INPATIENT SUBSTANCE USE DISORDER SERVICES (LEVEL 4 WITHDRAWAL MANAGEMENT SERVICES)

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 documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look 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-specific specifications take precedence.

OVERVIEW

Inpatient Substance Use Disorder Services (Level 4 Withdrawal Management Services) provide a planned substance use disorder treatment program offering 24-hour, medically managed evaluation and treatment for individuals who are experiencing severe withdrawal symptoms and/or acute biomedical complications because of a substance use disorder. Level 4 services are rendered in a hospital that can provide life support in addition to 24-hour physician and nursing care. Daily individual physician contact is a required component of this level of care. A multi-disciplinary staff of clinicians trained in the treatment of addictions and mental health conditions, as well as overall management of medical care, are involved in the Enrollee's treatment. The program staff facilitates the conjoint treatment of co-existing biomedical and behavioral health conditions.

SERVICE COMPONENTS

1. The program is in a designated addictions treatment unit in a licensed, acute care medical setting that offers intensive biomedical services.
2. The provider provides at least four hours of service programming per day, seven days per week, including weekends and holidays, with sufficient professional staff to conduct these services and to manage a therapeutic milieu.
3. 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 evaluation
c) Medical history and physical evaluation
d) Nursing assessment and 24-hour nursing care/services
e) 24-hour physician care
f) Daily medical management
g) Withdrawal Management
h) Development and/or updating of crisis prevention plans, and/or safety plans as part of the Crisis Planning Tools for youth, and/or relapse prevention plans, as applicable
i) Individual, family, and/or group therapy, as indicated
j) Psycho-educational groups
k) Pharmacology
l) Case and family consultation
m) Discharge planning/case management
n) Aftercare planning and coordination
o) Substance use disorder assessment and treatment services

4. Substance-specific withdrawal management protocols are individualized, documented, and available on-site. At minimum, these include withdrawal management protocols for alcohol, stimulants, opioids, and sedative hypnotics (including benzodiazepines).
5. The provider admits and has the capacity to treat Enrollees who are currently receiving methadone or other opioid replacement treatments. Such capacity may take the form of active, documented Affiliation Agreements with providers licensed to provide such treatments.
6. For adults who give consent, the provider makes documented attempts to contact family members, guardian, 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/care coordinator/discharge planner, etc. If contact is not made, the Enrollee's health record documents the rationale.
7. The provider is responsible for supplying each Enrollee with medications prescribed for physical and behavioral health conditions, and documents so in the Enrollee's health record.
8. Prior to supplying medications to the Enrollee, 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 inpatient mental health services program. The provider engages in the process of comparing the Enrollee's newly issued medication orders by the inpatient mental health services program to the medications that he/she has been taking in order to avoid medication errors. This involves:
    a) developing a list of current medications, i.e., those prescribed prior to admission to the inpatient mental health services program;
    b) developing a list of medications to be prescribed in the inpatient mental health services program;

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 clinician (PCC); and

e) communicating the new list to the Enrollee and, with consent, to appropriate caregivers, the Enrollee's PCC, and other treatment providers.

f) All related activities are documented in the Enrollee's health record.

9. The provider ensures that management, storage, and administration of medication comply with requirements established by accreditation standards and by the United States Drug Enforcement Agency and Food and Drug Administration.
10. All urgent consultation services, laboratory tests, and radiological exams resulting from the psychiatric/medical evaluation and physical examination, or as subsequently identified during the admission, are provided within 24 hours of the order for these services. All non-urgent consultation services related to the assessment and treatment of the Enrollee while on the inpatient unit 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 on the inpatient unit 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 unit 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, termination criteria, and information about peer and recovery-oriented services.
13. The program is responsible for updating its available capacity, three times per day at a minimum, seven days per week, 365 days per year on the applicable website. The program is also responsible for keeping all administrative and contact information up to date on the Massachusetts Behavioral Health Access website (www.MABHAccess.com).. 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.

STAFFING REQUIREMENTS

1. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Plan service-specific performance specifications, and the credentialing criteria outlined in the Plan provider manual found at providerexpress.com.
2. The provider is staffed with sufficient appropriate personnel to accept admissions 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year.
3. The provider utilizes primary medical and nursing staff to provide acute biomedical services in a defined addictions unit.
4. These staff are part of a multi-disciplinary staff, also including master's-level clinicians and milieu/counseling/clinical assistant/nursing aide staff. All staff have established skills, training, experience and/or expertise in the integrated treatment of individuals with substance use disorders, biomedical, and related mental health conditions.

5. The provider establishes a staffing pattern necessary for this level of care, as outlined in the DPH regulations, which includes the following positions:
    a) a senior clinician responsible for the clinical/educational operation of the substance use disorder service;
    b) licensed psychiatrist or licensed psychologist;
    c) registered nurse, nurse practitioner, or physician assistant;
    d) licensed practical nurse, case aides, and case management staff;
    e) if serving pregnant women, an obstetrician/gynecologist is available on staff or through an affiliation with a practice;
    f) food personnel trained in safe and sanitary handling and preparation; and
    g) sufficient staff to ensure coverage of all shifts.
6. The provider assigns each Enrollee a primary attending physician, registered nurse, and counselor/clinician upon admission.
7. The provider designates a physician licensed to practice medicine in the Commonwealth of Massachusetts as Medical Director. The Medical Director has completed a minimum of six months' clinical experience with alcohol and other drug-dependent persons, or 40 hours of documented continuing education credits in the treatment of addictions, within the first twelve months of employment.
8. The Medical Director or designated physician, who meets Plan's credentialing criteria, provides on-site psychopharmacological services, including methadone or other opioid replacement therapies.
9. The Medical Director's role minimally includes the following:
    a) ensuring each Enrollee receives a medical evaluation, including a medical history;
    b) ensuring that appropriate laboratory studies have been performed;
    c) signing all medical orders;
    d) attendance at weekly multi-disciplinary team meetings;
    e) peer review and/or oversight and monitoring of clinical care;
    f) involvement in therapeutic program development; and
    g) work with the clinical leadership team in monitoring the quality of care and outcomes within the program.
10. A physician (MD) is on call 24 hours per day, 7 days per week, 365 days per year to respond to medical emergencies, is available for a phone consultation to staff within 15 minutes of request and is available for a face-to-face consultation within 60 minutes of request. During weekday business hours, the physician is a psychiatrist who meets Plan's credentialing criteria. After 5:00 p.m. weekdays, and on weekends and holidays, the on-site physician available for emergency coverage may be a psychiatrically or non-psychiatrically trained physician capable of responding to, assessing, and treating medical emergencies within 15 minutes of being notified. If this staffing requirement is provided at any time by a non-psychiatrically trained physician, psychiatric consultation is provided by a psychiatrist on call who responds by telephone to a call within 15 minutes and, when needed, who has the capacity to come to the facility in person within 60 minutes of being notified.

11. A psychiatrist is on call 24 hours a day, 7 days a week, and is available for a phone consultation within 15 minutes of request. A psychiatrist is available 24 hours a day, 7 days a week for a face-to-face consultation within 60 minutes of request.
12. The provider has adequate psychiatric coverage to ensure all performance specifications related to psychiatry are met.
13. Enrollees have access to supportive milieu and clinical staff 24 hours per day, 7 days per week
14. The provider documents, over the course of a year, monthly scheduled in-service training sessions on the following topics, at a minimum, as required by the DPH regulations:
    a) The provider's All Hazards Emergency Response Plan;
    b) HIV/AIDS, sexually transmitted diseases (STDs) and viral hepatitis;
    c) Universal health precautions and infection control;
    d) Substance use disorders including tobacco and nicotine addiction, clinical assessment and diagnosis, treatment planning, relapse prevention and aftercare planning;
    e) Co-occurring disorders, including mental health disorders, gambling, and other addictive behaviors;
    f) Effects of substance use disorders on the family and related topics such as the role of the family in treatment and recovery; and
    g) Cultural competency including culturally and linguistically appropriate services (CLAS) or standards.
15. The provider ensures that clinical and direct care staff receive a minimum of one hour of individual or group supervision every other week, as outlined in the DPH regulations, and that staff who are not full-time receive supervision in proportion to the number of hours worked. Supervision of all clinical work is provided by a master's or doctoral-level licensed clinician with demonstrated expertise in the integrated treatment of Enrollees who are medically compromised and/or with a co-occurring disorder. The provider ensures that supervision of nursing staff is overseen by a registered nurse.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider develops linkages and working relationships with other service providers frequently utilized by Enrollees admitted to the program including the following:
    a) Inpatient mental health facilities
    b) Acute Treatment Services (ATS) for Substance Use Disorders Level 3.7
    c) Clinical Stabilization Services (CSS) for Substance Use Disorders Level 3.5
    d) Structured Outpatient Addiction Programs (SOAP)
    e) Transitional Support Services (TSS) for Substance Use Disorders
    f) Regional court clinics
    g) Residential support services
    h) Opioid Treatment Services
    i) Transitional supportive housing
    j) Sober housing
    k) Shelter programs

l) Other dual diagnosis programs

2. When necessary, the provider provides or arranges transportation for services required external to the hospital during the admission and, upon discharge, for placement into a step-down 24-hour level of care, if applicable. The provider also makes reasonable efforts to assist Enrollees upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-forms, etc.).
3. With Enrollee consent, for Enrollees who are DMH consumers, the provider notifies the DMH case manager, and/or DMH Community-Based Flexible Supports (CBFS) program and/or Program of Assertive Community Treatment (PACT) provider and/or DMH area office by noon of the following business day post-admission, or within one business day of identifying the Enrollee's involvement with this state agency and/or its service providers.
4. With Enrollee consent, the provider collaborates with the Enrollee's PCC as delineated in the Primary Care Clinician Integration section of the General performance specifications.
5. The provider develops an active working relationship with each of the local ESP/MCIs who are high-volume referral sources for the hospital. On an Enrollee-specific basis, the provider collaborates with any involved ESP/MCI providers upon an Enrollee's admission to ensure the ESP/MCI's evaluation and treatment recommendations are received, and that any existing crisis prevention plan, and/or safety plan, and/or relapse prevention plan is obtained from the ESP/MCI.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The provider accepts admissions 24 hours per day, 7 days per week, and 365 days per year.
2. Upon receipt of a referral call from an ESP/MCI 24/7/365, the provider confirms bed availability and agrees, as soon as possible and no later than within 30 minutes of the request for admission, to admit the Enrollee.
3. Immediately upon admission, a brief physical assessment of each Enrollee is conducted and documented in the Enrollee's health record.
4. Within three hours of admission, a registered nurse or designee completes a comprehensive nursing assessment with each Enrollee to assess his/her medical needs. If the designee is a licensed practical nurse (LPN), he/she must be supervised by a registered nurse or physician. The assessment includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score. The results are documented in the Enrollee's health record
5. Within 24 hours of admission, a thorough physical examination is conducted by a physician and documented for each Enrollee, and includes the following:
    a) an assessment of the Enrollee's substance use disorder;
    b) tests for the presence of opiates, alcohol, benzodiazepines, cocaine, and other drugs of abuse;
    c) a brief mental status exam;
    d) an assessment of infectious diseases, including TB, viral hepatitis, and STDs; pulmonary, liver, and cardiac abnormalities; dermatological and neurological sequelae of

addiction; and possible concurrent surgical problems. When indicated, laboratory tests for these conditions are ordered; and

e) a pregnancy test for women of child-bearing age.

6. Additionally, an initial clinical assessment of each Enrollee is conducted by a senior clinician, clinician (and approved in writing by a senior clinician), physician, nurse practitioner, or physician assistant within 24 hours of admission, is documented in the Enrollee's health record, and includes the following:
    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; and types of and responses to previous treatment;
    b) an assessment of the Enrollee's psychological, social, health, economic, educational/vocational status; criminal history; current legal problems; co-occurring disorders; trauma history; and history of compulsive behaviors such as gambling;
    c) an assessment of the Enrollee's HIV risk status and TB risk status;
    d) a diagnosis of the status and nature of the Enrollee's substance use disorder, or a mental or behavioral disorder due to use of psychoactive substances; and
    e) if a need for further evaluation is identified, the provider conducts or makes referral arrangements for necessary testing, physical examination, and/or consultation. All such activities are documented in the Enrollee's health record.
7. A physician sees the Enrollee daily. The physician consults to the treatment team and, prior to any medication changes, consults with the outpatient prescriber and agrees upon any medication changes in consultation with him/her. All such activities are documented in the Enrollee's health record.
8. The provider assigns a multi-disciplinary treatment team to each Enrollee within 24 hours of admission. A multi-disciplinary treatment team meets to review the assessment, the initial treatment/recovery plan, and the initial discharge plans within 24 hours of admission. On weekends and holidays, the treatment/recovery plan may be developed by an abbreviated treatment team, with a review by the full treatment team on the next business day.
9. The treatment/recovery plan, developed in conjunction with the Enrollee, current community-based providers including PCCs and behavioral health providers, family, guardian, and/or individual natural supports, includes, at a minimum, the following:
    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) evidence of the Enrollee's involvement in formulation of the treatment/recovery plan, in the form of the Enrollee's signature attesting agreement to the plan;
    c) service to be provided;
    d) service goals, described in behavioral terms, with timelines;
    e) clearly defined staff and Enrollee responsibilities and assignments for implementing the plan;
    f) description of discharge plans and aftercare service needs;
    g) aftercare goals;
    h) the date the plan was developed and revised;

i) signatures of staff involved in the formulation or review of the plan; and

j) documentation of disability, if any, which requires a modification of policies, practices, or procedures and record of any modifications made.

10. The provider ensures that the treatment/recovery plan and discharge plans are reviewed at least every 48 hours (a maximum of 72 hours between reviews on weekends), and are updated accordingly, based on each Enrollee's individualized progress.
11. Assessments, the initial treatment/recovery plan and discharge plan, and all treatment meetings are documented in the Enrollee's health record.
12. With Enrollee consent and the establishment of the clinical need for such communication, coordination with parents/guardians/caregivers, relevant school staff, and other treatment providers, including PCCs and behavioral health providers, is conducted by appropriate staff relative to treatment and care coordination issues. All such contact is documented in the Enrollee's health record.
13. The provider makes arrangements to obtain appropriate drug screening/testing, urine analysis, and laboratory work as clinically indicated, and documents such in the Enrollee's health record

Discharge Planning and Documentation

1. When the Enrollee's biomedical condition has stabilized to the extent that daily medical and nursing management for the biomedical condition is no longer necessary, the provider arranges for the Enrollee to move to the next appropriate level of care.
2. The provider conducts discharges 7 days per week, 365 days per year.
3. The provider ensures that active and differential discharge planning is implemented for each Enrollee by qualified staff who are knowledgeable about the medical necessity criteria for all Plan covered services.
4. At the time of discharge, and as clinically indicated, the provider ensures that the Enrollee has a current crisis prevention plan, and/or safety plan, and/or relapse prevention plan in place and that he/she has a copy of it. The provider works with the Enrollee to update the plan that they obtained from the ESP/MCI at the time of admission, or, if one was not available, develops one with the Enrollee prior to discharge. With Enrollee consent and as clinically indicated, the provider may contact the Enrollee's local ESP/MCI to request assistance with developing or updating the plan. The provider sends a copy of the plan to the ESP/MCI Director at the Enrollee's local ESP/MCI with Enrollee consent.
5. Prior to discharge, the provider assists Enrollees in obtaining post-discharge appointments, as follows: within 7 calendar days of discharge for outpatient therapy services (which may be an intake appointment for therapy services), if necessary; and within 14 calendar days of discharge for medication monitoring, if necessary. This function may not be designated to aftercare providers or to the Enrollee to be completed before or after the Enrollee's discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Enrollee's health record. If there are barriers to accessing covered services, the provider notifies the Plan Clinical Access Line and/or the regional office as soon as possible to obtain assistance. All such activities are documented in the Enrollee's health record.
    a) The provider provides, with Enrollee consent, a written discharge summary (or other such document(s) that contain the required elements) to the Enrollee, parents/guardians/caregivers, PCCs, and current behavioral health providers, no later

than within two weeks of the Enrollee's discharge. The discharge summary is documented in the Enrollee's health record and includes a summary of:

b) the course of treatment;
c) the Enrollee's progress;
d) the treatment interventions and behavior management techniques that were effective in supporting the Enrollee's progress;
e) medications prescribed;
f) recommended behavior management techniques when applicable; and
g) treatment recommendations, including those that are consistent with the service plan of the relevant state agency for Enrollees who are also involved with the Department of Mental Health (DMH), Department of Developmental Services (DDS), Department of Youth Services (DYS), or the Department of Children and Families (DCF); and/or the youth's Individual Care Plan (ICP) for those enrolled in Intensive Care Coordination (ICC).

6. The provider arranges for aftercare services which include the following:
    a) referrals to ensure a continuum of care for the Enrollee, including arrangements for further substance use disorder treatment and post-discharge counseling and other supportive services;
    b) information concerning available community-based service agencies and programs, which includes a description of services, addresses, phone numbers and the names of contact persons;
    c) referrals, the aftercare plan, and information provided to the Enrollee are documented in the Enrollee's health record; and
    d) Enrollee refusal of aftercare services is documented in the Enrollee's health record.

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.
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 youth 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.