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Owner	Matthew Yascolt: Director of Substance Use Disorder
Policy Area	Substance Use Disorders
Applicability	Detroit Wayne Integrated Health Network

SUD Substance Use Disorder Prevention Policy

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POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) for all providers to accurately enter all records, entries, and activities into the MPDS-SUDPDS system. To ensure compliance, all staff who receive funding from DWIHN should thoroughly read and review the Prevention Policy upon hire and whenever updates are made.

PURPOSE

The purpose of this policy is to ensure all direct services, prevention prepared communities, coalitions, and prevention services funded by DWIHN are entered into the system as outlined in the MPDS User Manual. Provider Agencies must maintain documentation that acknowledges receipt and understanding of the prevention MPDS user manual by personnel at the agency. This policy helps to ensure that 90% of prevention activities are directed to programs that are implemented as a result of an evidence-based decision-making process, and that likewise no more than 10% of prevention strategies and programs fall under information dissemination.

APPLICATION

1. The following groups are required to implement and adhere to this policy:
    a. DWIHN Board,
    b. DWIHN Staff including the following
        1. DWIHN PIHP Staff
        2. DWIHN Community Care Clinic Staff (Direct Care Staff)

3. DWIHN Community Care Clinic Staff (DWIHN staff operating as a CCBHC)
4. DWIHN Crisis Care Center Staff
5. DWIHN Mobile Crisis Staff

c. Contractual Staff
d. Clinically Responsible Service Provider (CRSP) and their subcontractors
e. Specialty Providers
f. Crisis Services Vendors
g. Credentialing Verification Organization (CVO)
h. Designated Collaborating Organizations (DCO)

2. This policy serves the following populations:
    a. Adults
    b. Children
    c. Individuals with Intellectual and/or Developmental Disabilities (I/DD)
    d. Serious Mental Illness (SMI),
    e. Serious Emotional Disturbance (SED),
    f. Substance Use Disorder (SUD)
    g. Autism
    h. Mild/Moderate levels of care
3. This policy impacts the following contracts/service lines:
    a. Autism
    b. Certified Behavioral Health Clinics
    c. General Fund
    d. Grants
    e. MI Coordinated Health Highly Integrated Dual-Eligible Special Needs Plan (MICH HIDE SNP)
    f. Medicaid
    g. SUD

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KEYWORDS

1. **Substance Abuse Prevention and Treatment Block Grant**—Provides funding to states, territories, and tribal entities for efforts in prevention and treatment of substance misuse.
2. **Community Mental Health Services Block Grant**—Supports grantees in carrying out plans for providing comprehensive community mental health services.
3. PA2 Funded Activities - Local funding supporting the prevention and treatment of substance use disorder

4. **SYNAR Amendment**—As part of the Substance Abuse Prevention and Treatment Block Grant, SAMHSA's Center for Substance Abuse Prevention oversees the implementation of the SYNAR Amendment, which requires states to have laws prohibiting the sale and distribution of tobacco products to minors.
5. **Evidence-Based Program**- An evidence-based program for substance abuse treatment is a program that has been scientifically evaluated and proven to be effective in treating substance abuse and prevention of SUD. These programs are based on the best available research and are designed to address the specific needs of individuals with substance use disorders.
6. **Coalition-** A coalition for substance abuse prevention is a group of organizations and individuals who work together to prevent substance abuse and promote healthy behaviors. These coalitions typically include representatives from schools, law enforcement, healthcare providers, community organizations, and other stakeholders who are committed to reducing the harm associated with substance abuse.
7. **DYTUR-**Designated Youth Tobacco Use Representative
8. **MPDS-**Michigan Prevention Data System
9. **ATOD-**Alcohol, Tobacco and other Drugs
10. **Indicated**- activities for early signs of substance use or addiction predisposition. Children of addicted parents who haven't experimented with substance abuse should be categorized as Selective.
11. **Selective-** activities that are targeted towards individuals or subgroups of a population who are at a higher risk of developing a disorder than the average person. These activities may be particularly helpful for those with a diagnosed mental illness, delinquent or violent youth, and similar behaviors.
12. **Universal Direct**- Interventions that are intended to benefit a specific group of participants but not based on individual risk can include things like school curriculum, after-school programs, parenting classes, and other similar initiatives that involve interpersonal and ongoing contact, such as coalitions.
13. **Universal-Indirect**- Programs and policies that address alcohol and drug use, such as advertising regulations, can be effective. Coalitions and initiatives like school programs can also provide support.

STANDARDS

1. All prevention activities and data shall be entered into the MPDS on a monthly basis. Failure to do so 30 days after the reporting period end may result in non-payment by DWIHN. Should any deletions, changes, or updates need to be made, providers are required to complete the DWIHN MPDS CHANGE REQUEST FORM and submit it to the substance use disorder (SUD) department at sud@dwihn.org.

   Areas of non-compliance include timely submission of monthly reports, staff rosters and school or partner agreements and any requested documentation from the SUD department.

   The non-submission of these documents will result in a hold of payment of services.

   a. When entering services in MPDS, it's important to keep the following in mind:

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1. Make sure to compare monthly reports with data in MPDS to ensure accuracy.
2. Review services by funding source to make sure they align with requirements and guidelines.
3. Verify activity services for accuracy and make any necessary edits or deletions for incorrect reporting.
4. Review prevention services daily and verify data for accuracy.
5. All prevention service activities that are funded in whole or part through the PIHP Region must be reported in the MPDS system.
6. MPDS captures direct face-to-face staff activities to a targeted population.
7. Non-direct hours should be captured using monthly reports.
8. A staff activity must meet certain requirements to qualify as an activity eligible for entry, such as being quantifiable as staff time and not capturing the outcome or product of the activity.
9. Direct services must be face-to-face and must include time spent in activities that support the implementation of a prevention activity.
10. Telephone or virtual alternatives may count as direct service and be a reportable activity if they take the place of a face-to-face encounter and meet the definition of direct service.
11. Prevention services must be focused on regional priorities, which include reduction of underage drinking, youth tobacco use, underage marijuana use prevention, and reduction of prescription drugs and over-the-counter medication misuse and abuse.
12. At least 90% of all services must be research-based, and identified evidence-based programs must be administered with fidelity.
13. No more than 10% of total direct service/units can be used for information dissemination.
14. Providers must utilize the DWIHN approved tracking mechanism or activity log to share at the time of their site visit
15. Services must be based on identified, current community needs based on a community needs assessment.
16. Services are collaborative in nature, representing coordination of resources and activities with other primary prevention providers.
17. Services need to be supportive of local coalitions, and providers should be a regular participant in county prevention coalition meetings.
18. Services must fall within one of the six federally defined strategies: information dissemination, education, problem identification and referral, alternatives, community-based, or environmental.
19. Services must be provided in a culturally competent manner, and providers should have a cultural competency policy and staff should attend cultural

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competency trainings

20. All media promoting programs funded all or in part by DWIHN must acknowledge the funding source by using text or a logo provided by DWIHN.
21. If a provider is planning on conducting a local media campaign, all materials must be approved by DWIHN and MDHHS for Block Grant.
22. Service providers will notify DWIHN when a staff member is no longer employed at their agency for the MPDS access for the staff member to be removed.

2. Designated Youth Tobacco Use Representatives (DYTURs)
    a. The federal SYNAR Amendment requires states to have laws in place prohibiting the sale and distribution of tobacco products to persons under 21 years-of-age and to enforce those laws effectively.
    b. SYNAR funds are not to be used to enforce state laws, we will ensure this by auditing activities under SYNAR, providers documenting all expenditures and our contract manager auditing the expenditures, and by focusing on the required compliance checks
    c. To comply with state expectations, DWIHN will contract with three providers to offer Designated Youth Tobacco Use Representatives (DYTURs) services. The DYTURs will be responsible for maintaining and updating the master tobacco retailer list, providing face-to-face vendor education, and conducting Formal SYNAR compliance checks. They are also expected to engage in county-level tobacco prevention coalitions, provide education to local law enforcement and community groups, maintain records of all tobacco compliance checks, and complete the Youth Access to Tobacco Activity Report annually.
    d. Providers contracted for DYTUR services must submit annual reports, including the Revised Master Tobacco Retailer List, Vendor Education and non-SYNAR Reports, Formal SYNAR Compliance Check Forms, and Youth Access to Tobacco Activity Report.
    e. All providers are also expected to enter Youth Tobacco Act activities into the MPDS no later than 30 days following reporting period end.

3. DYTUR Reporting
    a. Providers contracted for DYTUR services are expected to submit annual reports to DWIHN
    b. Revised Master Tobacco Retailer List (MRL)—Please remember, all tobacco retailers on the MRL must be verified by a phone call or personal visit. Verification must include the retailer name, address (including county), vendor type, and phone number. DYTURs are expected to identify retailers selling ENDS (e.g., e-cigs, vape pens, hookah pens, etc.) in their establishments during the MRL revision process. DYTURs must also add any known new retailers to the MRL;
    c. Vendor Education and non-SYNAR Reports—IMPORTANT: A minimum of 25% of the total number retailers for vendor education and non-SYNAR compliance checks

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must be completed prior to the start of the Formal SYNAR period.

d. Formal SYNAR Compliance Check Forms; and

e. Youth Access to Tobacco Activity Report
In addition, all providers contracted for DYTUR services are expected to enter Youth Tobacco Act (YTA) activities into the MPDS no later than 30 days following the reporting period end. These activities should minimally include vendor education, non-SYNAR compliance checks, and Formal SYNAR compliance checks.

f. DYTUR reporting forms and due dates will be provided by DWIHN. Providers are responsible for reviewing all reporting forms for completeness and accuracy prior to sending to DWIHN.

g. SAPT Block Grant funds cannot be used for law enforcement compliance checks, including Formal SYNAR and non-SYNAR activities, or tobacco cessation programs.

4. SAMHSA CSAP Strategies

   a. Service Providers will implement programming that adheres to the SAMHSA CSAP Strategies of which no more than 10% of prevention strategies and programs fall under information dissemination

      1. **Information dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and other drug use, misuse, and addiction on individuals, families, and communities.
      2. **Education** aimed at affecting knowledge, concepts, principles, critical life and/or social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities.
      3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use.
      4. **Problem identification and referral** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco, alcohol, or other drugs or those who have been determined to be at high-risk for these behaviors in order to assess if the behavior can be reversed by education to prevent further use.
      5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, inter-agency collaboration, coalition building, and networking.
      6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the misuse of alcohol, tobacco and other drugs used in the general population.

5. Credentialing and Certification

   a. All staff implementing EBPs: Must complete formal training that is specific to the Evidence Based Program(s) they are authorized to deliver

   b. Specifically Focused Staff: Must receive and complete training that is appropriate and fully aligned with their designated role and statement of work within the service

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model.

c. Required Credentials for Prevention Supervisors are:
    1. Certified Prevention Consultant – Michigan (CPC-M)
    2. Certified Prevention Specialist – Michigan (CPS-M) - only if credential is effective for three (3) years
    3. Certified Prevention Consultant
    4. Certified Prevention Specialist IC&RC (CPS) – only if credential effective for one (1) year or 2080 hours.
    5. Certified Health Education Specialist (CHES) – only if credential effective for one (1) year or 2080 hours.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, risk management program, and Quality Assessment/Performance Improvement Program (QAPIP) Work-plan.

The quality improvement programs of Network Providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

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COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, Contracted Network Providers, and their subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Michigan Department of Health and Human Services Medicaid Provider Manual (in effect, and as as amended)
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (PIHP/CMHSP contracts in effect, and as amended)
3. SAMHSA.gov/resource-search/ebp

RELATED POLICIES AND PROCEDURES

CLINICAL POLICY

NO

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments

- Provider Agency Manual
- SAMHSA Prevention Programs
- Strategic Prevention Framework

Approval Signatures

Step Description	Approver	Date
Clinical Review Committee	Shama Faheem: Chief Medical Officer	Pending
Clinical Review Committee	Marlena Hampton: Director of Utilization Management	Pending
Clinical Review Committee	Erik Hutchison: Vice President of Clinical Operations	Pending
Clinical Review Committee	Daniel West: Director of Crisis Services	03/2026
Clinical Review Committee	Cassandra Phipps: Director of Childrens Initiatives	03/2026
Clinical Review Committee	Jacquelyn Davis: Associate Vice President - Access and Strateg	03/2026
Clinical Review Committee	Marianne Frazho-Lyons: Director of Adult Initiatives	03/2026
Clinical Review Committee	April Siebert: Director of Quality Improvement	03/2026
Clinical Review Committee	Matthew Yascolt: Director of Substance Use Disorder	03/2026
Clinical Review Committee	Polly McCalister: Director of Recipient Rights	02/2026

Clinical Review Committee	Vicky Politowski: Director of Integrated Care	02/2026
Clinical Review Committee	Ryan Morgan: Director of Residential Services	02/2026
NCQA Committee	Tania Greason: Quality Administrator	02/2026
NCQA Committee	Margaret Keyes: Strategic Planning Administrator	02/2026
NCQA Committee	Justin Zeller: Project Manager	02/2026
NCQA Committee	Allison Smith: Director of Strategic Operations	02/2026
Clinical Officer Review	Stacey Sharp: Associate Vice President of Clinical Operatio	02/2026
Unit Review and Approval	Matthew Yascolt: Director of Substance Use Disorder Initiatives	02/2026

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Applicability

Detroit Wayne Integrated Health Network

Standards

No standards are associated with this document