STATE OF ALASKA - HEALTH AND SOCIAL SERVICES

DBH Comprehensive Behavioral Health Treatment and Recovery Grants - Program Service Types

FY2017

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Contents

Program Service Type #1 - Psychiatric Emergency Services (PES)

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- 7 AAC 72.110 – Written Agreements (Between DES/T Facilities and Grantees)
- Grantees must utilize the DSM-5 and ICD-10-CM, adopted by reference in 7 AAC 70.910, and the DC: 0-3R adopted by reference in 7 AAC 160.900

Target population: The Community Behavioral Health Center (CBHC or "grantee") funded to provide Psychiatric Emergency Services (PES) shall serve all people in the grantee's service area who are in need of emergency behavioral health services, regardless of ability to pay.

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

PART A. CORE SERVICES AND REQUIREMENTS

Grantees providing psychiatric emergency services have the following **core** responsibilities:

1. **Access.**
   Standard: CBHC's shall inform service area residents of the availability and manner in which local / regional emergency services can be accessed.

   - **Criteria 1a. Publicize Availability of PES.** The grantee shall take measures to inform the residents and social service agencies in the grantee's service area how the public can access Psychiatric Emergency Services (e.g., a specific description of the scope of the grantee's Psychiatric Emergency Services on the grantee's website, employing public service announcements, phone directory listings, public presentations, hospital information services, publicly-distributed brochures).
   - **Criteria 1b. Services Available to All Service Area Residents.** Psychiatric Emergency Services are rendered to any resident of the grantee's service area, regardless of the resident's ability to pay and whether the resident is presently an enrolled CBHC client or a Trust or Tribal beneficiary, or a non-beneficiary, or a person unknown to the CBHC and its clinicians.

2. **Availability.**
   Standard: CBHC's with PES grants have a 24/7 responsibility for all residents experiencing a behavioral health emergency in the grantee's service area.

   - **Criteria 2a. Availability of Masters-trained PES Staff.** The grantee shall ensure that a *master's level* mental health professional clinician, as defined in 7 AAC 70.990(28), is available 24/7 to respond to emergencies.

- **Criteria 2b. Availability of a Range of PES Services.** The Psychiatric Emergency Services provided by the CBHC/PES Grantee include crisis intervention, clinical screening and assessment, and crisis stabilization.
- **Criteria 2c. Availability of 24/7 Crisis Line Services.** Within the grantee's service area, initial behavioral health emergency phone calls are the responsibility of the grantee; however, these required crisis line services may be covered or provided by an affiliated service (e.g., a grantee's after-hours answering service; a community- or service area-wide crisis hotline; a phone in a local emergency room), so long as that service has the ability to immediately contact the grantees' on-call clinician when informed of a behavioral health emergency. AS 47.30.056(i) (2)(A)

3. **Response.**
Standard: While some interventions will inevitably lead to hospitalization, grantees are encouraged to pursue options for stabilizing clients locally; thus, where possible, referrals to local programs and services are preferred. [In many instances, there is less disruption to a person's / client's life if he or she can be supervised in a safe place close to home while medications (if prescribed or available) are adjusted by a local provider.]

- **Criteria 3a. Local Response Services.** Screening, assessment, and intervention services are provided by the grantee's mental health professional clinicians when a person in crisis presents with suicidal or homicidal ideation, or is gravely disabled and likely to need hospitalization. When a person in crisis is under the influence, as determined by medical exam, self-admit or behavior consistent with such influence, of alcohol or other drugs, including prescription and over the counter medications, and household/general use products that can be abused as inhalants the lead mental health clinician from the grantee agency may use clinical judgement regarding when a mental health assessment is appropriate.
- **Criteria 3b. Emergency Appointment / Contact Response Time.** A mental health professional clinician informed of an emergent matter must respond (face-to-face or by phone) to the request for emergency intervention / evaluation services within two (2) hours of contact by the crisis line responder. . If the lead mental health clinician has determined the patient is under the influence of a substance that would affect the outcome of the assessment (see criteria 3a.) and the assessment is delayed, the grantee agency is required to follow-up with the patient at least every 2 hours until an assessment can be completed.
- **Criteria 3c. Knowledge of Commitment Procedures.** When necessary, a grantee's mental health professional clinician must petition for an order for hospitalization for evaluation and arrange for secure transportation of the person in crisis to the evaluation and / or treatment services at a Designated Evaluation and Treatment (DET) Hospital, or at Alaska Psychiatric Institute (API). If the lead mental health clinician has determined the patient is under the influence of a substance that would affect the outcome of the assessment (see criteria 3a.) and the assessment is delayed, the grantee agency is required to follow-up with the patient at least every 2 hours until an assessment can be completed.
- **Criteria 3d. CBHC Follow-Up Services for Persons Not-Hospitalized.** Local behavioral health crisis follow-up services shall be provided by appropriate CBHC staff (not limited to PES staff) to ensure that the behavioral or psychological concerns associated with the individual's acute distress, impairment, or risk phase have been sufficiently resolved that the individual no longer presents as a danger to themselves or others or is no longer gravely disabled. This follow-up is intended to ensure stabilization and safety.

4. **Post-Hospitalization Follow-Up.**
Standard: Good continuity of care requires that persons discharged from psychiatric hospitalizations should be connected – or re-connected – to after-care services through their local CBHC/PES Grantee as quickly as possible.

Please note: 7 AAC 72.110 (entitled "Written Agreements") requires API and DES and DET hospitals to "enter into a written agreement" with the CBHC's within the communities to whom the hospitals regularly discharge patients. As a part of this agreement, the CBHC/PES Grantee, "after being notified by the facility of a patient's discharge from the facility," will schedule an appointment for that individual at their center for "within one week of the patient's discharge" [defined by DBH in this Program Service Type description as seven (7) calendar days], . There is an with the additional expectation that the CBHC/PES Grantee will make every effort to provide medication management services and, including a psychiatric evaluation, as soon after discharge from the hospital as possible. This expectation, of course, assumes that the person being discharged has agreed to this discharge plan and is interested in follow-up care from the identified CBHC.

- **Criteria 4a. CBHC/PES Grantee Role in Scheduling a Follow-up Appointment.** A CBHC/PES Grantee shall accommodate all requests for post-hospitalization follow-up appointments from API, North Star, and other hospitals, including DET hospital social workers. The CBHC/PES Grantee will ensure that follow-up appointments are scheduled at its clinic (or another CBHC) within seven (7) calendar days of the patient's date of discharge, and will, if possible, provide the discharging hospital's social worker with the name of the clinician with whom the discharged patient's intake or counseling session is scheduled. Whenever possible, this information is to be included on the patient's discharge release papers, so that the patient has access to their follow-up information after leaving the hospital. API and the CBHC may also arrange for telebehavioral health appointments or consultations when face to face follow up is not possible or feasible.
- **Criteria 4b. Documentation of the Follow-up Appointment.** It is the intent of this criteria that every hospitalized psychiatric patient will see a CBHC clinician (or a clinician at another CBHC) within seven (7) calendar days of their date of discharge from the hospital. To this end, the CBHC/PES Grantee will make every attempt to telephonically reconfirm any CBHC appointment made for a person while they were hospitalized and encourage that person's on-time appearance for their scheduled CBHC intake (if a new client) or follow-up counseling session (if a current client), regardless of whether the appointment is in-person or via video conferencing or telephonic.

5. **Face-to-Face Contact Required.**
Standard: Whenever possible, psychiatric emergency evaluations by mental health professional clinicians occur face-to-face.

- **Criteria 5a. Face-to-Face Contact Required.** Except as noted in Criteria 5b below, every emergency contact with an individual experiencing a psychiatric crisis (whether expressing suicidal or homicidal ideation, or is gravely disabled and likely in need of hospitalization) requires a face-to-face intervention, including screening and assessment services; however, a tele-behavioral health consult may be employed when available and as appropriate.

- **Criteria 5b. Service Location.** These crisis intervention services are provided in any location that provides reasonable safety for the individual in crisis and the grantee's (on-call) clinician (e.g., a CBHC clinic office, a school, the local jail, a hospital emergency room). If the mental health professional clinician is *more than 50 miles away* from the resident in crisis or if unusual weather or road conditions preclude the clinician's travel, then telephonic or telebehavioral health consultative services are provided by the clinician individually or in collaboration with an emergency responder closer to the resident in crisis.

PART B. CONTINUITY OF CARE

Standard: Psychiatric emergency services must be closely linked with local, ongoing behavioral health treatment and rehabilitation services, in order to ensure continuity of care for the recipient of CBHC services.

Grantees providing psychiatric emergency services have the following responsibilities with respect to meeting appropriate continuity of care expectations:

- **Criteria 6. The Grantee has a Written Disaster Response Plan.** Grantees are required to have a Disaster / Emergency Response Plan in place that not only describes how the agency and its staff will respond to a disaster or emergency that impacts the ability of the agency to operate normally and maintain its commitment to the safety of its staff and its clients, but also how the grantee's behavioral health resources will be employed / deployed in a local or service-area-wide natural or man-made disaster. The plan should address CBHC staff call-back procedures following a disaster, once staff has confirmed the status of their own family members, as well as the role CBHC clinical staff will assume in providing counseling services to area residents in need of support following a disaster.
- **Criteria 7. The Grantee has a MOA with the Nearest Local or Regional Hospital.** As stated in Criteria 4 above (Post-Hospitalization Follow-Up), the CBHC/PES Grantee will develop a written memorandum of agreement with any hospital within 50 miles of the grantee's main office, including any DET facilities. The MOA will describe CBHC/PES Grantee and hospital responsibilities when responding to a local or service area behavioral health crisis, including the option for shared emergency on-call services (so long as there is 24/7 community service area coverage). Where appropriate and applicable, the agreement will also describe the process for a hospital's credentialing of a grantee's mental health professionals and masters-level clinicians, so that mental health professional clinical staff are able to provide face-to-face patient screenings and assessments in the hospital's emergency department or acute care treatment unit (especially for other than DET hospitals).
- **Criteria 8. The Grantee Maintains MOA's with Local Law Enforcement.** The CBHC/PES Grantee will develop written agreements with local and service area law enforcement agencies for the handling of psychiatric emergencies, including protocols for grantee mental health professionals and master's level mental health professional clinicians to provide face-to-face screening and assessment at jails, juvenile detention facilities (if located within 50 miles of the grantee's clinic), and local hospitals. Screening and assessment shall include petitioning for orders for hospitalization for evaluation, if necessary and regular re-assessments (no less than once every 24 hours) of any persons in crisis being held for transport to an evaluation facility (DET or API).

- **Criteria 9. The Grantee May Rely on Associated Community / Village Persons to Assist When the Crisis is More than 50 Miles from a CBHC/PES Grantee Office.** If the grantee office is located more than 50 miles from the client in crisis, or if the agency's office is not accessible on the State road system, the on-call mental health professional clinician may assist local health / behavioral health aides or other reliable persons to assist Village Public Safety Officers (VPSO's) or Village Safety Officers (VSO's) to screen and assess clients for emergency detention. The VPSO / VSO may file the MC-105 form, titled "Notice of Emergency Detention and Application for Evaluation". The on-call clinician must be available by phone or radio for support to this process, which will allow the person experiencing a behavioral health crisis in a rural community to be transported to the nearest local or regional hospital for assessment and potential involuntary commitment for evaluation or treatment.

Program Service Type #2 - Withdrawal Management Services (formerly known as Detoxification Services)

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the DSM-5 and ICD-10-CM, adopted by reference in 7 AAC 70.910, and the DC: 0-3R adopted by reference in 7 AAC 160.900
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Target Population: The withdrawal management services provided by a Community Behavioral Health Center under a Comprehensive Behavioral Health Treatment and Recovery (CBHTR) Grant are intended to serve adult patients who, because of their use of alcohol and / or other drugs including opioids are frequent users of withdrawal management services, emergency medical services, public safety services, the emergency rooms of acute care hospitals, or API.

These programs must give preference to treatment as follows:

a) Pregnant injecting drug users
b) Other pregnant substance abusers
c) Other injecting drug users
d) Office of Children Services engaged families
e) All others

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

PART A. CORE WITHDRAWAL MANAGEMENT SERVICES AND REQUIREMENTS:

Grantees funded to provide withdrawal management services have the following **core** responsibilities as defined in 7 AAC 70.110.

1. **Admission Services**
   Standard: Admission to Withdrawal Management Services will be based on the criteria delineated in the Substance-Related Disorder category as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and the current SUD Patient Placement Criteria defined by the American Society of Addiction Medicine (ASAM Third Edition).
2. **Co-occurring Services**
   Standard: If, as a client progresses through withdrawal management, the client is observed to have a co-occurring psychiatric diagnosis that actively impacts – or may actively impact – the rate of a client's successful progress through treatment, it is incumbent on the grantee to seek qualified mental health assessment and clinical services for the client as a part of their plan of care.

3. **Discharge Planning**
   Standard: Comprehensive discharge planning will begin at admission, based on the results of the client's substance use disorder assessment Discharge planning will address matters such as referrals for SUD treatment (residential or outpatient), mental health treatment, housing, case management, screening for minor children (when appropriate), initiation of family counseling, peer support/navigation, and other areas necessary to support the client's stability and progress. As much as possible, referrals should be to specific programs or resources. Using approaches such as motivational interviewing may encourage and support client readiness and acceptance for engaging in additional treatment, as needed.
4. **General Statutory and Regulation Compliance**

   - DBH grantees funded to provide withdrawal management services must meet all current regulatory requirements found in the Alaska Administrative Code, including 7 AAC 70.100 – 7 AAC 70.160; 7 AAC 70.200 – 7 AAC 70.260; and 7 AAC 70.010 – 7 AAC 70.060; and the statutory requirements set forth in AS 47.37.140.

PART B. AMBULATORY AND NON-AMBULATORY RESIDENTIAL WITHDRAWAL MANAGEMENT SERVICES

DBH grantees funded to provide withdrawal management services may offer the following levels of care:

1. **Non-Ambulatory Residential Withdrawal Management Services**
   Standard: **Non-ambulatory withdrawal management patient services are provided by a grantee in a permanent facility with 24-hour observation and supervision by properly trained staff that provides structure and support to patients during the course of the client's treatment for withdrawal management. Non-ambulatory (i.e., inpatient) withdrawal management services are divided into two types: clinically managed or medically monitored.**

   - **1a. Clinically Managed Withdrawal Management Services.** (Defined in 7 AAC 70.110 (c, 1- 6) (f-i)

     - Staff providing clinically managed withdrawal management services may supervise a patient's use of self-administered medications for the control of the client's withdrawal symptoms;
     - Staff providing clinically managed withdrawal management services must have the ability to determine the appropriateness and necessity of transferring clients in need of medical services to a hospital.

   - **1b. Medically Monitored Withdrawal Management Services.** (Defined in 7 AAC 70.110 (d, 1-8) (f-i)

     - A grantee offering medically monitored withdrawal management services provides observation and supervised evaluation and withdrawal management delivered by qualified medical and nursing professionals in a hospital or permanent inpatient facility, with 24-hour observation, monitoring, and treatment.

- Note: medically monitored withdrawal management is not necessary for individuals who are actively using **only** cocaine, marijuana, or amphetamines. These individuals are not appropriate for Medically Monitored Residential Withdrawal Management.

2. **Ambulatory Withdrawal Management** (Defined in 7 AAC 70.110 (b. 1-6) (e-i)) ***Standard:*** A Behavioral Health Center grantee offering ambulatory (i.e., outpatient, non- residential) withdrawal management services provides treatment to individuals who are actively engaged in alcohol use disorder, opioid use disorder, or a use disorder involving other drugs, and is able to minimize the residential stays for these clients because the clients have adequate social or family support systems in place, and their medical condition(s) does not require a higher level of (non-ambulatory) withdrawal management services.

   A client of an ambulatory withdrawal management grantee must be concurrently receiving outpatient or residential substance use (not withdrawal management) treatment services.

   Withdrawal management is generally not necessary for individuals who are actively using only cocaine, marijuana, and amphetamines and therefore they are not appropriate for Ambulatory Withdrawal Management.

   - **2a. Ambulatory Withdrawal Management Services *without* Extended Onsite Monitoring** This level of care is currently not defined in regulation. All program approvals require agencies to meet the standard for ambulatory withdrawal management with extended on-site monitoring.

     - Ambulatory withdrawal management *without* extended onsite monitoring is an organized outpatient service which the grantee may provide in an outpatient office, clinic or treatment facility.
     - Grantees offering this lower level of onsite monitoring shall use trained clinicians who provide medically supervised evaluation, withdrawal management, and referral services according to a publicized, predetermined program. These planned services are provided in regularly scheduled sessions and are delivered under a defined set of grantee published policies and procedures and in accordance with identified, available medical protocols.

   - **2b. Ambulatory Withdrawal Management Services *with* Extended Onsite Monitoring** Ambulatory withdrawal management *with* extended onsite monitoring is similar to ambulatory withdrawal management without extended onsite monitoring (see 2a above), with the following *exceptions*:

     - The grantee's onsite monitoring services are not necessarily accessed at established hours or set according to a predetermined schedule, but the sessions held must be sufficient in number and time to effectively monitor and educate an individual regarding the stages of the withdrawal management process the individual is going through, and to assist the trained grantee staff in determining the individualized effects of each client's own withdrawal process;
     - An ambulatory withdrawal management services program with extended onsite monitoring is appropriate for those clients who may be dually diagnosed, i.e., clients who have co-occurring mental health and substance use disorder diagnoses, with a

primary focus on the need for SUD treatment, but whose psychiatric issues are such that active mental health treatment must be a key part of the patient's outpatient treatment plan and be managed accordingly.

PART C. MISCELLANEOUS:

- **Current Activity Schedule.** Grantees providing withdrawal management services have a current activity schedule that provides an amount of active treatment that is consistent with the program's stated ASAM Third Edition Level of Care and the standards as outlined in 7 AAC 70.110.
- **Readmission for Withdrawal Management.** The number of withdrawal management attempts for individuals may vary according to the degree and severity of addiction, drugs to which addicted, health and well-being, and support services necessary to assist an individual in their recovery. Participants who fail to complete a stay in withdrawal management shall not be held to a set number of days before consideration for readmission. If they present again for admission, they shall be readmitted based upon available space and clinical need. ***Each case shall be evaluated on an individual basis.***
- **Disaster/Emergency Response Plan.** Grantees are required to have a Disaster/Emergency Response Plan in place that describes how a grantee's behavioral health resources will be employed / deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, clients and family members following a disaster, as well as the role staff will assume in providing counseling services to clients.

Program Service Type #3 - Youth Residential Substance Use Disorder Treatment Services

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Target Population: The program is intended to serve youth who have not attained the age of eighteen years. Youth served in this program have been assessed as having a substance use disorder involving alcohol or other drugs, prescribed or over-the-counter medications, and/or household/general use products that can be ingested or used as inhalants. In order to maximize positive outcomes, this program is intended to include the patient's support network of family members, friends and/or employers in the treatment process.

These programs must give preference to treatment for youth as follows:

a) Pregnant youth injection drug users
b) Pregnant youth substance abusers
c) Youth injection drug users
d) Youth with children substance abusers
e) Youth with referrals from Office of Children Services, Division of Juvenile Justice
f) Youth in Foster Care
g) All others

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

In addition to the specific requirements described below, SUD grantees are required to meet the expectations outlined in the section titled **All Substance Use Disorder Treatment Types – Excluding Withdrawal Management Services, Section 1** (found on pages 51 to 53). Grantees who receive funding from the **Substance Abuse Prevention and Treatment (SAPT) Block Grant Program** must also meet the requirements outlined in **Section 2** (found on pages 53 to 61) of this document.

DHSS/BH will only fund the following Youth Residential service type:

- **Level III. 5 Clinically Managed High-Intensity Residential Services** 7 AAC 70.120 (a-e; h) (*20 or more hours of clinical/rehabilitation services per week)* Agencies must be approved to provide clinically managed high intensity residential services under 70.120 and clinic services under 70.030 to support the requirement for clinic services listed below. The Division acknowledges that while ASAM Third Edition does not distinguish Level 3 sublevels by the number of hours of services, DHSS Regulations require a specific number of

hours of treatment for reimbursement at varying levels of residential care. Approved residential substance use facilities are required to engage in community education and outreach to ensure that clients are aware of the availability of services. Residential substance use disorder treatment facilities are required to deliver services in a 24-hour staffed residential setting and have consultation available 24-hours a day, 7-days a week with a physician and emergency services. In addition to a physician's availability for 24-hour consultation, the Behavioral Health Services Integrated Regulations allows for a physician assistant, an advanced nurse practitioner, or the emergency medical staff of a general acute care hospital to provide consultation via telephone or in-person.

DHSS Behavioral Health encourages grantees to employ evidence-based practices in their treatment programs. However, DHSS Behavioral Health recognizes that some effective treatment programs employ a variety of therapies and services that meet the needs of individual clients.

Applicants should describe in their grant proposal why their proposed model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidence based research and/or previous program evaluation results. Approaches such as the *Transition to Independence Process* (see http://www.tipstars.org/) or *Motivational Interviewing* may encourage and support client readiness and acceptance for engaging in treatment. Applicants seeking to provide a cohort model should clearly articulate how the cohort model is the most effective treatment modality for their target population.

Core Services and Requirements:

Grantees are also responsible for adhering to the following requirements by either providing or assist the client in accessing:

- Program orientation and intake/admission:
    - Medical clearance of communicable diseases and referral for medical treatment as needed;
    - Application for applicable public assistance such as Medicaid.
- Interim services for wait listed clients (onsite or by referral)
- Individualized treatment planning and review:
    - Direct family involvement in treatment and discharge planning
    - Screening and bio-psychosocial assessments that include exposure to trauma, developmental history, cultural and religious background, sexual orientation and other factors which may impact treatment planning;
    - Family assessments that include social history, protective services or juvenile/adult justice involvement, housing/financial stability, placement history and relocations;
    - Screening and referral for any minor children, as appropriate.
- Substance use treatment to include:
    - Gender or gender orientation specific substance use disorder treatment
    - Individual, Group and, Family counseling (when indicated) focused on functional improvement, recovery and relapse prevention. Therapeutic interventions may

address past traumatic events, issues of relationships, physical and/or sexual abuse, and parenting;
- Cognitive behavioral social learning models emphasizing interventions that assist the individual in changing self-defeating beliefs and values, problem solving, interpersonal skills training, role playing, modeling, or cognitively mediated behavior modification.
- Curriculum based psycho-education groups (basic alcohol and drug education, relapse prevention, recovery, nutrition and infectious diseases, etc.).
- Specialized skill building groups organized around a common problem such as: anger management, parenting, domestic violence, stress reduction and gender specific issues;
- Referrals/introductions to self-help or community support groups.

- 24 hour crisis coverage for enrolled clients
- Referrals and case management (during treatment and for discharge planning), to include:
  - Continuing care;
  - Peer support and /or peer navigation;
  - Recovery support services, including referrals for family support services;
  - Linkage to community based support groups;
  - Medication management;
  - Housing and basic needs;
  - Linkage to services for minor children (behavioral health, day care, infant learning/early intervention, health, etc.)
  - Other support services (housing, education, employment, etc.)

Grantees are also responsible to have a Disaster/Emergency Response Plan in place that describes how a grantee's behavioral health resources will be employed / deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.

Program Service Type #4 - Residential Services for Youth with Serious Emotional Disturbance

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the DSM-5 and ICD-10-CM, adopted by reference in 7 AAC 70.910, and the DC: 0-3R adopted by reference in 7 AAC 160.900

Target Population: This program is intended to target youth who meet the criteria for serious emotional disturbance and who need out-of-home therapeutic placement. (Note: serving youth 18 and over in a youth residential care facility requires a variance from Health Care Services Certification and Licensing).

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core Services and Requirements:

- Residential services are therapeutic, rehabilitative and support services provided out- of-home in a community-based residential setting. Facilities are licensed in accordance with, Residential Child Care Facility Licensing 7 AAC 50.005 - 7 AAC 50.990.
- All providers must meet the restraint and seclusion requirements in 42 CFR 483.350-483.376.
- All providers must engage in community education and outreach to make clients aware of services.
- All providers must notify DBH of critical incidents using the form on the DBH website.
- Additionally, grantees providing residential services must comply with the requirement to notify the Division (their program manager) of any instances in which a client is found to be missing, seriously injured, or deceased. (Grantees may also be required to report these incidents to licensing or certification bodies). This requirement applies to any facility operated by the grantee or closely affiliated with the grantee, including facilities with on-site staff, assisted living homes, supported living homes, residential treatment, group homes, and crisis respite facilities.
- Grantees providing residential services must follow best practice principles, including:
    - Begin discharge planning when the youth enters placement, including providing services (as appropriate) to reunify/build "family[1]" relationships and social supports.
    - Develop an individualized behavioral health plan for each youth and ensure delivery of the services and supports in the plan.
    - Ensure case coordination with other community providers (schools, community mental health, work, OCS, DJJ) and with natural community supports.

[1] Anyone who fills the role of a family member in the youth's life.

- Establish mechanisms to elicit feedback from the youth and families served. DBH recommends use of "Building Bridges" tools (http://www.buildingbridges4youth.org/products/tools)
- Grant funds may support the following types of residential services:
    - **Therapeutic Group Home -** These are services providing treatment and support in a home-like setting by specially trained foster parents. Funds may also be used to locate and train foster parents. Residential grantees must have criteria to ensure that the training and experience of the foster parents is appropriate to meet the needs of the youth served in the home. Therapeutic Group Homes have a maximum of three beds for children and youth.
    - **Emergency Stabilization and Assessment Centers -** These centers provide interim services for youth whose behavioral problems cannot safely be managed in their present environment, who need short term, temporary placement, or may need stabilization and a thorough assessment of their needs.
    - **Residential Treatment -** These programs provide treatment services in a 24- hour staffed setting for a medium to long-term (6-12 months) period of time. The purpose of residential care services is to remediate specific dysfunctions which have been explicitly identified. These services are provided to children in residential care settings to treat debilitating psychosocial, emotional and behavioral disorders. These services provide a therapeutic environment for children/youth that are unable to be treated effectively in their own family home, a foster home or in a less restrictive and structured setting.
    - **Residential Diagnostic Treatment/Stabilization Residential Diagnostic Home -** These programs provide specialized treatment services for a subset of youth who present with a specific problem (e.g. sexual offending). The RDT is designed to provide comprehensive mental health and behavioral services to youth who exhibit more serious and destructive behaviors, have been identified as having more intensive needs, or need a more structured setting with psychiatric service available. They may be at high risk of out-of-state placement.

Program Service Type #5 - Adult Residential Substance Use Disorder Treatment Services

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Target Population: This program is intended to serve individuals aged 18 and older who experience a substance use disorder or co-occurring substance use and mental health disorder.

These programs must give preference to treatment as follows:

a) Pregnant injecting drug users
b) Other pregnant substance abusers
c) Other injecting drug users
d) Office of Children Services engaged families
e) All others

Clients requiring this level of care referred from an Alcohol Safety Action Program, a Therapeutic Court, or Alaska Psychiatric Hospital are a priority for admission.

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

In addition to the specific requirements described below, SUD grantees are required to meet the expectations outlined in the section titled **All Substance Use Disorder Treatment Types – Excluding Withdrawal Management Services, Section 1** (found on pages 51 to 53). Grantees who receive funding from the **Substance Abuse Prevention and Treatment (SAPT) Block Grant Program** must also meet the requirements outlined in **Section 2** (found on pages 53 to 61) of this document.

Core Services and Requirements:

All providers are required to engage in community education and outreach to ensure that clients are aware of the availability of services.

DHSS/BH will fund the following residential service types:

- **Level 3.1: Clinically Managed Low Intensity Residential Services**
  7 AAC 70.120 (a-f) *(a minimum of five hours of clinical and rehabilitative services per week)*. Examples are a halfway house or sober housing that offers at least five hours of rehab services. This level of care can also apply to the final phase of a 3.5 residential program, where individuals residing in a residential facility or Intensive Therapeutic Community Program are in need of reduced hours of clinical services and increased hours of employment seeking, exploring housing options and other community reintegration efforts. The primary

goal of Level 3.1 is to focus on a structured recovery environment that provides sufficient stability for the recipient. There is a heavy focus on ASAM Third Edition Dimensions 5 and 6.

- **Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services** 7 AAC 70.120 (a-e; g) (*20 or more hours of clinical and rehabilitative services per week*). This level of care is specific to persons with cognitive difficulties and provides a structured recovery environment in combination with high intensity, but often slower paced, services focusing on severe cognitive or functional impairment/limitations; severe deficits in interpersonal and coping skills, relapse prevention, overcoming lack of awareness about the effects of substance-related problems in their lives, and promoting eventual reintegration into the community. Cognitive impairments manifested in patients most appropriately treated in Level 3.3 services can be due to aging, traumatic brain injury, acute but lasting injury, or due to illness, and may be permanent or temporary. Mental health professionals are suggested as part of the staff milieu.
- **Level 3.5: Clinically Managed High-Intensity Residential Services** 7 AAC 70.120 (a-e; h) (*20 or more hours of clinical and rehabilitation services per week)* This level of care is designed to focus on stabilization of dangerous addiction signs and symptoms, initiation or restoration of a recovery process, and preparation for ongoing recovery. Level 3.5 clients may have multiple deficits which may include substance-related disorders, criminal activity, impaired functioning and disaffiliation from mainstream values. A global change in the recipient's lifestyle, attitude, and values is needed. Mental health professionals are suggested as part of the staff milieu.
- **Intensive Therapeutic Community** programs shall provide each client *a minimum of 20 hours of clinical services per week and 10 additional hours of peer driven activities*. Peer driven activities include: community meetings, house meetings, peer support activities, recreation, seminars, and self-help groups. Ten hours of the clinical and/or peer driven activities shall be provided during the evening and weekend hours.

Applicants seeking to provide a cohort model must demonstrate in their DHSS/BH grant proposal how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidence based research and/or previous program evaluation results.

DHSS/BH encourages grantees to employ evidence-based practices in their treatment programs. Examples include Trauma Informed Care, Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS/BH recognizes that some effective treatment programs employ a variety of therapies and services that do not completely meet the definition of "evidence-based practices" to effectively meet the needs of individual clients.

Applicants should ensure that clients are medically cleared for admission and provide referrals for medical treatment as needed. Program orientation will be provided at the Intake/Admission.

Grantees are required to have a plan in place that describes how a grantee's behavioral health resources will be employed / deployed in a local or service-area-wide natural or man- made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.

Program Service Type #6 - Adult Residential and Housing Services for Seriously Mentally Ill Adults

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the DSM-5 and ICD-10-CM, adopted by reference in 7 AAC 70.910, and the DC: 0-3R adopted by reference in 7 AAC 160.900

Target Population:

- A recipient is 21 years of age or older who meets criteria as seriously mentally ill (SMI) as defined in 7 AAC 70[2] and,
- Due to their level of impairment requires intensive services in community based housing and behavioral health clinical and rehabilitation services based upon the recipients needs as defined in a Mental Health Assessment or Integrated Behavioral Health Assessment.
- These services can also be provided to an individual between the ages of 18 and 21:
    - except for age falls within the definition of an adult with SMI and
    - the provider has determined that the SED youth is best served by receiving behavioral health services for adults in the community
        - This may be due to the unique characteristics of the youth, the physical structure of the home allowing separation and /or clinical judgment that the youth would be safe, given the composition of the other residents in the home.
        - In these instances the clear reason why the specific housing situation is appropriate for that youth should be documented in the clinical record, along with the approval of the placement by the youth's treatment team.

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core Services and Requirements:

Recipients of this service must have access to all services for adults with serious mental illnesses. These services are part of a continuum of care, ranging from outpatient clinic-based services to wraparound home-based supportive services. *The type of service and level of care is determined by an assessment process, resulting in a treatment plan that addresses problems identified in the assessment.* Treatment planning is conducted in a collaborative manner with clients and has the goal of assisting clients to live successfully and safely in the community based housing provided. At a minimum, the services identified in the list below must be provided by a grantee funded to provide outpatient SMI services. Alternatively, these services may be provided by a sub grantee, contractor or through a collaborative relationship providing housing.

[2] An updated regulatory package will be published in the near future, which may result in the definition of a seriously mentally ill adult having a new location in the regulation package.

- Client outreach and community education
- 24/7 emergency on-call/response capability for enrolled clients
- Client screening and assessment
- Individual, family and group psychotherapy
- In home visits
- Rehabilitative services, including Case Management, Comprehensive Community Support Services, Peer Support, and Recipient Support Services
- Psychiatric services (MD, ANP)
- Referral to other services necessary to address needs identified in the recipient's individualized service plan (Crisis Stabilization, education or vocational supports, heath care, social or emotional supports, basic needs, etc.)
- Access to Psychiatric Assessment and Pharmacologic Management;
- Access to Individual, Group and Family psychotherapy
- Psychiatric Assessment, Pharmacologic Management and Psychotherapeutic services may be provided by another Behavioral health provider with which the agency providing housing to the target population has an MOU. Adults who meet the above criteria for inclusion may have a co-occurring substance use disorder.

The following include practices that DHSS/BH requires in order to meet the particular needs of clients with serious mental illness.

- Grantees must provide an immediate response, either directly or through affiliated resources, to situations in which a client is likely to decompensate. Examples include: not appearing for a medication renewal appointment, losing medications, or eviction. Rapid response outreach services should be employed, but the grantee must also allow for client choice, to the extent practical in the manner of response and choice of responders.
- Grantees must have policies and procedures in place that define the selection process by which adults who meet the criteria for the target population are chosen for participation in the housing program.
- Adults with serious mental illness may not be excluded from treatment because they do not agree with, or do not follow, one or more parts of their treatment plan. Adjustments must be made to accommodate the person in the areas of the treatment plan they do follow, unless their situation becomes so unstable that inpatient care may be necessary.
- Adults with serious mental illness who have a history of serious acting out behavior may not be excluded from the program unless the agency can demonstrate that an individual presents a danger to himself or others that cannot be mitigated by the use of recipient support services and other wrap around interventions.
- Grantees must ensure that clients with substance use disorders can receive appropriate assessment and treatment; as far as is possible, the grantee should make every effort to integrate treatment for co-occurring disorders. This may entail having both kinds of treatment available on site, or at another site, in close collaboration with another treatment provider.
- Grantees providing residential services must comply with the requirement to notify the Division of any instances in which a client is found to be missing, seriously injured, or deceased. This requirement applies to any facility operated by the grantee or closely affiliated with the grantee, including facilities with on-site staff, assisted living homes, supported living homes, residential treatment, group homes, and crisis respite facilities.

- Grantees must develop a process to obtain feedback about programs and policies from the individuals served. Ideally, individuals will participate in program planning and program evaluation.

Program Service Type #7 - Women and Children Residential Substance Use Disorder Treatment

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Target Population: This program is intended to serve women aged 18 and older who experience a substance use disorder or co-occurring substance use and mental health disorder. Children may accompany their mothers to treatment and participate as necessary in age appropriate activities.

These programs must give preference to treatment as follows:

a) Pregnant injecting drug users
b) Other pregnant substance abusers
c) Other injecting drug users
d) Office of Children Services engaged families
e) All others

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

In addition to the specific requirements described below, SUD grantees are required to meet the expectations outlined in the section titled **All Substance Use Disorder Treatment Types – Excluding Withdrawal Management Services, Section 1** (found on pages 51 to 53). Grantees who receive funding from the **Substance Abuse Prevention and Treatment (SAPT) Block Grant Program** must also meet the requirements outlined in **Section 2** (found on pages 53 to 61) of this document.

Core Services and Requirements:

All programs are required to provide client outreach and community education to ensure that clients are aware of the availability of services.

DHSS/BH will fund the following residential service types:

- **Level 3.1: Clinically Managed Low Intensity Residential Services**
  7 AAC 70.120 (a-f) *(a minimum of five hours of clinical and rehabilitative services per week)*. Examples are a halfway house or sober housing that offers at least five hours of rehab services. This level of care can also apply to the final phase of a 3.5 residential program, where individuals residing in a residential facility or Intensive Therapeutic Community Program are in need of reduced hours of clinical services and increased hours of employment seeking, exploring housing options and other community reintegration efforts. The primary

goal of Level 3.1 is to focus on a structured recovery environment that provides sufficient stability for the recipient. There is a heavy focus on ASAM Dimensions 5 and 6.

- **Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services** 7 AAC 70.120 (a-e; g), (*20 or more hours of clinical and rehabilitative services per week*). This level of care is specific to persons with cognitive difficulties and provides a structured recovery environment in combination with high intensity, but often slower paced, services focusing on severe cognitive or functional impairment/limitations; severe deficits in interpersonal and coping skills, relapse prevention, overcoming lack of awareness about the effects of substance-related problems in their lives, and promoting eventual reintegration into the community. Cognitive impairments manifested in patients most appropriately treated in Level 3.3 services can be due to aging, traumatic brain injury, acute but lasting injury, or due to illness, and may be permanent or temporary. Mental health professionals are suggested as part of the staff milieu.

- **Level 3.5: Clinically Managed High-Intensity Residential Services** 7 AAC 70.120 (a-e; h), (*20 or more hours of clinical and rehabilitative services per week)* This level of care is designed to focus on stabilization of dangerous addiction signs and symptoms, initiation or restoration of a recovery process, and preparation for ongoing recovery. Level 3.5 clients may have multiple deficits which may include substance-related disorders, criminal activity, impaired functioning and disaffiliation from mainstream values. A global change in the recipient's lifestyle, attitude, and values is needed. Mental health professionals are suggested as part of the staff milieu.

Applicants seeking to provide a cohort model must demonstrate in their DHSS/BH grant proposal how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidence based research and/or previous program evaluation results.

DHSS/BH encourages grantees to employ evidence-based practices in their treatment programs. Examples include Trauma-Informed Care, Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS/BH recognizes that some effective treatment programs employ a variety of therapies and services that do not completely meet the definition of "evidence-based practices" to effectively meet the needs of individual clients.

Applicants should ensure that clients are medically cleared for admission and provide referrals for medical treatment as needed. Program orientation will be provided at the Intake/ Admission.

- Clinic services:
    - Group and individual psychotherapy to address underlying psychological and behavioral health problems that contribute to SA, promoting self-awareness, and behavioral change through interactions with peers;
- Rehabilitation Services:
    - Cognitive behavioral social learning models emphasizing interventions that assist the individual in changing self-defeating beliefs and values, problem solving,

interpersonal skills training, role playing and modeling, or cognitively mediated behavior modification.
  - Specialty skills building groups organized around a common problem such as: anger management, parenting, domestic violence, stress reduction and gender specific issues
  - Individual, Group and Family education and counseling focused on functional improvement, recovery and relapse prevention Examples include Introduction to 12 step and community support groups (AA, NA, Smart Recovery, Double Trouble, etc. Note that actual meeting attendance is not an acceptable substitute for clinical or behavioral health rehabilitation services); Education and vocational groups; and curriculum based psycho-education groups (basic alcohol and drug education, relapse prevention, recovery, nutrition and infectious diseases, etc.).

- Grantees are also responsible for adhering to the following requirements:
- Eligibility for public assistance programs;
- Primary medical care including: prenatal care
- Primary pediatric care for children including immunizations
- Infant learning, child care and/or therapeutic day care (i.e. Head Start)
- Gender specific substance use disorder treatment and other therapeutic interventions that may address: issues of relationships, sexual abuse, other trauma, and parenting
- Therapeutic interventions for children in custody of the women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse or neglect
- Supportive Employment and/or Vocational Training Services
- Educational support including GED preparation and completion
- Drug Free housing
- Sufficient case management and transportation services to ensure women and their children have access to the services provided above if not delivered on-site.

Grantees are required to have a plan in place that describes how a grantee's behavioral health resources will be employed / deployed in a local or service-area-wide natural or man- made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.

Program Service Type #8 - Outpatient Opioid Treatment Services

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations[3]:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Must allow Division of Behavioral Health (DBH) onsite and access to all requested documents (including client files) upon request whether with DBH notification or no prior notification of said onsite according to the following state statues and administrative codes:

- AS 47.30.590
- AS 47.30.540(b)
- AS 47.30.520- 47.30.620
- AS 47.37.140
- 7 AAC 78.240
- 7 AAC 105.220

Opioid Treatment Program (OTP) services include the dispensing of methadone, a specialized opioid compound (opioid agonist) that psycho-pharmacologically occupies opiate receptors in the brain, extinguishing drug cravings and establishing a maintenance state.

OTP's may also include other opioid agonist medication such as buprenorphine, and opioid antagonist medications such as naltrexone. Buprenorphine and naltrexone must be dispensed according the state and federal regulations and according to the medical provider's license and waivers.

Target Population: This program serves opioid dependent adults (18 years and older) and their families.

These programs must give preference to treatment as follows:

a) Pregnant injecting drug users
b) Other pregnant substance abusers
c) Other injecting drug users
d) Office of Children Services engaged families
e) All others

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

[3] It is the intent of DHSS to adopt emergency regulations for Opioid Treatment Services, once adopted these emergency regulations will be posted on the Division of Behavioral Health's website.

In addition to the specific requirements described below, SUD grantees are required to meet the expectations outlined in the section titled **All Substance Use Disorder Treatment Types – Excluding Withdrawal Management Services, Section 1** (found on pages 51 to 53). Grantees who receive funding from the **Substance Abuse Prevention and Treatment (SAPT) Block Grant Program** must also meet the requirements outlined in **Section 2** (found on pages 53 to 61) of this document.

DHSS/BH will fund the following outpatient Opioid Treatment Programs services:

Opioid Treatment Program (OTP) clinical service definitions are described below:

- Group, individual and family psychotherapy to address underlying psychological and behavioral health problems that contribute to SA, promoting self-awareness, and behavioral change through interactions with peers;
- Therapeutic behavioral social learning models emphasizing interventions that assist the individual in changing self-defeating beliefs and values, problem solving, interpersonal skills training, rational emotive therapy, role playing and modeling, or cognitively mediated behavior modification;
- Specialty groups (treatment groups organized around a common problem such as: anger management, parenting group, domestic violence, and stress reduction, gender specific group);
- Individual, group and family education and counseling focusing on functional improvement, recovery and relapse prevention; examples include Introduction to 12 step and community support groups (AA, NA, Smart Recovery, Double Trouble, etc.) Actual meeting attendance is not an acceptable substitute for clinical services; education and vocational groups.
- Curriculum based psycho-education groups (basic alcohol and drug education, relapse prevention, recovery, nutrition and infectious diseases, etc.).

Outpatient Level 1: This treatment occurs in regularly scheduled sessions usually totaling ***fewer than 9 hours*** of therapeutic services per week. Examples include weekly or twice- weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. Patients live at home, in supportive housing or residential treatment centers.

Outpatient Level 2.1: Treatment consists of regularly scheduled sessions within a structured program, with ***a minimum of 9 hours*** of therapeutic services per week. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in supportive housing.

Methadone and/or buprenorphine are most commonly prescribed in level 1 services because outpatient settings are the contexts in which opioid agonist medications are most offered.

Individuals receiving treatment at level 2, 3 levels, level 4 or co-occurring disorder treatments can also be concurrently enrolled in an OTP while receiving the appropriate level of substance use disorder treatment.

DHSS Behavioral Health encourages grantees to employ evidenced based practices in their treatment programs. Examples include Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS Behavioral Health

recognizes that effective treatment programs employ a variety of therapies and services to effectively meet the needs of individual patients.

Core services and requirements:

- Screening and Substance Use Disorder or Comprehensive, patient-centered assessment;
- Medical clearance and referral to medical services as needed;
- Interim services for wait listed patients (onsite or by referral);
- Short-term Tapering (Methadone Assisted Detoxification) for a period not less than 21 days;
- Long-term Tapering (Detoxification)for a period more than 30 days but not in excess of 180 days;
- Methadone Maintenance Treatment providing pharmacotherapy in conjunction with a comprehensive range of appropriate medical and rehabilitative services;
- Medication Maintenance for patients who are no longer in need of comprehensive services, but need continuing pharmacotherapy;
- Program orientation and intake/admission;
- Individualized, patient-centered, patient collaborated, recovery-focused treatment planning and review (this includes problem formulation and articulation of short- term, measurable treatment goals and activities: ASAM Third Edition)
- Individual counseling
- Group counseling (as indicated by need in their patient-centered multidimensional assessment and the patient's recovery goals)
- Co-occurring therapy (as indicated by need in their patient-centered multidimensional assessment and the patient's recovery goals) If not provided onsite by appropriately credentialed staff, then through appropriate collaborations across different settings and many levels of care.
- Health Education (education about HIV, tuberculosis, hepatitis C, sexually transmitted diseases and dangers of needle sharing.)
- 24 hours crisis coverage for enrolled patients;
- Referrals and Case management;
- Recovery Support Services;
- Continuing Care for patients who are no longer in need of pharmacotherapy but remain in need of rehabilitative services;
- Linkage to recovery support groups and services;
- Direct Family involvement in treatment when deemed appropriate;
- Transition management and discharge planning.
- Linkage to community based support groups.

Grantees are also responsible for adhering to the following requirements:

- Opioid Treatment Programs (OTP) must adhere to all rules, directives and procedures set forth in Title 42 Code of Federal Regulations (CFR), Part 8, titled "Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction."
- Opioid Treatment Programs must have a current, valid certification from SAMHSA to dispense an opioid agonist treatment medication for the treatment of addiction.
- Admission to an outpatient opioid treatment program will be based on a opioid dependence diagnosis, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-

V), and criteria for placement in an outpatient level of care, as defined by the American Society of Addiction Medicine Patient Placement Criteria (ASAM Third Edition) and Opioid Treatment Services (OTS).

- Grantees must utilize the Alaska Prescription Monitoring Program (APMP) for all patients upon admission to treatment, annually and for cause throughout treatment. DBH believes that utilizing the APMP database will assist OTPs in protecting patient health and safety, determining patient needs and treatment planning.
- Treatment must be individualized and attend to the multiple needs of the patient beyond his or her drug use. Examples include issues around co-occurring issues, housing, employment, legal and/or medical problems.

Program Service Type #9 - Outpatient Services for High Risk Children in Early Childhood and/or Youth with Serious Emotional Disturbance (SED) and their Families

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Target Population: This program is intended to target children under the age of 8 who have experienced two or more Adverse Childhood Experiences (ACES) as defined by the ACES study (see http://www.acestudy.org/) or children or youth who meet the criteria for a serious emotional disturbance as defined in 7 AAC 70.990 (10). Children and youth will have a demonstrated need for clinical or rehabilitation services due to behavioral health issues. Services are provided on a continuum of care that can encompass outpatient, home-based, school-based, and therapeutic out of home settings for youth and their families.

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core services and requirements:

At a minimum, grantees funded to provide SED Outpatient Services are expected to provide the following services:

- Community education and referral outreach
- Program orientation and intake/admission
- Interim services for wait listed clients (onsite or by referral)
- Screening and bio-psychosocial assessments that include exposure to trauma, developmental history/milestones, cultural and religious background, sexual orientation and other factors which may impact treatment planning
- Family assessments that include social history, protective services or juvenile/adult justice involvement, financial stability, exposure to trauma, housing/placement history and relocations
- Individualized treatment planning and review that includes direct youth and family involvement
- In-home supports and family training to assist in keeping infants, children and youth with behavioral health disorders in their homes.
- 24 hour crisis coverage for enrolled clients
- Individual, family and group psychotherapy
- Referral for EPSTD screenings
- Referrals and case management to access necessary services and supports including:
    - Benefits including WIC, Medicaid, housing vouchers, etc.

- Complimentary behavioral health services (gender specific substance abuse and/or mental health interventions to address issues of relationships, sexual abuse, trauma, family/parenting, etc.)
- Recovery support services, including referrals for family or peer support/navigation services.
- Linkage to community-based support groups.
- Screening and referral for any minor children, as appropriate (behavioral health, day care, infant learning/early intervention, education, health, etc.)
- Educational and vocational services and supports (GED preparation and completion, vocational rehabilitation, etc.)
- Services required post-discharge (continuing care, medication management, housing, family therapy, etc.)

Additional requirements below must be met by grantees funded to provide outpatient SED services:

- Must screen referrals for youth diagnosed with SED/SUD who are being released from a hospital, jail, juvenile justice facility, or other institution. The initial screening may include the following activities:
  - Meet with the youth, family and inpatient treatment team in person or by phone
  - Obtain releases and review necessary clinical information
  - Identify goals and resources required for an individualized transition plan
- If the screening reflects that the youth can be served by the grantee, the following activities would be appropriate prior to the youth's release to the community:
  - Participation in discharge planning with the youth and family
  - Apply for an Individualized Service Agreement when necessary to fund services or supports needed to support the youth's return to a community setting
  - Ensure the youth will have access to a medical professional with prescriptive authority before discharge medications have been exhausted
  - Identify the appropriate living situation/placement for the youth
  - Schedule intake assessment to occur within 7 days of youth's return to the community
  - Schedule appointment with a clinician within 24 hours of release as needed
- Must develop services for children and youth across the developmental spectrum. Expectations include:
  - Services for children under age 8 and their families
    - Using evidence-informed practices, assist parents and resource families to develop skills to support their children
    - Development of competencies to work with young children and their families
    - Development of a referral network with community or statewide resources such as the Infant Learning Program, Head Start, Parents as Teachers and other early childhood programs.

        - Utilization of case management services to plan for youth transitioning from early childhood mental health services (in cooperation with the early childhood services provider)

    - Provide age-appropriate services for transition age youth:

        - Development of transition plans that addresses needs in all life domains as youth move into adult behavioral health services, or are appropriately discharged from services (Life domains include housing, educational, vocational, social support, basic needs, etc.).
        - Include provisions in the transition plan to "step down" the service level if the adult treatment system does not provide comparable services, or if the plan is to discharge the youth.
        - Implementation of evidence-informed practices to work with transitional youth. DBH encourages use of the Transition to Independence Process (see http://www.tipstars.org).

General Youth Services Requirements:

In addition to the Core Services and Requirements described above, grantees are required to meet general requirements, including:

- Grantees must meet the restraint and seclusion requirements in 42 CFR 483.350- 483.376.
- Grantees must notify DBH of critical incidents using the form on the DBH website.
- Grantees must notify the Division (assigned program manager) of any instances in which a client is found to be missing, seriously injured, or deceased. (Grantees may also be required to report these incidents to licensing or certification bodies). This requirement applies to any program operated by the grantee or closely affiliated with the grantee, including programs with on-site staff, assisted living homes, supported living homes, residential treatment, group homes, and crisis respite facilities.
- Grantees must follow best practice principles, including:

    - Reliance on families as key partners in treatment. Grantees should develop collaborative relationships with parents, which support the family's capacity to meet their child's needs. Treatment services are expected to focus on the entire family system.

        - Consideration of the entire family system when assessing a child or youth.
        - Assessment and services, or referrals for assessment and services when emotional or behavioral disturbances are suspect in family members. This includes, when appropriate, screening of younger siblings.
        - Conduct collaborative treatment planning that is youth and family driven and supports children remaining in or returning to their homes, families and communities whenever appropriate
        - Coordination of services with provider agencies treating family members that respects each members rights to confidentiality

  - Inclusion of the youth, family and their natural support network in the treatment process (extended family, friends, teachers, employers, etc.)

- Principals of Trauma Informed treatment
- Collaboration with system partners to ensure that children, youth and families can access appropriate services and supports. Expectations include:

  - Establishment of agency agreements to improve transitions and ensure appropriate coordination with other agencies, Infant Learning, residential providers, developmental disability service providers, schools, health care providers, other social service providers, etc.)
  - Establishment of procedure to educate youth and families about accessing available resources
  - Linking youth and families with peer navigation and support

- Utilize evidence informed practices and approaches. Expectations include:

  - Development of staff capacity to deliver specialized services to children, youth and families who have specific needs (i.e. exposed to trauma, transition-aged, dually diagnosed, infants and young children, families, etc.)
  - Utilization of evidence-supported practices, which are culturally competent and cost effective for the target population(s) to be served.
  - Active evaluation of the impact of service models through tracking referrals, utilization, demographics, and clinical information and client outcomes. This includes developing a process to obtain feedback from the individuals. The Building Bridges Initiative provides tools to assist with this process: (http://www.buildingbridges4youth.org/products/tools)

- Grantees are required to have a Disaster/Emergency Response Plan that describes how a grantee's behavioral health resources will be employed / deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.

Program Service Type #10 - Youth and Family Outpatient Substance Use Disorder Treatment

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Target Population: This program is intended to serve youth who have not attained the age of 19 years; however, clients between the ages of 19 – 21 can be served through this program type if the assessment reflects a clear rationale for serving them in the youth program. Youth served in this program have been assessed as having a substance use disorder involving: alcohol or other drugs, prescribed or over-the-counter medications, and/or household/general use products that can be ingested or used as inhalants.

These programs must give preference to treatment for youth as follows:

a) Pregnant youth injection drug users
b) Pregnant youth substance abusers
c) Youth injection drug users
d) Youth with children substance abusers
e) Youth with referrals from Office of Children Services, Division of Juvenile Justice
f) Youth in Foster Care
g) All others

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

In addition to the specific requirements described below, SUD grantees are required to meet the expectations outlined in the section titled **All Substance Use Disorder Treatment Types – Excluding Withdrawal Management Services, Section 1** (found on pages 51 to 53). Grantees who receive funding from the **Substance Abuse Prevention and Treatment (SAPT) Block Grant Program** must also meet the requirements outlined in **Section 2** (found on pages 53 to 61) of this document.

DHSS/BH will fund the following outpatient service types (levels designated by ASAM Third Edition criteria):

- **Outpatient Level I:**
  This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. Clients live at home or in supportive housing.

- **Outpatient Level II.1:**
  Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 treatment hours per week. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in supportive housing.
- **Outpatient Level II.5:**
  Partial Hospitalization programs generally feature *20 or more hours* of clinically intensive programming per week as specified in the client's treatment plan. While receiving services clients may choose to live with family/friends or in other supportive housing within the community.

Core Services and Requirements:

Grantees must either provide or assist the client to access:

- Community education and referral outreach.
- Program orientation and intake/admission:
- Interim services for wait listed clients (onsite or by referral)
- Screening and bio-psychosocial assessments that include exposure to trauma, developmental history/milestones, cultural and religious background, sexual orientation and other factors which may impact treatment planning;
- Family assessments that include social history, protective services or juvenile/adult justice involvement, financial stability, exposure to trauma, housing/placement history and relocations;
- Individualized treatment planning and review that includes direct youth and family involvement:
- Substance use disorder treatment to include:
    - Gender or gender orientation specific substance use disorder treatment
    - Individual, Group and Family counseling (unless contraindicated) focused on functional improvement, recovery and relapse prevention. Therapeutic interventions may address past traumatic events, issues of relationships, physical and/or sexual abuse, and parenting;
    - Cognitive behavioral social learning models emphasizing interventions that assist the individual in changing self-defeating beliefs and values, problem solving, interpersonal skills training, role playing, modeling, or cognitively mediated behavior modification.
    - Curriculum based psycho-education groups (basic alcohol and drug education, relapse prevention, recovery, nutrition and infectious diseases, etc.).
    - Specialized skill building groups organized around a common problem such as: anger management, parenting, domestic violence, stress reduction and gender specific issues;
- 24 hour crisis coverage for enrolled clients
- Referrals and case management to access necessary services and supports including:

- Medical clearance of communicable diseases and referral for medical treatment including prenatal care, as needed.
- Benefits including WIC, Medicaid, housing vouchers, etc.
- Complimentary behavioral health services (gender specific substance abuse and/or mental health interventions to address issues of relationships, sexual abuse, trauma, family/parenting, etc.)
- Recovery support services, including referrals for family or peer support/navigation services.
- Linkage to community-based support groups.
- Screening and referral for any minor children, as appropriate (behavioral health, day care, infant learning/early intervention, education, health, etc.)
- Educational and vocational services and supports (GED preparation and completion, vocational rehabilitation, etc.)
- Services required post-discharge (continuing care, medication management, housing, family therapy, etc.)

General Youth Services Requirements

In addition to the Core Services and Requirements described above, grantees are required to meet general requirements, including:

- Grantees must meet the restraint and seclusion requirements in 42 CFR 483.350- 483.376.
- Grantees must notify DBH of critical incidents using the form on the DBH website.
- Reliance on families as key partners in treatment.
- Grantees should develop collaborative relationships with parents that support the family's capacity to meet their child's needs Treatment services are expected to focus on the entire family system.

    - Consideration of the entire family system when assessing a child or youth.
    - Assessment and services, or referrals for assessment and services when emotional or behavioral disturbances are suspect in family members. This includes, when appropriate, screening of younger siblings.
    - Conduct collaborative treatment planning that is youth and family driven and supports children remaining in or returning to their homes, families and communities whenever appropriate
    - Coordination of services with provider agencies treating family members that respects each members rights to confidentiality
    - Inclusion of the youth, family and their natural support network in the treatment process (extended family, friends, teachers, employers, etc.)
    - Collaboration with system partners to ensure that children, youth and families can access appropriate services and supports. Expectations include:

        - Establishment of agency agreements to improve transitions and ensure appropriate coordination with other provider agencies Infant Learning, residential providers, developmental disability service providers, schools, health care providers, other social service providers, etc.)
        - Establishment of procedure to educate youth and families about accessing available resources

    - Linking youth and families with peer navigation and support

- Utilize evidence informed practices and approaches. Expectations include:
    - Developing staff capacity to deliver appropriate services to children, youth and families who have specific needs (i.e. exposed to trauma, transition-aged, dually diagnosed, etc.)

- Using evidence-supported practices which are culturally competent and effective for the target population(s) to be served, which are cost-effective, and that the agency is functionally able to implement. Actively evaluate the impact of service models through tracking referral, utilization, demographic and clinical information and monitoring client outcomes. This includes developing a process to obtain feedback from the individuals served. The Building Bridges Initiative provides tools to assist with this process: (http://www.buildingbridges4youth.org/products/tools)
- Grantees are required to have a Disaster/Emergency Response Plan that describes how a grantee's behavioral health resources will be employed / deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.

Program Service Type # 11 - Outpatient Treatment for Adults with Serious Mental Illness

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the DSM-5 and ICD-10-CM, adopted by reference in 7 AAC 70.910

Target Population: An adult 21 years or older qualifies as seriously mentally ill (SMI) by meeting definition in 7 AAC 70[4]. Individuals 18-21 years old can be served under this program type if they, except for age, fall within the definition of an adult experiencing a serious mental illness.

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core Services and Requirements:

Services for adults with serious mental illnesses occur on a continuum of care, ranging from outpatient clinic-based services to community-based supportive services. The type of service and level of care is determined by an assessment process, resulting in a treatment plan that addresses problems identified in the assessment. Treatment planning is conducted in a collaborative manner with clients and has the goal of assisting clients to live successfully in the community. At a minimum, the services identified in the list below must be provided by a grantee funded to provide outpatient SMI services.

- 24/7 emergency on-call/response capability for enrolled clients
- Clinically appropriate and timely follow-up psychiatric and rehabilitative services to individuals being discharged from an institutional setting (see B. 2 below for specific requirements)
- Client screening and assessment
- Individual, family and group psychotherapy
- Outreach and home visits
- Rehabilitative services, such as Case management, Comprehensive Community Support , Peer Support and Recipient Support Services
- Psychiatric services (MD, ANP)

Additional Requirements

- Grantees funded to provide outpatient treatment to adults with serious mental illness must provide an immediate response, either directly or through affiliated resources, to situations in which a client is likely to decompensate. Examples include: not attending initial appointment post-institutional discharge, not appearing for a medication renewal appointment, losing

[4] An updated regulatory package will be published in the near future, which may result in the definition of a seriously mentally ill adult having a new location in the regulation package.

medications, or eviction. Rapid response outreach services should be employed, but the grantee must also allow for client choice, to the extent practical in the manner of response and choice of responders. Grantees must document efforts to re-engage individuals who have missed appointments or dropped out of treatment.

- Grantees must have written policies and procedures in place to allow the immediate acceptance of an adult with serious mental illness into treatment that is being released from a hospital, jail, or other institution. These policies and procedures will include the provision of follow up psychiatric and rehabilitative services to both new clients and clients currently enrolled with the grantee organization. For both new and existing clients, the person should be seen by a clinician within seven (7) calendar days, and have access to a psychiatrist, physician, physician's assistant, or advanced nurse practitioner with prescriptive authority before any discharge medications have been exhausted. Attempts to engage these individuals in treatment must be documented.
- Adults with serious mental illness may not be excluded from treatment because they do not agree with, or do not follow, one or more parts of their treatment plan. Adjustments must be made to accommodate the person in the areas of the treatment plan they do follow, unless their situation becomes so unstable that inpatient care may be necessary.
- ***Adults with serious mental illness may not be excluded from treatment because they have a history of being dangerous to others. Examples include histories of assault, arson, or sexual offending. The grantee will make adjustments in the delivery of services that provide for the safety of the person, the staff and other clients. The grantee may not refuse to serve a client with a history of dangerous behavior, unless the agency can demonstrate to the Division an imminent risk that cannot be mitigated, in which case the grantee must arrange for alternate services.***
- Grantees must ensure that clients with substance use disorders can receive appropriate assessment and treatment; as far as is possible, the grantee should make every effort to integrate treatment for co-occurring disorders. This may entail having both kinds of treatment available on site, or at another site, in close collaboration with another treatment provider.
- Grantees providing residential services must comply with the requirement to notify the Division of any instances in which a client is found to be missing, seriously injured, or deceased. This requirement applies to any facility operated by the grantee or closely affiliated with the grantee, including facilities with on-site staff, assisted living homes, supported living homes, residential treatment, group homes, and crisis respite facilities.
- Grantees providing services to this population must respond to a DBH request for a Level II assessment under the Preadmission Screening and Resident Review Program (PASRR). This State program, required by Federal law, provides screening to determine whether placement in a skilled nursing facility is appropriate when the individual has a serious mental illness. Grantees must use the assessment form provided by DBH and may also bill the Division for this service. Completed evaluations must be returned to the Division within 7 calendar days of the request.
- If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Program Service Type #12 - Adult Outpatient Substance Use Disorder Treatment

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Target Population: This program is intended to serve individuals aged 18 and older assessed as having a substance use disorder involving: alcohol or other drugs, including prescription and over-the-counter medications and household/general use products that can be used as inhalants. Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users and women with children.

These programs must give preference to treatment as follows:

a) Pregnant injecting drug users
b) Other pregnant substance abusers
c) Other injecting drug users
d) Office of Children Services engaged families
e) All others

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

In addition to the specific requirements described below, SUD grantees are required to meet the expectations outlined in the section titled **All Substance Use Disorder Treatment Types – Excluding Withdrawal Management Services, Section 1** (found on pages 51 to 53). Grantees who receive funding from the **Substance Abuse Prevention and Treatment (SAPT) Block Grant Program** must also meet the requirements outlined in **Section 2** (found on pages 53 to 61) of this document.

DHSS/BH will fund the following outpatient service types:

- **Outpatient Level I:** This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. Clients live at home or in supportive housing.
- **Outpatient Level II.1**: Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 treatment hours per week. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in supportive housing.
- **Outpatient Level II.5**: (Partial Hospitalization) programs generally feature *20 or more hours* of clinically intensive programming per week as specified in the client's treatment plan. While receiving services clients may choose to live with family/friends or in other supportive housing within the community.

Applicants seeking to provide a cohort model must demonstrate in their DHSS/BH grant proposal how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidence based research and/or previous program evaluation results.

DHSS Behavioral Health encourages grantees to employ evidence-based practices in their treatment programs. However, DHSS Behavioral Health recognizes that effective treatment programs employ a variety of therapies and services to meet the needs of individual clients.

Core Services and Requirements:

Grantees are also responsible for adhering to the following requirements by either providing or assist the client in accessing:

- Program orientation and intake/admission:
    - Application for applicable public assistance such as Medicaid.
- Interim services for wait listed clients (onsite or by referral)
- Individualized treatment planning and review:
    - Screening and bio-psychosocial assessments that include developmental history; including pregnancy and delivery, developmental milestones, and temperament;
    - Family assessments that include family social history, OCS involvement, exposure to trauma, placement history and relocations;
- Substance use treatment to include:
    - Gender or gender orientation specific substance use treatment
    - Individual, Group and, Family counseling (when indicated) focused on functional improvement, recovery and relapse prevention. Therapeutic interventions may address past traumatic events, issues of relationships, physical and/or sexual abuse, and parenting;
    - Cognitive behavioral social learning models emphasizing interventions that assist the individual in changing self-defeating beliefs and values, problem solving, interpersonal skills training, role playing, modeling, or cognitively mediated behavior modification.
    - Curriculum based psycho-education groups (basic alcohol and drug education, relapse prevention, recovery, nutrition and infectious diseases, etc.).
    - Specialized skill building groups organized around a common problem such as: anger management, parenting, domestic violence, stress reduction and gender specific issues;
    - Referrals/introductions to self-help or community support groups.
- 24 hour crisis coverage for enrolled clients
- Referrals and case management; Transition management and discharge planning to include:
    - Linkage to Supported Housing Services
    - Continuing Care

- Recovery support services, including referrals for family support services
- Direct family involvement in treatment and discharge planning
- Linkage to community based support groups

Program Service Type #13 - Women and Children Outpatient Substance Use Disorder Treatment

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Target Population: This program is intended to serve women aged 18 and older who present with dependence on, or chronic, disabling use/abuse of, alcohol or other drugs, including prescription and over the counter medications and household/general use products that can be abused as inhalants. This program is intended to include the woman's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes. **These programs must give preference to treatment as follows:**

a) Pregnant injecting drug users
b) Other pregnant substance abusers
c) Other injecting drug users
d) Office of Children Services engaged families
e) All others

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core Services and Requirements:

Admission to outpatient substance use disorder treatment services will be based on a substance use disorder diagnosis, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), and criteria for placement in an outpatient level of care, as defined by the American Society of Addiction Medicine Patient Placement Criteria – 2, Revised (ASAM Third Edition).

Grantees must ensure that clients with co-occurring mental health disorders can receive appropriate assessments and treatment; as much as is reasonably possible, the grantee must make every effort to integrate treatment for co-occurring disorders, whether provided on site or in close coordination with another provider. Grantees are also expected to provide or refer clients for Medication Assisted Treatment, as necessary and available.

In addition to the specific requirements described below, SUD grantees are required to meet the expectations outlined in the section titled **All Substance Use Disorder Treatment Types – Excluding Withdrawal Management Services, Section 1** (found on pages 51 to 53). Grantees who receive funding from the **Substance Abuse Prevention and Treatment (SAPT) Block Grant Program** must also meet the requirements outlined in **Section 2** (found on pages 53 to 61) of this document.

DHSS/BH will fund the following Outpatient service types:

- **Outpatient Level 1**: This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 hours of clinical services per week as specified in the client's treatment plan. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. The duration of treatment varies with the severity of the individuals clinical severity and function and his or her response to treatment. Clients live at home or in supportive housing.
- **Outpatient Level 2.1**: Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 hours of clinical services per week. Services are provided in amounts, frequencies, and intensities appropriate to the objectives of the treatment plan Such services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy and other therapies. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in supportive housing.
- **Outpatient Level 2.5**: (Partial Hospitalization) programs generally feature *20 or more hours* of clinically intensive programming per week as specified in the client's treatment plan. Level programs typically have direct access to psychiatric, medical and laboratory services. Examples of Level 2.5 programs are day treatment or partial hospitalization programs. While receiving services clients may choose to live with family/friends or in other supportive housing within the community.

DHSS/BH **will not fund** cohort groups with grant funding or with the revenues generated by the DHSS/BH grant without an approved waiver. Programs applying for a waiver from this policy must demonstrate in their DHSS/BH grant continuation how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidenced based research and/or previous program evaluation results.

- Clinic Services:
    - Group, Individual, and Family Therapy when indicated, to address underlying psychological and behavioral health problems which may include history of trauma that contribute to substance use disorders, promoting self-awareness, and behavioral change through interactions with peers;
- Community Support Services including:
    - Cognitive behavioral social learning models emphasizing interventions that assist the individual in changing self-defeating beliefs and values, problem solving, interpersonal skills training, role playing and modeling, or cognitively mediated behavior modification Specialty skills building groups organized around a common problem such as: anger management, parenting, domestic violence, stress reduction and gender specific issues);
    - Individual, Group and, when indicated family education and counseling focused on functional improvement, recovery and relapse prevention Examples include Introduction to 12 step and community support groups (AA, NA, Smart Recovery, Double Trouble, etc.) Note that actual meeting attendance is not an acceptable substitute for clinical or behavioral health rehabilitation services); education and vocational groups; and

- Curriculum based psycho-education groups (basic alcohol and drug education, relapse prevention, recovery, nutrition and infectious diseases, etc.).
- Assist client in accessing child care during treatment activities;
- Linkage to community based support groups;

DHSS Behavioral Health encourages grantees to employ evidence-based practices in their treatment programs. Examples include Trauma-Informed care, Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive- Expressive Therapy. However, DHSS Behavioral Health recognizes that effective treatment programs employ a variety of therapies and services to meet the needs of individual clients.

Grantees are responsible to provide or actively assist the client in accessing:

- Eligibility for public assistance programs;
- Primary medical care including: prenatal care
- Primary pediatric care for children including immunizations
- Child care and/or therapeutic day care (i.e. Head Start)
- Gender specific substance use treatment and other therapeutic interventions that may address: issues of relationships, sexual abuse, other trauma, and parenting
- Therapeutic interventions for children in custody of the women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse or neglect
- Supportive Employment and/or Vocational Training Services
- Educational support including GED preparation and completion

Program Service Type #15 - Peer and Consumer Support Services

Overall Program Service Type Description:

Within the State of Alaska, Peer and Consumer Support Services, as a program type, serves as a unifying construct (umbrella) for services which may appear dissimilar because they develop to meet the needs of individual communities but, that share common traits.

Because the programs are so dissimilar, to facilitate understanding they are designated 15A for adult programs and 15B for youth programs. The 15A type can provide resources to support appropriate persons in a community or be used for direct services. The specific program requirements are defined in the individual grant agreements. Peer Support Services has been a federally recognized Evidence-Based Practice since 2007. The services may be billable, dependent on a program meeting regulatory requirements. The core purpose of a peer operated service program is to provide support for persons who are engaging in their own recovery.

The following prerequisites only apply if the applicant is providing treatment services:

Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the DSM-5 and ICD-10-CM, adopted by reference in 7 AAC 70.910, and the DC: 0-3R adopted by reference in 7 AAC 160.900

Program Service Type #15 A: <u>Adult</u> Peer and Consumer Support Services

Target Population: Beneficiaries of services or resources provided under this program type 15A are:

- Adults experiencing a serious mental illness (SMI)
- Transitional age youth that assessment indicates can best be served in adult MH programs.
- Adults or appropriate by assessment transitional age youth needing adult SUD services.

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core Services:

Peer support services are both practical and supportive and are provided in a deliberate and organized manner. Peer support services can be provided in stand-alone peer operated programs or as an adjunct and bridging party in a more conventional professional setting.

Peer support staff members must be:

- Competent to provide peer support services by virtue of having experienced behavioral health issues in their life or their family and by having the necessary knowledge and skills required by their positions.
- Able to perform a wide range of tasks to assist consumers in regaining control over their own lives and recovery process.

Peer support work may include but not be limited to:

- operating peer club houses or drop-in centers
- serving on crisis teams or staffing warm hand-offs
- supporting people while they are on wait lists for behavioral health services
- doing group work (e.g. recovery, WRAP, double trouble in recovery, etc.)
- supporting people in emergency rooms
- working with people in the corrections/justice system
- helping people get connected to employment/education
- providing housing supports to prevent homelessness

Program Service Type #15 B: Child, Youth & Family Peer and Consumer Support Services

Target Population: The persons who would be the beneficiaries of services or resources provided under this program type are:

- Children under 8 who experience a severe emotional disturbance (SED) or are at risk of an SED (due to exposure to 2 or more traumatic events) and their families.
- Youth or adolescents who experience a severe emotional disturbance (SED).
- Transition age young adults (18 – 24) who experience a serious mental illness (SMI) or a substance use disorder and their families.
- Children and youth who experience a substance use disorder (SUD) and their families.

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core Services:

Peer support work may include but not be limited to:

- community education and referral outreach
- operating parent/peer drop-in centers
- serving on crisis teams or staffing warm hand-offs
- supporting people on wait lists for behavioral health services
- providing group parent/peer support, skill training, education
- providing individualized parent/peer coaching,
- providing life skill development and support (conflict management, relationships, budgeting, etc.)

- providing support in emergency/acute care rooms or other individual or family planning meetings (behavioral health, vocational rehabilitation, educational, etc.)
- working with clients in the corrections/justice/protective services systems
- helping clients get connected to employment/education and providing job coaching, employment or educational supports
- helping clients to obtain or maintain housing or housing supports
- providing navigation to access necessary services (medical, housing or basic needs assistance, services and supports, etc.)
- screening clients to ensure safety and appropriate referral
- providing crisis services and referral as needed
- providing consultation and technical services to DHSS and to other DHSS grantees, as requested

Additional Requirements:

- Peer support staff members must be:
    - Competent to provide peer support services by virtue of having experienced behavioral health issues in their life or in their family and by having the necessary knowledge and skills required by their positions.
    - Able to perform a wide range of tasks to assist consumers or family members in regaining control over their own lives and recovery process.
    - Provided with the appropriate training, supervision and support to work with the client populations to be served.

- Program Service Type 15 B grantees may be granted a Medicaid number to provide a limited array of services when/if DBH solicits for these services. Medicaid services by Program Service Type 15 B grantees will address gaps and bridge services and provide a short-term or low intensity behavioral health intervention. Grantees will be expected to refer individuals with on-going and intensive service needs to the Community Behavioral Health System or a private behavioral health provider and to facilitate this connection. Service will primarily include family and in-home, community and school-based rehabilitation. Program Service Type 15 B grantees and other DBH grantees will be expected to work together to minimize clinical duplication and ensure coordinated care.

- Grantees for Program Service Type 15 B must utilize all available funding streams and service providers to support clients appropriately. Funding (if available) that must be utilized includes:
    - Vocational rehabilitation for workforce supports
    - Community behavioral health centers for behavioral health treatment
    - Private behavioral health treatment providers
    - School services and supports
    - Supports through the Office of Children's Services or the Division of Juvenile Justice
    - Medicaid or insurance

Program Service Type #16 – Therapeutic Court

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the DSM-5 and ICD-10-CM, adopted by reference in 7 AAC 70.910, and the DC: 0-3R adopted by reference in 7 AAC 160.900
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Program Service Type # 16 A: CINA Therapeutic Court

Target Population: The primary target population for this program is parents who, due to their substance use disorder, have had their child (ren) removed from their custody or are in danger of having their child (ren) removed from their custody. The secondary target population includes family members and significant others who have been affected by the clients' substance use disorder and who are in need of education and support.

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core Services and Requirements:

- Provide substance use disorder and co-occurring substance use disorder and mental health treatment and case management to parents with pending child-in-need-of-aid cases.
- Provide a continuum of care including assessment and referral services, outpatient, intensive outpatient, residential and continuing care services, as appropriate to the individualized need of each CINA Therapeutic Court client. Treatment must be available promptly for court participants.
- Serve up to 20 individuals (whether in outpatient or residential treatment) with the understanding that this also includes providing support to these individuals' families.
- Provide services to both female and male referrals.
- Ensure that dual diagnosis treatment is available for CINA Therapeutic Court program participants.
- Assist CINA Therapeutic Court clients/parents to understand the dynamics of their family unit when the parent(s) is/are abusing substances and be sensitive to the impacts on child development and the well-being of the children in such fragile families. Treatment providers must be cognizant of the specialized treatment issues for parents or caretakers involved in the child welfare system.
- Ensure that treatment staff are culturally sensitive and understanding of the role of family cultures on clients struggling in treatment.
- Utilize Dialectical Behavioral Therapy (DBT) with CINA Therapeutic Court clients.
- Ensure that treatment staff are trauma informed and sensitive to the extent to which the life traumas these clients have experienced impact their ability to function in treatment, to meet expectations, and to change behaviors

- Ensure that the treatment programming and staff are sensitive to gender differences.
- Because clients enrolled in the CINA Therapeutic Court program may be employed, it is important that the outpatient treatment sessions available to CINA Therapeutic Court program participants be available both during the day and in the evening.
- Provide case management of each CINA Therapeutic Court client's progress through the substance use treatment process.
- Work in collaboration with the judge, the attorney general, the defense council, the social worker, the court coordinator, and an array of local service providers as necessary to support the efforts of the CINA Therapeutic Court participants.
- Utilize the ECourts Reporting System.

Program Service Type # 16 B - Palmer Therapeutic Court

Target Population: The primary target population for this program is offenders participating in the Palmer Therapeutic Court who experience co-occurring mental health and substance use disorders, but who may also experience traumatic brain injury and developmental delays. The secondary target population includes family members and significant others who have been affected by the clients' substance use disorder and who are in need of education and support.

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core Services and Requirements:

- Provide interim case management to Court participants;
- Work closely to coordinate with the Court Resources Program Team and participants;
- Purchase services for Court participants, as requested by the CRP Team
- Serve up to 20 clients annually.
- Provide one or more case managers to assist with service needs.
- Provide access to case management for PTC participants within (5) working days of referral from the Court.
- Secure AKAIMS consent to communicate with Court electronically and input case management notes/recommendations for court status reports no later than the Monday prior to participant court date.
- Provide case management and referral to appropriate services.
- Provide intensive outreach and case management to facilitate the client's uninterrupted participation in treatment services, including continued services to clients while in Residential SUD treatment.
- Provide 24 hour access to assistance by telephone for crises or problem situations.
- Ensure access to evidence-based parenting curriculum for clients or referrals, as needed.
- Coordinate case management with the Palmer Therapeutic Court Case Coordinator.
- Provide referral to treatment programs with admission based on DSM-V and ASAM Third Edition and with access to a continuum of care
- Create collaborative agreements with other agencies to provide mental health or substance use disorder treatment services.

- Collaborate with substance use disorder and mental health providers to develop a common treatment plan for clients receiving care from more than one agency.
- Ensure assessments and referrals are provided for families.
- Ensure that family issues identified in the clients' treatment plans are addressed.
- Program Discharges are approved by the entire Palmer Therapeutic Court Team.
- Assure those participants completing treatment have adequate and appropriate levels of continuing services and supports.

Program Service Type #20 – Permanent Supported Housing

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 7 AAC 70.990
- 7 AAC 135 Medicaid Coverage: Behavioral Health Services
- Grantees must utilize the DSM-5 and ICD-10-CM, adopted by reference in 7 AAC 70.910, and the DC: 0-3R adopted by reference in 7 AAC 160.900
- Grantees must utilize the ASAM Third Edition, adopted by reference in 7 AAC 70.910

Target Population: An adult 21 years or older who qualifies as seriously mentally ill (SMI) by meeting the definition in 7 AAC 70[5].

If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Core Services and Requirements:

Permanent Supportive Housing (PSH) is an evidence-based practice characterized by the availability of recovery-oriented services in integrated community settings coupled with safe and affordable housing. Grantees operating PSH programs will combine affordable housing with support services to promote recovery and self-sufficiency for individuals served by these programs. Support services will include a focus on assisting individuals to maintain long-term independent housing and using stable housing as a platform for individual health, recovery, and personal growth. Supportive housing integrates individuals into the community in the least restrictive setting possible and promotes self-sufficiency.

Types of supportive housing can range on a continuum that includes intensive models with a medical component (i.e. Assertive Community Treatment), high intensity community based services (i.e. Intensive Case Management), or low intensity community based services (i.e. standard outpatient). Some service models that fall under this Program Service Type (e.g. Assertive Community Treatment, Intensive Case Management, etc.) have *additional* program standards to which they need to comply as referenced in the original request for proposal or the signed grant agreement. For example, all Assertive Community Treatment teams must comply with the State of Alaska Assertive Community Treatment Program Standards and all Intensive Case Management teams must comply with the State of Alaska Intensive Case Management Program Standards.

All grantees operating PSH programs are required to adhere to the Substance Abuse and Mental Health Services Administration (SAMHSA)'s *Fidelity Scale for Permanent Supportive Housing*. The following are practices, based on SAMHSA's Fidelity Scale, which DHSS/BH requires in order to meet the needs of individuals receiving Permanent Supportive Housing:

[5] An updated regulatory package will be published in the near future, which may result in the definition of a seriously mentally ill adult having a new location in the regulation package.

- Grantee will provide a *choice of housing* to at minimum include: a) consideration of an individual's preference of type of housing and b) choice regarding living arrangements, particularly regarding roommates and any shared space.
- Grantee will provide *separation of housing and services* to at minimum include a functional separation between housing management and services staff.
- Grantee will provide *decent, safe, and affordable housing* to at minimum include: a) individuals paying 30% or less of their income for rent and b) housing in compliance with HUD Housing Quality Standards.
- Grantee will provide *housing integration* to at minimum include individuals living in housing units typical of the community, without clustering people with disabilities.
- Grantee will provide *rights of tenancy* to at minimum include: a) individuals having full rights of tenancy and b) tenancy *not* contingent in any way on compliance with program or treatment participation.
- Grantee will provide *access to housing* to at minimum include: a) full access to housing with no required demonstration of housing readiness and b) individual privacy in housing units.
- Grantee will provide *flexible and voluntary services* to at minimum include: a) individuals being offered a full range of services, b) individuals offered a choice of services with the ability to make changes to services as needs and preferences change, and c) services are consumer driven.

Additional Requirements:

- Grantees funded to provide permanent supportive housing services must formally enroll an individual into their services as soon as they begin working with the individual, even if the only service the individual is initially requesting is housing services. Formal enrollment includes an assessment, AST, CSR, initial treatment plan and enrollment into AKAIMS.
- Grantees must provide individuals with access to all services for adults with serious mental illnesses as specified in Program Service Type #11 Outpatient Treatment for Adults with Serious Mental Illness. Some services may be provided by another Behavioral Health Provider with which the grantee has an MOU.
- If a grantee is required to work with an external program evaluator (as noted in the RFP), all required data must be tracked and given to the external evaluator in a timely manner.
- If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services

All Substance Use Disorder Treatment Types – Excluding Withdrawal Management Services

Section 1:

These programs are intended to serve individuals who present with dependence on, or chronic disabling use/abuse of alcohol or other drugs, including prescription and over the counter medications, and household/general use products that can be abused as inhalants. Additionally, these programs are intended to include the client's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes.

These programs must give preference to treatment as follows:

a) Pregnant injecting drug users
b) Other pregnant substance abusers
c) Other injecting drug users
d) Office of Children Services engaged families
e) All others

In addition to the requirements detailed under the specific Program Service Type, agencies are required to meet the general requirements detailed below:

1. DBH is also committed to providing an integrated behavioral health service system. This includes delivery of Substance Use Services which are either Co-Occurring Capable or Co-occurring Enhanced services. Proposals for substance use programs are required to describe how they will meet one of the following definitions:

    a. ***Co-occurring Capable*** programs are those that incorporate, at every level, the concept that all care is person-centered and looks at "all aspects of program design and functioning in order to embed integrated policies, procedures and practices in the operations of the program" (ASAM Third Edition). These programs will have a "primary focus on substance use disorders, but capable of treating patients with sub-threshold or diagnosable but stable mental disorders. Psychiatric services available on-site or by consultation; at least some of the staff are competent to understand and identify signs and symptoms of acute psychiatric conditions. (ASAM Third Edition) "

    b. ***Co-occurring Enhanced*** programs are "designed to routinely (as opposed to occasionally) deal with patients that are more acute or associated with more serious disabilities." (ASAM Third Edition). "All staff are cross trained in addiction and mental health and are competent to understand and identify signs and symptoms of acute psychiatric and substance use conditions and treat both

unstable mental and substance use disorders concurrently. Treatment for both mental health and substance use disorders is integrated." (ASAM Third Edition)

2. Grantees must currently meet the requirements under AAC 70. 100-260 and maintain compliance throughout the grant period. Failure to meet the State Standards may result in grant suspension and disqualification for future funding.

3. Current Activity Schedule. Grantees providing substance use disorder services will have a current treatment activity schedule that provides an amount of active treatment that is consistent with the program's stated ASAM Third Edition level of Care and the standards as outlined in 7 AAC 70.120

4. Grantees are required to provide services that help families understand addiction and support the newly recovering family members. Examples include evening family process groups, education groups, presentations by Al-Anon speakers, etc. Involving key members of the client's support network in treatment leads to more positive outcomes.

5. Grantees will establish and maintain a waiting list of persons seeking treatment who cannot be admitted due to space or staffing constraints. The waiting list must comply with DHSS/BH's waiting list protocols, as established in AKAIMS, including a unique identifier for Injection Drug Users (IDU's). IDU's requesting treatment must be admitted no later than 14 days after the request. If there is no slot available IDU's must be provided with interim services within 48 hours and admitted no later than 120 days after the initial request.

6. It is important for SUD agencies to assure all clients are provided with harm and risk reduction counseling. To this end the following applies:

   a. Interim services provided to individuals on the wait list, can be provided by the program or another agency. Interim services, which require documentation, should include:

      - Counseling/education about HIV and TB that includes risks of needle sharing, transmission to sexual partners and infants, methods of risk avoidance and reduction.
      - Referral for HIV and TB testing and treatment.
      - Counseling on FASD and Fetal Drug Effects (FDE) for all applicants who are pregnant women.

   b. Treatment programs are required to have staff members trained to provide HIV/AIDS, Hepatitis B and C, Tuberculosis (TB) and FASD risk assessment, client education, early intervention, and risk reduction counseling. All clients must receive

these services. Trainings for blood-borne pathogens required for health profession employees are not sufficient to meet this requirement.

c. HIV/AIDS, Hepatitis B and C, Tuberculosis (TB), FASD screening and risk reduction counseling are to be addressed in policies and procedures related to infection control or occupation health and safety; and in policies and procedures related to client rights or treatment protocols.

7. Treatment must be individualized and attend to the multiple needs of the client beyond his or her drug use. Examples include serving individuals with developmental disabilities or other co-occurring needs and addressing issues around housing, employment, education, legal, medical problems.

8. Possible alcohol or other drug use while in treatment should be constantly monitored. Urinalysis and other tests are an effective way to help clients resist the urge to use. These tests also help providers detect lapses and make appropriate modifications to treatment plans and interventions as necessary.

9. Programs must have procedures for responding to clients who relapse while in treatment. These may include referral to a different level of care or different strategies and frequency of treatment interventions. The focus of these procedures should be on assisting the client to progress toward the completion of treatment goals.

10. When appropriate, grantees should attempt to make Medication-Assisted Treatment (MAT) available to clients both while they are in treatment and after they are released to their home communities (i.e. Antabuse, Naltrexone, or Buprenorphine).

11. Grantees shall not provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

12. If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

Disaster/Emergency Response Plan Grantees are required to have a plan in place that describes how a grantee's behavioral health resources will be employed / deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.

Additional requirements for All SUD Programs that receive funding from the Substance Abuse Prevention and Treatment (SAPT) Block Grant

Section 2:

§ 96.127 Requirements Regarding Tuberculosis (TB)

1. The program must, directly or through arrangements with other public or nonprofit private entities, routinely make available the following TB services to each individual receiving treatment for substance abuse:
    a) Counseling the individual with respect to TB
    b) Testing to determine whether the individual has been infected with mycobacteria TB to determine the appropriate form of treatment for the individual
    c) Appropriate medical evaluation and treatment for individuals infected by mycobacteria TB
2. For clients denied admission to the program on the basis of lack of capacity, the program must refer such clients to other providers of TB services.
3. The program must have infection control procedures to prevent the transmission of TB and that address the following:
    a) Screening patients and identifying those individuals who are at high risk of becoming infected
    b) Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2
    c) Case management activities to ensure that individuals receive such services
4. The program must report all individuals with active TB as required by State law and in accordance with Federal and State confidentiality requirements, including 42 CFR part 2.

§ 96.131 Treatment Services for Pregnant Women

1. The program must give preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant-funded treatment services.
2. If the program is an SAPT Block Grant-funded program that serves an injecting drug abusing population, the program must give preference to treatment as follows:
    a) Pregnant injecting drug users
    b) Other pregnant substance abusers
    c) Other injecting drug users
    d) All others
3. The program must refer pregnant women to the State when the program has insufficient capacity to provide services to any such pregnant women who seek the services of the program.

4. The program must make interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.

5. The program must offer interim services, when appropriate, that include, at a minimum[6], the following:

a) Counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur

b) Referral for HIV or TB treatment services, if necessary

c) Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women

§ 96.132 Additional Requirements

1. The program must make continuing education in substance abuse treatment and prevention available to employees who provided the services.

2. The program must have in effect a system to protect patient records from inappropriate disclosure, and the system must:

a) Comply with all applicable State and Federal laws and regulations, including 42 CFR part 2

b) Include provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure

§ 96.135 Restrictions on the Expenditure of the Grant

1. The program cannot expend SAPT Block Grant funds to provide inpatient hospital substance abuse services, except in cases when each of the following conditions is met:

a) The individual cannot be effectively treated in a community-based, nonhospital, residential program

b) The daily rate of payment provided to the hospital for providing the services does not exceed the comparable daily rate provided by a community-based, nonhospital, residential treatment program

c) A physician makes a determination that the following conditions have been met:

i. The primary diagnosis of the individual is substance abuse and the physician certifies that fact

ii. The individual cannot be safely treated in a community-based, nonhospital, residential treatment program

iii. The service can reasonably be expected to improve the person's condition or level of functioning

[6] Interim services may also include federally approved interim methadone maintenance

iv. The hospital-based substance abuse program follows national standards of substance abuse professional practice

d) The service is provided only to the extent that it is medically necessary (e.g., only for those days that the patient cannot be safely treated in a residential, community-based program)

2. Further, the program cannot expend SAPT Block Grant funds to:

a) Purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment.

b) Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

c) Provide financial assistance to any entity other than a public or nonprofit private entity

d) Make payments to intended recipients of health services.

e) Provide individuals with hypodermic needles or syringes.

f) Provide treatment services in penal or correctional institutions of the State.

§ 96.137 Payment Schedule

The program must ensure that SAPT Block Grant funds for special services for pregnant women and women with dependent children, TB services, and HIV early intervention services are the "payment of last resort" and the program must make every reasonable effort to do the following to pay for these services:

1. Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX, any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.
2. Secure from patients or clients payments for services in accordance with their ability to pay.

Audit

The program shall adhere to the following requirements:

1. If the program expends $500,000 or more in Federal financial assistance during the program's fiscal year, an independent financial and compliance audit must be completed by a Certified Public Accounting firm in accordance with Office of Management and Budget (OMB) Circular A-133. The program must also submit a data collection form and reporting package to the Federal Audit Clearinghouse.
2. The program may identify the amount of Federal Financial Assistance included in this award by

or

The awarding agency will advise the program of the amount of Federal Financial Assistance included in this award by

3. If the A-133 audit report includes findings or questioned costs, the program must develop and implement a corrective action plan that addresses the audit findings and recommendations contained therein.

4. The program must retain records to support expenditures and make those records available for review or audit by appropriate officials of SAMHSA, the awarding agency, the General Accountability Office and/or their representatives.

Salary Limitation

The program cannot use the SAPT Block Grant to pay salaries in excess of Level I of the Federal Senior Executive pay scale.

Charitable Choice

1. If the program is an SAPT Block Grant-funded program that is part of a faith-based organization, the program may:
   a) Retain the authority over its internal governance
   b) Retain religious terms in its name
   c) Select board members on a religious basis
   d) Include religious references in the mission statements and other governing documents
   e) Use space in its facilities to offer Block Grant-funded activities without removing religious art, icons, scriptures, or other symbols
2. If the program is an SAPT Block Grant-funded program that is part of a faith-based organization, the program cannot us SAPT Block Grant funds for inherently religious activities such as the following:
   a) Worship
   b) Religious instruction
   c) Proselytization
3. The program may only engage in religious activities listed under 2. above if both of the following conditions are met:
   a) The activities are offered separately, in time or location, from Block Grant-funded activities
   b) Participation in the activities is voluntary

4. In delivering services, including outreach activities, SAPT Block Grant-funded religious organizations ***cannot*** discriminate against current or prospective program participants based on:
   a) Religion
   b) Religious belief
   c) Refusal to hold a religious belief
   d) Refusal to actively participate in a religious practice
5. If an otherwise eligible client objects to the religious character of the program, the program shall refer the client to an alternative provider within a reasonable period of time of the objection.
6. If the program is a religious organization, the program must:
   a) Use generally accepted auditing and accounting principles to account for SAPT Block Grant funds similar to other nongovernmental organizations.
   b) Segregate Federal funds from non-Federal funds.
   c) Subject Federal funds to audits by the government.
   d) Apply Charitable Choice requirements to commingled funds when State/local funds are commingled with Block Grant funds.

§ 96.126 Capacity of Treatment for Intravenous Drug Abusers

If the program treats injecting drug users, the program must:

1. Within 7 days, notify the State whenever the program has reached 90 percent of its treatment capacity.

Admit each individual who requests and is in need of treatment for intravenous drug abuse:

   a) Not later than 14 days after making the request *or*
   b) Within 120 days of the request if the program has no capacity to admit the individual, the program makes interim services available within 48 hours, and the program offers the interim services until the individual is admitted to a substance abuse treatment program

2. Offer interim services, when appropriate, that include, at a minimum[7], the following:

   a) Counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur
   b) Referral for HIV or TB treatment services, if necessary
   c) Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women

[7] Interim services may also include federally approved interim methadone maintenance

3. Maintain a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.

4. Maintain a mechanism that enables the program to:
   a) Maintain contact with individuals awaiting admission
   b) Consult with the State's capacity management system to ensure that waiting list clients are admitted or transferred to an appropriate treatment program within a reasonable geographic area at the earliest possible time

5. Take clients awaiting treatment for intravenous substance abuse off the waiting list only when such persons:
   a) Cannot be located for admission into treatment *or*
   b) Refuse treatment

6. Carry out activities to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:
   a) The standard intervention model as described in *The NIDA Standard Intervention Model for Injection Drug Users: Intervention Manual*, National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992)
   b) The health education model as described in Rhodes, F., Humfleet, G.L. et al., *AIDS Intervention Program for Injection Drug Users: Intervention Manual*, (Feb. 1992)
   c) The indigenous leader model as described in Wiebel, W., Levin, L.B., *The Indigenous Leader Model: Intervention Manual*, (Feb. 1992)

7. Ensure that outreach efforts (have procedures for):
   a) Selecting, training, and supervising outreach workers
   b) Contacting, communicating, and following up with high-risk substance abusers, their associates, and neighborhood residents within the constraints of Federal and State confidentiality requirements
   c) Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV
   d) Recommending steps that can be taken to ensure that HIV transmission does not occur

§ 96.128 Requirements Regarding HIV

If the program is an SAPT Block Grant-funded HIV early intervention program, the program must make the following services available at the sites at which individuals are undergoing treatment for substance abuse:

1. Appropriate HIV/AIDS pre- and post-test counseling.
2. Appropriate HIV/AIDS tests:
   a) To diagnose the extent of the deficiency in the immune system
   b) To provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease
3. Therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.

The program must have established linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services and to facilitate referral.

The program must also ensure that HIV early intervention services are undertaken voluntarily, provided with patients' informed consent, and are not required as a condition of receiving substance abuse treatment or any other services.

§ 96.124 Certain Allocations: (Required Services for Programs Receiving Block Grant Funds Set Aside for Pregnant Women and Women with Dependent Children)

If the program receives SAPT Block Grant funds set aside for special services for pregnant women and women with dependent children (including women attempting to regain custody of their children), the program must provide or arrange for the following:

1. Primary medical care, including prenatal care, for women who are receiving substance abuse services.
2. Child care while the women are receiving services.
3. Primary pediatric care for the women's children, including immunizations.
4. Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.
5. Therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
6. Sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (1.) through (5.) above.

The program must also treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate.[8]

[8] Such an admission may not be appropriate, however, if, for example, the father of the child(ren) is able to adequately care for the child(ren).

The program must provide pregnant women, women with dependent children, and their children, either directly or through linkages with community-based organizations, a comprehensive range of services to include:

a) Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments
b) Employment and training programs
c) Education and special education programs
d) Drug-free housing for women and their children
e) Prenatal care and other health care services
f) Therapeutic day care for children
g) Head Start
h) Other early childhood programs