Required Reports

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

Injecting Drug Users 90% Capacity Treatment Report

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

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

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

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

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

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

PRIORITY POPULATION WAITING LIST DEFICIENCIES REPORT

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

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

Select from drop down box

Clients not meeting the federal waiting list requirements:

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

MCOSA QUARTERLY CLIENT SATISFACTION SURVEY REPORT

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

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

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

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

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

2. Recipient Rights Complaints from Funded Consumers:

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

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

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

Number of Outpatient clients	Number of IOP clients

Definitions:

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

MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE
REPORT OF DEATH FORM

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

Consumer Name : _____ **DOB**: _____

Case #_____ **SSN #**:_____

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

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

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

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

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

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

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

Medical: Primary Care Physician (PCP):_____

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

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

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

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

Use reverse side for additional medications:

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

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

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

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

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

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

☐ Incident Review ☐ Mortality Review
☐ Sentinel Event Review ☐ Root Cause Analysis ☐ Other: _____ (Describe)
☐ None: (If none explain) _____

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

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

Additional Comments:

MACOMB COUNTY COMMUNITY MENTAL HEALTH- SUD

CLIENT INCIDENT REPORT FORM

I. TO BE COMPLETED BY MCCMH-SUD CONTRACTED AGENCY

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

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

Date of Incident:	Time:	Location of Incident:

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

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

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

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

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

Signature of Person Completing Form: Date:

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

II. TO BE COMPLETED BY MCCMH-SUD

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

Determination:

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

Check one:

( ) MCCMH-SUD Plan of Action/Intervention ( ) Rationale For No Further Investigation

Provide a brief description:

MCCMH-SUD Signature: Date: