Service: Community Support

Service Definition

Community Support services consist of rehabilitative, environmental support and resources coordination considered essential to assist a youth/family in gaining access to necessary services and in creating environments that promote resiliency and support the emotional and functional growth and development of the youth. The service activities of Community Support include:

1. Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives;
2. Planning in a proactive manner to assist the youth/family in managing or preventing crisis situations; 3. Individualized interventions, which shall have as objectives:
    a. Identification, with the youth, of strengths which may aid him/her in achieving resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family;
    b. Support to facilitate enhanced natural and age-appropriate supports (including support/assistance with defining what wellness means to the youth in order to assist them with resiliency-based goal setting and attainment);
    c. Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, school and healthy social environments);
    d. Encouraging the development and eventual succession of natural supports in living, learning, working, other social environments;
    e. Assistance in the acquisition of skills for the youth to self-recognize emotional triggers and to self-manage behaviors related to the youth's identified emotional disturbance;
    f. Assistance with personal development, school performance, work performance, and functioning in social and family environment through teaching skills/strategies to ameliorate the effect of behavioral health symptoms;
    g. Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the youth's emotional disturbance;
    h. Service and resource coordination to assist the youth and family in gaining access to necessary rehabilitative, medical, social and other services and supports;
    i. Assistance to youth and other supporting natural resources with illness understanding and self-management;
    j. Any necessary monitoring and follow-up to determine if the services accessed have adequately met the youth's needs;
    k. Identification, with the youth/family, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

This service is provided to youth in order to promote stability and build towards age-appropriate functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in school and community activities. Supports based on the youth's needs are used to promote resiliency while understanding the effects of the emotional disturbance and/or substance use disorder and to promote functioning at an age-appropriate level. The Community Support staff will serve as the primary

coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, substance use disorder, medical services, crisis prevention and intervention services.

Admission Criteria

1. Individual must meet target population criteria as indicated above; **and one or more of the following**:
2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; **or**
3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services

Continuing Stay Criteria

1. Individual continues to meet admission criteria; **and**
2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.

Discharge Criteria

1. An adequate continuing care plan has been established; **and one or more of the following**:
2. Goals of Individualized Resiliency Plan have been substantially met; **or**
3. Individual/family requests discharge and the individual is not imminently in danger of harm to self or others; **or**
4. Transfer to another service is warranted by change in the individual's condition.

Service Exclusions

1. Intensive Family Intervention may be provided concurrently during transition between these services for support and continuity of care for a maximum of four units of CSI per month. If services are provided concurrently, CSI should not be duplication of IFI services. This service must be adequately justified in the Individualized Resiliency Plan.
2. Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives can be billed as CSI; however, the actual plan development must be billed and provided in accordance with the service guideline for Service Plan Development.
3. The billable activities of Community Support do not include:
    a. Transportation.
    b. Observation/Monitoring.
    c. Tutoring/Homework Completion.
    d. Diversionary Activities (i.e., activities/time for which a therapeutic intervention tied to a goal on the individual's recovery/resiliency plan (IRP) is not occurring).

Clinical Exclusions

1. There is a significant lack of community coping skills such that a more intensive service is needed.

2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition: Developmental Disability, Autism, Neurocognitive Disorder, Traumatic Brain Injury.

Required Components

1. Community Support services must include a variety of interventions in order to assist the individual in developing:
    a. Symptom self-monitoring and self-management of symptoms.
    b. Strategies and supportive interventions for avoiding out-of-home placement for youth and building stronger family support skills and knowledge of the youth or youth's strengths and limitations.
    c. Relapse prevention strategies and plans.
2. Community Support services focus on building and maintaining a therapeutic relationship with the youth and facilitating treatment and resiliency goals.
3. Contact must be made with youth receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the youth's support needs and documented preferences of the family.
4. At least 50% of CSI service units must be delivered face-to-face with the identified youth receiving the service and at least 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual records and are not aggregate across an agency/program or multiple payers).
5. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UK modifier).
6. Unsuccessful attempts to make contact with the individual are not billable.
7. When the primary focus of Community Support services for youth is medication maintenance, the following allowances apply:
    a. These youths are not counted in the offsite service requirement or the individual-to-staff ratio; and
    b. These youths are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.

<u>Staffing Requirements</u>

Community Support practitioners may have the recommended individual-to-staff ratio of 30 individuals per staff member and must maintain a maximum ratio of 50 individuals per staff member. Youth who receive only medication maintenance are not counted in the staff ratio calculation.

<u>Clinical Operations</u>

1. Community Support services provided to youth must include coordination with family and significant others and with other systems of care (such as the school system, etc.) juvenile justice system, and child welfare and child protective services when appropriate to treatment and educational needs. This coordination with other child-serving entities is an essential

component of Community Support and can be billed for up to 70 percent of the contacts when directly related to the support and enhancement of the youth's resilience. When this type of intervention is delivered, it shall be designated with a UK modifier.

2. The organization must have a Community Support Organizational Plan that addresses the following:
    a. Description of the particular rehabilitation, resiliency and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff.
    b. Description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, how case mix is managed, access, etc.
    c. Description of the hours of operations as related to access and availability to the youth served; and
    d. Description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Resiliency Plan.
3. Utilization (frequency and intensity) of CSI should be directly related to the CANS and to the other functional elements of the youth's assessment.
4. When clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of CSI (individual, group, family, etc.).

Service Accessibility

1. Specific to the "Medication Maintenance Track," individuals who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-evaluated with the CANS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.10. are no longer applied.
2. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:
    a. The use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or
    b. The use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.

    Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.

Billing & Reporting Requirements

1. When a billable collateral contact is provided, the H2015UK reporting mechanism shall be utilized. A collateral contact is classified as any contact that is not faceto-face with the individual.
2. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail

above with the appropriate GT modifier shall be utilized in documentation and claims submission.