



## *Performance Standards*

# **DRUG AND ALCOHOL MEDICALLY MONITORED SHORT-TERM RESIDENTIAL REHABILITATION PROGRAM**

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

**Disclaimer:** These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

# PERFORMANCE STANDARDS

## DRUG AND ALCOHOL MEDICALLY MONITORED SHORT-TERM RESIDENTIAL REHABILITATION PROGRAM

*Final*

*Updated: 02/01/05*

Community Care is committed to developing performance standards for specific levels of care in an effort to clearly identify and communicate performance expectations and promote consistency across like programs. The principal goal of this document is to identify basic performance expectations for this level of care. Community Care staff developed these standards with non-hospital rehabilitation providers and County staff. These standards are intended to clarify reasonable standards of practice for the provision of medically monitored (non-hospital) short-term residential rehabilitation programs. These standards are to serve as a tool to promote quality improvement. These standards are not to be interpreted as regulations, but instead are to add to the foundation provided by current licensing guidelines and regulations. It is Community Care's expectation that providers apply these performance standards when developing internal quality monitoring activities. Community Care will use this document as a guideline when conducting on-site quality reviews at provider sites.

### *GENERAL PROGRAM DESCRIPTION:*

Medically monitored short-term residential rehabilitation services are provided in a residential facility that is licensed by PA DOH as an inpatient non-hospital rehab provider designed to serve individuals with substance use disorders with moderate levels of impairment of social, occupational, or school functioning by providing 24-hour professionally directed evaluation, care, and treatment. Such residential programs are necessary when the provision of a safe and stable living environment is required for adequate recovery. The primary goal of services is rehabilitation from addiction.

#### **Goals of a Medically Monitored Short-term Residential Rehabilitation Program**

The primary goals of short-term rehabilitation are:

- Acceptance of the substance use disorder and completion of an ongoing recovery plan.
- Acquiring information about addiction, treatment, recovery and relapse prevention
- Identification of personal high risk relapse factors and a plan for managing this after treatment
- Acceptance of the need for ongoing involvement in treatment and support programs to aid recovery (AA, NA,)

- Identification of causes of poor treatment adherence in the past and strategies to cope with decreases in motivation for sobriety (if the consumer has had previous treatment).
- Facilitating participation in mutual support groups
- For MISA consumers, understanding of the relationships between addiction and mental illness and stabilization of mental health and drug and alcohol symptoms and plan for ongoing mental health services.

The consumer will initiate acquisition of skills necessary to manage recovery and/or concurrent medical/psych conditions without 24 hour monitoring, or be able to step down to a lesser level of care such as a halfway house.

### **Core Service Components**

Medically monitored short-term residential rehabilitation programs are expected to include the following core service elements to be delivered in a consumer-focused manner:

- 24 –hour observation, monitoring, and treatment to support the consumer’s recovery. Consumer to staff ratio is defined by Department of Health Drug and Alcohol licensing.
  - Availability of emergency medical services/referral to detoxification, if clinically needed as determined by the staff and consumer.
  - Specialized professional/medical consultation, and referral for tests such HIV testing, TB testing, and other laboratory tests per program clinical protocols within 7-14 days of admission, as needed.
  - Physical examination.
  - Physician evaluation within 24 hours, and no later than 72 hours under certain conditions, of admission. When a consumer is transferring to a medically monitored short-term rehabilitation program from another controlled environment where the consumer received a physical within the past twelve full months, physical may not be indicated. However, the program physician must review the previous physical information to make that determination.
  - A thorough biopsychosocial and cognitive functional assessment including a MISA screening is completed with the consumer, within three days of admission. The consumer is to be fully engaged in the assessment process. The assessment process is to be conducted in a strength-based manner.

- Program staff work collaboratively with the consumer to develop an individualized tailored treatment plan based upon the physical and biopsychosocial assessment, which clearly identifies the consumer's goals with specific treatment objectives for this episode of care. The treatment plan incorporates the consumer's strengths in the treatment process. Weekly reviews of the treatment plan with the consumer and other members of the treatment team will be conducted on a routine basis, consistent with the policies and program design of each program.
- Structured therapies including individual, group, marital and family, as appropriate to the individuals being served, are available in all programs. What therapy a consumer receives is completely dependent upon individual needs and his or her individualized treatment plan.
- Access or referral to occupational and vocational counseling. The residential rehab program is responsible to support the consumer to establish appropriate service linkages.
- Work closely with the consumer to monitor medications, if prescribed medications. When a consumer enters a residential rehab program on prescribed medications, the program staff talks to the consumer about the importance of collaboration and coordination with the prescribing physician, and seeks permission to coordinate care.
- Offer referral to D&A Case Management when appropriate/available, or other support services to the consumer. The services should be explained in detail in order for the consumer to make informed decisions about his or her care.
- Collaboration between treatment team participants and agencies involved in the provision of services to each consumer. The consumer must give consent before collaboration with outside agencies can occur.
- In partnership with the consumer, the development of an aftercare plan for referral into the continuum of care with identification of support services to facilitate a successful transition.
- Access to 12-step programming whether on-site or out in the community

## **Retention and Engagement**

Beginning with the first contact, providers work diligently with consumers to promote active and continued engagement in the program. A primary goal of the intake and assessment process is engaging the consumer in treatment. Providers seek appropriate consents to release information from consumers as early as clinically indicated, to utilize the consumers existing supports and to coordinate care. Providers fully inform

consumers entering medically monitored short-term residential rehabilitation programs of the intensive nature of this level of care and the level of commitment required to fully benefit from this 24 hour per day, 7 day per week program. Providers address, on a daily basis, any consumer reluctance to fully participate in the program. Providers use motivational interviewing techniques, whenever clinically possible, to support consumers in the change process and to increase engagement in treatment. When a consumer fails to fully participate in all of the program activities, the issue is discussed with the consumer in individual sessions. If a consumer is unable to participate to the extent necessary to benefit, the provider is expected to reassess the appropriate level of care for the consumer and assist with the transition to another level of care if appropriate. Providers document all efforts to promote full engagement of the consumer in the treatment program in the consumer's client record.

Consumers may identify barriers to full participation in treatment. Providers are expected to assist consumers in addressing such barriers to the extent possible. When consumers are involved in other systems, programs are expected to collaborate and coordinate with all involved systems to eliminate barriers to engagement in treatment and to ensure coordination of care.

In the event that a consumer leaves a program against medical or program advice, provided a proper consent to release information was obtained, the provider is expected to make an immediate referral for Drug and Alcohol Case Management services (when available) and another appropriate level of care. In addition, providers are to follow-up with the consumer within the first week of leaving the program to attempt to re-engage the consumer or assist the consumer in linking to other services, or a reassessment to determine the most appropriate level of care. For those consumers returning to a program after leaving against medical advice, the provider is to talk to the consumer about the reasons for the decision to leave and from a program perspective, what would help the consumer to stay.

### **Average Length of Stay**

All cases, length of stay needs to be individually determined, based upon a consumer's responsiveness to treatment and progress toward goals.

### **Staffing Standards**

All medically monitored short-term residential rehabilitation programs have written staffing plans that assure regular evaluation of the appropriateness of current staffing patterns in addressing the needs of the populations being served. All staffing patterns must meet licensing standards. Such plans should assess whether the quantity and expertise of current staff is adequate to assure quality. Staffing plans should also include processes for assuring the development of individual staff training plans that address the needs of the program and promote the professional growth of each staff member.

All providers are expected to support the development of cultural competence within their staff and programs by:

- Offering ongoing staff training opportunities
- Promoting an open, respectful work and treatment environment
- Offering programming that recognizes the cultural diversity among the individuals served
- Actively pursue staff diversity that reflects the population being served

Providers are expected to maintain documentation of all initiatives to further develop the cultural competency and sensitivity of staff, and interventions to improve the overall cultural competence of their programs.

Program staff is expected to include a program director, and a pool of counselors/therapists with the expertise necessary to meet the needs of the population being served. Programs are expected to have a clinical supervisor for every eight full-time therapists. Programs should also have clerical and support staff sufficient to ensure efficient and safe operations of all services provided. Those programs serving special populations, such as individuals with co-occurring disorders, are expected to have the necessary clinical expertise among staff to meet the needs of such specialized populations.

Staff should be fully trained in MISA screening, referral and internal and external treatment resources for consumers with mental health and substance use disorders. Staff should be trained on PCPC, ASAM (if serving adolescents), and Confidentiality rules and regulations.

## *REFERRAL AND ADMISSION PROCESS*

### **Access Standards**

All medically monitored short-term residential rehabilitation providers are expected to ensure timely access to care during identified hours of admission. Programs are encouraged to offer admission 24 hours a day, seven days a week, whenever the appropriate clinical resources are available. Providers are expected to offer access within 72 hours whenever clinically required, but to not exceed 7 seven days for routine referrals. In the event that a provider receives a referral and is unable to offer an appointment within the access standard, the provider is expected to communicate with Community Care, the referral source, and the consumer about the length of the access delay, in order for alternatives to be explored with the consumer in a timely manner. Providers are also expected to notify Community Care immediately when unable to provide timely access. Providers are also expected to begin discharge planning upon admission and to finalize arrangements for post-rehabilitation follow up services and supports, guided by a current PCPC assessment, within 7 days of discharge, to ensure timely access to continuation of care services. Discharge planning should include linkage with other recovery-oriented supports and services such as self-help groups, and recovery

support services, in addition to considering levels of care on the drug and alcohol service continuum.

## **Referral**

Medically monitored short-term residential rehabilitation providers are expected to:

- Establish working relationships with referral sources within the local behavioral health service delivery system.
- Upon receipt of a referral and exchange of a signed consent to release information from the consumer between the referral source and the provider, inform the referral source about the status of the referral.

## **Intake and Admission**

- Admission to this level of care is based upon the Pennsylvania Client Placement Criteria or ASAM Criteria, and requires telephonic preauthorization with Community Care prior to the admission. Providers are expected to record and retain copies of the PCPC Summary Sheets in consumer records.
- Each program is expected to have admission criteria in place consistent with the PCPC for medically monitored short-term residential services. Programs that potentially exclude consumers from admission who meet PCPC criteria must have written exclusionary criteria in policy.
- All programs are expected to have intake procedures that include the following:
  - Disclosure to consumers of the criteria for admission, an overview of the treatment program, and completion of treatment or discharge criteria. Such disclosure is to be documented in a progress note, the consent to treatment, or other consumer orientation materials.
  - Discussion of consumer rights and responsibilities in the program should occur during intake and be reviewed as needed with the consumer throughout treatment. Consumers should be given clear written materials explaining their rights and responsibilities, including the provider's process for consumers to report any dissatisfaction with services.
- Consumer orientation to the program, to include:
  - A review of program policies and guidelines for residents
  - Overview of the treatment planning process and the importance full participation in this process
  - Overview of what the consumer can expect from the treatment program
  - Explanation that fluctuating motivation during the early stages of rehab are typical and actions to deal with low motivation (talk to program staff or other residents, talk if experiencing a desire to leave the program AMA)
  - Ways of exercising rights and responsibilities

- Criteria for program completion and/or termination

## **TREATMENT PLANNING PROCESS**

### **Assessment**

- A comprehensive biopsychosocial assessment of each consumer should be completed within three days of admission to a medically monitored short-term residential program. The comprehensive assessment is to include an evaluation of the consumer's strengths, a clear description of the consumer's presenting problem, identification of supportive family and friends, an assessment of the consumer's attitude toward and ability to participate in the treatment process, and a discussion of what treatment interventions have been most helpful to the consumer in the past. A MISA screening is expected to be included, and referrals made as needed. During the assessment of the consumer's social supports, the provider should give the consumer information about available peer and family support groups available to the consumer and/or family/significant others, to further assist the consumer in the recovery process.
- The initial evaluation should also include a complete psychiatric history as reported by the consumer, and mental status examination including evaluation of mood, affect, thought content, presence or absence of suicidal and homicidal ideation, and a cognitive assessment. Providers are always expected to screen for co-occurring disorders to ensure that all treatment needs are addressed in the treatment planning process. A review of prior adherence or non-adherence to treatment and the relationship between poor adherence and relapse should be explored.
- Providers are also expected to obtain a complete physical history from the consumer. Consumers are also expected to receive a complete physical examination by a physician at the facility as soon as possible after admission, but no later than 72 hours of admission. The only exception to the requirement for a complete physical is when the provider receives evidence of a physical completed for the consumer within the last twelve months and the facility physician, after a face-to-face assessment of the consumer, determines that another complete physical is not indicated at this time.

Providers are expected to work with consumers to obtain permission and signed releases to seek information from previous behavioral health and physical health treatment providers to aid in the assessment and treatment planning process. Refusal of such permission is to be documented in the chart. It is understood that in some cases the client may be discharged prior to the information being received.

- The assessment of any family needs should also be addressed during the initial week of treatment. Providers are expected to discuss the importance of including family and significant others in treatment with consumers. When consumers consent to include family members or significant others in their treatment, providers should

make every effort to accommodate family members and significant others in treatment sessions, as appropriate. In addition, providers should provide referral and/or contact information for supportive services to family/significant others.

- All consents and other pertinent documents should be completed, signed, and incorporated in the consumer record during the initial assessment period. The provider should attempt to obtain consent to release information from all treatment providers that the member has been involved with for the past 12 months, especially those providers of the same or higher level of care.
- All biopsychosocial assessments are to be reviewed and signed by the primary clinician.

### **Development of the Treatment/Rehabilitation Plan**

- Providers are to use the comprehensive biopsychosocial assessment, the information obtained regarding previous treatment services, and consumer input as the foundation for the development of a treatment plan. The initial assessment process is expected to clarify the strengths of the consumer and the critical issues to be addressed in treatment. The treatment planning process leads to the development of strategies and interventions to address critical issues.
- Consumers are to fully participate with the treatment team in the development of their treatment and rehabilitation plans. Providers are expected to document their specific methods for engaging the consumer and other members identified by the consumer in the treatment planning process. Providers are expected to consult with other involved agencies (with client consent). The final written treatment/service plan is to be developed with the consumer. Providers should seek signatures on the treatment plan from the consumer and other treatment team members as appropriate or maintain documentation of the coordination of care among treatment team members on a standardized case consultation documentation form.
- Initial treatment plans are to be completed within the first day of treatment, with a comprehensive plan completed within 3 days of admission to the program. Comprehensive treatment/service plans are to include all of the following:
  - Specific, measurable goals for treatment, including short-term objectives, with targeted completion dates, as identified by the consumer, program staff, and other members of the treatment team. Goals should be realistic and achievable, and written in language that is easily understood by consumers. How the goals of this

episode of care fit with the consumer's overall plan for recovery should be discussed during the treatment planning process.

- Type and frequency of treatment and rehabilitation interventions or services.
- Identification of needed support services as a result of the biopsychosocial assessment, such as adult basic education, vocational assessment, life skills training, housing assistance, mental health services and case management. Referrals for any of the above services should be completed while the consumer is in treatment. If this is not possible, consumers should be referred for case management services for assistance (where available). This information/recommendations should also be included in aftercare plan.
- Identification of the responsibilities of each member of the treatment team, including individuals outside of the residential rehabilitation program
- Demonstration of coordination between providers and other service systems.
- All treatment plans are to be reviewed and signed by the clinical supervisor.
- The treatment plan and progress toward goals should be reviewed with the consumer at initiation and on a weekly basis.

#### **SERVICE DELIVERY STANDARDS:**

- Programs should always deliver interventions aimed at instilling hope, motivating consumers for change and recovery, engaging consumers fully in the treatment program, and retaining consumers in treatment and on the path of recovery.
- The individualized treatment plan developed in collaboration with the consumer should drive service delivery.
- At a minimum, consumers should receive a group intervention at least once per day which includes psycho educational groups at least twice per week and group therapy at least 5 times per week, individual therapy at least once per week, and family education or therapy at least one time per week when appropriate, unless refused by the consumer.
- Psychoeducational groups that best address the needs of the residents at the time should be offered, but at a minimum, should include topics such as coping skills development, relapse prevention, harm reduction, social support development, and addiction management skills.
- Programs are to create a therapeutic environment and milieu by providing the necessary structure and opportunity for interventions in real time to foster recovery. Facilitating frequent therapeutic group process among resident consumers is a necessary service element.

- Programs are to use multiple strategies to help consumers learn about recovery and face their addiction and related problems, such as “interactive” materials for psychoeducational groups and recovery assignments (videos, workbooks, etc.). Consumers are to be held accountable for completion of homework and other therapeutic assignments.
- Consumers may participate in self-help support groups in the community (as deemed appropriate by staff and consumer) as well as on the premises of the residential program. As consumers work toward their recovery and are preparing for transition back to their own home community, providers are expected to assist the consumer with finding a self-help support group in or near their permanent home community.
- Programs are expected to adopt written plans for the coordination of all consumer treatment and rehabilitation services. It is the responsibility of the residential program to ensure that all other ancillary services a consumer may be receiving are integrated into the consumer’s individualized holistic treatment plan.
- Programs are to deliver services in a culturally competent manner.
- All service delivery must be clearly documented by the provider.
- For consumers with co-occurring mental illness, special attention must be given to ensure the development of an integrated transition plan that addresses the consumer’s mental illness and addictive disorder. All such consumers should receive a psychiatric evaluation within 72 hours of admission.

## **DISCHARGE AND TRANSITION PLANNING**

Because continuing engagement in treatment across treatment programs is a key factor in achieving positive outcomes in addiction treatment, medically monitored short-term residential providers are expected to demonstrate comprehensive discharge and transition planning. Active discharge and transition planning is to be initiated upon admission to the program. A fully developed transition plan should be in place when a consumer is ready to leave the medically monitored short-term residential program. In anticipation of discharge, the provider will openly discuss with the consumer any potential barriers in successfully transitioning to the next level of care, to include personal and environmental barriers in order to develop plans to overcome such barriers. Successful transition management is a process that should be driven by the consumer, and should take into consideration a full array of both professional services and community supports. A comprehensive transition plan addresses the following areas:

- Information about the discharge/transition planning process, with an emphasize on the importance of follow-up after rehabilitation, identification of internal and external barriers to adherence to follow-up, and why follow-up is so important for ongoing recovery.

- Providers must ensure (with appropriate client consent) that information regarding the consumer's progress is provided to the agency where the consumer will be continuing care. The next or aftercare provider should be made aware of the consumer's current treatment plan goals and the progress toward goals to date.
- Aftercare plans must clearly delineate responsibilities for care of consumers during transition periods.
- Providers must ensure that all necessary referrals to the next service or support providers are completed in a timely manner. Needs, such as housing supports, transportation, job training, and childcare, must be addressed.
- Consumers should have the opportunity to meet/or speak to the next provider prior to discharge from the program when these options are available. Consumers must be made aware of their right to choose aftercare providers and guide this selection process. Consumers must then be made aware of all follow-up care appointments.
- Consumers must have access to prescribed medications during transition periods. Residential providers are responsible for knowing the date of the next psychiatric appointment and for ensuring that the consumer has an adequate prescription of medications prior to discharge from the facility, usually at least 2 weeks. If the program is unable to obtain a follow up appointment with a prescribing physician within this time frame, the facility should notify CCBHO for assistance.
- Consumers should have a single person to contact if any part of the aftercare plan does not occur as planned, or needs to be changed for any reason.
- Consumers should be made fully aware of local 12- step programs and attempts should be made to formally engage consumers in these programs prior to discharge, including a connection to a temporary sponsor, and other recovery support services.
- Family involvement is another key aspect of successful addiction treatment. To the extent permitted by the consumer, and appropriate, medically monitored short-term residential providers should engage family members and significant others in the transition planning process.
- Relapse prevention planning must be addressed in the transition plan.
- A plan for monitoring the implementation of the transition plan must be in place. The residential provider is responsible for monitoring the implementation of the transition plan until such time as the next provider assumes responsibility or the consumer refuses further intervention by the residential provider.
- Coordination with the PCP during this transition period is crucial. With the consumer's consent, the residential provider is expected to provide the PCP with the transition plan prior to the discharge date.

- All follow-up care appointments should be scheduled to occur within 7 days of discharge from the non-hospital residential program. If the above time is not able to be met, the provider should notify CCBHO for assistance. Scheduling will occur prior to discharge. The consumer should also be educated about the differences between primary rehabilitation and follow-up care.

## *QUALITY IMPROVEMENT AND OUTCOMES MEASUREMENT*

All non-hospital residential programs are expected to have a quality improvement plan in place, as part of the organization's overall quality improvement initiative, demonstrating the process for analysis of the data, and the development of quality improvement initiatives in response to this analysis. The quality improvement plan should include input from consumers. Providers are expected to share the information regarding the program's quality improvement plan during regularly scheduled quality audits by Community Care.

Obtaining data through an outcomes measurement program is essential to the development of a meaningful quality improvement plan. The following is a list of outcome indicators pertinent to medically monitored short-term residential services. Each program is expected to design an outcomes measurement plan that serves their overall program goals and agency mission. Examples of indicators a program may choose include:

- Sustained reduction in alcohol and/or drug use.
- Rate of inpatient or residential admissions during and after participation in the program.
- Rate of discharges due to program completion
- Level of functioning assessment
- Employment status
- Sustained reductions in public health and safety problems such as forensic involvement
- Housing stability
- Sustained increases in personal health and social function
- Family unification or reunification
- Rate of successful transition as evidenced by kept appointments in the next level of care for consumers who have completed the program
- Length and duration of abstinence post discharge.

Consumers should be surveyed regarding their satisfaction with the services they received, and the overall facility on at least an annual basis. Results of these surveys should be incorporated into the program's quality improvement plan.

Non-hospital residential providers should also survey referral sources to assess their satisfaction with the referral process and the treatment services provided by the program. Results of surveys of referral sources should also be incorporated into the program's quality improvement plan.