Million. The costs year to date are 23.79% more than last year as of February 2018. This is $236,000 over the budget.
d. Licensed Residential costs to date are $4.5 Million. The costs year to date are 6.13% more than last year as of February 2018. This is $202,000 under the budget.

<table>
<thead>
<tr>
<th></th>
<th>FY18 Actuals</th>
<th>FY19 Budget</th>
<th>FY19 Actuals</th>
<th>YTD % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct</td>
<td>$845,486</td>
<td>$958,333</td>
<td>$868,002</td>
<td>2.43%</td>
</tr>
<tr>
<td>Nov</td>
<td>$835,932</td>
<td>$958,333</td>
<td>$981,647</td>
<td>9.89%</td>
</tr>
<tr>
<td>Dec</td>
<td>$877,806</td>
<td>$958,333</td>
<td>$932,083</td>
<td>8.62%</td>
</tr>
<tr>
<td>Jan</td>
<td>$945,844</td>
<td>$958,333</td>
<td>$953,401</td>
<td>6.51%</td>
</tr>
<tr>
<td>Feb</td>
<td>$819,635</td>
<td>$958,333</td>
<td>$856,512</td>
<td>6.13%</td>
</tr>
<tr>
<td>Mar</td>
<td>$857,183</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr</td>
<td>$977,074</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>$897,254</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jun</td>
<td>$946,248</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jul</td>
<td>$973,928</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug</td>
<td>$955,501</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep</td>
<td>$907,217</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

![Licensed Residential Costs Chart]

- **Licensed Residential Costs to Date**: $4.5 Million.
- **Year to Date**: 6.13% more than last year as of February 2018.
- **Budget Underutilization**: $202,000.

- **Applied Behavior Analysis/Autism Costs to Date**: $1.3 Million.
- **Year to Date**: 40.70% more than last year as of February 2018.
- **Budget Overutilization**: $205,000.
f. A significant amount of General Fund is used to supplement Medicaid deductibles for our consumers on a spend-down. The number of cases that did not meet their spend-down deductible through February 2019 were 126. The number of cases that met their spend-down deductible through February 2019 were 146. The amount spent through February 2019 is $410,000.

4. **PIHP Revenue Key Points**
   
a. Medicaid, Healthy Michigan Plan and Autism funds are coming in at budget.
   
b. By funding source, Medicaid is showing a deficit of $3.0 Million.
   
c. By funding source, HMP is showing a deficit of $1.6 Million

5. **State General Fund Key Points**
   
a. General Fund programs and funding redirected to other Risk-Based programs is showing a deficit of $169,000.
   
b. General Fund overages are primarily resulting in the CLS and Licensed Residential business units.
   
c. General Fund funding has been redirected by the WCCMH as detailed below:
      
      i. $27,000 to SED Waiver
      
      ii. $77,000 to Child Waiver

6. **Local Key Points**
   
a. The majority of Local Funding comes from Washtenaw County.
   
b. Local Funds are showing a surplus of $299,000 through February 2019.
   
c. Uses of Local Funding include:
      
      i. The 10% GF Match of non-residential services
      
      ii. Local contribution – required by MDHHS
      
      iii. Local share for State Facilities
      
      iv. Shelter expenses and other Local needs

7. **Fund Balance**

WCCMH’s Fund Balance at the beginning of FY 2018 is $2.7 Million. The Fund Balance is unknown at this time due to unexpected end of year transactions. An update will be provided when available.
### Medicaid

**Revenue**
- B & B3: $16,157,734.80
- HSW: $9,660,869.00
- Prior Year Adjustments: -
- Care for Caid: $55,888.02
- Total Medicaid Revenue: $25,874,491.82

**Expense**
- Service Costs: $25,638,364.86
- Admin. Cost Allocation: $3,314,242.16
- Redirect To Cover COFR Exp.: -
- Redirect To Cover MiChild Exp.: -
- Total Medicaid Expense: $28,952,607.02

Medicaid Surplus/(Deficit): $(3,078,115.20)

### Autism Benefit

**Revenue**
- Medicaid Benefit: $1,042,304.17
- MIChild Benefit: -
- Total Autism Benefit Revenue: $1,042,304.17

**Expense**
- Medicaid Service Costs: $924,841.46
- Admin. Cost Allocation: $117,462.71
- MIChild Service Costs: -
- Admin. Cost Allocation: -
- Total Autism Benefit Expense: $1,042,304.17

Autism Surplus/(Deficit): -

### Healthy Michigan

**Revenue**
- $1,818,870.29

**Expense**
- $3,492,380.54

Healthy MI Surplus/(Deficit): $(1,673,510.25)

### General Fund

**Revenue**
- CMH Operations: $1,315,072.17
- CMH Operations Contra: -
- Categorical: -
- Redirect To SED Waiver: $(27,327.17)
- Redirect To Children's Waiver: $(77,515.38)
- Redirect To Injectable Meds.: $(1,500.98)
- Funding Fr. Other Local Sources: $27,460.27
- Total General Fund Revenue: $1,236,188.91

**Expense**
- Total General Fund Expense: $1,405,755.70

General Fund Surplus/(Deficit): $(169,566.79)
<table>
<thead>
<tr>
<th>Source</th>
<th>Revenue</th>
<th>Expense</th>
<th>Surplus/(Deficit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SED Waiver</td>
<td>$50,470.76</td>
<td>$50,470.76</td>
<td>$0</td>
</tr>
<tr>
<td>Children's Waiver</td>
<td>$241,902.69</td>
<td>$241,902.69</td>
<td>$0</td>
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<tr>
<td>Injectable Meds</td>
<td>$1,500.98</td>
<td>$1,500.98</td>
<td>$0</td>
</tr>
<tr>
<td>Grants &amp; Contracts</td>
<td>$646,571.08</td>
<td>$646,571.07</td>
<td>$0</td>
</tr>
<tr>
<td>CMHSP To CMHSP</td>
<td>$281,986.51</td>
<td>$(27,460.27)</td>
<td>$(254,526.24)</td>
</tr>
<tr>
<td>Local</td>
<td>$989,556.65</td>
<td>$689,972.44</td>
<td>$299,584.21</td>
</tr>
<tr>
<td>Private Grant &amp; NOR</td>
<td>$82,632.38</td>
<td>$73,422.38</td>
<td>$9,210.00</td>
</tr>
<tr>
<td>Grand Total</td>
<td>$31,984,489.73</td>
<td>$36,596,887.74</td>
<td>$(4,612,398.02)</td>
</tr>
</tbody>
</table>

** Denotes PIHP Medicaid Subcontracting Agreement Funds

<table>
<thead>
<tr>
<th>Surplus/(Deficit)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PIHP Medicaid</td>
<td>$(4,751,625.45)</td>
</tr>
<tr>
<td>WCCMH Surplus/(Deficit)</td>
<td>$139,227.42</td>
</tr>
<tr>
<td></td>
<td>$(4,612,398.03)</td>
</tr>
</tbody>
</table>

Page 7 of 8
### Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>FY 2019 Budget Amendment</th>
<th>FY 2019 Budget Amendment YTD</th>
<th>FY 2019 Current YTD Actuals</th>
<th>YTD Actuals Over/(Under) Amended Budget % (Q)</th>
<th>FY 2018 Prior YTD Actuals</th>
<th>YTD Actuals Over/(Under) Prior Year Actuals % (Q)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHIP Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Capitation:</td>
<td>$37,898,761</td>
<td>$15,791,150</td>
<td>$15,868,314</td>
<td>$77,164 0.49%</td>
<td>$26,677,820</td>
<td>($26,677,820) -3.62%</td>
</tr>
<tr>
<td>State Plan/B3</td>
<td>23,510,004</td>
<td>9,795,835</td>
<td>9,660,869</td>
<td>(134,966) -1.38%</td>
<td>15,868,314</td>
<td>9,660,869 8.97%</td>
</tr>
<tr>
<td>Healthy Michigan Capitation</td>
<td>4,001,682</td>
<td>1,667,368</td>
<td>1,818,870</td>
<td>151,503 9.09%</td>
<td>1,669,208</td>
<td>149,662 9.97%</td>
</tr>
<tr>
<td>Autism Capitation</td>
<td>2,951,725</td>
<td>1,229,885</td>
<td>1,313,725</td>
<td>101,840 8.28%</td>
<td>451,010</td>
<td>880,715 195.28%</td>
</tr>
<tr>
<td>Anticipated Medicaid Revenue</td>
<td>10,361,681</td>
<td>-</td>
<td>(4,337,367) -100.00%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL PHIP Revenue</strong></td>
<td>$78,723,853</td>
<td>$32,801,605</td>
<td>$28,679,778</td>
<td>($4,121,827) -12.57%</td>
<td>$28,798,038</td>
<td>($118,260) -0.41%</td>
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<tr>
<td><strong>MDHHS Revenue</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State General Funds</td>
<td>$3,147,193</td>
<td>$1,311,230</td>
<td>$1,315,072</td>
<td>$3,742 0.29%</td>
<td>$1,164,409</td>
<td>$150,663 12.94%</td>
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<tr>
<td>Medicaid Fee for Service</td>
<td>820,235</td>
<td>341,765</td>
<td>187,531</td>
<td>(154,234) -45.13%</td>
<td>190,075</td>
<td>(2,544) -1.34%</td>
</tr>
<tr>
<td>Grants &amp; Earned Contracts</td>
<td>3,509,117</td>
<td>1,462,132</td>
<td>671,600</td>
<td>(790,532) -50.07%</td>
<td>603,466</td>
<td>68,134 11.29%</td>
</tr>
<tr>
<td><strong>All Other Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Appropriation</td>
<td>$2,185,277</td>
<td>$910,532</td>
<td>704,444</td>
<td>($206,088) -22.63%</td>
<td>386,379</td>
<td>318,065 82.32%</td>
</tr>
<tr>
<td>Project Revenue</td>
<td>751,000</td>
<td>312,917</td>
<td>311,471</td>
<td>(1,446) -0.46%</td>
<td>295,687</td>
<td>15,784 5.34%</td>
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<tr>
<td>Other</td>
<td>1,172,977</td>
<td>488,740</td>
<td>841,238</td>
<td>352,498 72.12%</td>
<td>896,317</td>
<td>(55,079) -6.15%</td>
</tr>
<tr>
<td><strong>TOTAL Operating Revenue</strong></td>
<td>$90,309,652</td>
<td>$37,629,022</td>
<td>$32,711,134</td>
<td>($4,917,887) -13.07%</td>
<td>$32,334,371</td>
<td>$376,763 1.17%</td>
</tr>
</tbody>
</table>

### Operating Expenses

<table>
<thead>
<tr>
<th></th>
<th>FY 2019 Budget Amendment</th>
<th>FY 2019 Budget Amendment YTD</th>
<th>FY 2019 Current YTD Actuals</th>
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<th>YTD Actuals Over/(Under) Prior Year Actuals % (Q)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administrative Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Administration</td>
<td>$6,503,782</td>
<td>$2,709,909</td>
<td>$2,891,610</td>
<td>$181,701 6.71%</td>
<td>$2,764,278</td>
<td>$127,332 4.61%</td>
</tr>
<tr>
<td>Program Administration</td>
<td>3,408,000</td>
<td>$1,420,000</td>
<td>$1,472,851</td>
<td>$52,851 3.72%</td>
<td>1,453,784</td>
<td>19,067 1.31%</td>
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<tr>
<td><strong>Residential Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Living Supports</td>
<td>$26,400,000</td>
<td>$11,000,000</td>
<td>$10,714,765</td>
<td>($285,235) -2.59%</td>
<td>$10,297,243</td>
<td>$417,522 4.05%</td>
</tr>
<tr>
<td>Licensed Residential</td>
<td>11,500,000</td>
<td>4,791,667</td>
<td>4,589,645</td>
<td>(202,022) -4.22%</td>
<td>4,324,503</td>
<td>265,142 6.13%</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism Services</td>
<td>$2,850,000</td>
<td>$1,187,500</td>
<td>$1,392,889</td>
<td>$205,389 17.30%</td>
<td>$989,970</td>
<td>$402,919 40.70%</td>
</tr>
<tr>
<td>Case Management</td>
<td>4,816,278</td>
<td>2,006,783</td>
<td>2,037,297</td>
<td>$30,515 1.52%</td>
<td>1,886,829</td>
<td>150,468 7.97%</td>
</tr>
<tr>
<td>Supports Coordination</td>
<td>2,354,878</td>
<td>981,199</td>
<td>935,875</td>
<td>(45,324) -4.62%</td>
<td>893,939</td>
<td>41,936 4.69%</td>
</tr>
<tr>
<td>Skill Building</td>
<td>5,979,556</td>
<td>2,491,482</td>
<td>2,643,818</td>
<td>152,336 6.11%</td>
<td>2,576,918</td>
<td>66,900 2.60%</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>1,747,546</td>
<td>728,144</td>
<td>835,288</td>
<td>107,144 14.71%</td>
<td>806,441</td>
<td>28,847 3.58%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2,747,242</td>
<td>1,144,684</td>
<td>1,188,536</td>
<td>43,852 3.83%</td>
<td>1,072,123</td>
<td>116,413 10.86%</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>2,282,899</td>
<td>951,208</td>
<td>929,008</td>
<td>(22,200) -2.33%</td>
<td>805,000</td>
<td>124,008 15.40%</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>1,804,501</td>
<td>751,875</td>
<td>753,427</td>
<td>1,352 0.21%</td>
<td>704,083</td>
<td>49,344 7.01%</td>
</tr>
<tr>
<td>Other</td>
<td>7,938,205</td>
<td>3,307,585</td>
<td>3,195,830</td>
<td>(111,755) -3.38%</td>
<td>3,407,109</td>
<td>(211,279) -6.20%</td>
</tr>
<tr>
<td><strong>Other Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Inpatient</td>
<td>$5,400,000</td>
<td>$2,250,000</td>
<td>$2,486,948</td>
<td>$236,948 10.53%</td>
<td>$2,008,984</td>
<td>$477,964 23.79%</td>
</tr>
<tr>
<td>Local Matches &amp; Shelter</td>
<td>1,282,838</td>
<td>534,516</td>
<td>584,234</td>
<td>49,718 9.30%</td>
<td>580,481</td>
<td>3,753 0.65%</td>
</tr>
<tr>
<td>Grants &amp; Earned Contracts</td>
<td>3,299,917</td>
<td>1,377,470</td>
<td>671,600</td>
<td>(700,870) -51.07%</td>
<td>609,467</td>
<td>68,133 11.29%</td>
</tr>
<tr>
<td><strong>TOTAL Operating Expenses</strong></td>
<td>$90,309,652</td>
<td>$37,629,022</td>
<td>$37,323,621</td>
<td>($305,401) -0.81%</td>
<td>$35,175,152</td>
<td>$2,148,469 6.11%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Revenue Over/(Under) Expenses</th>
<th>-</th>
<th>-</th>
<th>(4,612,487)</th>
<th>(4,612,487)</th>
<th>(2,840,781)</th>
<th>(1,771,706)</th>
</tr>
</thead>
</table>
COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
March 13, 2019

Members Present: Judy Ackley, Greg Adams, Charles Coleman, Susan Fortney, Roxanne Garber, Sandra Libstorff, Charles Londo, Caroline Richardson, Sharon Slaton, Ralph Tillotson

Members Absent: Martha Bloom, Gary McIntosh

Staff Present: Jane Terwilliger, Kathryn Szewczuk, Stephannie Weary, Lisa Jennings, Trish Cortes, James Colaianne, Suzanne Stolz, Kristen Ora, Kate Aulette

Others Present: Laurie Lutomski, Maureen Stapleton

I. Call to Order
   Meeting called to order at 6:00 p.m. by Board Chair C. Londo.

II. Roll Call
   • A quorum of members present was confirmed.

III. Consideration to Adopt the Agenda as Presented

   Motion by C. Coleman, supported by R. Garber, to approve the agenda
   Motion carried

   • Old Business Item b: J. Terwilliger will include a brief CEO Report.
   • Old Business Item c will be conducted in closed session.

IV. Consideration to Approve the Minutes of the February 13, 2019 Regular Meeting and Waive the Reading Thereof

   Motion by S. Slaton, supported by R. Garber, to approve the minutes of February 13, 2019 Regular Meeting and waive the reading thereof
   Motion carried

V. Audience Participation
   None

VI. Old Business
   a. March Finance Report
      • S. Stolz presented the March finance report. Discussion followed.
      • S. Stolz gave an update on FY18, which was closed on 2/28/19. FY18 audit financials are due to the state on 3/31/19 but may not be completed on time. There are no
financial consequences for late submission. The compliance and single audits are scheduled to be completed on time.

b. Performance Bonus Incentive Plan (PBIP) for FY18
   • J. Terwilliger provided an explanation for the reduction in the PBIP of $16,058.12, and a tentative plan between the PIHP and McLaren Health.
   • J. Terwilliger provided an update on the Administrative Hearing, M. Scalera’s transition planning, and the CIO position.

c. Presentation of Evaluation Results and Recommendations

   Motion by C. Coleman, supported by R. Garber, for Board to go into closed session to discuss evaluation results and recommendations
   Motion carried

   • Regional Board meeting went into closed session at 6:32 p.m. All were excused from the meeting except for board members and J. Terwilliger.

   Motion by R. Tillotson, supported by S. Fortney, for Board to go back into open session
   Motion carried

   • Regional Board meeting went back into open session at 8:10 p.m.

   Motion by R. Tillotson, supported by S. Fortney, to accept the unsatisfactory CEO performance evaluation, to extend the CEO contract for 6 months, to require that the CEO develop a plan of correction within 30 days, and to perform an interim CEO evaluation at the 3-month mark of the contract extension
   Motion carried

<table>
<thead>
<tr>
<th></th>
<th>Ackley</th>
<th>Libstorff</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>Yes</td>
<td>Londo</td>
<td>Yes</td>
</tr>
<tr>
<td>Bloom</td>
<td>Absent</td>
<td>McIntosh</td>
<td>Absent</td>
</tr>
<tr>
<td>Coleman</td>
<td>Yes</td>
<td>Richardson</td>
<td>Yes</td>
</tr>
<tr>
<td>Fortney</td>
<td>Yes</td>
<td>Slaton</td>
<td>Yes</td>
</tr>
<tr>
<td>Garber</td>
<td>Yes</td>
<td>Tillotson</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Motion by S. Slaton, supported by G. Adams, to continue the CEO Evaluation Subcommittee meetings on a monthly basis as needed, to be determined by the subcommittee, with the meetings being open to all who would like to attend
Motion carried
VII. New Business

VIII. PIHP CEO Report to the Board
- OPB minutes are included with board packet.
- See Old Business Item b for the CEO report.

IX. Adjournment

Motion by R. Tillotson, supported by G. Adams, to adjourn the meeting
Motion carried
- Meeting adjourned at 8:20 p.m.

Judy Ackley, CMHPSM Board Secretary
# 2019 WCCMH Board, WCCMH Board Committees and WCCMH Board Officers (term of 4/1/19-3/31/20)

<table>
<thead>
<tr>
<th>Officers</th>
<th>Executive (meets quarterly)</th>
<th>Budget-Finance (meets monthly)</th>
<th>Program-Quality (meets monthly)</th>
<th>CMHPSM (meets monthly)</th>
<th>Officers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suzie Antonow</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Felicia Brabec</td>
<td>X</td>
<td></td>
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<tr>
<td>Carly Collins</td>
<td>X X</td>
<td></td>
<td></td>
<td>Treasurer/Budget-Finance Committee Chair</td>
<td></td>
</tr>
<tr>
<td>Anna Dusibiber</td>
<td>X X</td>
<td></td>
<td></td>
<td>Secretary</td>
<td></td>
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<tr>
<td>Nancy Graebner</td>
<td>X X</td>
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<tr>
<td>Ricky Jefferson</td>
<td>X X</td>
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<tr>
<td>Bob King</td>
<td>X</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>John Martin</td>
<td>X</td>
<td></td>
<td></td>
<td>Board Chair/Executive Committee Chair</td>
<td></td>
</tr>
<tr>
<td>Caroline Richardson</td>
<td></td>
<td></td>
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<tr>
<td>Katie Scott</td>
<td>X X</td>
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<tr>
<td>Patricia Spriggel</td>
<td>X</td>
<td></td>
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<td></td>
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<tr>
<td>Kari Walker</td>
<td>X X</td>
<td></td>
<td></td>
<td>Vice-Chair/Program-Quality Committee Chair</td>
<td></td>
</tr>
</tbody>
</table>

| total current assigned to Committees | 5 | 5 | 7 | 3 |

| # board members required for committee-per Bylaws | 7 (4 officers, 2 additional board members and immediate past board chair) (Executive Director is an ex-officio member) | 4 (Treasurer and not less than 3 other Board members) | 4 (Vice Chair and not less than 3 other board members) | 3 (per PIHP) |

| Quorum for committees | 4/6 | 3/5 | 4/7 |

Quorum for Board is 7/12

## Ex-officio committee members

<table>
<thead>
<tr>
<th>Doug Strong</th>
<th>Budget-Finance Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Role</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Felicia Brabec</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Carly Collins</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Anna Dusbiber</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>John Martin</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Kari Walker</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Amanda Carlisle</td>
<td>Washtenaw Housing Alliance</td>
</tr>
<tr>
<td>Derrick Jackson</td>
<td>Washtenaw County Sheriff's Office</td>
</tr>
<tr>
<td>Holly Haviland</td>
<td>Washtenaw Intermediate School District</td>
</tr>
<tr>
<td>Ray Rion</td>
<td>Packard Health</td>
</tr>
<tr>
<td>George Waddles</td>
<td>Community Member</td>
</tr>
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</table>
## WCCMH Grant Opportunities FY19

<table>
<thead>
<tr>
<th>Funder</th>
<th>Grant Name</th>
<th>Amount</th>
<th>Term</th>
<th>Purpose/Scope</th>
<th>Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated Funding (CoFu) (Funders: City of Ann Arbor, St Joseph Mercy Hospital)</td>
<td>Coordinated Funding</td>
<td>$100,000 Annually</td>
<td>7/1/2018-6/30/2020</td>
<td>Emergency shelter, transitional housing and/or homeless outreach</td>
<td>Y</td>
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<tr>
<td>Coordinated Funding (CoFu) (Funders: City of Ann Arbor, St Joseph Mercy Hospital, WCUW)</td>
<td>Coordinated Funding Carry-forward</td>
<td>$28,233</td>
<td>3/1/2019-9/30/2019</td>
<td>Funds from FY18 to be used for emergency shelter, transitional housing and/or client care for homeless individuals</td>
<td>Y</td>
</tr>
<tr>
<td>Michigan Department of Health and Human Services (MDHHS)</td>
<td>PATH (Projects for Assistance in Transition from Homelessness)</td>
<td>$122,122</td>
<td>10/1/2018-9/30/2019</td>
<td>Project for assistance in transition from homelessness</td>
<td>Y</td>
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<tr>
<td>Michigan Department of Health and Human Services (MDHHS)</td>
<td>SMI Criminal Justice Involved Persons</td>
<td>$149,915 FY19 $158,189 FY20</td>
<td>10/1/2018-9/30/2020</td>
<td>Divert and/or treat SMI justice involved persons</td>
<td>Y</td>
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<tr>
<td>Michigan Department of Health and Human Services (MDHHS)</td>
<td>Children’s Mental Health Block Grant</td>
<td>$100,000</td>
<td>10/1/2018-9/30/2019</td>
<td>Youth Crisis Response</td>
<td>Y</td>
</tr>
<tr>
<td>University of Michigan Health System</td>
<td>Michigan Opioid Collaborative</td>
<td>$61,692</td>
<td>10/1/2018-4/30/2019</td>
<td>Michigan Opioid Collaborative (MOC) Project to help expand Medication Assisted Treatment (MAT) for patients with Opioid Use Disorders (OUDs)</td>
<td>Y</td>
</tr>
<tr>
<td>Community Mental Health Partnership of Michigan (CMHSPM)</td>
<td>SUD PA2 Funded Special Initiatives</td>
<td>$100,000</td>
<td>10/1/2018-9/30/2019</td>
<td>SUD Enhanced Crisis Response Team</td>
<td>Y</td>
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<tr>
<td>Community Mental Health Partnership of Michigan (CMHSPM)</td>
<td>PMTO (Parent Management Training Oregon)</td>
<td>$12,925</td>
<td>10/1/2018-9/30/2019</td>
<td>Support and train our staff to be able to do the parent training program</td>
<td>Y</td>
</tr>
<tr>
<td>University of Michigan Health System</td>
<td>SIM Hublet</td>
<td>$45,250</td>
<td>8/1/2018-9/30/2019</td>
<td>Clinical community intervention that addresses the needs of frequent emergency department users</td>
<td>Y</td>
</tr>
<tr>
<td>US Department of Health and Human Services</td>
<td>CCBHC Expansion (Certified Community Behavioral Health Clinic Expansion)</td>
<td>$1,713,210 FY19 $1,784,971 FY20</td>
<td>12/31/2018-12/30/2020</td>
<td>Comprehensive collection of services that create access and stabilize people in crisis with a focus on recovery, trauma informed care and physical/behavioral health integration</td>
<td>Y</td>
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<tr>
<td>Community Mental Health Partnership of Michigan (CMHSPM)</td>
<td>ROOT</td>
<td>$42,525.65</td>
<td>10/1/2018-9/30/2019</td>
<td>Opioid overdose recovery team</td>
<td>Y</td>
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<tr>
<td>Community Mental Health Partnership of Michigan (CMHSPM)</td>
<td>Clubhouse</td>
<td>$54,664</td>
<td>11/1/2018-9/30/2019</td>
<td>Assist with Clubhouse attendance for individuals on a Medicaid spend down</td>
<td>Y</td>
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<tr>
<td>US Department of Justice</td>
<td>BJA (Behavioral Justice Assistance)</td>
<td>$114,558</td>
<td>10/1/2018-9/30/2019</td>
<td>Reduce the number of people in jail with MI/SUD</td>
<td>N</td>
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<tr>
<td>Community Mental Health Partnership of Michigan (CMHSPM)</td>
<td>Clubhouse Training</td>
<td>$4,000</td>
<td>11/1/2018-9/30/2019</td>
<td>Training for Clubhouse staff employed &lt;= one year</td>
<td>?</td>
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