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.

Enhanced Acute Treatment Services (E-ATS) for Individuals with Co-occurring Mental Health and Substance Use Disorders provide diversionary and/or step-down services for Members in need of acute, 24-hour substance use disorder treatment, as well as psychiatric treatment and stabilization. Detoxification services are provided through a planned program of 24-hour, medically monitored evaluation, care, and treatment and are tailored for individuals whose co-occurring mental health and substance use disorder requires a 24-hour, medically monitored evaluation, care, and treatment program, including the prescription and dosage of medications typically used for the treatment of mental health disorders. E-ATS services for individuals with co-occurring mental health and substance use disorders are rendered in a licensed, acute care or community-based setting with 24-hour physician and psychiatrist consultation availability, 24-hour nursing care and observation, counseling staff trained in substance use disorders and mental health treatment, and overall monitoring of medical care. Services are provided under a defined set of physician-approved policies, procedures, and clinical protocols. E-ATS are available for both adolescents and adults.

Individuals may be admitted to an E-ATS program directly from the community, including referrals from Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) providers, or as a transition from inpatient services.

Components of Service

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<tr>
<td>1.</td>
<td>The provider complies with all provisions of the corresponding section in the General performance specifications.</td>
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<tr>
<td>2.</td>
<td>Full therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional staff to conduct these services and to manage a therapeutic milieu. 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</td>
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all-inclusive and includes the components covered in the rate for this service, found at www.masspartnership.com.

a. Bio-psychosocial evaluation
b. Medical history and physical examination
c. Individual and group therapy
d. Psycho-education, including substance use disorder, relapse prevention, and communicable diseases
e. Development of behavioral treatment/recovery plans
f. Development and/or updating of crisis prevention plans, and/or safety plans as part of the Crisis Planning Tools for youth, and/or relapse prevention plans, as applicable
g. Initial substance use disorder assessment
h. Initial nursing assessment
i. Psychiatric evaluation and treatment
j. Pharmacological evaluation and treatment
k. Discharge planning/case management
l. Aftercare planning and coordination
m. Detoxification
n. 24-hour nursing care

3. The program provides a comprehensive, structured treatment program which incorporates the effects of substance use disorders, mental health disorders, and recovery, including the complications associated with dual recovery, and provides a minimum of four hours of service programming per day.

4. The provider has the capacity to treat Members with alcohol and/or other drug dependencies who are assessed to be at a mild to moderate risk of medical complications during withdrawal and who also have a concomitant psychiatric diagnosis.

5. The program admits and has the capacity to treat Members who are currently on methadone maintenance or receiving other opioid replacement treatments. Such capacity may take the form of documented, active Affiliation Agreements with a facility licensed to provide such treatments.

6. Substance-specific detoxification protocols are individualized, documented, and available on-site. At minimum, these include detoxification protocols for alcohol, stimulants, opioids, and sedative hypnotics (including benzodiazepines.)

7. With consent, the provider makes documented attempts to contact the parent/guardian/caregiver, 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.

8. The provider 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.

9. Prior to this, the provider 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 provider 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 E-ATS program. The provider engages in the process of comparing the Member’s medication orders newly issued by the E-ATS prescriber 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 E-ATS program;
   
   b. developing a list of medications to be prescribed in the E-ATS 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 and, with consent, to appropriate caregivers, the Member’s PCC, and other treatment providers.

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

10. All urgent consultation services resulting from the initial evaluation and physical exam, 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 E-ATS 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 E-ATS program is brief. All of these services are documented in the Member’s health record.

11. The milieu does not physically segregate individuals with co-occurring disorders.

12. A handbook specific to the program is given to the Member and parent/guardian/caregiver at the time of admission. The handbook includes but is not limited to Member rights and responsibilities, services available, treatment schedule, grievance procedures, discharge criteria, and information about family support and peer and recovery-oriented services.

13. 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 provider complies with all provisions of the corresponding section in the General performance specifications.

2. The provider 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.

3. The provider is staffed with sufficient appropriate personnel to accept admissions 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year.

4. The provider utilizes a multi-disciplinary staff, including the following, all with established skills, training, and/or expertise in the integrated treatment of individuals with substance use disorders and/or dependence as well as co-occurring psychiatric disorders:
   a. A licensed, master’s-level clinician responsible for clinical supervision; master’s-level clinician responsible for assessment and treatment services;
   b. Physician and psychiatry staff, as outlined below;
   c. Registered nurse (RN), nurse practitioner, or physician assistant; and
   d. Licensed practical nurse (LPN), case aides, and case management staff.

5. Members have access to supportive milieu staff, as needed, 24 hours per day, seven days per week, 365 days per year.

6. The provider designates a physician, licensed to practice medicine in the Commonwealth of MA, as medical director with demonstrated training, experience, and expertise in the treatment of substance use and co-occurring disorders, and who is responsible for overseeing all medical services performed by the program. The medical director is responsible for ensuring each Member receives a medical evaluation, including a medical history and ensuring that appropriate laboratory studies have been performed. The medical director is integrated into the administrative and leadership structure of the E-ATS program and is responsible for clinical and medical oversight, quality of care, and clinical outcomes, in collaboration with the nursing and clinical leadership team.

7. A physician (MD) is on call 24 hours a day, seven days a week, in order to respond to medical emergencies, and is available for a phone consultation within 60 minutes of request.

8. The provider has adequate psychiatric coverage to ensure all performance specifications related to psychiatry are met.

9. An attending psychiatrist who meets MBHP’s credentialing criteria, or one for whom the provider requests and receives a waiver, provides psychiatric consultation and psychopharmacological services to Members in the E-ATS program. The medical director may also provide on-site
psychopharmacological services, in consultation with the psychiatrist. The program may also utilize a psychiatric nurse mental health clinical specialist (PNMHCS) to provide on-site psychopharmacological services to Members, within the scope of their licenses and under the supervision of the medical director or other attending psychiatrist, as outlined within these performance specifications. The program may also utilize a psychiatry fellow/trainee to provide on-site psychopharmacological services to Members, 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 psychiatrist, as outlined within these performance specifications.

10. When the attending 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 providing psychiatric consultation and psychopharmacological services may be designated to a covering psychiatrist, or to a PNMHCS or a psychiatry fellow/trainee acting under the psychiatrist’s or medical director’s Member-specific supervision.

11. For programs that utilize a psychiatry fellow/trainee to perform psychiatry functions, all of the following apply:
   a. The psychiatry fellow/trainee must be provided sufficient supervision from psychiatrists to enable him/her to establish working relationships that foster identification in the role of a psychiatrist;
   b. The psychiatry fellow/trainee must have at least two (2) hours of individual supervision weekly, in addition to teaching conferences and rounds;
   c. If a psychiatry fellow/trainee conducts the initial face-to-face psychiatric evaluation of the Member, he/she presents the Member to the attending psychiatrist, or other 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.

12. 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 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 psychiatrist, will be responsible for this documentation;
   b. The supervision/consultation between the PNMHCS and the medical director, or another attending 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 psychiatrist, and the PNMHCS outlining how the PNMHCS can access the medical director, or another attending psychiatrist, when needed for additional consultation;
   d. The medical director, or another 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 Member to the attending psychiatrist, or other 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 psychiatrist, and the PNMHCS relative to Members’ medication regimens, especially those Members for whom a change in their regimen is being considered.

13. A psychiatrist is on call 24 hours a day, seven days a week and is available for a phone consultation within 60 minutes of request.

14. The provider provides all staff with supervision consistent with MBHP’s credentialing criteria. The provider ensures that supervision of nursing staff is overseen by a registered nurse.

15. The provider documents regularly scheduled, in-service training sessions for all staff on the following topics, at a minimum:
   a. The program’s All Hazards Emergency Response Plan;
   b. HIV/AIDS, sexually transmitted diseases (STDs) and Viral Hepatitis;
   c. Universal health precautions and infection control;
   d. Substance use disorders including tobacco and nicotine addiction, clinical assessment and diagnosis, treatment planning, relapse
prevention and aftercare planning;
e. The stages of change;
f. Motivational Interviewing;
g. Co-occurring disorders, including mental health disorders, gambling and other addictive behaviors;
h. Other topics specific to the requirements of the level of care and/or the population served;
i. Effects of substance use disorders on the family, family systems, and related topics such as the role of the family in treatment and recovery; and
j. Cultural competency including culturally and linguistically appropriate services (CLAS) or standards.

### Process Specifications

<table>
<thead>
<tr>
<th>Assessment, Treatment/Recovery Planning, and Documentation</th>
<th>1. The provider complies with all provisions of the corresponding section in the General performance specifications.</th>
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<tr>
<td></td>
<td>2. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year, within 30 minutes of the request for admission.</td>
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<td>3. At the time of admission, a comprehensive nursing assessment is conducted, which includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score.</td>
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<td>4. Within three hours of the admission, a registered nurse (RN) evaluates each Member to assess the medical needs of the Member. When the RN 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, this function (or functions) may be designated to a licensed practical nurse (LPN) acting under an RN’s or the physician’s Member-specific supervision. All activities are documented in the Member's health record.</td>
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<td>5. For direct admissions from the community, the provider ensures that a comprehensive medical history and a physical examination which conforms to the principles established by the American Society of Addiction Medicine, is conducted and documented for each Member within 24 hours of admission. If the examination is conducted by a qualified health professional who is not a physician, the results and any recommendations arising from the examination are reviewed by the nursing supervisor prior to implementation. This examination includes the following:</td>
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<td>a. An assessment of the Member’s substance use disorder;</td>
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<td>b. Tests for the presence of opiates, alcohol, benzodiazepines, cocaine and other drugs of abuse;</td>
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<td>c. A brief mental status exam; and</td>
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<td></td>
<td>d. An assessment of medical issues.</td>
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<td></td>
<td>6. For direct admissions from the community, a psychiatric evaluation of the Member is completed either on the day of the admission or within 24 hours</td>
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of the admission by a psychiatrist, or by a PNMHCS or a psychiatry fellow/trainee under the supervision of the medical director or another attending psychiatrist. For admissions of Members transitioning from other 24-hour levels of care, a psychiatric evaluation of the Member is completed within 48 hours of admission by a psychiatrist, or by a PNMHCS or a psychiatry fellow/trainee under the supervision of the medical director or another attending psychiatrist.

7. For all women of childbearing age, a pregnancy test is administered, prior to the administration of any medication(s).

8. All medical orders are signed by the medical director or a designated licensed physician.

9. An initial assessment of each Member is conducted by a senior clinician, physician, nurse practitioner, or physician assistant within 24 hours of admission and includes the following:
   a. A history of the use of alcohol, tobacco, and other drugs, including age of onset, duration, patterns and consequences of use; use of alcohol, tobacco, and other drugs by family members; and types of and responses to previous treatment;
   b. An assessment of the Member’s psychological, social, health, economic, educational/vocational status; criminal history; current legal problems; co-occurring disorders; trauma history; and history of compulsive behaviors such as gambling;
   c. An assessment of the Member’s HIV risk status and TB risk status;
   d. If a need for further evaluation is identified, the provider conducts or makes referral arrangements for necessary testing, physical examination, and/or consultation. All such activities are documented in the Member’s health record; and
   e. The initial assessment concludes with a diagnosis of the status and nature of the Member’s substance use disorder, or a mental health disorder due to use of psychoactive substances.

10. A counselor/clinician meets with the Member for the purposes of assessment, counseling, treatment, case management, and discharge planning.

11. The provider assigns a multi-disciplinary treatment team to each Member within 24 hours of admission. A multi-disciplinary treatment team meets to review the assessment and develop the initial treatment/recovery and discharge plans within 48 hours of admission. On weekends and holidays, the treatment/recovery plan may be developed by an abbreviated treatment team, with a review by the full treatment team on the next business day.

12. The provider completes a comprehensive and individualized treatment/recovery plan within 48 hours based on the assessment and developed in conjunction with the Member and, with consent, family, guardian, and/or individual natural supports, current community-based providers including PCCs and behavioral health providers, and other supports identified by the Member. The treatment/recovery plan is signed and dated.

13. The treatment/recovery plan, at a minimum, includes the following:
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<tr>
<td>a.</td>
<td>A statement of the Member’s strengths, needs, abilities, and preferences in relation to his/her substance use disorder treatment, described in behavioral terms;</td>
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<tr>
<td>b.</td>
<td>Evidence of the Member’s involvement in formulation of the treatment/recovery plan, in the form of the Member’s signature attesting agreement to the plan;</td>
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<tr>
<td>c.</td>
<td>Service to be provided;</td>
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<tr>
<td>d.</td>
<td>Service goals, described in behavioral terms, with time lines;</td>
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<tr>
<td>e.</td>
<td>Clearly defined staff and Member responsibilities and assignments for implementing the plan;</td>
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<tr>
<td>f.</td>
<td>Description of discharge plans and aftercare service needs;</td>
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<tr>
<td>g.</td>
<td>Aftercare goals;</td>
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<tr>
<td>h.</td>
<td>The date the plan was developed and revised;</td>
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<tr>
<td>i.</td>
<td>Signatures of staff involved in the formulation or review of the plan; and</td>
</tr>
<tr>
<td>j.</td>
<td>Documentation of disability, if any, which requires a modification of policies, practices, or procedures and record of any modifications made.</td>
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14. The treatment/recovery and discharge plans are reviewed by the multidisciplinary treatment team with each Member 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. All assessments, treatment/recovery and discharge plans, reviews, and updates are documented in the Member’s health record. All reviews and updates include signatures of the Member and the staff reviewing them.

15. The psychiatrist consults with the treatment team and makes best efforts to consult with outpatient prescribers prior to any psychotropic medication changes, and these changes are made if indicated. Other psychiatrists and/or a PNMHCS may also be available to consult with other members of the treatment team.

16. 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.

17. The program requests drug-screening services and other laboratory work when medically necessary as part of a diagnostic assessment or component of an individualized treatment/recovery plan that includes other clinical interventions. All requests are made in writing by an authorized prescriber, (e.g., physician, physician assistant, nurse practitioner, etc.). The prescriber documents in the Member’s health record medical necessity for the drug screen and test results.

18. For pregnant women, the provider coordinates care with her PCC and obstetrician/gynecologist (OB/GYN), and consults with those physicians as needed.

19. The provider provides continuous assessment of the Member’s mental
Performance Specifications  

| Discharge Planning and Documentation | 1. The provider complies with all provisions of the corresponding section in the General performance specifications.  
2. The provider conducts discharges 7 days per week, 365 days per year.  
3. At the time of discharge, and as clinically indicated, the provider ensures that the Member has a current crisis prevention plan, and/or safety plan, and/or relapse prevention plan in place and that he/she has a copy of it. The E-ATS provider works with the Member to update the existing plan, or, if one was not available, develops one with the Member before discharge. With Member consent and as applicable, the E-ATS provider may contact the Member’s local ESP/MCI to request assistance with developing or updating the plan. With Member consent, the provider sends a copy to the ESP/MCI Director at the Member’s local ESP/MCI.  
4. Prior to discharge, the provider assists the Member 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 provider 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.  
5. The provider engages the Member in developing and implementing an aftercare plan when the Member meets the discharge criteria established in his/her treatment/recovery plan. The provider provides the Member with a copy of the aftercare plan upon his/her discharge, and documents these activities and the plan in the Member’s health record. |  
| Service, Community, and Collateral Linkages | 1. The provider complies with all provisions of the corresponding section in the General performance specifications.  
2. With Member consent, if a Member is referred to another treatment setting, the provider collaborates in the transfer, referral, and/or discharge planning process to ensure continuity of care.  
3. The provider is responsible for developing and maintaining an active working relationship with each of the local ESPs/MCIs who are high-volume referral sources for the provider. On a Member-specific basis, the provider collaborates with any involved ESP/MCI providers upon a Member’s admission to ensure the ESP’s/MCI’s evaluation and treatment recommendations are received, and that any existing crisis prevention |
plan, and/or safety plan, and/or relapse prevention plan is obtained from the ESP/MCI.

4. The provider maintains active working relationships with the step-down programs for adults and adolescents, including but not limited to Children’s Behavioral Health Initiative (CBHI) services, especially with local providers of those levels of care that refer high volumes of Members to the provider and/or to which the provider refers high volumes of Members, to enhance continuity of care for Members. It is considered best practice to maintain written Affiliation Agreements or Memoranda of Understanding (MOU) with such providers.

5. With Member consent, the provider collaborates with the Member’s PCC as delineated in the Primary Care Clinician Integration section of the General performance specifications.

6. When necessary, the provider provides or arranges transportation for services required external to the facility during the admission and, upon discharge, for placement into a step-down 24-hour level of care, if applicable. The provider also makes reasonable efforts to assist Members upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.

### Quality Management (QM)

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