# COMMUNITY-BASED ACUTE TREATMENT (CBAT)

## PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are 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, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General Performance Specifications, the service-specific specifications take precedence.

## OVERVIEW

**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 an Enrollee'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 Enrollee'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 Enrollees to the unit 24 hours per day, 7 days per week, and 365 days per year.

## SERVICE COMPONENTS

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 Enrollees admitted to the program have individualized treatment plans.
4. Enrollees 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 Enrollee'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 Enrollee's treatment plan, family/guardian or significant others meet jointly with the Enrollee 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 an Enrollee's behavior.
9. The attending physician must meet with the Enrollee 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 Enrollee in the attending physician's stead. The attending physician, whenever possible, designates a consistent substitute to ensure that the Enrollee 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 Enrollee, and if clinically appropriate, the Enrollee's provider(s), family and/or guardian, to develop the treatment and discharge plan, including proper consent, and documentation in the Enrollee'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 Enrollee'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 an Enrollee's safety. All staff must be trained in and adhere to these policies and procedures.
    b) 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.
16. Consultations and psychological testing, as well as routine medical care, are included in the per diem rate.
17. 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 Enrollees, 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 can 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 OTHER 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 Enrollees, to enhance continuity of care for Enrollees.
2. With Enrollee 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 ESPs/MCIs who are high-volume referral sources for the hospital. The program holds regular meetings or has other contacts and communicates with the ESPs/MCIs on clinical and administrative issues, as needed, to enhance the referral and admission process and continuity of care for Enrollees. On a Enrollee- specific basis, the program collaborates with any and all ESP/MCI providers upon admission to ensure the ESP's/MCI's evaluation and treatment recommendations are received and any existing safety plan is obtained from the ESP/MCI.
4. With consent, the program contacts the appropriate local education authority (LEA) if the school system is involved with the Enrollee around educational planning, curriculum, and/or resources.
5. The program maintains a list of advocacy organizations, such as the ones listed on the provider resource page at providerexpress.com.

## 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 Enrollees 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 Enrollees 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 can participate in the process.

a) 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 Enrollees:
    i. A youth under the age of six; or
    ii. 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 ESP/MCI, Inpatient, ICBAT, or outpatient psychiatrist) or has not been evaluated by or reviewed with an ESP/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.

3. For the Enrollees identified above, a medical assessment of each Enrollee 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.
4. 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 Enrollees:
    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 ESP/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 Enrollee 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.
5. For the Enrollees identified above, a medical assessment of each Enrollee is conducted by a qualified staff within 48 hours of admission if one was not completed within the past 48 hours.
6. 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., ESP/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 Enrollee during the weekend or holiday; if not, the child psychiatrist, PNMHCS, or child psychiatry fellow/trainee evaluates the Enrollee face-to-face on the next business day.
7. Every Enrollee 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 Enrollee when in CBAT. The attending child psychiatrist meets with the Enrollee at least one to two times per week as dictated by the individualized treatment plan, writes psychiatry notes in

the Enrollee's health record, and ultimately serves as the Enrollee's primary physician. The attending child psychiatrist is an active participant on the Enrollee's treatment team and is available to consult with other Enrollees of the treatment team throughout the Enrollee's length of stay.

8. The attending child psychiatrist maintains the role as the Enrollee's primary physician throughout the Enrollee'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 Enrollee receives continuity of care. In these instances, the functions of meeting with the Enrollee at least one to two times per week and writing psychiatry notes in the Enrollee's health record may be designated to another child psychiatrist or to a PNMHCS or child psychiatry fellow/trainee acting under the Enrollee-specific supervision of the medical director or another attending child psychiatrist. The medical director or other attending child psychiatrist continues to serve as the Enrollee's attending child psychiatrist. They remain active within the CBAT program, keeping informed and overseeing the Enrollee's care, and is available and consults with other staff who are providing psychiatric care, as needed.
9. 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.
10. The psychiatric evaluation, preferably performed by the Enrollee'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 Enrollee, including a clinical formulation that explains the Enrollee'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.
11. 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 Enrollee and their family, and work toward building consensus in identifying strengths and developing a future vision for the Enrollee. 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 Enrollee's next living situation and treatment setting.
12. The program assigns a multi-disciplinary treatment team, consisting of a child psychiatrist and one or more other disciplines, to each Enrollee 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 Enrollee'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.)
13. 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 Enrollee'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 Enrollee's rapid return to the community. If the program determines the Enrollee 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 Enrollee's transition home.

14. The assessment and treatment plan address the possible barriers to the Enrollee's successful return to their living situation prior to the CBAT admission and includes treatment strategies and other efforts to mitigate those barriers.
15. 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 Enrollee's individualized progress. All assessments, treatment and discharge plans, reviews, and updates are documented in the Enrollee's health record. During each review, the CBAT program:
    a) Collaborates with the Enrollee'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 Enrollee's return to the community and arranges those services;
    c) Makes efforts to address and resolve any barriers preventing the Enrollee'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.
16. All reviews and updates of the treatment plan and discharge plan, as well as care coordination and disposition planning activities, are documented in the Enrollee's health record.
17. Assessments, treatment and discharge plans, treatment meetings, and all treatment planning activities are documented in the Enrollee's health record.
18. The program collaborates with the Enrollee, the ESP/MCI provider in the catchment area in which the Enrollee lives, and other clinical service providers to obtain the Enrollee's safety plan. The program collaborates with these entities to update the plan if needed or develops one if the Enrollee does not yet have one. With Enrollee consent, the ESP/MCI provider may share the safety plan with the program, which includes the safety plan and documents related collaboration in the Enrollee's health record.
19. With Enrollee 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 Enrollee'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 Enrollee-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 an Enrollee's discharge plan documents in the medical record all discharge related activities that have occurred while the Enrollee is in the facility (e.g., outpatient provider was called and an appointment was scheduled), and this reflects Enrollee 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 Enrollee's discharge form.

5. The completed discharge form, including referral to any agency, is available to and given to the Enrollee, and when appropriate, the Enrollee'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 Enrollee's discharge from the facility, and this is clearly documented in the Enrollee'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 Enrollee's safety plan and ensures that the Enrollee has a copy of the safety plan.

## QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, 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 may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.