



# 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**

### **Program Description**

Community Treatment Team (CTT) is established as a voluntary, primary, direct service which provides comprehensive and intensive outpatient mental health and addictions treatment in addition to rehabilitative 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. CTT 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 one service delivery team with minimal referral of members to other program entities for these interventions.

### **Treatment/Support Services**

The CTT program includes the following services:

- Psychiatric Evaluation
- Outpatient Therapy - Mental Health, Drug and Alcohol, MISA
- Medication Management
- Case Management/Service Coordination
- Peer Support
- Mobile Psychiatric Rehabilitation
- Housing Supports including assistance in accessing supported or independent living
- Vocational assessment, linkage, and supported employment
- Crisis Services
- Diversion Services
- Assistance in management of personal financial matters
- 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 (MNC) 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:

- Inpatient Mental Health
- Detoxification (medically managed and medically monitored)
- Residential Rehabilitation (medically managed and medically monitored)
- Halfway House for treatment of substance abuse
- Methadone Maintenance
- Acute Partial Hospital
- Site based or clubhouse psychiatric rehabilitation when this service is identified as a

next step for the member in the discharge planning for the CTT

- Short Term Respite
- Forensic Services
- Long Term Structured Residential

### **Service Capacity**

- 1:10 staff to member ratio.
- Based on the 1:10 staff to member ratio, the total team caseload is determined by multiplying the number of team members by 10. The psychiatrist and any clerical staff are not included in the formulation. For example, if a team has 10 staff members excluding a psychiatrist and office manager, the total capacity for the team is 100. If the 10 include the psychiatrist and office manager, the total capacity is 80.
- The team is expected to manage the level of frequency and intensity to ensure members are receiving adequate services based on need.

### **Service Intensity**

- The CTT has the capacity to provide an **average** of four face-to-face contacts per week per member experiencing severe symptoms, significant problems in daily living, or increased involvement in treatment or rehabilitation activities.
- Team capacity to rapidly increase or to decrease service intensity is based on the needs of the member and documentation supporting the frequency of contacts or attempts to contact.
- Many, if not all, team members share the responsibility for addressing the needs of all members requiring frequent contacts.

### **Place of Treatment**

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.

### **Hours of Operation**

- CTT is scheduled to provide treatment, rehabilitation, and support seven days per week, operating a minimum of three, 12 hour days per week and eight hours each weekend day and eight hours every holiday.
- CTT operates an after-hours crisis on-call system. The on-call person directly responds by telephone or face-to-face contact to team members and to emergency personnel on behalf of a member.
- Psychiatric back up is available 24 hours a day/seven 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 transition team, generally be between ages 16 and 25.
- II. Indicators of Continuous High Service Needs:  
Must have (a) and (b):
  - a. Three or more psychiatric and/or substance abuse hospitalizations or criminal incarcerations in the last year. For transition team, two or more encounters with delinquency or juvenile justice, or five face to face encounters with emergency services, in last year, or two or more suspensions or one 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 member by a treatment or case management provider for 45 days and supporting documentation that without behavioral health treatment and support, the member's well being and stability will be jeopardized).

Must have three 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 years.
- c. History of impulsive acting out, physical assault, or uncontrolled anger that resulted in physical harm, or real potential harm to others within last two years, e.g., assault, rape, and 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 results in member 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 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 member 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 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 MNC 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 county or oversight entity.

***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 member 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 lesser intensive level of support is appropriate.
- II. The member 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 member in the transition to services.
- III. The member and, if appropriate, the guardian, choose to withdraw from services and documented attempts by the program to re-engage the member with the service have not been successful.

***Exclusion Criteria***

There are individuals for whom CTT services are not appropriate. Bear in mind that 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:

- I. Current incarceration with a sentence of six months or more.
- II. Refusal by member and/or legal guardian for this level of support.
- III. The individual is acutely at risk to harm self/others, 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:

- Case Management/Service Coordination
- Assessment and Treatment/service planning
- Crisis Assessment, Intervention, and Stabilization
- Symptom Assessment and Management
- Individual Supportive Therapy, Group Therapy, and Family Therapy
- Medication prescription, administration, monitoring, and documentation
- Substance Abuse Treatment
- Rehabilitation, Education, and Work-Related Services
- Activities of Daily Living Services
- Social, interpersonal relationship, and leisure-time activity services
- Family education, support, and consultation
- Physical health-related services
- Diversion Services from a more restrictive level of support

## Staffing

CTT should be composed of a minimum of eight fulltime equivalent (FTE) mental health professionals and mental health workers, as defined by the Pennsylvania Code, excluding the psychiatrist. The following minimum staffing configuration must be met by each CTT:

The following positions function as specialists on the team and function as a primary case manager/case coordinator for a caseload of team members:

- One FTE Registered Nurse (RN) per 50 members who works on a fulltime basis and is designated to provide nursing services to assigned team members and work with the physician. The RN functions as a specialist to all team members and functions as a fully integrated team member.
- One FTE Substance Abuse Counselor (SAC) per 50 members who works on a fulltime basis and is designated to provide individual and group MISA services for team members and accesses MISA services for team members. The SAC functions as a specialist to all team members and functions as a fully integrated team member.
- One clinically trained generalist Mental Health Professional (MHP) who works on a fulltime basis and is designated to provide individual and group therapy to team members. The MHP functions as a specialist to all team members and functions as a fully integrated team member.

The following positions function as specialist team member and do **not** function as a primary case manager/case coordinator for a caseload of team members. This does not preclude the following positions from providing case management in the context of their role on the team.

- A team leader/supervisor who works on a fulltime basis and is the designated clinical and administrative supervisor of the team and also functions (50%) as a practicing clinician on the team. In addition, the team leader is the designated representative accountable for the coordination of care and quality improvement (QI) function of the team.
- A psychiatrist who works for a minimum of 20 hours per week per 50 members. The psychiatrist is designated to provide clinical and crisis services, monitor each member's clinical status and response to treatment, and 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.
- One FTE Rehabilitation/Vocational Counselor (RVC) per 50 members who works on a fulltime basis and is designated to provide or access rehabilitation and work related services for team members. This position does not function as a primary case manager/case coordinator for a caseload of team members. The RVC functions as a specialist to all team members and functions as a fully integrated team member.
- One Peer Specialist (PS) who works on a fulltime basis and is designated to provide peer support services which are highly individualized and promote member self-determination and decision making. This individual should be an individual who is or has been a recipient of mental health services and is willing to disclose their 'peer' status to team members. Because of their life experience with services, the specialist provides expertise that professional training cannot replicate. This position does not function as a primary case manager/case coordinator for a caseload of team members. The PS functions as a specialist to all team members and functions as a fully integrated team member.

## **Clinical Supervision**

- Team policies and procedures include a written policy and procedure that addresses the mode and type of supervision of all staff providing treatment, rehabilitation, and support services to ensure the implementation of best practice guidelines particularly those identified in the next section, 'Training and Education'. *NOTE: Experts other than the team leader or psychiatrist will provide specialized supervision, as needed, e.g., MISA and forensic.*
- Clinical supervision is documented in writing.
- Supervision and direction consist of:
  - Individual, side-by-side coaching sessions in which the supervisor accompanies an individual staff member to meet with members in regularly scheduled meetings or during crisis intervention.
  - Individual and group feedback, direction and teaching during daily organizational staff meetings and regularly scheduled treatment/service planning meetings.
  - Individual sessions.

## **Training and Education**

- Team members complete the ‘HealthChoices Standardized Orientation to Community Treatment Teams - Philosophy, Components, Roles, Standards, and Practices’.
- 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:
  - Harm Reduction Interventions
  - Recovery, CSP, CASSP, and BDAP
  - Serious Mental Illness and Substance Use Disorders
  - Clinical Assessment and Treatment of Major Mental Illness and Substance Disorders
  - Dialectical Behavioral Therapy
  - Cognitive Behavioral Intervention -Techniques and Strategies
  - Crisis Intervention -Techniques and Strategies
  - Risk Assessment and intervention techniques
  - Management of Dangerous Behaviors/Duty to Warn
  - Assessment and Treatment of Special Populations (homelessness, forensic, medically compromised)
  - Criminal Justice System
  - Supported employment techniques based on the ‘Choose, Get, Keep’ approach
  - Recovery principles and Recovery Management Assessment and Planning
- All staff members are in full compliance with department and other regulatory or accreditation bodies reporting requirements and other directives.

## **Team Communication and Planning**

- Team meetings are conducted Monday through Friday at regularly scheduled times. During each meeting the entire member caseload is reviewed.
- 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 the member.
- The team maintains an updated weekly schedule for each member. 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 member’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.
- The team maintains a daily staff assignment schedule that provides all member 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 members' weekly schedule, are determined then prioritized based on acuity, emergency and crisis situations. Each Friday, the team determines needed follow up or scheduled member contacts for the weekend.

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

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

An initial admission assessment and treatment/service plan are completed within 30 days of members' admission to the team. The assessment includes a member self assessment and the treatment/service plan is completed with the participation of the member, designated team members, including the psychiatrist, with discussion facilitated by the team leader, and includes the following areas:

- Psychiatric symptomatology and mental status.
- Psychiatric history, including adherence to and response to prescribed medical and psychiatric treatment.
- Risk factors and crisis/relapse prevention planning, historical and recent
- Medical, dental, and other health related needs.
- Extent and effect of drug or alcohol use.
- Housing situation, historical and recent.
- Activities of daily living skills.
- Social, vocational, and educational functioning.
- Extent and effect of criminal justice involvement.
- Recent and significant historical life events.

Upon completion of the initial assessment, the team leader and psychiatrist assign the member's working team that includes, at a minimum, a primary case manager/case coordinator, nurse, and psychiatrist. The primary case manager/coordinator and other team members' assignment are based on the clinical, treatment, functional, and service needs of the member as well as member preferences and caseload capacity.

### **Comprehensive Assessment**

A comprehensive assessment is initiated and completed within 90 days of admission by the assigned working team and is based on the following available information:

- Self-reports
- Reports of family members and other significant parties
- Written summaries from police, courts, and jails
- 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:

- Psychiatric evaluation
- Adherence to and response to prescribed medical and psychiatric treatment
- Medical, dental, and other health related needs
- Extent and effect of drug and alcohol use
- Housing situation
- ADL skills
- Vocational/educational functioning

- Extent and effect of criminal justice involvement
- Social functioning
- Risk factors and potential need for crisis services
- Recent and significant historical life events
- Social and family involvement

### **Treatment/Service Plan Standard**

- Plans are used as a therapeutic tool central to the individual's recovery work.
- Plans are developed using an individual and family centered treatment-planning process.
- Plans are reviewed, updated and signed or acknowledged by the member at least every six months or when there is a major change in the course of treatment.
- Using CSP, Recovery, and CASSP Principles, plans identify member preferences, needs, problems, strengths, goals, objectives, interventions addressing treatment and rehabilitation, persons responsible and measurable indicators.
- The following key elements are addressed in every plan: symptom stability, management and education, functioning, rehabilitation, daily structure, relationships, crisis/relapse plan, crisis alerts, and, if indicated, a directed care plan.
- The planning meeting includes the member, member identified participants, the coordinator of treatment and any staff and family involved with the member on a regular basis.
- Teams are responsible to ensure the member and the member'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 member's social/informal network in the formulation of plans.
- The team develops, reviews, and updates the goals, objectives, and interventions.
- The plan clearly documents the following: specific services to be received, the rationale for receiving services and who is responsible to deliver each documented service.
- The care manager or county/oversight can request a review when it is clinically indicated or for continuity of care review.

### **Outcomes**

The provider tracks the following areas by submitting data through the CTT Monitoring Application and by completion of determined clinical scales and member satisfaction surveys:

- Member satisfaction
- Increased adherence to treatment/service plan
- Improved clinical outcomes
- Vocational/educational gains
- Increased length of stay in community residence
- Increased use of natural supports
- Reduced utilization of inpatient level of support

- Improved physical health

Community Care tracks adherence to the CTT model and determines annual CTT performance outcomes by administering, on an annual basis, the Dartmouth Assertive Community Treatment Survey (DACTS) fidelity assessment.

### **Referral, Admission, Transfer, and Discharge**

- Any provider, member, or family member can make a referral directly or on behalf of a member. Prior to the referral, the member is in agreement and has knowledge that upon admission to the CTT all other 'CTT included services' are terminated. The care manager ensures that the Service Coordination Unit (SCU) is aware of the referral. At the point a referral is authorized, the member is offered a choice of where to receive CTT services.
- The care manager 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 10 working days. For county funded members, a representative from the county/oversight is involved in the referral or transfer process per Community Care/county or oversight written agreement.
- If the care manager 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 members, a representative from the county/oversight is involved in the determination process per the Community Care/county or oversight written agreement.
- For discharges, the CTT must submit a verbal request for discharge to the care manager for review and determination of disposition. All requests require review and approval by Community Care and the county/oversight.
- For transfers, the CTT must submit a verbal request for transfer to the care manager for review and determination of disposition. All requests require review and approval by Community Care and the county/oversight.
- If the member does not meet MNC for CTT service, the care manager authorizes an alternative and appropriate level of support and treatment necessary to address the member's needs. For county funded members, a representative from the county/oversight is involved in this process per Community Care/county or oversight written agreement.
- 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.
- The CTT can appeal the assignment, in writing, within 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 members, the county/oversight medical director completes the review.
- Community Care and the county/oversight entity, at anytime, can approve an assignment other than clinical evidence would indicate. This requires a

documented explanation and signature from Community Care, and, for county funded members, The Office of Behavioral Health.

- Upon admission, the CTT, or its designee, will fax, to the care manager and the referral contact, a completed 'Consent to Treatment' form which documents the member's verbal or written consent to participate in CTT. If an SCU transfer is required, the SCU contact closes the record once the 'Consent to Treatment' is received and the CTT opens the record under the new SCU in eCAP (county electronic monitoring system).
- If a member 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 for review.
- Within 24 hours of receiving the referral, the CTT will contact the hospital liaison to facilitate admission. If the member 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 working days of the referral. For all other referrals to CTT, the initial meeting with the member must occur within seven days of receipt of the referral (addition/clarification effective 9/15/05).
- Upon admission, the CTT forwards the 'Consent to Treatment' form to the referring liaison. If an SCU transfer is required, the prior SCU closes the record and the CTT opens the record under the new SCU in eCAP.

## **Engagement**

While we recognize that CTT is a voluntary service, it is incumbent on providers to make a significant effort to engage members in services.

- Guidelines for engagement:
  - Include the member in the admission process
  - Include the member in the assessment process
  - Meet the member in the member's environment
  - Include member identified family or other supports in facilitating engagement
  - Regularly check jails and hospitals
  - If the member is incarcerated or hospitalized, meet the member face-to-face at the facility
  - Meet member's during non-traditional hours
  - Practice member-centered treatment/service planning with the member leading the planning process
- The CTT attempts to engage for up to 90 days, at which point, if an admission has not occurred, a meeting is convened to determine the course of treatment and includes the member, CTT, county, and/or Community Care.
- Engagement efforts are documented in the CTT member record.

## **Transition Standard**

While receiving services from the CTT, a transition period may be necessary to ensure continuity of services.

- Transitions occur, as clinically indicated, and up to 90 days, beginning with the date of CTT admission.
- Upon admission, the CTT takes full and direct responsibility for case coordination and the provision of case management related to transition, treatment, and discharge planning.
- A transition meeting, scheduled by the CTT, occurs within two weeks of admission to CTT and must include the member, member identified participants, the CTT, and other provider staff involved with the member and family.
- The transition plan is documented in the CTT record and outlines the responsibilities of all parties involved in the transition and demonstrates a decrease in outpatient and/or case management services and an increase in CTT service.
- A total of two hours per month or a total of six hours in a 90-days period of Case Management can be billed.
- Exceptions to these guidelines must be discussed with the care manager and prior authorization obtained.

## **Inpatient Standard**

The CTT provides the following services when a member is admitted to an inpatient psychiatric, rehabilitation, and/or RTF facility:

- CTT takes full responsibility for all case management and service coordination responsibilities related to treatment/service planning and discharge planning.
- CTT provides advocacy and linkage between services and between member and the member's community contacts.
- CTT maintains regular face-to-face contact with the member 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.
- CTT assesses treatment progress, reviews the member'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.
- 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.
- CTT coordinates necessary community referrals as part of discharge planning.
- CTT takes responsibility for arranging transportation for community visits and for discharges.
- CTT escorts the member on community visits and when discharged.

*For Community Inpatient 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 member when clinically appropriate.
- Daily contact is expected with the facility contact and with the member, when clinically appropriate.

*For State Hospital Inpatient and RTF:*

- Within five days of admission to a state hospital or RTF, the CTT contacts the facility and the member, when clinically appropriate.
- The CTT provides, at a minimum, weekly face-to-face contact with the member and the facility.

**Diversion**

Diversion from an inpatient admission:

- CTT coordinates and collaborates with the emergency service provider to determine disposition.
- If diversion is questionable, the CTT provides face-to-face intervention.
- 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.
- CTT provides crisis alerts to all emergency facilities, with permission of member.

Diversion from state hospital admission:

- CTT co-coordinates all diversion plans with the county diversion liaison and the inpatient team.
- Prior to a state hospital admission, the CTT presents, in writing, a preliminary discharge plan to the county diversion liaison.