

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)  
Description of Services

(iii) Community Support - (adults) (CS)

Effective October 12, 2009, no new admissions to this service will be allowed.  
This service will end on June 30, 2010.

Community Support Services consist of mental health and substance abuse community based, rehabilitation services and interventions necessary for and individual to achieve rehabilitative, sobriety, and recovery goals. This medically necessary service directly addresses the recipient's diagnostic and clinical needs that are evidenced by the presence of a diagnosable mental illness and/or substance related disorder (as defined by the DSM-IV-TR and its successors), with symptoms and effects documented in a comprehensive clinical assessment and the Person Centered Plan.

The services are designed to:

- Enhance skills to address the complex mental health and/or substance abuse symptoms of adults who have significant functional deficits in order to promote symptom reduction;
- Assist recipients in acquiring mental health and/or substance abuse recovery skills necessary for self management and to address successfully vocational, housing, and educational needs.

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The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and goals outlined in the Person Centered Plan.

These shall include the following, as clinically indicated:

- Identification of strengths that will aid the individual in his or her recovery, as well as the identification of barriers that impede the development of skills necessary for independent functioning in the community.
- Individual (1:1) interventions with the recipient, unless a group intervention is deemed more efficacious.
- Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan.
- Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan.
- Psychoeducation regarding the identification and self-management of prescribed medication regimen, with documented communication to prescribing practitioner(s).
- Identification and self-management of symptoms.
- Identification and self-management of triggers and cues (early warning signs).
- Direct preventive and therapeutic interventions associated with the MH/SA diagnosis that will assist with skill building related to goals in the Person-Centered Plan.
- Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers).
- Assistance for the recipient and natural supports in implementing preventive and therapeutic interventions outlined in the Person-Centered Plan (including the crisis plan).
- Response to crisis 24/7/365 as indicated in the recipient's crisis plan and participation in debriefing activities to revise the crisis plan as needed.
- Relapse prevention and disease management strategies.
- Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs identified in the Person Centered Plan.
- Coordination and oversight of initial and ongoing assessment activities.

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Continued Service Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the Community Support service goals in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on current clinical assessment, history, and the tenuous nature of the functional gains or continues to meet the utilization criteria established by the NC Department of Health and Human Services;

One of the following applies:

1. Recipient has achieved current Community Support goals in the Person Centered Plan and additional goals are indicated as evidenced by documented symptoms.
2. Recipient is making satisfactory progress toward meeting Community Support goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Person Centered Plan.
3. Recipient is making some progress, but the Community Support interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
4. Recipient fails to make progress and/or demonstrates regression in meeting the Community Support goals through the strategies outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, with treatment recommendations revised based on findings.

The person-centered planning process, including treating providers, recipient and family members, determines whether the recipient needs to continue the service and meets continued service criteria during a Person Centered Plan review process, in which the QP participates and provides clinical guidance. Based on the person-centered planning team's assessment and recommendation, the provider is then required to request continued service authorization through Medicaid's utilization management organization which makes the final determination of medical necessity.

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Provider Agency and Service Requirements:

The service will be provided by an endorsed community support agency. The endorsement process includes Community Support service specific checklist, and adherence to the following:

- Rules for MH/DD/SA Facilities and Services,
- Confidentiality Rules,
- Client Rights Rules in Community MH/DD/SA Services,
- Records Management and Documentation Manual for Providers of Publicly Funded MH/DD/SA Services, CAP-MR/DD Services and LMEs and,
- Implementation Updates to Rules, revisions and policy guidance.

Providers enrolled in Community Support must be nationally accredited by one of the accrediting bodies approved by DHHS within one year of Medicaid enrollment.

The agency must have a full time licensed clinical professional on staff. The community based service is provided by qualified professionals and associate professionals as defined on Attachment 3.1-A.1, Pages 15a.2d through 15a.2f of this State Plan Amendment.

The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner. The providers of this service will also serve as a "first responder" in a crisis situation.

All Associate Professionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to North Carolina's supervision requirements and according to licensure or certification requirements of the appropriate discipline. These staff must also demonstrate compliance to the identified staff competencies. Non Post-Graduate degreed Qualified Professionals must be supervised by a Master's Level Qualified Professional, preferably Licensed.

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The Qualified Professional performs the activities, functions, and interventions of the Community Support service definition included in the chart below. For sixty days after the tiered have been implemented by the State, thirty-five percent (35%) of community support services must be delivered by qualified professionals. Six months thereafter fifty percent (50%) of community support services must be delivered by qualified professionals

The following chart sets forth the additional activities included in this service definition. These activities reflect the appropriate scope of practice for the Community Support staff identified below.

Community Support Services	
Professional Services	Skill Based Interventions
May only be provided by the Qualified Professional.	May be provided by the Qualified Professional or the Associate Professional (under the supervision, direction, and oversight of the Qualified Professional).
<ul style="list-style-type: none"> <li>• Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan</li> <li>• Psychoeducation regarding the identification and self-management of prescribed medication regimen, with documented communication to prescribing practitioner(s)</li> <li>• Direct preventive and therapeutic interventions that will assist with skill building related to goals in the Person-Centered Plan</li> <li>• Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers)</li> <li>• Assistance for the recipient and natural supports in implementing preventive and therapeutic interventions outlined in the Person-Centered Plan (including the crisis plan)</li> </ul>	<ul style="list-style-type: none"> <li>• Provision of skill-building interventions to rehabilitate skills negatively affected by their mental health and/or substance abuse diagnosis</li> <li>• Functional skills</li> <li>• Socialization, relational, and coping skills</li> <li>• Self-management of symptoms</li> <li>• Behavior and anger management skills</li> <li>• Implementation of preventive and therapeutic interventions that will facilitate skill building</li> <li>• Identification and self-management of symptoms</li> <li>• Identification and self-management of triggers and cues (early warning signs) Input into the Person Centered Plan modifications</li> </ul>

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Community Support Services (continued)	
Professional Services	Skill Based Interventions
<ul style="list-style-type: none"> <li>• Response to crisis 24/7/365 as indicated in the recipient’s crisis plan and participation in debriefing activities to revise the crisis plan as needed</li> <li>• Relapse prevention and disease management strategies</li> <li>• Psychoeducation of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs identified in the Person Centered Plan</li> <li>• Participation in ongoing assessment activities (observation and ongoing activities to address progress or lack thereof) of this service</li> <li>• Participation in the initial development and ongoing revision of Person Centered Plan.</li> <li>• Assessing and documenting the status of the recipient’s progress and the effectiveness of the strategies and interventions of this service as outlined in the Person Centered Plan.</li> <li>• Supportive counseling to address the diagnostic and clinical needs of the recipient</li> <li>• Supervision by the Qualified Professional of Community Support activities provided by Associate Professional staff. The Qualified Professional is responsible for the all the activities and interventions of this service</li> </ul>	

Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

There are systems limitations indicated to prevent this service from being provided while an adult is an inpatient or receiving residential treatment.