CSA Plan and Implementation Timeframes
April 15, 2009

I. CSA Plan

A. Introduction

New Mexico continues to move forward to transform its behavioral health services and systems to support client-centered, family-focused, and community-delivered care directed toward recovery and resiliency outcomes. One of the critical components is Core Service Agencies (CSA) for children and for adults. Designation of these multi-service agencies will be one of the most significant infrastructure initiatives proposed to date in New Mexico. CSAs are agencies designated to provide points of entry for children and adults with intensive needs, assuring comprehensive care in system of care fashion with wraparound and recovery approaches. These agencies will help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity, ensure that community support services are integrated into treatment, and develop the capacity for consumers to have a single point of accountability for identifying and coordinating their behavioral health, health and other social services.

CSAs will be responsible for performing various clinical home functions. In a clinical home, a designated provider helps an individual coordinate and manage all of their care. This empowers individuals, families, and providers to work as partners in their care in a spirit of personal and organizational accountability. The goal is to create a holistic and well-monitored treatment experience. This requires services to be accessible, family and person-centered, coordinated, and culturally appropriate. CSAs will engage consumers, coordinate assessments, create service plans and provide or coordinate a range of prevention, early intervention, treatment, and recovery services. They will be responsible for ensuring access to services, facilitating choice of providers, ensuring continuity of care and assisting with the successful transition to other services, levels of care, and service providers.

B. Core Service Agency Defined

A Core Service Agency (CSA) provides a point of entry and comprehensive care for children, youth, families, and adults, including those individuals and families with very intensive needs. To become a CSA:

1. An organization must be designated as a CSA by the Collaborative. See material below on CSA designation.
2. The organization must be certified to provide Comprehensive Community Support Services (CCSS). In addition the organization must provide:
   - 24/7 crisis intervention
   - Access to psychiatric evaluations
   - Access to medication management
   - Access to a range of other clinical services
3. The organization must provide Enhanced Assessment, Comprehensive Service Planning, and Comprehensive Service Plan Review. While these three services are not certified per se, the Collaborative will review the ability of organizations to provide these in the context of their sufficiency to support good practice or services.

C. Core Service Agency Designation

In order to get to a process for designating agencies to serve as CSAs, the Collaborative will:

1. Finalize CCSS certification standards and a single audit tool that will be used by both CYFD (LCA) and DOH (DHI)
2. Determine how we will certify or otherwise assure that the CSA provides 24/7 crisis intervention, enhanced assessment, comprehensive service planning and access to psychiatric evaluation, medication management, and other clinical services.

3. Decide which combination of standards and/or regulations will be used to designate the agency as a CSA. These are the standards/regulations that CSAs must comply with and be reviewed against. Generally, these would include:
   a. Standard requirements related to governance, clinical and management infrastructure, maintenance of a quality improvement program, record keeping, staffing, etc. These are reflected in general provisions CYFD uses for certifying agencies to participate in the Medicaid program. There are two additional provisions that would be added to ensure that organizations have critical administrative and clinical staff (a full time CEO and chief clinical officer) to perform CSA functions and deliver quality services.
   b. Standards regarding the target populations served by a CSA. The initial target populations are described in Section G of this document.

CSA qualifications that would ensure that CSAs perform activities that are necessary to function as a clinical home are provided in Attachment A.

D. CSA Phase In

CSAs will be designated in at least two phases. Organizations certified by CYFD to provide CCSS and Community Mental Health Centers (CMHC) will be eligible to apply for designation as a CSA in Phase One beginning July 1\textsuperscript{st}, 2009. The Collaborative will use the initial months of Phase One to pilot the CSA standards and eligibility criteria for Phase 2. This information will be used to make necessary changes to CSA standards and the application process for Phase 2. During Phase One provider readiness tools will be used to identify agencies that are eligible to apply for CSA designation in Phase Two.

The overall number and geographic locations of CSAs have been projected, using population, prevalence, geography, and service area. The projection includes 23 designations of adult CSAs and 21 designations of children’s CSAs. During Phase One, it is anticipated that 10 adult CSAs and 9 children’s CSAs will be designated from 6 Local Collaborative areas.

During Phase Two (beginning January, 2010) applications for CSAs will be taken from service areas that did not have the projected number of designated CSAs in Phase One. It is the intent that there will be at least one designated CSA by State FY 2011 in each geographic area represented by a Local Collaborative.

The schedule for Phases One and Two is as follows:

**Phase One:**
- May 1, 2009 Issue RFA
- July 1, 2009 Designate agencies as CSA’s
- July – Sept, 2009 Training and Collective Learning
- October 1, 2009 Start-up

**Phase Two:**
- January 1, 2010 Issue RFA
- April 1, 2010 Designate agencies as CSA’s
- April – June, 2010 Training and Collective Learning
- July 1, 2010 Start-up

A third phase could be added if there is not a sufficient number of agencies ready to be designated during Phases One and Two:
Designation of CSAs for tribal entities, including IHS and 638 agencies, will not be made in Phase One. These entities may elect to apply for CSA designation at a later date.

The Phase-in of CSAs will not affect the availability of CCSS. CCSS will continue to be available across the State, including rural areas. To ensure access to CCSS, agencies certified by CYFD or DHI as well as those agencies identified in the Medicaid state plan will be able to offer CCSS.

In FY 2012, only a CSA or an agency identified in the Medicaid state plan will provide CCSS. These organizations must ensure that CCSS continues to be available for individuals who do not reside in close proximity to a CSA. Agencies designated as CSAs will be required to re-apply for designation in a time period determined by the Collaborative.

**E. Clinical Home Functions**

At its fundamental level, a clinical home supports the definition of primary care as the site of first-contact, with responsibility for patients over time; providing comprehensive care that meets or arranges for most of a patient's healthcare needs; and coordinating care across a patient's conditions, care providers and settings.[1] Others have added criteria that include the patient having a regular doctor or source of care; having no difficulty contacting them by phone; having no difficulty getting care or medical advice on evenings and weekends; and experiencing office visits that were well organized and running on time.[2]

In addition, medical homes must be able to take a patient-activated approach to disease management and successfully support patients with chronic or more intensive conditions.

New Mexico's approach to lodging clinical home functions with Core Service Agencies is analogous to a primary care medical home, with CCSS providing the CSA with the capacity for: serving as the site of first contact; having responsibility for clients over time; arranging for important behavioral health services for the client; and coordinating care across providers. All CSAs will serve as a clinical home and ultimately will be the only providers who can bill for CCSS. New Mexico believes that adults and children with high needs and multi-system penetration will require comprehensive assessments, team-based multi-disciplinary planning process, 24/7 crisis intervention and access to psychiatric evaluation, medication management and clinical services. These providers must also possess additional qualifications in the areas of: experience in providing children's behavioral health services; recovery and wraparound expertise, quality improvement and administrative infrastructure.

Initially, CSAs were intended to enhance access and coordination of behavioral health services to children and their families. A primary vehicle for these enhancements was the development of clinical homes and availability of training and coaching for embedding a wrap around approach to care coordination. The clinical home pilot project has provided a learning laboratory for the implementation of CSAs for children and families. Specifically, the CSA will ensure a front door process that is welcoming and engaging. The development of an enhanced assessment and comprehensive service planning process will ensure that individuals with complex behavioral health needs will have their needs appropriately identified and articulated. CCSS will support the identification and coordination of resources that are identified in the plan. For many years CMHCs have performed various front door functions for adults with serious mental illness. The CSA initiative will ensure that these functions will be performed in a manner that is person

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centered and recovery focused. CMHCs will need to re-engineer their practices to ensure that assessments are strength based, consumers drive their recovery plans and community support services strengthen an individual's ability to locate and use the services and supports identified in these plans. The Collaborative must identify the levers and assistance needed for CMHCs to continue to change their practices to support an individual's recovery. All CMHCs will be offered the opportunity to become a CSA.

F. Local Lead Agencies for Supportive Housing

The New Mexico Behavioral Health Purchasing Collaborative has developed a Long Range Supportive Housing Plan for individuals with behavioral health and other needs. As part of the implementation of that Long Range Plan, the Collaborative will designate Local Lead Agencies (LLA) to serve as the lead agency for referrals and to be the single point of contact with developers and property managers of Low Income Housing Tax Credit or other types of affordable housing projects funded through Mortgage Finance Agency (MFA). It is anticipated that a LLA will be designated in each geographic area represented by a Local Collaborative. The functions of a CSA and LLAs are very intertwined. Individuals who access supportive housing will need various services and supports including community support and crisis services. Many individuals who seek services from a CSA will need supportive housing services. The Collaborative has identified the following responsibilities for an LLA:

- Arranging supportive services for people who are in need of and accessing permanent supportive housing.
- Entering into an agreement with a designated housing property manager of a MFA funded housing project with rental units targeted for priority consumers within a local geographic area.
- Managing tenant pre-selection and referral for the community and acting as primary point of contact for the developer.
- Agreeing to become a “preferred permanent supportive housing provider” as defined by the SE or agreeing to enter into an agreement with a “preferred permanent supportive housing provider(s)” as defined by the SE.
- Participating in local supportive housing capacity building and referral responsibilities as requested by the SE.

Entities interested in being designated as a CSA will have to either assume the responsibilities of a LLA or enter into a formal working agreement with the LLA.

G. CSA Application Process

Applications for CSA will be solicited through an RFI process (Request for Information). Applications will be received by the Statewide Entity who will submit recommendations on designations to the Collaborative. Items to be included in the application can be found in Attachment A, Part B.

H. Populations Served by CSA

The target populations for CSAs are:

1. Adults with a Serious Mental Illness (SMI), chronic substance abuse disorder, or co-occurring disorders (e.g., mental health/substance abuse; mental health/developmental disability) where the mental illness or condition either causes functional impairment or interferes with functioning in a way that inhibits recovery and resiliency goals.

2. Children with a Serious Emotional Disturbance (SED) where the emotional disturbance or condition either causes functional impairment or interferes with functioning in a way that inhibits recovery and resiliency goals.

3. Children at risk of Serious Emotional Disturbance. At-risk SED determination is based on the age of the individual, involvement in children’s services systems, and psychosocial stressors. At-risk SED includes those children up to the age of 21 years (and their families) referred by, or involved
with CYFD Protective Services, CYFD Juvenile Justice Services, and/or Tribal Social Services OR at high-risk for services and entry into CYFD Protective Services, CYFD Juvenile Justice Services, and/or Tribal Social Services. At least two psychosocial stressors must be present that either cause functional impairment or interfere with functioning in a way that inhibits recovery and resiliency goals.

I. CSA SERVICES

1. Comprehensive assessment: CSAs will coordinate a comprehensive, strengths-based assessment for all individuals seeking treatment. The assessments will be provided in at least two levels, a diagnostic evaluation (90801) and an enhanced assessment (H0031). Diagnostic evaluations can be provided by referring agencies. Admission criteria must be met for the enhanced assessment (H0031). Agencies designated as CSA’s will be reimbursed for the enhanced assessment using Medicaid rates.

2. Comprehensive service plans (T1007) and service plan reviews (T1007-TS) with crisis plans embedded in each. CSAs will coordinate a wrap around and recovery/resiliency driven planning process, including identification and coordination of a care planning team for each individual; assisting the child, family and adult to develop a plan of care; and identifying providers and resources in the community to provide services and supports identified in the plan of care.

3. Comprehensive Community Support Services (H2015)

4. Psychiatric services (evaluation and/or medication management) directly or through formal arrangements with providers

5. 24/7 Crisis Services

6. Access to services and supports available in the community directly or through referral arrangements. These include a range of prevention; early intervention; treatment; and recovery, resiliency and community supports. Attachment B provides a list of services that should be available directly or through referral by a CSA.

J. Training

CSA staff will be required to successfully complete training on:

1. Enhanced assessment, including functional assessment (CAFAS for children and as approved by BHSD for adult)

2. Comprehensive service plan and update

3. Comprehensive Community Support Services (CCSS) as required in the CCSS service definition

4. Individualized, strengths based, community systems of support (often referred to as wraparound services)

Training will be provided by the Statewide Entity in conjunction with the Purchasing Collaborative.

CSA representatives will be required to participate in a Collective Learning Group. Initially this group will meet monthly to identify implementation issues (standards, certification process, etc.) that will be changed for subsequent phases and implementation.

II. CSA Implementation Activities

In accordance with the timetable presented above, the following Phase One activities will take place by July 1, 2009, in conjunction with the Statewide Entity.

1. Draft the application packet
2. Develop application process and timelines
3. Issue the application
4. Receive and select applications
5. Conduct the application review
6. Recommend CSAs to the Collaborative
7. Develop the technical assistance and training plan for CSAs
ATTACHMENT A

CORE SERVICE AGENCY QUALIFICATIONS

A. BASIC REQUIREMENTS

In order to be considered for designation as a CSA, the organization must be certified by CYFD or DOH/DHI to provide Comprehensive Community Support Services. As part of those certifications, organizations are reviewed against the following sections of the regulations:

ADMINISTRATIVE REQUIREMENTS

7.20.11.15 Criminal Records Checks and Clearances. Agencies must obtain criminal background checks and fingerprints for all direct services staff.

7.20.11.16 Personnel (requirement for a Clinical Director, but % time is not specified). The agency provides staff who are trained, supervised and qualified to perform the functions for which they are responsible. The organization provides orientation, a training and development program, and supervision of all services by a clinical director. Annual, written performance reviews are conducted for all staff and personnel records are maintained that document employee information, job functions, training, any licensure requirements, etc.

7.20.11.17 Allegations of Abuse/Neglect, Complaints and Serious Incident Reporting. Details the process for reporting allegations, complaints or serious incidents to the LCA and/or law enforcement; for developing serious incident reports and requires the organization to have policies and procedures for investigating allegations of abuse and neglect.

7.20.11.18 Agency in the Community. The agency articulates a statement of purpose for its primary functions and provides culturally competent services for clients who are bicultural and/or who are non-English speaking, and for clients who have hearing issues requiring sign language services.

7.20.11.19 Agency Governance and Administration. Requires the agency to be legally authorized to operate, identify its governing body and administer its services in accordance with its own policies which support compliance with the certification requirements. Agencies may be organized as non-profit corporations, public or proprietary agencies, or tribal governments. The governing board must adopt by-laws and policies and procedures for the agency.

7.20.11.20 Quality Improvement and Utilization Review. The agency has a continuous quality improvement process through which it evaluates the effectiveness of services and has a written plan to achieve specified outcomes for each service. There is an annual plan and a committee process to identify trends and patterns that may affect client health, safety, and/or treatment efficacy.

7.20.11.21 Legal, Regulatory and Accreditation Compliance. Requires the agency to hold a license for each service required by state/local law and departmental regulation and to comply with accreditation requirements if they are accredited by an organization recognized by the department.

7.20.11.22 Client Participation, Protection and Case Review. Requires the agency to take all reasonable actions to protect the health, safety, confidentiality and rights of its clients. The agency informs all clients of their rights, protects the confidentiality of client records, maintains policy
that clients may refuse treatment or medication (unless the right has been limited by law or court order), and specifies in policies the conditions under which it serves minors without parental/legal guardian consent. Client records contain all required consent forms and written policies specify appropriate and permissible methods of behavior management and discipline. The agency maintains records and follows procedures governing the access to, storage, and release of, confidential information. Agency policy defines the content of the client record and prescribes practices for making record entries.

7.20.11.23 Intake, Assessment, Treatment Planning, Discharge Planning and Discharge. Agencies must establish criteria for admission conduct ongoing clinical assessments, develop/revise treatment plans and provide ongoing discharge planning with the participation of the treatment team. The assessment process must be multidisciplinary, involves the family or guardian, and includes consideration of the client’s physical, emotional, cognitive, educational, nutritional, and social development. A full EPSDT screen must be completed within 30 days of service initiation and a comprehensive assessment must occur before the comprehensive treatment plan is written. Within 30 days of admission, an educational evaluation or current, age-appropriate individualized education plan is completed; when indicated by clinical severity, a psychiatric evaluation, a psychological evaluation, when specialized psychological testing is indicated; and monthly updates on mental status and current level of functioning, performed by a licensed master’s or doctoral level behavioral health practitioner. An initial treatment plan must be developed within 72 hours of admission, with a comprehensive treatment plan completed within 14 days of admission. Components of the treatment plan are detailed. Standards require that any discharge of the client occurs in a manner that provides for a safe ad orderly transition.

As part of the CCSS certification process which all organizations would have completed, applicants submit policies and procedures that meet the standards, job descriptions and resumes of potential staff, and the results of the Criminal Record Checks.

In addition, potential CSAs would also submit a CSA application in which they would attest to meeting two additional standards: that they are administered by a full-time Executive Director and that all certified services are supervised by a full-time Clinical Director who meets the qualifications specified in 7.20.11. Further, a children’s CSA must provide Enhanced Assessment, Comprehensive Service Planning and Review, 24/7 crisis intervention, and access to psychiatric evaluations, medication management and a range of other clinical services. The CSA application would also include a letter of intent describing how and where the proposed services will be delivered, as well as a complete set of forms that will be used to document the services being provided.

**B. CAPABILITIES**

In its application, a CSA will also be required to demonstrate the following capabilities:

1. At least three years experience providing child or adolescent behavioral health services to children who meet the Collaborative’s definition of children with Serious Emotion Disturbance (SED) or children at risk of SED or adults who meet the Collaborative’s definition of adults with Serious Mental Illness (SMI)

2. Current participation in Medicaid and CBH funding (children) or Medicaid and BHSD funding (adults)

3. Demonstrated readiness to develop and deliver individualized, strengths based, community systems of support within a system of care, as evidenced by:
   a. A track record of consumer and/or parent and/or youth voice within the organization’s governance structure, service delivery model, and/or evaluation mechanisms
b. Current strength-based, family-focused and/or recovery practice and service models within the organization
c. Participation with Local Collaboratives in developing a broad array of services and supports.

4. Demonstrated readiness to respond to the unique needs of the predominant racial, ethnic, and linguistic populations (population critical mass) in the CSA’s geographic area as evidenced by:
   a. Bilingual/bicultural staff for population critical mass and/or interpreter services for linguistic populations in the area for whom the organization does not currently have appropriate or adequate bilingual/bicultural staff
   b. Any cultural or linguistic competency plans and initiatives undertaken within the past two years to strengthen cultural and linguistic competency or capacity

5. Administrative infrastructure, financial viability and infrastructure, and IT infrastructure to support the role of CSA including managed care experience and Statewide Entity billing experience. IT capability must include electronic billing/accounting capacity and a plan in place to move to an electronic record consistent with CMS 2010 requirements.

6. A Quality Improvement program with capacity specifically to address quality issues involved in care planning consistent with wraparound planning process, system of care principles, and/or recovery philosophy, which includes process improvement approaches, relevant data collection, fidelity measures (when appropriate), and outcome data monitoring

7. If serving children and youth, demonstrated competence working in partnership with parents and other caregivers of children with mental health needs, including engaging the family, identifying individual and family strengths, and facilitating the articulation of family vision and goals

8. If serving children and youth, demonstrated ability to work with families in accordance with the principles of Wraparound planning process as articulated by the National Wraparound Initiative, http://www rtc.pdx.edu/nwi/. If serving adults, demonstrated ability to work with consumers in accordance with the principles of Recovery. Various recovery approaches can be found on the SAMHSA website mental.health.samhsa.gov.

9. Demonstrable understanding of wraparound planning process and system of care principles and philosophy at all levels of the organization’s management, as reflected in training and/or programming experience

10. Ability to make services available when children, adolescents, adults and families need them, including evening or weekend hours (i.e., children should not have to miss school and adults should not have to miss work to participate in care planning); ability to facilitate care planning meetings at locations suitable to the client and/or family.

11. Access to services for persons with physical, cognitive, and other disabilities.

C. PERFORMANCE STANDARDS

Finally, CSAs will also be required to meet the following performance standards:

Referrals—CSAs will be required to accept referrals from many sources including Collaborative agency staff (juvenile justice, protective services), other providers, statewide entity and directly from consumers. There will be a no reject policy for CSAs to accept the referral and to determine if the individual meets the eligibility criteria.

Intake—Each CSA must perform an initial face to face intake within 24 hours (or sooner if the youth or adult is in crisis). This will require the organizations to have 24/7 capacity to respond to requests immediately.
Assessments and Service Plans—All CSAs must initiate an assessment (diagnostic or enhanced) within 72 hours of the initial intake.

Enhanced Assessments and Service Plans—the CSA must agree to use the format (or at a minimum the areas) for assessments and service plans specified by the Collaborative

Identification of Community Support Worker—Each CSA must provide the individual and their family a community support worker that will be responsible for assisting the individual and family through the assessment process and in developing the service plan.

Crisis Services—Each CSA must have immediate access to crisis stabilization services that may include in-home respite, pharmacological evaluation and treatment.

**Application Process**

Each designated clinical home will submit an application that attests to their adherence to the two specific administrative requirements for a full-time Executive Director as well a full-time Clinical Director and that describes how they demonstrate the CSA qualifications and capabilities. State staff will confirm that the applicant is certified by CYFD under 7.11.20 or by DHI using the same standards. The Statewide Entity will review the applicant against the qualifications, through a desk audit and a site visit. It will submit recommendations on CSA designation to the Collaborative who will make final decisions on designations.
### Attachment B

**Services Provided/ Coordinated by a CSA**

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<tr>
<td>Family support (education, employment,</td>
<td>Crisis Shelter</td>
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<tr>
<td>housing, parenting training, other)</td>
<td>Residential Treatment Centers (RTC)</td>
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</tbody>
</table>

**Outpatient**

| Outpatient psychotherapy                    | Inpatient/ Hospitalization     |
| Parent-infant and child-parent psychotherapy|                              |
| Outpatient substance abuse treatment        | Transition Services            |
| Co-occurring outpatient services            | From early childhood to early intervention |
| School based BH services (including special education) | From program to program |
| School linked BH services                   | From children’s system to adult system |
| Psychosocial rehabilitation                 | From juvenile correctional facilities to communities |
| Multi-Systemic Therapy                      | From foster care to independent living |
| Infant and early childhood services         | From school to RTC and back    |
| Outpatient detox                            | Natural Supports               |

**Intensive Outpatient**

| Intensive outpatient programs (IOP)         | Other Services and Supports   |
| Intensive home based                        | Housing                       |
| Other home based                            | Vocational/employment         |
|                                            | Education                     |
|                                            | Life and Social Skills        |