TUFTS Health Plan

a Point32Health company

Family Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1) Performance Specifications

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

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

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

- ☐ Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plan)
- ☐ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health One Care (a dual-eligible product)

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

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

DEFINITION

Family Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1) consists of a structured and comprehensive rehabilitative environment for families, including children up to the age of 18 that supports family recovery from trauma and the effects of Substance Use Disorder and encourages movement towards an independent lifestyle. Scheduled, goal-oriented clinical services are provided in a family focused treatment and recovery model, with the parent's(s) recovery from SUD central to the recovery of the family.

COMPONENTS OF SERVICE

The specific primary service elements for adults and children include the following elements:

1. A trauma-informed health and family needs assessment;
2. Family life advocacy services/integrated family treatment plan;
3. Individual and group substance use disorder counseling services, based on treatment plans;
4. Integrated and/or coordinated substance use disorder, mental health, domestic violence, and trauma services with appropriate releases of information and compliance with HIPAA and 42 CFR, Part 2 including individual, family, and group counseling sessions provided weekly;
5. Fetal Alcohol Spectrum Disorder (FASD) screening with an ability to provide individualized services for those with an FASD;
6. Individualized, family-focused discharge and aftercare planning;
7. Ability to provide appropriate medication management;
8. Parenting skills and supports that focus on building the parent-child relationship;
9. Ability to provide trauma-informed services to children and parents;
10. Housing/job search activities;

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1. Commercial products include HMO, POS, PPO, and CareLink℠ when Tufts Health Plan is the primary administrator.
2. Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

11. Self-help integrated into services;
12. Assistance in applying for public assistance and benefits;
13. On-site developmental services/activities for children not accessing child-care in the community; and
14. Afterschool programming for school age children and adolescents.

STAFFING REQUIREMENTS

1. One full-time Program Director who is responsible for all administrative and management functions of the program, including budget and personnel
2. One full-time Clinical Director/Senior Clinician, responsible for the supervision of all clinical staff, the clinical programming and counseling, staff development, implementation of best practices, and supervision of all clinical record keeping and reporting
3. One full-time Family Specialist (master's-level Senior Clinician) who will provide clinical family services through individual, group, and family therapy under the supervision of the Clinical Director
4. 8.5 full-time equivalent Recovery Specialists who will have caseloads and provide individual, group, and case management services under the supervision of the Clinical Director, as required under the LADC guidelines for II- and III- level clinicians. The recovery specialists are responsible for developing interagency linkages for the adults' and children's services, ensuring that all clients are getting linked to these services and that outside resources are being maximized.
5. One full-time Child Service Coordinator who is responsible for the children's portion of the family service plans, to oversee both in-house and out-of-the-house children's activities; to ensure that children are involved in developmentally appropriate activities while parent(s) are in sessions; to oversee the parenting skills classes for both the parents and children; to ensure that the educational needs of the children are being met; and to supervise the child-care assistant
6. One full-time Child Service Assistant who will assist in developing the children's part of the service plan, overseeing the children's activities, parenting classes, and educational needs of the children
7. Sufficient staff to ensure that a minimum of two Direct Care/Recovery Specialists are on at all times
8. Program staff will be knowledgeable of requirements and procedures for reporting suspected cases of abuse and neglect in accordance with M.G.L. Chapter 119, Section 51A.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES

1. Providers must maintain formal linkages to the following:
    - On- or off-site mental health services, necessary health and social services, (outpatient primary/pediatric care, Head Start, WIC, after school programs, early intervention, domestic violence programs, etc.), and opioid treatment services
    - HIV testing and counseling sites
    - The Department of Early Education and Care's childcare services through child care resource and referral agencies
    - Communication networks will be developed between parents, program staff, case managers, and other professionals involved with the family.
    - Programs will establish a referral process to ensure that referrals for children's medical and/or mental health services are scheduled when necessary and appropriate follow-up activities are conducted, in accordance with immunization and well child requirements.
    - Clients will be linked to housing resources through DHCD, BSAS, and community resources.
    - Other state agencies as indicated (may include DMH, DCF, DDS, MRC)
    - CBHI providers
    - Clients will be linked to resources regarding job readiness, skill building, and search services, as well as educational and training services as needed.
    - An updated list of community resources, such as legal aid, educational resources, child care, vocational/employment programs and other supportive services will be maintained.

QUALITY MANAGEMENT (QM)

The provider complies with all requirements set forth by payer.

PROCESS SPECIFICATIONS

Assessment, Treatment/ Recovery Planning and Documentation

1. The provider conducts a trauma-informed health and family needs assessment.
2. Ensure that Behavioral Health Clinical Assessments conducted by Behavioral Health Providers are in writing, dated and signed, and include, at a minimum, the following:
    - Clinical formulation, rationale for admission or continuance of care, discussion of any possible diversionary or lower levels of care, recommendations, and strengths.
3. In addition to an individualized SUD treatment plan for the caretaking parent, the provider creates a family like advocacy services/integrated family treatment/service plan that includes plans for both parent and child.
4. The provider ensures there are integrated service plans with other state agencies that are providing services to client (i.e., DTA, DCF, court system, etc.), with appropriate releases of information and compliance with HIPAA and 42 CFR, Part 2.

Discharge Planning and Documentation

The provider will develop an Individualized Discharge and Aftercare Plan, beginning at admission as part of the treatment planning process, to facilitate the family's transition to the community and support the member's recovery and will include treatment and case management after discharge, housing, childcare, transition to work, engagement in treatment activities, custody status, health and other necessary social services.

DOCUMENT HISTORY

- January 2024: Tufts Health One Care (a dual-eligible product) name change.
- June 2020: Template Updates