NORTH COUNTRY
COMMUNITY MENTAL HEALTH

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QUARTERLY PROVIDER MEETING AGENDA

Monday, February 9, 2026
Virtual on Teams

1:30pm	**Introductions**	Katie Lorence, Contract Manager
	Welcome & MDHHS PIHP RFP	Brian Babbitt, Chief Executive Officer
	Documentation & Training Updates	Amanda Cordova, Training Specialist
	Customer Services	Suzan Petee-Eubank, Quality & Utilization Spec
	Site Visits	Angela Balberde, Provider Network Manager
	MDHHS Audit & Confidentiality	Kim Rappeyea, Chief Operating Officer
3:00pm	**Open Discussion**	

THANK YOU FOR PARTICIPATING!

OUR NEXT QUARTERLY PROVIDER MEETING IS SCHEDULED FOR

~~**Wednesday, May 20th**~~
~~**10:00am – 12:00pm**~~
Virtual on Teams

• Please add providerrelations@norcocmh.org and constantcontact.com to email server contact lists.
• Provider Meeting information can be found here: http://www.norcocmh.org/provider-meetings/
• Please contact our Contract Manager, Katie Lorence, at klorence@norcocmh.org or call 231-439-1297 to suggest topics for future meetings.

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PROVIDER MEETING MINUTES

Monday, February 9, 2026
'TEAMS VIRTUAL MEETING'

PROVIDERS REPRESENTED: Alan Dyer BSC/BTL; Amanda Marentette - Community Homes, Inc; Amy Carter - Straits Area Services; Angie Taylor; Barb Sands; Carrie Borowiak - Crossroads Industries; Chris VanWagoner – NMRE; Delissa Payne - Spectrum Community Services; Fran Damoth Bigelow - Crossroads Industries, Inc.; GTI Mancelona - Becky Phillips: grand traverse industries; Jennifer Kucharek - Spectrum Community Services; Jessica Shrum - Grand Traverse Industries; Jordan Shep - Ohana AFC, Serenity AFC, Sheplers AFC; Jory Harland – CHHS; Lacy - Straits Area Services; Meredith Aleccia - North Arrow ABA; Micah Haven - Grand Traverse Industries; Roxanne McLintock - Northern Family Intervention Services; Ryder Specialized Care; Sherry Kidd - Listening Ear Crisis Center

NCCMH REPRESENTED: Amanda Cordova, Amy Christie, Andrea Rose, Angela Balberde, Ann Friend, Barb Woodhams, Brian Babbitt, Chanda Harwood, David Hornibrook, Dominique Cook, Katie Lorence, Kim Rappleyea, Lynne Pearson, Marcia Peterson, Michael Wolf, Pam Krasinski-Wespiser, Suzan Petee-Eubank

Introductions: Katie Lorence, Contract Manager

Welcome & MDHHS PIHP RFP Update: Brian Babbitt, Chief Executive Officer

- The MDHHS RFP proposed major structural changes including region consolidation and limiting delegation.
- North Country CMH opposed the RFP due to risks to access, service availability, administrative burden, and care fragmentation.
- MDHHS has cancelled the RFP; court affirmed its ability to competitively bid PIHPs.
- CMHSP roles reaffirmed under Mental Health Code.

Documentation & Training Updates: Amanda Cordova, Training Specialist
Detailed training on documentation best practices, emphasizing objective, factual, timely, and professional documentation.

Customer Services Update: Suzan Petee-Eubank, Quality & Utilization Spec
Overview of Customer Services functions, grievance and appeal processes, timelines, and 2025 data.

Site Visits: Angie Balberde, Provider Network Manager
Summary of site review requirements across General, HCBS, Safety, Medications, and Training categories. Common findings include missing IPOS/Care Plans, non-lockable doors, missing documentation of autonomy, and expired supplies.

MDHHS Audit & Confidentiality: Kim Rappleyea, COO & Privacy Officer
Overview of confidentiality laws, HIPAA identifiers, release/consent requirements, SUD rule changes, and law enforcement disclosure limitations.

ARCHIVED PRESENTATION MATERIAL: http://www.norcocmh.org/provider-meetings/

If you would like to hear about a specific topic at our quarterly provider meetings or wish to have staff from your program added to our invitation list, please email: providerrelations@norcocmh.org and let us know!

THANK YOU FOR PARTICIPATING IN OUR QUARTERLY PROVIDER MEETING.
VIRTUAL QUARTERLY PROVIDER MEETINGS WILL CONTINUE UNTIL NOTIFIED OTHERWISE.

UPDATED NEXT QUARTERLY PROVIDER MEETING:
Monday, May 4, 2026
VIRTUAL TEAMS MEETING
1:00PM – 3:00PM

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QUARTERLY PROVIDER NETWORK MEETING

Februrary 2026

AGENDA

1:30 pm	Meeting Begins
Introductions	Katie Lorence, Contract Manager
Welcome	Brian Babbitt, Chief Executive Officer
Documentation & Training Updates	Amanda Cordova, Training Specialist
Customer Services	Suzan Petee-Eubank, Quality & Utilization Spec
Site Visits	Angie Balberde, Provider Network Manager
MDHHS Audit & Confidentiality	Kim Rappleyea, COO
3:00 pm	Open Discussion

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Office of Recipient Rights:
1-800-281-0481

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THANK YOU

Next Meeting

~~Wednesday, May 20th~~

~~10:00am – 12:00pm~~

Virtual on Teams

Contract Manager
Katie Lorence – klorence@norcocmh.org

Provider Network Manager
Angie Balberde – abalberde@norcocmh.org

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PIHP Competitive Procurement

Brian Babbitt

Provider Network Meeting

February 9th, 2026

MI Mental Health System

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- Public mental health system Medicaid carve out for SMI, SED, and I/DD populations
- Mild and moderate are funded via MCOs
- CMHSP – safety net provider
- Authority – created by the county (county oversight and control)

Local Governance

14 - person board all appointed by the County Boards

6 - County Commissioners
6 – County appointments
2 – At large
1/3 Lived experience

Mental Health Code

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MCL 330.1206
Specifies the CMHSP's program ***shall*** include, at a minimum, ***all*** of the following:

(a) Crisis stabilization and response 24/7
(b) Identification, assessment, and diagnosis used to develop the IPOS
(c) Planning, linking, coordinating, follow-up, and monitoring
(d) Recipient training, treatment, and support, including rehabilitative services, and pre-vocational and vocational services
(e) Recipient rights services
(f) Mental health advocacy
(g) Prevention activities
(h) Any other service approved by the department

RFP Specifications

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- Not-for-Profit VS Public Entities
  - Excluded current Regional Entities
- Reduced number of regions from 10 to 3
  - Northern 21 counties lower MI combined with U.P.
  - Allowed multiple PIHPs per region.
- Did not allow the new PIHP to delegate:
  - Access Management (Identification, assessment, and diagnosis)
  - Utilization Management (Development & monitoring of IPOS)
  - Recipient Rights protections
  - Network Management (contract with providers)

Why we Opposed

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- Complicate access to services
  - Preauthorization (referral to specialist concept)
  - Which PIHP?
  - Contracts with multiple PIHPs in same region
- Reduce services available
  - PIHP is incented not to spend money
  - 15% admin vs current 3%
  - Additional upside (keep 100% of next 2%)
- Reduced quality services
  - Cost is primary focus
- It would make us direct competitors
- Would result in a position the we could not deliver the services we are statutorily required to deliver.

What Now?

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- MDHHS has cancelled the RFP
- The Judge ruled MDHHS can determine the number of PIHPs
- The Judge Ruled MDHHS can competitively bid the PIHPs
- The Judge did not prohibit privatization
- The Judge confirmed the role of the CMHSPs as defined in the Mental Health Code
- MDHHS will need to determine how to proceed
- We stand ready to partner in a path forward
- We will continue to protect the people we serve, our provider network, and local communities

Questions?

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But… Did you Document it?

Best Practice Guidelines for writing concise, timely and accurate documentation.

Best- Practice Documentation Guidelines

- Effective documentation is **objective, factual, timely, complete, and professional.** The goal is to create a record that is clear, defensible, and useful to others.

Types of Documentation

- Day notes
- Progress Notes
- Incident Reports
- Any Chart Documentation
- Personal Care Logs
- PCP Follow-Ups

Who Will (or Could) Read Documentation

- Home Manager
- Fellow Co-Workers
- Supports Coordinator/Case Manager
- NCCMH RN's
- NCCMH Finance
- NCCMH Risk Committee
- Recipient Rights
- Adult Protective Services

From the Michigan Medicaid Manual:

The clinical record must be ***sufficiently detailed to allow reconstruction*** of what transpired for each service billed

For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service.

If an abbreviation, symbol, or other mark is used, it must be standard, widely accepted health care terminology. Symbols, marks, etc. unique to that provider must not be used. (No slang!)

Core Principals of High-Quality Documentation

1. Facts only- No Opinions, Assumptions or Balme

Documentation must describe what was seen, heard or done… ***not*** what was believed or felt.

Avoid Opinions and Judgement:

"The client was acting crazy."

"The client refused because she was angry."

Use Facts and Observations:

“Client smelled strongly of alcohol, had slurred speech, and was unsteady while walking.”

“Client raised voice, paced room, and clenched fists.”

- *Why this matters:*
  Opinions weaken legal credibility and distort clinical or organizational understanding.

Be **Objective** and **Descriptive**

Use measurable and observable details

Weak Language

“The client was cranky.”

“The room was messy.”

“The client was rude.”

Strong, Fact-Based Language

"Client was crying, voice raised, and repeatedly wringing hands."

"Clothing, papers and food containers were on the floor; bed sheets were also on the ground."

"Client raised voice at other consumers and stated they were upset."

Be Clear, Specific and Complete

You must include:

- **Who** was involved
- **What** happened
- **When** it occurred *(date and time)*
- **Where** it occurred
- **What** actions were taken
- Outcome/Follow-up

Avoid Vagueness

Examples of Vagueness in documentation:

“Later in the day”	“Client had an issue”	“Staff handled the situation”	“Client fell in hallway”

Be Specific, and use Direct Quotes when possible.

“At 2:20PM Client BB stated, “I tripped in the hallway when I was walking because my shoe came untied.”

Direct quotes preserve accuracy and prevent interpretation.

Document Concurrently (or As Soon as Possible)

Record events in real time or immediately afterwards

Real-time documentation increases accuracy

Late entries should be clearly labeled as such (“*Late entry for 02/01/2026 at 4:30PM….”)*

4. Never reconstruct from memory incidents hours or days late *(Memory degrades rapidly and documentation loses credibility)*

*****Never alter, “clean-up,” back-date, destroy or erase documentation*****

*Ethical and legal documentation reflects **reality-** not appearances.*

What NOT to include in Documentation

❌ **Do Not Document**	**Why**
Personal opinions	Not defensible
Blame or accusations	Increases legal risk
Emotional language	Appears biased
Speculation	Cannot be verified
Sarcasm or slang	Unprofessional
Hearsay without clarification	Unreliable

Examples: Opinion-Based vs. Accurate

❌ Poor Documentation	✅ Best-Practice Documentation
The client was aggressive and out of control.	Client clenched fists, raised voice, and struck the table with an open hand.
Patient was drunk.	Patient smelled of alcohol, speech was slurred, and gait was unsteady.
Staff handled the fall.	DSP Smith assisted client to bed, assessed vitals, and notified Home Supervisor at 4:15PM via phone call.
Client refused treatment and was uncooperative.	Client stated, “I don’t want this injection,” and pulled arm away when approached.
Staff Mandted the Client	Staff used appropriate de-escalation techniques used in the Mandt System to help reduce t

What NOT to do: Poorly Written Documentation

“Bobby Bee was careless and fell because he wasn’t paying attention. The kitchen floor was probably still wet because staff had mopped a little bit before. Bobby Bee was upset and acting dramatic.”

Issues with this example:

- **Opinionated** (“careless,” “dramatic”)
- **Assumptions** (“probably wet”)
- **Blame placed**
- **No time, location or actions documented**

Best Practice Example of a Well-Written Documentation

Date/Time: 02/01/2026 4:30PM

Location: Kitchen

Client Bobby Bee was ambulating independently in the kitchen alongside the counter when client slipped and fell to the floor. Client stated, “I slipped because the floor was wet.” Staff observed moisture on the floor.

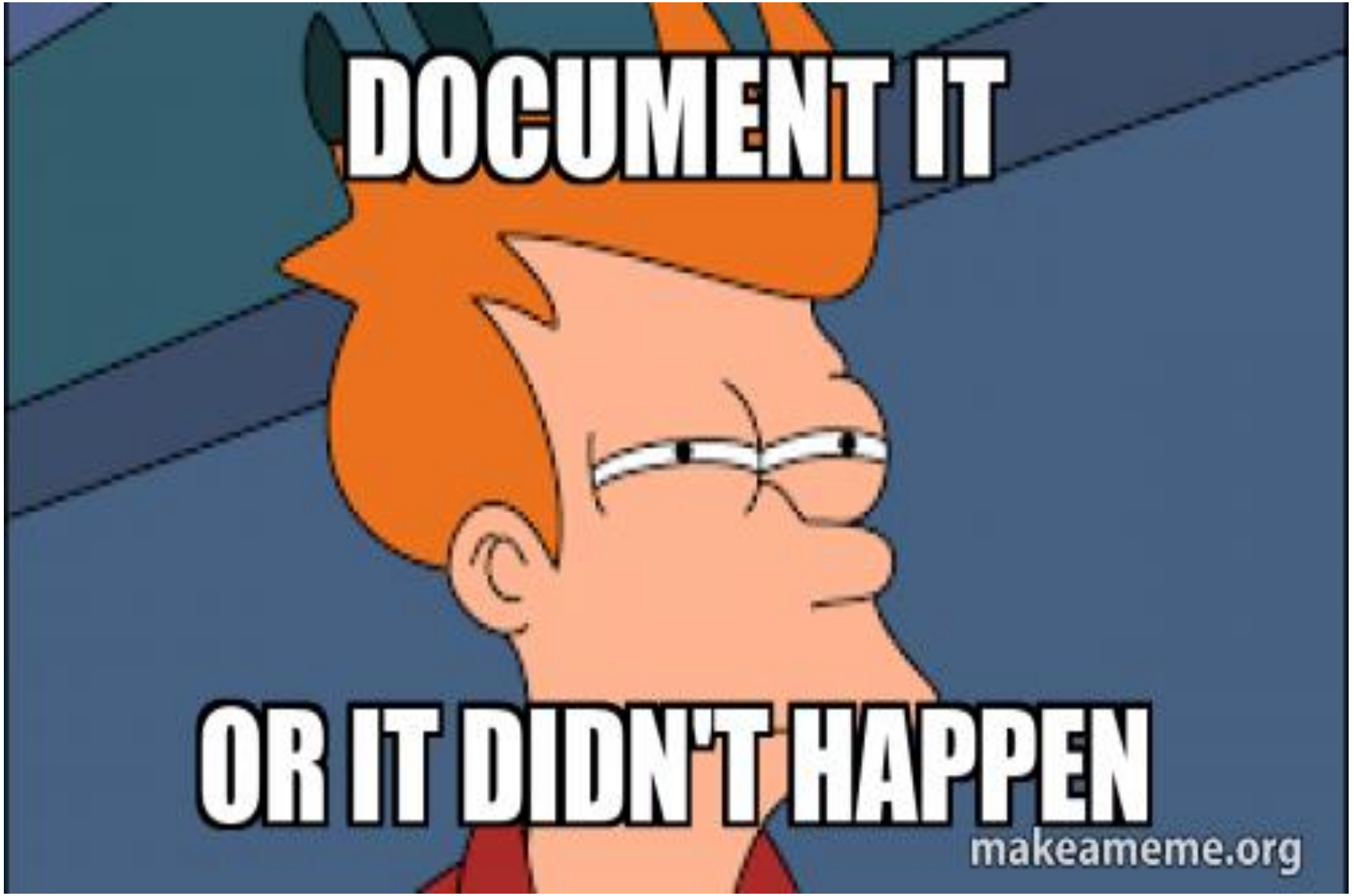
Client was alert and oriented x4. No visible injuries noted. Vital signs were obtained at 4:35PM and were within normal limits. Client denied pain. Head assessment started at 4:35PM according to fall protocol.

DSP Stefanie and DSP Amanda assisted client to a seated position and notified Home Manager via phone. Floor was dried of all moisture by both staff. Client was monitored for changes remainder of shift. No further issues were observed. Oncoming staff were briefed of incident and will continue head assessment.

Why this was strong documentation:

- Objective
- Included direct quotes
- Clear timeline of events
- No blame or assumptions
- Describes actions taken
- Focuses on observable facts

But did you Document it?



Training Handout: Best Practices for Documentation and Incident Reporting

Purpose: To provide clear guidelines for writing accurate, professional and concise documentation.

Why Documentation Matters

- Protects clients, staff and organizations
- Supports continuity of care and communication across all the board (CMH, Coworkers, PCP)
- Serves as a legal and regulatory record
- Preserves facts when memories fade
- Demonstrates professional accountability

Core Principles of High Quality Documentation

- Facts only: Document what you see, hear or do. No opinions or assumptions
- Objective and descriptive; use observable, measurable details
- Clear and Complete: Who, What, When, Where, Actions taken and Outcomes
- Use direct quotes when relevant: Capture exact client/observer statements
- Concurrent: Document in real time or immediately after. No later than the end of your shift.
- Professional: Neutral, respectful language. No slang
- Never alter records: Corrections must be dated, timed and explained.

Poor vs. Best Practice Documentation Examples

Poor: Client was aggressive.

Better: Client raised voice, clenched fists, and struck the table.

Poor: Client was drunk.

Better: Client had unsteady gait, slurred speech and smelled of alcohol.

Poor: Staff handled the fall.

Better: Staff assessed the client, obtained vitals, and notified Home Supervisor at 4:15PM.

Poor: Client was uncooperative.

Better: Client stated, “I don’t want this injection,” and pulled arm away from staff.

Best Practice Documentation:

Date of Incident: January 12, 2026 Time: 2:10 PM Location: Group Room B

Reported by: Amanda C.

Persons Involved: Client J.D., Staff M.R.

Description of Incident: At approximately 2:10 PM, Client J.D. stood up from a chair near the east wall of Group Room B. After taking two steps, J.D.’s right foot slid forward. J.D. fell onto their right side and made contact with the floor. Staff M.R., who was standing approximately six feet away, approached immediately. J.D. remained on the floor and stated, “I slipped.”

Immediate Actions Taken: Staff M.R. instructed J.D. to remain still. At 2:12 PM, RN L.S. arrived and assessed J.D. Vital signs were taken at 2:14 PM. J.D. reported pain rated “3 out of 10” in the right hip. No bleeding was observed. No visible deformities noted. At 2:18 PM, J.D. was assisted to a seated position using a gait belt and transferred to a wheelchair.

Notifications: Provider notified at 2:25 PM. Supervisor notified at 2:27 PM. Family notified at 2:45 PM.

Outcome: Client transported to clinic for further evaluation at 2:50 PM. Environmental Observations: Floor was dry. Client was wearing socks without shoes. No obstacles were observed in the immediate area.

Signature: _____ Date/Time: _____

Documentation Checklist

- Document as soon as possible after the event
- Include date, time, location
- Identify all persons involved
- Describe exactly was you saw and heard
- Use direct quotes when relevant
- Avoid opinions, assumptions and blame
- Describe actions taken, and by whom
- Record assessments and observations
- Document notification times
- Describe outcomes and next steps
- Note any environmental contributing factors
- Use professional, neutral language
- Sign and date

📝 Documentation Best Practices – Short Quiz

Name: _____
Date: _____
Department: _____

---

1. Which of the following is the BEST example of objective documentation?

A. “The client was rude and aggressive.”
B. “The client was clearly intoxicated.”
C. “The client raised their voice, clenched fists, and struck the table with an open hand.”
D. “The client was acting out.”

---

2. Why is concurrent documentation important?

A. It saves time later
B. It improves memory recall and accuracy
C. It reduces the risk of missing critical details
D. All of the above

---

3. Which statement should NOT be included in professional documentation?

A. “Client stated, ‘I don’t want this medication.’”
B. “Vital signs were taken at 1410.”
C. “The nurse was careless when giving medication.”
D. “Client was assisted to a wheelchair.”

---

4. Which elements should always be included in documentation?

A. Who, what, when, where
B. Actions taken and outcomes
C. Notifications and observations
D. All of the above

---

5. Which is the BEST example of using direct quotes?

A. “Client was upset about the rules.”
B. “Client refused group.”
C. “Client stated, ‘I’m not going in there.’”
D. “Client was noncompliant.”

---

6. What should you do if you make a documentation error?

A. Delete it and rewrite it
B. Leave it and don’t mention it
C. Correct it according to policy with date, time, and explanation
D. Ask someone else to fix it

---

7. Which of the following is an example of poor documentation?

A. “Patient reported pain 7/10 in left knee.”
B. “Medication administered at 0900.”
C. “Client was lazy and refused to participate.”
D. “Provider notified at 1435.”

---

8. True or False: Documentation should be written as if it may be read in court.

---

9. Which of the following best supports legal and professional standards?

A. Writing how you felt about the situation
B. Writing only what you observed, did, and were told
C. Leaving out details to save time
D. Waiting until the end of the week to document

---

10. What is the primary purpose of an incident report?

A. To assign blame
B. To punish staff
C. To provide a factual, accurate account of what occurred
D. To replace the client’s chart

Answer Guide:

1. C
2. D
3. C
4. D
5. C
6. C
7. C
8. True
9. B
10. C

Customer Services

The What and Who

Defining Customer Services

- We are all Customer Services Representatives for our clients, regardless of your position.
- Customer Services…
  - refers to the support and assistance given to a client
  - is conveying an atmosphere that is welcoming, helpful and informative

Why Do We Have Customer Services

- Per the NCCMH contract with our PIHP (PrePaid Inpatient Health Plan) which is the NMRE (Northern Michigan Regional Entity) we are required to provide Customer Services
  - Contactor must convey an atmosphere that is welcoming, helpful and informative. As per 42 CFR 438.66, these standards apply to Contractor and to any entity to which Contractor has delegated the customer service function in accordance with 42 CFR 438.230.

Functions of Customer Services

- Welcome and orient individuals to services and benefits available, and the provider network.
- Provide information about how to access behavioral health, primary health, and other community services.
- Provide information about how to access the various rights processes.
- Provide the "Your Rights When Receiving Mental Health Services in Michigan" booklet. Reference the following website for more information: https://cmham.org/services/bookstore/.
- Help individuals with problems and inquiries regarding benefits.
- Assist people with and oversee local complaint and grievance processes.
- Track and report patterns of problem areas for the organization

What Does Customer Services Do….

Grievances-an "expression of dissatisfaction" regarding service issues **other than** a service denial, reduction or termination of services. Or a Recipient Rights Complaint.

- Examples could be but not limited to: quality of care or services provided, or interpersonal relationships between a provider and client.
- Clients (including parents of minors and guardians) may file a grievance at any time either orally or in writing with the Customer Services staff.

Appeals-An appeal is a request by a client or their representative (with the client's written permission) to review an action or adverse benefit determination by a North Country CMH provider. An appeal filed with the Grievance and Appeal Coordinator is considered a local level appeal by a PIHP/CMHSP of an adverse benefit determination.

- This could be a denial of a new or additional service, reduction in the amount, scope or duration of an existing services, suspension of a services or termination of a service

How to File A Grievance

- If a provider of services is unable to provide a resolution to an issue with a client, staff should notify the client of their right to contact Customer Services to file a grievance.
- Clients (including parents of minors and guardians) may file a grievance at any time either orally or in writing with the Customer Services staff.
- The provider is expected to provide assistance to the client in contacting Customer Services if necessary.
- Providers can also help clients write a letter or use a Grievance form to express their grievance.
- Any client may file a grievance at any time – there are no time limits

What Happens When a Grievance is Filed?

- The Grievance and Appeal Coordinator will investigate the grievance with involved staff and supervisors of the affected service.
- The Grievance and Appeal Coordinator must provide a written acknowledgement to the client within 5 business days notifying them that their grievance was received. After a resolution or other outcome has been reached, a disposition letter is sent to the client; within 90 calendar days for Medicaid beneficiaries and within 60 calendar days for Non-Medicaid clients.
- Customer Services staff will forward grievances that are allegations of Recipient Rights violations to the Office of Recipient Rights.

What Happens When an Appeal is Filed?

- If a client receives an Adverse Benefit Determination (ABD) and does not agree, they have a right to file an appeal. How to file will be on the ABD notice sent to them.
- The first level of appeal for clients is at the local CMHSP level. Clients must use the local level process before asking for a State Fair Hearing.
  - Clients have 60 calendar days from the "Notice Date" to request a Medicaid local appeal.
  - Oral requests for appeals will be accepted and will act as the date the appeal request is officially received.
  - Appeals are coordinated by the Grievance and Appeal Coordinator in the Customer Services Office.
  - The Grievance and Appeal Coordinator will notify the appropriate staff (Supervisor, Director of the services involved) who will investigate the local appeal.
  - We have 30 calendar days from the date the local appeal request was received to provide the client with a written Notice of Local Appeal disposition.
  - Requests for expedited appeals will be honored if waiting for a standard time would seriously jeopardize the client's life or ability to attain, maintain or regain maximum function. Expedited appeals, if approved, must be resolved within 72 business hours.

What Services and Supports Are Available?

- The NMRE (North Country CMH's PIHP) maintains a guide to the services and supports available within our Region.

https://www.nmre.org/application/files/2517/3022/2462/Guide_to_Services_FY25_FINAL.pdf

Customer Service Data for 2025

- North Country CMH recorded 1055 Adverse Benefit Determination Notices for Fiscal Year 2025.
  - 833 Terminations of all services or of individual service not resulting in closure
  - 157 Reductions
  - 45 Suspensions
  - 20 Delays in service
  - In addition, 341 Denials of service were processed
    - 3 In patient Hospitalization
    - 40 IPOS(additional services request)
    - 298 Access/Intake
- North Country CMH recorded 107 Grievances and Appeals for Fiscal Year 2025
  - 58 Grievances
  - 37 Local Appeals
  - 22 Second Opinions

North Country Community Mental Health

The North Country CMH Customer Services representative:

Sue Petee

Quality and Utilization Mgmt. Specialist.

Ext 1280

Direct line 231-439-1280

1-877-470-3195

SITE REVIEW PRESENTATION

NORTH COUNTRY
COMMUNITY MENTAL HEALTH

February 2026

SECTIONS OF SITE REVIEW

- **GENERAL**
- **HCBS**
- **SAFETY**
- **MEDICATIONS**
- **TRAINING**

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GENERAL

- **Issues identified in most recent AFC LARA Inspection and Special Investigations have been adequately addressed**
- **Issues identified as requiring remediation in RR substantiated cases have been adequately addressed**
- **Sufficient Staffing/Staffing Pattern**
- **Staffing is available anytime that clients are in the facility**

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GENERAL (continued)

- **Provider assures staff who use personal vehicles to transport clients have insurance binder, certificate, or policy on file**
- **There is documentation of Proof of staff age (18+) for all staff**
- **Valid driver's license on file, if staff transport clients**
- **Criminal background check completed PRIOR to the date of hire and every 3 years after that**

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HCBS

- **Interior of site is free of surveillance/monitoring/recording devices**
- **IPOS and Care Plans are present and current for each client**
- **Clients have access to food at any time**
- **Nutritional food is present in the home in sufficient amounts to prepare three meals daily and any additional food that is requested**

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HCBS (continued)

- **The residential fund record matches the receipts and cash on hand**
- **The client(s) have access to their personal funds and resources at any time**
- **Resident bathroom and bedroom doors are lockable**
- **Clients are allowed to have visitors of their choosing at any time**
- **There is evidence that individual's have the freedom to control their schedule and activities**

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HCBS (continued)

- **Lease or signed LARA AFC Residential Care Agreement AND Summary of Discharge Rights**
- **NO HOUSE RULES**

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SAFETY

- **Vehicles used to transport clients are in safe operating condition**
- **First Aid kit(s) present at site and in vehicles used to transport clients**
- **Blood spill cleanup kit is on site**
- **Carbon Monoxide Detector is present and operational**
- **Smoke Alarms are present and operational. Documentation indicating that smoke alarms are tested periodically and inspected annually.**

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SAFETY (continued)

- **Fire Extinguishers present, accessible, and not expired. Documentation indicating that fire extinguishers are inspected annually**
- **Emergency and Evacuation drills were completed at least once during daytime, evening, and sleeping hours each quarter**
- **Documentation of emergency plans provided. Emergency numbers and contacts are easily accessible.**

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SAFETY (continued)

- Evacuation routes are posted and accurate
- Staff can identify designated tornado shelter onsite
- Evacuation Scores (E-Scores) documentation present and current
- Staff know how to access MSDS (Material Safety Data Sheets)
- All hazardous substances are labeled

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MEDICATIONS

- **Medications are properly stored and secured**
- **Prescriptions match Medical Administration Record (MAR) and labels on containers. Medications are not expired.**
- **Missed and Refused Medications are recorded on an IR and sent to NCCMH**

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TRAINING

- **IPOS Training Form is present and complete for each client's IPOS**
- **Staff were trained and are current in CPR/First Aid**
- **Staff were trained in Bloodborne pathogens**
- **Staff were trained in Emergency Procedures**
- **Staff who administer medications were trained in Medications Administration**
- **Staff were trained in MANDT**
- **Staff were trained on HCBS**

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COMMON FINDINGS

- **Not having current IPOS's and Care Plans onsite**
- **Bedroom doors not lockable by a unique key**
- **No documentation of outings and proof of individuals having the freedom to control their schedule and activities.**
- **Expired items in First Aid kits**
- **Expired medications**

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Where our **clients** and
community are the mission.

HOPE RECOVERY RESILIENCE WELLNESS

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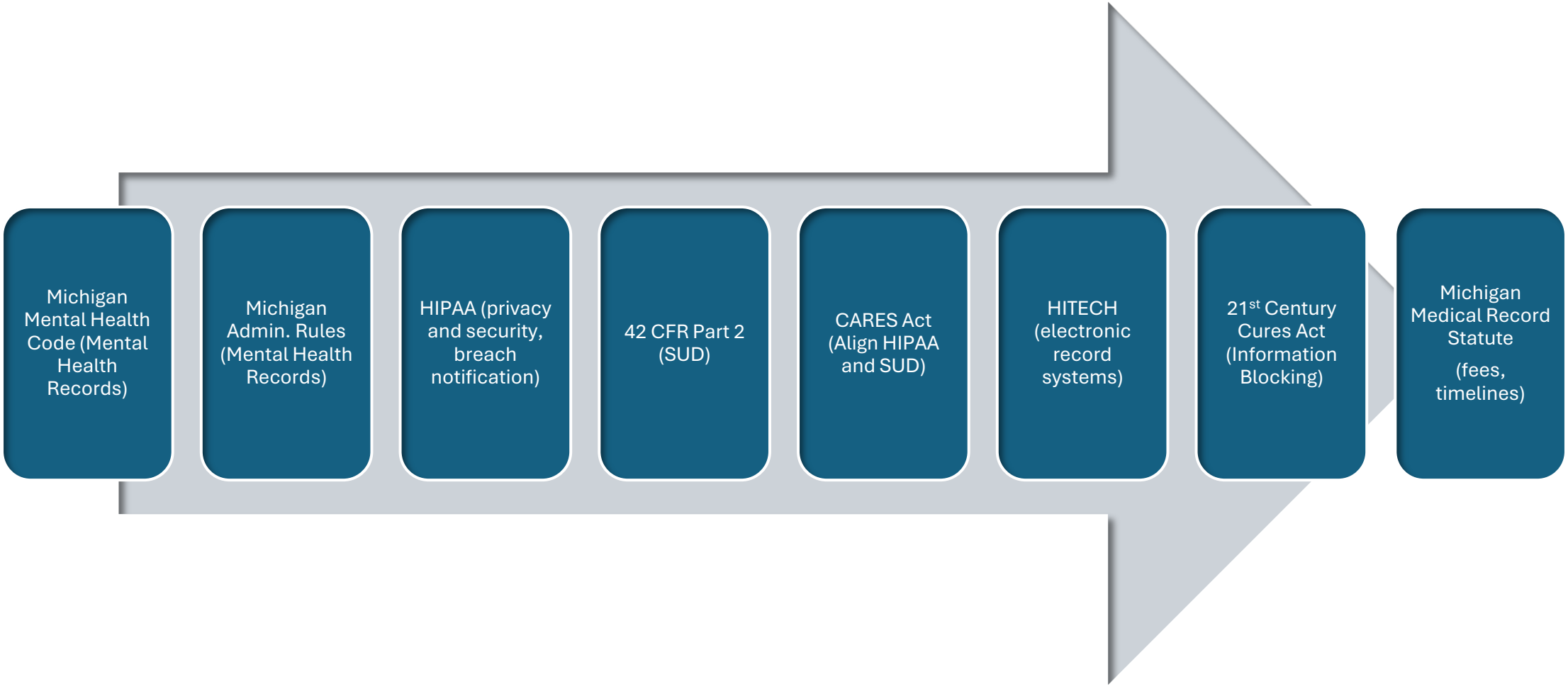
COMMUNITY MENTAL HEALTH

Confidentiality & Disclosure

2/9/26 Provider Network

Kim Rappleyea, COO, Privacy Officer

Confidentiality: Legal Authority



What is considered confidential?

- **Michigan Mental Health Code**: Information in the record and other information acquired while providing mental health services

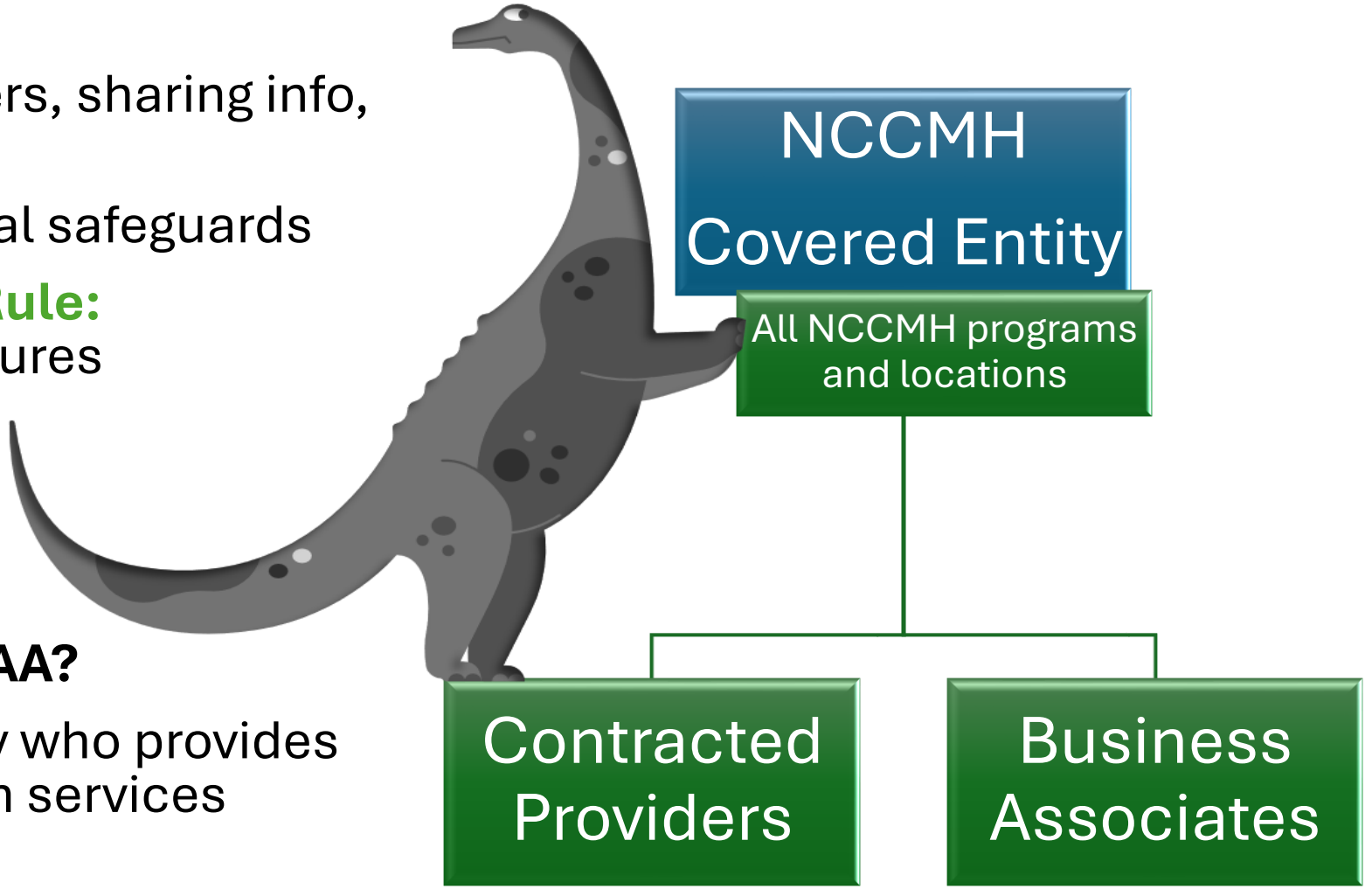
- **HIPAA:** Individually identifiable health information held or transmitted in any form or media, whether electronic, paper or oral, including demographic data that relates to the individual's past, present, or future physical or mental health condition, the provision of health care, or payment for care.

HIPAA: Health Insurance PORTABILITY and ACCOUNTABILITY Act

Privacy Rule: Identifiers, sharing info, parameters, rights

Security Rule: Physical safeguards

Breach Notification Rule: Impermissible disclosures



Who is bound by HIPAA?

Any individual or entity who provides medical/mental health services

Individually identifiable health information

The following identifiers of the individual, their relatives, employers, and household members:

Names

All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes

All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89

Telephone numbers

Vehicle identifiers and serial numbers, including license plate numbers

Fax numbers

Device identifiers and serial numbers

Email addresses

Website URLs

Social security numbers

IP addresses

Medical record numbers

Biometric identifiers, including finger and voice prints

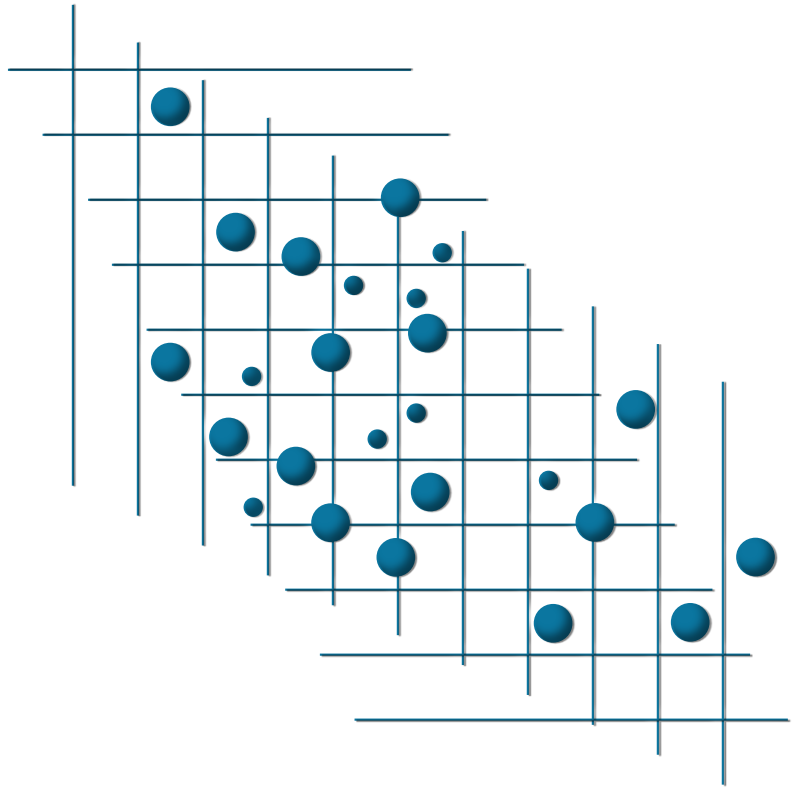
Health plan beneficiary numbers

Full-face photographs and any comparable images

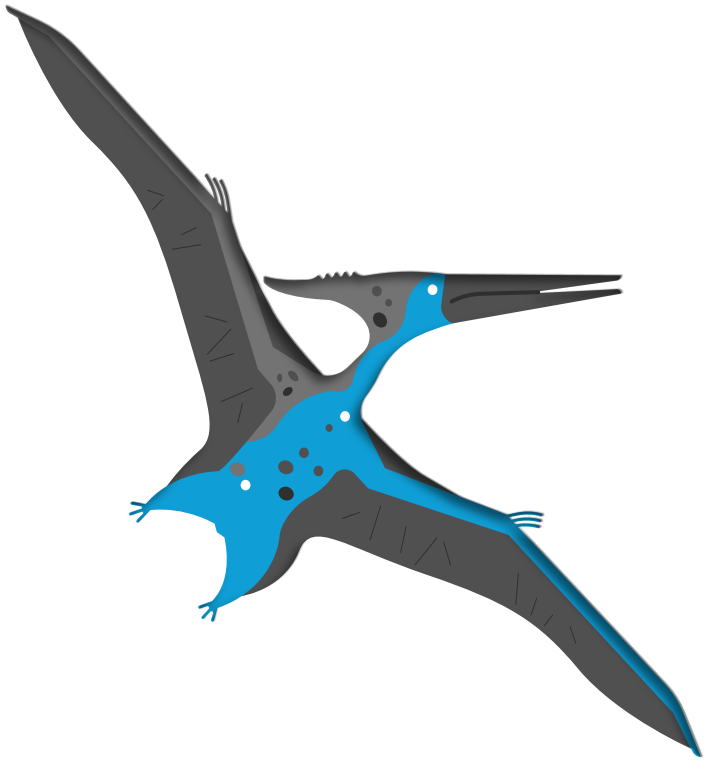
Account numbers

Any other unique identifying number, characteristic, or code, (except as permitted using specifications for re-identification)

Certificate/license numbers



Disclosure: Sharing without consent

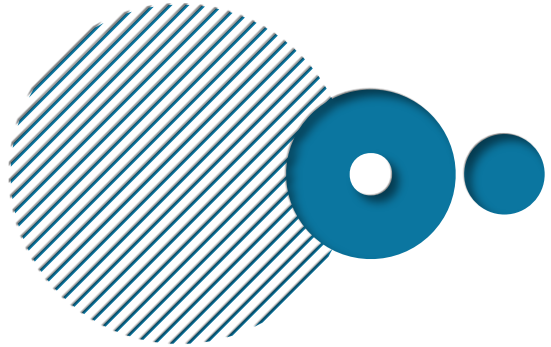


- **Treatment**- info shared between providers
- **Payment**-info shared with health plans/insurance
- **Operations**- info shared in audits, quality reviews, governing entities

TREATMENT aka Coordination of Care

Information necessary to treat, coordinate, or manage care *may* be shared between health care providers without a release.

Care Coordination *(without consent):*



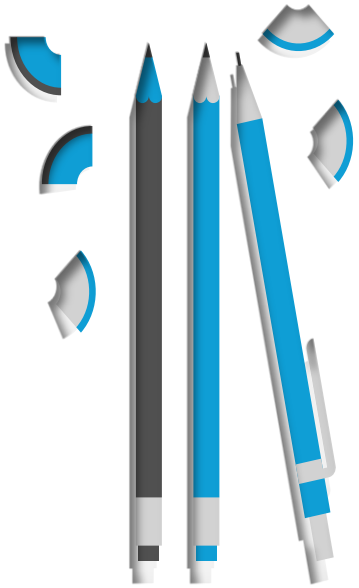
- **IS**

Sharing relevant information with any other medical/mental health provider including doctors, nurses, practices, contract providers, (i.e. AFC, Day Program, hospitals,) and/or anyone who bills health insurance/Medicaid/Medicare for medical/mental health service provision.

- **IS NOT**

Sharing any information with schools, jails (*except directly with medical staff*), lawyers, parole/probation, law enforcement, court, family members/friends, CPS, MDHHS*, administrative entities such as housing, social groups, non-profits (i.e. Challenge mountain, Salvation Army, etc.), etc.

Consent (MMHC):



"**Consent**" means a **written agreement** executed by a recipient, a minor recipient's parent, a recipient's legal representative with authority to execute a consent, or a full or limited guardian with the authority to consent, *or*

a **verbal agreement** of a recipient that is witnessed and documented by an individual other than the individual providing treatment.

VERBAL CONSENT CAVEAT: (SUD records require written consent in legal proceedings)

- **MDHHS 5515- Standard Consent Form**
  - Can be used as a single or as an all-inclusive consent.
  - If more than one party is listed on the form, information can be disclosed in any direction between parties.
  - Cannot be used for legal proceedings due to limitations on SUD records.
  - Consent forms that cover all legal requirements can be accepted from other providers.

EXTERNAL Record Requests (per the Michigan Mental Health Code/Administrative Rules)

For NCCMH to release records, requests must be made **in writing** and must include the following information for record keeping purposes :

- **The information being requested** (types and dates)
- **The name of the requestor** (individual, provider, entity)
- **The purpose claimed by the person requesting** (statement disclosing how the disclosed info is germane to the purpose– why?)
- **The subsection of 748 under which the disclosure will be made** (legal, benefits, coordination, risk of harm, oversight, client request)

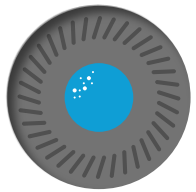
****A consent/release form is not a record request.*

Purpose:

The MMHC has different rules for disclosure discretion depending on the purpose: Some information **SHALL** or **MAY** be shared while other information can be shared **CONDITIONALLY** or only with **RELEASE** (consent.)

MHC Citation	PURPOSE:	Discretion
	Legal	
748 (5a)	Under an order or a subpoena of a court of record or a subpoena of the legislature, unless the information is privileged by law.	S
748 (5b)	A prosecuting attorney to participate in a proceeding governed by the MHC (AOT/ATO/NGRI, etc.)	S
748 (5c)	An attorney for the recipient, with the consent of the recipient, the recipient's guardian with authority to consent, or the parent with legal ***and*** physical custody of a minor recipient.	S R
748 (5d)	To comply with another provision of law. (i.e. Duty to Warn, APS)	S
748 (8)	Disability Rights Michigan (formerly named MPAS) if MHC criteria is met.	C
748 (8a)	Child abuse/neglect investigation. Mandated reporting or upon receipt of valid written request from CPS. Do NOT disclose name of reporter upon release.	C
	Benefits	
748 (5g)	A surviving spouse (or other legally authorized individual) of the recipient for the purpose of applying for and receiving benefits.	S
748 (7a)	For the recipient to apply for or receive benefits.(if benefits accrue to agency- Medicaid/Medicare)	M
	Coordination of Care/ Treatment	
748 (6a)	With consent, to a mental health service provider of the recipient.	M R
748 (7b)	For treatment, coordination of care, or payment for the delivery of mental health services	M
	Risk of Harm	
748 (7d)	To a provider of health or mental health services or a public agency (i.e. Law Enforcement) IF there is a compelling need for disclosure based upon a substantial probability of harm to the recipient or others.	M
	Oversight Agency	
748 (5e)	To the department (MDHHS) if necessary for the department to discharge its duties.	S
748 (5f)	To the Auditor General if necessary for the department to discharge its duties.	S
748 (7c)	For outside research, evaluation accreditation, or statistical compilation. The subject shall not be identified unless it is essential or impractical AND will not cause harm	M C
	Client Request	
748 (4)	An adult recipient without a guardian/not adjudicated as incompetent	S
748 (6b)	With consent from an authorized individual responsible for a recipient, *unless* in the written judgement of the holder the disclosure would be detrimental to the recipient or others.	M R C

New Rule SUD:



HIPAA, the MHC, and SUD rules have been aligned, and SUD records no longer require segregation and can be shared with others without specific written consent.

EXCEPT: Individuals cannot have their SUD records used against them in any legal proceeding.

SO: Records cannot be shared for **legal purposes** unless there is written consent.

AND: The MDHHS Standard Consent Form cannot be used for legal proceedings.

Law Enforcement (LE)

- **HARM:** When there is a substantial probability of harm to the recipient or others
- **BEHAVIOR:** *Only* when staff are unable to remove others from the situation and physical management is impractical, and/or unsuccessful
- **MISSING PERSON:** When police are looking for a missing person.
  - Demographics and description of physical characteristics
- **STAFF VICTIM OF A CRIME:** Basic info about suspected perpetrator of a crime--No records may be shared
- **CLIENT VICTIM OF A CRIME :**
  - to respond to an *LE request* for PHI when the victim agrees, or
  - in an emergency, or
  - The client is incapacitated if LE represent that PHI:
    - Will not be used against the victim, is needed to determine whether someone else committed a crime, is time sensitive and in the victim's best interest
- **STAFF CRIMINAL ABUSE OF A CLIENT:**
  - Immediately make a verbal report to law enforcement
  - Submit a written report within 72 hours including:
    - Client name, description of the criminal abuse and any other information that may help determine what happened
- **JAIL:** Only with medical staff and only for care coordination (i.e. medication lists, diagnosis, etc.)

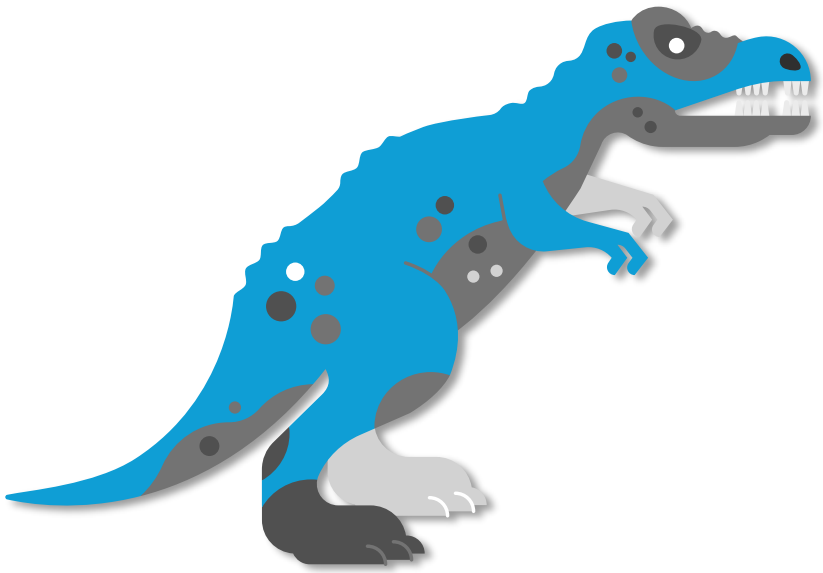
LAW ENFORCEMENT-
What to Report:

MINIMUM NECESSARY TO COMPLETE THE PURPOSE

- Dispatch calls are often made public, and they repeat the info called into 911 (law enforcement is not subject to HIPAA) which is picked up by third party apps/aggregators
- If you must give client name, use initials or first name only, explain nature of emergency and address and answer relevant questions.
- Pre-Building relationships with law enforcement using general information about the services you provide and the populations you serve can significantly help interactions when it counts.
- Clients and guardians, or staff with consent can sign up for:

Smart911

What to do when there is a disclosure of PHI:



A disclosure is *always* an MHC violation but may *not* always be considered a HIPAA breach.

Your responsibilities when there is a breach:

- Report it to the ORR and Complete an incident report (IR) that includes **ASAP**
- what was shared, how, with whom, and what actions were taken to mitigate the breach- for example, *"information was returned to the agency."*
- ORR will alert Privacy Officer of HIPAA breaches

Privacy Officer/ORR actions

- Gather facts of disclosure, perform risk analysis
- Notify the recipient in writing regarding the breach and mitigation efforts.

QUESTIONS?

DANCE LIKE NO ONE IS WATCHING AND...

DOCUMENT LIKE YOUR WORDS MAY SOMEDAY BE READ OUT LOUD IN OPEN COURT !