NEW YORK STATE | Office of Mental Health

Rehabilitative and Tenancy Support Services (RTS)

Objectives

- Provide background
- Discuss RTS service definitions and examples
- Review best practices and tips for documentation
- Demonstrate how to report service delivery and LPHA recommendations in the CAIRS system
- Answer any questions you may have

NY State Plan Amendment (SPA) #20-0005

NEW YORK STATE | Office of Mental Health

SPA #20-0005

- Approved for adoption November 1, 2020
- Added Housing Support Services under the Rehabilitative Services benefit
- Permits the State to pursue Medicaid reimbursement for Rehabilitative and Tenancy Support Services (RTS)

Benefit

- Eligible providers that participate receive enhanced OMH State Aid contract funding
- Implementation began January 2023
- Eligible housing types – supportive housing, SP-SRO, CR-SRO. ESSHI units are not eligible currently.

Requirements

- LPHA Recommendation for Services
- Monthly reporting in the Child and Adult Integrated Reporting System (CAIRS)
- Maintain service documentation on site

Additional guidance documents can be found on the OMH website

- Frequently Asked Questions (FAQ)
- Supportive Housing Guidelines (Issued September 30, 2022)
- State Plan Amendment (SPA) 20-05 *Rehabilitative Housing Tenancy Supports*

Rehabilitative and Tenancy Support Services

NEW YORK STATE | Office of Mental Health

Community Integration Skill-Building Services

Support for individuals who are transitioning into housing and integrating into their communities

1. Needs assessment
2. Community resource coordination
3. Treatment planning
4. Rehabilitative independent living skills training

Stabilization Services

Services to support individuals already living in the community remain stably housed

1. Tenancy support planning
2. Rehabilitative independent living skills training
3. Community resource coordination
4. Crisis planning
5. Crisis intervention

Needs Assessment

Individualized assessment to identify strengths, preferences, and barriers to maintaining housing stability and integration.

- Informs Individualized Service Plan
- Occurs at admission

Treatment Planning

Individualized support planning

- Identifies providers outside of the housing program
- Occurs with newly enrolled residents

Rehabilitative Independent Living Skills Training

Coaching and skill-building services to support the resident to establish or maintain housing stability

- For newly enrolled and established residents
- Ex. Understanding rights and responsibilities as a tenant; developing a budget; learning how to access transportation, etc.

Community Resource Coordination

Assistance to individuals with establishing a household, becoming oriented to the local community, and linking to services

- Includes advocacy and linkage with resources when community tenure is threatened
- For newly enrolled and established residents
- Ex. Benefits advocacy; connecting with primary care

Tenancy Support Planning

Individualized support planning with individuals to review, update, and modify the existing support plan

- Ongoing service with residents once they have become established
- Ex. Support plan reviews

Crisis Planning

Support planning for individuals well before a crisis, or after a crisis has occurred.

Help individuals and collaterals effectively recognize, manage, plan for, and prevent the escalation of symptoms or other factors so housing stability isn't jeopardized

Ex. Safety planning; linkage to primary care; crisis debrief

Crisis Intervention

Urgent and temporary support to individuals who are experiencing, or are at imminent risk of experiencing, a crisis.

These services aim to interrupt and/or reduce acute distress and associated behaviors that threaten housing stability

- Ex. Using de-escalation strategies; connecting with crisis resources (respite, ICSC, 9-8-8), etc.

Documentation

Important Factors

- What are important things to keep in mind about documentation?
  - Timeliness
  - Accuracy
  - Comprehensiveness

Helpful Information to Include in Charts

- Demographic information- age, gender, race, finances, insurance, social security number or non-citizens ID, religion, address, phone number, etc.
- All notes- progress, admission, discharge, etc.
- Intake and discharge plan
- Diagnoses and support plans
- Referrals
- Care network and contact information- providers, family, friends, emergency contacts, etc.
- Current Consents to release information

Best Practices - Progress Notes

- Date, type, mode, and place of contact.
- Duration of contact.
- Describe the services delivered if applicable.
- Resident’s response and progress pertaining to the Support Plan.
- Staff observations.
- Referrals and follow-up.
- Name, title, and signature of staff that provided the service(s).

Tips for Writing Good Notes

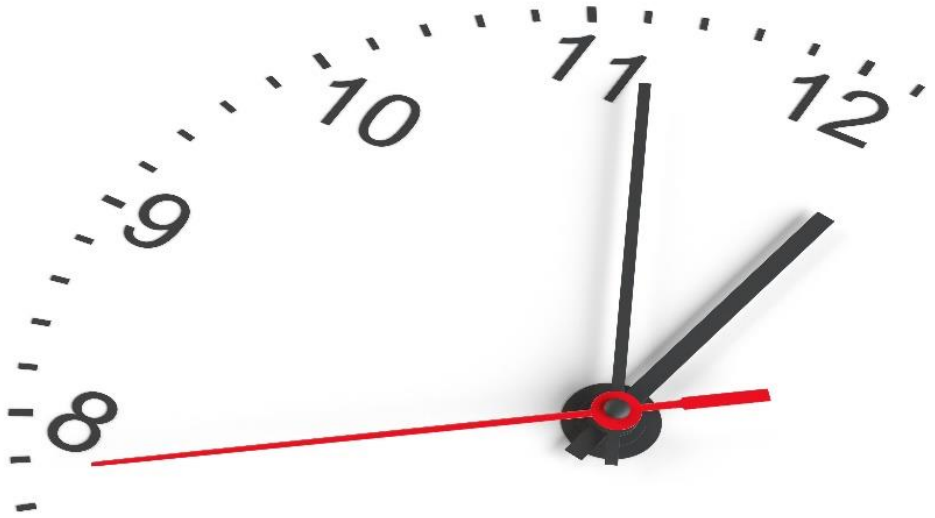
- Be detailed. Not every detail needs to be included, but it needs to be detailed enough someone else could read it and understand what happened.

- Include important information.
  - Safety/ health concerns, unaddressed needs, successes, challenges, etc.

- If something needs to be done, conclude with an action statement.
  - “The writer will call Dr. Anderson to follow up with the insulin referral.”

- Use objective language.
  - Don’t use “I,” “Me,” or “My.” Use language such as, “The writer observed…”
  - Using quotes from the staff or individual is okay as well.

Take a minute. Think about the 20th of last month. What did you wear? What did you eat? Who did you talk to? Did anything important happen?



Why Follow Best Practice Documentation Standards?

- Memory isn't that reliable. If you rely on memory, how can you be sure details are correct?
  - With good notes you don't need a good memory.

- Continuity of Care.
  - When information is relayed by word of mouth, it can be inaccurate or lost. What if the staff that knows the important information leaves the agency (planned or unplanned)? Now no one has the information. This can be detrimental to current staff and the individual's care.

- Audits.
  - Doing periodic spot audits aren't a bad idea. Don't wait until crunch time to ensure charts are accurate.

If You Didn’t Document It, It Didn’t Happen.

- Even if an attempt was unsuccessful, document it anyway. Document all attempts to assist individuals with reaching their goals.

- For example, if you attempted to engage an individual with an unplanned home visit and there was no answer at the door, document it. If you called the individual to discuss helping them schedule a doctor’s appointment and they didn’t answer, document it.

Incomplete Vs Detailed Notes: Example-Jane

Jane didn't want to take her medications and is non-compliant with her treatment plan.

- This note is not detailed enough. It appears Jane didn't take her medications, but the conversation ends there. Staff didn't ask why. Stigmatizing language was also used. The word "non-compliant" is not person-centered and is judgmental. This can be detrimental to an individual's care.

Jane didn't want to take her medications because they make her feel groggy. Staff and Jane called her mental health provider to discuss negative symptoms. An appointment with her doctor was set for 8/1/24 at 3pm to discuss further and review other options. Jane will take public transportation to this appointment and asked staff to help set a reminder in her phone. Staff walked through the steps of setting reminders and showed Jane how to enter this appointment in her calendar.

- This note is better because it has more details and does not use stigmatizing language. If another staff member were to work with Jane, they would know why she does not want to take these medications and there is an upcoming appointment to discuss a different treatment.

CAIRS

Documenting in CAIRS

- Completion of the LPHA recommendation
- Service level data
  - Report both RTS **and** non-billable services provided- up to 4 service per month per individual
  - Submitted within 30 days after the end of the service month

Tenancy Services- Documentation

- *Note- the only programs that are eligible for offering tenancy services are SP-SRO, CR-SRO, and scattered site supportive housing.
    - This excludes ESSHI.
- No physical documents are uploaded into CAIRS but agencies keep their own records for audit purposes.

Tenancy Services- Data Entry

- Click on Tenancy Services.
- Select program -> program type -> proceed -> yes.
- Select client -> Client Service Tab.
- Add LPHA information (name, NPI#, date of recommendation and expiration).
- Services are entered through a dropdown menu.
    - Enter all services (up to 4 per month) with dates and Y/N for billable or not billable.

Program Selection

Agency name: ACMH, Inc.
Facility name: ACMH, Inc.
Program unit: ACMH Bronx Supported Housing-Comm.Svcs
Program type: Supported Housing Community Services

Program Type Selection (Choose the program type you wish to work with)

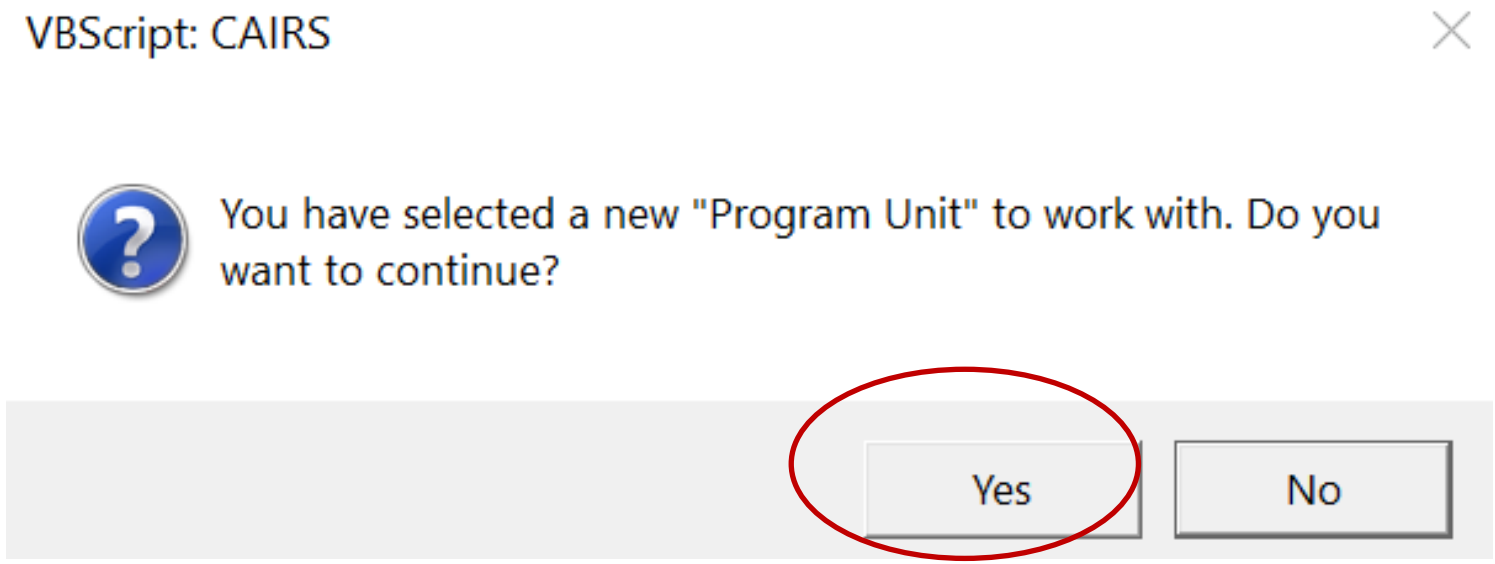
- ○ SRO Community Residence
- ○ Supported/Single Room Occupancy (SRO)
- ◉ Supported Housing Community Services

Program Unit Selection (Choose the program unit you wish to work with)

	Agency	Facility	Unit
◉	18780 - ACMH, Inc.	7062 - ACMH, Inc.	640 - ACMH - SH/PC Long Stay Creedmoor PC Queens - Comm. Svcs
○	18780 - ACMH, Inc.	7062 - ACMH, Inc.	637 - ACMH - SH/PC Long Stay Manhattan PC New York - Comm. Svcs
○	18780 - ACMH, Inc.	7062 - ACMH, Inc.	633 - ACMH - SH/PC Long Stay New York - Comm. Svcs
○	18780 - ACMH, Inc.	7062 - ACMH, Inc.	632 - ACMH - SH/PC Long Stay Queens - Comm. Svcs
○	18780 - ACMH, Inc.	7062 - ACMH, Inc.	638 - ACMH - Supported Apartments 638 New York - Comm. Svcs

Help

Proceed


VBScript: CAIRS
You have selected a new "Program Unit" to work with. Do you want to continue?
Yes
No

CAIRS Supported Housing Tenancy Services Data Entry

Agency name: ACM H, Inc.
Facility name: ACM H, Inc.
Program unit: ACM H - SH/PC Long Stay Creedmoor PC Queen
Program type: Supported Housing Community Services

Roster as of Date: 08/16/2024 ...

Select Recipient to Add Tenancy Service:

First Name: Yo
Last Name: Testttt
Tenancy Service Date: ...
Tenancy Service:
Billable:

Client Service Tab | Search for Recipient | Save Service | Exit | Clear

Client(s) Found: 7

Recipient Name	Recipient CIN	Admission Date	Discharge Date	Tenancy Service Claimed	Date of Service	Billable
Jack Bauer	JB09876A	03/01/2022		Community Integration Needs Assessment	11/14/2023	Y
Jack Black		08/21/2019		Tenancy Support Planning	12/05/2022	Y
Jack Black	BB22222A	01/01/2022		Job Training Service	11/05/2023	N
Richard Gallo	AB33433X	09/01/2021		Crisis Intervention	01/03/2023	Y
Dan House		09/14/2021		Tenancy Support Planning	09/15/2021	Y
Edward Smith	AB11960D	08/04/2015		Habilitation Service	10/02/2021	N
Yo Testttt		05/03/2016		Community Resources Coordination	11/01/2021	Y

Admission Date 5/3/2016 | Discharge Date | CIN

LPHA Recommendation Date ... | Recommendation Expiration Date

Recommending LPHA: First Name | Last Name | NPI

Tenancy Service	Billable	Service Date	Delete
Community Resources Coordination	Y	11/1/2021 ...	✕

+ Add

Exit | Save

Back to Top

Date ... Date

Recommending LPHA: First Name | Last Name | NPI

Tenancy Service	Billable	Service Date	Delete
Community Resources Coordination	Y	11/1/2021 ...	
		...	

- Community Integration Needs Assessment
- Community Resources Coordination
- Crisis Intervention
- Crisis Planning
- Educational Service
- Habilitation Service
- Job Training Service
- Other Non-billable Service
- Recreational Activity
- Rehabilitative Independent Living Skills Training
- Social Activity
- Tenancy Support Planning
- Treatment Planning
- Vocational Service

+ Add

QUESTIONS?

For questions about RTS:

OMH.SH@omh.ny.gov

General Questions:

Rana Meehan, Email: Rana.Meehan@omh.ny.gov

CAIRS Support:

Stephanie Smith, Email: Stephanie.Smith@omh.ny.gov