Enhanced Acute Treatment Services (E-ATS) ASAM Level 3.7
Performance Specifications

Providers contracted for this level of care are expected to comply with all requirements of this service-specific performance specifications. Providers contracted for this service and all contracted services are held accountable to the General performance specifications. The requirements within this service-specific performance specification take precedence over general performance specifications.

Enhanced Acute Treatment Services (E-ATS) provides services consisting of 24/7, medically monitored evaluation, care, and treatment services in a licensed acute care setting for members with co-occurring substance use and mental health diagnosis. The approach is highly structured to meet these challenges and to work with the Member to manage behavior and treat, simultaneously, mental health and substance use issues. Withdrawal management services are delivered by nursing and counseling staff, under the consultation of a licensed physician, to monitor an individual's withdrawal from alcohol and/or other drugs and to alleviate symptoms. Services include bio- psychosocial evaluation; individual and group counseling; psycho-educational groups; and discharge planning. In addition to 24/7 nursing care and observation, the team includes staff trained in addiction treatment and recovery principles who provide daily counseling and support.

Members who are appropriate for E-ATS level of care (LOC) are experiencing, or at high/or significant risk for withdrawal syndrome. These Members require 24-hour medically monitored nursing care and observation and cannot be effectively treated in a less intensive, non-medically resourced LOC but these Members do not require the medical and clinical intensity of a hospital based acute detoxification unit or the full resources of a general hospital, life-support equipment or psychiatric services. Referrals for E- ATS can originate from self-referral, physicians, Commonwealth Care Alliance (CCA) clinical staff, emergency rooms, state agencies or other ancillary providers.

Individuals may be admitted to an E-ATS program directly from the community, including referrals from Adult Mobile Crisis Intervention providers, or from an emergency department. Providers of this level of care are expected to accept and treat members to the unit 24 hours per day, 7 days per week.

COMPONENTS OF SERVICE:

Include the following:

- The facility notifies CCA BH UM within 48 hours of an admission by contacting **CCA' Provider Services line @ 866-420-9322.**

- The provider will maintain evidence-based and best practice addictions treatment in conjunction with the American Society of Addiction Medicine (ASAM) Criteria.
- Full therapeutic programming is provided with sufficient professional staff to manage a therapeutic milieu of services 24/7/365 including weekends and holidays. The scope of available services includes, but is not limited to:
    - Biopsychosocial evaluation
    - Medical history and physical examination
    - Pharmacological evaluation and treatment services
    - Initial substance use disorder assessment.
    - Initial nursing assessment
    - Detoxification
    - 24-hour nursing care
    - Psychosocial education, including SUD relapse prevention and communicable diseases
    - Development of behavioral/ treatment and recovery plan
    - Development and/or updating of crisis prevention plans, and/or safety plans
    - Psychiatric evaluation and treatment
    - Rehab and recovery resources and counseling
    - Discharge planning/case management
    - Aftercare and discharge planning
- The facility is expected to provide a comprehensive, formal structured treatment program which, at a minimum of four hours of service programming per day. The programming incorporates the effects of substance use disorders, mental health disorders and recovery, including the complications associated with dual recovery.
- The program admits and has the capacity to treat Members with alcohol and/or other drug dependencies who are assessed to be at mild to moderate risk of medical complications during withdrawal and who also have a co-occurring mental health disorder.
- The program admits and has the capacity be able 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.
- 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).
- With consent, the provider makes documented attempts to contact the parent/guardian/caregiver, family members, and /or other significant others within 48 hours of admission, unless clinically or legally contra indicated. The program providers them with all relevant information to maintaining contact with the program and the Member, included the names and phone numbers of key nursing staff, primary treatment staff, social worker/case manager/discharge planner, etc. If contact is not made, this is documented in Member's medical record.
- 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 including a reconciliation process to avoid inconsistencies in medication prescribing that may occur in transition of a Member from one care setting to another.

- Medication reconciliation includes reviewing the Member's complete medication regiment 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 including:
    - Developing a list of current medications, i.e., those the Member was prescribed prior to admission to the E-ATS program. Providers are encouraged to utilize MassPAT prescription monitoring program to support the medication reconciliation process.
    - Developing a list of medications to be prescribed in the E-ATS program.
    - Comparing the medications on the two lists
    - Making clinical decisions based on the comparison and, when indicated, in coordination with the Member's primary care provider (PCP)
    - Communicating the new list to the Member and, with consent, to appropriate caregivers, the Member's PCP, and other treatment providers.
- 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.
- The program does not physically segregate individuals with co-occurring disorders.
- The program providers a E-ATS handbook 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, peer and recovery orientated services.
- The program is responsible for updating its availability capacity per MassHealth guidelines on the Massachusetts Behavioral Health Access website (www.MABHAacces.com).

STAFFING REQUIREMENTS:

- The provider complies with the staffing requirements of the applicable licensing body. Programs should refer to staffing requirements documented in 105 CMR 164: Licensure of Substance Use Treatment programs.
- The provider is staffed with sufficient appropriate personnel to accept admissions 24/7, 365 days per year, and to conduct discharges 7 days per week, 365 days per year.
- 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 and/or dependence as well as co-occurring psychiatric disorders:
    - A licensed, master's-level clinician responsible for clinical supervision; master's level clinician responsible for assessment and treatment services.
    - Physician and psychiatry staff, as outlined below.
    - Registered nurse (RN), nurse practitioner, or physician assistant; and
    - Licensed practical nurse (LPN), case aides, and case management staff.
- Members have access to supportive milieu staff, as needed, 24/7, 365 days per year.
- 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 diagnosis, 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.

- A physician (MD) is on call 24/7, in order to respond to medical emergencies, and is available for a phone consultation within 60 minutes of request.
- The provider has adequate psychiatric coverage to ensure all performance specifications related to psychiatry are met.
- An attending licensed psychiatrist who meets credentialing criteria, or one for whom the provider request 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 this performance specification. 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 this performance specification.
- 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.
- For programs that utilize a psychiatry fellow/trainee to perform psychiatry functions, all of the following apply:
    - The psychiatry fellow/trainee must be provided sufficient supervision from psychiatrists to enable them to establish working relationships that foster identification in the role of a psychiatrist.
    - The psychiatry fellow/trainee must have at least two (2) hours of individual supervision weekly, in addition to teaching conferences and rounds.
    - 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
    - The program must use the following classification of supervision:
        - Direct supervision – the supervising physician is physically present with the

fellow and Member.

- 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 telephone and/or electronic modalities and is available to provide direct supervision.
- Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

- For programs that utilize a PNMHCS to perform psychiatry functions, all of the following apply:
  - 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 medical director or another attending psychiatrist, will be responsible for this documentation.
  - The supervision/consultation between PNMHCS and the Medical Director, or another attending psychiatrist, is documented and occurs at least one 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.
  - 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,
  - 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 PNMMHCS is not the attending for any Member.
  - If a PNMHCS conducts the initial face-to-face psychiatric evaluation of a Member, they present the Member to the attending psychiatrist, or other psychiatrist on duty, within 24 hours, and document all such activity.
  - There is documented active collaboration between the medical director, or another attending psychiatrist, and the PNMHCS relative to the Members' medication regimens, especially those for whom a change in their regimen is being considered.
- 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.
- 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.
- The provider documents regularly scheduled, in-service training sessions for all staff on the following topics, at a minimum:

- The program's All Hazards Emergency Response Plan.
- HIV/AIDS, sexually transmitted diseases (STDs) and Viral Hepatitis.
- Universal health precautions and infection control.
- Substance uses including tobacco and nicotine addiction, clinical assessment and diagnosis, treatment planning, relapse prevention and aftercare planning.
- The stages of change.
- Motivational Interviewing.
- Co-occurring disorders, including mental health disorders, gambling, and other addictive behaviors.
- Other topics specific to the requirements of the level of care and/or the population served
- Effects of substance uses on the family, family systems, and related topics such as the role of the family in treatment and recovery; and
- Cultural competency including culturally and linguistically appropriate services (CLAS) or standards

ASSESSMENT, TREATMENT, RECOVERY PLANNING AND DOCUMENTATION:

- The provider accepts admissions 24/7, 365 days per year within 30 minutes of the request for admission.
- At the time of admission, a comprehensive nursing assessment is conducted, which includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score.
- Within three hours of admission, a registered nurse (RN) evaluated each Member to assess their medical needs. When the RN is not scheduled to work or is out of any reason (i.e., vacation, illness), they designate a consistent substitute, as much as possible, to ensure that the Member receives continuity of care. In these instances, this function(s) may be designated to a licensed practical nurse (LPN) acting under RN's or physician's Member-specific supervision. All activities are documented in the Member's medical record.
- The provider assigns a multi-disciplinary treatment team to each Member within 24 hours of admission.
- For direct admissions from the community, the program ensures that a comprehensive medical history and physical examination which confirms to the principles established by the American Society of Addiction Medicine (ASAM), 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. The examination included the following:
    - Assessment of Member's substance use disorder
    - Tests for the presence of opiates, alcohol, benzodiazepines, cocaine, and other drugs of addiction
    - A brief mental status exam
    - An assessment of medical issues
- 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 psychiatrist evaluation of the Member is completed within 48 hours of admission by a psychiatrist, or by a PNMHCS or psychiatry fellow/trainee under the supervision of the medical director or another attending psychiatrist.

- For all women of childbearing age, a pregnancy test is administered, prior to the administration of any medication(s).
- All medical orders are signed by the medical director or a designated licensed physician.
- An initial assessment of each Member is conducted by a senior clinician, physician, nurse practitioner, or physician assistant (PA) within 24 hours admission that included the following:
    - 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
    - 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
    - An assessment of the Member's HIV risk status and TB risk status.
    - 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.
    - The initial assessment concludes with a diagnosis of the status and nature of the Member's substance use, or a mental health disorder due to use of psychoactive substances. A counselor/clinician meets with the Member for the purposes of assessment, counseling, treatment, case management, and discharge planning.
- A clinician meets with the Member for the process of assessment, counseling, treatment, case management and discharge planning.
- The provider assigns a multidisciplinary treatment team to each Member within 24 hours of admission. The multidisciplinary 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.
- The provider completes a comprehensive and individualized treatment/recovery plan within 48 hours based on assessment and developed in conjunction with the Member and, with consent, family, guardian, and/or individual natural supports, current community-based providers, including PCP and behavioral health providers and supports identified by the Member. The treatment plan is signed, dated and in Member's medical record.
- The treatment/recovery plan, at a minimum, includes the following:
    - A statement of the Member's strengths, needs, abilities, and preferences in relation to their substance use treatment, described in behavioral terms.
    - 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
    - Service to be provided.
    - Service goals, described in behavioral terms, with timelines.
    - Clearly defined staff and Member responsibilities and assignments for implementing the plan.

    - Description of discharge plans and aftercare service needs.
    - Aftercare goals
    - The date the plan was developed and revise.
    - Signatures of staff involved in the formulation or review of the plan.
    - Documentation of disability, if any, which requires a modification of policies, practices, or procedures and record of any modifications made.
- The treatment/recovery and discharge plans are review by the multidisciplinary treatment team with each Member at least every 48 hours (a maximum of 72 hours between reviews on weekends), and are updated accordingly, based on each Member's individual progress. All assessments, treatment/recover and discharge plans, reviews and updates are documented in the Member's medical record. All reviews and updated include signatures of the Member and the staff reviewing them.
- 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 psychiatrist and/or a PNMHCS may also be available to consult with other members of the treatment team.
- With the consent of the Member, the provider ensures that a treatment/recovery plan is completed and makes best efforts to involve current community-based providers including PCP's, Peer Recovery coaches, involved state agencies, behavioral health providers, family members, parents/guardians/caregivers, and/or significant others in the treatment planning process. Consent or refusal to include the above mentioned is documented in the Members medical record.
- The program request drug-screening services and other laboratory services when medically necessary as part of a diagnostic assessment or component of an individualized treatment/recovery plan includes other clinical interventions. All requests are made in writing by and authorized prescriber (i.e., physician, physician assistant, nurse practitioner, etc.). The prescriber documents in the Member's medical record necessity for the drug screen and test results.
- For pregnant women, the provider coordinates care with their PCP and OB/GYN, and consults with those physicians as needed.
- 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 medical record.
- The provider will reach out the Member's CCA Clinical Team via CCA's Provider Line (@ 866-420- 9332) to obtain appropriate collateral information and to inform CCA's Clinical Team of the treatment plan as well as aftercare plan. CCA's Clinical Team can support continuity of care upon discharge including support with transportation authorizations.

DISCHARGE PLANNING

- The provider conducts discharges 7 days per week, 365 days per year.
- At the time of discharge, and as clinically indicated, the provider ensures that the Member has a current crisis prevention, safety plan or relapse prevention plan in place that has been reviewed with the Member. For One Care and SCO Products and with Member consent, the provider will

work with the local Adult Mobile Crisis Intervention (AMCI) to collaborate on including the Members Crisis plan into the AMCI EHR if the Member is at high risk for self-harm.

- Prior to discharge, the provider assists Members in obtaining post- discharge appointments including:
    - An appointment within seven **(7)** calendar days of discharge for outpatient therapy services (which may be an intake appointment for therapy services)
    - An appointment within fourteen (**14)** calendar days of discharge for medication monitoring, if necessary
    - All discharge planning activities are documented in the Member's health record and clearly written on the discharge plan and reviewed with the Member prior to discharge.
    - The **Provider notifies CCA BH Transitions of Care team to alert CCA of Members discharge date and discharge plan. CCA can be contacted at 866-420-9332**. **The Member's discharge plan will be faxed to CCA BH UM department at 855-341-0720.**
    - If there are barriers to accessing covered services, the provider **notifies CCA' s Behavioral Health Transitions of Care team by calling CCA' s Provider Line at 866-420-9332**
    - If there are barriers to accessing covered services, the provider **notifies CCA' s Behavioral Health Transitions of Care team by calling CCA' s Provider Line at 866-420-9332**
- 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 their written aftercare plan upon their discharge and documents these activities in the in the Member's medical record. 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, outpatient or community- based provider, PCP, school, state agencies that are significant to the member's aftercare.

COMMUNITY AND COLLATERAL LINKAGES:

- 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.
- The provider is responsible for developing and maintaining an active collaborative relationship with each of the local AMCIs. 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 MCI.
- The provider maintains active collaborative relationships with step-down programs for adults 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.
- With Member consent, the provider collaborates with the Member's PCP as best practice for integrated care.
- When necessary, the provider provides or arranges for transportation for services required

external to the facility during the admission and upon discharge for placement to 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, including public transportation or utilizing CCA transportation benefit.

EXPECTED OUTCOMES AND QUALITY MANAGEMENT:

- The facility and/or program will develop and maintain a quality management plan which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
- The facility utilizes a continuous quality improvement process and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to members, including their families.
- The success of the program and the care and well-being of the members relies on a collaborative partnership with Commonwealth Care Alliance and its provider network.
- Providers are required to collect and measure outcome data and incorporate the data in treatment plans in the medical records.
- Clinical outcomes data must be made available to Commonwealth Care Alliance (CCA) upon request and must be consistent with CCA's performance standard for E-ATS level of care.
- Providers will comply with all applicable laws and regulations including but not limited to any and all applicable Medicare and/or Medicaid laws, regulations, and instructions of CMS and/or EOHHS relating to addressing and reporting Serious Reportable Events (SREs) and Adverse Incidents.
- Reportable adverse incidents must be reported to CCA and MassHealth Office of Behavioral Health within one business day as per policy and DMH licensing requirements. Providers must follow all laws and regulations for reporting Adverse Incidents (per MassHealth per MassHealth All Provider Bulletin 316).
- Network providers will comply with all requirements contained in their contract with CCA including any corrective actions required by CCA or applicable regulatory agencies.

DOCUMENT UPDATES:

- December 2024: Revised template