RECOVERY SUPPORT NAVIGATOR (RSN)

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

Recovery Support Navigator (RSN) services are staffed by paraprofessionals that provide care management and system navigation supports to Enrollees with a diagnosis of substance use disorder and/or co-occurring mental health disorders. The purpose of Recovery Support Navigation services is to engage Enrollees as they present in the treatment system and support them in accessing treatment services and community resources.

Enrollees can access RSN services based on medical necessity and/or a referral by a medical or behavioral health provider, Community Partner (CP), or other care manager, that has contact with the Enrollee and is able to identify the need for RSN services.

RSN services are appropriate for Enrollees with substance use disorder and/or co-occurring disorders who are in need of additional support in remaining engaged in treatment; identifying and accessing treatment and recovery resources in the community including prescribers for addiction and psychiatric medications; and/or developing and implementing personal goals and objectives around treatment and recovery from addiction and/or co-occurring disorders.

The RSN explores treatment recovery options with the Enrollee, helps clarify goals and strategies, provides education and resources, and assists Enrollees in accessing treatment and community supports. RSN is not responsible for an Enrollee's comprehensive care plan, or medical or clinical service delivery, but supports the Enrollee in accessing those services and participates as part of the overall care team when appropriate.

The Recovery Support Navigator service is based within a Licensed Behavioral Health Outpatient Clinic or an Opioid Treatment Center and Recovery Support Navigators can be deployed to any setting.

SERVICE COMPONENTS

1. Developing a set of goals and objectives in conjunction with the Enrollee, based on needs identified by the Enrollee and/or any care plans that exist for the Enrollee.
2. Identifying whether the Enrollee has a comprehensive care plan in place and a current provider responsible for implementing the care plan. This includes but is not limited to Community Partner (CP), primary therapist, Residential Rehabilitation Services (RRS) program counselor, primary care provider). If the Enrollee consents, ensuring coordination and communication with that provider and tailoring activities to the needs in the care plan.
3. Connecting the Enrollee with providers able to develop and implement a comprehensive care plan if the Enrollee does not have any such relationship. Such entities could include a primary care provider, prescribing psychiatrist, therapist, residential program, addiction pharmacotherapy providers, or a CP if eligible.
4. Supporting the Enrollee in understanding the treatment options available to them, including 24-hour programs, outpatient options, and all FDA approved options for addiction pharmacotherapy.
5. Providing information about, and facilitating access to, community and recovery supports, including supports for families.
6. Assisting the Enrollee in accessing treatment services including, but not limited to:
   a) Facilitating warm hand-offs to programs by maintaining relationships with addiction providers within the Enrollee's geographic area.
   b) Navigating insurance issues with Enrollees, including identify and explaining in-network and out-of-network providers and advocating with providers and Plans on the Enrollee's behalf.
   c) Providing temporary assistance with transportation to essential medical and behavioral health appointments while transitioning to community-based transportation resources.
   d) Delivering services on a mobile basis to Enrollees in any setting that is safe for the Enrollee and staff. Examples of such a setting are an Enrollee's home, an inpatient or diversionary unit, or a day program.
   e) Provide linguistically appropriate and culturally sensitive recovery support navigation that embraces the diversity of people's identities that include racial, ethnic, gender/gender identity, sex, sexual orientation, physical and intellectual challenges, and their chosen pathway to recovery.
7. When working with pregnant and/or parenting Enrollees, in addition to the requirements listed above, Recovery Support Navigators must:
   a) Work collaboratively with the pregnant and/or parenting Enrollees specifically designed to help the Enrollee identify needed services.
   b) Work collaboratively with the pregnant and/or parenting Enrollees specifically designed to help the Enrollee identify needed services for recovery and parenting. to create and coordinate Plan of Safe Care (also called Family Support Plan).

c) Work with Enrollee around perinatal health and support needs, housing needs, healthcare needs, income needs, mental health, and substance use treatment needs (including MAT), as identified in the Plan of Safe Care.

d) Become familiar with local resources, such as home visiting services, lactation support services, parenting support groups, childcare programs, and other services designed to support parents and/or parents in recovery. Develop partnerships with local service providers, including local DCF and Early Intervention staff to facilitate engagement and self-advocacy on part of the Enrollee.

e) Help Enrollee understand the DCF custody assessment process, and support Enrollee in advocating for custody as appropriate. Assist Enrollee in following through on a Plan of Safe Care, or a DCF Family Action Plan, if they have an open case.

STAFFING REQUIREMENTS

1. The RSN must be a bachelor-level paraprofessional and at a minimum, must have a bachelor's degree in social work, psychology or a related field. Those organizations who employ RSNs who do not meet these criteria may apply for a waiver for such staff person(s).
2. RSN staffs are supervised by a licensed, master's-level clinician with training and experience in providing support services to adults and/or youth with addiction and/or co-occurring disorders. Supervision includes Enrollee-specific supervision, as well as a review of the Enrollee's treatment plan and goals.
3. RSNs must possess sufficient knowledge and understanding about treatment and recovery from substance use disorders to fulfill the required activities in the Service Components section. This includes, but is not limited to, an understanding of addiction services available for MassHealth Enrollees, and resources available in the geographic area where they will serve Enrollees
4. The RSN is employed by a larger organization that provides mental health or addiction services and is licensed within the Commonwealth of Massachusetts.
5. Organizations employing RSNs must ensure that RSN staff receives documented, annual training to enhance and broaden their skills. The training topics include but are not limited to:
   a) common diagnoses across medical and behavioral health care;
   b) motivational interviewing and other engagement and outreach skills and strategies;
   c) service coordination skills and strategies;
   d) behavioral health and medical services, community resources and natural supports;
   e) insurance literacy;
   f) principles of recovery and wellness;
   g) cultural competence;
   h) managing professional relationships with Enrollees including but not limited to boundaries, confidentiality, and peers as RSN workers; and
   i) service termination.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider employing the Recovery Support Navigator maintains written affiliation agreements, which may include Qualified Service Organization Agreements (QSOAs), Memorandums of Understanding (MOUs), Business Associates Agreements (BAAs) or other 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, coordination of care planning and activities, as well as transition, aftercare, and discharge processes.
2. Organizations that employ Recovery Support Navigators are expected to have affiliation agreements with a wide variety of organizations, including behavioral health, medical, and non-medical service settings including:
    a) Addiction Services
        i. Non-24 Hour Addiction Treatment
            - Structured Outpatient Addiction Programs
            - Substance Use Disorder Outpatient Clinics
            - Opioid Treatment Programs
        ii. 24 Hour Addiction Treatment
            - Acute Treatment Services (Level 3.7)
            - Clinical Stabilization Services (Level 3.5)
            - Transitional Support Services (Level 3.1)
            - Residential Rehabilitation Services (Level 3.1)
    b) Other Behavioral Health
        i. Behavioral Health Community Partners
        ii. Emergency Service Programs (ESP)
        iii. Licensed Mental Health Centers
        iv. Partial Hospitalization Programs
    c) Medical Settings
        i. Emergency Departments
        ii. Primary Care Practices
        iii. Licensed Mental Health Centers
        iv. Hospital Settings
        v. OB/GYN Practices
        vi. Community Health Centers
    d) Other Settings
        i. Criminal Justice Programs
        ii. Specialty Drug Courts
        iii. Faith Based Organizations
        iv. Recovery Support Centers
        v. Supportive/Sober Housing

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The RSN works with the Enrollee to develop a set of goals and objectives that guide the activities of the RSN services. If an Enrollee has a care plan, such goals and objectives must be consistent and supportive of the overall care plan.
2. The goals and objectives will be used for documentation for clinical review and medical necessity.

Discharge Planning and Documentation

None

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.