Medicaid Alternative Service Definition

Title:	Critical Time Intervention		
Type:	**Medicaid Alternative Service**	**Code:**	**H0032U5**
Effective Date:	**2/1/2016**	**Units:**	**15 minutes**

SERVICE DESCRIPTION

Critical Time Intervention (CTI) is a time-limited intensive case management model designed to assist adults age 18 years and older with mental illness who are going through critical transitions, and who have functional impairments which preclude them from managing their transitional need adequately. CTI promotes a focus on recovery, psychiatric & physical rehabilitation, and full community inclusion.

It is not treatment, like ACTT or CST. It is an evidence-based practice there are four core principles that define CTI and set it apart from other services:

- Focuses on a critical transition period, and is time-limited
- Enhances continuity of care and prevents recurrent homelessness, frequent use of Emergency Departments (ED), crisis services, and psychiatric hospitalizations
- Identifies and strengthens formal and natural community supports
- Complements rather than duplicates existing services by creating, as needed, alternative pathways to care and services for those unable to access services through traditional structures

Individuals eligible for CTI may be navigating transitions which include the following:

- Discharge from psychiatric inpatient settings
- Release from correctional settings
- Transition out of foster care settings into adult services
- Transition from homelessness into housing
- Transition from highly structured residential settings, such as adult care homes, into independent living

Functional impairments should include Three or more of the following:

- Inability to navigate systems
- Difficulties in maintaining emotional controls
- Ineffective communication skills
- Disorganization
- Poor judgment and decision making skills
- Observable manifestations of mental illness
- Difficulty managing physical health conditions
- Not connected to a community provider
- At risk of homelessness or homeless
- Lack of positive social support/natural supports network
- Inadequate daily living skills
- Underemployment or unemployment
- Substance Use

As an evidence-based practice there are four core principles that define CTI and set it apart from other services:

1. Focuses on a critical transition period, and is time-limited
2. Enhances continuity of care and prevents recurrent homelessness and hospitalizations,
3. Identifies and strengthens formal and natural community supports
4. Complements rather than duplicates existing services by creating, as needed.

CTI services typically begin before an individual is discharged from a hospital, adult care facility, or other institution in order to begin to build a working relationship prior to discharge. CTI services might also begin with an individual who is service avoidant in need of outreach, engagement, and supports essential to their wellbeing and functioning while in transition to more traditional services and supports.

CTI is divided into three phases, lasting about three months each.

- Phase 1: Transition – In this phase the Implementation of the transition plan while providing emotional support. In this phase there is frequent contact with the individual in the community with a focus on active engagement with behavioral and physical health services and identifying and addressing housing needs. During the Transition phase goals are identified in a person-centered process and implemented in a highly individualized manner to address immediate needs related to the critical transition.

- Phase 2: Tryout – During the Tryout phase, Facilitate and test consumer's problem-solving skills and capacity of the support system. CTI supports an individual's engagement and effective participation in their own naturally occurring community supports and formal system of care.

- Phase 3: Transfer of Care – During this phase CTI promotes the transfer of services to other service providers and natural supports as well as remains available to solve problems in collaboration with providers and natural supports prior to discharge from CTI services.

Phase	Transition	Try-out	Transfer of Care
Timing	Months 1-3	Months 4-6	Months 7-9
Purpose	CTI provides assessment of social and health needs and develops and implements an individualized services plan to address immediate needs related to critical transition	CTI supports an individual's engagement and effective participation in their own support system. Facilitates and tests the individual's new problem solving skills	CTI remains available to solve problems in collaboration with the individual, and his/her providers and natural supports prior to discharge
Activities	CTI worker engages the individual. This includes making home visits or visits in the community including in shelters or on the street, introducing the individual to providers, and meeting with	CTI worker monitors the effectiveness of the support network; Helps to modify network as necessary;	CTI worker provides consultation but little direct services. The worker lets the individual solve their own problems. The workers ensures key caregivers/providers

	caregivers, helping the individual negotiate ground rules for relationships, mediating conflicts, and assess the potential of the individual's support system. Focuses on urgent/basic needs such as food, immediate medical care, shelter, warm clothing or blankets, access to essential medications; Accompanies individuals to community providers; Forges connections to social service systems, and assists the individual to apply for available benefits as indicated (phone, food and nutrition benefits, Medicaid, Disability, etc.); Connects the individual with medical care; Introduces the individual to vocational services and Meets with caregivers, family members, or informal supports to provide support and consultation, and/or to mediate conflicts.	Continues case management activities as necessary; Continues community based visits; Provides psychoeducation about self-management and successful navigation of the service systems and Completes any Phase I activities that still need resolutions. Less frequent meetings, and provides social crisis interventions and troubleshooting.	meets and agrees on long term support system. CTI worker reinforces the roles of support network members; Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification); May hold a party or some ceremonial recognition of successful transition out of CTI services. The CTI provider will hold a final treatment team meeting with services providers and natural supports.

Individual until transitioned to and is receiving CTI are served until transitioned to and engaged with the next provider through the structured and time limited 3 phase model. CTI Interventions result in effective transition and engagement. CTI works to keep individuals engaged in services and will not prematurely discharge except under the following circumstances: The individual no longer wishes to receive CTI support and has refused CTI services after reasonable attempts have been made to engage him/her in treatment and no safety issues or concerns are present; CTI has clearly not been of benefit to the individual and no additional engagement strategies are available; or the individual demonstrates behaviors that pose a threat to CTI staff safety and requires re-assessment for a different intervention strategy.

CTI allows for the possibility that the individual may be "lost" and temporarily unavailable. CTI may re-engage with individuals after they "drop out", or become unavailable for some period of time. If an individual is "lost" or "drop out" and then returns the CTI worker does not start over but picks up in the Phase the individual left in.

By the time CTI ends, individuals who were receiving CTI should be engaged with desired and appropriate community-based services which can provide ongoing support.

Program Philosophy, Goals and Objectives:

Critical Time Intervention (CTI) is a structured, nine-month intervention that provides support to people during and after a transition to community living from shelter, hospital, or other institutional setting, with the primary goal of preventing a return to homelessness and other adverse outcomes.

The individual receiving CTI largely drives the direction of the service by establishing goals that may include: housing, employment, access to mental health, substance abuse and medical treatment, access to benefits, improving family and social support, budgeting and money management, and building independent living skills.

CTI is intended to be an individual community-based service requiring frequent contact to build/re-establish a trusting, meaningful relationship to engage or re-engage the individual into services and/or assess for needs. The service is designed to:

- Promote recovery, hope, and empowerment
- Assist with locating and maintaining stable housing
- Assess for and provide linkage to the appropriate supports
- Identify methods to maximize independent living skills
- Assist in accessing benefits and appropriate formal services
- Assist in identifying and linking to informal community supports such as social networks and improved family relationships
- Reduce frequency and duration of hospitalizations
- Reduce frequency of Emergency Department visits
- Reduce utilization of crisis services
- Reduce criminal justice system involvement and days incarcerated
- Provide continuity of care regardless of life circumstances or recovery environment
- Improve compliance with medication
- Promote harm reduction, linkage to recovery treatment, and support sustained recovery maintenance

Pre-CTI

Develop a trusting relationship with client.

Phase 1: Transition

Provide support & begin to connect client to people and agencies that will assume the primary role of support.

• Locate Housing and make community/home visits
•Engage in collaborative assessments
•Meet with existing supports
•Introduce client to new supports
•Give support and guidance/direction to client and caregivers

Phase 2: Try-Out

Monitor and strengthen support network and client's skills.

•Observe operation of support network
•Mediate conflicts between client and caregivers/client and landlord
•Help modify network as necessary
•Encourage client to take more responsibility

Phase 3: Transfer of Care

Terminate CTI services with support network safely in place.

•Step back to ensure that supports can function independently
•Develop and begin to set in motion plan for long-term goals
•Hold meeting with client and supports to mark final transfer of care
•Meet with client and treatment team for last time to review progress made and discharge the individual from CTI.

Expected Outcomes:

Rigorous evaluations of CTI have shown that the program model results in significant reductions in the likelihood of homelessness and the number of nights that participants spent homeless compared to usual care. For persons with serious mental illness, the costs of CTI are mostly offset by savings associated with reductions in the use of shelter, health care, and other public services.

Expected Clinical Outcomes

The expected outcomes for this service are specific to the goals identified in the individual's CTI Service Plan, and may include, but are not necessarily limited to, the following:

- The individual will identify and engage in a stable housing plan
- The individual will re-engage/engage with providers and other support systems
- The individuals' utilization of community-based services will increase
- The individuals' state hospital admissions will be reduced
- The individuals' state hospital bed utilization will be reduced
- The individuals' admissions to emergency departments and other crisis care will be reduced
- The individuals' rate of incarceration will be reduced

PROVIDER REQUIREMENTS

Prior to implementation, the provider organization will ensure the team has completed, at a minimum, the approved basic Critical Time Intervention Training provided by a certified trainer approved by a NC DHHS approved trainer.

Critical Time Intervention services must be delivered by practitioners employed by mental health provider organizations that:

- Meet the requirements of 10A NCAC 27G;
- Meet the provider qualification policies, procedures, and standards established by the Department of Health and Human Services, DMA, and by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS). These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO.
- The organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO.
- The organization shall be established as a legally recognized entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS *Records Management and Documentation Manual*, and service implementation standards.
- The provider organization shall comply with all applicable federal and state requirements.
- For Medicaid services, the organization is responsible for obtaining prior authorization from Medicaid's approved vendor for medically necessary services identified in the PCP. The CTI provider organization shall comply with all applicable federal and state requirements. This includes but is not limited to North Carolina Department of Health and Human Services (DHHS) statutes, rules, policies, and Implementation Updates; Medicaid Bulletins; and other published instruction.

The CTI team will not be identified as the individual's first responder; however the provider must be affiliated with a comprehensive organization that provides mental health services, which include crisis response services.

Program Requirements

The individual receiving CTI largely drives the direction of the service by establishing goals that may include: housing, employment, access to mental health, substance abuse and medical treatment, access to benefits, improving family and social support, budgeting and money management, and building independent living skills.

CTI is intended to be an individual community-based service requiring frequent contact to build/re-establish a trusting, meaningful relationship to engage or re-engage the individual into services and/or assess for needs. The service is designed to:

- Promote recovery, hope, and empowerment
- Assess for and provide linkage to the appropriate supports
- Assist with locating and maintaining housing
- Develop Emergency Plan

- Identify methods to maximize independent living skills
- Assist in accessing benefits and appropriate formal services
- Assist in identifying and linking to informal community supports such as social networks and improved family relationships
- Reduce frequency and duration of hospitalizations
- Reduce frequency of Emergency Department visits
- Reduce utilization of crisis services
- Reduce number of homeless nights
- Reduce criminal justice system involvement and days incarcerated
- Provide continuity of care regardless of life circumstances or recovery environment
- Improve compliance with medication
- Promote harm reduction, linkage to recovery treatment, and support sustained recovery maintenance

CTI Teams meet weekly with the Team Lead for clinical supervision and to share practical strategies for working with individuals CTI services and their complex needs.

The CTI staff shall be available to provide multiple contacts per week as needed. CTI varies in intensity to meet the changing needs of the individuals served and are expected to taper in volume and frequency throughout the duration of the three phases.

A CTI worker must meet with an individual at least weekly during the first month of service

During Phase I, a CTI worker must have at least 18 community-based meetings with the client during Phase I, and must have at least 6 community-based meetings per month, of the 18 community based meeting at least three will be with a client's providers and/or informal supports during Phase I.

A CTI team may deliver up to an average of 3 hours/week of service in Phase 1, up to an average of 1½ - 2 hours of service/week in Phase 2, and up to an average of 1 hour/week of service in Phase 3.

CTI services are primarily delivered face-to-face with the individual and in locations outside the provider agency's facilities.

- 80% or more, averaged each month, of CTI services will be delivered face-to-face by the team with the individual.
- The remaining units may either be by phone or collateral contacts.

STAFFING REQUIREMENTS

Staffing Requirements

All treatment shall be focused on, and for the benefit of, the eligible beneficiary of CTI services. This service must be provided by a team of at a minimum of two dedicated full-time equivalent individuals. However, a team of three to four is recommended.

A. The Team Leader/Clinical Supervisor must be a full-time licensed mental health professional who has at least two years' experience with the knowledge, skills, and abilities required by the population to be served; and must hold any of the following licenses: Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist.

   The Team Leader acts as the *Clinical Supervisor* and carries a partial case load, no more than 1:10, while managing other direct practitioners.

AND

B. One FTE QP or Certified Peer Support Specialist who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals);

Other staff members must be at least .50 FTE dedicated to the CTI team and may be licensed professionals, QPs, APs or Paraprofessional staff, with strong preference for inclusion of a Certified Peer Support Specialist with a minimum of two years working with a mental health population.

The **Certified Peer Support Specialist** shall be an individual who is or has been a recipient of mental health or substance abuse services and is committed to his or her own personal recovery. A Certified Peer Support Specialist is a fully integrated team member who draws from his or her own experiences and knowledge gained as a recipient to provide individualized interventions to recipients of CTI services. The encouragement in taking responsibility for and actively participating in their own recovery. Certified Peer Support Specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities.

No CTI team member who is actively fulfilling a CTI team role may contribute to the staffing ratio required for another service during that time. When fulfilling the responsibilities of CTI services, the staff member shall be fully available to respond in the community.

The number of staff on the team is flexible, as long as caseload ratios are observed and the maximum caseload for a team does not exceed a total of 70 individuals being served. The maximum caseload ratio for a full-time CTI worker is 1:20. The maximum caseload ratio for a full-time fieldwork coordinator is 1:10. A CTI team may have a total of four staff serving a total of 70 individuals. Due to the varying level of intensity of work during each phase, admission to the team should be staggered to maintain a caseload of individuals in who are in each phase.

Note: Supervision of CTI staff is covered as an indirect cost and therefore should not be billed separately as CTI services.

Staff Training

As noted above, the provider organization ensures that all team members have completed the basic Critical Time Intervention training provided by a certified trainer approved by the DHHS prior to implementation of the service. All staff providing this service must have the following training within 90 days of hire to provide this service:

- Evidence Based Practice - Critical Time Intervention training, facilitated by approved training organization
- CTI Service Definition required components and planning 12 hours of Person Centered Thinking (PCT) from a Learning Community for Person Centered Practices certified PCT trainer (dated after March 31, 2011).
    - All new hires to CTI must complete the full 12 hour training

In addition to the basic Critical Time Intervention Training, all staff providing the service must have the following training within 90 days of hire to provide this service, staff shall complete the following training requirements:

- Person Centered Thinking (3 hours)
- Mental Health/Substance Use 101 (3 hours)
- Crisis Response Training (3 hours)
- Introduction to Motivation Interviewing (13 hours)

Within 90 days of hire, the Team Lead should have 10 hours of post graduate training in one or more of the following designated therapies, practices, or models:

- Cognitive Behavior Therapy or
- Trauma Focused Therapy (For example: Seeking Safety, TARGET, TREM, Prolonged Exposure Therapy for PTSD) or
- Illness Management and Recovery (SAMHSA Toolkit http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/default.asp.

1. Practices or models must be treatment focused models, not prevention or education focused models.
2. Each practice or model chosen must specifically address the treatment needs of the population to be served by each CTI.
3. Cognitive Behavior Therapy training must be delivered by a licensed professional.
4. Trauma-focused therapy and Illness Management and Recovery training must be delivered by a trainer who meets the qualifications of the developer of the specific therapy, practice or model and meets the training standard of the specific therapy, practice or model. If no specific

trainer qualifications are specified by the model, then the training must be delivered by a licensed professional.

The required trainings will be portable if an employee changes jobs any time after completing the minimum hour requirement, as long as there is documentation of such training in the new employer's personnel records

AND

c. On an annual basis, follow up training and ongoing continuing education for fidelity to the chosen modality (CTI) is required. If no requirements have been designated by the developers of that modality, a minimum of 10 hours of continuing education in components of the selected modality must be completed annually.

All follow up training, clinical supervision, or ongoing continuing education requirements for fidelity of the clinical model or EBP(s) must be followed.

POPULATIONS ELIGIBLE

Adults ages 18 and older with a diagnosis of SPMI

To be eligible for CTI, an individual must meet the following criteria:

A. A SPMI diagnosis, as defined in *DSM 5*, or its successors, with or without a co-occurring substance use disorder and/or a co-occurring developmental disability;
AND
B. Is not already connected to community based care that is currently meeting their clinical needs.
AND
C. Has at least **three** of the following functional impairments:

- At risk of homelessness or homeless
- Lack of positive social support/natural supports network
- Inadequate daily living skills
- Lack of basic subsistence needs (food stamps, benefits, medical care, transportation)
- Inability to manage money
- Substance use
- Unemployment/underemployment/lack of employment skills
- Difficulties in maintaining emotional control
- Poor judgment and decision making skills

Individuals eligible for CTI are navigating critical transitions and are not connected to other community based services currently meeting their clinical needs.

Critical transitions include the following:

- Discharge from psychiatric inpatient setting
- Release from correctional settings
- Transition from homelessness into housing
- Transition from highly structured residential settings, such as adult care homes, into independent living

ENTRANCE PROCESS

Referrals for CTI services may come from a hospital, jail, residential provider, care coordinator, physician, homeless shelter, law enforcement, crisis service, outpatient providers, or anyone else who recognizes the need for engagement and transition services on behalf of a consumer. When the CTI team receives a referral they will contact the individual's home LME-MCO for authorization, and introduction of CTI to the consumer will begin within 72 hours of the receipt of the referral. Phase 1 will begin as soon as the individual consents to the service.

A comprehensive clinical assessment or an abbreviated assessment and obtain any other available clinical referral materials upon referral to CTI that demonstrates medical necessity shall be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and be included in the CTI Service Plan or Person Centered Plan. The CTI Service Plan must include the beneficiary's signature and the worker's name, credentials, and date.

If completing an abbreviated assessment, the format of the abbreviated assessment is determined by the individual provider based on the clinical presentation. Although the abbreviated assessment does not have a designated format, the assessment must be completed by a licensed professional and must include the following elements:

a. The individual's presenting problems;
b. The individual's needs and strengths;
c. A provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission;
d. A pertinent social, family, and medical history; and
e. Evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the individual's needs.

CTI Team may meet with the individual prior to discharge from a hospital, residential setting, or other institutional setting (except jail or correctional facility). CTI service may not be billed, however if a provider has state funded alternative services, such as Hospital, Discharge, Planning, & Transition in their contract, this service may be billed. CTI is not intended to replace any discharge planning responsibilities of the institutional or residential setting.

The CTI provider will be responsible for the development of a CTI Service Plan/Person Centered Plan. The CTI goals should be very simple, addressing no more than 3 areas at a time and evolving with respect to the individual's progress, participation, and choices.

The CTI team will pro-actively assist individuals in the prevention of social crisis episodes. The CTI team is not expected to be on call as a "first responder" for crisis events, but is expected to assist the individual in the development of a detailed crisis plan, and to assure that the plan in as widely distributed to key partners to the extent allowed by the individual. The CTI team will utilize the current version of the Comprehensive Crisis Plan Prevention and Intervention Plan published by the NC DMH/DD/SAS.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider- manuals.html

EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/

UTILIZATION MANAGEMENT

For Medicaid-funded CTI services, prior authorization is required. To request the initial authorization, submit the PCP with signatures and the required authorization request form. In addition, submit a completed LME-MCO Consumer Admission and Discharge Form to the LME-MCO.

Up to 3 hours (12 units) of Pre-CTI service are allowed with prior authorization between referral and actual start-up of Phase I Transition services for the purpose of engagement and enrollment of the individual into the service.

CTI Services are expected to taper in volume and frequency throughout the duration of the 3 phases. A CTI team may deliver up to an average of 3 hours/week of service in Phase 1, up to an average of 1 ½ - 2 hours of service in Phase 2, and up to an average of 1 hour/week of service in Phase 3.

The average hours/week expectations may be suspended if an individual is "lost", unavailable or temporarily disinterested in CTI but likely to re-engage, with supporting documentation in the client record.

- **Prior authorization** by the LME-MCO is required before or on the first date of Phase I Transition implementation.
- The **initial authorization** will be for Phase 1 (months 1-3).
- **Re-authorization** will occur every 90 days.
- **Maximum** authorization will not exceed 312 units (78 hours) total for the 9 month period.
- Units will be authorized and billed in 15 minute units.

In addition, providers who deliver CTI to the Department of Justice/Transitions to Community Living Initiative consumer population shall work with the LME-MCO to assure data collection related to the outcomes established by the Division of MH/DD/SAS.

SERVICE ORDERS

A service order is required for this service. For Medicaid-funded CTI services, a signed service order shall be completed by the fully licensed team lead, according to his or her scope of practice. Each service order shall be signed and dated by the authorizing professional and shall indicate the *date* on which the service was ordered. A service order shall be in place *prior to* or on the day that the service is initially provided in order to bill Medicaid for the service. The service order shall be based on a comprehensive clinical assessment of the beneficiary's needs.

CONTINUED STAY CRITERIA

The individual is eligible to continue this service after the initial authorization period, if any of the following apply:

a. The individual has achieved the initial goals of the CTI Service Plan, however additional/new goals are indicated as evidenced by documented symptoms;

b. The individual is making satisfactory progress toward meeting goals and there is documentation supporting that the continuation of this service will be effective in addressing the goals outlined in the CTI Service Plan.

c. The individual fails to make progress or demonstrates regression in meeting the goals outlined in the CTI Service Plan, making necessary re-assessment and revision of Service recommendations.

d. The individual becomes "lost", unavailable or dis-interested in CTI service but has previously demonstrated gains and benefits, and may be willing to re-engage with the CTI provider.

DISCHARGE CRITERIA

Critical transition has been successfully achieved and the individual is fully engaged in services nine months from the phase 1 start date;

OR

The individual no longer wishes to receive CTI support and has refused CTI services after reasonable attempts have been made to engage him/her in treatment and no safety issues or concerns are present;

OR

The individual is clearly in need of a higher level of care and has been connected to the identified treatment;

OR

The individual demonstrates behaviors that pose a threat to CTI staff safety, and requires re-assessment for a different intervention strategy.

DOCUMENTATION REQUIREMENTS

Refer to the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

Consent

At the time of the initial service, the provider shall obtain the written consent from the legally responsible person for treatment for beneficiaries of all ages.

The minimum standard is a service note for each contact, service event, or intervention that includes the required elements outlined in the *Manual*.

Clinical Documentation - Provision of Services

Providers shall maintain health records that document the provision of services for which Medicaid reimburse providers. Provider organizations shall maintain, in each beneficiary's service record, at a minimum, the following documentation:

- Demographic information: the beneficiary's full name, contact information, date of birth, race, gender, and admission date;
- The beneficiary's name must be on each page generated by the provider agency;
- The service record number of the beneficiary must be on each page generated by the provider agency;

- The Beneficiary's Identification Number for services reimbursed by Medicaid must be on all treatment plans, service note pages, accounting of release, or disclosure logs, billing records, and other documents or forms that have a place for it;
- An individualized CTI treatment plan or PCP;
- Documentation of entrance criteria, continued service criteria, and discharge criteria;
- A copy of any testing, summary and evaluation reports;
- Documentation of communication regarding coordination of care activities; and
- All evaluations, notes and reports must contain the full date the service was provided (month, day, and year).

Service Notes and Progress Notes

There must be a progress note for each encounter that documents the following information:

- Date of service;
- Name of the service provided;
- Type of contact (face-to-face, phone call, collateral;
- Purpose of the contact (tied to the specific goals in the plan);
- Description of the interventions performed. Interventions must include active engagement of the beneficiary and relate to the goals and strategies outlined on the beneficiary's plan;
- Effectiveness of the intervention(s) and the beneficiary's response or progress toward goal(s);
- The duration of the service;
- Signature, with credentials, degree, and licensure of clinician who provided the service. A handwritten note requires a handwritten signature; however, the credentials, degree, and licensure may be typed, printed, or stamped; and
- Service notes must be written in such a way that there is substance, efficacy, and value.
- Interventions and supports must all address the goal(s) listed in the plan. They must be written in a meaningful way so that the notes collectively outline the beneficiary's response to interventions and supports in a sequential, logical, and easy-to-follow manner over the course of service.

Electronic Signatures

When an electronic signature is entered into the electronic record by agency staff [employees or authorized individuals under contract with the agency], the standards for Electronic Signatures found in the September 2011 Medicaid Bulletin must be followed.

A completed LME-MCO Consumer Admission and Discharge Form shall be submitted to the LME-MCO.

A documented discharge plan shall be discussed with the individual and included in the service record.

The DMH/DD/SAS Records Management and Documentation Manual can be found at:
http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/rmdmanual-final.pdf

SERVICE EXCLUSIONS

ACT or CST services may not be provided at the same time as CTI; however, CTI may be provided for someone transitioning from or to ACT or CST for a period of up to 30 days.

RESOURCES

Information about the Critical Time Intervention model including links to publications and training resources can be found at http://www.criticaltime.org

PROVIDER IMPLEMENTATION & MONITORING ACTIVITIES

Prior to implementation of the service, the provider will provide documentation for verification of the following:

1. Provider staff/team must complete, at a minimum, the basic CTI training by a certified training organization.
2. Completion of pre-assessment fidelity review tool, which is reviewed and approved by Network Management. Network Management may consult with UNC School of Social Work in determining a provider's readiness for service delivery.

UNC School of Social Work will provide technical assistance, consultation and oversight of implementation of the CTI service. Partners Behavioral Health Management intends to communicate directly with the UNC School of Social Work Team regarding needed technical assistance and provider performance

Partners BHM will utilize the fidelity review tool developed by Center for Advancement of CTI and adopted by UNC School of Social Work, for adherence to the fidelity to the model. Partners BHM will work collaboratively with UNC School of Social Work to ensure consistent reviews. Frequency of fidelity review will be conducted, at a minimum, annually.

Network Management will monitor service through routine monitoring and focused reviews.

Provider outcome expectations, meeting CTI fidelity Scale Protocols, will be outlined in the provider contract.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, its divisions or its fiscal contractor(s).

DMA Program Integrity or DHHS designated contractor may recoup payment if any service provided was not rehabilitative in nature such as habilitative or recreational activities or transportation. Rehabilitative means the same as defined in 42 C.F.R.440.130(d).