

SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH AUTHORITY
POLICY AND PROCEDURE MANUAL

Section: Recipient Rights
Policy Number: 4
Subject: **Access to Service**

Effective Date: 10/27/97
Last Revision Date: 5/9/16
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Policy

It shall be the policy of the Shiawassee County Community Mental Health Authority (SCCMHA) to provide care in response to a person's request and need which is within the organization's capacity, its stated mission and philosophy, and applicable law and regulation; and

To ensure reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability; and

To assist in the referral process for services to meet the person's identified needs which the organization cannot provide.

Purpose

To ensure the rights of persons to treatment or service with dignity and respect, within the agency's capability, mission, and applicable law and regulation, and

To ensure compliance with the Michigan Mental Health Code, the Michigan Department of Health and Human Services Administrative Rules, and standards of accrediting bodies.

Application

This policy applies to all programs of the SCCMHA and its staff and programs provided by contract agencies.

Standards

- A. Upon application for services and/or hospitalization, each recipient and family member will be supplied with the appropriate brochures explaining their rights. At the time services are first requested, SCCMHA will inform a recipient, his or her guardian, or other legal representative or the parent with legal custody of a minor recipient of the recipient's lawful rights in an understandable manner. If a recipient is unable to read or understand the materials provided, a provider shall make a reasonable attempt to assist the recipient in understanding the materials. A note describing the explanation of the materials and who provided the explanation shall be entered in the recipient's record.

- B. Family members will be given a family rights brochure explaining the rights afforded to family members. These rights include the right to:
 - 1. Be treated with dignity and respect,
 - 2. Receive information regarding the specific disability or illness affecting their lives, and
 - 3. Provide information to the treating professionals regarding treatment issues.
- C. Processes and mechanisms shall be established, monitored, and evaluated which facilitate choice in a recipient's access to the appropriate level of care, physicians and other professionals, and settings to provide care and service(s) based on the recipient's assessed need, desires, and the organization's capability to provide care.
- D. Admissions, continued stay, and discharge criteria shall be established for each level of care provided by the organization and shall be consistently applied to determine a recipient's eligibility for a service, continuation of a service, or discharge from a service, and reviewed quarterly.
- E. Changes in type of treatment/service or level of care shall be documented in the clinical record. Clinical justification for the change shall be included in the documentation.
- F. Notification shall be provided to a recipient or his/her guardian of the right to a second opinion if services are denied. If the request for a second opinion involves a preadmission screening denial of hospitalization the following shall be carried out:
 - 1. The Chief Executive Officer (CEO) shall arrange for a second opinion within three (3) working days, excluding Sundays and holidays, and
 - 2. The CEO, in conjunction with the Medical Director, shall review the second opinion if it differs from the original decision.
 - 3. The CEO's decision to uphold or reject the findings of the second opinion shall be confirmed in writing to the person requesting the second opinion. Both the CEO and the Medical Director shall sign the written decision or provide verification that the decision was made in conjunction with the Medical Director.
- G. Prompt access to service shall be provided to persons presenting with immediate needs for care.

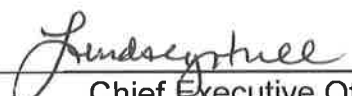
- H. Recipients shall enter the least intensive, restrictive and cost-sensitive setting or service which is appropriate and available and shall be transferred to less intensive, restrictive, and cost-sensitive settings or services as soon as their individual needs change.
- I. As appropriate to the setting(s) of care, services provided, and the recipient's condition, the recipient and, as appropriate, the family and/or significant other(s) shall receive information in order to make a knowledgeable decision about the following:
 - 1. Nature and goals of treatment, service, or care including changing, reviewing and discharge from treatment when maximum benefit is achieved.
 - 2. Hours during which treatment, service, or care is available.
 - 3. Costs for treatment, service, or care to be borne by the recipient, if any.
 - 4. The recipient's involvement, desires, and rights and responsibilities in the treatment, service, or care.
 - 5. Arrangements for care services to dependents, if necessary, during a recipient's involvement in his or her treatment, service or care.
 - 6. A recipient or legal representative may request a change or review of the treatment plan. A review of the plan will occur within thirty (30) days.
 - 7. In the event an individual is denied hospitalization or admission to services, he/she will be notified of the right to request a second opinion.
 - 8. The recipient may have individuals of his choice participate in the planning process. Any individual excluded for clinical purposes will be documented in the recipient's file.
- J. Processes and mechanisms shall be established, monitored, and evaluated which ensure continuity over time through assessment, planning, treatment and discharge phases of a recipient's services.
- K. Processes and mechanisms shall be established, monitored, and evaluated to ensure coordination among the health professionals from whom, and settings in which, the recipient receives care or services.

- L. Processes and mechanisms shall be established, monitored, and evaluated which provide for referral, transfers or discharge of the recipient to another level of care, health professional(s), or setting(s), if indicated, based upon the recipient's assessed need and desires and the organization's capability to provide care. The recipient shall be informed in a timely manner of the need for planning for discharge or transfer to another organization or level of care.

- M. If an external entity conducts a utilization review of care provided by the organization for the purpose of reviewing appropriateness of admission, continuation of the current level of care, and recipient care and services, and that review results in denial of care, services, or payment, decisions regarding the provision of care and services and/or discharge shall continue to be based on the care required by or the identified needs of the individual being served.

Approved by: 
Board Chairperson

9-26-2016
Date


Chief Executive Officer

9/28/16
Date

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Review/Revision Dates:

Date:	By:
1997 – 2007	Board Reviews
10/27/95, 1/13/97, 10/27/97, 1/18/05	Revisions, Becke Browne
8/27/07	Revised by Becke Browne
4/2/09	New formatting
7/27/09	Revised by Becke Browne
7/21/11	Reviewed by Recipient Rights Advisory Committee
7/19/12	Reviewed by Recipient Rights Advisory Committee
10/17/13	Reviewed by Recipient Rights Advisory Committee
12/11/14	Reviewed by Recipient Rights Advisory Committee
01/21/16	Annual Review by Recipient Rights Advisory Committee
5/9/16	Revised by Rebecca Browne