2020/21 OPR Scoring Descriptors

STANDARD	REFERENCES	SUPPORTING EVIDENCE & SCORING	Ancillary Community-Based Services Community Living Supports, Skill Building Assistance, Supported / Integrated Employment Services, Out-of-Home Non-Vocational and Pre-Vocational Services, Respite Care Services, Peer-Delivered or Operated Support Services, Clubhouse	Follow-Up
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT				
1.1 The provider has adequate physical safeguards in place to prevent unauthorized use or disclosure of Protected Health Information (PHI), including both policy and procedures to protect PHI. For example, paper records are locked with only appropriate staff members having access, and not left in open areas.	*HIPPA/HITECH* *42 CFR Part 2* *MH Code 330.1748*	Supporting Evidence: Paper file safeguards (e.g., locking paper files when not in use), policies and procedures regarding disclosure of PHI (including with other residents/customers, family members, law enforcement and/or other health professionals). Scoring: 2 points - No concerns. Ample precautions to protect confidential information are in place. 1 point - One or two minor suggestions for improvement. 0 points - Improvement needed in several areas; or potential for serious violation of privacy was noted.	**X**	
1.2 The provider has adequate technical safeguards in place to prevent unauthorized use or disclosure of PHI, including both policy and procedures to protect PHI. For example, password protection is used to access electronic records; encryption if PHI is being sent through email.	*HIPPA/HITECH* *42 CFR Part 2* *MH Code 330.1748*	Supporting Evidence: Computer safeguards (e.g., screen locks, password use, and regular password expiration), IT policies and/or procedures (e.g., prompt termination of access rights for terminated employees). Scoring: 2 points - No concerns. Ample precautions to protect confidential information are in place. 1 point - One or two minor suggestions for improvement. 0 points - Improvement needed in several areas; or potential for serious violation of privacy was noted.	**X**	
1.3 The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct (must have written certification that they have received, read, and will abide by SWMBH's Code of Conduct).	*PIHP Policy 10.1*	Supporting Evidence: A copy of the organization's Code of Conduct or acknowledgement of use of the SWMBH Code of Conduct. For evidence of "adoption" of the code of conduct - training records, policy and/or procedure regarding dissemination of the code, employee handbook with the code, posting of ways to report fraud, waste, and abuse. Scoring: 2 - Code of conduct is in place and evidence supports its adoption in the organization. 1 - Code of conduct has been developed or accepted from SWMBH, but efforts are not being made to make staff aware of its content or purpose. 0 - No code of conduct in place.	**X**	

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1.4 Staff know what to do if they suspect Medicaid fraud or abuse within the organization. (N/A if no hired staff - e.g., Family homes). Compliance training content may be reviewed to assess this item.	*Deficit Reduction Act; Patient Protection & Affordable Care Act of 2010; HealthCare & Education Reconciliation Act of 2010*	Supporting Evidence: Interviews with staff members and/or review of Compliance Training. Scoring: 2 - Staff consistently know who to report possible Medicaid fraud and abuse to, and various ways to report (phone, email, etc.). Or, Compliance Training clearly identifies reporting mechanisms, including to whom and how to report. Employees are current in compliance training. 1 - Not all staff interviewed knew who or how to report possible Medicaid fraud and abuse. Compliance training does not clearly indicate reporting mechanisms. 0 - Staff appear to be unaware of Medicaid fraud and abuse reporting and/or not addressed in compliance training.	**X**	
1.5 Plans for Improvement in response to citations / recommendations from the most recent reviews (licensing etc.) or licensing special investigations have been submitted to the appropriate agency, and there is evidence of implementation.	*Payor Contract requirement: LICENSES, ACCREDITATIONS, AND CERTIFICATIONS; AND, CREDENTIALING AND PRIVILEGING REQUIREMENTS AND QUALIFICATIONS*	Supporting Evidence: Documentation of trainings conducted, repairs made, implementation of changes made to policies, forms, procedures, etc., as identified in corrective action plan(s). Scoring: 2 - Follow up complete and done within time frames, or no recommendations or citations from recent reviews. 1 - Improvements address most, but not all, items cited for correction, or not completed within time frames. 0 - No response or very limited response implemented to address citations/recommendations and due date is past.	**X**	**X**
SECTION 2 - MEDICATION MANAGEMENT / HEALTH & SAFETY				
2.1 If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.	*AFC Licensing Rules R400.14312 (SGH); R400-1418 (FH)*	Supporting Evidence: The site review team will verify through a review of staff training files that medication is administered by or under the supervision of personnel who are qualified and trained.	**X**	
2.2 A provider shall record the administration of all medication in the recipient's clinical record, including 1) The dosage. 2) Label instructions for use. 3) Time to be administered. 4) The initials of the person who administers the medication, which shall be entered at the time the medication is given. 5) A resident's refusal to accept prescribed medication or procedures.	*Michigan Mental Health Code R 330.7158*	Supporting Evidence: The site review team will review at least 2 months' medication logs, medication containers, and physician instructions to ensure completeness and accuracy of information. Scoring: 2 - Medication logs appear to be completed fully and accurately. 1 - One to two minor errors are evident on medication logs such as failure to initial a medication administration that is otherwise documented. 0 - Multiple (more than two) errors or potentially harmful error(s) noted.	**X**	

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2.3 A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported and recorded.	*Michigan Mental Health Code R 330.7158*	Supporting Evidence: The site review team will review at least 2 months' medication logs, medication containers, and physician instructions to ensure completeness and accuracy of information. Medication errors should be appropriately reported. Medication errors with the potential for adverse reactions should be reported to the prescriber of the medication, such as if a person didn't get blood thinners, cardiac medications, or insulin; or if those types of medications were given to the wrong person. Other types of medication errors that could result in less serious adverse health reactions should be reported to poison control, or the pharmacy. One missed multivitamin, OTC medication, other non-essential medications for health such as anxiety medication do not require reporting to poison control or pharmacy. All medication errors must be noted in an incident report and in the person's record. Scoring: 2 - Medication error(s)/refusal(s) properly documented with appropriate follow up (e.g., contact to physician and documentation of instructions). 1 - One to two minor errors. 0 - Multiple (more than two) errors or potentially harmful error(s) noted. This item is N/A if no medication refusals or medication errors.	**X**	
2.4 If sharps are being used, there is a container on site for disposal which is not overfilled.	*OSHA Blood borne Pathogens standard (29 CFR 1910.1030)*	Supporting Evidence: The site review team will verify that containers are clearly labeled as Bio-Hazard and are kept in a secure area (for specialized residential) or in secure containers. Sharps are disposed of promptly once the container is full. (N/A if no sharps being used) Scoring: 2 - Sharps containers are used which are clearly labeled as Bio-Hazard and are kept in a secure area or in secure containers; provider has adequate procedure for disposing of sharps in a timely manner. 1 - Sharps containers are being used and kept in a secure area/secure containers, but are not clearly labeled as Bio-Hazard, or are not disposed of properly or promptly. 0 - Sharps containers not being used, or are being used but not kept in a secure area or in secure containers.		
2.5 Strategies to prevent the same incident from reoccurring are consistently documented in incident reports. Addendums to the individual plans of service are developed to address trends/concerns identified, as needed.	*Payor Contract Requirement: HEALTH AND SAFETY OF CUSTOMERS; RECIPIENT RIGHTS AND CONSUMER GRIEVANCE PROCEDURES*	Supporting Evidence: The site review team will verify that containers are clearly labeled as Bio-Hazard and are kept in a secure area (for specialized residential) or in secure containers. Sharps are disposed of promptly once the container is full. (N/A if no sharps being used) Scoring: 2 - Sharps containers are used which are clearly labeled as Bio-Hazard and are kept in a secure area or in secure containers; provider has adequate procedure for disposing of sharps in a timely manner. 1 - Sharps containers are being used and kept in a secure area/secure containers, but are not clearly labeled as Bio-Hazard, or are not disposed of properly or promptly. 0 - Sharps containers not being used, or are being used but not kept in a secure area or in secure containers.	**X**	

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2.6 Pets - if an agency has a pet or therapy animal on the premises, vaccination records should be available for review.	*DHHS site review*		X	
SECTION 3 - EMERGENCY RESPONSE				
3.1 Emergency evacuation maps/routes are displayed in prominent locations at the facility.	*AFC Licensing Rules R400.14318 (SGH)*	Supporting Evidence: Posted evacuation routes with exiting route specified. Scoring: 2 - Map(s) posted prominently with specified exiting route(s) marked. 1 - Map(s) not posted prominently or do not clearly mark exiting route(s). 0 - No map(s) posted.	X	
3.2 Program has a comprehensive set of written Emergency Response Procedures containing clear instructions in response to fire, severe weather, medical emergencies, and emergencies while transporting individuals served, if applicable. Score for facility-based programs.	*DHHS Recommendation from Site Review*	Supporting Evidence: Written procedures. Scoring: 2 - Procedures are clear and address each of the following - response to fire, severe weather, and medical emergencies; a plan for the continuation of services in event of emergency, and a plan for transporting individuals in the event of an emergency. 1 - Procedures do not address one of the required elements or are not clear. 0 - Procedures do not address two or more of more of the required elements.	X	
SECTION 4 - TRAINING				
4.1 Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) - (within 30 days of hire; annual update thereafter).	*MH Code: 330.1755(5)(f)*	Supporting Evidence: For all training and personnel items, the review team will verify by a review of staff personnel files or training records. Scoring: 2: 95-100% of staff selected completed each required training item within the stated timeframes. 1: 75-94.4% of staff completed the required training item within the stated timeframes. 0 – Less than 75% of staff have completed the training within the stated timeframes.	X	X
4.2 Person-Centered Planning (aka Individualized Service Planning) - within 60 days of hire; annual update thereafter).	*MDHHS Master Contract Attachment P.4.4.1.1*	Supporting Evidence: For all training and personnel items, the review team will verify by a review of staff personnel files or training records. Scoring: 2: 95-100% of staff selected completed each required training item within the stated timeframes. 1: 75-94.4% of staff completed the required training item within the stated timeframes. 0 – Less than 75% of staff have completed the training within the stated timeframes.	X	X
4.3 Cultural Diversity/Competency/Awareness (within 6 months of hire) (annual requirement).	*MDHHS Master Contract Part II(A) 4.5* *42 CFR 438.206*	Supporting Evidence: For all training and personnel items, the review team will verify by a review of staff personnel files or training records. Scoring: 2: 95-100% of staff selected completed each required training item within the stated timeframes. 1: 75-94.4% of staff completed the required training item within the stated timeframes. 0 – Less than 75% of staff have completed the training within the stated timeframes.	X	X

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4.4 Blood borne Pathogens (Preventing Disease Transmission, Infection Control - within 30 days of hire; annual update required).	*MIOSHA R 325.70016*		X	X
4.5 HIPAA (within 30 days of hire, annual updates).	*MDHHS Master Contract Part I18.16* *Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination*		X	X
4.6 Corporate Compliance (within 30 days of hire, annual updates).	*45 CFR 164.308(a)(5)(i) &* *45 CFR 164.503.(b)(1)*		X	X
4.7 Limited English Proficiency (LEP) (within 6 months of hire).	*Medicaid Integrity Program (MIP)* *Deficit Reduction Act (DRA)*		X	X
4.8 Individuals Plans of Service and Ancillary Plans (there is evidence that staff have been trained in the IPOS and in any applicable Support Plan for Individuals in their care before the provision of direct care [Behavior Treatment Plan, PT, OT, Nursing, etc.]).	*Michigan Mental Health Code 330.1708*	Supporting Evidence: Staff meeting minutes, training sign-ins, staff files. Scoring: 2: 95-100% of staff selected completed each required training item within the stated timeframes. 1: 75-94.4% of staff completed the required training item within the stated timeframes. 0 – Less than 75% of staff have completed the training within the stated timeframes.	X	X
4.9 Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (MDCH approved curriculum if restricted interventions included) - (within 30 days of hire & annual updates, if working with individuals with challenging behavior)	*MDHHS Master Contract Attachment P.1.4.1 and R 330.1806*		X	X
4.10 CPR (within 60 days as necessary for job duties; ongoing as required per the training program - usually every 2 to 3 years).	*42 CFR 438.400-424* *MDHHS Master Contract Attachment P 6.3.1.1*		X	X
4.11 First Aid (within 60 days and ongoing as required per the training program - usually every 2 to 3 years. Required if providing Aide or Behavior Technician services as defined in	*42 CFR 438.400-424* *MDHHS Master Contract Attachment P 6.3.1.1*		X	X
4.12 Grievances and Appeals (within 30 days of hire and annually for all in the following roles: Primary clinicians & SUD therapists (including residential/detox), Access/UM staff, Customer	*42 CFR 438.400-424* *MDHHS Master Contract Attachment P 6.3.1.1*		X	X
4.13 Customer Services (within 30 days of hire and annually for all in the following roles: Psychiatrists/nurses, Peer support specialists, Recovery coaches, Reception staff, Service	*42 CFR 438.400-424* *MDHHS Master Contract Attachment P 6.3.1.1*		X	X
4.14 MDHHS approved Clubhouse-specific training (within 6 months of hire and annually thereafter. Clubhouse staff).	*42 CFR 438.400-424* *MDHHS Master Contract Attachment P 6.3.1.1*		X	X
SECTION 5 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS				

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5.1 Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the verification protocol required by SWMBH policy 2.16; and subsequent verification of criminal back ground checks of current employees will occur no more than every 2 years. If an employee is working or has been working with a criminal history exclusion, SWMBH compliance department will be contacted for consultation.	*Contract Requirement; Public Act 59 (PA 218 400.734a); 5) AFC Licensing Rules: R.400.14201.13 (SGH); R.400.1404.6 (FH); PIHP Policy 2.16*	Supporting Evidence: The review team will verify by a review of staff personnel files that AFCs and hospitals are using the Michigan Workforce Background Check System and that each employee was registered prior to hire. For other services, it will be verified through a review of files that criminal background checks were completed prior to hire and bi-annually thereafter. If the Michigan Workforce Background Check System is being used, annual checks are not needed. Scoring: 2: 95-100% of staff selected meet criteria and have required documentation. 1: 75-94.4% of staff selected meet criteria and have required documentation. 0 – Less than 75% staff selected meet criteria and have required documentation. Note: For AFCs and inpatient, if hired prior to 2001, there was no criminal background check requirement prior to hire; however, annual checks were required from 2001 forward unless exempt. Finger printing became required in 2006.	**X**	**X**
5.2 Primary source verification of State driving infractions has been conducted prior to hire and annually thereafter, for staff who transport customers. Provider has policies and procedures in place to ensure safe transportation of Customers receiving Supports/Services.	*Payor Contract requirement: Transporting Customers*	Supporting Evidence: The review team will verify by a review of staff personnel files that driver's license checks have been completed prior to hire and annually thereafter for staff who transport persons served. Provider policy and procedure for staff transport of customers will be reviewed. Scoring: 2: 95-100% of staff selected meet criteria and have required documentation. Provider has clear policy/procedure which is consistently implemented. 1: 75-94.4% of staff selected meet criteria and have required documentation. Policy/procedure is lacking in some detail or evidence of consistency in implementation. 0 – Less than 75% staff selected meet criteria and have required documentation. Policy/procedure is substantially lacking in detail or evidence of consistency in implementation.	**X**	**X**
5.3 Personnel Performance Management: there is documented evidence that program has an adequate system to support, monitor, and complete at least annual performance evaluations of hired staff who provide direct care services.	*DHHS Site Visit Protocol B.1.3, 4.4.2(e), 5.4.2, 6.4.2, 7.4.1, 8.3.2*	Supporting Evidence: The review team will verify by a review of staff personnel files that performance evaluations are completed minimally on an annual basis. The team will verify through interview and review supervision notes (if applicable) that the organization has a system in place for the clinical supervision of clinical staff members. Scoring: 2: 95-100% of staff selected had an annual performance evaluation; the organization has a system in place for providing clinical supervision to credentialed staff. 1: 75-94.4% of staff selected had an annual performance evaluation and the organization has a system in place for providing clinical supervision to credentialed staff. 0 – Less than 75% staff selected had an annual performance evaluation; or the organization does not have a system in place for providing clinical supervision to credentialed staff.	**X**	**X**

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5.4 Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each employee is to be run through OIG and SAM exclusion databases prior to hire and at least annually thereafter.	*PIHP Policy 10.13; 42 CFR 438.602*	Supporting Evidence: The review team will verify by a review of staff personnel files that monitoring for exclusion from federal healthcare programs occurs prior to hire and annually thereafter. (Note - individuals with controlling interests in the organization may have ongoing OIG exclusion checks run through SWMBH's compliance dept. If it's confirmed that SWMBH has been supplied with all necessary information to run the checks, full credit should be given for those individuals for OIG screening). Scoring: 2: 95-100% of staff selected meet criteria and have required documentation. 1: 75-94.4% of staff selected meet criteria and have required documentation. 0 – Less than 75% staff selected meet criteria and have required documentation.	**X**	**X**
Home and Community Based Services / Non-Residential				
SECTION 6 - NEIGHBORHOOD / SETTING EXTERIOR				
6.1 Does the setting look similar to other buildings/ businesses in the neighborhood?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
6.2 Is the location accessible to generic services in the community?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
6.3 Is the outside of the setting in good condition?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
SECTION 7 - SETTING INTERIOR				
7.1 Are furnishings adequate and in good repair?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
7.2 Is the setting clean and free of odors?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
7.3 Is the non-residential setting physically accessible to all individuals (For example, does it have grab bars, a wheelchair ramp if needed)?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
SECTION 8 - INDIVIDUAL CHOICE				
8.1 Can individuals close and lock the bathroom door?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
8.2 Can individuals choose to come and go from the setting when they want?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
8.3 Do individuals have control over their schedule to the same extent as non HCBS individuals?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
8.4 Do individuals receive payment if employed, and is payment given directly to individuals?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
8.5 Does the setting allow individuals to schedule their work hours or days similar to their peers/co-workers who do not have disabilities?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***
SECTION 9 - TYPE OF SETTING				
9.1 Can people with different types of disabilities and individuals without disabilities work/participate in the setting?	*HCBS Final Rule 42 CFR 441.300-310*		***X***	***X***

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9.2 Is the setting separate from, outside of the building, and off the grounds of a hospital, nursing home, ICF/IDD, or IMD?	HCBS Final Rule 42 CFR 441.300-310		X	X
9.3 Is the setting located outside of a building and off the campus of an education program, school or child-caring institution?	HCBS Final Rule 42 CFR 441.300-310		X	X
9.4 If a paid position, do individuals have employee benefits (vacation, medical benefits) similar to co-workers who do not have disabilities and work similar schedules?	HCBS Final Rule 42 CFR 441.300-310		X	X
SECTION 10 - COMMUNITY INTEGRATION				
10.1 Are individuals encouraged to have full access to the community?	HCBS Final Rule 42 CFR 441.300-310		X	X
10.2 Do individuals receive services and supports in a setting where there is regular (more than once a week) opportunity for contact with people not receiving services?	HCBS Final Rule 42 CFR 441.300-310		X	X

Home and Community Based Services / Residential

SECTION 11 - NEIGHBORHOOD / HOME EXTERIOR				
11.1 Does the residence look similar to other residences in the neighborhood?	HCBS Final Rule 42 CFR 441.300-310		X	X
11.2 Is the location accessible to generic services in the community?	HCBS Final Rule 42 CFR 441.300-310		X	X
11.3 Is the outside of the home in good condition (no safety hazards)?	HCBS Final Rule 42 CFR 441.300-310		X	X
SECTION 12 - HOME INTERIOR				
12.1 Is the living environment comfortable?	HCBS Final Rule 42 CFR 441.300-310		X	X
12.2 Are furnishing adequate and in good repair?	HCBS Final Rule 42 CFR 441.300-310		X	X
12.3 Is the home clean and free from odors?	HCBS Final Rule 42 CFR 441.300-310		X	X
SECTION 13 - INDIVIDUAL CHOICE				
13.1 Can individuals personalize/decorate their room?	HCBS Final Rule 42 CFR 441.300-310		X	X
13.2 Can individuals close and lock their bedroom door?	HCBS Final Rule 42 CFR 441.300-310		X	X
13.3 Can individuals close and lock their bathroom door?	HCBS Final Rule 42 CFR 441.300-310		X	X
13.4 Can individuals choose to come and go from the home when they want?	HCBS Final Rule 42 CFR 441.300-310		X	X
13.5 Do individuals have access to food at any time?	HCBS Final Rule 42 CFR 441.300-310		X	X
SECTION 14 - TYPE OF SETTING				
14.1 Is the residence separate from, outside of the building, and off the grounds of a hospital, nursing home, ICF/IDD, or IMD?	HCBS Final Rule 42 CFR 441.300-310		X	X

STANDARD	REFERENCES	SUPPORTING EVIDENCE & SCORING	Ancillary Community-Based Services	Follow-Up
14.2 Is the residence located outside of a building and off the campus of an education program, school or child-caring institution?	*HCBS Final Rule 42 CFR 441.300-310*		*X*	*X*
SECTION 15 - COMMUNITY INTEGRATION				
15.1 Are individuals encouraged to have full access to the community?	*HCBS Final Rule 42 CFR 441.300-310*		*X*	*X*
15.2 Do individuals live and/or receive services and supports in a setting where there is regular (more than once a week) opportunity for contact with people not receiving services?	*HCBS Final Rule 42 CFR 441.300-310*		*X*	*X*