

OVERSIGHT POLICY BOARD

Regular Board Meeting

Patrick Barrie Conference Room

3005 Boardwalk Drive, Suite 200

Ann Arbor, MI

Thursday, April 27, 2023

9:30 a.m. – 11:30 a.m.



To Join by Phone:

1-267-831-0333, 1-301-715-8592 or

1-312-626-6799

Meeting ID: 879 0140 9760

To Join by Computer:

<https://us02web.zoom.us/j/87901409760?pwd=US9iWHq5UnVZTkVYSiJXOXVHd2Y5QT09>

Passcode: 742565

Agenda

1. **Introductions**, Welcome Board Members & Review Open Meetings Act Procedures– 10 minutes
2. Approval of Agenda (**Board Action**) – 2 minutes
3. Approval of December 1, 2022, OPB Minutes {Att. #1} (**Board Action**) – 5 minutes
4. Audience Participation – 3 minutes per person
5. Old Business
 - a. Finance Report {Att. #2} (Discussion) – 10 minutes
 - b. FY23 Funding Update (Discussion) – 5 minutes
 - c. FY24 Funding Update – continuation RFI (Discussion) – 5 minutes
6. New Business
 - a. Board Action Request- Policy Updates {Att. #3} (**Board Action**) – 15 minutes
 1. Fetal Alcohol Syndrome {Att. #3a}
 2. Substance Use Services Media Campaign {Att. #3b}
 3. SUD Residential Treatment Services {Att. #3c}
 4. Naloxone {Att. #3d}
 - b. Health Disparities to Health Equity Initiative (Discussion) – 10 minutes
 - c. Washtenaw County Health Dept It Is Possible Campaign Presentation (Discussion) – 15 minutes
 - d. Gambling Disorder Needs Assessment Update (Presentation) – 15 minutes
 - e. Opioid Settlement Funds (Discussion) – 5 minutes
 - f. PHE/Medicaid Changes (Discussion) – 5 minutes
 - g. MDHHS PIHP SUD Site Review {Att. #4} (Discussion) – 5 minutes
7. Report from Regional Board {Att. #5} (Discussion) – 5 minutes
8. SUD Director Updates (Discussion) – 5 minutes
 - a. CEO Update {Att. #6}
 - b. Staffing
 - c. Strategic Planning FY23 and FY24

VISION

“We envision that our communities have both an awareness of the impact of substance abuse and use, and the ability to embrace wellness, recovery and strive for a greater quality of life.”

9. Adjournment (**Board Action**)

*Next meeting: **Thursday, June 22, 2023**

Location: **3005 Boardwalk, Suite 200; Patrick Barrie Room**

VISION

"We envision that our communities have both an awareness of the impact of substance abuse and use, and the ability to embrace wellness, recovery and strive for a greater quality of life."

Oversight Policy Board Minutes

December 1, 2022

Patrick Barrie Conference Room
3005 Boardwalk Drive, Suite 200
Ann Arbor, MI 48108

Members Present: Mark Cochran, Kim Comerzan, Amy Fullerton (remote), Susan Longsworth, Frank Nagle (remote), Dave Oblak, Dave O'Dell, David Stimpson, Ralph Tillotson, Monique Uzelac, Tom Waldecker

Members Absent: Ricky Jefferson, Molly Welch Marahar, Carol Reader

Guests:

Staff Present: Stephannie Weary, Nicole Adelman, Matt Berg, CJ Witherow, Danielle Brunk, Alyssa Tumolo, Jane Goerge, Rebecca DuBois, Stacy Pijanowski, James Colaianne

Board Chair M. Cochran called the meeting to order at 9:36 a.m.

1. Introductions
2. Approval of the Agenda
Motion by R. Tillotson, supported by D. O'Dell, to approve the agenda
Motion carried
3. Approval of the October 27, 2022 Oversight Policy Board minutes
Motion by T. Waldecker, supported by K. Comerzan, to approve the October 27, 2022 OPB minutes
Motion carried
4. Audience Participation
 - None
5. Old Business
 - a. Finance Report
 - M. Berg presented. Discussion followed.
 - b. FY23 Funding Update
 - The PIHP received \$3 million in expanded COVID funds and has begun to allocate the funds. Some programs were able to be funded by COVID BG instead of PA2, which helped with PA2 balances a little bit.
6. New Business
 - a. PA2 Mini Grants/Funding Thresholds
 - Last month there was discussion about whether PA2 mini grants should be offered or not when a potential future shortage of PA2 funds is anticipated. OPB decided that counties without a potential PA2 shortage should still offer mini grants when appropriate.
Motion by T. Waldecker, supported by M. Uzelac, to set the PA2 balance threshold at 33% of projected annual expenses for each individual county. If an individual county's PA2 balance falls below 33% of projected annual expenses, no mini grants will be considered for that individual county.
Motion carried

b. Strategic Planning Update

- OPB reviewed some of the strategic planning highlights.
- N. Adelman will send out the RSA results to OPB.
- The next round of strategic planning will probably start early next year. The state has not released the template yet.
- Recovery housing in Livingston is currently only for women. N. Adelman noted that recovery housing within the region is not restricted to residents of the county, and that a Livingston resident is able to seek recovery housing services in 1 of the other counties in the region. N. Adelman agreed to keep the issue of recovery housing for men in Livingston in discussion with Livingston CMH.

c. Regional Access Feedback Update

- The PIHP is working through ways to get feedback regarding access from both the community and providers. N. Adelman plans to discuss with ROC approaching the Regional Advisory Board to start the gathering of community feedback from this group. A region-wide survey regarding access feedback is also under consideration.
- D. Oblak advised that he and his colleagues have noticed an improvement with access services. He and his colleagues have not had any issues with access.
- M. Uzelac noted that there is still a gap in services for youth, particularly for those who are unhoused or have unstable housing.
- Bring update on current regional discussion about electronic communications, like texting for access.
- K. Comerzan expressed concern about those who are not currently enrolled in service, and are not in the criminal justice system, and how to engage them in getting feedback on their experience with Access. It was agreed reaching/communicating with this population would be a challenge.
- D. Stimpson noted that some people do not have phone plans and are only to make/receive calls using public wi-fi.
- Staff will bring back updates from the regional workgroup that is currently working through electronic communication challenges related to service coordination.

d. Women's Specialty Services (WSS) Update

- Previously, people had the option to receive their WSS treatment at a different provider than their SUD treatment, being dually enrolled at 2 providers, which all SUD directors across the state support.
- The state has changed its interpretation of the WSS rule, disallowing the dual enrollment option, the end result of which is that some will have to choose either their WSS service or their other service (such as Methadone, for example). The SUD directors disagreed with this outcome. Our region continues to push back and advocate for the dual enrollment option.

7. Report from Regional Board

- R. Tillotson provided an update from the September board meeting, including approval of a 5-year CEO contract and budget approval.

8. SUD Director Updates

- a. CEO Update – see CEO report in packet for details.
- b. Staffing

- SUD Priority Population position is currently being revised. The plan is to have the position filled by the beginning of the calendar year.

9. Adjournment

Motion by R. Tillotson, supported by D. O'Dell, to adjourn the meeting

Motion carried

- Meeting adjourned at 10:30 a.m.

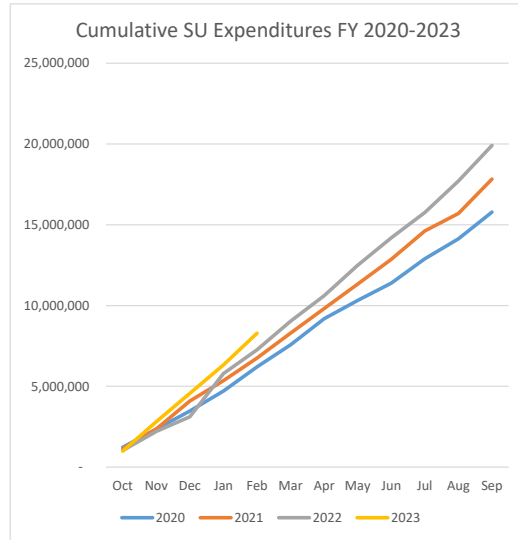
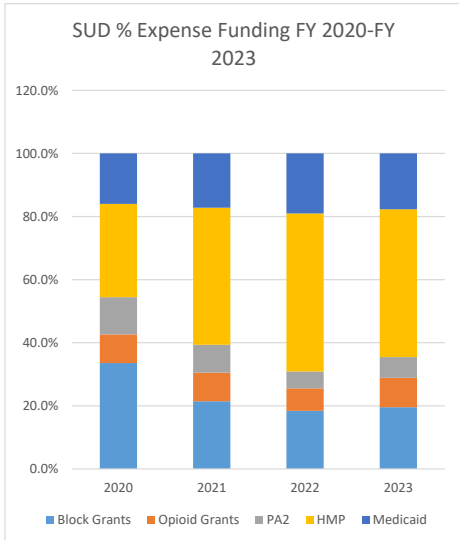
***Next meeting: Thursday, February 23, 2023**

Location 3005 Boardwalk, Suite 200; Patrick Barrie Room

DRAFT

**Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
February 2023 FYTD**

Summary Of Revenue & Expense	Funding Source							Total Funding Sources	FY22 YTD
	Medicaid	Healthy Michigan	Block Grants	OHH	Opioid Grants	Gambling Prev	SUD-PA2		
Revenues									
Funding From MDHHS	1,685,502	4,475,517	1,870,077	420,610	889,496	16,541		\$ 9,357,743	\$ 8,409,232
PA2/COBO Tax Funding Current Year							239,621	\$ 239,621	\$ 449,832
PA2/COBO Reserve Utilization							386,458	\$ 386,458	\$ 416,825
Other (lapse to state)			-	(136,318)	-	-	-	\$ (136,318)	\$ -
Total Revenues	\$ 1,685,502	\$ 4,475,517	\$ 1,870,077	\$ 284,292	\$ 889,496	\$ 16,541	\$ 626,079	\$ 9,847,504	\$ 9,275,889
Expenses									
Funding for County SUD Programs									
CMHPSM			\$ 44,957	\$ 187,758	\$ 889,496	\$ 16,541		1,138,751	505,499
Lenawee	237,024	467,745	113,363				\$ 63,881	882,012	912,362
Livingston	100,780	339,465	220,919				350,694	1,011,858	883,397
Monroe	350,662	546,263	461,537				68,363	1,426,825	1,440,283
Washtenaw	715,598	1,505,465	890,361				143,143	3,254,566	2,936,370
Total SUD Expenses	\$ 1,404,064	\$ 2,858,938	\$ 1,731,137	\$ 187,758	\$ 889,496	\$ 16,541	\$ 626,080	\$ 7,714,012	\$ 6,677,911
Administrative Cost Allocation	118,631	268,061	138,940	46,939			-	\$ 572,570	\$ 586,957
Total Expenses	1,522,694	3,126,999	\$ 1,870,077	\$ 234,697	\$ 889,496	\$ 16,541	\$ 626,080	\$ 8,286,583	\$ 7,264,868
Revenues Over/(Under) Expenses	162,807.91	1,348,519	(0)	49,595	\$ 0	\$ (0)	(0)	\$ 1,560,921	\$ 2,011,021



	Revenues	Expenditures	Revenues Over/(Under) Expenses
PA2 by County			
Lenawee	19,472	63,881	(44,409)
Livingston	59,035	350,694	(291,659)
Monroe	44,084	68,363	(24,279)
Washtenaw	117,030	143,143	(26,112)
Totals	\$ 239,621	\$ 626,080	\$ (386,458)

	FY 23 Beginning Balance (Prelim)	FY23 Budgeted Utilization	FY22 Projected Ending Balance	FY 22 YE Over/(Under) Expenses
Unallocated PA2				
Lenawee	307,023	(175,746)	131,277	(217,477)
Livingston	3,285,361	(351,264)	2,934,097	(453,675)
Monroe	241,428	(18,718)	222,710	(62,478)
Washtenaw	1,129,705	(344,431)	785,274	(491,669)
Total	\$ 4,963,518	\$ (890,159)	\$ 4,073,359	\$ (1,225,299)

CMHPSM SUD OVERSIGHT POLICY BOARD

BOARD ACTION REQUEST

FY23 PA2 Substance Use Services Policy Updates

Board Meeting Date: April 27, 2023

Action Requested: Review and approve FY23 Substance Use Services Policy Updates for SUD Residential Treatment, Naloxone, Fetal Alcohol Syndrome Disorder (FASD) and Substance Use Services Media Campaigns.

Background:

Policies are updated regularly, every three years unless updates are needed more frequently for a specific purpose. The SUD Residential and FASD policies have been updated to reflect updates in MDHHS policy, which includes primarily minor language changes. The Substance Use Services Media Campaign policy was also changed to reflect the MDHHS policy and includes an internal change in required form and provision of a required funding statement dependent on the fund source. Finally, the Naloxone policy was revised to remove a number of barriers in the policy now that the goal is get Naloxone out into as many individuals as possible to save lives. This removes the requirement of an MOU with CMHPSM, and also encourages free access to Naloxone through the MDHHS portal.

Connection to PIHP/MDHHS Contract, Regional Strategic Plan or Shared Governance Model:

Ensures ongoing program compliance.

Recommendation: Approve the four policy updates included above.

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN	<i>Policy and Procedure</i> Fetal Alcohol Spectrum Disorders Screening and Referral Policy
Committee/Department: SUD Services	Regional Operations Committee Review Date
Implementation Date	Oversight Policy Board Approval Date

I. PURPOSE

This policy serves to formulate expectations and establish a process for the screening and referral of children for Fetal Alcohol Spectrum Disorders (FASD) and FASD prevention strategies in treatment programs for women.

II. REVISION HISTORY

DATE	MODIFICATION
06-01-11	
10-2015	
01-2016	
4-2019	
OPB Approval Date	Language and resource updates

III. APPLICATION

<input type="checkbox"/> CMHPSM PIHP Staff, Board Members, Interns & Volunteers
<input type="checkbox"/> Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
<input type="checkbox"/> Mental Health / Intellectual or Developmental Disability Service Providers
<input checked="" type="checkbox"/> SUD Treatment Providers <input type="checkbox"/> SUD Prevention Providers
<input type="checkbox"/> Other as listed:

This policy will impact all Substance Use Disorders (SUD) providers included in CMHPSM network that serve women and services to their children.

IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Fetal Alcohol Spectrum Disorder (FASD): an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It

refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND) and alcohol related birth defects (ARBD).

V. POLICY

It is the policy of the CMHPSM to ensure that all SUD service providers establish and implement the procedures described in this policy pertaining to FASD prevention, screening, and referral.

VI. STANDARDS

- A. FASD prevention will be included in all substance use disorder treatment programs that serve women via education on the risks of alcohol consumption during pregnancy, screening for early FASD detection, and incorporating FASD services into program regimes. Prevention efforts will include the following prevention approaches recommended by the Institute of Medicine:
 - 1. Educating the public and influencing public policies.
 - 2. Targeting interventions towards groups with increased risk for FASD problems, e.g., women of childbearing age that consume alcohol.
 - 3. Utilizing prevention techniques for women who have exhibited high risk behaviors in the past, i.e., pregnant women who are consuming alcohol or who have given birth to a child who has been diagnosed with FASD.
 - 4. Educate regarding the benefits of early FASD screening and assessment where the risk of exposure is known and/or suspected to ensure the impact of Fetal Alcohol exposure can be mitigated.
- B. Providers will complete a FASD prescreening for children with whom they interact with during the mother's treatment episode. Clinical staff will screen for conditions and make appropriate referrals when necessary. A referral may be necessary when:
 - 1. Prenatal alcohol exposure is known and other FASD characteristics are evident.
 - 2. Prenatal alcohol exposure is known, despite the absence of other positive criteria.
 - 3. Information regarding prenatal exposure to alcohol is unknown, but concern has been expressed by a parent or caregiver of suspected FASD, or physical features associated with FASD can be observed.
- C. Service providers will consider prenatal exposure to alcohol when there are family situations or histories that indicate the need for referral for a diagnostic evaluation. Prenatal exposure will be considered for children in families who have experienced:
 - 1. Premature maternal death in relation to alcohol consumption.
 - 2. Cohabitation with an alcoholic parent.

3. Have a history of abuse or neglect.
4. Have a history of Child Protective Services involvement.
5. Have a history of transient care giving institutions, foster placements, or adoptive placements.

Women’s Specialty Providers are required to complete FASD training. There is not a state specific training for FASD screening. Relevant providers are expected to train their staff on the screening process and use of the screening tool, to ensure they know how to complete an FASD Prescreen, and document that staff were trained.

VII. Exhibits

- A. The Center for Disease Control has funded organizations to develop and evaluate criteria targeting various audiences with regards to FASD. The following websites provide information on prevention programs that have been developed, and may serve as valuable resources to provider staff in implementing FASD prevention strategies:

CDC FASD Homepage

<https://www.cdc.gov/ncbddd/fasd/index.html>

Michigan Department of Health & Human Services, *Enhanced Women’s Services; Treatment Technical Advisory #08*; https://www.michigan.gov/documents/mdch/TA-T-08_Enhanced_Women_Serv_375874_7.pdf

Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (MDHHS/OROSC). (2009). Substance Abuse Treatment Policy #11: Fetal Alcohol Spectrum Disorders. Retrieved from http://www.michigan.gov/mdhhs/0,1607,7-132-2941_4871_4877-133156--,00.html.

Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care. (2010). Treatment Policy #12, Women’s Treatment Services. Retrieved from http://www.michigan.gov/documents/mdhhs/P-T12_Women_Srv_eff_100110_338279_7.pdf

Project CHOICES (Changing High-Risk Alcohol Use and Increasing Contraception Effectiveness Study)

<https://www.cdc.gov/ncbddd/fasd/interventions.html>

SAMHSA

TIP 58: Addressing Fetal Alcohol Spectrum Disorders (FASD) | SAMHSA Publications

<https://www.samhsa.gov/resource/ebp/tip-58-addressing-fetal-alcohol-spectrum-disorders-fasd>

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Department of Health AND Human	X	

Services, Substance Use, Gambling, and Epidemiology Section (SUGE) Systems of, <i>Substance Abuse Treatment Policy #11</i> , Michigan.		
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COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN	<i>Policy and Procedure</i> Fetal Alcohol Spectrum Disorders Screening and Referral Policy
Committee/Department: SUD Services	Regional Operations Committee Review Date
Implementation Date (1st of month following approval)	Oversight Policy Board Approval Date

I. PURPOSE

This policy serves to formulate expectations and establish a process for the screening and referral of children for Fetal Alcohol Spectrum Disorders (FASD) and FASD prevention strategies in treatment programs for women.

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DATE	MODIFICATION
06-01-11	
10-2015	
01-2016	
4-2019	
OPB Approval Date	Language and resource updates

III. APPLICATION

<input type="checkbox"/> CMHPSM PIHP Staff, Board Members, Interns & Volunteers
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Service Providers of the CMHPSM and/or Regional CMHSP Partners:
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<input checked="" type="checkbox"/> SUD Treatment Providers <input type="checkbox"/> SUD Prevention Providers
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This policy will impact all Substance Use Disorders (SUD) providers included in CMHPSM network that serve women and services to their children.

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Fetal Alcohol Spectrum Disorder (FASD): an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It

refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND) and alcohol related birth defects (ARBD).

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It is the policy of the CMHPSM to ensure that all SUD service providers establish and implement the procedures described in this policy pertaining to FASD prevention, screening, and referral.

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 4. Educate regarding the benefits of early FASD screening and assessment where the risk of exposure is known and/or suspected to ensure the impact of Fetal Alcohol exposure can be mitigated.
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- C. Service providers will consider prenatal exposure to alcohol when there are family situations or histories that indicate the need for referral for a diagnostic evaluation. Prenatal exposure will be considered for children in families who have experienced:
1. Premature maternal death in relation to alcohol consumption.

2. Cohabitation with an alcoholic parent.
3. Have a history of abuse or neglect.
4. Have a history of Child Protective Services involvement.
5. Have a history of transient care giving institutions, foster placements, or adoptive placements.

5.—Women’s Specialty Providers are required to complete FASD training. There is not a state specific training for FASD screening. Relevant providers are expected to train their staff on screening process and use of the screening tool, to ensure they know how to complete an FASD Prescreen, and document that staff were trained.

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VII. Exhibits

- A. The Center for Disease Control has funded organizations to develop and evaluate criteria targeting various audiences with regards to FASD. The following websites provide information on prevention programs that have been developed, and may serve as valuable resources to provider staff in implementing FASD prevention strategies:

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<https://www.cdc.gov/ncbddd/fasd/index.html>

Michigan Department of Health & Human Services, Enhanced Women’s Services: Treatment Technical Advisory #08: https://www.michigan.gov/documents/mdch/TA-T-08_Enhanced_Women_Serv_375874_7.pdf

Field Code Changed

Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (MDHHS/OROSC). (2009). Substance Abuse Treatment Policy #11: Fetal Alcohol Spectrum Disorders. Retrieved from http://www.michigan.gov/mdhhs/0,1607,7-132-2941_4871_4877-133156--,00.html.

Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care. (2010). Treatment Policy #12, Women’s Treatment Services. Retrieved from http://www.michigan.gov/documents/mdhhs/P-T12_Women_Srv_eff_100110_338279_7.pdf

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Project CHOICES (Changing High-Risk Alcohol Use and Increasing Contraception Effectiveness Study)
<https://www.cdc.gov/ncbddd/fasd/interventions.html>

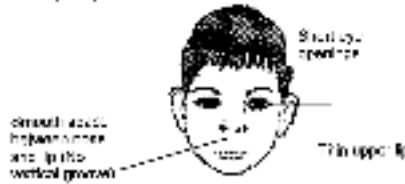
SAMHSA
TIP 58: Addressing Fetal Alcohol Spectrum Disorders (FASD) | SAMHSA Publications
<https://www.samhsa.gov/resource/ebp/tip-58-addressing-fetal-alcohol-spectrum-disorders-fasd> https://store.samhsa.gov/search_results?k=FASD

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Department of Health AND Human Services, Substance Use, Gambling, and Epidemiology Section (SUGE) Office of Recovery-Oriented Systems of, <i>Substance Abuse Treatment Policy #11</i> , Michigan.	X	

Michigan Department of Community Health
Fetal Alcohol Spectrum Disorders Program
FETAL ALCOHOL SYNDROME (FAS) PREG-SCREEN

FAS is a birth defect caused by alcohol use during pregnancy. FAS is a medical diagnosis. This form is not intended to take the place of a professional evaluation.



Last Name: _____		First Name: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address: _____			Race: _____	
City/State/Zip code: _____			Birthdate: _____	
Parent/Caregiver Name(s): _____			Home Phone: _____	
<input type="checkbox"/> Twin <input type="checkbox"/> Mother <input type="checkbox"/> Adopted <input type="checkbox"/> Other			Work Phone (if any): _____	

FACIAL FEATURES

If 2 or more of the identifying facial features are noted, the individual should be referred for a full FAS diagnostic evaluation.

IDENTIFIERS	Check or explain if no answer below
1. Height and weight seem small for age.	_____
2. Facial features (See diagram above):	_____
3. Size of teeth seems small for age.	_____
4. Behavioral concerns (any one of these qualifies as an identifier): <ul style="list-style-type: none"> • Sleeping/feeding problem • Mental retardation or IQ below normal expectations • Attention problems/impulsivity/overactive • Learning disability • Speech and/or language delays • Problems with reasoning and judgment • Acts younger than children the same age 	_____
5. Maternal alcohol use during pregnancy:	_____

Any previous diagnosis: _____

Screened _____ A42669 _____

Contact the nearest center to schedule a complete FAS diagnostic evaluation.

FAS DIAGNOSTIC CENTERS IN MICHIGAN		
Ann Arbor: 734-236-0977	Grand Rapids: 616-294-4219	Marquette: 906-225-4777
Tadusil: 313-593-7851	Kalamazoo: 269-387-7073	

Community Mental Health Partnership of Southeast Michigan/PIHP	<i>Policy and Procedure Substance Use Services Media Campaigns</i>
Committee/Department:	Regional Operations Committee Review Date
Implementation Date	Oversight Policy Board Approval Date

I. PURPOSE

To ensure all media campaigns are compatible with CMHPSM and MDHHS values; are coordinated with CMHPSM and MDHHS campaigns whenever feasible; and associated costs are proportionate to likely outcomes.

II. REVISION HISTORY

DATE	MODIFICATION
3.2021	Language updates
OPB Approval Date	Language Updates Campaign Request Form References

III. APPLICATION

This policy applies to all contractual organizations receiving any SUD funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), who are implementing a media campaign as part of their spectrum of prevention, harm reduction, treatment or recovery activities.

<input type="checkbox"/> CMHPSM PIHP Staff, Board Members, Interns & Volunteers
<input type="checkbox"/> Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
<input type="checkbox"/> Mental Health / Intellectual or Developmental Disability Service Providers
<input checked="" type="checkbox"/> SUD Treatment Providers <input checked="" type="checkbox"/> SUD Prevention Providers
<input type="checkbox"/> Other as listed:

IV. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

- Media Campaign: A media campaign promotes or highlights a community wellness issue through a variety of media including broadcast, digital and social channels. Messages regarding availability of services in the PIHP region are not considered to be media campaigns. This does not include promotion of agency events and agency-specific services.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Social Media: Social media is the collective of online communications channels dedicated to community-based input, interaction, content-sharing and collaboration. Examples include websites and applications dedicated to social networking and audio/video sharing platforms.

V. POLICY

Media campaigns must be compatible with CMHPSM and MDHHS values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. All campaigns must be reviewed by the CMHPSM prior to use of MDHHS-administered funding and submitted to the MDHHS for approval.

VI. STANDARDS

- A. All mass media campaigns including, but not limited to billboards, bus panel messages, public service announcements (print, radio, video recording or TV); and social media messaging; are required to be submitted to the CMHPSM.
- B. “Media Campaign Request Form” must be completed and associated materials (PSA Script, Media Message, Pictures, etc.) submitted to CMHPSM no less than 30 days prior to scheduled release.
- C. No campaign may be initiated until receipt of approval by MDHHS is obtained.
- D. Final versions must be submitted to CMHPSM.

VII. EXHIBITS

Media Campaign Request Form

VIII. REFERENCES

Michigan Department of Health and Human Services, Substance Use, Gambling and Epidemiology Section (MDHHS, SUGE). Special Provisions PG. 13

Michigan Department of Health and Human Services, Substance Use, Gambling and Epidemiology Section (MDHHS, SUGE). (2022). *External Campaign Request Form*.

Michigan Department of Health and Human Services (MDHHS), Substance Use, Gambling and Epidemiology Section (SUGE) & Office of External Affairs and Communications. (2022). *MDHHS Campaign Guidelines*.



Lenawee
Livingston
Monroe
Washtenaw

SUD PREVENTION & TREATMENT SERVICES

MEDIA CAMPAIGN REQUEST

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media (i.e., billboards, PSAs, bus panels). All media campaigns using CMHPSM grant funding must be approved by CMHPSM and Michigan Department of Health and Human Services (MDHHS)/Substance Use, Gambling and Epidemiology Section (SUGE) prior to implementation. This applies to media campaigns implemented by CMHPSM, Provider Networks and other contracted/sub-contracted organizations. Media campaigns must be compatible with guidelines found in the MDHHS Campaign Guidelines document and be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. All materials must be submitted for approval prior to final production. Submitted materials are subject to change based on feedback from CMHPSM and MDHHS.

Copies of final materials/products must be submitted to CMHPSM once approved.

- **What qualifies as a media campaign?**
 - A media campaign promotes or highlights a community wellness issue through a variety of media including broadcast, digital and social channels.
 - Messages regarding availability of services in the PIHP region are not considered to be media campaigns.
 - This does not include promotion of agency events and agency-specific services.
 - Marketing of a provider organization, program, event, etc. does not require approval from MDHHS.
- **What should be submitted for approval?**
 - Complete the attached Provider Media Campaign Request form (page 2) to initiate the campaign approval process.
 - Draft campaign materials should be submitted with the Provider Media Campaign Request form (page 2).
 - For example:
 - For a billboard campaign, submit draft graphics for approval.
 - For social media campaigns, submit draft message design for approval.
 - If applicable, include scripts, story boards and/or action descriptions. This is required for media campaigns involving an audio component (e.g. radio, video, etc.).

Submit form and relevant campaign documents to the CMHPSM contact associated with the funding for this campaign.

Please allow up to 40 days for the approval process. Once approved, CMHPSM will provide a funding statement to include on all materials dependent on funding source.

Provider Media Campaign Request:

Provider: Click or tap here to enter text.

Date Form Submitted:Click or tap to enter a date.

Contact Information:

Name: Click or tap here to enter text.

Email: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Project/Campaign Name: Click or tap here to enter text.

Funding Source: Click or tap here to enter text.

Campaign Start Date: Click or tap to enter a date.

1. Describe the goal(s) of this project campaign:

Click or tap here to enter text.

2. Who is the primary and/or secondary target audience? Who do you plan to reach?

Click or tap here to enter text.

3. What is the target location (County, city, etc.)?

Click or tap here to enter text.

4. What is the timing/date range of this project/campaign (e.g., Jan-March, year, etc.)?

Click or tap here to enter text.

5. What are the media components (e.g., billboards, radio, Facebook, video, etc.) to be used?

Click or tap here to enter text.

Please submit all relevant materials with this form for approval.

Community Mental Health Partnership of Southeast Michigan/PIHP	Policy and Procedure Substance Use Services Media Campaigns
Committee/Department:	Regional Operations Committee Review Date
Implementation Date (1 st of month following approval)	Oversight Policy Board Approval Date

I. PURPOSE

To ensure ~~that~~ all media campaigns are compatible with **CMHPSM and** MDHHS values; are coordinated with **CMHPSM and** MDHHS campaigns whenever feasible; and associated costs are proportionate to likely outcomes.

II. REVISION HISTORY

DATE	MODIFICATION
3,2021	Language updates
OPB Approval Date	Language Updates Campaign Request Form References

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III. APPLICATION

This policy applies to all contractual organizations receiving any SUD funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), who are implementing a media campaign as part of their ~~spectrum of prevention, harm reduction or, treatment or recovery activities-service activities.~~

<input type="checkbox"/> CMHPSM PIHP Staff, Board Members, Interns & Volunteers
<input type="checkbox"/> Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
<input type="checkbox"/> Mental Health / Intellectual or Developmental Disability Service Providers
<input checked="" type="checkbox"/> SUD Treatment Providers <input checked="" type="checkbox"/> SUD Prevention Providers
<input type="checkbox"/> Other as listed:

IV. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental

health, developmental disabilities, and substance use disorder services.

- o Media Campaign: ~~A media campaign, very broadly, is a message or series of messages conveyed through mass (county-wide) media channels including print, broadcast, social and electronic media. Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. A media campaign promotes or highlights a community wellness issue through a variety of media including broadcast, digital and social channels. Messages regarding availability of services in the PIHP region are not considered to be media campaigns. This does not include promotion of agency events and agency-specific services.~~

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Social Media: Social media is the collective of online communications channels dedicated to community-based input, interaction, content-sharing and collaboration. Examples include websites and applications dedicated to social networking and audio/video sharing platforms, forums, microblogging, social networking, social bookmarking, social curation, and wikis are among the different types of social media.

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V. POLICY

Media campaigns must be compatible with CMHPSM and MDHHS values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. All campaigns must be reviewed by the CMHPSM prior to use of MDHHS-administered funding and submitted to the MDHHS for approval.

VI. STANDARDS

- A. All mass media campaigns including, but not limited to billboards, bus panel messages, public service announcements (print, radio, video recording or TV); and social media messaging; ~~pharmacy bag campaigns;~~ are required to be submitted to the CMHPSM.
- B. "Media Campaign Request Form" must be completed and associated materials (PSA Script, Media Message, Pictures, etc.) submitted to CMHPSM no less than four weeks30 days prior to scheduled release.
- C. No campaign may be initiated until receipt of approval by MDHHS is obtained.
- ~~D.~~ Final versions must be submitted to CMHPSM

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VII. EXHIBITS

Media Campaign Request Form

VIII. REFERENCES

~~MDHHS supports and services contract; State of Michigan Standard Contract Terms p.4 1h; Part II (B) SUBSTANCE USE DISORDER (SUD) SERVICES; section 9.0 Media Campaigns p.13 #48 Media Releases~~

Michigan Department of Health and Human Services, Substance Use, Gambling and Epidemiology Section (MDHHS, SUGE). Special Provisions PG. 13

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MEDIA CAMPAIGN REQUEST

MEDIA CAMPAIGNS

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media (i.e., billboards, PSAs, bus panels). Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. Media campaigns must be compatible with Michigan Department of Health and Human Services' (MDHHS) values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. **Prior written approval from MDHHS is required.**

Provider:	Date:
Contact Person, Email, Phone:	
Mass Media Campaign Name:	
Type of Mass Media Mechanism to be Reviewed and Associated Cost:	
Target Message:	
Target Audience:	
Target Community:	
Targeted Outcome:	
Please attach the actual media message, method, PSA script, etc., where applicable.	



Lenawee
Livingston
Monroe
Washtenaw

SUD PREVENTION & TREATMENT SERVICES

MEDIA CAMPAIGN REQUEST

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Copies of final materials/products must be submitted to CMHPSM once approved.

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Please allow up to 40 days for the approval process. Once approved, CMHPSM will provide a funding statement to include on all materials dependent on funding source.

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Campaign Start Date: Click or tap to enter a date.

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Click or tap here to enter text.

Please submit all relevant materials with this form for approval.

Community Mental Health Partnership of Southeast Michigan/PIHP	<i>Policy</i> Residential Treatment Services Policy
Committee/Department: SUD Services	Regional Operations Committee Review Date 04/03/2023
Implementation Date	Oversight Policy Board Approval Date

I. PURPOSE

To establish the philosophy and requirements for residential treatment services to be consistent with the Recovery Oriented System of Care (ROSC) that are based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria that supports individualized services that maintain cultural, age and gender appropriateness.

II. REVISION HISTORY

DATE	MODIFICATION
3/2012	Original policy
8/17/2016	Update Language
11/2019	Update Language
3/2021	Update Language
3/2023	Updated Language

III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) for Substance Use Disorder services.

<input type="checkbox"/> CMHPSM PIHP Staff, Board Members, Interns & Volunteers
<input type="checkbox"/> Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
<input type="checkbox"/> Mental Health / Intellectual or Developmental Disability Service Providers
<input checked="" type="checkbox"/> SUD Treatment Providers <input type="checkbox"/> SUD Prevention Providers
<input type="checkbox"/> Other as listed:

IV. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM) – the Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP) – a program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity – the entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Core Provider – a local provider of substance abuse services utilizing the ROSC model that provides for and/or coordinates all levels of care for clients with substance use disorders.

Core Services - are defined as Treatment Basics, Therapeutic Interventions, and Interactive Education/Counseling. See the chart in the “Covered Services” section for further information.

Counseling – an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Crisis Intervention – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

Detoxification/Withdrawal Management – monitoring for the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

Face-to-Face- this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

Facilitates Transportation – assist the client, or potential client, or referral source in arranging transportation to and from treatment.

Family Counseling – face-to-face intervention with the client and the significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

Family Psychotherapy – face-to-face, insight-oriented interventions with the client and the significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

Group Counseling – face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

Group Psychotherapy – face-to-face, insight-oriented interventions with three or more clients.

Individual Assessment – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Counseling – face-to-face intervention for the purpose of goal setting and achievement, and skill building.

Individual Psychotherapy- face-to-face, insight-oriented interventions with the client.

Individual Treatment Planning- direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education – services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as didactic education.

Interactive Education Groups – activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

Medical Necessity – treatment that is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

Medication Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD) – These terms refer to medications used to treat Substance Use Disorder. They are most commonly referred to as MAT; MOUD is a newer term being used to replace MAT in cases when OUD is the primary diagnosis. Naltrexone can also be used for treatment of Alcohol Use Disorder (AUD).

Peer Support – individuals who have shared experiences of addiction and recovery and offer support and guidance to one another.

Professional Staff – as identified in the Staff Qualifications for SUD Treatment Services portion of the PIHP/MDHHS Contract include Substance Abuse Treatment Specialists, Substance Abuse Treatment Practitioner, Specially Focused Staff and Treatment Supervisor.

Psychotherapy – an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio- psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals.

Recovery – a process of change through which an individual achieves abstinence and improved health, wellness and quality of life. The experience (a process and a

sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.

Recovery Planning – process that highlights and organize a person's goals, strengths and capacities and to determine what barriers need to be removed or problems resolved to help people achieve their goals. This should include an asset and strength-based assessment of the client.

Recovery Support and Preparation – services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Referral/Linking/Coordination of Services – office-based service activity performed by a primary clinician or other assigned staff to address needs identified through the assessment, and/or of ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

Substance Use Disorder – a term inclusive of substance abuse and dependence that also encompasses problematic use of substances.

Toxicology Screening – screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non- laboratory urinalysis)

V. **POLICY**

CMHPSM will provide oversight and on-site monitoring to residential providers to ensure the philosophy, standards and requirements of individual specific residential services are being appropriately implemented and provided. The Access Departments will refer to external residential providers when necessary, based on capacity or clinical need and coordinate care with external provider. The number of hours of scheduled activities depend on the ASAM Level of Care and must take place throughout the week, including over the weekend. Throughout the residential level of services, assessment, treatment planning, and recovery support preparations are required.

VI. **STANDARDS**

The residential levels of care from ASAM are established based on the needs of the individual. As part of the purpose of this document, the short- and long-term descriptors will no longer be used to describe residential services. The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are described as follows:

ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are

similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows individuals the opportunity to develop and practice skills while reintegrating into the community.

This type of programming can be beneficial to individuals who do not acknowledge a substance use problem, and services would be focused on engagement and continuing treatment. Treatment at this level is sometimes necessary to due to deficits in the individual's recovery environment and length of stay in clinically managed Level 3.1 programs is generally longer than that of the more intensive levels of residential care. This allows the individual to practice and master the application of recovery skills.

Support Systems

Necessary support systems include telephone or in-person consultation with a physician and emergency services, available 24 hours a day, and 7 days a week. There also must be direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services. Programs should have the ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition. These programs should also have the ability to arrange for pharmacotherapy for psychiatric, Medication Assisted Treatment or Medication for Opioid Use Disorder. They should also have direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services such as literacy training and adult education.

Staff Requirements

Level 3.1 programs are staffed by allied health professional staff such as counselor aides or group living workers who are available onsite 24-hours a day or as required by licensing regulations. Clinical staff must be knowledgeable about the biological and psychosocial dimensions of substance use disorders and their treatment. They must also be able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Addiction physicians should review admission decisions to confirm clinical necessity of services. Specific required staff qualifications can be found in the Provider Qualification Chart (see VIII. References below). Supervision requirements can be found in the MDHHS provider requirements policy.

Co-occurring Enhanced Programs

These should be staffed by credentialed mental health professionals that have the ability to treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. These professionals should also have sufficient cross-training in substance use disorder and mental health to understand the signs and symptoms of mental health disorders, be able to understand and explain to the individual the purposes of different psychotropic medications and how they interact with substance use.

ASAM Level 3.3 – Clinically Managed Medium-Intensity Residential Services

The deficits for individuals at this level are primarily cognitive, either temporary or permanent. The individuals in this LOC have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace

and over a longer period of time. The individual's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

These programs provide a structured recovery environment in combination with medium intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.

Support Systems

Necessary support systems within this level include telephone or in-person consultations with a physician, or a physician assistant or nurse practitioner in states where they are licensed as physician extenders and may perform the duties designated here for a physician; and emergency services, available 24 hours a day, 7 days a week. They should have direct affiliations with other easily accessible levels of care or close coordination through referral to more and less intensive levels of care and other services. They need medical, psychiatric, psychological, laboratory and toxicology services available through consultation and referral as appropriate to the severity and urgency of the individual's condition.

Staff Requirements

Level 3.3 programs are staffed by physician extenders, and appropriately credentialed mental health professionals as well as allied health professional staff. These staff should be on-site 24 hours a day or as required by licensing regulations. In addition, one or more clinicians with competence in the treatment of substance use disorders should be onsite 24-hours a day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. They should also be able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff should also have specialized training in behavior management techniques. Specific required staff qualifications can be found in the Provider Qualification Chart (see VIII. References below). Supervision requirements can be found in the MDHHS provider requirements policy.

Co-occurring Enhanced Programs

This type of program needs to be staffed by credentialed psychiatrists and mental health professionals. They should be able to assess and treat people with co-occurring mental disorders and they need to have specialized training in behavior management techniques. Most, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of mental disorders and be able to understand and explain to the individual the purpose of psychotropic medication and its interactions with substance use.

ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

These programs are designed to treat individuals who have significant social and psychological problems. Treatment is directed toward diminishing individual deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the individual's educational and vocational deficits, as well as their socially dysfunctional behavior. Individuals at this level may have extensive treatment

or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The length of treatment depends on an individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the individual resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this individual population, the program will have to provide the individualized services to promote life skill mastery for each individual.

Support Systems

Programs in this level of care should have telephone or in-person consultation with a physician, or a physician assistant or nurse practitioner in state where they are licensed as physician extenders and may perform the duties designated here for a physician; emergency services, available 24 hours a day, 7 days a week. They must also have direct affiliations with other levels or close coordination through referral to more and less intensive levels of care and other services. They must also have arranged medical, psychiatric, psychological, laboratory, and toxicology services as appropriate to the severity and urgency of the individual's condition.

Staff Requirements

Level 3.5 programs staffed by licensed or credentialed clinical staff such as substance use disorder counselors and other professional staff who work with the allied health staff in interdisciplinary approach. Professional staff should be onsite 24-hours a day or per licensing regulations. One or more clinicians with competence in treatment of substance use disorders must be available onsite or on-call 24-hours per day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. Clinicians should be able to identify the signs and symptoms of acute psychiatric conditions and have specialized training in behavior management techniques. Specific required staff qualifications can be found in the Provider Qualification Chart (see VIII. References below). Supervision requirements can be found in the MDHHS provider requirements policy.

Co-occurring Enhanced Programs

This type of program should offer psychiatric services, medication evaluation and laboratory services. These services should be available by telephone within 8 hours and on-site or closely coordinated off-site staff within 24 hours, as appropriate by severity and urgency of the individual's mental health condition. These programs should be staffed by credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat the cooccurring mental health disorder and have specialized training in behavior management. They should also have cross-training to understand the signs and symptoms of co-occurring mental health disorders and be able to explain to the individual, the purpose of psychotropic drugs and how they interact with substance use.

ASAM Level 3.7 – Medically Monitored High-Intensity Inpatient Services

These programs offer a structured regime of professional 24-hour directed evaluation, observation, medical monitoring and substance use disorder treatment in an inpatient

setting. These programs operate in permanent facilities with inpatient beds and function under a set of defined policies, procedures and clinical protocols. These programs are for individuals with subacute biomedical and emotional, behavioral or severe cognitive problems that require individual treatment but do not require the full resources of an acute care general hospital or medically managed individual program.

These services are designed to meet needs of individuals who have functional limitations in Dimensions 1, 2, and 3. The care provided in these programs is delivered by an interdisciplinary staff of appropriately credentialed staff, including addiction credentialed physicians. The main focus of treatment is specific to substance related disorders. The skills of this team and their availability can accommodate withdrawal management and/or intensive inpatient treatment of substance use disorder, and/or integrated treatment of co-occurring subacute biomedical, and/or emotional, behavioral or cognitive conditions.

Support Systems

This level of care requires physician monitoring, nursing care, and observations are made available. The following staffing is required for this level of care: a physician must be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary; a registered nurse to conduct alcohol and other drug-focused nursing assessment at time of admission; an appropriately credentialed nurse is responsible for monitoring the individual's progress and for medication administration. There must be additional medical specialty consultation, psychological, laboratory and toxicology services available on-site through consultation or referral. There also must be coordination of necessary services or other levels of care are available through direct affiliation or a referral process. Psychiatric services should be available on-site through consultation or referral when presenting an issue that could be attended to at a later time. These services should be available within 8 hours by telephone or 24 hours in person.

Staff Requirements

These programs are staffed by an interdisciplinary staff (including physicians, nurses, substance use disorder counselors, and behavioral health specialists) who are able to assess and treat the individual and obtain and interpret information regarding the individuals psychiatric and substance use disorders. Staff should be knowledgeable about the biological and psychosocial dimensions of substance use disorders and other behavioral health disorders. The staff should have training in behavior management techniques and evidence-based practices. The staff should be able to provide a planned regimen of 24-hour professionally directed evaluation, care and treatment services. A licensed physician should oversee the treatment process and assure quality of care. Physicians perform physical examinations for all admitted to this level of care. These staff should have specific training in addiction medicine or addiction psychiatry and experience with adolescent medicine. Individuals should receive pharmacotherapy integrated with psychosocial therapies. Specific required staff qualifications can be found in the Provider Qualification Chart (see VIII. References below). Supervision requirements can be found in the MDHHS provider requirements policy.

Co-occurring Enhanced Programs

Programs at this level should offer appropriate psychiatric services, medication evaluation and laboratory services. A psychiatrist should assess the individual within four hours of admission by telephone and within 24 hours following admission in person, if not sooner, as appropriate by individual’s behavioral health condition. A registered nurse or licensed mental health clinician should conduct a behavioral health-focused assessment at the time of admission. If not done by a registered nurse, a separate nursing assessment must be done. The nurse is responsible for monitoring the individual’s progress and administering or monitoring the individual’s self-administration of psychotropic medications. These must also be staffed by addiction psychiatrists and credentialed behavioral health professionals who can assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management. These programs are ideally staffed by a certified addiction specialist physician, or a physician certified as an addiction psychiatrist. Some, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of psychiatric disorders and be able to explain to the individual the purpose of psychotropic medication and how they interact with substance use. The intensity and care should meet the individual’s needs.

ASAM LOC describe the need for treatment from the perspective of the level of impairment of the individual; with the higher level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the individual is based on the ASAM LOC determination. Due to the unique and complex nature of each individual, it is recognized that not every individual will “fit” cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a individual to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. In addition, variations in treatment that do not follow these guidelines should also be documented in the individual record.

The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the individual be successful in treatment and achieve recovery.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by a individual:

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
Dimension 1 Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; Concurrently receiving Level 1-WM or Level 2-WM	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-WM	At minimal risk of severe withdrawal at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-WM criteria	Approach “unbundled” withdrawal management for adults.

<p>Dimension 2 Medical conditions & complications</p>	<p>None or very stable, or receiving concurrent medical monitoring</p>	<p>None or stable or receiving concurrent medical monitoring</p>	<p>None or stable or receiving concurrent medical monitoring</p>	<p>Individual in significant risk of serious damage to physical health or concomitant biomedical conditions</p>
<p>Dimension 3 Emotional, behavioral, or cognitive conditions and complications</p>	<p>None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required</p>	<p>Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits</p>	<p>Demonstrates a repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client</p>	<p>Individual must be admitted into co-occurring capable or co-occurring enhanced program, depending on level of function or degree of impairment</p>

<p>Dimension 4 Readiness to change</p>	<p>Open to recovery but needs a structured environment to maintain therapeutic gains</p>	<p>Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level 1 motivational enhancement program (Early Intervention)</p>	<p>Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others; The client needs a Level 1 motivational enhancement program (Early Intervention)</p>	<p>Does not accept or relate the addictive disorder to severity of existing problems; need intensive motivating strategies; need 24hour monitoring to assure follow through with treatment plan</p>
<p>Dimension 5 Relapse, continued use or continued problem potential</p>	<p>Understands relapse but needs structure to maintain therapeutic gains</p>	<p>Has little awareness and needs intervention only available at Level 3.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction</p>	<p>Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences</p>	<p>Experiencing acute psychiatric/substance use disorder marked by intensification of symptoms of the substance-related disorder despite participation in a less intensive level of treatment; OR b) There is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services.</p>
<p>Dimension 6 Recovery/living environment</p>	<p>Environment is dangerous, but recovery achievable if Level 3.1. 24-hour structure is available</p>	<p>Environment is dangerous and client needs 24-hour structure to cope</p>	<p>Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting</p>	<p>Environment is dangerous and patient lacks skills to cope outside of highly structured 24-hour setting</p>

Admission Criteria

Admission to residential treatment is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider’s assessment process.
- Individualized determination of need.
- ASAM Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the ASAM Criteria below:
 - i. Withdrawal potential.
 - ii. Medical conditions and complications.
 - iii. Emotional, behavioral, or cognitive conditions and complications.
 - iv. Readiness to change – as determined by the Stages of Change Model.
 - v. Relapse, continued use or continued problem potential.
 - vi. Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and individual characteristics that include, but are not limited to, age, gender, culture, and development.

Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM Criteria. As a individual’s needs change, the frequency, and/or duration, of services may be increased or decreased as medically necessary. Individual participation in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

Service Requirements

The following chart details the required amount of services that have been established for residential treatment in the three levels of care. Documentation of all core services, and the response to them by the individual, must be found in the individual’s chart. In situations where the required services cannot be provided to a individual in the appropriate frequency or quantity, a justification must also be documented in the individual record.

Level of Care	Minimum Weekly Core Services	Minimum Weekly Life Skills/Self Care
ASAM 3.1* Individuals with lower impairment or lower complexity of needs	At least 5 hours of clinical services per week	At least 5 hours per week
ASAM 3.3* Individuals with moderate to high impairment or moderate to high complexity of needs	Not less than 13 hours per week	Not less than 13 hours per week
ASAM 3.5* Individuals with a significant level of impairment or very complex needs	Not less than 20 hours per week*	Not less than 20 hours per week*
ASAM 3.7* Individuals with significant	Not less than 20 hours per	Not less than 20 hours

level of impairment or very complex needs	week*	per week*
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*services are required to be provided throughout the week, including both weekend days

Covered Services:

The following services must be available in a residential setting regardless of the LOC and based on individual client need:

Type	Residential Services Description
Basic Care	Room, board, supervision, monitoring self-administration of medications, toxicology screening, facilitates transportation to and from treatment, treatment environment: structured, safe, and recovery oriented.
Treatment Basics <u>Core Service</u>	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services, preparation for 'next step.'
Therapeutic Interventions <u>Core Service</u>	Individual, group and family psychotherapy services; appropriate for the individual's needs; and crisis intervention. Services provided by an appropriately licensed, credentialed and supervised professional working within their scope of
Interactive Education /Counseling <u>Core Service</u>	Interaction and teaching with client(s) and staff that process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Ex: disease of addiction, mental health & substance use disorder.
Life Skills/Self-Care (building recovery capital)	Social activities that promote healthy community integration/reintegration, development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education.
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; family visits; coordination with treatment, support groups; maintaining a drug/alcohol free campus.
Medical Services <u>Core Service</u>	Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available on-site.

Treatment Planning & Recovery Planning:

Individuals entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the individual. Residential care should not be presented to individuals as being a complete episode of care. To facilitate the individual moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the individual for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the individual is aware that services will continue once the residential stay is over.

To make the transition to the next LOC, the residential care provider may assist the individual in choosing an appropriate service based on needs and location scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided as examples of activities that could take place if it were determined there would be a benefit to the individual. There could potentially be many other activities or arrangements that may be needed or the individual may require very little assistance. To the best of their ability, it is expected that the residential provider arranges for any needed assistance to ensure a seamless transfer to the next LOC.

Continuing Stay Criteria:

Re-authorization or continued treatment should be based on ASAM continued service criteria, medical necessity, and when there is a reasonable expectation of benefit from continued care.

The ASAM Assessment Dimensions must be used to assist in the determination of the level of care needed by a individual.

VII. EXHIBITS
None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPAA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Mental Health Code Act 258 of 1974	X	
The Joint Commission - Behavioral Health	X	

Standards		
Michigan Department of Health and Human Services (MDHHS) Medicaid Contract	X	
MDHHS Substance Abuse Contract	X	
Michigan Medicaid Provider Manual	X	
HITECH Act of 2009	X	
Michigan Department of Health AND Human Services, Substance Use, Gambling, and Epidemiology Section (SUGE)	X	

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition-Revised (ASAM PPC-2R)*. Chevy Chase, MD: American Society of Addiction Medicine, Inc.

3rd Edition: *The ASAM CRITERIA: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (2015); Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care. Michigan’s ROSC Glossary of Terms. http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Social Work General Rules. Promulgated pursuant to Michigan Public Act 368 of 1978, Sections 16145(3) and 18501, as amended. <http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf>

Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. *Treatment Policy #6, Individualized Treatment Planning*, (2012) https://www.michigan.gov/documents/mdch/Policy_Treatment_06_Invd_Tx_Planning_175180_7.pdf

Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. *Treatment Technical Advisory #7, Peer Recovery Support Services*, (2012) Michigan Department of Community Health, Office of Drug Control Policy,

https://www.michigan.gov/documents/mdch/TA-T-07_Peer_Recovery-Recovery_Support_230852_7.pdf

Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. *Treatment Policy #10: Residential Treatment Continuum of Services, (2017)*

https://www.michigan.gov/documents/mdhhs/Residential_TX_Policy_10_549861_7.pdf

Prepaid Inpatient Health Plans and Community Mental Health Services Program. *Access System Standards* (2015) Medicaid Managed Specialty Support Services Program FY20

<https://www.michigan.gov/->

[/media/Project/Websites/mdhhs/Folder1/Folder61/Policy_Tx_07_AMS.pdf?rev=48bba5f1e3c5456f9de18fe8a0957564](https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder1/Folder61/Policy_Tx_07_AMS.pdf?rev=48bba5f1e3c5456f9de18fe8a0957564)

Community Mental Health Partnership of Southeast Michigan/PIHP	<i>Policy</i>
Committee/Department: SUD Services	Residential Treatment Services Policy
Implementation Date (1st of month following approval)	Regional Operations Committee Review Date
	Oversight Policy Board Approval Date

I. PURPOSE

To establish the philosophy and requirements for residential treatment services to be consistent with the Recovery Oriented System of Care (ROSC) that are based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria that supports individualized services that maintain cultural, age and gender appropriateness.

II. REVISION HISTORY

DATE	MODIFICATION
3/2012	Original policy
8/17/2016	Update Language
11/2019	Update Language
<u>3/2021</u>	<u>Update Language</u>
<u>3/2023</u>	<u>Updated Language</u>

III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) for Substance Use Disorder services.

<input type="checkbox"/> CMHPSM PIHP Staff, Board Members, Interns & Volunteers
<input type="checkbox"/> Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
<input type="checkbox"/> Mental Health / Intellectual or Developmental Disability Service Providers
<input checked="" type="checkbox"/> SUD Treatment Providers <input type="checkbox"/> SUD Prevention Providers
<input type="checkbox"/> Other as listed:

IV. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM) – the Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP) – a program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity – the entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Core Provider – a local provider of substance abuse services utilizing the ROSC model that provides for and/or coordinates all levels of care for clients with substance use disorders.

Core Services - are defined as Treatment Basics, Therapeutic Interventions, and Interactive Education/Counseling. See the chart in the “Covered Services” section for further information.

Counseling – an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Crisis Intervention – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

Detoxification/Withdrawal Management – monitoring for the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

Face-to-Face: this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

Facilitates Transportation – assist the client, or potential client, or referral source in arranging transportation to and from treatment.

Family Counseling – face-to-face intervention with the client and the significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

Family Psychotherapy – face-to-face, insight-oriented interventions with the client and the significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

Group Counseling – face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

Group Psychotherapy – face-to-face, insight-oriented interventions with three or more clients.

Individual Assessment – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Counseling – face-to-face intervention for the purpose of goal setting and achievement, and skill building.

Individual Psychotherapy- face-to-face, insight-oriented interventions with the client.

Individual Treatment Planning- direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education – services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as didactic education.

Interactive Education Groups – activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

Medical Necessity – treatment which is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

Medication Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD) – These terms refer to medications used to treat Opioid Substance Use Disorder (OSUD). They are most commonly referred to as MAT.; MOUD is a newer term being used to replace MAT in cases when OUD is the primary diagnosis. Naltrexone can also be used to for treatment of Alcohol Use Disorder (AUD).

Peer Support – individuals who have shared experiences of addiction and recovery and offer support and guidance to one another.

Professional Staff – as identified in the Staff Qualifications for SUD Treatment Services portion of the PIHP/MDHHS Contract include Substance Abuse Treatment Specialists, Substance Abuse Treatment Practitioner, Specially Focused Staff and Treatment Supervisor.

Psychotherapy – an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio- psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals.

Recovery – a process of change through which an individual achieves abstinence and improved health, wellness and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.

Recovery Planning – process that highlight's and organize a person's goals, strengths and capacities and to determine what barriers need to be removed or problems resolved to help people achieve their goals. This should include an asset and strength based assessment of the client.

Recovery Support and Preparation – services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Referral/Linking/Coordination of Services – office-based service activity performed by a primary clinician or other assigned staff to address needs identified through the assessment, and/or of ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

Substance Use Disorder – a term inclusive of substance abuse and dependence that also encompasses problematic use of substances.

Toxicology Screening – screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non- laboratory urinalysis)

V. POLICY

CMHPSM will provide oversight and on-site monitoring to residential providers to ensure the philosophy, standards and requirements of client/individual specific residential services are being appropriately implemented and provided. The core providers Access Departments will refer to external residential providers when necessary based on capacity or clinical need and coordinate care with external provider. The number of hours of scheduled activities depend on the ASAM Level of Care and must take place throughout the week, including over the weekend. Throughout the residential level of services, assessment, treatment planning, and recovery support preparations are required.

VI. STANDARDS

The residential levels of care from ASAM are established based on the needs of the client/individual. As part of the purpose of this document, the short- and long-term descriptors will no longer be used to describe residential services. The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are described as follows:

ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows ~~client~~ individuals the opportunity to develop and practice skills while reintegrating into the community.

This type of programming can be beneficial to individuals who do not acknowledge a substance use problem, and services would be focused on engagement and continuing treatment. Treatment at this level is sometimes necessary due to deficits in the individual's recovery environment and length of stay in clinically managed Level 3.1 programs is generally longer than that of the more intensive levels of residential care. This allows the individual to practice and master the application of recovery skills.

Support Systems

Necessary support systems include telephone or in-person consultation with a physician and emergency services, available 24 hours a day, and 7 days a week. There also must be direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services. Programs should have the ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition. These programs should also have the ability to arrange for pharmacotherapy for psychiatric, ~~or anti-addiction~~ medication Assisted Treatments or Medication for Opioid Use Disorder. They should also have direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services such as literacy training and adult education.

Staff Requirements

Level 3.1 programs are staffed by allied health professional staff such as counselor aides or group living workers who are available onsite 24-hours a day or as required by licensing regulations. Clinical staff must be knowledgeable about the biological and psychosocial dimensions of substance use disorders and their treatment. They must also be able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. ~~Staff at this level are not involved in direct service provision, however, a~~Addiction physicians should review admission decisions to confirm clinical necessity of services. Specific required staff qualifications can be found in the Provider Qualification Chart (see VIII. References below). Supervision requirements can be found in the MDHHS provider requirements policy.

Co-occurring Enhanced Programs

These should be staffed by credentialed mental health professionals that have the ability to treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. These professionals should also have sufficient cross-training in ~~addiction-substance use disorder~~ and mental health to understand the signs and symptoms of mental ~~health~~ disorders, be able to understand and explain to the individual the purposes of different psychotropic medications and how they interact with substance use.

ASAM Level 3.3 – Clinically Managed Medium-Intensity Residential Services

The deficits for client individuals at this level are primarily cognitive, either temporary or permanent. The client individuals in this LOC have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client individual's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

These programs provide a structured recovery environment in combination with medium intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.

The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

Support Systems

Necessary support systems within this level include telephone or in-person consultations with a physician, or a physician assistant or nurse practitioner in states where they are licensed as physician extenders and may perform the duties designated here for a physician; and emergency services, available 24 hours a day, 7 days a week. They should have direct affiliations with other easily accessible levels of care or close coordination through referral to more and less intensive levels of care and other services. They need medical, psychiatric, psychological, laboratory and toxicology services available through consultation and referral as appropriate to the severity and urgency of the individual's condition.

Staff Requirements

Level 3.3 programs are staffed by physician extenders, and appropriately credentialed mental health professionals as well as allied health professional staff. These staff should be on-site 24 hours a day or as required by licensing regulations. In addition, one or more clinicians with competence in the treatment of substance use disorders should be onsite 24-hours a day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. They should also be able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff should also have specialized training in behavior management techniques. [Specific required staff qualifications can be found in the Provider Qualification Chart \(see VIII. References below\).](#) [Supervision requirements can be found in the MDHHS provider requirements policy.](#)

Co-occurring Enhanced Programs

This type of program needs to be staffed by credentialed psychiatrists and mental health professionals. They should be able to assess and treat people with co-occurring mental disorders and they need to have specialized training in behavior management techniques. Most, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of mental disorders and be able to understand and

explain to the individual the purpose of psychotropic medication and its interactions with substance use.

ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

These programs are designed to treat client/individuals who have significant social and psychological problems. Treatment is directed toward diminishing client/individual deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the client/individual's educational and vocational deficits, as well as his or her/their socially dysfunctional behavior. Client/Individuals at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The length of treatment depends on an individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client/individual resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client/individual population, the program will have to provide the right mix of individualized services to promote life skill mastery for each individual.

Support Systems

Programs in this level of care should have telephone or in-person consultation with a physician, or a physician assistant or nurse practitioner in state where they are licensed as physician extenders and may perform the duties designated here for a physician; emergency services, available 24 hours a day, 7 days a week. They must also have direct affiliations with other levels or close coordination through referral to more and less intensive levels of care and other services. They must also have arranged medical, psychiatric, psychological, laboratory, and toxicology services as appropriate to the severity and urgency of the individual's condition.

Staff Requirements

Level 3.5 programs staffed by licensed or credentialed clinical staff such as addiction substance use disorder counselors and other professional staff who work with the allied health staff in interdisciplinary approach. Professional staff should be onsite 24-hours a day or per licensing regulations. One or more clinicians with competence in treatment of substance use disorders must be available onsite or on-call 24-hours per day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. Clinicians should be able to identify the signs and symptoms of acute psychiatric conditions and have specialized training in behavior management techniques. Specific required staff qualifications can be found in the Provider Qualification Chart (see VIII. References below). Supervision requirements can be found in the MDHHS provider requirements policy.

Co-occurring Enhanced Programs

This type of program should offer psychiatric services, medication evaluation and laboratory services. These services should be available by telephone within 8 hours and on-site or closely coordinated off-site staff within 24 hours, as appropriate by severity and urgency of the individual's mental health condition. These programs should

be staffed by credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat the cooccurring mental health disorder and have specialized training in behavior management. They should also have cross-training to understand the signs and symptoms of co-occurring mental [health](#) disorders and be able to explain to the individual, the purpose of psychotropic drugs and how they interact with substance use.

ASAM Level 3.7 – Medically Monitored High-Intensity Inpatient Services

These programs offer a structured regime of professional 24-hour directed evaluation, observation, medical monitoring and [addiction-substance use disorder](#) treatment in an inpatient setting. These programs operate in permanent facilities with inpatient beds and function under a set of defined policies, procedures and clinical protocols. These programs are for [patients-clientindividuals](#) with subacute biomedical and emotional, behavioral or severe cognitive problems that require individual treatment but do not require the full resources of an acute care general hospital or medically managed individual program.

These services are designed to meet needs of [patients-clientindividuals](#) who have functional limitations in Dimensions 1, 2, and 3. The care provided in these programs is delivered by an interdisciplinary staff of appropriately credentialed staff, including addiction credentialed physicians. The main focus of treatment is specific to substance related disorders. The skills of this team and their availability can accommodate withdrawal management and/or intensive inpatient treatment of [addictionsubstance use disorder](#), and/or integrated treatment of co-occurring subacute biomedical, and/or emotional, behavioral or cognitive conditions.

Support Systems

This level of care requires physician monitoring, nursing care, and observations are made available. The following staffing is required for this level of care: a physician must be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary; a registered nurse to conduct alcohol and other drug-focused nursing assessment at time of admission; an appropriately credentialed nurse is responsible for monitoring the individual's progress and for medication administration. There must be additional medical specialty consultation, psychological, laboratory and toxicology services available on-site through consultation or referral. There also must be coordination of necessary services or other levels of care are available through direct affiliation or a referral process. Psychiatric services should be available on-site through consultation or referral when presenting an issue that could be attended to at a later time. These services should be available within 8 hours by telephone or 24 hours in person.

Staff Requirements

These programs are staffed by an interdisciplinary staff (including physicians, nurses, [addiction-substance use disorder](#) counselors, and behavioral health specialists) who are able to assess and treat the individual and obtain and interpret information regarding the individuals psychiatric and substance use ~~or addictive~~ disorders. Staff should be knowledgeable about the biological and psychosocial dimensions of [addictions substance use disorders](#) and other behavioral health disorders. The staff should have

training in behavior management techniques and evidence-based practices. The staff should be able to provide a planned regimen of 24-hour professionally directed evaluation, care and treatment services. A licensed physician should oversee the treatment process and assure quality of care. Physicians perform physical examinations for all admitted to this level of care. These staff should have specific training in addiction medicine or addiction psychiatry and experience with adolescent medicine. Individuals should receive pharmacotherapy integrated with psychosocial therapies. [Specific required staff qualifications can be found in the Provider Qualification Chart \(see VIII, References below\). Supervision requirements can be found in the MDHHS provider requirements policy.](#)

Co-occurring Enhanced Programs

Programs at this level should offer appropriate psychiatric services, medication evaluation and laboratory services. A psychiatrist should assess the individual within four hours of admission by telephone and within 24 hours following admission in person, if not sooner, as appropriate by individual's behavioral health condition. A registered nurse or licensed mental health clinician should conduct a behavioral health-focused assessment at the time of admission. If not done by a registered nurse, a separate nursing assessment must be done. The nurse is responsible for monitoring the individual's progress and administering or monitoring the individual's self-administration of psychotropic medications. These must also be staffed by addiction psychiatrists and credentialed behavioral health professionals who can assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management. These programs are ideally staffed by a certified addiction specialist physician, or a physician certified as an addiction psychiatrist. Some, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of psychiatric disorders and be able to explain to the individual the purpose of psychotropic medication and how they interact with substance use. The intensity and care should meet the individual's needs.

ASAM LOC describe the need for treatment from the perspective of the level of impairment of the [client/individual](#); with the higher ~~the~~ level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the [client/individual](#) is based on the ASAM LOC determination. Due to the unique and complex nature of each [client/individual](#), it is recognized that not every [client/individual](#) will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a [client/individual](#) to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. In addition, variations in treatment that do not follow these guidelines should also be documented in the [client/individual](#) record.

The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the [client/individual](#) be successful in treatment and achieve recovery.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by a [client/individual](#):

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
Dimension 1 Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; Concurrently receiving Level 1-WM or Level 2-WM	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-WM	At minimal risk of severe withdrawal at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-WM criteria	Approach “unbundled” withdrawal management for adults.
Dimension 2 Medical conditions & complications	None or very stable, or receiving concurrent medical monitoring	None or stable or receiving concurrent medical monitoring	None or stable or receiving concurrent medical monitoring	Individual in significant risk of serious damage to physical health or concomitant biomedical conditions
Dimension 3 Emotional, behavioral, or cognitive conditions and complications	None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required	Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits	Demonstrates a repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client	Individual must be admitted into co-occurring capable or co-occurring enhanced program, depending on level of function or degree of impairment

<p>Dimension 4 Readiness to change</p>	<p>Open to recovery but needs a structured environment to maintain therapeutic gains</p>	<p>Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level 1 motivational enhancement program (Early Intervention)</p>	<p>Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others; The client needs a Level 1 motivational enhancement program (Early Intervention)</p>	<p>Does not accept or relate the addictive disorder to severity of existing problems; need intensive motivating strategies; need 24hour monitoring to assure follow through with treatment plan</p>
<p>Dimension 5 Relapse, continued use or continued problem potential</p>	<p>Understands relapse but needs structure to maintain therapeutic gains</p>	<p>Has little awareness and needs intervention only available at Level 3.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction</p>	<p>Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences</p>	<p>Experiencing acute psychiatric/substance use disorder marked by intensification of symptoms of the substance-related disorder despite participation in a less intensive level of treatment; OR b) There is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services.</p>
<p>Dimension 6 Recovery/living environment</p>	<p>Environment is dangerous, but recovery achievable if Level 3.1. 24-hour structure is available</p>	<p>Environment is dangerous and client needs 24-hour structure to cope</p>	<p>Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting</p>	<p>Environment is dangerous and patient lacks skills to cope outside of highly structured 24-hour setting</p>

Admission Criteria

Admission to residential treatment is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider's assessment process.
- Individualized determination of need.
- ASAM Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the ASAM Criteria below:
 - i. Withdrawal potential.
 - ii. Medical conditions and complications.
 - iii. Emotional, behavioral, or cognitive conditions and complications.
 - iv. Readiness to change – as determined by the Stages of Change Model.
 - v. Relapse, continued use or continued problem potential.
 - vi. Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client/individual characteristics that include, but are not limited to, age, gender, culture, and development.

Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM Criteria. As a client/individual's needs change, the frequency, and/or duration, of services may be increased or decreased as medically necessary. Client/Individual participation in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

Service Requirements

The following chart details the required amount of services that have been established for residential treatment in the three levels of care. Documentation of all core services, and the response to them by the client/individual, must be found in the client/individual's chart. In situations where the required services cannot be provided to a client/individual in the appropriate frequency or quantity, a justification must also be documented in the client/individual record.

Level of Care	Minimum Weekly Core Services	Minimum Weekly Life Skills/Self Care
ASAM 3.1* <u>Clients-Individuals</u> with lower impairment or lower complexity of needs	At least 5 hours of clinical services per week	At least 5 hours per week
ASAM 3.3* <u>Individuals-Clients</u> with moderate to high impairment or moderate to high complexity of needs	Not less than 13 hours per week	Not less than 13 hours per week
ASAM 3.5* <u>Individuals-Clients</u> with a significant level of impairment or very complex needs	Not less than 20 hours per week*	Not less than 20 hours per week*

ASAM 3.7* <u>Individuals Clients</u> with significant level of impairment or very complex needs	Not less than 20 hours per week*	Not less than 20 hours per week*
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*services are required to be provided throughout the week, including both weekend days

Covered Services:

The following services must be available in a residential setting regardless of the LOC and based on individual client need:

Type	Residential Services Description
Basic Care	Room, board, supervision, monitoring self-administration of medications, toxicology screening, facilitates transportation to and from treatment, treatment environment: structured, safe, and recovery oriented.
Treatment Basics <u>Core Service</u>	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services, preparation for 'next step.'
Therapeutic Interventions <u>Core Service</u>	Individual, group and family psychotherapy services; appropriate for the individual's needs; and crisis intervention. Services provided by an appropriately licensed, credentialed and supervised professional working within their scope of
Interactive Education /Counseling <u>Core Service</u>	Interaction and teaching with client(s) and staff that process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Ex: disease of addiction, mental health & substance use disorder.
Life Skills/Self-Care (building recovery capital)	Social activities that promote healthy community integration/reintegration, development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education.
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; family visits; coordination with treatment, support groups; maintaining a drug/alcohol free campus.
Medical Services <u>Core Service</u>	Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available on-site.

Treatment Planning & Recovery Planning:

~~Client~~individuals entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the ~~client~~individual. Residential care should not be presented to ~~client~~individuals as being a complete episode of care. To facilitate the ~~client~~individual moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the ~~client~~individual for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the ~~client~~individual is aware that services will continue once the residential stay is over.

To make the transition to the next LOC, the residential care provider may assist the ~~client~~individual in choosing an appropriate service based on needs and location scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the ~~client~~individual. There could potentially be many other activities or arrangements that may be needed, or the ~~client~~individual may require very little assistance. To the best of their ability, it is expected that the residential provider ~~arrange~~arranges for any needed assistance to ensure a seamless transfer to the next LOC.

Continuing Stay Criteria:

Re-authorization or continued treatment should be based on ASAM-PPG continued service criteria, medical necessity, and when there is a reasonable expectation of benefit from continued care.

~~Continuing stay can be denied in situations where the client has decided not to participate in his/her treatment. This is evidenced by continued non-compliance with treatment activities, other behavior that is deemed to violate the rules and regulations of the program providing the services, or a demonstrated lack of benefit from treatment received, after documented attempts to meet the needs of the client, by adjusting the services, were made. Progress notes must support lack of benefit, and that other appropriate services have been offered, before a client can be terminated from a treatment episode.~~

The ASAM Assessment Dimensions must be used to assist in the determination of the level of care needed by a ~~client~~individual.

VII. EXHIBITS
None

VIII. REFERENCES

Reference:	Check if	Standard Numbers:
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SUD Residential Treatment Services

Page 14 of 16

Commented [DB1]: Confirm format with Stephannie

	applies:	
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPAA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Mental Health Code Act 258 of 1974	X	
The Joint Commission - Behavioral Health Standards	X	
Michigan Department of Health and Human Services (MDHHS) Medicaid Contract	X	
MDHHS Substance Abuse Contract	X	
Michigan Medicaid Provider Manual	X	
HITECH Act of 2009	X	
<u>Michigan Department of Health AND Human Services, Substance Use, Gambling, and Epidemiology Section (SUGE)MDHHS Office of Recovery Systems of Care</u>	X	

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition-Revised (ASAM PPC-2R)*. Chevy Chase, MD: American Society of Addiction Medicine, Inc.

3rd Edition: *The ASAM CRITERIA: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (2015); Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care. Michigan's ROSC Glossary of Terms. Retrieved from http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf.

~~Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Substance Use Disorder Service Programs. Promulgated pursuant to Michigan Public Act 368 of 1978, Section 6231(1), as amended. Retrieved from~~

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Social Work General Rules. Promulgated pursuant to Michigan Public Act 368 of 1978, Sections 16145(3) and 18501, as amended. Retrieved from http://www7.dleg.state.mi.us/orr/Files/AdminCode/104_85_AdminCode.pdf <http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf>

Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. *Treatment Policy #6, Individualized Treatment Planning*, (201206) Michigan Department of Community Health, Office of Drug Control Policy, https://www.michigan.gov/documents/mdch/Policy_Treatment_06_Invd_Tx_Planning_175180_7.pdf <http://www.michigan.gov/mdch/O,1607,7-132-2941-4871-4877-133156--,00.html>.

~~Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. *Treatment Policy #7, Access Management System*, (2006) Michigan Department of Community Health, Office of Drug Control Policy, <http://www.michigan.gov/mdch/O,1607,7-132-2941-4871-4877-133156--,00.html>.~~

Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. *Treatment Technical Advisory #7, Peer Recovery/Recovery Support Services*, (201208) Michigan Department of Community Health, Office of Drug Control Policy, https://www.michigan.gov/documents/mdch/TA-T-07_Peer_Recovery-Recovery_Support_230852_7.pdf <http://www.michigan.gov/mdch/O,1607,7-132-2941-4871-4877-133156--,00.html>.

Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. *Treatment Technical Advisory Policy #10: Residential Treatment Continuum of Services*, (2017) Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. [TA_10__Residential_TX_Continuum_of_Services__FINAL_33456_7.docx](https://www.michigan.gov/documents/mdhhs/Residential_TX_Policy_10_549861_7.pdf) https://www.michigan.gov/documents/mdhhs/Residential_TX_Policy_10_549861_7.pdf

Prepaid Inpatient Health Plans and Community Mental Health Services Program. Access System Standards (2015) Medicaid Managed Specialty Support Services Program FY20 https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder1/Folder61/Policy_Tx_07_AMS.pdf?rev=48bba5f1e3c5456f9de18fe8a0957564

Community Mental Health Partnership of Southeast Michigan/PIHP	Policy Overdose Education and Naloxone Distribution (OEND)
Department: Substance Use Services Author: Nicole Adelman	Regional Operations Committee Review Date 04/03/2023
Implementation Date	Oversight Policy Board Approval Date

I. PURPOSE

To reduce fatal overdoses and increase lifesaving response to overdoses by coordinating Overdose Education and Naloxone Distribution (OEND) of Community Mental Health Partnership of Southeast Michigan (CMHPSM) Naloxone and Naloxone Overdose Rescue Kits for organizations and community members.

II. REVISION HISTORY

DATE	MODIFICATION
12-2018	
4-2019	Language changes/updates/attachments
2-2022	Policy updates/attachment updates
10-2022	Policy updates/language changes/attachment updates

III. APPLICATION

This policy applies to all, organizations and community members who will be utilizing and/or providing CMHPSM approved overdose education training, naloxone and Naloxone Overdose Rescue Kits.

<input type="checkbox"/> CMHPSM PIHP Staff, Board Members, Interns & Volunteers
<input type="checkbox"/> Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
<input type="checkbox"/> Mental Health / Intellectual or Developmental Disability Service Providers
<input checked="" type="checkbox"/> SUD Treatment Providers <input checked="" type="checkbox"/> SUD Prevention Providers
<input type="checkbox"/> Other as listed:

IV. DEFINITIONS

Approved Training: Training on administration of naloxone that is provided by a CMHPSM authorized organization and any trainer within the community who received “Train the Trainer” instruction. Training should include experiential hands-on practice with the naloxone administration device when possible. The use of virtual training or virtual training platforms by trained trainers needs prior approval before implementation by CMHPSM trainers and/or CMHPSM staff. CMHPSM training is described as:

- **Train the Trainer:** This training is for organizations who would like to have their staff trained about overdose prevention, naloxone use/administration, and distribution of naloxone. Organizational staff who receive this training can:
 - Train others on how to administer naloxone
 - Provide (distribute) naloxone to those they train/serve
- **Community Layperson Training:** This is a basic overdose prevention training for anyone in the community who would like to know how to administer naloxone.
- **Healthcare Provider Training:** This is a basic overdose prevention training for anyone in the healthcare field who would like to know how to administer naloxone.
- **Law Enforcement Training:** This is a basic overdose prevention training for all law enforcement officers who would like to know how to administer naloxone.

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Opioid: A drug that is derived from the opium poppy or made synthetically. Opioids are narcotic sedatives that depress activity of the central nervous system, reduce pain, and induce sleep. First Responders often encounter opioids in the form of morphine, methadone, codeine, heroin, fentanyl, oxycodone and hydrocodone.

Naloxone: An opioid antagonist that can be used to counter the effects of an opioid overdose. Specifically, it can displace opioids from the receptors in the brain that control the central nervous system and respiratory system. It is marketed under various trademarks including, "Narcan." *Naloxone is only effective if administered to an individual who has opioids in their body.*

Naloxone Overdose Rescue Kit: A kit containing one box of Narcan® Nasal Spray (containing two doses of naloxone intranasal 4mg each) one pair of latex free gloves, one-way valve breathing barrier, instructional brochures, and other items and local resource information as applicable.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Responder: Any individual authorized to utilize CMHPSM provided naloxone or Naloxone Overdose Rescue Kit *who has completed an approved training.*

State Portal: Online portal for obtainment of naloxone which is made available to organizations through the MDHHS website.

Substance Use Disorder (SUD) Core Provider: A local provider of substance use services utilizing the ROSC Model that coordinates all levels of care for clients with substance use disorders.

Universal Precautions: An approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV, HCV and other blood borne pathogens.

V. POLICY

Through the authorization of the State of Michigan's Naloxone Standing Order (Exhibit A), only appropriately trained individuals are authorized to utilize CMHPSM provided naloxone and Naloxone Overdose Rescue Kits in an attempt to respond to an individual presenting with an apparent opioid overdose.

VI. STANDARDS

CMHPSM provided Naloxone/Naloxone Rescue Kits must be administered in accordance with approved training and training protocol. See Overdoseaction.org and Exhibit B for approved training.

CMHPSM does not require reports of naloxone use and incident reports should not be shared with CMHPSM.

CMHPSM internally tracks naloxone and naloxone rescue kits distributed to agencies/organizations, including lot # and expiration dates. If a lot is recalled, CMHPSM will notify the agencies in receipt of applicable Naloxone from CMHPSM. It is up to the agencies to further address the recall as appropriate.

1. EQUIPMENT AND MAINTENANCE

The organization or community member is responsible for the maintenance of the naloxone/Naloxone Overdose Rescue Kit once received and should follow expiration and storage instructions found in the package insert included with the NARCAN Nasal Spray product.

Expiration:

Expiration date printed on the naloxone box and on blister pack of the naloxone should be followed. It is important to check naloxone to ensure expiration date, and make arrangements for replacement 3-6 months prior to expiration.

2. DISTRIBUTION

For naloxone training and distribution, any organization that trains individuals on naloxone administration and/or distributes naloxone or Naloxone Overdose Rescue Kits **obtained from CMHPSM** will need to have all distributing staff complete the Train the Trainer course from a CMHPSM approved trainer. Each organization will be responsible to:

- A. Store the Naloxone Rescue kits in accordance with the storage instructions found in the package insert included with the NARCAN Nasal Spray product.
- B. Train individuals how to respond to opioid overdoses. Trainers should use one of the following training options:
 - a. Best Practice Training:

- i. Take ACTION curriculum and PowerPoint (Exhibit B)
 - ii. Web-based naloxone training www.overdoseACTION.org
- b. Other Training Options (to be used when above training options are unavailable or create additional barriers)
 - i. Educate the individual using the Opioid Overdose & Naloxone education brochure (Exhibit C)
 - ii. Attend another approved training by CMHPSM/MDHHS
 - Note: Any virtual training efforts must be preapproved by CMHPSM

3. REPLACEMENT

Naloxone Overdose Rescue Kits that have been used should be replaced. In the event the inventory is nearing depletion or expiration, the organization or community member should review ordering options found on the CMHPSM website: <https://www.cmhpsm.org/opioid-overdose-prevention-naloxone>.

4. ORDERING

Naloxone and Naloxone Overdose Rescue Kits can be ordered by organizations by contacting CMHPSM or completing the CMHPSM Naloxone Order Form available on the CMHPSM website (<https://www.cmhpsm.org/opioid-overdose-prevention-naloxone>).

Trained individuals and organizations are also able to order Naloxone directly through the [MDHHS Online Portal](#).

5. VIRTUAL TRAINING CONSIDERATIONS

When in-person training is unavailable, CMHPSM trainers may request pre-approval to provide virtual training. Trainers must have a plan to assess for fidelity and ensure participation via video conference platforms. Additionally, trainees will need to be able to demonstrate responding to an overdose, rescue breathing and other learning objectives of the training.

VII. EXHIBITS

- A. State of Michigan Naloxone Standing Order
- B. Take ACTION Opioid Overdose Training Curriculum Outline
- C. Patient Education Take ACTION brochure

VIII. REFERENCES

State of Michigan Enrolled Senate Bill No. 857
<https://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2014-PA-0314.pdf>

Occupational Safety & Health Administration: Bloodborne Pathogen Definitions
1910.1030(b)
[https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051#1910.1030\(b\)](https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051#1910.1030(b))

Community Mental Health Partnership of Southeast Michigan/PIHP	Policy Overdose Education and Naloxone Distribution (OEND)
Department: SUD Author: Nicole Adelman	Local Policy Number (if used)
Oversight Policy Board Approval Date TBD	Implementation Date TBD

I. PURPOSE

~~To reduce fatal opioid overdoses by allowing the training and distribution of Community Mental Health Partnership of Southeast Michigan (CMHPSM) issued Naloxone Overdose Rescue Kits by regional law enforcement agencies, first responders, crisis staff and other authorized individuals, such as trained community members.~~
 To reduce fatal overdoses and increase lifesaving response to overdoses by coordinating Overdose Education and Naloxone Distribution (OEND) of Community Mental Health Partnership of Southeast Michigan (CMHPSM) Naloxone and Naloxone Overdose Rescue Kits for organizations and community members.

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II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
12-2018		
4-2019	2.0	Language changes/updates/attachments
2-2022	3.0	Policy updates/attachment updates
6/10-2022	4.0	Policy updates/language changes/attachment updates

III. APPLICATION

~~This policy applies to all staff, organizations and community members who will be utilizing and/or providing CMHPSM approved overdose education training, naloxone and Naloxone Overdose Rescue Kits, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the CMHPSM, and any first responders, including community laypeople, who will be administering naloxone that are not under contract or in the provider network to utilize the CMHPSM issued Naloxone Overdose Rescue Kits.~~

IV. DEFINITIONS

Approved Training: Training on administration of naloxone that is provided by a CMHPSM authorized ~~agency; organization~~ Designated Law Enforcement Training Department in conjunction with Medical Personnel; Hospital; Health Department personnel or Michigan Department of Health and Human Services Designated

Trainers, and any trainer within the community who received “Train the Trainer” instruction. Training should include experiential hands-on practice with the naloxone administration device when possible. The use of virtual training or virtual training platforms by trained trainers needs prior approval before implementation by CMHPSM trainers and/or CMHPSM staff. CMHPSM training is described as:

- Train the Trainer: This training is for organizations who would like to have their staff trained about overdose prevention, naloxone use/administration, and distribution of naloxone. Organizational staff who receive this training can:
 - Train others on how to administer naloxone
 - Provide (distribute) naloxone to those they train/serve
- Community Layperson Training: This is a basic overdose prevention training for anyone in the community who would like to know how to administer naloxone.
- Healthcare Provider Training: This is a basic overdose prevention training for anyone in the healthcare field who would like to know how to administer naloxone.
- Law Enforcement Training: This is a basic overdose prevention training for all law enforcement officers who would like to know how to administer naloxone.

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Crisis Staff: Any staff assigned to a crisis response team/program within a CMHSP or substance use disorder (SUD) provider network who is involved in urgent/emergent responding to individuals engaged in using opioids and who are at risk of an overdose. This pertains to mobile outreach and crisis teams within the CMHSP, Regional Engagement Centers, emergency shelters, etc.

Opioid: A drug that is derived from the opium poppy or made synthetically. Opioids are narcotic sedatives that depress activity of the central nervous system, reduce pain, and induce sleep. First Responders often encounter opioids in the form of morphine, methadone, codeine, heroin, fentanyl, oxycodone and hydrocodone.

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Naloxone: An opioid antagonist that can be used to counter the effects of an opioid overdose. Specifically, it can displace opioids from the receptors in the brain that control the central nervous system and respiratory system. It is marketed under various trademarks including, "Narcan." *Naloxone is only effective if administered to an individual who has opioids in their body.*

Naloxone Overdose Rescue Kit: A kit containing one box of Narcan® Nasal Spray (containing two doses of naloxone intranasal 4mg each) one pair of latex free gloves, one-way valve breathing barrier, instructional brochures, and other items and local resource information as applicable.

Prescription Label: ~~A label that denotes the CMHPSM address, name of recipient agency, organization, event or individual; date of distribution; expiration date of the medication; sig notation, and prescriber name and address.~~

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Responder: Any individual authorized to utilize ~~a~~ CMHPSM provided naloxone or Naloxone Overdose Rescue Kit *who has completed an approved training.*

State Portal: Online portal for obtainment of naloxone which is made available to organizations through the MDHHS website.

Substance Use Disorder (SUD) Core Provider: A local provider of substance use services utilizing the ROSC Model that coordinates all levels of care for clients with substance use disorders.

Universal Precautions: An approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV, HCV and other blood borne pathogens

V. POLICY

Through the authorization of ~~a prescriber's standing order~~ the State of Michigan's Naloxone Standing Order (Exhibit A), only appropriately trained individuals are authorized to utilize CMHPSM ~~funded provided Naloxone-naloxone and Naloxone~~ Overdose Rescue Kits in an attempt to respond to an individual presenting with an apparent opioid overdose. ~~Tracking of distribution will be maintained by CMHPSM staff using a Naloxone Rescue Kit Distribution Log (Exhibit B).~~

Commented [AT1]: Change to State's Standing Order

VI. STANDARDS

~~1. CMHPSM provided Naloxone/Naloxone Rescue Kits must be administered in accordance with approved training and training protocol. See Overdoseaction.org and Exhibit DB for approved training.~~ ASSESSMENT AND ADMINISTRATION

~~In the event that a responder has arrived at the scene of a medical emergency prior to the arrival of EMS and has made a determination that the patient is displaying symptoms consistent with a suspected opioid overdose, the~~

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responding individual shall administer four milligrams of intranasal Narcan spray to the person by way of the nasal passages.

The following A.C.T.I.O.N. steps should be taken for **first responders** such as law enforcement officers:

- A. Responder shall use universal precautions.
- B. A brief medical assessment of the person as prescribed by First Aid Training can be conducted.
 - a. Taking into account statements from witnesses and/or family members regarding drug use.
 - b. Drug paraphernalia observed at the scene.
- C. The first responder shall
 - 1. **Arouse** the person using the "3 S's." Shout the person's name, shake the shoulders vigorously, and perform a sternal rub against the breastbone of the person.
 - 2. **Check** for signs of opioid overdose: pinpoint pupils, blue lips/fingernails, shallow/slowed or stopped breathing, snoring/gurgling sounds, unconsciousness, unresponsive to pain stimulus (sternal rub).
 - 3. **Telephone 911** For the first responder, communicate with dispatch
 - 4. **Intranasal/Intramuscular Naloxone** If the first responder makes a determination *the individual has symptoms consistent with a suspected opioid overdose, the Naloxone Overdose Rescue Kit shall be utilized.*
 - a. The first responder shall remove the back seal from the package, remove Narcan nasal spray, insert the nozzle into the nose, and push the plunger.
 - b. Note: in the event the responder is using another FDA-approved naloxone device, they should follow the accompanying package insert instructions.
 - 5. **Oxygen** After administering naloxone, the responder shall carry out appropriate resuscitation measures according to their First Aid Responder training (i.e. CPR and/or rescue breathing) as delivering oxygen to the person is critical in an overdose.
 - 6. **Naloxone Again** In the event the person does not resume breathing or regain consciousness, naloxone may be repeated every 2-3 minutes until EMS arrives.
 - a. EMS shall be contacted, and the person should be encouraged to be transported to the hospital for medical attention via EMS.
 - b. Responder should stay with the person until EMS arrives.
 - c. The person can be placed in a position of comfort once consciousness is regained and breathing resumes. If the person vomits, a recovery position shall be utilized (see image to right)



For **community layperson** administration, the following A.C.T.I.O.N. steps shall be taken: (It is recommended that the community layperson should use universal precautions if available prior to administering naloxone.)

- A. **Arouse** the person with the 3 S's: Shout the person's name, shake their shoulders vigorously, and perform a sternal rub by making fist and rubbing it along the breastbone of the person to check for pain response.
- B. **Check** for signs of an opioid overdose which may include some or all of these symptoms: pinpoint pupils, shallow/slow breathing or no breathing, gurgling/snoring-like sounds, unconsciousness, unresponsive to pain stimulus
- C. **Telephone 911**
- D. **Intranasal/Intramuscular Naloxone** administer intranasal naloxone by removing the back seal from the package, inserting the Narcan nasal spray nozzle into the nose, and pushing the plunger. *Note: in the event the responder is using another FDA approved naloxone device, they should follow the accompanying package insert instructions.*
- E. **Oxygen** As oxygen is critical to survival, the responder can deliver 2 rescue breaths initially and then 1 breath every 5 seconds, or perform CPR, or follow dispatch instructions. The responder can do what they are comfortable in performing and according to what they are trained to do while waiting for EMS to arrive.
- F. **Naloxone Again** If the person does not resume breathing or regains consciousness after the initial dose of Narcan nasal spray, the responder can repeat naloxone every 2-3 minutes until the person resumes breathing, regains consciousness, or EMS arrives.
 - a. Responder should stay with the patient until EMS arrives.
 - b. The person can be placed in a position of comfort once consciousness is regained and breathing resumes. If the person vomits or if the responder must leave the situation, a recovery position shall be utilized (see image to right)



Commented [AT2]: I recommend removing or shortening this. Individuals are not going to refer to our policy for training steps. We could instead link to our website or overdoseaction.org

Commented [RD3R2]: Agree- Under STANDARDS, maybe include: "CMHPSM provided Naloxone/Naloxone Rescue Kits must be administered in accordance with steps provided in approved training. See overdoseaction.org and EXHIBIT D"

2. REPORTING

A complete report of the incident shall be completed per the responders' organizational policies for internal reporting. CMHPSM does not require reports of naloxone use and incident reports should not be shared with CMHPSM.

CMHPSM internally tracks naloxone and naloxone rescue kits distributed to agencies/organizations, including lot # and expiration dates. If a lot is recalled, CMHPSM will notify the agencies in receipt of applicable Naloxone from CMHPSM. It is up to the agencies to further address the recall as appropriate.

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3-1. EQUIPMENT AND MAINTENANCE

It shall be the responsibility of the responders to inspect Naloxone Overdose Rescue Kits issued to them prior to the start of each shift (in the case of law enforcement) or at a minimum monthly, to ensure that the kits are intact. The responder organization or community member will be responsible for the assigned maintenance of the naloxone/Naloxone Overdose Rescue Kit once

~~received and must be able to account for it at all times. should follow expiration and storage instructions found in the package insert included with the NARCAN Nasal Spray product.~~

Commented [AT4]: This was very specific to law enforcement. I updated this to be more generic of those who receive our kits.

Expiration:

~~Please follow the e~~Expiration date printed on the naloxone box and on blister pack of the NARCAN Nasal Spray Product you havenaloxone should be followed. It is important to check your box of naloxone to ensure expiration date, and ~~to~~ make arrangements for replacement 3-6 months prior to expiration.

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Storage:

~~Store NARCAN Nasal Spray in accordance with the storage instructions found in the package insert included with NARCAN Nasal Spray product you have.~~

Commented [RD5]: I think this could be removed since it's now included above.

4.2. DISTRIBUTION

For community naloxone training and distribution, any organization that trains individuals on naloxone administration and/or distributes naloxone or Naloxone Overdose Rescue Kits **obtained from CMHPSM** will need to have at least two staff/representatives~~all distributing staff~~ complete the Train the Trainer course from a CMHPSM approved trainer. Each organization will be responsible to:

A. Store the Naloxone Rescue kits in accordance with the storage instructions found in the package insert included with the NARCAN Nasal Spray product you have. ~~Naloxone Overdose Rescue Kits should be stored in a secure, lockable cabinet limited to individuals who have received the Train the Trainer training.~~

Commented [AT6]: Is there a reason we require the naloxone to be locked? Shouldn't it be accessible?

B. Train individuals how to respond to opioid overdoses. ~~Trainers should use one of the following training protocol options:~~

Commented [AT7R6]: Agreed to remove

a. Best Practice Training:

i. Take ACTION curriculum and PowerPoint (Exhibit ~~F~~B)

ii. Web-based naloxone training www.overdoseACTION.org

B.b. Other Training Options (to be used when above training options are ~~unavailable or create additional barriers~~)

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a. ~~Take ACTION curriculum protocol and PowerPoint (Exhibit F) OR~~

b.a. At the minimum, educate Educate the individual using topics ~~covered in the Opioid Overdose & Naloxone~~ patient education brochure (Exhibit ~~G~~C) **OR**

~~e. Utilize the web based naloxone training found on www.overdoseACTION.org OR~~

~~d.b. Attend another approved training by CMHPSM/MDHHS~~

i. Note: Any virtual training efforts must be preapproved by CMHPSM

~~C. Sign a Receipt of Naloxone Overdose Rescue Kit (Exhibit H) and submit to CMHPSM.~~

~~D. Sign a Memorandum of Understanding (MOU) with CMHPSM if receiving Naloxone Overdose Rescue Kits for further distribution outside of agency staff (Exhibit ID).~~

- a. ~~If an individual/individual/organization can obtain naloxone (i.e., MDHHS State Portal, Community Organizations, etc.) does not have an affiliated organization or the organization is unable to sign a Memorandum of Understanding (MOU) with CMHPSM, they will need to work directly with CMHPSM to coordinate getting the distribution of naloxone rescue kits to trained individuals. CMHPSM may recommend the state naloxone portal or another local organization who has an MOU who can verify the training occurred and distribute a kit. This will be considered on a case by case basis and CMHPSM will need to document reason why an MOU cannot be obtained.~~

~~5-3. REPLACEMENT~~

~~Naloxone Overdose Rescue Kits that have been used should be replaced. In the event the inventory is nearing depletion or expiration, the agency organization or community member should notify the CMHPSM to determine if additional resources are available to replenish the supply review ordering options found on the CMHPSM website: <https://www.cmhpsm.org/opioid-overdose-prevention-naloxone> 3-6 months prior to expiration date.~~

~~6-4. ORDERING~~

~~Naloxone and Naloxone Overdose Rescue Kits and/or boxes of Naloxone can be ordered by trained individuals and organizations by contacting CMHPSM or completing the CMHPSM Naloxone Order Form available on the CMHPSM website (<https://www.cmhpsm.org/opioid-overdose-prevention-naloxone>).~~

~~To order Naloxone CMHPSM will need the following information:~~

- ~~• Ordering Individual's Name~~
- ~~• Organization~~
- ~~• Date Trained~~
- ~~• Trainer/Training Organization Name~~
- ~~• Number of Naloxone Overdose Rescue Kits needed or Naloxone only~~
- ~~• Date Needed~~
- ~~• Pick Up or Delivery (Delivery is dependent on location and ability of staff to deliver)~~

~~Trained individuals and organizations are also able to order Naloxone directly through the MDHHS Online Portal. Please note, that the State Portal is only for Naloxone. To order full Naloxone Overdose Rescue Kits contact CMHPSM directly.~~

~~7-5. VIRTUAL TRAINING CONSIDERATIONS~~

~~When in-person training is unavailable, CMHPSM trainers may request pre-approval to provide virtual training. Trainers must have a plan to assess for fidelity and ensure participant participation via video conference platforms. Additionally, trainees will need to be able to demonstrate responding to an overdose, rescue breathing and other learning objectives of the training. Training can be provided to all ages, but individuals must be 14 or older to receive naloxone medication/rescue kits.~~

Commented [AT8]: Should we include our standard response on disposal?

"Individuals/Organizations should dispose of naloxone using typical disposal methods. For more information, please contact: www.narcannasalspray.com or call 1-844-4NARCAN (1-844-462-7226).

Commented [RD9R8]: I don't think so... there might be a possibility for raising more questions?

Commented [RD10]: Is this needed?

Commented [AT11]: I think this can be removed

Commented [RD12R11]: I agree, and actually think the whole thing about the portal can be removed since this is specific to CMHPSM.

Commented [NA13R11]: Do we not want to promote the kits?

Commented [AT14R11]: We do promote the kits outside of the policy. We typically give individuals requesting naloxone the options and send our policy at the same time, so I'm not sure the promotion of the kits has to be in our policy. It's also in the order form.

VII. EXHIBITS

- A. ~~Prescriber's Standing Order for Opioid Overdose Rescue with Naloxone~~ [State of Michigan Naloxone Standing Order](#)
- B. ~~Naloxone Rescue Kit Distribution Log Sample~~
- ~~C.~~ [B. Take ACTION Opioid Overdose Training Curriculum Outline](#)
- ~~D.~~ [C. Patient Education Take ACTION brochure](#)
- ~~E.~~ [Receipt of Naloxone Overdose Rescue Kits](#)
- ~~F.~~ [Naloxone Distribution Memorandum of Understanding](#)

Commented [AT15]: Remove?

Commented [RD16R15]: I just updated exhibit A to be the link to what the state references (saved in attachment/exhibit folder).

VIII. REFERENCES

State of Michigan Enrolled Senate Bill No. 857
<https://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2014-PA-0314.pdf>

Occupational Safety & Health Administration: Bloodborne Pathogen Definitions 1910.1030(b)
[https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051#1910.1030\(b\)](https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051#1910.1030(b))



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

April 18, 2023

James Colaianne, CEO
Community Mental Health Partnership of Southeast Michigan (CMHPSM)
3005 Boardwalk Drive, Ste. 200
Ann Arbor, Michigan 48108

Dear Mr. Colaianne:

Thank you for the cooperation extended to the Michigan Department of Health and Human Services (MDHHS) staff during the March 9, 2023, virtual site visit.

PRESENT AT THE SITE VISIT

CMHPSM

Nicole Adelman, Substance Use Services Director
CJ Witherow, COO
Michelle Sucharski, CIO
Matt Berg, CFO
Jane Goerge, Prevention Coordinator
Joelen Kersten, Clinical Treatment Coordinator

MDHHS

Angie Smith-Butterwick, SUGE Section Manager
Lisa Coleman, Departmental Prevention Specialist
Heather Rosales, Women's Treatment Specialist
Ecole Barrow-Brooks, Analyst
Madison Watts, Site Review Analyst
Kelli Dodson, Site Review Coordinator

SITE VISIT FINDINGS

After careful consideration and review of the requirements and documentation submitted, we have determined that CMHPSM is in substantial compliance with the substance use disorder (SUD), Prepaid Inpatient Health Plan (SUD/PIHP) Compliance Protocol.

The following area was given partial compliance:

Women's Specialty Services (WSS)

Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such services, childcare for their dependent children.

James Colaianne, CEO
Community Mental Health Partnership of Southeast Michigan (CMHPSM)
April 18, 2023
Page 2

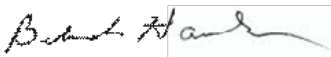
- Partial compliance. All WSS brochures must include the following statement, “Pregnant and Parenting Women are a priority for admission to treatment.”

As CMHPSM is already in the process of correcting the concerns noted, a Corrective Action Plan is not required. Currently, CMHPSM has the necessary tools in place to manage, maintain and report data from their provider network. Their providers will screen individuals to assess their needs and provide or make referrals for interventions as needed for individuals with an SUD.

We greatly appreciate CMHPSM for the site visit and their commitment to provide our staff with the necessary documentation.

If you have any further questions, please contact Kelli Dodson, Site Review Coordinator at dodsonk@michigan.gov.

Sincerely,



Belinda Hawks, MPA,
Director
Division of Adult Home and Community Based Services
Behavioral and Physical Health and Aging Services Administration

BH/kd

cc: Angie Smith-Butterwick
Kelli Dodson
Lisa Coleman
Heather Rosales
Ecole Barrow-Brooks
Madison Shutes

**COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
April 12, 2023**

Members Present: Judy Ackley, Patrick Bridge (remote), LaMar Frederick, Bob King, Molly Welch Marahar, Alfreda Rooks, Mary Serio, Holly Terrill, Ralph Tillotson

Members Absent: Roxanne Garber, Annie Somerville

Staff Present Kathryn Szewczuk, Stephannie Weary, James Colaianne, Matt Berg, Nicole Adelman, Connie Conklin, Stacy Pijanowski, CJ Witherow, Heather Schubbe

Guests Present: Margaret Debler, Andrew Brege

- I. Call to Order
Meeting called to order at 6:03 p.m. by Board Chair B. King.
- II. Roll Call
 - Quorum confirmed.
- III. Consideration to Adopt the Agenda as Presented
Motion by R. Tillotson, supported by M. Welch Marahar, to approve the agenda
Motion carried
- IV. Consideration to Approve the Minutes of the 2-8-2023 Meeting and Waive the Reading Thereof
Motion by J. Ackley, supported by M. Serio, to approve the minutes of the 2-8-2023 meeting and waive the reading thereof
Motion carried
- V. Audience Participation
None
- VI. Old Business
 - a. Board Information: March Finance Report – FY2023 as of February 28th
 - M. Berg presented.
- VII. Closed Session with CMHPSM Attorneys on Lawsuit
Motion by B. King, supported by M. Serio, to go into closed session to discuss litigation and trial strategy with attorneys regarding Case No. 2:16-cv-10936-PDB-EAS, pending in the Eastern District of Michigan, because discussion in open session will be detrimental to our financial, settlement, and trial positions in the case
Motion carried
Roll Call Vote
Yes: Ackley, Frederick, King, Welch Marahar, Rooks, Serio, Terrill, Tillotson
No:
Non-voting: Bridge
Absent: Garber, Somerville

CMHPSM Mission Statement

Through effective partnerships, the CMHPSM shall ensure and support the provision of quality integrated care that focuses on improving the health and wellness of people living in our region.

- The Regional Board entered into closed session to meet with attorneys M. Debler and A. Brege. Staff members J. Colaianne, C. Witherow, and S. Weary were also present.
- All other meeting attendees were excused from the meeting.

Motion by M. Serio, supported by R. Tillotson, to re-enter in to open session

Motion carried

Roll Call Vote

Yes: Ackley, Frederick, King, Welch Marahar, Rooks, Serio, Terrill, Tillotson

No:

Non-voting: Bridge

Absent: Garber, Somerville

- Meeting attendees were re-admitted into the meeting.

VIII. CEO Performance Review Committee Update

- M. Serio presented the compiled SWOT feedback from board members, OPB members, and CMH directors. The positive review does not require any corrective action related to CEO performance.
- The CEO Evaluation Committee and J. Colaianne will meet to develop clear and tangible goals for next year's review.

IX. New Business

a. Board Action: FY2023 Q1 QAPIP Status Report

- C. Witherow presented.
- There were no significant risks for any of the indicators.

Motion by M. Welch Marahar, supported by R. Tillotson, to approve status report of the FY2023 Q1 Quality Assessment and Performance Improvement Program (QAPIP)

Motion carried

b. Board Action: SIS Assessor Transition / SIS Quality Lead Elimination

Motion by R. Tillotson, supported by A. Rooks, to approve recommended job title changes for CMHPSM positions #112, #113 and #128. Reduce one position to a temporary status through 9/30/2023. Approve elimination of CMHPSM position #114 effective 4/12/2023.

Motion carried

c. Board Action: Contracts

Motion by M. Welch Marahar, supported by M. Serio, to authorize the CEO to execute the contracts/amendments as presented

Motion carried

d. Board Information: CEO Contract Authority Update

- J. Colaianne approved the region's participation of the CMHPSM at 5.4% of an Michigan Consortium of Healthcare Excellence (MCHE) project with the other 8 MCHE members, enacted within CEO contract authority.

e. Board Information: Annual Board Governance Review

- The Board will review the Board Governance Manual and policies listed below and forward any concerns/questions to the CEO. These items will be presented to the board in June for approval.
 - i. Board Governance Manual
 - ii. CMHPSM Bylaws
 - iii. CMHPSM CEO Authority – Employee Position Control and Compensation
 - iv. CMHPSM CEO General Scope of Authority
 - v. Conflict of Interest Policy

CMHPSM Mission Statement

Through effective partnerships, the CMHPSM shall ensure and support the provision of quality integrated care that focuses on improving the health and wellness of people living in our region.

- vi. Financial Stability & Risk Reserve Management
- vii. Investing
- viii. Procurement

X. Reports to the CMHPSM Board

- a. Board Information: FY2023 Q1-Q2 Strategic Metrics Report
 - J. Colaianne presented the 6-month report.
 - Going forward, an explanation of quadruple aim will be included in the report.
- b. Board Information: CEO Report to the Board
 - J. Colaianne's written report includes updates from staff, regional and state levels. Please see the report in the board packet for details.
- c. Update on CMHPSM Finance Department Incident
 - J. Colaianne advised the board of a situation in which the PIHP sent money to a false vendor based on a bad actor gaining control of a provider's email address. Staff didn't follow established process in verifying contact through phone or video call.
 - The PIHP continues to work with the Ann Arbor Police Department, the Michigan Municipal Risk Management Authority (MMRMA), and JP Morgan Chase bank fraud department, in an attempt to reclaim the money.
 - The funds will have to come out of PBIP, which are the only local dollars the PIHP has.
 - J. Colaianne will continue to update the board.
- d. Lakeshore PIHP Deficit Lawsuit Update
 - Lakeshore won their lawsuit against the state of Michigan, regarding the use of current year's funds to pay past-year's deficits.

XI. Adjournment

Motion by A. Rooks, supported by M. Serio, to adjourn the meeting

Motion carried

Meeting adjourned at 7:45 p.m.

Judy Ackley, CMHPSM Board Vice-Chair



CEO Report

Community Mental Health Partnership of Southeast Michigan

Submitted to the CMHPSM Board of Directors
April 6, 2023 for the April 12, 2023 Meeting

CMHPSM Update

- The CMHPSM held an all-staff meeting on February 13, 2023 and March 13, 2023. On March 27th we held an all staff training on some of the capabilities related to cloud based software capabilities within our Microsoft suite. We have recently started utilizing OneDrive to replace faxed in invoices, hosted documents to better collaborate and track changes and are working towards moving more projects to Microsoft Planner for project management updates.
- The CMHPSM leadership team is continuing to meet on a weekly basis. We recently moved our meetings to Fridays from Mondays.
- We had a significant issue in the CMHPSM finance department that I will give an in-person update on at the meeting.

COVID-19 Update

- We have recently worked to supply some PPE products to some of our SUD providers and we're currently working with MDHHS to obtain some additional COVID-19 test kits for our SUD service providers.
- The federal public health emergency is still planned to end on May 11, 2023 according to recent reports.

CMHPSM Staffing Update

- The CMHPSM currently has one open position that we are actively recruiting:
 - SUD Care Navigator
- We have recently hired Raquel Sparkman as our Compliance and Quality Improvement Manager. We were excited to have Raquel join the team as of March 13, 2023.
- We have also added James Luckey to our team as our Information Management Coordinator. James joins us after Eric Budnik moved on to other employment. James brings years of experience with electronic health records and information technology, we were excited to welcome James to the team on Monday April 3, 2023.
- More information and links to job descriptions and application information can be found here: <https://www.cmhpsm.org/interested-in-employment>

Regional Update

- Our regional committees continue to meet using remote meeting technology. The Regional Operations Committee will work with our committees to determine best practices moving forward related to in-person versus remote regional committee meetings.
- The Regional Operations Committee continues to meet on at least a weekly basis. The remote meetings are allowing our region to share best practices while obtaining a regional picture of our COVID-19 pandemic response.

Statewide Update

- Lakeshore Regional Entity has won a lawsuit in the Court of Claims related to repayment of their past deficits. I will give an in person update at our meeting related to the potential impact on our region’s deficit repayment.
- PIHP CEO meetings are being held remotely on a monthly basis. Since our last Regional Board meeting, the PIHP CEOs met on March 7, 2023 and April 4, 2023.
- The PIHP CEO / MDHHS operations meetings with MDHHS behavioral health leadership staff were held on March 2, 2023 and April 6, 2023. Included in the meetings are updates on the various emergency waivers and MDHHS COVID-19 funding that impact our service delivery systems, funding, and requirements. I provide a summary of those meetings to our regional directors at our Regional Operations Committee meetings each month.
- MDHHS re-enrollment processes will begin in April and May for individuals with a June enrollee date. The process will progress through eligibility month re-enrollment over a 12 to 14 month period to not overwhelm the MDHHS enrollment systems.
- A MDHHS-PIHP rate setting meeting was recently scheduled for April 19, 2023 to discuss a potential FY2023 rate adjustment to align with projected enrollment decline and FY2024 rate models.

Future Update

- We are planning to cover the following items at our June 2023 meeting:
 - FY2024-FY2026 Strategic Plan
 - Regional Board Member Conflict of Interest Form Renewal

- Potential meeting with Michigan State Legislature Representatives on the Behavioral Health committees

Respectfully Submitted,

A handwritten signature in blue ink, appearing to read "James Colaianne", is written over a light yellow rectangular highlight.

James Colaianne, MPA