COMMUNITY SUPPORT PROGRAM FOR HOMELESS INDIVIDUALS (CSP-HI)

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 Homeless Individuals (CSP-HI) provides support services to Enrollees who meet the following requirements:

- The Enrollee must meet one of the following criteria when the services begin:
  - experiencing chronic homelessness; or
  - experiencing homelessness and is a frequent user of acute MassHealth services as defined by:
    - Five or more ED visits within the past 12 months from the date of evaluation for CSP services; or
    - Three or more acute and/or psychiatric hospital inpatient admissions within the past 12 months from the date of evaluation for CSP services.
- The Enrollee must have identified a PSH opportunity and will be moving into housing within 120 days.

CSP for Homeless Individuals is a community-based service coordination and support level of care (hereafter, referred to as “CSP-HI services”) that coordinates the healthcare and community tenure needs of Plan[1] Enrollee experiencing homelessness. CSP-HI service providers offer 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-HI services are not clinical treatment

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

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-HI services are maximally flexible and designed to prevent hospitalization for individuals whose pattern of service utilization or clinical profile indicates high readmission risk.

To qualify for participation in MassHealth as a CSP-HI provider, a provider must have:

- experience providing services to persons with mental health disorders or substance use disorders or both;
- at least two years of history providing pre-tenancy, transition into housing, and tenancy sustaining supports to persons experiencing homelessness. This must include experience with serving people experiencing chronic homelessness and with documenting their chronic homeless status in accordance with requirements set by the U.S. Department of Housing and Urban Development.
- specialized professional staff with knowledge of housing resources and dynamics of searching for housing such as obtaining and completing housing applications, requesting reasonable accommodations, dealing with housing or credit histories that are poor or lacking, mitigating criminal records, negotiating lease agreements, and identifying resources for move-in costs, furniture, and household goods.

CSP-HI is a health-related social needs service for Enrollees who have identified a permanent supportive housing opportunity and will be moving into housing within 120 days.

CSP-HI includes assistance from specialized professionals who – based on their unique skills, education, or lived experience – can engage and support individuals experiencing 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-HI 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 get the skills and resources needed to maintain housing stability. CSP-HI services are delivered on a mobile basis to Enrollees in any setting that is safe for the Enrollee and staff. Services may be provided via telehealth, as appropriate. Details regarding the components of CSP-HI services can be found in 130 CMR 461.000.

CSP-HI 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.

The following Community Support Program for Homeless Individuals (CSP-HI) performance specifications are a subset of the Community Support Program (CSP) performance specifications. As such, CSP-HI providers agree to adhere to both the CSP performance specifications and to the CSP-HI performance specifications contained within. Where there are differences between the CSP and CSP-HI performance specifications, these CSP-HI specifications take precedence.

Definitions/Terms

At Risk of Homelessness – any Enrollee who does not have sufficient resources or support networks (*e.g.*, family, friends, faith-based or other social networks) immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation.

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.

Eviction – The process of obtaining a court order to remove a tenant and other occupants from a rental property including serving either a Notice to Quit or a request for temporary, preliminary, or permanent relief. Eviction may also refer to any instance in which such relief has been granted.

Homelessness – a condition of any Enrollee who lacks a fixed, regular, and adequate nighttime residence, and who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings including a car, park, abandoned building, bus or train station, airport, or camping group; or who is living in a supervised publicly or privately operated emergency shelter designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals. This includes those Enrollees who are exiting an institution (e.g., jail, hospital) where they resided for 90 days or less and were residing in an emergency shelter or place not meant for human habitation immediately before entering the institution.

Mental Health Disorder – any disorder pertaining to mental health as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Permanent Supportive Housing (PSH) – a model of housing that combines ongoing subsidized housing matched with flexible health, behavioral health, social, and other support services. “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.

Substance Use Disorder – any disorder pertaining to substance use as defined by the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*

SERVICE COMPONENTS

1. 130 CMR 461.000 establishes the requirements for participation of community support programs in MassHealth. All community support programs participating in MassHealth must

comply with the MassHealth regulations, including, but not limited to, regulations set forth in 130 CMR 461.000 and in 130 CMR 450.000: *Administrative and Billing Regulations*.

2. The CSP-HI provider delivers CSP-HI services on a mobile basis to Enrollees in any setting that is safe for the Enrollee and staff. Services may be provided via telehealth, as appropriate.
3. The CSP-HI provider must operate at least one location that is open and operated at least 40 hours per week within the Commonwealth of Massachusetts with the ability to provide onsite and community-based services.
4. A CSP-HI provider must have the capacity to provide at least the following service components:
    a) Intake Services
        i. The program must initiate service planning immediately by communicating with the referral source, if any, to determine goals, and document appropriateness of services.
        ii. If the Enrollee is referred by a 24-hour behavioral health level of care, including inpatient and diversionary providers, the program will participate, as appropriate, in Enrollee discharge planning at the referring provider.
        iii. If, during intake, the Enrollee is determined to be ineligible for CSP services pursuant to 130 CMR 461.403, the program must provide referrals to alternative services that may be medically necessary to meet the Enrollee's needs, if any.
    b) Needs Assessment. The program must conduct a needs assessment for every Enrollee.
    c) Service Planning. The program must complete a service plan for every Enrollee upon completion of the comprehensive needs assessment.
    d) Community Support Program Services. These services include those provided by the CSP-HI staff to the Enrollee and supervised by the staff identified in 130 CMR 461.411. CSP-HI services must foster Enrollee empowerment, recovery, and wellness and must be designed to increase an Enrollee's independence, including management of their own behavioral health and medical services. Services vary over time in response to the Enrollee's ability to use their strengths and coping skills and achieve these goals independently.
    e) Referral Services. The program must have effective methods to refer Enrollees promptly and efficiently to community resources. The program must have knowledge of and connections with resources and services available to Enrollees.
        i. Each program must have written policies and procedures for addressing an Enrollee's behavioral health disorder needs that minimally include personnel, referral, coordination, and other procedural commitments to address the referral of Enrollees to the appropriate health care providers.
        ii. When referring an Enrollee 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-HI provider and the provider to whom an Enrollee is referred. Each program must also ensure that the referral process is completed successfully and documented.
        iii. Referrals should result in the Enrollee 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.

f) Crisis Intervention Referrals. During business hours or outside business hours, each program must have capacity to respond to an Enrollee's behavioral health crisis. Under the guidance of a CSP-HI supervisor, the CSP-HI staff may implement interventions to support and enable the Enrollee to remain in the community, refer the Enrollee to crisis intervention services, or refer the Enrollee to other healthcare providers, as appropriate.

4. Discharge Planning. The program must provide discharge planning for each Enrollee receiving CSP-HI to expedite an Enrollee-centered disposition to other levels of care, services, and supports, as appropriate. Discharge from the program occurs in accordance with the clinical standards published by the MassHealth agency.
5. CSP-HI includes assistance from specialized professionals who can engage and support individuals experiencing homelessness in searching for permanent supportive housing; 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. In addition to the service components set forth in 130 CMR 461.410(A) and (B), CSP-HI services must also include:
    a) pre-tenancy supports, including engaging the Enrollee and assisting in the search for an appropriate and affordable housing unit;
    b) support in transition into housing, including assistance arranging for and helping the Enrollee move into housing; and
    c) tenancy sustaining supports, including assistance focused on helping the Enrollee remain in housing and connect with other community benefits and resources.

STAFFING REQUIREMENTS

1. Minimum Staffing Requirements: Each program must meet the minimum staffing and staff composition requirements outlined in 130 CMR 461.404 and 461.411 to adequately provide the required scope of services set forth in 130 CMR 461.410. The staff must include an adequate number of qualified personnel to fulfill the program's objective.
2. CSP-HI providers may also be CSP providers but are not required to be. CSP-HI providers are not required to be licensed by the Massachusetts Department of Public Health (DPH).
3. Provider staff must be directly accessible to the Enrollee, in person Monday through Friday, 9 A.M. to 5 P.M.
4. The Program must be accessible on an on-call basis when the site is closed to triage needs and offer referrals to qualified professionals, emergency services, or other mechanisms for effectively responding to a crisis.
5. The CSP-HI must establish an organizational chart showing major operating programs of the organization, the personnel in charge of each program, and the lines of authority, responsibility, and communication among and between personnel.
6. Program Director. The CSP-HI program must designate a professional as overall administrator and program director in charge of day-to-day administration of the program. The program director's responsibilities include:
    a) hiring and firing of CSP-HI staff;
    b) establishing and implementing a supervision protocol;
    c) establishing CSP-HI policies and procedures;
    d) accountability for adequacy and appropriateness of Enrollee service;

e) coordinating staff activities to meet program objectives;
f) program evaluation; and
g) establishing and supervising in-service training and education.

7. Multidisciplinary Staff
    a) The program must employ a multidisciplinary staff that can support the schedule of operations and provide services to Enrollees. A member of the program's professional or paraprofessional staff must be assigned to each Enrollee to assume primary responsibility for that Enrollee's case.
    b) The program must employ the number of staff necessary to implement all aspects of the service plan; maintain the Enrollee's records; initiate periodic review of the service plan for necessary modifications or adjustments; coordinate the various services provided by the program itself and by other agencies; coordinate referrals to other state agencies as needed; meet regularly with relatives and significant friends of the Enrollee; and monitor the Enrollee's progress in accomplishing the treatment goals.
    c) The program must have a licensed, master's-level behavioral health clinician or licensed psychologist to provide supervision to CSP-HI staff.
    d) All staff must have at least a bachelor's degree in a related behavioral health field, or two years of relevant work experience, or lived experience of homelessness, behavioral health conditions and/or justice involvement.
    e) Staff may include qualified Certified Peer Specialists and staff with lived experience of homelessness, behavioral health conditions or justice involvement.
8. CSP-HI staff must have access to a licensed, master's-level behavioral health clinician or licensed psychologist, with training and experience in providing support services to adults or youth with behavioral health conditions, to provide supervision. 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 program's policies and procedures and must include review of specific staff member issues, as well as a review of general principles and practices related to mental health, substance use disorder, and medical conditions.
9. Any staff of network providers of CSP-HI must also meet the following minimum qualifications:
    a) At least two years of history providing pre-tenancy, transition into housing, and tenancy sustaining supports to persons experiencing homelessness. This must include experience with serving people experiencing chronic homelessness and with documenting their chronic homeless status in accordance with requirements set by the U.S. Department of Housing and Urban Development.
    b) Specialized training or lived experience in behavioral health treatment for co- occurring disorders, trauma-informed care, and Traumatic Brain Injuries.
    c) Specialized training or lived experience in outreach and engagement strategies such as progressive engagement, motivational interviewing, etc.
    d) Specialized professional staff with knowledge of housing resources and dynamics of searching for housing including, but not limited to:
        i. Obtaining and completing housing applications
        ii. Requesting reasonable accommodations

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

10. The program must ensure that staff receive training to enhance and broaden their skills. Recommended training topics may include but are not limited to:
    a) common diagnoses across medical and behavioral healthcare;
    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 Enrollees 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.
11. Any staff, of any discipline, operating in the program must comport with the standards and scope of practice delineated in their professional licensure and be in good standing with their board of professional licensure, as applicable. Each program must notify the MassHealth agency of any staff who are sanctioned by the Department of Public Health or sanctioned by their board of licensure, as applicable.
12. The program must maintain a staffing plan that includes policies and procedures to ensure all staffing and supervision requirements pursuant to 130 CMR 461.000 are met.
13. The program must ensure appropriate protections against conflicts of interest in the service planning and delivery of CSP-HI services.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider makes best efforts to develop policies and linkages that promote communication and coordination of care with PCCs, to be knowledgeable of chronic medical conditions and diseases, to assess Enrollees' compliance with medical treatment, and to assist Enrollees with mitigating related barriers.
2. With Enrollee's consent, the provider consults and collaborates with family members, significant others, guardians, outpatient providers, PCCs and other medical providers, state agency representatives, day program staff, residential staff, and others who are involved in the

Enrollee's treatment. Contraindication and/or refusal of consent is documented in the Enrollee's health record.

3. Providers work with homeless providers and Continuums of Care (CoCs) to educate Enrollees and community about CSP-HI services. Providers work with housing agencies to obtain documentation of homeless status, and ensure the needs assessment, and Service Plan include specific housing components, and linkages to available services.

PROCESS SPECIFICATIONS

Written Policies and Procedures

1. Each community support program must have and adhere to written policies and procedures that include:
    a) a statement of its philosophy and objectives and of the geographical area served;
    b) an intake policy;
    c) admission procedures;
    d) service delivery procedures, including, but not limited to, development of the service plan, case assignment, case review, discharge planning, and follow-up on Enrollees who leave the CSP-HI;
    e) a referral policy, including procedures for ensuring uninterrupted and coordinated Enrollee care;
    f) recordkeeping policies, including what information must be included in each record, and procedures to ensure confidentiality;
    g) personnel and management policies, including policies for hiring, training, evaluation, supervision, and termination protocol for all staff;
    h) conflict of interest.

Provider Reporting Requirements

1. Each program must comply with all reporting requirements that may pertain to the practice, facility, policies or staffing of the program as directed by the MassHealth agency, and in compliance with 130 CMR 450.000: Administrative and Billing Regulations and 130 CMR 461.000.
2. Each provider must report adverse incidents to the MassHealth agency within 24 hours of discovery of the incident, or, if the incident occurs on a holiday or weekend, on the next business day, in a format specified by the MassHealth agency.
3. Providers must file such additional information as EOHHS may from time to time reasonably require.

Assessment, Treatment Planning and Documentation

1. Needs Assessment. The program must conduct a needs assessment for every Enrollee 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 Enrollee quarterly, at a minimum, or more frequently if needed, and must be entered in the Enrollee's health record.

c) The needs assessments must identify ways to support the Enrollee in mitigating barriers to accessing and utilizing clinical treatment services and attaining the skills and resources to maintain community tenure.

d) For CSP-HI, the timeframes for completing and updating the needs assessment may be extended as needed to allow for Enrollee engagement if the provider documents timely, yet unsuccessful, efforts to engage the Enrollee in completing or updating the assessment.

2. Service Planning. The program must complete a service plan for every Enrollee upon completion of the comprehensive needs assessment as follows:

a) The service plan must be person-centered and identify the Enrollee's needs and individualized strategies and interventions for meeting those needs;

b) As appropriate, the service plan must be developed in consultation with the Enrollee and Enrollee'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 Enrollee's presenting complaint:

i. Identified problems and needs relevant to services;

ii. The Enrollee's strengths and needs;

iii. A comprehensive, individualized plan that is solution-focused with clearly defined interventions and measurable goals:

iv. Identified clinical interventions, services, and benefits to be performed and coordinated by the provider;

v. Clearly defined staff responsibilities and assignments for implementing the plan;

vi. The date the plan was last reviewed or revised; and

vii. The signatures of the CSP-HI 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 Enrollee's needs, by reviewing and revising the goals and related activities.

3. Community Support Program Services. These services include those provided by the CSP-HI staff to the Enrollee and supervised by the staff identified in 130 CMR 461.411. CSP services must foster Enrollee empowerment, recovery, and wellness and must be designed to increase an Enrollee's independence, including management of their own behavioral health and medical services. Services vary over time in response to the Enrollee's ability to use their strengths and coping skills and achieve these goals independently. Services include:

a) Assisting Enrollees in improving their daily living skills so they can perform them independently or access services to support them in doing so;

b) Spending time with Enrollees and providers;

c) Providing Enrollees 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 Enrollee is linked to ongoing medication monitoring services and regular health maintenance;

d) Coordinating services and assisting Enrollees with obtaining benefits, housing, and healthcare;

e) Communicating with Enrollees 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 Enrollee 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.

Discharge Planning and Documentation

1. Discharge Planning. The program must provide discharge planning for each Enrollee receiving CSP-HI to expedite an Enrollee-centered disposition to other levels of care, services, and supports, as appropriate. Discharge from the program occurs in accordance with the clinical standards published by the MassHealth agency.
    a) The provider shall begin discharge planning upon admission of the Enrollee into the CSP-HI, with the participation of the Enrollee, and shall document all discharge planning activity in progress notes in the Enrollee's health record;
    b) As appropriate and applicable, the discharge planning process must involve the Enrollee's natural and community supports, current and anticipated future providers, current and anticipated future involved services agencies, and probation or parole staff.
    c) The discharge planning process must include crisis prevention and safety planning.
2. The program shall ensure that a written CSP-HI discharge plan is given to the Enrollee at the time of discharge along with the updated service plan and a copy is entered in the Enrollee's health record. With Enrollee consent, a copy of the written discharge plan shall be forwarded at the time of discharge to the following individuals or entities involved in or engaged with the Enrollee's ongoing care: family members, guardian, caregiver, and significant other; state agencies; outpatient or other community-based provider; physician; school; crisis intervention providers; probation, parole; and other entities and agencies that are significant to the Enrollee's aftercare.

Record Keeping Requirements

1. Each CSP-HI must obtain written authorization from each Enrollee or the Enrollee's legal guardian to release information obtained by the provider, to other community based providers, federal and state regulatory agencies, and, when applicable, referral providers or other relevant parties to the extent necessary to carry out the purposes of the program and to meet regulatory requirements. All such information must be released on a confidential basis and in accordance with all applicable requirements.
2. A CSP-HI must maintain Enrollee records in accordance with 130 CMR 450.000: *Administrative and Billing Regulations.* When an Enrollee is referred to any other provider, the program must maintain the original Enrollee record and forward a copy to the other provider.

3. Enrollee records must be complete, accurate, and properly organized.
4. The Enrollee's record must include at least the following information:
    a) the Enrollee's name and case number, MassHealth identification number, address, telephone number, gender identity, date of birth, marital status, next of kin, school, or employment status (or both), and date of initial contact;
    b) the place of service;
    c) the Enrollee's description of the problem, and any additional information from other sources, including the referral source, if any;
    d) the events precipitating the Enrollee's contact with the CSP;
    e) Written documentation that the Enrollee receiving services meets the clinical standards published by the MassHealth agency, including the following:
        i. CSP-HI providers must generate written documentation of homelessness from the local Continuum of Care Homeless Management Information System (HMIS) or comparable system used by providers of services for victims of domestic violence;
    f) the relevant medical, psychosocial, educational, and vocational history;
    g) a needs assessment of the Enrollee;
    h) short- and long-range goals that are realistic and obtainable and a time frame for their achievement;
    i) the Enrollee's service plan, updates, and related CSP service planning meetings, including schedule of activities and services necessary to achieve the Enrollee's goals, signed by both the CSP staff person and the Enrollee;
    j) written record of all services provided, including face-to-face, virtual, and collateral contacts, and including progress notes;
    k) a written record of the reassessments that includes recommendations for revision of the service plan, when indicated, and the names of the reviewers;
    l) the name(s) of the CSP staff person(s) responsible for providing services to the Enrollee;
    m) reports on all collateral consults and collaborations with family, friends, and outside professionals, including probation, parole, or correctional institution staff, who are involved in the Enrollee's treatment;
    n) all information and correspondence to and from other involved agencies, including appropriately signed and dated consent forms;
    o) when discharged, a discharge summary, including a summary of the Enrollee's services, a summary of the Enrollee's condition and response to services on discharge, achievement of goals, and recommendations for appropriate services that should be provided in subsequent programs by the same or other agencies to accomplish the Enrollee's long-range goals, and the program's future responsibility for the Enrollee's care;
    p) if the Enrollee fails to keep appointments or to adequately participate in the service plan, CSP-HI staff must make every effort to encourage the Enrollee to do so, and these follow-up efforts must be documented in the Enrollee's record.
5. The program must retain documentation reflecting compliance with the requirements of 130 CMR 461.000, including 130 CMR 461.403.
6. The program must maintain other records and reports as directed by EOHHS.
7. All records must be made available to the MassHealth agency upon request.

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.