NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Critical Time Intervention Teams – Long Island

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House Keeping

- All lines are muted for this presentation
- Slides will be made available on the procurement site
- Questions will be answered at the end in the time allotted
- Please enter all questions in chat
    - ALL questions will also be added to the Q&A document
    - Write questions clearly and in a question format
- Questions will be answered at the end in the time allotted
- This Webinar is one of two, both will be the same presentation, you do not need to attend both

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

CTI Teams RFP

The New York State (NYS) Office of Mental Health (OMH) announces the availability of funds for the development of nine (9) Adult Critical Time Intervention Teams (CTI Teams) located in New York City and Long Island. These CTI Teams will serve individuals during a critical transition time, who have mental illness, and who have not been successfully engaged in services during or after critical times in transition.

CTI Teams RFP

-CTI Teams will be modeled on Critical Time Intervention (CTI), an evidence-based approach that is a time-limited, phase-based care management service designed to help vulnerable individuals during critical times of transition in their lives.

-CTI promotes community integration, self-advocacy, and access to ongoing support by helping individuals develop and utilize strong ties to their professional and non-professional support systems during and after these transition periods.

-CTI includes assertive outreach and engagement with individuals in a higher-level of care settings as well as in the community with a focus on addressing key social care needs at the individual level.

-CTI places emphasis on helping individuals build skills and strengthen linkages to ongoing sources of support that will remain in place after the time-limited CTI intervention ends.

CTI Teams RFP

-A critical aspect of this program is the partnership between CTI Teams and hospitals (inpatient psychiatry units, emergency departments, and CPEPs).
-CTI staff must have full access to inpatient and ER settings, both to engage in relationship building with individual's served, and to partner in discharge and aftercare planning with hospital staff.
-CTI staff bring expertise in the continuum of local behavioral health services and supports, housing options, benefits, and other local resources necessary for community tenure.
-Hospitals and the CTI Team will work together to identify high need individuals who would benefit from CTI and immediately include CTI in aftercare planning.
-CTI Teams must use data, such as PSYCKES to assist with an informed discharge planning approach including the assessment of past supports, current providers, and clinical history relevant to the individual's community tenure and recovery.

CTI RFP – Key Events and Timelines

RFP Release Date	12/28/2023
Bidders Conference Long Island	1/11/2024
Bidders Conference NYC	1/16/2024
Questions Due by 4:00 PM EST	1/18/2024
Questions and Answers Posted on Website	2/1/2024
Proposals Due by 2:00 PM EST*	2/15/2024
Anticipated Award Notification	3/12/2024
Anticipated Contract Start Date	4/1/2024

Initial Awards and Allocations

Proposals will be ranked in each proposed region and nine (9) awards will be made as indicated below. The highest scoring application in Queens, Suffolk and Nassau will be awarded and the two highest scoring applications in Kings, Bronx and Manhattan will be awarded.

- Queens 1 CTI Team
- Kings 2 CTI Team
- The Bronx 2 CTI Team
- Manhattan 2 CTI Team
- Suffolk 1 CTI Team
- Nassau 1 CTI Team

Target Population/Eligibility Criteria

CTI has been applied with several populations in various types of transitions – veterans, people with mental illness, people who are homeless or involved with the criminal justice system, and other groups. For this request for proposal (RFP) for Adult CTI Teams, the target population is as follows:

1. Individuals who are at least age 18 years old (*see “young adult” exception below);
2. Individuals with complex mental health conditions, including co-occurring substance use, medical conditions, or co-occurring Intellectual or Developmental Disabilities (I/DD) for agencies who have the experience and knowledge to serve this population; and
3. Individuals who would benefit from an intervention during a critical transition in care, including but not limited to:

Target Population/Eligibility Criteria

- Individuals being discharged from an inpatient psychiatric hospital, who have had long-stay admissions or multiple admissions.
- Individuals being discharged from Emergency Room (ER)/ Comprehensive Psychiatric Emergency Program (CPEP) or other crisis services – who are not otherwise engaged, returning to ER/CPEP multiple times, and who lack community supports.
- Individuals who have not previously engaged in services after a critical transition.
- Individuals who are precariously housed or homeless or at risk of losing their housing.
- Other specialty populations in a critical time of transition (e.g., coming out of jail or prison.

*Individuals who are 16 years old or older, considered “young adults” in need of transitional support through complex children’s and adult service systems.

Introduction

The provider must commit to meeting CTI Team start-up requirements, including program location, staffing, and monthly ramp up deliverables.

CTI Team start-up will include the involvement of NYS OMH and other key agencies to provide training and support around the development of the team.

Monthly calls and meetings will be held to provide technical assistance and ensure the delivery of services consistent with programmatic objectives.

Introduction

The applicant must commit to documentation, tracking, data collection, and reporting requirements according to NYS OMH requirements that will be released as part of the implementation of the teams.

The applicant will establish a CTI Team based on Section 5 of the RFP.

This will include the use of the Critical Time Intervention Manual (2002) and the CTI Manual for Workers and Supervisors (2021) as a baseline for the evidence-based approach.

Introduction

Each CTI Team must have a well-defined working relationship with at least one (1) local Article 28 and/or Article 31 hospital (e.g., inpatient psychiatry units, emergency department and/or CPEP), or more in areas where there are multiple hospital systems within their awarded location.

This relationship must include a Memorandum of Understanding (MOU).

The CTI Team's MOU should outline a coordinated process for regular communication, process for referrals, discharge planning from the hospital, access to the hospital electronic medical record where possible, and a process for engaging in-person with individuals to provide the CTI intervention prior to discharge

Introduction

-CTI Teams will need to maintain relationships with hospitals, including regular meetings (i.e., rounds on the inpatient unit, inpatient case conferences and access meeting space on unit).

-It is important to note that when CTI Teams work with ER/CPEPs or other crisis services, workflows should be modified to meet the needs of those settings.

> For example, CTI staff and hospitals will need to plan for more immediate referral and engagement in shorter-term units.

-These workflows must be established prior to implementation by both the CTI Team and hospital leadership.

-In cases in which the hospital is the agency implementing the CTI Team, the above collaborations must exist within the internal structure of the hospital. Additionally, hospital-based CTI Teams must develop external relationships and MOUs with community-based organizations to ensure timely access of services.

Introduction

CTI Teams should consider partnering with more than one (1) hospital/facility, based on local need. CTI Teams should consider where additional relationships with hospitals in their county/borough may be needed, as well as with hospitals in nearby counties/boroughs where individuals may go to receive psychiatric inpatient services but return to county/borough where CTI Team is located.

Introduction

In order to support implementation of the hospital's person-centered discharge plan, the applicant must develop coordinated admission and transition plans with community providers, including:

- Housing providers, Certified Community Behavioral Health Clinics (CCBHC), Community Oriented Recovery & Empowerment Services (CORE), or Home and Community Based Services (HCBS) providers, Personalized Recovery Oriented Services (PROS), Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS), community services certified by the NYS Office of Addiction Services and Supports, community services licensed by the Office for People with Developmental Disabilities, and other community resources to coordinate needed services and supports for individuals to ensure their successful transition into community-based services.

Quality Infrastructure and Reporting Requirements

-CTI Teams will be required to submit regular reports to NYS OMH regarding all individuals referred to them, including but not limited to, completed referrals, reason for denial of referral if applicable, admission and discharge dates, characteristics of individuals served, diagnoses, referral source, services provided, discharge plan, disposition, community networking efforts, transition between stages of CTI, and follow-up.

-Information will also be submitted regarding performance indicators demonstrating that members' continuity of care has been assured (including stable housing) and that reliance on psychiatric center, inpatient and emergency department services has been reduced, and jail/prison time decreased.

-NYS OMH will provide programs with a template of the data items required for reporting for manual or bulk data entry.

Quality Infrastructure and Reporting Requirements

CTI Teams will have a systemic approach for self-monitoring and ensuring ongoing quality improvement including analyzing utilization review findings and recommendations. This information should be used to measure timeliness of services, disposition, and outcomes, and will inform the CTI Teams overall quality improvement plan. CTI Teams should ensure continuous quality improvement of services and development of the program including regular monitoring and evaluation of outcomes.

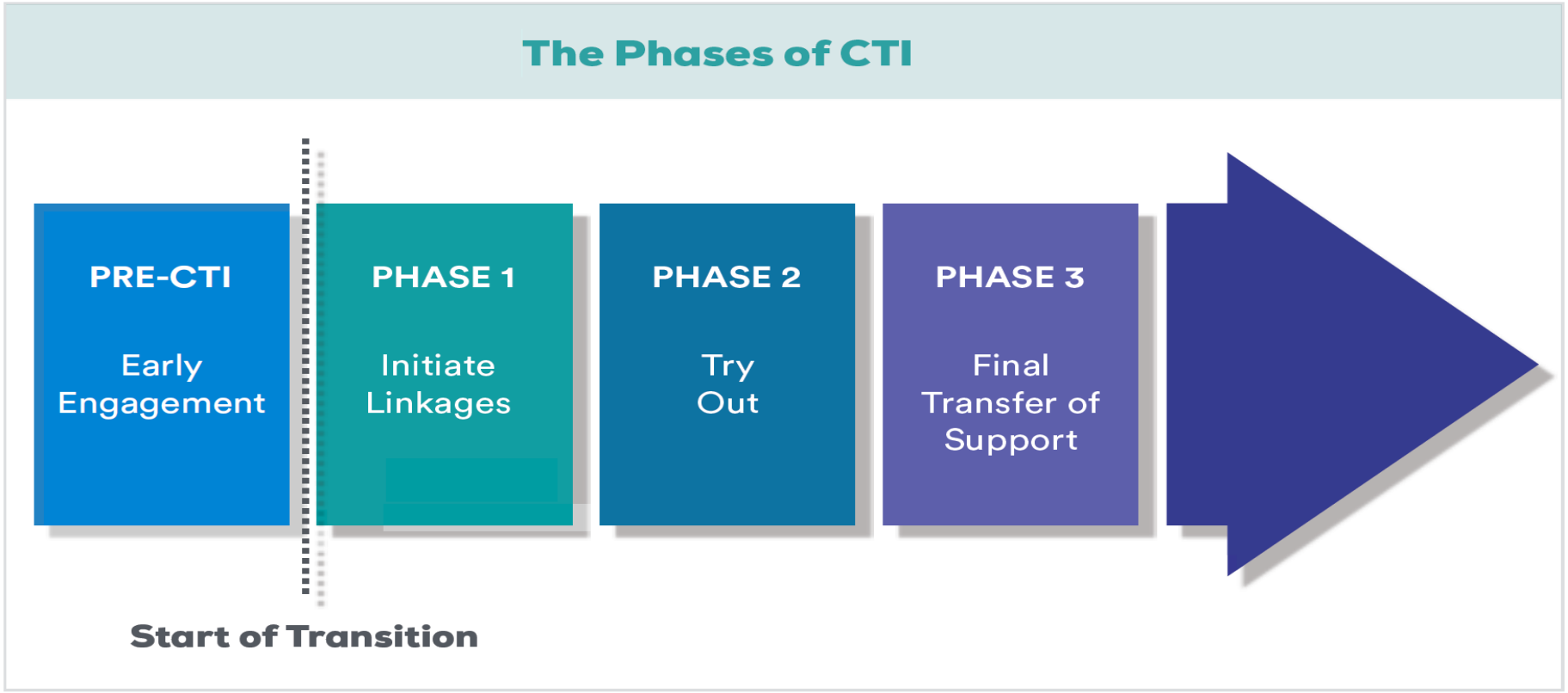
The Local Governmental Unit (LGU), Director of Community Service (DCS)/Mental Health Commissioner has a statutory authority and responsibility for oversight and cross-system management of the local mental hygiene system to meet the needs of individuals and families affected by mental illness, substance use disorder and/or intellectual/developmental disability in their communities. LGU collaboration is a vital part of the work of CTI Teams. Applicants must notify the LGU(s) of their intent to apply.

Objectives and Responsibilities

CTI Teams will follow the evidence-based approach of Critical Time Intervention which includes four (4) phases described in the RFP. Each of the phases requires the staff to have a skill set based on a non-judgmental, person-centered, strength-based approach that meets individuals where they are at, helps them identify what is important to them and communicates hope that recovery is possible. Refer to Critical Time Intervention Manual (2002) and the CTI Manual for Workers and Supervisors (2021) for more details.

All individuals who meet eligibility and are referred to a CTI Team will receive sustained and persistent outreach and engagement attempts, even if they initially decline services. The CTI Team will continue to work with individuals to ensure that their immediate needs are met (including clothing, shelter, and food), and that community linkages and supports remain solid.

Phased Approach



CTI Phases

Pre-CTI is the early engagement phase and is usually started prior to discharge. The Phase one (1) tasks of engagement, assessment and connecting to community resources are very labor-intensive. In Phase two (2), the worker will step back a bit to monitor the resource network and adjust as needed. Finally, as the intervention winds down in Phase three (3), the worker steps back further and assumes a monitoring role to ensure that needed resources are in place. Thus, the amount of contact that a worker has with both individuals and their resource networks declines over time, reflecting the way in which the worker's role shifts over the course of the intervention.

- CTI Manual for Workers and Supervisors 2021, p.15

Implementation – Referrals to CTI Teams

CTI Teams will receive referrals from hospitals, including inpatient psychiatric units, emergency departments, and CPEPs.

CTI Teams will work closely with the hospital(s), or other referral sources, to ensure timely access to services once a referral is determined appropriate. CTI Teams will begin efforts towards connection with referred individuals within 24 to 48 hours.

CTI Teams will conduct assertive and persistent outreach to establish trust and foster engagement. CTI Teams will provide coordinated care transition activities and support, starting from the time of referral through transition to community housing, treatment and supports.

CTI Teams must build and maintain relationships with hospitals, and other referral sources.

Documentation and Use of Technology

It is expected that the applicant has an electronic health record that can document referrals, assessments, and each encounter with the individual. It is also expected that the applicant maximizes the use of technology to help support the team's communication, quality improvement efforts, as well as each individual's transition and goals.

Applicants must have a plan on how they use digital technology to support client engagement in care. Technology supports include tools and resources for identifying potential clients, communicating, and responding to referral sources, communicating with clients and key support persons, care planning, and transition planning. Applicants should use digital tools available to staff as well as those available to clients.

CTI Teams will be expected to use data from Regional Health Information Organization (RHIOS)/Qualified Entities (QEs), PSYCKES, and other data systems as part of their work.

CTI Team Staffing

CTI Teams will hire staff with the appropriate qualifications to meet the needs of the target population and develop policies that maintain the caseload sizes according to the CTI Manual for Workers and Supervisors.

It is expected that each team be comprised of a multidisciplinary team of 10 staff.

CTI Teams will include: 1 FTE Team Leader, 1 FTE Registered Nurse/Licensed Practical Nurse, 3 FTE Mental Health Professionals, and 5 FTE Care Managers. It is recommended that CTI Teams hire one (1) to two (2) Peer Specialists in the role of Care Manager.

The CTI Team will serve a capacity of 130 individuals.

CTI Team Staffing

CTI Teams will ensure that staff are trained in CTI and other applicable evidence-based approaches (i.e., motivational interviewing, Integrated Dual Disorder Treatment, trauma informed care).

CTI Teams will be expected to participate in any CTI Team learning communities; complete all required trainings; access the Care Management Institute and utilize their training resources; and attend meetings to review progress, outcomes and develop best practices for CTI Teams.

CTI Teams should consider training staff in specialty areas such as housing, community resources, health and wellness, and vocational supports.

CTI Teams will maintain a plan for regular supervision of all staff members.

Hours of Operation

CTI Teams will have hours of operation that allows them to adequately provide all necessary services with consideration of the unique needs and availability of the individuals whom they serve. This may include evenings and weekends.

Operating Funding

Over the course of the contract, OMH plans to submit a Medicaid State Plan Amendment (SPA) to allow for Medicaid reimbursement.

Once approved, funding will change from full state aid coverage to a mix of state aid and Medicaid billing.

Providers will be expected to work with NYS OMH regarding any program or fiscal changes related to this movement to Medicaid coverage and must be prepared for funding to change in accordance with future program development.

This includes, but is not limited to, CTI Teams completing the steps needed to become licensed.

Operating Funding

Start-Up Funds:

One-time Start-up funds will be allocated as a lump sum at beginning of the contract for: $ 100,000

Start-up funds are used for initial costs associated with starting a new CTI Team including, but not limited to: Vehicle; Computers and tablets; Printers; Phone system and mobile devices; Office furniture; Office supplies; Recruitment; Utilities; Insurance; Promotional material and marketing; or Electronic Health Record (reporting capabilities).

Operating Funding

Year One Funding:

Until the CTI State Plan Amendment is approved, allowing for Medicaid billing, CTI teams will be fully funded with State Aid.

Subsequent to State Plan Amendment approval, newly licensed CTI teams will receive State Aid ramp-up funding for the first four months of operation, equal to one-quarter of the full annual team model amount.

The full annual and monthly values of State Aid funding are as follows:
Downstate $1,217,259 ($101,438)

Operating Funding

CTI Budget Model (Medicaid Revenue):

Upon SPA approval, the ongoing expected annual Medicaid revenue per team is as follows: Downstate $1,012,570

Medicaid Revenue is an estimate based on a monthly caseload size of 130.

On-going Net Deficit Funds:

Anticipated available ongoing annual net deficit funding per team is as follows

Downstate $ 178,689 (plus $26,000 in service dollars[1])

Expected Outcomes

- Increase outpatient engagement
- Decrease hospital readmissions
- Decrease number of visits to ER/CPEP
- Linkage and access to Mental Health services and community resources
- Expertise on Mental Health system in discharge planning
- Increased success with individuals meeting their recovery goals

Thank You!