Guidance for Outpatient Treatment, Residential, Residential Treatment Facility, and Care Management Programs on Collaborating with Hospitals on Admissions and Discharges to Support Recovery-focused System Change
October 2024

The goal of this document is to offer guidance to all community-based treatment, rehabilitative, care management, residential, and Residential Treatment Facility (RTF) programs that are licensed, designated, or funded by the Office of Mental Health on best practices and expectations for collaborating with hospital Emergency Departments (EDs), Comprehensive Psychiatric Emergency Programs (CPEPs), and Inpatient Psychiatric Units and each other regarding admissions and discharges for individuals with behavioral health presentations. Aspects of the guidance that are applicable only to certain programs are delineated below. Please refer to the appendix for applicable programs. Please note that this guidance covers the lifespan – children, youth, young adults, adults and older adults.

The Office of Mental Health and Department of Health recently released Guidance on Evaluation, Admission, and Discharge Practices for individuals who present with behavioral health conditions. A critical component of successful implementation of such guidance is ensuring a person-centered, trauma-informed and responsive, and recovery-oriented approach and increased coordination with community-based programs who are responsible for warm hand-offs when individuals step up to and down from higher levels of care. A collaborative community system can ensure successful post-discharge community tenure and help individuals, including those with the most complex needs, achieve personally meaningful and individually driven improved outcomes.

All the recommended activities outlined below are to always be considered in a person-centered context and be consistent with Olmstead which requires that recipients be offered services in the least restrictive and most integrated settings. Providers should bear in mind the individual's, and, as appropriate, family's preferences and construct plans of care based upon those expressed needs and preferences. There will be rare extenuating circumstances when specific recommended practices should not be used, and there will be circumstances when individuals clearly state they do not want the provider to pursue specific recommended practices. Providers must always balance individual needs and preferences with recommended standards of care and pursue plans of care centered around the individual's wishes whenever possible.

All community-based programs must keep their contact information up to date in the Mental Health Provider Data Exchange (MHPD), a web based application for use by providers, County Mental Health departments, and state agencies, to ensure that hospitals and other providers can locate accurate contact information through the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) to obtain timely collateral information.

For the purposes of this guidance, collateral source of information means anyone that has direct knowledge of the individual's pre-crisis baseline, events that led to the presentation, recent history, prior psychiatric and medical history, strengths, support networks, or risk factors. Collateral sources help with comprehensive mental health care consistent with person focused, family-centered, recovery-oriented care.
This could be:

1) People, as designated by the individual receiving services (or their legal guardian), considered a member of their family, friends, a caregiver/guardian, or member of their household;
2) Staff member(s) of a treatment, residential, RTF, or other community-based program; and/or
3) People, as designated by the individual receiving services (or their legal guardian), who otherwise interact regularly with the individual receiving services and seen as sources of information or support.

OMH providers should always make reasonable attempts to obtain consent from patients (or their legal guardian) to facilitate communication with other service providers and collaterals, where clinically appropriate and necessary to assure sound decision-making. If no signed consent can be obtained due to patient refusal or incapacity, providers may legally, and are expected to as part of their OMH licensure and OMH guidance, share the minimum necessary information in order to provide needed care, and for appropriate aftercare and care coordination with other services providers. As a reminder, the Federal Health Insurance Portability and Accountability Act (HIPAA) allows information sharing for the purposes of treatment and care coordination, with or without patient consent. This applies to Article 28 hospital programs, including emergency departments. OMH providers meeting certain criteria are allowed under both HIPAA and subdivision (d) of section 33.13 of the MHL to use or disclose PHI for treatment or care coordination purposes with other parties without a signed consent form. OMH has released Guidance for OMH Programs Regarding the Disclosure of Protected Health Information for Treatment Collaboration, Hospital Discharge Planning, or Care Coordination.

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Section I: Guidance for Community-Based Providers for Individuals Currently Enrolled in the Service/Program

Section IA: Communication and Collaboration with Hospital Providers

Outpatient Treatment and Rehabilitative Providers

1) These programs must develop policies and procedures for communicating information from the records of individuals served to hospital staff seeking information, including identifying staff who are responsible for such communication. Programs should have a system to allow hospitals to contact a staff member who can access and provide clinical information when an individual presents to an ED or CPEP. This function must be available during regular business hours for all programs. Additionally, and only for programs responsible to respond to crises after hours, it is expected that this function is available for hospital staff in the evening, overnight, and weekends/holidays.
2) Treatment Programs are expected to transmit the following to acute hospital programs:
   a. Current safety plans, psychiatric advance directives, and/or relapse prevention plans, if available. PSYCKES MyChois allows uploading of safety and other plans for individuals on Medicaid.
   b. List of family and other supports and their contact information, as well as any limitations on consent to share information.
   c. List of all community service providers and their contact information, as available, as well as any limitations on consent to share information.
   d. Pertinent critical clinical information, including but not limited to, current condition, active (or current) problem list, strengths, accurate medication list, estimate of individual's adherence to treatment, and diagnoses.
   e. Presentation within the last 12 months to mobile crisis and other crisis services, EDs, CPEPs, or inpatient units.
   f. Current suicide and violence risk assessment, if available.
3) As a suggested practice, programs should develop policies and procedures to create and routinely update summaries or face sheets (in hardcopy or electronic) with the above information to have available as a reference for the staff member(s) communicating with hospitals as well as for rapid transmission to the hospital team.
4) Outpatient providers are expected to collaborate with frequently used and nearby ED/CPEPs to develop communication protocols for circumstances when programs send individuals requiring emergency hospital evaluation to the ED/CPEP. They should ensure close communication with the ED/CPEP by:
   a. Proactively transmitting the summary information described above, when available, to the ED/CPEP based on procedures, timing and contacts collaboratively developed by hospital and community partners.

b. Developing communication protocols whereby program staff who send the individual to the ED/CPEP call the ED/CPEP and speak with ED/CPEP staff to provide collateral information. This may include the evaluating social worker (if a primary social worker is assigned), the ED physician, psychiatrist, or nurse practitioner. If a direct conversation is not possible or is declined by the hospital, this should be clearly documented.
c. Developing a system for sharing contact information for the community staff member who can be available to answer questions - during business hours for all programs and during all hours for programs responsible to respond to crisis after hours.
d. Developing communication protocols when an involuntary removal from the community pursuant to MHL §9.41, 9.45, 9.58, or 9.60 is initiated. Protocols must include direct communication of exactly what prompted the removal to ED/CPEP staff, especially the evaluating hospital psychiatrist or emergency physician determining if the individual meets criteria for an involuntary or emergency inpatient admission. The communication should be clearly documented. If a direct conversation is not possible or is declined, this should also be clearly documented.
e. Ensuring that legal guardians are contacted by the outpatient provider as soon as possible when minors are transported to the hospital.

5) Assertive Community Treatment (ACT) Teams are expected, unless there is a rare extenuating circumstance, to join in the ED/CPEP individuals who require emergency hospital evaluation and, where possible and as appropriate, remain with them, to speak with the hospital team, as necessary, and provide current collateral information. In the rare circumstance that despite assertive engagement, the individual over 18, or the parent/legal guardian of an individual under 18, declines accompaniment, the staff member should ensure that information is transmitted to the hospital by the time the individual is being evaluated at the hospital.
6) OnTrack Coordinated Specialty Care Teams are expected, unless there is a rare extenuating circumstance, to join in the ED/CPEP individuals who require emergency hospital evaluation and, where possible and as appropriate, remain with them, to speak with the hospital team, as necessary, and provide current collateral information. In the rare circumstance that despite assertive engagement, the individual over 18, or the parent/legal guardian of an individual under 18, declines accompaniment, the staff member should ensure that information is transmitted to the hospital by the time the individual is being evaluated at the hospital.

Care Management Providers

1) Programs must develop a protocol for identifying staff who are responsible for communicating information from the records of individuals served to hospital staff seeking information. Programs should have a system to allow hospitals to contact a staff member who can access and provide clinical information when an individual presents to an ED or CPEP. This function must be available during regular business hours for all programs. Additionally, and only for programs responsible to respond to crises after hours, it is expected that this function is available for hospital staff in the evening, overnight, and weekends/holidays.
2) Programs are expected to transmit the following to acute hospital programs:
   a. Current safety plans, psychiatric advance directives, and/or relapse prevention plans, if available. PSYCKES MyChois allows uploading of safety and other plans for individuals on Medicaid.

b. List of family and other supports and their contact information, as well as any limitations on consent to share information;
c. List of all community service providers and their contact information, as available, as well as any limitations on consent to share information;
d. Pertinent critical clinical information, including but not limited to, current condition (status), active (or current) problem list, strengths, accurate medication list, estimate of individual's adherence to treatment, and diagnoses;
e. Presentation within the last 12 months to mobile crisis and other crisis services, EDs, CPEPs, or inpatient units;
f. Current suicide and violence risk assessment, if available;

3) As a suggested practice, programs should develop summaries or face sheets (in hardcopy or electronic) with the above information to have available as a reference for the staff member(s) communicating with hospitals as well as for rapid transmission to the hospital team.
4) Care Management providers are expected to collaborate with frequently used or nearby ED/CPEPs to develop communication protocols for circumstances when programs send individuals requiring emergency hospital evaluation to the ED/ CPEP. They should ensure close communication with the ED/CPEP by:
   a. Proactively transmitting the summary information described above, when available, to the ED/CPEP based on procedures, timing and contacts collaboratively developed by hospital and community partners.
   b. Developing communication protocols whereby program staff who send the individual to the ED/CPEP should call the ED/CPEP and speak with ED/CPEP staff to provide collateral information. This may include the evaluating social worker (if a primary social worker is assigned), the ED physician, or psychiatrist. If a direct conversation is not possible or is declined by the hospital, this should be clearly documented.
   c. Developing a system for sharing contact information for the community staff member who can be available to answer questions - during business hours for all programs and during all hours for programs responsible to respond to crisis after hours.
   d. Developing communication protocols when an involuntary removal from the community pursuant to MHL §9.41, 9.45, 9.58, or 9.60 is initiated. Protocols must include direct communication of exactly what prompted the removal to ED/CPEP staff, that include the evaluating hospital psychiatrist or emergency physician determining if the individual meets criteria for an involuntary or emergency inpatient admission. The communication should be clearly documented. If a direct conversation is not possible or is declined, this should also be clearly documented.
   e. Ensuring that legal guardians are contacted by the outpatient provider as soon as possible when minors are transported to the hospital.
5) Intensive and wrap-around programs (e.g., SOS Teams, Specialty Mental Health Care Management, High-Fidelity Wraparound Care Management, Critical Time Intervention (CTI) teams, INSET teams, etc.) are expected, unless there is a rare extenuating circumstance, to join in the ED/CPEP individuals who require emergency hospital evaluation and, where possible and as appropriate, remain with them, to speak with the hospital team, as necessary, and provide current collateral information. In the rare circumstance that despite assertive engagement, the individual over 18, or the parent/legal guardian of an individual under 18, declines accompaniment, the staff member should ensure that information is transmitted to the hospital by the time the individual is being evaluated at the hospital.

Residential Treatment Facilities (Community-Based Inpatient Psychiatric Providers for Children and Youth) and Residential Providers

1) Programs must develop policies and procedures for communicating information from the records of individuals served to hospital staff seeking information, including identifying staff who are responsible. This function must be available during regular business hours for all programs.
   a) Additionally, in RTFs and residential programs with evening, overnight, and/or weekend/holiday staffing, it is expected that this function is available for hospital staff whenever a staff member is on duty.
   b) RTFs and residential programs should develop local communication protocols with hospital and other community partners, including how hospitals can contact on-duty staff members who can provide information when an individual presents to an ED or CPEP outside of standard business hours.
   c) RTFs and residential programs should have a protocol to ensure that supervisors and staff on the next shift are kept up to date of circumstances that may result in individuals being referred to the ED or CPEP.
2) Programs are expected to transmit the following to acute hospital programs, whenever available:
   a) Current safety plans, psychiatric advance directives, and/or relapse prevention plans, if available. PSYCKES MyChois allows uploading of safety and other plans for individuals on Medicaid;
   b) List of family and other supports and their contact information, as well as any limitations on consent to share information;
   c) If applicable, a list of all community service providers and their contact information, as available, as well as any limitations on consent to share information;
   d) Pertinent critical clinical information, including but not limited to, current condition (status), active (or current) problem list, strengths, accurate medication list, estimate of individual's adherence to treatment, and diagnoses;
   e) Recent presentations to mobile crisis and other crisis services, EDs, CPEPs, or inpatient units;
   f) Current suicide and violence risk assessment, if available;
   g) DSS 3074 Status of Bed Reservation form for Residential Treatment Facilities (RTFs) recipients.
3) As a suggested practice, programs should develop policies and procedures to create and routinely update summaries or face sheets (in hardcopy or electronic) with the above information to have available as a reference for the staff member(s) communicating with hospitals as well as for rapid transmission to the hospital team.
4) RTFs are expected to, unless there is a rare extenuating circumstance, join in the ED/CPEP individuals who require emergency hospital evaluation and remain with them as appropriate including to speak with hospital staff and provide current collateral information.
5) RTFs and residential providers are expected to collaborate with frequently used or nearby ED/CPEPs to develop communication protocols for circumstances when programs send individuals requiring emergency hospital evaluation to the ED/ CPEP. They should ensure close communication with the ED/CPEP by:

a) Proactively transmitting the summary described above, when available, to the ED/CPEP based on procedures, timing and contacts collaboratively developed by hospital and community providers.
b) Program staff who sent the individual to the ED/CPEP should call the ED/CPEP and speak with ED/CPEP staff to provide collateral information. This may include the evaluating social worker (if a primary social worker is assigned), the ED physician, or psychiatrist. If a direct conversation is not possible or is declined by the hospital, this should be clearly documented.
c) When minors are transported to the hospital, the RTF or residential program must notify their legal guardian as soon as possible.
d) For RTF recipients kept overnight, the program staff need to provide the ED/CPEP with the DSS 3074 Status of Bed Reservation form.

Section IB: Coordinated After-care and Discharge Planning

Outpatient Treatment and Rehabilitative Providers

For All Individuals:

1) Programs must develop policies and procedures for when an individual is admitted to an inpatient psychiatric unit, staff familiar with the individual should remain engaged with them and the hospital treatment team to follow the individual's progress and give input to discharge and aftercare planning. Hospital acute programs are directed to develop discharge plans in conjunction with the individual receiving services.
2) Additionally, ACT Teams and OnTrackNY providers should visit the individual while in the hospital setting prior to discharge, if possible, and be present on day of discharge, as appropriate, to accompany the individual back into the community.
3) Outpatient Treatment and Rehabilitative programs must offer follow-up scheduled appointments to individuals being discharged from EDs, CPEPs, and inpatient units within seven calendar days of discharge. A referral to an unscheduled walk-in intake clinic is not sufficient. However, offering an appointment with a specific time within walk-in hours is acceptable provided there is a staff member who is expecting the individual and will follow up if they do not attend.
    a. If the individual does not come to their scheduled appointment, the outpatient treatment or rehabilitative provider must attempt to engage the individual. Programs should utilize a range of approaches to foster engagement, including off site outreach and engagement services, peer services, telehealth and others, as available. This communication must be documented.
    b. If the individual does not come to their scheduled appointment and is enrolled in care management services, the outpatient treatment or rehabilitative provider must notify the care management provider, if applicable.
    c. If the individual does not come to their scheduled appointment, the outpatient provider may notify the hospital, in accordance with locally developed communication protocols, so that the hospital can ensure more discharge supports if the individual presents again.
    d. Additionally, some programs have stricter requirements:
        i) Mental Health Outpatient Treatment and Rehabilitation Services (MHOTRS) and Certified Community Behavioral Health Clinics (CCBHCs) must offer individuals who

are currently enrolled in the service or program a follow-up appointment within five business days of discharge from an acute setting.

ii) ACT and OnTrackNY Teams, in addition to contact on the day of discharge, should additionally have a scheduled appointment to see the individual within 72 hours of discharge.

4) On the first post-hospital discharge visit, outpatient programs must provide information on crisis resources, including 988, and the program's own crisis capabilities. If the first post-hospital discharge visit is not within 72 hours of discharge, the program should reach out to the discharged individual no later than 72 hours of discharge to offer an appointment reminder and provide information on crisis resources.
5) On the first post-hospital discharge visit, if the individual is not already connected to peer support services and if available, programs should provide information and connection to peer support services for outreach, connection, and engagement. Peer Support is an evidence-based practice. When an individual or family receives support from a peer with shared lived experience, their individual self-efficacy and autonomy improves, along with their communication, connections, social support, and community involvement. If peer support services are not currently provided by the program, information about any available community-based peer services should be offered.
6) For any individual attending primary or secondary school, and within legal requirements of consent, the outpatient treatment team should contact the minor's school and ensure the school team is aware of the recent hospital discharge and to be prepared to help integrate the minor back into normal routines.

Individuals with Complex Needs

7) For individuals with complex needs and repeated admissions, the hospital is directed to provide several communications to the receiving outpatient programs. The programs should have staff familiar with the individual available to receive and review the communications:
   a. A verbal clinical update within legal requirements for consent to the receiving outpatient treatment program as close as possible to the time of discharge; and
   b. A discharge summary within seven days of discharge. Outpatient treatment programs should have a protocol in place to receive the summary and ensure that the assigned psychiatrist or psychiatric nurse practitioner reviews it within 24 hours of receipt to ensure that critical-time tasks, including but not limited to ordering labs for continuing clozapine, are not missed. The inpatient discharge summary is different that the discharge instructions, which are handed to the individual at discharge.
8) If an individual with complex needs and repeated admissions is enrolled in a care management program, it should initiate, as applicable, a meeting with other service systems involved in the care of the recently discharged individual, including, but not limited to the LGU, the school, other outpatient treatment programs, residential programs, homeless shelters, peer support services, and social services to plan on how to decrease the individual's risk for readmission. The family should be included in meetings involving discharged adolescents and children and adults where applicable. The outpatient treatment and rehabilitative providers must participate in this meeting.
9) Individuals with Complex Needs will be identifiable by a new flag in PSYCKES that is expected to be available in the fourth quarter of 2024.

Care Management Providers

1) When an individual is admitted to an inpatient psychiatric unit, the care coordinator assigned to work with the individual and with whom they are engaged, or a back-up staff member who is familiar with the individual's recent history, should remain engaged with the hospital treatment team to follow the individual's progress and give input to discharge and aftercare planning. Hospital acute programs are directed to develop discharge plans in conjunction with the individual receiving services.
    a. Care Management Providers should assist hospital staff in coordinating with all other community-based service providers.
    b. CTI Teams, OMH Designated Specialty Mental Health Care Management Agencies (SMH CMAs), OMH-funded Pathway Home, Safe Options Support (SOS), and High-Fidelity Wraparound (HFW) programs should visit the individual while in the hospital setting prior to discharge if possible and be present on day of discharge to company the individual back into the community.
2) Care Management providers must connect with individuals being discharged from EDs, CPEPs, and inpatient units within seven days of discharge.
3) SOS Teams, CTI Teams, SMH CMAs, HFW, and Pathway Home programs and other high intensity care management programs must see the individual within 72 hours of discharge from the ED, CPEP, or Inpatient Psychiatric Unit.
4) Post-discharge, staff are expected to check-in frequently, ideally daily, until the first follow-up outpatient treatment appointment.
5) Ideally, a staff member should accompany the individual to the first post-discharge follow-up appointment. In the rare circumstance that despite assertive engagement, the individual declines accompaniment, the staff member should ensure that necessary information is transmitted to the treating provider.
6) On the first contact post-discharge, care management programs should provide psychoeducation on crisis resources, including 988, and the program's own crisis capabilities. When programs meet with individuals while still inpatient, information should be shared then, and reviewed after the first discharge appointment.
7) On the first contact post-discharge, if the individual is not already connected to peer support services and if available, programs should provide information and connection to peer support services for outreach, connection, and engagement. If peer support services are not currently provided through the program, information about any available community-based peer services should be offered.
8) The inpatient unit is directed to forward a comprehensive discharge summary within seven days of discharge. Care management programs should ensure that relevant information is distributed to all applicable parties supporting the individual, within the legal requirements for confidentiality. Note that the discharge summary is different from the discharge instructions, which will be handed to the individual at discharge.
9) For any individual attending primary or secondary school, and within legal requirements of consent, the community-based care management team should contact the minor's school and ensure the school team is aware of the recent hospital discharge and to be prepared to help integrate the minor back into normal routines.
10) For individuals with complex needs and repeated admissions, the care management program should initiate, as applicable, a meeting with other service systems involved in the care of the recently discharged individual, including, but not limited to the LGU, the school, other outpatient treatment programs, residential programs, homeless shelters, and social

services to plan on how to decrease the individual's risk for readmission. The family should be included in meetings involving discharged adolescents and children and adults where applicable. The outpatient treatment and rehabilitative providers must participate in this meeting.

Residential Treatment Facilities (Community-Based Inpatient Psychiatric Providers for Children and Youth) and Residential Providers

1) Programs must develop policies and procedures for when an individual is admitted to an inpatient psychiatric unit, staff familiar with the individual should remain engaged with the individual and the hospital treatment team to follow the individual's progress and give input to discharge and aftercare planning.
2) RTF staff should regularly participate in treatment team meetings in the hospital. RTFs should be actively involved in discharge planning. RTF Psychiatrists should be available for doc to doc to discuss any changes to diagnoses and medications.
3) RTF staff should closely monitor youth recently discharged from inpatient level of care, including with 1:1 staffing as appropriate, as they settle back into the RTF routine and milieu.
4) Post-discharge, staff in RTFs and congregate residential programs should check-in daily until the first post-discharge follow-up treatment appointment. Program staff should alert a supervisor if there are any concerns. A check-in is an informal contact where program staff see how the individual is feeling and whether they are settling back into the program routine.
5) Staff in non-congregate residential programs must have an in-person visit within 48 hours of discharge.
6) As applicable, if the individual does not go to their scheduled post-discharge outpatient treatment appointment, residential program must attempt to engage the individual and facilitate their re-engagement in outpatient care. If unsuccessful, the residential program should reach out to the outpatient treatment or rehabilitative provider, care management programs, and other community supports to strategize next steps.
7) RTFs and residential programs should provide information on crisis resources, including 988, and the agency's own crisis capabilities, as applicable.
8) If possible, RTFs and residential programs should provide information and connection to peer support services for outreach, connection, and engagement. If peer support services are not currently provided by the RTF or residential program, information about community-based peer services should be offered.
9) For individuals with complex needs and repeated admissions, the hospital is directed to provide several communications to the receiving RTF or residential program. The programs should have staff familiar with the individual available to receive and review the communication:
    a. a verbal clinical update within legal requirements for consent to the receiving RTF or residential program as close as possible to the time of discharge. Programs should have staff familiar with the individual available to receive the verbal sign-out; and
    b. a discharge summary within seven days of discharge but sooner where possible, and ideally on date of discharge. RTFs and residential programs should have a protocol in place to ensure the supervisor review the summary within 24 hours of receipt to ensure time-critical interventions, medication titrations, and appointments are understood and that questions or concerns can be conveyed to treatment providers. The inpatient

discharge summary is different that the discharge instructions, which are handed to the individual at discharge.

Collaboration Among Community Providers

To avoid the risk that a recently discharged individual receives too many contacts (from outpatient treatment, residential, and care management providers), programs should coordinate internally to streamline outreach efforts. If the individual is enrolled in intensive and wrap-around programs (e.g., ACT, SOS Teams, SMH CMA, HFW Care Management, CTI, INSET teams, OnTrackNY Coordinated Specialty Care, etc.), staff from these programs should take the lead on connecting with the individual and communicating with residential and treatment providers. Staff from RTFs and congregate residential programs should closely engage individuals who were recently discharged and alert treatment providers of any concerns. Outpatient treatment providers who serve individuals who do not have intensive or wrap-around supports and who live in a private residence or a non-congregate setting should take the lead on engaging with the individual post-discharge to help ensure successful engagement in outpatient programs. For individuals who are connected to peer services, an assigned peer can also help engage the individual; however, peer staff cannot be solely responsible for post-discharge engagement.

Section II: Referrals of New Individuals from Hospitals to Community Providers

Outpatient Treatment and Rehabilitative Providers

1) Upon accepting a referral for a new individual, outpatient treatment and rehabilitative programs should make every effort to contact the individual while they are still in the hospital, including via telehealth (video or audio-only) to help improve engagement post-discharge.
2) New referrals from hospital EDs, CPEPs, and inpatient units must be seen within seven calendar days of discharge from the hospital. A referral to an unscheduled walk-in intake clinic is not sufficient. However, offering an appointment with a specific time within walk-in hours is acceptable provided there is a staff member who is expecting the individual and will follow up if they do not show up. Community-based treatment programs should prioritize individuals being discharged from the hospital for any available intake appointment.
    a) If the scheduled follow-up appointment is not within 72 hours of discharge, the program should reach out to the discharged individual no later than 72 hours of discharge to offer an appointment reminder and provide information on crisis resources.
    b) During the initial appointment, programs should provide information on what to do if the individual feels increasing distress and information on crisis resources, including 988, and the program's own crisis capabilities.
    c) If the individual does not come to their scheduled appointment, the outpatient treatment provider must attempt to engage the individual. Programs should utilize a range of approaches to foster engagement, including off site outreach and engagement services, peer services, telehealth and others, as available. This communication must be documented.
    d) If the individual does not come to their scheduled appointment, the outpatient provider must engage with all other post-hospital discharge referrals, including but not limited to,

care management programs, CTI or SOS Teams, to inform them and coordinate a strategy to re-engage the individual. The outpatient program should also contact the discharging hospital program and ask for the hospital discharge staff for help in re-engaging the individual.

e) Additionally, as per, 14 NYCRR Part 599.6, Mental Health Outpatient Treatment and Rehabilitative Service (MHOTRS) programs must assure that those referred from inpatient, forensic, or emergency settings, those determined to be at high risk, and those determined to be in urgent need by the Director of Community Services (DCS) receive services within seven days. This is a slightly different requirement than for other programs. When receiving these referrals, MHOTRS programs should directly admit the individual to services and should not conduct pre-admission visits. When conducting the initial assessment, MHOTRS may use information obtained from the referring clinical team and/or DCS.

3) On the initial visit, if the individual is not already connected to peer support services and if available, programs should provide information and connection to peer support services for outreach, connection, and engagement. Peer Support is an evidence-based practice. When an individual or family receives support from a peer with relative lived experience, their individual self-efficacy and autonomy improves, as well as their communication, connections, support, and involvement. If peer support services are not currently provided by the program; information about any available community-based peer services should be offered.

Care Management Providers

1) Care management provides should rapidly enroll referred eligible individuals who are currently hospitalized and engage them in the hospital before discharge.
2) Upon hospital discharge, care management staff should check-in frequently, ideally daily, until the first post-discharge outpatient treatment appointment. Ideally, they should accompany the individual to the first follow-up appointment.
3) Upon enrollment, programs should provide information on crisis resources, including 988, and the program's own crisis capabilities.
4) On the first contact post-discharge, if the individual is not already connected to peer support services and if available, programs should provide information and connection to peer support services for outreach, social connection, and engagement. If peer support services are not currently provided through the program; information about any available community-based peer services should be offered.
5) If the individual does not come to their scheduled appointment, the care management provider must attempt to engage the individual. Programs should utilize a range of approaches to foster engagement, including off site outreach and engagement services, peer services, telehealth and others, as available. This communication must be documented.

Collaboration Among Community Providers

To avoid the risk that a recently discharged and newly referred individual receives too many contacts (from outpatient treatment, residential, and care management providers), programs should coordinate internally to streamline outreach efforts. Programs with an existing relationship with the individual must take the lead in engagement efforts. When there are no prior existing relationships, if the individual is newly enrolled in intensive and wrap-around programs (e.g., ACT, SOS Teams, SMH CMA, HFW Care Management, CTI, INSET teams,

OnTrackNY Coordinated Specialty Care, etc.), staff from these programs should take the lead on connecting with the individual and communicating with residential and treatment providers. Staff from RTFs and congregate residential programs should closely engage individuals who were recently discharged and alert treatment providers of any concerns. For individuals who are connected to peer services, an assigned peer can also help engage the individual; however, peer staff cannot be solely responsible for post-discharge engagement.

Appendix – Classification of Programs

****Please note these program classifications apply to this guidance only.**

Outpatient Treatment and Rehabilitative Programs

Program Name	Description	Target Population	Expected Length of Service	Capacity to Provide 24/7 In Person or On-Call Telephonic Coverage
Adult Assertive Community Treatment (ACT)	ACT Teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on the improvement of an individual's quality of life in the community and reducing the need for inpatient care, by providing intense community-based treatment services by an interdisciplinary team of mental health professionals. The ACT program has low staff-outpatient ratios; 24-hour-a-day, seven-day-per-week availability; enrollment of consumers, and flexible service dollars. Treatment is focused on individuals who have been unsuccessful in traditional forms of treatment. Specialty models include: Flexible ACT, Rural ACT, Shelter ACT, Forensic ACT, and Older Adult ACT.	Adults ages 18+	Individualized; >12 months	Yes
Young Adult ACT	Young Adult ACT provides comprehensive clinical treatment, as well as services/supports needed to	The program serves young adults, ages 18 to 25, with SMI who	3 years	Yes

	help young adults develop the skills needed for independence.	cannot be engaged in the traditional rehabilitation system and are high utilizers of intense services, such as ER's and inpatient hospitals.		
Youth ACT (YACT)	The Youth ACT program uses a multi-disciplinary team approach to serve children and/or youth with Serious Emotional Disturbance (SED), who are returning home from inpatient settings or residential services, at risk of entering such settings, or have not adequately engaged or responded to treatment in more traditional community-based services.	Children/youth ages 10-21 with a determination of SED and have continuous high service needs that are not being met in more traditional service settings.	Individualized; 12-18 months	Yes
Adult Behavioral Health Home and Community Based Services (BH HCBS)	A menu of stand-alone services that provide support for adults with behavioral health disorders to live, work, learn, and socialize in the settings of their choice. BH HCBS include: Habilitation, Pre-vocational Services, Transitional Employment, Intensive Supported Employment, Ongoing Supported Employment, and Education Support Services.	Adults ages 21+ with a behavioral health disorder Must be enrolled in a Health and Recovery Plan (HARP) or be HARP-eligible and enrolled in an HIV Special Needs Plan (SNP).	Individualized; 3-24 months	No
Children's Day Treatment	A non-residential program that integrates mental health services and educational services within a milieu for children and adolescents with serious emotional disturbance (SED).	Youth ages 3-18 with a diagnosed mental illness plus either an extended impairment in functioning due to emotional distress or a current impairment in	18-24 months	No

		functioning with severe symptoms that impacts educational progress.		
Children and Family Treatment and Support Services (CFTSS)	Home and community-based services to identify and intervene in a child/youth's mental health trajectory. Services support youth and family to educate, enhance skills, promote self-advocacy, and prevent the worsening of a mental health condition.	Youth, birth-21, experiencing symptoms associated with a mental health diagnosis.	Individualized; <6 months	No
Certified Community Behavioral Health Clinic (CCBHC)	Outpatient behavioral health services. Services include mental health and substance use treatment, crisis response, peer support, rehabilitation, screening and monitoring, etc.; provided in a variety of sites including schools and community offices.	Individuals with a designated mental health diagnosis or substance use diagnosis, across the lifespan.	Indefinite	Yes
Community Oriented Recovery and Empowerment (CORE) Services – Community Psychiatric Support & Treatment (CPST)	Mobile clinical treatment and intensive rehabilitation services provided by qualified clinical staff (licensed or permitted). CPST providers may or may not offer medication management.	Adults ages 21+ with a behavioral health disorder Must be enrolled in a Health and Recovery Plan (HARP) or be HARP-eligible and enrolled in an HIV Special Needs Plan (SNP) or Medicaid Advantage Plus (MAP) Plan.	Individualized; 3-24 months	No
Community Oriented Recovery and Empowerment (CORE) Services –	Goal-directed, non-clinical peer support services	Adults ages 21+ with a behavioral health disorder	Individualized; 3-24 months	No

Empowerment Services Peer Support		Must be enrolled in a Health and Recovery Plan (HARP) or be HARP-eligible and enrolled in an HIV Special Needs Plan (SNP) or Medicaid Advantage Plus (MAP) Plan.		
Community Oriented Recovery and Empowerment (CORE) Services – Family Support & Training (FST)	Psychoeducation and skill building for families of adults with SMI; may include skill building to support the individual's family relationships	Adults ages 21+ with a behavioral health disorder Must be enrolled in a Health and Recovery Plan (HARP) or be HARP-eligible and enrolled in an HIV Special Needs Plan (SNP) or Medicaid Advantage Plus (MAP) Plan.	Individualized; 3-24 months	No
Community Oriented Recovery and Empowerment (CORE) Services – Psychosocial Rehabilitation (PSR)	Psychoeducation, skill building, and rehabilitation counseling focused on living, working, learning, and socializing	Adults ages 21+ with a behavioral health disorder Must be enrolled in a Health and Recovery Plan (HARP) or be HARP-eligible and enrolled in an HIV Special Needs Plan (SNP) or Medicaid Advantage Plus (MAP) Plan.	Individualized; 3-24 months	No

Continuing Day Treatment	Active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to develop self-awareness and self-esteem through the exploration and development of patient strengths and interests	Adults ages 18+	Individualized; >12 months	Yes
Home Based Crisis Intervention	Provides in-community and in-home services/supports to help avert unnecessary psychiatric hospitalization or placement	Youth ages 5-20 in mental health crisis	4-6 weeks	Yes
Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)/ Clinic	Outpatient assessment and treatment for experiencing mental health concerns. Treatment is offered in a variety of sites including schools and community offices.	Individuals with a designated mental health diagnosis; ages served vary by agency.	Indefinite	Yes
Partial Hospitalization Program	Partial hospitalization programs shall provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program.	Lifespan; Children/youth & Adults with SED, significant mental health needs and service utilization that but for the availability of a partial hospitalization program, would necessitate admission to or continued stay in an inpatient hospital	Individualized; <6 months	Yes
Personalized Recovery Oriented Services	Personalized Recovery Oriented Services (PROS) is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's	Adults ages 18+	Individualized; >6 months	Yes

	recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. There are four "service components" in the program: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and Clinical Treatment (CT). Note that PROS Programs may be licensed with or without the Clinical Treatment component. Additionally, individuals served in a PROS with Clinical Treatment may choose to not enroll in that program's CT component.			
OnTrack	OnTrackNY is a network of Coordinated Specialty Care (CSC) teams across New York State that offers comprehensive, personalized support to teens and young adults impacted by unexpected changes in their thinking and perceptions.	Young Adults 16-30yo; experiencing psychosis for fewer than two years.	Individualized, Approximately 2 years	Yes

Care Management Providers

Program Name	Description	Target Population	Expected Length of Service	Capacity to Provide 24/7 On-Call Telephonic Coverage
Critical Time Intervention (CTI) Teams	Adult Critical Time Intervention (CTI) Teams provide time-limited, phase-based transitional services to support individuals through critical transitions, such as discharge from the hospital or emergency department. CTI Teams provide assertive outreach and engagement for individuals in higher-level care settings, address key social care needs in the community, help individuals develop strong ties to their support systems during and after transitions in care, and help individuals build skills and strengthen linkages to ongoing sources of support.	Adults ages 18+* *Some CTI Teams may accept referrals for young adults ages 16+	9 months	Yes
High Fidelity Wraparound (HFW)	Evidence-based care management process implemented within the Health Homes Serving Children program intended to provide coordinated, comprehensive, holistic, youth and family driven care to meet the needs of youth and families with multiple systems involvement and complex mental or behavioral health challenges.	Youth, ages 6-21, with SED, significant mental health needs and service utilization that places them at risk of long-term hospitalization or out of home placement.	12-18 months	Yes
Intensive and Sustained Engagement Teams (INSET)	Intensive and Sustained Engagement Teams (INSET) is a voluntary, peer-led engagement approach to support individuals in their healing and recovery journey. A 24/7 multi-disciplinary INSET team, comprised of Peer Specialists, family peer advocates, nurse	The program serves those identified as “high-risk/complex needs” individuals of at least 18 years of age who cycle in and out of the emergency department, inpatient, and/or forensic settings. The program	Length of Service is determined by the individual participant receiving	Yes

	practitioners, and licensed social workers/licensed mental health counselors, supports enrolled individuals in the least restrictive manner possible. These teams foster connections between individuals and communities, resources, and other supports and services to help individuals access their unique valued life goals.	also aims to conduct outreach and engage individuals historically absent from traditional services and those receiving, eligible, meeting some eligibility requirements, or stepping down from court-ordered Assisted Outpatient Treatment services.	INSET services	
Safe Options Support (SOS) Teams	Safe Options Support (SOS) Teams utilize an evidence-based Critical Time Intervention approach to provide intensive outreach, engagement, and care coordination services to individuals who are unsheltered. Services are provided for up to 12 months, including pre- and post-housing placement, with an intensive initial outreach and engagement period that includes multiple visits per week. SOS Teams connect participants with treatment and support services, while also prioritizing educational and vocational training and advancement, self-management skills, and self-care and well-being	Adults ages 18+ who are experiencing homelessness	9-12 months	Yes

RTF and Residential Programs

Program Name	Description	Target Population	Expected Length of Service	Capacity to Provide 24/7 On-Call Telephonic Coverage
Residential Crisis Support	Voluntary residential crisis program that providers supportive services to individuals at risk for or experiencing a mental health crisis. Services include service planning, crisis/safety planning, care coordination, peer support services, Medication management and monitoring, psychiatric crisis rehab and skills training	Adults ages 18+	Up to 28 days	Yes
Intensive Crisis Residence	Voluntary residential crisis program that provides treatment services to individuals at risk for or experiencing a mental health crisis. Services include comprehensive assessment, service planning, crisis/safety planning, individual, family and group counseling, care coordination, peer support services, medication therapy, medication management and monitoring, psychiatric crisis rehab and skills training	Adults ages 18+	Up to 28 days	Yes
Children's Crisis Residence	Provides a place stay for youth in mental health crisis; services include mental health assessment, service planning, family support, individual and family counseling and care coordination	Youth ages 5-20 in mental health crisis	1 – 21 days	Yes
Apartment Treatment	Provide a high level of support and skills training to individuals in	The program serves individuals 18 years or	18 months	Yes

	apartment settings. Apartment treatment is designed to be transitional in nature. Residents gain skills and independence, learn to use community programs, and develop a community support system of friends and family. Apartment sites are usually scattered-site rental units located in the community. Staff work on-site with each resident, providing rehabilitative and supportive services designed to improve an individual's ability to live as independently as possible, and eventually access more independent housing options.	older with SMI who are coming from a residential program, hospital, homeless or at risk of homelessness.		
Congregate Support	Single-site residential programs that provide support designed to improve or maintain an individual's ability to live as independently as possible and eventually access generic housing. Interventions are provided consistent with the resident's desire, tolerance, and capacity to participate in services.	The program serves individuals 18 years or older with SMI who are coming from a residential program, hospital, homeless or at risk of homelessness.	24 months	Yes
Congregate Treatment	Transitional, rehabilitative residential programs that teach skills, offer support, and help residents achieve the highest level of independence possible. These residences are single-site facilities, with private or shared bedrooms, for up to 48 individuals. Meals are provided, as well as on-site rehabilitative services.	The program serves individuals 18 years or older with SMI who are coming from a residential program, hospital, homeless or at risk of homelessness.	24 months	Yes
Community Residence/Single Room Occupancy (CR-SRO)	Service enriched, extended stay housing with on-site services for individuals who want private living	The program serves individuals 18 years or older with SMI who are	24 months	Yes

	units, but who have minimal self-maintenance and socialization skills. Living units are usually designed as studio apartments or as suites with single bedrooms around shared living spaces.	coming from a residential program, hospital, homeless or at risk of homelessness.		
Family Care	The program is a community placement with persons certified to deliver residential care in their own homes. Participants receive training, support, guidance and companionship that naturally occurs in families and communities.	The program serves individuals 18 years or older with SMI who are coming from a residential program, hospital, homeless or at risk of homelessness.	24 months	Yes
Supportive/Single Room Occupancy (SP-SRO)	Provides long-term or permanent housing where residents can access the support services they require to live successfully in the community. An SP/SRO can be located in a building existing solely as a SP/SRO, or integrated into a building that serves other population groups.	The program serves individuals 18 years or older with SMI who are coming from a residential program, hospital, homeless or at risk of homelessness.	Permanent Housing	No
Scattered-Site Supportive Housing	Provides long-term or permanent housing scattered throughout the community. Individuals are able to live independently with staff support as need or desired.	The program serves individuals 18 years or older with SMI who are coming from a residential program, hospital, homeless or at risk of homelessness.	Permanent Housing	No
Short-Term Transitional Residence (STTR)	The program offers supports and skills training in a comfortable, safe, and recovery-oriented environment. Enhanced staffing will provide skills development needed to move to a more independent housing setting. In addition to skill development, peer support, and linkages to community	The program serves individuals 18 years or older. A SMI is not required for admission.	120 days	Yes

	services, individuals will be supported in procuring benefits, where needed.			
Community Residence for Eating Disorder Integrated Treatment	Separate residential programs for adults and children diagnosed with an eating disorder. Provides on-site services including: assessment, service planning, discharge planning, clinical counseling and therapy, nutritional counselling, medication management, medication monitoring, symptom and behavior management, peer recovery support services	Ages 12 to 21 yo for adolescent programs, 21+ for adult programs	Based on medical necessity	Yes
Psychiatric Residential Treatment Facility (RTF)	RTFs are therapeutic programs that provide sub-acute inpatient psychiatric treatment to youth with complex mental health needs and support to their families. RTFs provide 24/7 medical and clinical supervision and services under the direction of a psychiatrist. RTFs provide onsite services including: individual, group and family therapy, psychotropic medication management, nursing services, crisis management, case coordination, dietetic services, , rehabilitation training, and therapeutic recreation..	Serve children and youth ages 5 to 21 years old with a primary designated mental health diagnosis and serious emotional disturbance (SED.) Youth have an IQ equal to or greater than 51. Youth's needs cannot be met in a less restrictive setting. They must have a history of high-risk psychiatric symptoms in multiple settings but do not meet medical necessity for acute hospital admission. Treatment in an RTF must reasonably be expected to improve the	Based on medical necessity	Yes

		psychiatric condition for which they are referred.		
Children's Community Residence	CCRs are therapeutic residences that provide rehabilitation and care coordination services for children with a mental health diagnosis and serious emotional disturbance (SED) and their families. Provides onsite services including: behavior support, case management, counseling, daily living skills training, family support, health services, medication monitoring, and socialization.	Serve children and youth ages 5 to 18 years old with a mental health diagnosis and SED. These youth have serious emotional regulation and social functioning problems in multiple settings requiring 24/7 supervision and daily rehabilitative treatment. Youth are able to attend school, engage in outpatient treatment and community activities.	Based on medical necessity	Yes