ACUTE TREATMENT SERVICES (ATS) FOR YOUTH
(ASAM Medically Monitored Intensive Inpatient Services)
and
CLINICAL STABILIZATION SERVICES (CSS) FOR SUBSTANCE USE DISORDERS FOR YOUTH
(ASAM Clinically Managed High Intensity Residential Services)

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-specification specifications take precedence.

OVERVIEW

Acute Treatment Services (ATS) for Youth: ASAM Medically Monitored Intensive Inpatient Services are specific to medically monitored withdrawal management services for addicted youth. The ATS for Youth performance specifications are a subset of the *Acute Treatment Services (ATS) for Substance Use Disorders: ASAM Medically Monitored Intensive Inpatient Services* performance specifications. As such, ATS for Youth providers agree to adhere to both the ATS for SUD performance specifications and to the ATS for Youth performance specifications contained within. Where there are differences between performance specifications for ATS for SUD and ATS for Youth, these ATS for Youth specifications take precedence.

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

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

1. Withdrawal signs and symptoms have been sufficiently resolved.
2. The member's symptoms can be safely managed at a less intensive level of care.

3. Induction onto FDA approved medication has been initiated, and the member is stabilized.

Clinical Stabilization Services (CSS) for Substance Use Disorders for Youth (ASAM Clinically Managed High Intensity Residential Services) consist of 24-hour, seven-day-per-week, clinically managed high-intensity residential services offered in community settings. Services are delivered by nursing, case management, clinical, and recovery support staff under the direction of a licensed medical provider (e.g., Physician, Nurse Practitioner, Physician Assistant) in collaboration with the multidisciplinary team. Services include a multidimensional bio-psychosocial assessment, treatment planning, individual and group counseling, psychoeducational groups, case management, medication monitoring, overdose education and prevention, and discharge planning.

CSS are provided to Enrollees whose symptoms of withdrawal do not require the intensity of ATS for SUD, are largely resolved or minimal, and whose multidimensional needs cannot be managed in a less intensive level of care. CSS providers are expected to manage mild medical complexities and or comorbidities. Admission to CSS for Substance Use Disorders is appropriate for Enrollees who meet the diagnostic and dimensional criteria specified in accordance with the American Society of Addiction Medicine Criteria®.

CSS for Substance Use Disorders for Youth performance specifications are a subset of the *Clinical Stabilization Services (CSS) for Substance Use Disorder (SUD)* performance specifications. As such, CSS for Youth providers agree to adhere to both the CSS for SUD performance specifications and to the CSS for Youth performance specifications contained within. Where there are differences between performance specifications for CSS for SUD and CSS for Youth, these CSS for Youth specifications take precedence.

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

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

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

The process of recovery is personal and occurs via different pathways. The program will establish a culture of recovery for the Enrollee, that is, an environment that reinforces individual strengths, coping abilities, resources, is holistic and addresses the whole person and their community, through staff/peer interactions, role modeling, and involvement in positive, pro-social activities.

Providers must demonstrate formal linkage agreements with licensed primary health care providers for referrals when needed and community based behavioral health agencies for the provision of mental health services for crisis intervention, treatment of co-occurring disorders and aftercare services including developmentally tailored recovery support services and caregiver psychoeducation and support services.

SERVICE COMPONENTS

1. At minimum, the provider complies with all requirements of the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*, including DPH reporting requirements.
2. The provider will confirm the youth's custody status.
3. The provider will ensure that youth are served in programs which are separate from programs serving adult populations.
4. Prior to providing any services to youth, the provider will inform DPH of the nature and scope of any services provided to adults in the same facility as those intended for services for youth. DPH shall determine whether such proximity of adult services constitutes a risk to the youth.
5. The provider will admit and have the capacity to treat Enrollees who are currently receiving Methadone or other medication for opioid use disorder. This capacity may take the form of active affiliation agreements with providers licensed to provide such treatments.
6. The provider is responsible for updating its available capacity, at a minimum once each day, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The provider is also responsible for keeping all administrative and contact information up to date on the website; and the provider is responsible for training staff on the use of the website to locate other services for Enrollees, particularly in planning aftercare services.
7. The provider offers treatment that is based on the developmental stages and needs of Youth, providing flexible, individualized treatment, rehabilitation and support/supervision that varies in intensity based on the Enrollee's need.
8. The provider will ensure that services promote family-guided and Enrollee-guided care focusing on skill building to enhance self-esteem, identify relapse triggers, build positive coping skills, and support vocational development and life skills training.
    a) The provider will offer psycho-educational groups that include HIV, sexually transmitted infections (STIs), and viral hepatitis counseling and testing; risk for overdose; identifying relapse triggers and strategies to cope with them; functional assessment of substance using behaviors, effective communication skills, introduction/overview to 12 Step Supports, Recovery High Schools and Residential Treatment.
9. The provider will ensure that families are incorporated in treatment as appropriate, and regular meetings with families are conducted.
    a) A crisis prevention plan, or safety plan, should be developed and parents/guardians/caregivers should be included in the process if consent of the Enrollee was given.
10. The provider will ensure available parent or care-giver support, counseling, education, and referral to support services for family members/guardians/caregivers. The purpose is to make sure family members have enough understanding of SUD to be a support for their child.
11. Therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional staff to maintain an appropriate milieu and conduct the services below based on individualized Enrollees needs. The provider provides a minimum of four hours of service programming per day. The scope of required service components provided in this level of care includes, but is not limited to, the following:

a) Medical monitoring of AOD Withdrawal Management and of the individual's progress;

b) Medication assisted Withdrawal Management as per current evidence-based practices or protocols;

c) Induction onto FDA-approved Medications for Addiction Treatment (MAT)/Medication for Opioid Use Disorder (MOUD) as clinically indicated and appropriate with referral for ongoing MAT/MOUD at discharge;

d) Access to psychiatric crisis evaluation and clinical services based on the biopsychosocial assessment;

e) HIV, Hepatitis C, TB, tobacco use, and other health-related education programs:

    i. HIV and Viral Hepatitis risk assessments are integrated as a part of each Enrollee's medical/nursing assessment;

    ii. HIV and Hepatitis C education/risk reduction education is provided for all Enrollees; and

    iii. Referral to HIV antibody counseling and testing sites and on-site HIV antibody counseling;

f) Education about the benefits and risks of medication approved for addiction treatment;

g) Opioid overdose risk and prevention;

h) Access to appropriate laboratory and toxicology tests;

i) Access to routine medications;

j) Counseling and case management which incorporates evidence-based practices, including individual, group, and family (including guardians/caregivers) counseling, education, and referral to support services;

k) Behavioral/health/medication education and planning;

l) Psycho-educational groups;

m) Access to peer support and/or other recovery-oriented services, either directly or through referral;

n) Development and/or updating of crisis prevention plans, or safety plans (inclusive of the youth's family/guardian/caregiver, provided consent was given) as part of Crisis Planning Tools, and/or relapse prevention plans, as applicable;

o) Introduction to self-help groups and the continuum of substance use disorder (SUD) and mental health treatment;

p) Direct operational affiliations with other services especially Clinical Stabilization Services, Transitional Support Services, Residential Rehabilitation Services, Opioid Treatment Programs, Office-Based Opioid Treatment, Community Behavioral Health Centers (CBHCs), and psychiatric services;

q) Case management that directly connects (warm handoff) to appropriate providers;

r) Management of mild-to-moderate medical complexities, with updates with primary care providers and specialists (with consent); and

s) Support services and referrals for family members and significant others.

12. Substance-specific withdrawal management protocols are individualized, documented, and available on-site. At minimum, these include withdrawal management protocols for alcohol, nicotine, stimulants, opioids, and sedative hypnotics (including benzodiazepines) with capacity to use all FDA-approved medications for the treatment of substance use disorders.
13. Co-occurring psychiatric services, medication evaluation and management, and related laboratory services are offered either directly or via referral. Such services are available virtually, or on-site within 24 hours, or referred to an off-site provider within 24 hours, as appropriate to the severity and urgency of the Enrollee's mental health condition.
14. The provider will ensure that for pregnant Enrollees, coordination with OB/GYN, pediatrics, and any other appropriate medical, social services providers, and state agencies will be provided.
15. Referral to the appropriate level of substance abuse treatment and mental health or other primary care as needed.
16. The provider offers developmentally appropriate services provided with competencies in culture, language, gender identity and gender expression, sexual orientation, and physical ability.

STAFFING REQUIREMENTS

1. If provider feels they cannot meet these specifications, Bureau of Substance Abuse Services (BSAS) has a waiver process for certain requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
2. The provider complies with the staffing requirements of the applicable licensing body and the staffing requirements outlined in 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs* and the staffing requirements in the applicable Plan provider manual.
3. The provider's multidisciplinary team includes professional and medical staff with experience in treating youth and specific training in child and teen development, including a minimum of five college credit hours in courses related to the topic.
4. Staffing must include nurses, physicians for psychiatric and pharmacological consultation, and clinical assistant/nurses' aide staff, all with established skills, training, and/or expertise in the treatment of individuals with substance use disorders; including:
    a) Medical Director: Massachusetts licensed physician with expertise in adolescent medicine who is available and responsible for oversight of the administration of all medical services performed within the program and provides on-site monitoring of care and evaluation. In addition, programs must have a licensed psychiatrist or psychologist on staff or available through a Qualified Service Organization Agreement;
    b) Program Director: Oversees the program, staff and operations;
    c) Clinical Director: at a minimum meets the qualifications for a Senior Clinician as defined in 105 CMR 164.000, provides direct supervision to non-medical clinical staff, including counselors, care coordinators, and recovery specialists. The clinical director reviews and/or participates in treatment planning and follow-up client care services:
        i. The Program Director and Clinical Director positions may not be combined;

d) Recovery Specialists, Counselors, and Nurses: required on site, seven (7) days a week, fifty-two (52) weeks a year, with a mix of roles on each shift as specified on the Youth Detox & Stabilization staffing grid. Care coordinators are required on site a minimum of five (5) days per week, Monday-Friday, as specified on the Youth Detox & Stabilization Staffing Grid. Psychiatric consultation is required twenty-four (24) hours daily, seven (7) days a week;

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

f) Psychiatrist or Psychiatric Nurse Practitioner: on staff or available through a Qualified Service Organization Agreement for psychiatric evaluation and consultation, as needed, to address the needs of Enrollees with co-occurring disorders;

g) Obstetrician/Gynecologist: on staff or available through a Qualified Service Organization Agreement to accommodate pregnant Enrollees;

5. All providers must have at least one staff member assuming each of the following roles:
   a) There is an **HIV/AIDS Coordinator**: responsible for overseeing confidential HIV risk assessment and access to counseling and testing; staff and resident HIV/AIDS and hepatitis education; and Department requirements for admission, service planning and discharge of HIV positive residents.
   b) There is a **Tobacco Education Coordinator**: responsible for assisting staff in implementing BSAS guidelines for integrating on of tobacco assessment, education, and treatment into program services.
   c) There is an **Access Coordinator**: responsible for development and implementation of the evaluation, plan, and annual review of the site's performance in ensuring equitable access to services as required by 105 CMR 164
   d) There is a **CLAS Coordinator** (Culturally and Linguistically Appropriate Services) who ensures that the service meets the language and cultural needs of the patients.
6. At minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider complies with all provisions of the 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to community connections collateral linkages.
2. When necessary, the provider provides or arranges transportation for services required external to the program during the admission and, upon discharge, for placement into a step down 24-hour level of care, if applicable. The provider also makes reasonable efforts to assist Enrollees upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.

3. The provider works collaboratively with parent/guardian, LEAs, and involved state agencies, including, but not limited to, DDS, DCF, DYS and others to coordinate treatment and discharge planning.
4. The provider includes information about community-based services and supports for youth and families, including, but not limited to, PPAL, NAMI, the Federation for Children with Special Needs, The Arc, DDS resources, and local advocacy and support groups in their wellness and recovery information and resources available to Enrollees and their families.
5. Provider must maintain formal linkages to the following:
    a. Linkage to services is initiated upon admission and as part of the treatment plan may include, but are not limited to:
        i. Mobile Crisis Intervention programs
        ii. Youth stabilization and residential programs
        iii. Other youth services
        iv. Recovery high schools
        v. Recovery support centers
        vi. ATS, CSS, TSS, RRS programs
        vii. Vocational training
        viii. Education support
        ix. Department of Youth Services (DYS)
        x. Department of Corrections (DOC)
        xi. Outreach sites
        xii. Opiate treatment programs
        xiii. Outpatient behavioral Health providers
        xiv. Community-based social service providers

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The provider complies with all provisions specified in 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to assessment and recovery planning.
2. A bio-psychosocial assessment is conducted within 24 hours of admission. Assessments include a formal screening for all psychosocial risk factors characteristic of youth with substance use disorders:
    a) Developmentally age-appropriate behaviors
    b) Cognitive functioning
    c) Physical maturation
    d) Existing peer and family supports, peer group, and family functioning
    e) Experience of trauma
    f) History of mental health diagnosis
    g) Availability of and access to recovery supports
    h) Social maturity

i) Education needs

3. A comprehensive nursing assessment is conducted at the time of admission, which includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score and/or a Clinical Opiate Withdrawal Scale (COWS) and CRAFFT Screening Tool. Results are documented in the Enrollee's health record.
4. A Registered Nurse (RN) evaluates each Enrollee within three hours of admission to assess the medical needs of the Enrollee. If an RN is unavailable, this function may be designated to a Licensed Practical Nurse (LPN) acting under an RN's or the physician's Enrollee-specific supervision. All activities are documented in the Enrollee's health record.
5. The provider ensures that a physical examination which conforms to the principles established by ASAM is completed for all Enrollees within 24 hours of admission. If the examination is conducted by a qualified health professional who is not a physician, the results and any recommendations arising from the examination are reviewed by the nursing supervisor prior to implementation.
6. The treatment/recovery and discharge plans are reviewed by the multi-disciplinary treatment team with each Enrollee at least every 48 hours (a maximum of 72 hours between reviews on weekends) 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.
7. The assigned case manager under the supervision of the Clinical Director meets with the Enrollee daily for the purposes of case management and discharge planning. All activity is documented in the Enrollee's health record.
8. With Enrollee consent, and the establishment of the clinical need for such communication, coordination with Enrollee's family/legal guardians/caregiver, etc., and other treatment providers, including primary care providers and behavioral health providers, is conducted by appropriate staff relative to treatment and care coordination issues. All such contact is documented in the Enrollee's health record.
9. For anyone who could become pregnant, a pregnancy test is administered prior to the administration of any medication(s).
10. For anyone who is pregnant, the provider coordinates care with their PCP and OB/GYN and consults with those physicians as needed.
11. The provider arranges appropriate drug screens/tests, urine analysis, toxicology samples, and laboratory work as clinically indicated, and documents these activities in the Enrollee's health record.
12. The provider ensures the continuous assessment of the Enrollee's mental status throughout the Enrollee's treatment episode and documents such in the Enrollee's health record.

Discharge Planning and Documentation

1. The provider conducts discharges 7 days per week, 365 days per year.
2. At the time of discharge, and as clinically indicated, the provider ensures that the Enrollee has a current crisis prevention plan, and/or safety plan, and/or relapse prevention plan in place and that they have a copy of it. The provider works with the Enrollee, and their family/legal guardians/caregiver to update the existing plan, or, if one was not available, develops one with the Enrollee and them prior to discharge. With Enrollee consent and as applicable, the provider may contact the Enrollee's local Adult or Youth Mobile Crisis

Intervention (AMCI/YMCI) to request assistance with developing or updating the plan. With Enrollee consent, the provider sends a copy to the AMCI/YMCI Director at the Enrollee's local AMCI/YMCI.

3. All medical follow-up appointments are scheduled prior to discharge and are documented in the Enrollee's health record. The facility will ensure that aftercare planning is initiated at the time of admission, continues throughout the treatment episode, and includes focus on the following:
    a) An individualized aftercare program designed to offer continued support to both the youth and the family, allowing for a smoother transition back into the home and community environment.
    b) Referrals to services and supports that address a more holistic set of needs including individual, group, and family counseling; psychiatry; vocational/educational services; safe and supportive housing options; social benefit programs for which the youth may be eligible; self-help and community-based recovery supports.
    c) Overdose prevention education as a necessary component of the treatment and aftercare plan for any youth who has been using opioids.
4. Provider will have Memorandum of Understanding (MOU) with and referral link to hospitals for medical or psychiatric stabilization needs that require a higher level of care as well as MOU with contracting agency operating BSAS Adolescent Central Intake and Care Coordination to refer youth to residential OAD treatment.
5. Provider will have MOU with Recovery High Schools to help with coordination of treatment and education of youth at recovery high that may have relapsed and need stabilization support.
6. Provider will coordinate care with community-based service providers upon discharge e.g., primary care, behavioral health providers, etc., to address both substance use and mental health needs, or other services as determined by the clinical assessment.
7. Discharge planning will include multiple stakeholders including family/legal guardians/caregiver, other state agency representatives, and community-based providers as appropriate.
8. Referrals to community-based counseling and support services for families will be provided as needed.
9. Collaboration with the youth's school district to ensure educational services are provided for any youth admitted for more than 14 days, in accordance with 603 CMR 28.03 (3)(c).

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. Specifically, the provider will work to improve these outcomes within their patient population receiving SUD treatment:
    a) Increase in MAT/MOUD induction and continuation
    b) Decrease in readmissions to ED and inpatient services
    c) Increase in referrals and transitions to lower levels of care
    d) Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions
2. 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.