Operation Manual for Prevention Providers

Prevention Services Guidelines

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Contents

I. INTRODUCTION AND INTENT

This document provides LRE guidelines for prevention services and is a reference source for issues relating to prevention activities funded through LRE.

NOTE: The application of PA2 ("Liquor Tax") funds for use for substance abuse prevention services is **not** described within these guidelines; PA2 application guidelines will be separately distributed as necessary.

II. GLOSSARY OF TERMS AND DEFINITIONS:

AAP: Annual Action Plan. Mandatory guidelines for the service development and delivery issued annually by MDHHS.

Adaption: Modifications made to a chosen intervention.

Behavioral and Physical Health and Aging Services Administration: Was formerly known as the SUD administrative oversight as OROSC at MDHHS. Due to the changes at MDHHS, this operation manual will refer to oversite at MDHHS.

CEW: Community Epidemiology Workgroup

CHES: Certified Health Education Specialist. Certification for those who work in the health education field.

Collaboration: The process by which people/organizations work together to accomplish a common goal or mission.

Community Coalition: Community coalitions are considered to be community-based organizations that have as their mission the reduction of substance abuse in a comprehensive and long term manner, with a primary focus on substance abuse related issues in their community. Coalitions are made up of community leaders, affected individuals, and concerned citizens.

Community Readiness: The community's awareness of, interest in, and ability and willingness to support, substance abuse prevention initiatives.

Core Components: Those elements of a program that fundamentally define its nature, and that analysis-from theory, from a logic model and/or from empirical evidence- shows are most likely to account for its main effects.

CSPPC: Community Strategic Prevention Planning Collaborative

Cultural Competence: The capacity of individuals to incorporate ethnic/cultural considerations into all aspects of work relative to the prevention and reduction of substance abuse.

Data Driven: A process whereby decisions are informed by and tested against systematically gathered and analyzed information.

DYTUR: Designated Youth Tobacco Use Representative (there is one for every county in the region)

Fidelity: The degree of fit between the developer-defined components of a substance abuse prevention program and its actual implementation in a given organizational or community setting.
LRE: Lakeshore Regional Entity

MCBAP: Michigan Certification Board for Addiction Professionals

MDHHS: Michigan Department of Health and Human Services

MPDS: Michigan Prevention Data System

PIHP: Pre-Paid Inpatient Health Plan; LRE is Region 3

Protective Factors: Conditions that build bonding and serve to buffer the negative effect of risk.

Risk Factors: Conditions that reduce bonding and inhibit the ability to form healthy behaviors.

RFI: Request for Information

SAMHSA: Substance Abuse and Mental Health Services Administration (US Department of Health and Human Services)

Specialty Grants: grants that are time limited and administered through the PIPH's such as:
SOR4: State Opioid Response Grant

SPF: Strategic Prevention Framework

III. MDHHS DIRECTION FOR PREVENTION

A. Strategic Prevention Framework (SPF) and Prevention Prepared Communities

Action Plan Guidelines are designed to foster the use of the SPF planning model in the development of prevention prepared communities. The SPF model should be used for the planning and implementing of all LRE funded prevention services.

The SPF model employs five steps:

Step 1: Assessment-Determine assets and needs;
Step 2: Capacity-Improve abilities to deliver substance abuse services;
Step 3: Planning-Develop strategies for communication and coordinating services;
Step 4: Implementation-Put strategies into action;
Step 5: Evaluation-Document the process and outcomes of implementation

A prevention prepared community is a community in which individuals, families, schools, workplaces, and communities take action to promote emotional health; and, to prevention and reduce mental illness, substance (including tobacco) abuse, and suicide, across the lifespan.

B. Priority Areas

MDHHS requires the following priority areas:

i. Reduction in underage drinking
ii. Reduction in prescription drug misuse, including a reduction in the misuse of opioids for non-medical purposes.
iii. Reduction in marijuana use among youth and youth adults.
iv. Reduction in underage youth tobacco access and tobacco use including electronic nicotine devices and vape products.
v. Increase in access to prevention services for older adults 55 and older.

NOTE: Activities that do not address these priority areas will **not** be funded through LRE prevention funding.

C. Project-Specific Requirements (Service Eligibility)

Prevention funds may be used for needs assessment and related activities. All prevention services must be based on a formal local needs assessment. The Department endorses a community-based, consequence-driven model of prevention. Based on the needs assessment, prevention activities should be targeted to high-risk groups and directed to those at greatest risk of substance use disorders and/or most in need of services within these high-risk groups. Providers may also provide targeted prevention services to the general population. The needs assessment should reveal the demand for strategies with universal, selective, or indicated populations.

MDHHS identifies high-risk subgroups which include but are not limited to children of substance abusers, pregnant women/teens, drop-outs, violent and delinquent youth, person with mental health problems, economically disadvantaged citizens, persons who are disabled, victims of abuse, person already using substances, and homeless and/or runaway youth. Additionally, children exposed prenatally to ATOD are identified as a high-risk subgroup. Please note that general community conditions such as economic deprivation do not meet the criteria for at risk. The risk must be directly attributed to the individuals being served (e.g. Court involvement, academic failure, parental substance abuse, documents family issues like neglect/abuse).

***Prevention and Mental Health Promotion**:* Prevention programming is intended to reduce the consequences of SUDs in communities by preventing or delaying the onset of use and reducing the progression of SUDs in individuals. Prevention is an ordered set of steps along a continuum that promotes individual, family and community health; prevents mental and behavioral disorders; supports resilience and recovery; and reinforces treatment principles to prevent relapse. This multi-component and strategic approach should cover all age groups including support for children, senior citizens, all socio-economic classes, diverse cultures, minority and populations that are under-served, service men and women, gender-specific and targeted groups that are at high-risk for developing a substance use disorder. Prevention service providers receiving substance abuse block grant and other federal funding via PIHPs must evaluate prevention services implemented in the PIHP catchment areas as specified by contract and/or grant reporting requirements.

IV. POPULATIONS – Please reference the most current manual labeled MICHIGAN PREVENTION DATA SYSTEM FOR SUBSTANCE USE DISORDER SERVICES (MPDS-SUDS) USER MANUAL FOR PROVIDER AGENCIES found at https://mpds.sudpds.com

A. Primary vs. Secondary Populations

When counting persons served, you may only count persons of the population that your program will come into direct contact with. This is considered the primary population. Often there is a secondary population, that is the population you are trying to impact. For example, teaching parenting skills to parents of high-risk adolescents to improve family management is designed to prevent the onset of problems among the adolescents. In this case you would count the parents as persons served but **not** count the youth unless they also received direct services.

For environmental and collaborative efforts where you are seeking to impact the general community though things such as media, you count your partners in the effort as the service recipients (e.g. coalition members, elected officials, etc.). Your secondary population would be the general community. In our current data collection system, there is no collection of secondary populations.

In our current data collection system, there are certain instances when you will be allowed to capture and enter collection of this secondary populations under “estimated reach.” This is entered under very specific circumstances.

B. Service Requirements:

A minimum of 90% of prevention expenditures will be directed to programs that are research based or model programs. Research based services are carefully implemented programs, strategies and activities based on a credible body of research demonstrating positive results, designed to prevent the use of alcohol, tobacco and other drugs.

No more than 10% of prevention expenditures may be spent on information dissemination activities, which must also be part of a multifaceted prevention strategy.

V. PLANNING DETAILS AND PROGRAM IMPLEMENTATION

A. Action Plan

Each contracted agency is required to create an Action Plan. The Action Plan lays out the initiatives and programs that the agency agrees to perform within the allotted budget during the fiscal year. If changes are made to the Action Plan, these changes may be submitted throughout the year. Please discuss the appropriate method for submitting plan changes with LRE.

The agency Action Plan for Prevention may consist of the following documents and be submitted by the determined date for approval, before a contract is issued:

1. Prevention Plan Narrative & Project Planning Sheets
2. Prevention Outcome Tracking Report
3. No Cigs for Our Kids Campaign Plan (DYTUR's only)
4. Budget Cost Detail forms and Supporting Narrative

*The SUD Prevention Manager will issue the most updated forms with due date for plan submission and required documents each fiscal year for contract Prevention Providers.

B. Project Proposals

All project activities must be submitted on the forms listed above by the due date determined by the LRE SUD Prevention Manager. Approval for these activities must be received from LRE before billing is allowed for the activity. To be approved a proposed project must:

- Have clear, measurable substance abuse specific goal(s)
- Have a reasonable estimate of time and resources expected to be used;
- Include provisions for documenting the activities and outcomes and report these to LRE in the manner indicated on the planning forms and the contract; and
- Clearly address one of the identified priority focus areas as detailed in Section IIIB

C. Public Health Approach (National Outcome Measures)

In recognition of federal prevention National Outcome Measures (NOM) and the process requirements in the Strategic Prevention Framework (SPF) model, providers are expected to implement (or maintain) a planning process and service delivery system that shows evidence of working toward community involvement and community level NOMs related change. NOMS for SUD Prevention should reflect at least the numbers of persons served by age, gender, race & ethnicity and total number of evidence -based programs and strategies.

Rational information on how targeted high-risk populations were selected must be provided in the annual planning process. Rationale must reflect the use of local, factual information derived from credible sources.

D. Units of Service Planning Requirements per FTE

LRE funded prevention providers are required to plan for a minimum of direct units of service based on the number of full-time equivalents (FTE's) included in each agency's annual prevention plan and budget. For each

1.0 FTE, 600 hours, or 2,400 units of direct service should be planned for completion during the fiscal year of service. Providers may choose to have a higher level of planned or expected direct service to account for agency productivity levels.

NOTE: This requirement will be monitored by LRE at the agency level (annually) and not at the individual staff level. It is recommended each program monitor individual staff direct hours. Consideration for direct units of service is given, based on the providers annual plan, functioning and roles/responsibilities (i.e. staff that lead a coalition may less hours based on the indirect planning hours and community-based functioning of the role).

E. PLAN CHANGES

If substantial changes are made to how a project will be implemented, an agency must submit a revised Project Planning Sheet for the appropriate project. Substantial changes would be limited to changes to the core components of the project.

F. Coalition Participation

All involvement with substance-use related coalitions that have been pre-approved by the LRE SUD Prevention Manager may be counted as direct service. These activities and organizations must be specifically listed in the provider's Action Plan and submitted for approval. Approval will require the identification of measurable substance abuse related outcomes to be achieved during the fiscal year.

Should new coalition participation opportunities and/or requests arise during the fiscal year, participation must be pre-approved by the LRE SUD Prevention Manager. LRE reserves the right to limit the level of coalition activity should it become disproportionate with the delivery of actual prevention services.

G. Leading a collaborative

The intervention is conducted using community-based process (e.g. coalitions, taskforces);

And

The collaborative process is compatible with the five-step prevention planning process, which includes: assessment, capacity building, planning, implementation, and evaluation with consideration for sustainability and cultural competence.

H. Participating in a collaborative:

It is necessary to participate in the collaborative in order to effectively conduct substance abuse prevention in your community;

And

You are representing substance abuse prevention.

NOTE: Attendance at a meeting by more than one staff member from an agency should be **limited.** Multiple attendances should occur only when each staff person serves a specific, separate, and active role on the collaborative. For example, if one staff attends as a chair of a certain workgroup, another staff may attend as a chair of the coalition, secretary to the coalition, etc.

I. Evaluation

Evaluation is an essential part of any prevention activity. Because of this, evaluation for each program must be pre-approved as part of the program proposal. The LRE SUD Prevention Manager is available if assistance is needed with a program's evaluation. Please refer to Section V: Evaluation for complete evaluation guidelines and information.

VI. EVIDENCE-BASED PREVENTION

All agencies' prevention programming/activity must be evidence-based. Programming/activity provided in the Information Dissemination Strategy will not be considered evidence based. All activities provided within the educational, community based, and environmental strategies will require demonstration of being evidence-based.

A. Categories of Evidence-Based Criteria Please reference the most current manual labeled MICHIGAN PREVENTION DATA SYSTEM FOR SUBSTANCE USE DISORDER SERVICES (MPDS-SUDS) USER MANUAL FOR PROVIDER AGENCIES found at https://mpds.sudpds.com defined under **EBP Service Type**

B. Fidelity and Adaptation

When using a program listed on a federal list or from a peer-reviewed journal it is considered to meet evidence-based status only when conducted locally with a balance between adaptation and fidelity. When an adaptation is made that may affect core components of an intervention for a program from a federal list it is necessary to contact the program developers for approval and to notify LRE of this approval. Fidelity assessment tools will be reviewed annually through the site visit. All Prevention Staff will be required to complete an annual form that they have reviewed the manual and technical specifications of any EBP Programs/Activities s/he was involved with in the past FY or is planning to be involved within the current FY. Attention to BOTH fidelity and adaptation is essential for successful implementation of evidence-based programs. Adaptations may be necessary due to the target population, community environment, political and funding circumstances, etc. However, adaptations must not modify core components of the program. The annual plan will require providers to address this area.

VII. EVALUATION

Evaluation is an essential part of every prevention activity. The evaluation for each program must be pre-approved as part of the program proposal. The following are guidelines for each program's evaluation planning.

A. Process and Outcome Evaluations

Every program must be evaluated for both process evaluation and outcome evaluation.

1. Process Evaluation

Process evaluation documents services that are actually delivered, whether they are delivered with fidelity to the plan, who receives them, etc. This type of evaluation is concerned with the method of delivery, rather than the effect the program has on its recipients. Process evaluation is only capable of assessing program implementation and providing information on procedural issues.

Process objectives provide benchmarks for activities being completed (when, to whom and to how many). For example; 'We plan to conduct six parent education classes of 12 sessions each, to serve 25 economically disadvantaged youth and their parents, send monthly newsletter to all parents, and sponsor one parenting symposium'.

2. Outcome Evaluation

Outcome evaluation focuses on the effects of a prevention activity on its targeted population. This evaluation is concerned with detecting any changes as a result of the activity, and the degree to which the change is the result of the prevention activity. This measure must be designed to show what has changed or improved among the population served that can reasonably be considered an effect of the prevention activity.

B. Survey Collection Related to Confidentiality

The survey data collected is confidential and participants' rights to privacy must always be respected. Staff who administer the evaluation tools should take steps to ensure that individual responses are kept private,

such as monitoring the location to make sure that participants are focusing on their own responses and collecting instruments in a closed folder/box or ensuring answers to surveys outcomes cannot be viewed by other participants. Although some participants may need assistance with understanding some items, it is not appropriate for instructors to help participants actually complete the instrument. Agencies should follow their organization's policies and guidelines regarding storage of confidential data files and consent forms.

C. Measurable Objectives

Evaluation cannot be attempted until **clearly stated, measurable objectives** are determined for a program. In order to be measurable, objectives must include the following: who will be affected, in what time frame, in what way, and by how much.

D. Program Evaluation by Strategy

1. Information Dissemination Strategy

The standard "pre-test, post-test" (possibly post-test only for information dissemination) format is often most appropriate here. For groups in which pre-test/post-test (quantitative) evaluation has been documented to be too burdensome or not to be possible, qualitative/anecdotal evidence is acceptable.

2. Education Strategy

The standard "pre-test, post-test" format is often most appropriate here. The pre/post-test should assess whether the outcome objectives of the program were reached. The evaluation should include information about the desired attitude, intention, and behavioral changes. It is important that recurring services programming be designed to focus on impacting behavior and less frequently on increasing knowledge. Research has shown that knowledge has little or no impact on behavior. Please note that it is often difficult to demonstrate an impact on behavior with pre/post-test evaluations for a program of limited duration.

The optimal program evaluation will collect both qualitative and quantitative data. For reporting purposes, the remarks of the participants or observers should be in written form or at the very least transcribed by the prevention professional and signed by the participant. In each case, where appropriate, anecdotal information should be collected, even when other types of evaluation are being conducted.

All evaluations will be pre-approved as part of the annual plan process. Deviation from these assigned parameters will need PIHP approval.

3. Community Based Strategy

All goals and objectives of community-based strategies must be directly related to impacting substance abuse usage.

Attendance at meetings will not be funded if the meetings have no measurable substance abuse related outcomes that will be reached within the fiscal year. Attendance at meetings, coalitions, and/or collaboration must be pre-approved as a part of the *program proposal* process by the SUD Prevention Manager before billing is allowed.

Collaborative efforts seek to combine efforts in order to achieve a greater outcome than any one agency could achieve and must have substance abuse specific objectives. A thorough evaluation of a collaborative effort should include an assessment of the functioning of the coalition and measure progress toward the group's objectives. If the agency is not the lead agency for the collaborative it may not be feasible to assess group functioning. In this case, measurement toward the group's objectives would be adequate.

Community based efforts designed to increase capacity without a collaborative group should set

measurable objectives that track progress toward increasing capacity (e.g., the number of volunteers recruited/trained).

4. Environmental Strategy

Environmental strategy efforts should have clear objectives on how they will change policies, norms or enforcement and delineate the impact that these changes will have. Evaluation of environmental strategies should track both progress toward achieving these changes in policies, norms, and enforcement (e.g., the number of vendors educated) and the impact of these changes (e.g. decrease sales to minors) should be tracked as appropriate.

E. Evaluation of Federal List Programs

LRE funded prevention activities require that an evaluation be done for each prevention activity. This is a requirement even when using a program from a federal list. Some program developers state that an outcome evaluation is self-contained in their model program if the program is done with fidelity. LRE requires that an evaluation component is conducted in order to ensure that the implementation done locally is acquiring positive results. There are many reasons why local implementation of a program may alter the expected results. LRE is accountable to our communities and must be able to show what results we have achieved locally with the use of public funding.

F. Satisfaction Surveys

It would be expected the SUD Provider completes an analysis of Customer Satisfaction Surveys and develops improvement plans when areas or staff facilitation fall below expected performance standards.

VIII. REPORTS

A. Due Dates

Due dates will be provided by the SUD Prevention Manager annually in October (See below for standard dates).

B. Required Reports and Site Review:

1. Annual Reports (determined by the state each fiscal year)

- Verification of Tobacco Master Retailer List (MRL): Due date TBD
- Synar Compliance Check Report: Due date TBD

2. Bi-annual Outcome Reports: Due April 10 and October 10

a) Prevention Outcomes Form
b) Youth Access to Tobacco Activity Report (bi-annually – TBD)
c) Other specialty grants as required:
   (1) *SOR 4 will be monthly – due by the 2nd Wednesday of each month

3. Monthly Reporting: MPDS data entry: Due by 10th of following month

4. Prevention Site-Visit/Observation: Scheduled late in the fiscal year to assess the current fiscal year. Each provider will receive an annual site review or desk audit. These are designed to monitor contract compliance, licensing requirements, prevention planning and implementation procedures. The site visit protocol and observation prep forms will be provided prior to scheduling. The SUD Prevention Manager reserves the right to observe a prevention program at any time throughout the fiscal year. Annual site visits will require an **LRE chosen month/year** for financial audit, including reconciliation of FSRs to the provider's accounting records. Supporting documentation will be required for each expenditure line item selected, and reviewed for allowability, proper support, and compliance with applicable guidelines and policies. Supporting documents: All applicable documentation for all LRE Prevention funded expenses, as indicated on FSR submissions utilizing block grant, PA2, SOR4, Gambling Prevention, etc for the provider agency. Trial Balance or General Ledger Detail, including invoices, receipts, supporting

documents, explanations of expenses, etc. for specified FSR(s). For indirect costs, providers will be asked to provide a copy of the applicable cost allocation plan document.

C. SUBSTANCE USE DISORDER – PREVENTION DATA SYSTEM

The prevention Data System is a contract requirement for all LRE funded direct service prevention activities. This is a web-based system that will require approval for staff (via LRE or MDHHS).

Information entered into the system will immediately be available for review at LRE and also the Michigan Department of Health and Human Services. For more detailed information on entering activities into the data system please refer to the document titled, "MPDS USER MANUAL." **Note**: All Block Grant (SAPT funded), Other Funded (PA2), Gambling Disorder Prevention, SOR4, (LRE funded) activities will need to be populated into MPDS (ensuring the funding source is correctly chosen).

1. **Type of Activity to Enter**

   Only **direct service** activities will be entered into the data system. Please reference the MPDS Manual under the **Activities Eligible for Entries.** The system is designed to capture staff activity that is face-to-face with recipients of service or in collaborative activities such as coalition meetings. All activity performed by prevention staff will not be captured by this system, only direct face-to-face activities. The system is not intended to capture all staff time. It is understood by LRE and MDHHS that the time entered in activities will be less than the total number of hours worked by an individual.

   Indirect activities supporting prevention activities are not reported to LRE. If an agency desires to collect information on indirect time for their staff, the agency will need to design and manage an additional data collection process for their own purposes.

2. **Username and passwords**

   LRE will assign a username and password for staff providing direct prevention services. Please note that LRE will only add a staff to the MPDS system once they have received the **New Hire Form**. This form must be submitted within 14 days of hire.

   A new process will be developed with MDHHS for access once the MPDS system upgrade is completed and active in FY 26.

3. **Staff vacancies**

   Provider will notify Lakeshore Regional Entity of any vacant staffing position in the program within 30 days of the position becoming open and give an update every 30 days thereafter until the position is filled. Lakeshore Regional Entity reserves the right to pro rate the monthly rate for the vacant position.

4. **Group Names**

   Group names used within the MPDS system will be approved by LRE through the annual planning process.

5. **Record Keeping (always used the latest version of the MPDS manual for advisement)**

   In addition to entering activities into MPDS, the provider is required to document the delivery of those activities. Examples of documentation are provided in the MPDS manual under Record Keeping. These records will be reviewed annually by the LRE SUD Prevention Manager at the audit/site visit. Record keeping (contact logs with time; attendance) must be retained for a minimum of 4 years.
   For a further detailed description, please reference the contract in section: ***Record Maintenance/Retention.***

6. **Funding Statement**
   LRE funded programs need to have a funding statement printed on all material that is advertising/promoting a service or event. It needs to include the following statement:

   "This publication is supported by a grant from the Michigan Department of Health and Human Services through Lakeshore Regional Entity. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of MDHHS or LRE".

D. BILLING

1. **Prevention Funding Structure**
   Prevention funding is based on actual cost. LRE will pay the allowable necessary expenses to run a prevention program. Funding is not directly linked to the number of units accomplished, but there are guidelines for the number of units of service that should be provided based on FTEs within the LRE budget. Please refer to **Section III Planning Details and Program Implementation** for more details.

2. **Pre-Approved Budgets**
   Budgets are pre-approved as a part of the planning process. LRE Budget Cost-Detail forms must be submitted estimating the costs of programming. ***Please see the boilerplate contract for the full entirety of the deviation allowable language.***

   The deviation allowance **does not** apply to the law enforcement tobacco compliance check allocation. This allocation must be spent in total on its designated purpose.

   Budgets may be adjusted throughout the year if necessary. Please contact the LRE SUD Prevention Manager for more details on the budget amendment process.

3. **Primary Prevention**
   State administered funds may only be applied to Primary Prevention. Primary Prevention is defined as services directed at individuals who have not been determined to require treatment for substance abuse. Please see **Section VIII: Funding Requirements and Restrictions, Primary Prevention** for more detailed information on Primary Prevention.

4. **Other Sources of Funding Notification**
   The LRE contract requires that your agency provide notification to the LRE regarding receipt of any federal, state, or local grants for substance abuse prevention services. This notification must be provided in writing to the LRE within 30 days of the award notice.

5. **Prevention Specialist/Participant Ratios** For the planning and implementation of a defined prevention direct-service activity, the following guidelines are ***recommended by the LRE*** to the reportable and billable prevention specialist/participant ratios:
   a) **Workshops and Trainings:** Generally, smaller groups with a higher level of interaction marked by an ongoing need for two-way communication and/or interaction. Units of direct service may be recorded for each staff member present that facilitates a substantial portion of the workshop.
   b) **Coalitions/Task Forces/Collaborative/Workgroups:** Generally, units of direct service may be recorded for only one staff person in this category, regardless of the number of participants. However, if each staff member is representing a different and clearly delineated role in the Collaborative, staff may each count their time as a direct unit of service. Examples may include chairing a workgroup/task force of the collaborative, chair of collaborative, etc.
   c) **Educational Groups:** Small groups marked by complex, two-way communication and interaction. Units of direct service may be recorded by one staff person if there are 9 recipients or less and by two staff persons if there are 10 recipients or more. However, education groups may also be to high-risk populations as noted below.

d) **High-Risk Populations:** Services provided to high-risk populations may require a greater ratio of staff to participants. Increased staff/participant ratios may be approved. If your agency believes this to be the case for a certain program, please contact the SUD Prevention Manager.

IX. FUNDING REQUIREMENTS AND RESTRICTIONS

A. Requirements

1. **High-Risk Populations**: It is the direction of MDHHS that services targeted to individuals target high-risk populations and address their specific needs. Rationale on how high-risk populations were selected by local providers must be provided in the annual program planning process. For more detailed information on high-risk populations see Section III. B. Public Health Approach and High-risk Populations.
2. **Evidence-Based Prevention:** MDHHS requires that 90% of prevention services funded by the PIHP be evidence-based. Therefore, LRE requires that 90% of each agency's prevention programming be evidence-based. Please see Section IV: Evidence-Based Prevention for more detailed information.

3. **Primary Prevention:** State-administered funds can and must be applied only to primary prevention services/activities. The SUD Federal Block Grant regulations in CFR 96.121 define primary prevention programming as, "Those directed at individuals who have not been determined to require treatment for substance abuse." Only primary prevention services can be reimbursed with LRE funds.

4. **Funding Acknowledgement:** Provider agencies are required to assure that any program reports, articles and publications that result from service activities and/or information gathered through use of state or federal funds specifically acknowledge receipt of that support from the MDHHS, LRE and/or other appropriate federal agencies. The funding statement can be found in this manual.

5. **Service Area**
   Prevention funds are allocated to the county in which the agency is located unless otherwise noted in the contract. If services are being requested outside of the county that you serve, prior approval from the LRE SUD Prevention Manager and the prevention provider in that county are required prior to any services being conducted. Providers may not limit access to the programs and services funded by the LRE to only residents of the LRE region.

B. RESTRICTIONS

LRE Prevention funding must follow the **Selected Specific Grant Requirements described in the SUD Prevention Specials Provision.** Furthermore, the following activities cannot be expensed, counted or reported as prevention services. Please see the contracts for specific funding allowables/restrictions for specific funding:

1. **Informational presentations** proposed or delivered as part of treatment program's outreach and/or case-finding efforts.
2. **Informational dissemination** that is not an integral part of an evidence-based prevention program.
3. **Tobacco –** Funds may not be used to support smoking cessation programs.
4. **Dual Enrollment.** Prevention service recipients may not be enrolled in treatment and prevention at the same time. The following exceptions apply:
   a) programs provided under the special FY 1997-98 women and children's services funding and specifically approved by LRE, or
   b) parenting programs that involve the entire family when one parent is enrolled in treatment services.
5. **Media Campaigns –** Media campaigns must be approved via the SUD Services Media Campaign Request Form and follow guidelines updated March 2023 and Octvia MDHHS. The request form must be submitted via the LRE staff to MDHHS.

6. **Alcohol –** Federal funds prohibit purchasing of alcoholic beverages.
7. **SUD Prevention Block Grant only (***added in FY 26***)** Funds shall not be used to purchase promotional items, including but not limited to clothing, commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags.

X. STAFF REQUIREMENTS

A. Staff Identification

Staff must be identified in the AAP if they are utilizing LRE money for their time or added during the year in the case of new hires or reassignments. Forms for reporting new hires or interns are provided as a separate form.

B. New Hires

When a new person is hired a 'New Hire Form" must be submitted to LRE within 14 days of the hire date. Please note that this form has been updated to be specific to those working in prevention services. This form must be accompanied by a resume or equivalent document.

If the newly hired person is an intern, please see the following section for what documentation will be necessary.

C. Interns

Internships provide a powerful learning experience for people who want to work in the human services field. If it is feasible, all professionals should welcome the opportunity to enrich the experience of prospective fellow professionals. While we welcome interns, it is important to ensure that they are involved in ways consistent with accepted standards and compatible with recipients' rights and needs. The following is LRE policy in this area.

Premise

- Interns are neophytes, academically learned but experientially unskilled.
- The purpose of an internship is to apply academic learning, under the guidance of a skilled professional, to real-life situations.

Therefore:

We assume a new intern to be unqualified to independently deliver any services to a client. Depending on the intensity of the learning situation, four to eight weeks should elapse before an intern can begin to provide prevention services without constant supervision. Four to eight weeks is optimal. In some cases, this supervised period may need to be extended.

If an intern is to be paid, their salary will need to be added to the Budget Cost Detail under salary. LRE will not cover the salary of an intern until their supervisor has reviewed their performance for four to eight weeks and certified in writing to LRE that they are able to work quasi-independently in a specific area.

D. Staff Training and Development

1. Certification Requirements

Prevention Provider staff (professionals and supervisors) must possess an active Certified Prevention certification through the Michigan Certification Board for Addiction Professionals (MCBAP) MCBAP Certifications - MCBAP - Michigan Certification Board for Addiction Professionals) or they may be credentialed through the National Commission for Health Education as a Certified Health Education Specialist (CHES) Health Education Specialist Certification - CHES®, MCHES® | NCHEC .

Prevention Supervisors: Commonly described as prevention program supervisors and represent individuals responsible for overseeing prevention staff and/or prevention services.	• Certified Prevention Consultant –Michigan (CPC-M) • Certified Prevention Consultant – IC&RC (CPC) • Certified Prevention Specialist – Michigan (CPS-M) • Certified Prevention Specialist – IC&RC (CPS) or Certified Health Education Specialist (CHES) – only if credential effective for one (1) year or 2080 hours. For further details see MICHIGAN PIHP/CMHSP PROVIDER QUALIFICATIONS	No state requirements specified.
Prevention Professionals: Commonly described as Program or Prevention Coordinator, Prevention Specialist or Consultant, or Community Organizer and have responsibility for implementing a range of prevention plans, programs, and services.	• Certified Prevention Specialist – Michigan (CPS-M) • Certified Prevention Consultant – Michigan (CPC-M) • Certified Prevention Specialist – IC&RC (CPS) • Certified Prevention Consultant – IC&RC (CPC) • Development Plan – Prevention (DP-P) – approved development plan in place • Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)	Supervision by MCBAP prevention credentialed staff or an approved alternative certification.

Reference Document: Substance Use Disorder (SUD) Credentialing and Staff Qualifications (michigan.gov) pg 7-8

Staff may also be funded if they have a registered development plan through MCBAP CPS Development Plan - MCBAP - Michigan Certification Board for Addiction Professionals, which is being actively pursued and properly supervised. In some cases, this certification requirement may be waived if prevention services are delivered by specifically focused prevention staff. Specifically, focused staff are those that consistently provide a specific type of prevention service and do not have responsibilities for implementing a range of prevention plans and programs. Specifically, focused prevention staff **must** have completed formal training for the specific program they are conducting, demonstrable through certificates of completion or similar documentation. **These specifically focused staff must be pre-approved by the SUD Prevention Manager to determine if they are exempt from certification effective 10/1/2020 and moving forward.**

Prevention Provider Oversight: SUD Prevention programs will be supervised by a designated person who is also a **Certified Prevention Supervisor** (as noted in the reference SUD Credentialing and Staff Qualifications). Prevention Professionals must be supervised by MCBAP prevention credentialed staff or an approved alternative certification (CPS, CPC or CHES). Prevention Supervisors must have had the MCBAP prevention credential for a minimum of three (3) years and must have the supervision of prevention staff job function stated in their agency job description or designated in organizational chart. When this oversight is not operationally feasible, the Provider Agency will ensure that arrangements are in place to secure adjunct supervision by a certified Prevention Supervisor. Arrangements may include a contract for oversight by a Certified Prevention Supervisor with at least monthly supervision times (documented with an agreement demonstrating agenda/meetings minutes) **OR** attend at least monthly

supervision times (documented with agenda/meetings minutes) with the LRE SUD Prevention Manager. *It should be noted this oversight requirement is not in reference to the MCBAP Development Plan supervision requirement NOR the day to day job functions at provider agencies.*

It is expected that agencies reasonably acknowledge the cost implications of certification requirements and incorporate these costs appropriately into their LRE budget or other funding sources for the fiscal year. Training and certification costs may be submitted as a part of the budget approval process but may not exceed 5% of the LRE prevention funding for the agency.

2. Temporary Work Assignments

In situations when an individual staff's roles and responsibilities temporarily encompass a role requiring certification, the individual performing the duties of the absent/vacant staff position will not be required to meet the certification requirement for the temporary position. However, the individual with the interim work assignment must have the certification or development plan appropriate to their regular roles and responsibilities. LRE must be notified of such cases prior to assigning temporary responsibilities when the assigned staff does not meet the certification required for the temporary assignment. The agency and LRE will develop a time-limited plan to ensure there is adequate and appropriate supervision.

3. Certification Responsibilities

Primary responsibility for assurance that credentialing requirements are met rests with the provider agency that directly employs or contracts with the individual professional to provide or supervise prevention services. Responsibilities of the individual, provider agency and the LRE are generally as follows:

The provider agency, that directly employs or contracts with the individual to provide prevention services, is responsible for verifying the ongoing certification status of the employee. This includes verification of the credentials, monitoring staff development plans, providing supervision (or helping establish supervision for agency providers who may not have appropriate credentialing) and compliance with continuing education requirements. Agencies must, upon request, furnish evidence of certification for appropriate staff.

4. Staff Development Plans/Ongoing Training

Agencies contracting with LRE agree to obtain ongoing training and staff development necessary to meet certification requirements detailed under their Certification Requirements as noted above in Definitions.

Provider will maintain documentation for all orientation and continuing education, which will include:

Training Requirement	Timing
Communicable Disease*	LRE requires all staff of contracting agencies complete at least level 1 Communicable Disease training; within 30 days of hire and then annually thereafter. Ongoing staff training needs shall be provided, in accordance with the provider policy.
Recipients Rights	Within 30 days of hire; Ongoing staff training needs shall be provided, in accordance with the provider policy.
Limited English Proficiency	Within 6 months of hire; Ongoing staff training needs shall be provided, in accordance with the provider policy.
HIPPA /HITECH Act	Within 15 days of hire; Ongoing trainings shall be provided, as needed, in accordance to the provider policy.
Corporate & Regulatory Compliance	Upon hire; Ongoing trainings shall be provided, as needed, in accordance to the provider policy.

Cultural Competence	Within 6 months of hire: Then as needed per providers Cultural Competence plan
Staff Training on Research-Based Prevention Programs	As evidenced by Attestation- Review of Required SUD Prevention Evidence Based Guidance Documents (required annually of all Prevention Staff-); Staff training logs and/or MCBAP certification

* All SUD providers staff with client contact should have at least a basic knowledge of HIV/AIDS, TB, Hepatitis, and STD/I, and the relationship to substance use.

Available free trainings may be found through: Substance Use Disorder (SUD) | Improving MI Practices

XI. TOBACCO

A. Tobacco as a Priority

Prevention objectives pertaining to tobacco use and access by young people are a priority to MDHHS. The priority is based on the following:

1. Public law requiring that states give priority to programs for populations that are at risk of developing substance abuse problems;
2. The need to ensure that strategies are implemented which discourage the use of tobacco by minors; and
3. The Synar Amendment final regulations regarding enforcement of state laws on youth's access to tobacco.

Restrictions won't allow MDHHS administered funds to be utilized for activities with a primary focus on educating about the health risks related to tobacco or for tobacco cessation activities. Funds or other support may be available through other divisions of MDHHS.

B. Responsibilities of Agencies designated for Tobacco Prevention

Each agency designated to receive prevention funding for tobacco initiatives must identify an individual to be the Designated Youth Tobacco Use Representative (DYTUR). Responsibilities of the DYTUR are detailed below:

1. **Formal Synar Compliance Checks**

   Each DYTUR is required to ensure that civilian compliance checks are completed with retailers that are identified through the Synar sample list. Additional guidance will be provided prior to the implementation period by MDHHS and the PIHP.

   Synar Coverage Study: Every three years, each state is also required to check the coverage and accuracy of the master list by conducting a coverage study as close as possible to the time of the Synar survey. "Coverage" indicates how completely the list contains (covers) all of the eligible outlets in the State for the Synar survey. An eligible outlet is a retailer that sells tobacco, vapor, or alternative nicotine products and is accessible to individuals under the age of 21. The coverage rate is the percentage of all eligible outlets in the State that actually appear on the master list (list frame). The coverage rate can be estimated through a coverage study, which is a special type of survey conducted to measure the coverage or incompleteness of the list. Coverage studies (CS) are conducted every three years as required and prescribed by CSAP. The Substance Abuse and Mental Health Services Administration (SAMHSA) recommendation is for a ninety (90) percent coverage rate; however, the actual mandate is for eighty (80) percent coverage. The study will also provide an additional means of checking address accuracy and outlet eligibility, beyond the various methods used to clean the list regularly. If your county is chosen for the Synar Coverage Study the DTYUR/Supervisor will be notified of their participation by the LRE Prevention Manager and expectation to comply with provided dates of completion provided by MDHHS.

2. **Non-Synar Compliance Checks**

   a. Promote the enforcement of state and local policies that ban or restrict the availability of

tobacco products to young people, sometimes called "stings." Protocol involves coordination with local law enforcement, and follow-up documentation for each establishment. Those establishments that did not sell should receive a congratulatory letter. Those that did sell should receive a letter detailing why their non-compliance is an issue. Materials should be given to each establishment that does not display the proper signage.

Compliance checks are completed equal to (or in excess of) 25% of the number of retailers in each county. An allocation to fund law enforcement compliance checks will be designated as appropriate.

b. Determine the extent of the problem and effectiveness of enforcement efforts by conducting tobacco availability to minors through compliance checks of over-the-counter, retail and vending machine sales.

3. Verification of Tobacco Vendor List

Each DYTUR must annually review, determine the accuracy, and correct the list of tobacco vendors within their county. This must include contact, by phone or site visit, to each retailer on the county list. Verification of the list must include:

a. confirmation that retailer continues to sell tobacco products;
b. confirmation that the business is still in operation; and
c. identify new tobacco vendors.

4. Community-Wide, Tobacco-Free Norms

Promote the development of community-wide tobacco-free norms among young people. The DYTUR should accomplish the objective either by working cooperatively with existing community organizations and tobacco prevention coalitions or by helping to establish community tobacco prevention organizations or coalitions. The DYTUR should represent the substance abuse field as contact points and advisors regarding youth tobacco-use prevention. The DYTUR should be actively involved with the local coalition and support their activities by:

a. Being the lead agency for the coalition and developing strategic planning; and/or
b. Assisting the lead agency by performing duties as requested.

5. Coordination Efforts

a. Steps must be taken to coordinate youth tobacco initiatives with other organizations in the county and region.
b. Objectives regarding coordination with local prosecuting attorney's office regarding youth access to tobacco must be designed and implemented.

XII. MEETING ATTENDANCE/PARTICATION REGIONAL PROJECTS

A. Prevention Meetings

Attendance at LRE-sponsored Regional Prevention Meetings by prevention supervisors is required. Agencies are responsible for the information or instructions provided at these meetings. Therefore, if it is not possible for the prevention supervisor to attend, the agency must designate a representative to attend in order to acquire the necessary information. The SUD Prevention Manager must be notified of this prior to the meeting.

B. TalkSooner

Providers are required to promote the TalkSooner.org campaign by way of its funded program services. Partnering counties within the region will have at least one representative via its provider network or coalition at roundtable TalkSooner meetings.

C. Coalitions

Providers are required to be active members in the local Substance Abuse Prevention Coalition. This includes attending regular coalition meetings, taskforces, events, subgroups, and or executive committees. Provider's contracted prevention services are expected to be aligned with the strategic plan of the Coalition as applicable.

D. Regional Prevention Projects

- Partnering counties within the region will have at least one representative via its provider network
  or
- Coalition at regional prevention projects planning and implementation meetings.

XIII. RECIPIENT RIGHTS REQUIREMENTS – PREVENTION

(Please see the Substance Use Disorder Prevention Special Provisions)

XIV. PRIMARY PREVENTION LICENSING –

Prevention services reduce the risk that an individual will develop problems that might require that he or she enter the substance abuse treatment system. The Prevention licensing category is Community Change, Alternatives, Information, Training (CAIT) – A CAIT licensed program must offer at least one of the following SUD services:

- Community Change – Planned efforts that are designed to change specific conditions to reduce the probability that substance use problems will occur among residents of the community.
- Alternatives – Providing planned non-treatment personal growth activities that are designed to help a participant meet his or her own personal needs and to reduce the risk of developing problems that may require that he or she enter the substance abuse treatment system.
- Information – Providing information to the public that is designed to reduce the risk that an individual will develop problems that may require that he or she enter the substance abuse treatment system.
- Training – Providing activities designed to improve the personal and social skills of a person who wishes to avoid substance use problems or who can help others avoid problems with substance use.

PIHPs are required to contract with a prevention provider that has a CAIT license, except if a governmental entity is directly offering SUD services. In this case, a license cannot be issued in accordance with MCL 333.6233(1), 333.1106(4), and 333.1104(7). Governmental entities include sovereign tribes, state government agencies, local city or county agencies, and other government units.