

Community Crisis Stabilization

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications.

The Community Crisis Stabilization (CCS) program provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older. CCS provides a distinct level of care where primary objectives of active multi-disciplinary treatment include: restoration of functioning; strengthening the resources and capacities of the Member, family, caregivers, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized crisis prevention plan; and linkage to ongoing, medically necessary treatment and support services. CCS staff provides continuous observation of, and support to, Members with mental health or co-occurring mental health/substance use disorder conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. Services at this level of care includes: crisis stabilization; initial and continuing bio-psychosocial assessment; care coordination; psychiatric evaluation and medication management; peer support and/or other recovery-oriented services; and mobilization of family/caregiver, natural supports and community resources. CCS services are short-term, providing 23-hour observation and supervision, and continual re-evaluation.

CCS provides a home-like, consumer-friendly, and comfortable environment conducive to recovery. CCS staff provides psycho-education, including information about recovery, wellness, crisis self-management, and how to access wellness and recovery services available in the Member's specific community. Guided by the treatment preferences of the Member, CCS staff actively involves family, caregivers, and other natural supports at a frequency based on Member needs. Treatment is carefully coordinated with existing and/or newly established treatment providers.

Note that the primary differences between CCS and inpatient level of care is the acuity of the Member, the unlocked setting, the level of psychiatry services, and an absence of immediate need for hospital-based diagnostic tests or general medical treatment. Admissions to CCS occur 24 hours per day, 7 days per week, 365 days per year based on determinations made by mobile and site-based Emergency Services Program (ESP) staff. Discharges from CCS occur 7 days per week, 365 days per year, and discharge processes include efficiencies that maximize service capacity. Readiness for discharge is evaluated on a daily basis, and the length of stay is expected to be very brief.

Components of Service

1. The ESP operates a CCS 24 hours per day, 7 days per week, 365 days per year for adults ages 18 and older. Admissions occur 24 hours per day, 7 days per week, 365 days per year and discharges occur 7 days per week, 365 days per year.
2. CCS provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less-restrictive, and voluntary alternative to inpatient psychiatric hospitalization.
3. CCS is primarily used as a diversion from an inpatient level of care; however, the service may be used secondarily as a transition from inpatient services if there is sufficient service capacity and the admission criteria are met. The ESP's outcomes are measured relative to the proportion of diversionary versus step-down admissions, with the expectation being that the majority are diversionary.
4. CCS provides a distinct level of care where primary objectives of active multi-disciplinary treatment include: restoration of functioning; strengthening the resources and capacities of the Member, family/caregiver, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized crisis prevention plan and/or safety plan; and linkage to ongoing medically necessary treatment and support services.
5. CCS services are short-term, providing 23-hour observation and supervision, and daily reevaluation and assessment of readiness for discharge.
6. CCS provides continuous observation of, and support to, Members with mental health or co-occurring mental health/substance use disorder conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services.
7. CCS services include: crisis stabilization; initial and continuing bio- psychosocial assessment; care coordination; psychiatric evaluation and medication management; peer support and/or other recovery-oriented services; mobilization of and coordination with family/caregiver and other natural supports, community treaters, and other resources; and psycho-education, including information about recovery, wellness, crisis self-management, and how to access wellness and recovery services available in the Member's specific community.
8. CCS is responsible for ensuring that each Member has access to medications prescribed for physical and behavioral health conditions, and documents so in the Member's health record.
9. Prior to this, the provider engages in a medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of a Member from one care setting to another. The provider does this by reviewing the Member'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 CCS. The provider engages in the process of comparing the Member's medication orders newly issued by the CCS to all of the medications that he/she has been taking in order to avoid medication errors. This involves:

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- a. developing a list of current medications, i.e., those the Member was prescribed prior to admission to the CCS;
 - b. developing a list of medications to be prescribed in the CCS;
 - c. comparing the medications on the two lists;
 - d. making clinical decisions based on the comparison and, when indicated, in coordination with the Member's primary care provider (PCP) and/or primary care team (PCT); and
 - e. communicating the new list to the Member and, with consent, to appropriate caregivers, the Member's PCP and/or PCT, and other treatment providers.
10. All related activities are documented in the Member's health record.
 11. Members who are admitted to the CCS have a community-based disposition in place at the time of admission.
 12. CCS is co-located with the ESP's community-based location in order to enhance service continuity and increase administrative efficiency to benefit those served. The overall ESP program operates in a fashion that ensures fluidity among ESP mobile services, site-based crisis services at the ESP community-based location, and the CCS, and minimizes inconvenience to Members in crisis.
 13. CCS provides a home-like, consumer-friendly, and comfortable environment conducive to recovery.
 14. The CCS is responsible for updating its available capacity, three times each day at a minimum, seven days per week, 365 days per year, on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The CCS is also responsible for keeping all administrative and contact information up to date on the website. The CCS is also responsible for training staff on the use of the website to locate other services for Members, particularly in planning aftercare services.

Staffing Requirements

1. The provider complies with the staffing requirements of the applicable licensing body and the credentialing criteria outlined in the Senior Whole Health Provider Manual, as referenced at www.SWHMA.com.
2. The ESP has a written staffing plan that clearly delineates (by shift) the number and credentials of its professional staff, including psychiatrists, nurses, bachelor's-level and master's level clinicians, milieu workers, and other mental health professionals in compliance with its capacity and the Senior Whole Health's CCS staffing model on a daily basis.
3. The ESP 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.
4. CCS provides awake staffing 24 hours per day, 7 days per week, 365 days per year.
5. With the use of fluidly trained staff and cross scheduling, programs respond to varying levels of demand in the ESP's three primary service components: adult services, the ESP community-based location, and the CCS program. All staff members share expertise in terms

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of clinical knowledge, service delivery (as appropriate for each discipline), and discharge planning.

6. CCS utilizes a multi-disciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use disorder conditions in adults.
7. The medical and clinical care of the CCS is managed by the ESP medical director and the CCS nurse manager. The medical director is a psychiatrist who meets Senior Whole Health's credentialing criteria, and the nurse is a registered nurse.
8. The ESP has adequate psychiatric coverage to ensure all CCS performance specifications relative to psychiatry are met.
9. The CCS has an attending psychiatrist who may be the ESP medical director or another psychiatrist. The attending psychiatrist, as much as possible, designates a consistent substitute to ensure that the Member receives continuity of care. The psychiatrist may delegate some psychiatric functions to a psychiatric nurse mental health clinical specialist (PNMHCS).
10. The CCS ensures 24 hours per day, 7 days per week, 365 days per year availability of a psychiatric clinician, either a psychiatrist or a PNMHCS that meets Senior Whole Health's credentialing criteria, including nights and weekends. The psychiatric clinician is available for a psychiatric phone consultation within 15 minutes of request and for a face-to-face evaluation within 60 minutes of request when clinically indicated.
11. The CCS's psychiatric clinicians provide psychiatric assessment, medication evaluations, and medication management, and contribute to the comprehensive assessment and discharge planning processes.
12. For programs that utilize a PNMHCS to perform psychiatry functions, all of 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 Members 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 Member, when a PNMHCS is utilized to provide direct psychiatry services to a given Member. The PNMHCS is not the attending for any Member;

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- e. If a PNMHCS conducts the initial face-to-face psychiatric evaluation of the Member, he/she presents the Member 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 Members' medication regimens, especially those Members for whom a change in their regimen is being considered.
13. The nurse manager, a registered nurse, has overall responsibility for the CCS and accountability to the ESP director. She/he performs the following functions: fills physician orders; administers medication; takes vital signs; coordinates medical care; contributes to comprehensive assessment, brief crisis counseling, individualized crisis prevention planning, and provider psycho-education; and assists with discharge planning and care coordination. The nurse manager leads treatment team meetings, or assigns a consistent staff member to do so. The nurse manager supervises licensed practical nurses (LPNs) and other staff working in the CCS. The nurse manager is a full-time position and works first shift or business hours unless otherwise approved by Senior Whole Health.
14. LPN staffing, appropriate to licensure level, assist the nurse manager with filling physician orders, administering medications, and monitoring vital signs. They work with the bachelor's-level staff to ensure an environment that promotes safety, recovery, and treatment. They contribute to the assessment, individualized crisis prevention planning, discharge planning, and care coordination processes. The ESP provides adequate LPN staffing to ensure that all CCS performance specifications are met. This staffing is generally expected to include an LPN on second and third shift on weekdays and all three shifts on weekends for average size CCS programs.
15. Master's-level clinicians are primarily responsible for conducting comprehensive assessments, brief crisis counseling, psycho-education, and treatment team functions as noted below. The ESP provides adequate master's-level clinician staffing to ensure that all CCS performance specifications are met. This staffing is generally expected to include a master's-level clinician working at least one shift per day.
16. Bachelor's-level milieu staff, preferably who are also credentialed as Certified Peer Specialists (CPSs), function within the CCS and are primarily responsible for ensuring an environment that promotes safety, recovery, and treatment. They contribute to the assessment, individualized crisis prevention planning, discharge planning, and care coordination processes. Staff who are certified as a CPS also provide peer-to-peer support and psycho-education about wellness and recovery. As resources and time permit, the CCS also has access to the CPSs who primarily staff the ESP's community-based location. The ESP provides adequate bachelor's-level milieu staffing, with CPS preferred, to ensure that all CCS performance specifications are met. This staffing is generally expected to include a bachelor's-level staff 24 hours per day, 7 days per week, 365 days per year for average size CCS programs.
17. The ESP ensures that all staff receive ongoing supervision appropriate to their discipline and level of training and licensure, and in compliance with Senior Whole Health's credentialing criteria. For CPSs, this supervision includes peer supervision.

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18. The ESP ensures that CCS staff receive the appropriate ESP staff training, including training required in the ESP performance specifications.

Process Specifications**Assessment, Treatment Planning, and Documentation**

1. The CCS assigns a multi-disciplinary treatment team to each Member within 24 hours of admission. The treatment team ensures that a comprehensive assessment and initial treatment and initial discharge plan are completed and that they are reviewed within 48 hours of admission.
2. During weekdays, a psychiatric clinician conducts a psychiatric assessment, including a medication evaluation, of each Member within 24 hours of admission. On weekends and holidays, a master's-level clinician may alternatively conduct the assessment and review the assessment, including the current medication regimen, and initial CCS treatment and discharge plan, with a psychiatric clinician by phone within six hours of the admission. A psychiatric clinician then conducts the psychiatric assessment within 24 hours, i.e., on Monday for weekend admissions, or the subsequent day for holiday admissions. Subsequent to the psychiatric assessment and medication evaluation, a psychiatric clinician provides ongoing, face-to-face assessment, stabilization, treatment, and medication management services to the Member throughout the Member's length of stay, as indicated by the CCS treatment plan.
3. All consultations indicated in the CCS treatment plan should be ordered within 24 hours of admission and provided in a timely manner.

Stabilization, Treatment, and Documentation

1. CCS staff provides 23-hour observation, supervision, support, and daily re-evaluation and assessment of readiness for discharge.
2. CCS staff engages Members in structured, therapeutic programming seven days per week, including treatment activities designed to: stabilize the Member; restore functioning; strengthen the resources and capacities of the Member, family/caregiver, and other natural supports; prepare for timely return to a natural setting and/or least restrictive setting in the community; develop and/or strengthen an individualized crisis prevention plan and/or safety plan; and link to ongoing, medically necessary treatment and support services.
3. CCS staff provides psycho-education, including information about wellness, recovery, crisis self-management, and how to access wellness and recovery services available in the Member's specific community.
4. Guided by the treatment preferences of the Member, CCS staff actively involves family/caregiver, and other natural supports at a frequency based on Member needs.
5. CCS staff carefully coordinates treatment with existing and/or newly established treatment providers.

Disposition Planning, Crisis Prevention/Safety Planning, and Documentation

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1. The CCS conducts discharges 7 days per week, 365 days per year.
2. Upon admission, the CCS:
 - a. assigns a clinician or other appropriate staff responsible for crisis prevention/safety planning, discharge planning, and ensuring a smooth transition to medically necessary services, if indicated; and
 - b. documents in the Member's health record all efforts related to these activities, including his/her participation in the discharge planning process.
3. CCS staff confirms and documents that, upon presentation to the ESP, the ESP clinician asked the Member, significant other/caregivers accompanying him/her, and/or community providers about the existence of an established crisis prevention plan and/or safety plan, and/or accessed any existing crisis prevention plan and/or safety plan on file at the ESP for the given Member. CCS staff obtains the crisis prevention plan and/or safety plan from the ESP clinician.
4. During the ESP intervention, the ESP clinician updates any existing crisis prevention plan and/or safety plan or creates one with the Member. The plan includes the presenting problem, the specific problem to be addressed along with a treatment plan, preferred disposition plan, and the involvement of others who may be available to support the Member before or during crises (i.e., providers, agencies, significant others/caregivers, and/or family members). The purpose of this plan is to expedite a client-focused disposition based on the experience gained from past treatment interventions. CCS staff obtains the updated or newly created crisis prevention plan and/or safety plan from the ESP clinician and updates it further during the course of treatment at the CCS.
5. Upon discharge, the CCS staff provides a copy of the updated crisis prevention plan and/or safety plan to the Member, and with consent, to family members/caregivers, the ESP, existing or new community treaters, and/or other identified collaterals.
6. Prior to discharge, the provider assists Members in obtaining post-discharge appointments, as follows: within seven (7) calendar days of discharge for outpatient behavioral health 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 Member to be completed before or after the Member's discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Member's health record. If there are barriers to accessing covered services, the provider notifies Senior Whole Health for assistance. All such activities are documented in the Member's health record.

Service, Community, and Collateral Linkages

1. With Member consent, treatment providers, family members, caregivers, and other collaterals are contacted within 24 hours of admission.
2. The CCS adheres to established program procedures for referral to a more restrictive, medically necessary behavioral health level of care when the Member is unable to be treated safely in the CCS.

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3. The CCS adheres to established program procedures for determining the necessity of a referral to a hospital when a Member requires non-psychiatric medical screening or stabilization.
4. The ESP and CCS maintain knowledge of, and relationships with, behavioral health levels of care and other community-based resources to which referrals are made for aftercare.
5. CCS and other ESP management and direct care staff develop and document organizational and clinical linkages with each of the high-volume referral source ESPs, hold regular meetings or have other contacts, and communicate with the ESPs on clinical and administrative issues, as needed, to enhance continuity of care for Members. On a Member specific basis, the CCS collaborates with the ESP upon admission to ensure the ESP's evaluation and treatment recommendations are received, and in preparation for discharge to develop or update any of the crisis prevention plans and/or safety plans.