IV COMMUNITY TREATMENT TEAM

Service Description and Common Service Settings	Magellan Specifications	Magellan Utilization Management Guidelines
Community Treatment Team (CTT) is a program that is primarily self-contained with a multi-disciplinary staff, ensuring ongoing individualized comprehensive assessment and providing intensive treatment/ rehabilitation and support services in the community. The population typically served are individuals with severe and persistent mental illness and who are at risk of decompensation and re-hospitalization even with the availability of traditional community based services. The CTT provides most of their services in the member's natural setting with minimal referral to other program entities until some degree of stabilization has been achieved and the member is ready for the transition to traditional community based treatment services. Some of the various treatment, rehabilitation, and support service functions will be assumed by virtue of a staff person's specialty area, while other generic activities can be carried out by most staff.	**Admission and Concurrent Service Components (Must meet *all* of the following)** 1. CTT provides services through a multi-disciplinary approach. All staff must have at least one year's experience with the SPMI population in direct practice settings. The staff must be comprised of at least four (4) full time equivalents. The composition of the team must include: a. The supervisor is a full-time licensed master's level mental health professional or RN with at least one year direct experience with the SPMI population, and at least one year program management experience. b. A Board Certified or Board Eligible Psychiatrist on a full or part-time basis. The Psychiatrist shall provide six (6) hours/week for every 20 members, and shall be accessible 24 hours day/7 days a week or have back up arrangements for coverage. Additional mental health professionals: a. At least one full time equivalent RN and one part-time RN for mobile medication administration.	**Admission Criteria** Target Population: Individuals with severe and persistent mental illness (SPMI) who are predicted to use or are using substantial amounts of inpatient care/crisis services with marked frequency. Individuals who are at risk of decompensation, and either are currently unsuccessful or predicted to be unsuccessful with their involvement with traditional service providers. Individuals either discharged or preparing for discharge from a State Hospital or individuals residing in the community and being served by the current behavioral health treatment system. 1. Validated DSM-IV Axis I or II diagnosis indicating a serious and persistent mental illness, with a GAF score of 50 or below. A licensed psychiatrist confirms this diagnosis after evaluation. 2. Must be 18 years of age or older. 3. Must be medically stable, but may need periodic or episodic medical follow-up.

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The provision of services is guided by the principle that members be maintained in a community setting at the least restrictive level of care with the focus on assisting members in achieving a maximum level of independence with an overall enhancement in their quality of life. Services are provided in the community wherever the member needs supportive, therapeutic, rehabilitative intervention: at his/her residence, place of work or leisure, provider program site etc. Program description to include recovery principles. **Common Settings:** • Mobile Assessment Stabilization and Treatment Team (MAST) • Community Treatment Team (CTT)	b. Psychiatric Rehab Specialist with BA degree. c. Mental Health Specialists/Case Managers minimum of BA degree. d. Other Mental Health Workers. *Existing MAST staff may be grandfathered as appropriate; however, when new staff is hired, they will meet full CTT requirements. 2. Services are provided within the team's scope of training and licensure/ certification. 3. Services are provided consistent with PA CSP principles. 4 Caseloads are based on staff-to-member ratios. The minimum rate for each full time equivalent is 5:1 and the maximum ratio is 10:1. 5 The Program will provide comprehensive bio-psychosocial assessments that include psychiatric evaluation, nursing assessment, psychosocial and rehabilitative functional assessments, and substance abuse evaluations. Also available are psychopharmacological consultation for medication adjustment and Psychological assessment for the purpose of differential diagnosis.	**Must Meet One of the Following:** 1. At least 3 or more acute episodes of psychiatric inpatient treatment within the past 12 months or 30 days or more on an acute psychiatric unit or state mental hospital during the last 12 months. *Two or more for MAST. 2. Currently does not receive mental health services despite documented efforts to engage the consumer by a licensed mental health or approved case management provider for at least 30 days, or member is being discharged from an acute or State hospital setting, and by history or clinical profile appears unlikely to be able to successfully access traditional community services. 3. Three or more contacts with crisis intervention/ emergency services within the past 6 months. *Two or more for MAST. If in the community, member must display the inability to be maintained, despite the current intensity of services, AND deemed at risk for further decompensation and re-admission to a psychiatric unit or a state hospital without CTT services. Member must be deemed in need of MAST services for a period of three to six months.

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	6. Following admission into the program and upon completion of the assessments. A strengths based comprehensive treatment/rehabilitation plan will be developed. The plan will include measurable outcomes and time lines, with the signature of the member as an active participant. The plan will be revised as needed to reflect the member's current, ever-changing needs. It must be revised at minimum once every three (3) months. 7. Required Services: a. Crisis Intervention 24 hours/7 days a week, Telephonic and in-person b. Supportive Psychotherapy c. Medication, prescription administration, monitoring, and documentation. d. Rehabilitation-work related assessment, intervention and support e. Social and Recreational Skills Training f. Activities of Daily Living Services g. Support Services: Health, Legal, Financial, Transportation, Living Arrangements, h. Advocacy	**Psycho/Social Factors (The presence of one of these increases the need for CTT services):** 1. Homelessness (i.e. living in shelters, or other places not fit for human habitation 2. Coexisting diagnosis of psychoactive substance abuse disorder, mental retardation, HIV/AIDS, or sensory developmental, medical, and/or physical disability. **Continued Stay Criteria:** 1. Validated DSM IV diagnosis Axis I or II, which remains the principal diagnosis, and continued SPMI symptomatology affecting the member's ability to function in the community and to access and utilize traditional treatment services. 2. There is a reasonable expectation that the member will benefit from the continued involvement of the CTT team. This is demonstrated by an observable positive response in the following areas of: a. Medication Compliance b. Reduction in the use of crisis services (If indicated as an issue in the treatment plan)

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	i. Education 8. The CTT's contacts with members will vary based on the member's clinical needs. The CTT will have the capacity to provide multiple contacts per week to the member. There will be at minimum two (2) contacts per week for all members, but multiple contacts may be as frequent as two (2) to three (3) times per day, 7 days per week. 9. Member's may receive CTT services and other treatment, rehabilitation, and support services for a period of up to six (6) consecutive months prior to a full discharge from the CTT in order to facilitate a successful transition to less intensive services.	c. Reduction in the use of inpatient episodes, and/or days spent in inpatient care, as compared to admission baseline figures. d. Enhancement of Social and Recreational skills (Improved communication and appropriate interpersonal behaviors) e. Improvement in activities of daily living Improvement in the member's community supports (Health, Legal, Transport, Housing, Finances, etc.) f. Enhancement of vocational skills or vocational readiness, as indicated. 3. The member expresses a desire to continue with CTT services, and exhibits compliance with the goals and objectives outlined in the plan of care. 4. The Member by virtue of continued symptomatology, and decreased level of functioning necessitates continued CTT involvement, with the withdrawal of such services resulting in an exacerbation of acuity and the increased need for inpatient/crisis services. 5. The member has not achieved six (6) months of demonstrated stabilization or is not at stabilization baseline, and continues to require this level of intervention *(For CTT only)

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		6. Active assessment of ongoing need for CTT services is completed every three (3) months. **Discharge Criteria:** 1. The member no longer meets continued stay criteria for CTT services 2. The member has successfully demonstrated the ability to function in the community with minimal CTT involvement and has demonstrated stabilization for a period of six (6) months. 3. The member has been successfully transitioned to traditional community treatment services, and meets Magellan UM criteria for coordinated lower levels of care. (ICM, Partial, IOP, PRS, etc.) 4. The member, with the mutual agreement of Magellan and the CTT/MAST concur that the goals, as set forth in the plan of care, have been achieved, and that a coordinated discharge plan has been documented and fully implemented. 5. The member moves out of the county of residence. 6. The member is incarcerated. 7. The member has consistently required additional services not provided by CTT/MAST.

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		8. The member has not benefited from CTT/MAST. An alternate plan of treatment has been developed with the member. 9. The member is deceased. **MAST Addendum** Discharge criteria to a higher level of care (PACT or CTT) 1. After a six (6) month stay on MAST, the member has not achieved demonstrated stabilization or is not at stabilization baseline, and continues to require this level of intervention.