COMMUNITY CRISIS STABILIZATION (CCS)

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

The Community Crisis Stabilization (CCS) program provides short-term, staff-secure, safe, and structured crisis stabilization and treatment services 24 hours per day, seven days per week, and 365 days per year (24/7/365) 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, including youth ages 18-20 under the Children's Behavioral Health Initiative (CBHI). 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 Enrollee, family, 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, as part of the Crisis Planning Tools for youth; and linkage to ongoing, medically necessary treatment and support services. CCS staff provides continuous observation of, and support to, Enrollees with mental health, substance use disorder (SUD), or co-occurring mental health/substance use disorders who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services.

CCS level of care is designed to manage SUD and co-occurring mental health/substance use disorders by providing addiction treatment that includes forms of individual/group behavioral therapy, variations of detox, psychopharmacology treatment, and linkages to medication-assisted treatment (MAT) interventions. Additional services at this level of care include crisis stabilization and treatment; 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 and

natural supports and community resources. CCS services are short-term, providing observation and supervision, hospital diversion, continual re-evaluation, and alternative placement for Enrollees boarding for higher levels of care.

CCS provides a home-like, consumer-friendly, and comfortable environment conducive to recovery. CCS staff provides psycho-education, individual and group therapy, including information about recovery, wellness, crisis self-management, and how to access wellness and recovery services available in the Enrollee's specific community. Guided by the clinical needs and treatment preferences of the Enrollee, CCS staff actively involves family and other natural supports. Treatment is carefully coordinated with existing and/or newly established treatment providers. With Enrollee consent, young adults who are involved with, or who are referred for, CBHI services – including Intensive Care Coordination (ICC) – CCS staff provides treatment recommendations and participates in team meetings, as appropriate.

Note that the primary differences between CCS and inpatient level of care is the acuity of the Enrollee, 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 24/7/365 based on determinations made by Emergency Services Program (ESP) staff, including hospital-based crisis services. Discharges from CCS occur 24/7/365, and readiness for discharge is evaluated on a daily basis.

SERVICE COMPONENTS

1. The ESP operates a CCS 24/7/365 for adults ages 18 and older. Admissions occur 24/7/365, and discharges occur 24/7/365.
2. CCS and ESP administration share responsibility for CCS admission decisions. CCS and ESP must have a written policy that outlines acceptance and admission determination protocol to CCS level of care 24/7/365. Every admission declination must be documented, logged, and reviewed in real time by a CCS and ESP administrator.
3. 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.
4. CCS is primarily used as a diversion from an inpatient level of care or as transition from inpatient services if there is sufficient service capacity and the admission criteria are met. CCS provides a distinct level of care where primary objectives of active, multi-disciplinary treatment include: stabilization; treatment; restoration of functioning; strengthening the resources and capacities of the Enrollee, family, 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 observation, supervision, and daily re-evaluation and assessment of readiness for discharge or reassessing and updating disposition recommendations for Enrollees boarding at CCS. Through this process, the CCS strives to meet benchmarks for length of stay against which the program is measured by the Plan.

6. CCS provides continuous observation of, and support to, Enrollees 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 will have linkages to MAT programs where Enrollees may be inducted while being stabilized at CCS.
8. CCS services include: crisis stabilization/treatment; 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 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 Enrollee's specific community.
9. CCS is responsible for ensuring that each Enrollee has access to medications prescribed, even if the Enrollee does not have a current prescription filled, for physical, medical, and behavioral health conditions and documents so in the Enrollee's health record. Neither medication access nor compliance should be considered a barrier to admission at CCS level of care.
10. The provider engages in a medication reconciliation process to avoid advertent inconsistencies in medication prescribing that may occur in transition of an Enrollee from one care setting to another. The provider does this by reviewing the Enrollee'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 Enrollee's medication orders newly issued by the CCS to all medications that they have been taking to avoid medication errors. This involves:
    a) Developing a list of current medications, i.e., those the Enrollee was prescribed prior to admission to the CCS;
    b) Developing a list of medications to be prescribed in the CCS;
    c) Refer to Prescription Monitoring program list to confirm current and past prescribed medications ordering necessary medical/behavioral health medications for the Enrollee if they do not have access to currently prescribed medication;
    d) Making clinical decisions based on the comparison and, when indicated, in coordination with the Enrollee's primary care clinician (PCC); and
    e) Communicating the new list to the Enrollee and, with consent, to appropriate caregivers, the Enrollee's PCC, and other treatment providers. All related activities are documented in the Enrollee's health record.
11. Medically stable conditions that can be reasonably managed in the community shall not automatically be deemed exclusionary. Homelessness should not be a barrier to admission.
12. CCS is co-located with the Community-Based Health Center (CBHC) 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 CBHC and the CCS and minimizes inconvenience to Enrollees in crisis.
13. CCS provides a home-like, consumer-friendly, and comfortable environment conducive to recovery.
14. The CCS is required to update its available capacity, three times each day at a minimum, once per shift, seven days per week, 365 days per year, on the Massachusetts Behavioral Health

Access website (www.MABHAccess.com). The CCS must keep 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 Enrollees, particularly in planning aftercare services.

15. The CCS prioritizes Enrollees residing in the ESP catchment area but is encouraged to admit Enrollees residing outside the catchment area when beds are available, and the Enrollee meets all admission criteria.

STAFFING REQUIREMENTS

1. 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 Plan's CCS staffing model on a daily basis.
2. The CCS program has a written "triage protocol" that streamlines the referral process and does not exclude anyone with behavioral health and/or medical needs who can be maintained in the community with minimal support. Any denials must be documented and undergo a "real time" administrative review to determine how the CCS could accommodate the person.
3. The ESP is staffed with sufficient appropriate personnel to accept admissions to, and facilitate discharges from, CCS 24/7/365.
4. CCS provides awake staffing 24/7/365.
5. With the use of fluidly trained staff and cross-scheduling, programs respond to varying levels of demand in the ESP's four primary service components: adult and youth mobile services, the ESP community-based location, and the CCS program. All staff members share expertise in terms 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 ESP has adequate psychiatric coverage to ensure all CCS performance specifications relative to psychiatry are met.
8. 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 Enrollee receives continuity of care. The psychiatrist may delegate some psychiatric functions to a psychiatric nurse mental health clinical specialist (PNMHCS).
9. The CCS ensures 24/7/365 availability of a psychiatric clinician, either a psychiatrist or a PNMHCS, that meets the Plan's credentialing criteria, including nights and weekends. The
10. 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 Enrollees reviewed. The agreement specifies whether the PNMHCS, 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 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 Enrollee, when a PNMHCS is utilized to provide direct psychiatry services to a given Enrollee. The PNMHCS is not the attending for any Enrollee;

e) If a PNMHCS conducts the initial face-to-face psychiatric evaluation of the Enrollee, they present the Enrollee 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 Enrollees' medication regimens, especially those Enrollees 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. They perform 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 the Plan.
14. LPN staff, 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
15. 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, unless otherwise approved by the Plan.
16. 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, unless otherwise approved by the Plan.
17. Bachelor's-level milieu staff, preferably who are also credentialed as certified peer specialists (CPSs) and/or recovery coaches (RCs), 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 or RC 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 and RCs who primarily staff the ESP's community-based location. The ESP provides adequate bachelor's-level milieu staffing, with CPS or RC preferred, to ensure that all CCS performance specifications are met. This staffing is generally expected to include a bachelor's- level staff 24/7/365 for average-size CCS programs, unless otherwise approved by the Plan.

18. The ESP and CCS ensure that all staff receive ongoing supervision appropriate to their discipline and level of training and licensure and in compliance with the Plan's credentialing criteria. For CPSs, RCs, and Family Partners, this supervision includes peer supervision.
19. The ESP and CCS ensure that CCS and ESP staff receive the appropriate ESP and CCS staff training, including training required in the ESP performance specifications.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. With Enrollee consent, treatment providers, family members, and other collaterals are contacted within 24 hours of admission.
2. For young adults who are involved with, or who are referred for, CBHI services, with Enrollee consent CCS staff provide treatment recommendations and participate in team meetings, as appropriate.
3. The CCS adheres to established program procedures for referral to a more-restrictive, medically necessary behavioral health level of care when the Enrollee is unable to be treated safely in the CCS.
4. The CCS adheres to established program procedures for determining the necessity of a referral to a hospital when an Enrollee requires non-psychiatric medical screening or stabilization.
5. 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.
6. The CCS provides education to Enrollees of ESP services and supports at the local ESP community-based location.
7. The CCS maintains a linkage with MAT providers to provide induction to Enrollees admitted to CCS who would benefit from MAT.
8. CCS leadership, ESP management, and direct care staff develop and document organizational and clinical linkages with each of the high-volume referral source ESPs and 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 Enrollees. On an Enrollee-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.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. Triaging CCS referrals should be done expeditiously, with 90 percent accepted within 60 minutes.

2. The CCS assigns a multi-disciplinary treatment team to each Enrollee upon admission. The treatment team ensures that a comprehensive assessment and initial treatment and tentative discharge plan are completed and that they are reviewed within 24 hours of admission. A psychiatric clinician conducts an in person psychiatric assessment, including a medication evaluation, of each Enrollee within 24 hours of admission.
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 observation, crisis treatment/stabilization supervision, support, and daily re-evaluation and assessment of readiness for discharge.
2. CCS staff engages Enrollees in structured, therapeutic programming seven days per week, including treatment activities designed to: stabilize the Enrollee; restore functioning; strengthen the resources and capacities of the Enrollee, family, 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 Enrollee's specific community.
4. Guided by the treatment preferences of the Enrollee, CCS staff actively involves family and other natural supports at a frequency based on Enrollee needs.
5. CCS staff carefully coordinates treatment with existing and/or newly established treatment providers.

Discharge Planning and Documentation

1. The CCS maintains the capacity to discharge Enrollees 24/7/365.
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 Enrollee's health record all efforts related to these activities, including the Enrollee's participation in the discharge planning process.
3. CCS staff confirms and documents that, upon presentation to the ESP, the ESP clinician asked the Enrollee and/or significant others accompanying them, 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 Enrollee. 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 Enrollee. 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 Enrollee before or during crises (i.e., providers, agencies, significant others, 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 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 Enrollee, and with consent, to family members, the ESP, existing or new

community treaters, and/or other identified collaterals.

6. Prior to discharge, the provider assists Enrollees in obtaining post-discharge appointments, as follows: within seven calendar days of discharge for outpatient 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 Enrollee to be completed before or after the Enrollee's discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Enrollee's health record. If there are barriers to accessing covered services, the provider notifies the respective payor to obtain assistance. All such activities are documented in the Enrollee's health record.

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.