TEAM BASED SERVICES
Community Support Team (CST)

Service Definition
Community Support Team is recovery and resiliency oriented, intensive, community-based rehabilitation and outreach service for adults and youth. It is team-based and consists of mental health rehabilitation interventions and supports necessary to assist the recipient in achieving and maintaining rehabilitative, resiliency and recovery goals. Community Support Team is designed to meet the educational, vocational, residential, mental health, co-occurring disorders (MH/SA, MH/DD, MH/Medical), financial, social and other treatment support needs of the recipient. Interventions are provided primarily in natural settings, and are delivered face to face, by telephone, or by video conference with individual recipients and their family/significant others as appropriate, to the primary well-being and benefit of the recipient. Community Support Team assists in the development of optimal developmentally appropriate community living skills, and in setting and attaining recipient (and family in the case of children) defined recovery/resiliency goals. It is available 24 hours per day, 7 days per week. A team-based approach to services must be documented in the clinical record, including the ITP.

Community Support Team may serve as a step down for individuals transitioning from more intensive or restrictive levels of care, or for those with psychiatric hospitalizations/repeated detoxification incidence in the past 18 months who are at risk of out of home placement. It is provided to recipients to decrease hospitalizations and crisis episodes and increase community tenure/independent functioning; increase time working, in school or with social contacts; and personal satisfaction and autonomy. Community support team may also serve as a step up from less intensive levels of care when those interventions have not succeeded in meeting the individual's clinical and rehabilitative needs. Through clinical interventions and supports based on identified, individualized needs, the recipient will reside in independent, semi-independent, or family living arrangements and be engaged in the recovery/treatment process. The purpose/intent of Community Support Team is to provide specific, measurable, and individualized mental health rehabilitation interventions to each person served through the reduction and management of symptoms and the development of stability and independence.

Source of Funding
Medicaid and non-Medicaid sources

Modality/Location
The modality and location of services can be any of the following:
- onsite and offsite;
- face to face, telephone, video conference; and/or
- individual and limited amounts of group.

Included Activities and Interventions

1. Promotion of the individual's active participation in decision making and self advocacy in all aspects of services and recovery.
2. Support for recovery and resilience activities, including assisting the individual to identify strengths, which may assist in recovery/resiliency and how to use them; and identification of barriers to recovery/resiliency and how to overcome them.
3. Assistance in developing strategies and supportive interventions for achieving placement in the least restrictive setting.
4. Assistance in building and maximizing family/significant other support skills. Such assistance must primarily be for the well-being and benefit of the individual.
5. Encouraging the identification of existing natural supports and the development and eventual succession of natural supports in all aspects of life. Assisting the individual to build a natural support team for treatment and recovery.
6. Education, training and assistance in the development of the individual's strengths, resources, preferences, and choices including such examples as the development of crisis contingency and Wellness Recovery and Action Plans (WRAP plans) .
7. In conjunction with the individual, family / significant other (if applicable) identification of risk factors related to relapse in mental health and/or co-occurring disorders, and development of strategies and plans to prevent relapse.
8. Assistance in the development of interpersonal, family and community coping, and functional skills (including adaptation to home, school, family and work environments) when the acquisition of those skills is impacted negatively by the individual's mental illness. Examples of skills include:
    a. Socialization skills:
        i. communication;
        ii. interpersonal relationships, including those with peers, family, authority figures, and within the community;
        iii. problem solving/conflict resolution;
        iv. management of sensory input and stress.
    b. Natural support system development:
        i. Self-directed engagement in community social activities (e.g. development of a social-recreational plan with the individual).
    c. Adaptation skills:
        i. identification of behaviors that interfere with performance;
        ii. implementation of interventions to alleviate problem behavior, including coping with symptoms of mental illness that affect the person's ability to successfully work, attend school and/or undertake family and community roles;
        iii. decrease at-risk behaviors;
        iv. development of capacity to follow directions and carry out assignments;
        v. acquisition of appropriate school and/or work habits.
    d. Adaptation to community, environment and/or family circumstances and realities.
    e. Family education, training and support designed to develop the family as a parenting and support system to the individual. Such activities must be directed toward the primary well-being and benefit of the individual.
    f. Skills related to developmental issues including:
        i. physical changes;

ii. emotional changes;
iii. sexuality;
iv. social development.

g. Daily living skills including:
i. age and developmentally appropriate daily and community living skills;
ii. personal hygiene and grooming;
iii. nutritional education;
iv. food planning, grocery shopping, cooking, and eating;
v. household maintenance, including housecleaning and laundry;
vi. money management and budgeting;
vii. shopping for daily-living necessities;
viii. community awareness and current events;
ix. identification and use of social and recreational skills;
x. use of available transportation;
xi. personal responsibility.

h. Work readiness activities (excepting skills related to a specific vocation, trade, or practice) including:
i. work-related social and communication skills;
ii. work-related personal hygiene and dress;
iii. work-related time management;
iv. other related skills preparing the recipient to be employable.

9. Counseling and intervention including but not limited to:
a. motivational interviewing;
b. stage-based interventions;
c. refusal skill development;
d. cognitive behavioral therapy;
e. psychoeducational approaches.
10. Development and support of skills used for coping with trauma issues.
11. Assisting the individual in symptom self-monitoring, reduction, and management to improve quality of life and to identify and minimize the negative effects of the mental illness and co-occurring disorders, which interfere with his/her ability to succeed within community, home, school, and work settings.
12. Support and consultation to individual's family and their support systems. Interventions must be directed primarily to the well-being and benefit of the individual.
13. Psychoeducation, counseling and skill building for individual's family and their support systems, when those interventions are directed primarily to the well-being and benefit of the individual, with or without the client being present. In all cases, the family or support system psychoeducation or skill building must relate to a need identified in the assessment and be reflected on the ITP.

Service Requirements

1. Community Support Team is provided to individuals or their family members (or significant natural support persons) and may be provided face-to-face, by telephone, and by videoconference.

2. A minimum of 60 percent of all Community Support Team interventions must be delivered in natural settings and out of the provider's office(s). This requirement will be monitored in aggregate for an agency for an identified billing period but will not be required for each individual.
3. Community Support Team occurs during times and at locations that reasonably accommodate the individual's and family's needs in community locations and other natural settings and at hours that do not interfere with his/her work, educational, and other community activities.
4. Community Support Team maintains a client-to-staff ratio of no more than 18 consumers per staff member. Client-to-staff ratio takes into consideration evening, weekend and holiday hours, needs of special populations, and geographical areas to be served.
5. Documentation must demonstrate that more than one member of the team is actively engaged in the direct service to each individual.

Staffing Requirements
Minimum staffing requirements for a Community Support Team include the following:

1. Fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must be a QMHP or LPHA.
2. RSAs or MHPs who work under the supervision of the QMHP and who work on the team in sufficient fulltime equivalents to meet the required client-to-staff ratio.
3. At least one member of the team shall be an individual in recovery from mental illness preferably a Certified Recovery Support Specialist (CRSS) or a Family Resource Developer (FRD). This staff person is a fully integrated CST team member who provides consultation to the team and highly individualized services in the community, and who promotes self-determination and decision making.
4. Each Community Support Team must be comprised of no fewer than 3 FTE staff meeting the required team components (shall include the team leader) and no more than 6 FTE staff or 8 different staff.

Documentation Requirements
1. All documentation will be prepared and delivered in accordance with the requirements of Rule 132.
2. Demonstrate evidence of more than one team member directly providing services to each individual.
3. Document in the assessment or elsewhere that the individual meets the specific admission criteria below.
4. The CST team shall conduct team meetings no less than once per week and maintain a written log.
5. The CST team shall maintain and review as a part of the treatment planning and review process a consumer developed Crisis Plan. If the consumer is a child, then the crisis plan should be developed with the child and family.

Service Exclusions

CST may not be billed in combination with CSI, CSR or ACT with the exception of preapproved services that may be billed on an individual basis and in accordance with a treatment plan in order to facilitate transition to and from CST. This allowable transition time will be subject to public payer prior authorization and will be limited to 30 days.

Admission Criteria
DHS/DMH or designee shall authorize CST services for eligible consumers who meet the following criteria:

Eligible Population
Community Support Team services are intended for adults, adolescents and children whose mental health needs require active team-based therapeutic and rehabilitative assistance and support to function at a developmentally appropriate level within home, community, work, and/or school settings. This includes those whose mental illness requires a team based outreach and support for their moderate to severe mental health symptoms, and who, with such coordinated clinical and rehabilitative support, may access and benefit from a traditional array of psychiatric services, a less intensive service intensity has been tried and failed or considered and found inappropriate at this time, AND who exhibit three (3) or more of the following:

1. Multiple and frequent psychiatric inpatient readmissions, including long term hospitalization;
2. Excessive use of crisis/emergency services with failed linkages;
3. Chronic homelessness;
4. Repeat arrest and incarceration;
5. History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing;
6. High use of detoxification services (e.g., two or more episodes per year);
7. Medication resistant due to intolerable side effects or their illness interferes with consistent self-management of medications;
8. Child and/or family behavioral health issues that have not shown improvement in traditional outpatient settings and require coordinated clinical and supportive interventions;
9. Because of behavioral health issues, the child or adolescent has shown risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent;
10. Clinical evidence of suicidal ideation or gesture in last three (3) months;
11. Ongoing inappropriate public behavior within the last three months including such examples as public intoxication, indecency, disturbing the peace, delinquent behavior;
12. Self harm or threats of harm to others within the last three (3) months;
13. Evidence of significant complications such as cognitive impairment, behavioral problem or medical problems.

Exceptions to these criteria may be submitted for authorization consideration but will require additional clinical documentation and justification from the provider.

Symptom and Functional Indicators
The person must be someone for whom traditional services and modes of delivery have not been effective, and the individual should have one or more of the following problems,

which are indicators of a need for continuous high level of services (i.e., greater than eight hours per month):

1. Two or more psychiatric inpatient readmissions over a 12 month period or one long term hospitalization of 180 days or more (Source: NAMI PACT Criteria);
2. Excessive use (2 or more visits in a 30 day period) of crisis/emergency services with failed linkages;
3. Chronic homelessness (HUD Definition of Homelessness);
4. Repeat (2 or more in a 90 day period) arrests and incarceration for offenses related to mental illness such as trespassing, vagrancy or other minor offenses;
5. Consumers with multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers;
6. Consumers who exhibit continuous functional deficits in achieving treatment continuity, self-management of prescription medication, or independent community living skills;
7. Consumers with persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or a high relapse rate;
8. Adult consumers with significant impairments as a result of his/her mental illness with a LOCUS composite score of 4 and above. Consumers who are youth exhibit scores of at least a score of 37 for problem severity on the worker's form of the Ohio Youth Problems, Functioning, and Satisfaction Scales (hereafter referred to as Ohio Scales).

Continued Stay Services Criteria

The following criteria are necessary for continuing treatment with CST services:

1. The person's severity of illness and resulting impairment continues to require CST
2. Services are consistent with the person's recovery goals, and for youth the family's, and are focused on reintegration of the individual into the community and improving his/her functioning in order to reduce unnecessary utilization of more intensive treatment alternatives (e.g., residential or inpatient)
3. The mode, intensity, and frequency of treatment is appropriate
4. Active treatment is occurring and continued progress toward goals is anticipated
5. Treatment planning is individualized and appropriate to the individual's changing condition, and includes the following as appropriate to stabilize and improve functioning:
    a. outreach (e.g., linkage with community agencies, educational presentations);
    b. assistance and referral with meeting basic needs (e.g., housing, food, medical care);
    c. psychosocial evaluation and treatment;
    d. crisis intervention;
    e. social rehabilitation;
    f. individual and family support, training, counseling and education, (e.g., symptom management);
    g. coordination and development of alternative support systems (e.g., religious organizations, self-help groups, peer support);
    h. protection and advocacy resources;

i. coordination of services, including vocational, medical, and educational needs;
j. medication and treatment monitoring.

The services listed in *5 a-j* are provided as needed and agreed upon in the treatment plan by providers and the individual, and for youth, the family.

The individual continues to require services in order to maximize functioning and sustain recovery or individual's support network (e.g., family, friends, and peers) is insufficient to allow for independent, or age appropriate living.

INITIAL (NEW) CST AUTHORIZATION PROCESS

To request an authorization for a consumer who is not currently receiving CST, the treating provider will submit a complete Request for Authorization of CST that includes:

1. LOCUS information for adults and Ohio Scales information for youth;
2. A treatment plan;
3. The consumer's initial crisis plan or youth/family crisis plan.

Once the initial CST request is submitted, the documents will be reviewed for adherence to clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services the Collaborative will enter an authorization for 90 days of services.

If the consumer continues to need CST services, the CST team must submit a reauthorization request before the initial authorization expires. This request should be submitted within two weeks prior to the initial authorization expiration date.

REAUTHORIZATION PROCESS for CST

To request a reauthorization for a consumer who is currently receiving CST, the treating provider will submit a complete request for authorization of CST packet that includes:

1. The Request for Authorization of CST form that includes LOCUS information for adults and Ohio Scales information for youth;
2. An updated CST treatment plan;
3. The consumer's crisis plan or youth/family crisis plan.

A LOCUS assessment should to be completed for adults as part of the authorization request. Typically a composite score of 4 indicates that the individual's needs are so pervasive and/or unpredictable, it is unlikely that other combinations of available community services have been or would be effective. There is a section on the request form where the provider can explain the variance between the clinical presentation and a LOCUS score below 4. Typically the LOCUS score is updated at the time of a treatment plan review or when the consumer's clinical condition warrants.

An Ohio Scales assessment should be completed for all youth as part of the authorization request. The scale will indicate if there are changes in the severity of symptoms or functioning of the youth. A score of 37 or higher on the problem scale will indicate the need of CST intensity of service.

Once the request for reauthorization of CST services is submitted, the documents will be reviewed for adherence to the clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services, the Collaborative will enter an authorization for up to 180 days of services.

If the clinical criteria are not met, the Collaborative will either authorize a 30 day transition period or the Collaborative will deny the requested service.

If the consumer continues to need CST services, the CST team is to submit a reauthorization request before the current authorization expires. This request should be submitted within two weeks prior to the current authorization expiration date.

Transition to or from CST services
When a consumer is transitioning into or out of CST, Community Support Individual (CSI), Community Support Residential (CSR), or ACT can be provided (in addition to CST) when clinically indicated for a period of 30 days.

In order to facilitate reimbursement, the CST provider must submit an updated Request for Authorization for CST completing the Transition Plan section and indicating the additional services that are clinically indicated. These additional services should also be included on the Individualized Treatment Plan. Examples of when this may occur include:

1. Crisis Residential: When an individual requires crisis residential to avert a hospitalization, CST services should continue in addition to the residential services. The provider should indicate the need for Community Support Residential that the client requires during the crisis residential stay.
2. Assertive Community Support Team: When an individual is being transitioned to Assertive Community Treatment, ACT should be indicated in the Transition Plan of the Request for Authorization for CST form. In addition, a Request for Authorization for ACT form must be submitted by the ACT provider.

Discontinuation of CST services:

Providers must notify the Collaborative when a consumer is discontinuing CST services by completing a "Notification of Discontinuance of CST Services" form and faxing it to the Collaborative or by entering the information in ProviderConnect. Discontinuance of CST services shall occur when:

1. Person requests termination from CST and is currently stable.
2. Person has improved to the extent that CST is no longer needed and recovery goals

have been met.
3. Person has moved out of the CST Teams' geographic area (provide linkage information to the new CST Team or community service).
4. Person has moved out of State (make attempts to link with other CST or community services).
5. Person cannot be located, in spite of repeated CST efforts. (Describe efforts to locate and continue CST services such as number of failed contacts, time elapsed since last contact, lack of leads on whereabouts from the person's emergency contact list)
6. Person is deceased.

Detailed information regarding discontinuance of CST services and linkage to other services must be documented in the consumer's clinical record.

Reasons for Medical Necessity denials of CST services
There is not evidence that the individual has exhibited 3 or more of the following (Rule: 59 Ill. Adm. Codes 132.150):
1. Multiple and frequent psychiatric inpatient readmissions, including long term hospitalization;
2. Excessive use of crisis/emergency services with failed linkages;
3. Chronic homelessness;
4. Repeat arrest and incarceration;
5. History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing;
6. High use of detoxification services (e.g., two or more episodes per year);
7. Medication resistant due to intolerable side effects or their illness interferes with consistent self-management of medications;
8. Child and/or family behavioral health issues that have not shown improvement in traditional outpatient settings and require coordinated clinical and supportive interventions;
9. Because of behavioral health issues, the child or adolescent has shown risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent;
10. Clinical evidence of suicidal ideation or gesture in last three (3) months;
11. Ongoing inappropriate public behavior within the last three months including such examples as public intoxication, indecency, disturbing the peace, delinquent behavior;
12. Self harm or threats of harm to others within the last three (3) months;
13. Evidence of significant complications such as cognitive impairment, behavioral problem or medical problems.

C**linical Denial Reasons for requests to continue CST Services**
There is no evidence that one or more of the following continue to exist:

- The person's severity of illness and resulting impairment continues to require CST;
- Services are consistent with the person's recovery goals and are focused on

reintegration of the individual into the community and improving his/her functioning in order to reduce unnecessary utilization of more intensive treatment alternatives (e.g., residential or inpatient);

- The mode, intensity, and frequency of treatment is appropriate;
- Active treatment is occurring and continued progress toward goals is anticipated;
- The services listed above are provided as needed and agreed upon in the treatment plan by providers and the individual, and for youth, the family;
- The individual continues to require services in order to maximize functioning and sustain recovery or individual's support network (e.g., family, friends, and peers) is insufficient to allow for independent, or age appropriate living;
- Individual has persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or medical or alcohol/substance abuse disorder.