Performance Specifications

Diversionary Services – 24-Hour

Acute Treatment Services (ATS) for Pregnant Women

Acute Treatment Services (ATS) for Substance Use Disorders

Clinical Stabilization Services (CSS) for Substance Use Disorders

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

Community-Based Acute Treatment Services (CBAT) for Children and Adolescents with Intellectual Disabilities/Autism Spectrum Disorders (ID/ASD)

Enhanced Acute Treatment Services (E-ATS) for Individuals with Co-occurring Mental Health and Substance Use Disorders

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

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Co-Occurring Enhanced RRS

RRS for Families with Substance Use Disorders

RRS for Pregnant and Post-Partum Women with Substance Use Disorders

RRS for Transitional Age Youth and Young Adults with Substance Use Disorders

RRS for Youth with Substance Use Disorders

Transitional Care Unit (TCU)

Youth and Transition-Age Youth Detoxification and Stabilization Services (YSS)

Performance Specifications

24-Hour Diversionary Services
Acute Treatment Services (ATS) for Pregnant Women

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. The requirements outlined within these service-specific performance specifications take precedence over previous performance specifications. Additionally, providers must meet all Department of Public Health/Bureau of Substance Addiction Services (DPH/BSAS) contractual and regulatory requirements within 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs.*

The following Acute Treatment Services (ATS) for Pregnant Women performance specifications are a subset of the ATS for Substance Use Disorders performance specifications. As such, ATS for Pregnant Women providers agree to adhere to both the ATS for Substance Use Disorders performance specifications and to the ATS for Pregnant Women performance specifications contained within. Where there are differences between the ATS for Substance Use Disorders and ATS for Pregnant Women performance specifications, these ATS for Pregnant Women specifications take precedence.

Acute Treatment Services (ATS) for Pregnant Women are for members who are pregnant and experiencing, or at significant risk of developing, an uncomplicated, acute withdrawal syndrome as a result of an alcohol and/or substance use disorder.

Components of Service

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider ensures that all service components required in the ATS for Substance Use Disorders level of care are provided to members enrolled in ATS for Pregnant Women.
3. The provider provides services to pregnant women who are medically stable and who do not require the medical and clinical intensity of hospital-based, medically managed withdrawal management or inpatient hospital, regardless of the number of weeks of gestation.
4. The provider admits and has the capacity to treat pregnant members who are currently receiving methadone or other opioid replacement treatments. Such capacity may take the form of documented, active Affiliation Agreements with providers licensed to provide such treatments.
5. The provider has specialized, expanded, and documented withdrawal management protocols for pregnant women, as well as documented medical protocols for prenatal examination and care, labor and delivery, and postpartum care.
6. The provider arranges all necessary medical and obstetric consultations within 48 hours of admission and documents this in the member's health record.
7. The provider ensures a minimum of one individual session per day that provides education and counseling on prenatal and postpartum care, HIV/AIDS, and other health-related issues, which is documented in the member's health record.
8. The provider is responsible for updating its available capacity, once each day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The provider is also responsible for keeping all administrative and contact information up to date on the website. The provider 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. If the program is experiencing a hardship in meeting these specifications, BSAS has a process for waiving regulatory and contractual requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
3. The provider complies with the staffing requirements of the applicable licensing body and the staffing requirements outlined in 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*. The program 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. The provider utilizes a multi-disciplinary staff.
4. The program's medical and nursing staff are responsible for ensuring that program staff coordinate care with the member's PCC and obstetrician/gynecologist and consult with those physicians as needed.

Service, Community, and Collateral Linkages

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. If the provider is not located within a medical facility with obstetric/gynecological capacity, the provider has a documented, operational agreement with a local obstetric/gynecological medical unit.
3. The provider has a documented, operational, emergency back-up agreement for obstetric/gynecological emergencies with a hospital within immediate proximity to the provider.
4. The provider complies with all provisions of the 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to community connections and/or collateral linkages.
5. Linkage to services is initiated upon admission and as part of the ongoing treatment/recovery plan, and includes but is not limited to the following, based on individual member needs:
    a. Prenatal care
    b. Family/reproductive health programs
    c. Early intervention programs
    d. High-risk infant/family support programs
    e. Healthy Start
    f. Women, Infants, and Children (WIC) and other nutritional programs
    g. Domestic violence shelters, safe housing, transitional living
    h. Violence prevention programs
    i. Child care/babysitting
    j. Housing
    k. Transportation
    l. Legal services
    m. Transitional assistance
6. 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.
7. Staff members are familiar with all of the following levels of care/services necessary to meet the needs of members being served and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated. The provider must maintain written Affiliation Agreements with local providers of these levels of care that refer a high volume of members to its program and/or to which the program refers a high volume of members. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
8. With member consent, the provider collaborates with the member's primary care provider and other community providers.
9. When necessary, the provider provides or arranges transportation for services required external to the program 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.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation;
    b. Decrease in readmission to ED and inpatient services;
    c. Increase in referrals and transitions to lower levels of care; and
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
2. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs*.
3. The provider will collect data to measure the quality of their services. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
4. The provider must report any adverse events that occur to the relevant authorities.

Process Specifications

Assessment, Treatment/Recovery Planning, and Documentation

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. A bio-psychosocial evaluation is conducted within 48 hours of admission by a registered nurse. This includes an obstetric/gynecological history and assessment, and, when medically indicated, a prenatal examination.
3. Assessments include a formal screening for all psychosocial risk factors related to pregnant women with substance use disorders.
4. Ongoing prenatal examinations are provided on-site and as medically indicated.
5. The assessment, treatment/recovery plan, and discharge plan address prenatal care issues (or postpartum issues, as appropriate) and are developed in consultation with the member's primary care clinician (PCC) and/or obstetrician/gynecologist. If a pre-existing obstetrician/gynecologist cannot be identified, the provider makes a referral immediately upon

admission.
6. All assessments, examinations, treatment/recovery plans, and other activities are documented in the member's health record.

Discharge Planning and Documentation
1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. All medical follow-up appointments are scheduled prior to discharge and are documented in the member's health record. The provider informs the member of these follow-up appointments verbally and in writing prior to discharge.

Performance Specifications

24-Hour Diversionary Services
Acute Treatment Services (ATS) for Substance Use Disorders

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. The requirements outlined within these service-specific performance specifications take precedence over previous performance specifications. Additionally, providers must meet all Department of Public Health/Bureau of Substance Addiction Services (DPH/BSAS) contractual and regulatory requirements within 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs.*

The performance specifications contained within pertain to the following services:

- Acute Treatment Services (ATS) for Substance Use Disorders: ASAM Medically Monitored Intensive Inpatient Services
- Acute Treatment Services (ATS) for Pregnant Women: ASAM Medically Monitored Intensive Inpatient Services

Acute Treatment Services (ATS) for Substance Use Disorders: (ASAM Medically Monitored Intensive Inpatient Services) consist of 24-hour, seven-day-per-week, medically monitored inpatient services that provide medically supervised withdrawal symptom management and/or induction onto maintenance treatment. Withdrawal management services are delivered by nursing and counseling staff, under the direction of a licensed medical provider (Physician, Nurse Practitioner, Physician Assistant), to monitor an individual's withdrawal from alcohol and other drugs and to alleviate symptoms.

Services include implementation of withdrawal management protocols; a multidimensional bio-psychosocial assessment; treatment planning; individual and group counseling; psycho-educational groups; case management; medication monitoring, and discharge planning.

Acute Treatment Services are provided to members experiencing, or at significant risk of developing, an uncomplicated, acute withdrawal syndrome as a result of an alcohol and/or other substance use disorder. members receiving ATS (ASAM Medically Monitored Intensive Inpatient Services) do not require the medical and clinical intensity of hospital-based, medically managed withdrawal management, nor can they be effectively treated in a less-intensive outpatient level of care. Admission to ATS (ASAM Medically Monitored Intensive Inpatient Services) is appropriate for members who meet diagnostic and dimensional admission criteria specified in accordance with the American Society of Addiction Medicine Criteria®.

Acute Treatment Services providers must facilitate access to treatment for co-occurring psychiatric conditions either directly or through referral for members with co-occurring disorders. Pregnant women receive specialized services within Acute Treatment Services (ATS) for Pregnant Women to ensure substance use disorder treatment and obstetrical care are treated concurrently. ATS services are provided in licensed freestanding or hospital-based programs.

Exclusion criteria must be based on clinical presentation and must not include automatic exclusions based on stable medical conditions, homelessness, medications prescribed including MOUD, compliance with medications, lack of prescription refills, or previous unsuccessful treatment attempts.

ATS programs will provide ASAM Medically Monitored Intensive Inpatient Services until:

1. Withdrawal signs and symptoms have been sufficiently resolved;
2. The member's symptoms can be safely managed at a less-intensive level of care; or
3. Induction onto FDA-approved medication has been initiated, and the member is stabilized.

Components of Service

1. At minimum, the provider complies with all provisions of the corresponding General performance specifications and requirements of the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*, including reporting requirements.
2. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year.
    a. A thorough physical examination, which conforms to principles established by the American Society of Addiction Medicine, is completed for all members within 24 hours of admission.
    b. A multidimensional biopsychosocial assessment is completed within 48 hours of patient's admission.
3. 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. The scope of required service components provided in this level of care includes, but is not limited to, the following.
    a. Medical monitoring of the individual's progress and medication administration as needed;
    b. Induction onto FDA-approved medications for addiction treatment (MAT)/Medication for Opioid Use Disorder (MOUD) as clinically indicated and appropriate with referral for ongoing MAT at discharge;
    c. Access to psychiatric crisis evaluation and clinical services based on the biopsychosocial assessment;
    d. HIV, Hepatitis C, TB, tobacco use, and other health-related education programs:
        i. HIV and Viral Hepatitis risk assessments are integrated as a part of each member's medical/nursing assessment;
        ii. HIV and Hepatitis C education/risk reduction education is provided for all members; and
        iii. Referral to HIV antibody counseling and testing sites and on-site HIV antibody counseling;
    e. Education about the benefits and risks of medication approved for addiction treatment;
    f. Opioid overdose risk and prevention;
    g. Access to appropriate laboratory and toxicology tests;
    h. Access to routine medications;
    i. Counseling and case management which incorporates evidence-based practices, including individual, group, and family counseling;
    j. Behavioral/health/medication education and planning;
    k. Psycho-educational groups;
    l. Access to peer support and/or other recovery-oriented services, either directly or through referral;
    m. Development and/or updating of crisis prevention plans, or safety plans as part of Crisis Planning Tools, and/or relapse prevention plans, as applicable;
    n. Introduction to self-help groups and the continuum of substance use disorder (SUD) and mental health treatment;
    o. Direct operational affiliations with other services especially Clinical Stabilization Services, Transitional Support Services, Residential Rehabilitation Services, Opioid Treatment

Programs, Office-Based Opioid Treatment, Community Behavioral Health Centers (CBHCs), and psychiatric services;
   p. Case management that directly connects (warm handoff) to appropriate providers;
   q. Management of mild-to-moderate medical complexities, with updates with primary care providers and specialists (with consent); and
   r. Support services and referrals for family members and significant others.
4. The provider provides a comprehensive, formal, structured treatment program which incorporates the effects of substance use disorders, mental health disorders, and recovery, including the complications associated with co-occurring disorders, and provides a minimum of four hours of service programming per day. At least two hours of psycho-educational group time per week is dedicated to the discussion of HIV/AIDS, Hepatitis C, and other health issues.
5. The provider ensures that all members have access to prescribers specializing in addiction medicine and are educated on their options for MAT/MOUD.
6. The provider has the capacity to treat members with alcohol and/or other substance use disorders who are assessed to be at a mild-to-moderate risk of medical complications during withdrawal.
7. The program admits and has the capacity to treat members currently maintained on MAT/MOUD for the treatment of opioid use disorder. Such capacity may take the form of documented, active Affiliation Agreements with providers licensed to provide such treatments.
8. Substance-specific withdrawal management protocols are individualized, documented, and available on-site. At minimum, these include withdrawal management protocols for alcohol, stimulants, opioids, and sedative hypnotics (including benzodiazepines) with capacity to use all FDA-approved medications for the treatment of substance use disorders.
9. With member consent and the establishment of the clinical need for such communication, the provider makes documented attempts to contact the following: the parent/guardian/caregiver, family members, and/or significant others; primary care physician (PCP); other prescribers; and other team members involved in the member's care, within 48 hours of admission, unless clinically or legally contraindicated.
10. The provider (with appropriate consent from the member) provides the above 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/case manager/discharge planner, etc. If contact is not made, the member's health record documents the rationale.
11. 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.
12. Prior to medication prescribing or administration, 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 ATS. The provider engages in the process of comparing the member's medication orders newly issued by the ATS prescriber to all of the medications that they have 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 ATS;
    b. Reviewing Massachusetts Prescription Awareness Tool (MassPAT);
    c. Developing a list of medications to be prescribed in the ATS;
    d. Comparing the medications on the two lists;
    e. Making clinical decisions based on the comparison and, when indicated, in coordination with the member's primary care clinician (PCC); and

   f. Communicating the new list to the member and, with consent, to appropriate caregivers, DMH, BH-CPs, the member's PCC, and other treatment providers. All activities are documented in the member's health record.
13. All urgent consultation services resulting from the intake evaluation and physical exam, or as subsequently identified during the admission, are provided within a timely manner for these services. Non-urgent consultation services related to the assessment and treatment of the member while in the 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 ATS program is brief. All of these services are documented in the member's health record.
14. The milieu does not physically segregate individuals with co-occurring disorders.
15. 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.
16. The provider is responsible for updating its available capacity, once each day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The provider is also responsible for keeping all administrative and contact information up to date on the website. The provider is also responsible for training staff on the use of the website to locate other services for members, particularly in planning aftercare services.
17. Co-occurring psychiatric services, medication evaluation and management, and related laboratory services are offered either directly or via referral. Such services are available virtually, or on-site within 24 hours, or referred to an off-site provider within 24 hours, as appropriate to the severity and urgency of the member's mental health condition.
18. The ATS will ensure that for pregnant members, coordination with OB/GYN, pediatrics, and any other appropriate medical, social services providers, and state agencies will be provided.
19. The ATS will facilitate access to Recovery Support Navigator (RSN) services and/or Peer Recovery Coach services either directly or through referral.
20. The provider trains all staff at the site on the use of ASAM Criteria®.
21. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards.

Staffing Requirements

1. If program is experiencing a hardship in meeting these specifications, BSAS has a process for waiving regulatory and contractual requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
2. The provider complies with the staffing requirements of the applicable licensing body and the staffing requirements outlined in 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*. The program 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. The provider utilizes a multi-disciplinary staff.
3. Staffing must include nurses, counseling staff, physicians for psychiatric and pharmacological consultation, and clinical assistant/nurses' aide staff, all with established skills, training, and/or expertise in the treatment of individuals with substance use disorders, including:
   a. A Medical Director who is responsible for all medical services performed by the program, either by performing them directly or by delegating specific responsibilities to qualified

healthcare professionals such as a Nurse Practitioner and Physician Assistant functioning under the Medical Director's supervision. The Medical Director or designee will ensure 24-hour clinical coverage, seven days per week on-site or remotely, for consultation, to examine, and assess members within 24 hours of admission. The Medical Director must be available to be onsite during any hours of program operation, as needed. The Medical Director should have demonstrated clinical experience treating substance use disorders and opioid use disorders in particular;

b. Nursing coverage must be flexed according to case mix, acute/complex clinical acuity, and the needs of members in the program, on-site 24/7. There must be a minimum of one nurse per 16 members, per shift. One of the nurses on the day and evening shifts must be a Registered Nurse;
c. A Nurse Manager, who provides direct and continuous supervision of nursing staff, is responsible for ensuring on-site 24/7 nursing coverage. Nursing staff support medication compliance and monitoring of symptoms;
d. A full-time Program Director who carries full responsibility for the administration and operations of the program;
e. A Clinical Director, who who meets the criteria in 105 CMR 164 for Senior Clinician and/or Clinical Supervisor. A Clinical Director is the designated authority responsible for ensuring adequate and quality behavioral treatment is being provided;
f. One recovery specialist per 16 members, per shift. The recovery specialist provides recovery-oriented supports the form of psychoeducation, peer supports, introduction to self-help groups, etc.;
g. Medically Monitored Intensive Inpatients Services (ATS) must designate at least two case managers, 12 hours each day, seven days a week, who are responsible for helping clients obtain medically necessary services, referral coordination, discharge planning, and follow-up;
h. There is a Psychiatrist or Psychiatric Nurse Practitioner on staff or available through a qualified service organization agreement for psychiatric evaluation and consultation, as needed to address the needs of members with co-occurring disorders; and
i. There is an obstetrician/gynecologist on staff or available through a qualified service organization agreement (QSOA) to accommodate pregnant members.

4. All ATS providers must have at least one staff member assuming each of the following roles:
    a. There is an **HIV/AIDS Coordinator**: responsible for overseeing confidential HIV risk assessment and access to counseling and testing; staff and resident HIV/AIDS and hepatitis education; and Department requirements for admission, service planning, and discharge of HIV-positive members;
    b. There is a **Tobacco Education Coordinator**: responsible for assisting staff in implementing BSAS guidelines for integrating on of tobacco assessment, education, and treatment into program services;
    c. There is an **access coordinator**: responsible for development and implementation of the evaluation, plan, and annual review of the site's performance in ensuring equitable access to services;
    d. There is a **Culturally and Linguistically Appropriate Services** (CLAS) **Coordinator** who ensures that the service meets the language and cultural needs of the members; and
    e. At minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.
5. The provider ensures that members have access to a supportive milieu and nursing staff 24 hours per day, 7 days per week, 365 days per year. members also have access to case management staff 12 hours a day.

Service, Community, and Collateral Linkages

1. The provider complies with all provisions of the 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to community connections and/or collateral linkages.
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. Staff members are familiar with all of the following levels of care/services necessary to meet the needs of members being served, and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated. The provider must maintain written Affiliation Agreements with local providers of these levels of care that refer a high volume of members to its program and/or to which the program refers a high volume of members. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
4. With member consent, the provider collaborates with the member's primary care provider and other community providers.
5. When necessary, the provider provides or arranges transportation for services required external to the program 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.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation;
    b. Decrease in readmission to ED and inpatient services;
    c. Increase in referrals and transitions to lower levels of care; and
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
2. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs*.
3. The provider will collect data to measure the quality of their services. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
4. The provider must report any adverse events that occur to the relevant authorities.

Process Specifications

Assessment, Treatment/Recovery Planning, and Documentation

1. The provider complies with all provisions specified in 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to assessment and recovery planning.
2. The provider has a policy regarding the speed at which they will inform the referral source/individual seeking admission (ideally within the hour after receipt of referral). The provider accepts admissions 24 hours per day, seven days per week, and 365 days per year.

Every admission declination must be documented and include reason for declination and referrals provided.

3. A comprehensive nursing assessment is conducted at the time of admission, which includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score and/or a Clinical Opiate Withdrawal Scale (COWS). Results are documented in the member's health record.
4. A Registered Nurse evaluates each member within three hours of admission to assess the medical needs of the member. If an RN is unavailable, this function 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.
5. The provider ensures that a physical examination which conforms to the principles established by ASAM is completed for all members 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.
6. The provider ensures that an individualized treatment plan is completed, as delineated in the General performance specifications and in conjunction with the member. The provider makes best efforts to also involve current community-based providers including primary care clinicians (PCCs) and behavioral health providers, family members, parents/guardians/caregivers, and/or significant others in the treatment planning process.
7. 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 an initial treatment/recovery plan and initial discharge plan 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.
8. The provider must document any missed sessions and attempts to make follow-up contact, the reason(s) given for absence, and if necessary, the staff's rationale for continuation or discontinuation of ATS.
9. The treatment/recovery and discharge plans are reviewed by the multi-disciplinary 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 and discharge plans, reviews, and updates are documented in the member's health record.
10. The assigned case manager under the supervision of the Clinical Director meets with the member daily for the purposes of case management and discharge planning. All activity is documented in the member's health record.
11. With member consent and the establishment of the clinical need for such communication, coordination with family members/partners/legal guardians, etc., and other treatment providers, including primary care providers 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.
12. For anyone who could become pregnant, a pregnancy test is administered prior to the administration of any medication(s).
13. For anyone who is pregnant, the provider coordinates care with their PCP and OB/GYN and consults with those physicians as needed.
14. The provider arranges appropriate drug screens/tests, urine analysis, toxicology samples, and laboratory work as clinically indicated, and documents these activities in the member's health record.
15. The provider ensures the continuous assessment of the member's mental status throughout the member's treatment episode and documents such in the member's health record.

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to discharge planning.
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 they have a copy of it. The provider works with the member to update the existing plan, or, if one was not available, develops one with the member prior to discharge. With member consent and as applicable, the provider may contact the member's local Adult or Youth Mobile Crisis Intervention (AMCI/YMCI) to request assistance with developing or updating the plan. With member consent, the provider sends a copy to the AMCI/YMCI Director at the member's local AMCI/YMCI.
4. The provider engages the member in developing and implementing an aftercare plan when the member meets the discharge criteria established in their treatment/recovery plan. The provider provides the member with a copy of the plan upon their discharge and documents these activities and the plan in the member's health record.
5. Prior to discharge, the provider assists members in obtaining post-discharge appointments, as follows: within seven 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. In the event of a discharge against medical advice (AMA), providers must ensure members are given resources to reconnect with services.
6. 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.

Performance Specifications

24-Hour Diversionary Services
Clinical Stabilization Services (CSS) for Substance Use Disorders

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. The requirements outlined within these service-specific performance specifications take precedence over previous performance specifications. Additionally, providers must meet all Bureau of Substance Addiction Services (BSAS) contractual and regulatory requirements.

The performance specifications contained within pertain to the following services:

- Clinical Stabilization Services (CSS) for Substance Use Disorders (ASAM Clinically Managed High-Intensity Residential Services)

Clinical Stabilization Services (CSS) for Substance Use Disorders (ASAM Clinically Managed High-Intensity Residential Services) consist of 24-hour, seven-day-per-week, clinically managed high-intensity residential services offered in community settings. Services are delivered by nursing, case management, clinical, and recovery specialists under the direction of a licensed medical provider (Physician, Nurse Practitioner, Physician Assistant) in collaboration with the multidisciplinary team.

Services include a multidimensional bio-psychosocial assessment; treatment planning; individual and group counseling; psychoeducational groups; case management; medication monitoring; and discharge planning.

Clinical Stabilization Services are provided to members whose symptoms of withdrawal do not require the intensity of ATS (ASAM Medically Monitored Intensive Inpatient Services), are largely resolved or minimal, and whose multidimensional needs cannot be managed in a less-intensive level of care. CSS providers are expected to manage mild medical complexities and or comorbidities. Admission to CSS (ASAM Clinically Managed High-Intensity Residential Services) is appropriate for members who meet the diagnostic and dimensional criteria specified in accordance with the American Society of Addiction Medicine Criteria®.

Exclusion criteria must be based on clinical presentation and must not include automatic exclusions based on stable medical conditions, homelessness, medications prescribed including MOUD, compliance with medications, lack of prescription refills, or previous unsuccessful treatment attempts.

CSS programs will provide ASAM Clinically Managed High-Intensity Residential Services until:

1. Post-acute withdrawal symptoms (PAWS) have been sufficiently resolved.
2. The member's symptoms can be safely managed at a less intensive level of care.
3. Induction onto FDA-approved medication has been initiated, and the member is stabilized.

Components of Service

1. At minimum, the provider complies with all requirements of the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164, including reporting requirements.
2. The provider accepts admissions 24 hours per day, seven days per week, 365 days per year. As part of admissions, the member must receive:

a. A thorough physical examination, which conforms to principles established by the American Society of Addiction Medicine (ASAM), is completed for all members within 24 hours of admission.
b. A multidimentional biopsychosocial assessment is completed for all members within 72 hours of admission.

3. Therapeutic programming is provided seven days per week, four hours a day, including weekends and holidays, with sufficient professional staff to maintain and appropriate milieu and conduct the services below based on individualized member needs. The scope of required service components provided in this level of care includes, but is not limited to, the following:
    a. Clinical and medical monitoring of the individual's progress and medication administration as needed;
    b. Nursing intervention as needed;
    c. Capacity to facilitate induction onto FDA-approved medications for addiction treatment (MAT)/Medication for Opioid Use Disorder (MOUD) as clinically indicated and appropriate with referral for ongoing MAT/MOUD at discharge;
    d. Access to psychiatric crisis evaluation and clinical services based on the biopsychosocial assessment;
    e. HIV, Hepatitis C, TB, tobacco use, and other health-related education programs;
        i. HIV and Viral Hepatitis risk assessments are integrated as a part of each member's medical/nursing assessment;
        ii. HIV and Hepatitis C education/risk reduction education is provided for all members; and
        iii. Referral to HIV antibody counseling and testing sites and on-site HIV antibody counseling;
    f. Education about the benefits and risks of medication approved for addiction treatment;
    g. Opioid overdose risk and prevention;
    h. Access to appropriate laboratory and toxicology tests;
    i. Access to routine medications;
    j. Counseling and case management which incorporates evidence-based practices, including individual, group, and family counseling;
    k. Behavioral/health/medication education and planning;
    l. Psycho-educational groups;
    m. Peer support and/or other recovery-oriented services;
    n. Development and/or updating of crisis prevention plans, or safety plans as part of Crisis Planning Tools for youth, and/or relapse prevention plans, as applicable;
    o. Introduction to self-help groups and the continuum of SUD and mental health treatment;
    p. Direct operational affiliations with other services especially Acute Treatment Services (ATS), Transitional Support Services (TSS), Residential Rehabilitation Services (RRS), Opioid Treatment Programs (OTP), Office-Based Opioid Treatment (OBOT), Community Behavioral Health Centers (CBHCs), and psychiatric services;
    q. Case management that directly connects (warm handoff) to appropriate providers;
    r. Basic medical care, which includes addressing non-SUD illnesses with updates to primary care providers (with consent); and
    s. Support services and referrals for family members and significant others.
4. The provider ensures that all members have access to prescribers specializing in addiction medicine and are educated on their options for MAT/MOUD.
5. Co-occurring psychiatric services, medication evaluation and management, and related laboratory services are offered either directly or via referral. Such services are available virtually, or on-site within 24 hours, or referred to an off-site provider within 24 hours, as appropriate to the severity and urgency of the patient's mental health condition.
6. The program admits and has the capacity to treat members currently maintained on

MAT/MOUD for the treatment of OUD. Such capacity may take the form of documented, active Affiliation Agreements with providers licensed to provide such treatments.

7. 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.
8. For adults who give 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 provider 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/case manager/discharge planner, etc. If contact is not made, the member's health record documents the rationale.
9. Prior to medication prescribing or administration, 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 CSS. The provider engages in the process of comparing the member's medication orders newly issued by the CSS prescriber to all of the medications that they have 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 CSS;
    b. Reviewing Massachusetts Prescription Awareness Tool (MassPAT);
    c. Developing a list of medications to be prescribed in the CSS;
    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 activities are documented in the member's health record.
10. All urgent consultation services resulting from the intake evaluation and physical exam, or as subsequently identified during the admission, are provided in a timely manner for these services. Non-urgent consultation services related to the assessment and treatment of the member while in the CSS 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 CSS 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 partner/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. For pregnant patients, the CSS is expected to provide coordination with OB/GYN, pediatrics, and any other appropriate medical and social services providers and state agencies.
14. The CSS will facilitate access to recovery support navigator services and/or peer recovery coach services either directly or through referral.
15. The provider is responsible for updating its available capacity, once each day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The provider is also responsible for keeping all administrative and contact information up to date on the website. The provider is also responsible for training staff on the use of the website to locate other services for members, particularly in planning

aftercare services.
16. The provider provides a comprehensive, formal, structured treatment program which incorporates the effects of substance use disorders, mental health disorders, and recovery, including the complications associated with co-occurring disorders, and provides a minimum of four hours of service programming per day. At least two hours of psycho-educational group time per week is dedicated to the discussion of HIV/AIDS, Hepatitis C, and other health issues.
17. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards.
18. The provider provides access to peer support and recovery-oriented activities.
19. The provider is responsible for ensuring all staff at site are trained in ASAM® criteria.

Staffing Requirements

1. If the program is experiencing a hardship in meeting these specifications, BSAS has a process for waiving regulatory and contractual requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
2. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements outlined in 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*, and the staffing requirements in the applicable health plan provider manual.
3. The provider utilizes a multi-disciplinary staff including nurses, counselors, physicians, psychiatrists, care coordination staff, recovery specialist staff, and clinical staff with skills, training, and/or expertise in established treatment protocols for members with substance use disorders (SUDs):
    a. Medical Director: who who is responsible for all medical services performed by the program, either by performing them directly or by delegating specific responsibilities to qualified healthcare professionals such as a nurse practitioner and physician assistant functioning under the Medical Director's supervision. The Medical Director or designee will ensure 24- hour medical coverage, 7 days per week either onsite, via telehealth, or through a Qualified Service Organization Agreement in compliance with 105 CMR 164., for consultation, to examine, and assess members within 24 hours of admission. The Medical Director should have demonstrated clinical experience treating substance use disorders and opioid use disorders in particular;
    b. Nursing staff: A minimum of 40 hours of nursing per week, including weekends and holidays to support medication compliance and monitoring of symptoms. Nurse time must be flexed according to case mix, acute/complex clinical acuity, and the needs of members in the program. Licensed Practical Nurses (LPNs) may be used in combination with an RN, to supplement nursing/member coverage, if requested, reviewed, and approved by the covering plan for programs serving a larger than average number of members;
    c. A full-time Program Manager (1 FTE) who will carry full responsibility for the administration and operations of the program;
    d. A full-time Clinical Director (1 FTE) who minimally meets the requirements of 105 CMR 164 criteria for Senior Clinician or Clinical Supervisor. A Clinical Director is the designated authority responsible for ensuring that adequate and quality behavioral treatment is being provided;
    e. Counseling: 1:8 counselor-to-member ratio, seven days per week for 12 hours per day (excluding overnight). Counselors have a CAC, CADAC, LADCI, or LADCII credential, or the

equivalent as defined by the Bureau of Substance Addiction Services (BSAS);
   f. Recovery Specialist: 1:16 specialist-to-member ratio on day and evening shifts, and 1:20 ratio on overnight shifts (24/7/365). Recovery specialists must have a minimum of a high school diploma or the equivalent as defined by the Bureau of Substance Addiction Services (BSAS); and
   g. Case Manager: Clinically Managed High-Intensity Residential Services (CSS) must: provide, at minimum, the full-time equivalent of one care coordinator or case manager to be present at the program 8 hours a day, five days per week. Additionally, CSS must provide, at minimum, the full-time equivalent of 2.5 counselors to be present at the program over a 12-hour span, seven days per week.
4. All CSS sites must have at least one staff member assuming each of the following roles:
   a. There is an **HIV/AIDS coordinator**: responsible for overseeing confidential HIV risk assessment and access to counseling and testing; staff and resident HIV/AIDS and hepatitis education; and Department requirements for admission, service planning,g and discharge of HIV-positive members;
   b. There is a **Tobacco Education coordinator:** responsible for assisting staff in implementing BSAS guidelines for integrating on of tobacco assessment, education, and treatment into program services;
   c. There is an **Access Coordinator**: responsible for development and implementation of the evaluation, plan, and annual review of the site's performance in ensuring equitable access to services;
   d. There is a **CLAS Coordinator** (Culturally and Linguistically Appropriate Services) who ensures that the service meets the language and cultural needs of the members; and
   e. At minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.
5. There is an obstetrician/gynecologist on staff or available through a qualified service organization agreement (QSOA) to accommodate pregnant members.
6. There is a Psychiatrist or Psychiatric Nurse Practitioner on staff or available through a qualified service organization agreement for psychiatric evaluation and consultation, as needed to address the needs of members with co-occurring disorders.
7. The provider ensures that members have access to a supportive milieu 24 hours per day, 7 days per week, 365 days per year. members also have access to clinical staff 12 hours a day and daily access to nursing staff.
8. The provider ensures that all staff receive supervision consistent with payer's credentialing criteria.
9. The provider ensures that team members have all trainings required by regulation, including training in evidence-based practices and are provided with opportunities to engage in continuing education to refine their skills and knowledge in emerging treatment protocols.

Service, Community, and Collateral Linkages

1. The provider complies with all provisions of 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to community connections and/or collateral linkages.
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. Staff members are familiar with all of the levels of care/services necessary to meet the needs of members and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated. The provider must maintain written Affiliation Agreements with local providers of these levels of care that refer a high volume of Membets to its program and/or to which the program refers a high volume of members. Such agreements

include the referral process, as well as transition, aftercare, and discharge process.
4. When necessary, the provider provides or arranges transportation for members for services required external to the program during the admission.
5. With member consent, the provider collaborates with the member's primary care provider and other community providers.
6. As needed, the provider also directly provides or arranges transportation seven days per week for the member to attend aftercare interviews, transitional appointments, residential placements, the next level of care or next-step placement, community-based peer support and recovery-oriented meetings, and medical and psychiatric visits. 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.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation;
    b. Decrease in readmission to ED and inpatient services;
    c. Increase in referrals and transitions to lower levels of care; and
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
2. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure ofSubstance Use Disorder Treatment Programs*.
3. The provider will collect data to measure the quality of their services. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
4. The provider must report any adverse events that occur to the relevant authorities and payers.

Process Specifications

Assessment, Treatment/Recovery Planning, and Documentation

1. The provider complies with all provisions specified in 105 CMR 164.000: *Licensure of Substance Use Disorder Treatment Programs* related to assessment and recovery/treatment planning.
2. The provider has a policy regarding the speed at which they will inform the referral source/individual seeking admission (ideally within the hour after receipt of referral). The provider accepts admissions 24 hours per day, seven days per week, 365 days per year. Every admission declination must be documented and include reason for decliniation and referrals provided.
3. The provider determines at the time of admission the medical and psychiatric appropriateness of all self-referred members, based on medical necessity criteria for CSS, and documents such in the member's health record.
4. The provider ensures that a physical examination is completed for all members 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.
5. The counselor/case manager works with the member to create an individualized recovery treatment/service plan based on the biopsychosocial assessment, including at a minimum:

a. A statement of the member's strengths, needs, abilities, and preferences in relation to their SUD treatment, described in behavioral terms;
b. The service to be provided and whether directly or through referral;
c. The service goals, described in behavioral terms, with timelines;
d. Clearly defined staff and resident responsibilities and assignments for implementing the plan; and
e. A description of treatment plans and aftercare service needs.

6. The provider makes best efforts to also involve current community-based providers including primary care clinicians (PCCs) and behavioral health providers, family members, parents/guardians/caregivers, and/or significant others in the treatment planning process.
7. The provider has documented policies and procedures that require contacting the member's PCP in the event of non-emergency illness and for calling emergency services when deemed appropriate for primary care coordination.
8. The provider must document any missed sessions and attempts to make follow-up contact, the reason(s) given for absence, and if necessary, the staff's rationale for continuation or discontinuation of CSS.
9. The provider assigns a multi-disciplinary treatment team to each member within 24 hours of admission. The nursing or counseling staff develops and reviews the assessment and individualized initial treatment/recovery and initial discharge plans with the member within 48 hours of admission.
10. The treatment/recovery and discharge plans are reviewed by the multi-disciplinary 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 needs. All assessments, treatment, and discharge plans, reviews, and updates are documented in the member's health record.
11. For all women of childbearing age, a pregnancy test is administered prior to the administration of any medication(s).
12. The provider makes arrangements to obtain appropriate drug screens/tests, urine analysis, and laboratory work as clinically indicated and documents these activities in the member's health record.
13. The provider ensures continuous assessment of the member's mental status throughout the member's treatment episode and documents such in the member's health record.

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164.000: *Licensure of Substance Use Disorder Treatment Programs* related to discharge planning.
2. The provider conducts discharges seven 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 that includes access to Naloxone and that they have a copy of it. The provider works with the member to update the existing plan, or, if one was not available, develops one with the member prior to discharge. With member consent and as applicable, the provider may contact the member's local Adult or Youth Mobile Crisis Intervention program (AMCI/YMCI) to request assistance with developing or updating the plan. With member consent, the provider sends a copy to the AMCI/YMCI Director at the member's local AMCI/YMCI.
4. Prior to discharge, the provider assists members in obtaining post-discharge appointments, as follows: within seven calendar days of discharge for lower levels of care, such as RRS or 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 activities are documented in the member's health

record.

5. The provider ensures active, post-discharge follow-up plans, recovery supports, and referrals by care coordinators to strengthen and sustain gains made while in this service, and to ensure successful engagement at the next level of care or within other ongoing services.

Performance Specifications

24-Hour Diversionary Services
Community-Based Acute Treatment (CBAT) for Children and Adolescents

Providers contracted for this 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**. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

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.

Providers of this level of care are expected to accept and treat members to the unit 24 hours per day, 7 days per week, and 365 days per year.

Components of Service

1. The program maintains all required licenses and has written admission and discharge criteria.
2. The program maintains full therapeutic, social, and recreational programming, utilizing professional staff seven days a week, including weekends and holidays, for at least six hours minimum per day.
3. All members admitted to the program have individualized treatment plans.
4. members being served have access to, on site, or by way of consultation, all services needed in their primary language. Services are provided in a cultural, linguistic and ethnically sensitive manner.
5. Whenever possible, all printed materials should be available in the member's primary language.
6. The program has the capacity to provide, at a minimum, the following:
    a. Psychiatric evaluation and services;
    b. Psychopharmacological evaluation and services;
    c. Psychosocial evaluation, monitoring and treatment;
    d. Medical evaluation;
    e. Medical monitoring;

f. 24-hour nursing care (at minimum LPN);
g. Medication monitoring;
h. Individual and group therapy;
i. Substance use evaluation and counseling;
j. Family evaluation and therapy;
k. Behavioral plans;
l. Psychological testing as needed;
m. Vocational assessment;
n. Rehabilitation and recovery resources and counseling;
o. Case management;
p. Discharge and aftercare planning;
q. 1:1 specialing when needed;
r. Therapeutic milieu;
s. Fire-setting and offender evaluation;
t. Neurological evaluation;
u. Nutritional counseling; and
v. Educational component, including an Individual Education Plan (IEP).

7. Unless clinically contraindicated on the member's treatment plan, family/guardian or significant others meet jointly with the member and treatment team as needed and should be, when possible, based on the schedule of the family. Timeliness/frequency of family therapy should not be a barrier to completion of necessary treatment.
8. A board-eligible/certified, child psychiatrist must be available 24 hours/day for:
    a. Phone consultation within 15 minutes of request; and
    b. On-site face-to-face evaluation within 60 minutes in response to request by staff secondary to concern over change in a member's behavior.
9. The attending physician must meet with the member within 24 hours of admission, then a documented minimum of weekly visit, and as frequently as necessary to address acute treatment needs preventing return to a less restrictive setting as rapidly as possible. The physician documents the meeting in the medical record. On days when the attending physician is unavailable, a clinical nurse specialist or an alternate psychiatrist carries out these functions for the member in the attending physician's stead. The attending physician, whenever possible, designates a consistent substitute to ensure that the member receives as much continuity in psychiatric care as possible.
10. Emergency psychiatric/medical services must be provided on-site or by contract.
11. A master's-level, child-trained, Child and Adolescent Needs and Strengths (CANS)-certified clinician conducts a psychosocial evaluation within 24 hours of admission, including an initial screen for potential substance use disorder issues/concerns.
12. The multidisciplinary team meets to coordinate with the member, and if clinically appropriate, the member's provider(s), family and/or guardian, to develop the treatment and discharge plan, including proper consent, and documentation in the member's record. The treatment team must review the initial plan within 72 hours of admission.
13. The record must contain written evidence of consent from the member's legal guardian for admission, treatment, and discharge in the program within 24 hours of admission. If no such consent is obtained, the record must show evidence of attempts, reason why consent cannot be obtained, and alternative legal consenter.
14. The program ensures residents have free access to private, outside communication, including phone and stamps, free of charge.
15. Restraint and Seclusion:
    a. The program must have policies and procedures in place regarding restraint and seclusion that meet regulations. It is expected that restraint and seclusion interventions will be employed as a last resort and will always ensure a member's safety. All staff must

be trained in, and adhere to, these policies and procedures; and
   b. Use of restraint-and-seclusion techniques must be documented appropriately and provide accurate and timely reporting to all applicable licensing authorities, for each occurrence, in accordance with applicable regulations.
16. Consultations and psychological testing, as well as routine medical care, are included in the per diem rate.
17. For providers accessing Carelon online portals, privacy and personnel policies are in place, including but not limited to accessing information in accordance with privacy rules and allowing staff to access only relevant information as it pertains to specific members and appropriate treatment sites within the facility.
18. 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 maintains appropriate staffing patterns to safely care for all children/adolescents at all times. The program is able to provide one-to-one staffing for observation and management when needed.
2. The program provides staffing 365 days a year, seven days per week, 24 hours a day, including awake, supportive, and overnight staff.
3. The program ensures that all clinical work is subject to regularly scheduled and ongoing supervision by the medical or clinical program director, who at a minimum is a master's-level licensed clinician who has at least three years of direct experience in the treatment of children and youth.
4. The program shall use a multidisciplinary staff (including nursing staff, credentialed counseling staff, psychiatric coverage, psychiatric consultation and clinical assistant/nurses aid staff), all with established skills training and/or expertise in the sub-acute treatment of children/adolescents, family systems, and related emotional/behavioral problems.
5. The multi-disciplinary staff shall, at a minimum, consist of:
   a. Nursing staff;
   b. Social workers or other master's-level clinicians;
   c. Counseling staff;
   d. Physician coverage;
   e. Psychiatry; and
   f. Clinical assistant.
6. Staffing should reflect the cultural, gender, and linguistic needs of the community it serves.
7. Criminal background checks are conducted on all staff members.

Service, Community, and Collateral Linkages

1. 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.
2. 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.
3. The program develops an active working relationship with each of the local Mobile Crisis Intervention (MCIs) who are high-volume referral sources for the hospital. The program holds

regular meetings or has other contacts and communicates with the 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 MCI providers upon admission to ensure the MCI's evaluation and treatment recommendations are received and any existing safety plan is obtained from the MCI.

4. 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.

Quality Management (QM)

1. The facility and/or program will develop and maintain a quality management plan that is consistent and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is used, and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to members, including youth and their families.
3. Clinical outcomes data must be made available upon request and must be consistent with Carelon's performance standards for this service.
4. All Reportable Adverse Incidents will be reported within one business day of their occurrence per Carelon policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a member, or to others by action of a member, who is receiving services, or has recently been discharged from services.
5. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

Process Specifications

Assessment, Treatment Planning, and Documentation

1. 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 a.m. to 11 p.m., 7 days per week, and 365 days per year.
    a. A best practice is for CBATs to have mechanisms to accept referrals from 11 p.m. to 7 a.m., e.g., 24 hours per day, so that referral sources do not need to wait until 7 a.m. to make a referral.
    b. An additional best practice is for CBATs to admit members from 11 p.m. to 7 a.m., e.g., 24 hours per day.
2. 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.
3. A child fellowship-trained psychiatrist, who is board-certified and/or who meet 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:
    a. A youth under the age of six; or
    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 MCI, Inpatient, ICBAT, or outpatient psychiatrist) or has not been evaluated by or reviewed with an MCI consulting psychiatrist who approved the admission. If the PNMHCS or child psychiatry fellow/trainee completes the initial evaluation, they review 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 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 they were 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 MCI consulting psychiatrist within 24 hours prior to the CBAT admission; or
    c. A youth who has been evaluated by their 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; or
    d. If the PNMHCS or child psychiatry fellow/trainee completes the initial evaluation, they review 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 p.m. on Monday, or the next business day for holiday admissions; or
    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., MCI, Inpatient or ICBAT provider), the psychosocial evaluation that they completed upon admission, and the youth's medication regimen upon admission; or
    c. The child psychiatrist determines if it is indicated that they 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.), they designate 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. They remain active within the CBAT program, keeping informed and overseeing the member's care, and are 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. They provide 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 providers and collateral contacts to obtain more comprehensive information and insight into the member and their 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 for 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 their living situation prior to the CBAT admission and includes treatment strategies and other efforts to mitigate those barriers.
17. The treatment and discharge plans are reviewed by the multi-disciplinary treatment team at least two times a week, and are updated accordingly, based on each member's individualized progress. All assessments, treatment and discharge plans, reviews, and updates are documented in the member's health record. 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 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 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.

Discharge Planning and Documentation

1. The staff member responsible for discharge planning develops a preliminary written discharge plan within 24 hours of admission.
2. Components of discharge planning incorporate member-identified concerns including, but not limited to: housing, finances, healthcare, transportation, familial, occupational, and educational concerns and social supports.
3. The treatment team staff member who is responsible for implementing a member's discharge plan documents in the medical record all discharge related activities that have occurred while the member is in the facility (e.g., outpatient provider was called and an appointment was scheduled), and this reflects member participation in its development.
4. To ensure successful transition to the community or next level of care, aftercare appointments, referrals to self-help groups, housing, etc., shall be documented on the member's discharge form.
5. The completed discharge form, including referral to any agency, is available to and given to the member, and when appropriate, the member's family or guardian at the time of discharge, which includes, but is not limited to, appointments, medication information, and emergency/crises information.
6. At least one initial aftercare appointment is scheduled not more than seven days from the member's discharge from the facility, and this is clearly documented in the member's medical record.
7. Prior to discharge, a CANS is completed by a certified CANS assessor.
8. In preparation for discharge, the program develops or updates the member's safety plan and ensures that the member has a copy of the safety plan.

Performance Specifications

24-Hour Diversionary Services
Community-Based Acute Treatment for Children and Adolescents (CBAT) with Intellectual Disabilities/Autism Spectrum Disorders (ID/ASD)

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**. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

CBAT for Children/Adolescents with Intellectual Disabilities/Autism Spectrum Disorders (ID/ASD) are specialized CBAT services for children and adolescents with co-occurring mental health conditions and/or ID/ASD. In addition to all the clinical service components provided within CBAT, the program provides clinical expertise and intervention specifically pertaining to youth with co-occurring mental health conditions and ID/ASD.

The following CBAT for Children/Adolescents with ID/ASD performance specifications are a subset of the CBAT performance specifications. As such, CBAT for Children/Adolescents with ID/ASD providers agree to adhere to both the CBAT performance specifications and to the CBAT for Children/Adolescents with ID/ASD performance specifications contained within. Where there are differences between the CBAT and CBAT for Children/Adolescents with ID/ASD performance specifications, these CBAT for Children/Adolescents with ID/ASD take precedence.

Components of Service

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider ensures that all service components required in the CBAT performance specifications are provided to members enrolled in CBAT for Children/Adolescents with ID/ASD. Additionally, the provider has the capacity to provide or refer to the following service components as clinically indicated by staff who have expertise in ASD/ID:
    a. Neurological assessment
    b. Neuropsychological testing
    c. Functional behavioral assessment and functional behavioral treatment planning
3. If clinically indicated, the program must provide, or refer, member to the following within two days of admission:
    a. Speech and language assessment
    b. Endocrinology consultation
    c. Nutritional consultation
    d. Genetic assessment if indicated by American Academy of Child and Adolescent Psychiatry (ACCAP) guidelines (Journal of American Academy of Child and Adolescent Psychiatry, vol. 56(11), pp 910-913)
    e. Occupational Therapy
    f. Physical Therapy
    g. Dental assessment
4. The provider admits and has the capacity to treat members who have co-occurring mental health conditions and/or ID/ASD. The provider ensures specific staffing, services, and programming to meet the clinically land milieu needs of this population.

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 Carelon service-specific performance specifications.
3. The provider ensures that the attending psychiatrist has had previous training, experience, and demonstrated expertise in treating children/adolescents with co-occurring mental health conditions and ID/ASD, and they are actively engaged in relevant training to maintain current expertise and relevant certification.
4. The program utilizes a multi-disciplinary staff with established skills, training and/or expertise in the treatment of members with mental health conditions and ID/ASD. This team includes **all** of the following modalities:
    a. Child psychiatry
    b. Behavioral psychology
    c. Board-Certified Behavioral Analyst
    d. Speech/language therapy including expertise in using augmentative communication devices
    e. Occupational therapy
    f. Social work
    g. Nursing
    h. Behavior technicians
    i. School liaison
    j. Parent/guardian
    k. Discharge Planning Coordinator: Discharge planning activities should include care coordination with state agencies, special education directors, and other state agencies as needed. It is essential that the discharge planning coordinator works with state and community resources to transition child/youth back to community with successful supports.
5. The provider has access to medical consultation with expertise in assessing the medical condition and needs of members with co-occurring disorders, including nutritional consult, and regularly screens for such conditions, as appropriate.
6. The provider ensures that mandatory trainings related to the clinical needs of this specialty population are provided for all staff directly responsible for providing any treatment component during a member's stay to ensure clinical competency among the treatment team. Trainings include but are not limited to the assessment and treatment of children/adolescents with ID/ASD, learning disorders, motor skills disorders, communication disorders, and common comorbid conditions and concerns (e.g., obesity, Post-Traumatic Stress Disorder, etc.).
7. The provider maintains staffing levels appropriate to ensuring the safety of members and treatment intensity to meet member clinical need and ensures a safety management technique recommended for this population.

Quality Management (QM)

1. The facility and/or program will develop and maintain a quality management plan that is consistent and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.

2. A continuous quality improvement process is used and will include outcome measures and satisfaction surveys to measure and improve the quality of care and service delivered to members, including youth and their families.
3. Clinical outcomes data must be made available upon request and must be consistent with Carelon's performance standards for this service.
4. All Reportable Adverse Incidents will be reported within one business day of their occurrence per Carelon policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a member, or to others by action of a member, who is receiving services or has recently been discharged from services.
5. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

Process Specifications

Assessment, Treatment Planning, and Documentation

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. All required assessments include the consideration of the impact and special needs related to the member's ID/ASD.
3. The provider ensures that assessments for children/adolescents with ID/ASD include, but are not limited to, the review of:
    a. History of placements outside the home and residential placements for special education for children and adolescents in the care and/or custody of the Commonwealth;
    b. History provided by parent/guardian;
    c. Educational records inclusive of progress reports within the last three years;
    d. Behavioral intervention data;
    e. Individualized Education Programs (IEPs), when applicable;
    f. Individual Care Plans (ICPs) for Intensive Care Coordination (ICC)-enrolled youth, when applicable;
    g. Neurological evaluation(s);
    h. Neuropsychological evaluation(s); and
    i. Other consultation reports (i.e., occupational therapy, physical therapy, etc.).
4. All treatment plans and treatment plan reviews and updates include goals and interventions specific to the member's needs related to their ID/ASD. The treatment and discharge plans will be reviewed by the multidisciplinary 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. The discharge planning coordinator as part of the multidisciplinary team will coordinate with staff from the Local Education Authority (LEA), Department of Developmental Services (DDS), Department of Children and Families (DCF), and/or other state agencies to ensure a successful discharge to the community. As part of the discharge planning process, members will have the opportunity, as appropriate, for home visits, and the treatment team will be available as a resource to families during home visits.
5. A data-collection check sheet is utilized and monitors the behaviors every 15 minutes.
6. There is a family behavior training program:
    a. Families should engage in treatment as much as possible, preferably in person.
    b. Qualified staff do behavior training on weekends when parents visit most.
    c. Families are expected to be doing behavior training during their visits to unit.
    d. Weekly family meetings are held.
    e. Staff will partner with families to address issues/concerns around access and equity
7. With appropriate consent and as applicable, staff from the LEA, DDS, DCF, and/or other state

agencies and providers are included in treatment and discharge planning processes and meetings.

Discharge Planning and Documentation

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider ensures that all discharge planning activities address the members' needs related to their co-occurring psychiatric conditions and ID/ASD, and the discharge and/or aftercare plan includes aftercare services that offer appropriate services to this population and their caregiving families.

Service, Community, and Collateral Linkages

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider works collaboratively with parent/guardian, LEAs, and involved state agencies including but not limited to DDS, DCF, and others to coordinate treatment and discharge planning.
3. The provider includes information about community-based services and supports for youth and families, including but not limited to the Federation for Children with Special Needs, The Arc, DDS resources, and local advocacy and support groups in their wellness and recovery information and resources available to members and their families.

Performance Specifications

24-Hour Diversionary Services
Enhanced Acute Treatment Services (E-ATS) for Individuals with Co-Occurring Mental Health and Substance Use Disorders

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**. 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 Mobile Crisis Intervention (MCI) providers, or as a transition from inpatient services.

Components of Service

1. 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:
    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
2. 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.
3. 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.
4. 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.
5. 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.)
6. 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.
7. 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.
8. 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 they have 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.
9. 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.
10. The milieu does not physically segregate individuals with co-occurring disorders.
11. 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.
12. 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 the staffing requirements of the applicable licensing body, the staffing requirements in the service-specific performance specifications, and the credentialing criteria outlined in the Provider Manual.
2. 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.
3. 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 the 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.), they designate 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, they present 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, they

present 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 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

Assessment, Treatment/Recovery Planning, and Documentation

1. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year, within 30 minutes of the request for admission.
2. At the time of admission, a comprehensive nursing assessment is conducted, which includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score.
3. 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.), they designate 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.
4. 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:
    a. An assessment of the member's substance use disorder;
    b. Tests for the presence of opiates, alcohol, benzodiazepines, cocaine and other drugs of abuse;
    c. A brief mental status exam; and
    d. An assessment of medical issues.

5. 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 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.
6. For all women of childbearing age, a pregnancy test is administered, prior to the administration of any medication(s).
7. All medical orders are signed by the medical director or a designated licensed physician.
8. 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:
    a. A statement of the member's strengths, needs, abilities, and preferences in relation to his/her substance use disorder treatment, described in behavioral terms;
    b. 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;
    c. Service to be provided;
    d. Service goals, described in behavioral terms, with time lines;
    e. Clearly defined staff and member responsibilities and assignments for implementing the plan;
    f. Description of discharge plans and aftercare service needs;
    g. Aftercare goals;
    h. The date the plan was developed and revised;
    i. Signatures of staff involved in the formulation or review of the plan; and

   j. Documentation of disability, if any, which requires a modification of policies, practices, or procedures and record of any modifications made.

14. The treatment/recovery and discharge plans are reviewed by the multi-disciplinary 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 health status throughout the member's treatment episode and documents such in the member's health record.

Discharge Planning and Documentation

1. The provider conducts discharges 7 days per week, 365 days per year.
2. 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 they have 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 MCI to request assistance with developing or updating the plan. With member consent, the provider sends a copy to the MCI Director at the member's local MCI.
3. Prior to discharge, the provider assists the member in obtaining post-discharge appointments, as follows: within **seven** 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 Northeast 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.
4. The provider engages the member in developing and implementing an aftercare plan when the member meets the discharge criteria established in their treatment/recovery plan. The provider provides the member with a copy of the aftercare plan upon their discharge and documents these activities and the plan in the member's health record.

Service, Community, and Collateral Linkages

1. 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.
2. The provider is responsible for developing and maintaining an active working relationship with each of the local MCIs who are high-volume referral sources for the provider. On a member-specific basis, the provider collaborates with any involved MCI providers upon a member's admission to ensure the 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 MCI.
3. 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.
4. 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.
5. 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 facility and/or program will develop and maintain a quality management plan that is consistent and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is used, and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to members, including youth and their families.
3. Clinical outcomes data must be made available upon request and must be consistent with performance standards of this service.
4. All Reportable Adverse Incidents will be reported within one business day of their occurrence per policy and licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a member, or to others by action of a member, who is receiving services, or has recently been discharged from services.
5. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

Performance Specifications

24-Hour Diversionary Services
Intensive Community-Based Acute Treatment (ICBAT) 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**. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

The following Intensive Community-Based Acute Treatment (ICBAT) for Children and Adolescents performance specifications are a subset of the Community-Based Acute Treatment (CBAT) for Children and Adolescents performance specifications. As such, ICBAT providers agree to adhere to both the CBAT performance specifications and to the ICBAT performance specifications contained within. Where there are differences between the CBAT and ICBAT performance specifications, these ICBAT specifications take precedence.

Intensive Community-Based Acute Treatment (ICBAT) for Children and Adolescents provides the same services as Community-Based Acute Treatment (CBAT) for Children and Adolescents but of higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment, and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat members with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization; ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

Components of Service

1. The ICBAT provider ensures that all service components required in the CBAT level of care are provided to members enrolled in ICBAT in sufficient combination and more frequently than for CBAT, in order to meet the higher level of acuity presented by members in ICBAT. This includes more frequent and more intensive staff supervision, clinical intervention and behavior management.
2. The ICBAT provider provides daily psychiatry/psychopharmacological evaluation and treatment to members at this level of care, 7 days per week, and 365 days per year.

Staffing Requirements

1. The ICBAT provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Carelon service-specific performance specifications and the credentialing criteria outlined.
2. The ICBAT provider maintains appropriate staffing patterns within the ICBAT level of care to safely care for all members presenting with higher levels of acuity at all times.

Service, Community, and Collateral Linkages

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

Quality Management (QM)

1. The facility and/or program will develop and maintain a quality management plan that is consistent and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is used, and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to members, including youth and their families.
3. Clinical outcomes data must be made available upon request, and must be consistent with performance standards of this service.
4. All Reportable Adverse Incidents will be reported within one business day of their occurrence per policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a member, or to others by action of a member, who is receiving services, or has recently been discharged from services.
5. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

Process Specifications

Assessment, Treatment Planning, and Documentation

1. Within 24 hours of admission for all members admitted to ICBAT, an initial face-to-face psychiatric evaluation is provided by one of the following:
    a. The Medical Director;
    b. Other child fellowship-trained psychiatrists who are board-certified and/or who meet Carelon's credentialing criteria for a child/adolescent psychiatrist;
    c. An attending child psychiatrist;
    d. A child psychiatry fellow/trainee; or
    e. A Psychiatric Nurse Mental Health Clinical Specialist (PNMHCS).
2. The ICBAT provider ensures that the Medical Director, other child fellowship-trained psychiatrists, the attending child psychiatrist, a child psychiatry fellow/trainee, or a PNMHCS meets with the member daily, provides daily psychiatric and pharmacological evaluation and treatment, and writes a daily psychiatry note in the member's health record.

Performance Specifications

24-Hour Diversionary Services
Residential Rehabilitation Services (RRS) for Substance Use Disorders

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications. Additionally, providers must meet all Bureau of Substance Addiction Services (BSAS) contractual and regulatory requirements.

The performance specifications contained within pertain to the following services:

- Residential Rehabilitation Services (RRS) for Substance Use Disorders: ASAM Clinically Managed, Low-Intensity Residential Services

Please refer to the performance specification attachment for each of these specialty services:

- Residential Rehabilitation Services (RRS) for Pregnant and Post-Partum Women
- Residential Rehabilitation Services (RRS) for Youth (ages 13-17)
- Residential Rehabilitation Services (RRS) for Transitional Age Youth (ages 16-21) or Young Adults (ages 18-25)
- Family Residential Rehabilitation Services (RRS)

Residential Rehabilitation Services (RRS) for Substance Use Disorders (ASAM Clinically Managed, Low-Intensity Residential Services) are clinically managed, low-intensity residential services that serve individuals who need a 24-hour, supervised, residential environment to fully stabilize in recovery, with the goal of successfully transitioning to a lower service setting (including outpatient counseling). Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and implementing recovery skills.

Admission to RRS, ASAM Clinically Managed, Low-Intensity Residential Services is appropriate for members who meet the diagnostic and dimensional criteria specified in accordance with the American Society of Addiction Medicine (ASAM®) criteria.

Exclusion criteria must be based on clinical presentation and not include automatic exclusions based on stable medical conditions, homelessness, medications prescribed including Medication for Opioid Use Disorder (MOUD), compliance with medications, or previous unsuccessful treatment attempts.

RRS programs will provide ASAM Clinically Managed, Low-Intensity Residential Services until the member's symptoms can be safely managed at a less-intensive level of care.

Components of Service

1. At minimum, the provider complies with all provisions of the corresponding section in the General performance specifications and with all requirements of the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*, including reporting requirements.
2. The provider ensures 24/7 coverage that maintains a supportive, therapeutic environment for members, at all times. The provider ensures that members have access to supportive, therapeutic milieu at all times, without exception.

3. The provider implements a daily schedule of activities designed to facilitate participation in the milieu and promote recovery. The provider facilitates morning meetings, a minimum of five times per week, convenes at least one communal meal per day, and convenes at least one house/community meeting per week, which provides structure for the community.
4. Clinically, these activities must include a minimum of five hours of clinical programming, individual, and/or group treatment sessions per week offered through the program. Topics for clinical and psychoeducational groups delivered in the program can include, but are not limited to, the following:
    a. Relapse and overdose prevention, recovery maintenance counseling and education, naloxone education, and administration training
    b. Mental health
    c. Stress reduction
    d. Nutrition
    e. Medication
    f. Education related to all medications approved by the FDA for the treatment of substance use disorders (SUD)
    g. Tobacco cessation
    h. HIV/AIDS, STIs, viral hepatitis
    i. Wellness topics
    j. Recovery support groups
5. For adults who give consent, the provider makes documented attempts to contact the parent/guardian/caregiver, family members, and/or significant others within one week of admission, unless clinically or legally contraindicated. The provider 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/case manager/discharge planner, etc. If contact is not made, the member's health record documents the rationale.
6. The provider ensures that program staff provide individualized case management services. Program staff facilitate comprehensive support and linkages for public assistance, SUD counseling, primary healthcare, insurance, self-help and mental health services, vocational/educational opportunities, housing, and criminal justice system support as appropriate.
7. The provider admits and has the capacity to treat members who are currently on Medication for Addiction Treatment (MAT)/MOUD, including education about the benefits and risks of MAT. Such capacity may take the form of documented, active affiliation agreements with a facility licensed to provide such treatments.
8. The provider has documented policies and procedures in place to allow for the safe and appropriate self-administration of medication(s) by members.
9. The provider ensures that each member has access to medications prescribed for physical and behavioral health conditions and documents this in the member's chart.
10. The provider ensures that the following medication management activities are completed for each member upon admission:
    a. Developing a list of current medications, i.e., those the member was prescribed prior to admission to the RRS and verifies with prescriber(s);
    b. Making clinical decisions based on the comparison and, when indicated, in coordination with the member's primary care clinician (PCC);
    c. Coordinating with providers to ensure members have access to medications that they are prescribed and coordinate any changes in medication with current prescribers;
    d. Overseeing medication passes; and

e. Communicating the new list to the member and, with consent, to appropriate caregivers, the member's PCC, and other treatment providers. All activities are documented in the member's health record.

11. The provider uses medication specialist staff (MMS) to keep records of patients' medications and oversee medication management. MMS provides medication support services that include: 16 hours of medication specialist services and eight hours of consultation around medication support; oversight and record keeping of resident medications; managing storage; and coordination of resident self-administration of medication.
12. For pregnant members, the provider must provide coordination with OB/GYN, pediatrics, and any other appropriate medical, social services providers, and state agencies.
13. The provider must facilitate access to recovery support navigator services and/or peer recovery coach services either directly or through referral.
14. The provider is responsible for updating its available capacity, once per week at a minimum, on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The provider is also responsible for keeping all administrative and contact information up to date on the website. he provider is also responsible for training staff on the use of the website to locate other services for members, particularly in planning aftercare services.
15. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards.
16. The provider trains staff on the use of ASAM® criteria.

Staffing Requirements

1. If the program is experiencing a hardship in-meeting these specifications, BSAS has a process for waiving regulatory-requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
2. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements outlined in 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*, and the staffing requirements in the applicable health plan provider manual.
3. The program is staffed with a full-time program director who carries full responsibility for the administration and operations of the program, including supervision of non-clinical staff.
4. The program is staffed with a distinct, full-time Clinical Director (1 FTE) who must possess at least a master's degree in a clinical or social science field and meets 105 CMR 164 criteria for Senior Clinician or Clinician Supervisor. A Clinical Director is the designated authority responsible for ensuring adequate and quality behavioral treatment is being provided.
5. The program is staffed with one Counselor or Case Manager, trained in addiction and mental health treatment, for every nine licensed beds.
6. The program is staffed by two FTE of Medication Specialists on-site, who are responsible for the oversight, storage, and coordination of self-administration of medication. Medication management includes resident self-administration oversight, storage, and coordination of all medication prescribed during treatment.
7. The program is staffed with at least two FTE direct care staff present on each shift as outlined below and in 101 CMR 164, seven days per week, 24 hours per day. Direct care staff include Recovery Specialist, Counselors, Case Managers, Clinical Supervisors, and Medication Specialists.
    a. No less than eight hours of awake coverage per shift per building;

   b. 16 hours of awake coverage for each day and evening shift per 30 licensed beds, prorated according to the number of licensed beds, i.e., less than 30 or more than 30; and
   c. Eight hours of awake coverage per overnight shift per 50 residents; 16 hours of awake coverage per overnight shift per 51 –100 residents; 24 hours of awake coverage per overnight shift per 101 –150 residents:
      i. At minimum, there shall be at least two recovery specialists or case aides present for each overnight shift.
      ii. Where the resident census exceeds 100 residents, the licensed or approved provider shall ensure four direct care staff are present on all shifts.
8. All RRS sites must have at least one staff member assuming each of the following roles:
   a. There is an **HIV/AIDS Coordinator**: responsible for overseeing confidential HIV risk assessment and access to counseling and testing; staff and resident HIV/AIDS and hepatitis education; and Department requirements for admission, service planning and discharge of HIV positive residents;
   b. There is a **Tobacco Education Coordinator:** responsible for assisting staff in implementing BSAS guidelines for integrating on of tobacco assessment, education, and treatment into program services;
   c. There is an **Access Coordinator**: responsible for development and implementation of the evaluation, plan, and annual review of the site's performance in ensuring equitable access to services as required by 105 CMR 164;
   d. There is a Culturally and Linguistically Appropriate Services **(CLAS) Coordinator** who ensures that the service meets the language and cultural needs of the members; and
   e. At minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.
9. The provider ensures that all staff receive supervision consistent with their credentialing criteria.
10. The provider ensures that team members have training in evidence-based practices and are provided with opportunities to engage in continuing education to refine their skills and knowledge in emerging treatment protocols.

Service, Community, and Collateral Linkages

1. The provider collaborates in the transfer, referral, and/or discharge planning process to ongoing recovery and/or treatment services, with member consent, to ensure continuity of care.
2. The staff members are familiar with all of the community collateral and supportive levels of care/services and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated.
3. The provider maintains written affiliation agreements, which may include Qualified Service Organization Agreements (QSOAs), MOUs, Business Associate Agreements (BAAs), or linkage agreements, with local providers of these levels of care necessary to meet the needs of members being served at the RRS, and that refer a high volume of members to its program and/or to which the program refers a high volume of members. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
4. With member consent, the provider collaborates with the member's primary care provider and other community providers.
5. When necessary, the provider arranges transportation for services required that are external to the program during the admission. The provider also makes reasonable efforts to assist members identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.
6. The provider demonstrates a capacity to work collaboratively with multiple systems, including SUD treatment providers, primary healthcare, community-based support services, housing search services, supportive housing service providers, mental health service providers, other relevant human services, and various aspects of the criminal justice system, as appropriate.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation;
    b. Decrease in readmission to ED and inpatient services;
    c. Increase in referrals and transitions to lower levels of care; and
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
2. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs*.
3. The provider will collect data to measure the quality of their services. The provider must have a rigorous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
4. The provider must report any adverse events that occur to the relevant authorities.

Process Specifications

Assessment, Treatment/Recovery Planning and Documentation

1. The provider complies with all provisions specified in 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to assessment and recovery planning.
2. The provider has a policy regarding the speed at which they will inform the referral source/individual seeking admission (ideally within the hour after receipt of referral). The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year. Every admission declination must be documented and include reason for declination and referrals provided.
3. The provider maintains standardized intake/admission log that tracks all applications for admission, documents admission decisions, reason for non-acceptance, and referrals made. The log shall be made available for review upon request. The provider facilitates referrals to appropriate services and/or resources in the case of admission denials.
4. The provider utilizes evidence-based assessment tools for assessing SUD and for ASAM level of care.
5. A counselor completes an initial biopsychosocial clinical assessment using ASAM dimensions to gain an understanding of addiction severity, co-occurring mental health issues and trauma, physical health issues, family and social supports, housing stability, and other issues for each member that includes the following elements:
    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; types of and responses to previous treatment; and risk for overdose;
    b. Assessment of the member's psychological, social, health, economic, educational/vocational status; criminal history; current legal problems; co-occurring disorders; disability status and accommodations needed, if any; trauma history; and history of compulsive behaviors, such as gambling. This assessment must be completed before a comprehensive service plan is developed;
    c. Assessment of the member's infectious disease status and risk (HIV, HCV, TB, COVID-19, etc.);
    d. Identification of key relationships (e.g., significant others) supportive to the individual's treatment and recovery;

   e. A list of the member's current medications, based on pharmacy labels, which shows the date of filling, the name and contact information of the prescribing practitioner, the name of the prescribed medication; and
   f. When indicated, providers must facilitate or make referral arrangements for necessary testing, physical examination, and/or consultation by qualified professionals.
6. The counselor/case manager works with the member to create an individualized recovery treatment/service plan based on the clinical assessment, including, at a minimum:
   a. A statement of the member's strengths, needs, abilities, and preferences in relation to their SUD treatment, described in behavioral terms;
   b. The service to be provided and whether directly or through referral;
   c. The service goals, described in behavioral terms, with timelines;
   d. Clearly defined staff and resident responsibilities and assignments for implementing the plan; and
   e. A description of treatment plans and aftercare service needs.
7. The clinical supervisor reviews and approves the assessment and individualized recovery treatment/service plan.
8. The provider must document any missed sessions and attempts to make follow-up contact, the reason(s) given for absence, and if necessary, the staff's rationale for continuation or discontinuation of RRS.
9. For anyone who could become pregnant, a pregnancy test is administered prior to the administration of any medication(s).
10. For anyone who is pregnant, the provider coordinates care with their PCP and OB/GYN and consults with those physicians as needed.

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to discharge planning.
2. The provider conducts discharges seven days per week, 365 days per year.
3. The counselor/case manager works with the member to create an individualized aftercare plan that must include:
   a. Referrals to individual, group and/or family outpatient aftercare as appropriate;
   b. Alcohol- and drug-free living environments;
   c. Vocational and educational opportunities;
   d. Resources to support access to programs that address social determinants of health (SDOH), such as housing, food, benefits, etc.; and
   e. Specify strategies to be used to follow-up with the member after the member leaves.
4. The counselor/case manager works with the member to ensure that recovery maintenance strategies are in place and working effectively and that referrals to services have met intended goals.
5. The clinical supervisor reviews and approves the aftercare plan.

Performance Specifications

24-Hour Diversionary Services
Co-Occurring Enhanced Residential Rehabilitation Services (RRS) for Substance Use Disorders

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications. Additionally, providers must meet all Bureau of Substance Addiction Services (BSAS) contractual and regulatory requirements.

Co-Occurring Enhanced Residential Rehabilitation Services (RRS) (ASAM Clinically Managed, Low-Intensity Residential Services) serve individuals who need a 24-hour, safe, structured environment, located in the community, which supports members' recovery from addiction and moderate to severe mental health conditions while reintegrating into the community and returning to social, vocation/employment, and/or educational roles. Scheduled, goal-oriented clinical services are provided in conjunction with psychiatry and medication management to support stabilization and development of skills necessary to achieve recovery. Clinical services are provided a minimum of five hours a week and additional outpatient levels of care may be accessed concurrently as appropriate.

Components of Service

1. At minimum, the provider complies with all provisions of the corresponding section in the General performance specifications and with all requirements of the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164 Licensure of Substance Use Disorder Treatment Programs, including reporting requirements.
2. Co-Occurring Enhanced RRS programs must ensure that members' medical, mental health, and addiction needs are being identified and addressed. Programs will ensure that members have access to prescribers of psychiatric and addiction medications through one of the following arrangements:
    a. The provider organization that is contracted for the Co-Occurring Enhanced RRS program must ensure timely access for members to psychiatry and addiction pharmacotherapy by also operating outpatient services, including but not limited to; an opioid treatment center, licensed mental health center, substance use disorder outpatient clinic, health center, primary care practice, bridge clinic, hospital, or hospital satellite. Programs be able to coordinate all activities related to the member's care, including psychiatric and clinical services; or
    b. The provider organization that is contracted for the Co-Occurring Enhanced RRS program must ensure timely access for members to psychiatry and addiction pharmacotherapy by utilizing a partnership model, codified through a formalized agreement, such as a memorandum of understanding (MOU), between partner organizations operating outpatient services, including but not limited to; an opioid treatment center, licensed mental health center, substance use disorder outpatient clinic, health center, primary care practice, bridge clinic, hospital or hospital satellite. The organizations that partner to provide the Co-Occurring Enhanced RRS services must both possess the infrastructure and implement protocols to ensure members in the program receive timely access to psychiatric and mental health services, including a medication assessment and diagnostic visit within 48 hours of admission, and that all psychiatric and clinical services

are coordinated with the program's clinical staff. The Co-Occurring Enhanced RRS program will have the ultimate responsibility to coordinate their members' care and ensuring that the members' behavioral health and medical treatment needs are being met, including facilitating transportation when necessary.

3. Co-Occurring Enhanced RRS programs shall provide clinical and milieu treatment delivered by an integrated team involving staff trained in substance use disorders, mental health, and psychiatry/medication management. Members' mental health and addiction pharmacotherapy needs must be addressed along with clinical and psychosocial needs.
    a. The program must provide onsite delivery of coordinated psychiatry by providing the infrastructure and protocols to ensure psychiatrists and/or mid-level practitioners spend time with program staff, attend team meetings, review treatment plans, and interact with the members in the program.
    b. Such infrastructure shall include, but is not limited to, providing space on site, shared staff with outpatient clinic, time in the daily schedule; procedures and protocols to ensure insure coordinated care.
4. Co-Occurring Enhanced RRS programs shall have on-site nursing to oversee medication administration and compliance, as well as monitoring of members' symptoms. Nursing time is flexed based on case mix and needs of the members. The program must have established medication administration protocols and support members in establishing and maintaining medication regimens.
5. Members must have access to psychiatrists and/or mid-level practitioners under the direction of a psychiatrist within 48 hours of admission to perform diagnostic and medication evaluations, provide refills if necessary, and to begin the process of medication reconciliation, adjustments.
    a. The Co-Occurring Enhanced RRS program shall ensure that the member goes through a medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur in the transition of a member from one care setting to this level of care.
    b. Results of the medication evaluation and medication reconciliation plan must be available to the staff in the program.
6. In addition to diagnostic and medication evaluations, members will receive clinical assessments based on the ASAM Criteria, as well as any supplemental clinical assessments that may be appropriate.
    a. The combined results of these assessments, along with information received from prior treatment histories and/or discharge plans, will become the basis of a member's treatment plan which is developed in conjunction with the member.
    b. The treatment plan must include clinical, psychosocial, and recovery goals, as well as a crisis and/or safety plan.
    c. members shall be reassessed throughout the treatment process to track progress, make necessary adjustments, and update goals and objectives.
7. Upon admission, the member's condition is assessed and stabilized with a goal of engaging the member in ongoing treatment. As the member stabilizes, and depending on the needs identified in the treatment plan, the goals of treatment will include, but are not limited to; better understanding of relationships between addiction and mental health, overcoming fears and insecurities, coping with stress, making sense of past trauma, identifying triggers, improving relationships with family and friends, establishing a stable, dependable routine, and developing interpersonal and other recovery skills, necessary for success in the community. The treatment provided in the program must have the following components:
    a. Treatment will be trauma responsive and address the intersection between trauma, mental health, and substance use disorders.
    b. Treatment services will include treatment planning, clinical interventions, milieu-based therapy, and family outreach and support when appropriate.

   c. The program will facilitate a morning meeting a minimum of five times per week, convenes at least one communal meal per day, and convenes at least one house/community meeting per week.
   d. The program will implement a daily schedule of activities designed to facilitate participation in the milieu and promote recovery, including a minimum of five hours of individual and/or group treatment sessions per week.
8. Co-Occurring Enhanced RRS programs shall provide care coordination activities, including, but not limited to identifying community resources, i.e., housing, employment, educational/vocational services, legal/justice related case management, recovery supports, behavioral health clinical services, and pharmacological services for mental health and addiction. Programs must begin care coordination, particularly related to the search for housing, at the beginning of treatment, in concert with all activities on the treatment plan.
9. Co-Occurring Enhanced RRS programs will support members in establishing and maintaining relationships with community-based prescribers. If a member has an existing relationship with a community-based prescriber for mental health or addiction pharmacotherapy, the program shall coordinate with the member's outpatient treaters, including the facilitation of transportation to the community-based prescriber location.
10. The provider must have documented policies and procedures in place to allow for the safe and appropriate self-administration of medication(s) by members.
11. The provider must ensure that each member has access to medications prescribed for physical and behavioral health conditions and documents this in the member's chart.
12. The provider shall train staff on the use of ASAM criteria.
13. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards.
14. The provider is responsible for updating its available capacity, once per week at a minimum, on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The provider is also responsible for keeping all administrative and contact information up to date on the website. The provider 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 will comply with all provisions of the corresponding section in the General performance specification.
2. The provider will comply with the staffing requirements of the applicable licensing body, the staffing requirements in the service-specific performance specifications, and the credentialing criteria.
3. If the program is experiencing a hardship in meeting these specifications, BSAS has a process for waiving regulatory requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
4. In accordance with one of the models listed in bullets 1a and 1b of the Components of Service section, the Co-Occurring Enhanced RRS programs shall develop an integrated staffing model which utilizes staff from affiliated outpatient clinics and/or health centers to address the full complement of needs for the members in the program, inclusive of all requirements in the components of service.
   a. Medical staff, which may include psychiatrists, addiction physicians, mid-level practitioners, and registered nurses, must be available through a health center and/or outpatient clinic to support the medical and pharmacological needs of the members in the program.

   b. Medical staff shall deliver medical and psychiatric services as allowable under the affiliated clinic license and in keeping with their supervisory requirements.
   c. The Co-Occurring Enhanced RRS per diem rate includes overhead to support integration of medical staff with program based clinical and direct care staff to ensure coordinated treatment planning and service delivery according to the requirements in the components of service section.
5. Program staff positions funded through the per diem rate include:
   a. A full-time program director who carries full responsibility for the administration and operations of the program
   b. A full-time clinical director who meets the definition of Licensed Professional of the Healing Arts (LPHA) (e.g., LICSW, LMHC, or LMFT, or LADC1) and is able to provide supervision to Licensure Track and master's-level clinicians, bachelor's-level paraprofessionals, and recovery specialists in the program. The clinical director must have experience, competency, and/or training in both addiction and mental health. A distinct, full-time recovery specialist supervisor who is able to supervise the staff providing treatment to individuals with both addiction and mental health needs.
   c. A mix of clinical and paraprofessional, and recovery specialist staff are responsible for delivering clinical services coordinating members' treatment plans, providing direct care, coverage and milieu supervision, facilitating a therapeutic milieu through meetings and groups, and addressing members' care coordination and aftercare needs. Program staff must contain an appropriate mix of LPHA, MA, BA, and recovery specialist staff with experience, competency, and/or training in mental health and substance use disorders.
   d. A part-time registered nurse to support medication compliance, and monitoring of symptoms. Nurse time must be flexed according to case mix and the needs of members in the program.
6. The program will designate from among the staff an HIV/AIDS/HEP C coordinator, a tobacco education coordinator (TEC), an access coordinator, and a culturally and linguistically appropriate services (CLAS) point person.
7. The provider will ensure that all staff receive supervision consistent with credentialing criteria.
8. The provider will ensure that team members have training in evidence-based practices and are provided with opportunities to engage in continuing education to refine their skills and knowledge in emerging treatment protocols.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
   a. Increase in MAT/MOUD induction and continuation;
   b. Decrease in readmission to ED and inpatient services;
   c. Increase in referrals and transitions to lower levels of care; and
   d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
2. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs*.
3. The provider will collect data to measure the quality of their services. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
4. The provider must report any adverse events that occur to the relevant authorities.

Process Specifications

Assessment, Treatment/Recovery Planning and Documentation

1. The provider must comply with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with all provisions specified in 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to assessment and recovery planning.
3. The provider will maintain a standardized intake/admission log that tracks all applications for admission, documents admission decisions, reason for non-acceptance, and referrals made. The log shall be made available for review upon request.
4. The provider shall facilitate referrals to appropriate services and/or resources in the case of admission denials.
5. The provider will utilize evidence-based assessment tools for assessing substance use disorders, mental health needs, and ASAM level of care.
6. A clinician must complete an initial biopsychosocial clinical assessment using ASAM dimensions to gain an understanding of addiction severity, co-occurring mental health issues and trauma, physical health issues, family and social supports, housing stability, and other issues for each member that includes the following elements:
    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; types of and responses to previous treatment; and risk for overdose;
    b. Assessment of the member's psychological, social, health, economic, educational/vocational status; criminal history; current legal problems; co-occurring disorders; disability status and accommodations needed, if any; trauma history; and history of compulsive behaviors, such as gambling. This assessment must be completed before a comprehensive service plan is developed.
    c. Assessment of member's HIV and TB risk status;
    d. Identification of key relationships (e.g., significant others) supportive to individual's treatment and recovery; and
    e. A list of the member's current medications, based on pharmacy labels, which shows the date of filling, the name and contact information of the prescribing practitioner, the name of the prescribed medication.
7. Staff will work with the member to create an individualized recovery treatment/service plan based on the clinical assessment, including, at a minimum:
    a. A statement of the member's strengths, needs, abilities, and preferences in relation to their substance use disorder treatment, described in behavioral terms;
    b. The service to be provided and whether directly or through referral;
    c. The service goals, described in behavioral terms, with time lines;
    d. Clearly defined staff and member responsibilities and assignments for implementing the plan; and
    e. A description of discharge plans and aftercare service needs.
8. The clinical supervisor reviews and approves the assessment and individualized recovery treatment/service plan.

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to discharge planning.
2. Staff will work with the member to create an individualized aftercare plan that must include:
    a. referrals to individual, group and/or family outpatient aftercare as appropriate;
    b. alcohol and drug-free living environments;
    c. vocational and educational opportunities;
    d. resources to support access to social benefit programs;

e. specific strategies to be used to follow-up with the member after the member leaves; and
f. a connection to a community-based prescriber for medications mental health and addiction as appropriate.

3. Staff will work with the member to ensure that recovery maintenance strategies are in place and working effectively and that referrals to services have met intended goals.
4. The clinical supervisor will review and approve the aftercare plan.

Service, Community, and Collateral Linkages

1. The provider shall comply with all provisions of the corresponding section in the General performance specifications.
2. The provider will collaborate in the transfer, referral, and/or discharge planning process to another treatment setting, with member consent, to ensure continuity of care.
3. The staff members must be familiar with all of the following levels of care/services and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated.
4. The provider maintains written affiliation agreements, which may include Qualified Service Organization Agreements (QSOA), Memorandum of Understanding (MOU), Business Associate Agreements (BAA) or linkage agreements, with local providers of these levels of care that refer a high volume of members to its program and/or to which the program refers a high volume of members. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
5. With member consent, the provider will collaborate with the member's PCC as delineated in the primary care clinician integration section of the General performance specifications.
6. When necessary, the provider must arrange transportation for services required that are external to the program during the admission. The provider also must make reasonable efforts to assist members identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.
7. The provider shall demonstrate a capacity to work collaboratively with multiple systems, including substance use disorder treatment providers, primary healthcare, community-based support services, housing search services, supportive housing service providers, mental health service providers, other relevant human services, and various aspects of the criminal justice system, as appropriate.

Performance Specifications

24-Hour Diversionary Services
Residential Rehabilitation Services (RRS) for Families

Providers contracted for this level of care or service will be 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**. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

The following Residential Rehabilitation Service (RRS) for Families performance specifications are a subset of the RRS for Substance Use Disorders performance specifications. As such, providers of RRS for Families agree to adhere to both the RRS for Substance Use Disorders performance specifications and to the RRS for Families performance specifications contained within. Where there are differences between the RRS for Substance Use Disorders and RRS for Families, these RRS for Families specifications take precedence.

Residential Rehabilitation Services (RRS) for Families consists of a structured and comprehensive rehabilitative environment for families, including children up to the age of 18 that supports family recovery from trauma and the effects of SUD and encourages movement towards an independent lifestyle. Scheduled, goal-oriented clinical services are provided in a family focused treatment and recovery model, with the parent/caregivers recovery from SUD central to the recovery of the family.

Components of Service

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with all licensing and standards of care requirements of the applicable licensing body.
3. The provider administers a trauma-informed health and family needs assessment and family life advocacy services/integrated family treatment plan.
4. The provider ensure the member receives at least five hours of individual and group, and family substance use disorder counseling services, based on treatment plans.
5. The provider provides or arranges for integrated and/or coordinated substance use disorder, mental health, domestic violence, and trauma services with appropriate releases of information and compliance with the Health Insurance Portability and Accessibility Act (HIPAA) and 42 CFR, Part 2.
6. The provider ensures for Fetal Alcohol Spectrum Disorder (FASD) screening with an ability to provide individualized services for those with an FASD.
7. The provider ensures individualized, family-focused discharge and aftercare planning.
8. The provider has the ability to provide appropriate medication management.
9. The provider ensure the member learns parenting skills as indicated by the treatment plan as well as that the member receives and supports focusing on building the parent/caregiver-child relationship; furthermore, the provider offers these services in a trauma-informed manner.
10. The provider ensure members receive the following services as needed:
    a. Housing/job search activities;
    b. Self-help integrated into services;
    c. Assistance in applying for public assistance and benefits;
    d. On-site developmental services/activities for children not accessing child-care in the

community; and
e. Afterschool programming for school age children and adolescents.

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 service-specific performance specifications, and the credentialing criteria outlined in the Provider Manual.
3. If the program is experiencing a hardship in meeting these specifications, the Bureau of Substance Addiction Services (BSAS) has a process for waiving regulatory requirements. The waiver process is described in the Department of Public Health (DPH) (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
4. The program is staffed with one full-time Program Director who is responsible for all administrative and management functions of the program, including budget and personnel.
5. The program is staffed with one full-time Clinical Director/Senior Clinician, responsible for the supervision of all clinical staff, the clinical programming and counseling, staff development, implementation of best practices, and supervision of all clinical record keeping and reporting.
6. The program is staffed with one full-time Family Specialist (master's-level Senior Clinician) who will provide clinical family services through individual, group, and family therapy under the supervision of the Clinical Director.
7. The program is staffed with 8.5 full-time Recovery Specialists who will have caseloads and provide individual, group, and case management services under the supervision of the Clinical Director, as required under the LADC guidelines for II- and III-level Clinicians.
8. The program is staffed with one full-time Child Service Coordinator who is responsible for the children's portion of the family service plans, to oversee both in-house and out-of-the-house children's activities.
9. The program is staffed with one full-time Child Service Assistant who will assist in the child service coordinator developing the children's part of the service plan.
10. The program is staffed with sufficient staff to ensure that a minimum of two direct care/recovery specialists coverage at all times.
11. The provider ensures that all program staff will be knowledgeable of requirements and procedures
for reporting suspected cases of abuse and neglect in accordance with M.G.L. Chapter 119, Section 51A.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance
specifications.
2. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation;
    b. Decrease in readmission to ED and inpatient services;
    c. Increase in referrals and transitions to lower levels of care; and
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.

3. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs*.
4. The provider will collect data to measure the quality of their services. The provider must have a rigorous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
5. The provider must report any adverse events that occur to the relevant authorities.

Process Specifications

Assessment, Treatment/Recovery Planning, and Documentation

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with all provisions specified in 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to assessment and recovery planning.
3. The provider conducts a trauma-informed health and family needs assessment.
4. In addition to an individualized SUD treatment plan for the parent/caretaker, the provider also creates an integrated family treatment service plan for the entire family.
5. The provider ensures there are integrated service plans with other state agencies that provide services to the client. The provider will coordinate the appropriate releases of information and compliance with HIPAA and 42 CFR, Part 2.

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to discharge planning.
2. The provider ensures that aftercare planning is initiated at the time of admission, continues throughout the treatment episode, and includes focus on the following:
    a. Treatment and case management after discharge;
    b. Housing;
    c. Child care;
    d. Transition to work;
    e. Engagement in treatment activities;
    f. Custody status; and
    g. Health and other necessary social services.

Service, Community, and Collateral Linkages

1. The provider complies with all provision of the corresponding section in the General performance specifications.
2. Providers must maintain formal linkages to the following:
    a. Mental health, health, and social services;
    b. Opioid treatment services;
    c. HIV testing and counseling sites;
    d. The Department of Early Education and Care's childcare services through child care resource and referral agencies;
    e. Communication networks between parents/caregivers, program staff, case managers, and other professionals involved with the family;
    f. Referrals for children's medical and/or mental health services, and appropriate follow-up activities, in accordance with immunization and well child requirements;
    g. Housing resources through DHCD, BSAS, and community resources;
    h. Other state agencies as indicated (may include DMH, DYS, DCF, DDS, MRC);

i. CBHI providers;
j. Job readiness, skill building, and search services resources;
k. Educational and training resources;
l. Legal aid; and
m. Child care.

Performance Specifications

24-Hour Diversionary Services
Residential Rehabilitation Services (RRS) for Pregnant and Post-Partum Women

Providers contracted for this level of care or service will be 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**. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

The following Residential Rehabilitation Services (RRS) for Pregnant and Post-Partum Women performance specifications are a subset of the RRS for Substance Use Disorders performance specifications. As such, providers of RRS for Pregnant and Post-Partum Women agree to adhere to both the RRS for Substance Use Disorders performance specifications and to the RRS for Pregnant and Post-Partum Women performance specifications contained within. Where there are differences between the RRS for Substance Use Disorders and RRS for Pregnant and Post-Partum Women, these RRS for Pregnant and Post-Partum Women specifications take precedence.

Residential Rehabilitation Services (RRS) for Pregnant and Post-Partum Women consists of a structured and comprehensive rehabilitative environment that is capable of serving the needs of pregnant and post-partum women, and their infants. "Post-partum" is defined as the period following childbirth up to one year. The program must support members' independence and resilience, and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle.

Components of Service

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with all licensing and standards of care requirements of the applicable licensing body.
3. The provider ensures assessment and management of gynecological and/or obstetric, prenatal, and other health needs are conducted by referral.
4. The provider ensures assessment of physical, mental, developmental, and/or other needs of infants is conducted and/or provided through linkages with relevant services.
5. The provider arranges for emergency hospital back-up for obstetric and gynecological services.
6. The provider arranges appointments for primary health, and mental health services including pediatric care, and specialized pediatric care as indicated.
7. The provider ensures that medical appointments during and after pregnancy are scheduled, and verification of whether these appointments have been kept is conducted.
8. The provider works with the member to create a treatment plan addressing parenting skills education, child development education and structured developmental activities, parent support, family planning, nutrition, violence, safe relationships, and other relevant issues.
9. The provider facilitates access, induction, maintenance, and ongoing support for members enrolled in pharmacotherapies for opioid use disorders.
10. The provider ensures access to services related to HIV/AIDS, hepatitis, and other STI counseling and testing as needed by the member.

11. The provider ensures assistance in accessing WIC and other nutritional programs.
12. The provider arranges for family planning and reproductive health resources.
13. The provider ensures appropriate counseling regarding the following as needed:
    a. Prenatal care;
    b. Nutritional education;
    c. Early child care issues;
    d. Neonatal Abstinence Syndrome;
    e. DCF;
    f. Breastfeeding;
    g. Effects of smoking on fetal and child development;
    h. Family preservation;
    i. Parenting skill;
    j. Budgeting;
    k. Access to resource; and
    l. Family planning.
14. The provider offers or coordinates opportunities for parent/child relational and developmental groups.

Staffing Requirements

1. The provider complies with all provision 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 service-specific performance specifications, and the credentialing criteria outlined in the Provider Manual.
3. A parenting specialist, child services coordinator, or clinical staff person with specific training in trauma and parenting must be available either through agency hire or contract.
4. If the program is experiencing a hardship in meeting these specifications, the Bureau of Substance Addiction Services (BSAS) has a process for waiving regulatory requirements. The waiver process is described in the Department of Public Health (DPH) (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation;
    b. Decrease in readmission to ED and inpatient services;
    c. Increase in referrals and transitions to lower levels of care; and
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
2. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs*.
3. The provider will collect data to measure the quality of their services. The provider must have a rigorous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.

4. The provider must report any adverse events that occur to the relevant authorities.

Process Specifications

Assessment, Treatment/Recovery Planning, and Documentation

1. The provider complies with all provisions of the corresponding section of the General performance specifications.
2. The provider complies with all provisions specified in 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to assessment and recovery planning.

Discharge Planning and Documentation

1. The provider ensures that upon discharge members have an individualized member aftercare plan which includes referrals to the following services, if indicated in the member's treatment plan:
    a. Family transitional/permanent living opportunities;
    b. Child care service;
    c. Vocational and educational rehabilitation services; and
    d. Primary health and mental health services (including pediatric care and specialized pediatric care as indicated), support services for survivors of intimate partner violence or sex trafficking, and other social services as needed.
2. The provider complies with all provisions of 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to discharge planning.

Service, Community, and Collateral Linkages

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider has a documented operational agreement with the administrator of the Pregnant Women's Access Line and regularly shares information about program availability and wait list.
3. The provider has a documented operational agreement with obstetrical practices and/or birthing hospitals in the area, allowing for coordinated prenatal and postpartum care.
4. The provider ensures collaboration with early intervention, home visiting, and other home-based outpatient services so that members can receive care from outpatient providers on-site.
5. The provider ensures linkage to services is initiated upon admission and as part of the ongoing treatment/recovery plan. Based on individual member needs, this includes, but is not limited to, the following:
    a. Prenatal care;
    b. Family/reproductive health programs;
    c. Early Intervention programs;
    d. High-risk infant/family support programs;
    e. Healthy Start;
    f. Women, Infants, and Children (WIC) and other nutritional programs;
    g. Medication-Assisted Treatment services;
    h. Intimate partner violence and safe relationships services;
    i. Violence prevention programs;
    j. Child care/babysitting;
    k. Housing preparation;
    l. Transportation;
    m. Legal service; and
    n. Transitional assistance.

Performance Specifications

24-Hour Diversionary Services
Residential Rehabilitation Services (RRS) for Transitional-Age Youth (Ages 16-21) and Young Adults (Ages 18-25) (TAYYA)

Providers contracted for this level of care or service will be 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**. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

The following Residential Rehabilitation Services (RRS) for Transitional-Age Youth and Young Adults performance specifications are a subset of the RRS for Substance Use Disorders performance specifications. As such, providers of RRS for Transitional-Age Youth and Young Adults agree to adhere to both the RRS for Substance Use Disorders performance specifications and to the RRS for Transitional-Age Youth and Young Adults performance specifications contained within. Where there are differences between the performance specifications for RRS and the RRS Transitional-Age Youth and Young Adults, these RRS for Transitional-Age Youth and Young Adults specifications take precedence.

Residential Rehabilitation Services (RRS) for Transitional-Age Youth and Young Adults consists of a structured and comprehensive therapeutic milieu that is developmentally appropriate for Transitional-Age Youth (ages 16-21) or Young Adults (ages 18 – 25). The program must reinforce a culture of recovery and wellbeing, self-help skills, and pro-social activities. The program must support members' recovery from alcohol and/or other drug use. Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and maintaining the skills necessary to function effectively in the community, including educational and/or employment opportunities, access to community-based services, and engagement with the recovery community.

Components of Service

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with all licensing and standards of care requirements of the applicable licensing body.
3. The provider offers treatment that is based on the developmental stages and needs of Transitional-Age Youth and Young Adults providing flexible individualized treatment, rehabilitation, and support/supervision that varies in intensity based on member need.
4. The provider ensures that services promote family- and member-guided care focusing on skill building to enhance self-esteem, identify relapse triggers, build positive coping skills, and support vocational development and life skills training.
5. The provider ensures that families are incorporated in treatment as appropriate, and regular meetings with families are conducted.

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 service-specific performance specifications, and the credentialing criteria outlined in the Provider Manual.
3. If the program is experiencing a hardship in meeting these specifications, the Bureau of Substance Addiction Services (BSAS) has a process for waiving regulatory requirements. The waiver process is described in the Department of Public Health (DPH) BSAS 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
4. The provider is staffed with one full-time program director designated exclusively for oversight of the program at each site, regardless of size. The Program Director must have demonstrated experience in treating substance use disorders, working with adolescents or young adults, and administrative/management. The Program Director and the Clinical Supervisor will jointly ensure the training and supervision of each direct care/milieu staff member.
5. The provider is staffed with one full-time Clinical Supervisor who provides a combination of individual, group, and family clinical services, as well as supervision of staff. The Clinical Supervisor will support the program director in providing individual and group supervision to direct care staff. The program is staffed with one full-time Case Manager to provide aftercare coordination and additional case management needs with providers and recovery resources.
6. The program is staffed with a direct-care Recovery Specialist to conduct assessments and provide individual and group services to members according to the following coverage parameters:
    a. A minimum of three direct-care Recovery Specialists are on shift from 7 a.m. until 11 p.m.
    b. A minimum of two direct-care Recovery Specialists are on shift from 11 p.m. until 7 a.m.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation;
    b. Decrease in readmission to ED and inpatient services;
    c. Increase in referrals and transitions to lower levels of care; and
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
2. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs*.
3. The provider will collect data to measure the quality of their services. The provider must have a rigorous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
4. The provider must report any adverse events that occur to the relevant authorities.

Process Specifications

Assessment, Treatment/Recovery Planning and Documentation

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with all provisions specified in 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to assessment and recovery planning.
3. The provider facilitates the members' medical and health history and assessment, including a physical exam, within two weeks of admission. The requirement of a physical exam can be waived with documentation of physical exam conducted within last year.
4. The provider completes a comprehensive biopsychosocial assessment within 72 hours of admission.
5. The provider completes an individual recovery treatment plan in collaboration with, and signed by, the member. The plan includes service goals described in behavioral terms, time frames, and an aftercare plan with referrals to services and ongoing recovery goals.

Discharge Planning and Documentation

1. The provider ensures that aftercare planning is initiated at the time of admission, continues throughout the treatment episode and includes focus on the following:
    a. An individualized aftercare program designed to offer continued support to both the young adult and the family, allowing for a smoother transition back into the home and community environment;
    b. Referrals to services and supports that address a more holistic set of needs including: individual, group, and family counseling; psychiatry; vocational/educational services; safe and supportive housing options; social benefit programs for which the resident may be eligible; self-help and community-based recovery supports; and
    c. Overdose prevention education as a necessary component of the treatment and aftercare plan for any individual who has been using opioids.
2. The provider complies with all provisions of 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to discharge planning.

Service, Community, and Collateral Linkages

1. The provider complies with all provisions of the corresponding section of the General performance specifications.
2. The provider will ensure that the program has clearly defined and formalized linkages to the following programs and services:
    a. Mobile Crisis Intervention;
    b. Adolescent stabilization and residential programs;
    c. Other transitional-age youth and young adult services;
    d. Recovery high schools;
    e. Recovery support centers;
    f. Homeless shelters;
    g. Acute Treatment Services (ATS);
    h. Transitional Support Services (TSS);
    i. Clinical Stabilization Services (CSS);
    j. Vocational training;
    k. Educational support;
    l. State agency services (DCF, DYS, DMH, DDS, MRC),
    m. Department of Corrections (DOC);
    n. Parole and probation;
    o. Outreach sites;

p. MAT/MOUD treatment providers;
q. HIV testing and counseling;
r. Primary health services, including reproductive health;
s. Outpatient behavioral health services; and
t. Community-based social service providers.

Performance Specifications

24-Hour Diversionary Services
Residential Rehabilitation Services (RRS) for Youth (Ages 13-17)

Providers contracted for this level of care or service will be 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**. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

The following Residential Rehabilitation Services (RRS) for Youth performance specifications are a subset of the RRS for Substance Use Disorders performance specifications. As such, providers of RRS for Youth agree to adhere to both the RRS for Substance Use Disorders performance specifications and to the RRS for Youth performance specifications contained within. Where there are differences between the performance specifications for RRS and the RRS for Youth, these RRS for Youth specifications take precedence.

Residential Rehabilitation Services (RRS) for Youth consists of a structured and comprehensive rehabilitative environment that is developmentally appropriate for youth (ages 13 – 17). The program provides developmentally appropriate services and support independence and resilience, and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle.

Components of Service

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with all licensing and standards of care requirements of the applicable licensing body.
3. The provider ensures individualized, youth-centered treatment plan, created in collaboration with the member.
4. The provider facilitates an educational assessment.
5. The provider ensures psychiatric consultation available 24 hours per day, seven days per week to provide assessment and pharmacological interventions.
6. The provider ensures collaborations with medical and psychiatric facilities.
7. The provider facilitates peer support and 12-Step meetings for adolescents.
8. The provider facilitates positive, pro-social recreational programming;
9. The provider ensures that all screening, assessment, treatment, psycho-education, recovery support services, materials and resources are:
    a. Developmentally appropriate (e.g., taking age, maturation, cognitive processing, decision-making skills, and other special needs of the adolescent into consideration);
    b. Trauma-informed; and
    c. Responsive to gender identity and expression, sexuality, and culture.

    Staff and clinical practices may not require adolescents to retell the details of their trauma experience(s) as part of treatment.
10. The provider ensures family engagement and involvement, including working with the member to identify family members available to engage in the adolescent's recovery efforts. Providers will adopt a broad definition of family that includes family of origin or family of choice.

11. The provider ensures family members are offered support services in accordance with the goals determined by the family unit. These services include: referrals to family clinicians as part of the aftercare and discharge plan; offering "family days" at the program where families of youth in treatment have opportunities to connect about their experiences; and referrals to support groups like Al-Anon, Families Anonymous, Learn to Cope, Allies in Recovery.
12. The provider will assess, identify and refer to continuing care and post-discharge services addressing the mental health and substance use disorder needs of the adolescent.

Staffing Requirements

1. The provider complies will all providers 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 service-specific performance specifications, and the credentialing criteria outlined in the Provider Manual.
3. If the program is experiencing a hardship in meeting these specifications, the Bureau of Substance Addiction Services (BSAS) has a process for waiving regulatory requirements. The waiver process is described in the Department of Public Health (DPH) (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
4. The program is staffed with one full time Program Director with demonstrated experience in substance use disorders and mental health treatment as well as adolescent treatment and administrative/management experience who oversees the program.
5. The program is staffed with one full-time, master's-level Clinical Director with demonstrated experience providing clinical treatment and supervision with adolescent treatment, substance use disorders, and mental health treatment. The Clinical Director will supervise the clinicians and will provide training to all staff that relates to enhancing the clinical understanding of substance use disorders and other challenges clients may be experiencing while in treatment.
6. The program is staffed with three full-time clinicians to work with individuals and families and assist with ongoing treatment and aftercare planning. One clinician must have demonstrated experience in working with families.
7. The program is staffed with 11.6 full-time equivalent Recovery Specialists, including a Resident Manager and two awake overnight staff every night.
8. The program is staffed with one full-time After-Care Coordinator who is responsible for identifying appropriate continuing care and post discharge services and resources while working to include the perspectives of multiple stakeholders to ensure as smooth a transition as possible to the discharge phase in the member's recovery plan.
9. The program is staffed with one full-time Educational Coordinator responsible for coordinating the student's educational progress, acts as a liaison between school districts/placements and the youth at the program to ensure residents are receiving work to be completed, and supports residents in doing this educational work while at the program.
10. The program ensures that nurses are available on site 20 hours per week to manage medications, provide brief assessment of member's health concerns, and assist in facilitating referrals to primary care and other medical services, as indicated.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation;
    b. Decrease in readmission to ED and inpatient services;
    c. Increase in referrals and transitions to lower levels of care; and
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
2. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs*.
3. The provider will collect data to measure the quality of their services. The provider must have a rigorous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
4. The provider must report any adverse events that occur to the relevant authorities.

Process Specifications

Assessment, Treatment/Recovery Planning, and Documentation

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with all provisions specified in 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to assessment and recovery planning.
3. The provider facilitates the member's medical and health history and assessment, including a physical exam, within two weeks of admission. The requirement of a physical exam can be waived with documentation of physical exam conducted within last year.
4. The provider completes a comprehensive biopsychosocial assessment within 72 hours of admission.
5. The provider completes that an individual recovery treatment in collaboration with and signed by the member. The treatment plan includes service goals described in behavioral terms with timeframes, and an aftercare plan that includes referrals to services and identifies ongoing recovery goals.

Discharge Planning and Documentation

1. The provider ensures that aftercare planning is initiated at the time of admission, continue throughout the treatment episode, and include focus on the following:
    a. An individualized aftercare program designed to offer continued support to both the member and the family, allowing for a smoother transition back into the home and community environment;
    b. Referrals to services and supports that address a more holistic set of needs include: individual, group, and family counseling; psychiatry; vocational/educational services; safe and supportive housing options; social benefit programs for which the member may be eligible; and self-help and community-based recovery supports; and
    c. Overdose prevention education as a necessary component of the treatment and aftercare plan for any individual who has been using opioids.
2. The provider complies with all provisions of 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to discharge planning.

Service, Community, and Collateral Linkages

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider will ensure that the program has clearly defined and formalized linkages to the following programs and services:
    a. Adolescent psychiatrist for consultation;
    b. Adolescent psychiatric inpatient setting;
    c. Adolescent Acute Treatment Services and stabilization programs;
    d. Other youth residential programs;
    e. Mobile Crisis Intervention;
    f. Recovery high schools;
    g. Other youth-serving agencies (DCF, DYS, DMH, DDS, MRC);
    h. Local outpatient and community-based providers;
    i. Outreach sites;
    j. MAT/MOUD treatment providers;
    k. Primary health services, including reproductive health;
    l. Outpatient behavioral health services;
    m. HIV testing and counseling;
    n. Housing services; and
    o. Educational and vocational services (including job readiness and job search skills).

Performance Specifications

24-Hour Diversionary Services
Transitional Care Unit (TCU)

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.** The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

Transitional Care Unit (TCU) services are designed for youth who are affiliated with a state agency, including Department of Children and Families (DCF), Department of Mental Health (DMH), and the Department of Youth Services (DYS), or identified as meeting medical necessity criteria for this level of care: 1) for whom the expected placement setting is home with parent(s)/guardian(s)/ caregiver(s), foster care, or community-based group home, residential; and 2) for members who no longer meet medical necessity criteria for continued stay at an acute inpatient or Intensive Community-Based Acute Treatment (ICBAT) or Community-Based Acute Treatment (CBAT) level of care. TCU services are provided in an environment that is less restrictive than inpatient and ICBAT/CBAT and more structured than partial hospitalization or outpatient treatment. TCU services are solely intended to meet the needs of youth who are ready to leave an acute inpatient setting or ICBAT/CBAT, and priority is given to youth in acute inpatient settings. TCU services are designed to facilitate transition, in a period not to exceed 30 days, to the youth's next placement setting through comprehensive transition planning and medically necessary behavioral health services. TCU services focus on engagement of the youth in increasing opportunities in the community in preparation for their successful transition, e.g., participating in school within the community, engaging in scheduled family visits, learning, practicing, and demonstrating new behaviors, patterns of interactions, and social skills, etc.

Components of Service

1. TCU providers maintain all required licenses and specifically adhere to the Department of Early Education and Care (EEC) licensure requirements for community-based programs.
2. The scope of required service components provided in this level of care includes, but is not limited to, the following:
    a. A comprehensive assessment inclusive of the MA Child and Adolescent Needs and Strengths (CANS) tool completed by a CANS-certified clinician, as part of discharge planning to determine the youth's functioning and need for medical, educational, functional, behavioral health, and other supports;
    b. Review of clinical bio-psychosocial assessment(s) and substance use disorder (SUD) assessment(s) from prior levels of care, and update them as indicated;
    c. Development and review of a treatment plan detailing treatment services to be provided during the TCU length of stay;
    d. Development of a discharge plan including detailed active plans for transitioning the youth to the next placement;
    e. Weekly progress review, tracking, and follow-up on actionable transition activities in the discharge plan;
    f. Development and review of a Safety Plan as part of the Crisis Planning Tools for youth;
    g. Individual, family, and group therapy;
    h. Trauma-informed assessment and treatment;

i. Medication management;
j. Crisis intervention;
k. Identification and facilitation of consultation services;
l. Convening and facilitating care planning team meetings for the purpose of discharge planning;
m. Minimum weekly contact with the parent/guardian/caregiver, or at other frequency, based on the discharge plan and with input from the state agency that the youth is affiliated with;
n. Minimum weekly contact with involved outpatient and CBHI providers;
o. Minimum weekly contact with the state agency that the youth is affiliated with; and
p. Minimum weekly contact with the next placement if other than parent/guardian/caregiver, e.g., receiving placement provider.

3. The TCU provider is responsible for supplying each member with medications prescribed for physical health and behavioral health conditions and documenting so in the member's health record.
4. All urgent consultation services are arranged within 24 hours of the order for these services. Non-urgent consultation services are provided in a timely manner, commensurate with the level of need. All of these services are documented in the member's health record.
5. TCU providers communicate and collaborate with the state agency that the youth is affiliated with to coordinate all routine and necessary medical, behavioral health, and dental care.

Staffing Requirements

1. The TCU provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the service-specific performance specification, and the credentialing criteria outlined in the Provider Manual. TCU providers ensure 24-hour staffing, seven days per week, 365 days per year, including awake, supportive overnight staff.
2. TCU providers ensure that a master's-level, child-trained clinician is assigned to each youth entering the program. Master's-level clinicians must be on site during business hours, at least one evening during the week, and one shift on Saturday and Sunday to meet the clinical and care coordination needs of youth in the program. For staffing for the remaining hours, an independently licensed clinician is available by telephone access for clinical consultation within 30 minutes.
3. TCU providers ensure adequate staffing of master's-level clinicians certified to administer the MA Child and Adolescent Needs and Strengths (CANS) tool.
4. TCU providers ensure that a board-certified child psychiatrist or a child-trained psychiatric nurse mental health clinical specialist (PNMHCS) acting under the psychiatrist's member-specific supervision and who meets Carelon's credentialing criteria is available by phone, 24 hours per day, seven days per week, for consultation related to treatment planning and medication concerns.
5. TCU providers ensure training for staff, upon hire and at least annually, that includes, at a minimum, a review of the following topics:
    a. TCU performance specifications and medical necessity criteria;
    b. DCF placement levels of care;
    c. The Children's Behavioral Health Initiative (CBHI) mission, values, vision, and services delivery system including but not limited: to performance specifications, medical necessity criteria, roles and responsibilities of each hub service, referral processes, and eligibility determination;
    d. Core clinical issues/topics as described in the TCU Operations Manual Medications and side effects ;
    e. First Aid/CPR;
    f. Child-serving systems and processes (e.g., DCF, DMH, DYS, Department of Early and

Secondary Education (DESE), etc.);
g. Systems of Care philosophy and principles;
h. Conflict resolution;
i. Family systems;
j. Risk management/safety planning;
k. Crisis intervention;
l. Trauma-informed care;
m. Child development;
n. Cultural, linguistic and socio-economic competency;
o. Restraint reduction/elimination techniques; and
p. Identification and treatment of problematic sexual behaviors and fire-setting.

Service, Community, and Collateral Linkages

1. TCU providers maintain regular, ongoing contact with Carelon regarding progress in accomplishing the action items in each member's transition/aftercare plan, census, and availability, including information regarding upcoming discharges.
2. The TCU provider maintains a documented, formal affiliation with the local Mobile Crisis Intervention (MCI) to facilitate collaboration and coordination of care around members' Safety Plans, as well as to access MCI crisis assessment, intervention, and stabilization services for members enrolled in TCU, as clinically indicated. With consent from the parent/guardian/caregiver, if required, when a youth is in need of intervention from MCI, the TCU clinician is in contact with the MCI staff at the time of referral to provide relevant information regarding the youth's functioning and crisis precipitants. In preparation for discharge, the TCU provider contacts the MCI where the youth will be placed to update or develop a Safety Plan.
3. The TCU provider maintains and documents linkages with community-based programs for children and adolescents, including CBHI services, to enhance continuity of care for members.
4. The TCU provider develops and documents organizational linkages with local agencies providing foster care services and community-based group homes as described in the TCU Operations Manual in order to improve access to these services and develop and maintain smooth transition planning.
5. The TCU provider develops linkages and policies that promote communication and coordination of care with local primary care providers.
6. With consent from the legal guardian, the TCU provider communicates and collaborates with all necessary individuals involved with the youth (e.g., existing behavioral health providers, probation officers, guardians ad litem, state agencies, attorneys, local education authorities (LEAs), physicians, etc.) for the purpose of treatment planning, transition planning, coordination of care, and discharge planning.
7. The TCU clinician maintains and documents regular, frequent telephonic contact with collateral service providers and state agencies and invites them with adequate notice to transition/care planning meetings to review progress on transition action items.
8. With consent, the provider contacts the appropriate LEA if the school system is involved with the member around educational planning, curriculum, and/or resources.

Quality Management (QM)

1. The TCU provider participates in all network management, utilization management, and quality management initiatives, activities, and meetings.
2. The facility and/or program will develop and maintain a quality management plan that is consistent and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.

3. A continuous quality improvement process is used, and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to members, including youth and their families.
4. Clinical outcomes data must be made available upon request and must be consistent with performance standards of this service.
5. All Reportable Adverse Incidents will be reported within one business day of their occurrence per policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a member, or to others by action of a member, who is receiving services, or has recently been discharged from services.
6. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

Process Specifications

Assessment, Treatment Planning, and Documentation

1. Admissions to TCU are accepted during business hours, five days per week.
2. The TCU provider complies with the following as part of the referral process to the TCU program:
    a. The TCU provider is notified of a potential admission to their program via receipt of an encrypted email containing the TCU referral.
    b. The TCU provider coordinates admissions with the sending facility and the state agency contact, ensuring and documenting in the member's health record that a master's-level, child-trained clinician participates in the discharge planning meeting at the referring facility to effect continuity of care for each youth who is referred.
3. The TCU provider contacts the parent/guardian/caregiver as determined by DCF, DMH, or DYS, within 24 hours of notification of pending admission by Carelon. All such activity is documented in the member's health record.
4. The child psychiatrist or PNMHCS meets with the youth and reviews their psychiatric medications at minimum within five (5) business days of admission but sooner if clinically indicated, and periodically thereafter for medication management purposes. All such activity is documented in the member's health record.
5. The Safety Plan, as part of the Crisis Planning Tools for youth, must be updated and/or completed by TCU staff within 72 hours of admission and documented in the member's health record. If additional risk issues are identified after this initial period, the Safety Plan is updated immediately upon identification of these issues.
6. A master's-level clinician reviews the clinical bio-psychosocial assessment(s) and SUD assessment(s) from prior levels of care and updates them, as indicated by completion of a brief assessment of the member. This initial assessment is completed upon admission and documented in the member's health record.
7. An initial treatment plan and an initial discharge plan are completed within 48 hours of admission by a master's-level clinician and documented in the member's health record.
8. The TCU provider assigns a multi-disciplinary treatment team to each member within 24 hours of admission.
    a. A multi-disciplinary treatment team meets to review the assessment and initial treatment plan and initial discharge plan within 48 hours of admission.
9. The TCU provider consults with DCF, DMH, or DYS within one (1) business day of admission to identify the care planning team and to plan for scheduling a meeting to give input into the treatment plan and discharge plan for the youth. This care planning team meeting occurs within five (5) business days of admission to the TCU.
10. A written treatment plan detailing treatment services to be provided during the TCU length of stay is generated within one (1) business day of the youth's care planning team meeting and is documented in the member's health record. Treatment plan requirements are delineated in the General performance specification.

11. A written discharge plan is generated within one (1) business day of the youth's care planning team meeting and is documented in the member's health record. With consent, copies of the treatment plan and discharge plan are distributed to all relevant collateral providers, parent(s)/guardian(s)/caregiver(s), and state agency representatives.
12. The discharge plan identifies:
    a. Tasks specific to reintegration into the community to be accomplished in life domains, such as educational, social/recreational, family/living, behavioral health/psychiatric and medical;
    b. The timeframes in which the tasks will be accomplished;
    c. Individuals responsible for the tasks; and
    d. Parties responsible for securing supports and services.
13. The discharge plan considers the youth's current functioning, efforts in locating and securing a placement resource, and services needed to support and ensure a successful transition to the next living situation. The discharge plan also includes the primary placement as well as the secondary/backup placement.
14. The discharge plan includes documentation of increasing opportunities the TCU provider actively makes available for the youth to spend time in the community, e.g., participating in school within the community, engaging in scheduled family visits, learning, practicing, and demonstrating new behaviors, patterns of interactions, social skills, etc.
15. A multi-disciplinary treatment team meets within three (3) business days of the initial care planning team meeting to review the comprehensive treatment plan and discharge plan. All such activity is documented in the member's health record.
16. The TCU provider coordinates care planning with all existing providers and state agency representatives and makes referrals for additional services as needed, including referrals to CBHI services. All care coordination activities are documented in the member's health record.
17. The TCU provider schedules and documents in the member's health record weekly care planning team meetings for the purpose of discharge planning for each youth enrolled in TCU. With consent, team members should include the child/adolescent, parent/guardian/caregiver, relevant TCU program staff, state agency contact, CBHI hub, and other relevant collaterals. Discharge plans are updated accordingly following each care planning team meeting to reflect progress in locating and securing a placement resource, any identified barriers and potential solutions, and/or changes in the youth's functioning or needs.
18. TCU providers are expected to provide Enhanced Care Coordination (ECC) staff updates relative to discharge plans and transition activities for all youth enrolled in TCU. All care planning team meetings, treatment plan updates, and discharge plan updates are documented in the member's health record.
19. For all ICC-involved youth, the TCU provider's treatment team involves the ICC from the point of admission, incorporates the ICC's treatment recommendations, participates in the Care Planning Team (CPT) for the youth, and participates in the CPT meetings that occur for care coordination and disposition planning. All such activities are documented in the member's health record.
20. The TCU provider documents active coordination of care with the state agency responsible for the youth, and/or other services and state agencies.

Discharge Planning and Documentation

1. Once a placement is identified, the TCU provider:
    a. Collaborates with the state agency and/or the parent(s)/guardian(s)/caregivers(s) and the youth to formulate a pre-placement visitation plan. The visitation plan affords opportunities to be introduced to the placement provided, to prepare and involve in planning with the youth and their family, to identify strengths and challenges relative to the transition, to become familiar with the setting, and to transfer learned skills;

   b. Coordinates with the state agency and/or the youth's legal guardian to ensure the youth is enrolled in the local school district where they will be residing;
   c. Facilitates timely referrals for all necessary supports and services identified in the youth's discharge plan in coordination with the state agency;
   d. Obtains weekly status updates on referral/application and wait time for all state agency-referred services and other services supporting a successful transition to the next living situation;
   e. For ICC-involved youth, engages the ICC staff in the discharge planning process and transfers to them care coordination responsibilities; the ICC staff becomes increasingly more active as the youth's transition home nears; and
   f. Documents all such activities in the member's health record.
2. If an appropriate placement has not been identified for the youth within four (4) weeks of their admission to the TCU, or if the primary placement is no longer a viable option at any time, the state agency pursues alternative placement options until another primary placement is secured and updates Carelon accordingly.
3. A comprehensive assessment inclusive of the MA CANS tool is completed prior to discharge and is documented in the member's health record.
4. Prior to discharge, the TCU provider convenes a final discharge planning meeting during which, with consent, copies of the youth's current discharge plan and Safety Plan are distributed to all participants. The plans include documentation of all identified providers with contact information and dates of scheduled appointments or visits, a list of all currently prescribed medications and dosages, and documentation of ongoing strategies, supports, and resources to assist the youth in sustaining gains made throughout the TCU service. All such activities and plans are documented in the member's health record.
5. The TCU provider ensures that the discharge plans for members who are involved with state agencies are coordinated with the appropriate area or site office. Difficulties determining or contacting the state agency case manager are communicated to the Department's area office. All contacts with state agencies are documented in the member's health record.
6. The TCU provider is responsible for immediate notification to Carelon and the state agency at the time of the youth's discharge.

Performance Specifications

24-Hour Diversionary Services
Youth and Transition-Age Youth Detoxification and Stabilization Services (also known as Youth and Transition-Age Youth Withdrawal Management and Stabilization Services) (YSS)

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. The requirements outlined within these service-specific performance specifications take precedence over previous performance specifications. Additionally, providers must meet all Department of Public Health/Bureau of Substance Addiction Services (DPH/BSAS) contractual and regulatory requirements within 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs.*

The performance specifications contained within pertains to a level of care that integrates the following services:

- Acute Treatment Services (ATS) for Substance Use Disorders: American Society of Addiction Medicine Criteria® (ASAM) Medically Monitored Intensive Inpatient Services
- Acute Treatment Services (ATS) for Pregnant Women: ASAM Medically Monitored Intensive Inpatient Services
- Clinical Stabilization Services (CSS) for Substance Use Disorders (American Society of Addiction Medicine Criteria® (ASAM) Clinically Managed High-Intensity Residential Services)

Youth and Transition-Age Youth Withdrawal Management and Stabilization is provided to adolescents ages 12 – 17 and transition-age youth ages 16-20 years of age (Youth and Transition-Age Youth outside of these age parameters may be eligible for admission based on a member's clinical needs and a program's milieu, and with approval from DPH's BSAS) and will provide acute care/stabilization services for male, female, and transgender identified adolescents, including people who are pregnant. Programs shall serve adolescents only and be located separately from any adult treatment services. The program will establish a culture of recovery for the participating adolescent, that is, an environment that reinforces a culture of recovery through staff/peer interactions, role modeling, and involvement in positive, pro-social activities. Providers must demonstrate formal linkage agreements with licensed primary healthcare providers for referrals when needed and community-based agencies for the provision of mental health services for crisis intervention and treatment of co-occurring disorders and aftercare services.

Youth and Transition-Age Youth Withdrawal Management and Stabilization treatment services are limited to adolescents who are not presenting with medical, mental health, or other behavioral-related needs that would warrant placement in a higher level of care (e.g., a potential client who is actively suicidal or homicidal). Eligible youth meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria and appropriate level of care determination according to ASAM criteria.

Acute Treatment Services (ATS) for Substance Use Disorders - component of this service: (ASAM Medically Monitored Intensive Inpatient Services) consists of 24-hour, seven-day-per-week, medically monitored inpatient services that provide medically supervised withdrawal symptom management and/or induction onto maintenance treatment. Withdrawal management services are delivered by nursing and counseling staff, under the direction of a licensed medical provider (Physician, Nurse Practitioner, Physician Assistant) to monitor an individual's withdrawal from alcohol and other drugs and to alleviate symptoms.

Services include implementation of withdrawal management protocols; a multidimensional bio-psychosocial assessment; treatment planning; individual and group counseling; psycho-educational groups; case management; medication monitoring; and discharge planning.

Acute Treatment Services are provided to members experiencing, or at significant risk of developing, an uncomplicated, acute withdrawal syndrome as a result of an alcohol and/or other substance use disorder. members receiving ATS (ASAM Medically Monitored Intensive Inpatient Services) do not require the medical and clinical intensity of hospital-based, medically managed withdrawal management, nor can they be effectively treated in a less-intensive outpatient level of care. Admission to ATS (ASAM Medically Monitored Intensive Inpatient Services) is appropriate for members who meet diagnostic and dimensional admission criteria specified in accordance with the American Society of Addiction Medicine Criteria®.

Providers must facilitate access to treatment for co-occurring psychiatric conditions either directly or through referral for members with co-occurring disorders. Pregnant women receive specialized services within Acute Treatment Services (ATS) for Pregnant Women to ensure substance use disorder treatment and obstetrical care are treated concurrently. ATS services are provided in licensed freestanding or hospital-based programs.

Exclusion criteria must be based on clinical presentation and must not include automatic exclusions based on stable medical conditions, homelessness, medications prescribed including MOUD, compliance with medications, lack of prescription refills, or previous unsuccessful treatment attempts.

Programs will provide ASAM Medically Monitored Intensive Inpatient Services components of services until:

1. Withdrawal signs and symptoms have been sufficiently resolved;
2. The member's symptoms can be safely managed at a less-intensive level of care; or
3. Induction onto FDA-approved medication has been initiated, and the member is stabilized.

Clinical Stabilization Services (CSS) – component of this service: CSS are provided to members whose symptoms of withdrawal do not require the intensity of ATS (ASAM Medically Monitored Intensive Inpatient Services), are largely resolved or minimal, and whose multidimensional needs cannot be managed in a less-intensive level of care.

Providers will provide ASAM Clinically Managed High-Intensity Residential Services – components of services until:

1. Post-acute withdrawal symptoms (PAWS) have been sufficiently resolved;
2. The member's symptoms can be safely managed at a less-intensive level of care; or
3. Induction onto FDA-approved medication has been initiated, and the member is stabilized.

Components of Service

1. At minimum, the provider complies with all provisions of the corresponding General performance specifications and requirements of the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*, including reporting requirements.
2. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year.
    a. A thorough physical examination, which conforms to principles established by the American Society of Addiction Medicine, is completed for all members within 24 hours of admission

   b. A multidimensional biopsychosocial assessment is completed within 48 hours of patient's admission
   c. A substance use assessment employing a validated substance use and co-occurring assessment tool
   d. Nursing assessment and monitoring to achieve and maintain physiological stability, provided in adherence to Commonwealth of Massachusetts Regulations (105 CMR 160.00)
3. 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. The scope of required service components provided in this level of care includes, but is not limited to, the following:
   a. Medical monitoring of AOD Withdrawal Management and of the individual's progress
   b. Medication-assisted Withdrawal Management as per current evidence-based practices or protocols
   c. Induction onto FDA-approved Medications for Addiction Treatment (MAT)/Medication for Opioid Use Disorder (MOUD) as clinically indicated and appropriate with referral for ongoing MAT at discharge
   d. Access to psychiatric crisis evaluation and clinical services based on the biopsychosocial assessment
   e. HIV, Hepatitis C, TB, tobacco use, and other health-related education programs:
      i. HIV and Viral Hepatitis risk assessments are integrated as a part of each member's medical/nursing assessment;
      ii. HIV and Hepatitis C education/risk reduction education is provided for all members; and
      iii. Referral to HIV antibody counseling and testing sites and on-site HIV antibody counseling.
   f. Education about the benefits and risks of medication approved for addiction treatment
   g. Opioid overdose risk and prevention
   h. Access to appropriate laboratory and toxicology tests
   i. Access to routine medications
   j. Counseling and case management which incorporates evidence-based practices, including individual, group, and family (including guardians/caregivers) counseling
   k. Behavioral/health/medication education and planning
   l. Psycho-educational groups
   m. Access to peer support and/or other recovery-oriented services, either directly or through referral
   n. Development and/or updating of crisis prevention plans, or safety plans (inclusive of the youth's family/guardian/caregiver, provided consent was given) as part of Crisis Planning Tools, and/or relapse prevention plans, as applicable
   o. Introduction to self-help groups and the continuum of substance use disorder (SUD) and mental health treatmen;
   p. Direct operational affiliations with other services especially Clinical Stabilization Services, Transitional Support Services, Residential Rehabilitation Services, Opioid Treatment Programs, Office-Based Opioid Treatment, Community Behavioral Health Centers (CBHCs), and psychiatric services
   q. Case management that directly connects (warm handoff) to appropriate providers
   r. Management of mild-to-moderate medical complexities, with updates with primary care providers and specialists (with consent)
   s. Support services and referrals for family members and significant others
4. The provider provides a comprehensive, formal, structured treatment program which incorporates the effects of substance use disorders, mental health disorders, and recovery, including the complications associated with co-occurring disorders, and provides a minimum of

four hours of service programming per day. At least two hours of psycho-educational group time per week is dedicated to the discussion of HIV/AIDS, Hepatitis C, and other health issues.
5. The provider ensures that all members have access to prescribers specializing in addiction medicine and are educated on their options for MAT/MOUD.
6. The provider has the capacity to treat members with alcohol and/or other substance use disorders who are assessed to be at a mild-to-moderate risk of medical complications during withdrawal.
7. The program admits and has the capacity to treat members currently maintained on MAT/MOUD for the treatment of opioid use disorder. Such capacity may take the form of documented, active Affiliation Agreements with providers licensed to provide such treatments.
8. Substance-specific withdrawal management protocols are individualized, documented, and available on-site. At minimum, these include withdrawal management protocols for alcohol, stimulants, opioids, and sedative hypnotics (including benzodiazepines) with capacity to use all FDA-approved medications for the treatment of substance use disorders.
9. With member consent and the establishment of the clinical need for such communication, the provider makes documented attempts to contact the following: the parent/guardian/caregiver, family members, and/or significant others; primary care physician (PCP); other prescribers; and other team members involved in the member's care, within 48 hours of admission, unless clinically or legally contraindicated.
10. The provider (with appropriate consent from the member) provides the above 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/case manager/discharge planner, etc. If contact is not made, the member's health record documents the rationale.
11. 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.
12. Prior to medication prescribing or administration, 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 program. The provider engages in the process of comparing the member's medication orders newly issued by the program prescriber to all of the medications that they have 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 program.
    b. Reviewing Massachusetts Prescription Awareness Tool (MassPAT).
    c. Developing a list of medications to be prescribed in the program.
    d. Comparing the medications on the two lists.
    e. Making clinical decisions based on the comparison and, when indicated, in coordination with the member's primary care clinician (PCC).
    f. Communicating the new list to the member and, with consent, to appropriate caregivers, DMH, BH-CPs, the member's PCC, and other treatment providers.
    g. Documenting all these activities in the member's health record.
13. All urgent consultation services resulting from the intake evaluation and physical exam, or as subsequently identified during the admission, are provided within a timely manner for these services. Non-urgent consultation services related to the assessment and treatment of the member while in the 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 program is brief. All of these services are documented in the member's health record.
14. The milieu does not physically segregate individuals with co-occurring disorders.
15. 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.
16. The provider is responsible for updating its available capacity, once each day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access (MABHA) website (www.MABHAccess.com). The provider is also responsible for keeping all administrative and contact information up to date on the website. The provider is also responsible for training staff on the use of the website to locate other services for members, particularly in planning aftercare services.
17. Co-occurring psychiatric services, medication evaluation and management, and related laboratory services are offered either directly or via referral. Such services are available virtually, or on-site within 24 hours, or referred to an off-site provider within 24 hours, as appropriate to the severity and urgency of the member's mental health condition.
18. The program will ensure that for pregnant members, coordination with OB/GYN, pediatrics, and any other appropriate medical, social services providers, and state agencies will be provided.
19. The program will refer to the appropriate level of substance use disorder treatment and mental health or other primary care as needed.
20. The program will offer developmentally appropriate services provided with competencies in culture, language, gender identity, sexual orientation, and disability.
21. Case management that directly connects (warm handoff) to appropriate providers is provided.
22. Basic medical care, which includes addressing non-SUD illnesses with updates to primary care providers (with consent), is provided.
23. Education on formal and informal support services and referral information for family members and significant others is incorporated into treatment and discharge planning.
24. The provider trains all staff at the site on the use of ASAM Criteria®.
25. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards.
26. Individual and Group Counseling and Family Services:
    a. Youth and family crisis de-escalation and engagement to support recovery
    b. Individual and group services utilizing motivational interviewing, cognitive behavioral therapy, or other evidence-based practice to support the adolescent engaging in treatment
    c. Family meetings and counseling, focused on addiction education, harm reduction, and referrals to community based services, to better support the adolescent in their recovery process
    d. Psycho-educational groups that include HIV, sexually transmitted infections (STIs), and viral hepatitis counseling and testing; risk for overdose; identifying relapse triggers and strategies to cope with them; introduction/overview to 12 Step Supports, Recovery High Schools, and Residential Treatment
27. Milieu management includes, but is not limited to:
    a. An operating seven (7)-day schedule of both mandatory and optional activities including physical recreational activities, in addition to the minimum number of sets of groups, and individual sessions required based on program size.
    b. Maintenance of a treatment environment that ensures client safety, operating in-house crisis intervention/crisis stabilization capabilities, and overall program security.
    c. Required staffing levels to ensure these services are delivered as set forth in the BSAS Youth Detox & Stabilization staffing guidelines.

d. An expectation that the program will provide the adolescents with healthy, nutritious meals and opportunities for both indoor and outdoor scheduled recreation.

Staffing Requirements

1. If program is experiencing a hardship in meeting these specifications, BSAS has a process for waiving regulatory and contractual requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
2. The provider complies with the staffing requirements of the applicable licensing body and the staffing requirements outlined in 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs* and have experience working with adolescents. The program 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. The provider utilizes a multi-disciplinary staff.
3. At a minimum, the program requires the following staffing:
    a. *Medical Director*: Massachusetts licensed physician with expertise in adolescent medicine who is available and responsible for oversight of the administration of all medical services performed within the program and provides on-site monitoring of care and evaluation. In addition, programs must have a licensed psychiatrist or psychologist on staff or available through a Qualified Service Organization Agreement;
    b. *Program Management:* includes 2.0 FTE to oversee administrative and clinical responsibilities at the program:
        i. Dedicated 1.0 FTE to oversee the program, staff and operations (this is considered the Program Director);
        ii. Dedicated 1.0 FTE, who at a minimum meets the qualifications for a Senior Clinician as defined in 105 CMR 164.000 (this is considered the Clinical Director) who provides direct supervision to non-medical clinical staff, including counselors, care coordinators, and recovery specialists. The clinical director reviews and/or participates in treatment planning and follow-up client care services;
        iii. The Program Director and Clinical Director positions may not be combined; and
        iv. Outreach, marketing, and attendance at BSAS required meetings.
    c. *Recovery Specialists, Counselors, and Nurses:* are required on site, seven (7) days a week, 52 weeks a year, with a mix of roles on each shift as specified on the Youth Detox & Stabilization staffing grid. Care coordinators are required on site a minimum of five (5) days per week, Monday-Friday, as specified on the Youth Detox & Stabilization Staffing Grid. Psychiatric consultation is required at all times, 24 hours daily, seven (7) days a week:
        i. *Nurses*: Refer to the Youth Withdrawal Management and Stabilization staffing grid for the number of daily on-site hours required, based on program licensed size. The Nurse is available to conduct nursing and medication assessments for all clients on admission. The Nurse is responsible for overseeing the dispensing of medication, monitoring client health progress, and participates on the interdisciplinary team. The Nurse may also deliver psycho-educational and health education groups. A Licensed Practical Nurse (LPN) may provide these services under the supervision of a Registered Nurse;
        ii. *Counselors*: Refer to the Youth Withdrawal Management and Stabilization staffing grid for the number of daily on site hours required based on program licensed size. The Counselor is an interdisciplinary team member who is responsible for working with assigned clients to develop and facilitate individual treatment plans.

Counselors provide the individual counseling, group psychotherapy, psycho-educational and family groups. The Counselor is a LADC I or II; or at a minimum must have a Master's or Bachelor's degree with specific substance use disorder treatment and youth development training and education;

iii. *Recovery Specialists*: Refer to the Youth Withdrawal Management and Stabilization staffing grid for the number of daily on site hours required per shift based on the program licensed size. The Recovery Specialist is a member of the interdisciplinary team and provides guidance and counseling support as appropriate. Recovery Specialists oversee and accompany the clients in various program activities to ensure conformance with schedules, milieu standards, program activities, and policies. Recovery Specialists may deliver psych-educational groups and can be an LADC II; or at a minimum must have a high school diploma with specific substance use disorder treatment and youth development training and education. Recovery Specialists may not deliver psychotherapy groups or individual counseling unless they have the qualifications defined for Counselor; and

iv. *Care Coordinator/Case Manager*: Refer to the staffing grid for the minimum number of daily Monday-Friday on site hours required based on program license size. The Care Coordinator assumes all case management responsibilities, while immediate clinical and medical needs are addressed by additional members of the treatment team. The Care Coordinator assists clients in obtaining necessary services while in the program and after discharge, by providing information, coordinating referrals, and following through with specified treatment plan goals. The Care Coordinator communicates with the treatment team and family/guardian/caregiver to ensure appropriate referrals to, and successful engagement in next step care.

4. The interdisciplinary team provides daily clinical services to assess and address the needs of each client. This includes overall stabilization, aftercare planning, monitoring medications and medical services, individual counseling and group work, and care coordination. The team provides services that employ evidence-based practices, among them Motivational Interviewing, Motivational Enhancement, and Cognitive Behavioral Therapy. Team members work with the youth to develop individual treatment plans that are realistic and attainable; facilitate engagement in substance use and other indicated treatment services; include family/caregiver, education, and ensure a successful referral to any next-step care. Service plans are developed with each client. This plan must specify goals that are attainable in this program, measurable objectives related to it, and program activities to meet those objectives. Care coordination focuses on successful referrals to care while in the program, and for next-step treatment after discharge. A major focus of care coordination is to facilitate and follow-up on the client's engagement in continuing care, with both the individual and any next step programs or services.
5. All members of the interdisciplinary team must receive supervision from a qualified supervisor at least bi-weekly, individually, or in groups no larger than four persons.
6. Providers agree to provide BSAS with all job descriptions for each position and the supervision arrangements for all administrative and direct service staff.
7. All staff receives education/training (and the opportunity to engage in continuing education) that exceeds the regulations at a minimum on the basics of:
    a. Trauma-informed care;
    b. Motivational Interviewing;
    c. Nonviolent crisis intervention and de-escalation;
    d. Suicide Prevention;
    e. Cultural awareness, including LGBTQIA+-specific training;

   f. Family Systems Theory and substance use disorder and recovery; and
   g. Youth Development
8. There is a Psychiatrist or Psychiatric Nurse Practitioner on staff or available through a qualified service organization agreement for psychiatric evaluation and consultation, as needed to address the needs of members with co-occurring disorders.
9. There is an Obstetrician/Gynecologist on staff or available through a qualified service organization agreement (QSOA) to accommodate pregnant members.
10. All providers must have at least one staff member assuming each of the following roles:
    a. There is an HIV/AIDS Coordinator: responsible for overseeing confidential HIV risk assessment and access to counseling and testing; staff and resident HIV/AIDS and hepatitis education; and Department requirements for admission, service planning, and discharge of HIV-positive members.
    b. There is a Tobacco Education Coordinator: responsible for assisting staff in implementing BSAS guidelines for integration of tobacco assessment, education, and treatment into program services.
    c. There is an Access Coordinator: responsible for development and implementation of the evaluation, plan, and annual review of the site's performance in ensuring equitable access to services.
    d. There is a Culturally and Linguistically Appropriate Services (CLAS) Coordinator: ensures that the service meets the language and cultural needs of the members.
    e. At minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.
11. The provider ensures that members have access to a supportive milieu and nursing staff 24 hours per day, 7 days per week, 365 days per year. members also have access to case management staff 12 hours a day.

Service, Community, and Collateral Linkages

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with all provisions of the 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to community connections and/or collateral linkages.
3. 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.
4. Staff members are familiar with all of the levels of care/services necessary to meet the needs of members being served, and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated. The provider must maintain written Affiliation Agreements with local providers of these levels of care that refer a high volume of members to its program and/or to which the program refers a high volume of members. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
5. With member consent, the provider collaborates with the member's primary care provider and other community providers.
6. When necessary, the provider provides or arranges transportation for services required external to the program 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.

7. Clearly defined and formal linkages with referral sources including BSAS Youth Central Intake and Care Coordination, other adolescent Withdrawal Management and stabilization programs, youth residential programs, other transition-age youth and young adult services, recovery high schools, other behavioral health services including the Children's Behavioral Health Initiative (CBHI) services, the criminal justice system, outreach sites, and other service providers is required. Defined linkages with a range of substance use disorder as well as non-substance use disorder-specific services is required, as they reinforce and support recovery in an integrated and mutual fashion. Increasing service capacity for under-served and priority populations may be broadened through specific, well-developed linkages. Effective wait list management is essential and required for facilitating timely and appropriate admissions, while supporting access for under-served populations.
8. The provider works collaboratively with parent/guardian, LEAs, and involved state agencies, including, but not limited to, DDS, DCF, DYS, and others to coordinate treatment and discharge planning.
9. The provider includes information about community-based services and supports for youth and families, including, but not limited to, PPAL, NAMI, the Federation for Children with Special Needs, The Arc, DDS resources, and local advocacy and support groups in their wellness and recovery information and resources available to members and their families.
10. Strong internal programming and linkages with primary health services including reproductive health, mental health services, HIV testing and counseling, housing services, and educational and vocational services (including job readiness and job search skills) are required. Assisting young people in developing skills and opportunities needed to transition from the youth stabilization program to the next stage in their move towards reintegration with family, reintegration with the community, and independence is essential in the development of an effective treatment plan.

Expected Outcomes and Quality Measurement

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation;
    b. Decrease in readmission to ED and inpatient services;
    c. Increase in referrals and transitions to lower levels of care; and
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
3. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs*.
4. The provider will collect data to measure the quality of their services. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
5. The provider must report any adverse events that occur to the relevant authorities.
6. Providers are expected to work closely with BSAS and to adhere to BSAS regulations to review and assess programmatic outcomes, further refine necessary service elements for Youth Withdrawal Management and Stabilization care, and evaluate how any element affects the quality of the services.

Process Specifications

Assessment, Treatment/Recovery Planning, and Documentation

1. The provider complies with all provisions specified in 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to assessment and recovery planning.
2. The provider has a policy regarding the speed at which they will inform the referral source/individual seeking admission (ideally within the hour after receipt of referral). The provider accepts admissions 24 hours per day, seven days per week, and 365 days per year. Every admission declination must be documented and include reason for declination and referrals provided.
3. A comprehensive nursing assessment is conducted at the time of admission, which includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score and/or a Clinical Opiate Withdrawal Scale (COWS) and CRAFFT Screening Tool. Results are documented in the member's health record.
4. A Registered Nurse (RN) evaluates each member within three hours of admission to assess the medical needs of the member. If an RN is unavailable, this function 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.
5. The provider ensures that a physical examination which conforms to the principles established by ASAM is completed for all members 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.
6. The provider ensures that an individualized treatment plan is completed, as delineated in the General performance specifications and in conjunction with the member. The provider makes best efforts to also involve current community-based providers including primary care clinicians (PCCs) and behavioral health providers, family members, parents/guardians/caregivers, and/or significant others in the treatment planning process.
7. 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 an initial treatment/recovery plan and initial discharge plan 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.
8. The provider must document any missed sessions and attempts to make follow-up contact, the reason(s) given for absence, and if necessary, the staff's rationale for continuation or discontinuation of ATS and CSS components of this level of care.
9. The treatment/recovery and discharge plans are reviewed by the multi-disciplinary 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 and discharge plans, reviews, and updates are documented in the member's health record.
10. The assigned case manager under the supervision of the Clinical Director meets with the member daily for the purposes of case management and discharge planning. All activity is documented in the member's health record.
11. With member consent and the establishment of the clinical need for such communication, coordination with family members/partners/legal guardians, etc., and other treatment providers, including primary care providers 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.
12. For anyone who could become pregnant, a pregnancy test is administered prior to the administration of any medication(s).

13. For anyone who is pregnant, the provider coordinates care with their PCP and OB/GYN and consults with those physicians as needed.
14. The provider arranges appropriate drug screens/tests, urine analysis, toxicology samples, and laboratory work as clinically indicated, and documents these activities in the member's health record.
15. The provider ensures the continuous assessment of the member's mental status throughout the member's treatment episode and documents such in the member's health record.
16. BSAS Standards of Care are required to be followed for the following areas: Co-Occurring Disorders and Trauma-Informed Services.

Referral, Care Coordination, and Follow-up

1. The provider will have a Memorandum of Understanding (MOU) with and referral link to hospitals for medical or psychiatric stabilization needs that require a higher level of care as well as an MOU with the contracting agency operating BSAS Adolescent Central Intake and Care Coordination to refer youth to residential OAD treatment.
2. The provider will have an MOU with recovery high schools to help with coordination of treatment and education of youth at recovery high who may have relapsed and are in need of stabilization support.
3. The provider will coordinate care with community-based service providers upon discharge, e.g., primary care and behavioral health providers, to address both substance use disorder and mental health needs, or other services as determined by the clinical assessment.
4. Discharge Planning will include multiple stakeholders including family/caregivers, other state agency representatives, and community-based providers as appropriate.
5. Referrals to community-based counseling and support services for families will be provided as needed.
6. Transportation services to facilitate transition to other services and attendance at necessary medical and mental health appointments will be arranged.
7. Appropriate linkages and collaborative agreements for prenatal care with ob/gyn providers for adolescents who are pregnant will be made in order to assure the health and safety of the female and her fetus during the detox process.
8. Collaboration with the youth's school district to ensure educational services are provided for any youth admitted for more than 14 days, in accordance with 603 CMR 28.03 (3)(c).

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to discharge planning.
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 they have a copy of it. The provider works with the member, and their family/guardian/caregiver to update the existing plan, or, if one was not available, develops one with the member and them prior to discharge. With member consent and as applicable, the provider may contact the member's local Adult or Youth Mobile Crisis Intervention (AMCI/YMCI) to request assistance with developing or updating the plan. With member consent, the provider sends a copy to the AMCI/YMCI Director at the member's local AMCI/YMCI.
4. The provider engages the member in developing and implementing an aftercare plan when the member meets the discharge criteria established in their treatment/recovery plan. The provider provides the member with a copy of the plan upon their discharge and documents these activities and the plan in the member's health record.
5. Prior to discharge, the provider assists members in obtaining post-discharge appointments, as follows: within seven 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. In the event of a discharge against medical advice (AMA), providers must ensure members are given resources to reconnect with services.
6. 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.

Quality Management (QM)

1. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase in MAT/MOUD induction and continuation
    b. Decrease in readmission to ED and inpatient services
    c. Increase in referrals and transitions to lower levels of care
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions
2. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge.
3. DPH/BSAS Licensing Regulation: The provider will collect data to measure the quality of their services. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
4. The provider must report any adverse events that occur to the relevant authorities.
5. Clinical outcomes data must be made available upon request and must be consistent with performance standards of this service.