Service Name	**Adult Substance Use Disorder Halfway House** **ASAM Level 3.1**
Setting	Halfway House SUD services are provided in the following setting in alignment with the current edition, American Society of Addiction Medicine (ASAM) level 3.1: • Facility
Licensure, Certification, or Accreditation	The agency providing this service must be licensed and accredited by CARF, TJC, or COA, and accredited to provide the level of care applicable to this service as required by DHHS Division of Medicaid and Long-Term Care (MLTC). Individual providers must be licensed as required by DHHS Division of Medicaid and Long-Term Care (MLTC).
Basic Definition	Halfway House is a transitional, 24-hour structured supportive living/treatment/recovery facility located in the community for individuals seeking reintegration into the community often after primary treatment at a more intense level. This service provides safe housing, structure and support, affording individuals an opportunity to develop and practice their interpersonal and group living skills, strengthen recovery skills and reintegrate into their community, find/return to employment or enroll in school. Services align with current edition ASAM 3.1 guidance.
Service Expectations (Information about this service is referenced in Title 471 chapter xx)	• Substance use disorder (SUD) assessment: by a licensed clinician, operating within their scope of practice, must be completed prior to the beginning of treatment and meet the requirements as noted in the SUD Assessment Medicaid Service Definition. • If a substance use disorder assessment was conducted within the previous 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there is new information available, an update to the SUD assessment must be documented in the form of an SUD addendum. The SUD addendum must reflect the individual's current status. • If a substance use disorder assessment was not conducted within the previous 12 months prior to admission to the service, or the prior SUD assessment is not relevant and does not contain the necessary information, then a substance use disorder assessment must be performed. • All individuals are to be screened for co-occurring mental health conditions throughout the SUD assessment. If the staff performing the SUD assessment is a licensed alcohol and drug counselor (LADC) or a provisionally licensed alcohol and drug counselor (PLADC), and a co-occurring mental health condition is known or suspected, a referral should be made to a licensed clinician who is able to diagnose and treat mental health conditions within their scope of practice and license. • The admission assessment will serve as the treatment/recovery plan until the treatment/recovery plan can be developed. • The initial treatment and recovery plan guiding the first seven days of treatment must be developed within 24 hours of admission to the service. • Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and relapse prevention, with the individual (consider community, family and other supports) within 14 days of admission

	• The Individualized Treatment, Rehabilitation, and Recovery Plan must be developed with the individual and their authorized family, supports, or both. Each record must contain a recovery-oriented individualized treatment, rehabilitation, and recovery plan for all services provided based on the individualized and person-centered assessment of the individual and the requirements of the Medicaid Service Definition. This plan must: • Be oriented to and apply the principles of recovery including but not limited to inclusion, direct and active participation, and a meaningful life in the community of one's choosing • Incorporate and be consistent with best practices • Include the individual's individualized goals and expected outcomes • Contain prioritized objectives that are measurable and time-limited • Describe therapeutic interventions that are recovery-oriented, trauma-informed, person-centered, and strength-based • Identify staff responsible for implementing the therapeutic interventions • Specify the planned amount, frequency, and duration of each therapeutic intervention • Delineate the specific behavioral criteria to be met for discharge or transition to a lower level of care • Include a component to avoid crises or admission to a higher level of care using principles of recovery and wellness • Document that the individual treatment, rehabilitation, and recovery plan is completed within the time frame specified in policies and Medicaid Service Definitions • Document that the plan has been developed, reviewed, updated, and revised with the direct and active involvement of the individual. If documentation shows that the individual is not achieving his/her goals, timely revision of the plan must be documented • Include the signature of the individual and/or guardian to indicate agreement with the plan • Be approved and signed by the licensed clinician • Review and update of the treatment/recovery plan under a licensed clinician with the individual and other approved family/supports every 30 days or more often as clinically indicated • The individual's authorized family must be offered the opportunity to participate in the individual's treatment (assessment, treatment/recovery planning, psychotherapy and discharge planning), if appropriate. This participation or lack of participation must be documented in the individual 's clinical record. • Medication Assisted Treatment (MAT) must be provided as needed. • Provides a minimum of 8 hours of skilled treatment and recovery focused services per week to include individual, family, and group psychotherapy and may include psychoeducational groups, motivational enhancement and engagement strategies • • Monitoring to promote successful reintegration into regular, productive daily activity such as work, school or family living • Other services could include family education, self-help group and support

	group orientation
	• Monitoring stabilized co-occurring mental health conditions
	  • Consultation, referral, or both for medical, psychological, and psychopharmacology needs
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	  • Other services could include:
	  • Drug screening
	  • Family psychoeducation
	  • Support group orientation
	Discharge planning is an ongoing process that occurs through the duration of service. The discharge plan must be strengths-based, recovery-oriented, trauma-informed and include participation by the individual and family or legal guardian as appropriate. The discharge plan must be documented in the individual's record. The discharge plan must:
	• Begin on admission and be updated on an ongoing basis with the direct and active participation of the individual, family, or legal guardian, as appropriate and with the individual's consent
	• Be a component of the Individualized Treatment, Rehabilitation, and Recovery plan and be consistent with the goals and objectives identified with the direct and active participation of the individual, family, or legal guardian as appropriate
	• Address the individual's need for ongoing services to promote recovery. A crisis/safety/relapse prevention plan must be in place and address triggers, helpful intervention strategies, and contact information for resources useful in a crisis
	• Document all referrals
	• Document pre-discharge planning, recommendations, and arrangements for post-discharge including but not limited to:
	a) Any ongoing treatment and rehabilitative service needs
	b) Care coordination with other treatment providers
	c) Referrals and resources to community-based support services
	d) Accessing and using medication
	e) Housing
	f) Employment
	g) Transportation
	h) Social connectedness – formal and informal support systems
	i) Plans to address unmet goals
	• All services must be provided with cultural competence
	
	• Crisis assistance must be available 24 hours a day, 7 days a week

Length of Service	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the treatment plan.
Hours of Operation	24 hours a day, 7 days a week

Desired Individual Outcome	• The individual has substantially met the treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • Individual's condition can be managed without the professional external supports and intervention at this level of care • Individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition
Admission Guidelines	• The individual meets the diagnostic criteria for a Substance Use Disorder as defined in the Diagnostic and Statistical Manual (DSM), current edition, as well as American Society of Addiction Medicine (ASAM), current edition, dimensional criteria for admission to this service. • The individual meets specifications in each of the six ASAM dimensions. • It is expected that the individual will be able to benefit from this treatment. • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual

Continued Stay Guidelines	It is appropriate to retain the individual at the present level of care if: • The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward their treatment goals, or • The individual is not yet making progress but has the capacity to resolve their problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals, or • New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively. • To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem(s), they should continue in treatment at the present level of care.