Community Support Programs (CSP), CSP for Chronically Homeless Individuals (CSP-CHI) and Social Innovative Financing (SIF) Performance Specifications

These performance specifications apply to the following Tufts Health Plan products:

- ☐ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

These performance specifications apply to the following Tufts Health Public Plans products:

- ☐ Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plan)
- ☐ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

Providers contracted for this level of care or service are expected to comply with all applicable regulations set forth in the Code of Massachusetts Regulations and requirements of these service-specific performance specifications, in addition to the General Behavioral Health Performance Specifications. All performance specifications are located in the Provider Resource Center.

DEFINITION

Community Support Programs (CSPs) provide an array of services delivered by a community-based, mobile, multidisciplinary team of paraprofessionals, supported by a clinical supervisor, to members with mental health or substance use disorder diagnoses, or to members whose psychiatric or substance use disorder diagnoses interfere with their ability to access essential medical services, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting.

In general, a Member who can benefit from CSP services has a disorder that has required hospitalization or has resulted in serious impairment with a risk of hospitalization. CSP services are used to prevent hospitalization. They are designed to respond to the needs of individuals whose pattern of utilization of services or clinical profile indicates high risk of readmission into 24-hour treatment settings. These services are designed to be maximally flexible in supporting individuals who are unable to independently access and sustain involvement with needed services.

Services include:

- Assisting members in enhancing their daily living skills;
- Providing service coordination and linkage;
- Assisting with obtaining benefits, housing, and health care;
- Developing a safety plan;
- Providing prevention and intervention; and
- Fostering empowerment and recovery, including linkages to peer support and self-help groups

These outreach and supportive services are directed toward adults, children, and adolescents and vary according to duration, type, and intensity of services depending on the changing needs of each individual. Community Support Services are expected to complement other services already in place for the individual.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this performance specification as Senior Products.

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:

- **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[3] . "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 CSP must be part of a larger mental health or substance use disorder services organization that is licensed within the Commonwealth of Massachusetts.
2. The CSP provider is accessible to the Member and the Member's family 24 hours per day, 365 days per year, directly or on an on-call basis. The CSP provider's rotation system provides back-up for afterhours care. These services are intended to be the first level of crisis intervention whenever needed by the Member. Based upon these emergency services conducted by the CSP provider both during operating hours and after hours, the provider may refer the Member, if needed, to an Emergency Services Program (ESP/MCI) for an emergency evaluation. An answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital emergency department (ED), is not sufficient.
3. The CSP provider provides mobile services 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.
4. The CSP provider will address a variety of complex treatment issues, including treatment resistance, limited self-care, impulsive behavior, and/or difficulty obtaining needed mental health and substance use treatment.
5. The CSP provider delivers services in accordance with an individualized treatment plan jointly developed by the following participants: the Member, treatment providers involved in the care of the Member, family/guardian/significant other with proper consent, and as needed, a DMH clinician when the Member is identified as DMH Continuing Care Eligible, and/or a DCF caseworker when appropriate. Such services may include, but are not limited to, transportation to appointments and other activities, training and assistance in decision making, vocational guidance, skills building, problem solving, and support in both crisis and non-crisis situations.
6. The CSP provider assertively provides outreach, care management monitoring, follow-up, and general assistance for Members in dealing with day-to-day activities or problems that may impede access to treatment or the progress of recovery.
7. The CSP provider facilitates and serves as an adjunct to psychotherapy services and primary care services for medical issues.

[3] Refer to National Alliance to End Homelessness

8. The CSP provider will encourage and facilitate the utilization of peer and natural support systems (i.e., self-help, peer support, etc.).
9. The CSP provides Members and their families with education, educational materials, and training about mental illness, substance use, and recovery and rehabilitation. The CSP 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 or SIF 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.

STAFFING REQUIREMENTS

1. The CSP provider will be staffed with paraprofessionals capable of meeting community support needs of psychiatric issues for children, adolescents, and adults, as well as issues related to substance use and/or co-occurring disorders. CSP programs will include, at a minimum, a staff worker with specialized training in child/adolescent development (for child/adolescent CSP programs), behavioral treatment, substance use/dual recovery issues, and family treatment/engagement/education regarding psychiatric and substance use recovery issues.
2. CSP programs and direct service workers will be supervised by a licensed, master's-level clinician with specialized training in adult or child development issues that are reflective of the Members served.
3. The CSP program will, at a minimum, provide weekly supervision of the direct service staff. Supervisors shall maintain records of supervision. When clinically indicated, the supervisor will accompany staff while providing direct services. The assigned clinician must pre-authorize this supervision.
4. The CSP provider ensures that a psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist is available to the staff and the supervisor for consultation on an as-needed basis.

For CSP-CHI and SIF, 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 and SIF, 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:
    - Obtaining and completing housing applications;
    - Requesting reasonable accommodations;
    - Dealing with poor housing history or lack of housing history; with poor or lack of credit history; or criminal record mitigation
    - Gathering supporting documentation

- Negotiating and completing lease agreements
- Identifying resources for move-in costs (first and last month's rent, security deposits), furniture, and household goods

Note: CSP-CHI providers may also be CSP providers but are not required to be.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES

1. The CSP provider facilitates service linkage with the Member's dentist. This may include helping to schedule appointments and helping with transportation to these appointments.
2. When state agencies (DMH, DCF, DYS, DPH, DESE, DDS, probation office, and the courts) are involved with the Member and when consent is given, the CSP provider participates in the development of an interagency service plan. Ideally, all parties, including the CSP provider, will sign this service agreement.
3. Building/supporting linkages with the Member's natural support system, including friends, family, significant others, and self-help groups (AA, NA, Double Trouble, etc.) will be an ongoing and active part of the Member's care plan.
4. A formal affiliation with the Emergency Service Program (ESP/MCI) is required.
5. CSP-CHI and SIF providers will establish and maintain linkages necessary for supporting Members ability to live successfully in their communities.

QUALITY MANAGEMENT (QM)

1. The program will develop and maintain a quality management plan that is consistent with that of Tufts Health Public Plans 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 will include outcome measures and satisfaction surveys to measure and improve the quality of care and service delivered to Members, including youth and their families.
3. Clinical outcomes data must be made available to Tufts Health Public Plans upon request and must be consistent with Tufts Health Public Plans' performance standard for community support programs.
4. All Reportable Adverse Incidents will be reported to Tufts Health Public Plans within 1 business day of their occurrence per Tufts Health Public Plans' policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a Member, or to others by action of a Member, who is receiving services managed by Tufts Health Public Plans or has recently been discharged from services managed by Tufts Health Public Plans.

PROCESS SPECIFICATIONS

Treatment Planning and Documentation

1. The CSP provider participates in discharge planning at the referring treating facility/provider location.
2. The CSP provider initiates service planning immediately upon receiving a referral for a Tufts Health Plan Member. With the Member's consent, the CSP worker will visit the Member and/or the Member's family in any safe setting within 24 hours of the referral and begin establishing treatment and safety plans.
3. The CSP provider completes the safety plan in collaboration with the Member and, whenever possible, with the ESP/MCI most frequented by the Member. The plan includes name(s) of provider(s), primary inpatient facility, ESP community-based resources and how to access them, and other community resources and/or natural supports that the Member chooses to include. The safety plan will be utilized by the Member, the CSP provider, and the ESP/MCI team to provide for safety and stabilization of the Member during a crisis period. The plan is faxed to the Member's most frequented ESP/MCI and other relevant parties within 24 hours of meeting the Member.
4. The CSP provider completes a bio-psychosocial assessment of the Member within two weeks of the initial contact with the CSP. The biopsychosocial assessment is updated, at a minimum, quarterly, or as needed.
5. For all ICC-involved youth, the Member's treatment team will involve ICC from the point of admission.
6. The CSP provider will ensure that CSP workers participate with CSP supervisors, outpatient providers, Tufts Health Plan care management clinician if applicable, the Member, and with consent, unless clinically contraindicated or legally barred, the Member's family/guardian/

significant other regarding the development of the treatment plan. All parties involved, including the Member, will sign the treatment plan.

7. The CSP provider completes a treatment plan that is solution focused with clearly defined interventions and measurable outcomes. The CSP provider will review/revise goals with the Member and, with consent and unless clinically contraindicated or legally barred, with the Member's family/guardian/significant other at least every 30 days.
8. The CSP provider will ensure that services are individually designed for each Member, with Member and family input, and with recommendations from an assigned Tufts Health Plan care manager, when applicable.
9. The CSP provider will collaborate with Members to design services aimed at maximizing Members' independence. The services will be designed to increase a Member's ability to accept greater levels of responsibility for his or her care and recovery. Services will naturally vary in response to the Member's ability to use his or her strengths and coping skills.
10. The CSP provider assists the Member in obtaining all needed medical and dental services, including ensuring that he/she is linked with his/her PCP and receives, at a minimum, an annual physical and dental exam.
11. The CSP provider reports to the assigned Tufts Health Plan care manager any concerning changes in behavior, unusual incidents or admissions to detox, or other non-pre-authorized levels of care.
12. For **CSP-CHI**, the provider must collect, maintain and submit to Tufts Health Plan--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 Tufts Health Plan 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. When clinically or legally indicated, the CSP provider will facilitate admission to other levels of care, including respite, crisis stabilization, and ATS. The program has a formal written agreement with an Emergency Service Program (ESP/MCI) regarding frequency of contact/communication to ensure access to more intense levels of psychiatric intervention for Members whose conditions warrant further emergency psychiatric intervention. The program will also maintain procedures to ensure access to emergent medical care for Members, if needed.
2. The CSP provider will begin discharge planning upon admission of the Member into the program.
3. The Member will be involved to the maximum extent possible in the discharge planning process. Such involvement will be noted within the discharge summary and treatment plan. With Member consent, and unless clinically contraindicated or legally barred, family members, significant others, DMH, and all providers involved in the care will be involved in the discharge planning process.
4. Discharge from the program will occur in consultation with the payer and when discharge criteria are met.
5. The CSP provider will give prior notice of planned service termination to other treatment facilities, DMH, state agencies, family members/significant others, and other relevant parties within 30 days prior to termination. For unplanned termination of services, the CSP provider will notify all relevant parties (including the payer) by 12 p.m. the following day, or the date of discovery of such termination.
6. Prior to discharge, an updated safety plan is developed in conjunction with the Member, and with consent, all providers of care and family members/significant others. The purpose of this plan is to expedite a Member-focused disposition to other levels of care when clinically indicated.
7. The program ensures that a written aftercare plan is available to the Member at the time of discharge. When consent is given, a copy of the written aftercare plan must be forwarded at the time of discharge to the following: family/guardian/significant other, DMH when the Member is an identified continuing care consumer, outpatient or community based provider, PCP, school, local Emergency Services Provider(s) (ESP/MCI), and other entities and agencies that are significant to the Member's aftercare.

DOCUMENT HISTORY

- February 2020: Template updates
- December 2020: Updated based on MassHealth Managed Care Entity Bulletin 44 and performance specifications currently in use by MassHealth