DEPARTMENT OF COMMUNITY HEALTH

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

PART 9. RESIDENTIAL PROGRAMS

SUBPART 1. GENERAL PROVISIONS

(By authority conferred on the director of the department of community health by section 6231 of 1978 PA 368, MCL 333.6231 and Executive Reorganization Order Nos. 1991-3, 1996-1, and 1997-4, MCL 333.36321, 330.3101, and 333.26324)

R 325.14901 Staffing.

Rule 901. (1) A program shall have 1 full-time staff member or a person designated by the program director on the premises at all times.

(2) The equivalent of 1 full-time counselor shall be available for every 10 residents.

History: 1981 AACS.

R 325.14902 Admission procedures.

Rule 902. (1) Clearly stated written criteria for determining the eligibility of individuals for admission shall be developed by the residential program.

(2) Information gathered in the course of the admission and assessment process shall be recorded on internally standardized forms. The completed forms shall become part of the applicant's case record.

(3) The program shall have written policies and procedures governing the admission process which set forth both of the following:

(a) The procedures to be followed when accepting referrals from outside agencies or organizations.

(b) The procedures to be followed, including those for referrals, when an applicant is found to be ineligible for admission.

(4) All of the following information shall be collected and recorded for all applicants before, or at the time of, admission:

(a) Name, address, and telephone number, when applicable.

(b) Date of birth and sex.

(c) Family and social history.

(d) Educational history.

(e) Occupation.

(f) Legal and court-related history.

(g) Present substance abuse problem.

(h) Date the information was gathered.

(i) Signature of the staff member gathering the information.

(j) Name of referring agency, when appropriate.

(k) Address, telephone number, and name of nearest relative to contact in case of emergency.

(l) History of current and past substance abuse or other counseling services received. The agency, type of service, and the date the service was received shall be indicated.

(m) Name, address, and telephone number of the most recent family or private physician.

(n) A substance abuse history, including information about prescribed drugs and alcohol, which indicates, at a minimum, all of the following information:

(i) Substances used in the past, including prescribed drugs.

(ii) Substances used recently, especially those used within the last 48 hours.

(iii) Substances of preference.

(iv) Frequency with which each substance is used.

(v) Previous occurrences of overdose, withdrawal, or adverse drug or alcohol reactions.

(vi) History of previous substance abuse treatment received.

(vii) Year of first use of each substance.

(5) During the admission process, every effort shall be made to assure that an applicant understands all of the following:

(a) General nature and objectives of the program.

(b) Rules that govern client conduct and infractions that can lead to disciplinary action or discharge from the program.

(c) Hours during which services are available.

(d) Costs to be borne by the client, if any.

History: 1981 AACS.

R 325.14903 Withholding information.

Rule 903. (1) An applicant shall retain the right to withhold any information that is not demonstrably necessary to the treatment process or to essential program operations.

(2) If a program finds it necessary to require certain information in addition to that described in R 325.14902 (4) and (5) as a condition of admission, there shall be a written policy delineating such information.

(3) If an applicant is found to be ineligible for admission, the reason shall be recorded in the client case record and, if appropriate, a referral to an appropriate agency or organization shall be attempted.

History: 1981 AACS.

R 325.14904 Medical examination.

Rule 904. (1) A client who has not had a medical examination within 6 months prior to admission shall have a medical examination performed under the supervision of a licensed physician as soon as practicable, but not later than 14 days after admission.

(2) Evidence of such examination and information relevant to the client's health status shall be included in the client's record.

History: 1981 AACS.

R 325.14905 Treatment plans.

Rule 905. (1) A client's social and psychological needs shall be assessed. The areas of concern shall include a determination of all of the following:

(a) Current emotional state.

(b) Cultural background.

(c) Vocational history.

(d) Family relationships.

(e) Educational background.

(f) Socioeconomic status.

(g) Any legal problems that may affect the treatment plan.

(2) A written treatment plan based upon the assessment made of a client's needs shall be developed and recorded in the client's case record. A treatment plan shall be developed as soon after the client's admission as feasible, but before the client is engaged in extensive therapeutic activities. The written treatment plan shall comply with all of the following:

(a) Be individualized based upon the assessment of the client's needs and, if applicable, the medical evaluation.

(b) Specify those services planned for meeting the client's needs.

(c) Include referrals for services that are not provided by the residential program.

(d) Contain clear and concise statements of the objectives the client will be attempting to achieve, together with a realistic time schedule for their achievement.

(e) Define the services to be provided to the client, the therapeutic activities in which the client is expected to participate, and the sequence in which services will be provided.

(3) The client shall participate in the development of the treatment plan and its objectives. The nature of this participation shall be described in the client's record.

(4) Review of, and changes in, the treatment plan shall be recorded in the client's case record. The date of the review or change, together with the names of the individuals involved in the review, shall also be recorded. The treatment plan shall be reviewed at least once every 90 days by the program director or his or her designee.

History: 1981 AACS.

R 325.14906 Client activities.

Rule 906. Ten or more hours per week of scheduled activities shall be available to a client. Included in these activities shall be 2 or more hours of formalized individual, group, or family counseling for each client. The hours of counseling actually provided should vary according to the needs of the client. There shall be documentation of planned social, educational, and recreational activities consistent with the needs of the client. Activities shall include all clients and shall take place days, evenings, and weekends if clients are present during these times.

History: 1981 AACS.

R 325.14907 Progress notes.

Rule 907. (1) A client's progress and current status in meeting the objectives established in the treatment plan, together with a statement of the efforts by staff members to help the client achieve these stated objectives, shall be recorded in the client's case record for every formal client counseling session. A progress note shall be dated and signed by the individual who makes the entry.

(2) All progress notes shall be dated and signed by the individual who makes the entry.

(3) If a client is receiving services at an outside resource, the program shall attempt to secure a written case summary, case evaluation, and other client records from that resource. These records shall be added to the client's case record.

(4) The ongoing assessment of the client's progress with respect to achieving treatment plan objectives shall be used to update the treatment plan.

History: 1981 AACS.

R 325.14908 Support and rehabilitative services.

Rule 908. (1) All of the following support and rehabilitation services shall be available to all clients either internally or through the referral process:

(a) Education.

(b) Vocational counseling and training.

(c) Job development and placement.

(d) Financial counseling.

(e) Legal counseling.

(f) Spiritual counseling.

(g) Nutritional education and counseling.

(2) A program shall maintain a current listing of services available on-site and by referral. This listing shall be reviewed with each client as part of the program's orientation procedure.

History: 1981 AACS.

R 325.14909 Client discharge and aftercare.

Rule 909. (1) Within 2 weeks after discharge, there shall be entered in the client's case record a discharge summary describing the rationale for discharge, the client's treatment and rehabilitation status or condition at discharge, and the instructions given to the client about aftercare and follow-up.

(2) Unless a client leaves voluntarily before his or her course of treatment is completed, a client shall not be discharged from a program while physically dependent upon a drug prescribed for him or her by the program physician, unless the client is given an opportunity to withdraw
from the drug under medical supervision and at a rate determined by the program physician or the client is referred to an outside resource which is willing to continue administering the drug.

(3) The offer to provide withdrawal or referral to another resource shall be made both orally and in writing. If the client refuses such an offer, the program shall attempt to

secure a signed statement from the client which verifies that the offer was made to, and was rejected by, the client. Failing that, a record shall be entered documenting the attempt.

(4) If a program provides aftercare services, a written aftercare plan shall be developed in partnership with the client before the completion of treatment. The aftercare plan shall state the client's objectives for a reasonable period following discharge. The plan shall also contain a description of the services the program will provide during the aftercare period, the procedure the client is to follow in reestablishing contact with the program, especially in times of crisis, and the frequency with which the program will attempt to contact the client for purposes of follow-up.

(5) The date, method, and results of attempts at contact shall be entered in the client's case record and shall be signed by the individual who makes the entry. If follow-up information cannot be obtained, the reason for failing to obtain the information shall be entered in the client's case record.

(6) Regardless of the method of contact utilized, the program shall protect the confidentiality of the client. Mailing envelopes that are identifiable as originating from the program shall not be mailed to a client. A post office box number may be used to determine if mail was undeliverable and to facilitate follow-up.

(7) If the program wishes to determine the status of clients who have been discharged, such follow-up shall be limited to methods which either assure client confidentiality or require formal written consent of the client.

History: 1981 AACS.

R 325.14910 Client records; content; maintenance.

Rule 910. (1) There shall be a case record for each client. All of the following items shall be filed in the case record, if applicable:

(a) Results of all examinations, tests, and other assessment information.

(b) Reports from referring sources.

(c) Treatment plans.

(d) Records of referrals to outside resources.

(e) Reports from outside resources, which shall include the name of the resource and the date of the report. These reports shall be signed by the person who makes the report or by the program staff member who receives the report.

(f) Case conference and consultation notes, including the date of the conference or consultation, recommendations made, and actions taken.

(g) Correspondence related to the client, including all letters and dated notations of telephone conversations relevant to the client's treatment.

(h) Treatment consent forms.

(i) Information release forms.

(j) Progress notes. Entries shall be filed in chronological order and shall include the date any relevant observations were made, the date the entry was made, and the signature and staff title of the person who makes the entry.

(k) Records of services provided. Summaries of services provided shall be sufficiently detailed so that a person who is not familiar with the program can identify the types

of services the client has received. General terms such as "counseling" or "activities" shall be avoided in describing services.

(l) Aftercare plans.

(m) Discharge summary.

(n) Follow-up information.

(2) A program shall provide sufficient facilities for the storage, processing, and handling of client case records. These facilities shall include suitably locked and secured rooms and files.

(3) Appropriate records shall be readily accessible to those staff members who provide services directly to the client.

(4) Client case records shall be maintained for not less than 3 years after services are discontinued.

(5) If a program stores client data on magnetic tape, computer files, or other types of automated information systems, security measures shall be developed to prevent inadvertent or unauthorized access to data files.

History: 1981 AACS.

R 325.14911 Residential detoxification program.

Rule 911. Residential programs which detoxify clients from alcohol or other drugs, but which are not designated as approved services programs, shall comply with all rules in subpart 2 of this part applicable to approved service programs with the exception of R 325.14921(2), R 325.14927(8), R 325.14927(9), and R 325.14927(12).

History: 1981 AACS.

SUBPART 2. APPROVED SERVICE PROGRAMS

R 325.14921 Approved service program licensing.

Rule 921. (1) A program that is designated by the administrator as an approved service program shall be licensed by the office as a residential program and shall comply with R 325.14922 to R 325.14928.

(2) An approved service program shall have access to duly licensed laboratories to conduct chemical testing to determine blood alcohol level.

History: 1981 AACS.

R 325.14922 Annual review; documentation.

Rule 922. There shall be documentation of an annual review, updating, and approval of all of the following by the governing body of the program:

(a) The triage process.

(b) Procedures for medical evaluation.

(c) Treatment protocol for incapacitated persons.

(d) The transportation plan.
(e) The plan for training staff and supportive personnel.

History: 1981 AACS.

R 325.14923 Training; documentation; written plan.

Rule 923. (1) There shall be documentation which verifies that approved service program staff and supporting personnel who work directly with clients are appropriately trained.

(2) There shall be a written plan for providing training.

(3) There shall be documentation that the written plan is developed in consultation with a physician.

History: 1981 AACS.

R 325.14924 Control register and client records.

Rule 924. (1) A program shall establish a control register which includes all of the following information:

(a) The name of the client.
(b) The date and time of client's arrival.
(c) The client's means of arrival and by whom transported.

(2) A program shall keep client records which shall include all of the following information:

(a) The medical exam and evaluation.
(b) The treatment plan.
(c) An evaluation of social and psychological needs.
(d) The discharge summary.

History: 1981 AACS.

R 325.14925 Physician and physician's designated representative; staffing requirements.

Rule 925. (1) An approved service program shall have a written agreement with a licensed physician.

(2) There shall be a licensed physician on call 24 hours a day, 7 days a week.

(3) An approved service program shall be staffed 24 hours per day, 7 days per week by a licensed physician or by a designated representative of a licensed physician. The designation of a representative shall be written and signed by the licensed physician.

(4) The physician shall review and countersign all medical evaluations, diagnoses, and treatment records at least once every 72 hours.

History: 1981 AACS.

R 325.14926 Triage process.

Rule 926. An approved service program shall have a written description of its triage process. There shall be documentation that this process is developed in conjunction with a licensed physician. The description shall include all of the following:

(a) The method used in determining the level of urgency of need of each individual client.

(b) Identification of the services to be performed, including transportation if necessary.

(c) The method of assigning the priority of required services.

History: 1981 AACS.

R 325.14927 Medical examination; substance abuse history; medical history; treatment of unconscious person and persons with severe medical complications prohibited; agreements with emergency medical departments; incapacitated persons; treatment plan for persons undergoing detoxification required; protective custody.

Rule 927. (1) A medical examination shall be performed every time a person who is apparently incapacitated is brought to an approved service program, unless the individual has been transferred from an emergency medical service where an examination was performed and documentation of
the examination is available to the program. If the examination is performed at the approved service program, it shall be performed by a physician or his or her designee.

(2) The medical examination that is performed upon arrival at the approved service program shall include an examination for illness and injury.

(3) Substance abuse history information shall be obtained as soon after admission as is practicable. This history shall include all of the following:

(a) Substances used in the past, including prescribed drugs.

(b) Substances used recently, especially those used within the last 48 hours.

(c) Substances of preference.

(d) Frequency with which each substance is used.

(e) Previous occurrences of overdose, withdrawal, or adverse drug or alcohol reactions.

(f) History of previous substance abuse treatment received.

(g) Year of first use of each substance.

(4) A complete medical history shall be obtained. The history shall contain all of the following information:

(a) Head injuries.

(b) Nervous diseases.

(c) Convulsive diseases.

(d) Major and minor operations.

(e) Major accidents.

(f) Fractures.

(g) Venereal infections.

(h) Cardiovascular diseases.

(i) Respiratory diseases.

(j) Endocrine diseases.
(k) Rheumatic diseases.
(l) Gastrointestinal diseases.
(m) Allergic diseases.
(n) Gynecological-obstetrical history, as appropriate.

(5) An approved service program shall not treat unconscious persons or persons with severe medical complications. These persons shall be transported to the nearest hospital which is capable of providing the necessary services. This transportation plan shall be included in the written triage process.

(6) Approved service programs shall have written agreements with emergency medical departments to provide services beyond the medical capacity of approved service programs.

(7) An approved service program shall have a written description of its procedures for a medical evaluation. This description shall be approved by the program physician.

(8) If an individual in an incapacitated condition is to be admitted to an approved service program, there shall be documentation in his or her medical exam records which explicitly attests to the individual's incapacitated condition. The basis of the decision, including blood alcohol level, if taken, shall be specified.

(9) If an individual is found not to be incapacitated, the approved service program medical records shall so state. An individual found not to be incapacitated cannot be held in protective custody, but may be voluntarily admitted for residential care services.

(10) Approved service programs shall have a written description of the protocol for treatment of incapacitated individuals. This protocol shall be approved by the program physician.

(11) There shall be a treatment plan for each client who undergoes detoxification at an approved service program. A standard of care procedure specifying an appropriate treatment regimen may be utilized. The treatment plan shall include all of the following:

(a) Those services necessary to meet the client's medical needs.

(b) Referrals to be made for medical and nursing services which are not provided by the program.

(c) Documentation that the treatment plan has been periodically evaluated and updated.

(12) The approved service program shall not keep an individual in protective custody more than 72 hours. If the physician deems it appropriate, an individual may voluntarily remain in the approved service program for more than 72 hours. The physician shall document the need for additional approved service program services beyond 72 hours in the client's medical records. The physician shall also enter documentation of the need for additional services in the medical records for each 24-hour period beyond 72 hours.

History: 1981 AACS.

R 325.14928 Discharge.

Rule 928. (1) Unless a client leaves voluntarily before his or her course of treatment is completed, a client shall not be discharged from an approved service program while

physically dependent upon a drug prescribed for him or her by the program physician, unless the client is provided with an opportunity to withdraw from the drug or the client is referred to an outside resource which is willing to continue administering the drug.

(2) The offer to provide withdrawal or referral to another resource shall be made both orally and in writing. If a client refuses such an offer, the program shall attempt to secure a signed statement from the client which verifies that the offer was made to, and rejected by, the client. Failing that, a record shall be entered documenting the attempt.

(3) There shall be documentation that an evaluation of the social and psychological needs of the client has been completed before discharge from the approved service program. A referral to treatment shall be made if appropriate and if desired by the client.

(4) After discharge from the approved service program, a discharge summary that describes the rationale for discharge, the client's medical condition at discharge, referrals made, and instructions given to the client shall be entered into the client's case record.

History: 1981 AACS.