Residential Rehabilitation Services (RRS) for Substance Use Disorders (ASAM Level 3.1)

Providers contracted for this service are expected to comply with all requirements of these service-specific performance specifications.

The performance specifications contained within pertain to the following services:

- Residential Rehabilitation Services (RRS) for Substance Use Disorders Level 3.1
- *Family Residential Rehabilitation Services (RRS)

**Please refer to the performance specification attachment for specialty services.*

Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1) consists of a structured and comprehensive rehabilitative environment that supports Members' independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle.

Components of Services

1. The provider complies with all licensing and standards of care requirements of the applicable licensing body.
2. The provider ensures that Members have access to supportive, therapeutic milieu and recovery specialists at all times, without exception.
3. There are currently three models for providing a therapeutic milieu:
   a. Therapeutic Communities (TC) support recovery through the establishment of a highly structured therapeutic milieu that emphasize resident treatment and recovery within the parameters of a program's structure. Behavior modification techniques are significantly employed in this setting. Program counselors maintain a considerable role in planning and delivering services to residents.
   b. Recovery Homes (RH) emphasize resident treatment and recovery within a structured, therapeutic milieu existing in the context of the surrounding community. An objective of treatment is to prepare the resident for eventual integration back into that community.
   c. Social Model Homes (SM) provide a therapeutic environment that emphasizes engagement with peer counseling, staff, and volunteers who collectively provide an experiential learning process and structured habilitation/rehabilitation service to include the external community in addition to the residential program.
4. The provider facilitates a morning meeting a minimum of five times per week, convene at least one communal meal per day, and convene at least one house/community meeting per week.
5. The provider implements 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. Topics for clinical and psychoeducational groups

delivered in the program or through community affiliations 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

6. The provider involves family and significant others in treatment when appropriate.
7. 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.
8. The provider admits and has the capacity to treat Members who are currently on methadone maintenance or receiving other opioid replacement treatments. Such capacity may take the form of documented, active affiliation agreements with a facility licensed to provide such treatments.
9. The provider has documented policies and procedures in place to allow for the safe and appropriate self-administration of medication(s) by Members.
10. The provider ensures 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 trains staff on the use of ASAM criteria, Level 3.1.
12. The program trains staff on the use of the Massachusetts Behavioral Health Access website (www.MABHAccess.com) to locate other services for Members, particularly in planning continuing care.

Staffing Requirements

1. The provider complies with the staffing requirements of applicable licensing bodies, the staffing requirements in the SWH service-specific performance specifications, and the SWH credentialing criteria.
2. The program is staffed with a full-time program director who carries full responsibility for the administration and operations of the program.
3. The program is staffed with a distinct, full-time clinical supervisor, who does not also occupy another position within the program, and who has completed a master's degree in a relevant field or possesses an LADC1 and is able to supervise the staff providing treatment to

individuals with both addiction and mental health needs, for every 30 licensed beds, pro-rated according to the number of licensed beds. The clinical supervisor is responsible for supervision of program staff.

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 with recovery specialists according to the following coverage parameters:
   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
6. The program designates from 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.
7. The provider ensures that all staff receive supervision consistent with SWHs credentialing criteria.
8. 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.

Process Specifications

Assessment, Treatment Planning/Recovery Planning and Documentation

1. The provider maintains 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 SWH upon request.
2. The provider facilitates referrals to appropriate services and/or resources in the case of admission denials.
3. The provider utilizes evidence-based assessment tools for assessing SUD and for ASAM level of care.
4. 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 Member 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 family members; types of and responses to previous treatment; and risk for overdose;
   b. 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.

   c. Assessment of Member's HIV and TB risk status;
   d. Identification of key relationships (e.g., significant others) supportive to individual's treatment and recovery;
   e. 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; and
   f. When indicated, providers must conduct or make referral arrangements for necessary testing, physical examination, and/or consultation by qualified professionals.
5. The counselor/case manager works with the Member to create an individualized recovery treatment/service plan based on the clinical assessment, including, at a minimum:
   a. A statement of the Member'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 time lines;
   d. Clearly defined staff and resident responsibilities and assignments for implementing the plan; and
   e. A description of discharge plans and aftercare service needs.
6. The clinical supervisor reviews and approves the assessment and individualized recovery treatment/service plan.

Disposition Planning and Documentation

1. The counselor/case manager works with the Member 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 social benefit programs; and
   e. Specify strategies to be used to follow-up with the Member after the Member leaves.
2. The counselor/case manager works 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 reviews and approves the aftercare plan.

Service, Community, and Collateral Linkages

1. The provider collaborates 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 are 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 QSOAs, MOUs, BAAs 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.

a. Adult Mobile Crisis Intervention (AMCI), formerly Emergency Service Program (ESP)
b. Acute Treatment Services (ATS) (Level 3.7)
c. Performance Specifications Residential Rehabilitation Services for Substance Use Disorders
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e. Clinical Stabilization Services (CSS) (Level 3.5)
f. Transitional Support Services (TSS) (Level 3.1)
g. Structured Outpatient Addiction Program (SOAP)
h. Regional court clinics
i. Medication Assisted Treatment, including Opiate Treatment
j. Programs and Office-Based Opioid Treatment
k. Transitional or permanent supportive housing
l. Sober housing
m. Substance use disorder and mental health outpatient counseling
n. services
o. Recovery Support Centers
p. Shelter programs
q. Criminal justice system
r. Outreach sites
s. Massachusetts Rehabilitation Services

4. With Member consent, the provider collaborates with the Member's PCP and Primary Care Team (PCT).
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 Members 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.