COMMUNITY-BASED ACUTE TREATMENT (CBAT) FOR CHILDREN AND ADOLESCENTS

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. Additionally, providers contracted for this service and all contracted services are held accountable to the General performance specifications, located at the beginning of the performance specifications section of the Provider Manual, found at www.masspartnership.com. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

These performance specifications apply to:

- Community-Based Acute Treatment (CBAT) for Children and Adolescents
- Intensive Community-Based Acute Treatment (ICBAT) for Children and Adolescents

Please also refer to the performance specifications attachment for this specialty service.

Community-Based Acute Treatment (CBAT) is provided to children/adolescents up to the age of 18 (youth ages 19-20 may be eligible for admission based on a program’s licensing requirements and a Member’s clinical needs) with serious behavioral health disorders who require a 24-hour-a-day, seven-day-a-week, staff-secure (unlocked) treatment setting. The primary function of CBAT is to provide short-term crisis stabilization, therapeutic intervention, and specialized programming in a staff-secure environment with a high degree of supervision and structure, with the goal of supporting the rapid and successful transition of the child/adolescent back to the community.

CBAT services are provided in the context of a comprehensive, multi-disciplinary, and individualized treatment plan that is frequently reviewed and updated based on the Member’s clinical status and response to treatment. Acute therapeutic services include, but are not limited to: psychiatric assessment and treatment; pharmacological assessment, monitoring and treatment; nursing; individual, group, and family therapy; care coordination; family consultation; and discharge planning.

Children/adolescents may be admitted to CBAT directly from the community or as a transition from inpatient services.

Components of Service

1. The program complies with all provisions of the corresponding section in the General performance specifications.
2. Therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional staff to maintain an appropriate milieu and conduct the services below, based on individualized Member needs.
3. The scope of required service components provided in this level of care...
includes, but is not limited to, the following. Please refer to the per
diem/service definition which is all-inclusive and includes the components
covered in the rate for this service, found at www.masspartnership.com.

- Psychiatric evaluation and treatment, inclusive of the Massachusetts
Child and Adolescent Needs and Strengths (CANS) tool completed
by a CANS-certified clinician, as part of discharge planning
- Medical history and medical assessment (basic physical examination
to assess for medical issues)
- Pharmacological evaluation and treatment
- Individual, group, and family therapy
- Educational component, including coordination with a Member’s
  Individualized Education Program (IEP), as applicable (excluding
  weekends and holidays)
- Development of behavioral plans and safety plans, as part of the
  Crisis Planning Tools for youth
- Specializing, as clinically indicated
- Therapeutic milieu

4. The program has the capacity to provide, or refer to, the following, as
clinically indicated:
- Assessment of fire-setting and/or sexual offending behaviors
- Assessment for Safe and Appropriate Placement (ASAP)
- Neurological evaluation
- Neuropsychological testing
- Nutritional counseling
- Psychological testing, if clinically indicated for stabilization and/or
to address diagnostic and treatment questions central to the CBAT
  assessment, treatment and discharge planning process
- Substance use disorder assessment and treatment planning

5. The program is responsible for ensuring that each Member has access to
medications prescribed for physical and behavioral health conditions and
documents so in the Member’s health record.

6. Prior to this, the program engages in a medication reconciliation process in
order to avoid inadvertent inconsistencies in medication prescribing that
may occur in transition of a Member from one care setting to another. The
program does this by reviewing the Member’s complete medication
regimen at the time of admission (e.g., transfer and/or discharge from
another setting or prescriber) and comparing it with the regimen being
considered in the CBAT program. The program engages in the process of
comparing the Member’s medication orders newly issued by the CBAT
program to all of the medications that he/she has been taking in order to
avoid medication errors. This involves:
   a. developing a list of current medications, i.e., those the Member was
      prescribed prior to admission to the CBAT program;
   b. developing a list of medications to be prescribed in the CBAT
      program;
c. comparing the medications on the two lists;
d. making clinical decisions based on the comparison and, when indicated, in coordination with the Member’s primary care clinician (PCC); and
e. communicating the new list to the Member’s parent/guardian/caregiver and, with consent, to the Member’s PCC, other treatment providers, and as appropriate to the Member.

All related activities are documented in the Member’s health record.

7. All urgent consultation services resulting from the psychiatric evaluation, medical history, and medical assessment, or as subsequently identified during the admission, are provided within 24 hours of the order for these services. Non-urgent consultation services related to the assessment and treatment of the Member while in the CBAT program are provided in a timely manner, commensurate with the level of need. Routine medical care (not required for the diagnosis related to the presenting problem) may be deferred, when appropriate, if the length of stay in the CBAT program is brief. All of these services are documented in the Member’s health record.

8. The program has consent from the parent/legal guardian for admission and makes documented attempts to contact the parent, guardian, family members, and/or significant others within 48 hours of admission, unless clinically or legally contraindicated. The program provides them with all relevant information related to maintaining contact with the program and the Member, including names and phone numbers of key nursing staff, primary treatment staff, social worker/care coordinator/discharge planner, etc. If contact is not made, the Member’s health record documents the rationale.

9. During an admission, parental/guardian/caregiver access to their children is a right and is not to be denied, unless it is specifically clinically or legally contraindicated. The program allows daily access to children and adolescents for parent(s), guardian(s), family member(s), or caregiver(s). Parental access is never prohibited as part of behavioral programming. All decisions relative to visitation and/or contact with parents/guardians/significant others is documented in the Member’s health record.

10. The program provides accommodations for Members to use telephones (free of charge) including allowing Members to speak with family members in their native language and providing postage stamps, in order to maintain contact with parents, guardians, family members, legal counsel, or caregivers, as legally allowed and clinically indicated.

11. The program is responsible for updating its available capacity, three times each day at a minimum, seven days per week, 365 days per year, on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The program is also responsible for keeping all administrative and contact information up to date on the website. The program is also responsible for training staff on the use of the website to locate other services for Members, particularly in planning aftercare services.
## Staffing Requirements

1. The program complies with all provisions of the corresponding section in the General performance specifications.

2. The program complies with the staffing requirements of the applicable licensing body, the staffing requirements in the MBHP service-specific performance specifications, and the credentialing criteria outlined in the MBHP Provider Manual, Volume I, as referenced at [www.masspartnership.com](http://www.masspartnership.com).

3. The staff includes a CBAT program director or supervisor who is an independently licensed, master’s-level or doctoral-level clinician. He/she is responsible for the clinical oversight and quality of care within the CBAT program, in collaboration with the medical director and ensures the provision of all CBAT service components. He/she is available for consultations regarding emergency or urgent situations.

4. The program has a written staffing plan that delineates (by unit, day and shift) the number and credentials of its professional staff, including an attending child psychiatrist(s), nurses, social workers, psychologists, and other mental health professionals, in compliance with its licensed capacity on a daily basis. The program director or supervisor collaborates with the medical director on the development and maintenance of the staffing plan for psychiatry.

5. The program is staffed with sufficient appropriate personnel to accept and admit admissions, at a minimum, during first and second shifts from 7:00 a.m. to 11:00 p.m., 7 days per week, 365 days per year. The program is staffed to conduct discharges 7 days per week, 365 days per year.

6. The program maintains appropriate staffing patterns to safely care for all children/adolescents at all times. Members have access to supportive milieu and clinical staff, as clinically indicated, 24 hours per day, 7 days per week, 365 days per year, including awake, supportive overnight staff.
   a. The program is able to provide short-term, episodic, one-to-one staffing for observation and management of significant clinical and/or safety issues that may arise, when clinically indicated, and/or as included in the treatment plan. Members for whom one-to-one staffing for extended periods of time is required may, upon further evaluation, be more appropriate and meet the criteria for a higher level of care than CBAT.

7. The program has adequate psychiatric coverage to ensure all performance specifications related to psychiatry are met.

8. The program appoints a medical director who is fully integrated into the administrative and leadership structure of the CBAT program and is responsible for clinical and medical oversight, quality of care, and clinical outcomes across all CBAT service components, in collaboration with the program director or supervisor and the clinical leadership team.
   a. The medical director is a child fellowship-trained psychiatrist who is board-certified and/or who meets MBHP’s credentialing criteria for
a child/adolescent psychiatrist (Note: MBHP’s credentialing criteria for child and adolescent psychiatrists states that they must be board-certified in general psychiatry by the American Board of Psychiatry and Neurology (ABPN) within two years of contracting with MBHP unless a waiver of this requirement is requested and received within two years of contracting with MBHP).

b. The medical director’s role may include the provision of direct psychiatry services and also includes:
   i. Teaching, training, and coaching; and
   ii. Oversight and monitoring of prescribing clinicians.

c. The medical director’s role also includes the following functions, in collaboration with the program director or supervisor and the clinical leadership team:
   i. Attendance at multi-disciplinary team meetings; and
   ii. Consulting with the multi-disciplinary team.

d. The medical director’s role also includes the following functions, in collaboration with the clinical leadership team:
   i. integration of the various assessments of the Member’s needs and strengths into a coherent narrative that can be used for treatment planning within the CBAT program and in the Member’s home and community;
   ii. development and utilization of the CBAT program’s unifying theory of treatment to guide its mission, vision and practice;
   iii. development of therapeutic programming; and
   iv. ensuring that programs remain child-focused and family-centered.

e. The medical director ensures psychiatric practice consistent with the best available evidence-based practices and parameters developed by the American Academy of Child and Adolescent Psychiatry (AACAP) when evaluating and treating youth with complex needs and/or medication regimens, e.g., when Members entering the CBAT program are on multiple psychiatric medications, or are in the custody of a state agency and are starting or continuing atypical antipsychotics. The medical director monitors this practice through oversight and supervision.

9. The program assigns to each Member an on-site attending child psychiatrist, who may be the medical director.

10. Psychiatric care is provided by the medical director and/or other child fellowship-trained psychiatrists, who are board-certified and/or who meet MBHP’s credentialing criteria. Psychiatric care consists of the provision of psychiatric and pharmacological assessment and treatment to Members in the CBAT program. The program may also utilize a child psychiatry fellow/trainee to provide psychiatric care, in conformance with the Accreditation Council for Graduate Medical Education (ACGME, www.acgme.org), in compliance with all Centers for Medicare & Medicaid Services (CMS) guidelines for supervision of trainees by attending
physicians, and under the supervision of the medical director or another attending child psychiatrist, as outlined within these performance specifications. The program may also utilize a psychiatric nurse mental health clinical specialist (PNMHCS) to provide psychiatric care, within the scope of their licenses and under the supervision of the medical director or another attending child psychiatrist, as outlined within these performance specifications.

11. A child psychiatrist is available to conduct initial face-to-face psychiatric evaluations, as follows:
   a. For all admissions on weekends and holidays, a child psychiatrist is available to review the master’s-level clinician’s assessment, initial treatment plan, and medication regimen by telephone within 24 hours. For most admissions, a child psychiatrist will then conduct a face-to-face evaluation of the Member on the next business day.
   b. A child psychiatrist will conduct initial face-to-face evaluations of youth who meet the following criteria, within 24 hours, 7 days per week:
      i. all admissions under the age of 6;
      ii. all admissions who have not been evaluated by another child and adolescent psychiatrist, such as a discharging inpatient psychiatrist, within 24 hours prior to the admission, or have not been reviewed with an ESP/MCI consulting psychiatrist who approved the admission; and
      iii. admissions meeting the criteria in ii above, but the CBAT child psychiatrist identifies the need for a face-to-face evaluation upon review of the master’s-level clinician’s assessment.

12. For programs that utilize a child psychiatry fellow/trainee to perform psychiatry functions, all of the following apply:
   a. The child psychiatry fellow/trainee must be provided sufficient supervision from child and adolescent psychiatrists to enable him/her to establish working relationships that foster identification in the role of a child and adolescent psychiatrist;
   b. The child psychiatry fellow/trainee must have at least two (2) hours of individual supervision weekly, in addition to teaching conferences and rounds;
   c. If a child psychiatry fellow/trainee conducts the initial face-to-face psychiatric evaluation of the Member, he/she presents the youth to the attending child psychiatrist, or other child psychiatrist on duty, within 24 hours; and
   d. The program must use the following classification of supervision:
      i. Direct supervision – the supervising physician is physically present with the fellow and Member.
      ii. Indirect supervision:
         • with direct supervision immediately available – the supervising physician is physically within the program,
and is immediately available to provide direct supervision.

- with direct supervision available – the supervising physician is not physically present within the program, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.

iii. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

13. For programs that utilize a PNMHCS to perform psychiatry functions, all of the following apply:

a. There is documented maintenance of: a collaborative agreement between the PNMHCS and the medical director, or another attending child psychiatrist; and a consultation log including dates of consultation meetings and list of all Members reviewed. The agreement specifies whether the PNMHCS or the medical director, or another attending child psychiatrist, will be responsible for this documentation;

b. The supervision/consultation between the PNMHCS and the medical director, or another attending child psychiatrist, is documented and occurs at least one (1) hour per week for the PNMHCS, or at a frequency proportionate to the hours worked for those PNMHCS staff who work less than full-time. The format may be individual, group, and/or team meetings;

c. A documented agreement exists between the medical director, or another attending child psychiatrist, and the PNMHCS outlining how the PNMHCS can access the medical director, or another attending child psychiatrist, when needed for additional consultation;

d. The medical director, or another child fellowship-trained psychiatrist, is the attending psychiatrist for the Member, when a PNMHCS is utilized to provide direct psychiatry services to a given Member. The PNMHCS is not the attending for any Member;

e. If a PNMHCS conducts the initial face-to-face psychiatric evaluation of the Member, he/she presents the youth to the attending child psychiatrist, or other child psychiatrist on duty, within 24 hours, and documents all such activity; and

f. There is documented active collaboration between the medical director, or another attending child psychiatrist, and the PNMHCS relative to Members’ medication regimens, especially those Members for whom a change in their regimen is being considered.

14. The program ensures 24-hour availability of a child fellowship-trained psychiatrist who is board-certified and/or who meets MBHP’s credentialing
criteria. When a child psychiatrist is not on-site at the CBAT, another child psychiatrist, or a child psychiatry fellow/trainee or PNMHCS who has access to a child psychiatrist for consultation, is available for phone consultation within 30 minutes of a request. The determination of the need to call the child psychiatrist on-call is based on the assessment of clinical and nursing staff working in the program as well as supervisory and/or on-call clinical and nursing staff. If there is a significant change in a Member’s clinical presentation, and as warranted by an assessment by a master’s-level or doctoral-level or nurse clinician and consultation with clinical and nursing supervisory and/or on-call staff, a face-to-face evaluation occurs within 60 minutes of a request when clinically indicated. The face-to-face psychiatric evaluation is provided on-site by the medical director, another child psychiatrist, a child psychiatry fellow/trainee, a PNMHCS, or the local Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) psychiatrist through an affiliation with the ESP/MCI, or other Affiliation Agreement. If the face-to-face psychiatric evaluation is conducted by a child psychiatry fellow/trainee or a PNMHCS, he/she presents the youth to the attending child psychiatrist, or other child psychiatrist on duty, within 24 hours.

15. The program has trained nursing staff (RN or LPN) available during day and evening shifts as needed, or the program utilizes its psychiatry and/or PNMHCS staffing to perform the functions below. These functions involve but are not limited to the admission process:
   a. RN staff can perform the following core functions: fill physician orders; administer medication and engage in a medication reconciliation process, as outlined within the Components of Service section of these specifications; take vital signs; coordinate medical care; contribute to comprehensive assessment, brief crisis counseling, individualized crisis prevention planning, and provider psycho-education; and assist with discharge planning and care coordination.
   b. LPN staffing, appropriate to licensure level, assist the RN with filling physician orders, administering medications, and monitoring vital signs, and contribute to the assessment, individualized crisis planning, discharge planning, and care coordination.
   c. After hours, the on-call child psychiatrist can be consulted relative to medical issues and concerns.

16. The program collaborates with the Member’s PCC, and/or has access to a consulting pediatrician via an Affiliation Agreement for medical consultation, as clinically indicated, when ordered by the attending child psychiatrist or otherwise needed.

17. Staffing includes at least one master’s-level clinician a minimum of eight hours a day during the week, and as needed to conduct admission assessments on weekends and holidays. Clinicians make best efforts to flexibly offer hours outside of normal business hours and on weekends when needed to accommodate families’ schedules and to be responsive to
the needs of youth and families. When a master’s-level clinician is not on-site, a masters-level or doctoral-level clinical supervisor is available for telephonic consultation within 30 minutes.

18. The program ensures adequate staffing of master’s-level clinicians certified to administer the MA CANS tool.

19. All staff directly responsible for providing any treatment components during a youth’s stay receive documented, program-related training, consistent with the individualized needs of the program and its target population, at least annually, on topics related to the acute treatment of children and adolescents with behavioral health conditions, including but not limited to family systems, child/adolescent development and behavior, risk management/safety planning, crisis prevention and restraint reduction, substance use disorder and/or co-occurring disorders, and the identification and treatment of problematic sexual behaviors and fire-setting behaviors.

20. All staff receive documented training and ongoing updated information regarding the current resources and levels of care that are available for youth upon discharge, including but not limited to Children’s Behavioral Health Initiative (CBHI) services, other behavioral health services, state agency services including DCF and DMH services and levels of care. Staff is knowledgeable enough about these resources to be able to develop realistic treatment and discharge plans.

21. The program provides all staff with supervision in compliance with MBHP’s credentialing criteria.

### Process Specifications

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<tr>
<th>Assessment, Treatment Planning, and Documentation</th>
<th>1. The program complies with all provisions of the corresponding section in the General performance specifications.</th>
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<tr>
<td></td>
<td>2. The program responds within 30 minutes to requests for admission, including evenings and weekends. At a minimum, the program accepts and admits Members during first and second shifts from 7:00 a.m. to 11:00 p.m., 7 days per week, 365 days per year.</td>
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<td>a. A best practice is for CBATs to have mechanisms to accept referrals from 11:00 p.m. to 7:00 a.m., e.g. 24 hours per day, so that referral sources do not need to wait until 7:00 a.m. to make a referral.</td>
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<td>b. An additional best practice is for CBATs to admit Members from 11:00 p.m. to 7:00 a.m., e.g. 24 hours per day.</td>
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<td>3. A master’s-level, child-trained clinician conducts a psychosocial evaluation within 24 hours of admission, or as soon as the youth and family are able to participate in the process.</td>
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<td>4. A child fellowship-trained psychiatrist, who is board-certified and/or who meets MBHP’s credentialing criteria, or a PNMHCS or child psychiatry fellow/trainee, provides an initial face-to-face psychiatric evaluation within 24 hours of admission for the following Members:</td>
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<td>a. A youth under the age of six; and</td>
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Effective July 1, 2014
b. A youth who has not been evaluated by a child psychiatrist for a face-to-face evaluation within the 24 hours prior to the CBAT admission (such as an ESP/MCI, Inpatient, ICBAT, or outpatient psychiatrist) or has not been evaluated by or reviewed with an ESP/MCI consulting psychiatrist who approved the admission.

If the PNMHCS or child psychiatry fellow/trainee completes the initial evaluation, he/she reviews it with the attending child psychiatrist or another child psychiatrist on duty within 24 hours.

5. For the Members identified above, a medical assessment of each Member is conducted by a qualified staff (e.g., psychiatrist, PNMHCS, or RN) within 24 hours of admission, if one was not completed within the past 24 hours.

6. A child fellowship-trained psychiatrist, who is board-certified and/or who meets MBHP’s credentialing criteria, or a PNMHCS or child psychiatry fellow/trainee provides an initial face-to-face psychiatric evaluation within 48 hours of admission for the following Members:
   a. A youth who has transitioned from an Inpatient or Intensive Community-Based Acute Treatment (ICBAT) level of care, where he/she was evaluated by a child fellowship-trained psychiatrist within 24 hours prior to the CBAT admission; or
   b. A youth who has been evaluated by or reviewed with an ESP/MCI consulting psychiatrist within 24 hours prior to the CBAT admission; or
   c. A youth who has been evaluated by his/her treating outpatient child and adolescent psychiatrist, who has clinical knowledge of the Member and familiarity with the CBAT level of care, within 24 hours prior to the CBAT admission.

If the PNMHCS or child psychiatry fellow/trainee completes the initial evaluation, he/she reviews it with the attending child psychiatrist or another child psychiatrist on duty within 24 hours.

7. For the Members identified above, a medical assessment of each Member is conducted by a qualified staff within 48 hours of admission, if one was not completed within the past 48 hours.

8. For admissions who meet the criteria for the 48 hour timeframe for the initial psychiatric evaluation and medical assessment, and the 48 hours falls on a weekend or holiday  (Noon Friday until Monday morning and holidays):
   a. These youth are assessed by the child psychiatrist, PNMHCS, or child psychiatry fellow/trainee by 5:00pm on Monday, or the next business day for holiday admissions.
   b. In the meantime, upon admission, the master’s-level clinician reviews with the on-call child psychiatrist by phone within 24 hours: the clinical information provided by the referral source (e.g., ESP/MCI, Inpatient or ICBAT provider), the psychosocial evaluation that he/she completed upon admission, and the youth’s medication regimen upon admission.
c. The child psychiatrist determines if it is indicated that he/she conduct an initial face-to-face evaluation of the Member during the weekend or holiday; if not, the child psychiatrist, PNMHCS, or child psychiatry fellow/trainee evaluates the Member face-to-face on the next business day.

9. Every Member is assigned an on-site attending child psychiatrist, who may be the medical director, who consistently provides, and is responsible for, the day to day and overall care of the Member when in CBAT. The attending child psychiatrist meets with the Member at least one to two times per week as dictated by the individualized treatment plan, writes psychiatry notes in the Member’s health record, and ultimately serves as the Member’s primary physician. The attending child psychiatrist is an active participant on the Member’s treatment team and is available to consult with other members of the treatment team throughout the Member’s length of stay.

10. The attending child psychiatrist maintains the role as the Member’s primary physician throughout the Member’s length of stay in the CBAT program. When the attending child psychiatrist is not scheduled to work or is out for any reason (e.g., vacation, illness, etc.), he/she designates a consistent substitute, as much as possible, to ensure that the Member receives continuity of care. In these instances, the functions of meeting with the Member at least one to two times per week and writing psychiatry notes in the Member’s health record may be designated to another child psychiatrist or to a PNMHCS or child psychiatry fellow/trainee acting under the Member-specific supervision of the medical director or another attending child psychiatrist. The medical director or other attending child psychiatrist continues to serve as the Member’s attending child psychiatrist. He/she remains active within the CBAT program, keeping informed and overseeing the Member’s care, and is available and consults with other staff who are providing psychiatric care, as needed.

11. If the program utilizes a PNMHCS or child psychiatry fellow/trainee to perform psychiatry functions within their license and scope of practice, the medical director is the attending psychiatrist. He/she provides oversight and consultation to the PNMHCS or child psychiatry fellow/trainee, as outlined within the Staffing Requirements section of these specifications.

12. The psychiatric evaluation, preferably performed by the Member’s attending child psychiatrist, or another child psychiatrist, a PNMHCS, or a child psychiatry fellow/trainee, consists of a medical history and an assessment of the psychiatric, pharmacological, and treatment needs of the Member, including a clinical formulation that explains the Member’s acute condition and maladaptive behavior. When possible, given parental/guardian/caregiver availability, the attending child psychiatrist, another child psychiatrist, PNMHCS, or child psychiatry fellow/trainee meets with the parent/guardian/caregiver in person or contacts by telephone as part of the initial evaluation.

13. The program ensures that clinical assessments stress the importance of identifying current treaters and collateral contacts to obtain more
comprehensive information and insight into the Member and his/her family, and work toward building consensus in identifying strengths and developing a future vision for the Member. A key component of this vision includes realistic discharge planning and recommendations to include identification of the clinical, social, and medical components needed in the Member’s next living situation and treatment setting.

14. The program assigns a multi-disciplinary treatment team, consisting of a child psychiatrist and one or more other disciplines, to each Member within 24 hours of admission, or on the next business day for weekend admissions. The program’s treatment team reviews the psychosocial and psychiatric assessments and develops an initial treatment and initial discharge plan within 48 hours of the Member’s admission. (On weekends, the master’s-level clinician performs these functions, and the multi-disciplinary treatment team reviews the assessment and plans on the next business day.)

15. The treatment and discharge plans specifically focus on identification of anticipated services, especially CBHI services (e.g., In-Home Therapy), that will facilitate and support the Member’s rapid return to the community. A determination is made and documented regarding the clinical appropriateness of the In-Home Therapy (IHT) service, and/or other clinical services, to facilitate and support the Member’s rapid return to the community. If the program determines the Member to be clinically appropriate for IHT, and/or other clinical services upon discharge, with the consent of the parent/guardian/caregiver, the process of referrals will be initiated by the CBAT within the next 24 hours. A main purpose is to ensure the participation of the IHT staff in planning for the Member’s transition home.

16. The assessment and treatment plan address the possible barriers to the Member’s successful return to his/her living situation prior to the CBAT admission, and includes treatment strategies and other efforts to mitigate those barriers.

17. The treatment plan and discharge plan are reviewed by the multi-disciplinary treatment team at least every 48 hours (a maximum of 72 hours between reviews on weekends) and are updated accordingly, based on each Member’s individualized progress. During each review, the CBAT program:
   a. collaborates with the Member’s ongoing or newly involved CBHI, outpatient, and/or other service providers regarding care coordination and discharge planning;
   b. continues to identify the services needed to facilitate the Member’s return to the community and arranges those services;
   c. makes efforts to address and resolve any barriers preventing the Member’s return to the community; and
   d. identifies appropriate back-up discharge plans in the event circumstances change, including the need for placement in an alternative living situation, when indicated.

18. All reviews and updates of the treatment plan and discharge plan, as well as care coordination and disposition planning activities, are documented
in the Member’s health record.

19. Assessments, treatment and discharge plans, treatment meetings, and all treatment planning activities are documented in the Member’s health record.

20. The program collaborates with the Member, the ESP/MCI provider in the catchment area in which the Member lives, and other clinical service providers to obtain the Member’s safety plan. The program collaborates with these entities to update the plan if needed, or develops one if the Member does not yet have one. With Member consent, the ESP/MCI provider may share the safety plan with the program, which includes the safety plan and documents related collaboration in the Member’s health record.

21. With Member consent and the establishment of the clinical need for such communication, coordination with parents/guardians/caregivers, relevant school staff, and other treatment providers, including PCCs and behavioral health providers, is conducted by appropriate staff relative to treatment and care coordination issues. All such contact is documented in the Member’s health record.

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<th>Discharge Planning and Documentation</th>
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<tr>
<td>1. The program complies with all provisions of the corresponding section in the General performance specifications.</td>
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<tr>
<td>2. The program conducts discharges 7 days per week, 365 days per year.</td>
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<td>3. The program ensures that active and differential treatment planning and discharge planning is implemented for each Member by qualified staff who are knowledgeable about the medical necessity criteria for all MBHP covered services, including but not limited to all the CBHI services.</td>
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<td>4. Discharge planning begins at admission, including plans for reintegration or integration into the home or other living situation, school, and community. If discharge to home/family is not an option, alternative placement is rapidly identified with regular documentation of active efforts to secure such placement.</td>
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<td>5. Prior to discharge, the program assists Members in obtaining post-discharge appointments, as follows: within 7 calendar days of discharge for outpatient therapy services (which may be an intake appointment for therapy services), if necessary; and within 14 calendar days of discharge for medication monitoring, if necessary. This function may not be designated to aftercare providers or to the Member to be completed before or after the Member’s discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Member’s health record. If there are barriers to accessing covered services, the program notifies the MBHP Clinical Access Line and/or the regional office as soon as possible to obtain assistance. All such activities are documented in the Member’s health record.</td>
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<td>6. In preparation for discharge, the program develops or updates the Member’s safety plan and sends a copy to the ESP/MCI Director at the Member’s local ESP/MCI provider with Member consent, or the program contacts the Member’s local ESP/MCI provider to request assistance with</td>
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developing or updating a safety plan. At the time of discharge, the program ensures that the Member has a copy of the safety plan.

7. The program provides, with Member consent, a written discharge summary (or other such document(s) that contain the required elements) no later than within two weeks of the Member’s discharge to the Member, parents/guardians/caregivers, PCCs, and current behavioral health providers. The discharge summary is documented in the Member’s health record and includes a summary of:
   a. the course of treatment;
   b. the Member’s progress;
   c. the treatment interventions and behavior management techniques that were effective in supporting the Member’s progress;
   d. medications prescribed;
   e. recommended behavior management techniques when applicable; and
   f. treatment recommendations, including those that are consistent with the service plan of the relevant state agency for Members who are also involved with DMH, Department of Developmental Services (DDS), Department of Youth Services (DYS), or Department of Children and Families (DCF); and/or the youth’s Individual Care Plan (ICP) for those enrolled in Intensive Care Coordination (ICC).

8. For all youth under age 21, the program makes best efforts to ensure a smooth transition for the return to home or discharge location, and to the next service, if any, by ensuring that a CANS-certified clinician at the program completes a CANS tool for all Members under the age of 21 as part of the discharge planning process. A copy of the CANS is maintained in the Member’s health record. With parent/guardian/caregiver consent, the program enters into the CANS IT System the information gathered using the CANS tool. Even without consent, the program ensures that the demographics and serious emotional disturbance (SED) determination are entered into the CANS IT System.

Service, Community, and Collateral Linkages

1. The program complies with all provisions of the corresponding section in the General performance specifications.

2. The program maintains, via Affiliation Agreements or Memoranda of Understanding (MOU), linkages with the step-down programs for adults, children and adolescents, including but not limited to Transitional Care Units (TCUs) and CBHI services, to which the program refers high volumes of Members, to enhance continuity of care for Members.

3. With Member consent, the program collaborates with any involved state agencies around the coordination of service provision, to facilitate consensus and consistency among service plans.

4. The program develops an active working relationship with each of the local ESPs/MCIs who are high-volume referral sources for the hospital.
The program holds regular meetings or has other contacts, and communicates with the ESPs/MCIs on clinical and administrative issues, as needed, to enhance the referral and admission process and continuity of care for Members. On a Member-specific basis, the program collaborates with any and all ESP/MCI providers upon admission to ensure the ESP’s/MCI’s evaluation and treatment recommendations are received and any existing safety plan is obtained from the ESP/MCI.

5. With consent, the program contacts the appropriate local education authority (LEA) if the school system is involved with the Member around educational planning, curriculum, and/or resources.