BEHAVIORAL HEALTH AMBULATORY DETOXIFICATION

Providers contracted for this level of care or service will be 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 to the General Behavioral Health Performance Specifications. All Performance Specifications are located online at tuftshealthplan.com in the Provider Resource Center.

Ambulatory Detoxification is the provision of medically necessary services in a clinic or, in some cases, physician office setting and under the direction of a physician, to stabilize the medical condition of an individual who experiences a serious episode of excessive substance use or withdrawal complications. Nursing and physician supervision must be provided during the course of treatment.

Ambulatory Detoxification is used when the Member experiences physiological dysfunction during withdrawal that is not severe enough to threaten life or significant bodily functions but requires medication for withdrawal from a substance (e.g., alcohol, barbiturates, and benzodiazepines). The Member must have a substance use disorder based on *DSM-V* criteria and be at significant risk for withdrawal symptoms.

Tufts Health Public Plans covers both ambulatory (including opioid replacement therapy) and acupuncture detoxification services. Acupuncture treatment is provided on an outpatient basis.

Components of Service	
	1. Ambulatory Program components include at a minimum: • Initial evaluation by psychiatrist • Physical exam within 24 hours of admission: for women of child-bearing age this should include a pregnancy test • Medication management and administration by a clinical nurse specialist • Case Management will be done by an assigned primary counselor/clinician • Counseling provided • Biopsychosocial evaluation by clinical staff • Treatment plans which are individualized, behavioral, and goal-oriented 2. The program shall be compliant with Department of Public Health Guidelines 105 CMR 164, including those stated in 105 CMR 164.074 regarding minimum treatment service requirements 3. Treatment may consist of intensive acupuncture administration for detoxification purposes in addition to one to two months of less intensive treatment, motivational and supportive counseling focused on engaging the Member to remain in acupuncture treatment, and participation in ongoing substance abuse outpatient treatment and self-help groups. 4. Psycho-educational, individual and group treatment that includes HIV, relapse prevention, and education regarding the medical aspects of treatment 5. Linkages to emergency services/after-hours backup is necessary to provide crisis and after-hours coverage. Linkage to the designated emergency service provider (ESP) is necessary for *Tufts Health Together* members. 6. Psychological testing, dual diagnosis services and psychiatric consults may be delivered by the local mental health resources

Staffing Requirements

1. All clinical services are delivered by staff who meet the qualification standards detailed by the Department of Public Health regulations Chapter 105 CMR 164.
2. The facility is responsible for providing staffing and supervision in accordance with THPP Behavioral Health General Performance Specifications, DPH and BSAS Licensing requirements.
3. The program shall designate a physician as medical director who shall be responsible for administering all medical services performed by the program.
4. The program shall provide training and supervision according to the standards set forth in 105 CMR 164.044. Supervisory staff shall include:
   - A physician with knowledge and experience in addiction medicine
   - A nurse with clinical experience in substance use disorders
   - A primary counselor to provide case management and motivational counseling that focus on engaging the client to remain in treatment
5. Acupuncture programs shall have on-site during the hours of operation:
   - A licensed acupuncturist
   - A minimum of one clinician
   - A physician assistant or nurse practitioner or registered nurse for the purpose of conducting the medical screening
6. Services are culturally and linguistically appropriate
7. The provider shall establish a staffing pattern in sufficient numbers and positions necessary for the level of care provided, which shall include the following positions:
   - Senior Clinician among direct service staff, who shall be responsible for the clinical/educational operation of the substance abuse service
   - Licensed psychiatrist or licensed psychologist on staff or available through organizational agreements
   - Registered nurse, nurse practitioner, or physician assistant on staff and on-site during hours of operation of the service
   - Licensed practical nurse, case aides and case management staff
   - If serving pregnant women, an obstetrician/gynecologist available on staff or through a qualified service organization agreement

Service, Community, and Collateral Linkages

1. Program staff coordinates treatment planning and aftercare with the Member's primary care clinician, outpatient, and other community-based providers, involved state agencies, educational systems, community supports and family, guardian, and/or significant others when applicable. If consent for such coordination is withheld or refused by the parent or guardian of a minor, then this is documented in the Member's record.
2. The provider ensures that a written aftercare plan is available to the Member at the day of discharge. When consent is given, a copy of the written aftercare plan is forwarded at the time of discharge to the referral source, family/guardian/significant other, DMH (if DMH member), outpatient or community based provider, PCP, school, and other entities and agencies that are significant to the Member's aftercare.
3. When other outpatient services are provided by others, these will be coordinated formal written treatment plans and structured communications between the two services.
4. Programs will maintain active affiliation agreements with other providers in order to ensure smooth transitions, appropriate referrals, and effective collaborations. These would include but not be limited to:
    - Clinical outpatient treatment programs
    - Primary care physician
    - Psychiatrist (as indicated)
    - Inpatient hospital or detox facilities
    - Residential and sober housing
    - Short-term addictions programs
    - Self-help groups
    - State agencies
5. The program shall establish written policies and procedures for provision of aftercare for clients who are discharged, which shall include provisions for Member participation in developing the aftercare plan and a method for contacting the Member, and this shall be reviewed continuously during treatment
6. All substance abuse treatment providers must track, by referral source:
    - Referrals for services
    - The outcome of each referral (i.e., admission, etc.)
    - If the substance use disorder treatment Provider refuses to accept a referral, the reason for the refusal

Quality Management (QM)	
	1. The facility will develop and maintain a quality management plan that is consistent with that of Tufts Health Public Plans 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 will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to Members, including youth and their families 3. Clinical outcomes data must be made available to Tufts Health Public Plans upon request. 4. All Reportable Adverse Incidents will be reported to Tufts Health Public Plans within 1 business day of their occurrence per Tufts Health Public Plans policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of an Member, or to others by action of an Member, who is receiving services managed by Tufts Health Public Plans or has recently been discharged from services managed by Tufts Health Public Plans. 5. To extent permitted by law, all substance use disorder treatment providers are to submit to DPH/BSAS the data required by DPH. 6. The facility/program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.
Process Specifications	
Treatment Planning and Documentation	1. The program shall complete an initial assessment for each client that includes the following elements: • 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 • An assessment of the client'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. When the initial assessments indicate a need for further evaluation, the program shall conduct or make referral arrangements for necessary testing, physical examination and/or consultation by qualified professionals. • The initial assessment shall be conducted by a senior clinician, clinician, physician, nurse practitioner or physician

	assistant • The initial assessment shall conclude with a diagnosis of the status and nature of the client's substance use disorder, using standardized definitions established by the American Psychiatric Association, or a mental or behavioral disorder due to use of psychoactive substances, as defined by the World Health Organization 2. Individually determined opioid replacement therapy dosage sufficient to block craving is established by the physician upon admission and reviewed with the Member's input during his or her course of treatment 3. The treatment plan and service goals will be individualized, behavioral, and goal-oriented with specific time frames for completion 4. In addition, the treatment plan and all subsequent updates, document, at a minimum, the following: • Clearly defined staff and client responsibilities and assignments for implementing the plan • Description of discharge plans and aftercare service needs • Aftercare goals • A statement of the client's strengths, needs, abilities, and preferences in relation to his or her substance abuse treatment 5. Signatures of staff involved in the formulation or review of the plan 6. An individual treatment plan is developed within two units of service 7. When treatment continues for three months or more, treatment plans shall be reviewed at least once every three months 8. Treatment will involve the Member, guardian(s) and family members to the extent possible, and when consent is given, in the development and modification of treatment and discharge plans 9. The physician will be responsible for the approval of the treatment plan and medical protocol for detoxification 10. Individual records contain signed documentation for each visit, each assessment, and dosing based on the requirements of the Department of Public Health requirements, Chapter 105 CMR-164
Discharge Planning and Documentation	1. Discharge planning begins at admission and is continuous throughout treatment involving linkage with outside providers, family, and all supports surrounding Member as appropriate. 2. Discharge planning is finalized, in consultation with the

	Member, when one of the following conditions is met: • Client has received optimum benefit from treatment and further progress requires either the client's return to the community or the client's referral to another type of treatment program; • The client has achieved the goals of the individual treatment plan. 3. Discharge planning shall include referrals to ensure a continuum of care for the Member, including arrangements for substance abuse treatment and post-discharge counseling and other supportive services. 4. All Members, parents and legal guardians are included (as appropriate, and with consent) in all aspects of aftercare planning and all such efforts are documented. 5. Information concerning available community-based service agencies and programs, including a description of services, addresses, phone numbers, and the names of contact persons shall be provided to Members upon discharge. 6. A written discharge plan with all appropriate follow-up appointments shall be given to all Members upon discharge, including the phone number to call in case of a crisis.