Youth Community Crisis Stabilization for Children and Adolescents

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

The **Youth Community Crisis Stabilization (Youth CCS/YCCS)** program provides, staff-secure, safe, and structured crisis stabilization and treatment services 24 hours per day, 7 days per week, and 365 days per year (24/7/365). Youth CCS is a community-based program that serves as a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization. It is preferred that the Youth CCS is co-located with the Youth Community-Based Mobile Crisis Intervention (YMCI), at the Community Behavioral Health Center (CBHC) location in order to enhance service continuity and increase administrative efficiency to benefit those served, but co-location is not required. This program serves children/adolescents up to and including the age of 18. Youth ages 18-20 may be eligible for admission based on a program's licensing requirements and an Enrollee's clinical needs. Admissions to Youth CCS occur 24/7/365, following a crisis evaluation determination by YMCI or hospital-based staff, or a determination by inpatient level staff of a need for a step-down level of care. Discharges from Youth CCS occur 24/7/365, and readiness for discharge is evaluated daily.

Youth CCS provides a home-like, Enrollee-friendly, and comfortable environment conducive to recovery and stabilization. Youth CCS services include comprehensive assessment; medication evaluation and pharmacologic interventions, including withdrawal management; nursing and milieu support; substance use treatment; individual, group, and family therapy; care management; family consultation; peer/family support; discharge planning, including coordination with school and providers; and information about recovery, wellness, crisis self-management, and how to access wellness and recovery services available in the Enrollee's specific community. All services are guided by the clinical needs and treatment preferences of the Enrollee, and parent/guardian, and Youth CCS staff actively involve family/caregivers and other natural supports. Treatment is carefully coordinated with existing and/or newly established treatment providers including the CBHC, recovery supports, CBHI services, school and other community-based services as appropriate. With Enrollee and/or parent/guardian consent, Youth CCS staff provide treatment recommendations and participate in team meetings, as appropriate. YCCS level of care is expected to manage chronic medical conditions typically managed in community settings, i.e., diabetes, seizure disorders, wound care, and morbid obesity (including access to bariatric equipment).

Service Components

1. Therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional and support staff to maintain an appropriate milieu and to conduct the services below, based on individualized Enrollee needs.
2. Admissions are accepted 24/7/365. Youth CCS is a service for children/adolescents up to and including the age of 18. Youth ages 18-20 may be eligible for admission based on a program's licensing requirements and an Enrollee's clinical needs.
3. The scope of required service components provided in this level of care includes, but is not limited to, the following:
    a) Intensive Therapeutic Milieu (1:3 minimum Direct Care: youth ratio)
    b) Comprehensive Assessment including but not limited to:
        i. Psychosocial assessment including individual, and family needs and strengths
        ii. Medical history and physical exam
        iii. Substance use disorder screening using the CRAFFT or other evidence-based screening tool, with appropriate integrated treatment or referral, as clinically indicated
        iv. Suicide risk screening using an evidence-based screening tool
    c) Pharmacological evaluation and treatment (including daily medication reconciliation):
        i. Upon admission, the program is responsible for ensuring that each youth has access to medications prescribed for physical and behavioral health conditions and documents accordingly in the youth's health record. Medication reconciliation will be performed upon admission to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of a youth from one care setting to another.
    d) Substance use treatment that is developmentally tailored and includes co-occurring capable psychosocial treatments such as, medications for addiction treatment, access to self-help group supports, etc.
        i. Youth CCS may provide support for SUD MOUD, as a pathway for Enrollees requiring initiation or bridging prescriptions for MOUD, as clinically appropriate.
    e) Treatment planning that develops a youth- and family-centered treatment plan that specifies the goals and actions to address the medical, social, therapeutic, educational, and other strengths and needs of the youth.
    f) Daily therapeutic intervention, focused on skills building and stabilization is required 7 days a week and should include individual, group, and family therapy as clinically indicated over the course of the stay. Meaningful therapeutic programing must be provided during weekend days by flexible staffing types. sub-Therapeutic interventions must include evidence-based practices best suited to meet the clinical needs of youth, including for substance use disorder treatment. Evidence-based practices may include but are not limited to: Dialectical Behavioral Therapy, Cognitive Behavioral Treatment, Brief Motivational Intervention and recreational groups such as art therapy, pet therapy, etc.
    g) Daily wellness activities, including but not limited to physical exercise, nutrition, yoga, meditation, mindfulness, etc.
    h) Development of behavioral plans and crisis/safety plans, as part of the Crisis Planning Tools for youth.
    i) Management of medical and psychiatric emergencies including overdose. Reasonable safeguards and emergency protocols should be in place to allow for support for Enrollees who experience suicidal ideation and substance use disorders.
    j) The program makes every effort to have family therapy sessions when appropriate at a frequency adequate to meet the clinical needs and support successful and timely discharge, with an average of 2-3 times per week, including weekends, in line with family availability

which may include youth, parent, guardian, siblings, grandparents, etc. The session should focus on helping the family/caregivers understand the clinical needs and how to support the youth, and may include skills development and psychoeducation for both the youth and family/caregivers. Family therapy may be conducted via telehealth as clinically indicated to support the access and availability of family engagement.

i. Clinical staff provide information to the youth and family about wellness, recovery, crisis self-management, and how to access wellness and recovery services in their community.

k) Discharge planning, beginning at admission, that includes:

i. Assisting the family and/or the previous placement provider in identifying appropriate treatment team members;

ii. Facilitating the treatment team meeting to identify the family's needs and strengths as well as strategies the family and youth successfully employ to meet their needs; and

iii. Contacting the Enrollee's school to develop a plan for facilitating school re- entry following the brief admission.

4. Youth CCS is a staff-secure facility. Enrollees are expected to participate in daily treatment and remain in the facility until completion of their treatment. Brief absences per Enrollees treatments plans, accompanied by staff or appropriate medical transportation may be allotted to avoid exacerbation of symptoms. This does not include for treatment that is expected to be provided at YCCS, i.e., therapy or psychiatry appointments. The Enrollee may be accompanied by family or guardian if medically necessary. YCCS must have policies and procedures for return to unit to evaluate for safety.

5. Youth CCS is responsible for ensuring that each Enrollee has access to medications prescribed for physical and behavioral health conditions and documents so in the Enrollee's health record.

a) Youth CCS will ensure access to clinically appropriate medications that have been prescribed but not filled.

i. This involves:

(1) Developing a list of current medications, i.e., those the Enrollee was prescribed prior to admission to the Youth CCS;

(2) Developing a list of medications to be prescribed in the Youth CCS;

(3) Utilizing MassPAT to confirm current and past prescribed medications and ensuring access to necessary medical/behavioral health medications for the Enrollee;

(4) Making clinical decisions based on the comparison and, when indicated, in coordination with the Enrollee's primary care clinician (PCC);

(5) Communicating the new list to the Enrollee and, with consent, to appropriate caregivers, the Enrollee's PCC, and other treatment providers; and

(6) Documenting all communication in the Enrollee's health record.

b) Youth CCS services must include or have a Memorandum of Understanding (MOU) with an SUD provider who can provide induction and bridging services for:

i. Buprenorphine, including for same-day induction, bridging, and maintenance for clients, including treatment referral services for follow-up counseling or Medication for Opioid Use Disorder (MOUD)

ii. Oral Naltrexone

(1) ***Note:*** *Storage and administration of medications should be limited to the scope of the provider's DPH clinic licensure; prior to prescribing MOUD, MassPat must be checked.*

iii. Providing access to Naloxone

(1) ***Note:*** *The provider must have a Massachusetts Controlled Substance Registration to store Naloxone on site.*

c) Youth CCS will have a documented protocol for induction with buprenorphine inclusive of response to precipitated withdrawal.

d) Youth CCS will have formal, documented linkages to Opioid Treatment Programs and Office-Based Opioid and Addiction Treatment (OTP/OBOT/OBAT) programs that include:

i. Language that provides protection of SUD treatment information per 42 CFR Part 2

ii. Contact information for verifying the last dose of dispensed MOUD

iii. Language describing the process of direct admission and/or rapid admission to OTP/OBOT/OBAT

6. The program has the capacity to refer and arrange appointments that may be clinically indicated to occur post-discharge, including, but not limited to, the following:

a) Outpatient individual, group, and/or family therapy

b) Partial hospitalization

c) Assessment for Safe and Appropriate Placement (ASAP)

d) Psychological testing, if clinically indicated, for stabilization and/or to address diagnostic and treatment questions central to the YCCS assessment, treatment, and discharge planning process

e) Neuropsychological testing

f) Nutritional counseling

g) Substance use disorder assessment and treatment planning including access to medication to treat opioid use disorders (MOUD)

7. All necessary consultation services resulting from the psychiatric evaluation, medical history, and physical, or that is subsequently identified during the admission, are provided within 24 hours of identification of Enrollee's need. All services are documented in the youth's health record. This may include consultation available within the Community Behavioral Health Center (CBHC) or externally, such as Massachusetts Child Psychiatry Access Program (MCPAP) for ASD/ID (Autism Spectrum Disorder/Intellectual Disability) for youth with ASD or an intellectual disability.

8. Parent/caregiver contact and involvement:

a) Admission: The program may have verbal consent from the parent/legal guardian for admission and makes documented attempts to have the parent, guardian, and/or previous placement provider attend an on-site admissions meeting, within 24 hours, unless clinically or legally contraindicated. The program provides the parent/legal guardian with all relevant information related to maintaining contact with the program and the youth during admission, including names and phone numbers of staff including the primary treatment staff (e.g., social worker, care coordinator, discharge planner, etc.).

b) Throughout an admission, parent/guardian access to their children is a right and is not to be denied unless it is explicitly clinically or legally contraindicated. The program assumes and ensures daily access to children and adolescents for the parent/guardian. Parent/guardian access is never prohibited as part of behavioral programming. All decisions related to visitation and/or contact with parents/guardians are documented in the youth's health record.

c) The program provides accommodations for youth to use telephones/virtual platforms (free of charge) including allowing youth to speak with family members in their native language and providing postage stamps, to maintain contact with parents, guardians, family members, legal counsel, or caregivers, as legally allowed and clinically indicated.

d) The program is expected to involve parents/guardians or other caregivers in all aspects of treatment while the youth is at the program.

9. The program must have an active license by the appropriate state agency and notify all insurance plans within 24 hours if there is a change in licensure status.

The Youth CCS is required to update its available capacity, three times each day at a minimum, once per shift, seven days per week, 365 days per year, on the Massachusetts Behavioral Health Access website (MABHAccess.com). The Youth CCS must keep all administrative and contact information up to date on the website. The Youth CCS 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. **Medical Director:** This board-certified or board-eligible Child Psychiatrist shall be responsible for clinical and medical oversight and quality of care for the YCCS. It is expected that if a YCCS is integrated in a CBHC, the CBHC shall appoint one of the psychiatrists, who is in the staffing pattern for the Youth Community-Based Mobile Crisis Intervention (YMCI), also known as Mobile Crisis Intervention (MCI) and/or YCCS (if applicable) and works directly in one or both of those service components on at least a parttime basis, as the youth Medical Director. They may also be the Medical Director of the CBHC and/or have other similar roles in that organization.

   If the CBHC subcontracts with another agency to provide YCCS services, the subcontracted agency must provide its own YCCS Medical Director. If a YCCS provider operates independently from a CBHC, the YCCS provider must provide its own YCCS Medical Director.

   The Medical Director is accountable for the psychiatric care delivered by them and/or other psychiatric clinicians during business hours, and the after-hours psychiatric consultation function fulfilled by them and/or other psychiatric clinicians. The Medical Director is responsible for supervising all psychiatrists and Psychiatric Advanced Practice Registered Nurses (APRNs) in any of the YCCS service components. The Medical Director individual shall be available for clinical consultation to YCCS staff members. Psychiatric consultation shall be provided in a variety of clinical and administrative areas, including consultation specific to the assessment, treatment, and disposition of individuals in the process of receiving YCCS services as well as negotiating issues related to medical screening and inpatient admissions.
2. **Clinical Program Director:** The Clinical Program Director is an independently licensed master's-level clinician who shall be responsible for the clinical oversight and the quality of care within the YCCS program, in collaboration with the Medical Director. The Clinical Program Director ensures the provision of all YCCS service components. They are available for consultations regarding emergencies or urgent situations.
3. **Child Psychiatrist or Psychiatric Advanced Practice Registered Nurse (APRN) with child/youth training:** The Child Psychiatrist shall provide psychiatric assessment, medication evaluations, and medical management and shall contribute to the comprehensive assessment and discharge planning. The program may employ an APRN to provide psychiatric care, within the scope of their license and under the supervision of the Medical Director or another attending Child Psychiatrist, as outlined within these performance specifications.
4. **Nurse Manager:** The Nurse Manager is a management position available to provide supervision and oversight with primary responsibility within the YCCS. They shall fill physician orders; administer medication; take vital signs; coordinate medical care; contribute to comprehensive assessment; conduct brief crisis counseling and individualized risk management/safety planning; provide psychoeducation; and assist with discharge planning and care coordination. . YCCS will have a protocol in place to provide withdrawal management support for Enrollees who are presenting with clinical symptoms of withdrawal and who present a low risk for medical complications. This protocol should be inclusive of assessment of signs of substance withdrawal and completion of standardized assessment tools such as the Clinical Opioid Withdrawal Scale (COWS), Clinical Institute Withdrawal Assessment for Alcohol (CIWA), and Clinical Institute Withdrawal Assessment for Benzodiazepines (CIWA B). The Nurse Manager will ensure completion of the following: brief crisis counseling and individualized risk

management/safety planning; provide psycho-education; and assist with discharge planning and care coordination.

5. **Registered Nurse (RN):** The RN performs the following core functions: fills physician orders; administers medication and engages in a medication reconciliation process, as outlined within the Components of Service section; takes vital signs; coordinates medical care; contributes to comprehensive assessment, brief crisis counseling, individualized crisis prevention planning, and provides psychoeducation; and assists with discharge planning and care coordination.
6. **Licensed Practical Nurse (LPN) staffing:** Appropriate to licensure level, the LPN shall assist the Nurse Manager with filling physician orders, administering medications, and monitoring vital signs inclusive of withdrawal symptoms. They shall also work with the bachelor's-level staff in ensuring an environment that promotes safety, recovery, and treatment. They shall contribute to assessment, individualized risk management/safety planning, discharge planning, and care coordination.
7. **Master's-level clinician staffing:** Clinicians shall be primarily responsible for conducting comprehensive assessments inclusive of the use of standardized assessment tools for suicide risk, brief crisis counseling, individualized risk management/safety planning, psychoeducation, discharge planning, and care coordination. The master's-level clinician will conduct or oversee individual, group, and family therapy.
    a) Master's-level clinician will be responsible to ensure the completion of discharge planning that includes education and referral to outpatient supports. The clinician will have oversight to ensure transmission of the discharge summary, current medication list, and outpatient appointments to all outpatient providers and involved state agencies. Efforts will be made to provide warm handoffs to relevant providers and identified supports. Youth CCS staff carefully coordinates treatment with existing and/or newly established treatment providers and other collaterals including the CBHC, BHCPs, care managers, schools and CBHI.
        i. Discharge Planning: this will include referrals to new providers as clinically indicated and follow-up appointments made with existing providers, with an effort to include the Enrollee and family/caregivers in making the appointments.
8. **Family support staff:** Family support staff shall provide ongoing support to families in navigating the behavioral health system and will support brief interventions that address a youth's behavior and safety. These staff members shall either have lived experience as caregivers of youth with special needs, preferably youth with behavioral health needs, or receive supervision and training on incorporating family systems in treatment and follow program procedures on incorporating family voice into treatment.
9. *(Optional)* **Young adult peer mentor:** Young adult peer mentors shall work with YCCS clients on life skills, specifically teaching skills to help youth successfully cope with a behavioral health diagnosis. These staff must have lived experience in coping with serious behavioral health condition(s).
10. **Mental health counselors***:* Staff with bachelor's degrees or high school diplomas who provide milieu support to clients; peer-certified and/or recovery coach staff preferred.
11. **Clerical staff:** Clerical staff shall be responsible for maintaining records, release of information forms, ensuring documentation is completed, and other administrative support.
12. **Maintenance staff:** shall be responsible for upkeep of Youth CCS location.
13. In addition to the above staffing requirements, there must be at least one staff member per shift trained in CPR and one staff member per shift trained in the use of Naloxone in the event of overdose.

Additional staffing requirements

1. The program has sufficient and appropriate personnel to accept and admit youth and to discharge youth 24/7/365. The program maintains a 1:3 staff-to-youth ratio during all waking hours.
    a) The program has a written staffing plan that delineates (by unit, day, and shift) the number and credentials of its professional staff, including attending Child Psychiatrist(s), Nurses, Social Workers, Psychologists, and other mental health professionals, in compliance with its licensed capacity. The Program Director or Supervisor collaborates with the Medical Director on the development and maintenance of the staffing plan.
    b) Staffing includes at least one master's-level clinician on-site at a minimum of 8 hours per day, five days per week with on-call availability over weekends. When a master's-level clinician is not on-site, a master's-level or doctoral-level clinical supervisor is available for telephonic consultation within 30 minutes.
    c) The program provides all staff with at least one hour of weekly supervision (individual, dyad, or group) appropriate to their level of licensure.
2. Staff include family support staff and may include access to young adult peer mentor supports. The family support staff ensures every parent/guardian/caregiver of the youth is contacted within 12 hours of admission.
3. Mental health counselors are staff with minimum high school diploma or equivalent who provide milieu support to youth which can include facilitating recreation groups; peer-certified and/or Peer Recovery Coach staff preferred. The YCCS provides at least two awake, overnight supportive staff 24/7/265.
4. The Medical Director's role may include the provision of direct psychiatry services and includes:
    a) Teaching, training, and coaching; and
    b) Oversight and monitoring of prescribing clinicians.
5. The Medical Director's role also includes the following functions, in collaboration with the program director or supervisor and the clinical leadership team:
    a) Attendance at multi-disciplinary team meetings, as requested by clinical staff;
    b) Consulting with the multi-disciplinary team;
    c) Integration of a thorough biopsychosocial assessment that can be used for treatment planning within the YCSS program and in the youth's home and community;
    d) Development of therapeutic programming; and
    e) Ensuring that programs remain child-focused and family-centered.
6. The program has adequate Child Psychiatrist/APRN coverage to ensure all performance specifications related to psychiatry are met:
    a) The program assigns a Child Psychiatrist/APRN, who may be the Medical Director, to each youth to conduct the initial evaluation of each youth within one business day of admission.
    b) Psychiatric care consists of the provision of psychiatric and pharmacological assessment and treatment to youth in the YCCS program and is provided by a board-certified Child Psychiatrist/APRN.
    c) When a child's treating Psychiatrist/APRN is not on-site at the YCCS, another Child Psychiatrist, or a child psychiatry fellow/trainee or APRN who has access to a Child Psychiatrist for consultation, is available for phone consultation within 30 minutes of a request.
    d) A face-to-face evaluation occurs within 60 minutes of staff request when clinically indicated through an assessment by qualified staff. The face-to-face psychiatric evaluation is provided on-site by the Medical Director, another Child Psychiatrist, a child psychiatry

fellow/trainee, or an APRN. Overnight and on weekends, an evaluation may occur via telehealth within 60 minutes of staff request.

e) After hours, the on-call Child Psychiatrist should be consulted regarding acute or ongoing medical issues and concerns.

7. The program has appropriately trained nursing staff (RN, LPN), available during daytime and evening shifts to perform the functions below. For overnight shifts, a nursing staff member must be available by phone with onsite access to the YCCS within 20 minutes. These functions include:
   a) RN staff perform the following core functions: fill physician orders; administer medication and engage in a medication reconciliation process, as outlined within the Components of Service section of these specifications; take vital signs; coordinate medical care; contribute to the comprehensive assessment; provide brief crisis counseling, individualized crisis prevention planning, and/or psychoeducation; and assist with discharge planning and care coordination.
   b) In alignment with their licensure level, LPN staffing shall assist the RN with filling physician orders, administering medications, and monitoring vital signs, and contribute to the assessment, individualized crisis planning, discharge planning, and care coordination.
8. The program collaborates and coordinates with the youth's treating providers, including primary care provider and psychopharmacological provider, within the next business day of youth admission.
9. Staffing includes at least one master's-level clinician on-site at a minimum of 8 hours per day, five days per week with on-call availability over weekends. When a master's-level clinician is not on-site, a master's-level or doctoral-level clinical supervisor is available for telephonic consultation within 30 minutes. The program provides all staff with at least one hour of weekly supervision (individual, dyad, or group) appropriate to their level of licensure. Weekend plans for therapeutic activity are pre-planned and staff is aware and prepared to follow through with plan as appropriate.

Staff training requirements

1. Staff is knowledgeable enough about these resources to develop clinically appropriate treatment and discharge plans that can be implemented in a timely manner. All staff receive training and ongoing updated information regarding the current continuum of care that is available for youth upon discharge, including but not limited to:
   a) CBHCs and other outpatient services,
   b) Children's Behavioral Health Initiative (CBHI) services,
   c) Family Resource Centers,
   d) State agency services including Department of Children and Families (DCF) and Department of Mental Health (DMH) services,
   e) Educational services including special education, and
   f) Family supports.
2. The program is responsible for staff being adequately trained to provide evidence-based practice. Additionally, all staff receive documented training in:
   a) Systems of Care philosophy;
   b) Family systems;
   c) Peer support;
   d) Partnering with parents/guardians;
   e) Child and adolescent development;
   f) Overview of the clinical and psychosocial needs of the target population (e.g., substance use disorder and/or co-occurring disorders, trauma-informed care, ethnic, cultural, and

linguistic considerations of the community, family-centered practice, crisis prevention intervention (CPI), or equivalent program);

g) Mandated reporting;

h) Psychotropic medications and possible side effects;

i) Risk management/safety plans; and

j) Family-driven crisis planning/management.

3. Clinical staff are additionally adequately trained in evidence-based practices best suited to meet the clinical needs of youth.

Service, Community and other Linkages

1. The program develops a Memorandum of Understanding (MOU) and actively works with each of the local CBHCs/YMCIs. The program maintains, via affiliation agreements, linkages with other step-down resources across the BH continuum of care for children and adolescents, including but not limited to partial hospital programs, CBHI services, and outpatient providers to which the program refers youth, to enhance continuity of care for youth.
2. With Enrollee and/or parent/guardian consent, treatment providers, family members, and other collaterals including BHCPs, care managers, and CBHI are contacted within 24 hours of admission.
3. With parent/guardian consent, the program collaborates with any involved state agencies to coordinate service provision, to facilitate consensus and consistency among service plans.
4. The YCCS program leadership holds monthly meetings with the CBHCs/YMCIs on clinical and administrative issues, as needed, to enhance the referral and admission process and continuity of care for youth. On a youth-specific basis, the program collaborates with all YMCI providers upon admission to ensure the YMCI's evaluation and treatment recommendations are received, and any existing crisis plan is obtained from the YMCI.
5. The program participates in the local Community Service Agency (CSA) System of Care monthly meetings.
6. The Youth CCS adheres to established program procedures for referral to a more-restrictive, medically necessary behavioral health level of care when the Enrollee is unable to be treated safely in the Youth CCS.
7. The Youth CCS adheres to established program procedures for determining the necessity of a referral to a hospital when an Enrollee requires treatment beyond the scope of the Youth CCS.
8. The YCCS maintain knowledge of, and relationships with, behavioral health levels of care and other community-based resources to which referrals are made for aftercare.
9. The YCCS provides education to Enrollees and family/caregivers of services and supports at the local CBHC location.

Process Specifications

Referral and admission

1. The provider triages Youth CCS referrals:

   a) Youth CCS staff will request and confirm receipt of any existing safety plan and/or crisis prevention plan from referring provider (e.g., inpatient unit, Emergency Department, MCI teams);

   b) The YCCS program accepts and admits youth 24/7/365 and responds with a decision to accept or decline within 60 minutes to requests for admission, including during evenings and weekends;

   c) The referring provider may request a subsequent review for any declined referrals, which

must be conducted within 60 minutes of request;

d) Ninety percent of referrals should be accepted without subsequent review within 60 minutes; and

e) YCCS is required to maintain a log of all referrals including date/time of referral and decision with explanation for all referrals declined. This log should include the age of the referred youth but should not include Protected Health Information.

2. Upon admission, the YCCS:

a) Assigns a multi-disciplinary treatment team to each Enrollee within 24 hours of admission. The program's treatment team reviews the comprehensive assessment and psychiatric assessment and in collaboration with the youth and family develops an initial treatment plan within one business day of the youth's admission. The school should be part of the treatment team whenever feasible, as return to school is essential for a successful transition home.

b) All consultations indicated in the Youth CCS treatment plan should be ordered within 24 hours of admission and provided in a timely manner.

c) A master's-level or doctoral-level child-trained clinician shall conduct an initial biopsychosocial assessment within 24 hours of admission, or as soon as the youth and family are able to participate in the process. A comprehensive assessment including collaboration with other providers and collateral contacts shall be completed within one business day of admission.

d) A board-certified Child Psychiatrist/APRN or child psychiatry fellow/trainee provides an initial evaluation within the next business day following admission, with on call consultation available over weekends as clinically indicated, which must include input from the child's parent/caregiver. The assessment includes the psychiatric, pharmacological, and social emotional needs of the youth, including a clinical formulation that explains the youth's acute condition and symptoms of clinical concern.

e) For all youth, a medical assessment of each youth is conducted by qualified staff (e.g., psychiatrist, APRN, or RN) within 24 hours of admission, or sooner as clinically indicated, if one was not completed within the past 24 hours. Please note that youth should not be required to receive an ED-provided "medical clearance" as a condition of admission to YCCS, except in rare cases when an acute medical situation may impact care in the YCCS.

Assessment, treatment planning and documentation

1. The program ensures that the comprehensive assessment:

a) Identifies current providers and collateral contacts to obtain more comprehensive information and insight into the youth and their family;

b) Works toward building consensus in identifying strengths and developing a future vision for the youth;

c) Addresses precipitating events that lead to the current admission; and

d) Includes recommendations that identify the clinical, social, and medical components needed to support the youth and parent/guardian in ensuring a safe return to home, school, and community.

2. The youth- and family-centered treatment plan will:

a) Specify the goals and actions to address the medical, social, therapeutic, educational, and other strengths and needs of the youth;

b) Identify strategies to support youth/family/guardian in reducing stressors that lead to YCCS; and

c) Work with the youth/family to identify strategies for preventing future crises.

3. The treatment plan and discharge plan are reviewed and updated as appropriate by the multi-disciplinary treatment team at least every 48 hours, based on each youth's individualized progress. During each review the YCCS program team:

    d) Collaborates with youth's ongoing or newly involved behavioral and physical health providers, school personnel, and/or other service providers regarding care coordination and discharge planning;

    e) Includes treatment team member in treatment planning meetings (virtually or in person). If a treatment team member is unable to participate in a team meeting, it is documented in the youth's record, and outreach and follow-up is done to those team members unable to attend; and

    f) Continues to identify the services needed to facilitate the youth's return to the community and arranges those services.

4. The attending Child Psychiatrist/APRN meets with the youth at a frequency appropriate to meet the clinical needs over the course of the stay, with an average of 1-2x per week, though with the ability to increase frequency as clinically indicated. The prescriber writes psychiatry notes in the youth's health record and coordinates with the existing prescriber if there is one. The attending Child Psychiatrist/APRN is an active participant on the youth's treatment team and is available to consult with other members of the treatment team throughout the youth's length of stay.

5. The program coordinates with existing service providers, which may include Intensive Care coordinators (ICCs), In-Home Therapy (IHT), PCP/PCC, CBHC, and others.

6. Assessments, treatments, and discharge plans, along with all coordination/treatment planning activities, are documented in the youth's health record.

Discharge planning and documentation

1. The Youth CCS maintains the capacity to discharge Enrollees 24/7/365. Discharge planning begins at admission, including plans for reintegration or integration into the home or other identified living situation, school, and community.

2. The discharge plans specifically focus on identification of anticipated services that will facilitate and support the youth's rapid return to the community. A determination is made and documented regarding the clinical appropriateness of the service, and/or other clinical services, to facilitate and support the youth's rapid return to the community. The program makes referrals where clinically indicated within 24 hours of admission. The main purpose is to ensure the participation of the community-based provider in planning for the youth's transition home. In instance where a youth requires more intensive clinician intervention, partial hospitalization should be considered to augment other services upon discharge.

3. The program ensures that active and differential treatment planning and discharge planning is implemented for each youth by qualified staff who are knowledgeable about the medical necessity criteria for all covered services.

4. Prior to discharge, the program assists youth in obtaining post-discharge appointments, as follows:

    a) Within two calendar days of discharge, there shall be appointments for appropriate behavioral health services; and

    b) Within seven calendar days of discharge, there shall be appointments for medication monitoring, if necessary.

    c) Scheduling post-discharge appointments may not be designated to aftercare providers or to the parent/guardian to be completed before or after the youth's discharge.

    d) These discharge planning activities, including the specific aftercare appointment date/time/location(s), are to be documented in the youth's health record.

e) If there are barriers to accessing covered services, the program notifies the youth's health plan as soon as possible to obtain assistance. All such activities are documented in the youth's record.

f) Prior to discharge, with consent, the program contacts the youth's school to ensure a smooth transition back into school.

g) A Child and Adolescent Needs and Strengths (CANS) assessment is completed by a certified CANS assessor.

h) In preparation for discharge, the program develops or updates a crisis plan with the youth and their family/caregiver and sends a copy to the CBHC/YMCI director at the youth's local CBHC/YMCI provider with parent/guardian consent. At the time of discharge, the program ensures that the parent/guardian and youth have a copy of the crisis plan.

i) The program conducts a discharge meeting with the multi-disciplinary team, inclusive of the parent/guardian and any youth, age 9 or older, as clinically and developmentally indicated.

j) The program provides, with appropriate consents, a written discharge summary (or other such document(s) that contain the required elements) no later than within 48 hours of the youth's discharge to the youth, parents/guardians/caregivers, primary care provider, school, and current behavioral health providers. The discharge summary is documented in the youth's health record and includes a summary of:

   i. The course of treatment;
   ii. The youth's progress;
   iii. The treatment interventions and behavior management techniques that were effective in supporting the youth's progress;
   iv. Medications prescribed;
   v. Recommended behavior management techniques when applicable; and
   vi. Treatment recommendations, including those that are consistent with the service plan of the relevant state agency for youth who are also involved with DMH, Department of Developmental Services (DDS), Department of Youth Services (DYS), or DCF; and/or the youth's Individual Care Plan (ICP) for those enrolled in Intensive Care Coordination (ICC).

Additional requirements

1. The YCCS is responsible for submission of monthly utilization data, including capacity, noted changes in capacity, and average daily census.

   a) The YCCS adheres to performance specifications and Quality Performance Measures (e.g., achieve 80 percent ADC, 90 percent of admissions to be accepted within 60 minutes).

   b) The YCCS administers and provides data from Patient Reported Satisfaction Surveys.

   c) The YCCS utilizes monthly performance/quality data provided by MassHealth's BH vendor to develop YCCS-specific goals including strategies to improve patient satisfaction.

   d) The YCCS participates in the creation of and utilizes the Provider Quality Management Plan, as needed.

   e) The YCCS communicates with the Plan in a timely manner regarding:

      i. Access issues;
      ii. Changes in leadership;
      iii. New initiatives affecting YCCS service delivery; and
      iv. Any time-sensitive/relevant issue.

   f) The Youth CCS is required to maintain a log of all referrals that include the following information: date/time of referral, Enrollee date of birth and/or age, Enrollee diagnosis, referring provider (e.g., MCI team name, Emergency Department name, Inpatient provider

name), and decision with explanation for all referrals declined and alternative referrals offered.

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.