

Co-Occurring Enhanced Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1) Performance Specifications

These performance specifications apply to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
- Tufts Medicare Preferred HMO (a Medicare Advantage product)²
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)²

These performance specifications apply to the following Tufts Health Public Plans products:

- Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- Tufts Health RITogether (a Rhode Island Medicaid Plan)
- Tufts Health Unify (OneCare Plan; a dual-eligible product)

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications.

DEFINITION

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 Members' 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 hours a week and additional outpatient levels of care may be accessed concurrently as appropriate.

COMPONENTS OF SERVICE

1. Co-Occurring Enhanced RRS programs must ensure that Members' medical, mental health, and addiction needs are being identified and addressed. Programs will ensure that Members have access to prescribers of psychiatric and addiction medications through one of the following arrangements:
 - i. The provider organization that is contracted for the Co-Occurring Enhanced RRS program must ensure timely access for Members to psychiatry and addiction pharmacotherapy by also operating outpatient services, including but not limited to; an opioid treatment center, licensed mental health center, substance use disorder outpatient clinic, health center, primary care practice, bridge clinic, hospital or hospital satellite. Programs be able to coordinate all activities related to the Member's care, including psychiatric and clinical services; or
 - ii. The provider organization that is contracted for the Co-Occurring Enhanced RRS program must ensure timely access for Members to psychiatry and addiction pharmacotherapy by utilizing a partnership model, codified through a formalized agreement, such as a memorandum of understanding (MOU), between partner organizations operating outpatient services, including but not limited to; an opioid treatment center, licensed mental health center, substance use disorder outpatient clinic, health center, primary care practice, bridge

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.

² Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

- clinic, hospital or hospital satellite. The organizations that partner to provide the Co-Occurring Enhanced RRS services must both possess the infrastructure and implement protocols to ensure Members in the program receive timely access to psychiatric and mental health services, including a medication assessment and diagnostic visit within 48 hours of admission, and that all psychiatric and clinical services are coordinated with the program's clinical staff. The Co-Occurring Enhanced RRS program will have the ultimate responsibility to coordinate their Members' care and ensuring that the Members' behavioral health and medical treatment needs are being met, including facilitating transportation when necessary.
2. Co-Occurring Enhanced RRS programs shall provide clinical and milieu treatment delivered by an integrated team involving staff trained in substance use disorders, mental health, and psychiatry/medication management. Members' mental health and addiction pharmacotherapy needs must be addressed along with clinical and psychosocial needs.
 - i. The program must provide onsite delivery of coordinated psychiatry by providing the infrastructure and protocols to ensure psychiatrists and/or mid-level practitioners spend time with program staff, attend team meetings, review treatment plans, and interact with the Members in the program.
 - ii. Such infrastructure shall include, but is not limited to, providing space on site, shared staff with outpatient clinic, time in the daily schedule; procedures and protocols to ensure insure coordinated care.
 3. Co-Occurring Enhanced RRS programs shall have on-site nursing to oversee medication administration and compliance, as well as monitoring of Members' symptoms. Nursing time is flexed based on case mix and needs of the Members. The program must have established medication administration protocols and support Members in establishing and maintaining medication regimens.
 4. Members must have access to psychiatrists and/or mid-level practitioners under the direction of a psychiatrist within 48 hours of admission to perform diagnostic and medication evaluations, provide refills if necessary, and to begin the process of medication reconciliation, adjustments.
 - i. The Co-Occurring Enhanced RRS program shall ensure that the Member goes through a medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur in the transition of a Member from one care setting to this level of care.
 - ii. Results of the medication evaluation and medication reconciliation plan must be available to the staff in the program.
 5. In addition to diagnostic and medication evaluations, Members will receive clinical assessments based on the ASAM Criteria, as well as any supplemental clinical assessments that may be appropriate.
 - i. The combined results of these assessments, along with information received from prior treatment histories and/or discharge plans, will become the basis of a Member's treatment plan which is developed in conjunction with the Member.
 - ii. The treatment plan must include clinical, psychosocial, and recovery goals, as well as a crisis and/or safety plan.
 - iii. Members shall be reassessed throughout the treatment process to track progress, make necessary adjustments, and update goals and objectives.
 6. Upon admission, Member's condition is assessed and stabilized with a goal of engaging the Member in ongoing treatment. As the Member stabilizes, and depending on the needs identified in the treatment plan, the goals of treatment will include, but are not limited to; better understanding of relationships between addiction and mental health, overcoming fears and insecurities, coping with stress, making sense of past trauma, identifying triggers, improving relationships with family and friends, establishing a stable, dependable routine, and developing interpersonal and other recovery skills, necessary for success in the community. The treatment provided in the program must have the following components:
 - i. Treatment will be trauma responsive and address the intersection between trauma, mental health, and substance use disorders.
 - ii. Treatment services will include treatment planning, clinical interventions, milieu-based therapy, and family outreach and support when appropriate.
 - iii. The program will facilitate a morning meeting 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.

- iv. The program will implement a daily schedule of activities designed to facilitate participation in the milieu and promote recovery, including a minimum of five hours of individual and/or group treatment sessions per week.
- 7. Co-Occurring Enhanced RRS programs shall provide care coordination activities, including, but not limited to identifying community resources, i.e., housing, employment, educational/vocational services, legal/justice related case management, recovery supports, behavioral health clinical services, and pharmacological services for mental health and addiction. Programs must begin care coordination, particularly related to the search for housing, at the beginning of treatment, in concert with all activities on the treatment plan.
- 8. Co-Occurring Enhanced RRS programs will support Members in establishing and maintaining relationships with community-based prescribers. If a Member has an existing relationship with a community-based prescriber for mental health or addiction pharmacotherapy, the program shall coordinate with the Member's outpatient treaters, including the facilitation of transportation to the community-based prescriber location.
- 9. The provider must have documented policies and procedures in place to allow for the safe and appropriate self-administration of medication(s) by Members.
- 10. The provider must ensure that each Member has access to medications prescribed for physical and behavioral health conditions and documents this in the Member's chart.
- 11. The provider shall train staff on the use of ASAM criteria, Level 3.1.
- 12. The program shall train staff on the use of the Massachusetts Behavioral Health Access website (MABHAccess.com) to locate other services for Members, particularly in planning continuing care.

STAFFING REQUIREMENTS

- 1. In accordance with one of the models listed in bullets 1a and 1b of the 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 Members in the program, inclusive of all requirements in the components of service.
 - i. 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 Members in the program.
 - ii. Medical staff shall deliver medical and psychiatric services as allowable under the affiliated clinic license and in keeping with their supervisory requirements.
 - iii. 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.
- 2. Program staff positions funded through the per diem rate include:
 - i. A full-time program director who carries full responsibility for the administration and operations of the program.
 - ii. 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 is able to 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 is able to supervise the staff providing treatment to individuals with both addiction and mental health needs.
 - iii. A mix of clinical and paraprofessional, and recovery specialist staff are responsible for delivering clinical services coordinating Members' treatment plans, providing direct care, coverage and milieu supervision, facilitating a therapeutic milieu through meetings and groups, and addressing Members' 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.
 - iv. 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 Members in the program.
- 3. 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.
- 4. The provider will ensure that all staff receive supervision consistent with payer requirements.

5. 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 COLLATERAL LINKAGES

1. The provider will collaborate in the transfer, referral, and/or discharge planning process to another treatment setting, with Member consent, to ensure continuity of care.
2. The staff members must be familiar with all of 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.
3. 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 Members to its program and/or to which the program refers a high volume of Members. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
 - Inpatient psychiatric hospitals
 - General hospitals
 - Emergency Services Program (ESP)
 - Emergency departments
 - Acute Treatment Services (ATS) (Level 3.7)
 - Clinical Stabilization Services (CSS) (Level 3.5)
 - Transitional Support Services (TSS) (Level 3.1)
 - Co-Occurring Capable Residential Rehabilitation Services (RRS) (Level 3.1)
 - Structured Outpatient Addiction Program (SOAP)/Day Treatment
 - Partial Hospitalization Programs
 - Community Crisis Stabilization (CCS)
 - Regional court clinics
 - Medication-Assisted Treatment, including Opiate Treatment Programs and Office-Based Opioid Treatment
 - Transitional or permanent supportive housing
 - Sober housing
 - Licensed community mental health centers
 - Substance use disorder outpatient clinics
 - Recovery support centers
 - Shelter programs
 - Criminal justice system
 - Outreach sites
 - Massachusetts rehabilitation services
 - Community health centers
 - Adult Community Clinical Services (ACCS)
 - Behavioral Health Community Partners (BH CP)
 - Recovery Learning Centers
 - Recovery Coaches
 - Recovery Support Navigators
 - Community Support Program (CSP)
 - Mutual Aid programs including AA and NA
4. With Member consent, the provider will collaborate with the Member's PCC as delineated in the primary care clinician integration section of the General performance specifications.
5. 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 Members identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.
6. 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.

QUALITY MANAGEMENT (QM)

The provider complies with all requirements set forth by payer.

PROCESS SPECIFICATIONS

Assessment, Treatment / Recovery Planning and Documentation

1. 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 by the payer upon request.
2. The provider shall facilitate referrals to appropriate services and/or resources in the case of admission denials.
3. The provider will utilize evidence-based assessment tools for assessing substance use disorders, mental health needs, and ASAM level of care.
4. 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 Member that includes the following elements:
 - i. 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;
 - ii. Assessment of the Member'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.
 - iii. Assessment of Member's HIV and TB risk status;
 - iv. Identification of key relationships (e.g., significant others) supportive to individual's treatment and recovery; and
 - v. A list of the Member'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.
5. Staff will work with the Member to create an individualized recovery treatment/service plan based on the clinical assessment, including, at a minimum:
 - i. A statement of the Member's strengths, needs, abilities, and preferences in relation to his/her substance use disorder treatment, described in behavioral terms;
 - ii. The service to be provided and whether directly or through referral;
 - iii. The service goals, described in behavioral terms, with time lines;
 - iv. Clearly defined staff and Member responsibilities and assignments for implementing the plan; and
 - v. A description of discharge plans and aftercare service needs.
6. The clinical supervisor reviews and approves the assessment and individualized recovery treatment/service plan.

Discharge Planning and Documentation

1. Staff will work with the Member to create an individualized aftercare plan that must include:
 - i. Referrals to individual, group and/or family outpatient aftercare as appropriate;
 - ii. Alcohol and drug-free living environments;
 - iii. Vocational and educational opportunities;
 - iv. Resources to support access to social benefit programs;
 - v. Specific strategies to be used to follow-up with the Member after the Member leaves; and
 - vi. A connection to a community-based prescriber for medications mental health and addiction as appropriate.
2. Staff will work with the Member 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.

DOCUMENT HISTORY

- June 2020: Template updates