Summit COMMUNITY CARE

Arkansas | Medicaid

Therapeutic communities program requirements and guidelines

Service code definition

Therapeutic communities (TC) are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. TC employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff serve as facilitators, emphasizing personal responsibility for one's life and self-improvement. The service emphasizes the integration of an individual within their community, and progress is measured within the context of that community's expectations:

- Level 1 provides the highest level of supervision, support, and treatment, as well as ensuring community safety in a facility of no more than 16 beds:
  - Clients who receive this level of care may have treatment needs that are severe enough to require inpatient care in a hospital, but do not require the full resources of a hospital setting.
  - The emphasis in this level is intensive services delivered using a multi-disciplinary approach, including physicians, licensed counselors, and highly trained paraprofessionals.

- Level 2 provides supervision, support, and treatment, but at a lower level than Level 1 and can be used as a step down from Level 1 to begin the transition back into a community setting that will not provide 24/7 supervision, service, and support:
  - Interventions shift from clinical to addressing the client's educational or vocational needs, socially dysfunctional behavior, and the need for stable housing.
  - Arranging for the full array of clinical and HCBS is critical for successful discharge.

Therapeutic communities Level 1

1. **Program requirements:**
   a. 16-bed capacity
   b. Physician on call at all times to respond within 20 minutes
   c. All staff must be certified as a TC provider and documented in the employee’s record.
   d. All members must have an Individualized Plan of Care.
   e. All services must be documented in a service log or other documentation for each home- and community-based service.
   f. Staff ratios are indicated by member need and documented on the member’s treatment plan.

g. Includes a team leader who is a mental health professional (MHP); must be assigned to each member to oversee the development, delivery, and monitoring of the treatment plan as well as supervision of the community support system provided (CSSP), performing home- and community-based services (HCBS) to the member.

2. **Admission criteria and continued stay criteria:**
   a. Chronic mental illness has been present for at least two years.
   b. Moderate dysfunction in daily living for at least three months, as indicated by impairment in **all** the following:
      i. Interpersonal functioning
      ii. Ability to concentrate and complete tasks
      iii. Ability to adapt and change
   c. Psychiatric, behavioral, or other comorbid conditions related to admission diagnosis have been associated with significant life disruption in the past two years, as indicated by one or more of the following:
      i. Two or more inpatient hospitalizations
      ii. Two or more residential admissions
      iii. Two or more partial hospital admissions
      iv. Requirement for crisis or emergency service interventions on two or more occasions
      v. Homelessness or need for support services to maintain functioning
      vi. Criminal justice involvement
   d. Long-term community-based residential care is needed for **all** the following:
      i. Care provided by or under the supervision of a licensed healthcare professional is required on a daily or near-daily basis (at least five days a week).
      ii. Care needs are more continuous in nature than can be provided with intermittent home care.
      iii. Patient does not have a caregiver who can provide supportive care needs (in other words, unavailable, caregiver burnout, persistent patient safety concerns despite caregiver training).
      iv. Patient does not have access to care support services for unmet needs (in other words, meal delivery, transportation)
   e. Situation and expectations are appropriate for long-term community-based residential care, as indicated by **all** the following:
      i. Recommended treatment is necessary, appropriate, and not feasible with less intensive intervention (in other words, less intensive support is unavailable or is not suitable for the patient's condition or history).
      ii. Targeted condition, symptoms, behaviors, and functional impairments related to underlying behavioral health disorder (or with potential to destabilize disorder) have been identified and are appropriate for long-term community-based residential care.
      iii. Skilled care is necessary as part of routine care.
      iv. Gaining a safe level of independence in function or the ability to meet skilled care needs outside of a long-term care facility is not anticipated due to the nature of the patient's condition.

v. Ongoing therapeutic interventions, skilled care, or functional support (in other words, support in activities of daily living) have been identified. They can be safely performed in a long-term skilled care facility.
vi. Patient and family or caregivers, as appropriate, are willing to participate in treatment voluntarily.
vii. There is no anticipated need for physical restraint, seclusion, or other involuntary control for safety (in other words, patient not actively violent or at risk for harm to self or others).
viii. Medical and behavioral health providers, as appropriate, are willing and able to follow the patient during the course of service.
ix. Biopsychosocial stressors potentially contributing to clinical presentation (in other words, comorbidities, illness history, environment, social network, ability to cope, and level of engagement have been assessed and are absent or manageable at the proposed level of care).

f. Continued stay criteria:
   i. Continued stay request meets all the following:
      1. Meets requirements in admission/initial request for TC Level 1
      2. Treatment plan with goals and progress measurement in place (including potential for restoration of function, if applicable)
      3. SDoH Assessment completed.
   ii. Appropriate treatment plan review:
      1. Maintenance of the current plan under which the patient is making substantial progress.
      2. Review and modification based on inadequate progress.
      3. No review deemed needed as the patient has progressed and is transitioning to a new level of care.
   iii. Begin discharge planning.
   iv. Symptom and functioning assessment at appropriate frequency documented.
   v. Physician evaluation of patient and progress at appropriate frequency documented.
   vi. Review of progress and medication need or adjustment at appropriate therapy documented.
   vii. Frequency of services: Up to 90 units (one unit = one day)

3. **Program treatment guidelines:**
   a. A minimum of 35 treatment hours should occur per week.
      i. Five of these treatment hours/encounters are being conducted by a Licensed Mental Health Professional with at least one treatment hour/encounter on an individual basis and not in a group setting.
      ii. Two encounters per month should be conducted by an MD/Psychiatrist/APRN/other prescriber for the individual's behavioral health needs.
   b. Participation in development and updates to Person-Centered Service Plan (PCSP), and Interdivisional Staffing when notified at least 24 hours (during business days) in advance, unless an emergency arises, by the Care Coordination team.

c. If a critical incident occurs, outreach and collaboration with the Care Coordination team on addressing the immediate needs.
d. If an individual has an Intellectual or Developmental Disability with behavioral issues needing TC Level 1, a Positive Behavioral Support Plan will be required.

4. **Expected outcomes:**
   a. Member completed an Annual Wellness Visit with PCP during TC Level 1 admission and post-discharge (12-month measure).
   b. Monitor admissions to ER, IP 30-day readmissions during TC Level 1 admission and post d/c measurement at 3, 6, 12 months (with the goal of reducing admissions post discharge).
   c. BH OP/HCBS compliance (appointments) at 3, 6, 12 months, and post-discharge at 3, 6, and 12 months.
   d. Monitor — legal, family, housing, employment, independence — post discharge at 3, 6, 12 months via assigned Care Coordinator (goal of increasing independence/reducing treatment failures and recidivism).
   e. Monitor LOS in TC Level 1 — comparative analysis of LOS to post-discharge success (success = above measures).
   f. Track/Monitor re-admissions to TC programs (goal: limit re-admissions) with LOS.

Therapeutic communities Level 2

1. **Program requirements:**
   a. All staff must be certified as a TC provider and documented in the employee's record.
   b. All members must have an Individualized Plan of Care.
   c. All services must be documented in a service log or other documentation for each home and community-based service.
   d. Staff ratios are indicated by member need and documented on the member's treatment plan.
   e. Ability for members to be seen when necessary, 24 hours per day.
   f. Care team includes a team leader who is an MHP; must be assigned to each member to oversee the development, delivery, and monitoring of the treatment plan, as well as supervision of the CSSP performing HCBS to the member.

2. **Admission criteria and continued stay criteria:**
   a. Chronic mental illness has been present for at least two years.
   b. Moderate dysfunction in daily living for at least three months, as indicated by impairment in **all** of the following:
      i. Interpersonal functioning
      ii. Ability to concentrate and complete tasks
      iii. Ability to adapt and change
   c. Psychiatric, behavioral, or other comorbid conditions related to admission diagnosis have been associated with significant life disruption in the past two years, as indicated by one or more of the following:
      i. Two or more inpatient hospitalizations

ii. Two or more residential admissions
iii. Two or more partial hospital admissions
iv. Requirement for crisis or emergency service interventions on two or more occasions
v. Homelessness or need for support services to maintain functioning
vi. Criminal justice involvement

d. Long-term community-based residential care is needed for **all** of the following:
   i. Care provided by or under the supervision of a licensed healthcare professional) is required daily or near daily (at least five days a week).
   ii. Care needs are more continuous in nature than can be provided with intermittent home care.
   iii. Patient does not have a caregiver who can provide supportive care needs (in other words, unavailable, caregiver burnout, persistent patient safety concerns despite caregiver training).
   iv. Patient does not have access to care support services for unmet needs (in other words, meal delivery, transportation).
e. Situation and expectations are appropriate for long-term community-based residential care, as indicated by **all** of the following:
   i. Recommended treatment is necessary, appropriate, and not feasible with less intensive intervention (in other words, less intensive support is unavailable or is not suitable for the patient's condition or history).
   ii. Targeted condition, symptoms, behaviors, and functional impairments related to underlying behavioral health disorder (or with potential to destabilize disorder) have been identified and are appropriate for long-term community-based residential care.
   iii. Skilled care is necessary as part of routine care.
   iv. Gaining a safe level of independence in function or the ability to meet skilled care needs outside of a long-term care facility is not anticipated due to the nature of the patient's condition.
   v. Ongoing therapeutic interventions, skilled care, or functional support (in other words, support in activities of daily living) have been identified. They can be safely performed in a long-term skilled care facility.
   vi. Patient and family or caregivers, as appropriate, are willing to participate in treatment voluntarily.
   vii. There is no anticipated need for physical restraint, seclusion, or other involuntary control for safety (in other words, patient not actively violent or at risk for harm to self or others).
   viii. Medical and behavioral health providers, as appropriate, are willing and able to follow the patient during the course of service.
   ix. Biopsychosocial stressors potentially contributing to clinical presentation (in other words, comorbidities, illness history, environment, social network, ability to cope, and level of engagement have been assessed and are absent or manageable at the proposed level of care).
f. Continued stay criteria:
   i. Continued stay request meets all the following:
      1. Meets requirements in admission/initial request for TC Level 2

2. Treatment plan is documented with goals and progress measurement in place (including potential for restoration of function, if applicable).
3. SDoH Assessment completed.
4. Appropriate treatment plan review:

ii. Maintenance of the current plan under which the patient is making substantial progress.
iii. Review and modification based on inadequate progress.
iv. No review deemed needed as patient has progressed and is transitioning to a new level of care.
1. Begin discharge planning.
2. Symptom and functioning assessment at appropriate frequency is documented.
3. Physician evaluation of the patient and progress at an appropriate frequency is documented.
4. Review of progress and medication need or adjustment at appropriate therapy is documented.
5. Frequency of services: Up to 90 units (one unit = one day).

3. **Program treatment guidelines:**
   a. A minimum of 30 treatment hours should occur per week:
      i. Three of these treatment hours/encounters are being conducted by a Licensed Mental Health Professional with at least one treatment hour/encounter on an individual basis and not in a group setting.
      ii. One encounter per month should be conducted by an MD/Psychiatrist/APRN/other prescriber for the individual's behavioral health needs.
      iii. Participation in development and updates to Person-Centered Service Plan (PCSP), and Interdivisional Staffing when notified at least 24 hours (during business days) in advance, unless an emergency arises, by the Care Coordination team.
   b. If a critical incident occurs, outreach and collaboration with the Care Coordination team on addressing the immediate needs.
   c. If an individual has an Intellectual or Developmental Disability with behavioral issues needing TC Level 2, a Positive Behavioral Support Plan will be required.

4. **Expected outcomes Level 2:**
   a. Member completed an Annual Wellness Visit with PCP during TC Level 2 admission and post-discharge (12-month measure).
   b. Monitor admissions to ER, IP 30 — day readmissions during TC Level 2 admission and post d/c measurement at 3, 6, 12 months (to reduce admissions post-discharge).
   c. BH OP/HCBS compliance (appointments) at 3, 6, 12 months, and post-discharge at 3, 6, and 12 months
   d. Monitor — legal, family, housing, employment, independence — post discharge at 3, 6, 12 months via assigned Care Coordinator (goal of increasing independence/reducing treatment failures and recidivism).

e. Monitor LOS in TC Level 2 — comparative analysis of LOS to post-discharge success (success = above measures).
f. Track/Monitor re-admissions to TC programs (goal: limit re-admissions) with LOS.

For additional support

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