RESIDENTIAL REHABILITATION SERVICES (RRS) FOR SUBSTANCE USE DISORDERS (ASAM Clinically Managed Low Intensity Residential 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 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 must meet all BSAS contractual and regulatory requirements, comply with applicable regulations set forth in the Code of Massachusetts Regulations and must meet 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

Residential Rehabilitation Services (RRS) for Substance Use Disorders (ASAM Clinically Managed Low Intensity Residential Services), are clinically managed low-intensity residential services that serve individuals who need a 24-hour, supervised, residential environment to fully stabilize in recovery, with the goal of successfully transitioning to a lower service setting (including outpatient counseling). Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and implementing recovery skills. Admission to RRS ASAM Clinically Managed Low Intensity Residential Services is appropriate for Enrollees who meet the diagnostic and dimensional criteria specified in accordance with the American Society of Addiction Medicine Criteria©.

The performance specifications contained within pertain to the following services:

- Residential Rehabilitation Services (RRS) for Substance Use Disorders (ASAM Clinically Managed Low Intensity Residential Services)
- Residential Rehabilitation Services (RRS) for Pregnant and Post-Partum Women
- Residential Rehabilitation Services (RRS) for Youth (ages 13-17)
- Residential Rehabilitation Services (RRS) for Transitional Age Youth (ages 16-21) or

Young Adults (ages 18-25)

- Family Residential Rehabilitation Services (RRS)

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.

RRS programs will provide ASAM Clinically Managed Low Intensity Residential Services until:

1. The Enrollee's symptoms can be safely managed at a less intensive level of care.

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. The provider ensures 24/7 coverage that always maintains a supportive, therapeutic environment for Enrollees, at all times. The provider ensures that Enrollees always have access to supportive, therapeutic milieu at all times, without exception.
3. The provider implements a daily schedule of activities designed to facilitate participation in the milieu and promote recovery. The provider facilitates morning meetings, a minimum of five times per week, convenes at least one communal meal per day, and convenes at least one house/community meeting per week, which provides structure for the community.

   Clinically, these activities must include a minimum of five hours of clinical programming, individual, and/or group counseling per week offered through the program. Topics for clinical and psychoeducational groups delivered in the program can include, but are not limited to, the following:

   a) Relapse and overdose prevention, recovery maintenance counseling and education, naloxone education, and administration training
   b) Mental health
   c) Stress reduction
   d) Nutrition
   e) Medication
   f) Education related to all medications approved by the FDA for the treatment of substance use disorders (SUD)
   g) Tobacco cessation
   h) HIV/AIDS, STIs, viral hepatitis
   i) Wellness topics
   j) Recovery support groups
4. For adults who give consent, the provider makes documented attempts to contact the parent/guardian/caregiver, Enrollee's family, and/or significant others within one week 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.

5. The provider ensures that program staff provide individualized case management services. Program staff facilitate comprehensive support and linkages for public assistance, substance use disorder counseling, primary health care, insurance, self-help and mental health services, vocational/educational opportunities, housing, and criminal justice system support as appropriate.
6. The provider admits and has the capacity to treat Enrollees who are currently on medication for addiction treatment MAT/MOUD, including education about the benefits and risks of MAT. Such capacity may take the form of documented, active affiliation agreements with a facility licensed to provide such treatments.
    a) The provider is responsible for updating its available capacity, once each day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com).
    b) The provider is also responsible for keeping all administrative and contact information up to date on the website.
    c) The provider is also responsible for training staff on the use of the website to locate other services for Enrollees, particularly in planning aftercare services.
7. The provider has documented policies and procedures in place to allow for the safe and appropriate self-administration of medications by Enrollees.
8. The provider ensures that each Enrollee has access to medications prescribed for physical and behavioral health conditions and documents this in the Enrollee's chart.
9. The provider ensures that the following medication management activities are completed for each Enrollee upon admission:
    a) Developing a list of current medications, i.e., those the Enrollee was prescribed prior to admission to the RRS and verifies with prescriber(s).
    b) Making clinical decisions based on the comparison and, when indicated, in coordination with the Enrollee's primary care clinician (PCC); and
    c) Coordinating with providers to ensure Enrollees have access to medications that they are prescribed and coordinate any changes in medication with current prescribers.
    d) Overseeing medication passes.
    e) Communicating the new list to the Enrollee and, with consent, to appropriate caregivers, the Enrollee's PCP, and other treatment providers. All activities are documented in the Enrollee's health record.
10. The provider uses medication specialist staff (MMS) to keep records of Enrollee's medications and oversee medication management. Medication specialist staff will provide medication support services that include: 16 hours of medication specialist services and eight hours of consultation around medication support, oversight and record keeping of resident medications, managing storage, and coordination of resident self-administration of medication.
11. For pregnant Enrollees, the provider must provide coordination with OB/GYN, pediatrics, and any other appropriate medical, social services providers, and state agencies.
12. The provider must facilitate access to recovery support navigator services and/or peer recovery coach services either directly or through referral.
13. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) Standards.
14. The provider trains staff on the use of ASAM Criteria ®.

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 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.

1. The provider complies with the staffing requirements of the applicable licensing body, and the staffing requirements outlined in 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*, and the staffing requirements in the applicable Plan provider manual.
2. The program is staffed with a full-time program director who carries full responsibility for the administration and operations of the program, including supervision of non-clinical staff.
3. The program is staffed with a full-time Clinical Director (1 FTE) who must possess at least a master's degree in a clinical or social science field and meets 105 CMR 164 criteria for Senior Clinician or Clinician Supervisor. A clinical director is the designated authority responsible for ensuring adequate and quality behavioral treatment is being provided.
4. The program is staffed with one counselor or case manager, trained in addiction and mental health treatment, for every nine licensed beds.
5. The program is staffed by 2 FTE Medication Specialists on-site, responsible for the oversight, storage, and coordination of self-administration of medication. Medication management includes oversight of resident self-administration, storage, and coordination of all medication prescribed during treatment.
6. The program is staffed with at least two FTE direct care staff present on each shift as outlined below and in 101 CMR 164, seven days per week, 24 hours per day. Direct care staff include recovery specialist, counselors, case managers, clinical supervisors, and medication specialists.
    a) No less than eight hours of awake coverage per shift per building.
    b) 16 hours of awake coverage for each day and evening shift per 30 licensed beds, prorated according to the number of licensed beds, i.e., less than 30 or more than 30.
    c) Eight hours of awake coverage per overnight shift per 50 residents; 16 hours of awake coverage per overnight shift per 51 –100 residents; 24 hours of awake coverage per overnight shift per 101 –150 residents.
    d) At minimum, there shall be at least two recovery specialists or case aides present for each overnight shift.
    e) Where the resident census exceeds 100 residents, the Licensed or Approved Provider shall ensure four direct-care staff are present on all shifts.
7. All RRS sites must have at least one staff member assuming each of the following roles:
    a) There is an **HIV/AIDS Coordinator**: responsible for overseeing confidential HIV risk assessment and access to counseling and testing; staff and resident HIV/AIDS and hepatitis education; and Department requirements for admission, service planning and discharge of HIV positive residents.
    b) There is a **Tobacco Education Coordinator:** responsible for assisting staff in implementing BSAS guidelines for integrating on of tobacco assessment, education, and treatment into program services.
    c) There is an **Access Coordinator**: responsible for development and implementation of the evaluation, plan, and annual review of the site's performance in ensuring equitable access to services as required by 105 CMR 164.

d) There is a **CLAS Coordinator** (Culturally and Linguistically Appropriate Services) who ensures that the service meets the language and cultural needs of the patients.
e) At minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.

8. The provider ensures that all staff receive supervision consistent with their credentialing criteria.
9. The provider ensures 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 collaborates in the transfer, referral, and/or discharge planning process to ongoing recovery and/or treatment services, with Enrollee consent, to ensure continuity of care.
2. The staff members are familiar with the levels of care/services necessary to meet the needs of the Enrollees being served, and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated.
3. The provider maintains written affiliation agreements, which may include QSOAs, MOUs, BAAs, or linkage agreements, with local providers of these levels of care necessary to meet the needs of the Enrollees being served at the RRS, and 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.
4. With Enrollee consent, the provider collaborates with the Enrollee's primary care provider.
5. When necessary, the provider arranges transportation for services required that are external to the program during the admission. The provider also makes reasonable efforts to assist Enrollees identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.
6. The provider demonstrates 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 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to assessment and recovery planning.
2. The provider has a policy regarding the speed at which they will inform the referral source/individual seeking admission (ideally within the hour after receipt of referral). The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year. Every admission declination must be documented and include reason for declination and referrals provided.
3. The provider maintains 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. The provider facilitates referrals to appropriate services and/or resources in the case of admission denials.
4. The provider utilizes evidence-based assessment tools for assessing SUD and for ASAM level of care.

5. A counselor completes 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 Enrollee's family; 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 infectious disease status and risk (e.g., HIV, HCV, TB, COVID-19, etc.);
    d) Identification of key relationships (e.g., significant others) supportive to individual's treatment and recovery;
    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; and
    f) When indicated, providers must facilitate or make referral arrangements for necessary testing, physical examination, and/or consultation by qualified professionals.
6. The counselor/case manager works 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 resident responsibilities and assignments for implementing the plan; and
    e) A description of treatment plans and aftercare service needs.
7. The clinical supervisor reviews and approves the assessment and individualized recovery treatment/service plan.
8. The provider must document any missed sessions and attempts to make follow-up contact, the reason(s) given for absence, and if necessary, the staff's rationale for continuation or discontinuation of RRS.
9. For anyone who could become pregnant, a pregnancy test is administered prior to the administration of any medication(s).
10. For anyone who is pregnant, the provider coordinates care with their PCP and OB/GYN and consults with those physicians as needed.

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to discharge planning.
2. The provider conducts discharges 7 days per week, 365 days per year.
3. The counselor/case manager works 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 programs that address social determinants of health (SDOH), such as housing, food, benefits, etc.; and
   e) specify strategies to be used to follow-up with the Enrollee after the Enrollee leaves.
4. The counselor/case manager works with the Enrollee to ensure that recovery maintenance strategies are in place and working effectively and that referrals to services have met intended goals.
5. The clinical supervisor reviews and approves 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 procedures to monitor, measure, and improve the activities and services it provides.
   a) Specifically, the provider will work to improve these outcomes within their patient population receiving SUD treatment:
      I. Increase in MAT/MOUD induction and continuation
      II. Decrease in readmissions to ED and inpatient services
      III. Increase in referrals and transitions to lower levels of care
      IV. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
   b) Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge per DPH/BSAS Licensing Regulation.
   c) The provider will collect data to measure the quality of their services.
2. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms.
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.