



Glossary of Services

- 1. Supported Housing:** Supported Housing is a category of community-based housing that is designed to ensure that individuals who are seriously and persistently mentally ill (SPMI) may exercise their right to choose where they are going to live, taking into consideration the recipient's functional skills, the range of affordable housing options available in the area under consideration, and the type and extent of services and resources that recipients require to maintain their residence with the community. Supported Housing is not as much considered a "program" which is designed to develop a specific number of beds; but rather, it is an approach to creating housing opportunities for people through the development of a range of housing options, community support services, rental stipends, and recipient specific advocacy and brokering. As such, this model encompasses community support and psychiatric rehabilitation approaches.

The unifying principle of Supported Housing is that individual options in choosing preferred long-term housing must be enhanced through:

- Increasing the number of affordable options available to recipients;
- Ensuring the provision of community supports necessary to assist recipients in succeeding in their preferred housing and to meaningfully integrate recipients into the community; and
- Separating housing from support services by assisting the resident to remain in the housing of his choice while the type and intensity of services vary to meet the changing needs of the individual.

- 2. Home and Community Based Services Waiver (HCBS):** HCBS was developed as a response to experience and learning gained from other state and national grant initiatives. The goals of the HCBS waiver are to:

- Enable children to remain at home, and/or in the community, thus decreasing institutional placement.
- Use the Individualized Care approach to service planning, delivery and evaluation. This approach is based on a full partnership between family members and service providers. Service plans focus upon the unique needs of each child and builds upon the strengths of the family unit.
- Expand funding and service options currently available to children and adolescents with a diagnosis of serious emotional disturbance and their families.
- Provide services that promote better outcomes and are cost-effective.

The target population of children eligible for the waiver are children with a diagnosis of serious emotional disturbance who without access to the waiver would be in psychiatric institutional placement. Parent income and resources are not considered in determining a child's eligibility.

The HCBS waiver includes six new services not otherwise available in Medicaid:

- **Individualized Care Coordination** includes the components of intake and screening, assessment of needs, service plan development, linking, advocacy, monitoring and consultation.
 - **Crisis Response Services** are activities aimed at stabilizing occurrences of child/family crisis where it arises.
 - **Intensive In-home Services** are ongoing activities aimed at providing intensive interventions in the home when a crisis response service is not enough.
 - **Respite Care** are activities that provide a needed break for the family and the child to ease the stress at home and improve family harmony.
 - **Family Support Services** are activities designed to enhance the ability of the child to function as part of a family unit and to increase the family's ability to care for the child in the home and in community-based settings.
 - **Skill Building Services** are activities designed to assist the child in acquiring, developing and addressing functional skills and support, both social and environmental.
3. **Mobile Integration Teams (MIT):** Mobile Integration Teams provide an array of services delivered by multidisciplinary professionals and paraprofessionals to successfully maintain each person in his or her home or community. The intent of this program is to address the social, emotional, behavioral and mental health needs of the recipients and their families to prevent an individual from needing psychiatric hospitalization. Examples of services include, but are not limited to, health teaching, assessment, skill building, psychiatric rehabilitation and recovery support, in-home respite, peer support, parent support and skills groups, crisis services, linkage and referral, outreach and engagement. The population to be served includes children and adolescents, their families, and adults. The services provided by this team can be provided in any setting, including an individual's residence, schools, as well as inpatient or outpatient treatment settings.
4. **Respite Services:** Temporary services (not beds) provided by trained staff in the consumer's place of residence or other temporary housing arrangement. Includes custodial care for a disabled person in order that primary care givers (family or legal guardian) may have relief from care responsibilities. The purpose of respite services is to provide relief to the primary care provider, allow situations to stabilize and prevent hospitalizations and/or longer-term placements out of the home. Maximum Respite Care services per Consumer per year are 14 days.
5. **Outreach:** Outreach programs/services are intended to engage and/or assess individuals potentially in need of mental health services. Outreach programs/services are not crisis services. Examples of applicable services are socialization, recreation, light meals, and provision of information about mental health and social services. Another type of service within this program code includes off-site, community-based assessment and screening services. These services can be provided at forensic sites, a consumer's home, other residential settings, including homeless shelters, and the streets.

- 6. Assertive Community Treatment (ACT) Program:** 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. Building on the successful components of the Intensive Case Management (ICM) program, 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.
- 7. Advocacy/Support Services:** Advocacy/support services may be individual advocacy or systems advocacy (or a combination of both). Examples are warm lines, hot lines, teaching daily living skills, providing representative payee services, and training in any aspect of mental health services. Individual advocacy assists consumers in protecting and promoting their rights, resolving complaints and grievances, and accessing services and supports of their choice. Systems advocacy represent the concerns of a class of consumers by identifying patterns of problems and complaints and working with program or system administrators to resolve or eliminate these problems on a systemic, rather than individual basis.
- 8. Intensive Case Management (ICM):** In addition to providing the services in the general Targeted Case Management program description above, ICM is set at a case manager/client ratio of 1:12. Medicaid billing requirements for the Traditional ICM model requires a minimum of four (4) 15-minute face-to-face contacts per individual per month. For programs serving Children and Families, one contact may be collateral. The Flexible ICM model requires a minimum of two (2) 15-minute minimum face-to-face contacts per individual, per month but must maintain a minimum aggregate of 4 face-to-face contacts over the entire caseload. For programs serving Children and Families, 25% of the aggregate contacts can be collaterals.
- 9. Crisis Intervention:** Crisis intervention services, applicable to adults, children and adolescents, are intended to reduce acute symptoms and restore individuals to pre-crisis levels of functioning. Examples of where these services may be provided include emergency rooms and residential settings. Provision of services may also be provided by a mobile treatment team, generally at a consumer's residence or other natural setting (not at an in-patient or outpatient treatment setting). Examples of services are screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs. This program type does not include warm lines or hot lines.
- 10. Non-Medicaid Care Coordination:** Activities aimed at linking the consumer to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of care coordination in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy. Care Coordination Services are provided to enrolled consumers for whom staff is assigned a continuing care coordination responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the consumer throughout the system of service. Persons with Medicaid may receive services from this program, however the program does not receive reimbursement from Medicaid.

- 11. Recovery Center:** A program of peer support activities that are designed to help individuals with psychiatric diagnosis live, work and fully participate in communities. These activities are based on the principle that people who share a common condition or experience can be of substantial assistance to each other. Specific program activities will: build on existing best practices in self-help/peer support/mutual support; incorporate the principles of Olmstead; assist individuals in identifying, remembering or discovering their own passions in life; serve as a clearinghouse of community participation opportunities; and then support individuals in linking to those community groups, organizations, networks or places that will nurture and feed an individual's passions in life. Social recreation events with a focus on community participation opportunities will be the basis for exposing individuals to potential passion areas through dynamic experiences, not lectures or presentations.
- 12. Self Help Program:** To provide rehabilitative and support activities based on the principle that people who share a common condition or experience can be of substantial assistance to each other. These programs may take the form of mutual support groups and networks, or they may be more formal self-help organizations that offer specific educational, recreational, social or other program opportunities.
- 13. Clinic Treatment:** A clinic treatment program shall provide treatment designed to minimize the symptoms and adverse effects of illness, maximize wellness, and promote recovery. A clinic treatment program for adults shall provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, injectable psychotropic medication administration (for clinics serving adults), psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, and psychiatric consultation. A clinic treatment program for children shall provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, psychiatric consultation, and injectable psychotropic medication administration.
- 14. Home-Based Crisis Intervention:** The Home-Based Crisis Intervention Program is a clinically oriented program with support services by a MSW or Psychiatric Consultant which assists families with children in crisis by providing an alternative to hospitalization. Families are helped through crisis with intense interventions and the teaching of new effective parenting skills. The overall goal of the program is to provide short-term, intensive in-home crisis intervention services to a family in crisis due to the imminent risk of their child being admitted to a psychiatric hospital. The target population for the HBCI Program is families with a child or adolescent ages 5 to 17 years of age, who are experiencing a psychiatric crisis so severe that unless immediate, effective intervention is provided, the child will be removed from the home and admitted to a psychiatric hospital. Families referred to the program are expected to come from psychiatric emergency services.
- 15. Crisis Housing/Beds (Adult):** Non-licensed residential program, or dedicated beds in a licensed program, which provide consumers a homelike environment with room, board

and supervision in cases where individuals must be removed temporarily from their usual residence.

16. Children & Youth Crisis/Respite: The intent of the crisis/respite program is to provide a short-term, trauma-sensitive, safe and therapeutic living environment, and crisis support to children and adolescents with serious emotional disturbances, their families and residential service providers.

The goal of the program is to:

- Stabilize the crisis situation and support the family or service provider's efforts to maintain the child in his or her current residence;
- Provide immediate access to treatment services;
- Increase engagement with peer and family support services;
- Improve the family/caregiver's ability to respond to the environmental/social stressors that precipitated the need for respite; and
- Decrease the inappropriate use of emergency departments, inpatient hospitalizations and/or other out-of-home placements.

This program is intended to be an opportunity to provide intense support and guidance to the youth and their family/caregivers so as to prevent a reoccurrence of the situation preceding the admission.

17. Transportation: The provision of transportation to and from facilities or resources specified in the Consumer's individual treatment plan as a necessary part of his/her service for mental disability. This includes all necessary supportive services for full and effective integration of the Consumer into community life.

18. Flexible Recipient Service Dollars: Flexible Recipient Service Dollars are not based on a particular fiscal model and are available to provide for a recipient's emergency and non-emergency needs. These funds are to be used as payment of last resort. The use of the service dollars should include participation of the recipient of services, who should play a significant role in the planning for, and the utilization of, service dollars. Services purchased on behalf of a recipient, such as Respite or Crisis Services, should be reported using this Service Dollar program code. Examples of services may include housing, food, clothing, utilities, transportation and assistance in educational, vocational, social or recreational and fitness activities, security deposits, respite, medical care, crisis specialist, homemakers and escorts. This program code cannot be allocated for AHSCM, ICM, SCM, BCM, ACT, RTF Transition Coordinators or Home and Community Based Waiver Services. Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR.

19. Family Support Services: Family support programs provide an array of formal and informal services to support and empower families with children and adolescents having serious emotional disturbances. The goal of family support is to reduce family stress and enhance each family's ability to care for their child. To do this, family support programs operate on the principles of individualized care and recognizing every child and family is unique in their strengths and needs. Connecting family members to other families with children with serious emotional problems helps families to feel less isolated and identify their own strengths. Family support programs ideally provide the following four core

services: family/peer support, respite, advocacy, and skill building/educational opportunities.

- 20. OnTrackNY:** OnTrackNY program is intended for early identification of psychotic symptoms and the development of early intervention strategies to mitigate the onset of psychotic disorders. These programs generally focus on serving transition-aged youth and young adults experiencing their first episode of psychosis.
- 21. On-Site Rehabilitation:** Program objective is to assist mentally ill adults living in adult congregate care settings, supervised or supported living arrangements to achieve their treatment and community living rehabilitation goals. Services include one or a combination of:
 - (1) consumer self-help and support interventions;
 - (2) community living;
 - (3) academic and/or social leisure time rehabilitation training and support services.Services are provided either at the residential location of the resident or in the natural or provider-operated community and are provided by a team that is either located at the residential site or which functions as a mobile rehabilitation team traveling from site to site.
- 22. Pathway Home Teams:** Pathway Home teams are multi-disciplinary, staffed by masters-level clinicians, case managers, registered nurses, and peers. Teams follow the evidence-based practice of the critical time intervention model of care, engaging clients intensively during the first 30 days. The team will work clients until they have settled back into the community and are linked with the services they need. While every situation is unique, this takes about six to nine months on average.
- 23. Family Resource Centers:** Family Resource Centers aim to strengthen secure attachment between parent and child relationships, and to promote healthy social-emotional development in children age five and under from high risk families residing in eight communities in the Bronx and Harlem.
- 24. High Fidelity Wraparound (HFW)** is a youth-guided, family-driven planning process that allows youth and their family achieve treatment goals that they have identified and prioritized, with assistance from their natural supports and system providers, while the youth remains in his or her home and community setting.
- 25. Mobile Residential Support Teams** focus on transitioning adults living in supported housing apartments into community living. Once these individuals are living in the community, Mobile Residential Support Teams visit them in their homes to help ensure that their basic needs are being met. Teams assist with discharge and community residential support for high risk individuals such as those with co-morbid medical conditions, dual diagnoses of mental illness and/or developmental disability.
- 26. Long Stay Teams** are services that assist with the transition of long stay individuals in State PC or residential settings into structured community settings. Long stay is defined as an adult with a State PC or residential length of stay exceeding one year.
- 27. Skilled Nursing Facility (SNF) Transition Supports:** The SNF Supports are designed to develop State-operated transition and support services for individuals discharged from State PCs to skilled nursing facilities or managed long-term care settings in the

community. Many individuals who are eligible for nursing home care but no longer require inpatient psychiatric treatment, may need some enhanced support during the transition to a nursing home. In addition, nursing homes have indicated a need for continuing engagement and consultation from OMH facility staff with expertise in managing complex comorbid conditions. The SNF initiative provides the necessary State staffing supports and psychiatric consultation services to help individuals successfully transition to and remain in the appropriate level of nursing or long-term care in the community rather than an inpatient institutional setting.

- 28. Sustained Engagement Support Team:** The Sustained Engagement Support Team (SES) is a centralized unit within the NYS Office of Mental Health that provides telephonic outreach to individuals who were unsuccessfully discharged from State-Operated adult outpatient clinics or ACT Teams in an effort to facilitate re-engagement in outpatient services. This includes adults who were discharged due to loss of contact, declination of services, and incarceration. The SES Team and OMH State-Operated outpatient providers work closely together to identify factors leading to disconnection from mental health treatment. The SES Team actively collaborates with providers, hospitals, and correctional facilities to coordinate referrals and discharge plans for individuals in need of re-engagement. The team also works with community providers to ensure continuity of care and assist in overcoming any barriers to engagement. Sustained Engagement data reflect the total number of individuals disconnected from care who were successfully re-engaged in services by this program.
- 29. Residential Stipend Adjustments:** OMH has directed a portion of reinvestment funds for targeted Supported Housing stipend and Single Room Occupancy (SRO) model adjustments to address funding gaps. Similar to residential investments in the prior budget cycles, OMH has targeted the resources using data to identify the highest priorities.
- 30. Peer Specialist Certification:** The NY Peer Specialist Certification process was developed to acknowledge peers who have acquired the skills that qualify them to assist another in their recovery journey. This process is operated by a board of experienced peer specialist from across NYS. The board is responsible for developing the standards for training and experience. Certification promotes a skilled workforce which is not able to tap new funding from new sources such as Medicaid. Finally, the process establishes the qualifications for professional recognition for individuals working in the mental health system based on “The Shared Personal Experience” paradigm.