Continuous Treatment Team (CTT)

Description:

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other peer support therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults and children and youth.

The intent is to provide intensive treatment to members with acute psychiatric problems in an effort to prevent the need for treatment in a more restrictive level of care, including inpatient hospitalization, residential treatment, or other out-of-home placement. The treatment is multi-systemic and community based in nature and will therefore include an array of services that are delivered in the home or in natural settings in the community. These services are provided through a strong partnership with the family and other formal and informal community supports.

The interventional program provides services including counseling, skills building, therapeutic intervention, advocacy, psychoeducational services, medication management as indicated, school based counseling and consultation with teachers (when applicable), and other specialized services deemed necessary and appropriate. CTT also provides 24/7 on call services to address crisis situations as they emerge.

When comorbid conditions are present, communication and coordination with physical health providers will occur and barriers to adherence with treatment recommendations and medication will be identified and addressed as needed. When co-occurring disorders are present, the Case Manager will act to assure that coordination between mental health and substance abuse providers is actively occurring in concert with the members needs at any given point in time.

Services rendered must be Evidenced-Based Practices and follow the principles of Recovery and Resiliency.

Admission Criteria:

ALL of the following criteria must be met:

1. The services must be recommended by a Tennessee licensed behavioral health clinician who is actively treating the member at the time of the recommendation, in addition to meeting all other prongs of the TennCare Medical Necessity Criteria.
2. The Member must demonstrate behavioral symptoms consistent with a DSM diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.

3. The member is at risk of placement in a more restrictive level of care (i.e. inpatient hospitalization, residential treatment) due to severe impairment in psychosocial functioning.
4. Less intensive services (e.g., standard case management, outpatient therapy) have either failed to measurably decrease acute symptomatology and maintain functioning, or there is evidence that these interventions are likely to fail if employed.
5. The Member's behavioral problems have measurably deteriorated within the past thirty (30) days, giving rise to significant change in school/work, home, or community functioning.
6. Symptoms require multi-level intervention.
7. In the case of children and adolescents, Comprehensive Child and Family Treatment (CCFT) criteria are not met (the individual is more a focus of treatment interventions than is the family system, and the risk of out-of-home placement is not immediate)

Continued Stay Criteria:

ALL of the following criteria must be met:

8. The member is at high risk of out of home placement if transitioned to a lower level of care (LOC).
9. The member's behaviors at home, school/work, and in the community remain at high risk for placement in a higher level of care. Triggers have been identified that promote instability and necessitate continued interventions. Any identified trigger must have a concrete intervention that is behaviorally oriented, is evidence-based, is practical and effective, is measurable, and time-limited in nature. Interventions are such that they lead to increased stability, decreased use of crisis services, and decreased risk of higher LOC, and focus whenever possible on enhancing existing system strengths (i.e. - the interventions are strengths-based and recovery oriented).
10. Transition to a lower level of care and steps to accomplish this transition are being put in place (i.e., discharge planning is continuously being addressed from initiation of services going forward and providers for aftercare services are being identified, including a crisis plan for when services have been completed).
11. Evidence of active participation in treatment (i.e.- attending 80% of scheduled sessions and completing 80% of assigned tasks) by the member is documented, or an effective and time-limited plan that will likely lead to more active participation of the member must be documented in the Treatment Plan.
12. Concrete evidence of benefit from CTT services (i.e. - progress) must be present and documented in the treatment plan and the continued services request form, or changes to the treatment plan and its interventions that will be reasonably likely to address any lack of benefit from CTT services (i.e.- progress), must be present in these same documents.

Exclusion Criteria:

13. Severity of psychosocial impairment due to a behavioral health condition requires higher intensity of intervention than can be provided through CTT, or

14. Member is receiving non-team based case management, CTT, CCFT, or PACT services from another provider at the time of the request, unless the services in question are being used in a transitional manner, or
15. Member refuses service.

Discharge Criteria:

Criteria 16 and 17 OR 18 must be met:

16. The member is no longer at high risk of out of home placement (i.e. inpatient hospitalization or residential treatment) due to behavioral health issues (i.e. - . the member has been functioning without a crisis that would result in out of home placement over the past 30 days)
17. The symptoms and behaviors identified as meeting authorization requirements (i.e.- Admission Criteria) have measurably decreased and functioning has improved to a point that care can be transitioned to less intensive LOC (e.g. Standard CM, Outpatient treatment, etc.).
18. There is lack of measurable progress or participation by the member and there is no clinical intervention that will likely change the lack of measurable progress or participation on behalf of the member (CTT is not intended to be a continuous support service).

P**rogram Service Expectations:**

Note: Service Expectations are not utilized to render medical necessity determinations. Service Expectations compliance will be monitored in the concurrent review process and deficiencies managed by the UnitedHealthcare Community Plan Quality Department.

1. The CTT treatment plan will include a Crisis Plan and will be developed within 10 business days of initiating CTT services. The treatment plan will include interventions that are:
    a. in conformance with the principles of Recovery and/or Resiliency;
    b. strengths-based;
    c. measurable and have time frames for completion; and
    d. include detail about transition/discharge planning.
2. CTT will actively coordinate with other behavioral health and medical treating providers throughout the episode of care, including assessment, treatment planning, active treatment, and discharge planning. When a member is receiving other case management services (e.g. non-team based case management, CCFT) at the time of admission to CTT, the CTT provider must notify and coordinate with the case management provider around admission and discharge. **CTT services should not occur in conjunction with other case management services unless only in a transitional manner (i.e. at admission and discharge for purpose of care coordination).**
3. Continued service reviews will be done every 3-4 weeks; this frequency may change based on the clinical issues of each case.

4. A transition staffing with the member and subsequent provider of step down services will occur prior to discharge and the staffing note will be forwarded to UnitedHealthcare Community Plan upon request.
5. The recommended typical length of stay in CTT is 30-90 days. Lengths of stay exceeding 90 days will need to be reviewed by a Physician Reviewer for consideration for alternate higher or lower levels of care.
6. A minimum of one face-to-face contact per week by team members is required. However, a sufficient number of weekly contacts by team members (either face-to-face with the member, or with collateral contacts) in order to affect measurable progress in treatment is highly recommended. Members who are just entering CTT services often require more contact services in order to achieve stabilization of their individual and systems issues that created the need for CTT services. Once again, UnitedHealthcare Community Plan emphasizes the overall importance of members making measurable progress towards identified treatment goals. When measurable progress is not clearly being documented, it will be incumbent upon the service provider to show that the number of hours to contact, member participation and treatment goals are sufficient in quality and quantity in order to reasonably expect that measurable progress is likely to occur in the near future.
7. The services are available on a 24-hour, seven days per week basis. CTT Case Managers are expected to become involved in circumstances that lead to emergent/urgent assessment needs, e.g. – for members in process of receiving a MCRT assessment for emergent/urgent placement.
8. Documentation is provided that ensures coordination and continuity of care is actively occurring and resulting in the development of collaborative relationships with treating psychiatrist, NPs, PCPs, therapists, DCS case managers, crisis services and other providers.
9. The staffing ratio of the case managers to members will conform to the minimum ratios as set forth in the Contractor Risk Agreement, Attachment I.