# Residential Rehabilitation Services (RRS) for Transitional Age Youth and Young Adults with 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 Plan)
- ☐ 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.

The following Residential Rehabilitation Services (RRS) for Transitional Age Youth and Young Adults with Substance Use Disorders performance specifications are a subset of the RRS performance specifications. As such, RRS Transitional Age Youth and Young Adults providers agree to adhere to both the RRS performance specifications and to the RRS for Transitional Age Youth and Young Adults performance specifications contained within. Where there are differences between the RRS and the RRS Transitional Age Youth and Young Adults performance specifications, these RRS for Transitional Age Youth and Young Adults specifications take precedence.

## DEFINITION

**Residential Rehabilitation Services (RRS) for Transitional Age Youth and Young Adults (Level 3.1)** consists of a structured and comprehensive therapeutic milieu that reinforces a culture of recovery and wellbeing, self-help skills, and pro-social activities that are developmentally appropriate for Transitional Age Youth (ages 16–21) or Young Adults (ages 18–25). Services will provide comprehensive alcohol and other drug residential treatment and recovery support for young people and their families, support Members in developing the skills necessary to function effectively in the community, promote and support education opportunities and/or employment skill development, facilitate access to community-based services, and foster engagement with the recovery community.

## COMPONENTS OF SERVICE

1. Treatment is based on the developmental stages and needs of Transitional Age Youth and Young Adults providing flexible individualized treatment, rehabilitation, and support/supervision that varies in intensity based on Member need.
2. Services promote family- and Member-guided care focusing on skill building to enhance self-esteem, identify relapse triggers, build positive coping skills, and support vocational development and life skills training.
3. Families are incorporated in treatment as appropriate, and regular meetings with families are conducted.

---

[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ 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.

## STAFFING REQUIREMENTS

1. Program Director – Programs must have one FTE Program Director for each site, regardless of size, designated exclusively for oversight of that program and not responsible for other agency programs/sites. The Program Director must have demonstrated experience in substance use disorders as well as experience working with adolescents or young adults and administrative/management experience. The Program Director will share with the Clinical Supervisor the role of ensuring training and supervision is addressed with each direct care/milieu staff member.
2. Clinical Supervisor/Manager – There is one FTE providing a combination of individual, group, and family clinical services and supervision of staff. This FTE will support the Program Director in providing individual and group supervision to direct care staff
3. Case Manager – There is one FTE case manager to provide aftercare coordination and additional case management needs with providers and recovery resources
4. Direct Care/Recovery Specialist – Sufficient staff to ensure that a minimum of three FTE direct care staff are on from 7:00am until 11:00pm and two FTE direct care staff are on from 11:00pm until 7:00am. Staff will conduct assessments and provide individual and group services to residents.

## SERVICE, COMMUNITY AND COLLATERAL LINKAGES

The provider will ensure that the program has clearly defined and formalized linkages to the following programs and services:

- Emergency Service Programs and Mobile Crisis Intervention
- Adolescent stabilization and residential programs
- Other transitional age youth and young adult services
- Recovery high schools
- Recovery support centers
- Shelters
- Acute Treatment Services (ATS)
- Transitional Support Services (TSS)
- Clinical Stabilization Services (CSS)
- Vocational training
- Educational support
- Criminal justice system
- Outreach sites
- Opiate treatment programs
- Outpatient behavioral health providers
- Community-based social service providers

## QUALITY MANAGEMENT (QM)

The provider complies with requirements set forth by payer.

## PROCESS SPECIFICATIONS

### Assessment, Treatment/Recovery Planning and Documentation

1. Medical and health history and assessment with physical exam within two weeks of admission OR documentation of physical exam conducted within last year
2. Comprehensive biopsychosocial assessment completed within 72 hours of admission
3. An individual recovery treatment plan must be completed in collaboration with and signed by the Member that includes service goals described in behavioral terms with time frames and an aftercare plan that includes referrals to services and identifies ongoing recovery goals.

### Discharge Planning and Documentation

Aftercare planning is an integral part of treatment and should be initiated at the time of admission and continue throughout the treatment episode and include focus on the following:

1. An individualized aftercare program should be designed to offer continued support to both the young adult and the family, allowing for a smoother transition back into the home and community environment and should include referrals to services and supports that address a more holistic set of needs including: individual, group, and family counseling; psychiatry; vocational/educational services; safe and supportive housing options; social benefit programs for which the resident may be eligible; self-help and community-based recovery supports; and

2. Overdose prevention education is a necessary component of the treatment and aftercare plan for any individual who has been using opioids.

**DOCUMENT HISTORY**

- June 2020: Template updates