

**TREATMENT POLICY #10**

**SUBJECT:** Residential Treatment Continuum of Services

**ISSUED:** May 3, 2013, December 1, 2016

**EFFECTIVE:** January 16, 2017

**PURPOSE:**

The purpose of this policy is to establish the requirements for residential services to the extent licensing allows based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to support individualized services that maintain cultural, age, and gender appropriateness.

**SCOPE:**

This policy impacts the Prepaid Inpatient Health Plan (PIHP) and its adult residential LOC service provider network.

**BACKGROUND:**

Residential treatment includes a wide variety of covered services with the provision of these services expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited in indicating what activities or services must be provided to clients in a residential program. They do indicate, however, that ten hours of scheduled activities, with two of those hours being formalized counseling, must take place each week.

At the time of their creation, these standards adequately met the needs of clients being served. In the time since the rules were promulgated, there have been many changes in the treatment field. The emergence of evidence-based best practices, the ASAM Criteria Third Edition (ASAM Criteria), and the stages-of-change models that have been developed. These changes have essentially left the administrative rules obsolete in the area of recommended services. This policy seeks to establish residential treatment criteria that will result in services that are provided in accordance with those outlined by ASAM, and are more reflective of services that have been shown to be effective in providing care to individuals receiving residential care.

Throughout the current residential level of services assessment, treatment planning, and recovery support preparations are required, and must be included in the authorized treatment services. Historically, residential services have been defined by length-of-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
- Long-term residential: 30 days or more in a program

This view of residential treatment has contributed to the expectation that all clients will equally benefit from the services being offered and resulted in clients with varying needs being admitted into the same program. This makes it more difficult to assure and provide services that are focused on addressing the individual needs of each client.

## **Definitions**

**Core Services** - are defined as Treatment Basics, Therapeutic Interventions, and Interactive Education/Counseling. See the chart in the “Covered Services” section for further information.

**Counseling** - an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

**Crisis Intervention** - a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher LOC if intervention is not provided.

**Face-to-Face** - this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

**Facilitates Transportation** - assist the client, potential client, or referral source in arranging transportation to and from treatment.

**Family Counseling** - face-to-face intervention with the client and their significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

**Family Psychotherapy** - face-to-face, insight-oriented interventions with the client and their significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

**Group Counseling** - face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

**Group Psychotherapy** - face-to-face, insight-oriented interventions with three or more clients.

**Individual Assessment** - face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

**Individual Counseling** - face-to-face intervention for the purpose of goal setting and achievement, and skill building.

**Individual Psychotherapy** - face-to-face, insight-oriented interventions with the client.

**Individual Treatment Planning** - direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

**Interactive Education** - services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as a "didactic" education.

**Interactive Education Groups** - activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

**Medical Necessity** - treatment that is reasonable, necessary, and appropriate based on individualized treatment planning and evidence-based clinical standards.

**Peer Support** - individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another in a treatment setting.

**Professional Staff** – as identified in the Staff Qualifications for SUD Treatment Services portion of the PIHP/MDHHS Contract include Substance Abuse Treatment Specialists, Substance Abuse Treatment Practitioner, Specially Focused Staff and Treatment Supervisor.

**Psychotherapy** - an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other biopsychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (Michigan Administrative Code, Social Work General Rules).

**Recovery:** A highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental, and physical well-being. ([http://www.michigan.gov/documents/mdch/ROSC\\_Glossary\\_of\\_Terms\\_350345\\_7.pdf](http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf))

**Recovery Planning** - purpose is to highlight and organize a person's goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

**Recovery Support and Preparation** - services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

**Referral/Linking/Coordination of Services** - office-based service activity performed by a primary clinician, or other assigned staff, to address needs identified through the assessment, and/or to ensure follow through with access to outside services, and/or to establish the client with another substance use disorder service provider.

**Substance Use Disorder** - a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

**Toxicology Screening** - screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non-laboratory urinalysis).

**Withdrawal Management** - monitoring for the purpose of preventing/alleviating medical complications related to no longer using, or decreasing the use of, a substance.

#### **REQUIREMENTS:**

The residential levels of care from ASAM are established based on the needs of the client. As part of the purpose of this document, the short and long-term descriptors will no longer be used to describe residential services. PIHPs will need to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM levels 3.1, 3.3, 3.5, and 3.7. The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are 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 focused 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.

This type of programming can be beneficial to individuals who do not acknowledge a substance use problem, and services would be focused on engagement and continuing treatment. Treatment at this level is sometimes necessary to due to deficits in the individual's recovery environment and length of stay in clinically managed Level 3.1 programs is generally longer than that of the more intensive levels of residential care. This allows the individual to practice and master the application of recovery skills.

*Support Systems*

Necessary support systems include telephone or in-person consultation with a physician and emergency services, available 24 hours a day, and 7 days a week. There also must be direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services. Programs should have the ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition. These programs should also have the ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. They should also have direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services such as literacy training and adult education.

#### *Staff Requirements*

Level 3.1 programs are staffed by allied health professional staff such as counselor aides or group living workers who are available onsite 24-hours a day or as required by licensing regulations. Clinical staff must be knowledgeable about the biological and psychosocial dimensions of substance use disorders and their treatment. They must also be able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff at this level are not involved in direct service provision, however, addiction physicians should review admission decisions to confirm clinical necessity of services

#### *Co-occurring Enhanced Programs*

These should be staffed by credentialed mental health professionals that have the ability to treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. These professionals should also have sufficient cross-training in addiction and mental health to understand the signs and symptoms of mental disorders, be able to understand and explain to the individual the purposes of different psychotropic medications and how they interact with substance use.

### **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 LOC 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.

#### *Support Systems*

Necessary support systems within this level include telephone or in-person consultations with a physician, or a physician assistant or nurse practitioner in states where they are licensed as

physician extenders and may perform the duties designated here for a physician; and emergency services, available 24 hours a day, 7 days a week. They should have direct affiliations with other easily accessible levels of care or close coordination through referral to more and less intensive levels of care and other services. They need medical, psychiatric, psychological, laboratory and toxicology services available through consultation and referral as appropriate to the severity and urgency of the individual's condition.

#### *Staff Requirements*

Level 3.3 programs are staffed by physician extenders, and appropriately credentialed mental health professionals as well as allied health professional staff. These staff should be on-site 24-hours a day or as required by licensing regulations. In addition, one or more clinicians with competence in the treatment of substance use disorders should be onsite 24-hours a day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. They should also be able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff should also have specialized training in behavior management techniques.

#### *Co-occurring Enhanced Programs*

This type of program needs to be staffed by credentialed psychiatrists and mental health professionals. They should be able to assess and treat people with co-occurring mental disorders and they need to have specialized training in behavior management techniques. Most, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of mental disorders and be able to understand and explain to the individual the purpose of psychotropic medication and its interactions with substance use.

### **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 or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The length of treatment depends on an 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.

*Support Systems*

Programs in this level of care should have telephone or in-person consultation with a physician, or a physician assistant or nurse practitioner in state where they are licensed as physician extenders and may perform the duties designated here for a physician; emergency services, available 24 hours a day, 7 days a week. They must also have direct affiliations with other levels or close coordination through referral to more and less intensive levels of care and other services. They must also have arranged medical, psychiatric, psychological, laboratory, and toxicology services as appropriate to the severity and urgency of the individual's condition.

*Staff Requirements*

Level 3.5 programs staffed by licensed or credentialed clinical staff such as addiction counselors and other professional staff who work with the allied health staff in interdisciplinary approach. Professional staff should be onsite 24-hours a day or per licensing regulations. One or more clinicians with competence in treatment of substance use disorders must be available onsite or on-call 24-hours per day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. Clinicians should be able to identify the signs and symptoms of acute psychiatric conditions, and have specialized training in behavior management techniques.

*Co-occurring Enhanced Programs*

This type of program should offer psychiatric services, medication evaluation and laboratory services. These services should be available by telephone within 8 hours and on-site or closely coordinated off-site staff within 24 hours, as appropriate by severity and urgency of the individual's mental health condition. These programs should be staffed by credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat the co-occurring mental health disorder and have specialized training in behavior management. They should also have cross-training to understand the signs and symptoms of co-occurring mental disorders and be able to explain to the individual, the purpose of psychotropic drugs and how they interact with substance use.

**ASAM Level 3.7 – Medically Monitored High-Intensity Inpatient Services**

These programs offer a structured regime of professional 24-hour directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. These programs operate in permanent facilities with inpatient beds and function under a set of defined policies, procedures and clinical protocols. These programs are for patients with subacute biomedical and emotional, behavioral or severe cognitive problems that require individual treatment but do not require the full resources of an acute care general hospital or medically managed individual program.

These services are designed to meet needs of patients who have functional limitations in Dimensions 1, 2, and 3. The care provided in these programs is delivered by an interdisciplinary staff of appropriately credentialed staff, including addiction credentialed physicians. The main focus of treatment is specific to substance related disorders. The skills of

this team and their availability can accommodate withdrawal management and/or intensive inpatient treatment of addiction, and/or integrated treatment of co-occurring subacute biomedical, and/or emotional, behavioral or cognitive conditions.

#### *Support Systems*

This level of care requires physician monitoring, nursing care, and observations are made available. The following staffing is required for this level of care: a physician must be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary; a registered nurse to conduct alcohol and other drug-focused nursing assessment at time of admission; an appropriately credentialed nurse is responsible for monitoring the individual's progress and for medication administration. There must be additional medical specialty consultation, psychological, laboratory and toxicology services available on-site through consultation or referral. There also must be coordination of necessary services or other levels of care are available through direct affiliation or a referral process. Psychiatric services should be available on-site through consultation or referral when presenting an issue that could be attended to at a later time. These services should be available within 8 hours by telephone or 24 hours in person.

#### *Staff Requirements*

These programs are staffed by an interdisciplinary staff (including physicians, nurses, addiction counselors, and behavioral health specialists) who are able to assess and treat the individual and obtain and interpret information regarding the individuals psychiatric and substance use or addictive disorders. Staff should be knowledgeable about the biological and psychosocial dimensions of addictions and other behavioral health disorders. The staff should have training in behavior management techniques and evidence-based practices. The staff should be able to provide a planned regimen of 24-hour professionally directed evaluation, care and treatment services. A licensed physician should oversee the treatment process and assure quality of care. Physicians perform physical examinations for all admitted to this level of care. These staff should have specific training in addiction medicine or addiction psychiatry and experience with adolescent medicine. Individuals should receive pharmacotherapy integrated with psychosocial therapies.

#### *Co-occurring Enhanced Programs*

Programs at this level should offer appropriate psychiatric services, medication evaluation and laboratory services. A psychiatrist should assess the individual within four hours of admission by telephone and within 24 hours following admission in person, if not sooner, as appropriate by individual's behavioral health condition. A registered nurse or licensed mental health clinician should conduct a behavioral health-focused assessment at the time of admission. If not done by a registered nurse, a separate nursing assessment must be done. The nurse is responsible for monitoring the individual's progress and administering or monitoring the individual's self-administration of psychotropic medications. These must also be staffed by addiction psychiatrists and credentialed behavioral health professionals who can assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management. These programs are ideally staffed by a certified addiction specialist physician,



or a physician certified as an addiction psychiatrist. Some, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of psychiatric disorders and be able to explain to the individual the purpose of psychotropic medication and how they interact with substance use. The intensity and care should meet the individual’s needs.

ASAM LOC describe the need for treatment from the perspective of the level of impairment of the client; with the higher the level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC determination. Due to the unique and complex nature of each client, it is recognized that not every client will “fit” cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. In addition, variations in treatment that do not follow these guidelines should also be documented in the client record.

The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment and achieve recovery.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by a client:

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
<b>Dimension 1</b> Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; concurrently receiving Level 1-WM or Level 2-WM	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-WM	At minimal risk of severe withdrawal at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-WM criteria	Approach “unbundled” withdrawal management for adults.
<b>Dimension 2</b> Medical conditions and complications	None or very stable; or receiving concurrent medical monitoring	None or stable; or receiving concurrent medical monitoring	None or stable; or receiving concurrent medical monitoring	Individual in significant risk of serious damage to physical health or concomitant biomedical conditions

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
<p><b>Dimension 3</b> Emotional, behavioral, or cognitive conditions and complications</p>	<p>None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required</p>	<p>Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits</p>	<p>Demonstrates repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client</p>	<p>Individual must be admitted into co-occurring capable or co-occurring enhanced program, depending on level of function or degree of impairment.</p>
<p><b>Dimension 4</b> Readiness to change</p>	<p>Open to recovery but needs a structured environment to maintain therapeutic gains</p>	<p>Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)</p>	<p>Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)</p>	<p>Does not accept or relate the addictive disorder to severity of existing problems; need intensive motivating strategies; need 24-hour monitoring to assure follow through with treatment plan</p>
<p><b>Dimension 5</b> Relapse, continued use, or continued problem potential</p>	<p>Understands relapse but needs structure to maintain therapeutic gains</p>	<p>Has little awareness and needs intervention only available at Level 3.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction</p>	<p>Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences</p>	<p>Experiencing acute psychiatric/substance use disorder marked by intensification of</p>

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
<b>Dimension 6</b> Recovery/living environment	Environment is dangerous, but recovery achievable if Level 3.1 24-hour structure is available	Environment is dangerous and client needs 24-hour structure to cope	Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting	Environment is dangerous and patient lacks skills to cope outside of highly structured 24-hour setting

**PROCEDURE:****Admission Criteria**

Admission to residential treatment is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider's assessment process.
- Individualized determination of need.
- ASAM Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the ASAM Criteria below:
  - 7) Withdrawal potential.
  - 8) Medical conditions and complications.
  - 9) Emotional, behavioral, or cognitive conditions and complications.
  - 10) Readiness to change – as determined by the Stages of Change Model.
  - 11) Relapse, continued use or continued problem potential.
  - 12) Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development.

Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM Criteria. As a client's needs change, the frequency, and/or duration, of services may be increased or decreased as medically necessary. Client participation in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

**Service Requirements**

The following chart details the required amount of services that have been established for residential treatment in the three levels of care. Documentation of all core services, and the response to them by the client, must be found in the client's chart. In situations where the required services cannot be provided to a client in the appropriate frequency or quantity, a justification must also be documented in the client record.

Level of Care	Minimum Weekly Core Services	Minimum Weekly Life Skills/Self Care
<b>ASAM 3.1</b> Clients with lower impairment or lower complexity of needs	At least 5 hours of clinical services per week	At least 5 hours per week
<b>ASAM 3.3</b> Clients with moderate to high impairment or moderate to high complexity of needs	Not less than 13 hours per week	Not less than 13 hours per week
<b>ASAM 3.5</b> Clients with a significant level of impairment or very complex needs	Not less than 20 hours per week	Not less than 20 hours per week
<b>ASAM 3.7</b> Clients with significant level of impairment or very complex needs	Not less than 20 hours per week	Not less than 20 hours per week

**Covered Services**

The following services must be available in a residential setting regardless of the LOC and based on individual client need:

Type	Residential Services Description
<b>Basic Care</b>	Room, board, supervision, self-administration of medications monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery-oriented.
<b>Treatment Basics</b> <u>Core Service</u>	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services; preparation for ‘next step’.
<b>Therapeutic Interventions</b> <u>Core Service</u>	Individual, group, and family psychotherapy services appropriate for the individual’s needs, and crisis intervention. Services provided by an appropriately licensed, credentialed, and supervised professional working within their scope of practice.
<b>Interactive Education /Counseling</b> <u>Core Service</u>	Interaction and teaching with client(s) and staff to process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Examples: disease of addiction, mental health, and substance use disorder.
<b>Life Skills/Self-Care (building recovery capital)</b>	Social activities that promote healthy community integration/reintegration; development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education.

Type	Residential Services Description
<b>Milieu/Environment (building recovery capital)</b>	Peer support; recreation/exercise; leisure activities; family visits; treatment coordination; support groups; drug/alcohol free campus.
<b>Medical Services <u>Core Service</u></b>	Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available on-site.

### **Treatment Planning/Recovery Planning**

Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over.

To make the transition to the next LOC, the residential care provider may assist the client in choosing an appropriate service based on needs and location scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the residential provider arrange for any needed assistance to ensure a seamless transfer to the next LOC.

### **Continuing Stay Criteria**

Re-authorization or continued treatment should be based on ASAM Continued Service Criteria, medical necessity, and a reasonable expectation of benefit from continued care.

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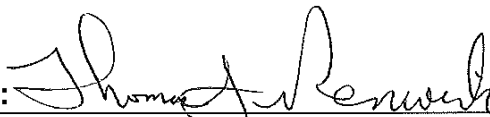
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**APPROVED BY:**



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