

**LAKESHORE REGIONAL ENTITY SERVICE DESCRIPTION**  
**Substance Use Disorder Community-Based Treatment**

*This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:*

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

**1. Definition or Description of Service**

- a. Community-based treatment for substance use disorders is an approach to clinical care that joins the benefits of effective treatment with the ongoing support of community-based care coordination. While behavioral health case management services typically separate clinical care from case management services, Michigan’s substance abuse licensing rules define Case Management as a program that “coordinates, plans, **provides**, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process” [emphasis added].
- b. Clinically organized case management service for persons with substance use disorders may be especially beneficial for individuals with documented complexity and evidence of chronicity of condition through one or more episodes of acute care (e.g., standard outpatient, residential, etc.). This service is targeted to those individuals whose situation points to the need for extended and continuing support and coordination of services in order to achieve a more durable recovery experience.
- c. Community-based substance use disorder services are intended for individuals with moderate to severe substance use disorder because of the chronic and relapsing nature of this disease. Symptoms such as ambivalence about treatment often require providers to provide outreach oriented care through an empathic, strengths-based approach. Extended time is spent in rapport building, developing client-directed goals and working toward holistic wellness with the sensibilities of harm reduction when indicated. Therapeutic treatment is evidence-based, provided in the community, and includes coordination of clinical interventions, case management and recovery support services.
- d. Success in this service can be defined in many ways including (but not limited to) the client achieving sobriety, decreasing substance use, decreasing risky behaviors, improving general health, securing safe/reliable housing and building recovery assets (often also known as recovery capital). Because of the chronic disease process with many of these individuals, success in one of these areas can take months or years. As long as continued progress on goals is being documented by the treatment team, the service continues.
- e. There are three types or varieties of recovery case management services available through the LRE , and each should be thought of as a flexible/moldable array of services to be provided:
  - i. Recovery Management – These services are typically provided to adults without ongoing current responsibilities to care for children. Services are meant to enhance current traditional treatment, link acute care episodes, work with individuals to stabilize bio-psycho-social issues, and provide/setup an on-going support network. Recovery Management authorizations should remain open and staff should be active during any other service that is delivered while the client is being served in Recovery Management (e.g., during detox, residential, hospitalizations, etc.). This is so that the team can work collaboratively with those other providers and teams, and assist with ongoing planning for engagement and continued care. A large component of Recovery Management is developing an empathic relationship and providing ongoing chronic disease management for the SUD condition. Flexibility and connecting individuals to

resources is a key for success. Recovery Management is ideal for individuals with a history of poor treatment retention, lack of continuity of care, and lack of any significant periods of recovery. Typically, these individuals have significant bio-psycho-social issues that contribute to poor treatment retention and continuity of care.

- ii. Family Engagement Therapy (FET) – This program’s objective is to provide comprehensive, family-focused, clinical services and case management in the home and other community-based settings for adults (usually women) with school-aged children. FET is designed to address the practical issues of child care, transportation, relationships, housing and/or other situations that can otherwise lead to insurmountable treatment barriers and pose risks to a client’s ability to parent his/her children. Clinical services include development of a family assessment and treatment plan, clinical services (including family therapy) and referral/coordination services. Case management services identify, evaluate and plan for basic family needs to be met.
- iii. Women’s Case Management (WCM) – This clinical service is focused on women with a moderate to severe substance use disorder who are pregnant, parenting a child 4 years or younger or who have had their parental rights terminated. Services offer clinical care, advocacy, education, community-based interventions, and coordination and support especially with the child welfare and legal systems.

f. Clinical Role Descriptions

	RM	FET	WCM
MA/MSW level Clinician	Yes	Yes	Yes
BA/BSW level Case Manager	No	Yes	Yes
Recovery Coach	Yes	Yes	No
Caseload Size	30-40	25-35	35-50
Percentage of active caseload expected to be seen face-to-face each month (hours if applicable)	75%	75%	75% (20 hours face-to-face client time/month)

- i. MA/MSW Level Clinician: The clinician is expected to provide clinically necessary service to the individual utilizing evidence-based interventions informed by a chronic disease management philosophy. These interventions should be provided in the community and with family members when needed, while maintaining appropriate professional boundaries. The clinician develops the individual plan of service and treatment plan and clearly documents interventions provided and progress observed/made.
- ii. BA/BSW Level Case Manager: The case manager provides advocacy and linkage to community services necessary for housing, financial aid, health care, and other essential services to address basic needs. Case management services will be community-based (vs. office-based). Case management interventions will provide an appropriate balance between expectation and caretaking, and seek to assist the individual only with what cannot be provided independently.
- iii. Recovery Coach: The recovery coach serves as a role model, mentor, advocate and motivator for individuals in early or unstable recovery in order to help avoid symptom recurrence and to help establish long-term recovery. The recovery coach provides an ongoing relationship with individuals to help keep them actively engaged in their recovery process, and to help to develop recovery assets and natural supports. Services accomplish goals by focusing on recovery community resources and motivations that already exist within most communities; employing a peer-driven, strength-based, and wellness-oriented approach that is grounded in the culture(s) of recovery; and leverages existing community resources.

## 2. Practice Principles

- a. The goal of community-based substance use disorder (SUD) services is to decrease SUD and mental illness (MI) symptoms by providing evidence-based interventions in a co-occurring capable environment. Treatment plans should be written collaboratively including client-directed goals, elicited through Motivational Interviewing.
- b. A Chronic Disease Management approach should be embraced, understanding that moderate to severe SUD is a chronic, relapsing disease with the potential for remission or recovery. Success – defined as fewer, less frequent and less severe recurrences – can be found in providing the individual enough treatment to equate a therapeutic dose.
- c. Providers need to be well-versed in Trauma-Informed Care, understanding that 85% of individuals with a severe SUD have extensive trauma histories. Teams should take care to focus on the client’s perception of safety, understand a need for control/self-direction, and should expect that SUD symptoms may not improve until PTSD has been addressed.
- d. For those clients who are not ready for formalized treatment, a Harm Reduction approach must be embraced, and mutually-developed goals based on wellness (and not necessarily sobriety) must be established and worked toward together. A working knowledge of Family Systems theory is necessary when working with family units in which addiction has become cyclical, or part of the family’s culture.

## 3. Credentialing Requirements

- a. The program must hold a current license for outpatient services from Michigan’s office of [Licensing and Regulatory Affairs](#).
- b. Professional staff must have a Master’s degree in an approved field of behavioral health and meet the qualifications of a “Substance Abuse Treatment Practitioner” (SATS) per the [Michigan PIHP/CMHSP Provider Qualifications Chart](#).
- c. Master’s level professional staff must also be credentialed by the [Michigan Certification Board for Addiction Professionals](#) as a CAADC, CADC, CCJP, or CCDP-D (or have a development plan for one of these credentials).
- d. Staff must be supervised by a Master’s prepared Clinical Supervisor with a MCBAP certified clinical supervisor certification (or development plan). Please refer to the [Michigan PIHP/CMHSP Provider Qualifications Chart](#) and [MCBAP](#) for a detailed listing of certification options and requirements, including student intern requirements.
- e. Recovery Supports – The individual completed Recovery Coach Training in compliance with MDHHS requirements and is supervised by a Master’s prepared clinical supervisor.
- f. As these standards are now being uniformly applied across the PIHP region, providers with specific challenges in meeting these requirements with legacy staff should contact their contracting entity to discuss options for compliance.

## 4. Service Requirements

- a. Provide, face-to-face co-occurring capable services in a welcoming environment. This includes integrated co-occurring screening, data collection/reporting, assessment, family-focused treatment planning, stage-matched interventions and ongoing evaluation to meet changing needs and abilities, including alternative service referrals as needed.
- b. Embrace a chronic disease management approach including outreach – frequent contacts and rapport building utilizing motivational interviewing, focusing on continued prevention of exacerbations, complications and relapse of the chemical dependency.
- c. Pre-recovery support to enhance readiness, in-treatment recovery support to enhance the strength and stability of recovery initiation, post-recovery support to enhance the durability and quality of recovery maintenance.

- d. Development of bio-psychosocial, integrated, family-focused assessment and treatment plan for each member of the family, as well as identification of gender-specific clinical issues (trauma, parenting, etc.).
- e. Linkage with needed resources and referrals including primary care, pediatric care, immunizations, developmental assessments, transportation and childcare services as needed.
- f. Collaboration with MDHHS, Child Protective Services, and any other involved providers.
- g. Ensure language interpretation, translation services and hearing interpreter services as needed.
- h. Programs serving pregnant or parenting women are required to provide immediate response to referrals of pregnant women and access to clinical services within twenty-four (24) hours of the individual's initial contact with the Access Center.
- i. Communicable Disease (Screening and Testing):
  - i. All individuals must be screened at assessment for risk of TB, STD, HIV, and Hepatitis in a manner that is consistent with the MDHHS Best Practice.
  - ii. If the screen identifies high-risk behavior, the individual must be referred for testing.
  - iii. Referral for testing is required for the following populations:
    - (1) Hepatitis C for all individuals with history of IDU.
    - (2) STD and HIV testing for all pregnant women.
  - iv. Mandatory TB testing for all individuals entering residential treatment within forty eight (48) hours of admission.
  - v. Referral agreements with Communicable Disease testing sites.
  - vi. Method for ensuring that the agency to which the individual has been referred has the capacity to accept the referral.
  - vii. Protocol for linking infected individuals with appropriate treatment/support resources.
  - viii. Protocol for recording the screening, referral, and linking activities in the individual's file.
  - ix. Completion of the Communicable Disease reporting requirements as specified by the Office of Recovery Oriented Systems of Care (OROSC).
- j. Health Education and Risk Reduction:
  - i. All individuals who are identified as having high risk behaviors must receive Health Education and Risk Reduction services delivered by a qualified provider.
  - ii. Health Education and Risk Reduction services must be documented in the individual's file.
  - iii. Staff Capability:
    - (1) A Training Plan to provide program staff with Level I Training as described in the APG, delivered by a qualified provider.
    - (2) A Training Plan to provide treatment staff with Level II Training as described in the APG, delivered by a qualified provider.
    - (3) Documented evidence of the implementation of the Training Plan.
- k. Fetal Alcohol Spectrum Disorder (FASD):
  - i. FASD prevention information must be provided to men and women in all substance use disorder treatment programs.
  - ii. For any treatment program that serves individuals with children, it is required that the program complete the FASD Pre-Screen for children they interact with during the treatment episode. In the event a child has a positive pre-screen, a referral must be made to a Fetal Alcohol Diagnostic Clinic.
- l. Michigan Mission-Based Performance Indicator System Access Requirements:
  - i. Ninety-five percent (95%) of persons requesting a screening for eligibility must be seen within fourteen (14) days from the request for service.
  - ii. Ninety-five percent (95%) of persons determined to be eligible for ongoing PIHP services must be seen within fourteen (14) days of the date of determination.

## 5. Training Requirements

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
- b. Provider will ensure and document that each staff is trained on the IPOS, prior to delivery of service.

## 6. Eligibility Requirements – Individuals served must:

- a. Have a DSM V diagnosis of substance use moderate or severe; co-occurring diagnoses are welcomed.
- b. Meet ASAM criteria for Outpatient, Intensive Outpatient, Detoxification or Residential Treatment.
- c. For Family Engagement Therapy (FET): Have custody of children, and have at least one (1) child between ages 4-18.
- d. For Women’s Case Management (WCM): Be pregnant, have children under age 4, or children placed out of the home.
- e. Individuals who require dual enrollment in Recovery Management, Family Engagement Therapy, Women’s Case Management, and/or other community-based services with case management components will be reviewed on a case-by-case basis.

## 7. Access Requirements

- a. For Family Engagement Therapy (FET), a CMHSP, a contracted provider, a Child Protective Services worker, or other community partner may make referrals by contacting the CMHSP access point of contact.
- b. For Recovery Management (RM), referrals may come from anyone inside or outside of the CMHSP/provider system. A referral may be made by contacting the CMHSP access point of contact.
- c. For Women’s Case Management (WCM), referrals may come from a CMHSP, a contracted provider or other community partner by contacting the CMHSP access point of contact.
- d. Priority Populations – Provider will prioritize services for the following populations (below). Admission time line standards will be met as stated in the contract. For pregnant women, if Provider cannot provide services within twenty-four (24) hours, the individual will be referred back to the CMHSP and then referred to an alternative service provider.
  - i. Pregnant Women-Injecting Drug Users – if the opiate use is significant, please refer to MAT services. If opiate use is not significant, detox can be commenced.
  - ii. Pregnant Women.
  - iii. Injecting Drug Users who have injected drugs in the past thirty (30) days.
  - iv. Parents whose children have been removed from the home under the Child Protection Laws of this State or are in danger of being removed from the home because of the parents’ substance abuse.
  - v. All others.
- e. Medicare – Individuals with Medicare insurance coverage will be referred to a Medicare Provider.

## 8. Authorization Procedures

- a. Family Engagement Therapy (FET) – Provider will complete a BH-TEDS and send it to the CMHSP for data entry and authorization. Authorization is for one (1) year, but can be renewed as long as need persists.
- b. Recovery Management (RM) – The individual will be authorized after a face-to-face meeting in which readiness for the service is assessed. The provider will complete a BH-TEDS and send it to the CMHSP at that time. Authorization for Recovery Management is for one (1) year, with the opportunity for renewal as need persists.

- c. Women's Case Management (WCM) – The provider will complete the BH-TEDS for data entry and authorization and will submit it to the CMHSP. WCM authorization is one (1) year with the opportunity for renewal for as long as the need persists.