

Inpatient Substance Use Disorder Services (Level 4 Detoxification Services)

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

Inpatient Substance Use Disorder Services (Level 4 Detoxification Services) provide a planned substance use disorder treatment program offering 24-hour, medically managed evaluation and treatment for individuals who are experiencing severe withdrawal symptoms and/or acute biomedical complications as a result of a substance use disorder. Level 4 services are rendered in a hospital that can provide life support in addition to 24-hour physician and nursing care. Daily individual physician contact is a required component of this level of care. A multidisciplinary staff of clinicians trained in the treatment of addictions and mental health conditions, as well as overall management of medical care, are involved in the Member's treatment. The program staff facilitates the conjoint treatment of co-existing biomedical and behavioral health conditions.

Components of Service

1. The program is located in a designated addictions treatment unit in a licensed, acute care medical setting that offers intensive biomedical services.
2. The provider provides at least four hours of service programming per day, seven days per week, including weekends and holidays, with sufficient professional staff to conduct these services and to manage a therapeutic milieu.
3. The scope of required service components provided in this level of care includes, but is not limited to, the following:
 - a. Bio-psychosocial evaluation
 - b. Psychiatric evaluation
 - c. Medical history and physical evaluation
 - d. Nursing assessment and 24-hour nursing care/services
 - e. 24-hour physician care
 - f. Daily medical management
 - g. Detoxification
 - h. Development and/or updating of crisis prevention plans and/or relapse prevention plans, as applicable
 - i. Individual, family, and/or group therapy, as indicated
 - j. Psycho-educational groups
 - k. Pharmacology
 - l. Case and family consultation
 - m. Discharge planning/case management
 - n. Aftercare planning and coordination
 - o. Substance use disorder assessment and treatment services

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4. Substance-specific detoxification protocols are individualized, documented, and available onsite. At minimum, these include detoxification protocols for alcohol, stimulants, opioids, and sedative hypnotics (including benzodiazepines).
5. The provider admits and has the capacity to treat Members who are currently receiving methadone or other opioid replacement treatments. Such capacity may take the form of active, documented Affiliation Agreements with providers licensed to provide such treatments.
6. For adults who give consent, the provider makes documented attempts to contact family members, guardian, caregivers, and/or significant others within 48 hours of admission, unless clinically or legally contraindicated. The provider provides them with all relevant information related to maintaining contact with the program and the Member, including names and phone numbers of key nursing staff, primary treatment staff, social worker/care coordinator/discharge planner, etc. If contact is not made, the Member's health record documents the rationale.
7. The provider is responsible for supplying each Member with medications prescribed for physical and behavioral health conditions, and documents so in the Member's health record.
8. Prior to supplying medications to the Member, the provider engages in a medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of a Member from one care setting to another. The provider does this by reviewing the Member's complete medication regimen at the time of admission (e.g., transfer and/or discharge from another setting or prescriber), and comparing it with the regimen being considered in the inpatient substance use disorder services program. The provider engages in the process of comparing the Member's medication orders newly issued by the inpatient substance use disorder services program to all of the medications that he/she has been taking in order to avoid medication errors. This involves:
 - a. Developing a list of current medications, i.e., those the Member was prescribed prior to admission to the inpatient substance use disorder services program;
 - b. Developing a list of medications to be prescribed in the inpatient substance use disorder services program;
 - c. Comparing the medications on the two lists;
 - d. Making clinical decisions based on the comparison and, when indicated, in coordination with the Member's primary care provider (PCP) and/or Primary Care Team (PCT); and
 - e. Communicating the new list to the Member and, with consent, to appropriate caregivers, the Member's PCP, and other treatment providers.All related activities are documented in the Member's health record.
9. The provider ensures that management, storage, and administration of medication comply with requirements established by accreditation standards and by the United States Drug Enforcement Agency and Food and Drug Administration.
10. All urgent consultation services, laboratory tests, and radiological exams resulting from the psychiatric/medical evaluation and physical examination, or as subsequently identified during the admission, are provided within 24 hours of the order for these services. All non-urgent consultation services related to the assessment and treatment of the Member while on

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the inpatient substance use disorder treatment unit are provided in a timely manner, commensurate with the level of need. Routine medical care (not required for the diagnosis related to the presenting problem) may be deferred, when appropriate, if the length of stay on the inpatient unit is brief. All of these services are documented in the Member's health record.

11. The milieu does not physically segregate individuals with co-occurring disorders.
12. The provider provides the Member and guardian/caregiver specific information on the inpatient substance use disorder treatment unit at the time of admission. The information includes but is not limited to Member rights and responsibilities, services available, treatment schedule, grievance procedures, termination criteria, and information about peer and recovery-oriented services.
13. The program is responsible for updating its available capacity, three times per day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The program is also responsible for keeping all administrative and contact information up to date on the website. The program is also responsible for training staff on the use of the website to locate other services for Members, particularly in planning aftercare services.

Staffing Requirements

1. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Senior Whole Health service-specific performance specifications, and the credentialing criteria outlined in the Senior Whole Health's Provider Manual, as referenced at www.SWHMA.com.
2. The provider is staffed with sufficient appropriate personnel to accept admissions 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year.
3. The provider utilizes primary medical and nursing staff to provide acute biomedical services in a defined addictions unit.
4. These staff are part of a multi-disciplinary staff, also including master's-level clinicians and milieu/counseling/clinical assistant/nursing aide staff. All staff have established skills, training, experience and/or expertise in the integrated treatment of individuals with substance use disorders, biomedical, and related mental health conditions.
5. The provider establishes a staffing pattern necessary for this level of care, as outlined in the DPH regulations, which includes the following positions:
 - a. A senior clinician responsible for the clinical/educational operation of the substance use disorder service;
 - b. Licensed psychiatrist or licensed psychologist;
 - c. Registered nurse, nurse practitioner, or physician assistant;
 - d. Licensed practical nurse, case aides, and case management staff;

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- e. Food personnel trained in safe and sanitary handling and preparation; and
 - f. Sufficient staff to ensure coverage of all shifts.
6. The provider assigns each Member a primary attending physician, registered nurse, and counselor/clinician upon admission.
 7. The provider designates a physician licensed to practice medicine in the commonwealth of Massachusetts as medical director. The medical director has completed a minimum of six months' clinical experience with alcohol and other drug-dependent persons, or 40 hours of documented continuing education credits in the treatment of addictions, within the first twelve months of employment.
 8. The medical director or designated physician, who meets Senior Whole Health's credentialing criteria, provides on-site psychopharmacological services, including methadone or other opioid replacement therapies.
 9. The medical director's role minimally includes the following:
 - a. ensuring each Member receives a medical evaluation, including a medical history;
 - b. ensuring that appropriate laboratory studies have been performed;
 - c. signing all medical orders;
 - d. attendance at weekly multi-disciplinary team meetings;
 - e. peer review and/or oversight and monitoring of clinical care;
 - f. involvement in therapeutic program development; and
 - g. work with the clinical leadership team in monitoring the quality of care and outcomes within the program.
 10. A physician (MD) is on call 24 hours per day, 7 days per week, 365 days per year to respond to medical emergencies, is available for a phone consultation to staff within 15 minutes of request, and is available for a face-to-face consultation within 60 minutes of request. During weekday business hours, the physician meets Senior Whole Health's credentialing criteria. After 5 p.m. weekdays, and on weekends and holidays, the on-site physician available for emergency coverage may be a psychiatrically or non-psychiatrically trained physician capable of responding to, assessing, and treating medical emergencies within 15 minutes of being notified. If this staffing requirement is provided at any time by a non-psychiatrically trained physician, psychiatric consultation is provided by a psychiatrist on call who responds by telephone to a call within 15 minutes and, when needed, who has the capacity to come to the facility in person within 60 minutes of being notified.
 11. A physician is on call 24 hours a day, 7 days a week, and is available for a phone consultation within 15 minutes of request. A physician is available 24 hours a day, 7 days a week for a face-to-face consultation within 60 minutes of request.
 12. The provider has adequate psychiatric coverage to ensure all performance specifications related to psychiatry are met.
 13. Members have access to supportive milieu and clinical staff 24 hours per day, 7 days per week.
 14. The provider documents, over the course of a year, monthly scheduled in-service training sessions on the following topics, at a minimum, as required by the DPH regulations:
 - a. The provider's All Hazards Emergency Response Plan;

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- b. HIV/AIDS, sexually transmitted infections (STIs) and viral hepatitis;
 - c. Universal health precautions and infection control;
 - d. Substance use disorders including tobacco and nicotine addiction, clinical assessment and diagnosis, treatment planning, relapse prevention and aftercare planning;
 - e. Co-occurring disorders, including mental health disorders, gambling, and other addictive behaviors;
 - f. Effects of substance use disorders on the family and related topics such as the role of the family in treatment and recovery; and
 - g. Cultural competency including culturally and linguistically appropriate services (CLAS) or standards.
15. The provider ensures that clinical and direct care staff receive supervision in accordance with DPH regulation 105 CMR 164.000. Supervision of all clinical work is provided by a master's- or doctoral-level licensed clinician with demonstrated expertise in the integrated treatment of Members who are medically compromised and/or with a co-occurring disorder. The provider ensures that supervision of nursing staff is overseen by a registered nurse.

Process Specifications

Assessment, Treatment/Recovery Planning, and Documentation

1. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year.
2. Upon receipt of a referral call from an Adult Mobile Crisis Intervention provider or after the Emergency Departments behavioral health crisis evaluation 24/7/365, the provider confirms bed availability and agrees, as soon as possible and no later than within 30 minutes of the request for admission, to admit the Member.
3. Immediately upon admission, a brief physical assessment of each Member is conducted and documented in the Member's health record.
4. Within three hours of admission, a registered nurse or designee completes a comprehensive nursing assessment with each Member to assess his/her medical needs. If the designee is a licensed practical nurse (LPN), he/she must be supervised by a registered nurse or physician. The assessment includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score and/or Clinical Opiate Withdrawal Scale (COWS). The results are documented in the Member's health record.
5. Within 24 hours of admission, a thorough physical examination is conducted by a physician and documented for each Member, and includes the following:
 - a. An assessment of the Member's substance use disorder;
 - b. Tests for the presence of opiates, alcohol, benzodiazepines, cocaine, and other drugs of abuse;
 - c. A brief mental status exam; and
 - d. An assessment of infectious diseases, including TB, viral hepatitis and STIs; pulmonary, liver, and cardiac abnormalities; dermatological and neurological sequelae of addiction; and possible concurrent surgical problems. When indicated, laboratory tests for these

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- conditions are ordered.
6. Additionally, an initial clinical assessment of each Member is conducted by a senior clinician, clinician (and approved in writing by a senior clinician), physician, nurse practitioner, or physician assistant within 24 hours of admission, is documented in the Member's health record, and includes the following:
 - a. A history of the use of alcohol, tobacco, and other drugs, including age of onset, duration, patterns, and consequences of use: use of alcohol, tobacco, and other drugs by family members; and types of and responses to previous treatment;
 - b. An assessment of the Member's psychological, social, health, economic, educational/vocational status: criminal history; current legal problems; co-occurring disorders; trauma history; and history of compulsive behaviors such as gambling;
 - c. An assessment of the Member's HIV risk status and TB risk status;
 - d. A diagnosis of the status and nature of the Member's substance use disorder, or a mental or behavioral disorder due to use of psychoactive substances; and
 - e. If a need for further evaluation is identified, the provider conducts or makes referral arrangements for necessary testing, physical examination, and/or consultation. All such activities are documented in the Member's health record.
 7. A physician sees the Member daily. The physician consults to the treatment team and, prior to any medication changes, consults with the outpatient prescriber and agrees upon any medication changes in consultation with him/her. All such activities are documented in the Member's health record.
 8. The provider assigns a multi-disciplinary treatment team to each Member within 24 hours of admission. A multi-disciplinary treatment team meets to review the assessment, the initial treatment/recovery plan and the initial discharge plans within 24 hours of admission. On weekends and holidays, the treatment/recovery plan may be developed by an abbreviated treatment team, with a review by the full treatment team on the next business day.
 9. The treatment/recovery plan, developed in conjunction with the Member, current community-based providers including PCPs and/or PCT and behavioral health providers, family, caregiver, guardian, and/or individual natural supports, includes, at a minimum, the following:
 - a. A statement of the Member's strengths, needs, abilities, and preferences in relation to his/her substance use disorder treatment, described in behavioral terms;
 - b. Evidence of the Member's involvement in formulation of the treatment/recovery plan, in the form of the Member's signature attesting agreement to the plan;
 - c. Service to be provided;
 - d. Service goals, described in behavioral terms, with timelines;
 - e. Clearly defined staff and Member responsibilities and assignments for implementing the plan;
 - f. Description of discharge plans and aftercare service needs;
 - g. Aftercare goals;
 - h. The date the plan was developed and revised;
 - i. Signatures of staff involved in the formulation or review of the plan; and

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- j. Documentation of disability, if any, which requires a modification of policies, practices, or procedures and record of any modifications made.
- 10. The provider ensures that the treatment/recovery plan and discharge plans are reviewed at least every 48 hours (a maximum of 72 hours between reviews on weekends), and are updated accordingly, based on each Member's individualized progress.
- 11. Assessments, the initial treatment/recovery plan and discharge plan, and all treatment meetings are documented in the Member's health record.
- 12. With Member consent and the establishment of the clinical need for such communication, coordination with guardians/caregivers and other treatment providers, including PCPs and/or PCT, and behavioral health providers, is conducted by appropriate staff relative to treatment and care coordination issues. All such contact is documented in the Member's health record.
- 13. The provider makes arrangements to obtain appropriate drug screening/testing, urine analysis, and laboratory work as clinically indicated, and documents such in the Member's health record.

Discharge Planning and Documentation

- 1. When the Member's biomedical condition has stabilized to the extent that daily medical and nursing management for the biomedical condition is no longer necessary, the provider arranges for the Member to move to the next appropriate level of care.
- 2. The provider conducts discharges 7 days per week, 365 days per year.
- 3. The provider ensures that active and differential discharge planning is implemented for each Member by qualified staff who are knowledgeable about the medical necessity criteria for all Senior Whole Health covered services.
- 4. At the time of discharge, and as clinically indicated, the provider ensures that the Member has a current crisis prevention plan, and/or safety plan, and/or relapse prevention plan in place and that he/she has a copy of it. The provider works with the Member to update the plan that they obtained from the Adult Mobile Crisis Intervention provider and/or the referring Emergency Department at the time of admission, or, if one was not available, develops one with the Member prior to discharge. With Member consent and as clinically indicated, the provider may contact the Member's local Adult Mobile Crisis Intervention provider and/or Emergency Department to request assistance with developing or updating the plan. The provider sends a copy of the plan to the Adult Mobile Crisis Interventions Program Director at the Member's local Adult Mobile Crisis Intervention provider and/or Emergency Department's behavioral health crisis team with Member consent.
- 5. Prior to discharge, the provider assists Members in obtaining post-discharge appointments, as follows: within 7 calendar days of discharge for outpatient therapy services (which may be an intake appointment for therapy services), if necessary; and within 14 calendar days of discharge for medication monitoring, if necessary. This function may not be designated to aftercare providers or to the Member to be completed before or after the Member's discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Member's health record. If there are barriers to

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- accessing covered services, the provider notifies Senior Whole Health's as soon as possible to obtain assistance. All such activities are documented in the Member's health record.
6. The provider provides, with Member consent, a written discharge summary (or other such document(s) that contain the required elements) to the Member, family/caregivers/guardians, PCPs and/or PCT, and current behavioral health providers, no later than within two weeks of the Member's discharge. The discharge summary is documented in the Member's health record and includes a summary of:
 - a. The course of treatment;
 - b. The Member's progress;
 - c. The treatment interventions and behavior management techniques that were effective in supporting the Member's progress;
 - d. Medications prescribed;
 - e. Recommended behavior management techniques when applicable; and
 - f. Treatment recommendations, including those that are consistent with the service plan of the relevant state agency for Members who are also involved with the Department of Mental Health (DMH) or Department of Developmental Services (DDS).
 7. The provider arranges for aftercare services which include the following:
 - a. Referrals to ensure a continuum of care for the Member, including arrangements for further substance use disorder treatment and post-discharge counseling and other supportive services;
 - b. Information concerning available community-based service agencies and programs which includes a description of services, addresses, phone numbers and the names of contact persons;
 - c. Referrals, the aftercare plan and information provided to the Member are documented in the Member's health record; and
 - d. Member refusal of aftercare services is documented in the Member's health record.
 8. For Members who leave Against Medical Advice (AMA), the provider will notify the Member's emergency contact, if appropriate.

Service and Community Linkages

1. The provider develops linkages and working relationships with other service providers frequently utilized by Members admitted to the program including the following:
 - a. Inpatient mental health facilities
 - b. Acute Treatment Services (ATS) for Substance Use Disorders Level 3.7
 - c. Clinical Stabilization Services (CSS) for Substance Use Disorders Level 3.5
 - d. Structured Outpatient Addiction Programs (SOAP)
 - e. Transitional Support Services (TSS) for Substance Use Disorders
 - f. Regional court clinics
 - g. Residential support services (halfway house)
 - h. Residential Rehabilitation Services (RRS) for substance use disorders Level 3.1
 - i. Opioid Replacement Therapy
 - j. Transitional supportive housing

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- k. Sober housing
- l. Shelter programs
- m. Other dual diagnosis programs
2. When necessary, the provider provides or arranges transportation for services required external to the hospital during the admission and, upon discharge, for placement into a step-down 24-hour level of care, if applicable. The provider also makes reasonable efforts to assist Members upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.
3. With Member consent, for Members who are DMH consumers, the provider notifies the DMH case manager, and/or DMH Adult Community Clinical Services (ACCS) program and/or DMH area office by noon of the following business day post-admission, or within one business day of identifying the Member's involvement with this state agency and/or its service providers.
4. With Member consent, the provider collaborates with the Member's PCP and/or PCT.
5. The provider develops an active working relationship with each of the local Adult Mobile Crisis Intervention provider who are high-volume referral sources for the hospital. On a Member-specific basis, the provider collaborates with any involved Adult Mobile Crisis Intervention providers upon a Member's admission to ensure the Adult Mobile Crisis Intervention providers and/or Emergency Departments behavioral health crisis teams evaluation and treatment recommendations are received, and that any existing crisis prevention plan, and/or safety plan, and/or relapse prevention plan is obtained from the Adult Mobile Crisis Intervention provider and/or the Emergency Departments behavioral health crisis team.