Community Support Program

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

The performance specifications contained within pertain to the following services:

- Community Support Program (CSP)
- CSP-Community Support Program for Chronically Homeless Individuals (CSP-CHI)

Community Support Programs (CSPs) provide an array of services delivered by community-based, mobile, paraprofessional staff, supported by a clinical supervisor, to Members with psychiatric or substance use disorder diagnoses, and/or to Members for whom their psychiatric or substance use disorder diagnoses interfere with their ability to access essential medical services. These programs provide support services that are necessary to ensure Members access and utilize behavioral health services. CSPs do not provide clinical treatment services, but rather provide outreach and support services to enable Members to utilize clinical treatment services and other supports. The CSP service plan assists the Member with attaining his/her goals in his/her clinical treatment plan in outpatient services and/or other levels of care, and works to mitigate barriers to doing so.

In general, a Member who can benefit from CSP services has a mental health, substance use and/or co-occurring disorder that has required psychiatric hospitalization or the use of another 24-hour level of care, or has resulted in serious impairment with a risk of admission. CSP services are used to prevent hospitalization. Usually in combination with outpatient and other clinical services, they are designed to respond to the needs of individuals whose pattern of service utilization or clinical profile indicates high risk of readmission into any 24-hour behavioral health inpatient/diversionary treatment setting. These services are designed to be maximally flexible in supporting individuals to implement their clinical treatment plans in outpatient and/or other levels of care and attain the skills and resources needed to maintain community tenure. Such services may include:

- Assisting Members in improving their daily living skills so they are able to perform them independently or access services to support them in doing so;
- Providing service coordination and linkage;
- Providing temporary assistance with transportation to essential medical and behavioral health appointments while transitioning to community-based transportation resources (e.g., public transportation resources, PT-1 forms, etc.);
- Assisting with obtaining benefits, housing, and health care;
- Collaborating with Emergency Services Programs (ESPs) and/or outpatient providers; including working with ESPs to develop, revise and/or utilize Member crisis prevention plans; and
- Fostering empowerment, recovery, and wellness, including linkages to recovery-oriented peer support and/or self-help supports and services.

These outreach and supportive services are directed primarily toward adults and vary according to duration, type, and intensity of services, depending on the changing needs of each individual. Community Support Program services are expected to complement other clinical services that are being utilized by the individual and support the Member's attainment of his/her clinical treatment plan goals.

Community Support Program for Chronically Homeless Individuals (CSP-CHI) is a more intensive form of CSP for chronically homeless individuals who have identified a permanent supportive housing (PSH) opportunity. Once housing is imminent with members moving within 120 days, members receiving CSP may receive CSP-CHI services. CSP-CHI includes assistance from specialized professionals who – based on their unique skills, education, or lived experience – have the ability to engage and support individuals experiencing chronic homelessness in searching for PSH, preparing for and transitioning to an available housing unit, and once housed, coordinating access to physical health, behavioral health, and other needed services geared towards helping them sustain tenancy and meet their health needs.

For purposes of these performance specifications, the following terms are used as defined below according to MassHealth Managed Care Entity Bulletin 44, October 2020 located at https://www.mass.gov/doc/managed-care-entity-bulletin-44-community-support-program-for-chronically-homeless-0/download:

- **Chronic Homelessness:** a definition established by the U.S. Department of Housing and Urban Development (HUD) of a disabled individual who has been continuously homeless on the streets or in an emergency shelter or safe haven for 12 months or longer, or has had four or more episodes of homelessness (on the streets, or in an emergency shelter or safe haven) over a three-year period where the combined occasions must total at least 12 months (occasions must be separated by a break of at least seven nights; stays in institution of fewer than 90 days do not constitute a break). To meet the disabled part of the definition, the individual must have a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairment resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of two or more of those conditions.
- **Permanent Supportive Housing (PSH)**: a model of housing that combines ongoing subsidized housing matched with flexible health, behavioral health, social, and other support service. PSH has been proven to be an effective intervention for persons experiencing chronic homelessness. "Housing First" is a specific PSH approach that prioritizes supporting people experiencing homelessness to enter low-threshold housing as quickly as possible and then providing supportive services necessary to keep them housed.

Components of Service

1. The scope of required service components provided in this level of care includes, but is not limited to, the following:
   a. Case management
   b. Development and/or updating of crisis prevention plan
   c. Direct time spent with Members and providers
   d. Needs assessment
   e. CSP service plan
   f. Service coordination and linkage, relative to services included in the Member's individualized CSP service plan as well as to the activities listed in the Service, Community, and Collateral Linkages section below
   g. Provision of temporary assistance with transportation to essential medical and behavioral health appointments while transitioning to community-based transportation resources
   h. Research time/telephone time assisting Members with obtaining benefits, housing, and health care
2. The CSP is part of a larger organization that provides mental health or substance use disorder services and is licensed within the Commonwealth of Massachusetts. This does not apply to providers of CSP-CHI.
3. The CSP service is accessible to the Member seven days per week, directly or on an on-call basis. Outside business hours, the CSP provides telephonic coverage. An answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital emergency department (ED), does not meet the after-hours on-call requirement.
4. If a Member experiencing a behavioral health crisis contacts the CSP provider during business hours or outside business hours, the CSP staff member, based on his/her assessment of the Member's needs and under the guidance of his/her supervisor, may: 1) refer the Member to his/her outpatient provider; 2) refer the Member to an ESP for emergency behavioral health crisis assessment, intervention, and stabilization; and/or 3) implement other interventions to support the Member and enable him/her to remain in the community, when clinically appropriate, e.g., highlight elements of the Member's crisis prevention plan and/or safety plan, encourage implementation of the plan, offer constructive, step-by-step strategies which the Member may apply, and/or follow-up and assess the safety of the Member and other involved parties, as applicable.
5. The CSP provider delivers CSP services on a mobile basis to Members in any setting that is safe for the Member and staff. Examples of such a setting are a Member's home, an inpatient unit, or a day program.
6. The provider assertively provides outreach, service coordination, monitoring, follow-up, and general assistance to Members in mitigating and managing any barriers that may impede access to services, participation in CSP services and/or clinical treatment services, or the progress of recovery.
7. The provider facilitates and serves as an adjunct to outpatient and/or other behavioral health services and primary care services for medical issues.

8. The provider encourages and facilitates the utilization of natural support systems (i.e., family/caregiver and friends) and recovery-oriented, peer support, and/or self-help supports and services (e.g., clubhouses, Recovery Learning Communities, AA, etc.).
9. The CSP provides Members and their families/caregivers with education, educational materials, and training about psychiatric and substance use disorder diagnoses and recovery. The provider facilitates access to education and training on the effects of psychotropic medications, as well as those for physical disorders, and ensures that the Member is linked to ongoing medication monitoring services and regular health maintenance.

For Members in CSP-CHI, the types of services available may be categorized as:
1. **Pre-Tenancy**: engaging the member and assisting in the search for an appropriate and affordable housing unit;
2. **Transition into Housing**: assistance arranging for and helping the member move into housing; and
3. **Tenancy Sustaining Supports**: assistance focused on helping the member remain in housing and connect with other community benefits and resources.

Services should be flexible with the goal of helping eligible members attain the skills and resources needed to maintain housing stability. CSP-CHI services may be delivered within housing, at provider sites, or in the community.

CSP-CHI cannot be used to cover the costs of any housing-related "goods," including, but not limited to: housing applications fees, criminal record checks, fees related to securing identification documents, transportation, security deposits, first month's rent, rent/utility arrearages, utility hookups, furnishings, moving expenses, or home modifications.

Senior Whole Health will approve of CSP-CHI services to be provided to members who meet a plan's medical necessity criteria for CSP and are chronically homeless as defined above.

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 provider is staffed with bachelor-level paraprofessionals. All staff, at a minimum, must have a bachelor's degree in social work, psychology or a related field.
3. CSP staff may have lived experience and offer their expertise as peers to Members enrolled in the CSP service and to CSP staff. Such CSP staff must meet the same requirements delineated above.
4. CSP staff are capable of meeting community support needs relative to mental health conditions for adults, as well as issues related to substance use, co-occurring disorders, and medical issues. CSP providers include, at a minimum, staff with specialized training in

behavioral treatment, substance use and co-occurring disorders, and family/caregiver engagement and education regarding mental health and substance use disorder recovery as well as medical issues.

5. CSP staff are supervised by a licensed, master's-level clinician with training and experience in providing support services to adults with behavioral health conditions. Supervision includes Member specific supervision, as well as a review of mental health, substance use disorder, and medical conditions and integration principles and practices.
6. The provider ensures that staff receive documented, annual training to enhance and broaden their skills. The training topics include but are not limited to:
   a. Common diagnoses across medical and behavioral health care;
   b. Engagement and outreach skills and strategies;
   c. Service coordination skills and strategies;
   d. Behavioral health and medical services, community resources and natural supports;
   e. Principles of recovery and wellness;
   f. Cultural competence;
   g. Managing professional relationships with Members including but not limited to boundaries, confidentiality, and peers as CSP workers; and
   h. Service termination.
7. The CSP staff and supervisor access additional consultation and services, as needed, through collaboration with the Member's outpatient treaters, prescribers, primary care provider (PCP) and/or Primary Care Team (PCT), ESP, and other providers.

For **CSP-CHI**, network providers must also have at a minimum, chronic homelessness experience and expertise as demonstrated by:

1. Direct experience with current or recent grants, projects, or initiatives targeted to chronically homeless individuals or staff with lived experience; and
2. Current or previous grants from HUD or the Veterans Administration (VA) that require the provider to document chronic homelessness. In lieu of administering HUD or VA grants, a provider that has received training on determining and documenting chronic homelessness from a designated HUD or VA funded technical assistance provider will have been determined to meet these criteria.

For **CSP-CHI**, network provider staff must meet the following minimum qualifications:

1. Specialized training or lived experience in behavioral health treatment for co-occurring disorders, trauma-informed care, and Traumatic Brain Injuries;
2. Specialized training or lived experience in outreach and engagement strategies such as progressive engagement, motivational interviewing, etc.
3. Knowledge of housing resources and dynamics of searching for housing including, but not limited to:
   a. Obtaining and completing housing applications;
   b. Requesting reasonable accommodations;

c. Dealing with poor housing history or lack of housing history; with poor or lack of credit history; or criminal record mitigation
d. Gathering supporting documentation
e. Negotiating and completing lease agreements
f. Identifying resources for move-in costs (first and last month's rent, security deposits), furniture, and household goods

*Please note that CSP-CHI providers may also be CSP providers but are not required to be.

Process Specifications

Assessment, Service Planning, and Documentation

1. The provider initiates CSP service planning immediately by actively communicating with the referral source about the reasons for referral and recommended goals for the CSP service. If the referral source is a 24-hour behavioral health inpatient/diversionary level of care, the CSP provider, with Member consent, participates in discharge planning at the referring treating facility/provider location, and documents this activity in the Member's health record.
2. The CSP staff contacts the Member within 24 hours of the referral and, with Member consent, schedules the first appointment to occur within 48 hours or, upon Member request, as soon as possible thereafter.
3. In collaboration with the Member, the provider begins an initial CSP needs assessment of the Member within 48 hours of the initial face-to-face contact with him/her. A comprehensive CSP needs assessment is then completed within two (2) weeks of the initial assessment. The CSP needs assessment, based on the components outlined within the Components of Service section, assists the CSP provider in identifying ways to support the Member in mitigating barriers to accessing and utilizing clinical treatment services and attaining the skills and resources to maintain community tenure. The CSP needs assessment is updated with the Member, at a minimum quarterly, or as needed, and is entered in the Member's health record.
4. With Member consent, the CSP worker and CSP supervisor obtain and review a bio-psychosocial assessment completed by the referring level of care, such as an inpatient provider, and/or another clinical treatment provider, such as the Member's outpatient services provider. The CSP worker and CSP supervisor utilize this bio-psychosocial assessment to help inform the completion of the CSP needs assessment and related CSP service planning. If the CSP referral is made by a non-behavioral health source (e.g., state agency case manager, PCP and/or PCT, etc.), the CSP provider and CSP supervisor, with Member consent, obtain and review any relevant assessment, referral form, and/or summary that may be available. All such activity is documented in the Member's health record.
5. In collaboration with the Member and upon completion of the comprehensive CSP needs assessment (within two weeks of the initial assessment), the provider completes a comprehensive, individualized CSP service plan that is solution-focused with clearly defined interventions and measurable goals, and that outlines all the activities to be performed and/or coordinated by the provider, in collaboration with the Member.

a. In the development of the CSP service plan, the provider ensures that CSP workers consider the referral source's reasons for referral, recommendations of goals, and discharge recommendations.
b. The goals of the CSP service plan support the Member's use of outpatient and/or other clinical treatment services and attainment of his/her treatment plan goals in those settings. CSP service plan goals also address barriers to the Member's ability to do so.
c. Additionally, with consent and unless clinically contraindicated, the CSP workers collaborate with CSP supervisors, family members/caregivers/guardians/significant others, outpatient and other community-based providers, state agencies, community supports, and the Member's PCP and/or PCT.
d. The CSP worker and the Member sign the CSP service plan.

6. The CSP supervisor oversees the development of the comprehensive needs assessment and CSP service plan through supervision meetings. The supervisor reviews and signs the CSP service plan within one week of its completion, i.e., within three weeks of the first appointment. As needed, the CSP supervisor seeks additional consultation and services through collaboration with the Member's outpatient treaters, prescribers, PCP and/or PCT, ESP, and other providers.
7. The provider updates the CSP service plan at least quarterly, or more frequently if there are significant changes in the Member's needs, by reviewing and revising the goals and related activities with the Member and with consent and unless clinically contraindicated, with the Member's family/guardian/caregiver/significant other. The CSP service plan, CSP service plan updates, and related CSP service planning meetings are documented in the Member's health record.
8. The provider collaborates with Members to design services aimed at maximizing their independence. The services are designed to increase a Member's ability to care for him or herself, manage his/her behavioral health and medical services, and support his/her wellness and recovery goals. Services vary over time in response to the Member's ability to use his or her strengths and coping skills and achieve these goals independently.
9. For CSP-CHI, the provider must collect, maintain and submit to Senior Whole Health--upon initial notification of admission to the program and subsequent notification(s) that the Member is continuing in the program--written documentation that the Member receiving CSP-CHI services is chronically homeless. Documentation of chronic homelessness should meet the HUD standards for recordkeeping and be generated from the local Continuum of Care Homeless Management Information System (HMIS). If HMIS records are not available, the provider must collect and submit to, Senior Whole Health other documents to prove chronic homeless status, but these must meet the HUD standards for determining and documenting chronic homelessness.

Discharge Planning and Documentation

1. The provider begins discharge planning upon admission of the Member into the CSP and documents all discharge planning activity in progress notes in the Member's health record.

2. The Member is involved in the discharge planning process. Such involvement is documented in the Member's health record. With Member consent, and unless clinically contraindicated, family members/caregivers, significant others, state agencies, the Member's PCP and/or PCT, community supports, outpatient and other community-based providers are involved in the discharge planning process. The purpose of this planning process is to expedite a Member-focused disposition to other levels of care, services and supports when clinically indicated and with Member consent. If the Member chooses not to consent to such coordination, this is documented in Member's health record.
3. Discharge from the program occurs when discharge criteria are met, as outlined within the CSP medical necessity criteria.
4. Prior to discharge, the provider collaborates with clinical service providers to ensure a crisis prevention plan and/or safety plan is developed and/or updated in conjunction with the Member, and, with consent, all providers of care and family members/significant others/caregivers. The crisis prevention plan and/or safety plan is entered in the Member's health record.
5. The program ensures that a written CSP discharge or aftercare plan is given to the Member at the time of discharge or mailed to the Member along with the updated crisis prevention plan and/or safety plan, and a copy is entered in the Member's health record. With Member consent, a copy of the written discharge or aftercare plan is forwarded at the time of discharge to the following: family/guardian/caregiver/significant other, state agencies, outpatient or other community-based provider, PCP and/or PCT, ESP, and other entities and agencies that are significant to the Member's aftercare.

Service, Community, and Collateral Linkages

1. The provider makes best efforts to develop policies and linkages that promote communication and coordination of care with PCPs and/or PCT, to be knowledgeable of chronic medical conditions and diseases, to assess Members' compliance with medical treatment, and to assist Members with mitigating related barriers.
2. With Member consent, the provider consults and collaborates with family members, significant others, guardians, caregivers, outpatient providers, PCPs and/or PCT, and other medical providers, state agency representatives, day program staff, residential staff, and others who are involved in the Member's treatment. Contraindication and/or refusal of consent is documented in the Member's health record.
3. Building/supporting linkages with the Member's natural support system, including friends, family, significant others, caregivers, and self-help groups, is an ongoing and active part of the Member's CSP service plan. This includes making available to Members recovery and wellness information and resources, such as peer support services, self-help groups (e.g., Manic Depressive Disorders Association, twelve-step groups such as AA, Al-Anon, family support groups and others), consumer-operated and recovery-oriented services and supports (e.g., Recovery Learning Communities and Independent Living Centers) and advocacy organizations (e.g., NAMI). As appropriate, Members may also be referred to other

supportive community services, such as holistic care, massage therapy, nutritional therapy, employment training centers, etc.

4. A working relationship with the local ESP is required to facilitate collaboration around Members' crisis prevention and/or safety plans, as well as to access ESP crisis assessment, intervention, and stabilization for Members enrolled in CSP, when needed.
5. The provider assists the Member in obtaining all needed medical services, including ensuring that he/she is linked with his/her PCP and/or PCT and receives, at a minimum, an annual physical. All such service coordination is documented in the Member's health record.
6. CSP-CHI will establish and maintain linkages necessarily for supporting Members ability to live successfully in their communities.