



**Detroit Wayne
Integrated Health Network**

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Detroit, MI 48202-2943
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www.dwihn.org

FAX: (313) 833-2156
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

CRSP/Outpatient Provider Meeting

Friday, November 17, 2023

Virtual Meeting

10:00 am –11:00 am

Agenda

Zoom Link: <https://dwihn-org.zoom.us/j/93220807823>

- I. Welcome/Introductions
- II. MRS – Nickco Dixon
- III. Claims Department – Quinetta Robinson
 - Claims Reminders (Pages 3-7)
- IV. Adult Initiatives –
 - Med Drop - Tanya Woodards (Page 8)
 - BHTEDS - Allison Gabridge (Pages 9-17)
 - MyStrength/ACT/PAR Completion - Denequa Mixon (Pages 18-39)
- V. Compliance Department – Kiara Merrity (Pages 40-42)
- VI. Recipient Rights Department – LaShanda Neely
 - ORR Training
 - Monitoring & Prevention (Pages 43-46)
- VII. Credentialing Department– Ricarda Pope-King
 - Credentialing Updates (Pages 48-53)
- VIII. Access Center – Joi Meeks
 - School Success Initiative Referrals – New Procedure
 - MDOC – Release of Information (ROI) and monthly progress report to case manager
 - Hospital Discharge Follow Up Appointments- Case Manager (7 Days) and MH Practitioner (30 Days)
 - CRSP Change – Request Forms and Adding an Addendum to the IPOS (Pages 54-65)
- IX. Administrative Updates – Eric Doeh, President and CEO

Board of Directors

Kenya Ruth, Chairperson
Karima Bentounsi
Angelo Glenn

Dr. Cynthia Tauog, Vice Chairperson
Angela Bullock
Jonathan C. Kinloch

Dora Brown, Treasurer
Lynne F. Carter, MD
Kevin McNamara

William Phillips, Secretary
Eva Garza Dewaelsche
Bernard Parker

Eric W. Doeh, President and CEO



- X. Questions
- XI. Adjourn



Claims Department
Quinnetta Robinson
Claims Manager

Claims Data Entry Status

- Please remember when a claim is in “claims data entry” status you the Provider have complete control over the claim. The claim can be edited and modified as it has not been submitted for claims adjudication.

Batch Date	Batch Status	# of Claims	Totals	
10/31/2023	Claim Data Entry	1	Claimed: \$4,250.00 Payable: \$0.00	View Claims in Batch Adjudication Report Take Over Batch View Batch Info Scanned/Uploaded Documents

- Please Do Not send inquiries through the PIHP claims mailbox if your claim is in this status. Some errors/edits will be resolved in the adjudication phase of your claims processing. There will be a clear and precise comment placed on the claim if the issue can not be resolved. This comment will identify what needs to occur to bring forth claim payment. Only when the claim has completed the adjudication process, and you disagree with the outcome or need further clarification an inquiry should be sent to PIHPclaims@dwihn.org for further claims review at a management level.

Personal Work Emails

- The PIHP claims mailbox is managed by DWIHN's claims leadership team which includes.
 - Quinnetta Robinson (Claims Manager)
 - Deabra Hardrick-Crump (Director of Claims)
 - Debra Schuchert (Claims Supervisor)
- Please send all claims inquiries via the PIHPclaims@dwihn.org mailbox to have your issue reviewed and refrain for utilizing the personal emails of the individuals listed above. Your claims issues will be addressed timelier and allows for us to better track patterns and identify the scale of claim issues.

Year End Closeout

- ▶ All outstanding encounters and claims **MUST** be submitted within MH-WIN by **Thursday, November 30, 2023**. All denials and rejections (including those incurred in the month of September) **MUST** also be submitted within MH-WIN by **Thursday, November 30, 2023**, with exception to MI Health Link (MHL), any submissions received after these dates will **NOT** be considered for reimbursement.

Contacts

- **Issues should be sent to the appropriate department.**
- Authorizations – pihpauthorizations@dwihn.org / residentialauthorizations@dwihn.org
- Contract issues – contact your Contract Manager
- System issues – mhwin@dwihn.org
- Finance issues - tomani@dwihn.org



Life is complicated.

**Getting your medication
doesn't have to be.**

People-first pharmacy care

Managing your prescriptions can be time consuming and overwhelming. That's why the team at Genoa Healthcare® started Genoa's MED DROP™ program. We can help you get — and stay on — your medications, keeping you out of the hospital and in your home.

The dedicated program staff can make things easier for you by:

- Bringing your medications to your residence or location in the community
- Educating you on your medications and providing strategies to help you remember to take them
- Organizing your prescriptions in pre-filled pill organizers and managing your refills
- Coordinating care with your case manager and treatment team

“This program helps me stay on my medications, even when I'm having a hard day.”

- Genoa consumer

Learn more

Talk to your case manager about completing a referral on your behalf or visit us at www.genoahealthcare.com for more information.

BHTEDS

A View from 4,000 Feet



2 Primary Purposes

Collect demographic information individuals who receive BH treatment services

Measures the direction and magnitude of change by using this T1-T2 model.

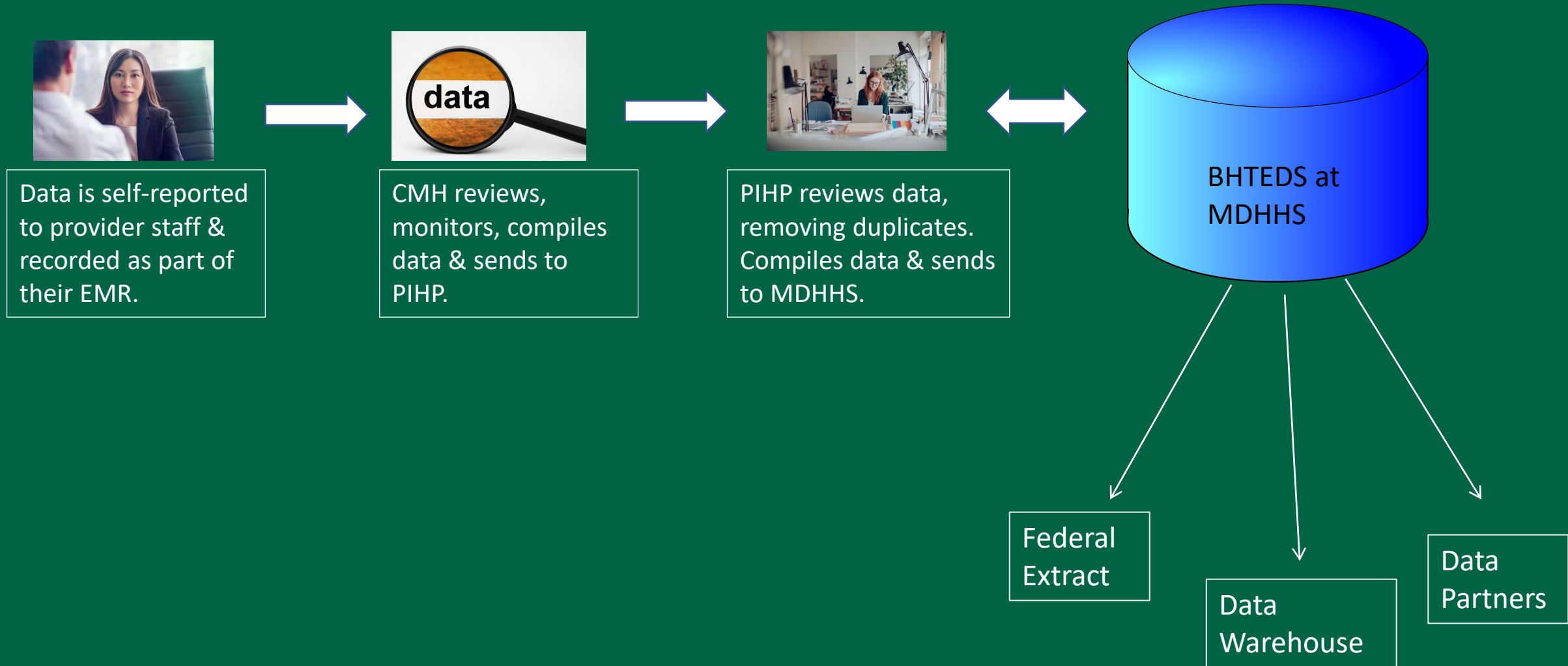




Episode

- Data captured at:
 - Admission
 - Update (at least annually)
 - Discharge
- To build an episode of Care

BHTEDS Data Flow



Demographic Information

Date of Birth

Sex Assigned at Birth

Gender Identity

Race

Hispanic or Latino Ethnicity

Pregnant at Service Start Date

County of Residence

Veteran Status (includes era, branch, family military history)

SSN, Medicaid ID, Medicare ID

Data that allows us to measure magnitude & direction of change

- How did their living condition change?
- How did their employment status change?
 - If they are not in competitive, integrated labor force, what are they doing?
 - Are they earning at least minimum wage?
 - What is their average hours worked in last 2 weeks?
 - What was their hourly wage in the last 2 weeks?
 - Has their annual income increased/decreased?

Data that allows us to measure magnitude & direction of change

- How has their level of education changed?
- Are they currently attending school?
- How has their interaction with law enforcement/criminal justice changed?
- How has their substance use changed? How has their LOCUS Score changed?
- How has their level of care changed?



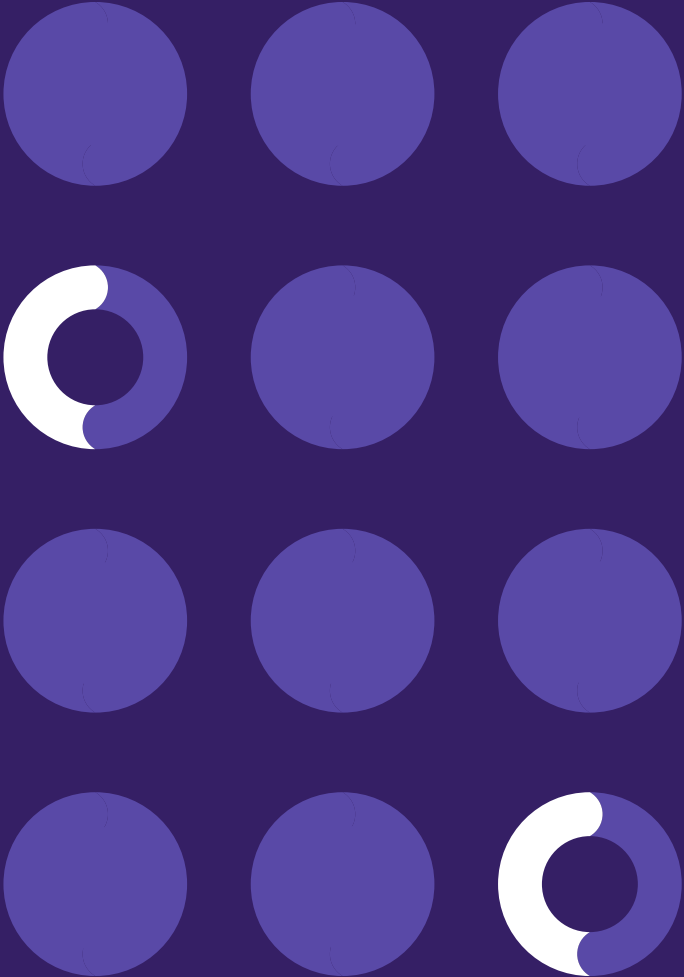
Considerations when using BHTEDS

- Not currently tied to MPI (but currently investigating).
- If person is open in multiple regions, they may have multiple overlapping BHTEDS episodes.
- SU – episode is at the provider level, so greater chance of multiple episodes in a given time period that is being analyzed (IE FY)
- Data is due to MDHHS by the end of the month of the month following Start/Update/End date.

In addition to demographic data, how has their life changed during the course of treatment?

- Used to defend funding.
- De-identified data shared with other agencies (i.e. MSP, MSU, WSU, GVSU, NDEWS, etc.
- Data shared w/Internal Partners)





Detroit Wayne Integrated Health Network

myStrength Overview Fall 2022

Detroit Wayne Integrated Health Network Vision for myStrength Partnership



Evidence-based self-help resources for emotional health and overall well-being

Explore all

Building resilience

- Mindfulness and meditation
- Reducing stress
- Balancing intense emotions

Conditions

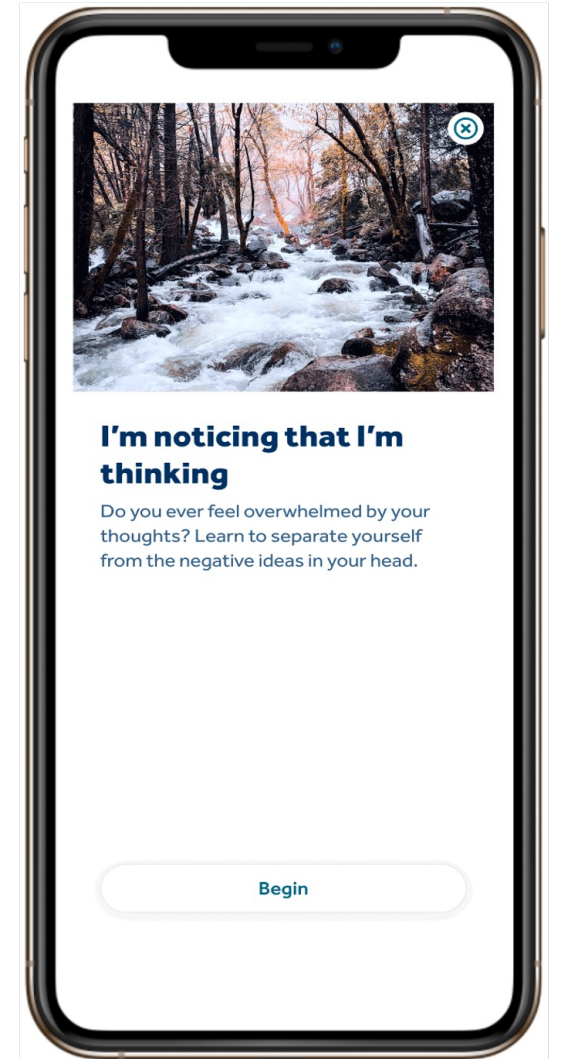
- Managing depression
- Managing anxiety
- Improving sleep

Navigating life [See all](#)

- Coping during COVID-19
- Pregnancy and early parenting
- Racism and discrimination
- LGBTQ+ emotional health

Physical activity

- Weight management
- Eating well
- Physical fitness
- Getting active



How does myStrength help?



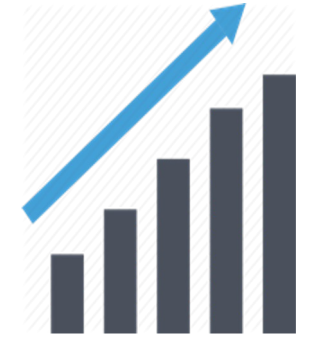
Evidence-based

MIND**BODY.**

Multi-condition
and holistic



Web-
responsive &
mobile tool for
your toolbox



Demonstrated
results



Personal
and relevant



Interactive,
available
24/7/365



Safe & Secure



Hopeful
and helpful

Digital programs offer broad coverage

Clinically comprehensive

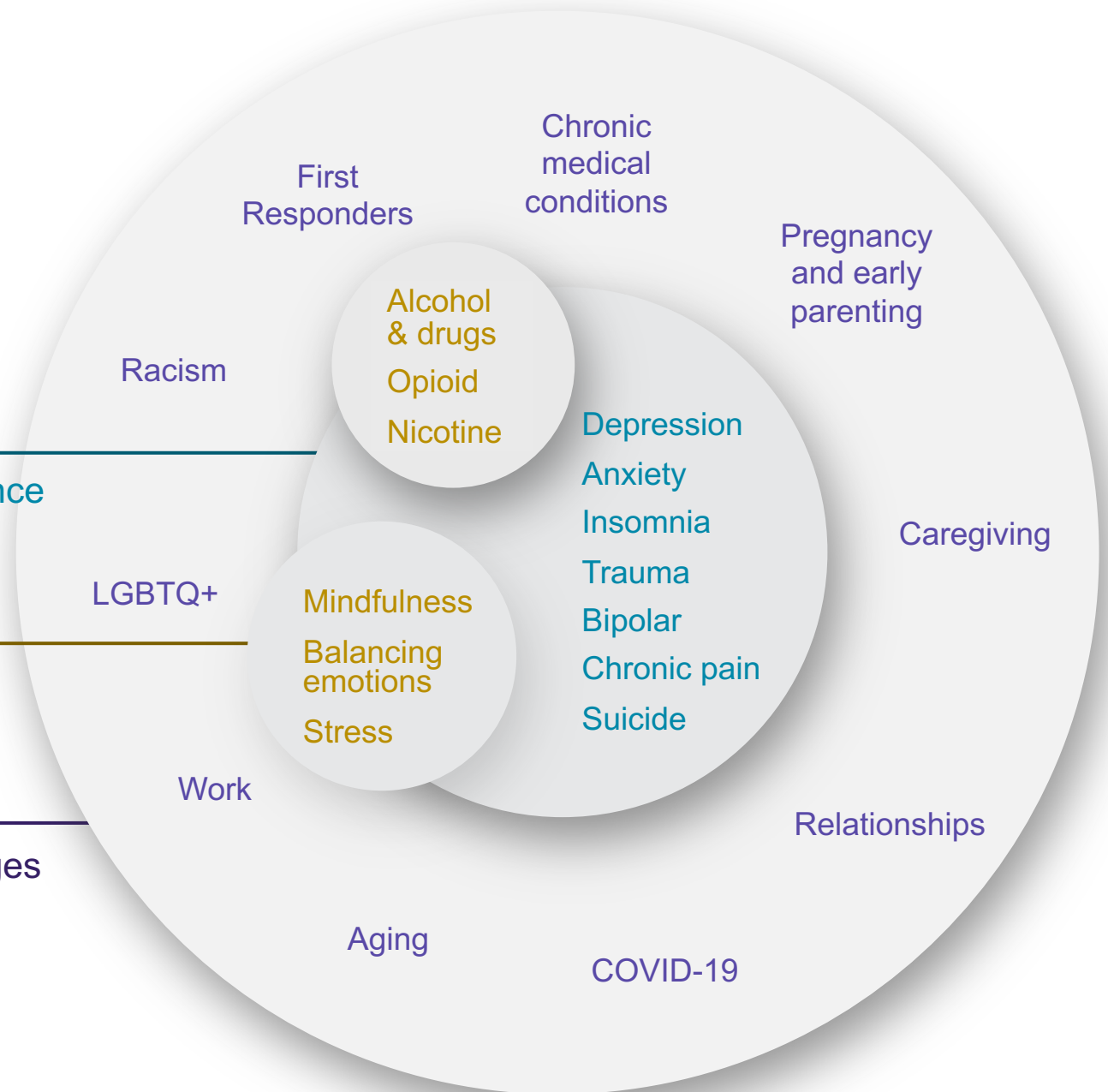
Highest prevalence conditions, including substance use

Tools for everyone

Tools to build resiliency at all acuity levels

Contextual and relevant

Managing distress from life events and challenges



Personalized Experience

The screenshot shows a user interface for emotional health assessment and activity recommendations. At the top, there is a question: "How is your emotional health today?" followed by five smiley face icons ranging from a sad face to a happy face. Below the icons, the words "Awful" and "Great" are positioned under the first and last icons respectively. Below this is a "RECOMMENDED" section titled "Managing anxiety" with a subtext "Learn simple, everyday skills to help manage anxiety." and a "Begin program" button. Below that is a "JUST FOR YOU" section titled "The surface and the d" with a subtext "This guided meditation will help" and a "Managing anxiety" title. Below this is a "TAKE A MOMENT" section titled "Feeling time move th" with a subtext "Is it possible to sense the pass". In the foreground, there is a detailed view of the "Managing anxiety" section, showing three activity cards: "The emotion cycle" (Your emotions are connected to all your experiences.), "Staying grounded in body and mind" (Skills to help ease anxiety.), and "New responses and experiences" (When you're ready, making small changes helps.).

Individualized Series of Activities

- Based on user preferences
- Adapted as feedback is provided

Diverse Activity Formats

- Sequential learning-based
- Video-guided
- Audio-guided meditation
- Inspirational
- Faith-based/non-denominational

Learning Engine Customization

- Designed by data science team
- Various models accounting for relevance, popularity, similarity, serendipity, etc.

Build a healthier mind for a stronger you

Get a flexible and comprehensive digital program with proven tools and dedicated support for stress, depression, sleep, and more.

Join now

myStrength Registration Experience

Access code for you as an employee:
DWIHNWellness



[Contact us](#)

[Log in](#)

[Sign up](#)

Get the most out of myStrength with the app. [Learn more >](#)

Build a healthier mind for a stronger you

Get a flexible and comprehensive digital program with proven tools and dedicated support for stress, depression, sleep and more.

Get started with myStrength¹ [Sign up](#)

¹Contact your employer, health plan or health provider to see if you're eligible for myStrength.



Sign up

What's your access code?

An access code is given to you by your mental wellness provider.

I am currently located outside of the United States

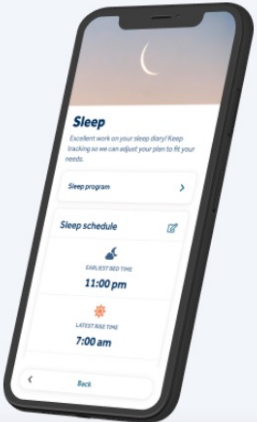
[Start your Journey](#)

Already a user? [Sign in](#)

AVAILABLE ON THE APP

Want to track your sleep?

Download the myStrength app to log entries in your sleep diary and get a personalized sleep schedule.



Registration Access Codes

myStrength Access Codes

It's EASY to refer a client to myStrength! Just provide them with a referral sharing the appropriate code from the list below. Then they can sign up in three quick steps.

Choose the Code based on the service area and/or program.

Client Sign-up Process

1. Go to www.mystrength.com, and click the **Sign-up** button.
2. When asked for an Access Code, enter the appropriate code.
3. Complete the sign-up process with a brief Wellness Assessment and personal profile.

	Description of service area / program	Consumer Access Code
1	INTAKE / WELLPLACE	<i>DWIHNwellplace</i>
2	Network provider staff - Employee Wellness	<i>DWIHNstaff</i>
3	SW Provider System consumers - With drop-down for consumer to choose provider, alphabetical list including OTHER	DWIHNc
4	Prevention Initiatives and Services	DWIHNp
5	DWMHA Refer Members to myStrength	DWIHNsupport
6	First Responders	DWIHN911
7	Intake/Access	DWIHNAccess
<i>To share myStrength with general community members or agency friends & family, please use the code below:</i>		
		DWIHNcares



Let's start by getting to know you better

We'll walk through a series of questions - it'll only take a few minutes. The more we learn about you, the better we can create a plan that fits your needs.

Next



What's on your mind?

Stress

Mood

Sleep

Relationships

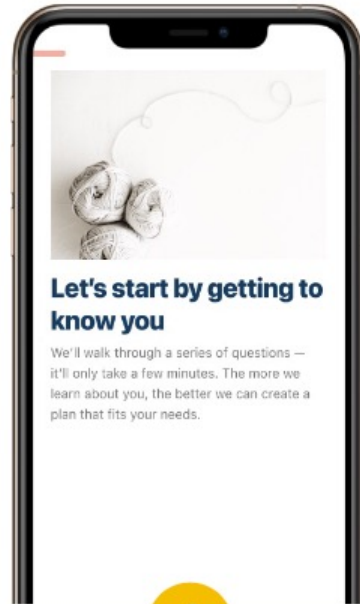
Substance use

Something else

<

Next

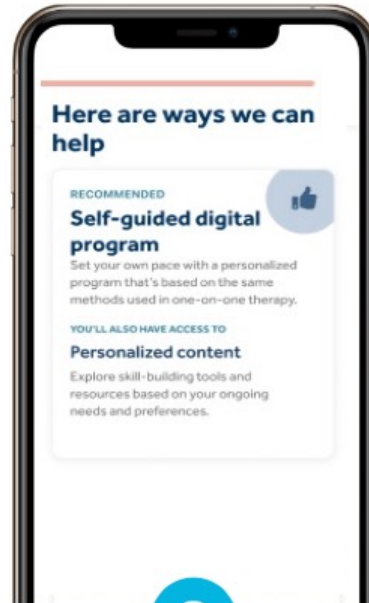
Powerful, iterative personalization



1

Clinical Assessment

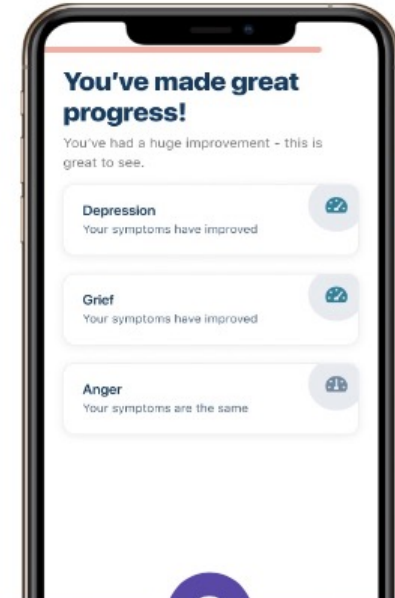
Prioritizes addressable condition(s) and evaluates acuity level



2

Personal Plan

Delivers a personalized plan with prioritized focus areas and reminders to stay on track



3

Regular Reassessment

Continuously adapts programming to flexibly meet evolving needs

myStrength Homepage Images from the Website



Home

Connect

Explore

Progress

Help

Hi, Julie. Here's a great place to start.

How are you today?



Awful



Great

Recommended

Managing depression

Learn simple, everyday skills to help improve your mood.

[Begin program](#)



Just for you

The role of gratitude

A practice for a rich life.



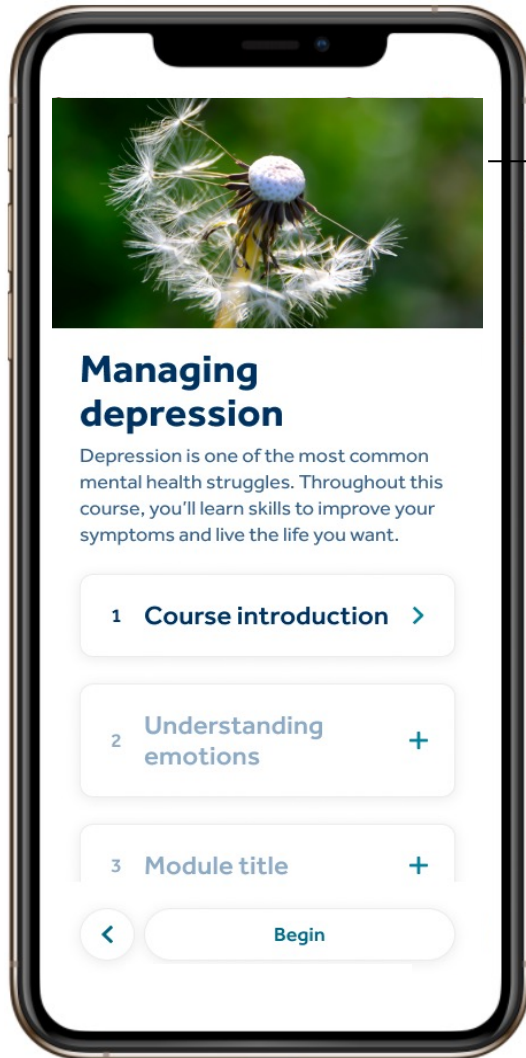
Take a moment

4-7-8 breathing

Breathe and count to feel grounded.



Structured digital courses



• Underlying principles:

Evidence-based
Mastery-focused
Measurement-based

01

Commitment

- Set expectations
- Establish symptom baseline
- Set goals

02

Course

- Series of learning modules over a recommended number of weeks
- Skills practice in each lesson
- Continuous mastery development
- Symptom reassessment

03

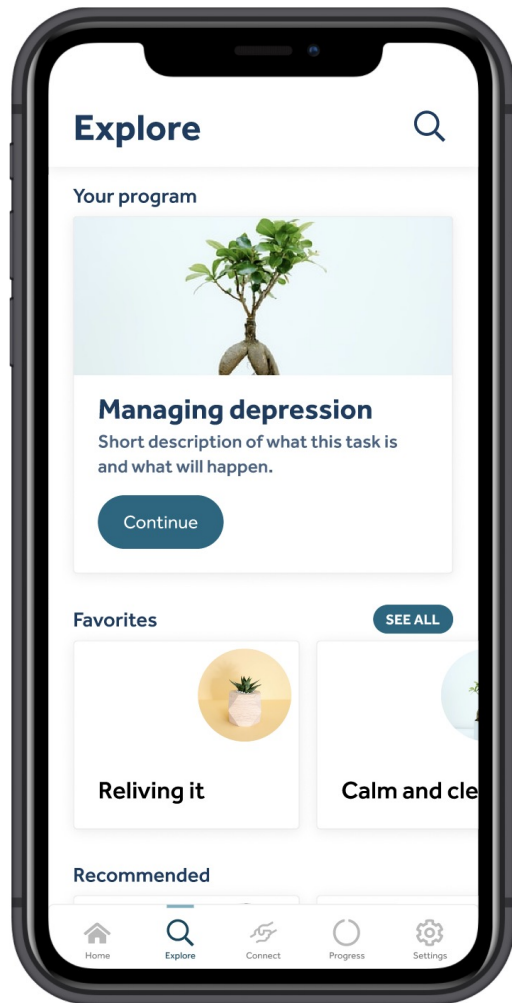
Graduation

- Review self-management maintenance plan
- Measure symptom improvement
- Earn printable certificate of completion

*Forthcoming capability, topics subject to change

Explore

Explore digital content beyond what is recommended in the personal plan on the home page



Structured Digital Programs: utilize proven, evidence,-based techniques and lead members through a defined curriculum.

Recommended Content: The personalized plan contains recommended content – articles, videos, tools and exercises, tailored for the member's needs and further tailored real-time by the member's preferences.

In the Moment Tools: Suggested weekly to member, designed to deliver immediate relief when dealing with episodic distress.

Sleep Program: A curated resource for members to learn about their sleep patterns and improve them through a series of activities.

A-Z Library: Covers a vast amount of content in several focus areas of interest with the ability to allow members to favorite & search.

How to Explore and Find Content on myStrength

Explore

Your program

Managing depression

Learn simple, everyday skills to help improve your mood.

Begin Program



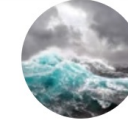
Just for you



The role of gratitude



4-7-8 breathing



Breathing to find calm



Breathing for balance

Favorites

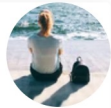
[See all](#)



Dining out: tips and tricks



Mindfulness and your hand



Traveling light



Your crisis plan

Take a moment



4-7-8 breathing



No judgment



Flip the switch



Mindful walking

Explore all

Using the Explore Using Key Word Search



- Home
- Connect
- Explore
- Progress
- Help

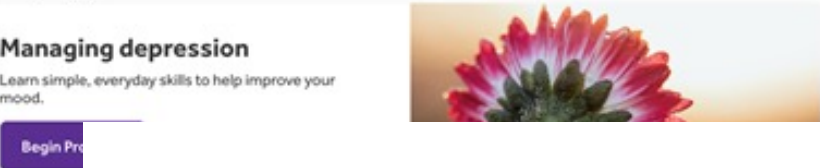
Julie ▾

Explore

Your program

Managing depression

Learn simple, everyday skills to help improve your mood.



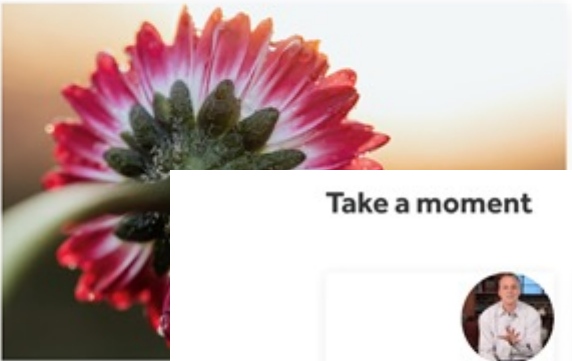
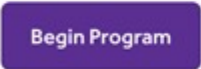
Julie ▾

Explore





Your program

Managing depression

Learn simple, everyday skills to help improve your mood.

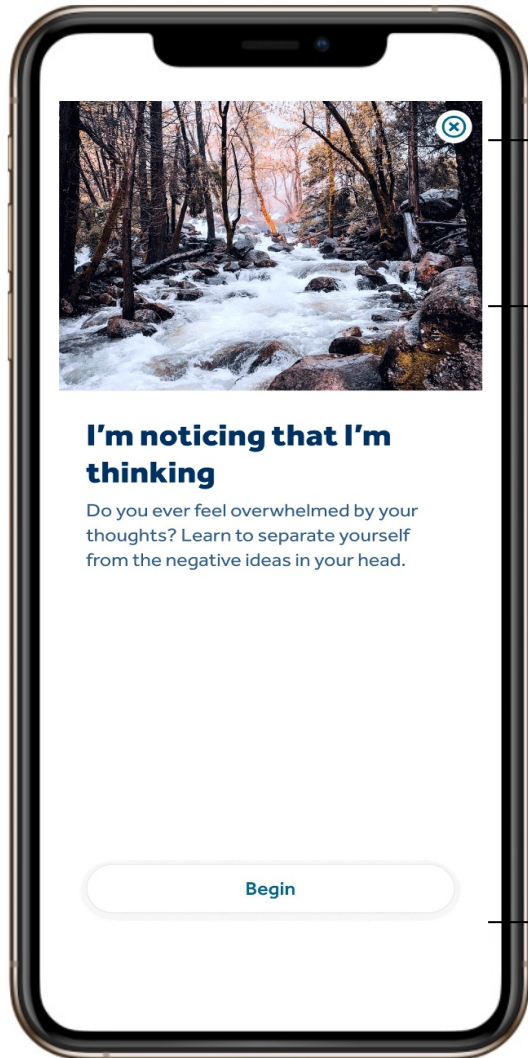


Take a moment

-  Boundary visual
-  Mindful eating
-  Mindfulness and your hand
-  Mindful yoga

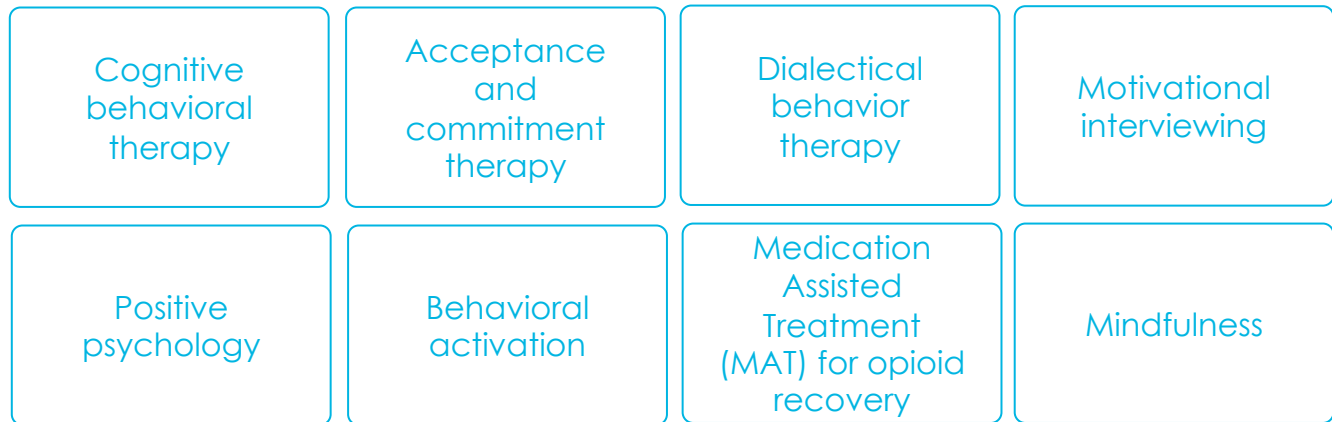


Recommended digital content



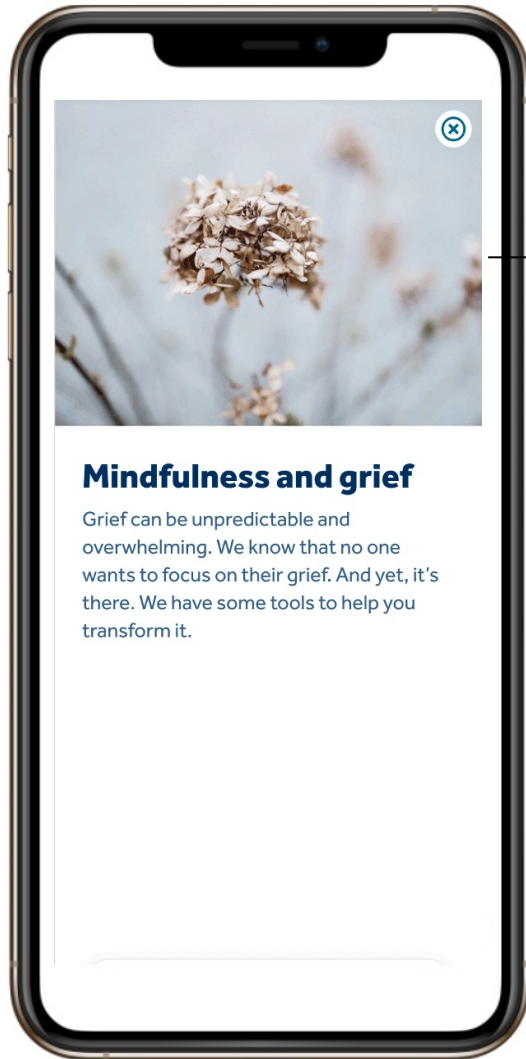
- **Linear, self-guided programs**

- **Based on evidence-based interventions**



- **Continually refreshed, based on member preference, as content is consumed**

In the moment tools

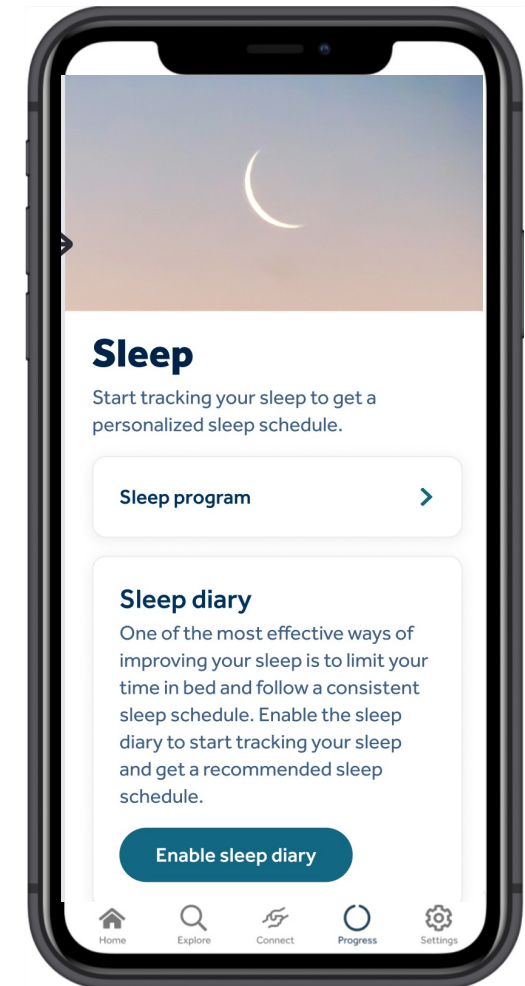


- **Short-form, actionable content designed to:**
 - Help members with episodic distress
 - Deliver immediate relief

Sleep Tracker

New and improved tools that support members in improving their sleep, no matter where they are in their journey.

- A central location to manage all sleep-related needs, that **dynamically adapts** to the needs of members
- **Guided messaging**, enabling members to know which next best action they should take at every step
- Updated visuals to easily **identify trends**, all at a single glance
- **Intelligent reminders** (push notifications, emails, and on Home) that help build a habit of tracking and optimizing their sleep schedules



Illustrative screen shot

Next Steps:

How will you share myStrength with
the people you serve?



Here Are Some Ideas To Get You Started



Initial Assessment

Discuss baseline wellness assessment results and tie-in to treatment goals



Individual Treatment Session

Share appropriate myStrength condition-specific handouts



Skill-Building/Homework

Assign eLearning modules, tools, and resources to align with treatment plan



Group Session

Use videos during group sessions for discussion or work through an eLearning module together



Client Self-Management after Discharge

Reinforce myStrength as a resource clients can use to continue self-management skills



Experience our solution for yourself



DETROIT WAYNE INTEGRATED HEALTH NETWORK

800-241-4949

www.dwihn.org

Reminders

- ▶ Provider Contact information up to date in MHWIN
- ▶ Responding to requests
- ▶ Time sensitive

Contact Us

- ▶ Compliance Hotline (313-833-3502)
- ▶ Attn: Corporate Compliance Officer
Detroit Wayne Integrated Health Network
707 W. Milwaukee, Detroit MI, 48202
- ▶ VIA EMAIL: compliance@dwhn.org



**DETROIT WAYNE INTEGRATED
HEALTH NETWORK**

800-241-4949

www.dwihn.org

ORR New Hire Recipient Rights Training

Updates:

- ❑ *ORR Trg. Info on the DWIHN website and (formerly) the MHWIN newsflash, now “NHRRT Info” has been updated, along with the FAQ’s form.
- ❑ *Current NHRRT availability-2 weeks out.
- ❑ *Register staff for NHRRT during the onboarding/orientation process.
- ❑ *NHRRT-available seats increased to accommodate an increase in attendee #s-50/class=600/mo.
- ❑ *Rating for “no shows” expanded-Incomplete.
- ❑ *If staff marked “Incomplete” for NHRRT, must contact Trainers at orr.training@dwihn.org to reschedule.
- ❑ *NHRRT vs. ARRT-Update ARRT on DWC.
- ❑ If Providers need to **cancel/reschedule** their staff for NHRRT, notify ORR Trainers at orr.training@dwihn.org. Please **do not** mark the person as cancelled in MHWIN.
- ❑ NHRRT conducted Mon-Wed each week from 10am-12pm. Evening NHRRT-2nd Tuesday of the month from 4pm-6pm. Check MHWIN for available training dates.
- ❑ If your staff experiences any issues with NHRRT, you may contact us via email at: orr.training@dwihn.org no later than 1/2 hour prior to the class start time.
- ❑ *NHRRT is held via the Zoom App-participants need a strong Wi-Fi signal to participate. Participants note: Wi-Fi strength prior to training, be familiar w/chat feature.
- ❑ Participants must be present online, with working cameras, and remain visible and available to communicate with us throughout the course.
- ❑ If your staff are OBSERVED DRIVING OR OTHERWISE NOT ENGAGED DURING THE TRAINING, they will be removed from the training and will need to be rescheduled.
- ❑ *NHRRT must be completed w/in 30 doh for new staff.

OFFICE OF RECIPIENT RIGHTS: MONITORING (SITE REVIEWS)

Updates:

- ▶ *ORR Monitoring-Prep for MDHHS Triennial Assessment-01/2024; to assess monitoring compliance
- ▶ *New Contracts/Address change-Vendors pls. include notification to ORR Monitoring Mgr. @ spride@dwihn.org
- ▶ *Providers please adhere to the requirements of the MMHC mandate re: NHRRT
- ▶ *Any violation(s) found requires a Corrective Action Plan. Provider has 10-business days from the date of the site visit to remedy violation
- ▶ *End of site review visit, Site Rep **required to sign & date page #4 of site review tool**

Important Reminder:

- ▶ Provider contact info and staff records should be kept current, as required in MHWIN
 - ▶ *Questions: esims1@dwihn.org or spride@dwihn.org
- ## Site Review Process:
- ▶ *ORR Site Visit conducted onsite (in person). Covid 19 Questionnaire-If +exposure, an alternative site review will be arranged
 - ▶ Review new staff hired since the previous site review-NHRRT must be completed w/i 30 doh
 - ▶ ORR accepts NHRRT obtained from *different* counties w/ evidence provided/verification
 - ▶ *ORR Reviewer looks for: required postings, RR booklets, confidential items stored, health/safety violations, interior/exterior of facility, interviews staff & members re: rights awareness and complaint filing

ORR Prevents Rights Violations

Prevention Unit Primary Responsibilities

- ▶ ***ORR Prevention Unit-no updates** for November 2023 Provider meetings
- ▶ Develop and implement prevention-related training initiatives & provide input with updating specific DWC trgs, ex: lrs
- ▶ Review Policies and Procedures & provide recommendations to address Recipient Rights-related matters
- ▶ Review substantiated complaint investigations and address concerns identified for prevention opportunities
- ▶ Ensure remedial action trainings & recommendations related to RR violations are in adherence to the Michigan Mental Health Code and MDHHS Administrative Rules.
- ▶ Goal is to ensure providers and staff are equipped with the required training & knowledge of RR policies & procedures, to assist in prevention of RR violations

Customer Service Due Process Updates

- 1. The Customer Service Due Process Department (Appeals) will begin conducting Desk Audits of the Adverse Benefit Determination (ABD) notices beginning January 8, 2024. The desk audits will be ensuring that the notices are completed in their entirety. This includes proper verbiage and grammar, all services that are being reduced, suspended or terminated are listed as well as legal references are being utilized. Please reach out to Dorian Johnson should you have any questions or concerns
- Technical assistance continues to be offered to do in person or virtual training to assist in the proper completion of ABDs. Please reach out to pihpmemberappeals@dwi hn.org or Due Process Manager, Dorian Johnson at djohnson@dwi hn.org for additional information.
- Our Member Grievance Specialists continue to train Grievance coordinators and their alternates regarding the proper way to assist in the processing of grievances. Should you have any questions or concerns regarding upcoming trainings, please reach out to pihpgrievances@dwmha.com

CREDENTIALING



42CFR438.214

General rules. The State must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers and that those policies and procedures, at a minimum, meet the requirements of this section.

(b) Credentialing and recredentialing requirements.

(1) Each State must establish a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate, and requires each MCO, PIHP and PAHP to follow those policies.

(2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of network providers.

(c) Nondiscrimination. MCO, PIHP, and PAHP network provider selection policies and procedures, consistent with [§ 438.12](#), must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(d) Excluded providers.

(1) MCOs, PIHPs, and PAHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

(2) [Reserved]

(e) State requirements. Each MCO, PIHP, and PAHP must comply with any additional requirements established by the State.

EVERY PROVIDER MUST BE CREDENTIALAED. CONTRACTING WITH DWIHN MAY BE IMPACTED IF YOU ARE NOT CREDENTIALAED. IF YOU HAVE NOT STARTED THE PROCESS IMMEDIATELY CONTACT THE CREDENTIALING UNIT AT PIHPCREDENTIALING@DWIHN.ORG OR YOUR PROVIDER NETWORK MANAGER AT PIHPPROVIDERNETWORK@DWIHN.ORG

Anytime you make any changes to your Microsite and Provider Source application you must re-attest by completing the Certification and Authorization form (include Organization name, organization representative name, signature, and date. If you do not re-attest Medversant will not see the document and continue to do outreach for what is missing in your file.

- Providers and practitioners are notified 6 months prior to the expiration of the initial or re-credentialing date. If you do not meet the re-credentialing date your file will be treated as a credentialing file.
-

IF YOU RECEIVE AN ADVERSE CREDENTIALING DECISION YOU HAVE THE RIGHT TO APPEAL. THE LETTER THAT YOU RECEIVED OF THE ADVERSE DECISION HAS AN APPEAL DOCUMENT ATTACHED THAT MUST BE RETURNED WITHIN 30 CALENDAR DAYS OF THE DECISION IN ORDER TO GET A REVIEW BY THE APPEALS COMMITTEE. THE APPLICANT WILL RECEIVE A DECISION WITHIN 7 BUSINESS DAYS OF THE FINAL DISPOSITION. **FAILURE** TO SEND A VALID REQUEST FOR APPEAL WITHIN 30 CALENDAR DAYS ALLOTTED SHALL CONSTITUTE WAIVER BY THE PRACTITIONER OF ANY RIGHT TO APPEAL.

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as “behavioral health” throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as “substance use disorder” throughout this form.

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

Why This Form Is Needed

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

Instructions

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

Section 1: About You

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

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

Section 2a: Sharing Information Between Individuals and Organizations

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

- | | |
|------------------------------|----------------|
| 1. <u>MDOC</u> | 4. <u>FQHC</u> |
| 2. <u>MDOC - Contractors</u> | 5. _____ |
| 3. <u>SUD Provider</u> | 6. _____ |

Section 2b: Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

- Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a.
- Do not share my information through the organizations listed below.
- Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only. List all health information exchanges or networks:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Section 3: What Information You Want to Share

Choose one option:

- Share **all** my behavioral health and substance use disorder records. This does not include “psychotherapy notes.”
- Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Section 4: Your Consent and Signature

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.

- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share “psychotherapy notes”.
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below. (For example, at the end of my treatment.)

Date, event, or condition: _____

State your relationship to the person giving consent and then sign and date below:

Self

Parent (Print Name) _____

Guardian (Print Name) _____

Authorized Representative (Print Name) _____

Signature

Date

Witness Signature (If Appropriate)

Date

TAKE AWAY YOUR CONSENT

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

Section 5: Who Can No Longer See Your Information

I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

Self

Parent (Print Name) _____

Guardian (Print Name) _____

Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

<p>Verbal Withdrawal of Consent</p> <p><input type="checkbox"/> The individual listed above in Section 1 has taken away his/her consent. List the individual who requested the withdrawal below, then sign and date below.</p> <p><input type="checkbox"/> Individual listed above in Section 1.</p> <p><input type="checkbox"/> Parent (Print Name) _____</p> <p><input type="checkbox"/> Guardian (Print Name) _____</p> <p><input type="checkbox"/> Authorized Representative (Print Name) _____</p>		
Signature of Person Who Received the Verbal Withdrawal	Print Name	Date
<p>Other Information for Health Care Providers and Health Plans</p> <p>This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent.</p>		
<p>Additional Identifiers (Optional)</p> <p>Medicaid _____ Last 4 of the Social Security Number _____</p>		
<p>Form Copy (Optional, Choose One Option)</p> <p><input type="checkbox"/> The individual in Section 1 received a copy of this form.</p> <p><input type="checkbox"/> The individual in Section 1 declined a copy of this form.</p>		

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.
<p>The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.</p>	

MONTHLY PROGRESS REPORT

Offender #	Individual's Name:		Date:		
Click to enter text.	Click to enter text.		Click to enter a date.		
Supervising Agent:		Email:	Telephone:		
Click to enter text.		Click to enter text.	Click to enter text.		
Supervisor:		Email:	Telephone:		
Click to enter text.		Click to enter text.	Click to enter text.		
Date of Report:	Click to enter a date.	Admit Date:	Click to enter a date.		
(RESIDENTIAL ONLY) Projected Discharge Date:		Click enter a date.			
During the month of Choose month. the offender has had the following appointments:					
<input type="checkbox"/> INDIVIDUAL THERAPY		<input type="checkbox"/> PEER RECOVERY COACH			
<input type="checkbox"/> CASE MANAGEMENT		<input type="checkbox"/> GROUP			
<input type="checkbox"/> PSYCHIATRIST		<input type="checkbox"/> OTHER (Primary Care visit, MAT Provider, Specialist, etc.)			
IF OTHER SELECTED PLEASE EXPLAIN:		Click or tap here to enter text.			
The individual cancelled appointments on:		Click to enter a date., Click to enter a date., Click to enter a date.,			
The individual missed appointments on:		Click to enter a date., Click to enter a date., Click to enter a date.,			
The provider cancelled appointments on:		Click to enter a date., Click to enter a date., Click to enter a date.,			
The individual has participated:		<input type="checkbox"/>	Not at all		
		<input type="checkbox"/>	Minimally		
		<input type="checkbox"/>	Fluctuates between participation and not participating		
		<input type="checkbox"/>	Consistently participating		
The individual has been drug tested:		Date:	Click to enter a date.	Results:	Choose an item.
		Date:	Click to enter a date.	Results:	Choose an item.

MONTHLY PROGRESS REPORT

Progress during treatment. Discuss treatment plan, progress towards goals, things they are doing well with, things they are struggling with and any suggested treatment recommendations:

Any changes of Medications associated with Medication Assisted Treatment:

Providers Name:

Click to enter text.

Email:

Click to enter text.

Phone Number:

Click to enter text.

MICHIGAN DEPARTMENT OF CORRECTIONS
 SUBSTANCE ABUSE TREATMENT REFERRAL

CFJ-306
 03/2020

Date	Offender Number	Offender Name	Offender DOB
Supervising Agent		Email	Telephone
Supervisor		Email	Telephone

Primary:
 Drug of Choice: Alcohol Cocaine Opiates Meth Other
If other explain _____

Route of Administration: Injection Oral Nasal Smoke
 Date of Last Use: _____ Frequency of Use Hourly Daily Weekly Monthly Yearly

Secondary:
 Drug of Choice: Alcohol Cocaine Opiates Meth Other
If other explain _____

Route of Administration: Injection Oral Nasal Smoke
 Date of Last Use: _____ Frequency of Use Hourly Daily Weekly Monthly Yearly

The offender is unable to control their substance use as evidence by: (check all that apply)

Offender has expressed desire for treatment

Two or more positive drug or alcohol tests within last six months

Family member has contacted agent to express concern regarding offender's substance abuse

Unsuccessful termination from a substance abuse treatment program within the last six months

Date: _____

Recent arrest by criminal justice agency for use/possession of alcohol or controlled substance

Other

If other explain _____

Previous treatment: Outpatient Number of times: _____ Dates (M/Y) _____
 Residential Number of times: _____ Dates (M/Y) _____

Offender has history/conviction for: Arson Sex Offense OUIL 3rd

Current medical condition: Cardiac Back Diabetes High BP Pregnancy Seizure Other
If other explain _____

Current or previous psychiatric problems: Yes No
If yes explain _____

On Medications: Yes No
If yes list _____

30 Day Supply of Meds available: Yes No

Availability: Immediately Available or Date Available: _____

Provider (Caller / Staff) Name:	Name of Facility:
Date:	LOC: Emergent Urgent Routine
DWIHN Access Call Center Staff Name:	Consumer's Name

Serious Emotional Disturbance (SED) Eligibility Checklist Children & Adolescents

1. Is the person a Wayne County Resident?
 - Yes. Type of proof received _____?**
 - City of Detroit Resident**
 - Out of Detroit (including Highland Park & Hamtramck) City _____**
 - No. Referred to appropriate county of residence _____**
 - _____ Yes. Declared as "Homeless" at Wayne County ER/Crisis Facility**

2. Does the person have insurance? _____ Yes. What Type?
 - Medicaid: Name of QHP _____**
 - Commercial Insurance; What type _____**
 - No. Uninsured**
 - DHS; (Foster Child-Request proof that Wayne County Ward)**
 - Other System Involvement (Substance Abuse, Juvenile Justice and/or Special School Services)**

3. Does the person have a DSM-V Diagnosis?
 - Yes. What is the code? _____**
 - No. Inform provider that person MUST have a Diagnosis.**
 - Suicidal or Homicidal Ideations? Plans? _____**

4. Is the person impaired in his/her ability to perform age-appropriate life activities, including:
 - Personal hygiene**
 - Self direction**
 - Activities for daily living**
 - Learning and recreation**
 - Social transactions and interpersonal relationships**
 - History of current use of prescribed psychotropic medications.**
 - History or currently psychotropic medications compliance**
 - History or currently the above issues related to use of substance**
 - Learning/Recreation-School attendance issues/educational issues**
 - Peer relationships**
 - Parental/Guardian relationships**
 - Legal problems**

DURATION

- A.) Has the person's symptoms/dysfunctions lasted for at least six months in a 12-month period;
OR
B.) Based on the current conditions/diagnosis, there is a reasonable expectation that the symptoms/dysfunction will continue for more than six months? Yes ___ or No ___

PRIOR SERVICE UTILIZATION

5. Has the person had any of the following?

- Four or more admissions to community inpatient unit/facility in a calendar year
- More than 30 days in a community inpatient in a calendar year
- More than 60 days state hospitalization in a calendar year
- More than 20 mental health visits in a calendar year (e.g. individual/group therapy)
- Current or history of contact with the criminal justice system (arrest, jail, incarceration, parole, probation)
- Family history of mental health concerns
- Family history of substance abuse

(Question #5 is only an FYI question. The person does not have to have any of these checked to be eligible)

6. Does the person have any current/history of substance abuse?

(Question #6 does not determine id the person is eligible for default or not.)

- Yes. What is the Diagnosis Code? _____
- Drug of Choice? _____
- Age of first use _____ How long has the person been currently using? _____
- Yes. Reported use in the last 30 days
- Reported history or current substance abuse treatment provider: _____
- How many times has the person been in substance abuse treatment? _____

Comments / notes (include reason for referral or enrollment):

Choose One Clinically Responsible Service Provider	
Population Served: Adults, Children/Adolescents/Youth with I/DD, SMI & SED	
<input type="checkbox"/> All Well Being Services (AWBS)	<input type="checkbox"/> Northeast Integrated Health
<input type="checkbox"/> Arab Community Center for Economic and Social Services (ACCESS)	<input type="checkbox"/> Psygenics
<input type="checkbox"/> Development Centers, Inc.	<input type="checkbox"/> Team Wellness Center
<input type="checkbox"/> Neighborhood Services Organization (NSO) No SED Children	<input type="checkbox"/> The Guidance Center
Population Served: Adults, Children/Adolescents/Youth with SMI & SED	
<input type="checkbox"/> Arab American and Chaldean Council (ACC)	<input type="checkbox"/> Hegira Health, Inc.
<input type="checkbox"/> Black Family Development, Inc.	<input type="checkbox"/> Lincoln Behavioral Services
<input type="checkbox"/> Community Care Services	<input type="checkbox"/> Ruth Ellis Center
<input type="checkbox"/> Community Network Services (CNS) Healthcare	<input type="checkbox"/> Southwest Counseling Solutions
Population Served: Adults, Children/Adolescents/Youth with I/DD	
<input type="checkbox"/> Community Living Services	<input type="checkbox"/> Macomb-Oakland Regional Center, Inc. (MORC)
<input type="checkbox"/> Goodwill Industries of Greater Detroit	<input type="checkbox"/> Wayne Center
Population Served: Adults Only with I/DD	
<input type="checkbox"/> JVS Human Services	<input type="checkbox"/> Services to Enhance Potential (STEP)
Population Served: Adults Only with SMI	
<input type="checkbox"/> Central City Integrated Health (CCIH)	
Population Served: Children/Adolescents/Youth with I/DD & SED	
<input type="checkbox"/> Starfish Family Services, Inc.	<input type="checkbox"/> The Children's Center
Population Served: Children/Adolescents/Youth with SED	
<input type="checkbox"/> Assured Family Services	

STEP 4: Your Signature. Please sign in the box below

Signature:	Date:
Please Print Name:	
Signature of the person helping you fill out the form:	

STEP 5: Please fill out the box below if you have a legal guardian or an appointed power of attorney. If you need help, call a **DWIHN Access Center Representative at: 1-800-241-4949 or (TDD) 1-866-870-2599 for the Hearing Impaired.**

Name:	
Address:	
Phone Number: ()	E-mail:
Relationship: ___ Parent: ___ Family Member ___ Spouse ___ Other ___ Guardian ___	

STEP 6: Please mail your application back to the address below (currently no walk-ins are being accepted).

**DWIHN Access Center
707 W. Milwaukee
Detroit, MI 48202**

You will receive a confirmation letter of your enrollment in the mail.