Performance Standards

Community Treatment Team

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

Disclaimer: These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.
Community Treatment Team

PERFORMANCE STANDARDS

These performance standards are the result of a series of meetings and discussions facilitated by Community Care with representation from network Community Treatment Team (CTT) providers, county and oversight entities, and persons who receive CTT services. These standards are intended to clearly articulate Community Care’s expectations of contracted CTT providers and to define the parameters of reasonable standards of practice for the provision of CTT services which follow the Assertive Community Treatment (ACT) model.

The standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement, facilitate progression toward evidence-based practices and promising practices, and to increase the consistency of CTT service delivery. Providers are expected to monitor adherence to the standards and to take actions where indicated to comply with the standards. These standards should not be interpreted as regulations, nor as a means to require or prohibit specific interventions for specific individuals. In addition, CTT programs are expected to follow the standards outlined in the PA Bulletin for the provision of ACT services.

Program Description

Community Treatment Team (CTT) is established as a voluntary, primary, direct service which provides a comprehensive and intensive approach to community-based mental health and addictions treatment, rehabilitation, and support services to persons with a serious and persistent mental illness and addiction problems. These individuals are not able to benefit from traditional, community mental health and drug and alcohol services. Community treatment team services are targeted for those persons who have not achieved and maintained health and stability in the community and for whom without these services would continue to experience hospitalization, incarceration, psychiatric emergencies, and/or homelessness.

Guided by CSP, Recovery and CASSP Principles, CTT services merge clinical, rehabilitative and support staff expertise within a transdisciplinary team which includes a psychiatrist, nurses, mental health professionals, and a variety of specialists (chemical dependency, vocational, and peer). CTT is primarily characterized by (1) low consumer to staff ratios; (2) providing services in the community rather than in the office; (3) shared caseloads and responsibility among team members; (4) 24-hour staff availability; (5) direct provision of services by the team (rather than referring consumers to other programs); (6) open-ended services to accommodate the needs of more chronic and long-term consumer needs; and (7) person-centered, recovery-oriented approaches that foster autonomy and community integration among the people it serves.
Treatment/Support Services Included

As a transdisciplinary team, CTT operates as the Single Point of Accountability (SPA) for a caseload of consumers. As the SPA, the CTT coordinates, directs, and is held accountable for ensuring that the consumer, the consumer’s supports, and all involved service providers fully participate in the assessment, planning, and on-going monitoring of services.

The CTT program includes the following services:

1) Psychiatric Evaluation
2) Outpatient Therapy-Mental Health, Drug and Alcohol, MISA
3) Medication Management
4) Case Management/Service Coordination
5) Peer Support
6) Mobile Psychiatric Rehabilitation
7) Housing Supports including assistance in accessing supported or independent living
8) Vocational assessment, linkage, and supported employment
9) Crisis Services including coordination of individualized crisis plans and services with residential/housing service providers, family/significant others, and other supports/services based on individual needs
10) Diversion Services
11) Assistance/support in management of personal financial matters and activities of daily living
12) Liaison with state and community inpatient facilities and the criminal justice system

Treatment/Support Services Excluded

Under usual circumstances, individuals involved in a CTT program have access to the following services in addition to the CTT when medical necessity criteria or legal necessity criteria are met. However, during utilization of any of the following services, the CTT takes full and direct responsibility for all case management and service coordination responsibilities related to transition, treatment and discharge planning:

1) Inpatient Mental Health
2) Extended Acute (hospital and community-based)
3) Crisis Residential Services
4) Detoxification (medically managed and medically monitored)
5) Residential Rehabilitation (medically managed and medically monitored)
6) Halfway House for treatment of substance abuse
7) Methadone Maintenance
8) Acute Partial Hospital
9) Site-based or clubhouse psychiatric rehabilitation when this service is identified as a next step for the consumer in the discharge planning from CTT
10) Short Term Respite
11) Forensic Services
12) Long Term Structured Residential

Service Capacity

CTT is intended to serve individuals with a need for intensive clinical intervention and supports and to be the primary service provider across a range of service domains. Therefore, CTT should maintain a low consumer-to-staff ratio in order to ensure adequate intensity and individualization of services.

1) 1:10 staff to consumer ratio.
2) Based on the 1:10 staff to consumer ratio, the total team caseload is determined by multiplying the number of team members by 10. The psychiatrist and program assistant are not included in the formulation. For example, if a team has ten (10) staff members excluding a psychiatrist and program assistant, the total capacity for the team is 100. If the ten (10) includes the psychiatrist and program assistant, the total capacity is 80. In addition, the maximum number of persons served by any team is 120.
3) The team is expected to manage the level of frequency and intensity to ensure consumers are receiving adequate services based on each individual's needs.
4) The team will maintain a gradual admission rate of no more than six consumers per month, and will maintain appropriate staffing levels throughout.

Service Frequency

CTT consumers require more intensive follow-up and CTT is the sole provider of a range of biopsychosocial services. CTT is highly invested in its consumers, and maintains frequent contact in order to provide ongoing, responsive support as needed. Frequent contacts are associated with improved consumer outcomes.

1) The CTT provides an average of three (3) face-to-face contacts per week. The frequency of contacts is determined by the treatment plan and by emerging needs. The CTT has the capacity to rapidly increase contacts for people experiencing severe symptoms, significant problems in daily living, or increased involvement in treatment or rehabilitation activities.
2) The team maintains documentation supporting the frequency of contacts or attempts to contact. Documentation should differentiate consecutive contacts by multiple team members as well as differentiate high frequency routine interventions, such as medication or money drops, from high frequency recovery-oriented services, such as employment supports.
3) Many, if not all team members share the responsibility for addressing the needs of all consumers requiring frequent contacts.

Service Intensity

In order to help consumers with severe and persistent symptoms maintain and improve their functioning within the community, quality high service intensity is often required.
1) The CTT provides two (2) hours of face-to-face contacts per week, per consumer, on average. The duration of contacts is determined by the treatment plan and by emerging needs. The CTT has the capacity to rapidly increase duration for people experiencing severe symptoms, significant problems in daily living, or increased involvement in treatment or rehabilitation activities.

2) The team maintains documentation supporting the duration of contacts as well as the quality of contacts demonstrating a balance between individualized and targeted growth-oriented interventions vs. group interventions. Documentation should differentiate high intensity case management interventions, such as moving or accessing resources, from high intensity recovery-oriented services, such as job development or bus training.

3) Many, if not all team members share the responsibility for addressing the needs of all consumers requiring intensive contacts.

Place of Treatment

Contacts in natural settings (i.e., where consumers live, work, and interact with other people) are thought to be more effective than when they occur in hospital or office settings, as skills may not transfer well to natural settings. Furthermore, the CTT can conduct a more accurate assessment of the consumer’s community setting through direct observations rather than relying on self-report. Medication delivery, crisis intervention and networking are more easily accomplished through home visits.

The CTT provides an average of 75% of service in the community, in non-office or non-facility based settings, including 24-hour supervised settings. Phone calls and contacts with collaterals or family members are not included in the 75% of service.

Hours of Operation

CTT consumers require ongoing, responsive support as needed including expanded support into evenings and over weekends to ensure that consumers experiencing increased severe and persistent symptoms, including co-occurring symptoms, maintain and improve their functioning and integration within the community. Expanded hours are associated with decreased utilization of crisis services.

1) CTT is scheduled to provide treatment, rehabilitation and support seven (7) days per week, operating a minimum of five (5), twelve (12) hour days per week and eight (8) hours each weekend day and eight (8) hours every holiday. A minimum of two staff should be available on the evening, weekend and holiday shifts.

2) CTT operates an after hours crisis on-call system. The on-call person directly responds by telephone or face-to-face contact to team consumers and to mental health emergency personnel on behalf of a consumer.

3) Psychiatric back up is available twenty-four (24) hours a day, seven (7) days per week.
Medical Necessity Criteria

Admission Criteria
Must Meet Criteria I, II and III or IV

I. Diagnosis:
The individual must have a primary diagnosis of Schizophrenia or other Psychotic disorder or Chronic Major Mood Disorder. For a transition-age team, the individual should generally be between ages sixteen (16) & twenty-five (25).

II. Indicators of Continuous High Service Needs:
Must have (a) and (b):

   a. Three (3) or more psychiatric and/or substance abuse hospitalizations or criminal incarcerations in the last year and/or current long-term hospitalization (180 days or longer) in an extended acute care program or state hospital. For a transition team, two (2) or more encounters with delinquency or juvenile justice, or five (5) face to face encounters with emergency services, in last year, or two (2) or more suspensions or one (1) expulsion, in the last year.
   
   b. Inability to participate or remain engaged or respond to traditional community based services. (Evidence exists of documented efforts to engage the individual by a treatment or case management provider for 45 days and supporting documentation that without behavioral health treatment and support, the consumer’s well being and stability will be jeopardized).

Must have three (3) of the following:

   a. There is evidence of current, co-existing mental illness and substance abuse/dependence.
   
   b. History of life threatening suicide attempt/life threatening self-harm in past two (2) years.
   
   c. History of impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to others w/in last 2 years (ex. assault, rape, arson)
   
   d. Lack of support system: limited or no support from family, other professionals, friends, and social programs.
   
   e. History of inadequate follow-through with elements of a treatment/service plan that resulted in consumer psychiatric or medical instability (lack of follow through taking medication, following a crisis plan, attending to health needs, or maintaining housing).
f. Command hallucinations regarding harm to self or others with inability to ignore.

g. Threats of physical harm to others, with or without follow through, in past two (2) years.

h. Current homelessness resulting in the individual living on the street, in a shelter or substandard housing, or; the individual is residing in a state operated inpatient bed or who has maximized time served and is in a facility/institution or the state inpatient diversion list or in a supervised community residence, or; the individual is clinically assessed to be able to live in a more independent living setting if intensive services are provided or in an effort to prevent admission to a more intensive level of support. *If the consumer is under 18 years of age and not an emancipated minor, and is at risk of separation from his/her family or the family/caregiver is homeless or is at imminent risk of becoming homeless.*

III. Functional Level-Must have one (1) of the following:

a. Global Assessment of Functioning (GAF) Scale Rating of 40 or below.

b. GAF Rating of 60 or below if the individual is 35 years of age or younger and has a documented history of violent or aggressive behavior.

IV. Exception Criteria:

The individual does not meet medical necessity criteria I, II and III, but is designated as appropriate to receive CTT Services by a multidisciplinary team which includes participation by representatives of Community Care in consultation with a Community Care Professional Advisor or the Allegheny County Office of Behavioral Health (OBH).

Continued Stay Criteria
Must meet one of Criteria I, II or III

I. Individual's condition continues to meet admission criteria.

II. There is reasonable expectation, based on the individual's current condition and past history, that withdrawal of CTT will impede improvement or result in rapid exacerbation or reoccurrence of symptoms or behaviors that cannot be managed in a less intensive level of support.

III. Treatment/service planning and subsequent therapeutic interventions reflect appropriate, adequate, and timely implementation of all treatment approaches in response to the individual's changing needs.

Discharge Criteria
Must meet Criteria I, II, or III
I. The consumer and team determine that CTT services are no longer needed based on the attainment of goals as identified in the treatment/service plan and a less intensive level of support is appropriate.

II. The consumer moves out of county and the CTT has facilitated the referral to the mental health services in the new place of residence and has assisted the consumer in the transition to services.

III. The consumer and, if appropriate, the guardian, choose to withdraw from services and documented attempts by the program to reengage the consumer with the service have not been successful.

Exclusion Criteria
There are individuals for whom CTT services are not appropriate. This does not mean that a particular individual is not able to receive the service but merely that CTT may not be useful under the following circumstances:

a) Current incarceration with a sentence of 6 months or more.
b) Refusal by consumer and/or legal guardian for this level of support.
c) The individual is acutely at risk to harm self/others, or sufficient impairment exists that requires a more intensive level of support beyond community based interventions or requires a treatment approach other than CTT.

Service Provision

The CTT is comprised of staff with skills in providing the following services in an ethnically and culturally competent manner based on recovery, CSP and CASSP principles:

1) Case Management/Service Coordination
2) Assessment and Treatment/Service Planning
3) Crisis Assessment, Intervention, and Stabilization
4) Symptom Assessment and Management
5) Individual Supportive Therapy, Group Therapy, and Family Therapy
6) Medication prescription, administration, monitoring, and documentation
7) Integrated Dual Disorder Treatment for individuals with Mental Illness and Substance Abuse issues
8) Rehabilitation, Education, Work-Related and Supported Employment Services
9) Activities of Daily Living Services
10) Social, interpersonal relationship, and leisure-time activity services
11) Family education, support and consultation
12) Physical health and wellness-related services
13) Diversion Services from a more restrictive level of support
Staffing

CTT should be composed of a minimum of ten (10) to twelve (12) full-time equivalent (FTE) mental health professionals and mental health workers, as defined by the Pennsylvania Code, excluding the psychiatrist. This includes, in addition to the Team Leader, four master’s prepared clinicians, who have at least two (2) years of clinical experience. The four (4) master’s prepared clinicians can include any position except the team leader, psychiatrist, or program assistant.

The following position requirements reflect the minimum staffing configuration that must be met by each CTT. Additional positions must be approved by the county and Community Care:

The following team positions do not function as a primary service coordinator. This however does not preclude the following positions from providing service coordination in the context of their role on the team:

1) A master’s prepared team leader/supervisor who works on a full-time basis and is the designated clinical and administrative supervisor, providing formal individual and group supervision in accordance with the standards outlined in the PA ACT Bulletin. The team leader must also be a certified peer specialist supervisor. The team leader also functions as a practicing clinician on the team, providing ten (10) hours of direct services each week. In addition, the team leader is the designated representative accountable for the coordination of care and quality improvement (QI) function of the team.

2) A psychiatrist who works for a minimum of 20 hours per week per 50 team consumers. Psychiatric coverage increases proportionate to the increase in the team caseload. For example, if the caseload increases to 55, psychiatric coverage increases to twenty-two (22) hours, and if the team caseload increases to 75, psychiatric coverage increases to thirty (30) hours. The psychiatrist is designated to provide clinical and crisis services, monitor each consumer’s clinical status and response to treatment, supervise staff delivery of services, and direct psychopharmacologic and medical treatment. The psychiatrist functions as a specialist to all team members and functions as a fully integrated team member.

3) One (1) FTE Rehabilitation/Vocational Counselor (RVC) per 50 team consumers. The RVC will preferably have a degree in rehab counseling and will work with a caseload of no more than 25 consumers. The RVC works on a full-time basis and is designated to provide rehabilitation and work related services for team consumers. The RVC is responsible for providing all Supported Employment Services, including engagement, assessment, job development, job coaching, and follow-along supports. If a team has more than one RVC, the RVCs will provide services for each other’s consumers as well as back-up and support. This position only provides vocational services and does not function as a primary case manager/service coordinator for a caseload of team consumers. The RVC functions as a specialist to all team members and functions as a fully integrated team member.
4) One (1) Peer Specialist (PS) who works on a full-time basis, is certified as a peer specialist, and is designated to provide peer support services which are highly individualized and promote consumer self-determination and decision-making. This individual is or has been a recipient of mental health services and is willing to disclose his or her “peer” status to team consumers. Because of his or her life experience with services, the specialist provides expertise that professional training cannot replicate. This position does not function as a primary case manager/service coordinator for a caseload of team consumers. The PS functions as a specialist to all team members and functions as a fully integrated team member.

5) One (1) FTE program assistant who is responsible for organizing, coordinating, and monitoring non-clinical operations in support of the team.

The following positions function as both specialists and primary service coordinators for a caseload of team consumers:

6) Three (3) FTE Registered Nurses (RN) who work on a full-time basis and who are designated to provide nursing services to assigned team consumers and work with the physician. The RNs function as specialists to all team members and function as fully integrated team members.

7) One (1) FTE Substance Abuse Counselor (SAC) per 50 consumers with CAC or other appropriate certification. The SAC works on a full-time basis and is designated to provide individual and group treatment services for team consumers with mental illness and substance abuse issues (MISA). The SAC is responsible for providing stage-wise assessment and treatment. This specialist also helps consumers access more intensive MISA services as clinically necessary (i.e. Non-Hospital Rehabilitation, Halfway House, etc.). The SAC functions as a specialist to all team members and functions as a fully integrated team member.

8) One (1) clinically trained generalist Mental Health Professional (MHP) who works on a full-time basis and is designated to provide individual and group therapy to team consumers. The MHP functions as a specialist to all team members and functions as a fully integrated team member.

Clinical Supervision

1) Team policies and procedures should include a written policy and procedure that addresses the mode, type and frequency of supervision of all staff providing treatment, rehabilitation and support services. This is to assure the implementation of best practice guidelines, particularly those identified in the next section, “Training and Education”. In addition, experts other than the team leader or psychiatrist can provide specialized supervision as needed (i.e. MISA, forensic, etc.).

2) Clinical supervision is documented in writing.

3) Supervision and direction consist of:
a) Individual, side-by-side coaching sessions in which the supervisor accompanies an individual staff member to meet with consumers in regularly scheduled meetings or during crisis intervention.

b) Individual and group feedback, direction, and teaching during daily organizational staff meetings and regularly scheduled treatment/service planning meetings.

c) Formal individual sessions, at least once every two weeks.

d) Formal group supervision, at least once per week for team.

e) Formal group supervision, at least once every two weeks for vocational and co-occurring specialists.

Training and Education

1) All team members should complete Community Treatment Team trainings, to include but not limited to: ACT Philosophy, Organizational Structure, Roles, Standards and Practices, Management, Leadership, and Evidence-Based Practices embedded in ACT.

2) To address the complex needs and high-risk behaviors of the CTT target population, it is required that on an annual basis, a minimum of 20 hours of training are dedicated to the following areas of competency and included in the development of annual individual team member plans:

   a) Harm Reduction Interventions
   b) Recovery, CSP, and CASSP Principles
   c) Integrated Dual Disorders Treatment (IDDT) for individuals with both Serious Mental Illness and Substance Use Disorders
   d) Clinical Assessment & Treatment of Major Mental Illness, Substance Disorders
   e) Dialectical Behavioral Therapy
   f) Cognitive-Behavioral Intervention Techniques and Strategies
   g) Crisis Intervention Techniques and Strategies
   h) Risk Assessment and Intervention Techniques
   i) Management of Dangerous Behaviors/Duty to Warn
   j) Assessment and Treatment of Special Populations (homeless, forensic, medically compromised)
   k) Criminal Justice System
   l) Supported employment techniques based on the Evidenced-Based Practice of Supported Employment
   m) Recovery principles and Recovery Management Assessment and Planning

In addition, all staff members are required to be in full compliance with department and other regulatory or accreditation bodies’ reporting requirements and other directives.
**Team Communication and Planning**

1) Team meetings are conducted Monday through Friday each week at regularly scheduled times. During each meeting, the entire consumer caseload is reviewed.

2) The team maintains a written daily log to update staff on team contacts and to provide a systematic means to assess the day-to-day progress and status of each consumer.

3) The team maintains an updated weekly schedule for each consumer. The weekly schedule is a schedule of all treatment and service contacts which staff carries out, on a daily basis, to fulfill the goals and objectives in the consumer’s treatment/service plan. The corresponding day on the schedule is reviewed at the daily meeting and is used to complete the daily assignment schedule.

4) The team maintains a daily staff assignment schedule that provides all consumer treatment and service contacts to be divided and shared by the staff working that day. Daily assignments, other than those scheduled and documented on the consumers’ weekly schedule, are determined then prioritized based on acuity, emergency and crisis situations. Each Friday, the team determines needed follow-up or scheduled consumer contacts for the weekend.

5) Completion of daily assignments is monitored by an identified shift manager, who may be either the team leader or another designated staff person. The shift manager relays information to the second shift/on-call following a formal policy/procedure.

6) At a minimum, the team will meet one day per week to review changes/updates in team consumers' treatment/service plans and weekly schedules.

**Initial Assessment, Initial Treatment/Service Plan and Assignment**

1) An initial Admission Assessment and Treatment/Service Plan are completed by the Team Leader and/or Psychiatrist during the first visit with the consumer. The initial assessment may include information gathered from the referral source, Community Care, any current treatment providers, the consumer and significant others. The assessment includes a consumer self assessment and, at a minimum, the following areas, including strengths listed for each appropriate item:

   a) Consumer name, date of birth, social security number, and telephone number
   b) Next of kin
   c) Emergency contact
   d) Date of initial visit by CTT
   e) Name and contact information of referral source
   f) Name and contact information of any/all current treatment and case management service providers
   g) Current social supports and community resources
   h) Current Multi-axial Diagnosis
   i) Current psychiatric symptomatology and mental status
j) Current medication list
k) Psychiatric history, including adherence to and response to prescribed medical and psychiatric treatment
l) Risk factors and crisis/relapse prevention planning, historical and recent
m) Advance Directives
n) WRAP plan
o) Medical, dental and other health related needs
p) Name/contact info of Primary Care Physician
q) Extent and effect of drug(s) and/or alcohol use
r) Housing situation, historical and recent
s) Activities of daily living skills
t) Social, vocational, and educational functioning
u) Extent and effect of criminal justice involvement
v) Recent and significant historical life events

2) An initial treatment plan is completed with the participation of the consumer on the day of admission and guides the team until the comprehensive assessment and treatment plan are completed. Interventions from the initial treatment plan should be reviewed with the team following the first CTT visit with the consumer. The initial treatment plan must include the following:

a) Consumer name
b) Date
c) Short Term Goals/Objectives
d) Problems to be addressed
e) Consumer and guardian participation
f) Consumer’s signature
g) Team Leader’s signature

3) Upon completion of the initial treatment plan, the team leader and psychiatrist assign the consumer’s working team that includes, at a minimum, a primary case manager/service coordinator, a nurse, and a psychiatrist. This working team is referred to as the Individual Treatment Team (ITT). The primary case manager/service coordinator and other team member’s assignment is based on the clinical, treatment, functional and service needs of the consumer as well as consumer preferences and caseload capacity. The ITT has continuous responsibility to: 1) be knowledgeable about the consumer’s life, circumstances, goals and desires; 2) collaborate with the consumer to develop and write the treatment plan; 3) offer options and choices in the treatment plan; 4) ensure that immediate changes are made as a consumer’s needs change; and 5) advocate for the consumer’s wishes, rights, and preferences. The ITT is responsible to provide much of the consumer’s treatment, rehabilitation, and support services.

Comprehensive Assessment and Psychiatric and Social Functioning History Timeline

While the assessment process involves the input of most, if not all, team members, the consumer’s ITT, including the psychiatrist, service coordinator, and other assigned
members will assume responsibility for completing the comprehensive assessment, completing, in conjunction with all team members, the Psychiatric and Social Functioning History Timeline, and finally, preparing the written narrative Summary Comprehensive Assessment. The comprehensive assessment and psychiatric and social functioning history timeline must be completed within six (6) weeks of the consumer’s admission to the program. As additional information becomes available after the initial six (6) weeks of CTT involvement, the comprehensive assessment and timeline should be updated accordingly.

The Comprehensive Assessment is based on the following available information:

a) Self-reports
b) Reports of family members and other significant persons
c) Written summaries from police, courts and jails
d) Reports from mental health and drug and alcohol outpatient and inpatient facilities

The Comprehensive Assessment includes a historical and recent evaluation of the following areas:

a) Psychiatric History, Mental Status, and Diagnosis: The purpose of the assessment is to carefully and systematically collect and assess information from the consumer, the family, and past treatment records regarding the onset, precipitating events, course and effect of illness, including past treatment and treatment responses, violence, trauma, risk behaviors, and current mental status. This enables the CTT to effectively plan with the consumer and his/her family the best treatment approach in order to ensure accuracy of the diagnosis, to eliminate or reduce symptomatology, and to improve social, vocational, and avocational functioning.

b) Physical Health: the purpose of the physical assessment is to thoroughly assess health status and any medical and dental conditions present to ensure that appropriate treatment, follow-up, and support are provided to the consumer.

c) Use of Drugs and Alcohol: The purpose of the drugs and alcohol use assessment is to obtain information about current and historical substance use and its relationship to mental health issues along with stage of change readiness. This enables the CTT to evaluate the etiology of the use of drugs and alcohol in order to ensure accuracy of diagnosis to effectively plan the best treatment approach.

d) Education and Employment: The purpose of the education and employment assessment (vocational profile) is to determine with the consumer, current school or employment status, interests and preferences regarding education, vocational training and employment, and how symptomatology has affected previous and current education and employment performance. This enables the CTT to effectively plan a normalizing structure that is helpful in symptom management.

e) Social Development and Functioning: The purpose of the social development and functional assessment is to obtain information from the consumer about his or her childhood, early attachments, role in family of origin, adolescent and young adult development, culture, religious beliefs, leisure activities, interests, and social skills. This enables the CTT to evaluate how symptomatology has
interrupted or affected personal and social development. It also collects information regarding the consumer’s involvement with the criminal justice system. In addition, it identifies social and interpersonal issues appropriate for supportive therapy.

f) Activities of Daily Living: The purpose of the activities of daily living assessment document a detailed chronology of where the consumer has lived and is to evaluate the individual’s current ability to meet basic needs (e.g., personal hygiene, adequate nutrition, medical care); the quality and safety of the consumer’s current living situation; the adequacy of the consumer’s financial resources; the effect that symptoms and impairments of mental illness have had on self-care; the consumer’s ability to maintain an CTT to determine the level of assistance, support, and resources the consumer needs to reestablish and maintain activities of daily living.

g) Family structure and relationships: The purpose of the family structure and relationships assessment is to obtain information from the consumer’s family and other significant people about their perspective of the consumer’s mental illness and to determine their level of understanding about mental illness as well as their expectations of CTT. This information allows the team to define, with the consumer, the contact or relationship CTT will have with the family in regard to the consumer’s goals, treatment, and rehabilitation.

h) Psychiatric and Social Functioning History Timeline: The timeline is used to develop a detailed overview of the significant events in a person’s life, the person’s experience with mental illness and his or her treatment history. The timeline can be particularly useful in helping see how various events in the individual’s life are related. In addition, the timeline can help to check for gaps in the information about a person’s life and if there are inaccuracies or conflicting information in the clinical records. Additional information may be added as it becomes available. The timeline is completed using all the information gathered in the Comprehensive Assessment. All assessment information is presented to the entire team by the ITT. The information is documented on the timeline in a chronological and categorized manner. The information is reviewed and discussed by the entire team and critical and significant historical information that helps shape the formulation of an individualized, current and relevant approach to the person’s treatment and recovery is highlighted.

On-going Assessments

In addition to completing the Initial and Comprehensive Assessment, at a minimum, members of the Individualized Treatment Team (ITT) continue to plan, monitor, and document consumer progress toward goals/objectives through the use of targeted assessments. The on-going areas of assessment include, but are not limited to, the following:

a) Physical Health: the purpose of on-going physical assessment is to promote a healthy lifestyle and prevent, and treat, in a timely manner, problematic medical and dental conditions and to ensure that appropriate treatment, follow-up, and support are provided to the consumer.
b) Use of Drugs and Alcohol: the purpose of on-going drugs and alcohol use assessment is to ensure that appropriate stage-wise treatment, intervention, and support are provided based on consumer's most current stage of change readiness.

c) Employment and Education: employment and educational assessments are aimed at problem-solving using environmental assessments and consideration of reasonable accommodations and occur on-site in community jobs and classrooms. This is to ensure that appropriate and highly individualized Supported Employment Services are provided and based on the consumer’s strengths and preferences and most current stage of change readiness.

Individualized Community Support Planning (Individualized Treatment Planning)

Individualized, comprehensive Community Support Plans must be completed with the consumer within eight (8) weeks of admission and reviewed, at a minimum, every six (6) months thereafter. CSP/Individualized Treatment Plan reviews should include a summary of goals/objectives from the prior period, progress made, goals/objectives accomplished and recommendations for next steps. Documentation of consumer participation in CSP/Treatment Planning process must be documented. Participation of family/guardian/significant others, social supports and other individuals of the member’s choosing will be encouraged and documented by the team. In addition:

1) Plans are used as a therapeutic tool central to the individual's recovery work.

2) Plans are developed using an individual and family centered treatment-planning process.

3) Plans are reviewed, updated and signed or acknowledged by the consumer at least every six (6) months or when there is a major change in the course of treatment.

4) Using CSP, Recovery, and CASSP Principles, plans identify consumer strengths, preferences, needs, problems, goals, objectives, interventions addressing treatment and rehabilitation, persons responsible, and measurable indicators.

5) The following key elements are addressed in every plan to offer consumers informed options and to encourage recovery and ensure no exclusion from any opportunity: psychiatric symptoms, illness education and management, housing, rehabilitation, employment, education, daily structure, relationships, crisis/relapse plan, crisis alerts, and, if indicated, a directed care plan and/or Advanced Directive.

6) The Individual Treatment Team planning meeting includes the consumer, consumer-identified participants, the coordinator of treatment, the peer specialist, and any staff and family/significant others involved with the consumer on a regular basis.

7) Teams are responsible to ensure the consumer and the consumer’s system of care is actively involved in the development of rehabilitation, recovery, and treatment.
goals. The team involves pertinent agencies and members of the consumer’s social/informal network in the formulation of plans.

8) The team develops, reviews, and updates the goals, objectives, and interventions on a regular basis. Plans are updated with the consumer every six (6) months, at a minimum.

9) The plan clearly documents the following: the ITT’s evaluation of his or her progress/goal attainment, the effectiveness of the interventions, and the consumer’s satisfaction with services since the last treatment plan, specific services and interventions to be received, the rationale for receiving services and interventions, and who is responsible to deliver each documented service.

10) Community Care or the county Office of Behavioral Health can request a review when it is clinically indicated or for continuity of care review.

**Member Rights and Grievance Procedures**

CTTs must have policies and procedures for consumer rights and grievance procedures that ensure compliance with federal and state laws, as well as contractual requirements set forth by the county and Community Care. The team members must fully understand, inform and respect consumer’s rights to appropriate treatment in a setting and under conditions that are most supportive of the person’s personal liberty and restrict such liberty only to the extent necessary consistent with each consumer’s treatment needs, applicable requirements of the law and applicable judicial orders. The CTT will maintain written consumer rights policies and procedures.

CTTs will be knowledgeable about and familiar with the mechanisms to implement and enforce consumer rights with regard to:

- a) Grievance and Complaint procedures (internal agency, county, HealthChoices, and state laws)
- b) Medicaid
- c) Americans with Disabilities Act
- d) Protection and Advocacy for Individuals with Mental Illness
- e) Mental Health Advance Directives

**Outcomes**

1) The provider tracks the following areas by submitting data through the CTT Monitoring Application and consumer satisfaction surveys:

- a) Consumer satisfaction
- b) Increased adherence to treatment/service plan
- c) Improved clinical outcomes
- d) Vocational/educational gains
- e) Increased length of stay in community residence
f) Increased use of natural supports  
g) Reduced utilization of inpatient level of support  
h) Improved physical health  

2) Community Care tracks adherence to the CTT model and determines annual CTT performance outcomes by participating in the administration, on an annual basis, of the most current Assertive Community Treatment Survey fidelity assessment.

CTT Advisory Committee

Each individual CTT program will have an advisory committee comprised of individuals receiving CTT, their families/significant others and other community stakeholders that meets at least quarterly or four (4) times per year. Individual CTT Advisory Committees will advise the CTT provider agency on quality improvement initiatives pertinent to the individuals served by the CTT. Each CTT provider agency will develop policies and procedures regarding the role of the CTT Advisory Committee and how information provided from CTT service recipients, families/significant others and other community stakeholders will be used to continually improve the quality of CTT and other services offered by the provider agency. This includes staff responsibilities for coordinating the location of the meetings, assigning a note taker, and distribution of meeting minutes and staff assignments to members and CTT staff. CTT Advisory Committee members will be encouraged to assist with completion of tasks identified. Staff from the CTT or other agency services will be encouraged to attend in order to receive advice, implement suggested changes/improvements to CTT service delivery, and solicit consumer feedback on progress toward implementing quality improvement activities selected by the group.

Each individual agency CTT Advisory Committee will nominate/elect five individuals to represent their CTT on the county-wide CTT Member Advisory Committee. This larger group will receive reports and feedback from each of the individual agency CTT Advisory Committees and offer advice to Community Care, and the county/oversight entity in the development of county-wide quality improvement activities toward building a recovery-oriented system of care. In Allegheny County, this will include the Allegheny County Department of Human Services and Allegheny HealthChoices, Inc (AHCI).

Referral, Admission, Transfer, and Discharge

1) Any provider, consumer, or family member can make a referral for CTT services directly or on behalf of a consumer. Prior to the referral, the consumer is in agreement and has knowledge that upon admission to the CTT all other ‘CTT Included Services’ will end through an agreed upon transition plan. The care manager/service coordinator ensures that the Service Coordination Unit (SCU) is aware of the referral. At the point a referral is authorized, the consumer is offered a choice of where to receive CTT services.

2) The care manager/service coordinator is responsible for coordinating all CTT referrals, transfers, and discharges. This process includes a thorough review of
current and historical clinical information and may take up to ten (10) working days. For county-funded services, a representative from the county/oversight entity is involved in the referral or transfer process per Community Care/county or oversight written agreement.

3) If the care manager/service coordinator has insufficient information for a determination, additional information is requested or a Multi-disciplinary Team (MDT) meeting is convened to facilitate a determination. For county-funded services, a representative from the county/oversight is involved in the determination process per the Community Care/county or oversight written agreement.

4) For discharges, the CTT must submit a verbal request for discharge to the care manager/service coordinator for review and determination of disposition. All requests require review and approval by Community Care and the county/oversight entity.

5) For transfers, the CTT must submit a verbal request for transfer to the care manager/service coordinator for review and determination of disposition. All requests require review and approval by Community Care and the county/oversight entity.

6) If the consumer does not meet medical necessity criteria for CTT service, the care manager/service coordinator authorizes an alternative and appropriate level of support and treatment necessary to address the needs of the consumer. For county-funded services, a representative from the county/oversight is involved in this process per Community Care/county or oversight written agreement.

7) Upon approval, the assigned CTT team leader, or designee, and the referring source are notified of the assignment. The completed referral form and initial authorization, for up to 150 hours, is faxed to the CTT within 24 hours of the approval.

8) The CTT can appeal the assignment, in writing, within thirty (30) days of assignment. Both a psychiatric evaluation and clinical rationale for the appeal must be included. A Community Care professional advisor is responsible for reviewing the appeal. For county-funded services, the county/oversight Medical Director completes the review.

9) Community Care and the county/oversight entity, at any time, can approve an assignment other than clinical evidence would indicate. This requires a documented explanation and signature from Community Care and, for county-funded services, the county/oversight entity.

10) If a consumer is referred from an acute or long-term inpatient facility, the SCU Hospital Liaison of record initiates the referral by completing a CTT Referral Form and submitting it to the care manager/service coordinator for review.

11) Within 24 hours of receiving the referral, the CTT will contact the Hospital Liaison to facilitate the first appointment with the member. If the consumer is in an acute or inpatient, the initial meeting must occur within 48 hours of the referral. If in a long-term facility, the initial meeting must occur within five (5) working days of the referral. For all other referrals to CTT, the initial meeting with the consumer must occur within
seven (7) days of receipt of the referral or within a timeframe agreed upon with the care manager/service coordinator.

a) After receiving the referral, the CTT will contact the care manager/service coordinator to inform of the planned initial appointment with the consumer. The CTT will also contact the referral source to inform them of the planned visit and request that the referral source join the CTT for the first visit to facilitate engagement and introduce the CTT and member.

**Engagement**

While we recognize that CTT is a voluntary service, it is incumbent on providers to make a significant effort to engage consumers in services. Efforts to engage consumers are not limited to the initial treatment phase. Engagement is a fluid, on-going process that extends throughout a consumer's relationship with CTT. Engagement strategies are individualized, planned and well thought out, based on input from a variety of sources. The input of family members, natural supports, and previous treatment providers is essential in developing engagement strategies that can effectively reach the consumer. Specifically, CTTs should:

- Include the consumer in the admission, initial assessment, and initial planning process as the primary stakeholder.
- Meet with the consumer in his/her environment and during non-traditional hours.
- Include consumer’s identified family, natural supports, and others as identified by the consumer.
- Meet consumers in jail or hospitals.

Retention of consumers is a high priority for CTT. CTT will ensure a process is in place for identifying consumers in need of more or less assertive engagement. Interventions are monitored to determine the success of these techniques, and the need to adapt the techniques/approach accordingly.

**Identifying consumers in need of assertive engagement**

Treatment issues to help identify consumers in need of assertive engagement include but are not limited to:

- Failure to keep appointments
- When a different approach is needed
- Retention in rehabilitation and/or treatment
- Failure to build a trusting relationship with team member(s)
- Inability to participate in assessment and treatment planning
- High utilization of crisis and IP services
- Homelessness
- Incarceration
- Substance Abuse use interfering with ability to participate in rehabilitation and/or treatment
- Psychiatrically or medically symptomatic and not accepting assistance/support/treatment
- High risk history and/or behavior of felonious activity and not in rehabilitation and/or treatment

Techniques and interventions utilized to engage consumers in treatment
The team works together to plan engagement strategies and are creative in their attempts to meet people “where they are at” in readiness for change. Good clinical judgment is utilized in determining when they need to be applied including:

1. **Motivational interventions**: interventions aim to respect and promote consumer choice, focus on maximizing collaboration and joint decision-making, are creative and focused on meeting the consumer’s identified needs to build rapport and foster a trusting relationship, for example:
   - assisting the consumer in apartment shopping
   - stopping to grab a cup of coffee
   - assisting the consumer in accessing benefits
   - assisting a consumer’s family member to access services

2. **Therapeutic limit-setting**: Therapeutic limit-setting interventions are influencing tactics that may limit or threaten to limit a consumer’s self-determination in various life areas but may be necessary during initial engagement if collaborative interventions fail or risks are too high. When motivational interventions have not worked and/or risk does not permit extensive trials of motivational interventions, therapeutic limit-setting interventions may be employed but are eventually titrated down to more collaborative interventions to promote empowerment and autonomy. Examples include but are not limited to:
   - interpersonal pressures used to increase medication adherence
   - access to money or housing to leverage against treatment participation
   - involuntary commitment to treatment if consumer meets local judicial criteria

The CTT attempts to engage for up to ninety (90) days, at which point, if an admission has not occurred, a meeting is convened to determine the course of treatment and includes the consumer, CTT, county and/or Community Care.

Engagement efforts are documented in the CTT consumer record.

**Transition Standard**
While receiving services from the CTT, a transition period may be necessary to ensure continuity of services.
1) Transitions occur, as clinically indicated, and up to 90 days, beginning with the date of CTT referral.

2) Upon referral, the CTT takes full and direct responsibility for case coordination and the provision of case management/service coordination related to transition, treatment and discharge planning.

3) A transition meeting, scheduled by the receiving CTT, occurs within two (2) weeks of referral and must include the consumer, consumer identified participants, the referring source(s), the CTT, and other provider staff involved with the consumer and family.

4) At the transition meeting, a transition plan is developed and outlines the responsibilities of the referring and receiving sources involved in the transition. The plan must demonstrate a decrease in the referring party’s services and an increase in CTT service. The plan must be documented in the CTT record.

5) A total of two (2) hours per month or a total of six (6) hours in a 90-days period of case management/service coordination can be billed.

6) Exceptions to these guidelines must be discussed with the care manager/service coordinator and prior authorization obtained.

**Inpatient Coordination of Hospital Discharge Planning**

Ongoing participation of the CTT during a consumer’s hospitalization and discharge planning allows the team to help maintain community supports (e.g., housing), and continuity of service. The CTT provides the following services when a consumer is admitted to an inpatient psychiatric, rehabilitation or RTFA facility:

1) CTT takes full responsibility for all case management and service coordination responsibilities related to treatment/service planning and discharge planning.

2) CTT provides advocacy and linkage between services and between consumer and the consumer’s community contacts.

3) CTT maintains regular face-to-face contact with the consumer and facility contact. All completed or attempted contacts are documented, with permission, in the facility chart, or communicated to the facility treatment team for documentation. The CTT must document completed or attempted contacts in the CTT chart.

4) CTT assesses treatment progress, reviews the consumer's chart and interviews the facility treatment team. All reviews and interviews are documented, with permission, in the facility chart or communicated to the facility contact for documentation. All completed or attempted reviews and interviews are documented in the CTT record.
5) CTT attends all treatment, discharge and diversion meetings and documents, with permission, in the facility chart or communicates attendance to the facility contact. All contacts are documented in the CTT record.

6) CTT coordinates necessary community referrals, discharge medications, and community disposition (e.g., housing, service planning), as part of discharge planning.

7) CTT takes responsibility for arranging transportation for community visits and for discharges.

8) CTT escorts the consumer on community visits and when discharged.

For **Community Inpatient (IP), Extended Acute Care (EAC), and Rehabilitation:**
- Within 24 hours of notification of admission to an inpatient or rehabilitation facility, the CTT contacts the facility treatment team and arranges a face-to-face contact with the consumer when clinically appropriate.
- Daily contact is expected with the facility contact and with the consumer, when clinically appropriate.
- CTT coordinates discharge and aftercare planning with IP, EAC or Rehabilitation providers. CTT will amend CTT treatment plan as necessary. CTT will develop a specific plan with the consumer regarding frequency of CTT contact post-discharge from IP, EAC or Rehabilitation. This plan will be written in the CTT record and amended based on individual needs. At a minimum, three (3) face to face contacts per week with the consumer are expected in the first month following discharge.

For **State Hospital Inpatient and RTF**
- Within five (5) days of admission to a state hospital or RTF, the CTT contacts the facility and the consumer, when clinically appropriate.
- The CTT provides, at a minimum, weekly face-to-face contact with the consumer and the facility.
- CTT coordinates discharge and aftercare planning with State Hospital or RTF provider. CTT will amend CTT treatment plan as necessary. CTT will develop a specific plan with the consumer regarding frequency of CTT contact post-discharge from State Hospital or RTF. This plan will be written in the CTT record and amended based on individual needs.

**Diversion and Coordination of Hospital/EAC Admissions**

CTT is closely involved in diversion and coordination of hospital/EAC admissions to ensure more appropriate use of psychiatric hospitalization and to maintain continuity of care.

1) During planning for diversion from an inpatient admission:
   a) CTT coordinates and collaborates with the emergency service provider to determine disposition.
b) The CTT provides face-to-face intervention at emergency rooms to make every effort to divert the consumer from inpatient psychiatric care.

c) All alternatives to hospitalization (23-hour observation bed, respite, diversion/step-down bed, in-home respite, etc.) are exhausted or clinically ruled out before an inpatient admission is approved.

d) CTT provides crisis alerts to all emergency facilities and Community Care, with permission of consumer.

2) During planning for diversion from state hospital admission:
   a) CTT co-coordinates all diversion plans with the County Diversion Liaison and the inpatient team.
   b) Prior to a state hospital admission, the CTT presents, in writing, a preliminary discharge plan to the County Diversion Liaison.