

NORTH COUNTRY COMMUNITY MENTAL HEALTH  
NORTHERN AFFILIATION  
ACCESS TO CARE PROGRAM PLAN  
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## I. MISSION

The Northern Affiliation is committed to the management and delivery of necessary services that ensure consumers have timely access to quality care in the most clinically appropriate, least restrictive environment and in the most caring, sensitive and confidential manner possible.

The Access Center provides an initial entrance point into the community mental health system for members of the community and network enrolled health care providers.

The Access to Care Program emphasizes solution focused treatment when approving rehabilitative and support services. Access Center care managers encourage providers to furnish immediate and effective, brief interventions to restore coping skills while utilizing and expanding the member's personal and immediate resources. The objective is to utilize emergency and more traditional services only when necessary and to emphasize personal and community-based resources whenever possible. Inpatient psychiatric services are approved only when clinical necessity is demonstrated.

The Access Center's primary role is to receive all requests for community mental health services made by members and their families. The Access Center determines eligibility and documents the need for clinical necessity; links members with providers; and if necessary, authorizes inpatient psychiatric hospitalization and limited out of network services and the payment for those services and monitors the need for continued hospitalization and out of network services. The goal is to insure that the members receive timely and appropriate services while minimizing unnecessary or unsuitable utilization or treatment services; i.e., the right care at the right time and at the right cost. To achieve this goal, the Northern Affiliation uses a network that utilizes a panel of accredited providers.

Network providers are selected for membership based upon specific credentialing criteria and are expected to work cooperatively with the Northern Affiliation to ensure quality community mental health services are delivered to members.

## II. SCOPE

The Scope of Northern Affiliation's Access to Care Program is comprehensive in nature, including but not limited to: Access to screening and assessment 24 hours a day, seven days a week, appropriate referral within a continuum of clinical services and care appropriate to consumer needs, and psychiatric hospitalization and out of network authorizations for services based upon member needs. Simply stated, the Northern Affiliation approves necessary, clinically appropriate behavioral health care services within the scope of the approved benefit plan.

## III. PHILOSOPHY

The Access Center operates philosophically from the belief that when people have difficulties, they also have individual strengths that can be tapped to move them beyond those difficulties and gain mastery of their lives within the context created by those difficulties. Access Center's care

managers encourage network providers to identify and capitalize upon consumer strengths. The Access Center presumes that when people work from their strengths, they become stronger, their coping skills increase and when new problems arise, they are more able to meet them.

Significant emphasis is placed upon the consumer's use of naturally occurring supports and community-based resources. This promotes a person-centered planning approach that reinforces positive outcomes and enhances provided support for recovery. Another critical component is that care is provided in the least restrictive manner possible. Interventions are focused upon decreasing the level of care whenever the member has mastered the necessary life skills or recovered to the point where he/she can benefit from increased strength recognition and development. The access system recognizes that a person-centered approach to treatment includes individual strengths, family and natural supports, and community resources, and understands that recovery is a journey of healing and transformation enabling a person with a mental illness to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. The Access to Care Program recognizes the value of, and strongly promotes, the use of other self-help programs as a part of the ongoing recovery process.

Northern Affiliation acknowledges that co-morbidity (mental health and substance use) is an expectation that must be addressed throughout the entire mental health system. All programs must address the likelihood that consumers requiring mental health services may have a substance use disorder. Northern Affiliation embraces a no wrong door policy in which consumer's needs and desires are assessed and linkages are made to appropriate providers in a seamless manner.

#### IV. AUTHORITY

The Access to Care Program operates under the direction and management of North Country Community Mental Health's Northern Affiliation, an affiliation of Community Mental Health Services Programs (CMHSPs) organized in the "Hub and Spoke" model described in the Michigan Department of Community Health's Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans, September 2000. The participants in this affiliation are AuSable Valley CMH, Northeast Michigan CMH, North Country CMH, and Northern Michigan Substance Abuse Services (NMSAS). North Country CMH has been selected as the "Hub," and as such, serves as the Prepaid Inpatient Health Plan (PIHP) and contract holder for the Spokes. Specific authority for the Northern Affiliation operations is through contact with Michigan's Department of Community Health and supporting agreements between North Country Community Mental Health and the other members of the Northern Affiliation. The Access To Care Plan is annually approved by the Operations Committee and the North Country CMH Board.

#### V. PROGRAM REVIEW

The entire Northern Affiliation access to care process and Access to Care Program is reviewed on an ongoing basis and is formally reviewed annually. The Access to Care Program Plan and all of its components are reviewed and updated as needed by the Northern Affiliation Director of Affiliation Services, Medical Director, Access Center Director, Service Quality and Innovation

Manager, and Provider Network Specialist. The analysis of consumer survey data will be included in this program review. The updated Access to Care Program Plan is presented to the Northern Affiliation Quality Oversight Committee and the Northern Affiliation Partners in Care Committee for input. The focus of this program review is upon process; i.e., methods, services, people, equipment and environment.

## VI. CAPACITY ANALYSIS

The capacity of the access process is reviewed on an ongoing basis. This review includes the periodic review of the Access indicators reported to the Michigan Department of Community Health, the access program's internal performance standards, and consumer satisfaction data. This information is reviewed by the Northern Affiliation's PIHP QI Committee on a quarterly basis. As indicated, appropriate adjustments are made to the access process to assure that capacity is adequate to demand.

## VII. PURPOSE

The Access to Care Program is a single point of access system which provides a centralized triage screening and phone assessment for referrals, and a system designed to ensure consumers timely access to the most clinically appropriate and cost-effective treatment, services, and care available. In addition, the Access to Care Program is utilized by providers seeking authorization of inpatient psychiatric hospitalization and limited out of network services. Providers can also obtain consultation and information regarding covered services and /or referrals to specialists or other providers.

## VIII. ACCESS TO CARE PROGRAM GOALS

Goals of the Northern Affiliation Access to Care Program are as follows:

1. Northern Affiliation's Access to Care Program provides behavioral health management of consumer's benefits to ensure:
  - Consumers have access to and receive covered services and care that are clinically effective.
  - Access is managed in a fiscally responsible, cost-effective manner.
  - Barriers to medically necessary and clinically appropriate services are minimized.
  - There are mechanisms in place to evaluate and make available to consumers, appropriate methods of treatment, services and care.
2. Northern Affiliation's Access to Care Program coordinates necessary, clinically appropriate behavioral health care services to ensure:
  - Access to appropriate screening, assessment, and referral 24 hours a day, seven days a week.
  - Appropriate referral to services and care, based on objective, publicized necessity criteria consistent with national standards. This includes Early and Periodic Screening and diagnostic Testing (EPSDT) specialty services

referrals to correct or ameliorate a qualifying condition discovered through the EPSTD screening process.

- A continuum of clinical services and care appropriate to the consumers' needs. If necessary, the Access Center will assist Providers in obtaining necessary transportation for EPSDT participants through the individual's Medicaid health plan or through the Department of Human Services.
  - Availability of knowledgeable, well trained behavioral health professionals.
  - Co-occurring disorders are recognized and addressed throughout the entire mental health system.
3. Northern affiliation's Access to Care Program participates with the Quality Assessment and Performance Improvement Program (QAPIP) in the outcomes management program that promotes effective, efficient service delivery. This insures:
- Internal performance standards are achieved.
  - External regulatory, licensing and accreditation standards are met.
  - Treatment, service and care are outcomes oriented.
  - Member clinical outcomes are measured and results integrated into the design and improvement activities of the Access Center's systems and provided services.
  - Member satisfaction is measured and results integrated into the design and improvement activities of systems and services.

## IX. PROGRAM COMPONENTS

1. Triage. Triage is the first step in the access process. It is the cornerstone of the service delivery system. The triage process allows access care managers to make relevant decisions about the scope and intensity of the intervention required for each person. Access care managers:
  - Identify the precipitating event or circumstance
  - Obtain a history of illness and an assessment of the severity of the current problem(s).
  - Obtain identifying information to determine the enrollee's benefits and billing information.
  - Assign the consumer to the most appropriate provider for assessment.
  - Complete a risk assessment documenting risk of self-harm, harm to others, or harm by others.
  - Complete direct linkage to Northern Michigan Substance Abuse Systems for substance use screening and assessment, when appropriate.
2. Benefit Verification. Access Center care managers and care advocates will collect consumer information to determine and verify benefits eligibility. Covered services are rendered to only eligible consumers or enrolled "members." When an individual is not eligible, appropriate referrals are provided.
3. Authorization of inpatient psychiatric hospitalization or out of network services. Upon receipt of a request for inpatient psychiatric hospitalization or out of network services for

an individual who is eligible for services, the Michigan Department of Community Health Medicaid Provider Manual and the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 09 DCH contract are used to determine the intensity of service supports necessary to achieve treatment benefits.

4. Referral for Assessment and Treatment. Referrals to contracted, non-CSSN providers, or out of network providers, for assessment and treatment are specific and defined in terms of place of service, types of service, and acceptable time frames. Authorizations for inpatient psychiatric hospitalizations, non-CSSN contract providers, and out of network services are sent to the requestor.
5. Subsequent authorization (re-authorization) for out of network providers. After the initial authorization, all on-going authorization and coordination of care is handled by the Access to Care Program. Treatment reviews are conducted and documented through discussion between the access care manager and the treatment provider. The consumer's current condition, history of treatment, and social support network are considered in determining and approving the effective treatment.
6. Description of the Referral Process
  - Upon receipt of a call from a provider or consumer, the Access Center care manager completes the initial triage and risk assessment, identifies the precipitating event, obtains a history of illness and collects identifying information. This information is entered into the Avatar software system.
  - If an emergent or urgent situation exists the Access Center directs the emergency services system of the CMHSPs to respond. This is done on a caller or client defined crisis situation to assure understanding of the problem from the point of view of the person seeking help.
  - If a routine situation exists the Access Center determines benefit services for eligible consumers.
  - The Access Center authorizes the service using the Medicaid Provider Manual and the current Medicaid Manual Specialty Supports and Services concurrent 1915 (b)/(c) Waiver Program and completes the referral by scheduling the assessment with the appropriate provider.
  - The provider completes the assessment and determines the need for additional services; the consumer and provider develop a person-centered plan and defined services.

## X. PROGRAM DESIGN

### 1. Facility

The Northern Affiliation's Access to Care Program's Access Center is located in Petoskey, Michigan. The address is: NCCMH, Northern Affiliation, One MacDonald Drive, Suite E, Petoskey, MI 49770. The telephone number is 1-800-834-3393.

## 2. Hours of Operation

The Access to Care Program Access Center operates Monday through Friday, 8:00 AM until 5:00 PM. During these business hours the Access Center will conduct screenings and arrange necessary care that is clinically appropriate to the needs of consumers.

Consumers and network providers may request services and authorizations by calling 1-800-834-3393, Monday through Friday, 8:00 AM until 5:00 PM. Calls will be triaged, benefits verified, out patient psychiatric and out of network services authorized, and appointments coordinated and made. Consumers and network providers may also leave messages for routine requests after 5:00 PM and a call will be returned on the next business day.

## 3. Third Level Crisis Intervention Services

Consumers requesting emergency services outside of normal business hours will do so by calling Third Level Crisis Intervention Services, 1-800-442-7315. Third Level will triage the calls, and if necessary, involve the local CMHSP Emergency Services System for an immediate screening and authorization of necessary inpatient psychiatric hospital services through the next business day. The local CMHSP making an outside of normal business hours authorization of inpatient psychiatric hospitalization services will inform the Access Center of all authorizations on the next business day. The Access Center acts on further requests for services.

## 4. Staffing

The Access to Care Program is staffed by a team of six individuals:

- One Access Center Director
- Three full time and one part-time (.5) Care Managers.
- One Secretary /Receptionist

The Access Center Director and Care Managers will generally have a minimum of a Masters Degree in Social Work, Counseling, or Psychology and appropriate license in the State of Michigan. All individuals should have a minimum of three years experience working in behavioral health organizations.

Access Center clinical staff members are required to maintain necessary credentials and clinical competency. They must provide documentation of professional credentials as defined for each discipline by state, professional and agency standards. Access Center clinical staff will be credentialed by North Country Community Mental Health's Clinical Services Committee. They must meet the standards and competencies defined in North Country Community Mental Health's Credentialing and Privileging Procedure for credentialing only. They do not need to be privileged.

New employees participate in an orientation program that is both general and specific. The new employee core training is defined in Item 5, below. The employee and the clinical supervisor identify needs for additional training and experience to meet the expectations of the position.

Clinical competency is maintained through participation in professional education and clinical supervision. Clinical staff must document a minimum of 15 hours per year of continuing

professional education regardless of the amount that may be required by the discipline standards, licensing or professional registries.

## 5. Staff Training

All Access Center personnel are required to complete 15 hours of continuing education each year. Continuing education may be obtained through organizational in-service training and from external sources such as hours offered by professional organizations and institutions of higher learning. All employees will attend mandatory annual training.

All new Access Center personnel will complete a core training which consists of:

- The history and purpose of the Access Center
- An introduction to behavioral healthcare management
- A review of benefit packages and claims payment systems
- Program implementation training to include:
  - Clinical criteria
  - Access Center policies and procedures
  - Appeals and grievances
  - Quality improvement
  - Provider networks
  - Specific information about prepaid health plans
  - Software
- Assessment of chemically dependent consumers
- Assessment of consumers with emotional, mental, and psychological issues
- Crisis intervention training

## 6. Software

The Northern Affiliation's Access Center uses the Avatar RAD plus information system for its software. This software stores information received from all segments of the delivery system. It does so through a modular arrangement of functions and applications, utilizing a relational database as the data repository, and a graphical user interface for input. The Avatar information system uses a modular approach to managing four main subsystems: Clinical, relationship manager, membership and claims.

## 7. Community Awareness

Access Center information regarding operations shall be widely disseminated in a manner so that consumers benefit. Newsworthy changes in operations will be reported to a targeted audience of consumers, advocacy groups, public, network providers, coordinating agencies, CMHSP employees and board members, and other community healthcare providers. This awareness campaign on single point access and the Access Center services may utilize: PSA, newspaper advertising, Website, billboards, radio, direct mail, calling card of Access Center information, and telephone directory yellow pages. Access Center information and contact information is contained in the Welcome to Community Mental Health Handbook.

## XI. ACCESS TO CARE PROTOCOLS

### 1. Care Determination

The Northern Affiliation's Access to Care Program arranges for behavioral health care that is most clinically appropriate to the needs of its consumers. Northern Affiliation's behavioral health criteria are based on national standards and are accepted professional practice. These standards and practices are defined in detail in the Medicaid Provider Manual and Medicaid Managed Specialty Supports and Services concurrent 1915 (b)/(c) Waiver Program . These documents provide the framework for determining who is eligible for which service, at what level of intensity and for how long. Access Center Care Managers use these guidelines in screening and referring individuals for services. Care Managers can deviate from these guidelines with approval of the Access Center Director. Provided behavioral health services are those services which are:

- Necessary to prevent dangerous behavior to self or others.
- Necessary to reduce symptoms of mental illness that impair the consumer's functioning and quality of life.
- Individualized specifically to the consumer's needs and are not in excess to the current needs and condition of the consumer.
- Person-centered and focused upon positive consumer outcomes.
- Empower the consumer to achieve/sustain the highest level of functioning possible.
- Provided in the most clinically appropriate, least restrictive environment possible.
- Embrace consumer dignity, rights, and responsibilities.
- Cost effective and resource efficient.
- Supportive of the recovery process.

The DCH Medicaid Provider Manual and Medicaid Managed Specialty Supports and Services concurrent 1915 (b)/(c) Waiver Program , documents establish the intensity criteria used to determine the most appropriate level and setting for treatment, services and care. The Access to Care Program Plan defines consumer intensity needs as emergency, urgent, and routine and defines these needs as follows:

**Emergent need** is a life threatening condition in which the consumer is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self harm or harm to others; and/or is displaying vegetative signs and is unable to care for self.

**Urgent need** is a condition in which the consumer is not actively suicidal or homicidal, denies having a plan, means, or intent for suicide or homicide but expresses feelings of hopelessness, helplessness or rage, and has potential to become actively suicidal or homicidal without immediate intervention. This consumer displays a condition which could rapidly deteriorate without immediate intervention, and without diversion and intervention will progress to the need for emergency services and care.

**Routine need** is a condition in which the consumer describes signs and symptoms which result in impairment and functioning of life tasks, impact the consumer's ability to participate in daily living, and/or have markedly decreased the consumer's quality of life.

The Access Center's licensed clinicians possess the education, training, and experience to determine the needs of customers, and match and refer the consumer to the most clinically appropriate care level, provider and setting.

## 2. Emergency and Urgent Care Needs

The Northern Affiliation's Access Center is committed to providing consumers with timely access to emergent, urgent and routine treatment, services, and care. The Access to Care Program offers immediate access to licensed clinicians 24 hours a day, seven days a week and conducts and arranges triage screening for mental health and substance use disorders, and makes referrals for emergency and urgent treatment, services, and care for consumers. The Access Center clinicians are available to handle the following requests: Emergency, urgent and crisis calls by consumers and authorizations for inpatient psychiatric hospitalizations and out of network services. This process is detailed in the NCCMH Northern Affiliation Administrative Manual.

In an emergency situation, the Access Center's first concern is for the safety and security of the consumer. Providers are encouraged to pre-certify and pre-authorize care whenever possible through the use of their emergency services programs. The Northern Affiliation's Access Center will authorize clinically necessary emergency care following admissions to emergency treatment, services, and care made during the hours the Access Center is not staffed. This provides for the authorization of inpatient psychiatric hospitalization services that occur during non-business hours; e.g., nights, weekends and holidays. The Access Center must be notified of any inpatient psychiatric hospitalization authorizations the next business day.

## 3. Routine Care Needs

The Access Center is committed to providing its consumers with access to initial routine DD, MI, SED, or SUD treatment, services and care. When a consumer requests routine care during business hours, he/she is screened, assessed for risk, and given an appointment with a licensed clinician. When requests are made through Third Level Crisis Intervention Services during non-business hours, the caller is provided the number for the Access Center and informed of how to access services during business hours. This process is detailed in the NCCMH, Northern Affiliation Administrative Manual.

## 4. Continued Care Needs

The Access Center authorizes initial inpatient psychiatric hospitalization and out of network treatment, services, and care based on clinical necessity through the provider contacting an Access Center care manager by calling 1-800-834-3393. The care manager authorizes initial care only after communicating with the provider or a provider representative. The Access Center care managers continue to authorize care based on clinical necessity/appropriateness criteria defined in the DCH Medicaid Provider Manual and Managed Specialty Supports and Services concurrent 1915 (b)/(c) Waiver Program. . Subsequent and continued authorizations are made through scheduled reviews with the care managers and the treating provider. This process is detailed in the NCCMH, Northern Affiliation Administrative Manual.

## 5. Information Needs

The Access Center may handle information requests from consumers and providers. Care managers and customer services representatives answer questions and respond to inquiries regarding demographics, covered benefits, non-clinical utilization, and eligibility verifications. This option is available during business hours only.

## XII. ALTERNATIVE ACCESS

Consumers are encouraged to access care through the 1-800-834-3393 Access Center number. However, the Access Center recognizes that consumer and providers may request services via other avenues. Those avenues may include:

- Hospital/rural clinic/facility emergency rooms.
- Walk-in clinics and other treatment locations.
- Behavioral healthcare provider offices.

The access system shall provide a timely, effective response to all individual who walk into a CMHSP office requesting services. For individuals who walk in with urgent or emergent needs, an intervention shall be immediately initiated. Those individuals with routine needs must be screened or other arrangements made within thirty minutes.

## XIII. ACCESS TO CARE STANDARDS

The Northern Affiliation is committed to providing timely access to services. The following access standards are established and monitored through the Northern Affiliation's QAPIP. Access to emergency care must be available 24 hours a day/seven days a week. Phone service must result in a live voice within time frames established in policy and procedures and encounter no phone trees. The organization's access system services shall be available to all residents of the State of Michigan, regardless of where the person lives, or where he/she contacts the system. Staff shall be welcoming, accepting and helping with all applicants for service.

- **Emergency Care.** The response to a request for emergency care results in an immediate response with an immediate arrangement made for a face-to-face evaluation. All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back.
- **Urgent Care.** The response to a request for urgent care results in an immediate response with the initial appointment scheduled within 48 hours. All urgent calls are immediately transferred to a qualified practitioner without requiring an individual to call back.
- **Routine Care.** The response to a request for routine care results in an immediate response with the initial assessment scheduled within 14 days.

## XIV. PROVIDER NETWORK

The Northern Affiliation is committed to providing consumers with the most competent and qualified providers available. The Northern Affiliation's provider network consists of licensed CMHSP employees and contracted professionals. Providers of Northern Affiliation's network undergo a rigorous credentialing and privileging process. This process includes the meeting of

established clinical credentialing criteria; provider application and review; primary source verification; granting of privileges; and monitoring of professional standards of practice. Referrals for treatment, services and care are made to network providers only.

## XV. PROGRAM DOCUMENTATION

The Northern Affiliation's Access Center has established documentation requirements to ensure pertinent consumer information is gathered in a sensitive and confidential manner. Documentation standards are set for triage, screening, referral, and treatment. Additionally, standards are established for care managers performing utilization management and review functions for continued care, physicians responsible for peer review and appeals activities, and in network providers. These standards are distributed and training provided to all parties responsible for documentation. Documentation is discussed in detail in the Provider Manual. Compliance to documentation standards is described in the NCCMH, Northern Affiliation Administrative Manual and monitored as described in the Northern Affiliation's QAPIP and the semiannual qualitative review..

The Access Screening Information Report provides the Northern Affiliation Access Center workers a standardized process to screen and triage consumers, to assess acuity of care needs, and make a timely referral to the Provider Network. The Access Screening Information Report may be completed telephonically at the Access Center, face-to-face at the Access Center, or at provider locations.

## XVI. AUTHORIZATION OF SERVICES

Access Care Managers never make a final determination regarding *the necessity of care*. This decision belongs to the provider who retains final clinical responsibility. Access Care managers do however determine whether the condition of the member and the nature of the service being provided *meet the parameters of and warrant the use of the benefit*. Any provider who disagrees with an access management decision or who feels a member is at risk for a denial of continued benefit utilization has the right to appeal. This right should be communicated at the time the use of the benefit is denied. The authorization of inpatient psychiatric hospitalization and out of network provider services is covered in detail in the North Country CMH, Northern Affiliation Administrative Manual, Chapter 4, Access to Care.

## XVII. GRIEVANCE AND APPEALS

Individuals requesting service from the Northern Affiliation shall have the right to appeal a denial and/or request a second opinion when denied services and or authorization following their initial request for services (Michigan Mental Health Code: Sec. 705(1), (2)). Additionally, for Medicaid beneficiaries, consumers and providers have the right to appeal denials for requested services throughout their episode of care. Individuals denied their requests for hospitalization may request a second opinion (Michigan Mental Health Code: Sec. 409(4), 498e (f4) and 498h (5)). A dispute resolution and grievance process also exists wherein a consumer may resolve concerns and disputes with the Northern Affiliation or their providers. The intent is to provide an easy and timely process to the consumer that encourages discussion, negotiation and

resolution of disputes. Complaint, grievance, and appeal procedures are detailed in the following North Country CMH, Northern Affiliation Administrative Manual.

These policies and procedures do implement the rights to appeal provided in the Michigan Mental Health Code, Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) /Waiver Program , Rights to Notice and Fair Health for Medicaid Eligible contained in 42CFR, Chapter IV, Subpart E, Section 431.200, or the Michigan Public Act 238, Section 6231 (1) of 1978, as amended.

## XVIII. CONSUMER RIGHTS

Consumers shall not be denied appropriate service on the basis of race, color, national origin, religion, sex, age, existence of mental or physical handicap, marital status, sexual preference, or political beliefs (Administrative Rules for Substance Abuse Service Programs R325.14304(1)). The screening of a consumer into a treatment or services program shall not result in the consumer being deprived of any rights, privileges, or benefits which are guaranteed to individuals by state or federal law or by the state or federal constitutions (1978 Public Act 368 and Promulgated Rules). Services will be provided in a safe, sanitary, least restrictive and humane environment. All consumers of the Northern Affiliation system have the right to be treated with dignity and respect.

## XIX. DEFINITION OF TERMS

**Appeal:** A request for a review of an action. An action is a decision that adversely impacts an individual's claim for services due to denial or limited authorization; reductions, suspension or termination of services; or failure to make an authorization decision within allowable timeframes.

**Assessment:** The process established by an organization for obtaining appropriate and necessary information about each individual seeking entry into a health care setting for service. The information is used to match an individual's need with the appropriate setting, care level, and intervention.

**Beneficiary:** An individual who is eligible for Medicaid and who is receiving or may qualify to receive services under the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program

**Community Mental Health Services Program (CMHSP):** A program operated under Chapter 2 of the Mental Health Code - Act 258 of 1974 as amended (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program).

**Consumer:** individual who receives services from the Michigan Department of Community Health or a Community Mental Health Services Program. It also means a person who has received the equivalent mental health services from the private sector (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program).

**Co-occurring disorder:** Co-occurring disorders refer to co-occurring substance use (abuse or dependence) and mental disorders. Consumers said to have co-occurring disorders have one or more disorders relating to the use of alcohol and /or other drugs of abuse as well as one or more mental disorders. (Substance Abuse Treatment for Persons with Co-Occurring Disorders. TIP 42, USDHHS, Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, 2005).

**Emergent Need:** A life threatening condition in which the consumer is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self harm or harm to others; and/or is displaying vegetative signs and is unable to care for self.

**Medical Necessity:** Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet the person's mental health/substance abuse needs, consistent with the persons, diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. (MDCH Medicaid Provider Manual, January 1, 2009).

**Person-centered Planning:** Means the process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life. It honors the individual's preferences, choices, and abilities (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program ).

**Prepaid Health Plan (PHP):** Organization that manages specialty health care services under the Michigan Medicaid Waiver Program for Specialty Services States approved concurrent 1915 (b)/1915(c) Waiver Program, on a prepaid, shared risk basis, consistent with the requirements of 42 CFR part 401 et al June 14, 2002, regarding Medicaid Managed Care. (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program ).

**Recovery:** Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. (Substance Abuse and Mental Health Services Administration Center for substance Abuse Treatment, National Mental Health Information Center).

**Routine Need:** A condition in which the consumer describes signs and symptoms which result in impairment and functioning of life tasks, impact the consumer's ability to participate in daily living, and/or have markedly decreased the consumer's quality of life.

**Urgent Need:** A condition, in which the consumer is not actively suicidal or homicidal, denies having a plan, means, or intent for suicide or homicide but expresses feelings of hopelessness, helplessness or rage, and has potential to become actively suicidal or homicidal without immediate intervention. This consumer displays a condition which could rapidly deteriorate without immediate intervention, and without diversion and intervention will progress to the need for emergency services and care.