NEW YORK STATE

Office of Alcoholism and Substance Abuse Services

Residential Re-Design Readiness Guide

Developed by the OASAS Residential Redesign Workgroup to assist programs in their discussions as they evaluate strategies towards implementation of the element(s) of residential.

www.oasas.ny.gov

Residential Redesign Overview:

This model will have a philosophy of intensive residential programming based on "Community of Method[1]" The model employs trauma informed and evidence based treatment and uses behavioral and social interventions to influence pro-social and pro-community norms including but not limited to: respect; work; and the value of others. This model will be: Patient-centered; and, Recovery-oriented. The overall redesign goal are to: match patients to the element of care that best meets their needs; set and prioritize patient goals; and, move people towards community re-integration. Specifically, redesign will

- Promote Recovery through the continuum of care rather than Disease management
- Shift from Program driven to Participant driven assessment, treatment planning and service delivery.
- Allow for participant entry and movement based on an assessment of individual risks, resources, values and preferences.
- Utilization of this "Evidenced Informed Social Learning Model" to foster positive change.
- The advantages of this allow for the incorporation of evidence based treatment models into the residential setting that is based on social learning model change principles.
- Empowerment of individuals and families in recovery that is strength based and success oriented to reward individuals and families with more independence and choice as soon as the individual shows signs of readiness to manage increased responsibility.
- Service duration is based on individual milestones versus a programmed length of stay. Programs will develop predicted element markers that indicate achievement of treatment goals that are individualized and geared toward movement to increasing independence.

The current OASAS certified treatment modalities that will be included in residential redesign are:

- Title 14 NYCRR Part 819: Intensive Residential; Community Residential; and, Supportive Living Title 14 NYCRR
- Part 816: Medically Monitored Crisis
- **NOTE: Title 14 NYCRR Part 818 Chemical Dependence Inpatient Rehabilitation Certified Programs ARE NOT included in this residential redesign initiative.**

[1] Community as Healer is the Therapeutic Communities basic approach of treating the whole person through the use of peer community. The social organization is utilized for creating a community where day to day activities and interaction are used to maximize therapeutic effects and is not simply the background administration for treatment. Please also see resources section of the document for links to SAMHSA Therapeutic Community Curriculum (Trainer and Participants manual)

Residential Redesign - Three Elements of Treatment:

Residential Redesign will incorporate: Three Elements of Treatment:

1. Stabilization Element - Individuals will be treated for mild to moderate withdrawal symptoms and will receive medically-directed care to treat acute problems and adjust to early recovery.

2. Rehabilitation[2] Element - Individual will learn to manage recovery within the safety of the program. NOTE: Within the context of the Residential redesign initiative "Rehabilitation" refers to rehabilitative component of residential treatment modality and is not synonymous with either the type of treatment / services(s); staffing; or level of medical care provided in an OASAS certified Part 818 Chemical Dependence Inpatient Rehabilitation Certified Program.

3. Community Re-integration. Individual will actualize skills developed in treatment and access resources/services within their community.

Readiness Document Purpose:

OASAS together with the provided populated Residential Redesign Workgroup, developed this residential redesign readiness document. This document is intended to facilitate OASAS certified residential programs in their discussions as they evaluate strategies towards implementation of Element(s) of the residential model.

After completing the readiness document programs will be better positioned to set and prioritize goals that include:

- Identifying potential services to better serve their population;
- Understanding how the current infrastructure of their organization could support implementation; and,
- Strengthen the program model to better meet the needs of the community.

[2] Title 14 NYCRR Part 818 Chemical Dependence Inpatient Rehabilitation Certified Programs ARE NOT included in this residential redesign initiative.

Readiness Document Structure:

Section One: The Preliminary Conversation: Programs start their readiness review process by using the steps outlined below to engage in foundation conversations that: articulate the current program's structure; the study of redesign elements; and, facilitate discussion.

Section Two: Provides topic specific discussion points for programs to develop strategies for offering some or all of the three redesign elements.

Section Three: Resources for provider reference as they engage in readiness discussion.

Provider Rating Scale:

Note that some items in the guide have requested that you describe your present/ future strategies. Then choose the answers that best reflect your level of readiness:

4 = We are ready now (we currently have the needed knowledge, resources, infrastructure, and linkages in place)

3= We are moderately ready (we are likely to implement in a timely manner)

2= We are somewhat ready (we will likely need an allocation of in house resources i.e identify needed subject matter experts within the organization to implement in a timely manner)

1= We are not ready (we will definitely require an allocation of in house resources and organization executive guidance to implement in a timely fashion.

SECTION ONE: The Preliminary Conversation:

Programs start the readiness review process by using steps outlined below:

Step One: Assessing the program's current:

- Target population
  - Demographics which describes the target population profile
  - List most prevalent (top five) substance abuse diagnoses
  - List most prevalent (top five) mental health diagnoses
  - List most prevalent physical health diagnoses(such as asthma, diabetes, cardiovascular disease)
  - Clinical /social supports
- Staffing configuration
- Physical Plant
- Connection / Linkages to the community of: Mental Health, Medical, and other Recovery Oriented Support Services.

Rating:

Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

Step Two: Understand the Model: Programs start the readiness review process by first exploring:

- The organizations overall treatment philosophy, goals, objectives and outcomes for each element and provide their description of: Stabilization; Rehabilitation; Reintegration
  - What services are offered in each Element
  - What is the general staffing for each Element
  - What is the clinical supervision format, process ,expectations, and outcomes

- For each identified Element describe the admissions criteria and process (not all patients need all Elements and not all programs have to offer each Element)
  - Patients enter the Element that best meets their individual needs
  - What patient profile is best serviced by each Element. Programs may also wish to refer to the updated LOCADTR 3.0.

Rating:
Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

Step Three: Current and Future delivery of the three Elements of care.

- What does / will your program offer and how does this fit within the continuum of services offered in the region / county?
- Would a different / additional Element allow you to broaden your services to serve current patients better and/or attract new patient groups?
    - In relationship to DSRIP ; HARP; and Health Homes how are you positioning your program?
    - What linkages are required to market the services you provide within the community?
- Access to Primary Care Services
    - Does your program Co-Locate Primary Care Services (e.g. is there an on –site Art 28 health clinic; or is there one in close proximity that is operated by programs overall structure?)
    - How does your program coordinate with Primary Care
    - Is your organization in close physical proximity to primary care provider
    - Do behavioral health and primary care providers contribute to a shared care and treatment plan for each patient
    - What opportunities do you see to improve access and coordination with primary care

Activity for Program Discussion: Utilize the crosswalk (Attachment A) to explore current program and redesign Elements:

Rating:

Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

Continue to Section Two

SECTION TWO: Topics for Detailed Discussion

Topic One: Shifting to New Design:

Population and Matching Care

- Identify the new target population inclusive of substance abuse, mental health, primary care needs, employment and other social determinants of health
- How will the LOCATDTR be used for each level of care/Element
- Identify assessment tools to be utilized, ie Trauma Assessment, Mental Health Status, Medical , etc.
- Subsequent assessment to further identify patient's initial and ongoing needs within the Elements of care.
- Describe information and educational process to inform clients about the new model

Rating:

Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

Topic Two: Treatment and Recovery Social Support Interventions:

- Identify patient goals and outcomes
- Select which Element will be provided and describe services to be offered in each Element
- Select Evidence based practices, treatment interventions, peer and recovery social support interventions including therapeutic community setting.
- Assess, modify, enhance, select curriculum (e.g. evidenced based protocols) to meet the needs of the population you will serve.
- How will client improvement be measured within the Element for transition to next level of care and clinical outcome?

Rating:

Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

Topic Three: Communication and Care Coordination:

- Describe process to coordinate and connect to next level of care in patient continuum within the surrounding community.
- Describe collaboration of care through high intensity coordination with other providers
    - Identify and update formal and informal relationships with recovery oriented systems of care and community organizations and resources e.g. linkages to housing; education, training, job readiness, and employment, etc.

- Care coordination entities (managed care plans; DSRIP PPS, health homes; local districts; and, other stakeholders)

- Describe the organizations process for engaging and communicating with family members and natural supports
  - How will providers communicate with individuals and or family members about setting treatment goals and recovery support plans
  - How will providers communicate with individuals and or families about medication compliance, activities of daily living and functional changes

- Describe your capacity to provide clients with Community Wellness Resources
  - Internal
  - External
    - Who will your organization partner with other community organizations to connect people with population specific wellness activities,
      - Refresh your linkage agreements

Rating:

Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

Topic Four: Preparing for new staffing pattern:

Assessing your Organization

- Identify existing staff and recovery peer advocate to support the new element(s)/ model
- Identify new staff and recovery peer advocate positions needed
- Identify staff training needs and program professional development plan
- Redefine purpose and function of clinical supervision to ensure quality and outcomes
- Describe and repurpose current physical space to support the new elements(s) / model
- Assess organizations processes and cultural norms to support new model
- Assess leadership culture to pursue implementation, encourage change and remove barriers e.g. staff buy-in, staff training.

Rating:

Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

Topic Five: Quality Management:

- Identify the electronic health record
- Identify data required
- Revise capacity to collect data; exchange information (internal and external) progress and outcome tracking capability
- Revise quality assurance and quality improvement policy and procedures
- Revise utilization of data, quality improvement projects (e.g. PDSA) to effect continuous quality change to meet expected patient outcomes

Rating:

Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

Topic Six: The Business Model:

- Financial Planning / Reporting:
    - What are your current unit of service cost and projected unit costs
    - What is the current cost/patient and projected cost/patient
    - What are your current and future revenue streams
    - What is the payor mix of your current patient base
    - Medicaid rate pending
    - Prepare draft budget that incorporates all components that transition to the new program model/Elements
    - Describe revenue cycle management

- Managed Care Plan Network Inclusion
    - Contracting and Relationships
        - Describe process for contracting, managed care credentialing of staff, and adherence to Plan requirements
    - Service Authorization:
        - How will you Use LOCADTR to justify medical necessity for the recommend level of care /Element
    - How will you justify medical necessity for the utilization review and length of stay
    - Describe quality management reporting to managed care
    - Describe procedures to submit claims to managed care companies.

Rating:

Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

Outreach and Marketing Strategies

- Positioning your program to contract with managed care companies:
    - Explain your program's client population
    - Demonstrate how the program model benefits enrollees overall health and recovery
    - Discuss your program's position within the overall community of treatment and recovery providers
    - Maintain ongoing dialog with plan representatives

Rating:

Using rating scale discussed on page three; and associated spreadsheet to describe or rate level of readiness for each bulleted item.

SECTION THREE: RESOURCES

Attachment A	Residential Redesign Modeling Crosswalk
Current - Part 819 Regulations	http://www.oasas.ny.gov/regs/index.cfm
Updated - Part 820 Regulations	INSERT LINK WHEN AVAILABLE Part 820 will be regulation assigned to the residential redesign.
Current - Part 816 Regulations	http://www.oasas.ny.gov/regs/index.cfm
Updated - Part 816 Regulations	INSERT LINK WHEN AVAILABLE
Current - Part 814 Regulations	http://www.oasas.ny.gov/regs/documents/814.pdf
Current - Part 814 Regulations	INSERT LINK WHEN AVAILABLE
OASAS Managed Care Webpage	http://www.oasas.ny.gov/mancare/index.cfm
DSRIP	https://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm http://www.oasas.ny.gov/ManCare/index.cfm
HARP	http://www.oasas.ny.gov/ManCare/index.cfm http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_transition.htm

SAMHSA Therapeutic Community Curriculum (Trainer and Participants manual)	http://store.samhsa.gov/product/Therapeutic-Community-Curriculum-Trainer-s-Manual/SMA09-4121 http://store.samhsa.gov/product/Therapeutic-Community-Curriculum-Participant-s-Manual/SMA09-4122
LOCADTR 3.0	http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm