ENHANCED ACUTE TREATMENT SERVICES (E-ATS) FOR INDIVIDUALS WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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 information, Plan expectations, your contract, and MassHealth guidance. This information should be 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

Enhanced Acute Treatment Services (E-ATS) for Individuals with Co-occurring Mental Health and Substance Use Disorders provide diversionary and/or step-down services for Enrollees in need of acute, 24-hour substance use disorder treatment, as well as psychiatric treatment and stabilization. Withdrawal management services are provided through a planned program of 24-hour, medically monitored evaluation, care, and treatment and are tailored for individuals whose co-occurring mental health and substance use disorder requires a 24-hour, medically monitored evaluation, care, and treatment program, including the prescription and dosage of medications typically used for the treatment of mental health disorders. E-ATS services for individuals with co-occurring mental health and substance use disorders are rendered in a licensed, acute care or community-based setting with 24-hour physician and psychiatrist consultation availability, 24-hour nursing care and observation, counseling staff trained in substance use disorders and mental health treatment, and overall monitoring of medical care.

Services are provided under a defined set of physician-approved policies, procedures, and clinical protocols. E-ATS are available for both adolescents and adults.

Individuals may be admitted to an E-ATS program directly from the community, including referrals from Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) providers, or as a transition from inpatient services.

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 Level 3.7 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.

SERVICE COMPONENTS

1. At minimum, the provider complies with all requirements of the Department of Public Health (DPH) licensure of substance abuse treatment programs (105 CMR 164), including DPH reporting requirements.
2. The provider accepts admission 24 hours per day, 7 days per week, 365 days per year.
    a) A thorough physical examination, which conforms to principles established by the American Society of Addiction Medicine, is completed for all Enrollees as part of the admission process.
    b) Medical and nursing care based on a comprehensive biopsychosocial assessment that was performed within 24 hours of Enrollee's admission
3. Full therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional staff to conduct these services and to manage a therapeutic milieu. The scope of required service components provided in this level of care includes, but is not limited to the following:
    a) Bio-psychosocial evaluation
    b) Medical history and physical examination
    c) Individual and group therapy
    d) Psycho-education, including substance use disorder, relapse prevention, and communicable diseases
    e) Development of behavioral treatment/recovery plans
    f) Development and/or updating of crisis prevention plans, and/or safety plans as part of the Crisis Planning Tools for Enrollees, and/or relapse prevention plans, as applicable
    g) Initial substance use disorder assessment
    h) Initial nursing assessment
    i) Psychiatric evaluation and treatment
    j) Pharmacological evaluation and treatment
    k) Discharge planning/case management
    l) Aftercare planning and coordination
    m) Withdrawal Management
    n) 24-hour nursing care
4. The program provides a comprehensive, structured treatment program which incorporates the

effects of substance use disorders, mental health disorders, and recovery, including the complications associated with dual recovery, and provides a minimum of four hours of service programming per day.

5. The provider has the capacity to treat Enrollees with alcohol and/or other drug dependencies who are assessed to be at a mild to moderate risk of medical complications during withdrawal and who also have a concomitant psychiatric diagnosis.
6. The program admits and has the capacity to treat Enrollees who are currently on methadone maintenance or receiving other opioid replacement treatments. Such capacity may take the form of documented, active Affiliation Agreements with a facility licensed to provide such treatments.
7. The program 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 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.
8. Substance-specific withdrawal management protocols are individualized, documented, and available on-site. At minimum, these include withdrawal management protocols for alcohol, stimulants, opioids, and sedative hypnotics (including benzodiazepines.)
9. With consent, the provider makes documented attempts to contact the parent/guardian/caregiver, family members, and/or significant others within 48 hours of admission, unless clinically or legally contraindicated. The program provides them with all relevant information related to maintaining contact with the program and the Enrollee, including names and phone numbers of key nursing staff, primary treatment staff, social worker/care coordinator/discharge planner, etc. If contact is not made, the Enrollee's health record documents the rationale.
10. The provider 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.
11. Prior to this, the provider engages in a medication reconciliation process to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of an Enrollee from one care setting to another. The provider does this by reviewing the Enrollee's complete medication regimen at the time of admission (e.g., transfer and/or discharge from another setting or prescriber) and comparing it with the regimen being considered in the E-ATS program. The provider engages in the process of comparing the Enrollee's newly issued medication orders by the E-ATS prescriber to the medications that he/she has been taking to avoid medication errors. This involves:
    a) developing a list of current medications, i.e., those the Enrollee was prescribed prior to admission to the E-ATS program;
    b) developing a list of medications to be prescribed in the E-ATS program;
    c) comparing the medications on the two lists;
    d) making clinical decisions based on the comparison and, when indicated, in coordination with the Enrollee's primary care provider (PCP); and
    e) communicating the new list to the Enrollee and, with consent, to appropriate caregivers,

the Enrollee's PCP, and other treatment providers.

f) All related activities are documented in the Enrollee's health record.

10. All urgent consultation services resulting from the initial evaluation and physical exam, or as subsequently identified during the admission, are provided within 24 hours of the order for these services. Non-urgent consultation services related to the assessment and treatment of the Enrollee while in the E-ATS program are provided in a timely manner, commensurate with the level of need. Routine medical care (not required for the diagnosis related to the presenting problem) may be deferred, when appropriate, if the length of stay in the E-ATS program is brief. All services are documented in the Enrollee's health record.
11. The milieu does not physically segregate individuals with co-occurring disorders.
12. A handbook specific to the program is given to the Enrollee and parent/guardian/caregiver at the time of admission. The handbook includes but is not limited to Enrollee rights and responsibilities, services available, treatment schedule, grievance procedures, discharge criteria, and information about family support and peer and recovery-oriented services.

STAFFING REQUIREMENTS

If program 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 DPH/BSAS Licensing Regulation. The program is responsible for informing the payer of any waivered requirements if the waiver is approved.

1. The provider complies with the staffing requirements of the applicable licensing body and the staffing requirements outlined in 105 CMR 164. The program is staffed with sufficient appropriate personnel to accept admissions 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year. The provider utilizes a multi-disciplinary staff.
    a) Any exceptions to staffing requirements must be approved by BSAS and communicated to the Plan. The waiver process is described in the DPH/BSAS Licensing Regulation.
2. The provider is staffed with sufficient appropriate personnel to accept admissions 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year.
3. The provider utilizes a multi-disciplinary staff, including the following, all with established skills, training, and/or expertise in the integrated treatment of individuals with substance use disorders and/or dependence as well as co-occurring psychiatric disorders:
    a) A licensed, master's-level clinician responsible for clinical supervision; master's-level clinician responsible for assessment and treatment services;
    b) Physician and psychiatry staff, as outlined below;
    c) Registered nurse (RN), nurse practitioner, or physician assistant; and
    d) Licensed practical nurse (LPN), case aides, and case management staff.
4. Enrollees have access to supportive milieu staff, as needed, 24 hours per day, 7 days per week, 365 days per year.
5. The provider designates a physician, licensed to practice medicine in the Commonwealth of MA, as medical director with demonstrated training, experience, and expertise in the treatment of substance use and co-occurring disorders, and who is responsible for overseeing all medical

services performed by the program. The medical director is responsible for ensuring each Enrollee receives a medical evaluation, including a medical history and ensuring that appropriate laboratory studies have been performed. The medical director is integrated into the administrative and leadership structure of the E-ATS program and is responsible for clinical and medical oversight, quality of care, and clinical outcomes, in collaboration with the nursing and clinical leadership team.

6. A physician (MD) is on call 24 hours a day, 7 days a week, to respond to medical emergencies, and is available for a phone consultation within 60 minutes of request.
7. The provider has adequate psychiatric coverage to ensure all performance specifications related to psychiatry are met.
8. An attending psychiatrist who meets Plan's credentialing criteria, or one for whom the provider requests and receives a waiver, provides psychiatric consultation and psychopharmacological services to Enrollees in the E-ATS program. The medical director may also provide on-site psychopharmacological services, in consultation with the psychiatrist. The program may also utilize a psychiatric nurse mental health clinical specialist (PNMHCS) to provide on-site psychopharmacological services to Enrollees, within the scope of their licenses and under the supervision of the medical director or other attending psychiatrist, as outlined within these performance specifications. The program may also utilize a psychiatry fellow/trainee to provide on-site psychopharmacological services to Enrollees, in conformance with the Accreditation Council for Graduate Medical Education (ACGME, acgme.org), in compliance with all Centers for Medicare & Medicaid Services (CMS) guidelines for supervision of trainees by attending physicians, and under the supervision of the medical director or another attending psychiatrist, as outlined within these performance specifications.
9. When the attending psychiatrist is not scheduled to work or is out for any reason (e.g., vacation, illness, etc.), he/she designates a consistent substitute, as much as possible, to ensure that the Enrollee receives continuity of care. In these instances, the functions of providing psychiatric consultation and psychopharmacological services may be designated to a covering psychiatrist, or to a PNMHCS or a psychiatry fellow/trainee acting under the psychiatrist's or medical director's Enrollee-specific supervision.
10. For programs that utilize a psychiatry fellow/trainee to perform psychiatry functions, all the following apply:
    a) The psychiatry fellow/trainee must be provided sufficient supervision from psychiatrists to enable him/her to establish working relationships that foster identification in the role of a psychiatrist;
    b) The psychiatry fellow/trainee must have at least two (2) hours of individual supervision weekly, in addition to teaching conferences and rounds;
    c) If a psychiatry fellow/trainee conducts the initial face-to-face psychiatric evaluation of the Enrollee, he/she presents the Enrollee to the attending psychiatrist, or other psychiatrist on duty, within 24 hours; and
    d) The program must use the following classification of supervision:
        i. Direct supervision – the supervising physician is physically present with the fellow and Enrollee.
        ii. Indirect supervision**:**
            - with direct supervision immediately available – the supervising physician is

physically within the program and is immediately available to provide direct supervision.

- with direct supervision available – the supervising physician is not physically present within the program but is immediately available by means of telephonic and/or electronic modalities and is available to provide direct supervision.

iii. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

11. For programs that utilize a PNMHCS to perform psychiatry functions, the following apply:
    a) There is documented maintenance of: a collaborative agreement between the PNMHCS and the medical director, or another attending psychiatrist; and a consultation log including dates of consultation meetings and list of all Enrollees reviewed. The agreement specifies whether the PNMHCS or the medical director, or another attending psychiatrist, will be responsible for this documentation;
    b) The supervision/consultation between the PNMHCS and the medical director, or another attending psychiatrist, is documented and occurs at least one (1) hour per week for the PNMHCS, or at a frequency proportionate to the hours worked for those PNMHCS staff who work less than full-time. The format may be individual, group, and/or team meetings;
    c) A documented agreement exists between the medical director, or another attending psychiatrist, and the PNMHCS outlining how the PNMHCS can access the medical director, or another attending psychiatrist, when needed for additional consultation;
    d) The medical director, or another psychiatrist, is the attending psychiatrist for the Enrollee, when a PNMHCS is utilized to provide direct psychiatry services to a given Enrollee. The PNMHCS is not the attending for any Enrollee;
    e) If a PNMHCS conducts the initial face-to-face psychiatric evaluation of the Enrollee, he/she presents the Enrollee to the attending psychiatrist, or other psychiatrist on duty, within 24 hours, and documents all such activity; and
    f) There is documented active collaboration between the medical director, or another attending psychiatrist, and the PNMHCS relative to Enrollees' medication regimens, especially those Enrollees for whom a change in their regimen is being considered.
12. A psychiatrist is on call 24 hours a day, 7 days a week and is available for a phone consultation within 60 minutes of request.
13. The provider provides all staff with supervision consistent with Plan's credentialing criteria. The provider ensures that supervision of nursing staff is overseen by a registered nurse.
14. The provider documents regularly scheduled, in-service training sessions for all staff on the following topics, at a minimum:
    a) The program's All Hazards Emergency Response Plan;
    b) HIV/AIDS, sexually transmitted diseases (STDs) and Viral Hepatitis;
    c) Universal health precautions and infection control;
    d) Substance use disorders including tobacco and nicotine addiction, clinical assessment and diagnosis, treatment planning, relapse prevention and aftercare planning;
    e) The stages of change;
    f) Motivational Interviewing;
    g) Co-occurring disorders, including mental health disorders, gambling, and other

addictive behaviors;

h) Other topics specific to the requirements of the level of care and/or the population served;

i) Effects of substance use disorders on the family, family systems, and related topics such as the role of the family in treatment and recovery; and

j) Cultural competency including culturally and linguistically appropriate services (CLAS) or standards.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider complies with all provisions of the 105 CMR 164 related to community connections collateral linkages.
2. With Enrollee consent, if an Enrollee is referred to another treatment setting, the provider collaborates in the transfer, referral, and/or discharge planning process to ensure continuity of care.
3. The provider is responsible for developing and maintaining an active working relationship with each of the local ESPs/MCIs who are high-volume referral sources for the provider. On an Enrollee-specific basis, the provider collaborates with any involved ESP/MCI providers upon an Enrollee's admission to ensure the ESP's/MCI's evaluation and treatment recommendations are received, and that any existing crisis prevention plan, and/or safety plan, and/or relapse prevention plan is obtained from the ESP/MCI.
4. The provider maintains active working relationships with the step-down programs for adults and adolescents, including but not limited to Children's Behavioral Health Initiative (CBHI) services, especially with local providers of those levels of care that refer high volumes of Enrollees to the provider and/or to which the provider refers high volumes of Enrollees, to enhance continuity of care for Enrollees. It is considered best practice to maintain written Affiliation Agreements or Memoranda of Understanding (MOU) with such providers.
5. With Enrollee consent, the provider collaborates with the Enrollee's PCP as delineated in 105 CMR 164.
6. When necessary, the provider provides or arranges transportation for services required external to the facility 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.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The provider complies with all provisions specified in 105 CMR 164 related to assessment and recovery planning.
2. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year, within 30 minutes of the request for admission.
3. At the time of admission, a comprehensive nursing assessment is conducted, which includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score.

4. Within three hours of the admission, a registered nurse (RN) evaluates each Enrollee to assess the medical needs of the Enrollee. When the RN is not scheduled to work or is out for any reason (e.g., vacation, illness, etc.), he/she designates a consistent substitute, as much as possible, to ensure that the Enrollee receives continuity of care. In these instances, this function (or functions) 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. For direct admissions from the community, the provider ensures that a comprehensive medical history and a physical examination which conforms to the principles established by the American Society of Addiction Medicine, is conducted, and documented for each Enrollee 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. This examination includes the following:
    a) An assessment of the Enrollee's substance use disorder;
    b) Tests for the presence of opiates, alcohol, benzodiazepines, cocaine, and other drugs of abuse;
    c) A brief mental status exam; and
    d) An assessment of medical issues.
6. For direct admissions from the community, a psychiatric evaluation of the Enrollee is completed either on the day of the admission or within 24 hours of the admission by a psychiatrist, or by a PNMHCS or a psychiatry fellow/trainee under the supervision of the medical director or another attending psychiatrist. For admissions of Enrollees transitioning from other 24-hour levels of care, a psychiatric evaluation of the Enrollee is completed within 48 hours of admission by a psychiatrist, or by a PNMHCS or a psychiatry fellow/trainee under the supervision of the medical director or another attending psychiatrist.
7. For all women of childbearing age, a pregnancy test is administered, prior to the administration of any medication(s).
8. All medical orders are signed by the medical director or a designated licensed physician.
9. An initial assessment of each Enrollee is conducted by a senior clinician, physician, nurse practitioner, or physician assistant within 24 hours of admission and includes the following:
    a) A history of the use of alcohol, tobacco, and other drugs, including age of onset, duration, patterns, and consequences of use; use of alcohol, tobacco, and other drugs by family members; and types of and responses to previous treatment;
    b) An assessment of the Enrollee's psychological, social, health, economic, educational/vocational status; criminal history; current legal problems; co-occurring disorders; trauma history; and history of compulsive behaviors such as gambling;
    c) An assessment of the Enrollee's HIV risk status and TB risk status;
    d) If a need for further evaluation is identified, the provider conducts or makes referral arrangements for necessary testing, physical examination, and/or consultation. All such activities are documented in the Enrollee's health record; and
    e) The initial assessment concludes with a diagnosis of the status and nature of the Enrollee's substance use disorder, or a mental health disorder due to use of

psychoactive substances.

10. A counselor/clinician meets with the Enrollee for the purposes of assessment, counseling, treatment, case management, and discharge planning.
11. The provider assigns a multi-disciplinary treatment team to each Enrollee within 24 hours of admission. A multi-disciplinary treatment team meets to review the assessment and develop the initial treatment/recovery and discharge plans within 48 hours of admission. On weekends and holidays, the treatment/recovery plan may be developed by an abbreviated treatment team, with a review by the full treatment team on the next business day.
12. The provider completes a comprehensive and individualized treatment/recovery plan within 48 hours based on the assessment and developed in conjunction with the Enrollee and, with consent, family, guardian, and/or individual natural supports, current community-based providers including PCPs and behavioral health providers, and other supports identified by the Enrollee. The treatment/recovery plan is signed and dated.
13. The treatment/recovery plan, at a minimum, includes the following:
    a) A statement of the Enrollee's strengths, needs, abilities, and preferences in relation to his/her substance use disorder treatment, described in behavioral terms;
    b) Evidence of the Enrollee's involvement in formulation of the treatment/recovery plan, in the form of the Enrollee's signature attesting agreement to the plan;
    c) Service to be provided;
    d) Service goals, described in behavioral terms, with timelines;
    e) Clearly defined staff and Enrollee responsibilities and assignments for implementing the plan;
    f) Description of discharge plans and aftercare service needs;
    g) Aftercare goals;
    h) The date the plan was developed and revised;
    i) Signatures of staff involved in the formulation or review of the plan; and
    j) Documentation of disability, if any, which requires a modification of policies, practices, or procedures and record of any modifications made.
14. 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/recovery and discharge plans, reviews, and updates are documented in the Enrollee's health record. All reviews and updates include signatures of the Enrollee and the staff reviewing them.
15. The psychiatrist consults with the treatment team and makes best efforts to consult with outpatient prescribers prior to any psychotropic medication changes, and these changes are made if indicated. Other psychiatrists and/or a PNMHCS may also be available to consult with other members of the treatment team.
16. 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 PCPs 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.

17. The program requests drug-screening services and other laboratory work when medically necessary as part of a diagnostic assessment or component of an individualized treatment/recovery plan that includes other clinical interventions. All requests are made in writing by an authorized prescriber, (e.g., physician, physician assistant, nurse practitioner, etc.). The prescriber documents in the Enrollee's health record medical necessity for the drug screen and test results.
18. For pregnant women, the provider coordinates care with her PCP and obstetrician/gynecologist (OB/GYN) and consults with those physicians as needed.
19. The provider provides continuous assessment of the Enrollee's mental health status throughout the Enrollee's treatment episode and documents such in the Enrollee's health record.

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164 related to discharge planning.
2. The provider conducts discharges 7 days per week, 365 days per year.
3. 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 he/she has a copy of it. The E-ATS provider works with the Enrollee to update the existing plan, or, if one was not available, develops one with the Enrollee before discharge. With Enrollee consent and as applicable, the E-ATS provider may contact the Enrollee's local ESP/MCI to request assistance with developing or updating the plan. With Enrollee consent, the provider sends a copy to the ESP/MCI Director at the Enrollee's local ESP/MCI.
4. Prior to discharge, the provider assists the Enrollee in obtaining post-discharge appointments, as follows: within seven (7) calendar days of discharge for outpatient therapy services (which may be an intake appointment for therapy services), if necessary; and within 14 calendar days of discharge for medication monitoring, if necessary. This function may not be designated to aftercare providers or to the Enrollee to be completed before or after the Enrollee's discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Enrollee's health record. If there are barriers to accessing covered services, the provider notifies the Plan Clinical Access Line and/or the regional office as soon as possible to obtain assistance. All such activities are documented in the Enrollee's health record.
5. The provider engages the Enrollee in developing and implementing an aftercare plan when the Enrollee meets the discharge criteria established in his/her treatment/recovery plan. The provider provides the Enrollee with a copy of the aftercare plan upon his/her discharge and documents these activities and the plan in the Enrollee's health record.

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; and
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 Enrollees 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.