NORTHPOINTE HEALTHCARE SYSTEMS

Written Plan for Professional Services

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INTRODUCTION

The purpose of the following Written Plan for Professional Services is to:

1. Provide a profile of programs and services that support recovery and stabilization for persons served;

2. Serve as a resource document for appropriate individuals inside and outside the organization;

This plan is reviewed annually and is revised as necessary in accordance with the changing needs of the persons served, the community, and regulatory bodies.

OVERVIEW OF THE ORGANIZATION

PREAMBLE
Northpointe Behavioral Healthcare Systems became an "Authority" under the Urban Cooperation Act effective January 1, 1995. This agreement merged the Community Mental Health (CMH) Boards of Dickinson-Iron and Menominee Counties. Northpointe operates within the rules and regulations of the Michigan Department of Health and Human Services. The roots of Dickinson-Iron (CMH) dates back to 1964, and Menominee's CMH began in 1968.

The merger between Menominee CMH and Dickinson-Iron CMH was a positive response to a rapidly changing behavioral healthcare environment. The merger represents a significant step toward improved quality of care for the residents of Iron, Dickinson, and Menominee Counties through integration. By utilizing the resources of the two separate agencies, Northpointe has been able to strengthen and expand its services offered to the residents of the three counties, and at the same time, reduce overhead costs by centralizing administrative operations.

Northpointe offers services to adults and children who suffer from a serious mental illness (SMI), serious emotional disturbance (SED), an Intellectual/Developmental Disability (I/DD), and/or a Co-Occurring substance abuse disorder. These services are developed and delivered to individuals ensuring that a person-centered philosophy is adhered to along with medical necessity criteria. Services are designed to support recovery and stabilization, enhance the quality of life, reduce symptoms, restore and/or improve functioning and support the integration of service recipients into the community. Services provided are in compliance with mandated licensing and regulatory bodies. Northpointe operates as a trauma informed system of care and promotes a Recovery-based system of care.

Persons may be referred to Northpointe by any internal or external staff, organizations, providers, family members or themselves. People are screened for eligibility by calling NorthCare Access. NorthCare Access either schedules the individual for an appointment at the local Community Mental Health agency or refers them to an appropriate community provider.

The main office and switchboard hours are Monday through Friday, from 8-4 CST, however service recipient's need guides the scheduling of services; medication assistance, community living supports, group therapy and other services may be provided during evening and weekend hours.

Northpointe is governed by a twelve (12) member Board representing each of the three counties. Agency operations are overseen by the Operations Team headed by the Chief Executive Officer, who is employed by the Board of Directors.

MISSION STATEMENT
Northpointe strives to improve the well-being of individuals and families through the delivery of excellent person-centered health services.

VISION STATEMENT
Northpointe will be recognized as a leader for delivery of high-quality integrated medical and behavioral health services for people with mental illness, intellectual/developmental disability, and/or Co-Occurring disorders regardless of the ability to pay. Priority shall be given to the severely mentally ill.

ORGANIZATIONAL GOALS

Northpointe establishes long-term goals (1-3 years), which are reviewed annually via the development of a strategic plan, operating budgets, and performance indicators.

The Strategic Plan is developed and written by members of the Operations Team with input from the Board of Directors, staff, individuals, and other stakeholders. The plan is revised/updated annually at a minimum.

Recognizing that the Strategic Plan establishes general, longer-range goals for Northpointe's growth and development, Performance Indicators (PI's) are an integral part of Northpointe's mission to improving our services by a system-wide, continuous quality improvement process. They are derived from the Strategic Plan as a method of verifying organizational effectiveness and efficiency. The Performance Indicators identify and measure vital functions of the organization while consolidating employees' efforts in the continuous improvement process. The PI's are determined in response to the Strategic Plan, derived from data collection/trending or in response to a suggestion for improvement. (For details, refer to Northpointe's Quality Assessment and Performance Improvement Program.)

Northpointe contracts with the Michigan Department of Health and Human Services (MDHHS) and Northcare (Medicaid), who provides approximately 92.5% of the agency's funding. The other 7.5% of our funding is generated by fee for service, contracts, donations and interest, contract revenue, Supplemental Security Income (SSI), grant funding and local governmental appropriations. Northpointe provides services to approximately 1600 individuals throughout the year.

Northcare is the Prepaid Inpatient Health Plan consisting of 5 affiliates: Pathways, Copper Country CMH, Gogebic CMH, Hiawatha BHS and Northpointe BHS. Northcare is the regional manager for the State's Mental Health Medicaid dollars. All of the five affiliates work collaboratively to ensure Medicaid recipients receive mental health services in an efficient and effective manner throughout the region.

Northpointe has a budget of 17.5 million dollars and employs approximately 260 staff. The treatment staff are multi-disciplinary and include Psychiatrists, Registered Nurses, Psychiatric Nurse Practitioners, Mastered-level Care Managers Bachelor-level Care Managers, Occupational Therapist, Speech Therapist, Physical Therapist, Behavior Analyst, Dietician, Vocational Rehabilitation Counselor, Community Support Staff and Peer Support Specialists.

Other staff positions that are integral to Northpointe's success include: Home Managers and Assistant Home Managers, Information Technologists, Maintenance, Transportation, Medical Records, Customer Service, Human Resources, Training Specialists, Contract Management, Recipient Rights, Finance, Quality Improvement, Crisis/Access Services and Administrative Supports.

S E R V I C E S

ASSERTIVE COMMUNITY TREATMENT/ INTEGRATED DUAL DISORDER TREATMENT

MISSION STATEMENT

Assertive Community Treatment (ACT) is a multidisciplinary, Integrated Dual Disorders Treatment (IDDT) team dedicated to providing acute, active and ongoing community-based psychiatric treatment, assertive outreach, rehabilitation, and support to adults with a persistent and severe mental illness and/or IDDT needs. The overall goal of treatment is to promote and maximize independence.

TREATMENT OBJECTIVES

The ACT/IDDT program provides a comprehensive, integrated set of clinical, medical, dual disordered and psychosocial rehabilitation services delivered within a mobile, multi-disciplinary team approach by qualified staff. There will be no greater ratio of 10 service recipients to 1 professional staff. The basic team is comprised of a Psychiatric Practitioner, an RN, a Licensed Masters Level Social Worker (LMSW), a Licensed Bachelors Level Social Worker (LBSW), Community Living Supports and Peer Supports Specialist as needed. The LMSW serves as the Team Leader. To maintain program integrity, ACT services are delivered in accordance with the following principles:

1. **Team Approach to Treatment**
   ACT staff will function as an IDDT team, with each clinical team member having equal responsibility for developing, implementing, and monitoring each treatment plan. Service recipients view the entire staff as their treatment manager. Each ACT recipient will receive services from ACT staff that represent separate disciplines relevant to the individual's needs, as identified through the person-centered planning approach. Efforts are made to recruit staff or volunteers who are peers to become team members, provide peer support or consultation to persons served by the ACT/IDDT Team.

2. **Assertive-Proactive Approach to Treatment**
   According to the individual's preference and clinical appropriateness, the majority of services are provided in the individual's home or other community locations rather than the team office. ACT/IDDT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the beneficiary. With the individual's consent, the ACT/IDDT Team provides services to the families and major supports of the individual by educating them about the individual's illness/disorder; the individual's strengths/abilities; role of family in therapeutic process; intervention to prevent/resolve conflict; offer treatment options for dual disorders and ongoing communication and collaboration between the team, their family, and their support system.
   The ACT/IDDT Team provides ongoing support and liaison services for individuals who are hospitalized, in the criminal justice system, or other restricted settings per state or other regulators.

3. **Rehabilitation**
   The team also provides basic services and supports essential to maintaining the individual's ability to function in community settings, including assistance with accessing basic needs through available community resources, such as food, housing, clothing, finances, transportation, treatment of dual disorders, medical care (vision/dental), and supports to allow individuals to function in social, educational, and vocational settings. ACT/IDDT assists the persons served to understand the impact of employment on accessing and securing future benefits. Skill training, problem solving, and services to support activities of daily living are provided.

4. **Least Restrictive Environment**
   Utilization of ACT/IDDT services in high acuity conditions/situations allows individuals to remain in their community residence and may prevent the use of more restrictive alternatives which may be detrimental to an individual's existing natural supports and occupational roles. This level of care is appropriate for individuals with a history of persistent mental illness who may be at risk for inpatient hospitalization, intensive crisis residential or partial hospitalization services, but can remain safely in their communities with considerable support and intensive interventions of ACT/IDDT.

5. **Advocacy**
   ACT/IDDT staff will ensure that an individual's needs and rights are met, including influencing human service systems to respond to individual's needs. The ACT/IDDT Team assists individuals to achieve their goals of choice in the areas of community living; vocational/educational development; and use of leisure-time opportunities.

6. **Titrated Treatment**
   Treatment is longitudinal and will fluctuate according to an individual's needs. For individuals with dual diagnosed disorders, treatment that addresses the substance use disorders must be included in the individual plan of services. The frequency of face-to-face contacts must be dependent on the intensity of the individual's needs, and delivered as documented in the treatment plan and service authorizations.

GOALS

1. The ACT/IDDT program is an individually-tailored combination of services and supports that may vary in intensity over time based on the individual's needs and condition. Services may include multiple daily contacts and 24-hour, seven-days-per-week crisis availability provided by a multi-disciplinary team which includes psychiatric practitioner and skilled medical staff.

2. To improve the individual's overall quality of life while increasing self-reliance, maximizing their recovery and developing a sense of empowerment.

3. To assist and support participating individuals in maintaining or transitioning to independent living to help them maximize independence and be contributing members of their community.

4. To ensure that individual directed goals are set.

5. To foster the development of a network of community supports.

6. To ensure the availability and accessibility of essential services necessary for the acquisition of life skills, symptom stabilization, dual disordered treatment and community adjustment.

POPULATION TO BE SERVED

Northpointe Behavioral Healthcare Systems will offer ACT/IDDT services to eligible adult individuals who are diagnosed with a chronically persistent mental illness exacerbated by severe symptoms, are in need of integrated dual disorders treatment and who otherwise may require more intensive and/or restrictive settings.

ENTRANCE CRITERIA

- The individual demonstrates psychological symptoms consistent with a DSM-V diagnosis of a major mental illness.
- The individual is 18 years of age or older.
- The individual manifests at least <u>one</u> of the following:
  - Serious mental illness with difficulty managing medications without ongoing support, or with psychotic/affective symptoms despite medication compliance.

- Serious mental illness with a dually diagnosed disorder.
- Serious mental illness who exhibit socially disruptive behavior presenting high risk for arrest and inappropriate incarceration, or those exiting prison or a county jail.
- Serious mental illnesses who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential or homeless shelters.
- Individuals with serious mental illness with complex co-morbid medical/medication conditions.
- The individual must have a mental illness; reflect in a primary, validated, DSM-V or
- ICD-10 Diagnosis. Practice guidelines suggest that ACT is not a good fit for Borderline Personality Disorders; though each case will be considered individually.
- The individual demonstrates the need for an intensive system of services in order to reduce frequency and/or duration of hospitalization.
- Meets MDHHS Level of Care Clinical consensus based on Medicaid Guidelines for ACT.
- ACT/IDDT is generally not intended for people living in a specialized residential setting or long term foster care unless plans include transitioning them to a less restrictive setting.

SEVERITY OF ILLNESS

Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc., and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance.

- Self-Care/Independent Functioning – Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational role performance expectations.

- Drug/Medication Conditions – Drug/medication compliance and/or coexisting general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care. Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify atypical side effects or concurrent physical symptoms and medical conditions.

- Risk to self or others – Symptom acuity does not pose an immediate risk of substantial harm to the person or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged. Harm or danger to self, self-mutilation and/or reckless endangerment or other self-injurious activity is an imminent risk.

- Individuals in need of Integrated Dual Disorders Treatment from a multi-disciplinary team whom specialize in their scope of practice.

INTENSITY OF SERVICE

ACT/IDDT Team services are clinically necessary to provide treatment in the least restrictive setting, to allow individuals to remain in vivo, to improve the individual's condition and/or allow the person to function without more restrictive care, and the person requires at least one of the following:

- An intensive team-based service is needed to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regime and stabilization necessary for recovery.
- The person's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression, and forestall the need for inpatient care or a 24-hour protective environment.

- The person has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports.
- Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.
- Frequent monitoring of medication regimen and response is necessary and compliance is doubtful without ongoing monitoring and support.
- Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.

DISCHARGE/TRANSITION CRITERIA:

Recovery must be sufficient to maintain functioning without the intensive support of ACT/IDDT as identified through the person centered planning process.

- The individual no longer requires the intensity of ACT/IDDT services.
- No longer meets MDHHS Level of Care and Clinical consensus based on Medicaid Guidelines for ACT.
- When the individual served demonstrates an ability to function in all major role areas (i.e. work, social, self-care) with only minimal assistance from the program for a period of one year or more as agreed to by the individual and his/her ACT/IDDT Team.
- Improvement and stability of psychiatric signs and symptoms (symptom stabilizations).
- Has improved ability to attend to basic physical needs/life skills or has been linked to other services to meet the transition to more independent living.
- Has demonstrated improved drug/medication compliance and/or compliance and/or co-existing general medical condition simultaneously addressed along with the psychiatric illness and can be carried out at a less intensive level of care.
- No longer has current potential danger to self and no longer has current potential danger to others.
- Individual has fostered the development of a network of community and natural supports, and can be transitioned into less intensive services.
- Individual has maximized their recovery through ACT/IDDT and will be transitioned to available and essential services. The individual and program staff members mutually agree to the termination of services.
- Individual's judgment is no longer as impaired to the extent that he/she is able to understand the need for treatment and make appropriate decision to appropriately seek treatment.
- Engagement of the individual in ACT/IDDT is not possible as deliberate, persistent and frequent assertive team outreach including face-to-face engagement attempts and legal mechanisms, when necessary, have been consistent, unsuccessful, and documented over many months; and an appropriate alternative plan has been established with the beneficiary.
- When the person served moves outside the geographic area of the team's responsibility. In such cases, the ACT/IDDT Team:
    - Arranges for transfer of mental health service responsibility to a provider in the location to which the individual served is moving.
    - When feasible, maintains contact with the individual served until service transfer is arranged.
- When the individual served is not court ordered and requests termination of services.
- When the team, despite repeated efforts, cannot locate the individual served.
- Documentation of transitioning with a provision to return to ACT/IDDT services, if needed, is completed by identified member(s) of the treatment team.
- Transition documentation includes the signatures of all team members, and the individual served when possible.

STAFF QUALIFICATIONS

All staff providing services are licensed professionals, within their respective disciplines in the State of Michigan and meet all Northpointe's training/ competency requirements. Peer Support staff are certified or working on certification through MDHHS. CLS staff must meet competencies required in job description. All team staff must have a basic knowledge of ACT/IDDT programs and principles acquired through ACT/IDDT specific training. Clinical guidance is provided to the team by the team leader. All staff must pass a Criminal Background Check and an Excluded Parties Check.

PROGRAM PROCEDURES

Specific components of the ACT program include the provision of the following key service elements:

1. **Referrals**
   Referrals may be generated from a variety of sources, including inpatient settings, outpatient, emergency services, friends/family, self-referral, other community agencies, or through an alternative sentencing agreement (jail diversion program).

2. **Assessments**
   An ongoing mutual process of identifying a individual's strengths, abilities, health and safety needs, and natural supports. Basic assessments for ACT recipients include a nursing, bio-psychosocial, substance abuse and psychiatric assessment, and with other specialized assessments as clinically indicated.

3. **Individual Plan of Service (IPOS)**
   The development of a individual's plan of service with provision for linkages to other services based on the needs of the individual. When the individual will receive other services in addition to ACT/IDDT, the plan will be the vehicle to address and coordinate the various service needs of the individual. The development of the plan is a collaborative process involving the individual, his/her support system, and the ACT/IDDT team. ACT/IDDT services and interventions must be consistent with the medical necessity of the individual beneficiary with the goal of maximizing independence. The IPOS is reviewed at a minimum of every 3 months, and modified as necessary, based on the needs of the individual served. Individuals with dual diagnosed treatment needs must have both mental health and substance abuse addressed in their IPOS.

4. **Monitoring of Services**
   An ongoing process of ascertaining what services have been delivered and whether they are adequate for the needs of the individual. This includes assessment of individual satisfaction and adjustments in the plan.

5. **Individual Treatment**
   Care Management services, therapy, psycho-education, dual disordered treatment and skill training for individuals and their families. ACT/IDDT strives to enhance the understanding of the individual served and their natural supports regarding their psychiatric disorder or behavioral health needs.

6. **Group Treatment**
   Education, socialization, skills training and problem-solving activities on a group basis.

7. **Health Services**
   Assessment of health status, needs and development of procedures, recommendations, and nursing services, which are directly linked to psychiatric services and medication (e.g., administering injections of psychotropic medications, taking blood pressure, monitoring vital signs, etc.).

8. **Psychiatric Services**
   Evaluations, medication prescription and review, hospitalization certification, service recommendations, and other services as identified by the ACT/IDDT team. The psychiatric practitioner educates the individual served, their family and significant others when appropriate, regarding their disabilities and abilities.

9. **Family Services**
   Educational and supportive services to families.

10. **Crisis Intervention Services**
   - ACT provides crisis intervention services
   - Initial crisis intervention plan with IPOS
   - Provides telephone intervention services
   - Advocates for jail diversions as clinically appropriate
   - Provides collaboration with other community organizations that provide emergency services to ensure continuity of care of the individuals served
   - Has capacity to provide a rapid response to early signs of relapse, including the capability to provide multiple contacts daily with individuals in acute need or with emergent conditions.

11. **Integrated Dual Disordered Treatment (IDDT) Services**
   The ACT/IDDT Team directly provides dual disordered treatment services that include interventions that assist the individual to:
   - Recognize relationships between substance abuse, mental illness, and psychotropic medications
   - Develop motivation for decreasing substance use
   - Develop coping skills and alternatives to substance use
   - Support periods of abstinence and sobriety
   - Access/utilize self-help or support groups

12. **Vocational Services**
   The ACT/IDDT Team directly provides vocational services by actively assisting the individual to find, obtain, and maintain employment or volunteer opportunities in community based sites that are consistent with their goals and desires.

13. **Hours of Operation**
   The ACT/IDDT team understands the importance of providing services 24-7. To meet this standard in our rural setting, the team is available Monday through Friday from 8 a.m. to 4 p.m. Contacts made after 4 p.m. are coordinated among the team members. The ACT/IDDT team rotates on-call coverage as assigned. . An updated list of individuals is forwarded to our on-call system for easy access.

14. **Daily Staff Meetings**
   Daily ACT/IDDT Team meetings include discussion of the following:
   - Review the clinical status of each individual;
   - Identify stage of treatment
   - Identify interventions to be applied for stage of treatment
   - Current needs; contacts needed;
   - Treatment that occurred during previous days;
   - Review goals and objectives PRN;
   - Develop daily work schedule;
   - Adjust intensity of services; and plan for potential emergency and crisis situations;
   - Medication education to be afforded PRN by medical staff.

APPLIED BEHAVIOR ANALYSIS (AUTISM) SERVICES

MISSION STATEMENT
To respond to the most urgent needs of the autism community, provide real help and hope so that all can reach their full potential (National Autism Society).

TREATMENT OBJECTIVE:
To provide early interventions and parent education required for positive outcomes in individuals under the age of 21 years who meet eligibility and medical necessity criteria.

GOAL:
To make a difference in individuals diagnosed with autism and their families future by providing quality and comprehensive services so they can meet their full potential

POPULATION: individuals under the age of 21 who meet eligibility and medical necessity criteria and are diagnosed with Autism Spectrum Disorder (ASD).

MEDICAL NECESSITY CRITERIA

- The individual must demonstrate substantial functional impairment in areas of social communication and social interaction in all of the following:
  - deficits in social-emotional reciprocity,
  - deficits in nonverbal communicative behaviors,
  - deficits in developing of relationships.
- The individual must also demonstrate substantial behavioral limitations in at least two of the following:
  - Stereotyped or repetitive motor movements,
  - use of objects or speech,
  - inflexibility in routines, fixated interests,
  - sensory issues in aspects of the individual's environment.

ENTRANCE CRITERIA:

- Open Northpointe Medicaid recipients under the age of 21
- Family/parent involvement
- Diagnostic assessments by qualified staff
- Coordination with the school and/or early intervention program is critical.
- Services are able to be provided in the individual's home and community
- Annual re-evaluation of eligibility criteria

DISCHARGE/TRANSITION CRITERIA:

- Completion of services as verified through testing and goals have been met;
- Individual turns 21 years old
- Parent withdraws individual from service.

EXCLUSIONARY CRITERIA

- The individual is not open for services at Northpointe
- A diagnosis by a qualified physician, psychiatrist, or psychologist is not provided
- Family is unable or unwilling to work on the ABA and IPOS.

STAFF QUALIFICATIONS

The autism benefit is provided by a team of licensed/registered professional as outlined in the Medicaid Provider Manual. Board Certified Behavior Analyst is required for overseeing the ABA services. ABA is provided by trained Community Support Aides.

PROGRAM PROCEDURE

Referrals will come in one of two ways:

1. **New referral** → MCHAT-SCQ or other age-appropriate assessment completed by doctor, teacher, etc. and found to be positive → NorthCare refers to CMH for initial assessment that includes the autism assessment.
   a. Once a referral is received we will do a preliminary IPOS that includes diagnostic assessment;
   b. A Specialty Referral will be completed for an Autism Independent Evaluation
2. **Existing service recipient** → Family is requesting autism services → MCHAT-SCQ or other age-appropriate assessment may be completed by doctor, teacher, mental health professional, etc. and found to be positive → Care Manager at CMH will complete:
   a. An IPOS amendment that includes diagnostic assessment, and if approved then the b;
   b. A Specialty Referral for an Autism Independent Evaluation

Follow the Autism Benefit Guidelines and Process in the Autism folder

Diagnosis:

1. Diagnosis of autism with the ADOS-2 and ADI-R.

Service levels:

- ***Focused Behavioral Intervention:*** services provided 15 or less hours per week
- ***Comprehensive Behavioral Intervention:*** services provided 16 or more hours per week

ABA services are not intended to supplant services provided in school or other settings
Each program is individualized to meet the needs of the individual and Family

CLUBHOUSE
Clubhouse Psychosocial Rehabilitation

MISSION STATEMENT
The Menominee Clubhouse named "House of Dreams" is devoted to providing a community-integrated supportive environment for adults recovering from a mental illness. The goal is to meet members where they are at in their recovery and encourage them to see the diverse talents and abilities that they each possess.

TREATMENT OBJECTIVES
A clubhouse program is a community-based psychosocial rehabilitation program in which the beneficiary (also called clubhouse "members"), with staff assistance, is engaged in operating all aspects of the clubhouse: including food service, clerical, reception, janitorial and other member supports and services such as employment, housing and education. In addition, members, with staff assistance, participate in the day-to-day decision-making and governance of the program and plan community projects and social activities to engage members in the community.

GOALS
Through the activities of the ordered day, clubhouse decision-making opportunities and social activities, individual members can achieve or regain the confidence and skills necessary to lead vocationally productive and socially satisfying lives.

PROGRAM COMPONENTS:

Symptom Identification and Care:
- Identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychological relapses;
- Gaining competence regarding how to respond to a psychiatric crisis;
- Gaining competence in understanding the role psychotropic medication plays in the stabilization of the members' well being;
- Working in partnership with members who express a desire to develop a crisis plan.

Competency Building:
- Community living competencies e.g., self-care, cooking, money management, personal grooming, maintenance of living environment;
- Social and interpersonal abilities e.g., conversational competency, developing and/or maintaining a positive self-image, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships;
- Personal adjustment abilities e.g., developing and enhancing personal abilities in handling every day experiences and crisis, such as stress management, leisure time management, or coping with symptoms of mental illness. The goal of this is to reduce dependency on professional caregivers and to enhance independence;
- Cognitive and adult role competency e.g., task-oriented activities to develop and maintain cognitive abilities, to maximize adult role functioning such as increased attention, improved concentration, better memory, enhancing the ability to learn and establishing the ability to develop empathy.

Environmental Support:

- Identification of existing natural supports for addressing personal needs e.g., families, employers, and friends;
- Identification and development of organizational support, including such areas as sustaining personal entitlements, locating and using community resources or other supportive programs.

POPULATION TO BE SERVED

Adults with Serious Mental Illness

ENTRANCE CRITERIA

Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured program with staff and peers and have identified psychosocial rehabilitative goals that can be achieved in a supportive and structured environment. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members, and must not have behavioral/safety or health issues that cannot adequately be addressed in a program with a low staff-to member ratio.

DISCHARGE/*TRANSITION CRITERIA*

Discharge: There is no discharge listed within the guidelines of the Medicaid provider manual, however, should an individual become gainfully employed in the community and clubhouse participation is limited due to work commitments, an individual would be considered a volunteer or mentor in clubhouse verses a member status. Participation in all/any activity would still be available to the beneficiary.

EXCLUSIONARY CRITERIA

The beneficiary is unable to participate in, and benefit from, the activities necessary to support the program and its members.
Beneficiaries who cannot participate in a low staff-to member ratio.

STAFF QUALIFICATIONS

The number of staff should be sufficient to effectively administer the program, but also allow the members sufficient leeway to participate meaningfully in the program.
Clubhouse staff shall include:

- One full-time on-site clubhouse manager who has a minimum of a bachelor's degree in a health or human services field and two years experience with the target population, or who is a licensed master's social worker with one year experience with the target population and certified, or registered by the State of Michigan or a national organization to provide health care services. The clubhouse manager is responsible for all aspects of clubhouse operations, staff supervision and the coordination of clubhouse services with case management and ACT;
- Other experienced professional staff licensed, certified, or registered by the State of Michigan or a national organization to provide health care services.

Other staff that are not licensed, certified, or registered by the State of Michigan to provide health care services may be part of the program, but shall operate under the supervision of a qualified professional. This supervision must be documented.

PROGRAM PROCEDURES

- Individuals have been clinically assessed, diagnosed and deemed appropriate for this comprehensive service;
- Clinical Care Managers will refer potential members utilizing the Clubhouse referral form;

- Individuals attending the Clubhouse may receive professional treatment monitoring as an adjunct to therapy, care management and psychiatric consultation;
- If attending the Clubhouse, there must be an authorization for H2014 services in the Individual Plan of Service.

ESSENTIAL ELEMENTS:

- All clubhouse members have access to the services/support and resources with no differentiation based on diagnosis or level of functioning;

- Members establish their own schedule of attendance and choose a unit that they will regularly participate in during the ordered day;

- Members are actively engaged and supported on a regular basis by clubhouse staff in the activities and tasks that they have chosen;

- Supportive services reflects the beneficiary's preferences and needs building on the person-centered planning process;

- Both formal and informal decision-making opportunities are part of the clubhouse units and program structures so that members can influence and shape program operations;

- Staff and members work side-by-side to generate and accomplish individual/team tasks and activities necessary for the development, support, and maintenance of the program;

- Members have access to the clubhouse during times other than the ordered day, including evenings, weekends, and all holidays: including New Year's Day, Memorial Day, Independence Day, Thanksgiving Day, and Christmas Day.

COMMUNITY HOUSING SERVICES

MISSION STATEMENT

Northpointe's community housing program provides specialized residential living ~~services~~ for individuals diagnosed with intellectual/developmental disabilities and/or individuals with mental illness with challenging behaviors and/or complex medical needs requiring 24 hour support and supervision. Our focus on advancing independence and growth in personal, social, and vocational skills through active engagement and integration within the greater community.

TREATMENT OBJECTIVES

Northpointe's community housing program is committed to providing safe, comfortable, and suitable treatment facilities for individuals with development disabilities and/or mental illness with complex needs. These facilities are integrated in and support full access to the greater community, ensure that the individuals' right of privacy and promotes independence in making life choices. Staff's focus and treatment as outlined in the Individual Plan of Service (and defined by Medicaid Manual: Community Living Supports (CLS) and Personal Care(PC) in a licensed residential setting) will adapt and evolve to meet the changing needs and desires of each individual, with respect, creativity, and professionalism in the least restrictive environment possible.

GOALS

1. To optimize individual self-help capabilities and promote independence and community involvement.

2. To identify and build on personal strengths.

3. To identify and develop a supportive environment to foster independence, assist individuals in taking responsibility and control of their lives.

4. To provide individuals the opportunity to develop skills and behaviors that enhance functioning in daily living, interpersonal relations, problem-solving and cognition, vocational skills, educational options, and employability.

5. To initiate and continue transition planning to a lesser restrictive environment.

6. To provide a continuum of community housing options toward movement to a lesser restrictive setting. This continuum may include CLS and/or personal care services to:
   - Facilities for adults having onsite supervision readily available;
   - A supported independent living situation preparing individuals for independent living, transitioning to an appropriate Adult Foster Care (AFC), or alternative living situation.
   - CLS staff will assist, remind, observe, guide and/or train as directed in the IPOS for each individual to achieve success and stability within their living setting.
7. To manage the utilization of all facilities, reduce admissions, length of stay, and/or usage of hospitals, state facilities and centers.

POPULATION TO BE SERVED

Northpointe service recipients with intellectual/developmental disabilities and/or individuals with mental illness who meet the medical necessity criteria; requiring assistance with challenging behaviors and /or complex medical needs requiring 24 hour awake supervision to meet their needs. The IPOS identifies the need to increase or maintain personal self-sufficiency; require assistance in facilitating their achievement of goals of community inclusion and participation, independence and/or productivity. This program is designed for individuals who would not be successful in a general AFC home and require a more structured level of care.

ENTRANCE CRITERIA

The individual must be a service recipient of Northpointe Behavioral Healthcare Systems. Community Housing program participation is based upon the individuals needs based on medical necessity. The primary factor of consideration in all participation is securing the least restrictive housing environment for the service recipient. An individual must require 24 hour awake supervision to meet their behavioral and/or medical needs. This program allows an individual (based upon the individual level of functioning) to live in the least restrictive environment within the community. Transition planning begins upon placement and is the responsibility of the Individual Plan of Service (IPOS) Team to direct its efforts toward arranging movement toward a more appropriate and less restrictive environment.

ENTRANCE PROCEDURES

1. The referring provider will complete the Functional Assessment for each individual. This will aid in the recommendation of appropriateness of the individual and the level/types of service needed.

2. A request to participate in the community housing program will be clinically reviewed by a Placement Review Committee (PRC).

   A. Participants in the PRC shall include, but not be limited to, representatives from the referral source, members of the treatment team, the proposed individual, his/her guardian, family members, representatives from the school district, the receiving facility's manager/provider and any other person identified through the IPOS process. The referral material will be reviewed for appropriateness of placement with consideration given to the following:
      1. Principle of least restrictive environment
      2. Primary diagnosis appropriate to the facility
      3. Programming, health, and safety needs of the individual
      4. Compatibility with others living within the facility. (i.e. personalities, diagnosis, male to female ratio)
      5. Overall needs of the individual.
      6. Approval from current housemates.

   B. The referring provider will facilitate the PRC process. The referring provider is responsible for assuring the appropriate paperwork is completed utilizing the AFC placement checklist form.
      1. The provider will provide the receiving facility manager with a copy of the completed necessary paperwork to maintain within the individual's file.
      2. If a dispute occurs regarding appropriateness of placement, resolution and determination of appropriateness of placement shall be determined by utilizing the person-centered planning process and/or Northpointe's grievance and appeals process.
      3. The referring provider will provide an AFC Assessment that identifies all of the individual's need for personal care, i.e. assistance with food prep; clothing and laundry; housekeeping; eating/feeding; toileting; bathing; grooming; dressing; transferring; ambulation; or assistance with self-administered medications.

4. An IPOS will include the specific personal care services to be delivered that is reviewed and authorized.

3. The receiving facility will:
   A. Be provided the clinical assessment(s), current treatment plan, current medication orders, any behavior plans, medical and immunization records and other necessary documentation to be maintained within the individual's electronic medical record;
   B. Not deny admission to an individual based on his/her race, religion, color, or national origin
   C Provide the individual/guardian with an Adult Foster Care (AFC) Agreement along with the Summary of Resident Rights: Discharge and Appeals. Complete the AFC Assessment with the guardian/individual and get a signed consent for medical treatment.

4. Individuals shall have access to and use of personal funds belonging to him/her. Exceptions shall be subject to provisions of the IPOS or as specified by the guardian and/or payee.
   A. A maximum value of money and valuables that can be accepted by a facility for safekeeping shall not exceed $200.
   B. The individuals' funds accepted will be recorded onto a Resident Funds Part II.
   C. The individual's funds shall be kept separate and apart from all funds and monies of the licensee.
   D. Individual's funds are subject at all times to a full and prompt accounting to the individual, guardian, and payee, this includes receipts for all spenditures.
   E. An individual, guardian, and/or payee shall have access to an itemized monthly statement of all charges against his/her funds and a copy will be sent to the guardian quarterly for review.
   F. An individual being discharged, or his/her guardian/payee, shall receive a prompt and reasonable payment of funds remaining on his/her account.

5. Upon admission, all individual and/or guardians will be informed by the provider or Home manager of the rights of individuals and will be given a Recipient Rights booklet that contains a Recipient Rights Complaint Form.
   A. Rights information is also posted in a visible place in all residential homes.
   B. Any individual or person on behalf of an individual may file a complaint with the Rights Office.
   C. Staff are required to assist with writing the complaint as necessary. Postage will be provided for the individual to mail the complaint if they do not have adequate funds.

DISCHARGE/TRANSITION CRITERIA

The current placement is no longer considered to be the least restrictive environment.

1. The individual displays behavior that:
   A. Is dangerous to self;
   B. Is a danger to other individuals in the facility,
   C. Results in extensive damage to the environment (seriousness may constitute an emergency);
   D. Indicates medical needs that cannot be met,
   E. The individual needs 24 hour skilled nursing.
   F. Involves extended incarceration

2. A placement is not in compliance with MDHHS, Public Health, LARA-AFC Licensing Agreement.

3. All decisions regarding transitioning of individuals from facilities shall be based on input and recommendations from the facility staff, interdisciplinary team, parent(s) or guardian(s) and other pertinent professionals. An Action Notice will be given or sent to the individual or guardian.

4. When a decision has been made to transition an individual, the individual/guardian will be given 30 day notice of need to transfer. All appropriate NBHS staff will also be notified of impending transfers. The current provider will complete a facility transition summary.

5. In an emergency transition, the individual or individual's representative will be provided with the following information no less than 24 hours before discharge.
   A. The notice shall be in writing and include the following:
      1. The reason for the proposed transition, including the specific risk.
      2. The alternatives to transition that have been attempted
      3. Location to where the individual will be transitioned, if applicable
   B. The primary provider of Northpointe shall confer with the affected agencies regarding the proposed transition. If Northpointe and Adult Protective Services agree that the emergency discharge is justified, then all of the following provisions shall apply:
      1. The individual shall not be transitioned until an appropriate setting that meets the individual's immediate needs is located.
      2. The individual shall have the right to file a complaint with MDHHS, Northpointe Recipient Rights Department; NorthCare's Recipient Rights Department and/or follow Northpointe's grievance and appeals process.
      3. If MDHHS finds that the individual was improperly discharged, the individual shall have the right to elect to return to the first available bed in the facility.
      4. The discharge summary shall be completed.

6. Northpointe employees shall not restrict the individual/guardian's ability to make his or her own living arrangements.

7. Northpointe may change the residency of an individual from one facility to another.

8. At the time of discharge, the individual or guardian will be provided a copy of the individual's records, if requested. This request would be made through the individual's case manager.

9. In the event the transition is unplanned by Northpointe, the Home Manger will notify the Care Manager and they will complete an IPOS Amendment or Transition plan, as applicable.

EXCLUSIONARY CRITERIA:

- All individuals requesting this level of service must meet medical necessity, have challenging behaviors and/or complex medical needs and has demonstrated the need for 24 hour awake supervision.
- The individual needs 24 hour skilled nursing.

STAFF QUALIFICATIONS

All staff must be at least 18 years old with a high school diploma or equivalent. Criminal Background Checks and Excluded Parties Check will be performed on all staff prior to being hired. Prior to beginning work, the staff must be fingerprinted, must pass a TB skin test, physical and drug screen. All Northpointe staff receives extensive training on a regular basis with specialty training geared to the specific facility. Specialty services are available, and the staff is degreed with appropriate licensure from the State of Michigan. Facility staff is managed by a qualified facility manager.

PROGRAM PROCEDURES

All new cases are referred through Northcare Access. Each new referral requires a comprehensive functional assessment to determine the appropriate needs and services for the individual. Community Housing programs provide structure; regular meetings between the individual and program personnel to ensure satisfaction with their living arrangement, roommate, if applicable, staff working within the home and their housemates. Individuals are encouraged to have control over their own schedule of activities, are provided with adequate lockable personal space for privacy and security of property; a homelike and comfortable setting. There are nutritional meals and snacks provided and individuals have access to food at any time. Transportation is provided for community activities, family visits and medical appointments. Individuals may have visitors as they wish and there is a private area available within each site for visits.

COMMUNITY LIVING SUPPORTS SERVICES IN PROGRAM SETTINGS

MISSION STATEMENT

Community Living Support Services is committed to providing a service option for individuals with intellectual developmental disabilities and mental illness. These service are integrated into the community and promotes full access to the greater community. This program is committed to optimizing individual's independence in making life choices, allows the individuals to select the daily activities and ensures the individual's rights are protected. This program must be the least restrictive treatment options for individuals as assessed as medically necessary in the individual's Person Centered Planning (PCP) process.

TREATMENT OBJECTIVES

Community Living Support Services will provide community-based options to: promote least restrictive treatment needs and housing support needs; assist individuals in maximizing skill abilities; and to assist individuals and families in the management of their specific needs (i.e.: recognizing signs of illness, dealing with mental illness, etc).

GOALS

1. To maximize and promote community networking, as defined in the Individual Plan of Service (IPOS).

2. To maintain least restrictive treatment options.

POPULATION TO BE SERVED

Each program has specific criteria and guidelines for participation

- ***Iron River Skill Building Program -*** This program is available in accordance to needs assessed in PCP. Assessed functioning levels of the individual and treatment team input will determine if skill building is appropriate to the individual. The service is community based and offers skill building activities, community living supports, and out of home non-voc. Staff ratio is high in order to address daily living needs.
- ***The Phoenix Center and Gathering Pointe*** - Program appropriateness is determined by the treatment team. The community based service provides community living supports, offers education on mental illness, health and safety, medications, and a variety of independent community activities.

ENTRANCE CRITERIA

- Open service recipient at Northpointe, 18 years of age
- The individual has a diagnosis of a major mental illness or Intellectual/Developmental Disability
- Services are authorized through the Individual Plan of Service
- The individual requires supportive services in order to improve or maintain current level of functioning
- The individual should be able to participate in group activities with minimal supervision, unless the individual is accompanied by a natural support to meet extra supervision or daily care needs.
- Medical necessity has been determined by treatment team which supports the service is the least restrictive community based option for the individual
- The individual must have a TB test or chest X-Ray prior to admission. Two step Tuberculosis (TB) skin test is required unless proof of negative TB skin test in the past 12 months, prior to attendance of programming and annually thereafter.

DISCHARGE/TRANSITION CRITERIA

- The individual or appointed guardian chooses not to, or is unable to, participate in programming.
- The treatment team can no longer identify medical necessity for the service.
- Transition to lesser restrictive service is assessed and consented to.
- Discharge could occur if an individual is non-compliant with the program rules. Review of such an occurrence will be documented in the individual's record.

EXCLUSIONARY CRITERIA

- Not an open Northpointe service recipient and/or under age 18.
- Service authorization is denied due to lack of support of medical necessity
- Services are not authorized through the Individual Plan of Service;

STAFF QUALIFICATIONS

The program is staffed by professionally trained Community Living Supports Aides or Peer Supports Specialists under the supervision of a qualified professional. All staff must pass a Criminal Background Check and an Excluded Parties Check. Staff must pass a physical and drug screen.

PROGRAM PROCEDURES

Individuals have been clinically assessed, diagnosed, and deemed appropriate for this comprehensive treatment program. Community Living Supports Services recipients may receive professional treatment monitoring as an adjunct to therapy, care management, and psychiatric consultation.

COMMUNITY LIVING SUPPORTS (CLS - Skill Building)

MISSION STATEMENT
Northpointe's Community Living Supports is committed to providing community-based services to children or adults diagnosed with an Intellectual/Developmental Disability (I/DD) or Severe Mental Illness (SMI). The primary objective is to provide services to promote independence in the community

TREATMENT OBJECTIVES
Community Living Supports utilizes the community and Northpointe staff to develop and enhance the necessary skills to live as independently as feasible, based on the individual's abilities, wants and desires.

GOALS
1. To promote independence, goal attainment, and living in the least restrictive environment
2. To coordinate services between Northpointe and Community Living Supports
3. To decrease the individual's risk for out-of-home placement
4. To continue to work with and meet the needs of the families and individuals

POPULATION TO BE SERVED
Community Living Supports are available to service recipients for whom such services are clinically appropriate to the treatment needs per clinical assessments.

ENTRANCE CRITERIA
1. The individual is an open Northpointe service recipient
2. The individual has a primary diagnosis of an Intellectual/Developmental Disability or Severe Mental Illness
3. Services are authorized through the Individual Plan of Service
4. The individual is at risk for out-of-home placement
5. The individual's symptoms impair his/her ability to function in the family, school or community
6. The family is in agreement and willing to actively work on treatment objectives and goals per the IPOS
7. The safety of family, children and Community Living Supports Aides can be maintained.

DISCHARGE/TRANSITION CRITERIA
1. The individual is no longer an open service recipient with Northpointe.
2. The safety of individuals, family, and/or Community Living Supports staff cannot be maintained.
3. Goals have been achieved through the IPOS.
4. The family does not work actively toward treatment goals and objectives per the IPOS

EXCLUSIONARY CRITERIA
1. The individual is not an open Northpointe service recipient
2. The individual does not have a primary diagnosis of an Intellectual/Developmental Disability or Severe Mental Illness
3. Services are not authorized through the IPOS
4. Less intensive forms of services are deemed appropriate
5. The individual is not at risk for out-of-home placement
6. The family is not in agreement and will not actively work on treatment objectives and goals per the IPOS
7. The safety of individuals, family, and/or Community Living Support workers can not be maintained

STAFF QUALIFICATIONS

Direct service is provided by Community Living Supports Aides with a minimum of a high school diploma or equivalent. Each aide completes all Northpointe trainings and any specialized training, as needed. Community Living Supports Service staff are supervised by the Community Living Supports Supervisor. All staff must pass a Criminal Background Check and an Excluded Parties Check. The service is monitored by the treatment team.

PROGRAM PROCEDURES

A. Referrals of agency service recipients to Community Living Support Services will be made by the primary provider according to the IPOS. The referring provider will:
   1. Discuss the team's recommendation for Community Living Supports with the individual and/or guardian and inform them of the entrance/exit criteria
   2. CLS staff will be notified through the electronic medical record and by invitation to the planning session
   3. If the individual would like to be considered for a training apartment, this should be identified within the plan of service, must be clinically appropriate and discussed with CLS supervisor.
   4. Monitor the implementation of individual's plan of service, coordinating the provision of service required by the plans, and evaluate the individual's response to services

B. Community Living Supports includes assisting, reminding, observing, guiding, and/or training in the following activities:
   1. Meal preparation;
   2. Laundry;
   3. Routine, seasonal, and heavy household care and maintenance;
   4. Activities of daily living (e.g. bathing, eating, dressing, personal hygiene);
   5. Shopping for food and other necessities of daily living;
   6. Money Management;
   7. Socialization and relationship building;
   8. Transportation to and from the individual's residence to the skill-building assistance training and between skills training sites if applicable;
   9. Participation in regular community activities and recreational opportunities (e.g. attending classes, movies, concerts and events in a park, volunteering, voting);
   10. Attendance at medical appointments;
   11. Acquiring or procuring goods, other than those listed under shopping and non-medical services;
   12. Reminding, observing and/or monitoring medication administration

CO-OCCURRING DISORDERS TREATMENT SERVICES

MISSION STATEMENT

Northpointe's Co-Occurring disorders treatment services provide an array of timely, responsive, and clinically appropriate services that promote the positive mental health and functioning of the children and adults being served.

TREATMENT OBJECTIVES

Co-Occurring disorders treatment is for individuals who have two or more disorders: Serious Mental Illness, Intellectual/Developmental Disability and Substance Abuse or Dependence and who meet the criteria to receive services at Northpointe. Northpointe services seeks to ensure the delivery of a comprehensive continuum of individualized services in a least restrictive environment, with a strong respect for the unique needs of each individual being served to reach their potential for self-reliance and positive emotional functioning.

GOALS

A. To offer individuals a cost-effective, time limited, quality-based range of individual, group, and family-centered Co-Occurring disorders treatment services in a least restrictive environment that are based upon an individualized, person-centered plan, which is goal-directed and serves to enhance or promote emotional/behavioral stability, growth, and independence. Staff will offer Co-Occurring treatment services following the clinical standards suggested by NorthCare
B. To promote an awareness of Co-Occurring disorders treatment, mental health and substance abuse related issues, and available services by actively participating in interagency collaborative initiatives, offering our availability for speaking engagements, displaying mental health informational materials, and participating in activities that promote "wellness" in both our schools and community at large

POPULATION TO BE SERVED

Co-Occurring disorders treatment services are provided to children, adolescents, and adults who are experiencing acute to moderate long-term emotional or behavioral impairments and substance abuse or dependence.

ENTRANCE CRITERIA

- There is documented evidence that the individual is experiencing mental health and substance abuse symptoms that have impaired their ability to function in one or more life areas
- The individual has met the medical necessity criteria for receiving services at Northpointe
- There is an expectation that the mode of therapies will enable the individual to become more functional in their life
- The individual demonstrates motivation to comply with service recommendations

DISCHARGE/TRANSITION CRITERIA

- The individual has met all the goals established for this service
- The individual demonstrates improved functioning as evidenced by a GAF score or another level of functioning tool (i.e. CAFAS, PECFAS, LOCUS)
- The individual voluntarily withdraws from service
- The individual moves out of catchment area
- Northpointe's therapy services are no longer medically necessary and/or the individual has been referred to another provider

EXCLUSIONARY CRITERIA

There is no documented evidence that the individual is experiencing mental health and substance abuse symptoms that have impaired their ability to function in one or more life areas.

STAFF QUALIFICATIONS

All services are provided by licensed mental health professionals in the State of Michigan. All staff must pass a criminal background check and an Excluded Parties Check. Staff are clinically supervised by a qualified professional either on an individual basis or within the treatment team. Staff are trained and qualified per NorthCare Co-Occurring requirements.

PROGRAM PROCEDURES

1. All individuals seeking or being referred for services will be assessed for clinical appropriateness by a qualified provider.

2. The case may be presented to the multidisciplinary treatment team. Based on clinical appropriateness and person-centered planning, therapy services are initiated. Services must be added to the individual's treatment plan and authorized per the NorthCare Benefit Plan.

3. Providers utilize a variety of evidenced based treatment modalities to ensure that individuals receive current, sensitive, relevant, and cost-effective services. Documentation is maintained on an ongoing basis regarding the specific treatment interventions that are provided. Some of these treatment modalities include the following:
   A. Individual Therapy is a treatment activity designed to reduce maladaptive behaviors, to maximize behavioral self-control or to restore normalized psychological functioning, reality orientation and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Cognitive Behavioral (CBT) and Dialectic Behavioral (DBT) are types of therapy staff are trained in.
   B. Family Therapy is joint therapy of an individual and family member(s) or other persons significant to the individual for the purpose of improving the individual /family function. It does not include individual or family planning.
   C. Group Therapy is a therapeutic modality that typically joins together a group of individuals under the leadership of a clinician for the purpose of working together for psychotherapeutic ends—specifically to improve all levels of the individual's functioning.

EMERGENCY SERVICES

MISSION STATEMENT

To prevent or reduce the debilitating consequences of emergent mental health problems commonly associated with a developmental crisis, environmental stresses, and/or mental/ emotional instability while minimizing the potential risk of injury to the individual or others.

TREATMENT OBJECTIVES

Emergency Services strive to provide immediately accessible intervention to individuals experiencing an acute mental health-related crisis. The severity and nature of the crisis will dictate the frequency of services delivered and the intervention outcome. Services include an after-hours telephone crisis line, crisis intervention screenings, emergency referrals, and pre-admission screenings for hospitalization, and crisis safety planning services.

GOALS

1. To provide immediate accessibility of crisis intervention services for individuals experiencing an acute mental health-related crisis.

2. To provide ongoing in-service training for all staff providing crisis intervention services to improve our capacity to respond effectively.

3. To provide face to face preadmission screening for inpatient hospitalization with a disposition made within 3 hours of when the person was clinically, medically or physically available.

POPULATION TO BE SERVED

Services are available to any individual experiencing an acute mental health-related crisis upon request or referral and who present within Northpointe's catchment area. Individuals seeking such services that are not residents of Dickinson, Iron, or Menominee Counties will be assessed, immediate crisis resolved, and referred to their local resources for follow-up care.

EXCLUSIONARY CRITERIA

No one is excluded from Emergency Services. The need for further services is determined at the time of the screening.

STAFF QUALIFICATIONS

All individuals providing services are licensed or registered professionals in the State of Michigan and have completed Northpointe's Emergency Services Training and ongoing Children's Trainings. All staff must pass a Criminal Background Check and an Excluded Parties Check.

PROGRAM PROCEDURES

A. Maintain a crisis response capacity that is well-publicized and immediately accessible upon request or referral

B. Services shall be directed to individuals requiring immediate intervention to prevent harm to self or others, or where such intervention will sufficiently contribute to satisfactory emotional stability

C. Outreach services may be mobilized in the event of natural disasters to minimize the emotional impact of such events and ensure the mental health needs of the community are adequately and timely addressed

D. Treatment services shall be of a brief goal-directed nature, emphasizing crisis resolution

E. Standing Orders – if any special medical care or crisis procedures are put into place, they must be documented in the electronic medical record using the "Crisis Alert Form". The form will be used to communicate to all involved parties

Emergency Services are designed to provide access to crisis intervention needs at all times, not just during those times when the agency is not normally in operation, i.e., evenings, weekends, and holidays. It further ensures the availability of crisis assistance to individuals experiencing an acute problem of disturbed thought, mood, behavior, or social relationship that requires immediate intervention. Services emphasize expediency in mobilizing an appropriate treatment response based on an assessment of the individual's treatment needs, skills, and available resources. Within this framework, Emergency Services strives to minimize the adverse effects of acute emotional distress on the individual and his/her family, reduces the risk of injury to the individual or others, and seeks to prevent unnecessary hospitalization.

Service Components:

- Telephone Crisis Line
  This service component allows 24-hour, seven (7) day-a-week accessibility to the local mental health system and is primarily designed to initiate a crisis intervention response for individuals experiencing an acute mental health problem. As such, the telephone crisis line is intended to enhance rather than serve as an alternative treatment service. Counselors are trained to respond to crisis support, answer mental health questions, and advise the individual of available treatment service options. The service will page or call emergency service staff after hours for emergency screenings at jails, hospitals and police departments.

- Crisis Support during normal office hours.
  Immediate intervention services are provided by a designated emergency services worker for individuals having no scheduled appointment who are experiencing severe symptoms of emotional decompensation or functional impairment. Such service contacts involve diagnostic evaluations, life-functioning assessment, short-term crisis support, and referral for follow-up services.

- Evaluation, Referral, and Hospitalization
  Upon request of local referral sources, trained staff provide crisis intervention services and pre-admission screenings which include mental status evaluations for possible admission to inpatient psychiatric facilities. These support activities promote appropriate utilization of hospital resources and facilitate inter-agency cooperation in arranging treatment services. Staff will refer to the Medicaid Provider Manual or Emergency Services Manual for specific medical necessity criteria for hospitalization.

- Back-up Clinical Supervisor
  Clinical Supervisors provide consultation, hospital authorization, and clinical direction to the emergency workers. They are available 24 hours, 7 days a week.

- Intensive Crisis Stabilization Services
  A multidisciplinary team, under the supervision of the psychiatrist, provide structured treatment and support activities and intensive crisis stabilization services are designed to provide a short-term alternative to inpatient psychiatric services. Services may be provided where necessary to alleviate the crisis situation, and to permit the individual to remain in, or return more quickly to their usual community environment.

Northcare will make authorization and approval decisions for services according to NorthCare Level of Care guidelines. If the hospital disagrees with the decision of Northcare, regarding either admission authorization/approval or the number of authorized days of care, the hospital may appeal to Northcare according to the terms of its contract with Northcare. If the hospital does not have a contract or agreement with Northcare, any appeals by the hospital will be conducted through the usual and customary procedures that Northcare employs in its contracts with other enrolled hospital providers.

If an individual or his/her legal representative disagrees with a Northpointe decision related to admission authorization/approval or approved days of care, he/she may request a reconsideration and second opinion from Northpointe. If Northpointe's initial decision is upheld, the individual has further redress through the Medicaid Fair Hearing process. Medicaid recipients can request a Medicaid Fair Hearing without going through local review processes.

FAMILY SUPPORT SUBSIDY PROGRAM

MISSION STATEMENT

The Family Support Subsidy Program is dedicated to providing financial support to families with severely handicapped children living in the parental/custodial home.

TREATMENT OBJECTIVES

1. To provide assistance to families while caring for a severely disabled child, in the hope of preventing or delaying out-of-home placement
2. Provide financial support to families of children with severe disabilities that enable the family to remain intact

GOALS

1. To assist and encourage individuals and families who are caring for an individual with severe disabilities at home in achieving and maintaining normative patterns of life
2. To provide information about and/or coordinate access to community services including those furnished by Northpointe

POPULATION TO BE SERVED

Family Support Program services are available to children who meet the following entrance criteria.

ENTRANCE CRITERIA

- The child must be under the age of 18
- The child must be living in the home of the family, and the family must reside in Michigan
- The school district's multidisciplinary team has recommended the child for one of the following diagnosis:
    1. Cognitive Impairment (must be below the 4.5 standard deviation)
    2. Severely Multiply Impaired (SXI)
    3. Autistic Impaired (AB)
- The taxable income for the family in the year preceding the date of application may not exceed $60,000

DISCHARGE/TRANSITION CRITERIA

- The child reaches his/her eighteenth (18th) birthday
- The ISD-IEPC team changes the primary diagnosis to a non-approved diagnosis
- The child can no longer be maintained in the parental home
- The family's annual income exceeds $60,000
- The family moves out of state

EXCLUSIONARY CRITERIA

Participation in the Family Support Subsidy Program is determined by meeting the State of Michigan's admission criteria listed above.

STAFF QUALIFICATIONS

All services are provided by trained individuals who are registered with the State of Michigan.

PROGRAM PROCEDURES

To qualify for Family Support Subsidy you must ask your Intermediate School District (ISD) about the program, you do not need to be an open service recipient with Northpointe.

HOME-BASED SERVICES
(Intensive Family-Based Services)

MISSION STATEMENT

Home Based service programs are designed to provide intensive services to children, young adults ages 18-21, and their families with multiple service needs who require access to an array of mental health services

TREATMENT OBJECTIVES

1. To promote improved family functioning and normal development
2. To support and preserve families and prevent out of home placements
3. To reunite families that have been separated (as appropriate)
4. To decrease the length of stay in psychiatric hospitals or other substitute care settings
5. To make the focus of treatment the family unit operating under a family plan of service. Treatment is based on the child's need with the focus on the family unit

GOALS

1. Facilitate the development and maintenance of a well-functioning family unit
2. The family will be able to meet the basic physiological needs of its members
3. The family unit will be less reliant on external resources
4. Reunite families who have been separated
5. Reduce the usage of, or shorten the length of stay in, psychiatric hospitals and other substitute care settings

POPULATION TO BE SERVED

This program will be made available to children and their families with multiple service needs who meet the criteria to receive specialty mental health services.

ENTRANCE CRITERIA

For all ages:

- A child has a mental, behavioral or emotional disorder sufficient to meet diagnostic criteria specified in the DSM, not solely the result of mental retardation, other Intellectual/Developmental Disability, Substance Abuse or a V-code diagnosis; or a parent with a DSM-V diagnosis that results in a care giving environment that places the child at risk for serious emotional disturbance

Plus

Ages 0 – 3:

1. Parent/Caregiver is currently an SMI open adult at NBHS (and infant is in Parent/Caregiver's home) or

2. Currently siblings in the home are SED and open to NBHS system and based on the current home environment the infant is at risk of becoming SED or

3. The CMHC consultant to Early On feels that the infant is at risk of becoming SED or I/DDC or

4. The screening clinician in conjunction with NBHS determines that the infant is at risk of becoming SED

5. Has substantial interference with, or limitation of, the child's proficiency in performing age appropriate skills, as demonstrated by at least 1 indicator from 2 of the following areas:
   - General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems
   - Distinct behavioral patterns along with sensory motor or organizational processing difficulty that inhibits the child's daily adaptation and interaction/relationships

- Incapacity to obtain critical nurturing; as determined through the assessment of child, caregiver, and environmental characteristics

Duration/History:
The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endure without intervention include:

- The infant/toddler's disorder(s) is affected by persistent multiple barriers to normal development (regulatory disorders, inconsistent parenting, chaotic environment, etc.) or
- Infant/toddler did not respond to less intensive, less restrictive interventions

Ages 4 – 6:
Substantial interference with, or limitation of, performing age-appropriate skills across domains. Exhibits at least one indicator from at least 3 of the following areas:

- Impaired Physical development, sensory, sensory motor or organizational processing difficulty, failure to control bodily functions
- Limited Cognitive development, as indicated by restricted vocabulary, memory, cause and effect thinking, ability to distinguish real and pretend, transitioning from self-centered to more reality-based thinking, etc.
- Limited capacity for self-regulation, inability to control impulses and modulate anxieties as indicated by frequent tantrums or aggressiveness towards others, prolonged listlessness or depression, inability to cope with separation from primary caregiver, inflexibility and low frustration tolerance, etc.
- Impaired or delayed social development as indicated by an inability to engage in interactive play with peers, inability to maintain placements in day care or other organized groups, failure to display social values or empathy toward others, absence of imaginative play or verbalizations commonly used by preschoolers to reduce anxiety or assert order/control on their environment, etc.
- Care giving factors which reinforce the severity of intractability of the childhood disorder and the need for multifaceted intervention strategies
- A total impairment score of 80 or more on the PECFAS

Duration/History: The following specified length of time criteria for determining when the youth's functional disabilities justify his referral for enhanced support services:

- Evidence of three (3) continuous months of illness
- Three (3) cumulative months of symptomology/dysfunction in a 6 month period; or
- Conditions that are persistent in their expression and are not likely to change without intervention.

Ages 7 –21:
For purposes of qualification for home-based services, children and adolescents may be considered markedly or severely functionally impaired if the minor has:

- An elevated subscale (rated at 20 or greater) on at least two elements of the Child/Adolescent Section of the CAFAS
- An elevated subscale score (20 or greater) on one element of the CAFAS Child/Adolescent Section, combined with an elevated subscale score (20 or greater) on at least one CAFAS element involving Caregiver/Care giving Resources; or
- A total impairment score of 80 or more on the CAFAS Child/Adolescent Section
- The young adult is determined to meet SED criteria

Duration/History: The following specify the length of time the youth's functional disability has interfered with his/her daily living and led to his/her referral for home-based services

- Evidence of six continuous months of illness, symptomatology, or dysfunction
- Six (6) cumulative months of symptomatology /dysfunction in a 12 month period
- On the basis of a specific diagnosis, disability is likely to continue for more than one (1) year

DISCHARGE/TRANSITION CRITERIA

- The child/adolescent and other family members demonstrate improvement and stability in psychiatric signs and symptoms
- There is evidence that the family has achieved a level of self-sufficiency that they no longer demonstrate the ongoing need for multiple service involvement
- The identified child/adolescent no longer is at substantial risk for out-of-home placement
- The identified child/adolescent has achieved a CAFAS score of less than 80 (on the 8 scale sum)
- The child/adolescent has acquired the life skills necessary to function adequately in the family, school or community
- The goals of the child/adolescent and family have been achieved or are assessed to be at a level that any remaining treatment needs can be effectively met through a less intensive service program
- The child/family moves outside of the geographic area of the program's responsibility
- The family voluntarily withdraws from service or requests a clinically appropriate transition to another program
- The safety of the child/adolescent, other family members or treatment staff can no longer be ensured
- The identified individual has reached the age of 21 and is no longer eligible for continued services in the Home-Based program

EXCLUSIONARY CRITERIA

Participants must meet the specific entrance criteria detailed above

STAFF QUALIFICATIONS

Home-based services are supervised by a qualified child mental health professional with at least three years of clinical experience. This person is trained and has experience in the examination, evaluation, and treatment of minors and their families. Home-based services are rendered by qualified staffs who meet the qualifications of a child mental health professional as defined in Rule 330.2105 (b) of the Administrative Rules for Children's Diagnostic and Treatment Services. To serve infants and toddlers and their families, staff must have achieved Infant Mental Health endorsement, Level II or higher.

The family-to-worker ratio should not exceed 15:1 for a full time employee.

If home-based services are to be provided to persons with developmental disabilities, the child mental health professional must also be a Qualified Intellectual Disability Professional (QIDP) as defined in 42 CFR 483.430.

All staff are registered or licensed with the State of Michigan and maintain Northpointe's competency requirements. All staff must pass a Criminal Background Check and an Excluded Parties Check.

PROGRAM PROCEDURES

1. A request for service is initiated by the family and/or service provider. This request contains a statement of the family's needs and priorities. This request initiates development of a family plan of service, utilizing the person-centered approach to care.
2. The Plan of Service contains information regarding the priorities and goals of the family. Those goals and priorities may include procurement of resources necessary to meet the intensive needs of the family. The Plan of Service can also include information regarding the medical and safety needs of the family. The Plan of Service includes information about those services that are being provided/coordinated by other agencies. The Plan of Service also includes identification of family strengths and resources. Each family will be offered the opportunity to develop a Family Crisis Plan.

3. The Plan of Service is used as an authorization to provide continuity and coordination of services within (and outside) the agency. Community resources are utilized as appropriate to the individual's needs.
4. Home-based services combine individual, family, group therapy, crisis intervention, psychiatric care case management, and collateral contacts. Home-based services could also include skill development (behavior management, life, conflict resolution, problem solving, anger management, decision making); school based services; substance abuse services; positive youth development; nutritional and health; service coordination; and medication management/monitoring services. Services are provided in the family home or community setting a minimum of four hours per month.
5. The agency's emergency services are available to all Home-based recipients (see "Emergency Service" section), 24 hours a day, and 7 days a week.

OBRA SERVICES

MISSION STATEMENT

OBRA services are committed to assuring that the individual's mental health needs are being addressed within the nursing home environment as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1987. Services strive to provide the least restrictive treatment options and promote maximum independence to all individuals. Services are mandated and authorized by the Department of Health and Human Services.

TREATMENT OBJECTIVES

The OBRA program assures a comprehensive assessment (PASARR) is completed to identify mental health treatment needs, level of care and least restrictive placement options.

GOALS

1. To provide comprehensive assessments and follow-through of mental health services to OBRA-identified individuals.
2. To provide education and training to nursing home staff in an attempt to encompass a team approach to better serve the individual's hopes, dreams and desires.

POPULATION TO BE SERVED

Services are available to individuals of any age, referred through the Level II process, those currently residing in a nursing home, or those seeking placement.

ENTRANCE CRITERIA

OBRA services are available to individuals referred through the Level II process, whether within the nursing home or appropriate referrals. The Level II process is initiated by the referring agency (i.e., hospital, practitioner, healthcare professionals or nursing facility) completing the Level I process (MDHHS 3877 and 3878 forms) and sending them to the local CMH. Upon receiving the Level I forms (3877/3878, if needed), the OBRA staff will determine if a Level II comprehensive assessment is needed depending on diagnostic criteria, evidence of mental illness/Intellectual/Developmental Disability and/or medication regime. The recommendations made through the Level II process must be authorized through the Department of Health and Human Services/OBRA office.

A MDHHS 3878 form is utilized to identify "exception criteria." "Exception criteria," according to OBRA state guidelines, includes "has supported primary diagnosis of dementia, is in a coma, or meets three criteria for convalescent care." For non-OBRA-identified clients, current agreements with nursing homes are on file with our contract manager.

DISCHARGE/TRANSITION CRITERIA

- Individual meets exception criteria (i.e., dementia or coma)
- Individual withdraws from services
- Person-centered goals have been achieved
- Individual's needs have been met more appropriately by referral agent

Note: Though individual may appeal MDHHS recommendations or services, the Level II comprehensive assessment is federally mandated.

EXCLUSIONARY CRITERIA

Individuals who do not meet the Entrance Criteria are excluded from this service.

STAFF QUALIFICATIONS

Various professionals provide services on an as-needed basis. OBRA coordinator has a minimum of a bachelor's degree. Level II psychosocial assessments are completed by a state licensed professional, registered social worker (if completed by a Licensed Bachelors Level Social Worker (LBSW), it must be reviewed/ approved by a certified social worker). All treatment professionals of Northpointe will complete trainings and maintain competency. All staff must pass a Criminal Background Check and an Excluded Parties Check.

PROGRAM PROCEDURES

1. Assessment services will be provided in accordance with MDHHS guidelines. The Level II assessment is the initiating tool to determine the individual's mental health needs and identify least restrictive placement needs. The Level II comprehensive assessment includes a psychosocial assessment, nursing assessment, and psychiatric/psychological assessment, depending on the diagnosis. Occupational and speech assessments are mandated for the I/DD population.

2. OBRA program services may include:
   - Person-centered planning and interdisciplinary team participation
   - Mental health monitoring to ensure mental health needs are being met
   - Collaborative facilitation for placement in an alternative setting, if deemed appropriate through the Level II comprehensive assessment process

3. Clinical Support Services may include:
   - Psychiatric evaluation
   - Psychotropic medication review by qualified practitioner
   - Crisis intervention for mental health-related emergencies
   - Screening/referral for inpatient psychiatric treatment
   - Individual Therapy
   - Nursing home mental health monitoring
   - Care plan participation with interdisciplinary team

4. Educational training may be provided to nursing home staff and community at large, emphasizing mental health issues.

***BILLING*:** Services are provided through PASARR funding.

PARENT SUPPORT PARTNERS

MISSION STATEMENT
Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning.

TREATMENT OBJECTIVE
Parent Support Partners, serving as an equal member of the treatment team, will assist in identifying goals within the Family Centered Plan that will support the parent to develop skills, knowledge, resources, and confidence in parenting a child with a serious emotional disturbance or Intellectual /Developmental Disability.

GOAL
The PSP service, provided by another parent/caregiver who has first-hand experience navigating public child serving agencies and raising a child with serious emotional disturbances and intellectual /developmental disabilities, will focus on increasing confidence and competence in parenting skills, increasing the parent's knowledge to better navigate systems and partner with service providers, and empower the parent to develop sustainable natural support networks after formal service delivery has ended. Parent to parent support has been shown to improve outcomes for youth and their families. Having access to a parent who "has been there" enhances caregiver engagement, which improves retention rates in treatment, decreases a caregiver's sense of hopelessness and isolation, and increases satisfaction with services.

POPULATION
Parents and caregivers whose youth are receiving services from Northpointe.

ENTRANCE CRITERIA
- Must be the parent or caregiver of a child (birth to 21years) who is currently receiving services a t Northpointe
- The parent/caregiver is in need of services to assist them with relating to and caring for a child with serious mental illness, serious emotional disturbance or developmental disability

DISCHARGE/TRANSITION CRITERIA
- The child is no longer receiving services at Northpointe
- The parent/caregiver become confident and empowered and have learned the skills that will enable them to assist their child to improve in functioning.

EXCLUSIONARY CRITERIA
- The parent/caregiver does not have a child currently receiving services at Northpointe.

STAFF QUALIFICATIONS
The trained parent support partner, who has or had a child with special mental health needs.
The peer-parent support partner must complete the MDHHS approved statewide training curriculum and be provided regular supervision and team consultation by the treating professionals. Completion of the training curriculum is documented by a Certificate of Completion which must be maintained in the parent support partner's personnel file.

PROGRAM PROCEDURES
PSP must be an identified service (s5111) in the IPOS to provide support, information, skill development, and resources to families to accomplish treatment goals.

PROGRAM OBJECTIVES

To increase family involvement and engagement within the treatment process and to equip parents with the skills necessary to address the challenges of raising a youth with special needs thus improving outcomes for youth with SED and I/DD who are involved with the public mental health system

- Empowerment
- Self-Sufficiency
- Increased Confidence
- Increased Competence

PEER SUPPORTS SERVICES

MISSION STATEMENT
Peer-delivered or peer-operated support services are programs that provide individuals with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive patient roles and identities, and to build and/or enhance self-esteem and self-confidence.

TREATMENT OBJECTIVE
Peer specialist services provide individuals with opportunities to support, mentor and assist individuals to achieve community inclusion, participation, independence, recovery, resiliency and/or productivity. All services and supports for individuals and their families shall be provided within the context of a true partnership that instills hope and a belief that the individuals can recover.

GOAL
To gain trust and respect of other individuals based on shared experience and perspectives and assist with planning and negotiating human services systems. Activities provided by peers are completed in partnership with individuals for the specific purpose of achieving increased beneficiary community inclusion and participation, independence and productivity.

POPULATION
Adults with a Severe Mental Illness (SMI) who are served by Northpointe with a current emphasis on those served by ACT/IDDT.

ENTRANCE CRITERIA
- Must be an open Northpointe service recipient
- Individuals utilizing Peer Support Services must freely choose the individual who is providing Peer Support Services.
- If attending the Drop-in center, there must be an objective in their Individual Plan of Service.

DISCHARGE/TRANSITION CRITERIA
- When the individual is no longer utilizing Northpointe services
- When the individual chooses to no longer work with the Peer Support Specialist
- When the goals set for the individual and Peer Support Specialist have been attained

EXCLUSIONARY CRITERIA
- The individual is not open at Northpointe
- The individual has a primary diagnosis of Intellectual/Developmental Disability

STAFF QUALIFICATIONS
- For individuals who are functioning as Peer Support Specialists, MDHHS requires specialized training and certification
- Must be a service recipient or former service recipient of mental health or substance abuse services
- Peer Support Specialist must receive all of Northpointe's mandated trainings for employees who work with service recipients
- All staff must pass a Criminal Background Check and an Excluded Parties Check

PROGRAM PROCEDURES
- Individuals have been clinically assessed, diagnosed and deemed appropriate for this comprehensive service

- Individuals receiving Peer Supports Services may receive professional treatment monitoring as an adjunct to therapy, care management and psychiatric consultation.
- If attending the Drop-In center there must be an authorization for H0023.

PROGRAM OBJECTIVES

- Vocational assistance provides support for individuals seeking education and/or training opportunities, finding a job, achieving successful employment activities, and developing self-employment opportunities (reported as skill-building or supported employment).
- Housing assistance provides support locating and acquiring appropriate housing for achieving independent living; finding and choosing roommates; utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements; making applications for Section 8 Housing vouchers; managing costs of room and board utilizing an individual budget; purchasing a home; etc.
- Services and supports planning and utilization assistance provides assistance and partnership in
  - ✓ The person-centered planning process
  - ✓ Developing and applying arrangements that support self-determination
  - ✓ Directly selecting, employing or directing support staff
  - ✓ Sharing stories of recovery and/or advocacy involvement and initiative for the purpose of assisting recovery and self-advocacy
  - ✓ Accessing and applying for entitlements
  - ✓ Developing wellness plans
  - ✓ Developing advance directives
  - ✓ Learning about and pursuing alternatives to guardianship
  - ✓ Providing supportive services during crises
  - ✓ Developing, implementing and providing ongoing guidance for advocacy and support groups

PSYCHIATRIC SERVICES

MISSION STATEMENT

Psychiatric services will be provided in a timely fashion to individuals who are in need of clarifying diagnosis, response to treatment, and/or to consider alternative treatment methods. The service of tele-psychiatry will be made available if deemed clinically appropriate.

TREATMENT OBJECTIVES

1. To clarify diagnosis
2. To recommend therapeutic interventions
3. To prescribe and monitor effectiveness of psychotropic medications
4. To determine the mental and emotional functioning and capacities of an individual
5. To evaluate the presence or absence of psychopathology, including extra pyramidal symptoms and Tardive Dyskinesia

GOAL

To enhance the habilitative services that meets the individual's needs and reflects their wishes and desires for treatment and recovery.

POPULATION TO BE SERVED

All persons eligible for Northpointe services who have been pre-authorized and deemed medically necessary.

ENTRANCE CRITERIA

- The individual must be an open at Northpointe and receiving services
- The individual is in need of a psychiatric evaluation to clarify diagnosis to recommend a course of treatment
- The individual is in need of a clinical certificate to initiate or renew hospitalization or Alternative Treatment Orders (ATO) or alternative Outpatient Treatment Orders (AOT)

DISCHARGE/TRANSITION CRITERIA

- There is documented evidence that the individual is no longer in need of further services to help stabilize his/her symptoms
- The individual's symptoms have stabilized to the point that care can be transferred to a primary care practitioner
- The individual voluntarily withdraws or moves out of the catchment area

EXCLUSIONARY CRITERIA

- The individual is not open and actively receiving services at Northpointe.
- The individual will not accept other services through Northpointe, as psychiatric is not a stand alone service

STAFF QUALIFICATIONS

All psychiatric practitioners providing services are licensed in the State of Michigan as a practitioner and must be board eligible or board certified in psychiatry and/or licensed in the State of Michigan as a Psychiatric Nurse Practitioner, under clinical supervision of the Medical Director. All staff must pass a Criminal Background Check and an Excluded Parties Check.

PROGRAM PROCEDURES

1. A Northpointe primary clinician and/or individual's primary care physician may request a psychiatric evaluation when there is a need to clarify a diagnosis, the response to treatment, and/or consider alternative treatment methods for individuals who meet the eligibility criteria.
2. If a primary care physician (PCP) is treating the individual, it is recommended that the primary care physician be contacted/notified (after a release of information is obtained) about the need for psychiatric evaluation to determine if the PCP has any questions for the psychiatric practitioner. The PCP may already be ordering psychoactive meds, and/or it may be necessary to request that the PCP change or order psychoactive meds after the psychiatric evaluation.
3. The primary clinician must generally have completed a bio-psychosocial assessment and engaged the individual in a therapeutic relationship for at least three sessions (including the assessment) prior to a referral being completed for an evaluation. Exceptions to this are psychiatric hospital discharges or emergent/urgent needs. Enough information must be gathered to assist the psychiatric practitioner in answering the questions and substantiating a diagnosis, which is all documented in the clinical record prior to the psychiatrist practitioner's first contact with the individual.
4. The psychiatric/medical services referral form is completed by the primary clinician and forwarded to their clinical supervisor and the Director of Nursing for screening. Once approved, a Customer Service Representative will schedule the appointment with the psychiatric practitioner. The primary clinician will be notified of the appointment time and date. If indicated, the primary clinician may schedule time to talk to the psychiatric practitioner before the psychiatric practitioner first meets the individual.. If indicated, the primary clinician may be present during the psychiatric evaluation or meet with the psychiatric practitioner afterward. The primary clinician may also discuss the case at weekly Treatment Team meetings.

PSYCHOLOGICAL SERVICES

MISSION STATEMENT
Northpointe's Psychological Services is committed to playing a role in the diagnosis and treatment planning of agency service recipients.

TREATMENT OBJECTIVES
Psychological services assist providers in accurately diagnosing an individual, which aids in the individual plan of service development and/or assist in ensuring the appropriate use of behavioral analysis resources.

GOALS
1. To use standardized assessments for the purpose of defining a diagnosis
2. To offer therapeutic recommendations based on assessment results
3. To develop individual programs and interventions to maximize behavioral self control, or to restore normalized psychological functioning and emotional adjustment
4. To participate in the Behavior Treatment Review Committee (BTC) process/treatment to address any individual plan that may include or propose restrictive or intrusive techniques, or psycho-active medications for behavioral control

POPULATION TO BE SERVED
Northpointe Behavioral Healthcare Systems will offer psychological services to individuals who meet criteria to receive Specialty Mental Health Services and have been preauthorized and deemed medically necessary.

ENTRANCE CRITERIA
- The primary clinician has deemed the service medically necessary
- The individual/guardian is receptive and agreeable to psychological services
- The individual's diagnosis needs clarification
- The individual's abilities/functionality needs assessing to aid in treatment planning
- The individual has engaged in significant physical aggression, self abuse, or property damage or is at risk of being placed in a more restrictive setting

DISCHARGE/TRANSITION CRITERIA
- Testing is completed
- Behaviors exhibited by the individual plateau for a significant period (1+ yr)
- Parental/Guardian/Caregiver/ Individuals involvement is inconsistent for an extended period (3+mo)
- Individual/guardian withdraws from service

EXCLUSIONARY CRITERIA
The individual does not meet the entrance criteria

STAFF QUALIFICATIONS
Psychological services are provided by fully licensed, limited licensed or temporary limited licensed psychologists. These individuals adhere to all state regulations, standards, and policies, and maintain their competency. All staff must pass a Criminal Background Check and an Excluded Parties Check.

PROGRAM PROCEDURES

1. The Care Manager will discuss with the psychologist if psychological services are medically necessary prior to completing a Specialty Discipline Referral form
2. A Specialty Discipline Referral form is completed by the Care Manager upon agreement with the individual/guardian
3. The Specialty Discipline Referral form is signed by the supervisor of the Care Manager
4. The form is then sent to the psychologist who will schedule and complete the appropriate service(s) in a timely manner
5. Consent for Behavioral Treatment is obtained by the individual/guardian if determined necessary

RESPITE SERVICES

MISSION STATEMENT

Northpointe's Respite Program is committed to providing respite services to families caring for individuals diagnosed with a Serious Mental Illness and/or Intellectual/Developmental Disability in their family home in order to maintain those individuals in the least restrictive/ community-based setting. Respite Care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short term, intermittent basis to relieve the individual's family or caregiver from daily stress and care demands.

TREATMENT OBJECTIVES

The Respite Program's objective is to maintain the family unit and incorporate individuals in their community with natural supports.

GOALS

1. To provide the least restrictive/community-based services to individuals using person-centered processes
2. To utilize Care Managers to assist in identifying and implementing support strategies to promote community inclusion and participation (in the same manner as other citizens)
3. To facilitate independence, and encourage productivity to maintain or increase self-sufficiency

ENTRANCE CRITERIA

- The individual meets the criteria of having an I/DD, MI or SED diagnosis
- The individual resides in the family home or licensed children's foster care.
- Priority is given to individuals before the age of eighteen
- There will be an annual IPOS authorizing respite services. Care Managers assist in developing an IPOS through the person-centered planning process. The IPOS identifies who does what, functions to be performed, and the frequency of face-to-face and other contacts. The frequency and scope of supports coordination contacts must consider health and safety needs
- Supports coordination involves working closely with the individual and/or guardian to ensure their ongoing satisfaction with the process and outcomes of the supports, services, and available resources. This does not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services
- Respite services are obtained through self determination process where respite providers are enrolled with the fiscal intermediary service of their choice

DISCHARGE/TRANSITION CRITERIA

- The individual no longer resides in the family home or licensed children's foster care.
- The individual has developed natural supports or other means of assistance to maintain their level of self –sufficiency and respite services are no longer needed
- The individual has moved or withdrawn from services

EXCLUSIONARY CRITERIA

Individuals would be excluded from these programs who do not meet the entrance criteria

STAFF QUALIFICATIONS

All services are provided by trained individuals. They must be trained by the family or foster care provider on the specific needs of the individual and the treatment plan. Programs are managed through the self determination process and the use of a fiscal intermediary registered with the State of Michigan. Respite providers must be at least 18 years old, complete Recipient Rights training, be certified in First Aid; and successfully pass a Criminal Background Check and Excluded Parties Check.

PROGRAM PROCEDURES

A. For individuals who are an open service recipient with Northpointe, ask your Care Manager about Respite Services
B. For persons who are not an open service recipient contact NorthCare Access to determine eligibility for Respite **ONLY**
C. Once it has been determined that the child/adult meets criteria the family will be scheduled for an appointment
D. At the appointment staff will determine:
    1. Financial responsibility
        a. If the individual has Medicaid there is no financial responsibility, unless there is a spend-down
        b. If the family is responsible for payment, it will be based on ability to pay
    2. Individual Plan of Service (IPOS)
        a. Respite ONLY – Once it is determined that the only services the family chooses is respite, then the respite IPOS will be completed. The IPOS will authorize the Respite Services and list the allotted total payment amount and detail the number of hours, rate of pay etc.
        b. If an "open" individual, Respite services will be included in the IPOS
E. Once the individual is open for Respite, the family needs to enroll the respite workers as providers with the Fiscal Intermediary of their choice. To complete this task, ask your assigned Care Manager for the contact information.
F. Respite Reimbursement Vouchers will be provided to the family. These are to be completed and turned into the Fiscal Intermediary at least monthly. Vouchers submitted more that 30 days following service delivery will not be approved.
G. If the family needs assistance with finding a respite worker, they may contact the Respite Coordinator. The Respite Coordinator is the holder of a provider list and will work with the family to help them find a skilled worker that they are comfortable with to provide the services.
H. Paying someone to care for your child/adult while you are at work/ at school is not reimbursable through the respite program.
I. For specifics on respite service implementation see the Respite Care Service Guidelines.
J. If a family uses the authorized respite prior to fiscal year ending, they can request additional respite if deemed medically necessary. The parent/guardian needs to submit a letter to the Respite Coordinator or the Care Manager identifying the reasons why they need additional respite. The request will be reviewed by the respite coordinator.

SPECIALTY SERVICES
(Occupational Therapy, Dietary, Physical Therapy and Speech)

MISSION STATEMENT
Northpointe's Specialty Services are committed to playing a role in the diagnosis and treatment planning of agency service recipients.

TREATMENT OBJECTIVES
Specialty services assist providers in accurately treating an individual, which aids in the individual plan of service development.

GOALS
Occupational Therapy (OT): To promote the highest practicable level of independent function and interaction, within the individual's least restrictive environment
Dietary Services: To promote optimal nutritional health for individuals with an identified nutrition problem
Physical Therapy (PT): To promote the highest practical level of independent function and movement, with or without assistive devices
Speech-Language Pathology (SLP): To aid in the correction, prevention or alleviating the disability, to allow basic functional communication

POPULATION TO BE SERVED
Northpointe Behavioral Healthcare Systems will offer Specialty services to individuals who meet criteria to receive Specialty Mental Health Services and have been pre-authorized and deemed medically necessary.

ENTRANCE CRITERIA
- The primary clinician has deemed the service medically necessary
- The individual/guardian is receptive and agreeable to stated specialty service
- The individuals abilities/functionality needs assessing, to aid in treatment planning
- Need for specialty evaluation identified and authorized in IPOS

Occupational Therapy referral will be made if individual has identified needs (or desired outcomes) that meet one or more of the following criteria:

1. Individual has desire/potential/ability to develop new skills in areas of self-care, home management, community living skills, play/leisure skills, and psychosocial skills
2. Individual is anticipating a move to a less restrictive level of service or living arrangement
3. Individual has experienced a recent decline (or at risk for decline) in level of function in areas of activities of daily living, play/leisure because of physical, cognitive, or psycho-social deficits, particularly involving a progressive degenerative condition
4. Individual is at risk for moving to more restrictive setting because of sensory-motor (ex: loss of mobility, or motor skills to meet Activities of Daily Living (ADL) needs), cognitive, or social skill deficits
5. Individual possesses a physical or sensory impairment requiring adaptive aids for ADLs or mobility (wheelchair) or instruction on compensatory techniques to meet ADL, vocational, play/leisure, and mobility needs

Dietary services referral will be made if an individual has an identified nutrition concern that is not being fully addressed through other resources in the community (e.g., Diabetes Education, etc.), and the individual is agreeable to diet education, training or other medical nutrition therapy to address that concern:

- Examples of nutrition problems prompting entrance to dietary services: specialized nutrition such as tube-feeding; nutrition-related disease such as diabetes mellitus, chronic kidney disease, hyperlipidemia, anorexia nervosa, bulimia, obesity, GI disease; disorders of swallowing; abnormal eating patterns or inadequate access to food that results in dietary imbalances or malnutrition

Physical Therapy referral will be made if the individual has identified needs (or desired outcomes) that the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, will aid in the preventing, correction of, or alleviating of a disability

- Informal Consultation only without a formal written PT evaluation and recommendations
- PT evaluation with recommendations only. Evaluations may be comprehensive or targeted to specific area of function. Written recommendations to be followed up on by others and included in the individual's IPOS
- A re-evaluation, between annual evaluations, if condition or need significantly changes and will have documentation and written recommendations or treatment suggestions
- Evaluation with written guidelines, procedure, or treatment suggestions. This type of programming does not require ongoing staff training or ongoing treatment monitoring in order to be implemented effectively, but should be included in the individual's IPOS
- Evaluation with formal treatment goals and objectives. This will include staff training and treatment monitoring based on individual need. It may also involve direct PT services. Treatment monitoring may be performed by OT or care manager when appropriate, as documented in the individual's IPOS

Speech-Language Pathology(SLP) referral will be made if the individual has identified functional communication needs. An evaluation and care for non-verbal conditions, hearing impaired, receptive language, expressive language, need for augmentative communication system (signing, picture symbols, communication book or device), social interaction skills, articulation, swallowing, stuttering and enunciation to develop a basic level of functional communication.

- SLP evaluation with recommendations only
- SLP evaluation with written guidelines or procedures
- SLP evaluation with formal treatment goals and objectives

DISCHARGE/TRANSITION CRITERIA

- Individual /Guardian withdraws from service
- (OT) Identified equipment needs have been met
- (OT) Individual has plateaued in progress and no additional needs are identified
- Dietary goals are met and no additional needs are identified
- (PT) goals have been met with no further identified needs
- (SLP) goals have been met with no further identified needs

EXCLUSIONARY CRITERIA
The individual does not meet the entrance criteria

STAFF QUALIFICATIONS
Specialty services are provided by fully licensed Occupational Therapist, Physical Therapist, Dieticians, and Speech-Language Therapist. These individuals adhere to all state regulations, standards, and policies, and maintain their competency. All staff must pass a Criminal Background Check and an Excluded Parties Check. If working directly with children must also complete Criminal Background Check through DHS.

PROGRAM PROCEDURES
1. The Care Manager will discuss with the specialty service provider to ensure that requested services are medically necessary prior to completing a Specialty Discipline Referral form
2. A Specialty Discipline Referral form is completed by the Care Manager upon agreement with the individual/guardian
3. The Specialty Discipline Referral form is signed by the supervisor of the Care Manager
4. The approved Specialty Discipline Referral form is then sent to the physician for signature
5. The form is then sent to the specialty service provider who will schedule and complete the appropriate service(s) in a timely manner

SUPPORTS COORDINATION

MISSION STATEMENT

Northpointe Supports Coordination Services is committed to providing least restrictive, community-based services to individuals diagnosed with a Serious Mental Illness (SMI) and/or Intellectual/Developmental Disabilities (I/DD), with a focus on advancing independence and growth. This will be achieved through creative and innovative treatment approaches on a continuum of progressively lesser restrictive treatment options, which ensures the quality of life and safety of the individual and others.

TREATMENT OBJECTIVES

Supports Coordination incorporates principles of empowerment, community inclusion, health and safety assurances, and use of natural supports. Supports Coordination involves working closely with the individual and/or guardian to ensure their ongoing satisfaction with the process and outcomes of the supports, services, and available resources. This does not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Care Managers assist in developing an IPOS through the person-centered planning process. The IPOS identifies who does what, functions to be performed, and the frequency of face-to-face and other contacts for each service authorized. The frequency and scope of Supports Coordination contacts must consider health and safety needs and include linking, coordinating and monitoring services.

GOALS

1. To provide the least restrictive/community-based services to individuals using person-centered processes
2. To use Care Managers to assist in identifying and implementing support strategies to promote community inclusion and participation (in the same manner as other citizens)
3. To facilitate independence, and encourage productivity to maintain or increase self-sufficiency

POPULATION TO BE SERVED

Available to all open Northpointe service recipients based on eligibility and medical necessity

ENTRANCE CRITERIA

Supports Coordination services are selected based on the intensity of individual need and this is reflected in the NorthCare Benefit Plan.

DISCHARGE/*TRANSITION CRITERIA*

1. Individual/guardian no longer desires or requires service coordination and that role is assumed by individual, guardian, or other natural support
2. Individual no longer resides in catchment area and service coordination is transferred to another

EXCLUSIONARY CRITERIA

Individual would be excluded from this service if they do not meet the medical necessity criteria to be an open Northpointe service recipient.

STAFF QUALIFICATIONS

All services are provided by licensed/registered professionals, in accordance with Michigan PIHP/CMHSP provider qualification per Medicaid services a Bachelors degree in a human service field, a nursing or occupational therapy degree, and are a Qualified Mental Health Professional or Qualified Intellectual Disability Professional (QMHP or QIDP) or working towards that. They will also complete Northpointe's trainings and maintain competency. All staff must pass a Criminal Background Check and an Excluded Parties Check. Staff are clinically supervised on an ongoing basis by a qualified professional. Staff will have a working knowledge of the appropriate services available and support systems relevant to the service recipient.

PROGRAM PROCEDURES

All cases are referred through the person centered planning process. Northpointe's Supports Coordination Services are a coordinated network of individualized treatment and habilitative programming offered by Northpointe. The frequency and scope (face-to-face and telephone) of supports coordination contacts must reflect the intensity of the individual's health and welfare needs identified in the IPOS.

Supports Coordination functions include:

- planning and/or facilitating person-centered planning
- annual bio-psychosocial assessments
- developing IPOS
- linking, coordinating, follow-up, advocacy, authorizing and monitoring of services and supports
- brokering of providers of services and supports within the authorized NorthCare Level of Care plan
- assistance with access to entitlements and/or legal representation
- coordination with Medicaid Health Plan or other health care providers
- available to all individuals who meet eligibility criteria (priority population)

Supports Coordination is reportable only as face-to-face contacts with the individual. Related contacts are also a function of a Care Managers (e.g. phone calls, arrange supports), including activities that ensure:

- the needs and desires of the beneficiary are determined
- the supports and services desired and needed by the individual are identified and implemented
- housing and employment issues are addressed
- social networks are developed
- appointments and meetings are scheduled
- person-centered planning is provided and Independent Facilitation is made available
- natural and community supports are used
- the quality of the supports and services, as well as the health and safety of the individual is monitored
- income/benefits are maximized, including providing direct assistance with obtaining other insurance or state plan benefits as requested by the individual
- information is provided to ensure the individual/guardian is informed about Self-determination
- monitoring of individual budgets, when applicable, for over or under utilization of funds is provided
- activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning.

Additionally, supports coordination for I/DD individuals involves coordinating on the process of initial Habilitation Supports Waiver eligibility certification and re-certification, and on the process of evaluation and re-evaluation of the beneficiary's Level of Care.

Supports Coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Skill Building Services, Supported Employment, or Community Living Services. While

supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverage and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

Habilitation Waiver

Supports Coordination involves working with the Habilitation Supports Wavier (HSW) recipient, family/guardian, and identified specialized service providers to develop the IPOS. Support strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. The frequency and scope of supports coordination contacts must reflect the intensity of the individual's health and welfare needs identified in the IPOS. Face-to-face contacts at least monthly and related contacts are provided to include: determining the desires and needs of the individual; identifying and implementing appropriate supports and services; addressing housing and employment issues; developing social networks; scheduling meetings and appointments; and providing person-centered planning using natural and community supports. The quality of supports, services, health and safety is monitored ongoing with efforts to maximize income and benefits. Coordination of waiver eligibility certification and annual re-certification is documented, and review of the supports and services occur at intervals specified in the IPOS. A HSW recipient must receive at least one HSW service and one supports coordination service per month in order to retain eligibility.

HSW recipient may also receive other Medicaid State Plan or alternative services. Service Selection Guidelines are used in determining the amount, duration, and scope of services and supports to be used. These services are specified and authorized in the individual's IPOS, developed through the person-centered planning process.

HSW recipient must be enrolled through the Michigan Dept. of Health and Human Services enrollment process completed by NorthCare. Annual verification for the enrollment process must include that the individual:

- has an Intellectual/Developmental Disability (as defined by Michigan law)
- is Medicaid-eligible
- is residing in a community setting
- if not for HSW services, would require ICF/MR (institutionalization) level of care services and
- chooses to participate in HSW in lieu of ICF/MR services

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another Community Mental Health agency, and death.

Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by Northpointe, does not receive at least one HSW service and one supports coordination service per month, withdraws from the program voluntarily, or dies.

Value purchasing for HSW services and supports will be used. Assistance shall be given to individuals to examine their first-and-third party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-covered activities, supports, or services.

Reimbursement for services rendered under the HSW is included in the Northpointe capitation rate.

TARGETED CASE MANAGEMENT

MISSION STATEMENT
Targeted case management services are dedicated to ensure that appropriate community supports / services are attained and maintained for the individual needs of persons with a serious mental illness SMI or SED) or Intellectual/Developmental Disability(I/DD).

TREATMENT OBJECTIVES
To assist individuals in gaining access to needed medical, social, educational, and other services as defined in the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

GOALS
To provide goal-oriented and individualized supports for individuals served through assessment, planning, linkage, advocacy, coordination, and monitoring activities to assist persons in gaining access to needed health and dental services, financial assistance, housing, employment, education, social and other services, and natural supports through the person-centered planning process

POPULATION TO BE SERVED
Targeted case management services are available to individuals based on eligibility and medical necessity. Targeted case management services are available for all children with Serious Emotional Disturbance (SED), adults with Serious Mental Illness, persons with an Intellectual/Developmental Disability, and those with Co-Occurring Substance Use Disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from Northpointe, and/or are unable to independently access and sustain involvement with needed services.

ENTRANCE CRITERIA
- The individual has a primary diagnosis of a mental illness, and is SED, SMI, I/DD or Co-Occurring
- The individual has multiple service needs, and is unable to access these services independently
- Severity of illness and resulting impairment continues to require ongoing support, and improvement would not be expedited with another level of service
- The individual requires assistance to enhance functioning in daily living activities
- The individual has a high level of vulnerability and is functionally limited
- The individual needs assistance in developing the competencies they need in order to increase their support network

DISCHARGE/TRANSITION CRITERIA
- There is evidence that the individual has developed a level of self-sufficiency that they no longer exhibit multiple service needs or are able to access community supports independently
- The individual demonstrates improvement in their severity of illness, which can effectively be managed without ongoing case management support
- The individual has acquired the independent living skills necessary to maintain daily living activities or is in a residential living arrangement that provides ongoing supervision, care and support
- The individual has developed an adequate natural support network
- The individual no longer meets criteria to receive Specialty Mental Health services
- The individual voluntarily withdraws from services
- The individual moves outside of the geographic area of the program's responsibility

EXCLUSIONARY CRITERIA
Individuals would be excluded from this level of services if they do not meet the entrance criteria.

STAFF QUALIFICATIONS

All services are provided by licensed/registered professionals, in accordance with the State of Michigan regulations that possess at least a Bachelors degree in a human service field, a degree in nursing or occupational therapy and are a Qualified Mental Health Professional or Qualified Intellectual Disability Professional (QMHP or QIDP) or working towards that. All staff must pass a Criminal Background Check and an Excluded Parties Check.

They will also complete Northpointe's trainings and maintain competency, and obtain state licensure required Continuing Education Credits. Staff are clinically supervised on an ongoing basis by a Qualified Mental Health Professional or Qualified Intellectual Disability Professional (QMHP or QIDP). Staff will have a working knowledge of the appropriate services available and support systems relevant to the individual.

PROGRAM PROCEDURES

1. The individual is determined in need of targeted case management at intake, at the initiation of the treatment planning process, or at any other time due to changing circumstances.
2. The assigned care manager is responsible for coordinating necessary assessments, ensures the Person Centered Planning (PCP) process takes place and results in an IPOS, linking/coordinating and monitoring service delivery.
3. Ensures that the IPOS identifies what services and supports will be provided, who will provide them, and how the care manager will monitor (i.e. interval of face-to-face contacts) the services and supports identified under each goal and objective.
4. The assigned care manager oversees the implementation of the IPOS, promotes recovery, supports individual's goals and desires for optimizing independence, and encourages productivity in activities that lead to maintenance of or increase in self-sufficiency.
5. Justification for targeted case management and the continuation of it must be documented in the individual's clinical record. Gaps in service provision will be identified and addressed.
6. The care manager will support the individual's dreams, goals and desires; optimizing independence, promoting recovery and assisting in the development of natural supports.
7. The care manager will communicate with primary and other healthcare providers including making referrals and advocating, assuring continuity of care, as well as linking with financial services, medical, transportation, and other community services.
8. The care manager will assist with crisis planning, after hours contact, develop safety plans, and coordinate any necessary services including community supports after hospitalization.
9. The care manager will facilitate the transition process, including arrangements for follow up services.
10. Assessment – The provider must have the capacity to perform an initial written comprehensive bio-psychosocial assessment addressing the individual's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the individual. The individual plan of services must also reflect such changes.
11. Documentation – The individual's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the individual, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the individual's needs, and delivered as documented in the treatment plan and service authorization.
    The care manager must review services at intervals defined in the individual plan of service.
    The plan shall be kept current and modified when indicated (reflecting the intensity of the individual's health and welfare needs). An individual, his/her guardian, or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess individual's satisfaction

12. Monitoring – The care manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the individual. Frequency and scope (face-to-face and telephone) of monitoring activities must reflect the intensity of the individual's health and welfare needs identified in the individual plan of services.

THERAPY SERVICES

MISSION STATEMENT
Northpointe's therapy services provide an array of timely, responsive, and clinically appropriate services that promote the positive mental health and social functioning of the children and adults being served.

TREATMENT OBJECTIVES
Therapy services seek to ensure the delivery of a comprehensive continuum of individualized services in a least restrictive environment, with a strong respect for the unique needs of each individual being served to reach their potential for self-reliance and positive emotional functioning.

GOAL
To offer individuals a cost-effective, time limited, quality-based range of individual, group, and family-centered psychoeducation services in a least restrictive environment that are based upon an individualized, person-centered plan, which is goal-directed and serves to enhance or promote emotional/behavioral stability, growth, and independence.

POPULATION TO BE SERVED
Therapy services are provided to children, adolescents, and adults who are experiencing acute to moderate long-term emotional or behavioral impairments on a time limited basis, as authorized by the NorthCare Benefit Plan.

ENTRANCE CRITERIA
- There is documented evidence that the individual is experiencing symptoms that have impaired their ability to function in one or more life areas
- There is an expectation that the mode of therapy, utilizing Evidence Based Practices, will enable the individual to become more functional in their life
- The individual demonstrates motivation to comply with therapy

DISCHARGE/TRANSITION CRITERIA
- The individual has met all the goals established for this service
- The individual demonstrates improved functioning as evidenced by the GAF score or another level of functioning tool (i.e. CAFAS, LOCUS)
- The individual voluntarily withdraws from service
- The individual moves out of catchment area
- Northpointe's Therapy services are no longer medically necessary and/or the individual has been referred to another provider

EXCLUSIONARY CRITERIA
- There is no documented evidence that the individual is experiencing symptoms that have impaired their ability to function in one or more life areas
- The individual does not want nor is willing to comply with therapy

STAFF QUALIFICATIONS
All services are provided by Masters Level licensed mental health professionals in the State of Michigan. All staff must pass a Criminal Background Check and an Excluded Parties Check.
Staff are clinically supervised by a qualified professional either on an individual basis or within the treatment team. Clinicians are trained and demonstrate competency in each Evidence Based Practice (EBP) that is appropriate to the therapy authorized for an individual.

PROGRAM PROCEDURES

1. All individuals seeking or being referred for services will be assessed for clinical appropriateness by a qualified provider.
2. The case may be presented to the multidisciplinary treatment team. Based on clinical appropriateness and person-centered planning, therapy services are initiated.
3. Clinical staffs utilize a variety of evidenced based treatment modalities to ensure that individuals receive current, sensitive, relevant, and cost-effective services. Documentation is maintained on an ongoing basis regarding the specific treatment interventions that are provided. Some of these treatment modalities include the following:
   a. Individual therapy is a treatment activity designed to reduce maladaptive behaviors, to maximize behavioral self-control or to restore normalized psychological functioning, reality orientation and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Staffs are trained in Cognitive Behavioral Therapy (CBT) and Dialectic Behavioral Therapy (DBT).
   b. Family therapy is joint therapy of an individual and family member(s) or other persons significant to the individual for the purpose of improving the individual/family function. It does not include family planning.
   c. Group therapy is a therapeutic modality that typically joins together a group of individuals under the leadership of a clinician for the purpose of working together for psycho-therapeutic ends—specifically to improve all levels of the individual's functioning.

VOCATIONAL PROGRAMMING SERVICES

MISSION STATEMENT
Northpointe's Vocational Services strives to promote competitive employment through an evidenced based model using a wide range of physical, social, cultural and support services designed to provide the knowledge, skills and attitudes that prepare individuals for employment.

TREATMENT OBJECTIVE
Vocational Services may be a blend of internal and external providers working together to provide job development, initial and ongoing support services to assist individuals to obtain and maintain competitive employment that would otherwise be unachievable without supports.

GOAL
To provide a continuum of vocational services to Northpointe service recipients, promoting economic self-sufficiency.

POPULATION
Vocational Services are provided to individuals with Intellectual/Developmental Disabilities and/or Serious Mental Illness who meet the criteria to receive Specialty Mental Health services and request Vocational Training.

ENTRANCE CRITERIA
- Meets the definition of Intellectual/Developmentally Disabled or severely, persistently mentally ill as defined in the Michigan Mental Health Code
- Is at least 18 years of age and a resident of Northpointe's catchment area
- The disability is significant/chronic to the point where vocational opportunities are not possible without supports
- Requires structured intervention to maintain or increase vocational skills
- Services deemed appropriate through a person-centered plan
- The person has requested vocational services

DISCHARGE/TRANSITION CRITERIA
- Individual has met the vocational treatment goals and the person-centered planning team deems the individual inappropriate for vocational services
- Individual's needs can be served in a lesser restrictive treatment environment
- Individual moves out of the catchment area or passes away
- Services are no longer requested from individual or guardian
- The individual has successfully obtained competitive employment and no longer needs supports

EXCLUSIONARY CRITERIA
- The individual is not an open Northpointe service recipient
- Services are not deemed appropriate through a person-centered plan
- The person does not want vocational services

STAFF QUALIFICATIONS
All vocational treatment staff will meet all contract requirements, licensing/accreditation standards, and be managed by a qualified professional. All staff must pass a Criminal Background Check and an Excluded Parties Check.

PROGRAM PROCEDURES

All individuals are referred through the treatment planning process.

- Each individual requesting Vocational service should complete a referral packet to Michigan Rehab Services and/or the vocational services of their choice. The Northpointe care manager provider will assist in this process.
- Each new referral will receive a comprehensive assessment by the vocational service, to determine the appropriate need and services for the individual.
- The referral packet to the vocational service will include all requested information with special note to the legal histories (i.e. felony convictions). The IPOS must take any legal history into account when planning for the safety of all individuals in a vocational environment
- Upon completion of the bio-psychosocial assessment, an IPOS or an IPOS Amendment is completed to include the vocational service as part of the plan. Included in this meeting are the individual, Northpointe provider, guardian, vocational service representation and any of the following as appropriate: Michigan Rehabilitation Services (MRS) Representative, home provider, family members, etc.

VOCATIONAL CONTINUUM

A full continuum of services is offered through Vocational Services. This continuum will include, but not be limited to:

1. **Volunteer Experience** – Volunteer experience is defined as an individual choosing to donate their time with no financial compensation to a site of their choice at a specified day and time. The appropriate staff, as determined in the IPOS, will monitor the individual's volunteer experience.
2. **Prevocational Services** – Prevocational services are services designed to teach the skills necessary for vocational advancement. Individuals receiving prevocational services will be monitored by the appropriate staff as determined in the IPOS.
3. **Skill-Building Assistance** - Consists of activities that assist an individual to increase their economic self-sufficiency and/or to engage in meaningful activities. The services provide knowledge and specialized skill development and/or support.
4. **Mobile Work Crew Services** – Consists of a small group (8 or less) of individuals who move from site to site (The site may not be within the vocational service site) to perform work. The crews have their own equipment. Job training and supervision are usually the responsibility of the service provider agency.
5. **Enclave Services** – Consists of a small group (8 or less) of individuals working within a business or factory. The "business or factory" may not include the vocational service site. Supervision and training may be combined or separate positions. Preferably supervision and training would be provided by the employer but may be provided by the service provider agency.
6. **Community Employment Services** – Assist persons seeking employment to choose, obtain, and retain integrated employment in the community or in their own businesses. Such services may be described as individual placements, supported employment, transitional employment or placements in enterprises owned and managed by the persons served, personnel employment agencies, mobile work crews, contracted work groups, or other community-integrated designs. The ultimate goal is competitive employment. Competitive job options have permanent status rather than temporary or time-limited status. Employment is competitive so that anyone can apply, pays at least minimum wage, can be part-time or full-time, and occurs in the community. Community employment services do not require a person to participate in pre-placement or other training as a prerequisite to obtaining employment.
7. **Competitive Employment** - Work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and for which an individual is compensated at or above the minimum wage, but not less than the customary or usual wage and level of benefits paid by the Employer for the same or similar work performed by individuals who are not disabled

8. **Integrated Setting** - A setting typically found in the community in which an individual with the most severe disabilities interacts with non-disabled individuals, other than service providers (like job Coaches), to the same extent that non-disabled individuals in comparable positions interact with other persons.

WRAPAROUND SERVICES

MISSION STATEMENT
Wraparound Service Facilitation and Coordination for children and adolescents is a highly individualized planning process performed by specialized Wraparound facilitators employed by Northpointe, other approved community-based approved mental health and intellectual/ developmental disability service providers, or its provider network who, using the Wraparound model, coordinate the planning for and delivery of services and supports that are medically necessary for the child and family.

TREATMENT OBJECTIVE
The planning process followed by Wraparound Facilitator identifies the family's strengths and needs, as well as strategies and outcomes.

GOAL
Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies, and informal supports. The Child and Family Team create a highly individualized plan of service for the child and family. The plan may consist of other non-mental health services that are secured from, and funded by, other agencies in the community. The wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child beneficiary and family, and is developed in partnership with other community agencies.

POPULATION
The Wraparound process works with children and young adults, 18-21 who meet the criteria for SED, that, due to safety and other risk factors, require services from multiple systems and informal supports.

REFERRAL PROCESS:
A child can be referred for Wraparound Services by any community agency, or a Northpointe clinician. The referral will be reviewed by the Community Team. If the referral is accepted by the Community Team, the child would need to go through Northpointe's access to receive services (if not already an open Northpointe service recipient).

***ENTRANCE CRITERIA*:**
Children served in wraparound shall meet two or more of the following:

- Children who are involved in multiple systems;
- Children who are at risk of out-of-home placements or are currently in out-of-home placement;
- Children who have been served through other mental health services with minimal improvement;
- The risk factors exceed capacity for traditional community-based options;
- Numerous providers are serving multiple children in a family and the outcomes are not being met.

DISCHARGE/TRANSITION CRITERIA

- The child and family have reached their outcomes identified by the child and family team;
- Children and/or the families/guardians no longer wish to participate in Wraparound services;
- The identified child in the case reaches the age of 21.

EXCLUSIONARY CRITERIA
The child does not meet the Entrance Criteria.

STAFF QUALIFICATIONS

Wraparound facilitators must:

- Complete MDHHS Wraparound trainings;
- Demonstrate proficiency in facilitating the wraparound process
- Pass a criminal background check and an Excluded Parties check;
- Be supervised by an individual who meets criteria as a qualified mental health professional who has completed MDHHS required trainings.

PROGRAM PROCEDURES

The Community Team, which consists of parents, agency representatives, and other relevant community members, oversees Wraparound services.

Coverage includes:

- Planning and/or facilitating planning using the Wraparound process that reflects a family driven/youth guided approach.
- Meeting frequency is based on family needs and level of risk.
- Developing an IPOS utilizing the Wraparound process;
- Developing a crisis/safety plan utilizing the Wraparound process;
- Linking to, coordinating with, follow-up of, and/or monitoring of community services involved with the child and family;
- Brokering of providers of services with the assistance of the Wraparound Community Team;
- Assistance with access to other entitlements;

Coverage excludes:

- Case management that is the responsibility of the child welfare, juvenile justice, or foster care systems;
- Case management for legal or court ordered non-medically necessary services;
- Services and supports that are the responsibility of other agencies on the Community Team.
- Northpointe Supports Coordination or Targeted Case Management

SERVICES AND SETTINGS:

- Wraparound services are delivered in the family's home, school, community and/or office. The setting is determined by the family served;
- Frequency of service is determined by the individual needs of the family;
- Days and hours of service are determined by the individual needs of the family and can include evenings and weekends when necessary;