New York State Community Oriented Recovery and Empowerment Services

An 1115 Waiver Demonstration of Adult Rehabilitation Services Operations Manual for Designated Providers

Issued October 2021

NEW YORK STATE | Office of Mental Health | Office of Addiction Services and Supports

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Section 1 : Program Overview

Introduction & Background

Community Oriented Recovery and Empowerment (CORE) Services are person-centered, recovery-oriented, mobile behavioral health supports intended to build skills and self-efficacy that promote and facilitate community participation and independence.

CORE Services are authorized under the 1115 Demonstration Waiver and replace Adult Behavioral Health Home and Community Based Services (BH HCBS) as a benefit for Health and Recovery Plan (HARP) enrollees and HARP-eligible HIV/Special Needs Plan (SNP) enrollees. Transitioning four Adult BH HCBS to CORE Services will improve access to services and use the expertise of clinicians and rehabilitation practitioners to support the eligibility and intake process.

State Administrative Structure

Community Oriented Recovery and Empowerment (CORE) Services are jointly overseen and monitored by the NYS Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS). Providers are designated by both State agencies and are assigned to OMH or OASAS as a host-agency for the purposes of ongoing oversight and monitoring

Target Population

(CORE) Services Demonstration includes HARP enrollees and HARP-eligible HIV/SNP enrollees who would benefit from CORE Services in the pursuit of valued recovery goals.

Menu of Services

CORE consists of four services:
- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation (PSR)
- Family Support and Training (FST)
- Empowerment Services – Peer Support

Statement of Key Principles

HARPs were developed to promote significant improvements in the Behavioral Health System as we move into a recovery-based Managed Care delivery model. A recovery model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, educational, employment, housing, and health and well-being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self-direction, social inclusion, and coping skills.

CORE Services will provide opportunities for eligible adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. CORE designated

providers will work together with managed care plans, service providers, plan members, families, and government partners to help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders. This partnership will be based on the following key principles:

Person-Centered Care: Services should reflect an individual's goals and emphasize shared decision-making approaches that empower individuals, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the person's overall well-being and full community participation.

Recovery-Oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, employment, and social skills and be offered in community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

Integrated: Services should address both physical and behavioral health needs of individuals. Whenever possible, the Individual Service Plan should address social determinants of health (SDOH).[1]

Data-Driven: Providers should use data to define outcomes, monitor performance, and promote health and well-being. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

Evidence-Based: Services should utilize evidence-based practices where appropriate and provide or enable continuing education and ongoing support activities to promote uptake of these practices.

Trauma-Informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives. (SAMHSA, 2014)

Peer-Supported: Peers will play an integral role in the delivery of services and the promotion of recovery principles.

Culturally Competent: Serving individuals in a manner that is respectful and responsive to the unique cultural attributes of the people being served. Spiritual beliefs, art/music, fashion and culinary interests should all be leveraged to support recovery. Additionally, special attention should be given to being responsive to the social, economic, and system-level factors that might be promoting or impeding the individual's recovery goals.

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[1] The Centers for Disease Control and Prevention (CDC) defines social determinants of health (SDOH) as "the conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life-risks and outcomes" (2020). These include healthcare access and quality; education access and quality; social and community context; economic stability; and, neighborhood and built environment.

Flexible and Mobile: Services should adapt to the specific and changing needs of each individual, using off-site community service delivery approaches along with therapeutic methods and recovery approaches which best suit each individual's needs. CORE Services, may be provided in homes or off-site, including appropriate community settings such as where an individual works, attends school or socializes.

Inclusive of Social Network: The individual, and when appropriate, family members and other key members of the individual's social network are always invited to initial meetings, or any necessary meetings thereafter to mobilize support.

Coordination and Collaboration: These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family and other key natural supports and service providers.

Section 2 : Pathway to Access

"No Wrong Door" Referral Pathway

A central pillar of the CORE Services demonstration is the "No Wrong Door" referral pathway, which enables HARP members to easily access the services with as few barriers to admission as possible. HARP members may learn about CORE Services through any number of sources, including through the Managed Care Organization (MCO), Health Home Care Manager (HHCM), inpatient and outpatient clinicians, primary care practitioners, family and friends, or provider outreach and education efforts. Providers may develop their own referral requirements and intake paperwork or forms. Once a HARP member expresses an interest in receiving the services, they may work with any qualified Licensed Practitioner of the Healing Arts (LPHA) to establish eligibility and obtain a recommendation for services.

Eligibility & Recommendation by a Licensed Practitioner of the Healing Arts

An individual must have met the New York State (NYS) high-needs behavioral health (BH) criteria (commonly referred to as the HARP eligibility algorithm) and be enrolled in an eligible Plan type, HARP or HIV SNP to be eligible for CORE Services. CORE Services require a recommendation of a Licensed Practitioner of the Healing Arts (LPHA).

Individuals meeting the NYS high-needs BH criteria are assigned a Medicaid Recipient Restriction Exception H-code within eMedNY. You can find out someone's H-code status by looking in ePACES or PSYCKES, or by calling their MCO.
- H1 indicates an individual is enrolled in a HARP and has met the BH high-needs criteria.
- H4 indicates an individual is enrolled in a HIV SNP and has met the BH high-needs criteria.
- H9 indicates an individual has met the NYS BH high-needs criteria.[2]

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[2]Individuals falling into this category are eligible to receive CORE Services when enrolled in a HARP or HIV/SNP. Eligible individuals with an H9 wishing to enroll in a HARP or HIV-SNP may contact NY Medicaid Choice at 1-855-789-4277 for enrollment options.

For the purposes of making a recommendation for CORE Services, LPHA qualifications are as follows: Physician; Physician's Assistant; Nurse Practitioner; Registered Professional Nurse; Licensed Psychologist; Licensed Psychoanalyst; Licensed Creative Arts Therapist; Licensed Marriage and Family Therapist; Licensed Mental Health Counselor; Licensed Clinical Social Worker; and, Licensed Master Social Worker under the supervision of a Psychiatrist, Psychologist, or LCSW employed by the agency.

The LPHA's recommendation must be in writing and a copy of it should be maintained in the individual's CORE case record. The LPHA does not need to be employed by the CORE designated provider; however, if the LPHA is not a member of the CORE provider's staff, then the recommendation should also include their National Provider Identifier (NPI).

The LPHA recommendation may be obtained as part of the referral process or during the Intake & Evaluation (I&E) process described below. The LPHA recommendation must be obtained prior to completion of the initial Individual Service Plan.

The State has provided a template for the LPHA recommendation, which includes the recommendation for specific CORE Services and a determination of medical necessity. See the LPHA Memo for more information.

Intake & Evaluation Process

Upon acceptance of a referral, the CORE provider will schedule an Intake & Evaluation (I&E) with the individual, at the individual's convenience.

The intake and evaluation process for CORE is a person-centered process intended to engage the individual in a discussion of:

- the individual's recovery goal(s),
- the individual's strengths and resources,
- the individual's barriers and needs,
- the individual's preferences for service delivery (including days, times, staffing, etc.), and
- how the CORE service will be used to support attainment of their goal.

Individuals will engage in services for many different reasons, and present at various stages of change, with many different expectations, aspirations, and perspectives about their recovery journey. They will have different ideas of what successful services and supports would look like for them, including the steps they believe will get them to their goal. The intent of the intake and evaluation period is to listen carefully to what the individual is saying and to skillfully work with the individual to a mutual understanding of the problem the individual has presented, the outcome that is desired and some initial steps to begin developing the roadmap to those outcomes.

The I&E process is conducted by a member of the staff qualified to provide the service. I&E sessions must be documented in the individual's CORE case record; this documentation may appear in an intake form and/or progress notes. The documentation should include a description of the discussion and a summary of the individual's goal(s), strengths and resources, barriers and needs.

The Intake & Evaluation process results in an initial Individual Service Plan (ISP) (see section 3 below), which should be completed within 30 days of the first session/visit or within 5 sessions, whichever is greater.

For information on billing and claiming during the I&E process, please refer to the Benefit and Billing Guidance.

MCO Notification

The provider is responsible for notifying an individual's MCO within three (3) business days after their first Intake & Evaluation session. This notification is completed using the Provider Service Initiation Notification template, which can be submitted electronically to the individual's MCO. See the Benefit & Billing Guidance for more information on the notification process.

Section 3 : Service Planning and Documentation

Key Terms & Concepts

Recovery Goal: A statement that expresses the individual's desire for positive change and improvement in their lives, ideally captured in their own words. Goals answer the basic question: What do you want? For example:

- I want to feel better and manage my symptoms
- I want to take better care of my health, including my mind
- I want my own place to live
- I want a full-time job
- I want to complete my education

Objective: Something the individual will do or accomplish as a step toward achievement of the goal. Objectives should address identified barriers to the goal and should drive the ISP forward. Objectives should answer the questions: How will you achieve that? What steps will you take? When will you take them? Who will help you?

Scope of Services, or Intervention: The activities and services provided by CORE staff that help the individual achieve objectives and goals.

Person-Centered Planning & the Individual Service Plan (ISP)

Person-centered services start with an ISP that is created using the individual's own language and is consistent with the person's values, culture, beliefs, and goals. Person-centered planning is a collaborative process where the individual participates in the development of the goal and planning for services to the greatest extent possible. It is important to support an individual's personal motivation for seeking services and to ensure the recovery/service planning remains non-judgmental and free from bias. Using a person's own words in identifying what elements of their substance use or mental health

barriers they find problematic, and prioritization of their main goals, helps to align the ISP to the person. In this way, the individual is placed "in the driver's seat" of their recovery.

The person-centered planning process focuses on what the individual is saying and their framing of the problems and potential solutions. The practitioner is active in guiding, reframing, raising discrepancies, offering compassion and hope by taking what the individual is saying and translating that into a plan of action that recognizes the individual as an individual. Person-centered planning is strengths-based. CORE staff are expected to engage the individual in person-centered planning both during the I&E process and throughout service delivery. Focused attention should be given to understanding and addressing the impact of the social determinants of mental health and wellness, including housing, income/finances, and impact of discrimination.

Note that person-centered services include harm reduction[3] options for individuals who wish to continue risky behaviors/ substance use but who also want to:
- reduce the risk of transmission of illness secondary to use,
- avoid overdose,
- test a sample of substance,
- learn ways of living healthier,
- gain support, and
- reduce social isolation.

CORE Service providers must be prepared to engage the individual using harm reduction techniques and/or refer to outside harm reduction programs that provide these services.

Quality Indicators of Person-Centered Planning

The following quality indicators should be used to guide the person-centered planning process:
1. The individual is engaged in a shared decision-making process. The service provider shares knowledge and recommendations with the individual that are necessary for the individual to make meaningful, informed choices.
2. Families (of choice) and significant others are encouraged to engage in planning and services, at the consent of the individual engaged in CORE Services.
3. Service planning meetings are held at times and locations that are convenient for the individual.
4. The individual is supported in sharing their goals, needs, and preferences.
5. Goals are written in the individual's own words, using I-statements.
6. The process reflects cultural humility, respecting the individual's background, beliefs, values, and culture.
7. Written materials are provided in a way that is understandable to the individual.
8. The individual is offered an opportunity to sign their ISP.
9. The individual is offered a copy of their ISP.

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[3]The New York State Department of Health AIDS Institute defines harm reduction as, "an approach and a set of practical strategies targeted to reduce the negative consequences associated with substance use" (Stancliff, 2019).

ISP Administrative Requirements

The following elements are required to be included the ISP:

1. The individual's name;
2. The provider agency's name;
3. The type of service;
4. The primary service delivery location based on individual preference;
5. The effective date of services;
6. Service frequency;
7. Service duration;
8. The individual's recovery goal(s);
9. Specific and measurable objective(s) related to the goal;
10. The individual's strengths, talents, resources, and abilities, as related to attainment of the goal;
11. The individual's behavioral health barriers and needs, as related to attainment of the goal;
12. The scope of services (interventions/methods and modality) provided by CORE staff;
13. Documentation that the individual was involved in the development of the ISP (for example, a progress note describing their participation, the individual's dated signature, or documentation of a refusal to sign);
14. The name, title, and credentials/qualifications of the staff developing the ISP; and,
15. The dated signature of the staff who developed the ISP.

ISP Reviews

The ISP is reviewed with the individual whenever there is a significant change in their life which necessitates a change to the frequency, duration, or scope of services, or the goal. Examples of a significant change include but are not limited to:

- attainment of goal(s) and objective(s),
- adding or changing goals based on the individual's request,
- a move to a new home or residential setting,
- a change in employment status or educational attainment,
- a change in relationship status or household composition,
- a recent hospitalization, or
- no progress toward goal, etc.

The individual's goal and the effectiveness of the interventions provided should be regularly considered and discussed to ensure a collaborative, person-centered planning process driven by the individual. If no significant change has triggered a review within a six-month period, the ISP must be reviewed (based on the previous review date).[4]

The ISP review is facilitated using a person-centered planning approach by a member of the CORE staff who is qualified to deliver the service. A summary of the ISP review must be documented in a progress note or case note; the review summary is documented whether or not the ISP requires up-

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[4]The ISP review must occur within 6 months the previous review, or by the end of the calendar month in which the 6th month occurs. For example, if an ISP is developed on September 15, 2021 and there are no significant life events triggering a review prior to the 6-month mark, then a semi-annual review must be completed by March 31, 2022.

dates or revisions. This summary must include the date of the review, the names of the individuals present, a summary of progress made, a description of the individual's involvement in the review process, and a notation of any changes made to the ISP. If no changes are made to the ISP, the summary should include the reason that no changes were necessary.

Documentation of Service Encounters ("Progress Notes")

Documentation of each billable visit or session is required. This documentation may be completed using a person-driven concurrent or collaborative documentation approach, or it may be completed after the fact. Documentation of service encounters will reflect interventions relevant to the ISP and should include the following required elements:

1. Name of individual receiving services,
2. Type of service provided,
3. Date of service provided,
4. Location of service,
5. Modality (In-Person, Telehealth/Telepractice, Collateral Contact),
6. Duration of service, including start and end times,
7. Description of interventions to meet Recovery Plan goals: to include a narrative description of staff actions, and
8. The name, qualifications, dated signature of the staff person delivering the service.

Progress notes indicating an ISP review must include:
9. A summary of the ISP review, as described above.

Documentation of service encounters shall be completed contemporaneously, at the time of service delivery or shortly thereafter.

Non-Billable Notes

Non-billable contacts with the individual and other collateral are an important part of the individual's course of services. CORE providers shall routinely conduct non-billable outreach and engagement. It is important to document any information pertinent to the individual's services, such as outreach and attempts to re-engage the individual during gaps in services. Non-billable contacts should be documented in a contact log, case note, or non-billable progress note. Providers have some discretion in which non-billable contacts are documented. For example, routine appointment reminder calls or texts might not be documented, but a letter attempting to outreach to a disengaged individual should be noted.

Discharge Process & Summary

Individuals may be discharged from CORE Services for many reasons, including achievement of recovery goals, transition to another service provider or level of service, and/or dis-engagement or becoming lost to contact. Effective discharge planning is an extension of the person-centered planning process and is critical to the individual's ongoing recovery process; discharge planning begins at intake and is ongoing throughout the episode of care. Discharge planning involves:

- collaboration and communication with the individual and appropriate collaterals, including the MCO, and
- the identification services and/or supports needed to sustain recovery, minimize the risk of relapse, and ensure optional health and well-being of the individual.

Upon discharge, the CORE Services provider is responsible for completing a discharge summary which includes the following required elements:

1. Date of discharge,
2. Reason for discharge,
3. Summary of progress (or lack thereof) while receiving services, and
4. The dated signature of the staff completing the summary.

The discharge summary must be completed no later than 2 weeks after the date of discharge. It may be documented in a progress/case note or in a formal discharge summary form. It is recommended that the discharge summary be shared with the MCO upon completion. With appropriate consent and as applicable, the discharge summary can also be shared with the Health Home Care Manager and other involved providers.

Section 4 : The Case Record

Required Elements of Case Record

The case record refers to the complete chart for each individual receiving services. The case record consists of the following required elements:

1. Documentation of Service-Specific Intake & Evaluation,
2. LPHA Recommendation/ Determination of Medical Necessity,
3. Individual Service Plan, initial and all updates,
4. ISP Review Summaries (all),
5. Documentation of Service Encounters (Progress Notes),
6. Non-Billable Notes/ Contacts,
7. Signed Consents (e.g. HIPAA, consent for services),
8. Notices (e.g. rights and responsibilities, grievances, complaints), and
9. Discharge Summary.

The above list is not intended to limit what may appear in a case record. Agencies may choose to include any other documentation that is relevant, including miscellaneous correspondence with the individual and other collaterals.

Note: Designated Providers providing more than one CORE Service to a single individual may choose to maintain a single CORE case record or separate ones, but this structure should be consistent across all CORE case records. For example, if an individual is receiving both Community Psychiatric Support and Treatment and Empowerment Services – Peer Support, they agency could choose to either maintain two separate CORE case records or a single case record that includes both services.

Maintenance of Records

Case records shall be securely retained for a minimum of six years following an individual's discharge from services.

Section 5 : Services

Community Psychiatric Support and Treatment

Service Definition

Community Psychiatric Support and Treatment (CPST) includes goal-directed supports and solution-focused interventions with the intent to achieve person-centered goals and objectives. This is a multi-component service that consists of therapeutic interventions such as clinical counseling and therapy, which assist the individual in achieving stability and functional improvement. CPST addresses behavioral health barriers that impact daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community participation.

CPST is designed to provide mobile treatment services to individuals who have difficulty engaging in site-based programs, or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment. CPST allows for delivery of services within a variety of permissible off-site settings including, but not limited to, community locations where the individual lives, works, learns, and/or socializes.

Components

CPST may be provided to an individual and their family of choice. Components may be delivered to the family with or without the individual present if the intervention is for the benefit of the individual and with the individual's informed consent. Interventions should be evidence-based. CPST includes the following components:

1. *Person-Centered Assessment, Service Planning, Documentation, and Collaboration:* A person-centered planning process is used to elicit the individual's recovery goal, establish objectives, and plan treatment services and interventions. This component is used to regularly monitor progress toward goals and objectives, with updates being made to the ISP as needed. Staff may use a person-driven concurrent or collaborative documentation process to support this work.[5] This component may be used to support and facilitate a transition to site-based outpatient clinical treatment services, such as an Article 31/32 Clinic or FQHC. Family and collaterals may support the process by providing input and historical information. Collaboration includes synchronous communication between the CPST provider and other providers to ensure integrated, collaborative care.[6]

2. *Individual and Family Psychotherapy and Counseling:* Therapeutic communication and interaction for the purpose of encouraging personal growth and development and supporting the individual's capacity to achieve life roles they value. This component includes evidence-based and best practice interventions that address targeted symptoms and/or recover the person's

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[5]In order for documentation to count as billable time, it must be done concurrently with the individual.

[6] Note: Communication may occur between the CPST provider and psychiatric prescribers, primary care practitioners and other medical specialists, housing/residential staff, employment/rehabilitation staff, and Health Home Care Management staff, for the exclusive benefit of the individual.

capacity to cope with or prevent symptom interference with daily activities. Psychotherapy should promote community inclusion and may encompass interventions to facilitate readiness for and engagement of the individual in wellness self-management, school, and employment training services, which are provided by other specialized service providers. This component may be delivered to families for the benefit of the individual.

3. *Integrated Co-Occurring Disorder Treatment:*[7] An evidence-based practice using an integrated care model involving motivational interviewing, stage-wise interventions, cognitive-behavioral, and harm reduction techniques which are designed to restore functionality and promote recovery for individuals with co-occurring substance use disorder and mental illness. This component could also include Tobacco Use Disorder Treatment. When delivering integrated treatment, communication and collaboration with other service providers (e.g., housing, supported employment, psychiatric prescriber, etc.) is critical.

4. *Crisis Prevention:* Interventions provided to help prevent individuals from experiencing future crisis and reduce the risk of repeated crisis. The CPST provider supports the individual with effectively responding to or avoiding identified precursors or triggers that would pose risk to remaining in a natural community location, including assisting the individual and collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

5. *Intensive Rehabilitation Counseling:* Customized interventions designed to intensely assist an individual in attaining and sustaining meaningful life roles. This component may be used to provide active, intensive rehabilitation and support to an individual who is contemplating a rehabilitation goal, or has made a commitment to achieving their goal, or to provide targeted, intensive interventions necessary to address immediate risks. Rehabilitation counseling is used to assist the individual with independent living skills, identification and engagement in support services, promotion of recovery, and restoration of functioning.

CPST may also include the following optional components:

6. *Health Monitoring:* The continued measuring of specific health indicators associated with increased risk of medical illness and early death. For adults, these indicators include, but are not limited to, checking lab work, taking vitals, and recording weight, waist circumference, and body mass index (BMI).

7. *Medication Treatment:* Monitoring and evaluating target symptom response, ordering and reviewing diagnostic studies, writing prescriptions and medication education. This component may include Medication Assisted Treatment (MAT) and Nicotine Replacement Therapy (NRT).

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[7] Also referred to as "Integrated Dual Disorders Treatment" (IDDT) and "Focus on Integrated Treatment" (FIT)

Practitioner Qualifications

CPST may be delivered by the following qualified staff, within their scope of practice. Qualified staff must complete required trainings within timeframes specific in the Staff Training Memo. See below chart for qualifications by service component

Component	Qualified staff who may deliver
Person-Centered Assessment, Service Planning, Documentation, and Collaboration; Intensive Rehabilitation Counseling	Psychiatrist, Psychiatric Nurse Practitioner, Psychologist, Social Worker, Mental Health Counselor, Marriage and Family Counselor, Psychoanalyst, Creative Arts Therapist, Certified Rehabilitation Counselor
Individual and Family Psychotherapy; Integrated Co-Occurring Disorder Treatment; Crisis Prevention	Psychiatrist, Psychiatric Nurse Practitioner, Psychologist, Social Worker, Mental Health Counselor, Marriage and Family Counselor, Psychoanalyst, Creative Arts Therapist
Health Monitoring	Psychiatrist, Physician, Nurse Practitioner, Psychiatric Nurse Practitioner, Physician's Assistant, RN, LPN
Medication Treatment	Psychiatrist, Psychiatric Nurse Practitioner

Student Interns may also deliver components appropriate to their educational program. See Provider Types in Appendix for details on degrees, licenses, and/or permits required for each of the above qualified staff.

Psychosocial Rehabilitation

Service Definition

Psychosocial Rehabilitation (PSR) is designed to assist an individual in improving their functional abilities to the greatest degree possible in settings where they live, work, learn, and socialize. Rehabilitation counseling, skill building, and psychoeducational interventions provided through PSR are used to support attainment of person-centered recovery goals and valued life roles. Approaches are intended to develop skills to overcome barriers caused by an individual's behavioral health disorder and promote independence and full community participation.

Components

Psychosocial Rehabilitation is provided individually and in groups. PSR includes the following components:

1. *Person-Centered Assessment, Recovery Planning, Documentation, and Collaboration:* A person-centered planning process is used support the individual's recovery goal. This component includes but is not limited to:
    a. Engaging the individual in shared decision making around service and recovery planning;

    b.   Regular assessment of progress toward goals and updating the ISP, as needed. The PSR practitioner may include record keeping exercises designed to support the individual in monitoring their progress. Staff may use a person-driven concurrent or collaborative documentation process to support this work;[8] and,

    c.   Communicating with collaterals, including other providers, to ensure integrated, collaborative services and access to necessary supports/resources.

2. *Individual Psychoeducation and Skill Building:* Interventions designed to develop or improve personal coping strategies, prevent crises, and promote recovery. These interventions are tailored to the individual's goal and are adapted to where the individual lives, works, learns, and socializes. Providers may utilize the Wellness Self-Management (WSM) approach[9]. This component includes but is not limited to:

    a.   Mental health and addiction psychoeducation;

    b.   Coping skills and stress reduction/management skills training;

    c.   Problem-solving skills training;

    d.   Medication education and self-management skills training; and

    e.   Crisis prevention planning.

3. *Rehabilitation Counseling:* Individualized, goal-driven interventions that facilitate, promote, and improve functioning in living, working, learning, and social environments. Rehabilitation Counseling is used to help the individual choose, get, and keep valued life roles. This component includes but is not limited to:

    a.   Identification of strengths and resources which may aid the individual in achieving recovery; supporting the individual's personal development, work and academic performance, and functioning in social and family environments through teaching skills/strategies to ameliorate the effect of behavioral health symptoms;

    b.   Resource and support coordination to help an individual identify, assess, develop and secure available supports to ensure their success and satisfaction in their stated rehabilitation goals. This may include working with the individual to use their existing supports, finding new supports, and modifying available supports to meet their needs;

    c.   Identification of personal, environmental, and behavioral health barriers that may impede the development of skills necessary for functioning in work or school, with peers, and with friends and family;

    d.   Develop, strengthen, and support the individual's independent community living skills and community participation through self-advocacy and system navigation; promoting access to necessary rehabilitative, medical, social, academic, and other services and supports;

    e.   Instruction in accessing and using community resources such as transportation, translation, and communication assistance; for example, helping to secure TTY services, language services, or other adaptive equipment needs;

    f.   Instruction and skill building to increase the individual's capacity to independently manage their own financial resources, including public benefits and entitlements, scholarships and financial aid, work incentives, and earned income;

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[8]In order for documentation to count as billable time, it must be done concurrently with the individual.
[9]The Wellness Self-Management and Wellness Self-Management+ Workbooks, as well as online training modules for staff, are available to all CORE providers through the Center for Practice Innovation (CPI) Learning Community.

g.   Establishing and sustaining personal relationships and a supportive recovery social net work; assisting in identification of resources where an individual's personal and/or professional interests can be enhanced and shared with others in the community by connecting with natural supports and recovery resources, including family, community networks and civic engagement/ volunteering, and faith-based communities;

h.   Skill development to support social skills and functional skills, including but are not limited to adaptation to home, work, school, and social environments, learning and practicing inter personal skills, time management, technology/ computer literacy, personal money management/budgeting, household management, academic survival skills, etc.;

i.   Skill development to support the individual to self-recognize emotional triggers and to self-manage behaviors related to the behavioral health disorder;

j.   Skill programming to support the individual to develop step by step plans to use the skills successfully in their lives. Skills programming is intended to help an individual overcome barriers to successful skill implementation;

k.   Cognitive remediation, including specific drills, activities and exercises, designed to enhance an individual's functioning in the environment of their choice. These skills include but are not limited to, the ability to pay attention, remember, process information, solve problems, organize and reorganize information, communicate and act upon information; and,

l.   Ongoing counseling, mentoring, advocacy and support for the purpose of sustaining an individual's success and satisfaction in their valued life role.

Practitioner Qualifications

PSR must be provided by staff who meet the minimum criteria for unlicensed behavioral health staff and who have completed the required trainings within timeframes specified in the Staff Training Memo. The Staff Training Memo includes enhanced training for staff delivering PSR to individuals with employment- and education-related goals.

Unlicensed behavioral health staff must receive clinical supervision by a qualified supervisor.

Limitations and Exclusions

Psychosocial Rehabilitation does not include task-specific job training (i.e., job coaching).

Family Support and Training

Service Definition

Family Support and Training (FST) offers instruction, emotional support, and skill building necessary to facilitate engagement and active participation of the family in the individual's recovery process. The FST practitioner partners with families through a person-centered or person-directed, recovery orient ed, trauma-informed approach.

Family is defined as the individual's family of choice. This may include persons who live with or provide support to a person, such as a parent, spouse, significant other, children, relatives, foster family, in-laws, or others defined as family by the individual receiving services. Family does not include individuals who are employed to care for the individual receiving services.

Components

Family Support and Training is provided individually and in groups. It may be provided to an individual and their family of choice. Components may be delivered to the family with or without the individual present if the intervention is for the benefit of the individual and with the individual's informed consent. Components may also be delivered to the individual without the family present, as appropriate. FST includes the following components:

1. *Person-Centered Recovery Planning, Documentation, and Collaboration:* A person-centered planning process is used to elicit the individual's recovery goal, establish objectives, and plan family-based interventions. This component includes, but is not limited to:
   a. Working with the individual and their family to learn about their experiences with mental illness and/or addiction, their strengths and resources, and their goals.
   b. Regular monitoring of progress toward goals and objectives, with updates being made to the ISP as needed. Staff may use a person-driven concurrent or collaborative documentation process to support this work.[10]
   c. The FST practitioner communicates with other providers as needed to ensure integrated, collaborative care.

2. *Education:* Dissemination of information that will increase the family's knowledge base and improve their ability to support the individual. This component may include education on topics including, but not limited to:
   a. Recovery concepts and support options,
   b. Diagnosis-specific information about mental illness and addiction,
   c. Treatment and rehabilitation options,
   d. Advocacy,
   e. Recovery planning,
   f. Person-centered care,
   g. Trauma,
   h. Self-Care,
   i. Behavioral intervention strategies,
   j. Crisis intervention and prevention,
   k. Safety planning,
   l. Violence and suicide prevention,
   m. Community integration and participation, and
   n. Navigating the behavioral health and public benefits systems.

3. *Skill Building and Support:* Collaboration with the individual and their family to develop positive interventions to support and sustain healthy, stable relationships within the family. This component may include, but is not limited to:
   a. Assisting the family to create a safe and supportive environment in the home,
   b. Providing or connecting family to mediation and conflict resolution services,
   c. Developing coping and problem-solving skills that draw upon the family's strengths,
   d. Increasing family communication skills, boundaries, and emotional health and wellness, and
   e. Facilitating family and friends support groups.

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[10]In order for documentation to count as billable time, it must be done concurrently with the individual.

Practitioner Qualifications

FST must be provided by staff who meet the minimum criteria for unlicensed behavioral health staff and who have completed the required trainings within timeframes specified in the Staff Training Memo.

Unlicensed behavioral health staff must have access to clinical supervision by a qualified supervisor.

Limitations & Exclusions:

This service is provided only at the request of the individual. All FST must be included in the individual's ISP and for the benefit of the Medicaid covered participant.

Empowerment Services – Peer Support

Service Definition

Empowerment Services – Peer Support (Peer Support) are non-clinical, peer-delivered services with focus on rehabilitation, recovery, and resilience. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural supports and community resources.

Peer Support must include the identified goals or objectives in the individual's ISP, with interventions tailored to the individual. These goals should promote utilization of natural supports and community services, supporting the person's recovery and enhancing the quality of their personal and family life. The intentional, goal-directed activities provided by this service emphasize the opportunity for peers to model skills and strategies necessary for recovery, thereby developing the individual's skills and self-efficacy. These services are provided through the perspective of a shared personal experience of recovery, enhancing the individual's sense of empowerment and hope.

Components

Peer Support is provided individually. It includes the following components:

1. *Person-Centered Recovery Planning, Documentation, and Collaboration:* A person-centered planning process is used support the individual's recovery goal. This component includes but is not limited to:
   a. Engaging the individual in shared decision making around service and recovery planning.
   b. Reviewing progress toward goals and objectives; updating the ISP as goals are met or other changes are needed. Staff may use a person-driven concurrent or collaborative documentation process to support this work.[11]
   c. Communicating with other providers such as prescribers, treatments providers, case managers, or employment specialists, to ensure integrated, collaborative care.

2. *Advocacy Support:* This component assists in building self-advocacy skills and raising awareness of existing social support and services. This component does not replace the role of a care manager/coordinator. This component includes, but is not limited to:
   a. Building the individual's skills and self-efficacy related to Shared Decision Making (e.g., MyPSYCKES),

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[11]In order for documentation to count as billable time, it must be done concurrently with the individual.

    b. Developing of mental health care directive and psychiatric advance directives (PADs),

    c. Working alongside the individual as they seek and obtain benefits and entitlements, food, shelter, and permanent housing,

    d. Raising the awareness of existing services and community resources, pathways to recovery and helping an individual to remove barriers that exist for access to them,

    e. Connecting individuals to "warmlines"[12] and peer-run groups in the community (in-person or online), and

    f. Advocating on behalf of the individual and supporting their self-advocacy during appointments.

3. *Activation and Engagement in Recovery*: This component focuses on engagement in the recovery process, increasing their sense of hope and purpose, and empowering the individual to achieve their goals make positive changes. This component includes, but is not limited to:

    a. Validating the individual's experiences and feelings and conveying hope to the individual about their own recovery,

    b. Relating their own recovery stories and sharing and describing personal recovery practices, and helping the individual to discover recovery practices that will work for them,

    c. Modeling of recovery lifestyle, including participation in recovery activities that might be beyond the scope of treatment providers,

    d. Assisting the individual with identifying activities in selecting and utilizing the things that promote a sense of passion, purpose and meaning into their life and coaching the individual as they identify barriers to engaging in these activities,

    e. Wellness coaching with a focus on whole health, which may include discussing and sharing ongoing personal efforts to enhance health, wellness, and recovery,

    f. Assisting the individual to select and use self-directed recovery tools such as Wellness Recovery Action Planning (WRAP) and recovery plans, and

    g. Celebrating the individual's efforts and accomplishments.

4. *Community Participation:* This component uses peer support and skill building to support full community engagement and participation. Peers provide personalized support to assist the individual in developing social networks, engaging in meaningful activities, and building healthy relationships. This component includes, but is not limited to:

    a. Utilizing shared personal experience to support skill development that guides the individual towards a more independent life in the community (e.g. personal banking, accessing public transportation, finding and attending community events, and membership in community organizations),

    b. Exploring community spaces that promote integration, inclusion, and participation (bridging from the individual's home to the community),

    c. Supporting the individual in attending community activities and appointments when requested,

    d. Assisting the individual to help connect to long-term natural supports that enhance the quality and overall security of life.

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[12]Warmlines are a telephone or virtual service for people who are looking to discuss daily struggles. They are often staffed with self-identified peers, who listen, offer support, share their experiences, and offer up community resources (Mental Health America, 2020). Warmlines are available in many communities across NYS.

5. *Transitional Support:* This component provides transitional support for individuals with long or repeated hospitalizations, detox admissions, or other institutional stays as they make the transition back to their home communities. Peers may also provide support to individuals as they transition to a different level care. The intent is for a peer to develop a supportive relation-ship with the individual prior to discharge. Support may be provided using a "peer bridger" model.[13] This component includes, but is not limited to:

   a. Periodic engagement with the individual after discharge from a hospital, emergency depart-ment, inpatient detox, residential treatment or inpatient psychiatric units to facilitate communi-ty tenure,

   b. Linking people to another level of care (e.g. outpatient to inpatient detox, inpatient detox to residential treatment),

   c. Bridging from jail or prison to an individual's home[14] or to a treatment provider (i.e. residential treatment, Open Access Center, etc.),

   d. Bridging from a hospital, psychiatric unit, inpatient or residential treatment to an individual's home,[15] and

   e. Bridging from institutional settings (i.e. adult home, community residence, or residential treat-ment to community-based settings.

6. Pre-Crisis and Crisis Support: This component uses peer support to address an individual in distress or crisis. The certified peer uses their knowledge of local resources, treatment, services and supports the preferences of the individual. Interventions provided under this component do not need to be included on the ISP. This component may include, but is not limited to:

   a. Providing reassurance and support to an individual in distress or crisis,

   b. Employing non-clinical crisis support, especially after periods of hospitalization or incarcera-tion,

   c. Assisting the individual with putting their wellness, crisis plans or recovery plan into action,

   d. Accompanying, supporting, and advocating on behalf of an individual in an emergency room or crisis unit or preparing to be admitted to detox, residential or other service to deal with crisis, and

   e. Providing short-term post-crisis support to an individual who has been discharged from an emergency room, crisis unit, or crisis respite residence, or incarceration.

Practitioner Qualifications

Peer Support must be provided by a Certified Peer who has completed the required trainings within timeframes specified in the Staff Training Memo.

Certified Peers must receive clinical supervision by a qualified supervisor.

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[13]The Peer Bridger Model was developed in 1994 by the New York Association for Psychiatric Rehabilitation Services (NYAPRS) to support the recovery and community inclusion of people who live with major mental health and addiction relat-ed challenges. Peer Bridgers are trained to support those individuals to make successful transitions from OMH psychiatric centers and state operated community residences to their communities of choice. Accordingly, their main focus is to assist people to improve their health and meet their personal and community goals, while reducing avoidable crises and readmis-sions (NYAPRS, n.d.).

[14]Note: Medicaid services provided while an individual is incarcerated may not be reimbursable.

[15]Note: Medicaid services provided to an individual residing in a Psychiatric Center may not be reimbursable

Section 6 : Service Delivery

Person-Centered Service Delivery

CORE Services are delivered using a person-centered approach and in accordance with the ISP developed collaboratively between the individual and the CORE staff. Services are delivered with respect to the individual's preferences regarding days, times, modalities, and locations that are convenient for them and best suited for their desired outcomes.

Caseload Size

CORE Services do not have prescribed caseload ratios. Staff and supervisors may carry mixed caseloads if they meet the required staff qualifications, including staff training. Providers must maintain practitioner and supervisory caseloads that are appropriate and reflective of a strong clinical rationale. Caseload sizes should consider several factors, including the needs each individual on the caseload and the abilities and skillset of the staff member.

Individual and Group Services

While all CORE Services may be delivered individually (1:1), PSR and FST may also be delivered in groups. Groups are often used to develop skills, improve self-efficacy, and increase social supports. Participation in CORE groups is always voluntary, and the group must be aligned with the individual's goal(s), objective(s), and barriers or needs, as indicated on their ISP.

Table 1 Individual & Group Services by Service-Type

	1:1 Services	Group Services
Community Psychiatric Support & Treatment	Allowed	Not Allowed[16]
Psychosocial Rehabilitation	Allowed	Allowed
Family Support & Training	Allowed	Allowed
Empowerment Services – Peer Support	Allowed	Not Allowed[17]

[16]As is noted in the Service Components for CPST, it may be delivered to an individual's family at the request of the individual and for the exclusive benefit of the individual. An example of this would be the delivery of clinical family psychoeducation to a individual's family. CPST provided to family members is considered 1:1 and is billed using the same rate codes as 1:1 service delivery, even if more than one family member is present. Such services must be included on the ISP.

[17]While there is not currently a rate code for group services for Empowerment Services – Peer Support, it is noted that Certified Peers are qualified unlicensed behavioral health staff and therefore may deliver psychosocial rehabilitation in groups. Such groups must fall under the appropriate service components for PSR.

PSR Groups

PSR groups may last from 15 minutes to 1 hour and may be delivered on the same day as a 1:1 PSR session with an individual. Groups sizes range from 2 to 10 individuals.

FST Groups

FST groups may last from 15 minutes to 90 minutes and may be delivered on a same day as a single-family session. Groups are made up of 2-3 HARP members' families. While FST is only delivered at the request of the individual, the individual is not required to attend group sessions. There is no limit on how many family members may participate per HARP member.

Note: If a single individual's family is receiving services, the session is not billed as a group, regardless of the number of family members present

Intensity of Services

The scope and intensity of CORE Services are based on the level of support needed to support the individual in achieving their recovery goal and sustaining recovery (see Person-Centered Planning and the ISP). These services are not personal care services nor a replacement for custodial care in an institutional setting.

CORE Services are not subject to hard caps; however, the State has recommended unit ranges by session, which may be exceeded when appropriate. These ranges are intended to illustrate the scope of services and program design.

Table 2 Recommended Unit Range, per session, for CORE Services

Service	Rate Code(s)	Recommended Daily Unit Range	Minutes Conversion
Community Psychiatric Support and Treatment	7790, 7791, 7792, 7793	1-6	15-90 min.
Psychosocial Rehabilitation (Individual) [18]	7784, 7785, 7810, 7811	1-12	15-180 min.
Psychosocial Rehabilitation (Group)	7786, 7787, 7788	1-4	15-60 min.
Family Support and Training (Individual)	7799	1-12	15-180 min.
Family Support and Training (Group)	7800	1-6	15-90 min.
Empowerment Services – Peer Support	7794	1-16	15-240 min.

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[18] 1:1 PSR services may be delivered in any combination on a single day, including PSR with an Employment Focus and PSR with an Educational Focus, up to a total of 12 units per day. The range may be exceeded as appropriate, as outlined above.

Exceeding the Recommended Unit Range

The Individual Service Plan (ISP) should be developed utilizing the above recommended ranges. The recommended unit range does not apply to an individual in crisis, although the crisis should be clearly documented in a service encounter note ("progress note").

These ranges may be exceeded when a short-term increase in intensity supports goal acquisition. Outside of crisis situations, the decision to exceed the recommended range should only be made in consultation with the Clinical Supervisor, who should consider whether a higher level of care is needed. An example of when it might be appropriate to exceed the recommended range is an individual who is returning to school and requires Psychosocial Rehabilitation to take day-long college tours and attend college fairs.

Recommended Unit Ranges and Utilization Management

The State reserves the right to change the above recommended daily unit ranges as we review utilization data in the years ahead

Bundling Services & Innovative Program Designs

Providers that are designated to provide multiple services are encouraged to develop innovative program designs using the four CORE Services as building blocks for person-centered, integrated care. CORE Services may be provided through interdisciplinary teams that include a clinical supervisor and/or CPST practitioner, offering treatment, rehabilitation, and support to individuals receiving services. Team-based models may be particularly useful in working as a step-down from more intensive levels of care, such as ACT, PROS, CDT, and Partial Hospitalization. Teams may tailor interventions for special populations such as individuals experiencing homelessness or housing insecurity, transition age youth (21+), criminal justice-involved individuals, individuals being discharged from a hospital or psychiatric center, etc.

Providers interested in delivering bundled services may want to take advantage of the flexibility offered in this Operations Manual to:
- Combine multiple services in a single CORE Case Record,
- Add multiple services to a single ISP (i.e. an integrated recovery plan),
- Work collaboratively with outside prescribers at an outpatient clinic or CCBHC,
- Involving the Health Home Care Coordinator a part of the team,
- Partner with housing and residential programs to provide services in an individual's home, and/or,
- Blend in-person and telehealth service delivery modalities based on each individual's needs and preferences.

Providers do not need any additional approval or permission from NYS to implement a bundled program design. We encourage any providers that are considering an innovative program design to contact their local field office for technical assistance.

Providers are further encouraged to consult the Benefit and Billing Guidance regarding allowable service combinations. Duplicate billing restrictions may apply and should be considered on a service-by-service basis

Telehealth Services

Designated providers may apply for approval to deliver services via Telehealth.
- For OMH-Hosted CORE Services providers, the application process and service delivery are governed by Part 596 regulations. Current telemental health guidance may be found on the OMH Telemental Health Services website.
- For OASAS-Hosted CORE Services providers, the application process and service delivery are governed by Part 830 regulations. Current telepractice guidance may be found on the OASAS website.

The State reserves the right to establish additional guidance and telehealth service standards at a later date.

Location of Services

CORE Services must be offered in the setting best suited to support goal acquisition, including in the individual's home and other community-based locations. In doing so, CORE Services offer opportunities for in vivo skill development and support.[19] For example, if an individual needs access to a computer and internet to research community resources, it may be appropriate to meet at a library in their community.

PSR, FST, and Peer Support may be delivered onsite and/or offsite. CPST must be delivered offsite unless there is a clinical rationale for delivering services onsite for a limited basis. This clinical rationale must be documented in a progress note. CORE Services may not be delivered onsite due to staff convenience.

CORE Services should not be provided for the purpose of transportation. Individuals should be encouraged to utilize public transportation, community and natural supports, and Medicaid Transportation as appropriate. CORE Services may be provided while transporting an individual if the staff member engages in active service delivery and meets all service requirements while in transit. For example, a staff person might drive an individual to the bank to establish an account, and while in the car or on the subway, that staff member engages the individual in skill building exercises, or a peer specialist may accompany an individual to assist with engaging in a treatment setting such as detox or inpatient.

Communication and Collaboration with Collaterals

Collaterals include the individual's family, and others significant in their life or integral to their identified goals, who provide a direct benefit to the individual. Collateral contacts are conducted in accordance with, and for the purpose of advancing the individual's identified goals and for coordination of services with other community mental health and medical providers. Collateral contacts must be provided for the direct benefit of the individual.

Collaterals should be identified through person-centered planning, with the opportunity for the individual to make an informed decision about communication and collaboration with the collateral.

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[19] "In vivo" skill development refers to services delivered in "real life" or natural environments. The use of in vivo skill development and support promotes the application of skills learned in meaningful ways and contributes to generalization of the skill.

Documentation of collateral contacts must include:
1. the name of the collateral,
2. their relationship to the individual, and
3. a description of how the contact helped support or advance the individual's identified goals.

The provider is responsible for maintaining a Consent to Release/Receive Information in the individual's case record.

Section 7 : Supervision

Clinical Supervision

Clinical supervision is critical to the success and quality of all CORE Services. In lieu of caseload and staffing ratios, clinical supervision must be available to all staff providing direct services. Clinical supervision includes case consultation to address individuals with increasing psychiatric needs, referral to alternative services, risk management, and addressing any other health and safety concerns. This consultation may also be provided when an individual is not making expected progress and the direct service staff requires guidance and support to adjust their interventions. Ensuring regular availability and check-in with a clinical supervisor supports quality care, staff morale and retention, and overall professional development.

Supervision by trained and qualified supervisors helps staff understand and respond more effectively to all types of clinical needs or scenarios. It specifically addresses assessment, case conceptualization, treatment strategies, and discharge planning. Supervision aids in addressing the unique needs of each individual. It provides a mechanism to ensure that clinical directives are followed and facilitates the implementation and improvement of evidence-based practices (EBPs) (SAMHSA, 2014).

Each designated provider must maintain a Staffing Plan for CORE Services to ensure delivery of services by appropriate and qualified staff and access to clinical supervision as described above. This Staffing Plan must be made available to the State upon request. It is recommended that direct service staff receive a minimum of one hour of clinical supervision for every 40 hours of service provision.

Clinical Supervisor Qualifications

Clinical supervision for PSR, Peer Support, and Family Support and Training must be provided by one of the following qualified and credentialed staff: Certified Rehabilitation Counselor (CRC), Credentialed Alcoholism and Substance Abuse Counselor (CASAC) – Advanced Counselor, Creative Arts Therapist, Psychoanalyst, Psychologist, Marriage and Family Therapist, Mental Health Counselor, Nurse Practitioner, Nurse Practitioner in Psychiatry, Physician, Physician Assistant, Psychiatrist, Registered Professional Nurse, or Social Worker.

See Provider Types in appendix for details on degree, licensure, certification, and/or permits required.

Clinical supervision for CPST should be appropriate to the licensure and scope of practice of the practitioner.

Clinical supervisors should understand the scope of each CORE service and must complete required trainings as outlined in the Staff Training Memo.

Administrative/Task Supervision Model

Designated providers may choose to implement an administrative/task supervision model, in addition to the above described clinical supervision. In this model, an administrative or task supervisor may be used as a more frequent or regular form of staff support that may focus on activities such as:

- Day-to-day workload management and coordination,
- Training and onboarding of new staff,
- Coaching and mentoring,
- Teaching and supporting interventions required to provide defined services and components, and
- Completion of chart reviews and other quality assurance activities.

Using a split supervision model creates a career ladder for certified peers and other unlicensed behavioral health staff and may help support retention of qualified staff.

Section 8 : Health & Safety

Incident Management & Reporting

CORE Services are an unlicensed/uncertified service type and therefore not subject to Title 14 NYCRR Parts 524 or 836. CORE Services designated providers are required to comply with the incident reporting and management requirements as delineated in the CORE Services Incident Reporting and Management Guidance.

Section 9 : Employment & Ticket to Work

CORE Services & Employment First

Employment First principles promote the notion that employment should be the first option for individuals seeking rehabilitation and treatment supports while experiencing a disability and should be offered in tandem with associated services. Evidence tells us that employment is integral to improvements in social determinants of health and significantly reduces reliance on public benefits such as entitlements and healthcare expenditures. NYS recognizes the importance of employment and education in an individual's path to recovery and seeks to weave related supports into all program types, including CORE Services.

SSA and Ticket to Work

The Ticket-to-Work program is a Social Security Administration (SSA) initiative which aims to reduce reliance on public benefits and assist beneficiaries to achieve greater economic independence. NYS OMH partners with NYS DOL to oversee and manage the New York Employment Services System (NYESS) Administrative Employment Network (AEN), which is a cross-systems employment services resource, an online collaborative case management system, and has the unique ability to generate federal revenue which is reinvested in New York's employment services infrastructure.

New York Employment Services System (NYESS) Reporting for PSR Providers

NYESS is a one-of-a kind cross-systems collaborative employment services case management data system that allows an individual record to be accessed by provider partners, while also gathering data required to inform policy and track outcomes. While NYESS data entry and participation are not mandated at this time, the State plans to emphasize the unprecedented opportunity NYESS offers for both individuals receiving supports and the services system as a whole. NYESS is a comprehensive resource for all things related to employment for individuals of all abilities, regardless of funding source, program model, or agency affiliation, and makes available high impact but easily accessible tools such as the NYESS Customer Resource page, which focuses on working while experiencing disability.

Section 10 : Rights & Responsibilities

Service Recipient Rights

Individuals receiving CORE Services are entitled to the rights defined in this section. Designated providers and MCOs are responsible for the protection of these rights.
a. The right to an Individual Service Plan (ISP) and to participate to the fullest extent possible in the development and revision of that plan.
b. The right to participate voluntarily in and to consent to participation in services.
c. The right to receive a prompt and reasonable response to requests for services, or a stated future time to receive services in accordance with their ISP.
d. The right to be informed of and to understand the standards that apply to their conduct, to receive timely warnings for conduct that could lead to discharge and to receive incremental interventions for conduct contrary to agency standards.
e. The right to know the name, position, and function of any individual providing services to the individual, and to communicate with the director, medical director, board of directors, and/or other responsible staff, up to and including the Commissioners of OMH and/or OASAS.
f. The right to confidentiality of clinical records, which shall be maintained in accordance with section 33.13 of the Mental Hygiene Law and applicable Federal law and regulations.
g. The right to access their clinical records, consistent with section 33.16 of the Mental Hygiene Law and applicable Federal laws and regulations.
h. The right to receive appropriate services that is suited to their needs, and skillfully, safely, and humanely administered with full respect for their dignity and personal integrity.

i.   The right to receive services in an environment that is safe, sanitary, and free from the presence of addictive substances.
j.   The right to be treated by staff who are free from chemical dependence.
k.   The right to receive services in a non-discriminatory manner, and to be treated in a way that acknowledges and respects their cultural environment.
l.   The right to a maximum amount of privacy consistent with the effective delivery of services, both in community-based and office-based settings.
m. The right to freedom from abuse and mistreatment by CORE staff.
n.   The right to be informed of the designated provider's grievance policies and procedures, and to initiate any questions, complains or objections accordingly.
o.   The right to receive in writing, upon request, the reasons for a recommendation of discharge and to be informed of the process, if any, to review such discharge recommendation.

Service Recipient Responsibilities

Participation in CORE Services is voluntary. Each individual is expected to:
a.   Work toward their recovery goal(s);
b.   Treat staff and other service recipients with courtesy and respect;
c.   Respect other individuals' right to confidentiality;
d.   Participate in developing and following the ISP;
e.   Participate in services as outlined in the ISP; and,
f.   Inform staff of significant life changes which may require a change in the ISP or service delivery·

Section 11 : Staff Training & Competencies in Evidence Based Practice

Training and workforce development are critical to the success of CORE Services. Staff and super Training and workforce development are critical to the success of CORE Services. Staff and supervisors should be well-versed in essential competences, service-specific skills, and evidence-based practices. Training requirements will vary by service type, and supervisors may choose to assign additional trainings, or electives, based on need.

Required trainings are completed in the Center for Practice Innovation (CPI) Learning Community, an online learning management system (LMS). The CPI LMS will also be used to track completion of these trainings. Provider-specific information (staff, completion dates, etc.) will be available upon request. It is the responsibility of the provider agency to ensure required trainings and timeframes are met.

Initial staff and supervisor training requirements are outlined in the Staff Training Memo, which may be revised as necessary. Any changes in training requirements will be announced via the CORE Services Listserv. Designated providers should be aware that compliance with staff training requirements are directly linked to their ongoing designation status and reimbursement for claims.

Section 12 : Staff Transportation

Staff Transportation (mileage, public transportation fare) is an add-on rate that may be billed when directly related to the face-to-face delivery of CORE Services. Staff Transportation must only be used when services are delivered off-site. Examples of off-site settings include the individual's apartment, a local public library, coffee shop, community center, etc.

Staff Transportation reimbursement is intended to compensate designated providers for the cost of provider staff travel for CORE Services only and travel must be related to the individual's service. Costs associated for programs, services, and purposes other than CORE Services cannot qualify for reimbursement under this category.

See Benefit and Billing Guidance for more information about claiming Staff Transportation.

Section 13 : Designation, Oversight & Monitoring

Designation

CORE Services may only be provided by organizations designated by OMH and OASAS. Designation is granted by service-type, and organizations may apply to provide some or all services. Designated providers are subject to oversight and monitoring by the State as described in this section and must comply with the Terms and Conditions for CORE Service Providers.

Active Status

Providers are expected to remain in active status in order to maintain their designation status. To be in active status, the provider must:
1. be prepared to accept and serve individuals referred, OR
2. have accepted referrals and be currently providing services, but is at capacity and cannot accept new referrals; AND
3. be under contract with at least one Managed Care Organization to deliver CORE Services; AND
4. have qualified and trained staff to deliver all services for which the provider is designated.

If a Provider is temporarily unable to deliver a service, they must notify the State. See below.

Qualifications and Criteria for CORE Services Providers

The State may periodically accept new applications for CORE Services providers. Qualified organizations must meet administrative and service-specific qualifications and criteria, as follows:

1. Administrative designation qualifications and criteria for all CORE Services:
   a. The organization is currently in good standing with the State (OMH and OASAS).
   b. The organization has connected with the Local Government Unit (LGU) to discuss and review local planning needs.
   c. The organization demonstrates:
      i. expertise in serving the target population,
      ii. the capacity to deliver services in community-based settings,
      iii. alignment with the values and principles outlined in Section 1 of the Operations Manual (see application guide for more details on how this criteria is demonstrated).
   d. The organization has an internal infrastructure in place to support key business and clinical operations, including capacity for: risk management, quality assurance, information security, telehealth/tele-practice, addressing complaints/grievances, and billing/claiming.
   e. The organization has developed appropriate Policies and Procedures (P&P) related to CORE Services (see Terms & Conditions for complete list of required P&P).
2. Service-specific designation qualifications and criteria:
   a. Community Psychiatric Support & Treatment:
      i. The organization demonstrates an understanding of CPST and experience delivering similar services.
      ii. The organization employs or will employ qualified staff to deliver CPST.
      iii. The organization understands and implements staff training requirements. Staff employed in this service will complete required trainings within specified timeframes.
      iv. The organization has a license or certification from OMH and/or OASAS to deliver similar treatment services (e.g. Article 31/32 Clinic, Personalized Recovery Oriented Services, Partial Hospitalization, Comprehensive Psychiatric Emergency Programs, Assertive Community Treatment, etc.).
   b. Psychosocial Rehabilitation:
      i. The organization demonstrates an understanding of PSR and experience delivering similar services.
      ii. The organization employs or will employ qualified staff to deliver and supervise Psychosocial Rehabilitation, including staff with appropriate training to deliver evidence-based interventions in support of employment and education goals.
      iii. The organization understands and implements staff training requirements. Staff employed in this service will complete required trainings within specified timeframes.
   c. Family Support and Training:
      i. The organization demonstrates an understanding of FST and experience delivering similar services.
      ii. The organization employs or will employ qualified staff to deliver and supervise Family Support and Training.
      iii. The organization understands and implements staff training requirements. Staff employed in this service will complete required trainings within specified timeframes.
   d. Empowerment Services – Peer Support:
      i. The organization demonstrates an understanding of Empowerment Services – Peer Support and experience delivering similar services.
      ii. The organization employs or will employ qualified staff to deliver and supervise Empowerment Services – Peer Support.

    iii. The organization understands and implements staff training requirements. Staff employed in this service will complete required trainings within specified timeframes.

Overview of Oversight & Monitoring Process

Upon designation to provide CORE Services, providers are subject to oversight and monitoring by the State, as described in this section.

For providers licensed or certified by OMH or OASAS to provide other services, such as Outpatient Clinic, oversight of CORE Services may be combined with the existing recertification process for such services, using the CORE Service Standards. For providers that are not currently licensed or certified to provide other OMH or OASAS services, OMH and OASAS will use a parallel oversight process to complete oversight and monitoring reviews at a minimum frequency of once every 36 months. Oversight and monitoring reviews may occur remotely via record requests and telephone interviews or in-person during site visits. In addition to these routine reviews, additional remote reviews or site visits may occur at any time, for example, in response to a quality complaint or allegation of abuse or neglect. The State may initiate a review without advanced notice.

Upon completion of an oversight and monitoring review, a Summary of Findings will be issued, which may include a Statement of Deficiencies (SOD), if of the State determines the provider is not in compliance with service requirements. The Summary of Findings will indicate if the provider is required to submit a proposed Corrective Action Plan (CAP) to address deficiencies identified in the Summary of Findings within a specified time frame.

OMH and OASAS reserve the right to request immediate corrective action during a monitoring review or to move up the due date for a CAP.

Upon receipt of a CAP, the State will review the Plan and send a notification to the provider of one of the following: (1) approval of the CAP, (2) request for additional corrective actions, or (3) rejection of the CAP and initiation of sanctions.

Note: when a CAP is approved, the State may perform additional site visits to monitor compliance with the CAP.

Suspension or Termination of Designation

A CORE Services provider may be subject to sanctions, including suspension or termination of designation for one or more designated services. If a provider's designation is suspended, the provider will be required to cease new admissions to the services for which their designation is suspended. If a provider's designation is terminated, the Provider will be required to cease providing services on the effective date of the termination. OMH/OASAS will communicate with providers in writing regarding sanctions, including applicable effective dates. OMH/OASAS will also notify Contracted Managed Care Organizations (MCOs) when sanctions are imposed.

Designated providers may be subject to sanctions if the State, in its sole discretion determines that the provider is not in compliance with any provision in this Operations Manual or applicable Service Stan-

dards, or the Terms and Conditions of CORE designation. Sanctions may also be imposed if the State determines there are substantial risks to the health or safety of service recipients. The State may initiate sanctions outside of the formal oversight and monitoring review process, as a result of an oversight and monitoring review, or for failure to complete a state-approved CAP within agreed upon timeframes, where permitted.

When termination of designation is initiated, the provider will receive a Notice of Decision (NOD), including information regarding:
1. Which services are impacted by the termination of designation;
2. A timeframe for the termination of designation; and,
3. Information necessary to file an appeal.

The standard timeframe for the termination of designation will be 45-60 days, during which time the provider is expected to safely transition any individuals currently served to another designated provider or level of service.

The provider may appeal the termination of designation in writing within 14 business days of the date of the NOD. Appeals are written appeals only; there is no right to a hearing. OMH and OASAS will consult on all appeals and issue a final decision within 14 business days of receipt of the appeal.

In no event shall the State be liable for expenses and obligations arising from the services(s) in the Provider's Designation after the termination date. The Provider shall not submit any claims for payment for services, expenses or obligations incurred after the date of termination of the Provider's Designation.

Appendices

Appendix A: Glossary

The following words and terms, when used in this document, shall have the following meanings, unless the context clearly indicates otherwise.

a. *Collateral:* The individual's family, and others significant in their life, that provide a direct benefit to the individual.

b. *Family:* The individual's family of choice. This may include persons who live with or provide support to a person, such as a parent, spouse, significant other, children, relatives, foster family, in-laws, or others defined as family by the individual receiving services. Family does not include individuals who are employed to care for the individual receiving services.

c. *Health Home Care Manager:* Also known as a HHCM or Care Coordinator, this is a qualified in dividual employed by a Care Management Agency to provide comprehensive care coordination to individuals enrolled in Health Home. The care manager works with each Health Home member to create a person-centered plan of care and to coordinate the member's linkage to needed services and supports for improved health and wellness.

d. *Individual Placement and Support:* An evidence-based model of supported employment.

e. *Intervention, or Scope of Service:* The activities and services provided by CORE staff that help the individual achieve objectives and goals.

f. *Objective:* Something the individual will do or accomplish as a step toward achievement of the goal. Objectives should address identified barriers to the goal and should drive the ISP forward. Objectives should answer the questions: How will you achieve that? What steps will you take? When will you take them? Who will help you?

g. *Off-Site:* Home and community-based service locations. For the purposes of CORE Services, provider-owned and controlled settings where an individual resides may be considered "off-site," unless it is also the primary work location for the staff member providing services.

h. *Onsite:* Program space owned or controlled by the CORE Services provider. This may include an office or clinic setting.

i. *Policy and Procedure:* Policy describes a guideline or plan for addressing a specific issue, concern, or topic. Procedure describe the process that staff, managers, and the organization will follow in accordance with the policy. Procedures typically include who is responsible for different tasks and the steps needed to accomplish the task. Effective policies and procedures support high quality service delivery and compliance with State and Federal policies and regulations.

j. *Recovery Goal:* A statement that expresses the individual's desire for positive change and improvement in their lives, ideally captured in their own words. Goals answer the basic question: What do you want?

k. *Wellness Self-Management:* An evidence-informed, curriculum-based practice designed to assist adults to effectively manage serious mental health problems. WSM+ is a version of the practice that has been designed for individuals with co-occurring mental illness and substance use disorder.

Appendix B: Definition of Provider Types

The below definitions describe the licensure, certification, or other minimum credentials for specific practitioner types

a. *Clinical Staff* are practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness and substance use disorders and shall include the following:

   i.   Physician: An individual who is currently licensed or possesses a permit to practice medicine issued by the New York State Education Department;

   ii. Psychiatrist: An individual who is currently licensed or possesses a permit to practice medicine issued by the New York State Education Department and who is either a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by such Board or is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by such Board;

   iii. Physician assistant: An individual who is currently registered or possesses a permit to practice as a physician assistant issued by the New York State Education Department;

   iv. Nurse practitioner: An individual who is currently certified or possesses a permit to practice as a nurse practitioner issued by the New York State Education Department;

   v.   Psychiatric nurse practitioner: An individual who is currently certified or possesses a permit to practice as a nurse practitioner with an approved specialty area of psychiatry issued by the New York State Education Department;

   vi. Registered nurse: An individual who is currently licensed or possesses a permit to practice as a registered professional nurse issued by the New York State Education Department;

   vii. Psychologist: An individual who is currently licensed or possesses a permit to practice as a psychologist issued by the New York State Education Department;

   viii. Social worker: An individual who is either currently licensed to practice as a licensed master social worker (LMSW) or as a licensed clinical social worker (LCSW) issued by the New York State Education Department;

   ix. Mental health counselor: An individual who is currently licensed or possesses a permit to practice as a mental health counselor issued by the New York State Education Department;

   x.   Marriage and family therapist: An individual who is currently licensed or possesses a permit to practice as a marriage and family therapist issued by the New York State Education Department;

   xi. Psychoanalyst: An individual who is currently licensed or possesses a permit to practice as a psychoanalyst issued by the New York State Education Department; and,

   xii. Creative arts therapist: An individual who is currently licensed or possesses a permit to practice as a creative arts therapist issued by the New York State Education Department.

b. *Licensed Practitioners of the Healing Arts (LPHAs)* are practitioners possessing a license from the New York State Education Department who are qualified by credentials, training, and experience to make a recommendation for CORE Services and shall include the following:

   i.   Physician: An individual who is currently licensed to practice medicine issued by the New York State Education Department;

   ii. Physician assistant: An individual who is currently registered to practice as a physician assistant issued by the New York State Education Department;

    iii. Nurse practitioner: An individual who is currently certified to practice as a nurse practitioner issued by the New York State Education Department;

    iv. Registered nurse: An individual who is currently licensed to practice as a registered professional nurse issued by the New York State Education Department;

    v. Psychologist: An individual who is currently licensed to practice as a psychologist issued by the New York State Education Department;

    vi. Social worker: An individual who is either currently licensed clinical social worker (LCSW) issued by the New York State Education Department or licensed to practice as a licensed master social worker (LMSW), under the supervision of a psychiatrist, psychologist, or LCSW employed by the agency;

    vii. Mental health counselor: An individual who is currently licensed to practice as a mental health counselor issued by the New York State Education Department;

    viii. Marriage and family therapist: An individual who is currently licensed to practice as a marriage and family therapist issued by the New York State Education Department;

    ix. Psychoanalyst: An individual who is currently licensed to practice as a psychoanalyst issued by the New York State Education Department; and,

    x. Creative arts therapist: An individual who is currently licensed to practice as a creative arts therapist issued by the New York State Education Department.

c. *Certified Peers* are practitioners possessing a below specified certificate who are qualified by credentials, training, and lived experience to provide direct services related to the treatment of mental illness and substance use disorders and shall include the following:

    i. Certified peer specialist: An individual who has been certified through the New York Peer Specialist Certification Board, including individuals who have a current provisional certification (NYCPS-P);

    ii. Certified recovery peer advocate: An individual who has been certified through the New York Certification Board, including individuals who have a current provisional certification (CRPA-P).

Certified peers receive annual training as a condition of maintaining their credential from the Board and receive clinical supervision by competent mental health professionals.

d. *Other Certified or Credentialed* Staff are practitioners who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness and substance use disorders and shall include the following:

    i. Certified rehabilitation counselor: An individual certified by the Commission on Rehabilitation Counselor Certification as a rehabilitation counselor;

    ii. Credentialed Alcohol and Substance Abuse Counselor: An individual who holds a credential by the Office of Addition Services and Supports (OASAS). Education/ Training/ Qualifications and functions permitted vary based on counselor category; See [OASAS SUD Counselor Scope of Practice](#) for more details.

e. *Unlicensed Behavioral Health Staff* are qualified by professional and/or personal experience in a behavioral health setting. Unlicensed staff must be at least 18 years of age and have a high school diploma or equivalent. These practitioners include:

    i. *Certified peers (as defined above)*

    ii. *Other paraprofessionals* with 1-3 years of relevant work experience in a behavioral health setting or a bachelor's degree.

f. *Student Interns* are individuals who are participating in a supervised educational program at an institution approved by the State Education Department leading to a degree and eligibility for NYS licensure or certification under one of the following professions:

    i.   Creative Arts Therapist (CAT),

    ii.   Psychoanalyst,

    iii. Psychologist,

    iv. Marriage and Family Therapist,

    v.   Mental Health Counselor,

    vi. Nurse Practitioner,

    vii. Nurse Practitioner in Psychiatry,

    viii. Physician,

    ix. Physician Assistant,

    x.   Psychiatrist,

    xi. Registered Professional Nurse,

    xii. Social Worker.

Appendix C: Terms and Conditions for Designated Providers

To ensure quality care and participant safety, CORE Services providers agree to adhere to these Terms and Conditions as a condition of designation. These Terms and Conditions include compliance with State and federal regulations, policies and guidance, CORE Service Standards, and this Service Operations Manual.

State and Federal Regulations

1. The Provider will maintain its standing as an enrolled Medicaid provider (or at which time they become an enrolled Medicaid provider) and shall comply with the rules, regulations and directives pertaining to Medicaid providers including 18 NYCRR 504. The forms needed to become an enrolled Medicaid provider can be found on the eMedNY website.

2. The Provider represents and warrants that staff, including sub-contracted/per diem staff, who will be providing services,
   a. are not currently excluded, debarred, or otherwise ineligible to participate in any federal health care programs as defined in 42 U.S.C.§ 1320a-7b(f) (the "federal healthcare programs"),
   b. have not been convicted of a criminal offense related to the provision of healthcare items or services, and
   c. are not, to the best of the Provider's knowledge, under investigation or otherwise aware of any circumstances which may result in an employee or sub-contractor being excluded from participation in the federal healthcare programs.
   d. This shall be an ongoing representation and warranty during the term of this Designation and the Provider will notify OMH/OASAS of any change in the status of the representations and warranty set forth in this section.

3. The Provider represents and warrants that staff, including sub-contracted/per diem staff, who will be providing services have undergone required background checks prior to providing services in an unsupervised setting, in accordance with MHL sections 19.20, 19.20a, 31.35, 14 NYCRR 550, 14 NYCRR 806 and SSL 424-a. These background checks are as follows:
   a. For OMH-hosted providers: The Justice Center's Criminal Background Check for providers of service who contract with or is approved or otherwise authorized by the Office of Mental Health to provide services
   b. For OASAS-hosted providers: The Criminal Background Check process for OASAS certified, authorized or otherwise approved programs
   c. For all providers: The Staff Exclusion List
   d. For all providers: The Statewide Register for Child Abuse and Maltreatment (SCR)-NB.[20]

4. The Provider will formulate and implement a written management plan to protect health history information related to an individual who has been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or a Human Immunodeficiency Virus (HIV)-related illness or a HIV infection or laboratory tests performed on an individual for HIV-related illness. The Provider will ensure staff, to whom confidential information is disclosed as a necessity for

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[20] Please be advised that this check is conducted through the Office for Child and Family Services (OCFS) and may take several weeks to complete.

providing services and in accordance with Article 27-F of the Public Health Law, are fully informed of the penalties and fines for re-disclosure in violation of the New York State law and regulation.

5. The Provider will safeguard the confidentiality of information. The Provider shall maintain the confidentiality of all such information regarding services provided in conformity with the provisions of applicable State and Federal laws and regulations, including but not limited to Article 27-F of the New York Public Health Law, Social Security Act,42 USC 1396a (a)(7), 42 C.F.R. Part 2, New York Mental Hygiene Law section 33.13 and The Health Insurance Portability and Accountability act (HIPAA) at 45 CFR Parts 160 and 164. Any breach of confidentiality by the Provider, its agents or representatives shall be cause for OMH/OASAS to terminate the Provider's Designation.

6. The Designation of any provider to deliver CORE Services described in the Provider Manual does not replace or supersede any other licensure requirements that may be applicable to providers acting within their scope of practice in accordance with NY State Educational licensing requirements.

State Policy, Manuals, and Guidance Documents

7. The Provider shall comply with the CORE Services Operations Manual for Designated Providers, which may be amended from time to time. The Provider shall comply with the HARP/Mainstream Behavioral Health Billing and Coding Manual and the CORE Services Benefit and Billing Guidance that sets forth procedures for billing and claiming for CORE services,
which may be amended from time to time.

8. The Provider acknowledges that OMH, OASAS, DOH, or Local Government Units (including the Department of Health and Mental Hygiene in New York City), may conduct an audit, inspection, and/or review of this Provider, including the right to inspect any books or records, including individual case records, and interview any staff or individuals receiving services, and that any books or records requested by such offices shall be made available upon such request. The provider shall participate in any audit, inspection, and/or review pursuant to this section.

9. The Provider will participate, at the request of OMH, OASAS, DOH, or Center for Medicare and Medicaid Services (CMS), in any evaluation and monitoring activities including reports, monitoring visits, and satisfaction surveys.

10. The Provider shall maintain personnel records for all staff, including sub-contracted/per diem staff, who will be providing services or supervision. These records must minimally include:
    a. Resume or application demonstrating appropriate experience to deliver or supervise services, as necessary to meet minimum staff qualifications;
    b. Verification of degree, licensure, or other certifications/credentials, as necessary to meet minimum staff qualifications; and,
    c. Documentation of required trainings.

11. The Provider shall maintain policies and procedures regarding:
    a. The intake, including the referral process and completion of the service-specific evaluation;
    b. recommendation for services by a Licensed Practitioner of the Healing Arts (LPHA);
    c. discharge, including the process for transferring an individual to another service provider or level of care;
    d. communication and collaboration with Health Home Care Managers and other collaterals, as appropriate;

    e.   person-centered service planning and development of the Individual Service Plan (ISP); documentation of services provided, including completion of the service encounter notes and other non-billable notes;

    f.   crisis and emergency response;

    g.   transportation of individuals receiving services by agency staff;

    h.   provision of clinical supervision for all direct service providers/staff;

    i.   compliance with all applicable requirements of state and federal laws, regulations and OMH/OASAS guidance;

    j.   quality improvement and utilization review;

    k.   incident management, reporting, and review;

    l.   secure record retention specific to the provision of services;

    m. staff training and workforce development;

    n.   community safety for staff;

    o.   confidentiality and disclosure of PHI in accordance with state and federal laws;

    p.   verification of employment history, personal references, work record, and qualifications, as well as criminal history record checks of employees; and,

    q.   grievance process for individuals receiving services which ensures the timely review and resolution of an individual's complaints and which provides a process enabling the individual to request review by the State when resolution is not satisfactory. Provider must have a compliance officer or other administrative structure available to process and address grievances and/or complaints reported by individuals receiving services.

12. The Provider shall promote the competency of its workforce by registering in the [Center for Practice Innovation](#) (CPI) learning management system (LMS) and ensuring appropriate staff conduct required training as directed by OMH and OASAS.

13. The Provider shall develop and maintain a Staffing Plan including clinical supervision by a qualified supervisor for all designated CORE Services.

14. The Provider will have capacity to deliver services with respect to each individual's preferences regarding modalities and locations that are convenient for them and best suited for their desired outcomes, including a capacity to provide in-person services in off-site settings.[21]

CFR Reporting Requirements

15. The Provider must complete an annual Consolidated Fiscal Report (CFR) and must report these services under the appropriate program code(s). CFRs are required by all service providers who operated a certified program, are designated as a BH HCBS service provider, and/or received funding from OMH and/or OASAS. Please review the current Consolidated Fiscal Report Transmittal Letter, Manual, and Appendices for more information. Additional information regarding document submission information may be found on the [OMH](#) and OASAS websites.

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[21]Off-site is defined as: Home and community-based service locations. For the purposes of CORE Services, provider-owned and controlled settings where an individual resides may be considered "off-site," unless it is also the primary work location for the staff member providing services.

To complete the above, the Provider must establish itself as an OMH or OASAS provider within the interagency system by completing an Agency Contact Form. Completion of this form allows the provider to obtain an agency code and user ID, if it hasn't done so already. This form may be obtained by emailing the [OMH Bureau of Rehabilitation Services and Care Coordination](#).

Designation Status

16. The Provider shall notify OMH/OASAS of any material change in the disclosures set forth in its application for designation. Examples of material changes may include, but are not limited to, a change in CEO or primary contact for CORE Services or a change in address/ sites.
17. Sole practitioners and/or group practices are only eligible for designation if they are able to meet and attest to all Terms & Conditions outlined herein.
18. A provider may withdraw their Designation at any time upon written notice of no fewer than 45 days to OMH/OASAS.
19. Continued designation status is contingent upon completion of required trainings.
20. The State may terminate the Provider's designation, upon written notice of termination to the Provider, if the Provider fails to comply with these Terms and Conditions and/or with any laws, rules, regulations, policies or procedures affecting CORE Services, or if the health, safety or well-being of an individual is at risk. If the Provider's designation status is terminated, the Provider will safely transition any individuals currently served to another provider or level of service.
21. In no event, shall the State be liable for expenses and obligations arising from the services(s) in the Provider's Designation after the termination date. The Provider shall not submit any claims for payment for services, expenses or obligations incurred after the date of termination of the Provider's Designation.

Appendix D: CORE Service Standards ted Providers

These Service Standards are intended to briefly describe the standards for all designated providers. The standards are derived from the Operations Manual, State and Federal Regulations, the Terms and Conditions for CORE Services Providers, and other policy and guidance documents. Please note that this document will be used to guide the State oversight process, but it should not be considered all-inclusive of the requirements for CORE Services providers.

INTAKE/EVALUATION & SERVICE PLANNING		
Area of Focus	**Standard**	**Reference**
1.1 Intake & Evaluation	1. The Provider Agency maintains documentation of the Intake & Evaluation (I&E) sessions in the Case Record. 2. The Case Record includes a signed LPHA Recommendation for the specific service(s) received, completed by a qualified practitioner. 3. Information obtained during the I&E process is incorporated into the ISP. 4. The I&E process is person-centered and is completed within 30 days or 5 sessions, whichever is longer and depending on the individual's unique needs and preferences.	Sec. 2

1.2 Person-Centered Planning and the ISP	1. The individual is engaged in a person-centered planning process throughout their episode of care.
	  a. There is evidence in the progress notes that day-to-day interventions and modalities are matched to the individual's unique needs and preferences.
	  b. There is evidence in the record that the individual was actively involved in the development of their ISP.
	
	2. The ISP includes all required elements:
	  a. The individual's name;
	  b. The provider agency's name;
	  c. The type of service;
	  d. The primary service delivery location based on individual preference;
	  e. The effective date of services;
	  f. Service frequency;
	  g. Service duration;
	  h. The individual's recovery goal(s);
	  i. Specific and measurable objective(s) related to the goal;
	  j. The individual's strengths, talents, resources, and abilities, as related to attainment of the goal;
	  k. The individual's behavioral health barriers and needs, as related to attainment of the goal;
	  l. The scope of services (interventions/methods and modality) provided by CORE staff;
	  m. Documentation that the individual was involved in the development of the ISP (for example, a progress note describing their participation, the individual's dated signature, or documentation of a refusal to sign);
		Sec. 3

	n. The name, title, and credentials/qualifications of the staff developing the ISP; and, o. The dated signature of the staff who developed the ISP. 3. Goals are written in the individual's own words, using I-statements. 4. There is evidence in the case record that the ISP has been reviewed with the individual whenever there is a significant change in their life which necessitates a change to the frequency, duration, or scope of services, or the goal. If no significant change has triggered a review within a six-month period, there is evidence in the case record that the ISP has been reviewed (based on the previous review date). 5. The case record includes a summary of each ISP Review, and the review summary is documented whether or not the ISP requires updates or revisions.	
1.3 Collaboration & Collateral Contacts	1. The value of sharing information with other parties is discussed with the individual and their consent is sought and documented as appropriate. 2. The Provider develops effective partnerships among the individual, family, and other key natural supports and service providers, as evidence by documented collaboration with collaterals in progress notes and non-billable documentation.	Sec. 6	

SERVICE DELIVERY & DOCUMENTATION (GENERAL)		
Area of Focus	**Standard**	**Reference**
2.1 Recovery-Oriented	1. Services support the acquisition of person-centered goals and are provided based on the principle that all individuals have the capacity to recover from mental illness and SUD, as evidenced by interviews with staff and individuals receiving services and language used in intakes/evaluations, service plans, and progress/ encounter notes.	Sec. 1
2.2 Trauma-Informed Care	1. Services are delivered with a trauma-informed approach that is supportive and avoids re-traumatization. All services engage individuals with the assumption that trauma has occurred in their lives.	Sec. 1
2.3 Flexible and Mobile	1. Interventions and modalities are adapted to meet the specific and changing needs of each individual, using service delivery approaches to best suit each individual's needs and preferences. This includes decisions about individual vs. group-based services and use of telehealth. 2. Service locations, whether onsite or offsite, are delivered in the setting most appropriate for skill development and goal acquisition. Onsite service delivery is only used with respect to the individual's preference and choice.	Sec. 1

2.4 Documentation of Service Delivery	1. Documentation of service delivery includes all required elements:
	  a. Name of individual receiving services
	  b. Type of service provided
	  c. Date of service provided
	  d. Location of service
	  e. Duration of service, including start and end times
	  f. Description of interventions to meet Recovery Plan goals: to include a narrative description of staff actions and the modality (Face to Face, Telephone, Collateral Contact)
	  g. Staff name, qualifications, signature and date
	
	2. The case record documents the full episode of care, including an explanation of any gaps in service delivery. Gaps in care occur when the frequency, scope, and duration of services do not occur as agreed to in the ISP.
		Sec. 3

2.5 Discharge Planning & Summary	1. There is evidence in the case record that the discharge planning process includes collaboration and communication with the individual and appropriate collateral, including the MCO, and the identification services and/or supports needed to sustain recovery, minimize the risk of relapse, and ensure optional health and well-being of the individual.
	
	2. For individuals who have been discharged from CORE Services, a Discharge Summary is added to the case record no later than 2 weeks from the date of discharge. The Discharge Summary includes the following required elements:
	  a. Date of discharge,
	  b. Reason for discharge,
	  c. Summary of progress (or lack thereof) while receiving services, and
	  d. The dated signature of the staff completing the summary.
		Sec. 3

SERVICE-SPECIFIC STANDARDS		
Area of Focus	**Standard**	**Reference**
3.1 Psychosocial Rehabilitation	1. Interventions included in the ISP are designed to assist an individual in im proving their functional abilities to the greatest degree possible in settings where they live, work, learn, and socialize. Rehabilitation counseling, skill building, and psychoeducational interventions are used to support attainment of person-centered recovery goals and valued life roles. 2. The ratio of recipients to staff is documented in the progress note (e.g. 4:1, 1:1). 3. Individuals with work- and school-related goals receive appropriate evidence-based and evidence-informed rehabilitation interventions.	Sec. 5
3.2 Community Psychiatric Support & Treatment	1. Services are provided off-site. Exceptions may be made if there is a clinical rationale for delivering services onsite, as documented in a progress note. 2. Interventions included in the ISP are time-limited, goal-directed supports and solution-focused, with the intent to achieve stability and functional improvement. 3. Services are provided on a 1:1 basis with the individual, their family, and/or other collateral.	Sec. 5
3.3 Family Support & Training	1. Interventions included in the ISP offer instruction, emotional support, and skill building necessary to facilitate engagement and active participation of the family in the individual's recovery process. 2. Services are provided 1:1 or in groups consisting of family members. Group size does not exceed 16 individuals. 3. The individual receives support in identifying "family of choice," including friends, roommates, significant others, etc., who can be supportive in the recovery process. 4. The individual receives assistance and support in deciding how much information to share with each family member.	Sec. 5
3.4 Empowerment Services – Peer Support	1. Interventions included in the ISP are intentional, goal-directed activities that emphasize the opportunity for peers to model skills and strategies necessary for recovery, thereby developing the individual's skills and self-efficacy. 2. Service delivery is provided through the perspective of a shared personal experience of recovery, enhancing the individual's sense of empowerment and hope. 3. Services are provided 1:1.	Sec. 5

ADMINISTRATION		
Area of Focus	**Standard**	**Reference**
4.1 Data-Driven Service Delivery	1. The Provider Agency actively and systematically seeks feedback from individuals receiving services and collaterals regarding services. 2. The Provider Agency has quality assurance processes in place to ensure that data is collected, analyzed and utilized on a routine basis to change and improve services, in response to identified needs. 3. Data obtained from Incident Review Committee (IRC) trends, satisfaction surveys results, and other quality assurance activities is used in training and service improvement initiatives.	Sec. 1
4.2 Staff Qualifications & Competencies	1. Services are provided by qualified staff who meet the respective qualifications and training requirements indicated in the Operations Manual and Staff Training Memo. 2. Direct Practitioners receive appropriate clinical supervision based on their licensure/certification and scope of work. (Qualifications for supervisory staff may be found in the Operations Manual.) 3. Supervisors assign and staff complete relevant elective trainings based on need. 4. Services utilize evidence-based practices and evidence-informed approaches where appropriate.	Sec. 7,
4.3 Caseload Size	1. CORE Services Staff and Supervisory caseloads (including mixed caseloads) are appropriate and reflective of a strong clinical rationale, including the person-centered needs and preferences of each individual receiving services and the strengths and abilities of each staff member. .	Sec. 6
4.4 CORE Services Provider Designation Application	1. The application on file in the Application Database is reflective of the Provider Agency's current information, including: a. Agency Name and DBA, if applicable b. Agency NPI and MMIS c. Administrative Address d. Executive Director and Primary Contact for Adult BH HCBS e. Services offered f. Sites/ Service Locations (counties served)	Sec. 13

4.5
Active Status
	1. The Provider Agency remains in active status, as defined by:
	   a. prepared to accept and serve individuals referred, OR
	   b. has accepted referrals and is currently providing services, but is at capacity and cannot accept new referrals; AND
	   c. is under contract with at least one Managed Care Organization to deliver CORE Services; AND
	   d. has qualified and trained staff to deliver all services for which the provider is designated.
		Sec. 13

4.6 CORE Services Policies & Procedures	1. The Provider Agency's maintains Policies & Procedures (P&P) as outlined in the Terms and Conditions for CORE Service Providers, and the P&P align with programmatic requirements as outlined in Operations Manual and these Service Standards.	Appendix C

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