TUFTS Health Plan

a Point32Health company

Enhanced Acute Treatment Services (ATS) 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 this level of care or service will be expected to comply with all applicable regulations set forth in the Code of Massachusetts Regulations and 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

Enhanced acute treatment service is a 24-hour therapeutically planned group living program serving Members with co-occurring psychiatric and substance use disorders (SUD) who are motivated and have sufficient potential to respond to active treatment. The approach is highly structured to meet these challenges and to work with the Member to manage their behavior and distress, and treat, simultaneously, mental health and substance use issues. Included with these services, the program also provides individualized therapeutic treatment.

The Member is assessed as not being at risk for severe withdrawal, and is in need of psychiatric services (e.g., Member may have suicidal ideation [without plan or intent] secondary to their substance use at the time of admission). Enhanced acute treatment services are centered on a clinical approach, which seeks to stabilize behavior shortly after a crisis or may be used as a step-down service from a more intensive level of care.

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

Enhanced acute treatment services may be provided to adolescent and adult Members.

COMPONENTS OF SERVICE

1. The facility maintains all required licenses.
2. All behavioral health enhanced acute treatment service providers must accept for admission or treatment all Members for whom Tufts Health Plan has determined admission or treatment is Medically Necessary, as long as the Member is assessed as not being at risk for severe withdrawal, has suicidal ideation without plan or intent, and a bed is available in an age-appropriate unit.
3. Full therapeutic programming is provided with sufficient professional staff 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:
4. 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
5. Scope of services includes, but is not limited to:
    - Psychiatric and medical evaluation

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[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.

- Medical monitoring of mild withdrawal symptoms
- Pharmacological services
- Individual therapy
- Group therapy
- Family evaluation and therapy (as needed)
- Vocational assessment
- Rehab recovery counseling
- Substance abuse assessment, evaluation, and treatment planning
- Behavior plans
- Discharge planning
- Ability to provide limited 1:1 specialing

6. The program admits Members 24 hours per day, 7 days per week, 365 days per year.
7. A behavioral health multidisciplinary team is assigned to each Member within 24 hours of admission.
8. 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.
9. A comprehensive, formal structured treatment program is in operation, and which, at a minimum, includes 3 hours or more of psychoeducational groups/day. Additional psychoeducational groups are conducted on health-related issues, at least one hour per week of which will be devoted to HIV/hepatitis risk and the AIDS virus.
10. The facility attempts to contact family members, guardian and/or significant others within 24 hours of admission, unless clinically or legally contraindicated, providing them with all relevant information for maintaining contact with the program.
11. A psychiatrist evaluates each Member on the day of admission to assess the medical, psychiatric, substance abuse, pharmacological and treatment needs of the Member and meets face to face at least 3 times per week thereafter. 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.
12. Facility must coordinate with contracted ESPs in the service area(s), including procedures to credential and grant admitting privileges to ESP psychiatrists.
13. Member's agreement/disagreement with the treatment/discharge plans should be documented in the Member's record.
14. All medically necessary consultation services are provided within 24 hours of the order for these services.
15. Unless clinically contraindicated by the treatment team and when consent is given, the facility schedules family meetings, conferences or joint treatment sessions with the guardian, family members, caretakers and/or significant others of the Member at least twice per week or to the maximum extent the family participation is possible.
16. 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.

STAFFING REQUIREMENTS

1. The facility will maintain appropriate staff to patient ratio to safely care for Members 24 hours per day, 7 days per week, 365 days per year.
2. The facility shall utilize a multidisciplinary staff with skills training and/or expertise in the integrated treatment of sub-acute, bio-medical, and related emotional/behavioral problems with a 24-hour facility.
3. The multidisciplinary staff shall, at a minimum, consist of:
    - Nursing staff
    - Counseling staff
    - Medical physician
    - Psychiatrist
    - Clinical assistant
4. The medical director (or their designee) will provide onsite psychopharmacological services.
5. All counseling staff will be cross trained in the treatment of mental health and addictions counseling and will be a combination of those with certifications in alcohol counseling, alcohol and drug addictions counseling, clinical master's degrees and milieu counselors.
6. The facility ensures that all clinical work is subject to regularly scheduled and ongoing supervision by, at minimum, an independently licensed clinician who has, at minimum, three years of direct experience in the treatment of the dual diagnoses. Supervisors must maintain supervision notes.

7. Facility is responsible for providing staffing and supervision in accordance with Tufts Health Plan's behavioral health general performance specifications, and Department of Public Health (DPH) and Bureau of Substance Addiction Services (BSAS) licensing requirements.
8. Facility must have 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. 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 provider (PCP), outpatient and other community-based providers, involved state agencies, educational system, 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. Facility must coordinate treatment and discharge planning with the state agencies (e.g., Department of Children and Families [DCF], DMH, Department of Youth Services [DYS], Department of Disability Services [DDS]) with which the Member has an affiliation.
3. The facility ensures that a written aftercare plan is available to the Member on 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, appropriate state agency, outpatient or community-based provider, PCP, school, and other entities and agencies that are significant to the Member's aftercare.
4. The program shall maintain formal, active affiliation agreements for service linkages with the following levels of care, and must be able to take referrals from and refer to these levels of care when appropriate:
    - Emergency service programs
    - Psychiatric inpatient facilities
    - Level IV medically managed detoxification
    - Outpatient programs specific to the treatment of dual disorders
    - Structured outpatient addictions programs
    - Substance abuse halfway housing and long-term residential programs
    - Chronic and transitional care facilities
5. The program will admit and have the capacity to treat Members who are on methadone or other opioid replacement therapy. Therefore, all programs will either have onsite replacement capacity or have active affiliation agreements with opioid replacement therapy programs for administration both during the Member's stay at the facility and for timely referrals to aftercare when clinically indicated.
6. When necessary, the facility provides or arranges transportation for placement into the next designated level of care with Tufts Health Public Plan's continuum of care or other appropriate aftercare.

QUALITY MEASUREMENT (QM)

1. The facility will develop and maintain a quality management plan that is consistent with that of Tufts Health Plan, 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 Plan upon request and must be consistent with Tufts Health Public Plan's performance standard for Enhanced Acute Treatment Services.
4. All Reportable Adverse Incidents will be reported to Tufts Health Plan within one business day of their occurrence, per Tufts Health Plan 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 managed by Tufts Health Plan or has recently been discharged from services managed by Tufts Health Plan.
5. The facility/program will adhere to all reporting requirements of DPH and/or DMH regarding Reportable Adverse Incidents and all related matters.

PROCESS SPECIFICATIONS

Treatment Planning, Discharge Planning and Documentation

Treatment and discharge planning shall include at least:

1. 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.

2. Identification and assignment of a facility-based case manager for the Member. This staff member shall be involved in the establishment and implementation of treatment and discharge planning.
3. The Member is invited to participate in treatment planning or documentation is provided explaining why the Member would not participate in treatment planning.
4. Subsequent treatment plans show significant Member/family involvement, unless clinically or legally contraindicated. A staff member records the Member's understanding of the goals of the treatment and discharge plan in the Member's own words. The plan is signed by the Member/guardian.
5. Identification of the new acute clinical services, as well as supports, covered services continuing care with any established providers, the identification of any new providers and the covered services that will be added.
6. Identification of the Member's state agency affiliation, release of information and coordination with any state agency case worker assigned to the Member
7. Identification of non-clinical supports and the role they serve in the Member's treatment and aftercare plans
8. Scheduling of discharge/aftercare appointments in accordance with the access and availability standards
9. Recommendation for the initial frequency of aftercare services and supports
10. Identification of barriers to aftercare and the strategies developed to address such barriers
11. 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)
12. Assurance that inpatient and 24-hour diversionary providers provide a discharge plan following any behavioral health admission to other providers working with the Member and PCP
13. Ensure that providers invite 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, and for adult Members, only when the Member has consented to their involvement.
14. Ensure that services contained in the Member's discharge plan are offered and available to Members within seven business days of discharge from an inpatient setting.
15. Ensure that Members who require medication monitoring will have access to such services within 14 business days of discharge from a behavioral health inpatient setting;
16. In collaboration with the Member, develop an individualized discharge plan for the next service or program anticipating the Member's movement along a continuum of services.
17. Ensure that the treatment and discharge plan for Members who are state agency clients is coordinated with appropriate state agency staff.
18. Make best efforts to ensure a smooth transition to the next service or to the community
19. Document all efforts related to these activities, including the Member's active participation in discharge planning.
20. 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.
21. 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.
22. 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/or emergency/crises information.
23. 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.
24. For those Members discharged on medications, at least one psychiatric medication monitoring appointment is scheduled no more than 14 days after discharge.

DOCUMENT HISTORY

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