MID-STATE HEALTH NETWORK

SUBSTANCE USE DISORDER SERVICES PROVIDER (SUDSP) MANUAL

Effective Date: APRIL 1, 2015

TABLE OF CONTENTS

MID-STATE HEALTH NETWORK
SUBSTANCE USE DISORDER SERVICES
PROVIDER MANUAL
Effective April 1, 2015

INTRODUCTION

Welcome to the Mid-State Health Network (MSHN) substance use disorder (SUD) services provider manual. We are pleased to be working with you in the provision of effective prevention and treatment services for persons with varied substance use disorders in our 21 county Pre-Paid Inpatient Health Plan (PIHP) region. (A full listing on the 21 counties can be found on MSHN's website; www.midstatehealthnetwork.org.)

The purpose of this manual is to offer you information and guidance about the requirements associated with your contracted role in the MSHN region. This manual is a referenced attachment to your contract for MSHN services and may be revised at any time.

It is important that all providers understand that there are applicable state and regional standards and expectations for service providers. MSHN is under contract as a PIHP and Coordinating Agency with the Michigan Department of Community Health (MDCH), with all the associated obligations and requirements for the use of public funds. MSHN, as one of the ten (10) PIHPs in Michigan, has various provider network management obligations, including but not limited to, assurance of overall compliance, service array adequacy, and provider competency. A key reference for all SUD services is the SUD section of the current FY 2015 PIHP contract between MSHN and MDCH, *"Contract Attachment P.II.B.A., Substance Use Disorder Policy Manual*." In addition, for all statewide Substance Use Disorder Services, MDCH published *An Orientation Manual for Substance Use Disorder Services* in February 2014. MDCH guidance in this document includes the appropriate SAMHSA references. Michigan has a published MDCH *Medicaid Provider Manual*, which is updated on a quarterly basis and applies to any Medicaid covered services for enrolled, eligible beneficiaries, contained in the "*Mental Health/Substance Abuse,"* chapter. These documents are located on the MSHN website.

Providers are expected to be familiar with and adhere to all standards, requirements, and legal obligations contained in these referenced MDCH guidance and requirement documents applicable to the specific services being purchased and provided. For efficiency, MSHN will highlight but will not duplicate or reiterate all of the detail of those requirements in this document unless otherwise specified. Providers should review the Table of Contents provided by MDCH in these three key documents to ensure that they have reviewed and understand all content pertinent to their specific service delivery scope of work. MSHN will make every effort to inform SUD providers about changes in state requirements as they are known and/or applicable, as well as advise providers about MSHN policy changes and updates to this manual.

In addition, MSHN has applicable policies posted on the organizational website (www.midstatehealthnetwork.org) with which providers are expected to comply. Additionally, each local community mental health service programs (CMHSP) within MSHN's 21 counties has its own *Customer Service Handbook.* It is available on their websites, and provides SUD relevant information as contacts for MSHN. This handbook is to be offered to all clients served. Key examples of applicable MSHN policies for SUD providers include, but may not be limited to:

Advance Directives
Behavioral Health Recovery Oriented System of Care
Compliance and Program Integrity
Confidentiality and Notice of Privacy
Conflict of Interest Policy
Credentialing: Background Checks and Primary Source Verification
Credentialing: Monitoring
Credentialing: Suspension and Revocation
Critical Incidents
Cultural Competency
Evidence-Based Practices
Income Eligibility for MSHN Benefits (Policy & Procedure)
Medicaid Beneficiary Appeals/Grievances
Medicaid Information Management
MSHN's Corporate Compliance Plan
Monitoring and Oversight
Provider Appeal Procedure for Substance Use Disorder (SUD) Providers
Provider Network Management
Quality Management
Recipient Rights
Record Retention
Service Philosophy, Access System
Service Provider Reciprocity
SUD Services – Women's Specialty Services (Policy & Procedure)
Use of Public Act 2 Dollars

MSHN has posted the current *MSHN 3 Year SUD Strategic Plan for Prevention, Treatment & Recovery, FY 2015 – 2017*, as approved by MDCH. This plan delineates MSHN current priorities for SUD services in the region as well as the local communities covered by MSHN, and may be found at http://www.midstatehealthnetwork.org/board/2014/docs/MSHN_SUD_Strategic_Plan_FY2015-2017.pdf.

It is your responsibility as a provider to be familiar and comply with the state and regional policies and requirements, as well as any other legal statutes pertaining to your business operations. You are subject to state and regional monitoring and/or audit reviews as a part of your contractual agreement(s), including all aspects of compliance, given the use of public funding sources. The purpose of this manual is to offer you specific guidance as a SUD provider to assist you in being successful in your compliance as well as promotion of positive health outcomes for the persons with substance use disorders whom you serve. Please feel free to direct questions to MSHN at any time on any matter related to your service scope and requirements.

MSHN Governance Board is representative of the 12 Community Mental Health Service Programs in the region. The MSHN Board has policy and fiduciary responsibilities for all contracts with MDCH including SUD administration and services. Additionally, and as required by statute, the MSHN PIHP region has a SUD Oversight Policy Board (OPB), whose members represent each of the 21 counties in the region. The list of these board members can be found on the MSHN website, along with a calendar of their regional meetings: http://www.midstatehealthnetwork.org/board/SUD. The SUD-OPB is advisory to the MSHN Board of Directors and serves as the authority to approve the region's plan for use of Public Act 2 funds.

MSHN welcomes the opportunity to take into account your experience and input, and together work to expand our partnership for the benefit of individuals with substance use disorders who require our services. Should you have any comments or suggestions for improving this manual, please contact MSHN. You are also expected to communicate in a timely manner with MSHN regarding any compliance, fraud and abuse, critical/sentinel events, capacity issues, program location or contact changes, or other similar matters.

The key contact at MSHN for SUD services is:

Dani Meier, PhD, MSW
Director, Health Integration, Treatment and Prevention
SUD Recipient Rights Consultant
Mid-State Health Network
530 West Ionia Street
Suite F
Lansing, Michigan 48933
dani.meier@midstatehealthnetwork.org
Office: 517-253-0279
Fax: 517-253-7552

Sub-Regional Entities

MSHN elected to subcontract with three sub-regional entities (SREs) in 2015 for the local management of substance use disorder services. As a provider you may have contracts with one, several or all three of the SREs doing business in the MSHN region, however, MSHN expects that there will be uniform contract expectations and common local practices to support your work. The three SREs for MSHN are Community Mental Health for Clinton, Eaton and Ingham Counties (**CEI),** Bay-Arenac Behavioral Health (dba **Riverhaven)** and Saginaw Community Mental Health Authority (**Saginaw).** MSHN currently delegates the day to day management of SUD services through these three SREs in our network.

Riverhaven SRE – Darren McAllister, Director
(Arenac, Bay, Huron, Montcalm, Shiawassee, Tuscola, Clare, Gladwin, Isabella, Mecosta, Midland, Osceola)

BABHA Access Center
201 Mulholland, Bay City, Michigan, 48708
Phone: (800) 448-5498
Fax: (989) 497-1321

CEI SRE – Toby Bayless, Director
(Clinton, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Jackson, Newaygo)

Care Coordination Center (CCC)
838 Louisa Street, Suite B, Lansing, MI 48911
Phone: (517) 346-8459
Toll Free Phone: (888) 230-7629 Fax: (517) 272-3015

Saginaw SRE – Ginny Reed, Director
(Saginaw)

Saginaw County SUD Treatment & Prevention Services (Amy Murawski, Director)
1600 N. Michigan Avenue, Suite 501, Saginaw, MI 48602
Phone: (989) 758-3781
Toll Free Phone: (855) 277-8277
TDD: (989) 758-3725
Fax: (989) 758-3746

"Admission" is that point in an individual's relationship with an organized treatment service when the intake process has been completed and the individual is entitled to receive services of the treatment program.

"AMS" stands for Access Management System which is required by the Michigan Department of Community Health to screen, authorize, refer and provide follow-up services.

"ASAM" stands for the American Society for Addiction Medicine. It is the medical association for Addictionologists. The members developed the patient placement criteria. The most recent is The ASAM Criteria, 3rd Edition.

"ASI" stands for Addiction Severity Index and is a semi structured interview designed to address seven potential problem areas in clients with substance use disorders for determining level of care.

"Assessment" is those procedures by which a program evaluates an individual's strengths, weaknesses, problems and needs, and determines priorities so that a treatment plan can be developed.

"CareNet" is the web-based data system used by MSHN for collection of state and federal data elements, PIHP performance indicators, utilization management (authorization of services), and reimbursement.

"CMHSP" stands for Community Mental Health Service Program.

"Co-Occurring Disorders" are concurrent substance-related and mental disorders. Use of the term carries no implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other.

"Continued Service Criteria" is in the process of client assessment, certain problems and priorities are identified as justifying admission to a particular level of care. Continued Service Criteria describe the degree of resolution of those problems and priorities and indicate the intensity of services needed. The level of function and clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for continued service.

"Continuum of Care" is an integrated network of treatment services and modalities, designed so that an individual's changing needs will be met as that individual moves through the treatment and recovery process.

"Cultural Competency" is defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs (including religious), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment and is achieved over time.

"Discharge Summary" is the written summary of the client's treatment episode. The elements of a discharge summary include description of the treatment received, its duration, a rating scale of the clinician's perception of investment by the client, a client self-rating score, description of the treatment and non-treatment goals attained while the client was in treatment, and detail those goals not accomplished with a brief statement as to why.

"Discharge/Transfer Criteria" is in the process of client assessment, certain problems and priorities are identified as justifying treatment in a particular level of care. Discharge/Transfer Criteria describe the degree of resolution of those problems and priorities and thus are used to determine when a client can be treated at a different level of care or discharged from treatment. Also, the appearance of new problems may require services that can be provided effectively only at a more or less intensive level of care. The level of function and

clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for discharge or transfer.

"DSM-V" is the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, by the American Psychiatric Association. It is a practical and useful tool for clinicians with brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in diagnostic criteria.

"Early Intervention" is a specifically focused treatment program including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process including individuals who may not meet the threshold of abuse or dependence. (The ASAM Criteria, 3rd Edition Level .05 Early Intervention)

"Health Care Eligibility/Benefit Inquiry (270)" is used to inquire about the health care eligibility and benefits associated with a subscriber or dependent.

"Health Care Eligibility/Benefit Response (271)" is used to respond to a request inquiry about the health care eligibility and benefits associated with a subscriber or dependent.

"HMP" stands for Healthy Michigan Plan which became effective on April 1, 2014 in Michigan as a Medicaid expansion program to serve newly enrolled persons, and has also expanded the array of services available under this new benefit for persons with substance use disorders in need of treatment.

"Episode of Care" is the period of service between the beginning of a treatment service for a drug or alcohol problem and the termination of services for the prescribed treatment plan. The first event in this episode is an admission and the last event is a discharge. Any change in service and/or provider during a treatment episode should be reported as a discharge, with transfer given as the reason for termination. For reporting purposes, "completion of treatment" is defined as completion of all planned treatment for the current treatment episode.

"Individualized Treatment" is treatment designed to meet a particular client's needs, guided by a treatment plan that is directly related to a specific, unique client assessment.

"Intensity of Service" is the number, type, and frequency of staff interventions and other services (such as consultation, referral or support services) provided during treatment at a particular level of care.

"Length of Service" is the number of days (for residential care) or units/visits/encounters (for outpatient care) of service provided to a client, from admission to discharge, at a particular level of care.

"Level of Care" as used in The ASAM Criteria, 3rd Edition, this term refers to a discrete intensity of clinical and environmental support services bundled or linked together and available in a variety of settings.

"Level of Function" is an individual's relative degree of health and freedom from specific signs and symptoms of a mental or substance-related disorder, which determine whether the individual requires treatment.

"Level of Service" as used in ASAM Criteria, 3rd Edition, this term refers to board categories of patient placement, which encompass a range of clinical services such as early intervention, detoxification, or opioid maintenance therapy services and levels of care such as intensive outpatient treatment or clinically managed medium-intensity residential treatment.

"MAPS" stands for Michigan's Automated Prescription Service. It is a web-based service to monitor prescriptions for individuals in Michigan. The website is: https://www.michigan.gov/lara/0,4601,7-154-35299_63294_63303_55478---,00.html.

"Matching" is a process of selecting treatment resources to conform to an individual client's needs and preferences, based on careful assessment. Matching has been shown to increase treatment retention and thus

to improve treatment outcome. It also improves resource allocation by directing clients to the most appropriate level of care and intensity of services.

"Medical Necessity" means determination that a specific service is medically (clinically) appropriate and necessary to meet a client's treatment needs, consistent with the client's diagnosis, symptoms and functional impairments and consistent with clinical Standards of Care.

In considering the appropriateness of **any** level of care, the four basic elements of **Medical Necessity** should be met:

1. Client is experiencing a Substance Use Disorder reflected in a primary, validated, DSM5 or ICD-10 Diagnosis (not including V Codes) that is identified as eligible for services in the MSHN Provider Contract.
2. A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.
3. The treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by substance use disorder or mental health professionals.
4. It is the most appropriate and cost-effective level of care that can safely be provided for the client's immediate condition based on The ASAM Criteria, 3rd Edition.

"Medically Necessary Services" means substance use disorder treatment services that are necessary for screening and assessing the presence of a substance use disorder, and/or are:

- Required to identify and evaluate a substance use disorder that is inferred or suspected and/or are;
- Intended to treat, ameliorate, diminish or stabilize the symptoms of substance abuse including impairment on functioning and/or are;
- Expected to arrest or delay the progression of a substance use disorder and to forestall or delay relapse and/or are;
- Designed to provide rehabilitation for the clients to attain or maintain an adequate level of functioning.
- Symptom alleviation alone is not sufficient for purposes of admission.

"Medicaid Health Plans" or MHPs are those organizations funded by the state to provide coverage for the physical health care and limited behavioral health benefits of enrollees.

"Non-urgent cases" are those clients screened for substance use disorder services but who do not require urgent (immediate) services.

"Peer Support/Recovery Supports" are programs designed to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer Recovery programs are designed and delivered primarily by individuals in recovery and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.

"PIHP" stands for the Prepaid Inpatient Health Plan(s) funded by the state for Medicaid and Healthy Michigan Program services.

"Program" is a generalized term for an organized system of services designed to address the treatment needs of clients.

"SAMHSA" stands for Substance Abuse and Mental Health Services Administration. It is the federal agency which oversees the funding to the states for substance use disorder and mental health services. It is a department within the U. S. Department of Health and Human Services.

"SAPT" stands for Substance Abuse, Prevention, and Treatment Grant. It is the community grant (block) funding from SAMHSA for substance use disorder treatment and prevention services in the 50 states.

"Readiness to Change" refers to an individual's emotional and cognitive awareness of the need to change, coupled with a commitment to change. When applied to addiction treatment and particularly assessment Dimension 4, "Readiness to Change" describes the individual's degree of awareness of the relationship between his or her alcohol or other drug use or mental health problems, and the adverse consequences of such use, as well as the presence of specific readiness to change personal patterns of alcohol and other drug use.

"Recognize, Understand and Apply" is the distinction that the criteria made between an individual's ability to *recognize* an addiction problem, *understand* the implications of alcohol and other drug use on the individual's life, and *apply* coping and other recovery skills in his/her life to limit or prevent further alcohol or other drug use. The distinction is in the difference between an intellectual awareness and more superficial acknowledgement of a problem (recognition) and a more productive awareness of the ramifications of the problems for one's life (understanding); and the ability to achieve behavior change through the integration of coping and other relapse prevention skills (application).

"Stages of Change" refers principally to the work of Prochaska and DiClemente, who describe how individuals' progress and regress through various levels of awareness of a problem, as well as the degree of activity involved in a change in behavior.

"Support Services" are those readily available to the program through affiliation, contract or because of their availability to the community at large (for example, 911 emergency response services). They are used to provide services beyond the capacity of the staff of the program on a routine basis or to augment the services provided by the staff.

"Transfer" is the movement of the client from one level of service to another, within the continuum of care.

"Treatment" is the application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.

"Urgent cases" are those clients screened for substance use disorder services (i.e. pregnant women) and must be offered treatment within 24 hours.

All Office of Recovery Oriented Systems of Care polices and technical advisories discussed in this manual can be located at the following website address:
http://www.michigan.gov/mdch/0,4612,7-132-2941_4871_45835_48569-133156--,00.html

Access Management System/Service Access

MSHN adheres to requirements for access management as described in the Office of Recovery Oriented Systems of Care (OROSC) Treatment *Policy #7: Access Management Services (AMS).*

The AMS encompasses the requirements of the *Medicaid Provider Manual* with regard to SUD treatment; MSHN contractual obligations related to access; the Balance Budget Act (BBA) related to Medicaid managed care administrative requirements; as well as the requirements of *OROSC Policy #07, Access Management System.*

MSHN is responsible for providing SUD treatment services to individuals if they have Medicaid insurance, Healthy Michigan Plan, are enrolled in the MiChild program or have no insurance and cannot pay for services. Under special situations, MSHN may serve some clients who have commercial or other insurance.

All clients residing or presenting in the MSHN area requesting SUD treatment services must be assessed through a MSHN AMS. AMS consists of the administrative responsibilities associated with screening for eligibility, managing resources (including demand and access), ensuring compliance with various funding sources, meeting medical necessity, ensuring timely transfers from one provider to another for continuing care, and assuring quality of care. Activities to carry out these responsibilities may include referral to other community resources when these services are needed by the individual seeking substance use disorder (SUD) treatment services.

MSHN is responsible for assuring the availability and operation of an efficient and effective AMS including assurance that staff performing these functions is skilled, trained, supervised and appropriately credentialed when carrying out clinical functions. MSHN expects providers to ensure that access to services for individuals seeking SUD treatment services is efficient, consumer-friendly, timely, and effective. Furthermore, there is an overarching goal that SUD treatment access be integrated with Community Mental Health Service Programs' (CMHSPs) 24/365 crisis and access services. For out of county persons, access will be coordinated with the appropriate CMHSP and/or PIHP access center.

Individuals seeking SUD treatment services may access SUD services at each of the funded providers listed in the *Customer Services Handbook* or they may also receive health information, referrals to community resources, and screening appointments through the access management system at any access point for MSHN, including any CMHSP. To receive services or information about services, individuals may call the site nearest to where they live.

Individuals who have Medicaid or Healthy Michigan Plan and are in need of medically necessary services receive their services as an enrollee benefit. For individuals who have no insurance or MiChild, there is no guarantee of services if there is no funding available to provide those services. MSHN must provide services to as many individuals as possible within the financial resources that are available. Sometimes individuals may be placed on a waiting list if there is not enough funding to provide services immediately and the individuals do not qualify for Medicaid or Healthy Michigan Plan. Individuals <u>will not be put on a waiting list if they have Medicaid or Healthy Michigan Plan</u>.

In some circumstances MSHN may need to fund services from an agency that does not have a contract with the local region in order to meet a client's needs. If that is the case, the purchase of 'off panel' provider services should be facilitated by MSHN. MSHN access staff as well as provider staff will coordinate to help make these arrangements for clients when necessary and appropriate.

The AMS must provide access, screening and referral 24/7days a week. For emergency services, this requires the capacity to make information available as to what other entity is providing the emergency service and how to access services. Pregnant women requesting or seeking treatment are considered urgent requests and must be screened and referred as soon as possible but no later than 24 hours upon contact. For routine service requests, the minimum timeliness standard for conducting individuals' screening, level of care determination, provider selection (placement activities) and admission to treatment is 14 calendar days from individuals' first contact with the AMS. These specified time frames do not apply to people while they are incarcerated.

The AMS must abide by the priority population according to the SAPT community (block) grant regulations at CFR 96.131. MDCH has defined the following as priority populations for SUD treatment services and have admission preference in the order listed over any other client accessing the system: clients who are pregnant injecting drug users, pregnant users, injecting drug users, or parents of children who have been or are at risk of being removed from their home, in that order. Each MSHN contracted provider must meet the needs of individuals in these groups first. After that, MSHN may fund services for others who meet criteria for treatment.

If individuals in the priority population have to wait for services, they are to be offered interim services according to Section 96.121 of the SAPT Block Grant. Interim services must minimally include what is listed in the state policies, and provision of these services, or the refusal of such, will be documented in client files.

Clients served have freedom of choice to choose their provider from the available options. If individuals do not quality for SUD services, MSHN sites may 'warm transfer' such individuals to a provider of the individuals' choice or directly to Provider staff who will actively assist individuals to find other agencies in the community to best assist in meeting the client's needs.

Clients are to be provided an appointment for an assessment at a qualified provider of their choice, within the provider network, according to the established timeliness standards. Providers are to accept completed Biopsychosocial assessments that meet State and Federal requirements and are performed by qualified staff from all referral agencies. In these cases, Providers will conduct an assessment update to reduce the burden of duplicate Biopsychosocial assessments for individuals. It is expected that if individuals have completed such an assessment during the past six (6) months, they will not have to experience another assessment at the provider level. Rather, an update will be conducted to determine any change(s) to the assessment, development of a treatment plan with the client will occur, and any accreditation requirements of the agency will be completed. If the assessment sent by the referral agency does not include all of the requirements, providers are not required to accept this assessment or may decide to provide the assessment update to obtain the missing information.

Service Codes & Rates

Service payment rates by each service code are included in each SUD treatment provider's specific contract as Attachment B. MSHN seeks to have common regional rates and consistent payment methodologies for providers in the region. Reimbursement may be fee for service, cost settlement, or cost reimbursement as agreed upon. As a public funder of services, MSHN expects proper use of all funds used to support services

and integrity of the documentation of provider costs associated with services purchased. Rates are based on best value, competitive and comparable market information. Unless otherwise referenced directly in the contract with providers with specific codes, the reference for service codes is the *PIHP/CMHSP Encounter Reporting, HCPCS and Revenue Codes, Reporting Cost per Code and Code Chart* published by MDCH, the most current version, located at:
http://www.michigan.gov/documents/mdch/Revised_MHCodeChart_January2015Changes_479139_7.pdf.

Provider Authorizations & Claims

All treatment providers contracted for MSHN SUD services must use the internet-based information system known as CareNet, a product of Net Smart Technologies. CareNet is the mechanism for the provider network members to request authorization for SUD services for clients who meet admission criteria. CareNet also serves as a central location for collecting and analyzing data. MSHN will establish authorized provider access to CareNet and offer a common CareNet platform for provider use in the region.

In all cases the treatment provider is responsible for entering demographic, financial, insurance, admission and authorization data into the CareNet system. CareNet includes screening, assessment, treatment and demographic information for all clients served.

The provider is responsible for the hardware and software requirements of:

- Commercial Internet Service Provider
- Internet Explorer 9.0 or higher
- Internet browser
- Windows 7 or higher based on operating system

The provider shall electronically submit a claim utilizing CareNet to request reimbursement for authorized services once provided. The provider will submit all the necessary information and support for all billed services. MSHN is the payer of last resort and the provider must be knowledgeable about and seek other payment options wherever appropriate. Questions about payment source should be directed to MSHN whenever necessary to ensure funded services are provided. Claims must be submitted in a timely manner and claims for unauthorized services will not be paid by MSHN. Determination of inappropriate use of funds would be cause for repayment.

Capacity

MSHN may place a hold on admission referrals to a program if that provider exceeds capacity. The treatment provider should provide notice in the event there are any capacity limitations and/or any inability to accept new referrals at any time. The treatment provider is also responsible for notifying any change in occupancy or other service capacity or capability status relevant to their MSHN contract scope of work for SUD services. MSHN may elect to seek or add providers to the regional panel to meet existing or new needs of consumers at any time. Providers may be interested in MSHN's publication, *Assessment of Network Adequacy*, which is refreshed typically on an annual basis. This document is located on the MSHN website.

Customer Service

MSHN is responsible to ensure appropriate customer services to meet client and provider needs, including but not limited to resource information and referrals. MSHN and providers will collaborate to meet any special

needs of any client, including but not limited to those who have hearing or vision impairments, those who need written or oral interpreter services, those who have limited English language proficiency, or clients who need any other special accommodation to receive needed SUD treatment. Customer services is an important aspect of assuring that persons needing SUD treatment have information about how to access and/or be assessed for SUD treatment, as well as other relevant community resources to meet potential client and other community representatives or citizens informational needs.

Communicable Disease

MSHN adheres to requirements for communicable disease as described in the OROSC Prevention *Policy #2: Addressing Communicable Disease Issues in the Substance Abuse Service Network.*

All MSHN funded treatment programs must have a procedure in place for all clients entering their programs for treatment stating individuals will be appropriately screened for risk of Tuberculosis, Hepatitis B and C, STDs and HIV. Minimally the procedure is to include:

- A high risk screening check list to be completed by the client and reviewed by appropriate staff to determine if a referral for testing in necessary based on risk exposure and to provide information regarding available resources if already infected.
- A protocol for accessing Hepatitis C testing for all clients with a history of IDU.
- A protocol for accessing STD (including Chlamydia) and HIV testing for all pregnant women presenting for treatment.
- A requirement for staff to follow-up to ensure that clients who are referred receive such services.
- For Residential Programs only**,** all clients entering residential treatment will be tested for Tuberculosis upon admission.

All funded programs will meet state reporting requirements while adhering to federal and state confidentiality requirements, including 42 CFR Part 2 and Confidentiality of HIV/AIDS Information.

Health education and risk reduction education (HERR) for at-risk clients must be provided at the treatment provider's site or referred to the local public health department. Follow-up must be monitored and documented in the Client's record.

It is important for all staff working in a substance use disorder treatment program to have at least a minimum knowledge of communicable disease. Knowledge standards are expected to be consistent with the roles and responsibilities of program and clinical staff. Minimum standards are listed in the OROSC Policy under Minimum Knowledge Standards for Substance Abuse Professionals – Communicable Disease Related. Appropriate training for new staff is to be completed within the first three (3) months of hire with updated training every two (2) years thereafter. Approved training can be located on the Improving MI Practices website at http://improvingmipractices.org/ or through the local MSHN SRE. Documentation of completion of initial training is to be kept in the employee's record as well as documentation of updated training.

MSHN will monitor compliance with this requirement with review of contractor employee records during annual quality assurance site review and is subject to ad hoc review at any time.

Physical Health Care Coordination & Integration

MSHN expects providers will collaborate and coordinate services with other health care providers as appropriate, including primary care practitioners. Individuals living with SUD(s) often have one or more physical health problems such as lung disease, hepatitis, HIV/AIDs, cardiovascular disease and cancer and mental health disorders such as depression, anxiety, bipolar disorder and schizophrenia. Research indicates that persons with substance abuse disorders have:

- 9 time greater risk of congestive heart failure
- 12 time greater risk of liver cirrhosis
- 12 times the risk of developing pneumonia

Substance use disorders also complicate the management of other chronic disorders. Individuals with addictions and co-occurring physical illnesses may require health care that includes multiple healthcare providers, including SUD providers and primary care providers. The integration of primary and addiction care can help address the interrelated physical illnesses, improve health outcomes and improve coordination of care by reducing the back-and-forth referrals between behavioral health and primary care offices. Efficacy of new medications for the treatment of substance use disorders give providers new tools to fight addiction by expanding the range of treatment options for individuals with alcohol and drug addictions. By helping individuals achieve and sustain recovery, primary care providers can improve treatment for chronic conditions such as diabetes, asthma and hypertension and support the efforts of SUD treatment providers.

Attributes of integrated care for addiction providers with primary care are:

- Self-management and recovery support: A person actively partners with their health care professional(s) to manage their health and recovery, working to maintain recovery and wellness by setting goals to change behaviors.
- Person-centeredness: A person's health care is self-directed and based on a partnership between the individual and a team of providers, and when appropriate, the individual's family. The provider works to ensure that treatment decisions respect the person's wants, needs and preferences. The person receives education and support in engaging in their care and making healthcare related decisions.
- Delivery system design: A team manages healthcare delivery that encompasses a collaborative approach with an expanded scope of provider types who have clearly defined roles.
- Clinical decision support: Treatment services and provider processes embrace evidence-based clinical guidelines.
- Clinical information systems: Information sharing systems identify relevant treatment options and other data on individuals and populations.
- Community resources: Relationships with other community resources (e.g. housing, employment) help support and meet individual's needs and preferences.

MSHN supports the promotion of the 8 dimensions of wellness from SAMHSA: emotional, financial, social, spiritual, occupational, physical, intellectual and environmental.

Healthy Michigan Plan (HMP)

The Healthy Michigan Plan (HMP) effective April 1, 2014 in Michigan has served to expand SUD services to newly enrolled persons, and has also expanded the array of services available under this new benefit for persons with substance use disorders in need of treatment. MSHN will be seeking to continue to expand defined services under this benefit to support clients (eligible enrollees/beneficiaries) with substance use disorders, according to published Medicaid Manual parameters.

Medicaid/MiChild Verification/Reimbursement

The provider, upon admitting a client record into the CareNet system, must have the Medicaid card and perform a 270/271 eligibility check. Each month, while the client is in the program, the provider must check for a current Medicaid card and/or perform an eligibility check verifying coverage. If the copy or a 270/271 check has not been performed, reimbursement may be held up and any re-authorization requests may be placed into pending until the issue is resolved.

Providers are responsible to determine a client's Medicaid HMP or MiChild eligibility verification at the time of admission. Providers can confirm eligibility verification report by calling Medicaid's Medifax line: 1-888-696-3510 or MiChild Hot Line 1-888-988-6300. Providers will perform monthly Medicaid, HMP, or MiChild eligibility verification checks and have the report placed in client's chart with a copy of the insurance card- or perform a 270/271 eligibility check. It is the provider's responsibility to verify if there has been a change of coverage if the client has third party insurance coverage, Medicaid, HMP or MiChild eligibility prior to authorization.

Retrospectively, if it is determined that the client was NOT covered by Medicaid during the service period, the claim may be rejected and the provider notified. It is then the responsibility of the provider to notify the Access Management System and follow the established policy/procedure for obtaining payment under the Community Grant program (Block Grant).

Providers may be requested to assist clients or MSHN in submitting evidence of client disability and/or treatment provision or cost, in order to obtain and maintain benefit eligibility, including justification for ongoing Medicaid deductibles.

Since federal regulations are specific regarding billing for Medicaid, HMP, MiChild or federal portion of community (block) grant funds, and eligibility requirements change from month to month, active eligibility in Medicaid, HMP, or MiChild or other third party insurance plans must be verified on a monthly basis and filed in the Consumer's chart or an eligibility check performed. Covered MiChild services are limited to outpatient and residential treatment. If the status of the client's insurance changes during a treatment episode, the provider must update the change on the Insurance Screen in CareNet.

Automated Request Processing (ARP)

MSHN may elect in some circumstances to use an automated request processing for service authorizations with providers. In these cases, an Initial and Re-authorization Request by a provider may be automatically approved unless one or more of the following exists:

1. There are four or more outpatient treatment admissions within a year before the request begin date, across all Providers.
2. The request contains services for Residential CPT codes: H0018 or H0019.
3. The request contains more than one unit of CPT code H0001 or H0001 with the following modifiers: HA, HD, HH, HR, and H9.
4. There is more than one unit of H0001, with or without modifiers, requested and/or paid and adjudicated for the client within the past 180 days across all providers.
5. The Military Service field is marked 'yes' on client's most recent admission at the requesting Provider.
6. The request is a 4th authorization request for detox services, and client has 3 admissions for detox services in the last 12 months.

7. The request indicates that the client's income "exceeds eligibility guidelines".
8. The request contains a combination of the following codes: H0010 (Medically Monitored Detox), H0012 (Clinically Managed Detox), H0018 (Residential Stabilization), H0019 (Long-term Residential) with or without modifiers.
9. There is more than 180 days in the requested date range (outpatient).

If an Authorization Request fails to meet any one criterion from the list above, the request will not be automatically approved by the system, and will be sent to the Access Management Center for their review, in the same manner as if the Automated Request Processing (ARP) function was not in place.

If an Authorization request is automatically approved by CareNet, the system will insert a note into the Authorization record in the Authorization Comments section that reads, "System Message: Request was automatically approved". The date and time will display. In addition, a "stamp" will appear on the client's authorization history screen for that particular approved authorization with says, "Auto-Approved" under the Status column.

Conversely, if an Authorization request fails to meet any of the Automated Request Processing criteria and was not automatically approved, the system will insert a note into this record, in the "Request Comments" section, noting that the request was not automatically approved.

Medicaid Recipients with other Primary Insurance

MSHN will authorize Medicaid payment of services only after all other active insurances have been billed and/or denied. Medicaid recipients who have any other insurance code either listed on the Medicaid Card or, indicated through 270/271 information, or have coverage through Medicare Part B, Medicare is the primary insurance for SUD treatment and these clients must be transferred into a program that has an authorized Medicare provider.

For Medicaid recipients who have insurance other than those listed above, the primary insurance must be billed for SUD treatment coverage prior to billing Medicaid. These client services will not be authorized or paid by Medicaid funding until all other insurance coverage has been exhausted.

Reimbursable Diagnoses

Services for clients with substance use disorders will be provided only for applicable and appropriate substance use disorder diagnoses as included in the DSM-5 (effective October 1, 2015). The SUD diagnosis must be the primary diagnosis for SUD funds to be used for payment of services provided. SUD diagnoses applicable for reimbursement are delineated in the CareNet system.

Confidentiality & Privacy

MSHN contracted SUD treatment providers shall comply with the Federal Drug and Alcohol Confidentiality Law (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 – Privacy Standards (45 CFR Parts 160 and 164). MSHN requires provider compliance with all federal and state confidentiality and privacy laws.

42 CFR PART 2 – FEDERAL DRUG AND ALCOHOL CONFIDENTIALITY LAW

42 U.S.C. Section 290dd-3, 290ee-3 for Federal laws and 42 C.F.R. Part 2 for the Code of Federal Regulations protects client records and status within the context of SUD treatment. Generally, the program may not acknowledge to anyone outside the program that a client attends a program, or disclose any information identifying a client as an alcohol or drug abuser without a written signed release unless:

- The disclosure is allowed by a special court order; or
- The disclosure is made to medical personnel in a medical emergency;
- The disclosure is made to qualified personnel for research, audit, or program evaluation; or
- The disclosure is made when the client commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (MDCH, Requirements for Reporting Abuse and Neglect)

45 CFR PARTS 160 AND 164 – HIPAA Privacy

In conjunction with the protections under 42 U.S.C. and 42 CFR, all clients have all their personal health records protected under HIPAA, 45 CFR. The client record contains information that under HIPAA is called Protected Health Information or PHI.

There are nineteen (19) data elements considered PHI. They are: name, address (including street address, city, county, zip code and equivalent geocodes), name of relatives, name of employer, all dates (including birth, death, date of service, admission, discharge, etc.), telephone numbers, fax number, health plan beneficiary number, account numbers, certificate/license number, any vehicle or other device serial number, web Universal Resource Locator (URL), Internet Protocol (IP) address number, finger or voice prints, and photographic images.

Employee Confidentiality

MSHN will protect the confidentiality of the SUD treatment service clients and their records as provided by law. Every contracted/sub-contracted program staff member involved in MSHN funded work is expected to read and abide by the provisions of the MSHN standards of conduct for confidentiality and privacy. MSHN may offer a standard form for this purpose.

- Every staff member will sign an employee confidentiality and/or privacy statement at time of employment;
- A signed copy of the statement will be placed in the staff personnel file;
- A review of the confidentiality policy will be provided annually to the staff; and,
- A new, signed confidentiality/privacy form will be obtained from each staff member annually.

Recipients Rights for Substance Use Disorder Services

MSHN adheres to the 1981 Administrative Rules for Substance Abuse Programs in Michigan; Section R325.14301to R325.14306 on Recipient Rights. The Administrative Rules are located at http://www7.dleg.state.mi.us/orr/Files/AdminCode/103_67_AdminCode.pdf.

MSHN will establish a Recipient Rights Policy and Procedure for the purpose of protecting the rights of recipients (clients) receiving SUD services from MSHN providers to comply with the 1981 Administrative Rules for Substance Abuse Programs in Michigan. This applies to all services provided for clients receiving SUD treatment, prevention, and recovery support services within the provider network.

Recipients (clients) have the right to know about the services they are receiving, to make a complaint about a possible violation to those rights, and expect a resolution. The recipient rights process establishes a method in which if a client believes his or her rights have been violated, there is a known procedure to follow. The first step in this process the program director will designate one staff member to function as the program rights advisor. The rights advisor shall:

(a) Attend all of the Substance Abuse Licensing training pertaining to recipient rights.
(b) Receive and investigate all recipient rights complaints independent of interference or reprisal from program administration.
(c) Communicate directly with the Coordinating Agency Rights Consultant when necessary.

Rights of recipients shall be displayed in a public place on a poster to be provided by MDCH. Brochures, rights, and posters are available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_48558-15090--,00.html#TxBrochure. The Recipient Rights poster will indicate the designated rights advisor's name and telephone number.

The Recipient Rights Consultant for MSHN is:
Dani Meier, PhD, MSW
Director, Health Integration, Treatment and Prevention
SUD Recipient Rights Consultant
Mid-State Health Network
530 West Ionia Street, Suite F
Lansing, Michigan 48933
dani.meier@midstatehealthnetwork.org
Office: 517-253-0279
Fax: 517-253-7552

Contact people at the local level for Recipient Rights questions are:
CEI SRE – Jeanne Diver, MPA
(Clinton, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Jackson, Newaygo)
838 Louisa Street, Suite B, Lansing, MI 48911
diver@ceicmh.org
Phone: (517) 887-5290
Fax: (517) 272-3015

Riverhaven SRE – Rebecca Emmenecker, LLPC, LBSW, CAAC
(Arenac, Bay, Huron, Montcalm, Shiawassee, Tuscola, Clare, Gladwin, Isabella, Mecosta, Midland, Osceola)

201 Mulholland, Bay City, Michigan, 48708
remmenecker@babha.org
Phone: (989) 895-2847
Cell Phone: (989) 415-0757
Fax: (989) 895-2878

Saginaw SRE – Amy Murawski, MS, CAC, CPS
(Saginaw)
1600 N. Michigan Avenue, Suite 501, Saginaw, MI 48602
amurawski@saginawcounty.com
Phone: (989) 758-3748
Fax: (989) 758-3746

Cultural Competency

The Federal Register provides National Standards for Culturally and Linguistically Appropriate Services.
It is critical that MSHN provider network members strive toward cultural competency for all persons from diverse cultural backgrounds in our communities who are in need of accessing SUD treatment and prevention services. Cultural response includes removing barriers and embracing differences, in order to offer safe and caring environments for all who are in need of services.

Cultural competency can be defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program, or among individuals which enables them to work effectively cross-culturally. Further, it refers to the ability to honor and respect the beliefs (including religious), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment and is achieved over time, according to the National Center for Cultural Competency.

It is the expectation that each SUD prevention/treatment provider will have applicable policies and training of staff relative to cultural competency and available to MSHN for review, including governance and practitioners providing treatment. MSHN expects that providers will demonstrate training competencies to support a diverse population of clients served and seek to establish a diverse workforce to meet client needs. MSHN will endorse a variety of methods to help ensure cultural competency, including recognition in the regional strategic plan and other support as indicated.

Assessment tools and/or methods used must be culturally sensitive, reliable, and validated, whenever possible, for use with racial and ethnic minorities. Service/support/treatment plans and discharge plans must incorporate the natural supports and strengths specific to the racial and ethnic background of the client, family, community, faith-based, and self-help resources. Prevention, education and outreach efforts will include linkages with racial, ethnic, and cultural organizations throughout the community.

Documentation & Records

MSHN adheres to MDCH's General Schedule #20 – Community Mental Health Services Programs' Record Retention and Disposal Schedule, located at http://michigan.gov/documents/hal/mhc_rm_gs20_195724_7.pdf. MSHN's policy regarding record retention

is located at: http://www.midstatehealthnetwork.org/policies/docs/policies/Information%20Reporting%20-%20Record%20Retention.090214.pdf.

All services, such as, assessments, treatment planning, referrals, progress notes, discharge planning and all other content relative to service delivery must be properly documented in CareNet as well as the provider's SUD treatment/medical record by properly credentialed clinicians and linked to an individualized treatment plan. All progress notes must be signed and any clinicians under a professional development plan must have notes co-signed by a properly credentialed and authorized supervisor.

All records are subject to audit by MDCH or MSHN, including event verification as required for federal Medicaid compliance. MSHN and providers could also be subject to federal audit relative to the use of Medicaid funds. Secure storing of records must meet requirements for privacy, security and retention, including any electronic records.

Destruction of records needs to follow the policy and retention and disposal schedule listed above. Disposial must be properly executed with cross-cut shredding or other such proper disposal under the supervision of an authorized person.
Requests for client records from legal contacts or other entities as well as FOIAs should be coordinated with MSHN prior to release.

Discharge Planning

MSHN requires that effective discharge planning will be provided for clients, and that follow-up services meet contractual and regulatory requirements.

Discharge Planning is considered an integral part of SUD treatment, particularly but not limited to higher intensity services and shorter term levels of care. Consideration of the continuum of care and long term recovery needs of the client will be considered at every step of treatment planning. Discharge planning provides improvements to the quality of care and improves outcomes and controls cost, by assuring coordination and collaboration with mental health, SUD and other health providers to fully address the needs of the client. It is critical that all providers and organizations serving a client act together to develop an integrated health aftercare plan and then implement this ongoing aftercare plan in an environment that eliminates barriers and duplication of services.

1. Discharge Planning will occur according to best practices and the provider organizations' admission and discharge policy(ies).
2. A review of all clients discharge plan for all levels of care will be completed to ensure that appropriate follow-up care is arranged for those ending treatment.
3. A written Discharge Plan will be prepared to ensure continuity of service and will be distributed to parties involved to carry out the plan.
4. The MSHN contracted provider network will ensure that all clients are appropriately discharged from their care.
5. Aftercare services are incorporated into the treatment plan, and needs are identified and addressed in the discharge plan.
6. Follow up SUD treatment services from a detox and or residential facility will be completed not more than seven (7) days after discharge.
7. Consumer satisfaction surveys will be distributed to the clients at discharge.

Notification of Closure

All network providers if ending service contracts will notify their clients of the intent to close in no less than 30 days before the closure of the program. Each client, as coordinated with the responsible MSHN contact, will be notified in writing of:

- Date of closure.
- Directions regarding obtaining continued treatment.
- Where their records will be transferred.
- How to obtain information from their records.
- Procedure for transferring their records.
- The need for a signed release of information prior to the transfer of records.

The provider closing will notify MSHN of the client's needs and choices through weekly review and/or CareNet, and MSHN may ask the provider to assist the client with transfer to another treatment provider.

Providers who provide outpatient services must have a mechanism to notify clients in a reasonable manner regarding unexpected program or site closure, such as due to inclement weather, building damage, etc.

Performance Indicators

MSHN Providers are responsible to meet the timeliness standards for Medicaid and Healthy Michigan Plan in accordance with the most current Michigan Mission-Based Performance Indicator System PIHP Reporting Codebook, in which there are three (3) timeliness performance indicators as listed below:

- Indicator 2: *The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service (by five sub-populations: MI-adults, MI-children, DD-adults, DD-children, and persons with Substance Use Disorders). Standard = 95%*
- Indicator 3: *Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional ((by five sub-populations: MI-adults, MI-children, DD-adults, DD-children, and persons with Substance Use Disorders). Standard = 95% within 14 days*
- *Indicator 4b: The percentage of discharges from a sub-acute Detox unit during the quarter that were seen for follow-up care within 7 days. Standard=95%.*

Other performance measures may be defined specific to the contractor and/or specific type.

Prevention provider specific outcomes will be delineated in the contract as appropriate.

Provider Sanctions

Providers will be subject to sanctions from MSHN when contract expectations are not met or maintained, including but not limited to corrective action plans, repayment of funds, suspension of referrals or contract termination. Providers will be offered opportunity to correct non-compliance wherever reasonable, and sanctions will be issued in writing, commensurate with the level of non-compliance.

General Business Requirements

Providers are responsible to ensure all provision of services are in compliance with local municipality and state and federal business requirements, including business records, reporting, and adherence to all relevant statutes. Providers must be in compliance with all applicable standards and expectations from the most current *MDCH Substance Use Disorder Services (SUDS) Program Audit Guidelines,* which include single financial audit requirements for providers in receipt of federal funds above a $500,000 level in a fiscal year.

Continuing Education

MSHN will monitor compliance of the establish minimum training requirements for SUD treatment and prevention service provision for all contracted providers MSHN providers will be subject to corrective action plans if not met and sustained. All contracted/subcontracted providers are responsible to ensure that all staff members involved in direct service delivery meet and maintain all continuing education requirements for needed credentials.

TREATMENT SERVICES

Providers should refer to the Michigan Medicaid Manual for complete descriptions of treatment services, along with all relevant MDCH and MSHN policies and references noted in this manual. MDCH/OROSC policies referenced in this manual are located at: http://www.michigan.gov/mdch/0,4612,7-132-2941_4871_45835_48569-133156--,00.html.

Evidence-Based Practices

MSHN requires all SUD treatment providers to document and provide evidence-based programs for 100% of their services. Treatment providers must demonstrate knowledge and competencies in practice relevant to service provision. Each provider is monitored at least annually with regular site visits to verify that the evidence-based programs are being provided and that staff and clinicians have the requisite training and qualifications for the practices in which they are engaging clients. Core elements of evidence-base practice include motivational interviewing, trauma-informed care and positive behavioral supports. Recognizing the stages of change for persons recovering from SUDs is an important component of evidence-based service provision. Providers should take steps to ensure fidelity to evidence-practice models, including sustaining fidelity when valid models and/or program staffing changes occur, which may require new training or credentials in maintain integrity of clinical service provision. MSHN reserves the right to endorse evidence-based practices in use by funded provider programs.

Co-Occurring Mental Health and Substance Abuse Disorders

MSHN will provide a welcoming, assessable, integrated service to individuals with co-occurring SUDs and mental health disorders. The Access Management System within MSHN provider network shall routinely screen for co-occurring disorders.

MSHN will provide continuous and comprehensive services to individuals with substance use and psychiatric disorders in a coordinated or integrated manner. MSHN recognizes that the stages of change and recovery may be disparate for individuals between any present co-occurring disorder conditions.

MSHN provider programs will demonstrate competency in the provision of services for those who have co-occurring conditions Programs that address mental health and substance use disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning are defined as Co-occurring Capable Programs. Programs are deemed co-occurring capable as evidenced by their score on the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit. In region Outpatient Treatment Providers are expected to complete the DDCAT with scores of "3" or better on each item in order to be designated as co-occurring capable.

Providers are encouraged to utilize the DDCAT Toolkit to enhance services based upon their current status. This toolkit offers tools and materials that will improve services for those with co-occurring disorders.

Case Management

MSHN adheres to requirements for case management as described in the OROSC *Treatment Policy #08: Substance Abuse Case Management Program Requirements*.

Case Management is an effective enhancement to intervention in the treatment of substance use disorders. This is especially true for clients with multiple disorders, who may not benefit from traditional substance use disorder treatment, who require multiple services over extended periods of time, and/or who face difficulty gaining access to those services. Such an intervention can establish a stronger foundation for a client's recovery, reduce costs and enhance long term recovery for those who have addictive disorders, by assuring they have access to all needed services.

Case management services are those services which will assist clients in gaining access to needed medical, social, educational/vocational and other services. Core elements of case management include assessment; planning; linkage; and coordination and monitoring to assist clients in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and supports developed through the individualized treatment planning process. Services are provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Case managers may follow clients as they progress through the continuum of care. Case management services may continue after discharge from treatment for up to six (6) months as stated in OROSC policy #8 and as authorized by MSHN.

Case management services are not a case-finding activity as funded by MSHN but rather supportive activities to enhance each client's long term recovery from an addictive disorder.

MSHN SUD treatment providers may determine the need for case management services during their assessment process or at any time during the treatment planning process. MSHN SUD treatment providers may determine and utilize a case management needs assessment of their own choosing as long as it meets the following guidelines: it must be in a written format (electronic is accepted.); the needs assessment is to be kept in the consumer record; and, incorporated into the client's treatment plan. (Note: *There is an example of a case management needs assessment located on the MSHN website.*)

It is MSHN's expectation that **at a minimum, one (1) encounter per month is to be face-to-face** with the client. The frequency of case management encounters is to be determined by the individualized needs of the client based on the results of a needs assessment.

Case management services shall be available to **only** clients in MSHN funded SUD treatment system who **are not eligible or served** in this manner through mental health, public health, other community human service agencies and/or DHS agencies.

Case management services shall be guided by each client's treatment plan which will incorporate case management goals and outcomes and is consistent with the individualized, coordinated, comprehensive treatment plan of service.

Case management service providers shall establish linkages with other agencies in the human services and community resources network for referral to ensure continued case management services beyond six (6) months after discharge, if necessary for the client.

The treatment record of clients receiving case management services must contain documentation for the determination of need for case management services, and case management activity notes indicating the following information:

1. Date of contact and/or service;
2. Duration of case management contact/services;
3. Name of agency and/or person being contacted;
4. Nature of case management services requested and extent of services requested; and/or
5. Nature of case management services provided and extent of services provided;
6. Place of service and/or referral.

Detoxification

The Medicaid Manual states: sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required.

Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate.

Expectations:

1. All clients entering residential detoxification must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.
2. Sub-acute detoxification is one component of a comprehensive SUD treatment strategy; detoxification is the beginning phase of SUD treatment.
3. Sub-acute detoxification will be authorized as part of a planned SUD treatment episode, with the clinical pathway detailed in the authorization of services and explained to the client prior to admission into detoxification services.

4. The sub-acute detoxification provider will facilitate the client's transfer to the next level of care.
5. The sub-acute detoxification provider is to provide a safe withdrawal from the drug(s) of dependence and enable the client to become drug free.
6. The sub-acute detoxification is to be provided in a supportive environment, with caring staff, sensitivity to cultural issues, confidentiality, and selection of appropriate detoxification medication (if needed) in order that the withdrawal is humane and protects the client's dignity.
7. The sub-acute detoxification provider is to prepare the client for ongoing SUD treatment of his or her SUD by emphasizing detoxification is the beginning **phase of SUD treatment**, not a treatment modality in itself. Detoxification is an opportunity to offer clients information and to motivate them for longer term treatment.
8. Clients in sub-acute detoxification may begin to attend treatment programming depending on their ability to participate. If the sub-acute detoxification provider will continue SUD treatment in either stabilization or Long-term residential, full participation to begin **no later** than the third day of admission. If it is determined the client is not medically stable by the third day, the client is to follow the medical clinician's recommendation.

Pregnant Women

Pregnant women (IDU or not) need to be offered admission into detoxification services within twenty-four (24) hours after the initial screening. It is **highly recommended** pregnant women whose primary drug(s) of choice are alcohol, benzodiazepines, and/or barbiturates (Sedatives-Hypnotics) be referred to an acute care medical hospital where the stress of detoxification on the pregnancy will be appropriately monitored until her need for detoxification or stabilization while pregnant is no longer needed, she can then be safely treated in a less intensive level of care.

Co-Occurring Disorders

For those individuals admitted into sub-acute detoxification already on prescribed non-addictive psychotropic medications for such diagnoses as depression, schizophrenia, anxiety, or bi-polar, it is advisable to keep them on those medications while being detoxed from alcohol and/or other drugs (legal or illegal).

If an individual is admitted into sub-acute detoxification and is on prescribed addictive medications, it is recommended that those medications be on hold during detox. The detox protocol will cover the withdrawal from these medications. The goal is to move the client from addictive prescribed medications to non-addictive medications while in SUD treatment.

For those individuals not on any prescribed psychotropic medications and if indicated, they may be started on the appropriate non-addictive psychotropic medications.

Early Intervention - Treatment

MSHN adheres to the recommendations as described in the OROSC *Treatment Technical Advisory #09: Early Intervention.*

ASAM Criteria; 3rd Edition defines Early Intervention as "an organized service that may be delivered in a wide variety of settings. Early intervention services are designed to explore and address problems or risk factors that appear to be related to substance use and addiction behavior, and to help the individual recognize the harmful consequences of high risk substance use and/or addictive behavior."

Early Intervention is a new allowable service for SUD treatment providers as prevention services has offered this level of services as Problem Identification and Referral (PIR) for many years. An important distinction is in PIR no SUD diagnosis is made; while for SUD treatment services a diagnosis is required, at least a provisional one. The provision of prevention's early intervention services or PIR will be discussed in the Prevention Section of this manual.

SUD treatment providers may offer Early Intervention Services to clients who for a known reason are at risk for developing a substance-related disorder as described in the DSM-5. But for whom there is not yet sufficient information to document placement in the criteria for diagnosis.

Early Intervention Services are intended to be available to all individuals for whom the service is indicated as potentially beneficial; specifically those individuals determined to be in the early stages of alcohol/substance use and/or identified as being in the *early* stages of change (pre-contemplation, contemplation).

It is the intention of MSHN that Early Intervention Services in a SUD treatment setting be available to all eligible persons as clinically appropriate and as funding permits. Every Outpatient Services provider in the network is expected to either have a direct-operated Early Intervention component or a formal letter of agreement with a prevention provider or another outpatient services provider in the network to provide Early Intervention Services.
The focus of Early Intervention services in a SUD treatment setting is on stage-based, client-directed interventions to change risky behavior Early Intervention treatment service functions include screening, individualized service planning, interventions, treatment, referring, and advocacy. Providers of early intervention services must document the provisional diagnosis (at a minimum, Level 0.5 of The ASAM Criteria, 3rd Edition) of eligible recipients in the CareNet system as part of the screening and authorization process.

Early Intervention services should be time-limited and short-term and may be used as a stepping stone to the next level for those clients identified in an early stage of change. Early Intervention service providers must address the detection and prevention of communicable diseases, including hepatitis, tuberculosis, and HIV.

Early intervention services may be provided in individual or group modalities. It is expected that the majority of contacts between the service provider and the client will occur in the setting most conducive to treatment success. Such settings may include but are not limited to clients' home, school or other safe community settings or clinical settings such as an outpatient clinic, community centers, churches, etc. Service providers are required to document all services on the appropriate clinical form and made a part of the client's permanent record.

JAIL BASED SERVICES

This section applies to providers whose service delivery extends to providing SUD treatment in a jail setting.

Jail-based SUD treatment can be an important aspect for an individual's rehabilitation process and with that in mind, MSHN will provide SUD treatment services to those in need, including services for clients who are incarcerated in the MSHN region, regardless of the client's county of residence.
However, providing SUD treatment services within the jail setting has barriers and complications relating specifically to it being provided in the jail. The provider has no control over client availability and knowledge of the actual release due to the jail's capacity. With MSHN's understanding of the barriers and complications involved, the following guidelines should be utilized when providing services to incarcerated clients:

- It is understood why treatment should begin as close to the scheduled release date as possible, usually within thirty (30) days; yet, this is not always feasible within the jail setting due to unscheduled early releases. The SUD treatment provider will assess the client when the client presents for services and begin the process of developing a treatment plan for post-jail. Jail-based services are not to be long-term in nature but considered a bridge between incarceration and return to the community.
- Each client will have an individual assessment, treatment plan and intake completed (there will be no "group intakes").
- Prior to the provision of services, clients will make a commitment to continuing in SUD treatment services once they are released from jail.
- All clients receiving services while incarcerated will have a referral made to an SUD provider in their respective county of residence, with an appointment date and time that is scheduled close to the next business day following their release date. Since there will be a possibility of clients being released early, clients are to have all the necessary referral information as soon as possible to be able to schedule an appointment themselves after early release.
- It is an expectation of MSHN if clients are released from jail early, every attempt will be made to contact the clients to help ensure a successful transition to their community SUD treatment provider is made. Documentation will be in the clients' file.
- The provider of jail-based services will secure a release to both the receiving provider and the client's home region, if not MSHN.
- All appointment dates and times will be documented in the CareNet system for each client in his/her discharge summary. A note will be made in the discharge note section of the discharge summary in CareNet stating if the client was released early.
- The provider of jail-based services will ensure that each client that receives any jail-based services will have documentation in CareNet for the services.

Medication Assisted Treatment

Note: MDCH issued New Guidelines for the Provision of Medication Assisted Treatment Services for Opiate Use Disorder in September 2014, however those guidelines are not yet part of the MDCH-PIHP contractual agreements.

MSHN adheres to the requirements as described in OROSC's *Treatment and Recovery Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery* and *OROSC'S Treatment and Recovery Policy #03: Buprenorphine.*

Medication Assisted Treatment (MAT) is a specialized SUD treatment service which is highly regulated on a state and federal level. There is considerable detail involved with the provision of MAT services; therefore MSHN has developed this separate MAT provider manual which describes how to meet the state and federal regulations and MSHN's expectations. Further revisions of this manual will be an expectation as state and federal MAT guidelines continue to be updated.

MEDICATION-ASSISTED TREATMENT (MAT):

According to the Treatment Improvement Protocol #43, as published by the U.S. Department of Health and Human Services (US HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for

Substance Abuse Treatment (CSAT) the definition of Medication Assisted Treatment for Opioid/Opiate Dependence is:

> "...any treatment for Opioid/Opiate addiction that includes a medication (e.g. methadone, buprenorphine, Naltrexone) approved by the U.S. Food and Drug Administration (FDA) for Opioid/Opiate addiction detoxification or maintenance treatment."

It is the intention of MSHN that MAT for Opioid/Opiate dependence will be available to individuals, once **clinical eligibility and medical necessity** has been determined via appropriate screening and assessment. MSHN will fund SUD therapeutic (clinical) treatment services as an adjunct to methadone/buprenorphine/naloxone (e.g. Suboxone) assisted therapy through the ORT programs.

Decisions to admit an individual for MAT must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria. Admission procedures require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process. The physician may refer the individual for further medical assessment as indicated.

According to the Medicaid Provider Manual, the definition of **medical necessity** "is the determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services."

Medical necessity requirements shall be used to determine the need for MAT as an adjunct SUD clinical treatment and recovery service. All six dimensions of the American Society of Addiction Medicine (ASAM) Criteria must be addressed:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications.
3. Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)
4. Treatment acceptance/resistance
5. Relapse/continued use potential
6. Recovery/living environment

<u>PRIORITY POPULATION ADMISSIONS:</u>

Priority population admission Persons presenting for treatment are admitted to treatment in the following order:

1. Pregnant injecting drug users.
2. Pregnant substance abusers.
3. Injecting drug users.
4. Parents whose children have been removed from the home or are in danger of being removed from the home due to the parents' substance abuse.
5. All others.

As each client is unique and presents with individual concerns, providers are encouraged to contact MSHN SUD access centers to discuss exceptions on a case-by-case basis.

PURPOSE OF MAT:

MAT for Opioid/Opiate Dependence is intended to stabilize a client and foster readiness to make continued SUD clinical and medication treatment decisions. An individual currently abusing Opioids/Opiates and seeking treatment services may not be initially capable of making such decisions regarding their continuing treatment needs. Not all individuals are appropriate for MAT, although they may meet clinical and medical criteria.

MAT is part of a broader continuum of care for substance use disorders that should include appropriate levels of care determined by the assessment process. It is expected all MAT providers contracted with MSHN will offer many various services such as; individual and group counseling and therapy, recovery support, and case management. MSHN promotes the use and value of group counseling and therapy in MAT.

MSHN expects providers to assess the stage of change for every client to determine their readiness for change as a means of ensuring that the provision of MAT services will best meet the needs of the client. Individuals identified as having a diagnosis of Opioid/Opiate dependence *and* who are in the **preparation or action stage of change** may be authorized for admission to MAT services.

Individuals identified as having diagnosis of Opioid/Opiate dependence and are in the **pre-contemplation or contemplation stage of change** will not be authorized for admission to MAT services. Such individuals will be offered Early Intervention services.

MSHN recognizes that Opioid/Opiate addiction may be an incurable brain disease that can last a lifetime; however, it is not the intention of MSHN to provide funding for MAT indefinitely. Intensive MAT will be offered to those clients with Opioid/Opiate dependence in order to enable them to reacquire the life skills as well as the degree of recovery to assume financial responsibility for their own treatment within three (3) years of their induction into treatment. Medical decision-making must be involved and any exceptions to this 3 year time frame must be provided in detail to MSHN by the provider physician.

MINIMUM REQUIREMENTS:

MSHN requires that MAT providers offer at least the following services:

- Comprehensive psychosocial assessment with an initial diagnosis of Opioid/Opiate dependency of at least one-year duration
- Coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers
- Physical examination upon admission and as appropriate during the course of treatment
- Mandatory Four-month reviews to determine continued eligibility
- Daily attendance requirements for medication dispensing
- Must be used as an adjunct to Opioid/Opiate SUD treatment which must include a counseling component
- Mandatory toxicology screening at intake and randomly during the induction period, to be conducted at a rate of no less than two per month. Beyond induction period, random toxicology screening to be conducted at a rate of no less than once per month; more if toxicology screening indicates possible relapse; toxicology screening must assay for Opioids/Opiates, cocaine, amphetamines, cannabinoids, benzodiazepines and methadone metabolites
- Identification of co-occurring disorders and neuropsychological problems

- Counseling to stop substance use and addictive behaviors as well as manage drug cravings and urges
- Evaluation of and interventions to address family problems
- HIV and hepatitis C virus (HCV) testing, education, counseling, and referral for care
- Referral for additional services as needed.

General minimum service requirements for authorizing treatment for buprenorphine/ naloxone services:

- Comprehensive psychosocial assessment with an initial diagnosis of Opioid/Opiate dependency
- Coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers
- Used as an adjunct to Opioid/Opiate SUD treatment which must include a counseling component
- Physical examination upon admission
- Mandatory Four-month reviews to determine continued eligibility
- Mandatory toxicology testing at intake and randomly during the induction period, to be conducted at a rate of no less than two per month. Beyond induction period, random toxicology screening to be conducted at a rate of no less than once per month; more if toxicology screening indicates possible relapse; toxicology screening must assay for Opioids/Opiates, cocaine, amphetamines, cannabinoids, benzodiazepines and methadone metabolites
- Identification of co-occurring disorders and neuropsychological problems
- Counseling to stop substance use and addictive behaviors as well as manage drug cravings and urges
- Evaluation of and interventions to address family problems
- HIV and hepatitis C virus (HCV) testing, education, counseling, and referral for care
- Referral for additional services as needed.

Additional information regarding buprenorphine:

- The medication buprenorphine (Suboxone/Subutex) is not funded through MSHN, and may be funded through self-pay or through the pharmacy benefit for Suboxone through Medicaid. It must be preauthorized through the Medicaid pharmacy benefit.

- All physicians, including those at an ORT, must have a waiver from SAMHSA, permitting them to prescribe or dispense Suboxone. There is no limit to the number of clients for whom Suboxone can be dispensed from an ORT. The maximum number of active clients from a physician in private practice would be 30 clients for the first year of prescribing and 100 clients thereafter.

<u>COVERED SERVICES:</u>

Covered services for methadone and pharmacological supports and laboratory services, as required by Federal regulations and the Administrative Rules for Substance Abuse Service Programs in Michigan, include:

- Methadone medication
- Nursing services
- Physical examination
- Physician encounters (monthly)
- Laboratory tests
- TB skin test (as ordered by physician)

<u>CONDITIONS OF TREATMENT</u>:

The following conditions of treatment will be expected for <u>all clients</u> wishing to enter or re-enter medication assisted treatment.

- Discontinuation of the use of all illicit and non-prescribed drugs and alcohol.
- Regular attendance at the medication-assisted treatment provider for dosing (daily, until such time that the client meets criteria for take home dosages in the case of methadone, and as clinically and medically appropriate for buprenorphine).
- Attendance at all group and/or individual treatment sessions.
- Adherence to all program rules.
- Provide the name, addresses and phone numbers of all medical, dental, and pharmacy providers.
- Produce valid prescription or medication bottles with physician name on the label for all controlled substances within one week of admission.
- Prescribed medications may have to be changed in order to better coordinate treatment.
- Enrollment in one medication-assisted treatment program only.
- Evidence of continued work toward goals outlined in treatment plan.
- No altered urine screens or non-compliance with drug testing.

Expectations of ORT providers are, but are not limited to:

- A Michigan's Automated Prescription Services (MAPS) report must be completed for individuals receiving either buprenorphine/naloxone or methadone prior to initial dosing. For clients receiving methadone, a MAPS report must also be completed prior to off-site dosing being approved. Off-site dosing is not allowed without documented coordination of care by the MAT provider's physician and the prescriber of identified controlled substances, which include, but may not be limited to: Opioid/Opiates, benzodiazepines, muscle relaxants. This coordination must be documented in the doctor's notes. Documentation must be individualized, identifying the client, the diagnosis, and the length of time the client is expected to be on the prescribed medication. It is recommended that MAPS be completed, at a minimum, during every 120-day physician review on all individuals that are receiving medication-assisted treatment with either methadone or buprenorphine/naloxone.
- MAT/ORT treatment providers must inform clients of daily attendance requirements, mandatory counseling requirements, toxicology testing requirements and other program participation requirements outlined in this protocol document both at admission and throughout the course of treatment.

PAIN MANAGEMENT:

It is the expectation that clients seeking Opioids/Opiates for chronic pain issues will be referred to a primary care physician. MSHN does not fund the use of methadone or buprenorphine/naloxone for pain management. A clear diagnosis of Opioid/Opiate dependence must be present prior to any MSHN funds being utilized for clients with chronic pain.

Individuals receiving methadone as treatment for an opioid addiction may need pain medication in conjunction with this adjunct therapy. The use of non-opioid analgesics and other non-medication therapy is recommended whenever possible. Opioid analgesics as prescribed for pain by the individual's primary care physician (or dentist, podiatrist) can be used; they are not a reason to initiate detoxification to a drug-free state, nor does their use make the individual ineligible for using methadone for the treatment of opioid addiction. The methadone used in treating opioid addiction does not replace the need for pain medication. It is recommended that individuals inform their prescribing practitioners that they are on methadone, as well as any other medications. On-going coordination (or documentation of efforts if prescribing practitioners do not respond) between the OTP physician and the prescribing practitioner is required for continued services at the OTP and for any off-site dosing including Sunday and holidays.

MEDICAL MARIJUANA:

The *Treatment and Recovery Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery* states; "Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana." Although there are no prescribers of medical marijuana in Michigan, individuals are authorized by a physician to use marijuana per Michigan law. For enrolled individuals, there must be a copy of the MDCH registration card for medical marijuana issued in the individual's name in the [client] chart or the "prescribed medication log". A copy of the client's ***registration card*** must be included in the client chart.

Outpatient Services

MSHN adheres to the requirements as described in OROSC's *Treatment Policy #09: Outpatient Treatment Continuum of Services.*

Outpatient SUD treatment services is an organized level of care which may be delivered in a wide variety of settings, in which addiction treatment staff provides professionally directed evaluation and treatment for substance-related disorders. In outpatient services, addiction, mental health treatment, or general health care personnel, including addiction-credentialed physicians, provide professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services. Such services are provided in regularly scheduled sessions of (usually) fewer than nine contact hours for adults and fewer than six hours for adolescents. The services follow a defined set of policies and procedures or clinical protocols, Individual, couple, group and family therapy are common modalities appropriate for substance use disorder outpatient care. Outpatient treatment is the level of care with the least amount of restriction, so it is important that clients are able to maintain a degree of safety outside of session.

Co-Occurring Disorders

Clients are said to have co-occurring disorders when he or she have one or more substantiated mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

As per The ASAM Criteria, 3rd Edition, Co-Occurring substance-related and mental disorders are appropriate at an Outpatient level **if one of the two criteria below is met.**

1. The client's disorders are of *moderate severity* and have responded to more intensive treatment services. The mental disorders have resolved to an extent that addiction treatment services are assessed as potentially beneficial. However, ongoing monitoring of the client's mental status is required.
2. The client's disorders are of *high severity* and are chronic, but have stabilized to such an extent that integrated mental health and addiction treatment services are assessed as potentially beneficial. Clients who have severe and chronic mental health disorders may not have been able to achieve sobriety or maintain abstinence for significant period of time (months) in the past; nevertheless, they are appropriately placed in outpatient services because they need engagement strategies and intensive case management.

Peer Recovery/Recovery Supports

MSHN adheres to the recommendations described in OROSC's *Treatment Technical Advisory #7: Peer Recovery/Recovery Supports.*

Persons in treatment for SUD experience better treatment outcomes and life experience improvements when their other problems, whether caused by the disorder or not, are addressed concurrently. Peer Recovery/Recovery Support services are intended to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary to enhance clients' recovery. These programs are designed and delivered primarily, but not exclusively, by individuals in recovery (peers) and offer social emotional and/or educational supportive services to help prevent relapse and promote recovery. MSHN encourages the use of both peer and non-peer facilitated recovery support services.

Recovery support services will be available to all qualifying clients entering SUD treatment services. This does not necessarily mean every provider in the network has to have a direct-operated peer recovery/recovery support services component. Any provider choosing to not have a direct-operated peer recovery/recovery support services component must have a formal referral agreement with a provider located in the client's county of residence that offers peer recovery/recovery support services. Such referrals must be documented in the client's written record.

Peer recovery/recovery support services do not include: therapy or other clinical services, ongoing transportation to regular appointments, participation in activities that might jeopardize the coach's own recovery.

MSHN highly discourages agencies/organizations from hiring or assigning staff to dual roles – either therapists as recovery coaches or recovery coach in a therapist role. This can be very confusing for both client and recovery coach and can diminish the role of peer recovery/recovery support services.

Individuals employed as recovery coaches are an integral part of the treatment recovery team that includes, but may not be limited to, Therapists and Counselors, Case Managers and Family and Friends. Cooperation and collaboration among treatment professionals are essential to ensure the success of recovery support services.

Persons employed to provide peer recovery/recovery support services must complete the Michigan Department of Community Health and MSHN-approved Connecticut Community for Addiction Recovery (CCAR) model training curriculum. Other training curricula may be available, but must be approved by MDCH as well as MSHN in order to be billable. This training should be completed prior to hire or as part of a new hire process (to be completed within an initial employment period). Appropriate continuing education in addiction and peer recovery/recovery supports is required. Peer recovery/recovery support staff should be considered part of the treatment team receiving all recommended agency training appropriate to the position (ethics, boundaries, confidentiality, etc.) to meet agency requirements.

Recovery Housing

Recovery housing is supportive, sober living settings for those in recovery from substance use disorders. Recovery housing is not a clinical treatment per se, but offers positive, safe and adjunctive living arrangements for the provision of outpatient or other evidence-based treatment services. MSHN may elect to fund recovery housing in certain communities based on need. While no SUD license is required for this type of housing, MSHN will establish standards based on the National Affiliation of Recovery Residencies (NARR) housing standards and conduct provider site reviews when this service is purchased.

Residential Services

MSHN adheres to the requirements of OROSC's *Treatment Policy #10: Residential Treatment Continuum of Services*.

Residential SUD treatment services offer a planned and structured regimen of care in a 24-hour residential setting. Treatment services adhere to defined policies, procedures, and clinical protocols. They are housed in, or affiliated with, permanent facilities where clients can reside safely. They are staffed 24-hours a day.

As stated in OROSC's Treatment Policy #10, "Historically, residential services have been defined by length-0f-stay, not by the needs of the client. This has resulted in essentially two descriptors for residential services: short-term residential: less than 30 days in a program, and long-term residential: 30 days or more in a program." Current CPT/HCPC coding continues this structure whereas The ASAM Criteria, 3rd Edition and OROSC's policy is based on a continuum ranging from least intensive residential to the most intensive medically monitored intensive inpatient services. The ASAM Criteria, 3rd Edition continues describing the "differences between Level 3 programs may be based partially on intensity (e.g., Level 3.1 requires a minimum of 5 hours of treatment per week compared to Level 3.5 which provides 24-hour services and supports). However, the defining differences between these levels of care are the functional limitations of the clients and the services provided to respond to those limitations. The goal is to provide a flexible system with overlapping levels of care making transition between levels of care as seamless as possible." OROSC's Treatment Policy #10: Residential Treatment Continuum of Care is based on this structure.

According to this policy, MSHN is expected to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM Levels 3.1, 3.3, and 3.5. The frequency and duration of residential treatment services are expected to be guided by The ASAM Criteria, 3rd Edition and described as follows:

ASAM Level 3.1: Clinically Managed Low-Intensity Residential Services: These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focusing on improving the individual's functioning and coping skills in Dimension 5 and 6. The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

ASAM Level 3.3: Clinically Managed Medium-Intensity Residential Services: These programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning. The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this level of care have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

ASAM Level 3.5: Clinically Managed High-Intensity Residential Services: These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in

focus; addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment and/or criminal justice histories, limited work and educational experiences, and antisocial value systems. The length of treatment depends on the individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual.

Women's Specialty Services

MSHN adheres to the requirements and recommendations made by OROSC in the following Treatment Policies and Treatment Technical Advisory:
Treatment Policy #11: Fetal Alcohol Spectrum Disorders; Treatment Policy #12: Women's Treatment Services; and, Technical Advisory #8: Enhanced Women's Services.

Women specialty services (WSS) are based on the provision of or the arrangement for the five federal requirements listed below:

1. Primary **medical** care for women who are receiving substance use disorder treatment.
2. Primary **pediatric** care for their children including immunizations.
3. **Gender specific** substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting.
4. **Child care** while the women are receiving these services, therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.
5. Sufficient **case management and transportation** services to ensure that women and children have access to the services provided in the first four requirements.

Additionally, WSS is to be gender competent which is defined as the "capacity to identify where difference on basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population."

Gender competence can be a characteristic of anything from individual knowledge and skills, to teaching, learning and practice environments, literature and policy. Wherever present, gender competence promotes equality in treatment and outcomes for men and women. Those treatment programs engaged in the practice of gender competence will be providing specialized programming. Focused not only on substance use disorder, but also, for example, on trauma, relationships, self esteem, and parenting. Staff serving this population should have training in women's issues relating to the previously mentioned programming areas, as well as HIV/STDs, family dynamics, and potentially child welfare.

PREVENTION PROVIDERS

Prevention providers must adhere to appropriate cultural competency, recipient rights, and confidentiality and privacy conditions in this manual, as well as any other policies of MSHN or the state applicable to their provision of prevention services. Prevention contract arrangements funded by MSHN are based on identified local community needs and will vary from one community to another, including short term projects, ongoing services,

and collaborations with key community partners. Each contract for prevention services will include specific detail regarding scope of work, reporting and/or outcomes, as well as financial status reports (FSR) or claims submission for MSHN reimbursement.

Prevention Services

MSHN will elect to contract for appropriate prevention services based on local community needs in keeping with the *MSHN 3 Year SUD Strategic Plan for Prevention, Treatment and Recovery, FY 2015 – 2017.*
Prevention Providers and Youth Development Programs are required to verify in writing the use of evidence-based services at the time of contract initiation and/or renewal.

MSHN requires that all contracted prevention Providers adhere to the following MDCH prevention guidelines (subject to revisions by MDCH):

- Prevention Activities must be focused on State and Regional priorities which include; 1) Reduction of Underage Drinking, 2) Reduction of Youth Tobacco Use, 3) Reduction of Prescription Drug and Over the Counter Medication misuse and abuse, and risk and protective factors associated with these problems. Whenever possible, providers should also address childhood obesity, infant mortality and immunization.
- At a minimum, ninety-five percent (95%) of all services must be researched based. Contracted prevention providers are to follow the guidelines outlined in the Guidance Document on Evidence-Based Programs developed by the State. The document can be found on the MDCH web-site at: http://michigan.gov/documents/mdch/Mich_Guidance_Evidence-Based_Prvn_SUD_376550_7.pdf
- Services should address both high-risk populations and the general community.
- No more than twenty-five (25%) of total direct services/units can be in the Federal Strategy of Information Dissemination and services under this category must tie into your agencies overall prevention plan. Contracted Providers must have a system in place to track total number of services/units delivered in each of the approved Federal Strategies.
- Services need to be based on identified, current community needs.
- Services are collaborative in nature representing coordination of resources and activities with other primary prevention providers – e.g. local health departments, community collabratives and the Department of Human Services' prevention programs for women, children and families and older adults.
- Services need to be supportive of community coalitions.
- Services must fall within one of the six federally defined strategies: information dissemination, education, problem identification and referral, alternatives, community based and environmental.
- Services must be provided in a culturally competent manner.
- All provider prevention literature must acknowledge funding source.

MSHN requires that all prevention services incorporate some method of evaluation. Contracted Providers must include all process evaluation data as outlined in Michigan Licensing rules. In addition, Providers need to incorporate the following processes:

- Completion of Satisfaction Surveys.
- Completion of Short-term Outcome Evaluation identifying knowledge, attitude and behavior changes. For all programming outside of information dissemination, Providers must be able to

demonstrate how they know the program was effective. (What were the goals of the program and were those goals obtained.)

- Development of a Performance Improvement plan, which incorporates evaluation outcomes, utilizing data to make program changes and identify how services impacted program goals and objectives.
- Providers need to be aware of and attempt whenever possible to collect data elements identified in the National Outcome Measures (i.e. Past 30 day use, perceived risk).

If a Provider charges a fee for any prevention activity funded in part or entirety by MSHN, the provider must adhere to the following guidelines:

- Provider must have a policy in place that is specific to charging for prevention services and the policy must identify how Provider will assure that services are not denied based on ability to pay. A copy of this policy is to be submitted to MSHN prior to the beginning of the contract period, and updated yearly.
- Any prevention services that require payment must have a brochure or flyer that clearly states that scholarships are available. Provider must present these brochures or flyers when advertising or promoting the activity.
- Provider must identify fees collected for prevention services as program income on their monthly FSRs.

<u>COORDINATION OF SERVICES</u>

All Providers must be able to identify, at their site visit, how they coordinate services with other community agencies and coalitions. Coordination of Services should at a minimum include:

- Department of Health and Human Services (formerly the 2 departments of Human Services and Community Health)
- Local Schools
- Law Enforcement
- School Resource Officers (where applicable)
- Teen Health Centers (where applicable)
- Community Coalitions
- Local Health Departments and or Qualified Health Centers (where applicable)

Whenever possible, Providers are encouraged to enter into referral agreements with community agencies. MSHN will offer or support technical assistance for this as requested.

<u>Designated Youth Tobacco Use Representation (DYTUR)</u>

This activity shall a) Maintain and update the tobacco retailer list and information for represented county; b) Responsible for Synar civilian compliance check inspections and reporting; c) Provide vendor education to at least 50% of county tobacco retailers with the Michigan Department of Community Health vendor education information and protocol; d) Maintain records of any tobacco compliance checks being completed within the represented county, including compliance check of activity outside of MSHN funding; and e) Completion of the Youth Access to Tobacco Activity Report annually. Appropriate technical assistance, trainings, and protocol will be provided by MSHN.

<u>DYTUR Meetings</u>

Providers receiving funding for DYTUR services will have the opportunity to attend all State level meetings pertaining to the youth tobacco act. If DYTUR staffs are not required by the State to attend, MSHN Prevention Coordinator(s) will attend and bring information back to DYTUR staff.

DYTUR Reporting

Providers receiving funding for DYTUR activities will submit the following reports to MSHN Prevention Coordinator(s) by the due dates provided in separate documentation:

- Youth Access to Tobacco Activity Report –Format will be provided.
- Non-SYNAR and Vendor Education reports should be sent by the due date provided by the MSHN Prevention Coordinator(s). If no non-Synar checks have been completed in that quarter, Providers must send an email to the MSHN Prevention Coordinator(s) informing that no checks were completed and the DYTURs plan for completing the non-Synar Checks.
- Formal SYNAR Compliance Check forms – Due the fifth (5^{th}) business day of month following SYNAR compliance check period.
- Corrected Vendor List –Please note, that ALL vendors on the list must be verified either by a phone call or personal visit. Verification must include; Vendor name, address (including county) and phone number. DYTUR staff must also add any new vendors they have knowledge about in their counties.

Early Intervention- Prevention

MSHN adheres to the recommendations described by OROSC in Treatment Technical Advisory #9: Early Intervention. As the Early Intervention under SUD treatment services is described elsewhere in this manual, this section will focus on prevention's role in Early Intervention services.

Prevention Early Intervention services typically exist within the community being served (e.g. schools, community centers, etc.). "Prevention" refers to this level of service under the federal strategy of Problem Identification and Referral (PIR), and defines it as "helping a person with an acute personal problem involving, or related to SUDs, to reduce the risk that the person might be required to enter the SUDs treatment system" (U.S. CFR, 1996).

PIR aims to identify those who have indulged in the illegal use of drugs in order to assess if their behavior can be reversed through education. PIR does not include any activity designed to determine if an individual is in need of treatment. Examples of methods used by Prevention Staff include driving while intoxicated education programs, employee assistance programs, and student assistance programs. (FY 2012-14 Action Plan Guidance)

PIR service activities are not required to occur in the context of an existing licensed SUD treatment program, however Providers of Prevention Early Intervention services must have appropriate Prevention licensure (CAIT).

PIR services must be delivered by individuals in provider organizations who have been credentialed as a Certified Prevention Specialist (CPS) or Certified Prevention Consultant (CPC) with appropriate documentation from the Michigan Certification Board for Addiction Professionals (MCBAP). Supervision of an identifiable PIR services program must be by an individual credentialed as a MCBAP prevention credentialed staff or an approved alternative certification.

SELECTED REFERENCES

Carroll, K. (Ed.). (2000). *Approaches to Drug Abuse Counseling*. National Institute on Drug Abuse. Rockville, MD. [On-line]. Available: http://archives.drugabuse.gov/pdf/ADAC/ApproachestoDACounseling.pdf.

Center for Substance Abuse Treatment. (2004). *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol (TIP) Series 40.* Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf.

Center for Substance Abuse Treatment. (2005). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43.* Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: http://adaiclearinghouse.org/downloads/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs-51.pdf.

Center for Substance Abuse Treatment. (2005). *Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42.* Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: http://www.breining.edu/TIP42CoOccDis.pdf.

Center for Substance Abuse Treatment. (2009). *Clinical Supervision and Professional Development of the Substance Abuse Counselor*. *Treatment Improvement Protocol (TIP) Series 52.* Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: http://www.readytotest.com/PDFs/TIP52.pdf.

Center for Substance Abuse Treatment. (2009). *Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series 51.* Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: http://adaiclearinghouse.org/downloads/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women-42.pdf.

Mee-Lee, D. (Ed.). (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* American Society of Addiction Medicine. Chevy Chase, MD.

Morris, J, Day, S., Schoenwald, S. (2010) *Turning Knowledge Into Practice: A Manual For Behavioral Health Administrators & Practitioners About Understanding & Implementing Evidence-Based Practices, 2nd Edition.* The Technical Assistance Collaborative, Inc. Boston MA. [On-line]. Available: http://www.tacinc.org/media/13067/Turning%20Knowledge%20into%20Practice.pdf.

Munetz, M., Griffin, P. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services 57:* 544-549. [On-line]. Available: http://publicdefender.mt.gov/training/Session3.pdf.

Rollnick, S., Miller, W. R. (2013). *Motivational Interviewing: Helping People Change. Third Edition.* The Guilford Press. New York, NY.

The Iowa Practice Improvement Collaborative Project. (2003). *Evidence-Based Practices: An Implementation Guide for Community-Based Substance Abuse Treatment Agencies.* The Iowa Consortium for Substance Abuse Research and Evaluation. Iowa City, IA. [On-line]. Available: http://iconsortium.subst-abuse.uiowa.edu/EBP%20Guide.pdf.

Substance Abuse and Mental Health Services Administration. (2009). *Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) KIT.* Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Rockville, MD. [On-line].

Available: http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367.

Institute for Social Research. (2011). *Jail Based Substance Abuse Treatment Literature Review.* Institute for Social Research, University of New Mexico. Albuquerque, NM. [On-line]. Available: http://isr.unm.edu/reports/2011/jail-based-substance-abuse-treatment-literature-review..pdf.

Mann, C., Frieden, T., Hyde, P., Volkow, N., Koob, G. (2014). *Medication Assisted Treatment for Substance Use Disorders*. Informational Bulletin. [On-line]. Available: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-11-2014.pdf.

Substance Abuse and Mental Health Services Administration. (2011). *Dual Diagnosis Capability in Mental Health Treatment Toolkit Version 4.0*. Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: http://ahsr.dartmouth.edu/docs/DDCMHT_Toolkit.pdf.

Substance Abuse and Mental Health Services Administration. (2012). *General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occuring Mental and Substance Use Disorders.* Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: http://www.ncdsv.org/images/SAMHSA_GeneralPrinciplesUsePharmacologicalAgentsTreatIndividualsCo-OccuringMentalSubstanceUseDisorders_2012.pdf.

Substance Abuse and Mental Health Services Administration. (2013).*Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment*. *Technical Assistance Publication (TAP) Series 33.* Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: http://store.samhsa.gov/shin/content//SMA13-4741/TAP33.pdf.

Substance Abuse and Mental Health Services Administration. (2014). *Improving Cultural Competence. Treatment Improvement Protocol (TIP) Series No. 59.* Substance Abuse and Mental Health Services Administration. Rockville, MD. [On-line]. Available: http://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf.

Tsemberis, S., Gulcur, L., Nakae, M. (2004). Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis. *American Journal of Public Health 4:* 651-656. [On-line]. Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf.