Community Support Program (CSP)

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 service:

- Community Support Program (CSP)

Community Support Program (CSP) provides 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.

Community Support Program 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.

Components of Service

1. The scope of required service components provided in this level of care must foster member empowerment, recovery, and wellness and must be designed to increase a member's independence, including management of their own behavioral health and medical services. Services vary over time in response to the member's ability to use their strengths and coping skills and achieve these goals independently. Services include:
   a. 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;
   b. Spending time with members and providers;

   c. Providing members and their families with education, educational materials, and training about behavioral health and substance use disorders and recovery. The provider facilitates access to education and training on the effects of psychotropic medications, and ensures that the member is linked to ongoing medication monitoring services and regular health maintenance;
   d. Coordinating services and assisting members with obtaining benefits, housing, and healthcare;
   e. Communicating with members or other parties that may include appointment reminders or coordination of care;
   f. Collaborating with crisis intervention providers, state agencies, and outpatient providers, including working with these providers to develop, revise, and utilize member crisis prevention plans and safety plans; and
   g. Encouraging and facilitating the utilization of natural support systems, and recovery-oriented, peer support, and self-help supports and services.
2. The CSP is part of a larger organization that provides mental health or substance use disorder services and is licensed by the Massachusetts Department of Public Health (DPH).
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 Behavioral Health Mobile Crisis Intervention team, 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, each program must have capacity to respond to a member's behavioral health crisis. Under the guidance of a CSP supervisor, the CSP staff may implement interventions to support and enable the member to remain in the community, refer the member to crisis intervention services, or refer the member to other healthcare providers, as appropriate.
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
   a. Traumatic brain injuries; and
   b. Safety protocols.
10. 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), behavioral health crisis intervention team, and other providers.

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 CSP program must designate a professional as overall administrator and program director in charge of day-to-day administration of the program.
3. The CSP program must employ a multidisciplinary staff that can support the schedule of operation and provide services to members. A member of the program's professional or paraprofessional staff must be assigned to each member to assume primary responsibility for that member's case.
4. 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, or two years of relevant work experience.
5. CSP staff may have lived experience of homelessness, behavioral health conditions or justice involvement; 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.
6. 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.
7. CSP staff must have access to a licensed, master's-level clinician or licensed psychologist, with training and experience in providing support services to adults with behavioral health conditions. Each staff member must receive supervision appropriate to the staff member's skills and level of professional development. Supervision must occur in accordance with the CSPs policies and procedures and must include review of specific member issues, as well as a review of general principles and practices related to mental health, substance use disorder, and medical conditions.
8. The provider ensures that staff receive training to enhance and broaden their skills. The recommended training topics may 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;
    h. Service termination;
    i. Motivational Interviewing;
    j. Accessibility and accommodations;
    k. Trauma-informed care;
    l. Traumatic brain injuries; and
    m. Safety protocols.

9. 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), behavioral health crisis intervention team, and other providers.

Assessment, Service Planning, and Documentation

1. Intake Services.
   a. The CSP provider must initiate service planning immediately by communicating with the referral source, if any, to determine goals, and document appropriateness of services.
   b. If the member is referred by a 24-hour behavioral health level of care, including inpatient and diversionary providers, the program will participate, as appropriate, in member discharge planning at the referring provider.
   c. If, during intake, the member is determined to be ineligible for CSP services, the program must provide referrals to alternative services that may be medically necessary to meet the member's needs, if any.
2. Needs Assessment. The CSP provider must conduct a needs assessment for every member as follows:
   a. The needs assessment must be completed within two (2) weeks of the initial appointment.
   b. The needs assessment must be updated with the member quarterly, at a minimum, or more frequently if needed, and must be entered in the member's health record.
   c. The needs assessments must identify 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.
3. Service Planning. The CSP provider must complete a service plan for every member upon completion of the comprehensive needs assessment as follows:
   a. The service plan must be person-centered and identify the member's needs and individualized strategies and interventions for meeting those needs;
   b. As appropriate, the service plan must be developed in consultation with the member and member's chosen support network including family, and other natural or community supports;
   c. As appropriate, the program must incorporate available records from referring and existing providers and agencies into the development of the service plan, including any bio-psychosocial assessment, reasons for referral, goal, and discharge recommendations.
   d. The service plan must be in writing, and must include at least the following information, as appropriate to the member's presenting complaint:
      - Identified problems and needs relevant to services;
      - The member's strengths and needs;
      - A comprehensive, individualized plan that is solution-focused with clearly defined interventions and measurable goals.
      - Identified clinical interventions, services, and benefits to be performed and coordinated by the provider;
      - Clearly defined staff responsibilities and assignments for implementing the plan;
      - The date the plan was last reviewed or revised; and

- The signatures of the CSP staff involved in the review or revision.

e. The service plan must be reviewed and revised at least every 12 months. The service plan must be updated if there are significant changes in the member's needs, by reviewing and revising the goals and related activities.

4. Referral Services. The program must have effective methods to refer members promptly and efficiently to community resources. The program must have knowledge of and connections with resources and services available to members.
   a. Each program must have written policies and procedures for addressing a member's behavioral health disorder needs that minimally include personnel, referral, coordination, and other procedural commitments to address the referral of members to the appropriate health care providers.
   b. When referring a member to another provider for services, each program must ensure continuity of care, exchange of relevant health information, and avoidance of service duplication between the CSP provider and the provider to whom a member is referred. Each program must also ensure that the referral process is completed successfully and documented.
   c. Referrals should result in the member being directly connected to and in communication with community resources for assistance with housing, employment, recreation, transportation, education, social services, health care, outpatient behavioral health services, and legal services.
5. Crisis Intervention Referrals. During business hours or outside business hours, each program must have capacity to respond to a member's behavioral health crisis. Under the guidance of a CSP supervisor, the CSP staff may implement interventions to support and enable the member to remain in the community, refer the member to crisis intervention services, or refer the member to other healthcare providers, as appropriate.

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, Behavioral Health Mobile Crisis Intervention team, 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 Mobile Crisis Intervention Provider is required to facilitate collaboration around members' crisis prevention and/or safety plans, as well as to access behavioral health mobile crisis intervention services for a 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.