MCCMH-SUD New Provider Training

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Referral Processes

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Outpatient Referral Process

- Providers may receive referrals from MCCMH-SUD contracted residential or detox providers, MCO (Managed Care Operations) or direct calls from clients.
- Intakes should be scheduled ASAP but no later than: 24 hours for priority populations; 7 days from discharge from detox/residential treatment; 14 days for all others.
- If you cannot provide a timely appointment, the client should be referred to MCO to find a provider that can provide a timely intake.
- All providers are required to keep a phone screening log. This screening should check for priority population status, residence, insurance and SUD treatment needs. The phone screen should also include an area to document: the appointment offered date, the appointment date accepted, any no shows and any rescheduled appointments.

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Detox/Residential Referral Process

- Providers will receive referrals from MCCMH MCO.
- Staff will contact your agency along with the client via three-way call to facilitate the referral.
- Intakes should be scheduled ASAP but no later than: 24 hours for priority populations; 7 days from discharge from detox; 14 days for all others.
- If you cannot provide a timely appointment, the client may be offered a referral to another provider to ensure timely access to treatment.
- All providers are required to check for eligibility and medical necessity upon the clients' arrival to treatment. This includes checking for insurance/income status as well as ASAM criteria.

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Intake Process

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Intake Procedures

- At admission, complete a Release of Information and Fee Agreement Form with the client.
- Send a copy of the release to MCO with a Request To Open Case form. (see next slides)
- MCO will then open the case in FOCUS and notify provider via FOCUS.
- Provider then adds an Admission record, SUD Self-Pay Policy & insurance information form into FOCUS.
- Higher levels of care such as IOP, MAT, withdrawal management and residential treatment require prior authorization in FOCUS. Once the admission and other forms have been added, an authorization request can be submitted.
- Authorization requests must be submitted prior to the provision of the next service for IOP and within 24 hours for residential services.

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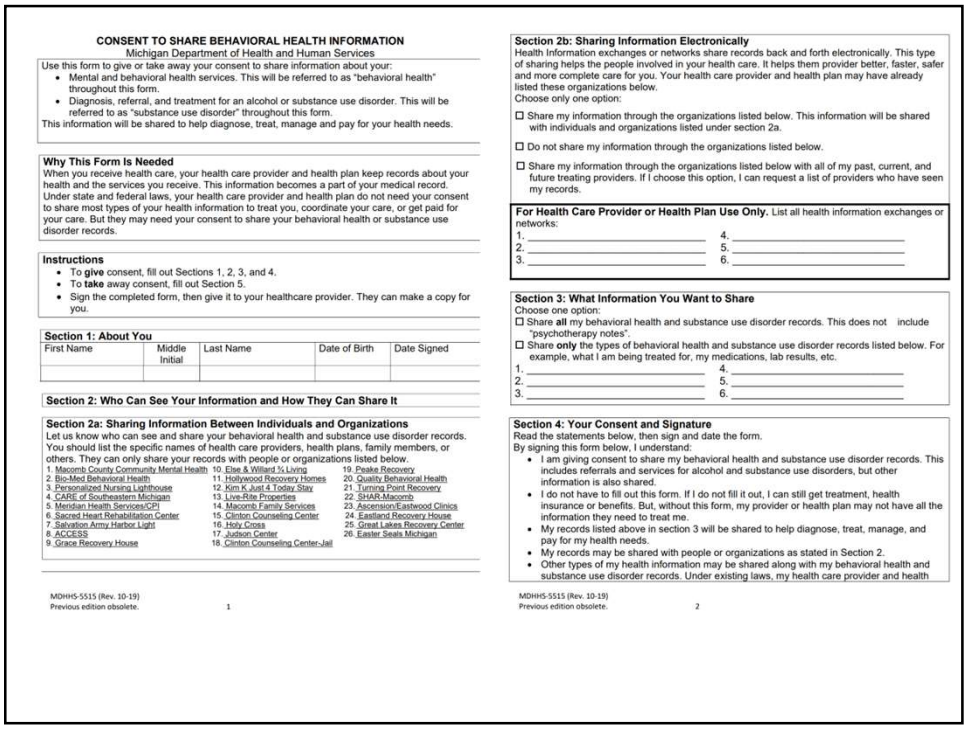

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION
Michigan Department of Health and Human Services

Use this form to give or take away your consent to share information about your:
- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage and pay for your health needs.

Why This Form Is Needed
When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions
- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Section 5.
- Sign the completed form, then give it to your healthcare provider. They can make a copy for you.

Section 1: About You

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2: Who Can See Your Information and How They Can Share It

Section 2a: Sharing Information Between Individuals and Organizations
Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

1. Macomb County Community Mental Health
2. Bio-Med Behavioral Health
3. Personalized Nursing Lighthouse
4. CARE of Southeastern Michigan
5. Meridian Health Services/CPI
6. Sacred Heart Rehabilitation Center
7. Salvation Army Harbor Light
8. ACCESS
9. Grace Recovery House
10. Else & Willard ¾ Living
11. Hollywood Recovery Homes
12. Kim K Just 4 Today Stay
13. Live-Rite Properties
14. Macomb Family Services
15. Clinton Counseling Center
16. Holy Cross
17. Judson Center
18. Clinton Counseling Center-Jail
19. Peake Recovery
20. Quality Behavioral Health
21. Turning Point Recovery
22. SHAR-Macomb
23. Ascension/Eastwood Clinics
24. Eastland Recovery House
25. Great Lakes Recovery Center
26. Easter Seals Michigan

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Previous edition obsolete. 1

Section 2b: Sharing Information Electronically
Health Information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provider better, faster, safer and more complete care for you. Your health care provider and health plan may have already listed these organizations below.
Choose only one option:

☐ Share my information through the organizations listed below. This information will be shared with individuals and organizations listed under section 2a.

☐ Do not share my information through the organizations listed below.

☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only. List all health information exchanges or networks:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Section 3: What Information You Want to Share
Choose one option:
☐ Share **all** my behavioral health and substance use disorder records. This does not include "psychotherapy notes".
☐ Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Section 4: Your Consent and Signature
Read the statements below, then sign and date the form.
By signing this form below, I understand:
- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information is also shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information they need to treat me.
- My records listed above in section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.
- My records may be shared with people or organizations as stated in Section 2.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health

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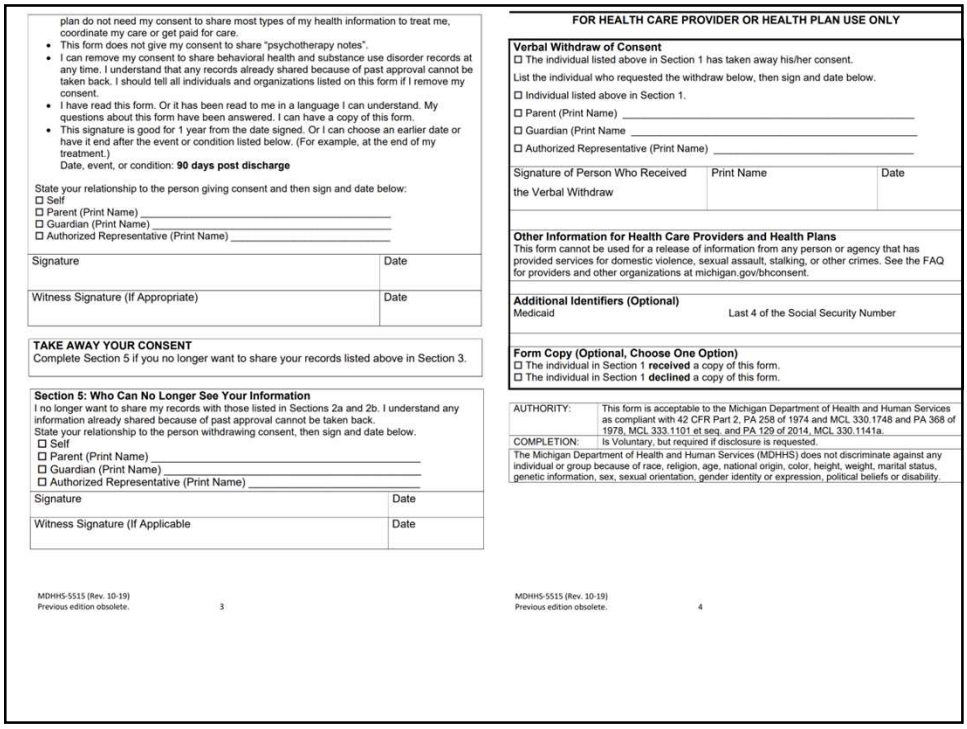

plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes".
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for 1 year from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below. (For example, at the end of my treatment.)
  Date, event, or condition: **90 days post discharge**

State your relationship to the person giving consent and then sign and date below:
☐ Self
☐ Parent (Print Name) _____
☐ Guardian (Print Name) _____
☐ Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

TAKE AWAY YOUR CONSENT
Complete Section 5 if you no longer want to share your records listed above in Section 3.

Section 5: Who Can No Longer See Your Information
I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.
State your relationship to the person withdrawing consent, then sign and date below.
☐ Self
☐ Parent (Print Name) _____
☐ Guardian (Print Name) _____
☐ Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Applicable	Date

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FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdraw of Consent
☐ The individual listed above in Section 1 has taken away his/her consent.
List the individual who requested the withdraw below, then sign and date below.
☐ Individual listed above in Section 1.
☐ Parent (Print Name) _____
☐ Guardian (Print Name _____
☐ Authorized Representative (Print Name) _____

Signature of Person Who Received the Verbal Withdraw	Print Name	Date

Other Information for Health Care Providers and Health Plans
This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent.

Additional Identifiers (Optional)
Medicaid Last 4 of the Social Security Number

Form Copy (Optional, Choose One Option)
☐ The individual in Section 1 **received** a copy of this form.
☐ The individual in Section 1 **declined** a copy of this form.

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

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Macomb County Community Mental Health
Office of Substance Abuse

SUD PROVIDER REQUEST TO OPEN CASE

Admission Date			
Requesting Agency		Site Location	
Person Making Request		Contact Number	

Consumer Demographic Information:			
First Name		Last Name	
Other Name Used		SSN	
Gender	☐ Male ☐ Female	Date of Birth	
Address		City	
State		Zip	
Home Phone		Alt. Phone	

	Insurance Information: Check all that apply
☐	Medicaid
☐	Healthy Michigan Plan
☐	MiChild
☐	Block Grant/PA2
☐	Women Specialty Funds
☐	Other _____

Scan this form and consumer signed release to "SUD Release" in the Focus System Message

or

Fax this form and release to Access Center at 586-948-0223

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Intake Procedures Continued

- At intake, each client must be provided with a copy or access to the "Help When You Need It" booklet, Privacy Notice, Confidentiality information, information on Advanced Directives and information regarding Recipient Rights. Documentation that each client was provided these documents must be included in the client chart.
- This is often documented in a consent for treatment form signed by the client.
- The "Help When You Need It" Handbook, "Know Your Rights" booklet and Privacy Notices can be found on our website: www.mccmh.net under community resources.

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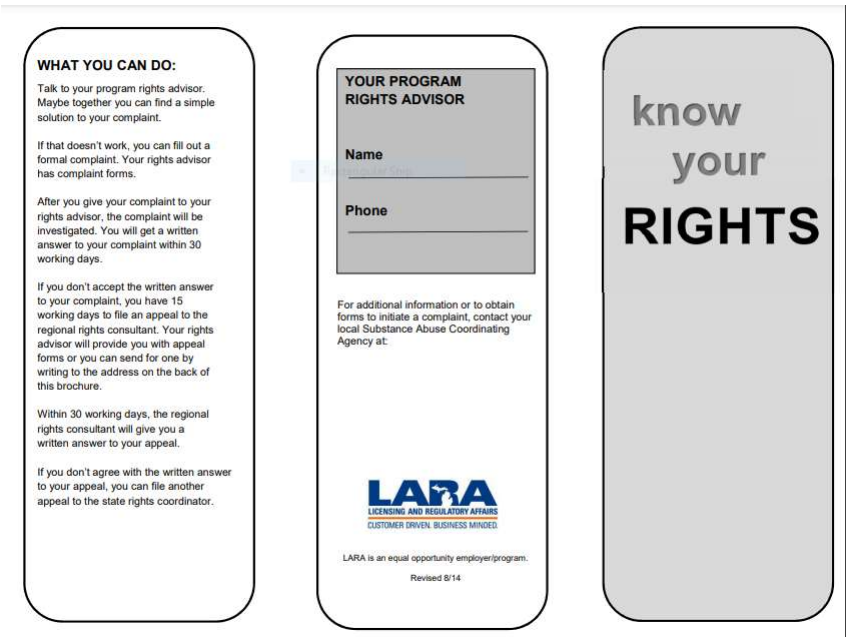

WHAT YOU CAN DO:

Talk to your program rights advisor. Maybe together you can find a simple solution to your complaint.

If that doesn't work, you can fill out a formal complaint. Your rights advisor has complaint forms.

After you give your complaint to your rights advisor, the complaint will be investigated. You will get a written answer to your complaint within 30 working days.

If you don't accept the written answer to your complaint, you have 15 working days to file an appeal to the regional rights consultant. Your rights advisor will provide you with appeal forms or you can send for one by writing to the address on the back of this brochure.

Within 30 working days, the regional rights consultant will give you a written answer to your appeal.

If you don't agree with the written answer to your appeal, you can file another appeal to the state rights coordinator.

YOUR PROGRAM RIGHTS ADVISOR

Name _____

Phone _____

For additional information or to obtain forms to initiate a complaint, contact your local Substance Abuse Coordinating Agency at:

LARA
LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

LARA is an equal opportunity employer/program.

Revised 8/14

know your **RIGHTS**

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Authorizations

- IOP, withdrawal management and residential auth should be submitted in FOCUS within one day. MCO cannot back date any authorizations.
- Authorization requests should align with the treatment plan and agreed upon treatment modality.
- If client is continuing in treatment beyond the time period of the first authorization, submit a reauthorization request to MCO. A treatment plan must be uploaded to the FOCUS system with any reauthorization request.
- Once MCO has responded to the authorization request, you will receive a message in the FOCUS system. Be sure to read all responses as an authorization may be "approved" but could be 'reduced'. Any denial will have a reason for denial and may have instructions on what needs to be completed prior to re-submitting the request.

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Authorizations

Services Requiring Authorization FY24

Service Name	CPT Code
Withdrawal MGMT	H0010/H0012
Residential Lodging, Per Diem	S9976
Residential Treatment Per Diem	H0018/H0019
Recovery Housing	H2034
Intensive Outpatient	H0015
Opioid Health Homes	S0280

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Clinical Documents

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Clinical Assessment

- All MCCMH-SUD contracted providers must use the ASAM Continuum or GAIN assessment tools.
- New clients should receive an assessment at intake.
- If the GAIN or ASAM Continuum are started but cannot be completed at intake, they can be completed at the next appointment. The date the assessment was completed is the date the intake code would be billed.
- If the client has been in treatment with another provider within the last 45 days, your agency should obtain a copy of the ASAM Continuum completed with that agency and review/record updates with the client rather than completing a new ASAM Continuum.
- ASAM Continuum or GAIN Assessments must be completed annually. Once the annual assessment is completed a BH-TEDS update should be entered into FOCUS.
- All sections of the ASAM Continuum must be completed including any notation needed about level of care not matching the ASAM Continuums recommendation.

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Clinical Assessment Cont.

Assessments should also include an interpretive summary completed by the clinician. This summary should be clinical in nature rather than a historical re-telling of biopsychosocial history and unique to the client served.

Example: New is a 39 year old, Caucasian, single female. She presents with a history of alcohol use. She reported periods of clean time in the past, the longest being two years after the birth of her son in 2012. Most recently, she has been drinking up to ten beers a few times per week. New recently lost her job due to absences. She has been living with her boyfriend for the last six months. New reports that he does drink on occasion but has never had any SUD treatment. New reported recent symptoms of anxiety including: excessive worry about the future, insomnia, fatigue, trouble concentrating, and trouble with decision making. New presents with diagnoses of Alcohol Use Disorder-Moderate and Generalized Anxiety Disorder. It is recommended that she attend monthly individual sessions and weekly group sessions to explore triggers for use, increase positive coping mechanisms, explore employment needs/opportunities, increase knowledge of addiction and post acute withdrawals and decrease symptoms of anxiety. New may benefit from a psychiatric evaluation to clarify mental health

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Adding and ASAM Continuum

Please see instruction sheet for detailed instructions on adding an ASAM Continuum.

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Other Required Documents

- Communicable disease risk screens must be completed for all clients. Any client identified as “high risk” must be provided with a referral for follow up care. (Referrals must be documented)
- All clients must have an initial fee agreement complete in full. These are then reviewed every 90 days or if there is a change in the clients' income.
- Any clients funded by Block Grant must have verification of income in the chart. This may be a bank statement, check stub or letter attesting to lack of income.
- All charts must include documentation of whether or not a client has a primary care physician and if so, coordination of care with that physician (with a release of information). Any client without a PCP should be assisted in obtaining a PCP or given a referral to a FQHC.
- The Communicable Disease Risk Screen and Fee Agreement Form can be located at our website: www.mccmh.net in the Substance Use Provider Manual

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Fee Agreement Form

Admission Date: ____________ Agency ID (optional): ____________

MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE (MCOSA)
VERIFICATION OF INCOME & FEE AGREEMENT FORM

Name: ______________________________
(Last) (First) (Middle)

Social Security Number (required): ____________ Date of Birth: ____________

Marital Status: ☐ Single ☐ Married/living with partner ☐ Divorced ☐ Separated ☐ Widowed

Current County of Residence: ☐ Macomb ☐ Other ____________

Number of Dependents (include self): ________ Ages (include self): ____________

I understand that a portion of the cost of my treatment may be subsidized by public funds. As required by eligibility guidelines, I hereby certify that my *current* yearly income is as follows:

Hourly Wage: $________ Hours worked in past two (2) weeks: ____________

Annual Personal Income: $__________ Annual Household Income: $__________

Source(s) of Income: ☐ Employment ☐ Unemployment ☐ Disability
☐ Alimony/Child Support ☐ Parent (only if you are under 18)
☐ Spouse/partner ☐ Public Assistance ☐ Other (specify): ________

I understand that public funding should be the funding of last resort, and I certify that my *current* health insurance status is as follows:

Health Insurance/HMO/PPO:	☐ Yes	☐ No	If yes, Name of Insurer: ____________
VA Healthcare Benefits:	☐ Yes	☐ No	
Medicare:	☐ Yes	☐ No	
Healthy Michigan Plan (HMP):	☐ Yes	☐ No	
Medicaid:	☐ Yes	☐ No	
Medicaid w/Deductible/Spend-Down:	☐ Yes	☐ No	Deductible Amount (if known): $________

Client to read and initial:

______ ***I verify that the above statements are true, to the best of my knowledge. I understand that I will be required to provide verification of the above information for the purpose of substantiating eligibility for public funds and/or determining the fees to be charged for the services provided.***

______ ***I understand that if I am otherwise eligible for third-party insurance coverage, including Medicaid or Healthy Michigan Plan, and do not apply for, or decline to use my insurance, MCOSA is not obligated to supplement the cost of my treatment.***

______ ***I understand that I cannot be enrolled in more than one MCOSA-funded (Medicaid, Healthy Michigan, Block Grant) treatment program at the same time, and will inform my therapist if I am enrolled in any substance use treatment elsewhere. If I choose to remain at my other substance use treatment program, MCOSA will not fund my current request for substance use treatment and I will be responsible for any costs incurred.***

1 MCOSA Fee Agreement Form.Rev 6/17

COMPLETED BY PROVIDER:

Section 1 – Verification of Residency – *Maintain proof of documentation in client file*

- Q Driver's License/State ID with Macomb County Address
- Q Mail addressed to client with Macomb County Address
- Q Other ______________________________

Section 2 – Admission Category – Meets MCOSA Quality Assurance Guidelines, ASAM criteria and Medical Necessity criteria for admission to the following category below:

- Q Detox/Residential – no copay
- Q Methadone Assisted Treatment
- Q IOP/Outpatient
- Q Outpatient Significant Other Admission (*Maximum length of outpatient funding up to 12 sessions in 90 days; not eligible for reauthorization)*
- Q Outpatient Relapse Prevention (*Admission for an individual with a diagnosis of Substance Dependence in Sustained Full or Partial Remission, with the sole purpose of averting an impending relapse. Maximum length of outpatient funding up to 12 sessions in 90 days. If client experiences relapse during treatment, update admission category)*
- Q Case Management – no copay
- Q Peer Recovery Coach – no copay
- Q Adolescent Outreach Program – no copay

Section 3 – Reimbursement Level Assignment

Type of Income Verification (**attach proof to this Fee Agreement form)*:

- Q Medicaid/Healthy Michigan (verified in the MCOSA data system)
- Q *Pay stub
- Q *Income tax return
- Q *Unemployment
- Q *Receipt of application for Healthy Michigan Plan/Medicaid
- Q *Other: ______________________________

Check one: Q Medicaid: No co-payment Q Healthy Michigan Plan: No co-payment Q Community Grant: Co-payment amount per service: $______ Effective Date: ____________	
Explanation for exception, if applicable:	
Client Acknowledgment & Acceptance of Fee Signature: Date:	**Agency Authorization** Signature: Date:

Note: There is a minimum fee for **Community Grant (Block Grant/PA2)** clients. Those needing to have this fee waived must complete the "MCOSA Client Fee Waiver Request/Authorization" form, which must be forwarded to MCOSA for approval. See QA Guidelines in Chapter 3 of the MCOSA Provider Manual for instructions.

2 MCOSA Fee Agreement Form.Rev 6/17

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Client Name: ____________ *Agency ID (optional):* ____________

Fee Review

A review of assigned fees is required every 90 days, when submitting Outpatient (Drug-free and Methadone) re-authorization request, or when client financial situation changes, whichever comes first.

Fees Reviewed on (Date): ________ **Financial Situation Changed:** ☐ **No (skip to signatures)** ☐ **Yes** **If yes,** current household income $________ (attach verification to fee agreement) Revised Fees Amount: $________ New Amount Effective On (Date): ________	
Explanation for exception, if applicable:	
Client Acknowledgment & Acceptance of Fees: Signature: Date:	**Agency Review:** Signature: Date:

Fees Reviewed on (Date): ________ **Financial Situation Changed:** ☐ **No (skip to signatures)** ☐ **Yes** **If yes,** current household income $________ (attach verification to fee agreement) Revised Fees Amount: $________ New Amount Effective On (Date): ________	
Explanation for exception, if applicable:	
Client Acknowledgment & Acceptance of Fees: Signature: Date:	**Agency Review:** Signature: Date:

Fees Reviewed on (Date): ________ **Financial Situation Changed:** ☐ **No (skip to signatures)** ☐ **Yes** **If yes,** current household income $________ (attach verification to fee agreement) Revised Fees Amount: $________ New Amount Effective On (Date): ________	
Explanation for exception, if applicable:	
Client Acknowledgment & Acceptance of Fees: Signature: Date:	**Agency Review:** Signature: Date:

(Attach additional pages of "Fee Reviews" to this fee agreement packet, if needed.)

3 MCOSA Fee Agreement Form.Rev 6/17

Page 3 of the Fee Agreement is completed every 90 days or if there is a change in the clients' income. If there are changes to the clients' income, a new SUD self-pay policy should be added in FOCUS to reflect this.

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Macomb County Community Mental Health Services
Office of Substance Abuse
FY2024 Sliding Fee Scale - Effective 10/01/2023

Step 1 - Determine Reimbursement Level

Find the client's family size in the left-most column of the chart below. Follow that line to the right until you reach the cell in which the client's household income falls. The Level number on the top of that column is the client's reimbursement level.

	Level 1 0-138% Poverty		Level 2 139-200% Poverty	
Family Size	Min. Income	Max Income	Min. Income	Max Income
1	$0	$20,120	$20,121	$29,160
2	0	27,214	27,215	39,440
3	0	34,307	34,308	49,720
4	0	41,400	41,401	60,000
5	0	48,493	48,494	70,280
6	0	55,586	55,587	80,560
7	0	62,680	62,681	90,840
8	0	69,773	69,774	101,120
9	0	76,866	76,867	111,400
10	0	83,959	83,960	121,680
11	0	91,052	91,053	131,960
12	0	98,146	98,147	142,240

Step 2 - Determine Fee Corresponding to Calculated Reimbursement Level

In the left-most column of the chart below, locate the reimbursement level determined above. Follow the line to the right until you reach the column that describes the service being provided. The fee (co-pay) is the dollar amount identified in that cell.

Level	Outpatient Session/IOP Chair Day	Methadone Dose
1	2.00	0.20
2	5.00	0.35

Recovery Homes - 50% daily rate copay applies after 60 days of service

*Income Eligibility levels are based upon the 2023 U.S. Department of Health & Human Services (Federal) Poverty Guidelines.

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SUBSTANCE ABUSE COMMUNICATION FORM
TO PRIMARY CARE PHYSICIAN

Date:_____

To: _____
Primary Care Physician

_____
Address City State Zip

From: _____
Treatment Agency

_____
Therapist and Psychiatrist (if applicable)

_____
Address City State Zip

(___)_____ (___)_____
Phone Number Fax Number

Re: _____ _____
Client Name Date of Birth

The above client was admitted to _____ on _____
Level of care Date

Treatment Plan: Type_____ Frequency_____ Est. length of Tx_____
Diagnosis:_____

Medication(s) Prescribed:_____
_____
_____

Comments:_____
_____
_____

Date of last session: _____ Treatment completed? Yes_No___

We ask that the Primary Care Physician please send information related to relevant medical history, current medications prescribed and treatment to the above psychiatrist/therapist.

Thank you for your assistance.

Date sent:_____ Initials of sender:_____ Method: Fax__ Mail__
cc: client chart

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Example form that can be utilized for care coordination with primary care physicians.

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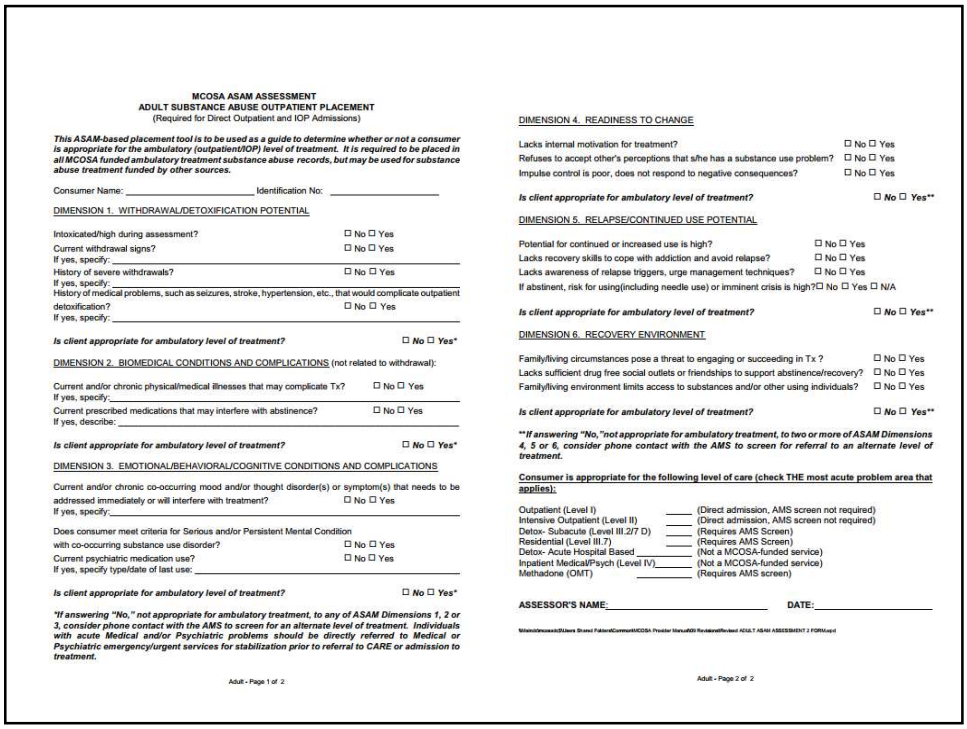

MCOSA ASAM ASSESSMENT
ADULT SUBSTANCE ABUSE OUTPATIENT PLACEMENT
(Required for Direct Outpatient and IOP Admissions)

This ASAM-based placement tool is to be used as a guide to determine whether or not a consumer is appropriate for the ambulatory (outpatient/IOP) level of treatment. It is required to be placed in all MCOSA funded ambulatory treatment substance abuse records, but may be used for substance abuse treatment funded by other sources.

Consumer Name: _____ Identification No: _____

DIMENSION 1. WITHDRAWAL/DETOXIFICATION POTENTIAL

Intoxicated/high during assessment? ☐ No ☐ Yes
Current withdrawal signs? ☐ No ☐ Yes
If yes, specify: _____
History of severe withdrawals? ☐ No ☐ Yes
If yes, specify: _____
History of medical problems, such as seizures, stroke, hypertension, etc., that would complicate outpatient detoxification? ☐ No ☐ Yes
If yes, specify: _____

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes**

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS (not related to withdrawal):

Current and/or chronic physical/medical illnesses that may complicate Tx? ☐ No ☐ Yes
If yes, specify: _____
Current prescribed medications that may interfere with abstinence? ☐ No ☐ Yes
If yes, describe: _____

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes****

DIMENSION 3. EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

Current and/or chronic co-occurring mood and/or thought disorder(s) or symptom(s) that needs to be addressed immediately or will interfere with treatment? ☐ No ☐ Yes
If yes, specify: _____

Does consumer meet criteria for Serious and/or Persistent Mental Condition with co-occurring substance use disorder? ☐ No ☐ Yes
Current psychiatric medication use? ☐ No ☐ Yes
If yes, specify type/date of last use: _____

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes****

****If answering "No," not appropriate for ambulatory treatment, to any of ASAM Dimensions 1, 2 or 3, consider phone contact with the AMS to screen for an alternate level of treatment. Individuals with acute Medical and/or Psychiatric problems should be directly referred to Medical or Psychiatric emergency/urgent services for stabilization prior to referral to CARE or admission to treatment.***

Adult - Page 1 of 2

DIMENSION 4. READINESS TO CHANGE

Lacks internal motivation for treatment? ☐ No ☐ Yes
Refuses to accept other's perceptions that s/he has a substance use problem? ☐ No ☐ Yes
Impulse control is poor, does not respond to negative consequences? ☐ No ☐ Yes

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes*****

DIMENSION 5. RELAPSE/CONTINUED USE POTENTIAL

Potential for continued or increased use is high? ☐ No ☐ Yes
Lacks recovery skills to cope with addiction and avoid relapse? ☐ No ☐ Yes
Lacks awareness of relapse triggers, urge management techniques? ☐ No ☐ Yes
If abstinent, risk for using(including needle use) or imminent crisis is high? ☐ No ☐ Yes ☐ N/A

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes*****

DIMENSION 6. RECOVERY ENVIRONMENT

Family/living circumstances pose a threat to engaging or succeeding in Tx ? ☐ No ☐ Yes
Lacks sufficient drug free social outlets or friendships to support abstinence/recovery? ☐ No ☐ Yes
Family/living environment limits access to substances and/or other using individuals? ☐ No ☐ Yes

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes*****

*****If answering "No," not appropriate for ambulatory treatment, to two or more of ASAM Dimensions 4, 5 or 6, consider phone contact with the AMS to screen for referral to an alternate level of treatment.***

Consumer is appropriate for the following level of care (check THE most acute problem area that applies):

Outpatient (Level I) _____ (Direct admission, AMS screen not required)
Intensive Outpatient (Level II) _____ (Direct admission, AMS screen not required)
Detox- Subacute (Level III.2/7 D) _____ (Requires AMS Screen)
Residential (Level III.7) _____ (Requires AMS Screen)
Detox- Acute Hospital Based _____ (Not a MCOSA-funded service)
Inpatient Medical/Psych (Level IV)_____ (Not a MCOSA-funded service)
Methadone (OMT) _____ (Requires AMS screen)

ASSESSOR'S NAME:_____ **DATE:**_____

Adult - Page 2 of 2

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Treatment Plans/Progress Notes

- A valid treatment plan must be in place prior to the provision of ongoing services.
- Treatment Plans should include documentation of client involvement including client signature and use of clients' own words in the development of the plan. Treatment plans not signed by the client are not considered valid plans.
- Plans should identify goals with specific objectives, services, activities and time frames for completion. Objectives should be specific and measurable and match the time frames given.
- Progress notes must contain the file number, date/time of session, clinicians' signature and clinician credentials. They should also include documentation of progress toward goals/objectives.
- Group session notes must include the items listed above as well as the number of participants in the group.

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Goal/Objective Samples

Example: Goal that is not specific or measurable

Goal: Abstinence.

Objectives:

1-Report no use of substances at each appointment.

2-Report less urges to use.

Example 2: Goal that is specific, measurable and shows what interventions will be provided

Goal: "I want to stay clean".

Objectives:

1-Client will participate in random UDS with no positives while in treatment.

2-Client will attend weekly groups and actively engage in sessions.

3- Client will develop a pros and cons lists of use.

4- Client will participate in individual sessions where the therapist will utilize Motivational Interviewing and Cognitive Behavioral Therapy to explore triggers for use and more positive coping techniques.

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Change in Level of Care

- If a client presents with a need for a higher level of care or additional services such as recovery housing a change in level of care request should be submitted through FOCUS.
- In this form you must provide up to date information regarding the clients' current stage of change, current medications, current participation in treatment, what services are being requested and clinical justification for those requests.

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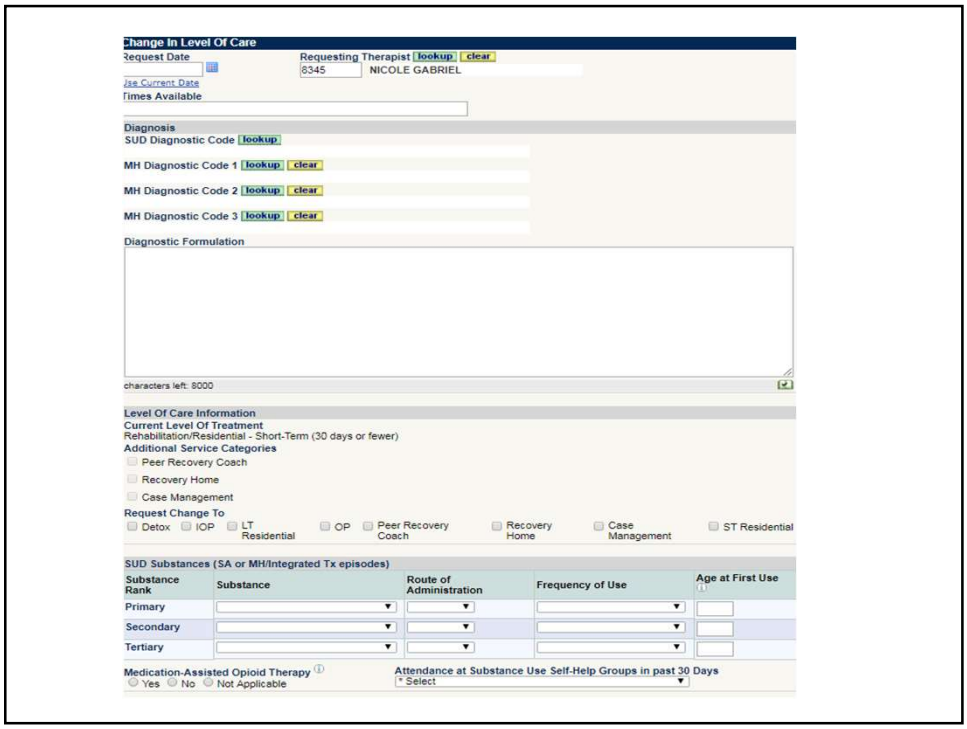
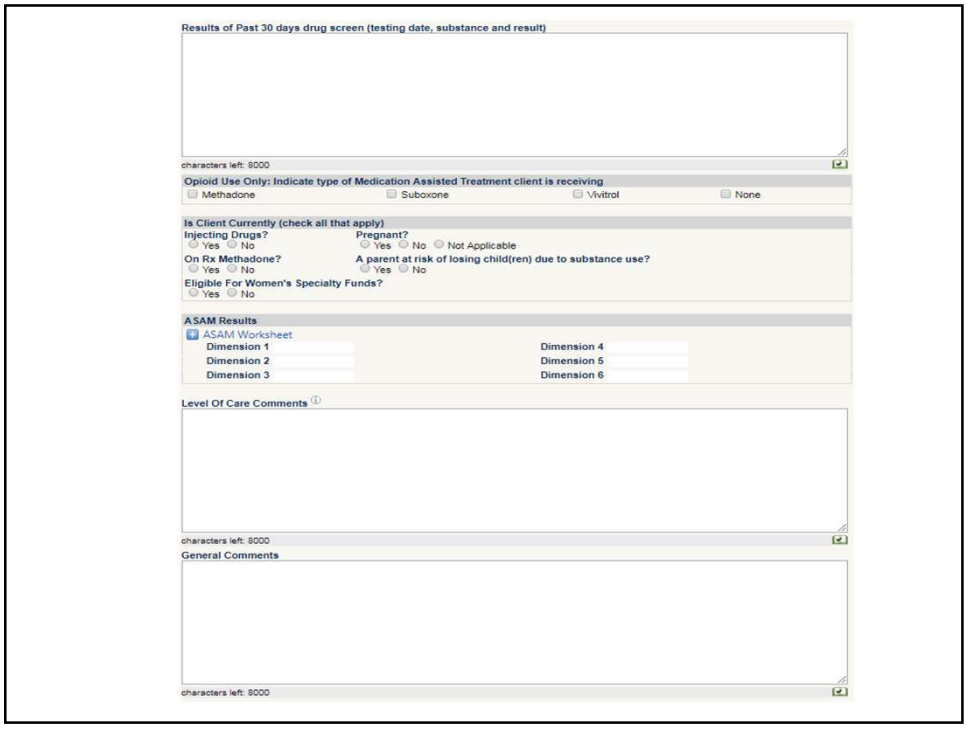

Change In Level Of Care
Request Date
Requesting Therapist lookup clear
6345 NICOLE GABRIEL
Use Current Date
Times Available
Diagnosis
SUD Diagnostic Code lookup
MH Diagnostic Code 1 lookup clear
MH Diagnostic Code 2 lookup clear
MH Diagnostic Code 3 lookup clear
Diagnostic Formulation
characters left: 8000
Level Of Care Information
Current Level Of Treatment
Rehabilitation/Residential - Short-Term (30 days or fewer)
Additional Service Categories
Peer Recovery Coach
Recovery Home
Case Management
Request Change To
Detox IOP LT Residential OP Peer Recovery Coach Recovery Home Case Management ST Residential
SUD Substances (SA or MH/Integrated Tx episodes)
Substance Rank
Substance
Route of Administration
Frequency of Use
Age at First Use
Primary
Secondary
Tertiary
Medication-Assisted Opioid Therapy
Yes No Not Applicable
Attendance at Substance Use Self-Help Groups in past 30 Days
* Select

27


Results of Past 30 days drug screen (testing date, substance and result)
characters left: 8000
Opioid Use Only: Indicate type of Medication Assisted Treatment client is receiving
Methadone Suboxone Vivitrol None
Is Client Currently (check all that apply)
Injecting Drugs?
Yes No
Pregnant?
Yes No Not Applicable
On Rx Methadone?
Yes No
A parent at risk of losing child(ren) due to substance use?
Yes No
Eligible For Women's Specialty Funds?
Yes No
ASAM Results
ASAM Worksheet
Dimension 1
Dimension 2
Dimension 3
Dimension 4
Dimension 5
Dimension 6
Level Of Care Comments
characters left: 8000
General Comments
characters left: 8000

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Recovery Home Referrals

- To ensure clients have safe, secure, sober housing to fully focus on treatment, MCCMH-SUD can provide short term funding for recovery housing with contracted recovery home providers.
- Individuals should only be referred to a MCCMH-SUD funded recovery home if they are highly motivated for recovery, in the action stage of change and willing to participate in regular treatment.
- Inappropriate referrals can threaten the integrity of the homes as well as the recovery of the other residents.
- MCCMH-SUD relies on clinicians' judgement to ensure appropriate referrals are made to the homes. Once at the home, any extension requests would come from the recovery home providers.
- MCCMH-SUD had created a flow-chart that staff can use to determine if a client is appropriate for funding.
- Clients can also be referred to recovery housing and self-pay if they are able.

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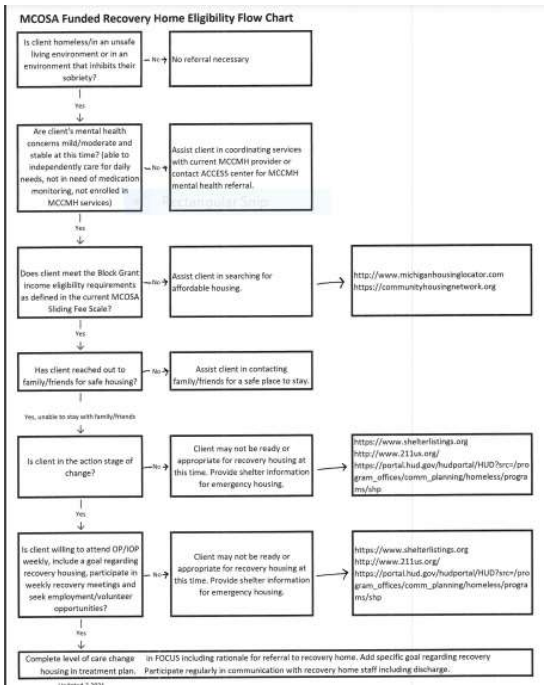

30

Discharges

- Discharges should be entered into FOCUS within 30 days of the last session or sooner if the discharge is planned.
- Those clients who drop out of treatment should have outreach efforts documented in the chart (letters, phone calls, etc).
- If appropriate, after care referrals should be provided to all clients regardless of the nature of their discharge.
- All aftercare referrals should be documented in the FOCUS discharge.
- The discharge date is the last date a service was provided.
- Withdrawal Management, IOP and Residential treatment are not considered the last step in a treatment episode. Therefore any client discharging from one of these levels of care should be provided with an aftercare referral.

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Administrative Requirements

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Adding New Staff

- When a new staff member is hired to see MCCMH-SUD funded clients, the program must first ensure that they meet the credentialing requirements of the MCCMH-SUD contract.
- The supervisor would send a Directors Verification form to MCCMH-SUD for review/approval. These can be submitted to mcosa@mccmh.net
- Any staff requiring FOCUS access should have a request form completed and submitted by their supervisor. These can be submitted to mcosa@mccmh.net.
- Staff cannot provide services to MCCMH-SUD funded clients until they have an approved Director's Verification Form on file.
- Providers must complete an initial credentialing review and re-credential staff every two years.
- Staff must complete required training within 90 days of hire and every two years to align with re-credentialing.
- Staff must maintain any licenses/certifications required to provide services per MDHHS staff credentialing rules.

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SUD Required Trainings

All MCCMH-SUD Required Trainings can be found at www.mccmh.net in the Substance Use Provider Manual

- Communicable Disease Level 1 (improving MI Practices)
- SUD Recipient Rights (Improving MI Practices)
- Corporate Compliance (internal to your agency)
- Cultural Diversity (Brainier)
- New Employee Orientation (internal to your agency)
- SUD Basics of Confidentiality (Improving MI Practices)
- Limited English Proficiency (Brainier)
- Integrated Primary and Behavioral Health (Brainier)
- Grievance and Appeals (Brainier)

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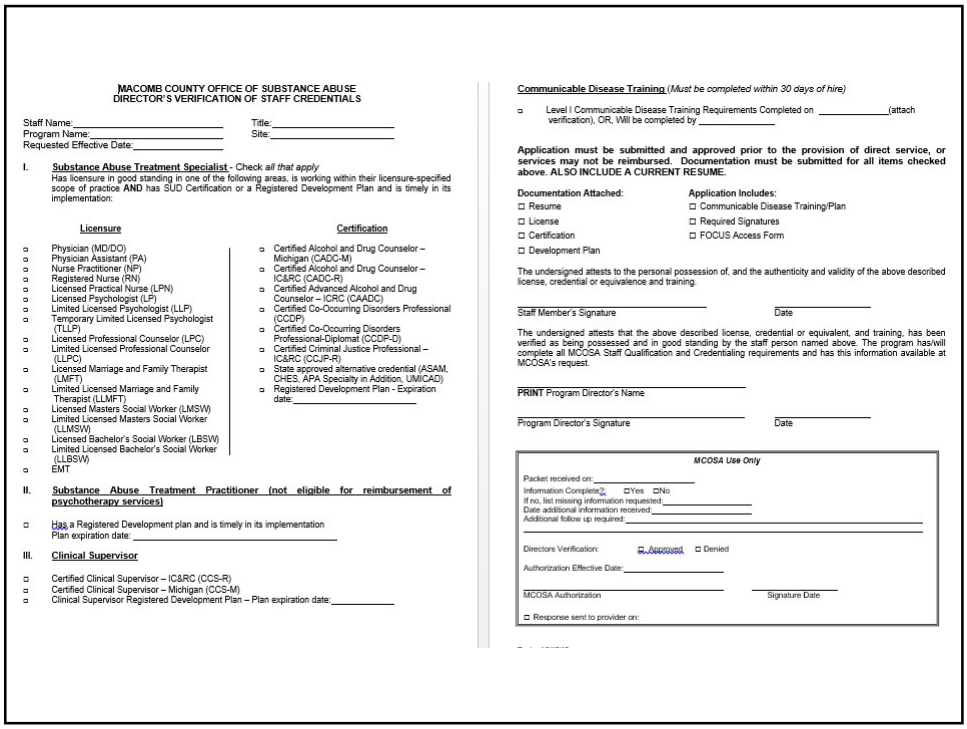

MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE
DIRECTOR'S VERIFICATION OF STAFF CREDENTIALS

Staff Name:_____ Title:_____
Program Name:_____ Site:_____
Requested Effective Date:_____

I. **Substance Abuse Treatment Specialist** - Check *all that apply*
Has licensure in good standing in one of the following areas, is working within their licensure-specified scope of practice **AND** has SUD Certification or a Registered Development Plan and is timely in its implementation:

Licensure

- ▫ Physician (MD/DO)
- ▫ Physician Assistant (PA)
- ▫ Nurse Practitioner (NP)
- ▫ Registered Nurse (RN)
- ▫ Licensed Practical Nurse (LPN)
- ▫ Licensed Psychologist (LP)
- ▫ Limited Licensed Psychologist (LLP)
- ▫ Temporary Limited Licensed Psychologist (TLLP)
- ▫ Licensed Professional Counselor (LPC)
- ▫ Limited Licensed Professional Counselor (LLPC)
- ▫ Licensed Marriage and Family Therapist (LMFT)
- ▫ Limited Licensed Marriage and Family Therapist (LLMFT)
- ▫ Licensed Masters Social Worker (LMSW)
- ▫ Limited Licensed Masters Social Worker (LLMSW)
- ▫ Licensed Bachelor's Social Worker (LBSW)
- ▫ Limited Licensed Bachelor's Social Worker (LLBSW)
- ▫ EMT

Certification

- ▫ Certified Alcohol and Drug Counselor – Michigan (CADC-M)
- ▫ Certified Alcohol and Drug Counselor – IC&RC (CADC-R)
- ▫ Certified Advanced Alcohol and Drug Counselor – ICRC (CAADC)
- ▫ Certified Co-Occurring Disorders Professional (CCDP)
- ▫ Certified Co-Occurring Disorders Professional-Diplomat (CCDP-D)
- ▫ Certified Criminal Justice Professional – IC&RC (CCJP-R)
- ▫ State approved alternative credential (ASAM, CHES, APA Specialty in Addition, UMICAD)
- ▫ Registered Development Plan - Expiration date:_____

II. **Substance Abuse Treatment Practitioner (not eligible for reimbursement of psychotherapy services)**

- ▫ Has a Registered Development plan and is timely in its implementation
Plan expiration date: _____

III. **Clinical Supervisor**

- ▫ Certified Clinical Supervisor – IC&RC (CCS-R)
- ▫ Certified Clinical Supervisor – Michigan (CCS-M)
- ▫ Clinical Supervisor Registered Development Plan – Plan expiration date:_____

Communicable Disease Training *(Must be completed within 30 days of hire)*

- ▫ Level I Communicable Disease Training Requirements Completed on _____(attach verification), OR, Will be completed by _____

Application must be submitted and approved prior to the provision of direct service, or services may not be reimbursed. Documentation must be submitted for all items checked above. ALSO INCLUDE A CURRENT RESUME.

Documentation Attached:
- ☐ Resume
- ☐ License
- ☐ Certification
- ☐ Development Plan

Application Includes:
- ☐ Communicable Disease Training/Plan
- ☐ Required Signatures
- ☐ FOCUS Access Form

The undersigned attests to the personal possession of, and the authenticity and validity of the above described license, credential or equivalence and training.

Staff Member's Signature _____ Date _____

The undersigned attests that the above described license, credential or equivalent, and training, has been verified as being possessed and in good standing by the staff person named above. The program has/will complete all MCOSA Staff Qualification and Credentialing requirements and has this information available at MCOSA's request.

PRINT Program Director's Name _____

Program Director's Signature _____ Date _____

MCOSA Use Only

Packet received on:_____
Information Complete?: ☐Yes ☐No
If no, list missing information requested:_____
Date additional information received:_____
Additional follow up required:_____

Directors Verification: ☐ Approved ☐ Denied

Authorization Effective Date:_____

MCOSA Authorization _____ Signature Date _____

☐ Response sent to provider on:

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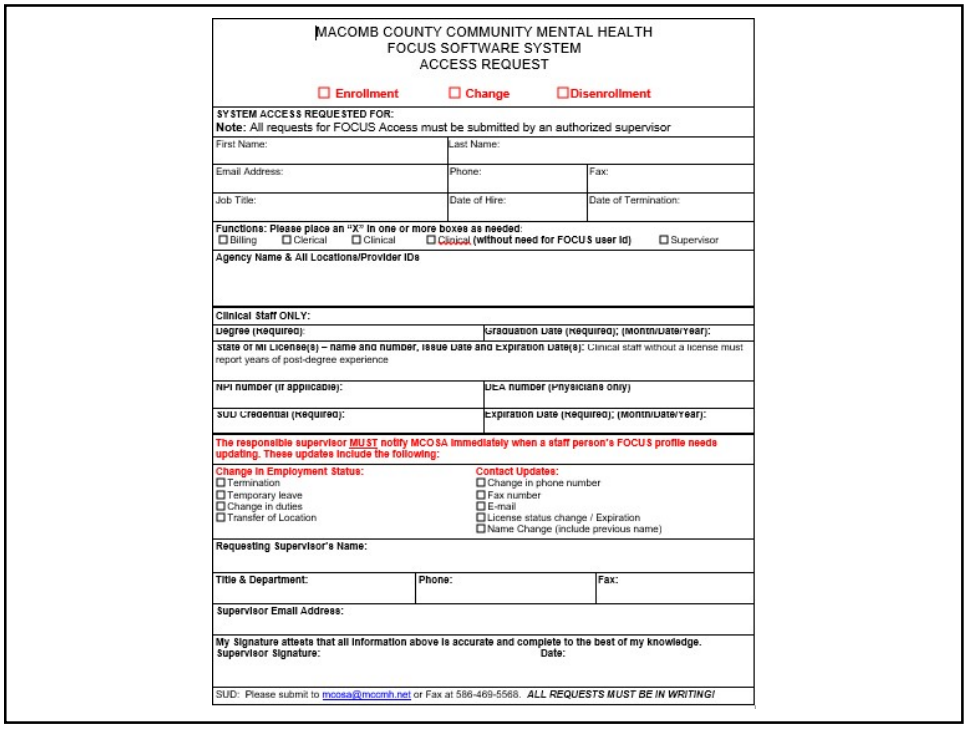

MACOMB COUNTY COMMUNITY MENTAL HEALTH
FOCUS SOFTWARE SYSTEM
ACCESS REQUEST

☐ **Enrollment** ☐ **Change** ☐ **Disenrollment**

SYSTEM ACCESS REQUESTED FOR:
Note: All requests for FOCUS Access must be submitted by an authorized supervisor

First Name:	Last Name:	
Email Address:	Phone:	Fax:
Job Title:	Date of Hire:	Date of Termination:

Functions: Please place an "X" in one or more boxes as needed:
☐ Billing ☐ Clerical ☐ Clinical ☐ Clinical **(without need for FOCUS user id)** ☐ Supervisor

Agency Name & All Locations/Provider IDs

Clinical Staff ONLY:

Degree (Required):	**Graduation Date (Required); (Month/Date/Year):**
State of MI License(s) – name and number, issue Date and Expiration Date(s): Clinical staff without a license must report years of post-degree experience	
NPI number (if applicable):	**DEA number (Physicians only)**
SUD Credential (Required):	**Expiration Date (Required); (Month/Date/Year):**

The responsible supervisor MUST notify MCOSA immediately when a staff person's FOCUS profile needs updating. These updates include the following:

Change in Employment Status:
☐ Termination
☐ Temporary leave
☐ Change in duties
☐ Transfer of Location

Contact Updates:
☐ Change in phone number
☐ Fax number
☐ E-mail
☐ License status change / Expiration
☐ Name Change (include previous name)

Requesting Supervisor's Name:

Title & Department:	**Phone:**	**Fax:**

Supervisor Email Address:

My Signature attests that all information above is accurate and complete to the best of my knowledge.
Supervisor Signature: **Date:**

SUD: Please submit to mcosa@mccmh.net or Fax at 586-469-5568. ***ALL REQUESTS MUST BE IN WRITING!***

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Required Reports

- Injecting Drug Users 90% Capacity Report-quarterly (Nicole G.)
- Priority Populations Waiting List Deficiencies Report-monthly (Nicole G.)
- Customer Satisfaction Survey Reports-quarterly (OP providers must include number of no shows) (Nicole P.)
- Death Reports should be submitted as soon as staff are notified but no later than the end of shift (Nicole P.)
- Incident Reports should be submitted within 24 hours (Nicole P.)
- WSS providers must complete a monthly report on WSS services and referrals (Nicole G.)
- WSS providers must submit the Child Referral Report bi-annually and the WSS Annual report (Nicole G.)

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Injecting Drug Users 90% Capacity Treatment Report

Due dates: 1/31, 4/30, 7/31 and 10/31. Submit by the due date, to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

Region – PIHP:	
Fiscal Year:	
Quarter:	
Date Submitted or Date Revised:	
Contact Person's Name, Title:	
Contact Person's Email:	

If you have IDU providers who have reached 90% capacity during the quarter, complete the following table for each provider*. Insert rows if necessary. If you do not have IDU providers who reached 90% capacity during the quarter, you must type "NA" in Column A.

*You must also report the 90% capacity event to MDHHS-BHDDA-Contracts-MGMT@michigan.gov by close of business the day after the provider notifies you and not to exceed seven days from the date that the provider reached capacity. MDHHS will compare your immediate notifications with this quarterly report to determine compliance with 45 CFR § 96.126.

Column A	Column B	Column C	Column D	Column E
Name of Providers (Serving Injecting Drug Users) at or Above 90% Capacity During the Quarter	**Start Date of Being at 90% Capacity**	**End Date of Being at 90% Capacity**	**Provider's Michigan Licensing and Regulatory Affairs (LARA)**	**Provider's Federal Inventory of Behavioral Health Services (I-BHS) Number**

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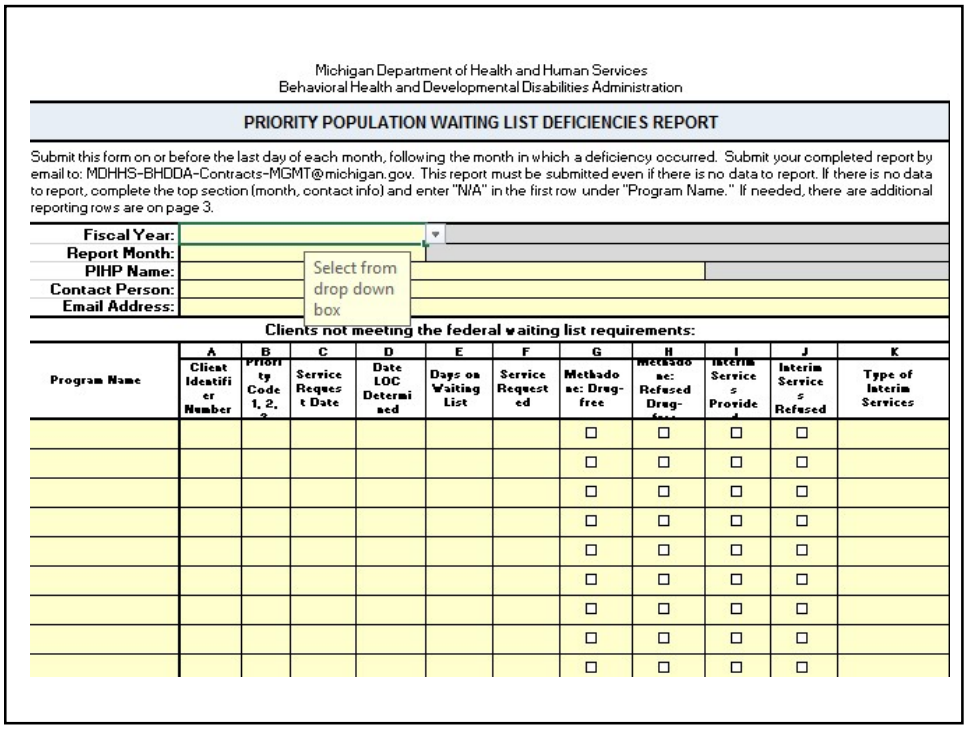

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration

PRIORITY POPULATION WAITING LIST DEFICIENCIES REPORT

Submit this form on or before the last day of each month, following the month in which a deficiency occurred. Submit your completed report by email to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov. This report must be submitted even if there is no data to report. If there is no data to report, complete the top section (month, contact info) and enter "N/A" in the first row under "Program Name." If needed, there are additional reporting rows are on page 3.

Fiscal Year:	
Report Month:	
PIHP Name:	
Contact Person:	
Email Address:	

Select from drop down box

Clients not meeting the federal waiting list requirements:

Program Name	A Client Identifier Number	B Priority Code 1, 2, 3	C Service Request Date	D Date LOC Determined	E Days on Waiting List	F Service Requested	G Methadone: Drug-free	H Methadone: Refused Drug-free	I Interim Services Provided	J Interim Services Refused	K Type of Interim Services
							☐	☐	☐	☐	
							☐	☐	☐	☐	
							☐	☐	☐	☐	
							☐	☐	☐	☐	
							☐	☐	☐	☐	
							☐	☐	☐	☐	
							☐	☐	☐	☐	
							☐	☐	☐	☐	
							☐	☐	☐	☐	

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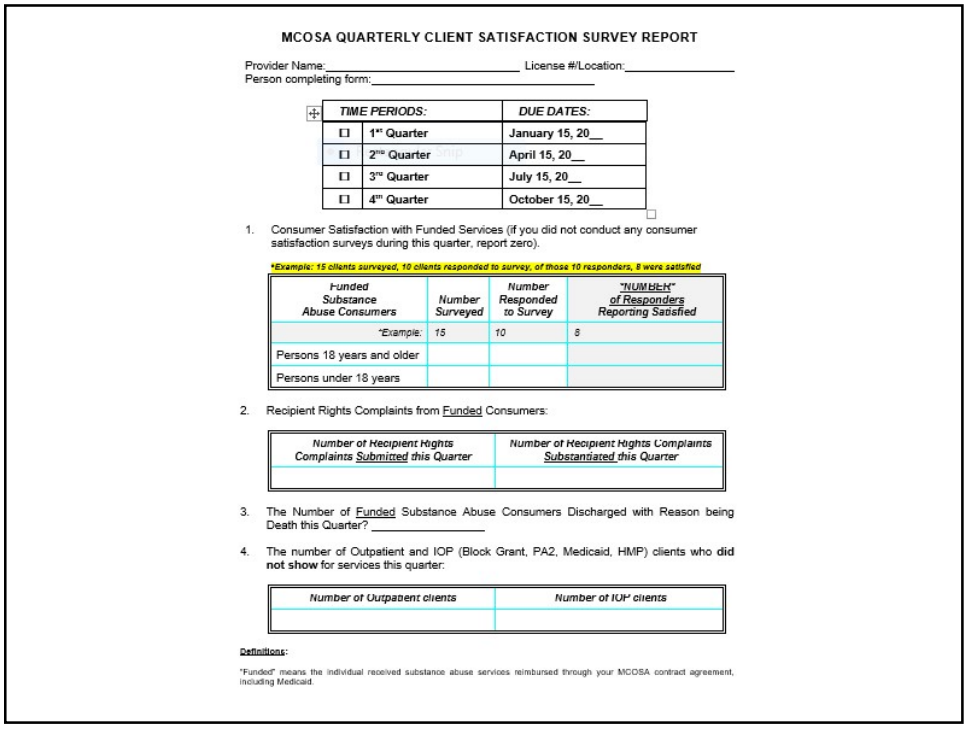

MCOSA QUARTERLY CLIENT SATISFACTION SURVEY REPORT

Provider Name:_____ License #/Location:_____
Person completing form:_____

	TIME PERIODS:	*DUE DATES:*
☐	1st Quarter	January 15, 20__
☐	2nd Quarter	April 15, 20__
☐	3rd Quarter	July 15, 20__
☐	4th Quarter	October 15, 20__

1. Consumer Satisfaction with Funded Services (if you did not conduct any consumer satisfaction surveys during this quarter, report zero).

**Example: 15 clients surveyed, 10 clients responded to survey, of those 10 responders, 8 were satisfied*

Funded Substance Abuse Consumers	*Number Surveyed*	*Number Responded to Survey*	*"NUMBER" of Responders Reporting Satisfied*
**Example:*	*15*	*10*	*8*
Persons 18 years and older			
Persons under 18 years			

2. Recipient Rights Complaints from Funded Consumers:

Number of Recipient Rights Complaints Submitted this Quarter	*Number of Recipient Rights Complaints Substantiated this Quarter*

3. The Number of Funded Substance Abuse Consumers Discharged with Reason being Death this Quarter? _____

4. The number of Outpatient and IOP (Block Grant, PA2, Medicaid, HMP) clients who **did not show** for services this quarter:

Number of Outpatient clients	*Number of IOP clients*

Definitions:

"Funded" means the individual received substance abuse services reimbursed through your MCOSA contract agreement, including Medicaid.

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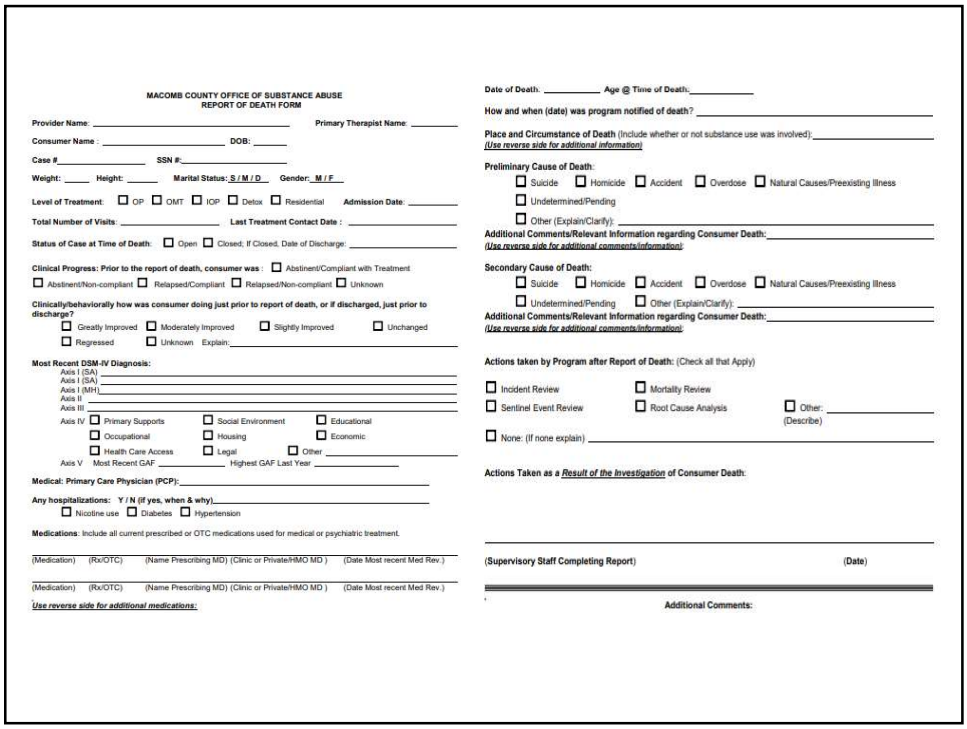

MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE
REPORT OF DEATH FORM

Provider Name: _____ **Primary Therapist Name**: _____

Consumer Name : _____ **DOB**: _____

Case #_____ **SSN #**:_____

Weight: _____ **Height**: _____ **Marital Status**: S / M / D **Gender**: M / F

Level of Treatment: ☐ OP ☐ OMT ☐ IOP ☐ Detox ☐ Residential **Admission Date**: _____

Total Number of Visits: _____ **Last Treatment Contact Date** : _____

Status of Case at Time of Death: ☐ Open ☐ Closed; If Closed, Date of Discharge: _____

Clinical Progress: Prior to the report of death, consumer was : ☐ Abstinent/Compliant with Treatment
☐ Abstinent/Non-compliant ☐ Relapsed/Compliant ☐ Relapsed/Non-compliant ☐ Unknown

Clinically/behaviorally how was consumer doing just prior to report of death, or if discharged, just prior to discharge?
☐ Greatly Improved ☐ Moderately Improved ☐ Slightly Improved ☐ Unchanged
☐ Regressed ☐ Unknown Explain:_____

Most Recent DSM-IV Diagnosis:
Axis I (SA) _____
Axis I (SA) _____
Axis I (MH)_____
Axis II _____
Axis III _____
Axis IV ☐ Primary Supports ☐ Social Environment ☐ Educational
☐ Occupational ☐ Housing ☐ Economic
☐ Health Care Access ☐ Legal ☐ Other _____
Axis V Most Recent GAF _____ Highest GAF Last Year _____

Medical: Primary Care Physician (PCP):_____

Any hospitalizations: Y / N (if yes, when & why)_____
☐ Nicotine use ☐ Diabetes ☐ Hypertension

Medications: Include all current prescribed or OTC medications used for medical or psychiatric treatment.

(Medication) (Rx/OTC) (Name Prescribing MD) (Clinic or Private/HMO MD) (Date Most recent Med Rev.)

(Medication) (Rx/OTC) (Name Prescribing MD) (Clinic or Private/HMO MD) (Date Most recent Med Rev.)

Use reverse side for additional medications:

Date of Death: _____ **Age @ Time of Death**:_____

How and when (date) was program notified of death? _____

Place and Circumstance of Death (Include whether or not substance use was involved):_____
(Use reverse side for additional information)

Preliminary Cause of Death:
☐ Suicide ☐ Homicide ☐ Accident ☐ Overdose ☐ Natural Causes/Preexisting Illness
☐ Undetermined/Pending
☐ Other (Explain/Clarify): _____
Additional Comments/Relevant Information regarding Consumer Death:_____
(Use reverse side for additional comments/information):

Secondary Cause of Death:
☐ Suicide ☐ Homicide ☐ Accident ☐ Overdose ☐ Natural Causes/Preexisting Illness
☐ Undetermined/Pending ☐ Other (Explain/Clarify): _____
Additional Comments/Relevant Information regarding Consumer Death:_____
(Use reverse side for additional comments/information):

Actions taken by Program after Report of Death: (Check all that Apply)

☐ Incident Review ☐ Mortality Review
☐ Sentinel Event Review ☐ Root Cause Analysis ☐ Other: _____ (Describe)

☐ None: (If none explain) _____

Actions Taken *as a Result of the Investigation* of Consumer Death:

_____
(Supervisory Staff Completing Report) **(Date)**

Additional Comments:

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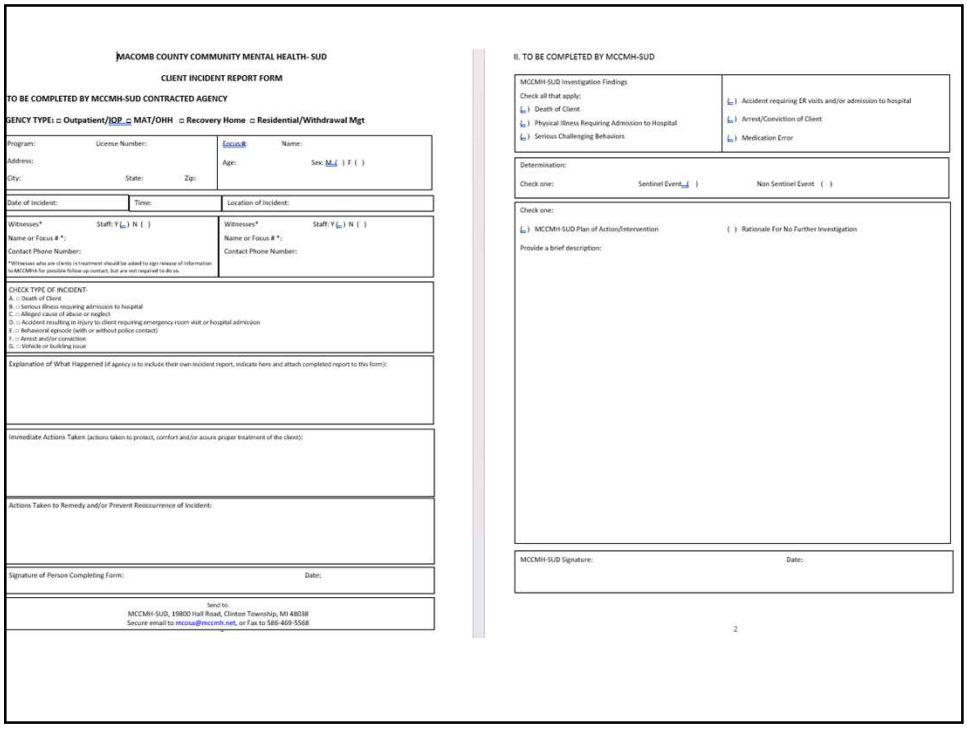

MACOMB COUNTY COMMUNITY MENTAL HEALTH- SUD

CLIENT INCIDENT REPORT FORM

TO BE COMPLETED BY MCCMH-SUD CONTRACTED AGENCY

GENCY TYPE: □ Outpatient/IOP □ MAT/OHH □ Recovery Home □ Residential/Withdrawal Mgt

Program: License Number:	Focus#: Name:
Address:	Age: Sex: M ( ) F ( )
City: State: Zip:	

Date of Incident:	Time:	Location of Incident:

Witnesses* Staff: Y ( ) N ( )	Witnesses* Staff: Y ( ) N ( )
Name or Focus # *:	Name or Focus # *:
Contact Phone Number:	Contact Phone Number:
*Witnesses who are clients in treatment should be asked to sign release of information to MCCMH for possible follow up contact, but are not required to do so.	

CHECK TYPE OF INCIDENT-
A. □ Death of Client
B. □ Serious Illness requiring admission to hospital
C. □ Alleged cause of abuse or neglect
D. □ Accident resulting in injury to client requiring emergency room visit or hospital admission
E. □ Behavioral episode (with or without police contact)
F. □ Arrest and/or conviction
G. □ Vehicle or building issue

Explanation of What Happened (if agency is to include their own incident report, indicate here and attach completed report to this form):

Immediate Actions Taken (actions taken to protect, comfort and/or assure proper treatment of the client):

Actions Taken to Remedy and/or Prevent Reoccurrence of Incident:

Signature of Person Completing Form: Date:

Send to:
MCCMH-SUD, 19800 Hall Road, Clinton Township, MI 48038
Secure email to mcosa@mccmh.net, or Fax to 586-469-5568

II. TO BE COMPLETED BY MCCMH-SUD

MCCMH-SUD Investigation Findings Check all that apply:	
( ) Death of Client	( ) Accident requiring ER visits and/or admission to hospital
( ) Physical Illness Requiring Admission to Hospital	( ) Arrest/Conviction of Client
( ) Serious Challenging Behaviors	( ) Medication Error

Determination:
Check one: Sentinel Event ( ) Non Sentinel Event ( )

Check one:
( ) MCCMH-SUD Plan of Action/Intervention ( ) Rationale For No Further Investigation
Provide a brief description:

MCCMH-SUD Signature: Date:

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Monthly Women's Specialty Report

Macomb County Community Mental Health Substance Use Services

This report must be completed monthly and submitted to Nicole.gabriel@mccmh.net

Agency submitting report: _____

Month reported: _____ Date submitted: _____

Total number of women who received WSS services during this reporting period.	
Number of pregnant women served during this reporting period.	
Number of women who delivered babies while in services during this reporting period.	
Number of children in service with mother.	
Percentage of women served who were able to identify a primary/prenatal care physician at admission or who were provided assistance in obtaining a PCP.	
Percentage of women served who were provided Gender Specific Treatment.	
Percentage of women served who had their transportation needs met.	
Percentage of women served who had their case management needs met.	
Number of children who received services with their parent.	
Number of children served who were provided referrals for primary care and/or immunization.	
Percentage of children in services with their parent who were provided with a referral for pediatric/immunization follow up.	
Number of children served who were provided EBP treatment services or were referred to EBP treatment services.	
Percentage of children who were eligible that received a referral for therapy.	
Number who refused services for their children.	
Number of children in residential treatment with current CPS or Foster Care involvement.	

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Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration

CHILD REFERRAL REPORT

This report must be submitted electronically each quarter by the due date to: EGRAMS. Submit to the SUGS Women's Specialty Services project. Due dates are: 1/31, 4/30, 7/31 and 10/31.

This report is to identify the number of children who "enter" services with their mother. Though the child might not be physically present, the clinician and case manager should ask about any concerns regarding the child/ren, and record and track all referrals made for services.

Region - PIHP:	SELECT
Fiscal Year:	SELECT
Quarter:	SELECT
Date Submitted or Date Received:	
Contact Person's Name, Title:	
Contact Person's Email:	

Select from drop-down box

REPORTING TABLE	Prevention Services	Treatment Services	Mental Health Services	Other
1. Number of Children Referred				
2. Number of Children Who Accessed				
3. Number Who Refused Services				
4. Number of Children Entering Residential Treatment with their	N/A		N/A	N/A
5. Number of Children in Residential Treatment with Current CPS or	N/A		N/A	N/A

COMMENTS:

INSTRUCTIONS:

See complete Instructions on next tab.

1. Indicate the total number of children referred for each service category listed across the top. There may be some "duplication" if a child is referred for more than one service.
2. Indicate the number of children (parents) who accessed the service they were referred to. This will require follow up with the family.
3. Indicate the number of children (parents) who refused the service they were referred to.

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WOMEN'S SPECIALTY SERVICES (WSS) ANNUAL REPORT

PIHP Name:

Fiscal Year:

This form must be completed annually (for the prior Fiscal Year) and submitted electronically, by November 30, as an attachment report to the Women's Specialty Services (WSS) project in EGRAMS. The form will be available to download in EGRAMS.

Instructions are included after the report form, beginning on page 7.

The Michigan Department of Health and Human Services requires each agency that provides substance abuse services to pregnant women and women with dependent children, funded by the Substance Abuse Prevention and Treatment Block Grant, to complete an annual report. The report covers services that are specifically funded by the women's block grant set-aside. These programs and services are designed for this population consistent with the Federal Block Grant law and regulations applicable to the set-aside program.

45 CFR Part 96.131 requires providers of services to pregnant women to "publicize the availability to such women of services from the facilities and the fact that pregnant women receive such preference. This may be done by means of street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community-based organizations, health care providers, and social service agencies."

Publicizing Women's Specialty Services

Please indicate any and all activities that apply to your agency's publicity/outreach process for women's services.

TV Ads	☐
Radio Ads	☐
Newspaper Ads	☐
Internet	☐
Printed matter, e.g. pamphlets	☐
Outreach/speaking engagements	☐
Other Specify	☐

Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

Unduplicated Treatment Services Provided

Provide the following information on all programs that the PIHP determines provides gender competent treatment services to women eligible for specialty and receiving ancillary services (case management, transportation, child care and etc.):

Provider	DWP in Region Provider	Out of Region Provider	Number of Women with Dependent Children	Number of Women Trying to Regain Custody	Number of Pregnant Women	Total Number of Children

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Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

Prepaid Inpatient Health Plan (PIHP) Specific Information

Indicate the number of children receiving ancillary services:

Designated Specialty Program Information

Provider	Type of Service Provided (OP, Res., etc.)	Capacity Women-Children

Outcome Information

Provide information from all programs on the following:

Provider	DWP Provider (Check)	Number of Pregnant Women Who Completed Treatment or Transferred	Number of Drug Free Births (at time of delivery)	Number of Women Served Who are Pregnant in Treatment	Number of Eligible Women Who are Still in Treatment

Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

Program Information

If any programs changed their services during the fiscal year, please indicate the following:

- What specific changes were made
- Why were the changes made
- Describe the impact of the changes in terms of outcomes

Describe how the Pre-Paid Inpatient Health Plan is working to ensure **improvements** in the following areas:

1. Babies of pregnant women are born drug free:
2. Children receive effective and meaningful therapeutic interventions:
3. Systems collaboration:
4. Please indicate any other service improvements that you have made or are in the process of implementing:
5. Describe your service provision for fathers who are also considered to be primary caregivers for their minor children.

We are interested in identifying gender specific women's evidence-based programs and/or evidence-based practices offered in Michigan. Examples of evidence-based programs are curriculum-based programs such as "Seeking Safety" or "Beyond Trauma" and the parenting program "Nurturing Parent." Examples of evidence-based practices include "motivational interviewing" and "Family Group Decision Making." Promising practices are programs or strategies that show characteristics of evidence-based practice/program without having proven itself through documented research and replication, but for which you have at least some local evaluation data to support program effectiveness.

Please provide information on any women's gender specific evidence-based programs/practices offered by your agency:

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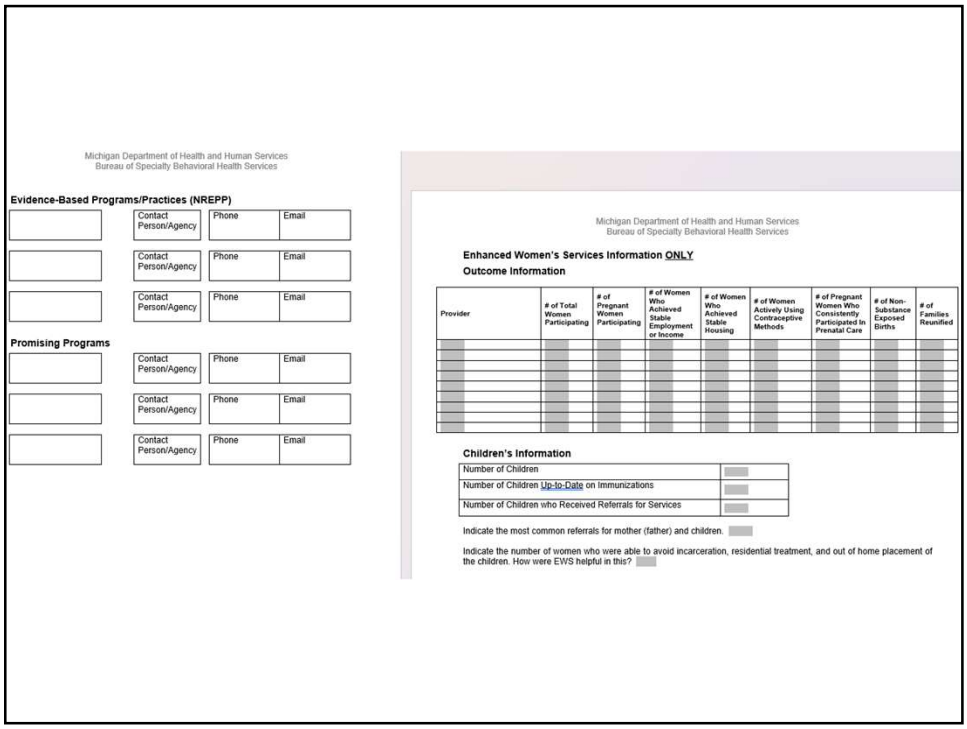

Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

Evidence-Based Programs/Practices (NREPP)

	Contact Person/Agency	Phone	Email

Promising Programs

	Contact Person/Agency	Phone	Email

Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

Enhanced Women's Services Information ONLY

Outcome Information

Provider	# of Total Women Participating	# of Pregnant Women Participating	# of Women Who Achieved Stable Employment or Income	# of Women Who Achieved Stable Housing	# of Women Actively Using Contraceptive Methods	# of Pregnant Women Who Consistently Participated In Prenatal Care	# of Non-Substance Exposed Births	# of Families Reunified

Children's Information

Number of Children	
Number of Children Up-to-Date on Immunizations	
Number of Children who Received Referrals for Services	

Indicate the most common referrals for mother (father) and children.

Indicate the number of women who were able to avoid incarceration, residential treatment, and out of home placement of the children. How were EWS helpful in this?

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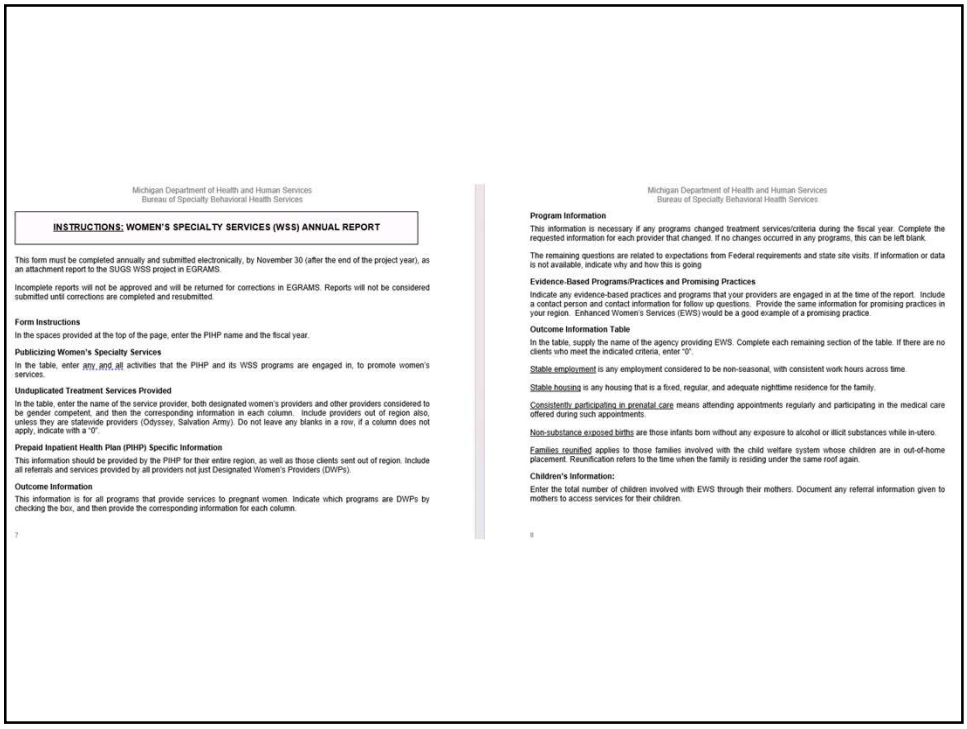

Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

INSTRUCTIONS: WOMEN'S SPECIALTY SERVICES (WSS) ANNUAL REPORT

This form must be completed annually and submitted electronically, by November 30 (after the end of the project year), as an attachment report to the SUGS WSS project in EGRAMS.

Incomplete reports will not be approved and will be returned for corrections in EGRAMS. Reports will not be considered submitted until corrections are completed and resubmitted.

Form Instructions

In the spaces provided at the top of the page, enter the PIHP name and the fiscal year.

Publicizing Women's Specialty Services

In the table, enter any and all activities that the PIHP and its WSS programs are engaged in, to promote women's services.

Unduplicated Treatment Services Provided

In the table, enter the name of the service provider, both designated women's providers and other providers considered to be gender competent, and then the corresponding information in each column. Include providers out of region also, unless they are statewide providers (Odyssey, Salvation Army). Do not leave any blanks in a row, if a column does not apply, indicate with a "0".

Prepaid Inpatient Health Plan (PIHP) Specific Information

This information should be provided by the PIHP for their entire region, as well as those clients sent out of region. Include all referrals and services provided by all providers not just Designated Women's Providers (DWPs).

Outcome Information

This information is for all programs that provide services to pregnant women. Indicate which programs are DWPs by checking the box, and then provide the corresponding information for each column.

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Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

Program Information

This information is necessary if any programs changed treatment services/criteria during the fiscal year. Complete the requested information for each provider that changed. If no changes occurred in any programs, this can be left blank.

The remaining questions are related to expectations from Federal requirements and state site visits. If information or data is not available, indicate why and how this is going

Evidence-Based Programs/Practices and Promising Practices

Indicate any evidence-based practices and programs that your providers are engaged in at the time of the report. Include a contact person and contact information for follow up questions. Provide the same information for promising practices in your region. Enhanced Women's Services (EWS) would be a good example of a promising practice.

Outcome Information Table

In the table, supply the name of the agency providing EWS. Complete each remaining section of the table. If there are no clients who meet the indicated criteria, enter "0".

Stable employment is any employment considered to be non-seasonal, with consistent work hours across time.

Stable housing is any housing that is a fixed, regular, and adequate nighttime residence for the family.

Consistently participating in prenatal care means attending appointments regularly and participating in the medical care offered during such appointments.

Non-substance exposed births are those infants born without any exposure to alcohol or illicit substances while in-utero.

Families reunified applies to those families involved with the child welfare system whose children are in out-of-home placement. Reunification refers to the time when the family is residing under the same roof again.

Children's Information:

Enter the total number of children involved with EWS through their mothers. Document any referral information given to mothers to access services for their children.

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Helpful Links

Most required documents can be found on our website:

www.mccmh.net

Scroll to the bottom of the main page and you will find a link to the Substance Use Services Provider Manual

https://www.mccmh.net/mcosa-provider-manual/

MDHHS Required Reports:

Fiscal Year 2024 SUD (Non-Medicaid) Reporting Instructions and Forms (michigan.gov)

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FOCUS EMR Overview

Main (pcesecure.com)

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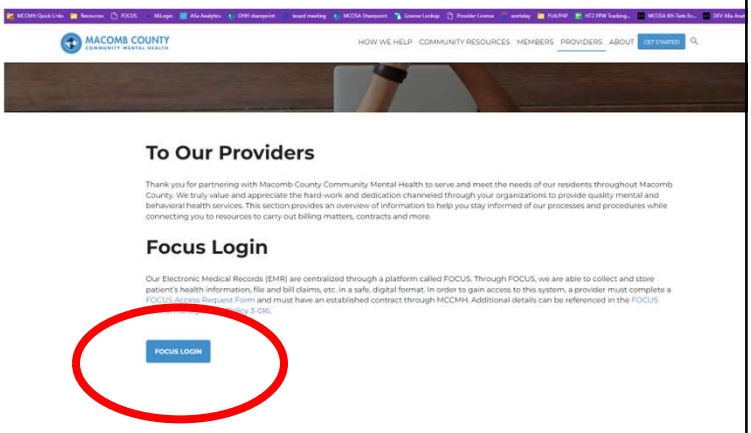
FOCUS Link



www.mccmh.net

Providers

Current Providers

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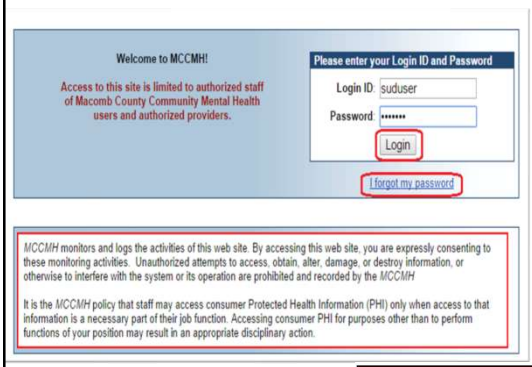
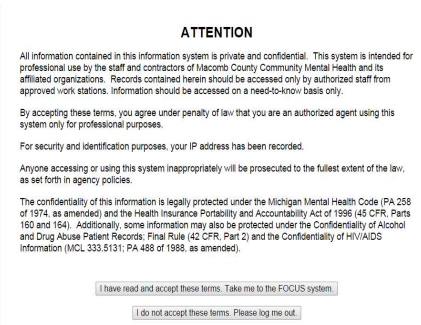
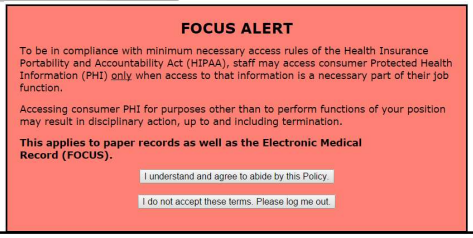
First Time FOCUS Login







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FOCUS Passwords

Passwords must be 10 characters long and contain one of the following:

- At least one capital letter
- At least on lower case letter
- At least one special symbol
- At least one number

To reset your FOCUS Password contact MCOSA at mcosa@mccmh.net.

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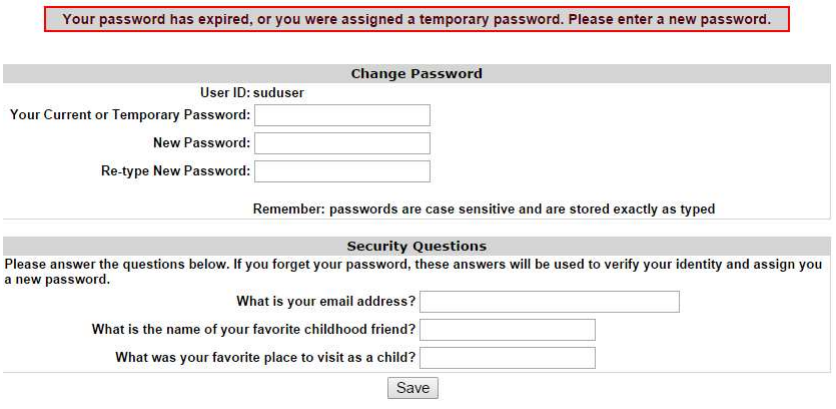
Security Questions and Password Reset



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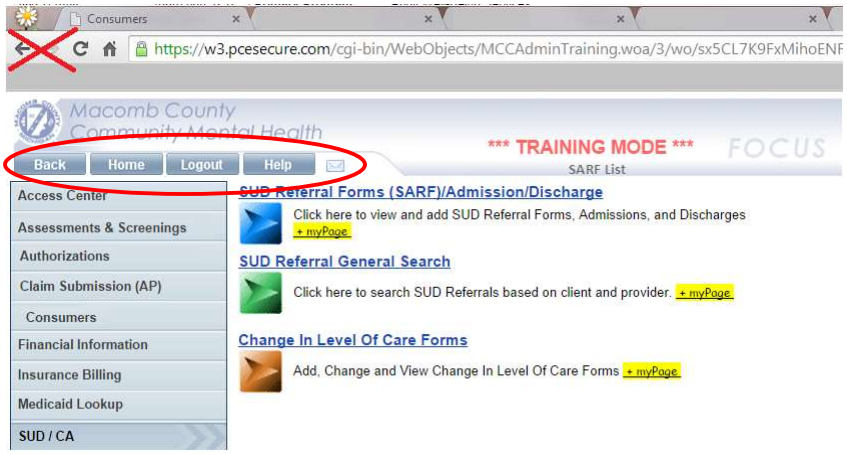
Basic Navigation



55

Locating a Client

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If your Client is not in FOCUS…

- Send the Release of Information Document to MCO
- Complete the 'SUD Provider Request To Open Case' form and send to MCO

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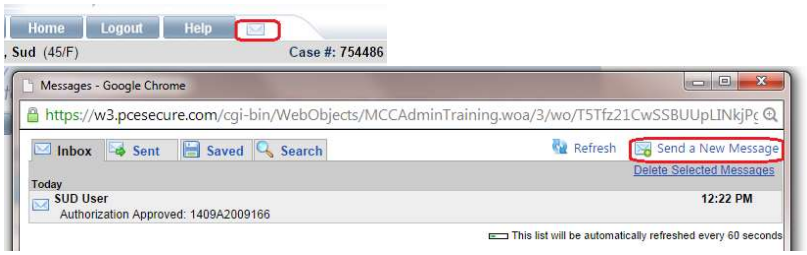
Release of Information Process

- Scan and Save signed Release & Open Case Request form in your documents labeled with the clients name
- If you cannot scan a document fax it to 586-948-0223
- In Focus click on the system messages envelope



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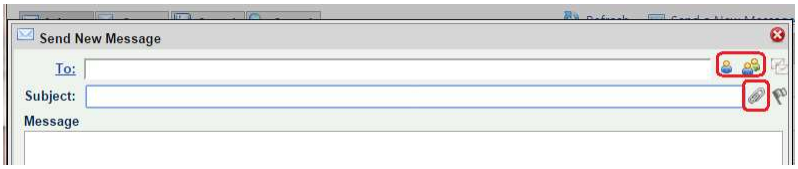
Release of Information Process

- Attach documents to system message (More details in the next slide)



- If faxing you must still send a message to *SUD Release*
- MCO will reply to your message once case is open/Referral is released
- Contact MCO if you need assistance

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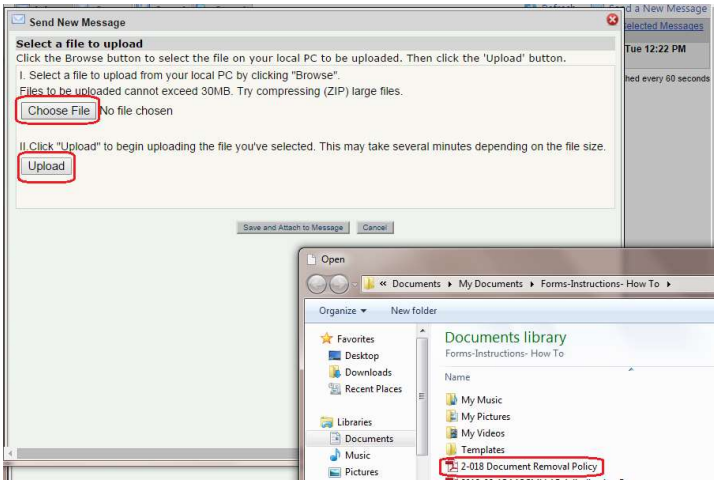
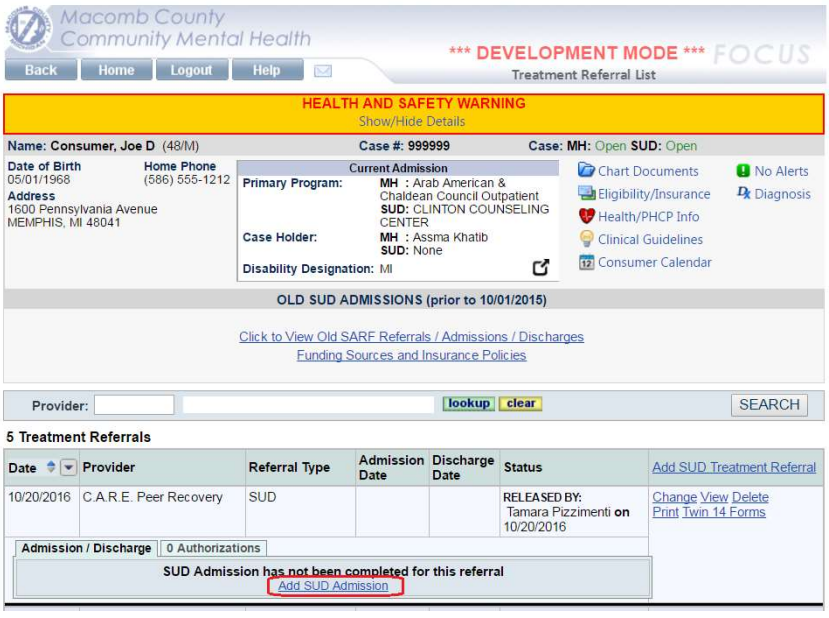
Scanning and Uploading



60

Once in the Client Chart in FOCUS

61



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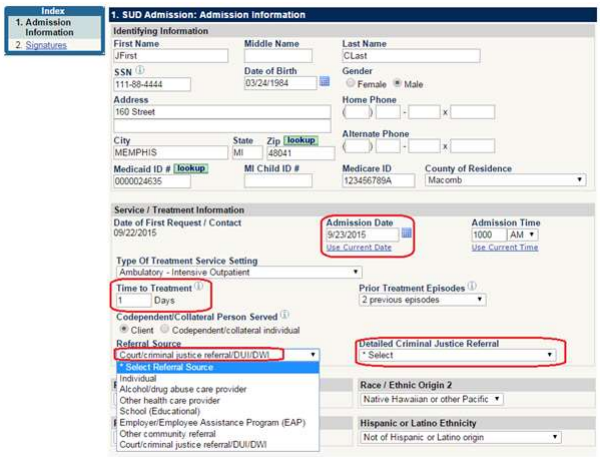
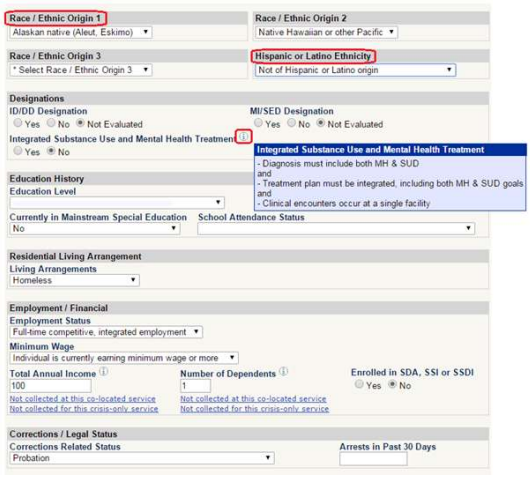
FOCUS Admission a/k/a BH TEDS Admission

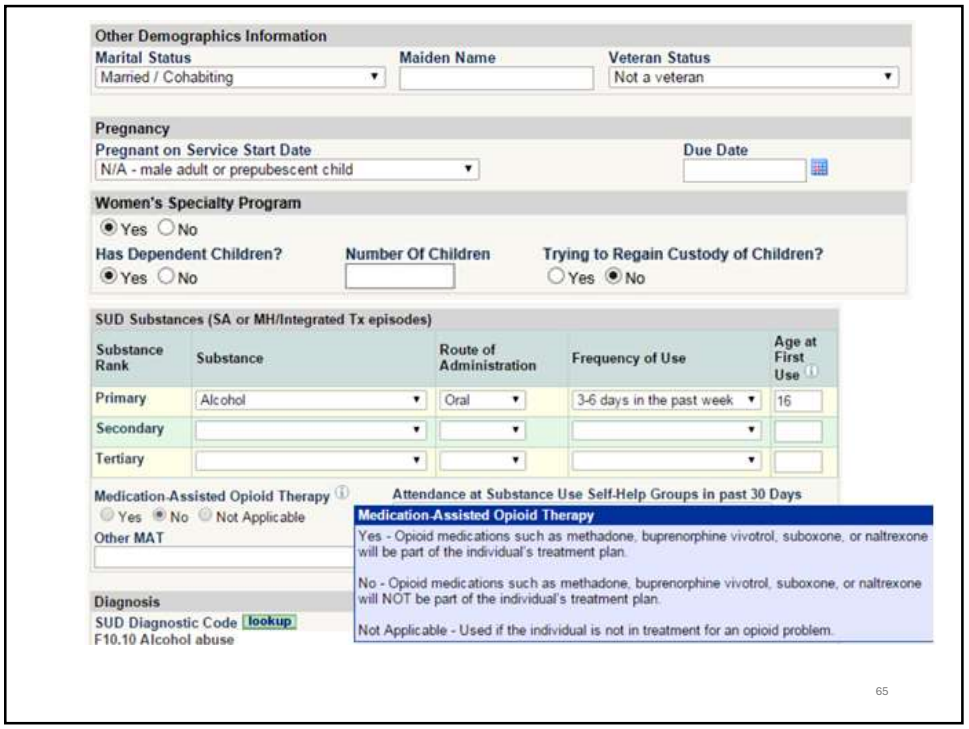


63

Admission continued



64


Other Demographics Information
Marital Status
Married / Cohabiting
Maiden Name
Veteran Status
Not a veteran
Pregnancy
Pregnant on Service Start Date
N/A - male adult or prepubescent child
Due Date
Women's Specialty Program
Yes No
Has Dependent Children?
Yes No
Number Of Children
Trying to Regain Custody of Children?
Yes No
SUD Substances (SA or MH/Integrated Tx episodes)
Substance Rank
Substance
Route of Administration
Frequency of Use
Age at First Use
Primary
Alcohol
Oral
3-6 days in the past week
16
Secondary
Tertiary
Medication-Assisted Opioid Therapy
Yes No Not Applicable
Other MAT
Attendance at Substance Use Self-Help Groups in past 30 Days
Medication-Assisted Opioid Therapy
Yes - Opioid medications such as methadone, buprenorphine vivotrol, suboxone, or naltrexone will be part of the individual's treatment plan.
No - Opioid medications such as methadone, buprenorphine vivotrol, suboxone, or naltrexone will NOT be part of the individual's treatment plan.
Not Applicable - Used if the individual is not in treatment for an opioid problem.
Diagnosis
SUD Diagnostic Code lookup
F10.10 Alcohol abuse
65

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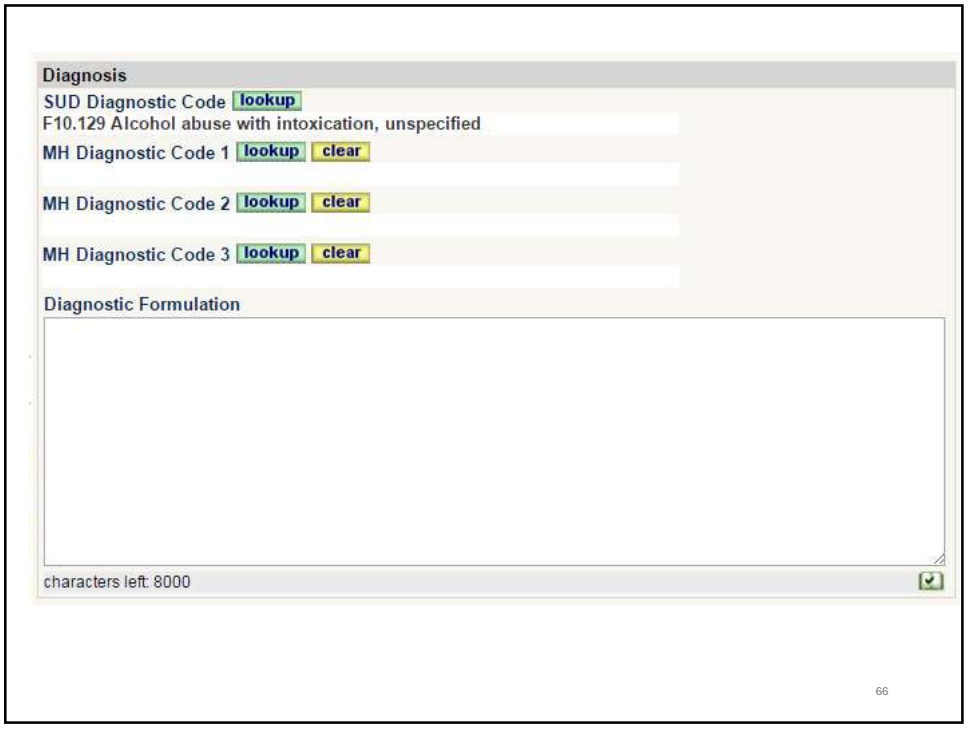
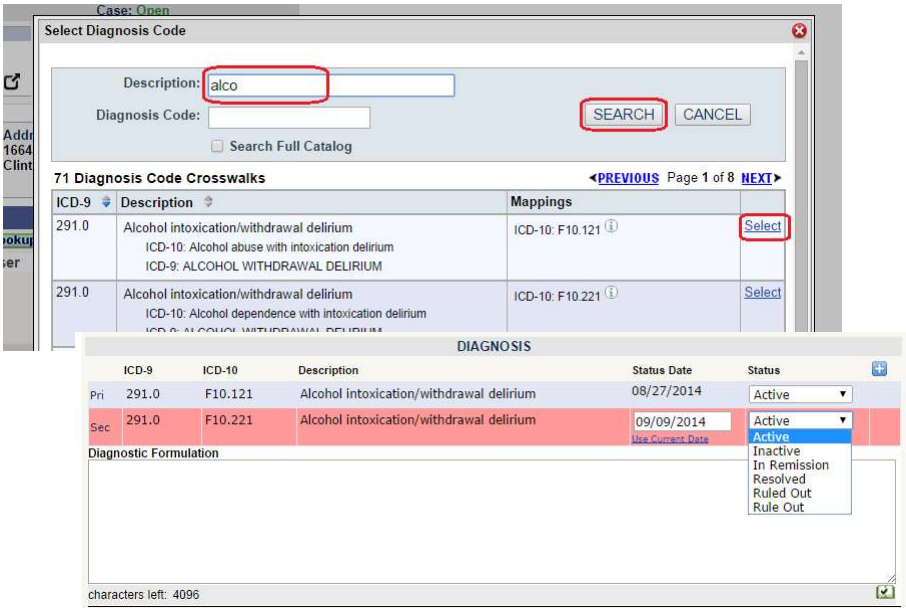
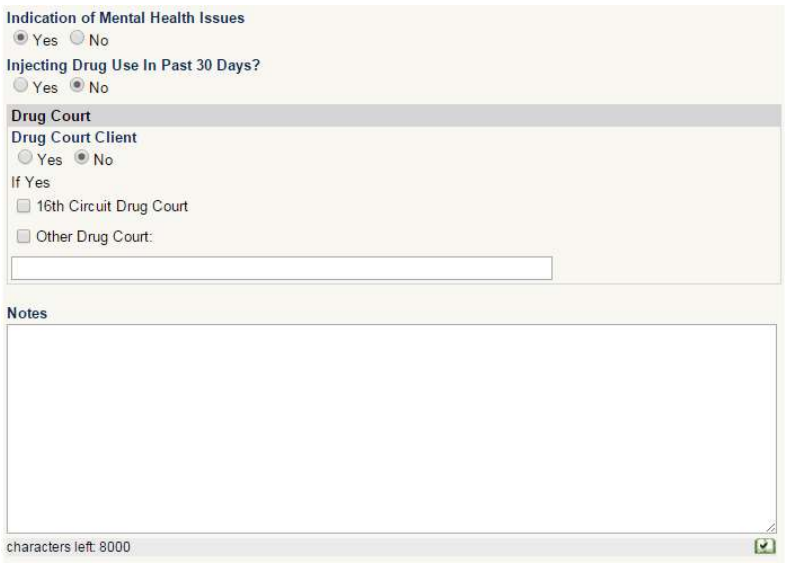

Diagnosis
SUD Diagnostic Code lookup
F10.129 Alcohol abuse with intoxication, unspecified
MH Diagnostic Code 1 lookup clear
MH Diagnostic Code 2 lookup clear
MH Diagnostic Code 3 lookup clear
Diagnostic Formulation
characters left: 8000
66

66

Adding a Diagnosis



67



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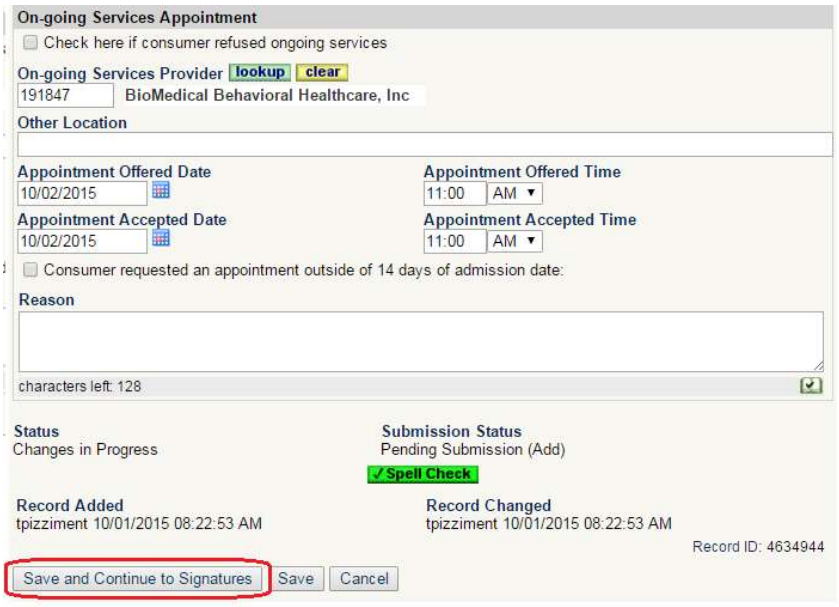

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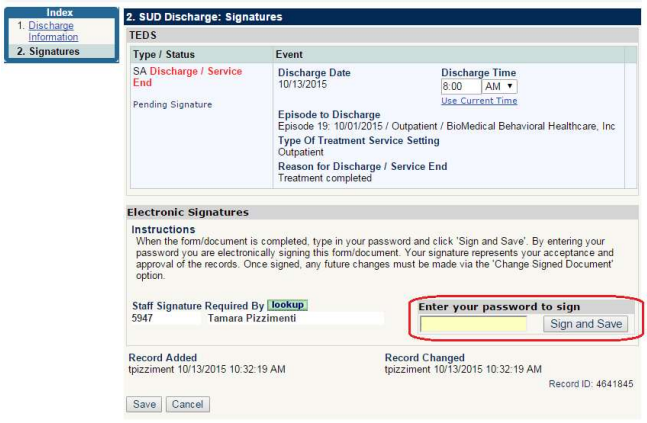
Signatures



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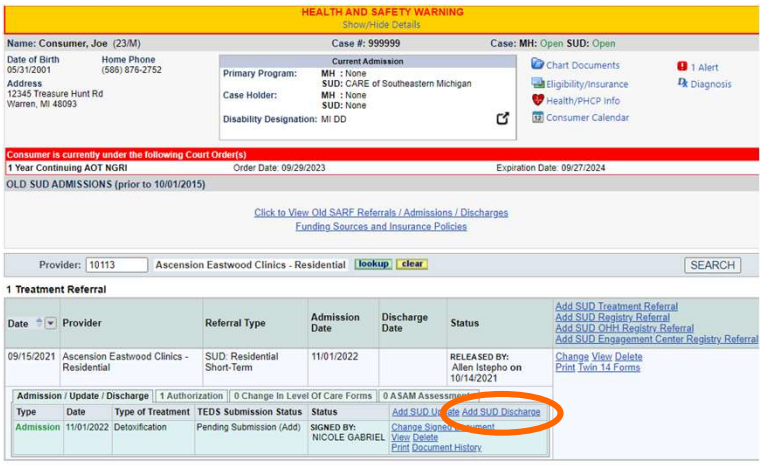
70

FOCUS Discharges



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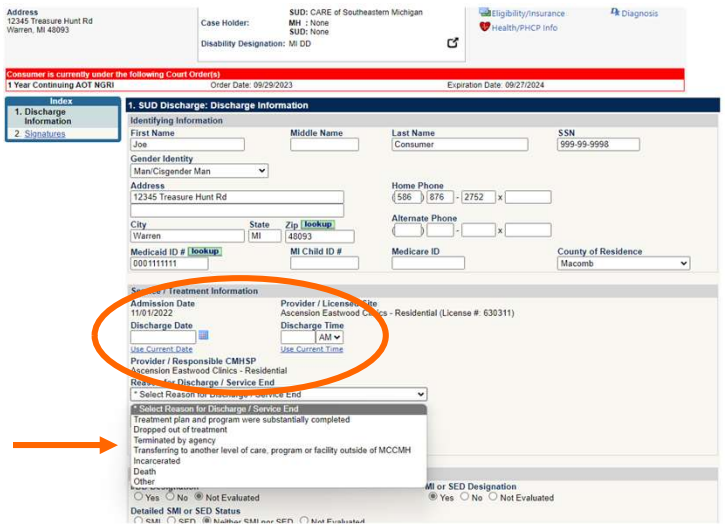
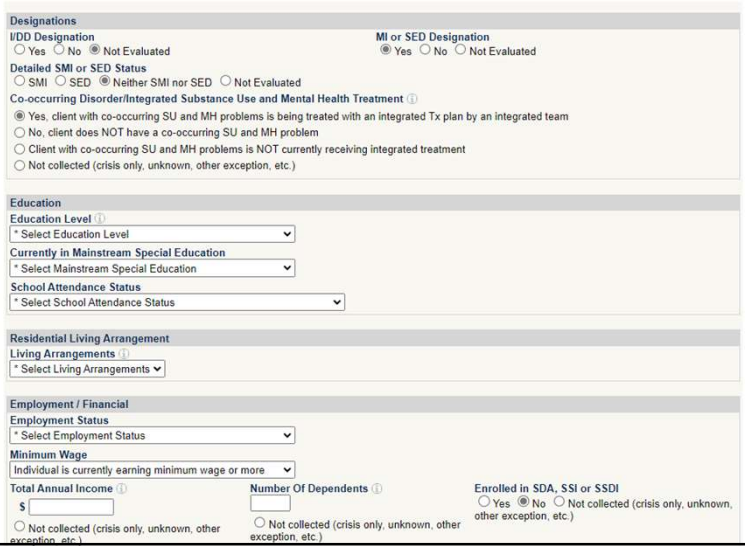
FOCUS Discharges



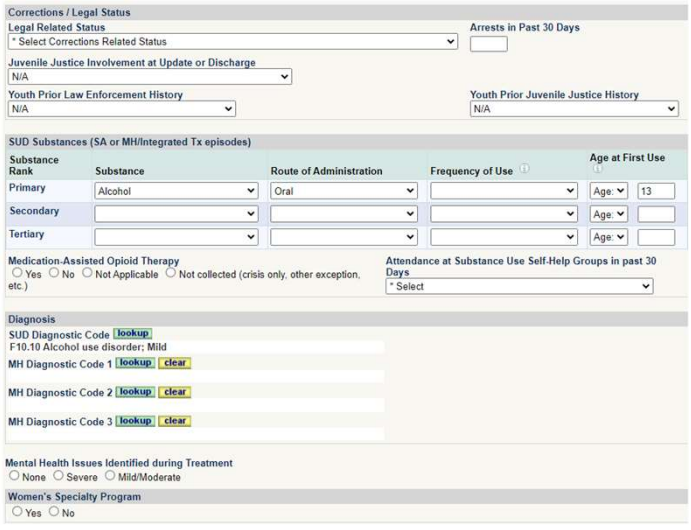
72

FOCUS Discharge



73

FOCUS Discharge



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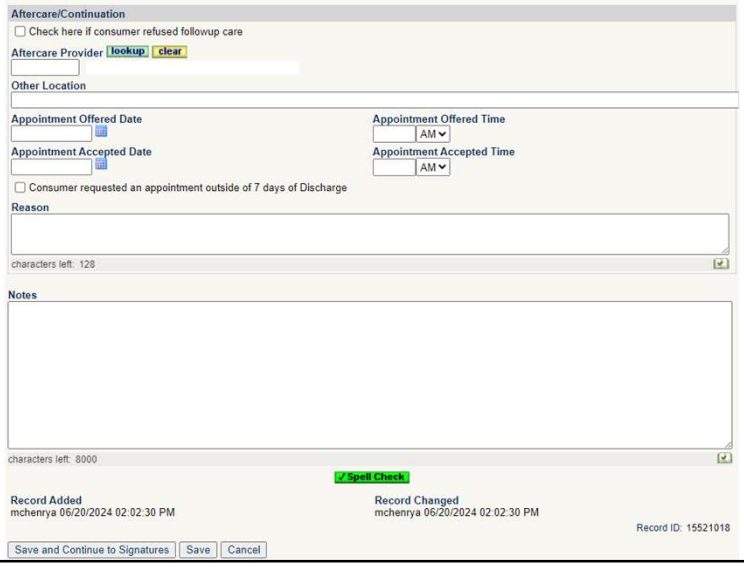
FOCUS Discharge



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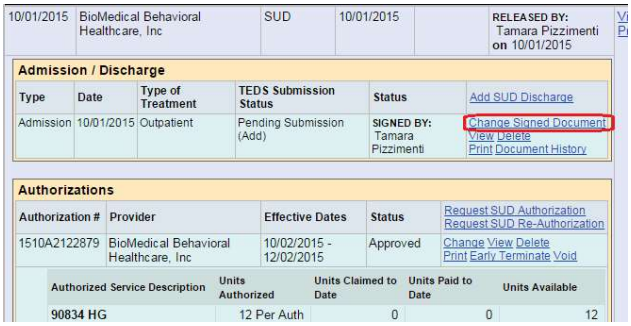
SUD Treatment Referral/Admission Form Changes

- Make sure the text in the "Reason for Change" text field is detailed.



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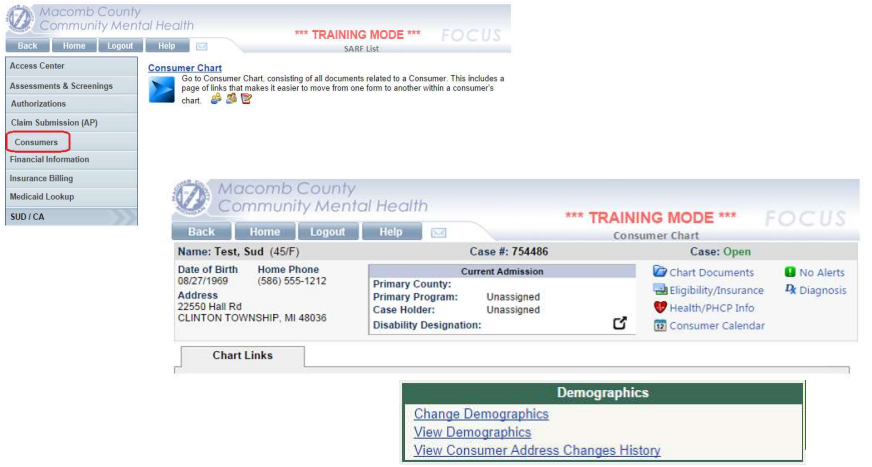
Client Demographics



77

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WARNING!!

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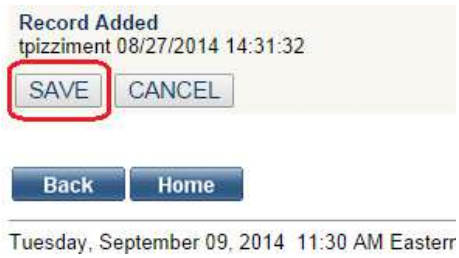
FOCUS will time out after 59 minutes on the same page. Save your work often to avoid it getting lost.



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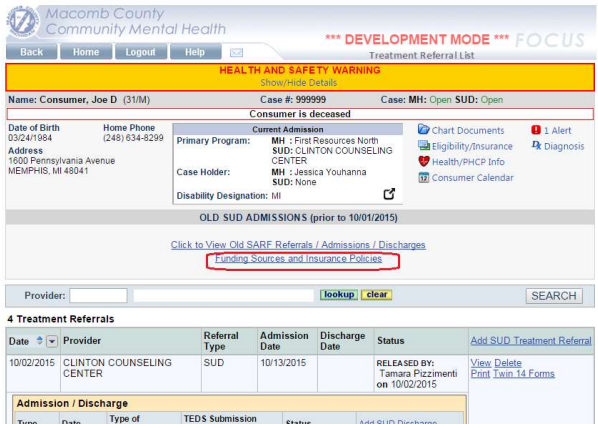
Funding Sources & Insurance Policies



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Funding Sources and Insurance Policies

1.) All Clients are required to have a SUD Self-Pay Policy entered upon admission into services

2.) Women's Specialty Services Policy required for WSS providers rendering WSS services

- For any Policy, click the link and complete data entry for each line -

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MCCMH SUD Billing

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General Billing Guidelines

Definitions

Claim – one bundle of services for a single client being billed

Batch – all monthly agency claims bundled together

Batch Guidelines

Standalone Batches

1.) 3rd party Insurance

2.) MiHealth Link

3.) Methadone Dosing (H0020)

All batches are due by the 10th of the following month.

For example – all June batches are due by July 10th

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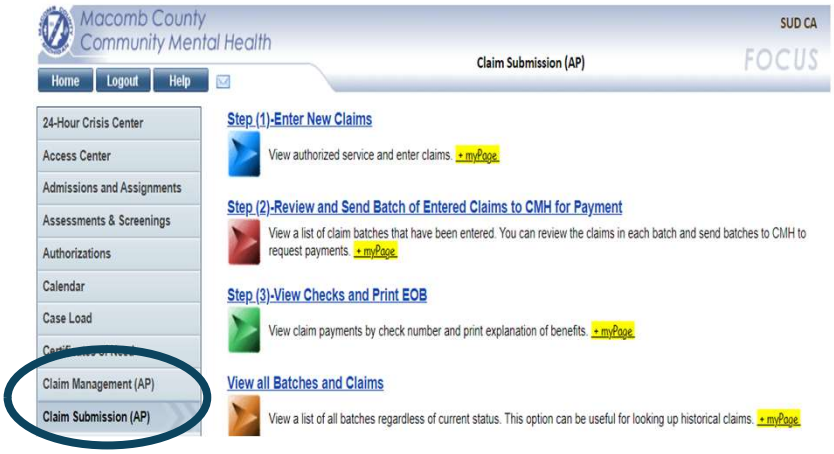
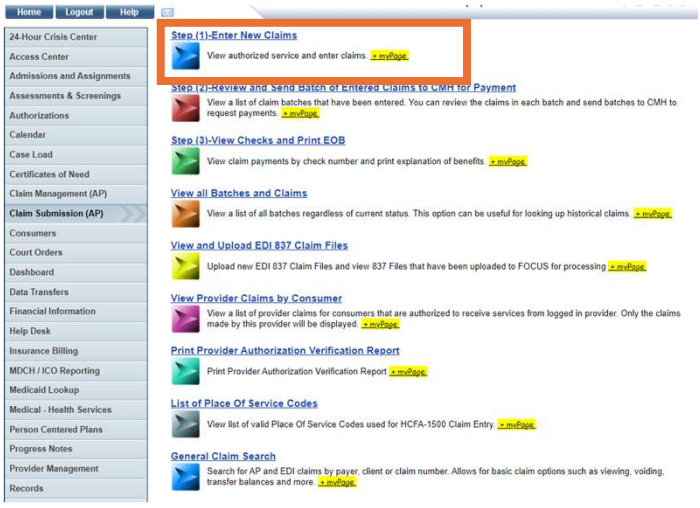
Billing Process



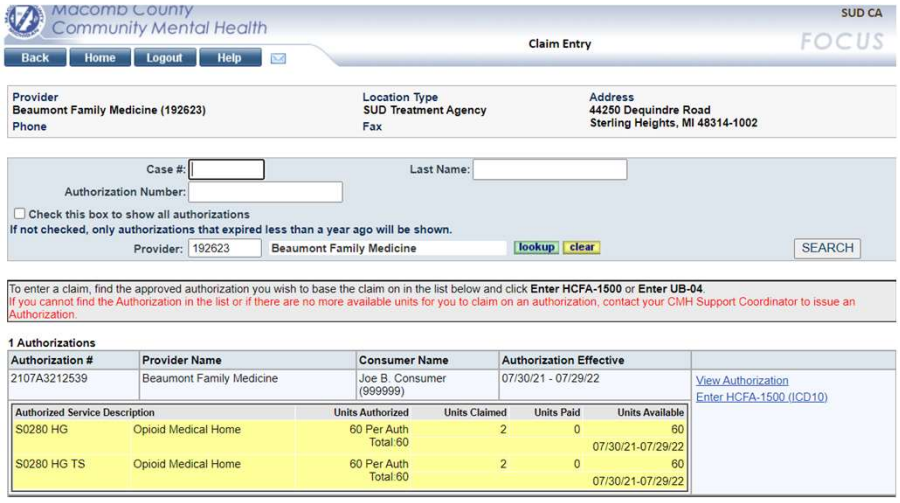
83

Billing Process Continued



84

Billing Process Continued



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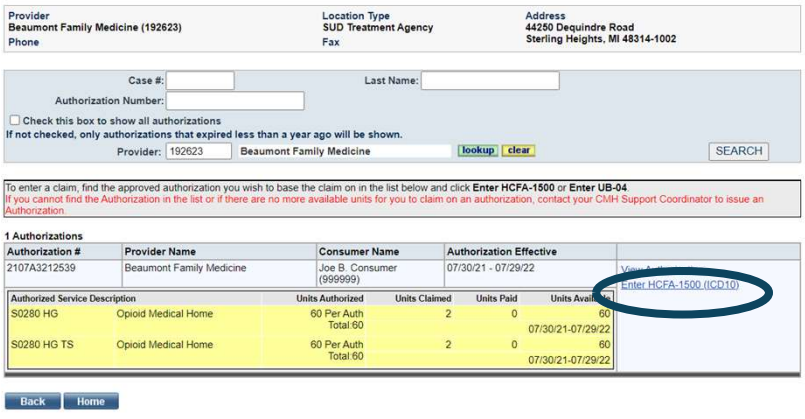
Entering a Claim



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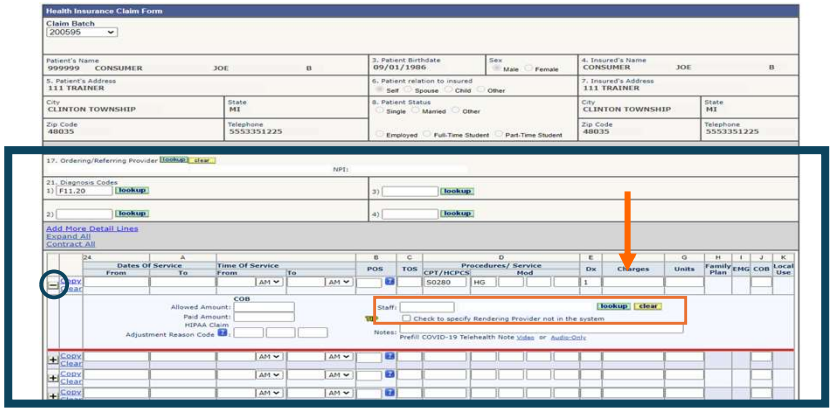
Adding Claim Details



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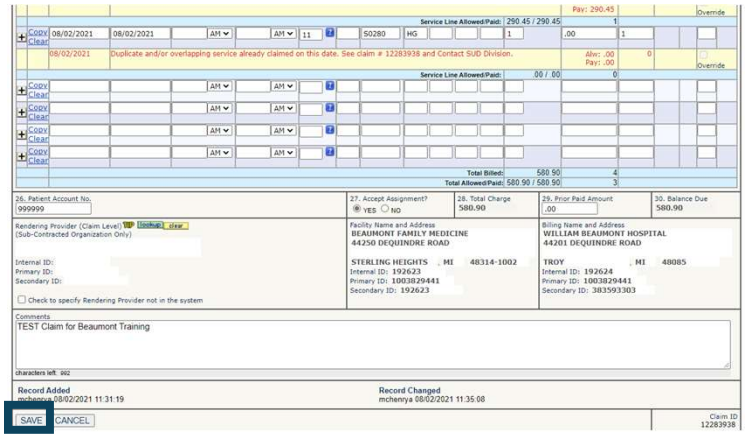
Submitting Completed Claims



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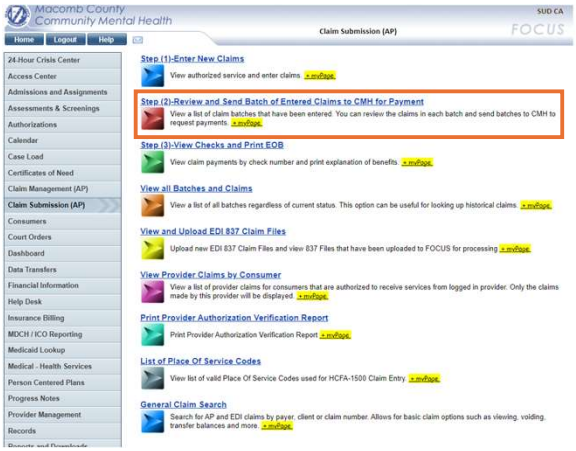
Checking Claim Integrity



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Checking Batch Integrity

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Running Reports to Check for Errors

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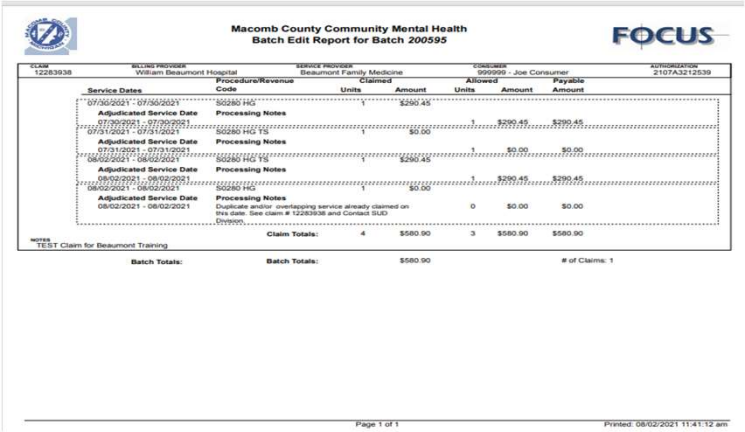
Adjudication Report Sample



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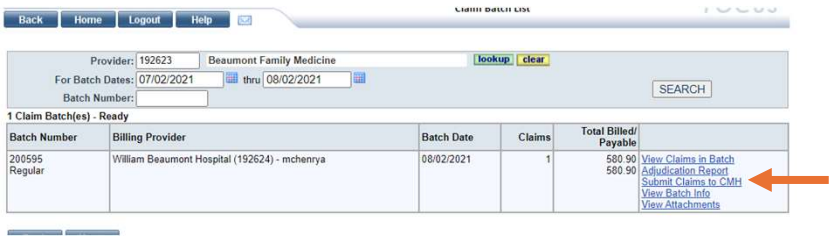
Sending Batches to MCCMH SUD Division



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Required Modifiers for Billing (staff credentials)

Modifier	Description
AF	Specialty physician
AG	Physician
AH	Clinical psychologist
HN	the rendering provider has a highest educational attainment of a bachelor's degree
HO	the rendering provider has a highest educational attainment of a master's degree
HP	the rendering provider has a highest educational attainment of a doctoral degree
TD	RN
TE	LPN/LVN

Staffing Modifiers

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Required Modifiers for Billing (treatment type/group size)

Modifier	Description
HH	Integrated Mental Health/Substance Abuse Program
HD	Women's Specialty Service
HG	Opioid addiction treatment program

Modifier	Description
UP	Three total patients served
UQ	Four total patients served
UR	Five total patients served
US	Six or more total patients served

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Frequently Asked Questions

- Q: What do I do if the client is being discharged from residential and already completed and ASAM Continuum there?
- A: If a consumer is discharging from residential to your facility, the ASAM continuum should be requested when the consumer calls to schedule the appointment.
- Q: How do I know if they already completed an ASAM Continuum within the last 45 days?
- A: When clients call to schedule an appointment, they should be asked if they have received treatment from any other provider in the last 45 days. If they have, they can request to have their assessment sent to you by their previous provider.
- Q: What do I do once I receive the ASAM from another provider?
- A: Review the ASAM Continuum to note any changes and add a progress note noting any changes and including updated level of care determination

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Frequently Asked Questions, cont.

- Q: What do I do if a client says that they are at a recovery home and need a referral for their housing to be funded?
- A: Use the flowchart to determine if the client is appropriate for funding, ensure that the home they are residing at is contracted with MCCMH-SUD, submit a change in level of care request. If these items are not met, other housing options should be explored with the client
- Q: What do I do if the client refuses aftercare when leaving a higher level of care?
- A: Check the box at the bottom of the FOCUS discharge indicating that the client refused aftercare and provide them with the contact information for MCO if they want treatment in the future.

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MCCMH-SUD Contacts

- FOCUS Password resets: mcosa@mccmh.net
- FOCUS removal requests, quality concerns, audits, grievances, appeals or recipient rights concerns: nicole.palazzolo@mccmh.net
- FOCUS issues, contract questions, reports : nicole.gabriel@mccmh.net
- Billing questions: donna.fisher@mccmh.net or tykeisha.hudson@mccmh.net
- OHH/SUD Health Home questions: adam.mchenry@mccmh.net
- Prevention questions: ricki.torsch@mccmh.net
- Billing verification audits: heather.gilbert@mcch.net
- Priority Populations or grants: teresa.crosby@mccmh.net

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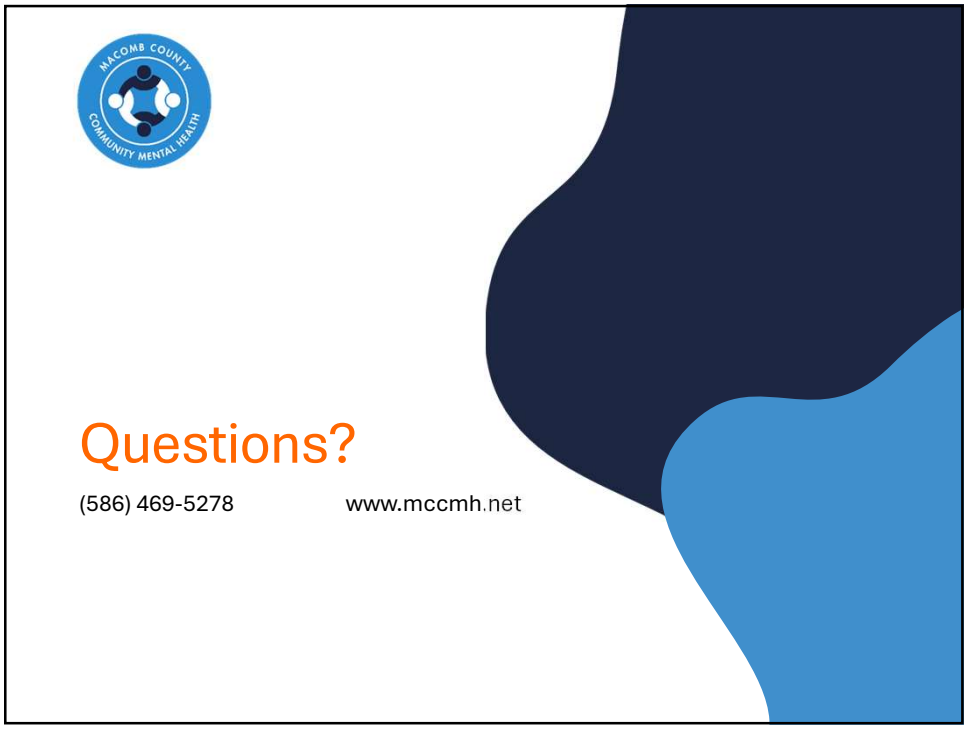

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