Office of
Mental Health

Adult Enhanced Step-Down: Transitional Residence Setting and Critical Time Intervention (ESD TRS/CTI)

2026

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1. Background and Introduction

After receiving feedback from individuals, families and service providers across New York State (NYS), it was clear that a nuanced and specialized approach was necessary to address the needs of individuals who have both mental health and intellectual or developmental disabilities. In 2024, The NYS OMH and OPWDD partnered to create the Enhanced Step-Down program. This program aims to eliminate silos that can exist across service systems and impact access to care.

A small number of people with co-occurring behavioral health (BH) disorders and Intellectual/ Developmental Disability (I/DD) present frequently to acute-care behavioral health settings, like psychiatric emergency rooms and inpatient units. Although a small number, an accurate diagnosis and assessment, navigation of the cross-systems involved, access to appropriate services and workforce limitations with regard to the specialized needs of this population may result in long lengths of stay in these less-than-optimal care settings.

The Enhanced Step Down (ESD) program is designed to provide a high level of clinical expertise to evaluate and assess individuals, identify client strengths and barriers, and support successful transitions to the community from acute care behavioral health settings.

ESD programs are comprised of two closely related and highly integrated components: a specialty Critical Time Intervention (CTI) Team and a Transitional Residential Setting (TRS). CTI is a phase-based and time limited intervention designed to help people transition out of acute care behavioral health settings. The model helps people connect and establish long-term relationships with community providers and resources. ESD CTI adapts the CTI model to include clinical and systems expertise in co-occurring I/DD and Behavioral Health and the ability to directly assist with evaluations, assessments, documentation, eligibility applications, and positive behavioral support planning.

A small proportion of individuals receiving ESD CTI will also receive short-term, specialized transitional housing in the ESD TRS. The TRS is a home-like environment serving up to five (5) individuals at a time for those who may benefit from additional support after leaving the hospital. The TRS has a high staffing ratio and close clinical oversight of direct support staff. The ESD CTI and TRS components share a common program director and key staff. They will work as one team to ensure that individuals in the TRS are able to move to a more community-based housing setting.

Agencies will establish the ESD program according to this guidance, and work in collaboration with OMH to conform to any additional guidance forthcoming.

2. Eligibility Criteria

ESD is targeted towards the small proportion of people with co-occurring mental health diagnoses and intellectual and/or developmental disorders (suspected or diagnosed) who are presenting frequently to acute behavioral health settings, or who have long lengths of stay on inpatient psychiatric units.

Individuals are eligible for admission to the ESD Program if they meet the following admission criteria:

- Age 18 and older,
- Resident of NYS,
- Diagnosed with a mental illness,
- Diagnosed with a co-occurring intellectual and/or developmental disability or suspected to have an I/DD with one or more functional limitations and/or a developmental delay,
- Currently admitted to an inpatient psychiatric unit or in a Comprehensive Psychiatric Emergency Program (CPEP) or emergency department (ED),
- Psychiatrically stable and no longer requiring hospital-based care, and
- Requiring intensive transitional assistance to secure and support a safe and appropriate discharge from the hospital setting (i.e., time-limited, intensive case management to facilitate access to available resources, while transitioning to an appropriate residential setting).

Individuals who are admitted to the TRS must meet the following additional admission criteria:

- Ability to self-administer medications with supervision,
- Ability to self-preserve (evacuate) independently in the event of an emergency,
- Ability to reside safely in the TRS environment within the support available in this setting, and
- Experience impairment in functioning due to their mental illness and intellectual and/or developmental disorder, such that they require intensive rehabilitative support in a residential setting with 24-hour supervision.

Providers may only adjust the admission criteria with approval from the State.

NOTE: Health plan coverage and Office for People with Developmental Disabilities (OPWDD) eligibility do not prohibit eligibility for the ESD Program.

3. ESD Program

The ESD program will have the capacity to serve 30 individuals. Everyone enrolled in the ESD program will receive ESD CTI services; five (5) of those individuals may also reside in and receive additional support from the Transitional Residential Setting. This section describes the key program requirements that will apply to the ESD program as a whole.

3.1 Partnership with Hospitals

A critical aspect of this program is the partnership and collaboration between the ESD program and partner hospital(s). The ESD staff should be given full access to inpatient and ED/CPEP settings, both to engage in relationship building with individuals served, and to partner in

discharge and aftercare planning with hospital staff. Hospitals and the ESD CTI team will work together to identify individuals with high needs who would benefit from the ESD program and immediately include ESD staff in after-care planning.

Each ESD program 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 ESD Program** that includes:

- A coordinated process for routine and regular communication (e.g., regular meetings, rounds on the inpatient unit, inpatient case conferences, and trainings);
- Easy access to the hospital for ESD staff, including access to meeting space on the unit;
- Access to the hospital electronic medical record where possible;
- A process for referrals and discharge (aftercare) planning from the hospital;
- A process for ESD staff to engage in-person with individuals to provide CTI interventions prior to discharge;
- A process for ESD staff to engage with hospital staff prior to the individual's discharge from the hospital, and, if referred to the TRS, to coordinate the transition to the residence;
- Provide the ESD team with psychological testing, mental health notes and reports including psychosocial evaluations, physical health assessments, discharge paperwork, incident, restraint, PRN data, etc. to aid referral and linkage to services; and
- Communication to the hospital staff post-discharge from the hospital about whether the individual made it back into the community and engaged with ESD.

It is important to note that when the ESD team works with EDs/CPEPs or other crisis services, workflows should be modified to meet the needs of each setting. These workflows must be established prior to implementation of the ESD program and clearly reflect the full support of the hospital clinical and administrative leadership. If receiving a referral from a CPEP, the ESD team should connect with CPEP Peer Bridgers to help engage with individuals in the CPEP during the pre-CTI phase.

In geographic areas where there are multiple hospitals or hospital systems, the ESD program may partner with additional hospitals based on the geographic area's capacity and local need. The ESD program *may* accept referrals from local hospitals, emergency departments, psychiatric centers, and CPEPs without a formal MOU with the hospital *if:*

- The ESD Team has the capacity to accept the referral, and
- The hospital is able to effectively include the ESD Team in aftercare planning, and
- The hospital is able to facilitate access for in-person engagement prior to discharge, and
- There are defined and agreed upon written workflows addressing the above.

The ESD team must establish an MOU in cases where there will be ongoing collaboration with a hospital.

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

3.2 Relationships with Community Based Providers

In order to support implementation of the individual's person-centered discharge plan, the ESD team is expected to have broad and deep knowledge of the local service systems that serve people with co-occurring mental health diagnoses and intellectual and/or developmental disabilities. The ESD team should collaborate closely with an individual's established community providers and supports, while identifying additional or enhanced resources needed to build a support network that comprehensively addresses crises and health-related social needs. The ESD team shall also recognize that co-occurring medical conditions are common with this population, which will require frequent collaboration and linkage to medical/specialty care providers and services. It is very important that ESD teams build and maintain relationships with community providers, organizations, and support entities and stay up to date on existing and emerging resources to support comprehensive and coordinated planning.

These services will vary by region and may include:

- OPWDD Developmental Disabilities Regional Office (DDRO),
- OMH Field Offices (FO),
- Local Housing Single Point of Access (SPOA),
- Health Home/Care Coordination Organizations (CCOs) and Specialty Mental Health Care Management Agencies (SMH CMAs),
- Certified Community Behavioral Health Clinics (CCBHC),
- Personalized Recovery Oriented Services (PROS),
- Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) Programs,
- OPWDD-certified Article 16 outpatient clinics,
- 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),
- Office of Temporary and Disability Assistance (OTDA),
- Department of Health Offices,
- 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,
- Primary care and specialty care,
- Home care services or home health aide,
- Family and/or family of choice including close friends, neighbors or advocates,
- Rehabilitation services,
- Housing agencies/shelter system,
- ACCESS-VR/educational systems/institutions,
- Self-help/peer-run services,
- Independent living centers,
- Clubhouses and Recovery centers,
- Transportation services,
- Domestic violence services,
- Care Coordination services,

- Self-advocacy organizations (e.g., The Self-Advocacy Association of New York State, Inc. (SANYS),
- Intensive and Sustained Engagement (INSET teams),
- Local government units including Department of Homeless Services, Adult Protective Services, etc.,
- Family Services (NYC Administration for Children's Services, Office of Children and Family Services, Department of Social Services, Child Protective Services),
- Local correctional facilities, local law enforcement, and other forensic organizations such as parole and probation, and
- Natural community supports including churches/spiritual centers, libraries, parenting programs, community centers, and other local groups/organizations and social activist organizations, etc.

The ESD team will identify and facilitate access to appropriate housing in a timely manner upon transition out of the hospital, which may include utilization of the ESD TRS. ESD staff will interface with the local SPOA and DDRO (as applicable) for access to the appropriate residential setting, which may include certified or non-certified housing, or housing subsidies with wrap-around community services. Contact with SPOA and the DDRO Specialty Liaison should be made as soon as possible.

OPWDD DDRO Specialty Liaison
When the ESD CTI case manager becomes aware that an individual has been OPWDD-involved at any time, suspects an individual may be OPWDD eligible, and/or determines an individual may benefit from OPWDD services, the ESD CTI case manager will take appropriate steps to initiate resources. **The ESD CTI case manager will contact the OPWDD DDRO Specialty Liaison as soon as possible**. Failing to contact the DDRO Specialty Liaison may result in delays with reviews for OPWDD eligibility and waiver enrollment, or waiver reenrollment.

Relationship with Local Government Unit (LGU)
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**. ESD programs shall have mechanisms for formal communication and collaboration with the LGU to aid provision of timely linkages of care and quality services.

3.3 Referral and Intake Process

The ESD team will work with their partner hospitals to identify high need individuals who have co-occurring mental health disorders and intellectual and/or developmental disabilities who would benefit from the ESD program.

The referral workflows with individual partner hospitals shall be streamlined, efficient, and timely, and outlined in the MOU (see Section 3.1 Partnership with Hospitals). ESD and partner hospitals should design their referral workflows in a way that allows for timely receipt of referrals

and facilitates in-person connection with the referred individual by the ESD CTI staff. CTI staff should make every effort to contact the individual:

- within 24 to 48 hours when referred from a hospital inpatient unit, and
- prior to discharge, when referred from the ED or CPEP.

ESD CTI staff will document communications and efforts (including attempted efforts) for coordination of referrals.

A referral to ESD CTI should provide information the ESD team needs to determine if the individual meets basic eligibility criteria for enrollment in ESD, including but not limited to the basic demographics, clinical information (including diagnosis for a mental illness and a co-occurring intellectual and/or developmental disability or suspected I/DD), description of the current episode of care, reason for referral, and provider contact information.

ESD CTI staff may also gather additional documentation (e.g., diagnostic evaluations, physical health screens, etc.) needed to complete the intake and make the determination of the individual's eligibility and need for the ESD program.

Where it is possible, staff should utilize:

- Collateral contacts as a resource to collect available data;
- Regional Health Information Organization (RHIO) or Qualified Entity (QE) to access an individual's records from multiple settings, including hospitals and other providers; and
- Use of data, such as PSYCKES, to assist with an informed transition approach from the hospital to the community, including the assessment of past supports, current providers, and clinical history relevant to successful community tenure and recovery.

For referrals for admission into the TRS, the ESD CTI team member must gather the following additional documents:

1. A recent physical exam, and any relevant reports of physical diagnostic examinations and assessments, including findings and conclusions;
2. a psychosocial assessment.
3. a psychiatric evaluation; and
4. any other documents that support admission to the TRS (e.g., behavioral data, declination of residential opportunities, review of emergency services recently utilized, etc.).

ESD CTI staff will complete an Immediate Needs Assessment as part of the intake process and early engagement period with the individual and continues through admission into ESD. Documentation gathered (e.g., diagnostic evaluations) may also be used to identify immediate needs. The Immediate Needs Assessment identifies the urgent and priority resources the individual needs related to housing, food, clothing, behavioral health, intellectual and/or developmental disabilities, physical health, employment, benefits, educational, social, financial, family, criminal justice, activities of daily living and/or safety concerns. This also includes an individualized assessment of the person's ability to access transportation and independently navigate the community safely. Staff and the individual may begin identifying possible interventions appropriate for community transition, including immediate linkages needed to service providers.

ESD teams should closely coordinate care with any existing providers. ESD is a short-term intervention intended to successfully transition individuals into the community and to ensure engagement with providers and other supports. The ESD team will identify and link individuals to new services needed and help improve engagement with current providers and/or avoid loss of existing services (e.g., advocacy support or addressing social care needs interfering with engagement). To help determine if a referral to ESD is appropriate as a complement to existing services, teams should ensure the following:

- ESD does not disrupt any existing services or pose barriers to providers in delivery and/or billing of services (e.g., duplicative)
- The services are tightly coordinated, and
- Both services are necessary to support successful engagement in community services.

Individuals receiving services from an OPWDD-designated Care Coordination Organization (CCO) may be co-enrolled in ESD. For these individuals, ESD CTI staff will work closely with the CCO, who remains primarily responsible for coordination of OPWDD services overall. ESD CTI staff must ensure services are aligned with the individual's Life Plan with the CCO and leveraging the clinical expertise of the ESD program to supplement where needed.

After the intake and Immediate Needs Assessment are completed, the ESD team will determine appropriateness for ESD services based on the eligibility criteria outlined above. The ESD staff will inform the referring hospital about the determination made and if not accepted for enrollment in ESD, provide the hospital with the reasoning why.

There are 4 potential outcomes to ESD referrals:

1. ESD CTI-Only (See Section 4 "Critical Time Intervention"): A good candidate for CTI only services might have an existing residential setting in the community and needs would include diagnostic testing, behavioral support planning, navigation of service systems, and connection to appropriate community services and supports.

2. ESD CTI + TRS (CTI services as described in Section 4 and TRS as described in Section 5): A good candidate for both CTI + TRS services might have the needs described above but not have a safe residential disposition or could benefit from further stabilization in the community prior to transitioning back to a previous setting or a new setting. All individuals in the ESD TRS will receive ESD CTI services that begin prior to discharge from the hospital setting. The unique benefits offered by the TRS include transitional housing, skill building, and therapeutic services in a comfortable, safe, recovery-oriented, home-like environment. ESD CTI and TRS staff will work as one team to support individuals, including an enhanced clinical staffing model, expertise in the complex clinical systems and behavioral health needs of this population.

3. Ineligible for ESD: This may arise if someone does not have either an I/DD or BH diagnosis or doesn't meet other inclusion criteria.

4. Declines ESD Services: After initial steps at engagement, individuals may decline ESD services.

3.4 Staffing

Each ESD program is managed by a single Program Director who provides clinical and administrative oversight for all ESD staff. By sharing key staff between both components of the program, the ESD program will maximize the support and expertise available to all individuals served, whether they reside in the TRS or not:

- The CTI Team Leader and Care Manager provide CTI services for all individuals in the ESD program, including those in the TRS.
- The Nurse, Behavior Intervention Specialist, and Consultant Psychiatrist provide services across both the CTI and TRS components.
- The Residential Clinical Coordinator, Residential Manager, Clinician, and Direct Support Professionals focus on TRS residents, but collaborate closely with the CTI and shared staff for those individuals.

The ESD CTI team will serve up to 30 individuals at a time; 25 will receive CTI-only services while five (5) will receive CTI services while staying in the TRS. The Case Manager will have the majority of the ESD CTI caseload, with the CTI Team Leader, Registered Nurse, and Behavior Intervention Specialist carrying small caseloads as appropriate or necessary.

The ESD Residential Clinical Coordinator and Clinician will provide training, modeling, coaching, and supervision for Direct Support Staff. While clinical staff will not typically be expected to provide direct support services and supervision to residents, it may be required at times to support staff development.

3.5 Staff Roles, Qualifications and Caseloads

ESD teams will hire staff with the appropriate qualifications and experience to meet the needs of the target population. Teams consist of licensed, professional, and paraprofessional staff, as defined below. It is the provider's responsibility to ensure that all services are provided by staff within their scopes of practice, level of competence, and under supervision, which is commensurate with their training, experience, and skills.

The ESD team must have at least one (1) FTE qualified practitioner to provide and interpret diagnostic psychological evaluations, including intelligence quotient testing and comprehensive assessments for autism spectrum disorder (ASD), as they are often required to establish OPWDD eligibility and determine need for other services. It is important that this practitioner has the proper credentials, training and supervised experience in the use and interpretation of standardized measures of intelligence and adaptive behavior, per the standards of their profession and NYS Office of the Professions, as well as any additional requirements related to the intended purpose of evaluation. See OPWDD Eligibility Guidelines for further information.

Program Director – Oversees the full ESD program, including ESD CTI-only and the TRS components. Directly supervises the ESD CTI Team Leader, Residential Clinical Coordinator, and Residential Manager.

The ESD Program Director is responsible for the operational, clinical and administrative oversight, ensuring adherence to state guidelines, program fidelity and organizational goals. The Program Director is responsible for establishing and maintaining relationships with various stakeholders, including hospitals, OPWDD, OMH, community agencies and other systems of care; establishing workflows and policy and procedures; oversight of hiring staff and onboarding and training protocols; clinical oversight of staff; facilitating monthly ESD Program Management Meeting; and oversight of quality assurance, data collection, reporting, and overall performance monitoring

> *Minimum Qualifications:* Licensed mental health professional and should have experience with programs serving behavioral health and intellectual and/or developmental disabilities. If the Program Director is practicing psychotherapy or any other State Education Department activity restricted to specific licensure, permit and supervisory structures, the program must ensure staff are acting within scope of practice.

CTI Team Leader (TL) - Manages the ESD CTI component of the ESD program, promotes fidelity to the CTI model and provides supervision of the CTI Case Manager.

The CTI Team Leader manages regular and consistent relationships and communications with partner hospitals; conducts weekly Team Meetings; facilitates routine Case Presentations; reviews the entire CTI caseload; monitors CTI Phase Plans and dates; updates CTI Resource Lists; monitors quality of care, staff productivity and wellness; ensures collaborative relationships with other community agencies and resources; and ensures mechanisms for reporting are in place.

> *Caseload:* Encouraged to carry a small caseload, as needed.
>
> *Minimum Qualifications*: Licensed mental health professional and should have specific expertise in navigating eligibility and referral processes for OMH, OPWDD, and other programs serving individuals with co-occurring behavioral health conditions and intellectual and developmental disabilities. If the TL is practicing psychotherapy or any other State Education Department activity restricted to specific licensure, permit and supervisory structures, the program must ensure staff are acting within scope of practice.

Case Manager (CM) - Provides ESD CTI services to the fidelity of the CTI model.

The Case Manager actively engages individuals in the ESD program, works collaboratively with hospital discharge teams, community providers and internal ESD staff to ensure seamless delivery of ESD CTI services; completes CTI Intake and Immediate Needs Assessment and other documentation requirements; develops person-centered Phase Plans; shares knowledge of community resources; coordinates housing, mental health, developmental services and other community resources and provide linkage to resources; engages individuals in skill building;

offers crisis management; assists individuals in navigating complex systems; and works with informal supports.

> *Caseload*: Will carry the majority of the CTI census which may include up to five (5) individuals from the TRS; see also CTI Team Leader, Behavior Intervention Specialist and Registered Nurse role descriptions.
>
> *Minimum Qualifications:* 18+ years of age with a High School diploma (or equivalent) plus one (1) year or more experience and specific expertise in navigating eligibility and referral processes for OMH, OPWDD, and other programs, and in serving individuals with behavioral health conditions and intellectual and/or developmental disabilities.

Behavior Intervention Specialist (BIS) - **Designs and implements behavior support plans and activities for individuals** with a variety of neurodevelopmental disabilities and related behavioral health disorders, using approaches that are trauma-informed, multidimensional and individualized to the needs of the individual. The BIS will also provide direction for ESD staff to fully implement support for each individual's behavioral needs.

The BIS will work with collaterals and an individual's natural supports on the implementation of behavioral strategies. When needed, the BIS collaborates with hospitals, the TRS and with the individual's support network in community settings on behavioral support planning and with implementation of support plans while individuals are in inpatient or emergency settings.

> *Caseload*: As needed for CTI and TRS (based on immediate or emerging participant needs).
>
> *Minimum Qualifications:* Licensed Mental Health Professional, Board Certified Behavior Analyst or Licensed Behavior Analyst. Should have experience serving individuals with co-occurring behavioral health conditions and intellectual and/or developmental disabilities. If the BIS is practicing psychotherapy or any other State Education Department activity restricted to specific licensure, permit and supervisory structures, the program must ensure staff are acting within scope of practice.

Registered Nurse (RN) - **Brings integrated basic health care and health education into the ESD program (CTI and TRS)** and individuals' Phase Plans. The RN collaborates with the consulting Psychiatrist and medical health providers.

For individuals receiving CTI-only services, the RN's focus is on assessing basic health and medical needs, coordinating health care with community medical providers (e.g. primary care physicians, medical specialists, etc.), and providing rehabilitation, education and support services.

For individuals within the TRS, the RN will provide basic health assessments, identify medical needs, coordinate health care with community medical providers, supervise medication, directly monitor possible side effects, support individual's skill building around medication management (e.g., organizing medications) and provide rehabilitation, education and support intended to help the individual manage their health care needs independently (or alternative supports ongoing).

Caseload: As needed for individuals in both CTI-only and TRS, with individuals with complex health needs.

Minimum Qualifications: Possess a license and current registration as a registered professional nurse in New York State and should have experience serving individuals with co-occurring behavioral health conditions and intellectual and/or developmental disabilities.

***Residential Clinical Coordinator (RCC)* - Primarily responsible for the daily clinical oversight in the residential program.**

The RCC will continuously evaluate the TRS therapeutic environment. The RCC will be present in the residence milieu to ensure professional relationships are established with each resident, to assist the team in remaining goal focused and ensure that the program is clinically based and trauma informed. The RCC may provide a level of weekend and evening coverage at the TRS in order to accomplish these goals.

The RCC oversees the Clinician, provides training and clinical supervision for the Direct Care Professionals, collaborates with the Behavior Intervention Specialist, and consults with CTI staff and hospitals on referrals to the TRS. The RCC may complete assessments, provide consultation, and facilitate group programming as appropriate and needed.

Minimum Qualifications: Licensed mental health professional and should have experience serving individuals with co-occurring behavioral health conditions and intellectual and/or developmental disabilities. If the RCC is practicing psychotherapy or any other State Education Department activity restricted to specific licensure, permit and supervisory structures, the program must ensure staff are acting within scope of practice.

***Residential Manager* - Manages the daily operations, program coordination, and administrative (non-clinical) oversight of the TRS**.

The Residential Manager's responsibilities include shift scheduling and coordination; ordering supplies; fulfilling and organizing medications (per policy and procedure); and procuring food and assuring that nutrition and dietary plans are followed. The Residential Manager is additionally responsible for maintaining and enforcing regulations, guidance, and codes, and assuring staff documentation, timesheets, and employee performance reviews are timely and complete.

Minimum Qualifications: Bachelor's Degree with at least one (1) year of supervisory experience and should have experience providing services to individuals with co-occurring behavioral health and intellectual and/or developmental disabilities.

Direct Support Professionals (DSP) **- Provide the day-to-day direct care with individuals in the TRS,** using person-centered, trauma-informed approaches to support individuals with behavioral health and intellectual and/or developmental disabilities.

DSPs promote safety and recovery by supporting individuals with activities of daily living, developing and enhancing independent living skills by modeling skills as well as offering one on one and group support instruction, teaching behavior self-management, and assisting with making connections in the community to support increased independence. Particular focus is on maintaining a therapeutic environment, establishing routines, reinforcing individual's Phase Plans and behavior support plans as needed, promoting strategies for overall health and wellness, promoting recovery and independence, and responding to and managing crisis as needed.

Each TRS will maintain a minimum of three (3) direct support professionals during day shifts and two (2) awake staff members on overnight shifts, with the flexibility to increase staffing on certain days, shifts, or time frames depending upon any changing needs of the current TRS cohort. This staffing allows for richly supporting each treatment and habilitation plan, providing transportation and support for community integration, and attending to any emergent needs.

> *Minimum Qualifications:* Must be 18 and over and possess a High School Diploma or equivalent, and highly preferred that DSPs possess a valid driver's license. DSPs should have a minimum of 1 year of direct care experience with individuals with behavioral health conditions and intellectual and/or developmental disabilities and have an interest in working with individuals with moderate to severe behavioral challenges in a strengths-based, person-centered residential program.

Clinician **- Observe, build rapport and develop working clinical knowledge of the TRS residents and related clinically based programming.** The clinician is clinically supervised by and works closely with the Residential Clinical Coordinator.

The clinician helps support an effective therapeutic milieu, facilitates group programming (e.g., clinically based and psychoeducational groups) and TRS house meetings, designs individuals' schedules, manages day-to-day emergent needs, and provides individual counseling/psychotherapy as needed. The clinician collaborates with the interdisciplinary ESD team, collaterals, and an individual's natural support network. In coordination with the Residential Clinical Coordinator, the clinician will also assist with daily operations and clinical oversight including co-development and support of staff training, collaborate with the respective provider agencies, and serve as a clinical resource for ESD staff. The clinician may provide a level of weekend and evening coverage at the TRS to accomplish these goals.

> *Minimum Qualifications:* Licensed mental health professional (with assessment, psychotherapy, etc., within their scope of practice) and should have experience providing services to individuals with co-occurring behavioral health diagnoses and intellectual and/or developmental disabilities. If the clinician is practicing any State Education

Department activity restricted to specific licensure, permit and supervisory structures, the program must ensure staff are acting within scope of practice.

***Consulting Psychiatrist* - Available to consult with the interdisciplinary clinical team**, provide support for ESD staff on individuals regarding diagnosis and treatment, and collaborate with other clinical providers.

Caseload: Potentially provide very limited psychiatry services as a bridge to more permanent services.

Minimum Qualifications: License and current registration to practice medicine in New York State, and completion of a training program in psychiatry approved by *The American Board of Psychiatry and Neurology* and should have experience in psychopharmacology and psychiatric care for individuals with co-occurring behavioral health diagnoses and intellectual and/or developmental disabilities.

3.6 Supervision

A unique feature of the ESD program is the high level of clinical representation on the ESD team and the provision of supervision through weekly team meetings (see Section 3.8), direct supervision and consultation, case conferences and daily communication.

Professional staff must have access to clinical supervision as required by their permit or licensure under New York State Education Department. The Program Director should regularly review the effectiveness of service provision and support professional and paraprofessional staff with identifying individuals' barriers and service needs.

3.7 Staff Team Meetings

The ESD program will hold regularly scheduled meetings to support program operations, facilitate communication among the ESD team in the coordination of services, and provide for formal group supervision.

ESD Program Management Meeting

This meeting is facilitated by the ESD Program Director and held at least once per month. The purpose of this non-clinical meeting is to establish consistent practices, discuss ESD program strengths and needs, and to further develop and maintain quality services. Attendees will include CTI Team Leader, Residential Clinical Coordinator, Residential Manager, and key agency administrators (e.g., Director of Operations, Quality Improvement/Quality Assurance, Clinical Director or Medical Director, etc.).

Clinical Meetings

The ESD program will hold two (2) regularly scheduled meetings to be used as a formal group clinical supervision and to discuss individuals' progress. The clinical meetings provide a forum for joint problem solving, making rapid adjustments to best meet individuals' needs, and support from the multidisciplinary team.

- **TRS Residents - Clinical Meeting**: This meeting is facilitated by the Residential Clinical Coordinator or the Program Director and includes all members of the ESD team (CTI and TRS) to discuss current TRS residents together. The purpose of this meeting is to review the progress of each person residing in the TRS including any concerns related to daily schedules, planned activities, staffing, crisis situations that may require additional protections and planning, and resources or supply needs within the program. The TRS staff will report on individuals' day-to-day outcomes and needs. CTI staff will report on CTI phases for each TRS resident, updates on community connections made, pending admissions and discharges from the TRS, and provide background and updates for the ESD Team to provide input for transition planning. The TRS Clinical Meeting is to be held at least once per week for one (1) hour.

- **CTI-Only - Clinical Meeting:** The purpose of this meeting is similar to the TRS residents – Clinical Meeting, but specific to review of individuals on the CTI-Only caseload; see Section 4.5 "CTI Team Meeting" for full details. This meeting is facilitated by the ESD CTI Team Leader at least once per week, and attended by the Program Director, CTI Case Manager, Behavior Support Specialist, and Registered Nurse.

3.8 Hours of Operation and 24/7 Availability

The ESD program will have hours of operation that ensure availability and adequate provision of services necessary to meet the unique needs of the individuals served. All ESD staff will be provided with 24/7 support from an Administrator on Duty.

The ESD CTI staff will typically work standard business hours but are highly encouraged to offer flexible work hours to accommodate schedules of individuals served (e.g., 10:00 am - 6:00 pm, 11:00 am - 7:00 pm, weekends, etc.). The ESD CTI team must have a mechanism by which hospitals can connect with ESD CTI staff 24/7 (e.g., should an enrolled individual present at the ED or hospital).

The ESD TRS will operate 24/7 with awake overnight staffing. TRS staff will largely provide TRS services, in-person support, and conduct program monitoring activities and supervision during standard business hours. The ESD clinical team is responsible for responding to emergencies or to escalating situations, supporting both ESD staff and residents, and determining the course of action for any situation that requires support exceeding those available within the ESD Program.

ESD TRS shall have a protocol for handling emergencies and emerging crises that may arise during evening and overnight hours. Staff will also utilize the agency Administrator on Duty system.

3.9 Safety and Crisis Response Policy

It is critical that the individuals served and the ESD staff feel safe. The ESD program must develop a safety policy and procedure for the ESD program. Policy areas may include but are

not limited to best practices in personal safety, TRS crisis and safety practices, CTI-only crisis and safety practices, community safety, transportation safety, crisis de-escalation techniques and emergency response protocols.

3.10 Service Dollars

ESD programs are given Service Dollars funding by OMH to further assist individuals served by the ESD program. The intent of service dollars is to support an individual's basic or specific needs in developing and maintaining situations for living, working and socializing in the community, which enhances their potential for growth and independence. Many services are available through the Local Department of Social Services (DSS), Medicaid or community agencies. Therefore, all efforts should be made to access these alternate resources first. If alternate resources are not available to meet the needs of the individuals, then Service Dollars may be expended.

For individuals initially engaging with the ESD team in pre-CTI services, service dollars may be used to pay for things needed in preparation for discharge from the hospital/ED/CPEP, on day of discharge and through the initial transition back into the community. For example, basic necessities like clothing, toiletries, furnishings (e.g., bed, air conditioner, dishes), food and medical care/supplies needed to return home, emergency shelter, transportation, fees for obtaining identification, etc. as well as to support engagement with community services.

For individuals enrolled in the ESD program, service dollars can be utilized to pay for emergency expenses (e.g., security deposit to secure an apartment, medications) as well as for covering the cost of services and supplies that will support attainment of recovery goals, community inclusion and stronger ties to natural supports. For example, connections with social interests (gyms, clubs, etc.), enrollment in classes, childcare to support the individual in attending vocational training and appointments, housing (securing housing, installing safety features such as grab bars), and medical costs (co-pays, equipment, nutritional services, etc.). Service dollars cannot be utilized to purchase alcohol, tobacco products, cannabis, or lottery tickets. Cash should not be provided to individuals.

All ESD programs are to have monitoring and management procedures in place for the tracking of service dollars expended, and demonstrating appropriate use of this funding (as documented in the individual's record).

4. Critical Time Intervention

ESD CTI is modeled on Critical Time Intervention, 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. It was originally developed for working with individuals who were unhoused but is now being applied to a broader population with behavioral health issues. ESD CTI further adapts the CTI model to work with people with co-occurring intellectual and/or developmental disabilities and behavioral health needs.

This section will first broadly lay out the key aspects of traditional CTI, all of which apply to ESD CTI. Then it will provide an overview of how ESD CTI adapts the traditional CTI model. Finally, it

will outline details of implementation, pointing out where the traditional CTI model has been adapted specifically for the ESD program.

4.1 Traditional CTI: Core Principles, Values, and Key Aspects

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 staff tasks associated with each phase
- Time-limited approach
- Frequency of contacts between the individual and the CTI staff intentionally decreases 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 staff:

- 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

Key Aspects - One critical aspect of traditional CTI is the partnership between CTI and hospitals, as well as the knowledge of and expertise in connections to outpatient services and community supports.

Other key aspects of traditional CTI include 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. CTI requires staff to have a skill set based on a non-judgmental, person-centered, strength-based approach that meets individuals where they are, helps individuals identify what is important to them and communicates hope that recovery is possible. 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. The CTI model 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, libraries, 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.

4.2 ESD CTI: Adapting the Model

All of the above core principles, values, and key aspects apply to the ESD CTI model. In general, ESD CTI adds the following features that are not part of the traditional CTI model:

- Clinical and systems expertise in co-occurring I/DD and Behavioral Health.
- Clarifying diagnoses through documentation gathering and direct diagnostic evaluation (including psychological testing and assessments for autism spectrum disorder). The ESD program should have the ability to complete these evaluations while participants are admitted to inpatient settings.
- Navigating service referral and enrollment processes, including submitting documentation to OPWDD or other agencies for eligibility determination when appropriate.
- Consulting with hospitals, community providers, and natural supports on creating a positive behavioral support plan.
- Providing psychiatric consultation on medication management.
- Having cross systems familiarity with OMH and OPWDD resources and processes.
- Targeting a timeline of 9-12 months (see Section 4.4 “CTI Phases”).
- Offering short-term counseling and psychotherapy services as needed, while connecting individuals to long-term clinical services in the community.
- Potential connection to a dedicated, specialized, short-term residential setting as a step-down from inpatient care for up to five participants at a time.

4.3 CTI Services

ESD CTI will follow the evidence-based approach of the Critical Time Intervention model which includes four (4) CTI phases described in Section 4.4; refer to Critical Time Intervention Manual (2002) and the CTI Manual for Workers and Supervisors (2021) for more details on the CTI Model.

All individuals referred to the ESD program and who meet eligibility (see Section 2) will receive persistent outreach and engagement attempts, even if the individual is initially hesitant to engage in services. The ESD CTI staff will work with individuals to ensure that their immediate needs are met (including shelter, food, medication and clothing), and that community linkages and supports remain solid.

CTI services are provided based upon an individual’s assessed condition and Immediate Needs Assessment, which forms the basis for establishing a person-centered Phase Plan. 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 Phase Plan.

ESD CTI services include:

Clinical Service: Services generally provided by professional staff with clinical expertise to accurately assess and diagnose individuals, identify strengths and barriers, develop behavior intervention plans, conduct assessments and risk assessments/safety planning, and complete other documentation required for needed services.

Clinical services are provided by CTI Team Leader, Behavior Intervention Specialist, Registered Nurse and/or Consulting Psychiatrist.

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, intellectual/developmental, and behavioral health condition and history. This service engages each individual and collaterals, as applicable, as active partners in developing, reviewing, and modifying a course of care that supports the individual's progress toward recovery and community integration.

Person-Centered Planning services are provided by the CTI Team Leader, CTI Case Manager, Behavior Intervention Specialist, and/or Registered Nurse.

Psychosocial Rehabilitation Services: Psychosocial rehabilitation services motivate and support individuals to engage in mental health and other community-based supports 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 individual. 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.

Psychosocial Rehabilitation services are provided by the CTI Team Leader, CTI Case Manager, Behavior Intervention Specialist, and/or Registered Nurse.

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 staff will proactively assist individuals in the prevention of crisis episodes. The CTI staff are not expected to be on call as a "first responder" for crisis events but are 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.

Crisis Prevention Services are provided by the CTI Team Leader, CTI Case Manager, Behavior Intervention Specialist, and/or Registered Nurse.

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.

Health Services are provided by the Registered Nurse or Psychiatrist.

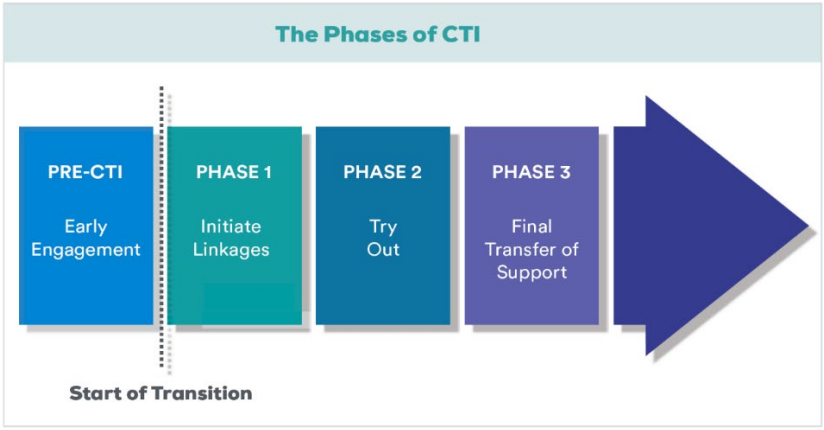
Care Coordination Services: Care Coordination services to support individuals living in the community or transitioning between levels of care. Care coordination is an active

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.

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, or 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.
Care coordination services are provided by CTI TL, CM, BIS and RN.

4.4 CTI Phases

The CTI model is divided into four phases: A "Pre-CTI" Phase (Early Engagement), Phase 1 (Initiate Linkages), Phase 2 (Try Out) and Phase 3 (Final Transfer of Support). The CTI Phases 1 – 3 were envisioned as each lasting three (3) months, for a total program length of nine (9) months (see diagram).



However, in the ESD program, flexibility in timeframes for the CTI Phases *may* be warranted when serving individuals with co-occurring behavioral health and intellectual and/or developmental disabilities. The complex needs of this population require individualized approaches and considerations when identifying needs and options for each individual. For instance, the Pre-CTI Phase may be prolonged due to additional tasks related to determining eligibility for other services. Cross-system collaboration that is needed to secure community services and the availability of resources/waitlists may also impact timeframes, such as someone in the TRS and CTI Phase 3 waiting for an available slot in more permanent housing in the community.

Regardless of the adjustments to the specific lengths of time in particular CTI Phases in individual situations, the general outcome is to:

- Have defined goals and staff tasks for each CTI Phase, and

- Use a time-limited approach of initially high intensity contacts and services that gradually decrease over subsequent phases.

Pre-CTI - Early Engagement Phase – Goals during these initial contacts include development of a trusting relationship with the individual, gathering information for intake, eligibility and beginning an assessment of existing resources, prior to discharge from the hospital.

Pre-CTI contacts are of moderate intensity. Data suggests that the greater the time, intensity, and number of contacts provided prior to discharge from the hospital/ED or CPEP, the better the outcomes.

Tasks performed during the Pre-CTI/Early Engagement Phase include but are not limited to:

- Early engagement with the individual to build rapport and trust. This should take place via multiple contacts made prior to hospital discharge, when possible, with at least one (1) in-person contact.
- Gather contact and basic demographic information.
- Use hospital data systems and PSYCKES to determine the individual's history of treatment, and identify existing providers, resources, and other supports.
- Initiate the Immediate Needs Assessment with the individual which reflects their cultural and linguistic needs. This brief assessment focuses on the individual's priority and urgent needs, focused mainly on resources and referrals needed to maximize the success of the individual's hospital discharge.
- Work with the individual and natural supports, and the hospital team to develop a hospital discharge plan, inclusive of the individual's identified strengths and preferences. Providing suggestions and information for community resources and referrals needed to support the individual's recovery goals and transition to the community. Transition supports could range from arranging transportation to connecting to housing and/or to connect to clinical resources to provide behavioral support planning to the residential or family setting.
- Connect to housing. Depending on the individual's unique situation, this could include initiating referral to the ESD TRS, housing referrals into the OMH and OPWDD systems, and providing transition support as a bridge to existing or new housing.
- Communicate with existing and prospective providers and natural supports (e.g., family, friends, roommates, etc.) of the individual's hospital discharge plan and recovery goals.
    - Establishing relationships and clarifying roles with existing supports, for example New York Systemic, Therapeutic, Assessment Resources and Treatment (NYSTART)/Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD), CCOs, and Health Home/Health Home Plus.

During the Pre-CTI phase, the ESD CTI Team will simultaneously work closely with hospital/ED/CPEP staff, as applicable, to:

- Gather documentation of any completed diagnostic evaluations and assessments;
- Navigate the appropriate service referral and enrollment processes, including referrals for appropriate residential supports and services;
- Provide consultation on creating a positive behavioral support plan with the individual;
- Provide any needed psychiatric consultation on medication management;

- Work closely with existing supports in the community (e.g., family, existing residences, shelter, etc.); and
- Engage with the OPWDD DDRO Specialty Liaison if the individual has been OPWDD involved or is likely to be eligible for and benefit from OPWDD services.

Phase 1 – Transition to the Community/Initiate Linkages – The key goals of this phase are providing support and beginning to connect the individual to the people and providers that will assume the primary role of support in the community.

Months 1 - 3 post-hospital discharge are of high service intensity, with emphasis being on in-person engagement with the individual. **The standard for number of encounters provided during Phase 1 is eight (8) or more per calendar month.** Encounters can be a combination of in-person contact with the individual (ideally in their residence or in the community), telehealth, and collateral contacts with outside providers and/or the individual's natural supports. The mode and frequency of encounters should be specific to what works best for the individual's preferences and needs.

It is recommended that at least five (5) encounters be in-person contact with the individual.

Core tasks performed during Phase 1 include:

- Confirm with the referring hospital and other providers that everything needed for the hospital discharge plan is all set in terms of treatment, support, basic needs, income/benefits, cell phone access, transportation, food, safety, adequate heat, lighting, etc.
- Give case presentations at the CTI team meeting and TRS Clinical Team meeting.
- On the day of discharge from the hospital, accompany the individual to their community setting, unless the individual does not want this support.
- Working with the community setting (family, residence, TRS) on transitioning positive behavioral support and crisis planning from the hospital to the community setting. Or, if these haven't been completed in the hospital setting, creating them in the community.
    - For those individuals admitted to the ESD TRS, collaborating with the TRS on the initial transition from the hospital and on establishing initial supports setting.
- Establish a routine check-in plan with the individual to provide support as the individual adjusts to their new environment and develop a collaborative relationship. Check-ins may take place in the individual's residence and/or other places in the community. Help identify solutions to resolve barriers and/or concerns related to their transition to the new setting/support system.
- Create the Phase plan for Phase 1 with the individual; see Section 6.2 "Phase Plan" for full requirements. Encourage the individual to identify and express where they would like to see change in terms of the new setting or support, ensuring they have a voice in their plan and take more responsibility for their recovery, including advocating with their medical team around medication issues.
    - The Behavior Intervention Specialist will prepare the Behavior Support Plan with the individual, when applicable; see Section 6.3 "Behavior Support Plan" for further details.

    - Prepare a crisis support plan with the individual (and their natural supports, if consented) that can be activated if needed by the individual; see Section 6.4 “Safety Support Plan” for further details.
    - CTI staff are encouraged to inform individuals of PSYCKES MyCHOIS[1], a PSYCKES application where individuals have access to their clinical information and useful recovery tools and can create a personalized plan (including a safety plan for emergencies) to support shared decision-making.
- Establish relationships and clarify roles with existing supports, for example New York Systemic, Therapeutic, Assessment Resources and Treatment (NYSTART)/Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD), CCOs, and Health Home/Health Home Plus.
- Link individual to needed services and resources, such as:
    - Psychiatric consultation for those needing interim psychiatric services prior to establishing care and for those requiring diagnostic clarification.
    - ESD program will complete psychological testing that would assist with OPWDD eligibility AND/OR clinical formulation.
    - For those with established OPWDD eligibility, seeking eligibility or re-enrollment in waiver services, and maintaining regular connections with the OPWDD DDRO Specialty Liaison.
    - Continue pursuing connection to appropriate residential services through either the OPWDD CRO process or the Local Governmental Unit’s process for OMH or other supportive housing, as appropriate and needed.
    - Continuing to connect to services appropriate for the individual’s clinical needs and that the person qualifies for (e.g. Article 16/31 clinic, Federally Qualified Health Centers, CCBHC, PROS, OPWDD services, etc.).
    - Observe individual’s initial engagement with support network by accompanying them to medical, psychiatric, and other provider visits. Coordinate and/or participate in Collateral meetings.
- Work with the individual to identify meaningful community interactions or activities – e.g., involvement with a faith community, gym membership, social clubs, libraries, arts groups, community-based peer support services, and other services to support work and education goals, etc.
- Provide coaching to improve community living and interpersonal skills.
- If the individual is re-admitted to an acute service (e.g., an emergency department, CPEP/inpatient 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.

Phase 2 - Try Out – Goals of this phase include monitoring and strengthening of the individual’s skills in self-advocacy and use of their support network.

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[1] For more information about My Collaborative Health Outcomes Information System (MyCHOIS), visit the PSYCKES website at https://omh.ny.gov/omhweb/psyckes_medicaid/initiatives/other/.

Months 4 - 6 are of moderate service intensity, with emphasis still being on in-person engagement with the individual. **The standard for number of encounters provided during Phase 2 is six (6) or more per calendar month.** Encounters can be a combination of in-person contact with the individual (ideally in their residence or in the community), telehealth, and collateral contacts with outside providers and/or the individual's natural supports. The mode and frequency of encounters should be specific to what works best for the individual's preferences and needs.

It is recommended that at least four (4) encounters be in-person contact with the individual. Interaction with community contacts will change as the individual attains more and more self-reliance.

Tasks performed during Phase 2 include but are not limited to:

- Review progress on Phase 1 focus areas with the individual
- Create the Phase plan for Phase 2 with the individual; see Section 6.2 "Phase Plan" for full requirements.
    - Make necessary updates to the crisis and behavioral support plans, as appropriate.
- Continue to provide in-person support to the individual but decreasing the number of contacts with the individual to six (6) or more times per calendar month.
- Step back to monitor linkages to existing resource network and adjust as needed.
    - Collaborate with the individual's formal and informal support network to ensure communication and delivery of services are meeting the individual's needs.
    - Continue to coordinate and participate in collateral support meetings for discussing strategies to further strengthen the individual's engagement and ability to utilize support network. Mediate between individual and support network when needed and adjust resource network accordingly.
    - Continue close collaboration with the OPWDD DDRO Specialty Liaison and START/CSIDD.
    - Collaborate with CCOs or Health Home/Specialty Mental Health Care Managers (as applicable), LGU and SPOAs, on access to and plan for transition to longer-term care coordination services post-ESD.
- Continue to collaborate with the ESD TRS for those residing there to identify and prepare the individual for eventual move to more permanent and least restrictive housing setting.
- Continue providing coaching and opportunities for the individual to improve self-advocacy skills to communicate their goals to their support network.
- 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 3 with individual, in *preparation* to reduce the frequency of visits and move to more of a monitoring role.

Phase 3 - ***Final Transfer of Support*** - Tasks in this final phase are related to transfer of care, achievement recognition and termination from ESD.

Months 7 - 9 are of low service intensity. **The standard for number of encounters provided during Phase 3 is four (4) or more per calendar month.** Encounters can be a combination of in-person contact with the individual (ideally in their residence or in the community), telehealth, and collateral contacts with outside providers and/or the individual's natural supports. The mode and frequency of encounters should be specific to what works best for the individual's preferences and needs.

It is recommended that at least two (2) encounters be in-person contact with the individual. Interaction with community contacts will change as the individual attains self-reliance.

Tasks performed during Phase 3 include but are not limited to:

- Review progress on Phase 2 focus areas with the individual.
- Create the Phase Plan for Phase 3 with individual; see Section 6.2 "Phase Plan" for full requirements.
    - Make necessary updates to the crisis and behavioral support plans, as appropriate
- Step back number of check-ins with the individual to four (4) or more encounters per month, serving a purely monitoring role.
- Work with the individual on a Psychiatric Advanced Directive, Health Proxy, Medical Orders for Life Sustaining Treatment (MOLST) as applicable, assist with accessing personal PSYCKES through MyCHOIS, and assist with voter registration, if the individual is interested.
- Hold the final transfer of support meeting with the individual and support/resource network, ensuring that the individual and supports can function independently post-ESD.
- Prepare and finalize a discharge summary.
- Hold the wrap-up meeting to provide the discharge summary to the individual, acknowledge all that has been accomplished and celebrate graduation from the ESD program.

For full details regarding discharge, see Section 7 "Discharge Planning from ESD".

4.5 CTI Team Meeting

The purpose of the CTI Team Meeting is for the team to review individuals on the CTI caseload for current status and progress, coordination of CTI services, and leveraging of the ESD team's clinical expertise to support crisis situations and aid linkage to appropriate community care. The CTI Team Meeting is facilitated by the ESD CTI Team Leader and held at least once per week, typically in the morning before CTI staff head out in the field to deliver services. Staff who will attend the Team Meeting include the Program Director, CTI Team Leader, CTI Case Manager, Behavior Intervention Specialist, and Registered Nurse. CTI Team meetings will review the following:

- New ESD CTI referrals including:
    - A brief description of the individual;
    - Assignment to the care manager (or other team member based on need for particular expertise); and

    - Collaboration with TRS Residential Clinical Coordinator and Residential Manager for clients in need of the TRS.
- Current status of individuals in Pre-CTI.
- Case presentations for all individuals in early Phase 1:
    - The case presentation is prepared and facilitated by CTI staff assigned to the individual (e.g. Case Manager, CTI Team Leader, or Behavior Intervention Specialist) to introduce the individual to the team including the TRS staff as applicable, provide background information, and identify key focus areas and immediate needs;
- Review of any individuals who had a recent event or change in community status and determine an immediate follow-up plan, including but not limited to:
    - Individuals experiencing a crisis and
    - Individuals requiring hospitalization/ER/CPEP:
        - Review plan for visiting individuals while hospitalized, communication with inpatient staff and collaterals, plan for discharge and follow-up care;
        - Team Leader should check Qualified Entities (a local hub where a region's electronic health information is stored and shared, formerly known as Regional Health Information Organizations) prior to team meetings for receipt of any hospitalization/ED alerts - and related medical documentation - for review during the meeting.
    - Individuals who have had a recent incarceration; and
    - Other significant events affecting individuals served.
- CTI Caseload Review include updates provided by the ESD CTI Case Manager or primary team member assigned for individuals on the ESD CTI caseload to include:
    - The Phase each individual is in, when a transition (to next Phase or upcoming discharge) will occur, activities they have completed since the previous review, and activities planned for the upcoming week(s);
    - Schedule any specialty visits needed from other staff (including TRS staff, as applicable) and/or CTI visits needing coverage;
    - Each caseload review should be brief; and
    - Each individual served by the ESD CTI team should be reviewed at least once a month.
- The ESD CTI Team Leader should ensure that staff follow decisions made in team meetings and that activities identified are being carried out.
    - Team Leader uses the Phase-Date form to reference upcoming transitions and update any changes to dates.
    - For individuals being discharged from ESD CTI within a month, the staff should include the date of the Final Transfer of Support meeting and the proposed date of the Wrap Up Meeting with the individual.
- Opportunities for the team to share resources or expertise in specific areas relevant to the needs of the individuals served as well as arranging for outside experts to present to the team.

4.6 CTI Case Conferences

Case conferences are an integral part of the CTI model. The case conference is a formal, planned, and structured activity that brings the individual, service providers/collaterals, and their natural supporters together to problem solve treatment challenges in a coordinated and integrated way. Case conferences are typically facilitated by the CTI staff primarily responsible for the individual's case. Every individual has a unique support system; therefore, the frequency and type of meeting may vary from person to person.

4.7 CTI Team Forms

Resource Lists

A *Resource List* shall be kept up to date by the CTI Team Leader and will be made available to all ESD staff, as appropriate. 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 CTI Model 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 CTI Team Leader will update the form with actual dates for transition between Phases, ideally within two (2) weeks of the transition. The form should also include an area to note whether individuals ended CTI early and the reason if applicable.

5. Transitional Residence Services (TRS)

The TRS serves as an alternative to more restrictive settings not meeting the current needs for individuals with MH/IDD (e.g., continued hospitalization or emergency room stay). The targeted length of stay for the TRS component of the ESD Program is approximately six (6) months, though providers will have flexibility to ensure a positive discharge outcome. The TRS provides short-term stabilization, ongoing assessment & connection to resources and support for the individual.

The ESD team will work together to provide support to help the individual develop independence and community readiness by teaching new skills, building on skills already developed, identifying strategies to decrease risks, and establishing appropriate resources for both the individual and their support system. This includes providing safe and appropriate housing while establishing eligibility for OPWDD and/or OMH services.

5.1 Admission to the TRS

The TRS will provide:

- ESD CTI services, including exploring, identifying and connecting to community resources to achieve successful community tenure.

- 24/7 in-person support including monitoring and supervision with awake overnight staffing.
- Direct care support, skill building (habilitation and rehabilitation to help individuals attain, keep, or improve skills and functioning for daily living), and positive behavioral support.
- Daily structured activities including psychoeducational and therapeutic supports.
- Immediate needs assessment and development of a comprehensive support plan.
- Three (3) meals per day, in addition to nutritious snacks and beverages.
- Transportation to and assistance with appointments and community resources.
- Supervision of self-administration of medication.
- Promote overall health and wellness.
- Assistance with money management.
- Support and assistance with the upkeep of common areas and bedrooms.
- Education, training, and support of family/guardians, residential staff, and other supports to ensure a smooth transition to community living.

The daily structured activities should include but are not limited to behavior intervention services, in-house counseling or psychotherapy (unless and until the individual is connected to outside treatment services), individual and group-based skill building, house meetings, and recreational activities.

The ESD team will work together to connect each individual to meaningful community activities outside of the TRS including social activities, employment, volunteer activities, classes or other educational opportunities, participation in religious communities, etc.

Individuals cannot be required to leave the residence to attend specific structured programming. However, the team should be connecting individuals to resources within their community as quickly as possible and minimize dependency on the time-limited services offered within the TRS, such as counseling and psychotherapy.

5.2 Medication Procedures

Medication guidance for the ESD Program follows OMH regulations pertaining to community residential settings, which does NOT include administering of medications or requiring compliance with individuals' prescribed medication regimen. It does, however, include providing individualized skill development, support, and assisting individuals with making informed decisions about their medication.

Medication monitoring and support services are psychoeducation and skills training services, conducted by any staff trained on the agency's ESD program medication monitoring/support services policy and procedures. This includes interventions to ensure appropriate management of medications through understanding the role and effects of medication in treatment, identification of side effects and potential interactions of medications.

Medication management and support Is a service provided by staff and involves teaching, reinforcing, and offering supportive services with the individual and includes storage, monitoring, recordkeeping and supervision associated with the self-administration of medication (SAM). Supervision of self-administration of medication means guiding and supporting the individual to

identify, open, pour, take, their prescribed medication, maintain medication organizers and utilize other alternative equipment to assist with medications as needed.

Medication supervision includes staff observing, coaching, prompting and role playing with the individual to support their self-administration of prescribed medications. Services also include skills training in self-administration of medication in accordance with medication administration logs, monitoring and supervision associated with the use of medication, including appropriate dosage and frequency, and the review of the appropriateness of an existing regimen by staff with the prescriber.

This service does not include prescribing medication, as psychiatric prescribing is a separate service. Medication management and support does include a certain degree of reviewing the appropriateness of the individuals' existing regimen with their physician.

Activities which focus on educating individuals about the role and effects of medication in treating symptoms of mental illness and training in the skill of self-medication are also included, e.g., providing education on how to: open medication bottles, identify medication(s), understand medication regimen and directions as prescribed, and encourage independence with taking medications as prescribed.

The key principles of a self-administering medication system (SAM) are to promote independence, dignity, and personal responsibility while ensuring safety and adherence to prescribed treatment. This system promotes structure and support without taking away the individual's control over their own care.

Medications are required to be stored securely (locked box, cabinet, storage unit). Access is given only to the individual and/or staff. Medication packaging is typically dispensed in the pharmacy in blister packs, pill organizers, or labeled bottles that make it easier to track doses and times. Reminders and cues are utilized with individuals working through a self-administering medication system. These include alarms, reminders, supervision, verbal prompts, written schedules and charts. A medication log to record when dosages are taken are maintained for each person. Staff may review logs with the individual to ensure consistency.

A SAM usually includes a step system whereby individuals progress in the level of independence in medication management. A typical Step System looks like this:

Step 1 - Full Staff Supervision

- Individuals start by being fully supervised by staff.
- Individual medications are stored securely by staff.
- Staff provides reminders and prompts to the individual during medication times.
- Individual takes the medication in the presence of staff.
- Staff provide education on prescribed medications.
- Staff tracks doses and communicates with prescriber directly.

Purpose: Build consistency, routine, and trust in the process.

Step 2 – Staff Prompting

- Staff provide prompts to the individual during medication times.
- Medications are still stored securely by staff
- Individual takes the medication in the presence of staff.

- Staff provide education on medications during medication times; the individual begins to demonstrate an understanding of medications prescribed.
- Staff still track doses and communicate with prescriber directly; however, staff begin to instruct individuals on how to do this independently.

Purpose: Shift responsibility to the individual while maintaining strong support.

Step 3 – Shared Responsibility

- Staff may still provide reminders (alarms, verbal prompts, or written schedules) but the support is reduced for the individual to retrieve and take medications independently.
- Medications are stored in a lockbox or pill organizer filled directly by the individual with staff supervision and made accessible to the individual (staff have backup access if needed).
- Individual takes medications independently but notify staff.
- Staff routinely check in to ensure that doses are not missed.
- Staff provide education on medications during medication times; individual demonstrates an understanding of medications prescribed.
- Staff and the individual jointly track doses and communicate with prescriber collaboratively.

Purpose: Practice independence with a safety net in place.

Step 4 – Independent with Oversight

- Individual uses reminders (alarms, charts, blister packs) to self-manage.
- Staff assist the individual with tracking doses and with communicating with prescriber directly.
- Medications are stored (in personal lockbox or storage); the individual holds their own medications and takes independently.
- Individual understands what medications are prescribed and why they are prescribed.
- Staff periodically check medications weekly to ensure doses are not missed and to ask supportive questions.

Purpose: Encourage self-management while reducing staff involvement.

Step 5 – Full Independence

- Individual uses reminders (alarms, charts, blister packs) to self-manage.
- Individual stores medications without staff involvement.
- Individual self-tracks doses and communicates with prescriber directly.
- Individual has full understanding of medications prescribed.
- Staff only step in if concerns arise (missed doses, health issues, safety risks).

Purpose: Full autonomy and empowerment.

SAM progression is individualized where some individuals may remain at Step 2 or 3 if that is safest. Movement between steps should be based on ability, safety, and consistency, not just time. Regression to an earlier step is not a failure; it's a support adjustment. Movement through step 5 is not necessary to achieve discharge from the TRS.

PRNs must be person-driven and made accessible to individuals per prescriber orders. Staff can remind/encourage/prompt individuals to use PRNs when presenting symptoms could be treated with a prescribed PRN, according to prescriber orders.

Staff must develop PRN protocols for individuals in the TRS and to include them in an individual's record to aid with medication supervision.

The ESD Program will create procedures to monitor, store, review, and access prescribed medications for individuals served in the TRS. Procedures should include appropriate recordkeeping, medication storage and staff oversight of individual's self-administration of prescribed medication.

All shall be consistent with applicable Federal and State laws and regulations.

5.3 Restraint and Seclusion Policy

This guidance aims for the safest, least restrictive support in alignment with autonomy and dignity. Restraints and seclusion are NOT allowed in the ESD program. Behavior support plans for individuals in the ESD TRS Program will follow OMH regulations pertaining to community residential settings and CANNOT include restraints or seclusion. Agency policies must explicitly state the prohibited use of restraints and seclusion, must be integrated into the ESD staff training program and communicated to all relevant staff. The policy must describe alternative methods to be used in lieu of restraint and seclusion.

Restraints are defined as intentional suppression of freedom of movement or autonomy. It is any physical or chemical measure that restricts freedom of movement or access to one's body that the individual cannot remove easily.

Behavioral support plans will prioritize positive reinforcement, skill building, proactive and reactive staff response, and teaching of adaptive alternative behaviors. Staff must prioritize proactive, preventive, and non-physical strategies at all times.

Safe alternatives to restraint and seclusion include the use of:

- positive behavioral supports,
- predictable routines and structure,
- sensory supports (fidgets, weighted blanket, headphones),
- safe physical environment including comfort rooms/calming spaces (e.g., not seclusion but voluntary soothing environments),
- crisis de-escalation techniques (e.g., verbal de-escalation, staying calm, acknowledging feelings, redirecting to a safe activity, distracting, voluntary cool down time in a safe place, and suggesting grounding techniques (e.g., breathing, mindfulness, tapping),
- skill building (e.g., emotional regulation training, social skills groups, functional communication, and problem-solving skills), and
- collaborative/supported problem-solving.

ESD programs are expected to provide trauma informed environments which include choice and autonomy, prioritizing rapport and trust, active listening and validation with clear and calm communication. TRS properties cannot be locked or secured to prevent a person leaving the premises.

All staff are required to complete annual training in trauma-informed care, de-escalation, and collaborative problem solving.

Staff are expected to document and debrief all crisis incidents, focusing on prevention strategies for the future. Regular review of incidents to identify trends and systemic triggers is required to evaluate and make continuous improvements to the program.

5.4 Personal Care and Hygiene Policy

Personal Care and hygiene guidance for the ESD TRS program follows OMH regulations pertaining to community residential settings, which does NOT include staff physically conducting these tasks for individuals in care.

The ESD program emphasizes independence, dignity, and skill-building. While staff provide structured support, coaching, teaching behavior self-management, verbal prompting and monitoring, hands-on assistance with personal care and hygiene is not permitted. Residents are expected to manage their own self-care to the best of their ability, with staff support as needed (e.g. set-up, verbal prompting, modeling, etc.).

Staff are responsible for prompting and reminding individuals about hygiene routines (e.g. “It’s shower time” or “remember to brush your teeth”). Staff also model healthy hygiene practices during skill building groups, educating individuals on hygiene and self-care through workshops, one on one teaching, or resource handouts.

Staff are to monitor for safety concerns that create health risk, unsanitary living spaces and affect community living. Staff should encourage independence through habilitation plans that set goals, track progress, and provide positive reinforcement. Staff should report hygiene or self-care concerns to clinical staff for follow-up in treatment planning.

Staff cannot provide direct hands-on care (including bathing, toileting, brushing teeth, dressing, or grooming); staff cannot physically assist in performing hygiene tasks or enter private spaces (bathrooms, bedrooms during dressing times) to provide direct hands-on care.

Individuals are expected to maintain their own daily hygiene including bathing, oral care, dressing and grooming, keep their personal living space clean and sanitary, communicate with staff if they need additional coaching or support strategies, and participate in life skills groups focused on health and self-care. These are all pre-requisite skills for independent living and may assist with opening up residential opportunities and supporting successful community living.

When an individual struggles with self-care, the ESD clinical team should discuss how to best support the person, and may include:

- Provide visual reminders/schedules/checklists for hygiene routines,
- Set up reminder systems (alarms, whiteboards, daily planners),
- Offer step by step verbal guidance outside the bathroom or bedroom,
- Conduct skills training groups on hygiene, laundry, room care, and other ADLs and IADLs
- Adjust the individual’s behavior support plan, and
- Involve family/guardians and other supports, when appropriate, for reinforcement of self-care skills.

In rare situations where an individual's hygiene presents a serious health or safety risk (e.g. lice infestation, infection concerns), the ESD team member will:

1. Document concerns and collaborate with other members of the clinical team.
2. Engage the individual in problem-solving and treatment planning.
3. Involve medical professionals if needed

6. ESD Documentation Requirements

6.1 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 staff who provided the contact.

The case record will be available to all ESD staff and include the following information:

i. Individual demographic information;
ii. Individual's collaterals' information;
iii. Admission information including source of referral, date of admission, rationale for admission, the date service commenced, presenting problem and initial service needs of the individual for ESD CTI services, and where applicable TRS services;
iv. Intake and Immediate Needs Assessment;
v. Diagnoses;
vi. Medication list and doctor orders, as applicable;
vii. Consent forms;
viii. Documentation that, upon admission, the individual has a verified receipt of their rights;
ix. Documentation the individual was educated in self-preservation procedures, regarding emergency evacuation and fire safety procedures upon admission and at least monthly thereafter (TRS individuals only);
x. Any documentation supporting behavioral health, intellectual and/or developmental disabilities and physical health care (e.g., hospital discharge summary, reports of mental and physical diagnostic exams, IQ testing, evaluations, assessments, tests, or consultations), as applicable;
xi. Case Service Notes;
xii. Phase Plans;
xiii. Behavior Support Plans, as applicable;
xiv. Safety Plans, as applicable;
xv. Psychiatric Advanced Directives, Health Proxy, Medical Orders for Life Sustaining Treatment, as applicable
xvi. Documentation of medication management services, in-house counseling or psychotherapy (unless and until the individual is connected to outside treatment services), individual and group-based skill building, house meetings, and recreational activities (TRS individuals only);
xvii. Communication and Services Logs (TRS individuals only);

xviii. Significant incidents involving the individual; and
xix. Discharge Plan Summary.

6.2 Phase Plan

The individual plays a central and active role in the development and execution of their Phase Plan and should have input on and agree upon any objectives, goals, and/or referrals outlined in their plan. This shared decision-making process is an essential aspect of the ESD program. ESD staff will employ a person-centered planning approach to identify the individual's strengths, preferences, barriers and needs, exploration of protective and risk factors, past successes, and to develop the initial Phase Plan.

For individuals enrolled in an OPWDD Care Coordination Organization (CCO) or Department of Health (DOH) Health Home (HH), the CCO Care Coordinator or HH Care Manager must be invited to participate in the TRS assessment and planning process. For individuals enrolled in a CCO, the ESD staff developing the Phase Plan must collaborate closely with the care manager to ensure alignment with the individual's care management services and care plan.

The Phase Plan is completed within 30 calendar days of transition/discharge date from the hospital or transitional setting during Phase 1.

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

Phase Plans should be streamlined, addressing no more than 1-3 essential goals over the course of the ESD program intervention. These goals are determined to be the most critical by the individual 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 behavioral health treatment and medication management,
- navigating service eligibility,
- referrals and linkage to housing,
- daily living skills,
- money management and benefits,
- 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 resource linkages or skill-building objectives to support goal acquisition;

5. Summary of work completed during the previous phase, including progress and outcomes, lack of progress and rationale, 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; and
7. Name, title, and dated signature of the staff developing the Phase Plan.

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 is not actively engaged to participate in the review, the ESD team may continue to conduct the review and update the Phase Plan, while simultaneously continuing to engage the individual in identifying their successes, needs, preferences, and progress. If no changes are needed, that should be indicated in the Phase Pln.

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.

The Phase Plan - and addendums for Behavior Support planning and Safety Support planning (see Sections 6.3 and 6.4) – is a living document that is updated as goals are achieved, new goals created and as the individual moves through the phases.

6.3 Behavior Support Plans

The Behavior Intervention Specialist (BIS) will be responsible for the development of a person-centered and individualized behavior support plan for individuals in the ESD program, when needed and at any point throughout the individual receiving services in the ESD program. The Behavior Support Plan will be an addendum to the individual's Phase Plan, and prioritizes positive reinforcement, skill building, and adaptive behaviors. Plans will actively reinforce and teach the individual alternative skills and adaptive (replacement) behaviors that will enhance or increase the individual's autonomy, personal satisfaction, degree of independence, and sense of success.

The behavior support plan will be developed in conjunction with the individual and their supports and will be updated as changes occur. The BIS will coordinate with hospital staff on existing behavior support plans while the individual is in Pre-CTI, within the individual's new community setting upon the individual's discharge from the hospital and in the TRS if applicable.

6.4 Safety Support Plans

A Safety Support Plan is a written list of strategies and resources an individual can turn to when feeling overwhelmed, hopeless, or at risk of harming themselves or others. It is a mental health emergency plan and a roadmap created by the individual when in a calm state to guide themselves when things feel unmanageable.

ESD programs will develop Safety Support Plans as an addendum to their Phase Plans, when warranted, with individuals served. Safety Support Plans will include, but not limited to, a self-identified list of:

- warning signs that a crisis may be developing;
- internal coping strategies, people and settings that provide distractions;
- people with whom they can ask for help (including specific method to reach those supports);
- professionals or agencies they can contact during a crisis;
- methods to make the environment safe for themselves in a crisis event; and

- identify at least one important thing that is most important to them and worth living for.

6.5 Service Notes

All staff are responsible for ensuring documentation of service contacts, collateral contacts, and attempted contacts. These are documented in the individual's chart and daily communication log. All service notes must include:

1. CTI Phase,
2. Modality of contact: the mode of contact or attempted contact with the individual and/or their collateral(s). Modalities include In-Person meeting or visit, audio-visual telehealth, or phone Call (Audio-Only Telehealth). Specify location of contact such as office-based meeting or community-based meeting. Mode for sharing or exchanging information such as text message, email, and letter or other correspondence, should also be noted.
3. Name of individual(s)/collateral(s) involved in contact, if applicable,
4. Date,
5. Length of contact,
6. Brief identification of the individual activities and staff interventions related to the Phase Plan,
7. Any identified next steps, and
8. Date and signature of staff providing contact.

At times, ESD 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 providing 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.

7. Discharge Planning for ESD

The process of planning for successful discharge includes identifying the resources and supports needed for the transition of an individual to other programs, making the necessary referrals and ensuring engagement. Discharge planning should be done collaboratively with the individual, ESD staff and other supports involved with the individual's recovery, and should align with the goals, needs, and desires of the individual.

7.1 Discharge Planning from TRS

For individuals in the TRS, discharge planning begins at the time of admission. The discharge planning process shall continue throughout a resident's stay. The discharge planning process shall include, at a minimum, the following activities throughout the process:

1. involvement of the resident, program staff, other community service providers including ESD staff, and collaterals as appropriate and agreed to by the resident;
2. clinical assessment of the resident's psychiatric status as well as assessment of the resident's rehabilitation, physical, social, and residential needs and goals, which is conducted by clinical staff who are qualified by credentials, training and experience to conduct such assessments;
3. provision to the resident of options for appropriate residential environments and other necessary services;
4. completion of referrals to appropriate community service and residential providers; and
5. arrangements for appointments, where the resident so agrees, with community service and residential providers.

A resident who is discharge-ready can be discharged. Discharge readiness requires that:

1. discharge planning activities have been fully followed;
2. appropriate alternative housing has been identified; and
3. the resident is willing to relocate to such housing.

For individuals in the TRS whose needs have been determined by clinical staff as no longer able to be safely maintained within the ESD TRS program, the decision to discharge from the TRS should only be considered after ongoing and various documented attempts at intervention by the ESD staff and community resources (e.g., behavior support plans, individual skill building, group skills training groups, etc.) have been exhausted.

7.2. Discharge Planning for ESD CTI

The ESD CTI Case Manager will begin the preparation and discussion of discharge as part of CTI Phase 3. By this time, the ESD CTI Case Manager has reduced frequency of contact, initiated discussions of longer-term goals with the individual, and in conversations with the individual identifying they are managing their supports independently, and the attained goal areas. The individual should actively be engaging with their providers and sources of supports.

The ESD CTI Case Manager discusses discharge readiness and planning with the CTI Team Leader and seeks approval from the CTI Team Leader and ESD team to move forward with the discussion and process.

The ESD CTI Case Manager meets with the individual using shared decision making to agree upon the individual’s overall discharge plan. If the individual expresses a lack of readiness for discharge or if goals reflect a lack of discharge readiness, the CTI Case Manager and the individual will identify next steps and document discussion. To aid this, the Case Manager shall discuss with the CTI Team Leader and hold a case conference (to include the individual, the ESD team, and the individual’s supports) to identify remaining discharge steps.

Reasons for Discharge from the ESD CTI may include:

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 meet their needs (like ACT, HH+, other Residential Housing, 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. Relocation.
8. Death.

Final Transfer of Support Meeting

A final transfer of support meeting is scheduled and held during the last month of Phase 3, typically within two (2) weeks of the planned discharge date. This meeting will include the individual served, the assigned CTI Case Manager, representative(s) of the ESD clinical team, current and new housing and clinical providers (as applicable), and any natural supports (family, advocates, friends, or anyone else the person has identified as part of their support system) wishing to be part of their care).These meetings may occur in-person or through telehealth dependent on the best fit for the individual.

During the final transfer meeting, the ESD team reviews the individual's progress and finalizes the discharge plan from ESD CTI. The meeting should review the individual's goals, areas for continued progress (e.g., continuity of established services and/or housing, recommended efforts to access services not yet established, and sharing of specific interventions and treatment strategies that have been identified while in the transitional residence), and review of all upcoming appointments scheduled and resources to ensure a successful discharge, including planned transportation as appropriate. ESD staff will use a warm hand-off approach to transfer services according to the individual's preference.

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.

The Discharge Plan Summary must include the following information, when applicable:

- Contact information for the individual's outpatient 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), CCO;
- Contact information for the individual's residential setting, as applicable;
- 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; and
- The individual's crisis plan, if applicable.

The finalized discharge plan summary should be shared with the receiving housing and case management providers, as applicable.

Wrap-up Meeting

This is the last meeting with the individual during the final month of Phase 3. This meeting is to allow for the ESD CTI staff and the individual to reflect on the achievements and progress of the individual over the course of the intervention. The ESD CTI staff reviews the resources and supports and encourages the individual to continue utilization of available resources. The ESD CTI staff provides the individual with the *Discharge Plan Summary* to ensure they have all information available to them.

The ESD program should be available for consultation and support to the individual and their support system for up to three (3) months following discharge.

8. Program Organization

8.1 Diversity, Equity, Inclusion

ESD programs must ensure efforts are made to eliminate disparities in access, quality of care, and treatment outcomes for underserved, unserved, and marginalized populations. Efforts may include outreach and education about services and access, linkages to advocacy organizations, and policy development.

Underserved, marginalized, and unserved populations may include but are not limited to people of color, members of the LGBTQ+ community, older adults, Veterans, individuals who are deaf and hard of hearing, individuals who are visually impaired, individuals with limited English proficiency (LEP), immigrants, and individuals re-entering communities from incarceration.

To continue eliminating disparities, achieve health equity, and improve treatment outcomes for marginalized, underserved and unserved populations, the agency will:

- *Document training strategies* 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. Cultural training should be regularly re-evaluated and updated based on additional needs that arise in the community.
- *Ensure Language Access*: ESD programs must ensure the provision of language assistance services to recipients with limited English proficiency (LEP) and/or other communication needs (e.g., deaf or hard of hearing) at no cost to the individual to facilitate timely access to all health care and services. Inform individuals of their right to receive language assistance services in their preferred language, verbally and in writing. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area, with a focus on the varied reading levels among the service user population. ESD programs will make all necessary documents available in the individual's preferred language (i.e., releases, documents pertaining to rights). Make efforts to provide the individuals identified as collaterals with language assistance services in their preferred language, verbally and in writing. All staff will be trained in the ESD program's process of connecting individuals served with language access services. ESD programs will ensure staff, including but not limited to managerial staff, are available to assist all staff with language access services. Ensure the competence of individuals providing language assistance, recognizing that

the use of untrained individuals and/or minors as interpreters will be avoided. Language access services must be made available in such a way that assessment, intervention, and/or treatment services will not be delayed. For more information about Limited English proficiency please see https://www.justice.gov/crt/limited-english-proficiency.

8.2 Programmatic Policy and Procedures

ESD teams should work with their agencies and partner hospital(s) to develop, periodically review, and revise (when appropriate) administrative and programmatic policy and procedures.

The Provider shall maintain policies and procedures regarding:

i. Written criteria for eligibility, admission and discharge from the program.
ii. Policies should include a mechanism for screening individuals for eligibility for the ESD program at the time of referral and assuring that those referred are admitted timely.
    a. Timely response to referrals and access to the ESD program, for both the ESD CTI and TRS components.
    b. Referral workflow and communication plan established is clear and key stakeholders are 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 ESD team.
iii. Procedures to share pertinent individual information (e.g., significant events, behaviors, interventions, etc.) to ensure that the appropriate ESD team members are informed of an individual's current status.
iv. Assertive engagement practices addressing disparities in access and individual engagement and retention that include, at minimum, plans for outreach and re-engagement efforts commensurate with an individual's assessed risk.
v. 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.
vi. Medication support services.
vii. Personal Hygiene and daily tasks support services.
viii. Behavior Support Plans.
ix. Implementation of crisis support and de-escalation techniques with prioritization of positive reinforcement, skill building, and adaptive behaviors to be used instead of restraint and seclusion.
x. Transportation of individuals receiving services by agency staff.
xi. Discharge policy that addresses both planned and unplanned discharge scenarios.
xii. Provision of supervision for all staff.
xiii. Staff training and workforce development.
    a. Training staff in specialty areas such as mental health diagnoses, intellectual and developmental disabilities, housing, local community resources, language access services, integrated care, health and wellness, safety and educational/vocational supports.
    b. Maintaining records on staff trainings completed.
xiv. Incident management, reporting, and review.

xv. Quality Management including data collection, analysis, how it will be used for quality improvement, including the process to ensure fidelity to the model.
xvi. Secure record retention specific to the provision of services.
xvii. Confidentiality and disclosure of protected health information in accordance with state and federal laws.
xviii. 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.
xix. Workforce recruitment and retention, including maintaining ESD staffing requirements, addressing how teams will manage if staffing vacancies exist, 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.

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

i. Resumé or application that demonstrates the 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 represents and warrants that all staff - including contracted and per-diem staff - providing CTI or TRS services have undergone appropriate criminal background checks, in accordance with NYS law and regulations and are not - to the best of the provider's knowledge - excluded from participation in federal healthcare programs.

8.3 Use of Technology and Documentation

It is expected that ESD programs 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.

ESD programs must have a plan on how they use digital technology to support engagement of individuals in care. Technology support includes tools and resources for identifying potential individuals to serve, communicating, and responding to referral sources, communicating with individuals in care and key support persons, care planning, and transition planning. ESD programs should use digital tools available to staff as well as those available to individuals served.

ESD programs must have access to and use data from Regional Health Information Organization (RHIOS)/Qualified Entities (QEs), PSYCKES, and other data systems to leverage clinical and service utilization information available to support coordination of care and quality service provision.

8.4 Outcomes

The expected outcomes for the ESD program are specific to the goals identified in the individual's Phase Plan, and may include, but are not necessarily limited to, the following:

- The individual will engage in a stable housing plan or home.
- The individual will engage or 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.

8.5 Reporting Requirements

ESD programs will be required to submit regular reports to NYS OMH regarding all individuals referred to the ESD program, receiving ESD CTI services and served in the TRS, including but not limited to: characteristics of individuals served, diagnoses, previously existing services (e.g. OPWDD eligibility, CCO enrollment, etc.), referrals received (including reason for denial of referral if applicable), referral source, services provided, phase information, TRS Length of stay (as applicable), transition between phases of ESD CTI, community networking efforts, referrals made to community services and resources and follow-up, discharge dates, discharge plan, and disposition.

ESD programs will also report data to be used as performance indicators for assuring continuity of care; including linkage to stable housing, reduced reliance on psychiatric inpatient and emergency department services, and jail/prison time decreased.

NYS OMH will provide ESD programs with a template and instructions for all data reporting required.

8.6 Quality Management

The Agency will develop a process to systematically monitor, analyze, and improve the performance of the ESD Program and ensure continuous quality improvement. The plan will include:

i. A quality supervisory and operational infrastructure that assures adherence to this guidance and fidelity to the CTI model;
ii. Verification of service provision, timeliness and quality that supports goal attainment;
iii. Identification of service provision which needs improvement;
iv. Collection of data relevant to expected program outcomes;
v. Monitoring data via outcome reporting platforms shared by NYS OMH;
vi. 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;
vii. Corrective action/process improvement plans specific to the results of the analysis.

ESD programs should ensure continuous quality improvement of services and development of the program including regular monitoring and evaluation of outcomes.

9. Definitions

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 Agency's offices.

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.

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

Licensed Mental Health Professional: Creative Arts Therapist, Marriage and Family Therapist, Mental Health Counselor, Psychoanalyst, Psychologist, Licensed Master Social Worker, and Licensed Clinical Social Worker.

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.

Shared Decision Making: Assists Individuals 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.

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.

Addendum 1: Staff Training & Competencies

ESD providers are to ensure all ESD staff possess key knowledge, skills and competencies required for provision of quality services and improved outcomes for individuals served in the ESD program. ESD provider training and resources should be commensurate with population(s) served, acuity, and guided by research and outcome informed practices. ESD teams shall continually evaluate and confirm staff qualifications and competencies, including monitoring of licensure, knowledge and skills to appropriately deliver interventions within scope. Staff qualifications, including specialized training and/or certifications, must be documented and maintained by the agency, in accordance with applicable laws and regulations.

Recommended trainings include:

- Agency and ESD Program's Policy and Procedures
- CTI model (see Addendum 2)
- Trauma-Informed Care
- Person-Centered Care
- Cultural Competence
- Psychiatric Disorders
- Intellectual and Developmental Disorders
- Dual diagnosis and co-morbidity
- Complex Service System Needs
- Sexual Development and Sexuality
- Social Determinants of Health
- Crisis Management
- CPR/First Aid/Choking
- Narcan administration
- Mandated Reporter
- Positive Behavioral Support and De-escalation
- Rehabilitation Services
- Habilitation Services
- Dignity of Risk
- Positive Psychology
- Crisis Resolution and Debriefing
- Suicide Prevention
- Crisis Safety Plan Development
- Professional Boundaries
- Working on Interdisciplinary Teams

Programs should consider the frequency of refresher training for maintaining skills, and updated training needed to remain current with best practice standards. Providers may require additional training to support ESD staff with specific individual clinical presentations, services and interventions.

Training resources readily available for staff can be accessed at:

- OMH Funded Training for Providers
- Training | Office for People With Developmental Disabilities,

- Center for Practice Innovations,
- Continuing Medical Education Statewide Satellite Grand Rounds,
- McSilverTA,
- New York Alliance for Inclusion & Innovation - Home Page,
- Resources - The Summit Center, and
- Using PSYCKES-Recorded Webinars

Specific staff and supervisor training requirements and recommendations are subject to change as new resources are developed. Any changes will be updated in this guidance and shared with the ESD programs.

Addendum 2: CTI Model Training Resources

The trainings listed below are part of the Center for Practice Innovations (CPI) CTI learning community series. They are not necessarily intended for individuals with co-occurring intellectual and developmental and behavioral health conditions; however, they do provide a foundation for providing services under the CTI Model. This includes:

- 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