CO-OCCURRING ENHANCED RESIDENTIAL REHABILITATION SERVICES (RRS) FOR SUBSTANCE USE DISORDER (LEVEL 3.1)

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available information, Plan expectations, your contract, and MassHealth guidance. This information should be materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations, and all requirements of these service-specific performance specifications. In addition, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General performance specifications, the service-specification specifications take precedence.

OVERVIEW

Co-Occurring Enhanced Residential Rehabilitation Services (RRS) meet the American Society for Addiction Medicine (ASAM) definition for Level 3.1 Co-Occurring Enhanced. This shall mean a 24-hour, safe, structured environment, located in the community, which supports Enrollees' recovery from addiction and moderate to severe mental health conditions while reintegrating into the community and returning to social, vocation/employment, and/or educational roles. Scheduled, goal-oriented clinical services are provided in conjunction with psychiatry and medication management to support stabilization and development of skills necessary to achieve recovery.

Clinical services are provided a minimum of five (5) hours a week and additional outpatient levels of care may be accessed concurrently as appropriate.

Exclusion criteria must be based on clinical presentation and not include automatic exclusions based on stable medical conditions, homelessness, medications prescribed including MOUD, compliance with medications, lack of prescription refills, or previous unsuccessful treatment attempts.

SERVICE COMPONENTS

1. At minimum, the provider complies with all requirements of the Department of Public Health (DPH) licensure of substance abuse treatment programs (105 CMR 164) including DPH reporting requirements.

2. Therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional staff to maintain an appropriate milieu and conduct the services below based on individualized Enrollee needs. The scope of required service components provided in this level of care includes, but is not limited to, the following:
    a) Bio-psychosocial evaluation
    b) Psychiatric consultation
    c) Psychopharmacological consultation
    d) Medical monitoring
    e) Medication monitoring
    f) Withdrawal Management
    g) Individual, group, and family therapy
    h) Behavioral/health/medication education and planning
    i) Psycho-educational groups
    j) Medical history and physical examination
    k) Nursing assessment
    l) Substance use disorder assessment
    m) Relapse prevention
    n) High risk/HIV education
    o) Peer support and/or other recovery-oriented services
    p) Development and/or updating of crisis prevention plans, or safety plans as part of Crisis Planning Tools for Enrollee, and/or relapse prevention plans, as applicable
    q) Discharge planning/case management
    r) Aftercare planning and coordination
    s) Routine medications
3. The provider provides a comprehensive, formal, structured treatment program which incorporates the effects of substance use disorders, mental health disorders, and recovery, including the complications associated with dual recovery, and provides a minimum of four hours of service programming per day. At least two hours of psycho-educational group time per week is dedicated to the discussion of HIV/AIDS, Hepatitis C, and other health issues.
4. The provider has the capacity to treat Enrollees with alcohol and/or other drug dependencies who are assessed to be at a mild to moderate risk of medical complications during withdrawal.
5. The program must admit and have the capacity to treat enrollees who are currently on medication for addiction treatment (MAT) or medication for opioid use disorder (MOUD). Such capacity may take the form of documented, active Affiliation Agreements with providers licensed to provide such treatments.
6. The program is responsible for updating its available capacity, at a minimum once each day, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The program is also responsible for keeping all administrative and contact information up to date on the website. The program is also responsible for training staff on the use of the website to locate other services for Enrollees, particularly in planning aftercare services.

7. For adults and for emancipated minors who give consent, the provider makes documented attempts to contact the parent/guardian/caregiver, family members, and/or significant others within 48 hours of admission, unless clinically or legally contraindicated. The provider provides them with all relevant information related to maintaining contact with the program and the Enrollee, including names and phone numbers of key nursing staff, primary treatment staff, social worker/case manager/discharge planner, etc. If contact is not made, the Enrollee's health record documents the rationale.
8. The provider is responsible for ensuring that each Enrollee has access to medications prescribed for physical and behavioral health conditions, and documents so in the Enrollee's health record.
9. Prior to this, the provider engages in a medication reconciliation process to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of an Enrollee from one care setting to another. The provider does this by reviewing the Enrollee's complete medication regimen at the time of admission (e.g., transfer and/or discharge from another setting or prescriber) and comparing it with the regimen being considered in the RRS. The provider engages in the process of comparing the Enrollee's newly issued medication orders by the RRS prescriber to all medications that he/she has been taking to avoid medication errors. This involves:
    a) Developing a list of current medications, i.e., those the Enrollee was prescribed prior to admission to the RRS;
    b) Developing a list of medications to be prescribed in the RRS;
    c) Comparing the medications on the two lists;
    d) Making clinical decisions based on the comparison and, when indicated, in coordination with the Enrollee's primary care provider (PCP); and
    e) Communicating the new list to the Enrollee and, with consent, to appropriate caregivers, the Enrollee's PCP, and other treatment providers.
    f) All activities are documented in the Enrollee's health record.
10. All urgent consultation services resulting from the initial evaluation and physical exam, or as subsequently identified during the admission, are provided within 24 hours of the order for these services. Non-urgent consultation services related to the assessment and treatment of the Enrollee while in the RRS program are provided in a timely manner, commensurate with the level of need. Routine medical care (not required for the diagnosis related to the presenting problem) may be deferred, when appropriate, if the length of stay in the RRS program is brief. All these services are documented in the Enrollee's health record.
11. The milieu does not physically segregate individuals with co-occurring disorders.
12. A handbook specific to the program is given to the Enrollee and parent/guardian/caregiver at the time of admission. The handbook includes but is not limited to Enrollee rights and responsibilities, services available, treatment schedule, grievance procedures, discharge criteria, and information about family support and peer and recovery-oriented services.

STAFFING REQUIREMENTS

If program feels they cannot meet these specifications, Bureau of Substance Abuse Services (BSAS) has a waiver process for certain requirements. The waiver process is described in the DPH/BSAS Licensing Regulation. The program is responsible for informing the payer of any waivered requirements if the waiver is approved.

1. The provider complies with the staffing requirements of the applicable licensing body, and the credentialing criteria outlined by the applicable licensing body, and the staffing requirements outlined in 105 CMR 164 and the staffing requirements in the applicable Plan provider manual.
    a) Any exceptions to staffing requirements must be approved by BSAS and communicated to the Plans. The waiver process is described in the DPH/BSAS Licensing Regulation.
2. In accordance with Components of Service section, the Co-Occurring Enhanced RRS programs shall develop an integrated staffing model which utilizes staff from affiliated outpatient clinics and/or health centers to address the full complement of needs for the Enrollees in the program, inclusive of all requirements in the components of service.
    a) Medical staff, which may include psychiatrists, addiction physicians, mid-level practitioners, and registered nurses, must be available through a health center and/or outpatient clinic to support the medical and pharmacological needs of the Enrollees in the program.
    b) Medical staff shall deliver medical and psychiatric services as allowable under the affiliated clinic license and in keeping with their supervisory requirements.
    c) The Co-Occurring Enhanced RRS per diem rate includes overhead to support integration of medical staff with program based clinical and direct care staff to ensure coordinated treatment planning and service delivery according to the requirements in the components of service section.
3. Program staff positions funded through the per diem rate include:
    a) A full-time program director who carries full responsibility for the administration and operations of the program.
4. A full-time clinical director who meets the definition of Licensed Professional of the Healing Arts (LPHA) (e.g., LICSW, LMHC, or LMFT, or LADC1) and can provide supervision to Licensure Track and master's-level clinicians, bachelor's-level paraprofessionals, and recovery specialists in the program. The clinical director must have experience, competency, and/or training in both addiction and mental health. A distinct, full-time recovery specialist supervisor who can supervise the staff providing treatment to individuals with both addiction and mental health needs.
5. A mix of clinical and paraprofessional, and recovery specialist staff are responsible for delivering clinical services coordinating Enrollees' treatment plans, providing direct care, coverage, and milieu supervision, facilitating a therapeutic milieu through meetings and groups, and addressing Enrollees' care coordination and aftercare needs. Program staff must contain an appropriate mix of LPHA, MA, BA, and recovery specialist staff with experience, competency, and/or training in mental health and substance use disorders.
6. A part time registered nurse to support medication compliance and monitoring of symptoms. Nurse time must be flexed according to case mix and the needs of Enrollees in the program.

7. The program will designate from the among the staff an HIV/AIDS/HEP C coordinator, a tobacco education coordinator (TEC), an access coordinator, and a culturally and linguistically appropriate services (CLAS) point person.
8. The provider will ensure that all staff receive supervision consistent with credentialing criteria.
9. The provider will ensure that team members have training in evidence-based practices and are provided with opportunities to engage in continuing education to refine their skills and knowledge in emerging treatment protocols.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider complies with all provisions of 105 CMR 164 related to community connections and collateral linkages.
2. The provider will collaborate in the transfer, referral, and/or discharge planning process to another treatment setting, with Enrollee consent, to ensure continuity of care.
3. The staff members must be familiar with the following levels of care/services and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated.
4. The provider maintains written affiliation agreements, which may include Qualified Service Organization Agreements (QSOA), Memorandum of Understanding (MOU), Business Associate Agreements (BAA) or linkage agreements, with local providers of these levels of care that refer a high volume of Enrollees to its program and/or to which the program refers a high volume of Enrollees. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
    a) Inpatient psychiatric hospitals
    b) General hospitals
    c) Emergency Services Program (ESP)
    d) Emergency Departments (ED)
    e) Medically Managed Withdrawal Management (ASAM Level 4)
    f) Acute Treatment Services (ATS) (Level 3.7)
    g) Clinical Stabilization Services (CSS) (Level 3.5)
    h) Community Overdose Prevention Programs
    i) Co-Occurring Capable Residential Rehabilitation Services (RRS) (Level 3.l); Co-Occurring Enhanced Residential Rehabilitation Services (COE RRS) (Level 3.1)
    j) Structured Outpatient Addiction Program (SOAP)/Day Treatment
    k) Partial Hospitalization Programs (PHP)
    l) Community Crisis Stabilization (CCS)
    m) Regional court clinics – (Drug Court Programs, Family Drug Court Programs)
    n) Medication-Assisted Treatment/ Medication Addiction Treatment, including Opioid Treatment Programs and Office-Based Opioid Treatment
    o) Community Behavioral Health Centers (CBHCs)
    p) Community Mental Health Centers (CMHCs)
    q) Behavioral health urgent care centers
    r) Transitional or permanent supportive housing
    s) Sober housing

t) Substance use disorder outpatient clinics
u) Recovery support centers
v) Shelter programs
w) Criminal justice system
x) Outreach sites
y) Massachusetts rehabilitation services
z) Community health centers
aa) Adult Community Clinical Services (ACCS)
bb) Behavioral Health Community Partners (BHCP)
cc) Recovery Learning Centers
dd) Organizations that provide recovery coaching services
ee) Organizations that provide recovery support navigators
ff) Community Support Program (CSP), including: CSP for Chronically Homeless Individuals (CPS-CHI), and Program of Assertive Community Treatment (PACT)
gg) Mutual Aid programs including SMART Recovery, Alcoholics Anonymous and Narcotics Anonymous
hh) Department of Mental Health (DMH) residential programs

5. With Enrollee consent, the provider collaborates with the Enrollee's primary care provider as delineated in 105 CMR 164.
6. When necessary, the provider must arrange transportation for services required that are external to the program during the admission. The provider also must make reasonable efforts to assist Enrollees identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.
7. The provider shall demonstrate a capacity to work collaboratively with multiple systems, including substance use disorder treatment providers, primary health care, community-based support services, housing search services, supportive housing service providers, mental health service providers, other relevant human services, and various aspects of the criminal justice system, as appropriate.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164 related to assessment and recovery planning.
2. The provider makes and documents a decision, as soon as possible, whether to admit the Enrollee. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year.
3. The provider will maintain a standardized intake/admission log that tracks all applications for admission, documents admission decisions, reason for non-acceptance, and referrals made. The log shall be made available for review upon request.
4. The provider shall facilitate referrals to appropriate services and/or resources in the case of admission denials.
5. The provider will utilize evidence-based assessment tools for assessing substance use disorders, mental health needs, and ASAM level of care.

6. A clinician must complete an initial biopsychosocial clinical assessment using ASAM dimensions to gain an understanding of addiction severity, co-occurring mental health issues and trauma, physical health issues, family and social supports, housing stability, and other issues for each Enrollee that includes the following elements:
    a) A history of the use of alcohol, tobacco, and other drugs, including age of onset, duration, patterns, and consequences of use; use of alcohol, tobacco, and other drugs by family members; types of and responses to previous treatment; and risk for overdose;
    b) Assessment of the Enrollee's psychological, social, health, economic, educational/vocational status; criminal history; current legal problems; co-occurring disorders; disability status and accommodations needed, if any; trauma history; and history of compulsive behaviors, such as gambling. This assessment must be completed before a comprehensive service plan is developed.
    c) Assessment of Enrollee's HIV and TB risk status;
    d) Identification of key relationships (e.g., significant others) supportive to individual's treatment and recovery; and
    e) A list of the Enrollee's current medications, based on pharmacy labels, which shows the date of filling, the name and contact information of the prescribing practitioner, the name of the prescribed medication.
7. Staff will work with the Enrollee to create an individualized recovery treatment/service plan based on the clinical assessment, including, at a minimum:
    a) A statement of the Enrollee's strengths, needs, abilities, and preferences in relation to his/her substance use disorder treatment, described in behavioral terms;
    b) The service to be provided and whether directly or through referral;
    c) The service goals, described in behavioral terms, with timelines;
    d) Clearly defined staff and Enrollee responsibilities and assignments for implementing the plan; and
    e) A description of discharge plans and aftercare service needs.
8. The clinical supervisor reviews and approves the assessment and individualized recovery treatment/service plan.

Discharge Planning and Documentation

1. Staff will work with the Enrollee to create an individualized aftercare plan that must include:
    a) referrals to individual, group and/or family outpatient aftercare as appropriate;
    b) alcohol and drug-free living environments;
    c) vocational and educational opportunities;
    d) resources to support access to social benefit programs;
    e) Specific strategies to be used to follow-up with the Enrollee after the Enrollee leaves; and
    f) a connection to a community-based prescriber for medications mental health and addiction as appropriate.
2. Staff will work with the Enrollee to ensure that recovery maintenance strategies are in place

and working effectively and that referrals to services have met intended goals.

3. The clinical supervisor will review and approve the aftercare plan.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides. Specifically, the provider will work to improve these outcomes within their patient population receiving SUD treatment:
    a) Increase in MAT/MOUD induction and continuation
    b) Decrease in readmissions to ED and inpatient services
    c) Increase in referrals and transitions to lower levels of care
    d) Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including Enrollees and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.