

SUBSTANCE USE DISORDER - PROVIDER APPLICATION FORM

Substance Use Disorder Provider: Application Process

Overview

We are screening providers to become accredited in substance use disorder (SUD). Please submit policies, program descriptions, and client materials that document how you meet or plan to meet each measure. Please use this form to help the reviewers identify where in your documentation to look for details about how you meet the measure. Include document names and page numbers in the application text boxes to guide the reviewers and summarize or clarify the written material provided. Please refer to the Quality Measures Guidance for Providers document found [here](#) for details about the measures.

If you have any questions, please contact provider.contracting@coaccess.com.

Measure 1

The organizational leadership demonstrates a commitment to quality treatment of substance use disorders.

Provide materials that depict the organization's commitment and capacity to oversee substance use services such as organizational charts; documents outlining training and credentialing of clinical/medical leadership; organizational mission, vision, and values; clinical supervisory structure; and policies on how the organization uses data to improve clinical care.

Measure 2

The organization and its programs have clear operational definitions.

Provide a program description for each program and level of care within the program that includes the services provided, service approach, and staffing. Provide admission, discharge, and continuing stay criteria for each program (and level of care within the program if multiple levels of care are provided in the same program). For Level 3 residential and withdrawal management programs, include medical and other exclusion criteria based on the program and population served.

Measure 3

Clinically integrated provider trainings are regularly provided to staff.

Provide policies, training descriptions, and other materials that demonstrate how staff are trained in substance use disorders and related clinical and administrative content at hire and throughout their employment. Include documentation that demonstrates that training is tailored to the populations you serve and the levels of care you provide.

Measure 4

Treatment approaches used are based on current evidence of clinical effectiveness.

Provide policies or program descriptions that identify the specific evidence-based and best practices in use in each level of care. Provide documentation about the rationale for the use of these practices based on the population served and level of care. Include policies outlining how staff are trained or supervised to ensure that these practices are fully implemented with fidelity.

SUBSTANCE USE DISORDER - PROVIDER APPLICATION FORM

Measure 5

The provider implements procedures to continually assess and adjust treatment planning and level of care.

Provide documentation about how screening and assessment procedures address the six dimensions outlined by American Society of Addiction Medicine (ASAM). Include admission, discharge, and continuing stay criteria that are aligned with ASAM for the level(s) of care provided. Provide policies that outline the staff responsible to assess level of care in between formal treatment plan reviews and how transfer/discharge needs are assessed prior to step-down or discharge.

Measure 6

Substance use monitoring (urine screening, oral fluid tests, breathalyzers) is a standard part of substance use treatment at all levels of care.

Provide policies and/or program materials that discuss the clinical rationale for substance use monitoring as a component of clinical care.

Measure 7

Relapse is not a criterion for discharge and is considered a part of the recovery process.

Provide policies and/or program materials describing the organization or program's approach to continued use and relapse. Include client materials that describe how relapse is addressed as a part of treatment planning.

Measure 8

Patients are actively encouraged to become involved in social and recovery support activities tailored to their individual needs and preferences.

Provide policies and/or client materials that demonstrate the program philosophy related to social and recovery support. Include written documentation on any specific efforts to assist clients in building new skills and interests and in withdrawal management programs demonstrate how patients are referred for ongoing social support following discharge/transfer.

Measure 9

Individual counseling is a standard part of treatment.

Provide policies, program descriptions, or other materials that demonstrate how often individual counseling is provided and the kinds of issues addressed. Include written documentation about how the mix of individual and group treatment is determined and how resistance to participation in group treatment is handled. In withdrawal management programs, demonstrate how individualized counseling is provided to enhance motivation to seek ongoing care.

SUBSTANCE USE DISORDER - PROVIDER APPLICATION FORM

Measure 10

The initial contact is predominately a clinical intervention rather than an administrative intake exercise.

Provide policies, training materials, patient materials, and other documentation that demonstrates that developing a therapeutic alliance and engaging the individual in treatment is the goal of the initial contact. Include documentation of the steps taken to reduce motivational and tangible barriers in access to care and how the program ensures that when the program or level of care they provide is not the best fit, the program ensures that the individual gets to the level of care/program needed.

Measure 11

Family and other support systems are routinely involved in treatment.

Provide documentation that relapse prevention planning includes addressing family stressors and support. Level 2.1 Intensive Outpatient, Level 3 residential programs and all adolescent services provide program descriptions or other documentation of how family involvement is a routine part of treatment. (This measure does not apply to withdrawal management programs.)

Measure 12

Providers have procedures to complete follow-up calls on all patient no-shows and these procedures include working with patients on motivational and tangible barriers to access to care.

Provide policies related to missed appointments and/or admissions, how staff are trained to address motivational or tangible barriers to access and how support is provided to individuals who have patterns of repeated no-shows. (This measure is not applicable to withdrawal management programs.)

Measure 13

Providers accept patients who are currently receiving medications for treatment of addiction and do not discourage the use of medication for treatment of alcohol and opioid use disorders.

Provide admission criteria and policies demonstrating that receiving medication for treatment of addiction is not a reason for denial of treatment, procedures for educating patients on the potential benefit of medications for treatment of alcohol use and opioid use disorders, and how patients are provided with medications for treatment of addiction either directly or through referral. Provide written documentation demonstrating expertise and procedures for treating pregnant women who are seeking treatment for opioid use disorders.

Measure 14

All providers treating substance use disorders are capable to screen for mental health conditions and provide a basic level of mental health treatment.

Provide admission criteria, program descriptions, and/or policies that demonstrate that people are not excluded from treatment due to a mild or moderate mental health disorder and how properly credentialed staff are made available to screen for mental health disorders and treat or refer to treatment.

SUBSTANCE USE DISORDER - PROVIDER APPLICATION FORM

Measure 15

Providers continually assess the treatment needs of patients, tailor length of stay to individual needs, and provide coordinated transitions between levels of care.

Provide program descriptions and/or patient materials that demonstrate that the duration and intensity of treatment will vary based on the needs of the patient and how transitions to higher or lower levels of care are facilitated.

Measure 16

Emergency services are available to active patients.

Provide documentation about how enrolled patients can reach a clinician affiliated with the organization in the event of an emergency and how staff in Level 3 residential and withdrawal management programs have access to medical/clinical consultation outside of regular business hours.

Measure 17

Program employs strategies to provide easy access to treatment.

Provide policies or other documentation demonstrating how the organization facilitates access to treatment for the population they serve and makes appointments/admissions available outside business hours.

Measure 18

Programs screen and refer for infectious diseases that commonly co-occur with substance use disorders.

Provide policies outlining the protocols for screening, testing, and referring patients for treatment of infectious illnesses that commonly co-occur with substance use disorders.

SUBSTANCE USE DISORDER - PROVIDER APPLICATION FORM

ADOLESCENT TREATMENT (Skip this section if you are NOT providing adolescent treatment)

Measure 19

Providers working with adolescents rely on evidence-based practices and highly trained staff when delivering group therapy.

Provide documentation related to the credentialing of staff conducting adolescent group therapy and the way the use of group therapy is planned based on the needs of the population.

Measure 20

Providers serving adolescents provide care that is developmentally appropriate to their needs.

Provide documentation outlining how the organization ensures that staff is skilled in work with adolescents and clinical interventions are appropriate to the needs of adolescent populations.

Measure 21

Providers serving adolescents use evidence-based treatment approaches that are specific to adolescent substance use.

Provide program descriptions and policies that identify the evidence-based approaches used and their rationale based on the population served.

Applications should be downloaded and sent as an attachment to provider.contracting@coaccess.com

SUBSTANCE USE DISORDER - PROVIDER APPLICATION FORM

In addition to the previous information, the following information also needs to be provided within the same application:

- The completed application signed and dated

- A copy of the current professional liability insurance policy declaration sheet with the name of the organization, coverage dates, and the amounts of coverage listed. Professional liability includes insurance coverage with minimum limits of \$500,000 per incident and \$3 million aggregate, which are required for network participation. If the entity is covered through self-insurance trust, the Federal Tort Claims Act (FTCA) or have governmental immunity, please not below and provide such documentation.

- A copy of the organization's W-9

- A copy of the organization's current Colorado license, or if not subject to Colorado licensure, a copy of the certification notification from the State of Colorado

- If the organization provides in-house laboratory services, please submit a copy of the Clinical Laboratory Improvement Amendments (CLIA) certificate

- If accredited, a copy of the most recent accreditation certificate

- If the organization is not accredited, please include the most recent copy of the outpatient behavioral health (OBH) site survey, or a copy of the letter from OBH that shows that the facility was reviewed, the findings of the review, and that the facility corrected any findings

- An organizational chart that outlines the decision-making authorities. Include executive leadership, clinical leadership that have an authority on SUD treatment, clinical supervisors and individual providers who have expertise in substance use disorder treatment.

- Documentation or policy and procedures that are informative to the SUD facility procedures

SUBSTANCE USE DISORDER - PROVIDER APPLICATION FORM

Application Information

Legal name of organization:		
DBA name (if applicable):		
NPI number:	Tax ID:	Medicaid site ID:
Languages:		
Website:		
Do you offer cultural competency training to employees?: Y <input type="checkbox"/> N <input type="checkbox"/>		
Do you have accommodations for disability access?: Y <input type="checkbox"/> N <input type="checkbox"/>		
Does the office have parking spaces that are van-accessible?: Y <input type="checkbox"/> N <input type="checkbox"/>		
Is there an approach to the entrance of the building/office that complies with the federal Americans with Disabilities Act guidelines, with accessible parking spaces that are identified with signage?: Y <input type="checkbox"/> N <input type="checkbox"/>		
Does the office have accessible examination rooms for individuals with disabilities?: Y <input type="checkbox"/> N <input type="checkbox"/>		
Does the office have accessible medical equipment to accommodate individuals with disabilities during examinations?: Y <input type="checkbox"/> N <input type="checkbox"/>		
Does the office effectively communicate with individuals who have hearing, vision, speech, or cognitive disabilities?: Y <input type="checkbox"/> N <input type="checkbox"/>		

General Office Hours: (add your hours of operation for each day of the week)

Monday	a.m./p.m.	to	a.m./p.m.
Tuesday	a.m./p.m.	to	a.m./p.m.
Wednesday	a.m./p.m.	to	a.m./p.m.
Thursday	a.m./p.m.	to	a.m./p.m.
Friday	a.m./p.m.	to	a.m./p.m.
Saturday	a.m./p.m.	to	a.m./p.m.
Sunday	a.m./p.m.	to	a.m./p.m.

SUBSTANCE USE DISORDER - PROVIDER APPLICATION FORM

Application Information

Physical address: (Please attach a facility roster if there are multiple sites and include NPI and Medicaid site ID for each location)

Credentialing mailing address (if different from above):

Administrative contact (person responsible for the completion of this application):

Contact name:

Phone:

Email address:

Fax number:

Application contact and title (if not the CEO or executive director)

Phone:

Email:

SUBSTANCE USE DISORDER - PROVIDER APPLICATION FORM

Attestation And Consent For Release Of Information

Please include an explanation of any question(s) answered yes.

1. Within the past three years, has the facility had any Medicare and/or Medicaid sanctions?

Y N

2. Within the past three years, has the facility had any remedies imposed by the State to include State monitoring, civil monetary penalties, denial of Medicaid payment for new admissions, or temporary management and/or closure?

Y N

All information provided on this application or in connection with this application is complete and accurate to the best of the organization's knowledge. The organization understands that this application does not entitle the organization to participation in Colorado Access and/or Child Health Plan *Plus* (CHP+) State Managed Care Network networks. The organization agrees that entities providing information in good faith, pursuant to this release, shall not be liable for any act or omission related to the evaluation or verification of information contained in this application. All information submitted to Colorado Access by such entities will be treated as confidential. The organization further agrees to notify Colorado Access in a timely manner of any changes to the information provided on the application, including any Medicare and Medicaid sanctions or remedies imposed by the State.

I attest and certify that the medical and/or clinical staff is legally and professionally qualified for the positions to which they are appointed.

I attest that this organization credentials its individual practitioners.

The organization hereby authorizes any accrediting body, governmental entity, association, organization, person or Insurance Company to release the information requested herein and to provide confirmation of the answers contained herein to Colorado Access or any affiliate of Colorado Access. This authorization shall be valid for so long as the organization is a Colorado Access and/or CHP+ State Managed Care Network contracted provider. A copy of the signature is as binding as the original.

Signature of chief administrator or authorized Person

Date:

Print name of chief administrator or authorized Person