NEW YORK STATE | Office of Addiction Services and Supports

RESIDENTIAL REDESIGN CONVERSION APPLICATION

SECTION 1 – Administrative Information			
Entity/Administrative Headquarters Mailing Address			
Applicant's Legal Name			
Street	Room/Suite	Floor	
City, Town, Village	State	Zip Code + 4	
Application Contact Person			
Name of Contact Person	Position/Affiliation with Applicant		
Telephone Number	E-Mail Address		
Conversion Site			
Provider No.	Operating Certificate No. (attach a copy)	PRU No.	
Current Service Type			
Street	Current # beds	Proposed # Beds	
City, Town, Village	State	Zip Code + 4	

Enrollment in the New York State Medicaid Program

- Is the Program/applicant currently enrolled in the New York State Medicaid Program?
  - o If so please, include the program's MMIS/Medicaid number here _____

- Medicaid enrollment will be necessary for a program seeking OASAS Part 820 Residential Redesign certification For the Element(s) of Stabilization, Rehabilitation and Reintegration if not currently enrolled in the New York State Medicaid Program.

- If a program determines that it must enroll in the New York State Medicaid Program, please check the box below to request an OASAS-issued Letter of Intent: ***You will need to include this signed OASAS Letter of Intent when enrolling in the overall New York State Medicaid program enrollment package.***

  ☐ Applicant must enroll in NYS Medicaid Program and is requesting a Letter of Intent

- The New York State Medicaid Part 820 Enrollment instructions and form may be found at: https://www.emedny.org/info/ProviderEnrollment/OASAS/index.aspx

SECTION 2 - Proposal Narrative

Attachment #1 - Program Approach and Services – Required Approach for Each Element

A detailed response must be submitted for each segment listed below and labeled accordingly.

1. Identify how you will target the element of care to specific patient needs. **Label your response as PA #1.**
2. Provide a detailed list of expected goals with indicators of goal obtainment and discharge or transition criteria. Programs will develop predicted element markers including goals for completion of stabilization, rehabilitation, and reintegration. **Label your response as PA #2.**
3. Discharge planning must begin at admission and address the wide range of concerns that affect its participant (e.g., physical health, mental health, family issues, housing, etc.). Demonstrate how participants will be linked to other Elements of Care, Recovery Oriented System of Care and Community Resources. **Label your response as PA #3.**
4. Provider must have the capacity to interface with Medicaid Managed Care companies and submit claims; please describe a plan to bill and communicate with plan staff. **Label your response as PA #4.**
5. Describe your experience delivering treatment services that utilize best and promising practices that are appropriate to each of the elements that you are applying for (Stabilization, Rehabilitation, and Reintegration). **Label your response as PA #5.**
6. Describe your experience with integration of SUD services with mental health and physical health services (e.g., services for chronic health issues, pain management, co-occurring disorders). **Label your response as PA #6.**
7. Provider should demonstrate through documented staff training and case review systems the ability to address co-occurring mental health and substance use disorders, as well as integration of physical health with behavioral health concerns. **Label your response as PA #7.**
8. Provider should show ability to provide meaningful care coordination either with its own staff or through work with health homes or other care management agencies. **Label your response as PA #8.**
9. Clinical Supervision should be provided by staff with appropriate levels of training and education and with demonstrated experience in delivering chemical dependency treatment services for each element of care for which the program applied. **Label your response as PA #9.**
10. Provider should demonstrate the ability to provide person-centered services for individuals who need ongoing support to seek, obtain, and maintain employment. Employment support services should be included in the initial assessment and admission process and continue throughout treatment and beyond as ongoing follow-along support of a long-term recovery plan. **Label your response as PA #10.**
11. Provider should demonstrate a clear understanding of Trauma Informed, Person Centered Care and Recovery Oriented Systems of Care, and utilize processes to obtain regular feedback from participants on the quality of services provided. Providers should be able to demonstrate the use of peer-based recovery services as part of the participant's long-term recovery plan. **Label your response as PA #11.**

Attachment #2 Key Concepts

The applicant will demonstrate the ability to integrate these key concepts:

1. Shift from Program driven to Participant driven assessment, treatment planning and service delivery. **Label your response as Key Concept #1.**

2. Treatment planning and decision making is based on an assessment of individual risks, resources, values and preferences. Identify the assessment tools that will be utilized in your measurement based care model for each element. **Label your response as Key Concept #2**.

3. Service duration is based on individual milestones versus a programmed length of stay. Demonstrate how the program will move individuals through care, based on obtainment of the goals identified in an individualized treatment plan and speak to how your agency will integrate flexible lengths of stay. **Label your response as Key Concept #3.**

4. Medication-Assisted Treatment must be available and offered to all patients as indicated in each element and staff must be thoroughly trained on uses of addiction medicine and its relation to long-term recovery. **Label your response as Key Concept #4.**

5. Provider should demonstrate the ability to provide family-based services and address the impact of addiction on family systems, including family issues for those who are involved with the child-welfare system. Provider should demonstrate the ability to provide family based services or linkages to these services as needed. **Label your response as Key Concept #5.**

6. Proposal must identify how the program will evaluate the sufficiency of Medical, Mental Health, and Clinical staff time. Indicate how adjustments in staffing patterns will be made. List the data sources that will be utilized to inform this decision**. Label your response as Key Concept #6.**

Attachment #3 Policies, Procedures and Methods

1. Submit appropriate policies, procedures and methods which represent the day-to-day operation within the element consistent with Part 820.5 (1-17), i.e., admission and discharge criteria should be developed in collaboration with medical director. Refer to the Policies, Procedures and Methods Checklist for guidance. **Label your response as Attachment #3.**

   Restrict your submission to the policies and procedures as identified in the Policies, Procedures and Methods Checklist.

   Note: This checklist is intended for internal use by applicants in preparing/reviewing policies and procedures documentation and should not be submitted with the Part 820 Residential Redesign application.

Attachment #4 Elements Requested

☐ **Stabilization**

For applications that propose to deliver the stabilization element, the submission must also include:

1. A medical protocol attestation for ancillary withdrawal services signed by the program's Medical Director after reading the Guidance on medical protocols for Withdrawal Management for OASAS Certified Programs. The guidance and attestation can be found at https://oasas.ny.gov/providers/ancillary-withdrawal-certification. Technical assistance in this area may be obtained by contacting Grace Hennessy at: Grace.Hennessy@oasas.ny.gov. **Label your response as Stabilization #1.**
2. A description of the services that will be offered and staff responsible. **Label your response as Stabilization #2.**
3. A description of the assessment/tools, the process, including time frames and staff responsible. **Label your response as Stabilization #3.**
4. A sample treatment plan/service plan for a resident in stabilization. **Label your response as Stabilization #4.**
5. Metrics for evaluation of this Element (e.g., elimination of withdrawal symptoms, decreased mental health symptoms, decrease in anxiety). **Label your response as Stabilization #5.**
6. Describe how intake services will be provided 7 days a week. **Label your response as Stabilization #6.**

☐ **Rehabilitation**

For applications that include proposals to deliver the rehabilitation element, the submission must also include:

1. A description of the services that will be offered and staff responsible. **Label your response as Rehabilitation #1**.
2. A description of the assessment/tools, the process, including time frames and staff responsible. **Label your response as Rehabilitation #2.**
3. A sample treatment plan/service plan for a resident in rehabilitation. **Label your response as Rehabilitation #3.**
4. Metrics for evaluation of this Element (e.g., decrease/elimination of cravings, decrease in depression, decrease in anxiety. **Label your response as Rehabilitation #4**.

☐ **Reintegration**

For applications that include proposals to deliver the reintegration element, the submission must also include:

1. A description of the services that will be offered. **Label your response as Reintegration #1**.
2. A description of the assessment/tools, the process, including time frames and staff responsible. **Label your response as Reintegration #2.**
3. Identify the five hours a week of rehabilitative services that will be provided within the PRU. **Label your response as Reintegration #3**
4. A sample treatment plan/service plan for a resident in reintegration. **Label your response at Reintegration #4.** .
5. Metrics for evaluation of this Element (e.g., linkage to primary care physician, housing and employment). **Label your response as Reintegration #5.**

Attachment #5 – Organizational Capacity

1. Describe how your agency will support the implementation of each of the proposed Elements and explain how each Element fits into your agency's mission. **Label your response as Organizational Capacity #1**.

2. Describe the organizational capacity to collaborate with other community stakeholders, treatment service providers, and managed care plans. Identify the service providers with whom you have developed linkages and include MOU's to demonstrate the linkages for the provision of specialized services. **Label your response as Organizational Capacity #2.**

3. Attach a job description of the qualifications and experience that will be required for each key staff position. Demonstrate how your staffing for the proposed services meets the Element requirements. . Attach an organizational chart specific to the PRU. **Label your response as Organizational Capacity #3.**

4. Complete and attach a Residential Redesign Personnel Qualification Worksheet and a Staffing Pattern Worksheet Schedule for each Element you are applying for.

Attachment #6 - Program Effectiveness

1. Explain how you will use the data to determine program effectiveness and to make improvements in program practices. **Label your response as Program Effectiveness**.

Attachment # 7 – Facility Compliance

Facilities must comply with current Part 814 General Facility Requirements, including all Federal, State and Local Code requirements. If necessary, attach the program's plan for bringing the facility into compliance. Please clarify how your existing physical plant will accommodate the 820 enhanced staffing patterns. Label your response as Facility Compliance.

SECTION 3
Staffing Patterns for Elements of Care

Staffing Requirements
• A residential program of 10 beds or more shall have a full-time Program Director who is a QHP and shall have five years or more of full-time work experience in a SUD treatment setting unless otherwise approved by the Office.
• A residential program with fewer than 10 beds shall, at minimum, have a part time program director who is a QHP and shall have five years or more of full-time work experience in a SUD treatment setting.
• A residential service shall have a Clinical Supervisor who is a QHP with at least three years of clinical experience in SUD treatment.
• A residential service shall have a qualified individual designated as the Health Coordinator.

Applicable to Stabilization

Staffing Requirements
• Registered nurse as defined in Part 800 Regulation
• LPN for medication monitoring
• Medical Director as defined in Part 800 Regulation. In addition, the Medical Director must possess a DATA 2000 waiver. Proposal must identify how the program will evaluate sufficiency of medical director time and make adjustments. All residents in stabilization who are in need of assessment for withdrawal or Medication Assisted Treatment must be seen by the physician. There must be on-call physician for stabilization.
• Psychiatrist and/or psychiatric nurse practitioner to evaluate all residents who have a history of mental health disorder or who are exhibiting symptoms. Program must identify how it will evaluate the sufficiency of psychiatric time and make adjustments as needs increase or decrease.
• LMSW or LCSW or LMHC or Family Therapist in sufficient numbers to provide regularly scheduled psychotherapy to all residents who are in need of such services (see Clinical Standards document for guidance on assuring sufficient staffing pattern).
• CASACs in sufficient numbers to serve as the primary counselor. At least one CASAC available at all times. Proposal must identify how the program will evaluate sufficiency of CASAC time and make adjustments.
• Milieu staff all shifts in sufficient numbers available at all times.
• Two staff per overnight shift, one of which must be a clinical staff member as defined in Part 800 Regulation.
• Vocational Counselor
• Case Manager

Applicable to Rehabilitation

Staffing Requirements
• Registered nurse as defined in Part 800 Regulation
• LPN available on-site daily including weekends
• Medical Director as defined in Part 800 Regulation. In addition, the Medical Director must possess a DATA 2000 waiver.
• Psychiatrist and/or psychiatric nurse practitioner to evaluate all residents who have a history of mental health disorder or who are exhibiting symptoms
• LMSW or LCSW or LMHC or Family Therapist in sufficient numbers to provide regularly scheduled psychotherapy to all residents who are in need of such services (see Clinical Standards document for guidance on ensuring sufficient staffing).
• CASACs in sufficient numbers to serve as the primary counselor. At least one CASAC available at all times.
• Milieu staff all shifts in sufficient numbers available at all times.
• Two staff per overnight shift, one of which must be a clinical staff member as defined in Part 800.
• Vocational Counselor

Applicable to Reintegration

Staffing Requirements for Congregate Care Settings
• Clinical staff in sufficient numbers to serve as care coordinator.
• Milieu staff in sufficient numbers to facilitate activities of daily living, community meetings, and engagement of residents in recovery skills building.
• Case Manager
• Two staff per overnight shift, one of which must be a clinical staff member as defined in Part 800.
Staffing Requirements for Scattered Site Settings
• The Reintegration Element in scattered sites should provide linkages to services within the community to meet the needs of participants.

Instructions for Residential Redesign
Personnel Qualifications Worksheet

Complete a separate form(s) for each Residential Element

Enter the Provider's Legal Name, the Residential Element and the applicable PRU #	Enter the provider's legal name as it appears on the operating certificate; identify the residential element and the appropriate PRU #.
Employee Name and/or Employee Title	Enter employee name and/or title or position, including the Medical Director, Program Director, Clinical Supervisor and Health Coordinator (example: **Jane Doe – Clinical Supervisor**; **Joe Smith – Health Coordinator**)
# of Weekly Hours Dedicated to this Operating Certificate	Enter the number of the employee's weekly hours that will be dedicated to this Operating Certificate.
Education	Enter the highest degree obtained or the highest grade completed. (example: **MSW**; **Associate's**; **GED**)
Experience	List general experience and training in chemical dependence services. (**identify training and/or experience which meets Part 820 requirements**)
QHP	Enter a check mark (✓) if the employee is a Qualified Health Professional (QHP) or a CASAC Trainee (CASAC-T)
License/Credential # -- Expiration Date	Enter License and/or Credential number and expiration date, if applicable. (example: **CASAC #1234 – 09/30/15**; **CASAC Trainee #123 – 07/15/15**; **LCSW #321 – 11/15/15**; **MD #7890 – 06/30/15**)

Personnel Qualifications Worksheet

Employee Name and/or Employee Title	# of Weekly Hours Dedicated to this Operating Certificate	Education	Experience	QHP (Y/N)	License/Credential # Expiration Date	Verified (Office Use Only)

STAFFING PATTERN WORKSHEET SCHEDULE

Complete a form for each Residential Element and attach as many sheets as necessary. Enter the employee's typical work schedule.

Provider Legal Name_____ Residential Element_____ PRU # _____

Title/FTE	Shift	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1st Shift							
	2nd Shift							
	3rd Shift							
	1st Shift							
	2nd Shift							
	3rd Shift							
	1st Shift							
	2nd Shift							
	3rd Shift							
	1st Shift							
	2nd Shift							
	3rd Shift							

SECTION 4

Provider Attestation

For submission of this application electronically, I understand that by typing my name below, I am attesting that I am authorized to represent the applicant and hereby give my assurance of all applicable standards required for the proposed service.

Provider Authorization for Submission

Authorized Provider Representative Signature	Title	Date

OASAS Official Use Only

Date Reviewed _____

Reviewer's Name _____

Reviewer's Signature _____

Approved Date _____

Applications should be submitted to:

NYS OASAS

Bureau of Certification

1450 Western Avenue

Albany, NY 12203

or via-e-mail to:

Certification@oasas.ny.gov