TUFTS Health Plan

a Point32Health company

Behavioral Health Community-Based Acute Treatment for Children and Adolescents and Intensive Community-Based Acute Treatment for Children Adolescents Performance Specifications

These performance specifications apply to the following Tufts Health Plan products:

- ☐ Tufts Health Plan Commercial[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

These performance specifications apply to the following Tufts Health Public Plans products:

- ☐ Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plan)
- ☐ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☐ Tufts Health One Care (a dual-eligible product)

Providers contracted for Community-Based Acute Treatment for Children and Adolescents (CBAT) and Intensive Community-Based Acute Treatment for Children and Adolescents (ICBAT) will be expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations and all requirements of these service-specific performance specifications, in addition to the General Behavioral Health Performance Specifications. All Performance Specifications are located in the Provider Resource Center.

DEFINITION

Community-Based Acute Treatment (CBAT) is a 24-hour therapeutically planned group living program that provides individualized therapeutic treatment. CBAT is not equivalent to acute, intermediate, or long-term hospital care, but rather is a less restrictive environment that allows for stabilization as an alternative to inpatient care or to further stabilization and integration following an acute stay. The CBAT program must be both physically and programmatically distinct if it is a part of a larger treatment program.

The CBAT program serves Members who have sufficient potential to respond to active treatment, who need a protected and structured environment, and for whom outpatient or partial hospitalization is not adequate and acute hospital inpatient treatment is not necessary. During treatment, the Member and his or her family members are expected to participate in treatment as appropriate. All children and adolescents enrolled in a CBAT program must have parent or guardian consent. The CBAT program must comply with all requirements relating to restraint and seclusion set forth in 42 CFR 441.151 subpart D and 42 CFR 483 subpart G.

Intensive Community-Based Acute Treatment (ICBAT) is a 24-hour level of care provided in the same setting as the CBAT, to Members who are at a greater level of acuity who require both staffing and therapeutic programming of a higher level of intensity.

COMPONENTS OF SERVICE

1. The facility maintains all required licenses.
2. All Behavioral Health Inpatient Providers must accept for admission or treatment all Members for whom Tufts Health Plan has determined admission or treatment is Medically Necessary, regardless of clinical presentation, as long as a bed is available in an age-appropriate unit.
3. Full therapeutic programming is provided with sufficient professional-staff-to-patient ratio to manage a therapeutic milieu of services seven days per week, including weekends and holidays. The scope of available services includes but is not limited to the provision of:

---

1. Commercial products include HMO, POS, PPO, and CareLink℠ when Tufts Health Plan is the primary administrator.
2. Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

- Psychiatric and medical evaluation
- Pharmacological services
- Individual therapy
- Group therapy
- Family evaluation and therapy
- Psychological testing
- Vocational assessment
- Rehab and recovery resources and counseling
- Substance use evaluation and counseling
- Education
- Behavioral plans

4. The program ensures that therapeutic milieu programming, utilizing professional staff, occurs seven days per week, including weekends and holidays.
5. Members being served have access, on-site or by way of consultation, to all services needed in their primary language. Services are provided in a cultural, linguistic, and ethnically sensitive manner.
6. Whenever possible, all printed material should be available in the Member's primary language.
7. The program has the capacity to provide, at a minimum, the following:
8. Services the program must also make available to Members:
    - Psychological testing, as needed
    - Fire setting and offender evaluation
    - Neurological evaluation
    - Nutritional counseling
    - Educational component, providing accommodations per their Individual Education Pan (IEP)

Note: For Intensive Community-Based Acute Treatment (ICBAT) services, any of the above services will be provided at an intensity and frequency greater than for non-intensive CBAT.

9. Unless clinically contraindicated on the Member's treatment plan, family/guardian or significant others meet jointly with the Member and treatment team at least twice weekly and should be, when possible, based on the schedule of the family.
10. Program ensures availability of a board-certified, child psychiatrist 24 hours/day.
11. Psychiatrist must be available for: a) phone consultation within 15 minutes of request, 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.
12. The attending physician must meet with the Member within 24 hours of admission and at least one to two times per week as dictated by the individual treatment plan. The physician documents 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 his or her stead. The attending physician, as much as possible, designates a consistent substitute to ensure that the Member receives as much continuity in psychiatric care as possible.

Intensive Community-Based Acute Treatment Services: The attending physician must meet with the Member upon admission and daily. A Clinical Nurse Specialist or an alternate psychiatrist may carry out these functions for the Member in his/her stead. The attending physician, as much as possible, designates a consistent substitute to ensure that the Member receives as much continuity in psychiatric care as possible.

a) A master's-level, child-trained, CANS-certified clinician conducts a psychosocial evaluation within 24 hours of admission, including an initial screen for potential substance abuse issues/concerns.
b) A Behavioral Health Multidisciplinary Team is assigned to each Member within 24 hours of admission.
c) The Behavioral Health Multidisciplinary Team meets, completes, and to the maximum extent practicable, reviews the Member's treatment plan within 24 hours of admission, modifies the treatment plans as needed and, during the Member's stay, periodically meets to review and modify the treatment plan.
d) 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.
e) The program ensures Members have free access to private, outside communication, including phone and stamps, free of charge.
f) The facility must promote continuity of care for Members who are readmitted to Behavioral Health Inpatient and 24-Hour Diversionary Services by offering them readmission to the same Provider when there is a bed available in that facility.

g) The facility must coordinate with contracted ESPs in the Service Area(s), including procedures to credential and grant admitting privileges to ESP psychiatrists.
h) The facility must convene regular meetings and conduct ad hoc communication on clinical and administrative issues with ESPs to enhance the continuity of care for Members.

Restraint and Seclusion:

1. 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.
2. When a program utilizes restraint and seclusion techniques they must be documented appropriately and provide accurate and timely reporting to all applicable licensing authority, for each occurrence, in accordance with applicable regulations.

STAFFING REQUIREMENTS

1. The program maintains all required licenses and accreditations and will immediately notify Tufts Health Public Plans of the revocation, limitation, or suspension or other conditions placed on the license or certification/accreditation.
2. The program maintains appropriate staff-to-patient ratio 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.
3. The facility shall utilize a multidisciplinary staff with skills training and/or expertise in the integrated treatment of children and youth.
4. The facility ensures that all clinical work is subject to regularly scheduled and ongoing supervision by, at minimum, a master's-level independently licensed clinician who has, at minimum, three years of direct experience in the treatment of the target population. Supervisors shall maintain notes of supervision.
5. The program provides staffing 365 days a year, seven days per week, 24 hours a day, including awake, supportive, overnight staff.
6. The program shall utilize 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.
7. The multi-disciplinary staff shall, at a minimum, consist of:
    - Nursing staff
    - Social workers or other master's-level clinicians
    - Counseling staff
    - Physician coverage
    - Psychiatry
    - Clinical assistants
8. The facility must have a human rights and restraint and seclusion protocols that are consistent with the DMH regulations and include training of the provider's staff and education for Members regarding human rights.
9. The facility must have a human rights officer, who shall be overseen by a human rights committee, and who shall provide written materials to Members regarding their human rights, in accordance with applicable DMH regulations and requirements.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES

1. Facility staff coordinates treatment planning and aftercare with the Member's primary care clinician, outpatient, and other community-based providers, involved state agencies, educational systems, community supports and family, guardian, and/or significant others when applicable. If consent for such coordination is withheld or refused by the parent or guardian of a minor, then this is documented in the Member's record.
2. The facility must coordinate treatment and discharge planning with the state agencies (e.g., DCF, DMH, DYS, DDS) with which the Member has an affiliation.
3. The facility notifies the appropriate DMH regional office of every Member followed by that office who is admitted to the unit.
4. The facility ensures that a written aftercare plan is available to the Member/Member's guardian at the day of discharge. When consent is given, a copy of the written aftercare plan is forwarded at the time of discharge to the referral source, family/guardian/significant other, applicable state agency, outpatient or community-based provider, PCP, school, and other entities and agencies that are significant to the Member's aftercare.

In the case of children or youth involved with CBHI services, the facility social worker or other clinician will collaborate with those providers, including but not limited to Community Service Agencies (CSA). The facility will accommodate requests from a CSA to facilitate or attend a team meeting while the Member is at the facility.

5. The program/provider will develop organizational and clinical linkages with each of the high-volume referral source ESPs, hold regular meetings, and communicate with the ESPs on clinical and administrative issues, as needed, to enhance continuity of care for Members.
6. The program/provider will use best efforts to develop linkages and policies that promote communication and coordination of care with PCPs and will coordinate and facilitate PCP referrals for Members who present with no known PCP.
7. The program maintains a list of advocacy organizations, such as the ones listed on the provider resource page at tuftshealthplan.com.
8. Relationships will be established with a local Educational Advocate to assist with school planning as needed.

QUALITY MANAGEMENT (QM)

1. The facility will develop and maintain a quality management plan that is consistent with that of Tufts Health Public Plans, and which utilizes appropriate measures to monitor, measure and improve the activities and services it provides.
2. A continuous quality improvement process is utilized, 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 to Tufts Health Public Plans upon request and must be consistent with Tufts Health Public Plans' performance standard for acute inpatient services.

All Reportable Adverse Incidents will be reported to Tufts Health Public Plans within one business day of their occurrence per Tufts Health Public Plans 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 an Member, who is receiving services managed by Tufts Health Public Plans or has recently been discharged from services managed by Tufts Health Public Plans.

PROCESS SPECIFICATIONS

Treatment Planning and Documentation

1. A facility-based case manager is identified and assigned upon admission. This staff member shall be involved in the establishment and implementation of treatment and discharge planning.
2. The provider will ensure that an individualized written assessment is completed for any Member entering treatment. The written assessment will be utilized to develop the treatment plan.
3. The provider will ensure that assessments are conducted and include, but are not limited to, review and assessment of:
    - History of presenting problems
    - Chief complaints and symptoms
    - Past BH/SA history
    - Past medical history
    - Family, social history, and linguistic and cultural background
    - For children in the care and/or custody of the Commonwealth, history of placements outside the home
    - Current substance abuse
    - Mental status exam
    - Previous medication trials, current medications, and any allergies
    - Diagnosis and clinical formulation
    - Level of functioning
    - The individual's strengths and, for children and adolescents, family strengths
    - Name of PC
    - Individualized Education Plan (IEP)
4. Ensure that Behavioral Health Clinical Assessments conducted by Behavioral Health Providers are in writing, dated and signed, and include, at a minimum, the following:
    - Clinical formulation, rationale for admission or continuance of care, discussion of any possible diversionary or lower levels of care, recommendations, and strengths.
5. The program's treatment team (or on weekends, a member of the treatment team) establishes a provisional treatment and discharge plan within 24 hours of the Member's admission.

6. The facility makes every effort to ensure the Member/family/guardian is invited to participate in treatment planning, or documentation is provided explaining why the individual would not participate in treatment planning. When the court appoints a guardian, the facility additionally involves the guardian in treatment planning and other decision making. Subsequent treatment plans show significant Member/family involvement, unless clinically or legally contraindicated. The Member/guardian signs the plan and copies are made available upon request.
7. Clinical family treatment meetings are held at a minimum of once a week for CBAT and twice a week for ICBAT. If a family is unable to travel to the facility, telephonic meetings will be held.
8. Tufts Health Public Plans clinicians may attend treatment team meetings regarding Members.
9. The treatment plan shall include at least:
    a) Identification of the new acute clinical services, as well as supports, covered services and the continuing care with any established providers, and the identification of any new providers and the covered services that will be added.
    b) Identification of the Member's state agency affiliation, release of information, and coordination with any state agency case worker assigned to the Member.
    c) Identification of non-clinical supports and the role they serve in the Member's treatment and aftercare plans.
    d) Scheduling of discharge/aftercare appointments in accordance with the access and availability standards set forth in Section 2.9.B.2.e.
    e) Recommendation for the initial frequency of aftercare services and supports
    f) Identification of barriers to aftercare, and the strategies developed to address such barriers

Procedures to monitor for the earliest identification of the next available aftercare resource required for the Member who has remained in the Behavioral Health Inpatient and 24-Hour Diversionary setting for non-medical reasons (e.g., the recommended aftercare resources were not yet available).

Discharge Planning and Documentation

1. A Discharge Plan is initiated within 24 hours of admission.
2. Providers involve Members' family members, their guardians, outpatient individual practitioners, state agency staff, as appropriate and if applicable, and other identified supports to participate in Discharge Planning to the maximum extent practicable, including behavioral health treatment team meetings, developing the discharge plan, when appropriate.
3. 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.
4. The facility must ensure that services contained in the Member's Discharge Plan are offered and available to Members within seven business days of discharge.
5. The facility must ensure that Members who require medication monitoring will have access to such services within 14 business days of discharge.
6. Components of Discharge Planning incorporate Member's identified concerns, including but not limited to; housing, finances, health care, transportation, familial, occupational, educational, and social supports. The treatment team staff member who is responsible for implementing a Member's Discharge Plan documents in the medical record all of the discharge-related activities that have occurred while the Member is in the facility, and this reflects Member participation in its development. The completed Discharge Form, including referral to any agency, is available 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.
7. A written Discharge Plan must be provided to other providers working with the Member, including the PCP.
8. The facility must develop, in collaboration with the Member, an individualized Discharge Plan for the next service or program anticipating the Member's movement along a continuum of services.
9. The Facility must ensure that the treatment and Discharge Plan for Members who are state agency clients is coordinated with appropriate state agency staff.
10. The Facility must make best efforts to ensure a smooth transition to the next service or to the community.
11. The Facility must document all efforts related to these activities, including the Member's active participation in Discharge Planning.
12. Prior to discharge, a CANS is completed by a certified CANS assessor.

DOCUMENT HISTORY

- January 2024: Tufts Health One Care (a dual-eligible product) name change.
- July 2020: Template Updates