COMMUNITY SUPPORT PROGRAM FOR CHRONICALLY HOMELESS INDIVIDUALS (CSP-CHI)

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 documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look 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-specific specifications take precedence.

OVERVIEW

Community Support Program for Chronically Homeless Individuals (CSP-CHI) provides support services to Enrollee who are: experiencing chronic homelessness as defined by the Department of Housing and Urban Development (HUD), have a disability, and are living in supportive housing, or receiving CSP services to secure and maintain supportive housing.

CSP for Chronically Homeless Individuals is a community-based service coordination and support level of care (hereafter, referred to as “CSP-CHI services”) that coordinates the healthcare and community tenure needs of Plan[1] Enrollee experiencing chronic homelessness. CSP-CHI service providers (hereafter, referred to as “Provider”) provide an array of support services and outreach delivered by community-based, mobile, paraprofessional staff to ensure Enrollee access and utilize health services and other supports. CSP-CHI services are not clinical treatment services but are supported by clinical supervisors and provide support for Enrollees to achieve their clinical service plan goals. In combination with outpatient and medical services, CSP-CHI services are maximally flexible and designed to prevent hospitalization for individuals whose pattern of service utilization or clinical profile indicates high readmission risk.

CSP-CHI is a more intensive form of CSP for chronically homeless individuals who have identified a PSH housing opportunity. Once housing is imminent with Enrollees moving within 120 days, Enrollees receiving CSP may receive CSP-CHI services. CSP-CHI includes assistance from specialized

[1] Plan” is a stand-in for any managed care plan that adopts these performance specifications.

professionals who – based on their unique skills, education, or lived experience – can 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. The types of CSP-CHI services available may be categorized as:

- **Pre-Tenancy**: engaging the Enrollee and assisting in the search for an appropriate and affordable housing unit;
- **Transition into Housing**: assistance arranging for and helping the Enrollee move into housing; and
- **Tenancy Sustaining Supports**: assistance focused on helping the Enrollee remain in housing and connect with other community benefits and resources.

Services should be flexible with the goal of helping eligible Enrollees 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.

Definitions/Terms

Chronic homelessness: As defined 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.

Chronic homelessness disability requirement: According to HUD, chronic homelessness must include one or more of the following conditions: Substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments from brain injury, or chronic physical illness or disability. HUD regulations detail examples of evidence of a qualifying disability.

Natural supports: According to Substance Abuse and Mental Health Services Administration (SAMHSA), natural supports refer to variety of people who are engaged in supportive relationships with people outside of health care settings. Examples include family, friends, other loved ones, landlords, employers, neighbors, and any other person who plays a positive, but nonprofessional, role in someone's recovery.

Supportive housing: According to the U.S. Interagency Council on Homelessness, Supportive Housing is an evidence-based housing intervention combining non-time-limited affordable housing

assistance with optional wrap-around supportive services for people experiencing homelessness to live independently.

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.

SERVICE COMPONENTS

1. **Service component scope:** Required service components provided in this level of care include:
    a) Needs assessments
    b) Developing, utilizing, and updating Enrollee CSP-CHI service plan (hereafter, referred to as "Service Plan")
    c) Developing, utilizing, and updating of Enrollee safety plan
    d) Service coordination and linkages with formal and informal services and supports, including healthcare and housing providers
    e) Assisting Enrollees access transportation related to housing search and healthcare
    f) Outreach and engagement services that vary according to duration, type, and intensity
    g) Direct time spent with Enrollees and providers
    h) Assisting Enrollees improve their daily living skills to perform them independently
    i) Case management
    j) Assisting Enrollees obtain housing, benefits, and health care
2. **Recovery and wellness:** Recovery, wellness and empowerment principles and practices are incorporated in service delivery, trainings, and quality improvement activities.
3. **Cultural competence:** Provider accommodates the Enrollee's individual needs and community contexts; respects the diverse population served; ensures access to culturally competent clinicians and other collaterals; makes available diverse linguistic material as necessary; and integrates cultural competence in trainings and quality improvement activities.
4. **Consent:** The Provider complies with laws and standards regarding consent and privacy.
5. **Service accessibility**: CSP-CHI service is accessible 7 days a week, directly or on-call, and mobile as needed (e.g., Enrollee's home, shelter, public accommodation, day program, or other setting).
6. **Crisis:** If an Enrollee experiences a behavioral health crisis and contacts the Provider, as clinically appropriate, may:
    a) refer the Enrollee to outpatient provider;
    b) refer the Enrollee to an ESP; and/or
    c) implement other interventions such as Enrollee's safety plan.

7. **Education:** The CSP-CHI provider educates Enrollees and their natural supports about substance use and psychiatric disorders, recovery and medications, and links with regular health services.

STAFFING REQUIREMENTS

1. **Staff credentials:** Providers ensure staff are qualified through education, experience, and training. The Provider is staffed with bachelor-level paraprofessionals and/or individuals with lived experience. Those organizations that have staff members who do not meet these criteria may apply for a waiver through Plan's waiver process as necessary.
    a) **Chronic Homelessness experience and expertise** as demonstrated by:
        i. direct experience with current or recent grants, projects, or initiatives targeted to chronically homeless individuals or staff with lived experience; and
        ii. 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.
    b) **Any staff of network providers of CSP-CHI must also meet the following minimum qualifications:**
        i. Specialized training or lived experience in behavioral health treatment for co- occurring disorders, trauma-informed care, and Traumatic Brain Injuries.
        ii. Specialized training or lived experience in outreach and engagement strategies such as progressive engagement, motivational interviewing, etc.
        iii. 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
        iv. CSP-CHI providers may also be CSP providers but are not required to be.

Please note that CSP-CHI providers are not required to be licensed by DPH, accredited by Joint Commission, or other nationally recognized accreditation service. CSP-CHI providers instead must meet the Provider Requirements in MCE Bulletin 44.

2. **Staffing:** CSP-CHI staff can meet community support needs relative to mental health substance use disorders, co-occurring disorders, medical issues, and long-term homelessness.
3. **Supervision:** CSP-CHI staff are supervised by a behavioral health clinician. Supervision includes Enrollee-specific supervision, as well as a review of mental health, substance use disorder, and medical conditions and integration of principles and practices.
4. **Staffing compliance:** The Provider complies with the staffing requirements, of the applicable licensing body, in these performance specifications, and the Plan credentialing criteria.
5. **Trainings:** The Provider ensures that staff receives training appropriate to population needs.
    a) **Policies and procedures:** The Provider offers orientations and ongoing information about the Provider's and Plan's policies and procedures, including: Provider Manual; Medical Necessity Criteria; authorization procedures; performance specifications; per diem/per services definitions; adverse incident reporting; and alerts.
    b) **Regular training topics:** Common medical and behavioral diagnoses; progressive engagement and outreach strategies; service coordination strategies and resources; behavioral health, medical services, community resources and natural supports; recovery and wellness; cultural competence; confidentiality and boundaries; evidence-based interventions such as Critical Time Intervention and Housing First; and discharge planning.
    c) The CSP-CHI staff and supervisor access additional consultation and services, as needed.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. **Agency engagement:** Providers engage with state and federal-funded programs as applicable.
2. **Transportation:** Providers make reasonable efforts to assist Enrollee identify and/or facilitate transportation options while transitioning to community-based transportation resources.
3. **Healthcare access:** The Provider assists the Enrollee in obtaining all needed medical services.
4. **Health coordination**: The Provider coordinates care with Enrollee's primary care clinician to be knowledgeable of medical conditions, to assess Enrollee's compliance with medical treatment, and to assist mitigating related barriers.
5. **Housing coordination**: Providers work with homeless providers and Continuums of Care (CoCs) to educate Enrollees and community about CSP-CHI services. Providers work with housing agencies to obtain documentation of chronic homeless status, and ensure the needs assessment, and Service Plan include specific housing components, and linkages to available services.
6. **Facilitates community linkages**: The Provider facilitates the use of formal and informal resources including community and natural support systems, wellness programs, vocational assistance programs, and peer and self-help supports and services.
7. **Consultation and collaboration:** With consent and as clinically appropriate, the provider consults and collaborates with natural supports, outpatient and medical providers, state agency representatives, and others involved in the Enrollee's treatment.
8. **Emergency Services Programs (ESPs)**: Provider works with ESP providers on safety plans, and:
    a) Responds to referrals from the ESP in a timely fashion.

b) Trains staff on proper use of ESP, including alternatives to Emergency Departments.
c) Educates Enrollees on ESP service availability, and how to access services locally.
d) With Enrollee consent, sends a copy of their safety plan to the Enrollee's local ESP.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. **Service access and availability**: The Provider reports service availability as required by the Plan, reduces waiting lists, and contacts the Plan for assistance with making referrals as needed.
2. **Service documentation:** The Provider documents care coordination efforts: assessments; plans and updates; services provided; collateral contacts; and goal progress in the health record. Additionally Providers are accountable to HUD regulations that govern chronic homelessness verification and recordkeeping requirements.
3. **Referrals:** Referrals sources may range (homeless providers, Plans, Providers, MassHealth, self-referrals, etc.). Upon referral, Provider initiates service planning with the referrer about the referral reasons and recommended service goals. If the referral is an inpatient setting, discharge planning may occur on-site, but Enrollees must still meet the chronic homeless definition.
4. **Initial contact:** The CSP-CHI staff contacts the Enrollee within 24 hours of the referral and schedules the first appointment to occur within 48 hours as possible.
5. **Needs assessment**: With the Enrollee, the Provider begins an initial needs assessment of the Enrollee within 48 hours of the initial face-to-face contact. It is recommended that within 2 weeks of the initial assessment, a *comprehensive* needs assessment is completed. The comprehensive assessment identifies ways to mitigate barriers to accessing clinical treatment and attaining the skills to obtain and maintain community tenure.
    a) Assessment includes complaints and symptoms; behavioral health, medical, substance use, developmental, and social history; linguistic and cultural background; mental status examination; medications and allergies; barriers to housing; diagnosis and clinical formulation supported by the clinical data gathered, rationale for treatment, and recommendations; level of functioning; and key providers.
    b) The Provider assigns a multi-disciplinary treatment team to each Enrollee which meets to review the assessment, initial treatment plan and discharge plan.
    c) The initial outcome measurement is administered on or before the comprehensive assessment to ensure clinical data was integrated into the initial assessment process.
    d) Provider obtains and reviews a bio-psychosocial assessment (or any relevant assessment, referral form, and/or summary) completed by the referral source.
6. **Service Plan**: Built upon the needs assessment, the Provider and Enrollee complete a comprehensive, individualized Service Plan with clearly defined interventions and activities to be performed and/or coordinated by the Provider, measurable goals, time frames, the Enrollee's strengths, links to primary care and other collaterals.
    a) The Provider considers the reasons for referral and recommendations of goals.
    b) Service Plan goals support access to clinical services and attainment of treatment goals.
    c) Service Plan includes a housing component relative to housing search and stabilization.

d) As appropriate, Provider collaborates with healthcare providers, homeless agencies, state agencies, and collaterals to ensure alignment with other service recommendations.
e) Service planning includes natural support systems, social, and medical assessments.
f) Service plan is consistent with Enrollee's age and changing condition.
g) The CSP-CHI worker and the Enrollee sign the Service Plan.

7. **CSP-CHI supervision**: The CSP-CHI supervisor oversees the needs assessment and Service Plan. The supervisor reviews and signs the Service Plan within one week of its completion. As needed, the supervisor consults with the Enrollee's healthcare providers, ESP, and other collaterals.
8. **Service Plan updates**: The Provider updates the Service Plan quarterly, and/or once the Enrollee obtains housing, by reviewing and revising the goals and related activities based on continual reassessment of the Enrollee.
9. **Provider-Enrollee collaboration:** The Provider collaborates with Enrollees to design services to increase their ability to care for themselves, manage their behavioral health and medical services, and support their wellness goals. Services vary over time.
10. **Collateral and natural support collaboration:** With consent, and as appropriate, natural supports, health providers, state agencies, community-based programs, and other collaterals are participants in the service delivery process, including assessment, service planning and updates, services, care coordination, and related meetings.

Discharge Planning and Documentation

1. **Enrollee termination:** If the Enrollee terminates without notice, every effort is made to re-engage the Enrollee or to transfer the Enrollee to another appropriate source of care.
2. **Provider responsibilities:** Provider ensures staff understanding of discharge/termination planning, and identifies barriers to utilizing aftercare services, in line with benefit coverage.
3. **CSP-CHI Service discharge documentation:** Beginning of discharge activity, discharge involvement, and safety and discharge plan are entered in the Enrollee's health record.
4. **Beginning of discharge planning:** Discharge planning occurs at beginning of CSP-CHI service.
5. **Discharge involvement:** As appropriate, the Enrollee, natural supports, state agencies, outpatient and community-based providers are involved in the discharge planning process.
6. **Discharge criteria:** Discharge occurs as clinically appropriate. There is no expectation for length of time in CSP-CHI service (i.e., Enrollees may continue receiving CSP-CHI services post-housing as clinically appropriate). Any of the following is sufficient for discharge:
    a) Enrollee no longer meets admission criteria or meets criteria for different level of care;
    b) Service Plan goals and objectives have been substantially met;
    c) The Enrollee is not utilizing or engaged in the CSP-CHI service;
    d) Consent for the CSP-CHI service is withdrawn;
    e) The Enrollee is not making progress toward Service Plan goals.
7. **Safety plan:** The provider ensures crisis prevention/safety plan is developed and/or updated, and, with consent, collaborates with providers and natural supports. Such a plan is designed to expedite a consumer-focused disposition in the event of a psychiatric crisis.

8. **Discharge plan*:*** Individualized discharge plan developed and given to the Enrollee at discharge with the updated safety plan. With Enrollee consent, the discharge plan is forwarded to state agencies, outpatient or community-based providers, ESP, or other significant entities.
    a) Identification of the Enrollee's needs, including housing; finances; medical care; transportation; employment; natural, community and social supports; and safety plan.
    b) List of aftercare services and supports including providers and community resources.

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.
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 youth 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.