Office of Mental Health

Adult Critical Time Intervention Teams (CTI)

Program Guidance

2024

Table of Contents

1. Background

The New York State (NYS) Office of Mental Health (OMH) announced the availability of funds for the development of Adult Critical Time Intervention Teams (CTI Teams) statewide in late 2023 and early 2024. These CTI Teams serve individuals who have behavioral health needs and who have not been successfully engaged in services during or after critical times in transition.

CTI Teams are modeled on Critical Time Intervention (CTI), an evidence-based model that is a time-limited, phase-based care management approach focused on enhancing continuity of care during transitional times, for example from a hospital to community. CTI promotes community integration, self-advocacy, and access to ongoing support by helping individuals develop and utilize strong ties to their professional and non-professional support systems during and after transition periods. CTI includes assertive outreach and engagement with individuals in higher-level of care settings, as well as in the community, with a focus on addressing key social care needs at the individual level. A critical aspect of this program is the partnership between CTI Teams and hospitals (inpatient psychiatry units, emergency departments, psychiatric centers, and CPEPs), as well as the knowledge of, and expertise in, connections to outpatient services and supports.

CTI helps individuals build skills and strengthen linkages to ongoing sources of support that will remain in place after the time-limited CTI intervention ends. This includes informal supports such as local businesses, employment, neighbors, faith communities, banks and credit unions, pharmacies, community centers, and local not-for-profit organizations that provide free or low-cost meals and clothing, as well as behavioral and physical health service providers.

1.1 Core Principles and Values

Core Principles - While CTI shares a number of characteristics with traditional care management, the following core principles distinguish it from many other similar interventions:

- Intervention is focused on a critical transition period
- Phase-based care management with clear tasks associated with each phase
- Time-limited approach – 9-12 months
- Frequency of contacts between the individual and the CTI Team intentionally decrease over time
- It is highly focused and voluntary
- Small caseload size is essential
- Work is a team approach and community-based
- Supervision is provided through structured team meetings

Core Values – A set of core values guides the approach taken by CTI teams:

- Strengths-Based and Skill-building
- Based on Shared Decision-Making
- Individualized
- Recovery-Oriented
- Wellness, self-management

- Cultural humility
- Open, honest communication
- Trauma-Informed
- Harm Reduction

1.2 CTI References & Resources

CTI Teams will use the Critical Time Intervention Manual (2002) and the CTI Manual for Workers and Supervisors (2021) as an additional reference to support the evidence-based approach. In the event that there is a discrepancy between the above manuals and NYS regulations and guidance, CTI Teams must follow NYS regulations and guidance.

2. Eligibility Criteria

CTI has been applied with several populations in various types of transitions – veterans, people with mental illness, people who are experiencing homelessness or involved with the criminal justice system, and other groups. This guidance is specific to adult CTI Teams, and the target population is individuals aged 18 and older who meet the following eligibility criteria:

1 Individuals diagnosed with mental illness and have complex needs as evidenced by recent hospitalization, multiple hospitalizations, emergency room or other crisis service contact, homelessness, involvement in the criminal justice system, lack of engagement in mental health services, or cooccurring disorders.[1],

2 Will benefit from an intervention during a critical transition in care, including but not limited to:
   - Individuals being discharged from an inpatient psychiatric hospital, who have had long-stay admissions or multiple admissions, or
   - Individuals being discharged from Emergency Room (ER)/Comprehensive Psychiatric Emergency Program (CPEP) – who are not otherwise engaged, returning to ER/CPEP multiple times, and who lack community supports; and

CTI Teams will prioritize those being discharged from hospital settings as outlined above. However, with prior approval through OMH Field Offices, at times CTI Teams may also serve:

- Individuals who have not previously engaged in services after a critical transition, e.g., crisis respite or other crisis services,
- Individuals who are precariously housed or experiencing homelessness or at risk of losing their housing, and
- Other specialty populations in a critical time of transition (e.g., post incarceration or prison).

[1] Note that eligible individuals also include those with co-occurring mental illness and substance use, medical conditions, or Intellectual or Developmental Disabilities (I/DD) for providers based upon their experience and knowledge to serve this population.

3. Community Inclusion/Partnerships

3.1 Relationship with Hospital

CTI Teams must build and maintain relationships with hospitals, and other referral sources. CTI Teams will need to maintain relationships with hospitals, which includes regular meetings (i.e., rounds on the inpatient unit, inpatient case conferences and access meeting space on unit, trainings). In cases where the hospital is the agency implementing the CTI Team, the above collaborations must exist within the internal structure of the hospital and be fully supported by the clinical and administrative leadership of the hospital.

CTI staff must have full access to inpatient and ER settings, both to engage in relationship building with individuals served, and to partner in discharge and aftercare planning with hospital staff. CTI staff bring expertise in the continuum of local behavioral health services and supports, housing options, benefits, and other local resources necessary for community tenure. Hospitals and the CTI Team will work together to identify high need individuals who would benefit from CTI and immediately include CTI in aftercare planning. CTI Teams must use data, such as PSYCKES[2], to assist with an informed discharge planning approach including the assessment of past supports, current providers, and clinical history relevant to successful community tenure and recovery.

Each CTI Team must have at least one (1) well-defined working relationship with a local Article 28 and/or Article 31 hospital (e.g., inpatient psychiatry units, emergency department, and or CPEP). This relationship must include a memorandum of understanding (MOU) between the hospital and the CTI Team that includes:

- a coordinated process for routine and regular communication,
- easy access to hospital for CTI staff,
- a process for referrals and discharge (aftercare) planning from the hospital,
- access to Regional Health Information Organization (RHIO) or Qualified Entity (QE) where available to access client records from multiple settings, including hospitals and other providers,
- a process for engaging in-person with individuals to provide the CTI intervention prior to discharge.

MOUs must remain on site with CTI programs for review by OMH as requested. The MOU must be kept current and up to date.

It is important to note that when CTI Teams work with ER/CPEPs or other crisis services, workflows should be modified to meet the needs of the settings. These workflows must be established prior to implementation by both the CTI Team and hospital leadership and as stated above reflects the full support of the clinical and administrative hospital leadership.

---

[2] Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) is a HIPAA-compliant web-based application designed to support clinical decision making, care coordination, and quality improvement in New York State.

CPEPs currently employ or will employ a minimum of two Peer Bridgers whose role is to help bridge individuals utilizing CPEP services to community resources that help foster community inclusion and connection as well as create and/or sustain natural supports and peer self-help resources. CTI teams should connect with these staff to help them engage with individuals in the CPEP during pre-CTI.

In areas where there are multiple hospitals or hospital systems, CTI Teams may partner with additional hospitals based on their capacity and local need. It is noted that CTI Teams *may* accept referrals from local hospitals, emergency departments, Psychiatric Centers, and CPEPs even if the Team has not established a formal MOU with the hospital if the team has the capacity to accept the referral and the hospital is able to effectively include the team in aftercare planning and facilitate access for in-person engagement prior to discharge. Teams must get an MOU in cases where there will be ongoing collaboration with a hospital.

3.2 Partnership with Community Based Providers

In order to support implementation of the hospital's person-centered discharge plan, the CTI Team must develop coordinated admission and transition plans with community providers, including but not limited to:

- Housing and residential services providers,
- Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) and Certified Community Behavioral Health Clinics (CCBHC),
- Personalized Recovery Oriented Services (PROS),
- Community Oriented Recovery & Empowerment Services (CORE) and Home and Community Based Services (HCBS) providers,
- Community services certified and funded by the NYS Office of Addiction Services and Supports (OASAS), the Office for People with Developmental Disabilities (OPWDD), Office of Temporary and Disability Assistance (OTDA), Health Homes (HH) and Specialty Mental Health Care Management Agencies (SMH CMAs), and
- Other community resources to coordinate needed services and natural and professional supports for individuals to ensure their successful transition into community-based services.

The CTI Team is charged with care coordination of services and supports and identification or modification of supports to promote community tenure and manage behavioral and physical health needs. CTI teams should work with the individual's existing community supports to address crises and health-related social needs (social determinants of health).

CTI teams should develop agreements for assuring service continuity with other systems of care including, but not limited to:

- Family Services (NYC Administration for Children's Services, Office of Children and Family Services, Department of Social Services, Child Protective Services),
- Adult Protective Services,
- Benefit services (Department of Social Services, Social Security Income, NYS Office of Temporary Disability Assistance etc.),
- Emergency service programs, such as crisis residences and crisis stabilization centers,

- State and local psychiatric hospitals,
- Rehabilitation services,
- Housing agencies/shelter system,
- ACCESS-VR/educational institutions,
- Self-help/peer-run services,
- Independent living centers,
- Clubhouses,
- Primary care and specialty care,
- INSET teams,
- Local government units like Single Point of Access, Department of Social Services, shelter systems, Department of Homeless Services, etc.,
- Natural community supports, including parenting programs, churches/spiritual centers, and other local groups/organizations and social activist organizations, and
- Local correctional facilities, local law enforcement, and other forensic organizations such as parole and probation.

3.3 Partnerships with Local Communities & Social Supports

CTI Teams will offer to support individuals with building and strengthening relationships in their local communities. Social isolation and loneliness are associated with poor physical and mental health outcomes. Natural supports and non-behavioral health services are vital to many individuals' recovery. CTI Teams must establish a familiarity with culturally appropriate supports in their local community, which may include but is not limited to, faith communities, barbershops and hair salons, gyms and fitness centers, neighborhood and community centers, pride centers, art centers, and self-help groups. Connecting individuals with organizations and groups that are rooted in cultural competence and sensitivity may enhance the effectiveness of CTI.

CTI Teams should also work to include the individual's family of choice in services, when possible and with the individual's consent. This may include facilitating referrals to family peer support services, family psychoeducation, family support groups, or family therapy. When making such referrals and linkages, the intent is always to improve the capacity of the family to support the individual's recovery.

4. Program Organization and Operations

4.1 Referral Process & Requirements

CTI Teams will receive referrals from hospitals, including inpatient psychiatric units, psychiatric centers, emergency departments, CPEPs, and other crisis services. The process and mechanisms for these referrals must be included in the MOU and should be streamlined, efficient, and timely.

CPEP/ER workflows and inpatient unit referral workflows will be different based on admission/discharge timeframes. Policies and Procedures should include processes to ensure timely response to referrals and access to CTI services. Upon receiving a referral, the CTI Teams will engage with referred individuals within 24 hours for those on an inpatient unit and within 8 hours for those in ED or CPEP.

CTI Teams must maintain records for each individual who is referred and found ineligible (screened out), opts out of services after assertive engagement efforts are made (opted out), or discharged.

4.1.1 Initial Engagement

Upon receiving a referral, for an inpatient unit, the CTI team will respond to a new referral within 24 hours, engaging the individual immediately thereafter. The CTI Teams will engage with a referred individual within 8 hours in an ER/CPEP. Timeframes may be extended to accommodate location and team size limitations for Upstate and Rural teams.

Engaging individuals in CTI is an important role of the Team. Assessment and intake should be conversational in nature. Staff should be trained to complete this process with minimal notetaking and with forms being completed after the session. A lack of engagement should not be seen as a failure on the part of the individual. The team must seek to effectively engage individuals and employ a range of outreach strategies tailored to individual needs and preferences. The team is expected to be persistent in engaging and building trust with individuals who initially are less engaged. The team uses a variety of methods (e.g., using motivational interviewing techniques) to promote engagement with the least engaged individuals, including street outreach, offering to meet in a more casual setting, or visiting the individual in their home. As part of the engagement process, the team will fully explain to individuals the array of available services. Individual choice with regard to participation in services will be respected. Staff will also have access to service dollars that can be used as part of the engagement process to meet a recipient's need for food, clothing, etc. Staff are trained and learn through observation of more seasoned staff to reflect a perspective of daring optimism in their interactions with recipients. A non-judgmental, person-centered approach that relays that the team genuinely cares about them as unique individuals and believes (sometimes more than they do themselves) that change can happen, and their goals are achievable.

See Section 4.11 of this guidance for more information on engagement throughout the phases of CTI.

4.2 Staffing

CTI Teams are multidisciplinary teams that vary in size and composition based upon geographic location:

- Downstate (10 staff with a monthly capacity of 130 individuals),
- Upstate (7 staff with a monthly capacity of 80 individuals) or
- Rural (3 staff with a monthly capacity of 30 individuals).

CTI Teams will hire staff with the appropriate qualifications to meet the needs of the target population and develop policies that maintain the caseload sizes. Teams consist of licensed, professional, and paraprofessional staff, as defined below.

Caseloads should be evenly distributed, taking into account what phase each individual is in. For example, in a caseload of 15, there should be 6-7 individuals in each phase of CTI.

For CTI Teams in NYC, all eligible CTI Team staff are expected to obtain and maintain 9.58 certification.

4.2.1 Staff Qualifications

Licensed Practitioners of the Healing Arts (LPHA): a subset of professional staff, as defined below, who are licensed by the New York State Education Department (NYSED) including:

- Physician: An individual currently licensed to practice medicine issued by NYSED;
- Physician Assistant: An individual currently registered to practice as a physician assistant issued by NYSED;
- Nurse Practitioner of Psychiatry: An individual currently certified to practice as a nurse practitioner issued by NYSED;
- Registered Nurse (RN): An individual currently licensed to practice as a registered professional nurse issued by NYSED;
- Psychologist: An individual currently licensed to practice as a psychologist issued by NYSED;
- Social Worker: An individual who is either currently a licensed clinical social worker (LCSW) issued by NYSED or a licensed Master of Social Work (LMSW) practicing under the supervision of a psychiatrist, psychologist, or LCSW employed by the agency;
- Mental Health Counselor: An individual currently licensed to practice as a mental health counselor issued by NYSED;
- Marriage and Family Therapist: An individual currently licensed to practice as a marriage and family therapist issued by NYSED;
- Psychoanalyst: An individual currently licensed to practice as a psychoanalyst issued by NYSED; and
- Creative Arts Therapist: An individual currently licensed to practice as a creative arts therapist issued by NYSED.

Professional Staff: Professional staff are qualified by credentials, training and experience to provide and supervise the provision of CTI Services, consistent with New York State scope of practice laws and rules, including:

Certified Psychiatric Rehabilitation Practitioner, which means an individual who is currently certified as a Psychiatric Rehabilitation Practitioner by the Psychiatric Rehabilitation Association;

Creative Arts Therapist, which means an individual who is currently licensed or has a limited permit to practice as a creative arts therapist by NYSED, or who has a master's degree in a mental health field from a program approved by NYSED and registration or certification by the American Art Therapy Association, American Dance Therapy Association, National Association of Music Therapy or American Association for Music Therapy;

C*redentialed Alcoholism and Substance Abuse Counselor,* which means an individual who is currently credentialed as a Credentialed Alcoholism and Substance Abuse Counselor by the New York State Office of Addiction Services and Supports;

Licensed Practical Nurse, which means an individual who is currently licensed or permitted as a licensed practical nurse by NYSED and is supervised by a registered professional nurse, licensed physician, or physician assistant;

Marriage and Family Therapist, which means an individual who is currently licensed or has a limited permit to practice as a marriage and family therapist by NYSED or who has at least a master's degree required for licensure as a marriage and family therapist pursuant to the NYS Education law;

Mental Health Counselor, which means an individual who is currently licensed or has a limited permit to practice as a mental health counselor by NYSED or who has at least a master's degree required for licensure as a mental health counselor pursuant to the NYS Education law;

Nurse Practitioner, which means an individual who is currently certified or has a limited permit to practice as a nurse practitioner by NYSED;

Nurse Practitioner in Psychiatry, which means an individual who is currently certified as a nurse practitioner in psychiatry by the New York State Education Department. For purposes of this Attachment, nurse practitioner in psychiatry will have the same meaning as psychiatric nurse practitioner, as defined by NYSED;

Physician, which means an individual who is currently licensed or has limited permit to practice as a physician by NYSED;

Physician Assistant, which means an individual who is currently registered or has a limited permit to practice as a physician assistant or a specialist's assistant by NYSED;

Psychiatrist, which means an individual who is currently licensed or has a limited permit to practice as a physician by NYSED and who is certified by, or eligible to be certified by, the American Board of Psychiatry and Neurology;

Psychoanalyst, which means an individual who is currently licensed or has a limited permit to practice as a psychoanalyst by NYSED or who has at least a master's degree required for licensure as a psychoanalyst pursuant to the NYS Education law;

Psychologist, which means an individual who is currently licensed or limited permit to practice as a psychologist by NYSED, or who has at least a master's degree in psychology;

Psychoanalyst, which means an individual who is currently licensed or has a limited permit to practice as a psychoanalyst by NYSED or who has at least a master's degree required for licensure as a psychoanalyst pursuant to the NYS Education law;

Psychologist, which means an individual who is currently licensed or limited permit to practice as a psychologist by NYSED, or who has at least a master's degree in psychology;

Registered Professional Nurse, which means an individual who is currently licensed or has a limited permit to practice as a registered professional nurse by NYSED;

Rehabilitation Counselor, which means an individual who has either a master's degree in rehabilitation counseling from a program approved by NYSED or current certification by the Commission on Rehabilitation Counselor Certification;

Social Worker, which means an individual who is currently licensed or has a limited permit to practice as a master social worker (LMSW) or clinical social worker (LCSW) by NYSED or who has at least a master's degree required for licensure as a social worder pursuant to the NYS Education law;

Therapeutic Recreation Specialist, which means an individual who has either a master's degree in therapeutic recreation from a program approved by NYSED or registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society.

Paraprofessional Staff: Paraprofessional staff must be at least 18 years of age and have attained a bachelor's degree or be at least 18 years of age, have attained a high-school diploma or equivalent, and at least six (6) months of direct care experience with individuals with serious mental illness.

4.2.2 Staff Roles & Caseload Limits

Team Leaders (TL) are Licensed Practitioners of Healing Arts (LPHA) with 3-5 years post-licensure experience working with individuals who have mental health, or co-occurring mental health and substance use disorders. The Team Leader provides supervision to staff, conducts weekly team meetings, manages relationships with hospitals, runs regular case presentations, ensures continuity between fieldwork and meetings, reviews the entire caseload, promotes model fidelity, staff productivity and staff wellness, monitors quality of documentation, updates resource lists, monitors phase dates, assists in covering caseloads when needed, and manages the caseloads for all staff.

Registered Nurse/Licensed Practical Nurse (RN/LPN) will bring integrated care into the CTI model. RN is the preferred staffing for this position, however there is flexibility around hiring an LPN. RN/LPNs will carry a caseload, providing CTI work as well as addressing medical needs. RN/LPNs are responsible for assessing basic health and medical needs within their scope of practice, coordinating health care with community medical providers (e.g., primary care physicians, specialists, etc.), rehabilitation, education, and support services. RN/LPNs will carry a smaller caseload to allow the flexibility to work with individuals who may have medical needs they can support, from other staff's caseloads. RNs and LPNs will need to work within scope of practice.

Caseload Maximum: 10

Mental Health Professional (MHP) is a Professional who works within scope of practice. MHPs are Care Managers but in addition to Care Management tasks, they resolve clinical and rehabilitative needs, when within scope of practice, that impact the individual's ability to meet recovery goals. MHPs:

- Provide therapeutic interventions for both mental health and substance use disorders,
- Educate individuals about mental health, treatment, and recovery,
- Teach skills for coping with specific symptoms and stress management, including development of a crisis management plan, developing a relapse prevention plan, including identification/recognition of early warning signs and rapid intervention strategies.

Caseload Maximum: 15

Care Managers (CM) can be professionals or paraprofessionals. CMs provide CTI services and carry a caseload. Care managers develop the person-centered care plan, share knowledge of community resources, provide linkage to resources, engage individuals in skill building, offer crisis management, collaborate with other providers, assist individuals in navigating complex systems, and work with informal supports. Care Managers have specific training and care coordination skills that are needed for population and setting.

Caseload Maximum: 15

Peer Staff/Care Managers: Peer specialists are adults who have themselves experienced mental illness, substance use, homelessness, or trauma conditions. The Peer Specialist provides the CTI services as a Care Manager from a lived-experience and non-clinical perspective. Peer Specialists should be able to become provisionally certified[3] if not already within one year of hire, and work to become fully certified thereafter. Youth Advocates may be hired and utilize the cross-certification process to become dually certified and credentialed as a YPA/CPS.[4]

4.2.3 Staff Supervision

A unique feature of the CTI model is the provision of supervision through the weekly team meeting (see section 4.7 of this guidance). Staff supervision may also occur both formally, through regularly scheduled direct supervision and consultation, as well as informally through case conferences and daily communication[5]. Paraprofessional and Professional staff are supervised by an LPHA. LPHAs supervising peers should be trained in peer values and practices.

CTI Teams should have a quality supervisory and operational infrastructure that assures fidelity to the CTI model. Team meetings and supervision are facilitated by the Team Leader. Professional staff must have access to clinical supervision as required by their permit or licensure under NYSED. The Team Leader should regularly review the effectiveness of service provision and support professional and paraprofessional staff with identifying individuals' barriers and service needs.

4.3 Team Composition

It is expected that each team be comprised of a multidisciplinary team as follows:

- Downstate CTI Teams have a capacity of 130 individuals per month and include 10 Full Time Equivalents (FTEs) comprised of:
  - 1 FTE Team Leader,
  - 1 FTE Registered Nurse/Licensed Practical Nurse,
  - 3 FTE Mental Health Professionals, and
  - 5 FTE Care Managers.

---

[3] NYCPS-Provisional Application Form (nypscb.org)

[4] Youth Peer Advocate to Certified Peer Specialist (P) (nypscb.org)

[5] See Team Approach Section for details.

It is recommended that downstate CTI Teams hire two (2) Peer Specialists[6] in the role of Care Manager.

- Upstate CTI Teams have a capacity of 80 individuals per month and include 7 FTEs comprised of:
    - 1 FTE Team Leader,
    - 1 FTE Registered Nurse/Licensed Practical Nurse,
    - 1 FTE Mental Health Professionals, and
    - 4 FTE Care Managers.

It is recommended that upstate CTI Teams hire two (2) Peer Specialists in the role of Care Manager.

- Rural CTI Teams have a capacity of 30 individuals per month and include 3 FTEs comprised of:
    - 1 FTE Team Leader, and
    - 2 FTE Care Managers.

It is recommended that rural CTI Teams hire one (1) Peer Specialist in the role of Care Manager.

On the CTI Team, Peer Specialists are care managers with lived experience. Peers must be paid a salary that is equitable and comparable to other CMs on the team. Peer specialists are in a unique position to demonstrate recovery, educate individuals about self-help techniques and self-help group processes, teach effective coping strategies based on personal experience, teach wellness management skills, assist in clarifying rehabilitation and recovery goals, and assist in the development of community support systems and networks.

4.4 Staff Training Requirements & Learning Community/Collaboratives

CTI Team staff are trained in CTI and other applicable evidence-based approaches (e.g., motivational interviewing, Integrated Dual Disorder Treatment, trauma informed care). CTI Teams are expected to participate in any CTI Team learning communities; complete all required trainings; access the Care Management Institute to utilize the Care Management Institute and their training resources; and attend meetings to review progress, outcomes and develop best practices for CTI Teams. CTI Teams should train staff in specialty areas such as housing, community resources, integrated care, health and wellness, and vocational supports.

All CTI staff, including both professional and paraprofessional staff, are required to complete State-approved training in the CTI model. This training will be made available at no cost to CTI Teams through the Care Management Institute, I-CONECT, at the Center for Practice Innovations (CPI).

CTI Teams must:

- Ensure staff have access to the CPI Learning Management System (LMS);
- Ensure that all staff complete State-approved trainings for CTI;

[6] Peer Specialists are individuals with lived experience, in this role they will be care managers with lived experience. Certification is not required but is highly recommended.

- Support staff training in applicable evidence-based approach training (e.g., motivational interviewing, integrated treatment for co-occurring disorders, trauma-informed care, etc.) through agency resources or CPI;
- Participate in any Learning Communities/Collaboratives organized by the Care Management Institute, as outlined in the Staff Training & Competencies addendum to this guidance;
- Fully utilize the training, technical assistance, support, and resources available through the Care Management Institute/ CPI; and
- Attend meetings to review progress, outcomes, and develop best practices for CTI in NYS.
- Ensure staff have annual training.

Specific staff and supervisor training requirements are subject to change as new resources are developed. As such, these requirements are outlined in the Staff Training & Competencies addendum to this guidance. Any changes to these requirements will be updated in the addendum and shared via OMH's CTI listserv.

The success of CTI Teams will be based in part on their ability to navigate local systems and resources. Teams should additionally consider how they will train staff in specialty areas such as housing, local community resources, integrated care, health and wellness, and vocational supports, potentially by inviting other agency staff/experts to present on issues/techniques that will be helpful to the recipients served by the CTI team

4.5 Team Approach

4.5.1 Conduct Weekly Team Meeting

Team meetings, often scheduled in the morning, must be held a *minimum* of once a week. These meetings are used as a formal group supervision modality. The team meeting is critical to facilitate frequent communication among team individuals about individual progress and to help make rapid adjustments to best meet individual needs. The team meeting provides a forum for joint problem-solving and support from the multidisciplinary team.

Team meetings enable staff to substitute for each other when a staff is not available (vacation, illness, scheduling conflict) or when another staff person's professional or personal experience may be a better match for a specific issue or need. CTI teams should develop procedures to share pertinent individual information (e.g., significant events, behaviors, interventions, etc.) to ensure that all team members are informed of an individual's current status. Staff should identify the phase the individual is in, any obstacles with meeting outcomes/goals, and make a plan to resolve any current or foreseeable challenges. The Team Leader will designate a note taker for each meeting who will take brief notes.

The Team Leader facilitates the meetings to include:

- Review of any new referrals, assignment to a care manager, and current status of existing referrals;
- Opportunities to share resources or expertise in specific areas relevant to the needs of the recipients served as well as arranging for outside experts to present to the team;
- Review of any case presentations due for individuals in early Phase I;

- Team Leader reviews caseload to schedule any visits needing coverage or specialty visits from other staff individuals, and will additionally review:
    - Individuals on the CTI Team who have had a recent hospitalizations/ER/CPEP visits and a plan for visiting individuals while hospitalized, communication with inpatient staff, plan for discharges, and follow-up care;
        - CTI teams must access to QEs/RHIOs for purposes of receiving hospitalization alerts and for medical documentation. This should be checked for any hospitalizations prior to the organization staff meeting for review during the meeting.
    - Individuals on the CTI Team who have had a recent incarceration, or people experiencing a crisis;
- Staff will then review caseloads and provide updates on the phase the individual is in, when a transition will occur (including if they will be discharged in the next few weeks), the activities they have completed since the prior discussion, and present planned activities for the upcoming week(s). The supervisor should ensure that staff are following decisions made in the previous staff meetings and that activities identified are being carried out;
    - Caseload review entails a brief review of individuals (no longer than 1 minute per person);
    - Each individual served by the team should be reviewed at least once a month;
    - For individuals being discharged within a month, the staff should include the date of the final transfer of support call/meeting and the proposed date of the wrap up meeting with the individual.
    - Team Leader uses the Phase-Date form to reference upcoming transitions and update any changes to dates;
- It is recommended that individuals who require more detailed conversation (e.g., case presentations) are saved for further review at the end of the meeting. This will help maintain the flow of the meeting and help ensure meetings conclude within the desired time. This allows for significant events, high-risk situations, safety concerns, and emerging needs to be addressed to determine service delivery.

4.5.2 Case Presentations

Case presentations are given during the weekly team meeting for individuals who are early in Phase 1. The case presentation is prepared and facilitated by the primary team member working with the individual. This process is intended to introduce the individual to the team, provide background information, and identify key focus areas and immediate needs.

4.6 Case Conferences

CTI teams use case conferencing to troubleshoot, and problem solve treatment challenges and coordinate care between providers and/or collaterals. Case conferencing should be a formal, planned, and structured activity, separate from routine contact, that brings together the individual, service providers, and other supporters (e.g., family of choice) for the purpose of assuring integrated and well-coordinated care. Case conferences are an integral part of CTI; however, each individual has a unique support system and therefore the frequency and type of meeting may vary from person to person.

4.7 Team Safety

It is critical that the CTI staff feel safe at work as to provide the best quality of care. The CTI team provides services in the community where individuals live, learn, work, and socialize. Safety of the staff in the community is an important focus. The agency must develop a safety plan specific to the CTI team and ensure that all staff individuals are trained in community safety and routinely follow the safety plan.

As a mobile community-based program, CTI staff should spend the majority of their time in the field. Staff should be able to communicate quickly, respond to individual needs, maintain flexibility, and adapt to changes in the field, and mitigate both internal and external conflicts. Ongoing communication between CTI staff is essential to safety, morale, and program operations.

Consider things like an “officer of the day,” a staff that remains at the office for the day; use whiteboards for staff to sign in and sign out (officer of the day can monitor); have a policy for transporting individuals, and medication if necessary; have a policy for staff meeting with individuals where there is potential concern (double-team); make sure safety plans are up to date.

When conducting outreach, there are many factors to take into consideration, including personal safety. There are many precautions that can be taken to ensure safety while working in the field as discussed below.

While Engaging Individuals

Be mindful of the associations people may make based on accessories or clothing: a government ID on a lanyard, branded clothing, etc. Staff should always pay attention to how people are reacting to them.

Use trauma informed approach and be cognizant of trauma histories.

Speak calmly and at a conversational volume – staff should never yell or raise their voice.

Give people their personal space – avoid cornering or crowding people and try to maintain two arms-length distance. When interacting with someone who is seated, avoid standing directly over them.

Stay attentive and responsive to non-verbal signals. Do not attempt to speak over an agitated person or challenge their beliefs.

Safety Precautions

Make sure that cell phones are charged at all times and fully accessible. Program emergency numbers into your phone so they can be accessed promptly.

Make note of locations of nearest exits.

Staff should position themselves in a way in which their back isn’t facing a wall and in a way that allows for a path to exit an area should a safety concern arise. Keep hands in front of one’s body in an open, relaxed position.

Develop a shared safety agreement among team individuals, such as a safety word/phrase. Make sure all team individuals know what it means and have a shared response plan.

Should concerns arise that someone is a safety risk to themselves or others, staff should call program leadership for further guidance. If harm is actively occurring or staff are concerned for someone's imminent safety, they should call 911, request Emergency Medical Services, and remain at the location to await their arrival.

Staff should always trust their intuition and leave the environment if something feels amiss. Ensuring personal safety is of the utmost priority!

Alcohol and Substance Use

Intoxication with alcohol or other drugs such as cocaine, methamphetamine, and some types of cannabinoids can lead to greater disinhibition, impulsivity, and/or paranoia. This can lead to unpredictable behavior that might place the individual or the staff individual in a dangerous situation. While it is not possible to know who is intoxicated, staff should never engage with someone actively using substances or drinking alcohol. If staff witness someone drinking or using substances, they should assess the situation from a distance. If the individual appears to be a safety risk to themselves or others, staff should call program leadership for further instruction. If harm is actively occurring or staff are concerned for someone's imminent safety, they should call 911, request Emergency Medical Services, and remain at the location to await their arrival.

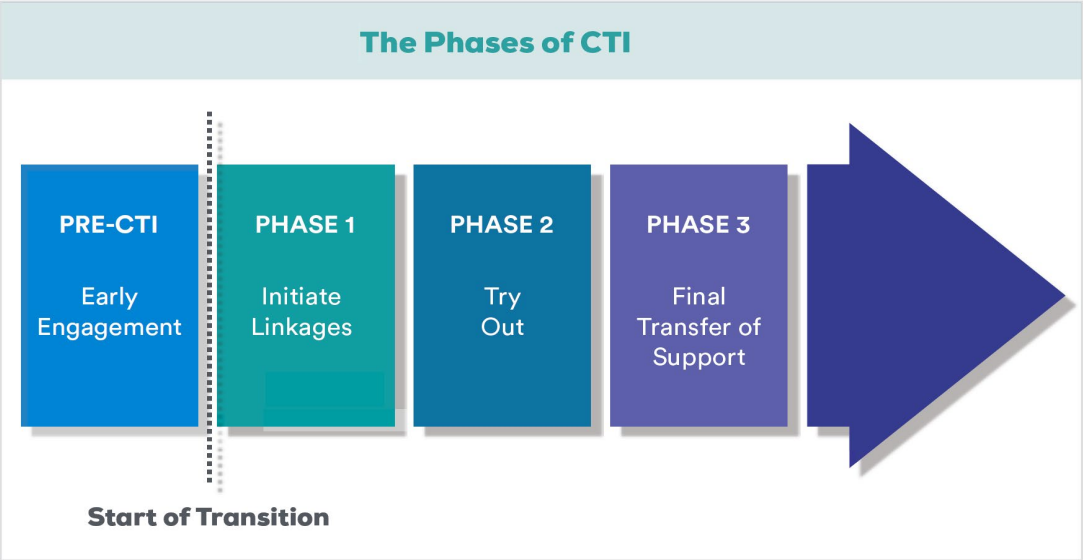
4.8 Hours of Operation / 24/7 availability

CTI Teams will have hours of operation that allow them to adequately provide all necessary services with consideration of the unique needs and availability of the individuals whom they serve. CTI Teams will have a process to ensure hospitals can connect with them 24/7.

4.9 Phases of CTI

CTI Teams will follow the evidence-based approach of Critical Time Intervention which includes four (4) phases described below. Each of the phases requires the staff to have a skill set based on a non-judgmental, person-centered, strength-based approach that meets individuals where they are, helps them identify what is important to them and communicates hope that recovery is possible. Refer to Critical Time Intervention Manual (2002) and the CTI Manual for Workers and Supervisors (2021) for more details.

All individuals who meet eligibility and are referred to a CTI Team will receive sustained and persistent outreach and engagement attempts, even if they initially decline services. The CTI Team will continue to work with individuals to ensure that their immediate needs are met (including clothing, shelter, and food), and that community linkages and supports remain solid.



Pre-CTI is the early engagement phase and is usually started prior to discharge. The Phase I tasks of engagement, assessment and connecting to community resources are very labor-intensive. In Phase II, the worker will step back a bit to monitor the resource network and adjust as needed. Finally, as the intervention winds down in Phase III, the worker steps back further and assumes a monitoring role to ensure that needed resources are in place. Thus, the amount of contact that a worker has with both individuals and their resource networks declines over time, reflecting the way in which the worker's role shifts over the course of the intervention.[7]

Following enrollment into the CTI Team, the CTI Team should begin working with individuals to identify their unique needs, goals, and preferences. The CTI Team seeks to engage individuals in a manner that is welcoming and person-centered by utilizing a range of strategies that should support the individual's needs, goals, and preferences, which should lead into the development of the individualized assessment and care plan. Examples of strategies include meeting people where they are, active listening, advocating for needs, shared decision making and minimizing barriers to care. The CTI team should tailor their work with each individual based on their needs and should address critical needs or situations in a time sensitive manner.

The CTI Team should support individual linkage to an array of services and resources that should address the individuals identified needs (e.g., obtaining employment, securing benefits) as outlined in their assessment and care plan. These services may include, but not be limited to, behavioral health treatment, substance use treatment, physical health treatment, community support services and natural supports that should support goal attainment as outlined in the care plan. The CTI Team should have ongoing collaboration with the individual's providers and supporters to advocate the individual's needs, as appropriate, and to provide the best quality of care.

Pre-CTI Early Engagement Phase - Prior to discharge from the hospital or other transitional settings are of moderate intensity. Development of a trusting relationship with the individual

[7] CTI Manual for Workers and Supervisors 2021, p.15

occurs. Data suggests that the greater the time, intensity, and number of contacts pre-discharge the better the outcomes. Tasks in this phase include but are not limited to:

Early engagement with the individual to build rapport and trust prior to discharge from the hospital – this should include multiple contacts, when possible, with at least one (1) in-person contact.

Conduct an immediate needs assessment and gather contact information and any other needed information. Begin the assessment process using hospital data systems or PSYCKES to determine history of treatment, existing resources, and other supports.

Working with the hospital team on identifying the strengths and weaknesses of proposed discharge plans.

Communicating with existing or prospective providers and other key stakeholders of the individual's recovery and transition goals (e.g., family, friends, roommates, etc.).

Assisting with housing and transportation.

Facilitating and suggesting other referrals that will maximize the success of the individual's discharge and recovery plan.

Phase I Initiate Linkages – Months one (1) to three (3) post discharge are high intensity. Number of in-person meetings with the individual in phase I should be eight times per calendar month. Providing support and beginning to connect the individual to the people and providers that will assume the primary role of support in the community. Tasks in this phase include but are not limited to:

Confirm with providers that everything is all set according to the discharge plan. In terms of treatment, support, and basic needs, assess needs such as income/benefits, cell phone access, transportation, food, safety, adequate heat, lighting, etc.

On the day of discharge, accompany the individual to their community setting unless the individual does not want this support.

Create the plan for Phase I with the individual. Encourage the individual to identify and express where they would like to see change in terms of the new setting or support. This allows the individual to take more responsibility for their recovery, including advocating with their medical team around medication issues.

Observe operation of the individual's support network by accompanying them to medical, psychiatric, and other provider visits.

Develop a collaborative relationship with the individual. Establish with the individual a routine check-in plan that may decrease in frequency over time as the individual adjusts to their new home; Check-ins may take place in the individual's home or other places in the community.

Prepare with the individual a crisis and support plan that can be activated if needed by the individual. CTI staff should use the safety plan in PSYCKES so it can be shared amongst providers.

Give a case presentation at the team supervision meeting.

If the individual is admitted to an acute service (e.g., an emergency department, CPEP/inpatient (IP) visit), then the team will work with the individual, crisis supports, or hospital treatment team to resolve the crisis and return the individual back to their community setting as soon as possible.

Identify and link individual to resources. Help identify solutions to resolve barriers and/or concerns related to successful transition to the new setting/support system and achievement of the discharge/recovery plan.

Improve community living and interpersonal skills.

Phase II Try Out - Months four (4) to six (6) post discharge are moderate intensity. Monitoring and strengthening of the support network and the individual's skills in self-advocacy. Tasks in this phase include but are not limited to:

Step back to monitor linkages to resource network. Continuing to observe the operation of the network while decreasing the number of in-person meetings with the individual to six times per calendar month from more frequent contacts during Phase 1.

Mediate between individual and resource network if needed. Adjust resource network as needed.

Work with the individual to identify or augment community and social supports, social prescribing, that can provide meaningful interactions or activities – e.g., involvement with a faith community, gym membership, social clubs, arts groups, community-based peer support services, and other services to support work and education goals, etc.

If the individual is admitted to an acute service (e.g., emergency department, CPEP/IP), the team will work with the individual, crisis supports, or hospital treatment team to resolve the crisis and return the individual back to their community setting as soon as possible.

Planning for Phase III with individual, reducing the frequency of visits to four times per month. Move to more of a monitoring role.

Phase III Final Transfer of Support - Months six (6) to nine (9) post discharge, low intensity. Termination and Achievement Recognition – Tasks in this phase include but are not limited to:

Rebuilding of social networks and relationships.

Holding a final transfer of support meetings with the individual and resource network ensuring that the individual and supports can function independently.

Holding a wrap-up meeting with the individual to acknowledge all that has been accomplished and celebrate graduation.

Preparing a discharge summary and disenrolling the individual from the service.

Working with the individual on a Psychiatric Advanced Directive[8], assisting with accessing personal PSYCKES through MyCHOIS, and assisting with voter registration if the individual is interested.

---

[8] ADVDIR.p65 (ny.gov)

The phases, their objectives, and the transitioning tasks specific to each are summarized in the table below and described in detail in the sections that follow.[9]

PHASE:	OBJECTIVES:	TRANSITIONING TASKS:
Pre-CTI **Early Engagement** · *Before transition period* · *Moderate Intensity*	Start to engage client and assess existing resources	· Engage client and start to develop trusting relationship · Conduct initial assessment · Identify existing resources · Gather contact information
Phase 1 **Initiate Linkages** · *Months 1-3* · *High Intensity*	Assess client in the community, develop collaborative relationship, improve skills and link to resources	· Develop collaborative relationship with client · Conduct community-based assessments · Present case to team to brainstorm focus areas · Plan for Phase 1 with client · Identify resources and link client to them · Improve community living and interpersonal skills
Phase 2 **Try Out** · *Months 4-6* · *Moderate Intensity*	Monitor and adjust client skills and capacity of resource network, enhance client's ability to utilize resources	· Review progress on Phase 1 focus areas with client · Plan for Phase 2 with client · Step back to monitor linkages to resource network · Mediate between client and resource if necessary · Adjust resource network as needed
Phase 3 **Final Transfer of Support** · *Months 7-9* • *Low Intensity*	Wrap up CTI with client and ensure resource network is securely in place	· Review progress on Phase 2 focus areas with client · Plan for Phase 3 with client Step back to a purely monitoring role · Hold Final Transfer-of-Support meetings or calls with client and resource network · Hold Wrap-Up meeting with client · Hold celebration or graduation

[9] CTI Manual for Workers and Supervisors, pg. 16

4.10 Service Intensity

The CTI Team has the capacity to provide the frequency, intensity, and duration of staff-to-individual contact required by each individual's immediate needs and their person-centered service plan. They have the capacity to increase and decrease contacts based upon daily assessment of the individual's need, with a goal of maximizing independence. A minimum contact is 15 minutes. Contacts can be provided in-person, audio-only, or audio/video.[10]

CTI services may involve contact with collaterals, including family, and others significant in the individual's life, for the direct benefit of the beneficiary and in accordance with the individual's person-centered plan of care.

The pre-CTI step of the CTI model emphasizes a moderate level of contact visits. This is vital to building rapport and assisting the individual to meet basic needs. These contacts may happen multiple times a week with visits lasting several hours, but frequency and duration should vary depending upon the individual's needs.

During Phase I, a higher level of contacts are provided which focuses on supporting and linking the individual to providers and building a support network. As the individual establishes a connection to their support system, the CTI Team should start reducing contact volume.

During Phase II, frequency of contacts will be reduced. At this point, the CTI Team should be monitoring the individual's progress, engagement with providers and supports, and re-assessing needs.

During Phase III, frequency of contacts should be occurring less often allowing individuals to become independent in accessing their supports and community resources. The CTI Team begins a discussion with the individual to determine if the individual has maximized the benefit of the program and is ready for discharge.

CTI Teams should follow the below minimum expectations:

> Pre-CTI and Phase I: minimum 8 contacts/month (combo of in-person and telehealth) with the individual. A minimum of 5 contacts must be in person.
>
> Phase II: minimum 6 contacts/month (combo of in-person and telehealth) with the individual. A minimum of 4 contacts must be in person.
>
> Phase III: minimum 4 contacts/month (combo of in-person and telehealth) with the individual. A minimum of 2 contact must be in person.

Based on the CTI model, it is recommended that two encounters during each Phase (three-month period) should be with an individual's provider(s) and/or informal support.

4.11 Service definitions

CTI services are provided based upon an individual's assessed mental health condition and immediate needs screening, which forms the basis for establishing a person-centered plan of care for CTI Services. CTI services may involve contact with collaterals, including family, and

---

[10] Telehealth Services Guidance for OMH Providers must be followed.

others significant in the individual's life, for the direct benefit of the beneficiary and in accordance with the individual's person-centered plan of care.

Medically necessary CTI Services include:

Person-Centered Planning: Person-centered planning is a continuous process of assessing an individual's strengths, goals, barriers to achieving goals, and service needs, through the observation and evaluation of the individual's current mental, physical, and behavioral health condition and history. This service engages each individual and collaterals, as applicable, as an active partner in developing, reviewing, and modifying a course of care that supports the individual's progress toward recovery and community integration.

> Practitioner Qualifications: Person-Centered Planning services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

Psychosocial Rehabilitation Services: Psychosocial rehabilitation services to motivate and support individuals receiving CTI Services to engage in mental health and other community based supportive services and continue to participate in the recovery process. Psychosocial rehabilitation services also motivate and support collaterals to engage in the treatment and discharge planning process for the benefit of the Medicaid beneficiary. Psychosocial Rehabilitation services assist in developing and enhancing an individual's stability in the community and address the symptoms of mental illness that interfere in the individual's ability to function in the community. Psychosocial rehabilitation services also include skills development and relapse prevention training services for the individual or collaterals, as applicable, to help the individual identify solutions to and resolve problems that threaten recovery and to restore age-appropriate skills which were lost or delayed due to the symptoms of mental illness.

> Practitioner Qualifications: Person-Centered Planning services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

Crisis Prevention Services: Crisis Prevention services to safely and respectfully de-escalate situations where individuals are experiencing or are at risk of acute distress or agitation which require immediate attention.

The CTI team will pro-actively assist individuals in the prevention of social crisis episodes. The CTI team is not expected to be on call as a "first responder" for crisis events but is expected to assist the individual in the development of a detailed crisis plan, and to assure that the plan is as widely distributed to key partners to the extent allowed by the individual.

> Practitioner Qualifications: Crisis Prevention Services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

Health Services: Health services include gathering of data concerning the individual's physical health, history, and any current signs and symptoms, and need for referral to appropriate medical services.

Practitioner Qualifications: Health Services are provided by a Registered Professional Nurse, Licensed Practical Nurse, Physician Assistant, Nurse Practitioner, Physician, or Psychiatrist.

Care Coordination Services: Care Coordination services to support individuals living in the community or transitioning between levels of care. Care coordination is an active process that includes screening for service needs, helping beneficiaries by coordinating services and supports, referral and linkage, and identification or modification of supports, to promote community tenure and manage behavioral and physical health needs.

Practitioner Qualifications: Care coordination services are provided by professional staff and paraprofessional staff.

4.12 Person-centered planning

Person-centered services start with recognizing each participant as a unique individual. The person-centered planning is strengths-based and consistent with the individual's values, culture, beliefs, and goals. Person-centered planning is a collaborative process where the individual participates in the development of goals and planning for services to the greatest extent possible. Person-centered planning incorporates the direct feedback and input from the individual regarding their perceived barriers and strengths and prioritizes their main goals to align the service plan to the individual.

CTI Team staff take an active role in guiding, reframing, raising discrepancies, and offering compassion and hope by translating direct individual feedback into a person-centered plan of action. CTI staff are expected to engage the individual in person-centered planning during the intake process and throughout service delivery. Focused attention should be given to understanding, and addressing the impact of, the social determinants of mental health and wellness, including housing, income/finances, and the impact of discrimination. A person-centered plan includes planned services necessary to facilitate achievement of recovery goals. It is strengths-based, culturally responsive, and responsive to individual preferences and choices.

4.13 Outcomes

The expected outcomes for this service are specific to the goals identified in the individual's CTI Service Plan, and may include, but are not necessarily limited to, the following:

- The individual will identify and engage in a stable housing plan or home
- The individual will engage and re-engage with providers and other support systems
- The individuals' utilization of community-based services will increase
- The individuals' hospital admissions will be reduced
- The individuals' hospital bed utilization will be reduced
- The individuals' admissions to emergency departments and other crisis care will be reduced
- The individuals' rate of incarceration will be reduced
- The individuals' life role goals around education and employment are addressed

5. Documentation requirements

5.1 Intake

Immediate Needs Screening is a brief assessment of the individual's immediate needs. CTI staff collect information for the Immediate Needs Assessment during the pre-CTI Phase. Assessment determines an individual's health and behavioral health needs, and strengths in order to determine interventions appropriate for community transition, including necessary linkages to other services providers.[11] Immediate Needs includes identifying basic demographics of the individual and the individual's identified needs, which can include housing, food, clothing, behavioral health (mental health and addiction), physical health, employment, and benefits, educational, social, financial, family, criminal justice, activities of daily living and safety concerns. It is important to include the individual's aspirations, needs/wants, in their own words.

Staff may review screenings or assessments that are available from other sources, such as psychiatric, substance use, and medical, as available, or as needed.

Where possible, staff should utilize PSYCKES and collateral contacts as a resource to collect available data to avoid assessment fatigue during the intake and transition process.

5.2 LPHA Recommendation

An LPHA staff on the CTI team must recommend and document the medical need for CTI services. Examples of "medical need for CTI" may include but are not limited to: increasing capacity to better manage treatments for diagnosed mental illness(es); restoring or rehabilitating functional level; increasing ability to identify and advocate for effective supports; facilitating active participation in their community, school, work, or home environment; sustaining wellness and life skills; strengthening resiliency, self-advocacy, self-efficacy and/or empowerment; building and strengthening natural supports and family relationships; or, improving effective utilization of community resources. Documentation of the LPHA recommendation must be completed as part of the pre-CTI Phase and upon the start of Phase I. The recommendation must include:

- the qualifying diagnosis or diagnoses,
- an explanation of the individual's needs and how they would benefit from CTI services
- name, credentials of the qualified LPHA making the recommendation, and
- dated signature of the qualified LPHA.

The CTI Team will maintain the LPHA recommendation in the case record.

5.3 Phase Plan

CTI staff will employ a person-centered planning approach to identify the individual's strengths, preferences, barriers and needs, and to develop the initial Phase Plan. The Phase Plan is completed within 30 calendar days of transition/discharge date from the hospital or transitional setting during Phase I.

---

[11] For the initial assessment, the CTI Manual references a psychological assessment; this should be understood by NYS CTI Teams as an assessment of behavioral health needs.

Phase Plans should be person-centered and streamlined, addressing no more than 1-3 essential long-term goals over the course of the CTI intervention. These goals are determined to be the most critical that would ensure linkage to services to meet their needs and support continued community tenure. Goals typically fall into the following focus areas:

- linkage to psychiatric treatment and medication management,
- daily living skills,
- money management and benefits,
- linkage to substance use/ addiction treatment,
- referrals and linkage to housing,
- referrals to educational and employment opportunities and
- community inclusion and family reconnection, if desired.

While there may be multiple goals or new goals may emerge, the focus for the work remains on the initial, essential goals. The new or additional goals are not ignored but instead staff identify and connect individuals to community supports that can be utilized by the individual to achieve those goals as they arise.

Phase Plans must minimally include:

1. The individual's name and date of birth,
2. The date the plan was developed, the Phase #, and Phase start date
3. Identification of the individual's essential long-terms goal(s) to support community tenure,
4. Planned linking or skill-building objectives to support goal acquisition,
5. Summary of work during the previous phase, including progress, lack of progress, referrals, and linkages, if the objective(s) were met,
6. Identification of collateral(s) identified by the individual as someone important to their recovery and to whom services may be delivered on their behalf, as applicable,
7. Name, title, and dated signature of the staff developing the Phase Plan.

The individual plays a central and active role in the development and execution of their Phase Plan and should agree with any objectives, goals, and/or referrals outlined in the plan. This shared decision-making process is an essential aspect of the CTI team's work. Phase Plans are reviewed at the start of each phase and updated accordingly. Individuals and their identified collaterals must be invited to participate in the review of their Phase Plan. If an individual refuses to participate in the review, the CTI Team may conduct the review and update the Phase Plan without the individual, based on their knowledge of the individual's needs, preferences, and progress. If no changes are needed, that should be indicated in the case record.

To accommodate scheduling needs and preferences of the individual and their collaterals, the review of the Phase Plan may occur within 2 weeks (14 calendar days) before or after the start of a new phase. For example, if an individual begins Phase I on 10/01/2024, they will be moving to Phase II on 01/01/2025, meaning that their Phase Plan should be reviewed between 12/18/2024 and 01/14/2025.

The assigned staff has primary responsibility for the development of the Phase Plan, in conjunction with the individual, family representatives, providers and other supports, as appropriate.

5.4 Documentation of service delivery

Service contacts, collateral contacts, and attempted contacts are documented in the Communication and Service Log (CSL). Logged contacts must include, where applicable:

i. Phase #,
ii. Modality of contact (office-based meeting, community-based meeting, attempted contact, telehealth, phone call)
iii. Name of individual(s)/collateral(s) involved in contact, if applicable,
iv. Date,
v. Length of contact,
vi. Brief identification of the individual activities and staff interventions related to the Phase Plan,
vii. Any identified next steps,
viii. Date and Signature of staff who completed the contact.

CTI teams should ensure that reimbursement is obtained for services identified and provided in accordance with an individual's goals and needs. At times, CTI teams may identify the need for a new service that was not included on the Phase Plan, often in response to an urgent situation or crisis. When this occurs, the staff who provides the services should clearly describe the need for the service or rationale for providing it in the case record. If the service is or will be needed on a regular and routine basis, it must be added to the Phase Plan.

5.5 Discharge Planning

Discharge planning is central to CTI and begins at intake. Phase III of the CTI model outlines the preparation and discussion of discharging the individual. By this time, the Care Manager has reduced frequency of contact, started discussions of longer-term goals with the individual, and has identified that the individual is managing their supports independently, and the attained goal areas. The individual should actively be engaging with their providers and sources of supports.

The Care Manager discusses discharge planning with the CTI Team Leader and seeks approval to move forward with the process. If the individual is ready for discharge, the Care Manager should discuss the discharge plan with the individual and ensure the individual has the supports necessary to assist with any continued needs. The Care Manager should schedule a final meeting with the individual and their supporters to reflect on all of their achievements while enrolled in the CTI program and provide any additional resources as needed. If the individual is not ready for discharge, the Care Manager and Team Leader will discuss next steps and hold a case conference with their supports to determine remaining discharge steps.

Discharge Readiness Checklist: The Care Manager and CTI Team Leader may use the information below for guidance when reviewing discharge readiness for CTI individuals. This may not be relevant to all individuals or required in order to achieve discharge.

- Has the individual secured stable housing or home?
- Is the individual’s current housing without major deficiencies or safety issues?
- Is the individual connected with all needed service providers (medical, behavioral health, substance use, case management or care management)?

- Does the individual understand who their providers are and why they would contact them?
- Has the individual verbalized an understanding of their current health conditions, including the importance of medical visits and medications?
- Has the individual identified a support system to assist with their ongoing medical and/or behavioral health needs?
- Has the individual maintained stability without the assistance of mobile crisis visits or use of psychiatric emergency departments over the past six months?
- Is the individual able to manage his or her finances (i.e., pay bills, pay rent, budget, etc.) or are the necessary supports in place to assist with these tasks?
- Is the individual aware and capable of following through with his or her next recertification for SSI and/or Medicaid or are the necessary supports in place to assist?
- Has discharge been discussed with other (consented) providers?
- Has discharge been discussed with the individual?
- Does the individual demonstrate an understanding of his or her plans post-discharge?
- Will the individual be at significant risk in terms of losing housing, medical, mental health or substance abuse needs if the case is closed?

Final Transfer of Support

A final transfer of support meeting is scheduled and held during the last month of Phase III with the individual and resource network, as applicable. During the final transfer meeting, the group reviews recipient progress, their ongoing system of support and finalize plans for discharge from CTI.

These meetings may occur in-person or through telehealth.

Wrap-up Meeting

This is the last meeting with the individual during the final month of Phase III. This meeting is to allow for the care manager and the individual to reflect on the work that has been done over the course of the intervention and the progress made. The care manager provides the individual with the Discharge Plan Summary or ensures they have the information available to them. The care manager reviews the resources and supports and encourages the individual to utilize them.

Discharge Plan Summary

The Discharge Plan Summary is a document that provides information for the individual regarding services, supports, and resources available. This should be completed with the individual and provided to them with all contact information available as an additional resource. The Discharge Plan Summary must include the following information, when applicable:

- Contact information for the individual's outpatient mental health and addiction treatment providers and the date, time, and location of their next scheduled appointment(s);
- Contact information for the individual's ongoing care coordination services or referrals, if applicable (e.g., Health Home Care Management);
- Identification of natural supports and resources the individual is currently engaged with;

- Information for local crisis/diversion services that may be available in the event of a relapse or crisis.

Reasons for Discharge:

1 Has met goals and objectives and completed all phases of CTI.
2 Has not met goals and objectives, but has completed all phases of CTI.
3 Has met goals and objectives, but has not completed all phases of CTI (early discharge)
4 Transferred to services that better meets their needs (like ACT, HH+, etc.) prior to completion of all phases.
5 Loss to contact, after assertive outreach efforts were made.
6 Long term incarceration or hospitalization (6 months or more).
7 Re-location.
8 Death.

5.6 Case Records

A complete case record is maintained for all individuals in accordance with recognized and accepted principles of record-keeping:

i. Case records shall be periodically reviewed for quality and completeness by the agency quality assurance program; and
ii. All entries in case records shall be dated and signed by the appropriate staff.

The case record shall be available to all CTI team staff and shall include the following information:

i. Individual demographic information;
ii. Immediate Needs Screening;
iii. LPHA Recommendation and Diagnoses;
iv. Consent forms;
v. Any documentation supporting behavioral health or physical health care (e.g., hospital discharge summary, reports of mental and physical diagnostic exams, assessments, tests, or consultations), as applicable;
vi. Phase Plans;
vii. Communication and Services Logs; and
viii. Discharge Plan Summary.

5.7 Team Forms

Resource Lists

A resource list shall be kept up to date and available to all staff. The list should share important community resources available and necessary information to access the resources. The list is updated as new resources are discovered, or when old ones no longer exist. The list may also include any special directions staff have found helpful in utilizing available resources.

Phase-Date Form

The Phase Date Form is a record of each individual and where they are in the Phased approach maintained and utilized by the Team Leader. The form timeline should begin with individuals in pre-CTI and include anticipated dates for the start and end of each Phase. The Team Leader will

update the form with actual dates for transition between Phases, ideally within 2 weeks of the transition. The form should also include an area to note whether individuals ended CTI early and the reason if so.

Implementation Self-Assessment Form

The Implementation Self-Assessment Form serves as a brief internal program audit. The Team Leader should complete this with staff input and use it to monitor how closely they are following CTI guidance/model. CTI teams should include this quality assessment as part of quarterly reports provided to NYS OMH.

6. Eliminating Disparities and Achieving Health Equity

CTI integrates the principles of person-centered, culturally responsive, trauma-informed care, addressing the impact of discrimination, stigma, and cross-system collaboration into its service philosophy. CTI provides services with consideration of cultural/linguistic preference through the use of the cultural formulation interview process and cultural assessment. An essential aspect of CTI is recognizing the importance of family, community-based, and faith-based supports. To continue the work of eliminating disparities, achieving health equity, and improving treatment outcomes for marginalized populations, the agency should:

1. Have a mission statement that includes information about the intent to serve individuals from marginalized/underrepresented populations.
2. Have an updated diversity, inclusion, equity, or cultural/linguistic competence plan that includes:
    i. Workforce diversity (data-informed recruitment to hire, train and retain staff and supervisors from the most prevalent cultural groups of its CTI individuals);
    ii. Workforce inclusion;
    iii. Reducing disparities in access, quality, and treatment outcomes; and
    iv. Solicit input from diverse community stakeholders and organizations.
3. Documented training strategy for topics related to diversity, inclusion, cultural competency, and reduction of disparities in access, quality, and treatment outcomes. Training topics should include implicit bias, diversity recruitment, creating inclusive work environments, and providing language access services.
4. Meet the language access needs of the individual's served by CTI, including:
    i. Use of data to identify the most prevalent language access needs;
    ii. Availability of staff who speak the most prevalent languages;
    iii. Provision of best practice approach to provide language access services (in-person, phone, video interpretation);
    iv. Having key documents and forms translated into the languages of the most prevalent cultural group of CTI individuals served by the team; and
    v. Efforts to address other language accessibility needs, such as Braille and limited reading skills should also be planned for.

7. Best Practices

Trauma-informed care

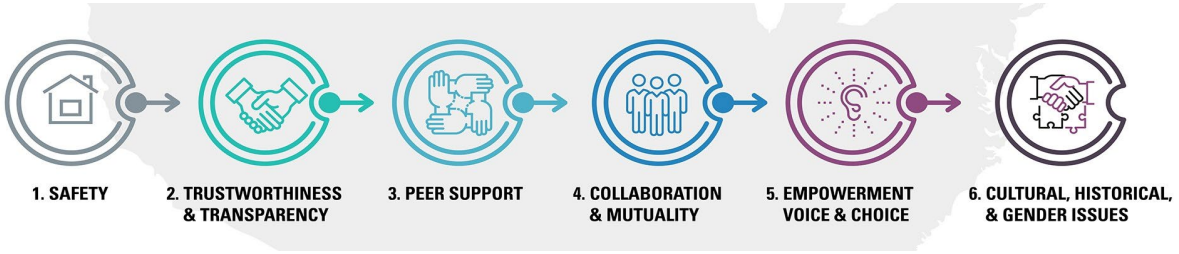
Respect and compassion for the individuals we serve begins with an understanding that the experience of hospitalization is traumatizing in both an acute and ongoing sense. The experience of losing a stable place to live, no matter how many times it has occurred, is a fresh trauma, and continuing to live without stability is an ongoing trauma that does not end with temporary shelter placement.

The experience of trauma is still poorly understood, as are its effects on physical and mental health. Trauma has been linked to a wide variety of physical and mental health challenges and difficulties with executive function. Individual traumas are unique, and each person handles their experiences differently.

CTI team individuals should always be mindful of how their appearance and demeanor may affect others. Respecting others' boundaries is vital to building trust. At the same time, it's important for staff to understand that past experiences make it hard for many people to communicate their boundaries. When in doubt, team individuals should err on the side of caution.

Guiding Principles of Trauma-Informed Approach

(via SAMHSA's National Center for Trauma-Informed Care)



Person-Centered Approach

A person-centered perspective prioritizes the dignity and independence of the individual in any individual-staff relationship. Being person-centered means focusing on the individual and their expressed needs and wants. CTI staff are expected to treat each individual with respect. This means treating each person as an individual, and enabling them to achieve their own objectives, in their own time. When providing services, staff should not assume they know or understand what the individual is going through. It is important to allow space for the individual to say "no." The process of building rapport can take time and many encounters.

Individual Engagement

Gaining the trust of known and prospective individuals and building a rapport and relationship with them is vital to the work of the CTI teams. Developing a relationship starts with getting to know each person, which may include approaching them multiple times and in different ways – some people simply do not "click," but on another day or with another staff person, a prospective individual may engage.

CTI staff should respect each individual's personal space, their belongings, their feelings, their beliefs, and their reactions. Always act with compassion: ask if the individual has eaten or has basic necessities, then listen attentively to their response even if it seems unrelated to the

questions. Stay attentive and responsive to non-verbal signals, which may indicate signs of frustration or lack of connection. Balancing persistence with empathy is key.

Cultural Sensitivity

Being culturally sensitive means being aware, knowledgeable, and accepting of a culture that is not your own. It also, increasingly, means accepting sub- and counter- cultures that may exist within a given culture. While the term “culture” is often used to refer to ethnicity or national origin, culture is an expression of shared experience, which goes beyond family ties.

All sorts of shared experiences produce an affiliated culture, and that culture is expressed through often-unspoken norms of behavior. There is a culture unique to life on the streets and when you interact with someone who is unsheltered on the street, your respective cultures are also coming into contact. A person-centered approach requires that staff respect and validate all people’s experiences.

Culture is built on shared experiences, but not everyone is treated equally or made to feel equally welcome everywhere.

CTI teams have the opportunity and responsibility to connect with individuals in a more compassionate way than they have experienced in the past, in order to begin rebuilding trust. Staff should do their best to understand and accept the cultural and personal history of those being served, even (and especially) when they may not respond with equal courtesy. That is the best way to demonstrate the intent to listen, to understand, to respect, and to help.

Effective Communication

Effective communication is not simply a set of instructions; it is a skill that should be intentionally practiced and improved. There is no one correct way to communicate. Simply put, communication is effective when it works. This requires a clear sense of the goal of a given interaction. In outreach, the objective of most interactions is one of the following:

To build rapport, relationships, and trust

To inform (most often regarding social services or housing resources)

To listen (to an individual’s history and needs)

To encourage (usually encouraging an unsheltered individual to accept services or a transitional housing placement – a first step on the path back to stability)

Various factors may affect the chances that a chosen communication strategy will work. Some of these factors may be outside of the team’s control, such as: an individual’s mood, their past experiences, and their biases. Some examples of best practices for effective communication include:

Introducing oneself by first name and pronouns, explaining why the team is there, and what they hope to talk about. Ask the individual what name they prefer to be called by.

Starting a general conversation: instead of asking if someone needs services or if they want to come inside, staff should try to build a caring, professional relationship.

Asking individuals if they would be more comfortable talking in another language.

Motivational Interviewing

Motivational interviewing (MI) is a practice used to help individuals find internal motivation to make changes to their lives and maintain those changes. MI is typically used in a clinical setting, but the core principles and methods can be used by anyone to improve their engagement efforts. The goal is to guide the conversation, over time, in a way that allows the individual to make their own decisions and take action.

The basic principles of MI are:

- Find motivation: identify the individual's goals and hopes
- Clarify the conversation: listen for and clarify the difference between the current and desired situation
- Validate experiences: demonstrate empathy for the individual's perspective and situation
- Accept resistance: avoid arguing or preaching
- Support self-determination: provide support for change; avoid making decisions on behalf of others

The focus is on finding ways to move past their resistance, and discovering the source of that resistance, in order to provide each person with service options they want and should continue using in the long term.

Motivational interviewing is a skill that should be built and practiced deliberately. Getting feedback from coworkers can also be very helpful – a debrief immediately after leaving an interaction, while the situation is still fresh, can be one of the best ways to improve.

Harm Reduction Principles

Harm reduction is a theory and practice that acknowledges the harm caused by situations like living unsheltered or using substances. In a harm reduction model, the goal is to recognize that not all harmful behaviors can be stopped, nor all harmful situations avoided. Instead, harmful situations and actions are identified, and a plan is made to reduce the *degree* of harm.

For example, a treatment provider may operate a needle-exchange program, thus allowing users of intravenous drugs like heroin to obtain clean needles to inject with. This reduces the harm done by reducing the likelihood of spreading bloodborne pathogens by re-using or sharing needles.

CTI teams may see a variety of harmful behaviors in the course of their work, and staff should strive to engage individuals using an approach which is informed by harm reduction principles. Consider what harm is being done, and if there is potential to reduce that harm even by small degrees. Often the first and hardest step is acknowledging that a change may be needed or even helpful – motivational interviewing techniques (above) can be useful in this regard.

8. Programmatic Policy and Procedures

CTI teams should work with their individual agencies and partner hospital(s) to develop, periodically review, and revise as appropriate all programmatic and administrative policies and procedures.

The provider shall maintain personnel records for all staff, including sub-contracted/per diem staff, who will be providing services or supervision. These records must minimally include:

i. Resume or application demonstrating appropriate experience to deliver or supervise services, as necessary to meet minimum staff qualifications.
ii. Verification of degree, licensure, or other certifications/credentials, as necessary to meet minimum staff qualifications.
iii. Documentation of required training.

The Provider shall maintain policies and procedures regarding:

i. Written criteria for eligibility, and discharge from the program. Policies should include a mechanism for screening individuals at the time of referral and assuring that those referred are admitted to the CTI team timely.
    a. Timely response to referrals and access to CTI services. Upon receiving a referral, the CTI Teams will engage with the referred individual within 24 hours for those on an inpatient unit and within 8 hours for those in ED or CPEP.
    b. Referral workflow and communication plan established to include clear referral workflow and key stakeholders that will be included.
    c. Regularly scheduled team availability by phone contact and on-site presence at the hospital setting(s).
    d. Procedures outlining timely access to hospital sites including ED, CPEP, and inpatient unit for Team.
ii. Procedures to share pertinent individual information (e.g., significant events, behaviors, interventions, etc.) to ensure that all team members are informed of an individual's current status.
iii. Assertive engagement practices addressing individual engagement and retention including, at minimum, plans for outreach and re-engagement efforts commensurate with an individual's assessed risk.
iv. Hours of operation that allow staff to adequately provide all necessary services with consideration of the unique needs and availability of the individuals whom they serve.
v. Quality Management including data collection, analysis, how it will be used for quality improvement, including the process to ensure fidelity to the model.
vi. Transportation of individuals receiving services by agency staff.
vii. Provision of supervision for all staff.
viii. Incident management, reporting, and review.
ix. Secure record retention specific to the provision of services.
x. Staff training and workforce development.
    a. Training staff in specialty areas such as housing, local community resources, integrated care, health and wellness, and vocational supports.
xi. Community safety for staff.
xii. Confidentiality and disclosure of protected health information in accordance with state and federal laws.
xiii. Individual grievance process that ensures the timely review and resolution of individual complaints, and which provides a process enabling individuals to request a review by NYS OMH when resolution is not satisfactory.

xiv. Workforce recruitment and retention, including maintaining CTI staffing requirements, addressing how teams will manage if down staff, efforts to recruit and retain a workforce that is representative of the people they serve, and to develop cultural competency skills in their current and prospective workforce through staff development and training.

9. Quality Management/Reporting

The Agency will develop a process to systematically monitor, analyze, and improve the performance of the CTI team in assisting individuals to connect to community supports. The plan will include:

i. A data collection process that provides information relevant to specific outcomes,
ii. Monitoring data via outcome reporting platforms shared by NYS OMH, such as Tableau,
iii. Data analysis conducted by the team and the agency to identify trends, verify goal achievement, service quality, areas of improvement, and the impact of corrective actions,
iv. A verification of service provision and quality that supports goal attainment,
v. Any identification of service provision which needs improvement, and
vi. Corrective action/process improvement plans specific to the results of the analysis.

CTI Teams are required to submit regular reports to NYS OMH regarding all individuals referred to them, including but not limited to: completed referrals (reason for denial of referral if applicable), phase information, discharge dates, characteristics of individuals served, diagnoses, referral source, services provided, discharge plan, disposition, community networking efforts, transition between stages of CTI, all referrals, and follow-up. Information will also be submitted regarding performance indicators demonstrating that individuals' continuity of care has been assured (including stable housing) and that reliance on psychiatric center, inpatient and emergency department services has been reduced, and jail/prison time decreased. NYS OMH will provide programs with a template of the data items required for reporting for manual or bulk data entry.

CTI Teams have a systemic approach for self-monitoring and ensuring ongoing quality improvement including analyzing utilization review findings and recommendations. This information should be used to measure timeliness of services, disposition, and outcomes, and will inform the CTI Teams overall quality improvement plan. CTI Teams should ensure continuous quality improvement of services and development of the program including regular monitoring and evaluation of outcomes. CTI teams must complete the CTI Self-Assessment every 6 months based on the date the team initially began operation. The Self-Assessment must be available upon request and should be used by the CTI Team for quality improvement and adherence to the model.

The Local Governmental Unit (LGU), Director of Community Service (DCS)/Mental Health Commissioner has a statutory authority and responsibility for oversight and cross-system management of the local mental hygiene system to meet the needs of individuals and families affected by mental illness, substance use disorder and/or intellectual/developmental disability in their communities. LGU collaboration is a vital part of the work of CTI Teams.

Programs are required to maintain accurate reporting and case records according to Regulation and Program Guidance.

Program providers must have a quality, supervisory, and operational infrastructure to support submitting data to OMH regarding all enrolled clients, including client-identified data. OMH will provide programs with a template of the data items required for reporting. Information will also be submitted regarding performance indicators demonstrating that recipients' continuity of care has been assured.

CTI teams will have a systematic approach for self-monitoring and ensuring ongoing quality improvement of services, including analyzing utilization review findings and recommendations. Providers should ensure continuous quality improvement of services, including regular monitoring and evaluation of outcomes.

9.1 Documentation and Use of Technology

It is expected that CTI teams have an electronic health record that can document referrals, assessments, and each encounter with the individual. It is also expected that the applicant maximizes the use of technology to help support the team's communication, quality improvement efforts, as well as each individual's transition and goals.

CTI teams must have a plan on how they use digital technology to support client engagement in care. Technology supports include tools and resources for identifying potential clients, communicating, and responding to referral sources, communicating with clients and key support persons, care planning, and transition planning. CTI teams should use digital tools available to staff as well as those available to clients.

CTI teams must have an electronic health record (EHR) and describe the EHR. OMH is exploring a clinical data interoperability system based on the HL7 FHIR® standard (R4 or higher) for optimal compatibility that will connect directly with provider EHRs to extract required data elements and limit provider reporting burden. Applicants who don't have EHRs that support FHIR® standard can also securely submit data files to NYS OMH Platform using a secure file transfer method (MFT Process, SFTP, etc.).

CTI Teams must use data from Regional Health Information Organization (RHIOS)/Qualified Entities (QEs), PSYCKES, and other data systems as part of their work.

9.2 Monthly Reporting Requirements

CTI Teams should submit monthly reports to OMH as requested. The data will be regarding outreach activities and individuals receiving services, phases, discharge dates, characteristics of individuals served, diagnoses, referral source, services provided, discharge plan, disposition, and follow-up.

Information should also be submitted regarding performance indicators demonstrating that individuals' continuity of care has been assured (including stable housing), decrease in reliance on psychiatric center (PC), inpatient (IP), and emergency department (ED) services, and Social Determinants of Health have been addressed.

10. Billing

Monthly fees are based on projected costs necessary to operate a CTI team of corresponding caseload and specialization and are calculated by dividing allowable projected annual costs by 12 months, caseload size, and annual volume. Such monthly fee is then adjusted by a factor to

account for fluctuations in case load or when the provider cannot submit monthly claims because a minimum contact threshold cannot be met. No costs for room and board are included when calculating CTI reimbursement rates.

CTI services are reimbursed via a monthly fee based on the number of contacts in which CTI services, including any combination of medically necessary CTI subcomponent services are provided during a calendar month. A CTI services provider may not bill more than one monthly fee for the same individual in the same month.

CTI services provided by New York State Office of Mental Health licensed or authorized adult CTI services providers to individuals aged 16 and over will be reimbursed via a tiered, regional monthly fee based on the number of contacts in which CTI services were provided to the eligible individual or collateral during the calendar month, as follows: There are three fee levels. Level 1 for a minimum of eight contacts; Level 2 for a minimum of six contacts; and Level 3 for a minimum of four contacts per calendar month.

CTI service contacts above the contact standards for billing the Level 1 monthly fee will be eligible for a per contact add-on fee. Providers may not exceed 10 add-on service claims per recipient, per calendar month. Recipients that require additional service contacts must not be denied such contacts upon reaching the billable limit.

The number of monthly visits should be determined by individual need and be consistent with their phase plan. Additionally, any fee level can be billed at any point throughout the phases, there is no preset requirement outside of need.

No more than one contact per day is counted for reimbursement purposes, except if two separate contacts are provided on the same day, including one face-to-face contact with an individual and one collateral contact.

Contacts include the provision of telehealth services unless otherwise stated, consistent with New York State guidelines.

11. Quality Improvement

The State is establishing a State funded quality pool for CTI. Specific criteria and requirements that must be met for programs to receive funding from the quality pool are being evaluated to best meet provider and recipient needs. Quality pool funding will allow for program innovation and expand funding for providers meeting or exceeding set targets.

12. Co-enrollment Allowances / Limitations

Limitations on amount and duration of CTI Services:

Due to the time-limited nature of CTI services and to promote the transition to other appropriate services, reimbursement for CTI services shall be limited in the event that the beneficiary is also enrolled in and receiving other Medicaid-funded care coordination services, including Assertive Community Treatment, Health Home Care Management (including HH+), and Coordinated Specialty Care Services for individuals experiencing first-episode psychosis. Reimbursement for CTI services shall be limited to one full calendar month during which both a CTI service provider and the other care coordination services provider qualify for Medicaid reimbursement.

No limitations for PROS, MHOTRS, CCBHC, CORE, Residential, supported employment, peer support services, clubhouses.

13. Service Dollars

Each CTI Team has access to service dollars that should be utilized to assist individuals who are engaged during outreach or enrolled in the CTI program. Service Dollar funding can be used to purchase basic necessities such as clothing, toiletries, and medical supplies, as well as food and drink. These funds can be used to meet both basic or specific needs and foster engagement or strengthen ties with staff.

For individuals enrolled in CTI, service dollars can be utilized to cover fees for obtaining identification, transportation, rental assistance, and apartment furnishings. Service dollars are also available to facilitate connections with social interests (gyms, clubs, etc.), and the team should budget for service dollars to assist the individual with these important community inclusion efforts. Cash should not be provided to CTI individuals and shouldn't be utilized to purchase alcohol, tobacco products, cannabis, or lottery tickets. All CTI teams should have monitoring and management procedures in place for the tracking and appropriate use of this funding.

14. Definitions / Glossary

Care Manager: In the context of CTI, a Care Manager is a team member who works one-on-one with individuals to create and manage their Phase Plans. Care managers work closely with individuals to assess their needs and refer and link them to services.

Collateral Persons: Individuals of the individual's family or household, family of choice, or others who regularly interact with the individual (e.g., landlord, criminal justice staff, employer), are directly affected by or can affect the individual's condition, and who are identified in the service plan as having a role in the individual's treatment. Contacts made with a defined collateral person are provided for the direct benefit of the individual receiving services. Collateral contacts are conducted in accordance with, and for the purpose of, advancing the individual's care plan and for coordination of services with other community mental health and medical providers.

Community: refers to a place/location other than the CTI team's office.

Community Inclusion: Meaningful participation in an individual's community through connection to employment, volunteer opportunities, faith-based organizations, memberships, and other activities of their choosing. These connections provide a sense of value and belonging, as well as improved feelings of well-being and self-esteem.

Critical Time Intervention: A time-limited evidence-based practice that mobilizes support for vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and both formal and informal support systems during these critical periods.

Discharge Planning: The process of planning for successful discharge from a program. Discharge planning includes identifying the resources and supports needed for the transition of an individual to another program and making the necessary referrals. This also includes

linkages for treatment, rehabilitation, and supportive services as needed. Discharge planning should be done collaboratively with staff, the individual, and other supports involved with the individual's recovery, and should align with the goals, needs, and desires of the individual.

Employment: Employment at prevailing wages in regular, integrated work settings with the same supervision, responsibilities, and wages as non-disabled workers.

Linkage: Occurs when an individual has successfully engaged with or accessed services or resources in the community. Linkages are often the result of a successful referral, although individuals may independently link to services and resources.

Modality: The modality is the mode of contact or attempted contact with the individual and/or their collateral(s). Modalities include Phone Call (Audio-Only Telehealth), Audio-Visual Telehealth, In-Person Meeting or Visit, Text Message, Email, and Letter or Other Correspondence.

Psychiatric Advanced Directive (PAD): A mental health or psychiatric advance directive (PAD) is a legal tool that allows a person with mental health and co-occurring substance use challenge(s) to state their preferences for treatment and services, especially for emergency situations. Psychiatric advance directives are meant to protect a person's autonomy and allow them to direct their own care even during a crisis.

Peer Specialists: Peer specialists are adults who are individuals who have themselves experienced mental illness, substance use, homelessness, or trauma conditions. The Peer Specialist provides the CTI services as a Care Manager from a lived-experience and non-clinical perspective.

Person-Centered Planning: The process of developing a relationship between the CTI team and the individual such that the individual and the team are partners in planning for the individual's recovery. The planning includes developing goals related to life roles, identifying choices and options, determining action steps, and identifying and securing the services needed to achieve the goals.

Referral: Occurs when a Care Manager or other service provider refers an individual to a service or resource. Referrals may include providing the individual with information about the service or resource, completing necessary applications or referral packets, and scheduling intake appointments or meetings. A successful referral results in a *linkage* to services or resources.

Shared Decision Making: An emerging best practice in behavioral and physical health that aims to help people in treatment and recovery have informed, meaningful, and collaborative discussions with providers about their health care services. It involves tools and resources that offer objective information. People in treatment and recovery can then weigh that information against their personal preferences and values. Shared decision-making tools empower people who are seeking treatment or in recovery to work together with their service providers and be active in their own treatment.

Social Prescribing: A new approach that looks at connecting individuals with supports within their community, other than medical/behavioral health providers. Linking individuals to local, non-clinical services including community groups, volunteer/charity organizations, etc.

Warm Handoff: A transfer of care between two (2) individuals of the care team, where the handoff occurs directly with the individual who will receive services, or who is receiving services. This transparent handoff of care allows individuals to hear what is said and engages them in communication, giving them the opportunity to clarify or correct information or ask questions about their care.

Wellness Recovery Action Plan (WRAP): A self-directed wellness tool anyone can use to get well, stay well, and make their life more the way they want it to be. The WRAP process supports individuals in identifying the tools that keep them well and creating action plans to put them into practice in everyday life.

Addendum 1: Staff Training & Competencies

CTI Teams are required to attend Learning Collaboratives and Learning Communities when they are scheduled. It is expected that at least one staff person from each team attends.

Learning Collaboratives (LC): are designed to help programs/organizations make meaningful innovations to meet important goals and outcomes. Individuals representing programs/organizations meet to learn from one another as well as from experts. They collect and use data to drive quality improvement efforts. Moreover, learning collaboratives are platforms where theory and practice are carefully discussed and implemented by the individuals of the LC. Individuals review ideas/concepts, try them in the field, and return to the group to share their observations. The trainings below are part of the CTI learning collaborative.

- CTI Model Overview
- Critical Time Intervention – Staff and Supervisors
- Safety Overview
- Cultural Competency
- Recovery-oriented, person-centered approach
- PSYCKES
- Documentation
- De-escalation
- Behavioral Health and Medication Management 101
- Team-Based Care: Establishing a Team-oriented Culture in Your Organization
- Suicide Prevention for Healthcare Workers
- Trauma-Informed Approach
- Violence Risk Assessment
- Harm Reduction
- Opioid Overdose / Naloxone Rescue Training
- Motivational Interviewing

Learning Community: are an active learning community, in collaboration with OMH, to review progress, outcomes and develop best practices for CTI Teams. Learning community activities should involve, at a minimum, quarterly meetings with OMH and key stakeholders to assure that the teams' caseloads are full, and that case-level and program-wide concerns can be quickly addressed. The focus of the Learning Community should be around:

- The CTI Model
- Philosophy and Values
- Delivery of Services
- Role Specific Responsibilities