ADULT AMBULATORY DETOXIFICATION
(ASAM Level 2-WM Withdrawal Management)

SECTION I. STATEMENT OF WORK:

A. PURPOSE:
   To provide safe withdrawal for clients physically dependent upon alcohol and other drugs and who are able to engage and participate in concurrent treatment services.

B. ELIGIBLE POPULATION:
   Adult Texas residents who meet financial criteria for DSHS-funded substance use disorder services and meet The Diagnostic and Statistical Manual of Mental Disorders criteria for a diagnosis of substance withdrawal who do not meet disease severity criteria for residential medically monitored, (ASAM Level 3.7-WM), withdrawal management.

C. SERVICE REQUIREMENTS:
   1. Administrative Requirements
      a. Contractor shall comply with all applicable rules adopted by DSHS related to substance use disorder services and published in Title 25 of the Texas Administrative Code (TAC), including the following Chapters:
         (1) Chapter 441 - General Provisions;
         (2) Chapter 442 - Investigations and Hearings;
         (3) Chapter 447 - Department-funded Substance Abuse Programs;
         (4) Chapter 448 - Standards of Care; and
         (5) Chapter 140, Subchapter I - Counselor Licensure.
      b. Contractor shall document all specified activities and services in the Department of State Health Services (DSHS) Clinical Management for Behavioral Health Services (CMBHS) system as directed by Local Authority in accordance with the Contract and instructions provided through DSHS training, unless otherwise noted. Documents that require client or staff signature shall be made available to Local Authority for review upon request. Contractor shall upload to an administrative note in CMBHS clinical documentation that is handwritten and not transcribed into the client’s CMBHS record: e.g. diagnostic tests such as the Clinical Institute Withdrawal Assessment (CIWA) or Beck Depression Inventory, physician orders, etc. Contractor will turn in CMBHS Security Attestation Form and List of Authorized Users to Local Authority prior to implementation of contract.
      c. Contractor shall adopt policies and procedures that conform with 25 TAC §448.504 (relating to Quality Management) and that include methods of assessing client satisfaction with Contractor’s services.
      d. Contractor shall maintain policies and procedures related to the retention of clients in Contractor’s services, including protocols for addressing clients absent from treatment and policies defining treatment non-compliance.
      e. Contractor shall ensure that all medical and program directors participate in programmatic conference calls as scheduled by Local Authority. Contractor’s executive management may participate in the conference calls, but medical and program directors shall participate unless otherwise agreed to by Local Authority in writing.
      f. Contractor shall have representative staff attend OSAR quarterly regional collaborative meetings.
      g. Contractor shall have a medical director who is a Texas licensed physician. The medical
director shall be responsible for admission, diagnosis, medication management, and client care. The medical director, or designated physician assistant or nurse practitioner shall approve all medical policies, procedures, guidelines, tools, and the medical content of all forms. Contractor shall have the following approved and in place prior to serving any clients:

(1) Screening instruments and procedures;
(2) Protocols or standing orders for all classes of drugs of abuse (opiates, alcohol and other sedative- hypnotic/anxiolytics, inhalants, stimulants, hallucinogens) that are consistent with guidelines published by nationally recognized organizations (e.g., Substance Abuse and Mental Health Services Administration, American Society of Addiction Medicine, American Academy of Addiction Psychiatry);
(3) Procedures to deal with medical emergencies;
(4) Additional protocols or standing orders for medication and monitoring procedures for pregnant women that address effects on the fetus of detoxification and medications used. Procedures for pregnant women shall include referral for perinatal care; and
(5) Special consent forms for pregnant women identifying risks of detoxification inherent to mother and fetus.

h. Contractor shall have a licensed vocational nurse (LVN) or registered nurse (RN) on duty and onsite for at least eight hours every day, and a physician or designated physician assistant or nurse practitioner on call 24 hours a day.

i. Contractor shall maintain a list of community resources and document referrals when appropriate to ensure that children of the client have access to services to address their needs and support healthy development. This includes primary pediatric care, early childhood intervention services, substance use disorder prevention services, and other therapeutic interventions that address the children’s developmental needs and any issues of abuse and neglect.

j. Contractor shall not deny admission to services based solely on the type or category of substance the client has been using. Contractor shall not deny access to treatment services at any level solely on the basis that a client is taking or may need to take a prescribed medication or is receiving medication-assisted therapy. Contractor shall accept referrals and make the necessary accommodations to continue treatment services for clients meeting DSHS admission criteria who are also receiving medication-assisted therapy. Medication-assisted therapies include opioid substitution therapy and other various uses of medications in the treatment of substance use disorders. Further, Contractor shall accept referrals and make the necessary accommodations to continue treatment for clients meeting DSHS admission criteria who are also currently taking or in need of access to prescribed medication for active or potentially reoccurring mental health or physical health issues.

k. Contractor shall ensure continuous access to emergency medical care, including provisions for back-up physician coverage when the medical director, or designated physician assistant or nurse practitioner, is unavailable. Contractor shall have written procedures to deal with medical emergencies, and staff shall be trained on these procedures. Contractor shall have a written policy regarding back-up physician coverage.

l. Reporting: Contractors shall report the previous day’s attendance to the Local Authority by 9:00 a.m. Central Time. For example: Monday’s daily attendance may be reported on Tuesday and Friday’s attendance may be reported on the following Monday. The Local Authority will enter this information into the DSHS Clinical Management for Behavioral Health Services System (CMBHSS).

m. Contractor shall engage and collaborate with community resources, using memoranda
of understanding (MOUs) to document collaborative relationships. Contractor shall maintain all required MOUs on file for review by Local Authority. MOUs shall specifically define what and how services will be provided to clients and their families, including specific engagement strategies and procedures. All MOUs shall be signed by both parties, individualized, annually renewed, and contain beginning and end dates. Contractor shall have MOUs in place within 60 days of the start date of the Contract with the following:

1. All DSHS-funded Outreach, Screening, Assessment, and Referral providers (OSAR) in Contractor’s Region that shall address, at a minimum, the following:
   a) How Contractor will report capacity and treatment availability information to each DSHS-funded OSAR provider in the Region;
   b) Referral processes when immediate capacity is not available:
      i) Whether Contractor or DSHS-funded OSAR provider will provide initial required interim services;
      ii) Whether Contractor or DSHS-funded OSAR provider will provide weekly contact for clients on Contractor’s waiting list.
   c) The MOU shall include established DSHS Priority Population requirements; and
   d) The MOU shall describe quarterly updating of specific contact information for key agency staff that handle day-to-day client placement activities.

2. All LMHAs within Contractor’s HHS Region and service area. MOUs shall address, at a minimum, the following:
   a) Appropriate referrals to and from Contractor and LMHA for indicated services;
   b) Emergency referrals and transportation assistance for clients in crisis;
   c) Follow-up contact with the LMHA to facilitate the enrollment and engagement of clients in LMHA services;
   d) Follow-up contact from the LMHA with Contractor to coordinate subsequent services; and
   e) Documentation of referral and other case management services provided.

3. DFPS regional office in which Contractor is located. The MOU shall address the regional referral process, coordination of services, and sharing of information between Contractor and DFPS.
   a) All indigent referrals for services must be coordinated through the OSAR for financial eligibility and clinical screening prior to referral and authorization for services.

n) Contractor shall utilize The Diagnostic and Statistical Manual of Mental Disorders criteria for a substance use disorder to determine client diagnosis.
o) Contractor shall train staff and develop a policy to ensure that information gathered from clients is conducted in a respectful, non-threatening, and culturally competent manner.

2. Service Delivery
   a) Contractor will refer all indigent individuals seeking service to the OSAR to document financial eligibility and conduct and document screening. This screening process will determine the individual's needs and will result in documented referral(s) to appropriate resources. If referral to services is made, an accompanying authorization will be sent as well. Authorization is required for payment due to limited funding.
   b) Contractor shall ensure every individual admitted to services meets the DSM criteria for substance withdrawal. Contractor shall document the specific client signs and symptoms that meet the criteria for the disorder in the assessment in CMBHS.
   c) When appropriate, Contractor shall provide pre-admission case management to reduce barriers to treatment, enhance motivation, stabilize life situations, and facilitate engagement in treatment.
d) For all individuals seeking treatment services who are determined to have a diagnosis of opioid/opiate use disorder, Contractor shall engage the individual in a process of informed consent and document using the form provided by DSHS. This form shall be uploaded to an administrative note in CMBHS.

e) Contractor shall conduct and document screening for tuberculosis, hepatitis B and C, sexually transmitted diseases (STD), and Human Immunodeficiency Virus (HIV).

(1) If the screening indicates the client is at risk for these communicable diseases, Contractor shall refer the client to the appropriate community resources for further testing and counseling.

(2) If the client is at risk for HIV, Contractor shall refer the client to pre- and post-test counseling on HIV.

(3) If the client is HIV-positive, Contractor shall refer the client to a DSHS-funded HIV Early Intervention (HEI) case manager or an HIV Ryan White case manager if no HEI case manager is available, and consider referral to the DSHS-funded statewide HIV residential provider.

f) Ambulatory detoxification shall not be a stand-alone service. Contractor, in collaboration with Local Authority, shall ensure the client is simultaneously admitted to a substance use disorder outpatient treatment service while admitted to ambulatory detoxification services.

g) Contractor shall provide all services in a culturally, linguistically, and developmentally appropriate manner for clients, families, and/or significant others. Contractor shall train staff and develop policies and procedures to ensure that service delivery and information gathering is conducted in a respectful, non-threatening, and culturally competent manner.

h) The medical director, or designated physician assistant or nurse practitioner, shall clinically authorize all admissions and conduct a face-to-face examination within 24 hours of admission. Contractor shall not require a client to obtain an outside history and physical to meet this requirement, or as a condition of admission. If the physician determines an admission was not appropriate, Contractor shall refer the client to the OSAR for referral to an appropriate service provider and document this referral. Contractor shall document the authorization and examination and include the following:

(1) History and physical examination of each client to establish the diagnosis;

(2) Assessed level of intoxication or withdrawal potential;

(3) Determination of the type of substance use disorder treatment needed; and

(4) Identification of potential physical and mental health problems and/or diagnoses that warrant further assessment.

i) The medical director or designated physician assistant or nurse practitioner shall document clinical justification for each client’s length of stay. Upon completion of detoxification services, the client record shall document that the client’s withdrawal symptoms have been sufficiently reduced so that the client is medically stable and no longer in need of management of acute withdrawal symptoms. The medical director or designated physician assistant or nurse practitioner shall sign a statement to this effect. Upon completion of detoxification services, Contractor shall encourage the client to continue engagement in treatment services. Contractor shall complete a documented discharge plan prior to discharge or transfer.

j) Contractor shall document a plan that contains the goal of successful and safe detoxification.

k) Contractor shall provide documented monitoring to manage the client’s physical withdrawal symptoms. Monitoring shall include documented observation of changes in mental status, vital signs, and response of the client’s symptoms to the prescribed detoxification medications. Contractor shall conduct monitoring at a frequency consistent with the degree of severity of the client’s withdrawal symptoms, and the drug(s) from which the client is withdrawing. The physician or designated physician assistant or nurse practitioner shall use recognized clinical
instruments such as the CIWA, as tools for monitoring withdrawal from various substances.

l) Contractor shall have clear documentation by the physician, or designated physician assistant or nurse practitioner that the client’s symptoms are not, or are not expected to be, of a severity that requires residential detoxification services and may be managed by a minimum of once-a-day monitoring in an ambulatory setting. Contractor shall provide sufficient oversight and evaluation of client’s vital signs and symptoms at least daily to ensure prescribed medications are controlling withdrawal. Contractor shall ensure that the client’s medical history does not include severe withdrawal and that the client’s current mental and physical functioning allow for self-administration according to the prescribed detoxification schedule.

m) Contractor shall make medication available to manage withdrawal/intoxication from all classes of drugs of abuse. Contractor may use medication regimens, protocols or standing orders, but shall document detoxification tailored to each client's needs based on vital signs and symptom severity (objective and subjective).

n) In addition to the management of withdrawal states, Contractor shall provide documented services, including daily individual interactions with an RN, QCC, or counselor intern, designed to do the following:
   (1) Assess the client's readiness for change;
   (2) Offer general and individualized information on substance use disorders; and
   (3) Engage the client in treatment using Motivational Enhancement Therapy or motivational interviewing techniques.

o) Contractor shall provide overdose prevention education to clients on Contractor’s waiting list. Contractor shall also provide overdose prevention education to all clients prior to discharge, including those that received it prior to admission:
   (1) General overdose prevention education shall be provided to all clients as a part of treatment education requirements to include education on naloxone (including possible local access if available).
   (2) Specific overdose prevention activities shall be conducted with clients with opioid use disorders and those clients that use drugs intravenously to include:
      (a) Education on naloxone (including possible local access if available);
      (b) Education about and referral to DSHS-funded HIV Outreach services for clients with IV drug use history; and
      (c) Referral to local community resources that work to reduce harm associated with high risk behaviors associated with drug use.

p) Contractor shall ensure access to adequate and appropriate medical and psychosocial tobacco cessation treatment as follows:
   (1) Assess tobacco use for all clients, entering the appropriate nicotine use disorder as an official diagnosis, if applicable; and
   (2) Provide all tobacco users who are motivated to quit with a referral to hospital or other local cessation resources. Unless otherwise directed by the Local Authority, Contractor shall offer a referral to the DSHS-funded Quitline (telephone-based tobacco cessation counseling services) with a fax referral for Nicotine Replacement Therapy (NRT).

q) Contractor shall complete referral follow-up for each referral entered into CMBHS.

r) Contractor shall document all referrals to recovery housing in CMBHS using the dropdown choice for recovery housing for the referral and by selecting the recovery housing dropdown choice in the Discharge Referral Destination field on the discharge assessment.

D. STAFFING AND STAFF COMPETENCY REQUIREMENTS:

1. All personnel shall receive the training and supervision necessary to ensure compliance with
DSHS rules, provision of appropriate and individualized treatment, and protection of client health, safety, and welfare.

2. Contractor shall ensure that all direct care staff receive a copy of the service requirements within this statement of work.

3. Substance use disorder counseling shall be provided by a QCC, graduate, or counselor intern. Substance use disorder education and life skills training shall be provided by counselors or individuals who have appropriate specialized education and expertise. All counselor interns shall work under the direct supervision of a QCC.

4. Clinical staff shall have specific documented training in the following within 90 days from the start date of the Contract or the date of hire, whichever is later:
   a) Motivational Enhancement Therapy or motivational interviewing techniques;
   b) Trauma, abuse and neglect, violence, Post-Traumatic Stress Disorder, and related conditions;
   c) Cultural competency, specifically including, but not limited to, gender and sexual identity and orientation issues;
   d) Medicaid eligibility; and
   e) State of Texas co-occurring psychiatric and substance use disorder (COPSD) training.
      Contractor shall access www.centralizedtraining.com website for COPSD training.

5. Licensed Chemical Dependency Counselors shall recognize the limitations of the licensee’s ability and shall not provide services outside the licensee’s scope of practice or licensure, or use techniques that exceed the person’s license authorization or professional competence.

6. Contractor shall develop and implement a mechanism to ensure that all direct care staff have the knowledge, skills, and abilities to provide detoxification services, as they relate to the staff member’s job duties. Contractor shall be able to demonstrate through documented training, credentials, and/or experience that all direct care staff have knowledge regarding detoxification, including but not limited to areas regarding the following:
   a) Signs of withdrawal;
   b) Observation and monitoring procedures;
   c) Pregnancy-related complications (if Contractor admits women);
   d) Complications requiring contacting appropriate medical services;
   e) Appropriate interventions;
   f) Frequently used medications including purpose, precautions, and side effects, and
   g) All policies and procedures, forms, and tools, which shall be approved by the medical director or designated physician assistant or nurse practitioner, including the following:
      (1) Screening instruments and procedures;
      (2) Protocols and standing orders for specific drug categories;
      (3) Protocols to deal with medical emergencies;
      (4) Additional protocols or standing orders for medication and monitoring procedures for pregnant women that address the effects on the fetus of detoxification and medications used; and
      (5) Special consent forms for pregnant women identifying risks of detoxification inherent to mother and fetus.

SECTION II. PERFORMANCE MEASURES:

1. Contractor shall ensure that the majority of clients achieve sustained remission from the symptoms of their substance abuse disorder.

2. Contractor shall be bound by the measures in the table below that are applicable to the services Contractor is to provide under this Program Attachment as indicated in the Program
Services and Unit Rates table in Section VII Funding:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Unit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Ambulatory Detoxification Services</td>
<td>70%</td>
</tr>
<tr>
<td>Percent who complete detoxification services</td>
<td></td>
</tr>
<tr>
<td>Percent of clients with concurrent admission to outpatient treatment services</td>
<td>100%</td>
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</tbody>
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SECTION III. PROGRAM SERVICE AREA:

Contractor shall deliver services or activities to clients in the following counties: Collin County

SECTION IV. ELIGIBLE POPULATION:

Adults age 18 and over; men and women

SECTION V. PAYMENT METHOD:

Fee for service billing based on current State rates for all Substance Abuse Services. Contractor will be paid on a monthly basis for all authorized services on eligible clients.

SECTION VI. BILLING INSTRUCTIONS:

Contractor shall submit claims for services to the Local Authority through CMBHS monthly. Once DSHS pays the claim to the Local Authority, the Local Authority will then pay the Contractor within 15 days.

SECTION VII. FUNDING:

Contractor shall contribute an amount equal to at least five percent (5%) of the total Local Authority funding of the Program Attachment expenditures in matching cash or in-kind contributions from sources eligible to be used for matching purposes. Contractor shall comply with the Match requirements stated in the DSHS General Provisions. Match will be reported on a quarterly basis. Contractor will be responsible to report Match on the SUD Match Form to the Local Authority by the 10th day following the quarter being reported. Dates will be provided in the contract.

PROGRAM SERVICES AND UNIT RATES:

See LifePath FY17 SUD Rates and Capacity Sheet for details on unit rates and monthly service capacity limits.