

**Critical Time Intervention (CTI) (State-Funded)**

**Service Definition and Required Components**

Critical Time Intervention (CTI) is an intensive 9 month 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. For the purpose of this definition, CTI defines a critical transition as occurring within no more than 45 days from the start of service. CTI promotes a focus on recovery, psychiatric rehabilitation, and bridges the gap between institutional living and community services. CTI differs from traditional case management because it is time limited, focused, and follows a three phased approach. Unlike some other models, timing of movement through the phases is defined by the program model, not the readiness of the individual.

**Eligibility Criteria**

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

- A. A primary SPMI/SMI diagnosis. Individuals with a primary diagnosis of an intellectual/developmental disability, substance use disorder or personality disorder are not the intended eligibility group, 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
  - Inability to perform activities of daily living adequately
  - Lack of basic subsistence needs (food stamps, benefits, medical care, transportation)
  - Inability to manage money
  - Substance use with negative impact
  - Unemployment/underemployed/lack of employment skills

AND

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 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

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.

Pre-CTI: Ten hours of Pre-CTI is built into this definition. Pre-CTI services begin before an individual is discharged from a hospital, adult care facility, or other institution in order to establish an initial relationship before the transition begins. Pre-CTI can also be used with an individual who is homeless prior to the individual moving into housing.

CTI is divided into three identified phases lasting three months each.

**Phase 1: Transition to the Community** – In this phase, there is frequent contact with the individual in the community, focusing on active engagement with behavioral health services, and identifying and addressing housing-related issues in order to prevent future episodes of homelessness or housing instability. A transition plan is implemented while providing emotional support.

**Phase 2: Tryout** – In this phase, the team increasingly encourages individuals to manage problems independently after connecting them to supportive services.

**Phase 3: Transfer of Care** - This phase, promotes the transfer from CTI to other community supports, both formal and informal and termination of CTI services occurs with a support network safely in place.

| <b>Phase</b> | <b>Transition</b>  | <b>Try-out</b>  | <b>Transfer of Care</b>  |
|--------------|--|---|--|
| 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 service 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 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; | CTI worker monitors the effectiveness of the support network;<br>Helps to modify network as necessary;<br>Continues case management activities as necessary;<br>Continues community based visits;<br>Provides psychoeducation about self-management and successful navigation of the service systems and<br>Completes any Phase I activities that still need resolutions. Less frequent meetings, and provides social crisis interventions and troubleshooting. | CTI worker provides consultation but little direct service. The worker lets the individual solve their own problems. The worker ensures key caregivers/providers meet and agree on long term support system. Reinforces the roles of support network members;<br>Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification);<br>May hold a party or some other ceremonial recognition of |

|   |   |
|---|---|
| <b>NC Division of Mental Health,<br/>Developmental Disabilities, and<br/>Substance Abuse Services</b> | <b>State-Funded Critical Time<br/>Intervention<br/>Date Published: July 1, 2016</b> |
|---|---|

|  |   |  |   |
|--|---|--|---|
|  | 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.); Introduces the individual to vocational services. |  | successful transition out of CTI services. A final meeting is held to formally recognize the end of interventions and relationship. |
|--|---|--|---|

Individuals receiving CTI are served until transitioned to and engaged with the next provider through the structured and time-limited 3 phase model. CTI works to keep individuals engaged in services. CTI allows for the possibility that the individual may not be actively engaged in services. CTI may re-engage with individuals after they disengage in active services, or become unavailable for some period of time. If an individual is not actively engaged in services and then returns, the CTI worker doesn't pick up on where they left off but starts on the phase the individual would have been in should they have stayed in continuous service.

At the end of the nine months, individuals who were receiving CTI should be engaged with desired and appropriate community-based services which can provide ongoing support.

**Provider Requirements**

Critical Time Intervention services must be delivered by practitioners employed by mental health provider organizations that meet the requirements of 10A NCAC 27G, the provider qualification policies, procedures, and standards established by the Department of Health and Human Services. 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 and contracted by the LME-MCO. Additionally, 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 and contracting process, DMH/DD/SAS Joint 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.

Providers of CTI services should utilize any tools, training, documents, forms, and learning opportunities provided by the Department of Health and Human Services.

Prior to implementation, the provider organization will ensure that all team members have completed, at a minimum, the Critical Time Intervention training provided by a certified trainer approved by NC DHHS within 60 days of hire.

### **Staffing Requirements**

This service must be provided by a team of, at a minimum, two full-time equivalent positions (2 FTEs) – a Fieldwork Coordinator/Clinical Supervisor and a CTI worker.

The Fieldwork Coordinator/Clinical Supervisor must be a full-time, dedicated, fully licensed mental health professional who has at least two years of 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 or Licensed Marriage and Family Therapist.

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

The number of staff on a 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/Clinical Supervisor 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 who are in each phase.

### **Staff Training and Supervision Requirements**

As noted above, the provider organization ensures that all team members have completed the Critical Time Intervention training provided by a DHHS approved trainer 60 days from the date of hire.

In addition to the basic Critical Time Intervention training, all staff providing this service must have the following training within 90 days of hire.

- Person Centered Thinking (3 hours)
- Crisis Response Training (3 hours)
- Introduction to Motivational Interviewing (13 hours)

Additionally, all staff that is either an Associate Professional, Paraprofessional or a North Carolina Certified Peer Support Specialist must complete the following training within 90 days of hire:

- Mental Health/Substance Use 101 (3 hours)

These initial training requirements may be waived if the employee can produce written documentation certifying their successful completion of the required trainings within the past 12 months.

For each year of employment, each CTI team member shall receive an additional three hours of training in an area that is fitting with their area of expertise. This additional training may be in the form of locally provided training, online workshops and regional or national conferences.

Broader topics of additional training may include:

- Family Psychoeducation;
- Recovery Oriented Approaches

- Recovery Planning
- Benefits Counseling
- DHHS approved Individual Placement and Support/Supported Employment
- Psychiatric Rehabilitation
- Limited English Proficiency (LEP), blind or visually impaired, deaf and hard of hearing accommodations
- NAMI psychoeducational trainings
- Psychiatric Advanced Directives
- SOAR (SSI/SSDI outreach, access and recovery) Stepping Stones to Recovery
- Permanent Supportive Housing, such as the SAMHSA evidenced based practices toolkit, Housing First: Pathways Model to End Homelessness for People with Mental Illness and Addiction, and other evidenced based models
- Trauma Informed Care
- Wellness and Integrated Health Care
- Wellness Management and Recovery interventions (includes WRAP, IMR/WMR)
- Supervising NC Certified Peer Support Specialists
- DHHS Approved Tenancy Support
- Money management and budgeting skills

All team members shall receive weekly clinical supervision from the team's clinical supervisor.

Clinical Supervision is the provision of guidance, feedback, and training to team members to assure that quality services are provided to the individuals served and to maintain and facilitate the skills of the supervisee to assure all members of the team are utilizing and maintaining fidelity to the evidence-based CTI model.

CTI Teams meet weekly for clinical supervision and to share practical strategies for working with individuals and their complex needs. Each meeting should include the following:

- Report on previous week's activities, starting with the to do list from the last supervision meeting
- Review any new cases/individuals referred to the CTI team
- Reinforcement of CTI principles and practices
- In depth discussion of high priority cases, usually between 4-8 individuals. Additionally, each individual should be discussed at minimum once a month
- Plan for resolving barriers to implementation of CTI
- Make a "To Do List" for upcoming week.

Additional individual clinical supervision sessions between the Fieldwork Coordinator/Clinical Supervisor and a team member shall occur as needed.

The Fieldwork Coordinator/Clinical Supervisor shall maintain documentation of both supervision and training activities. Fieldwork Coordinator/Clinical Supervisor must document supervision using the CTI Team Supervision Form.

### **Service Type and Setting**

CTI is intended to be flexible in its approach to meet the needs of adults in their current settings and locations, and during transition to new settings. CTI should complement rather than duplicate existing

services. It is expected that a significant amount of service delivery will occur in various non-traditional community settings such as “on the street” encounters with homeless individuals.

This service can be delivered as part of the discharge planning process from facilities.

### **Program Requirements**

The individual receiving CTI 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.

Because of the financial difficulties individuals receiving CTI services are likely to experience, the rate for this service includes the cost of obtaining and completing documentation critical to support individuals during life transitions, including but not limited to: photo identification, housing application fees, birth certificates, criminal background checks, and credit checks. It is the responsibility of the provider to ensure that the cost of obtaining these documents is not a barrier to transitions, and that if the individual cannot cover the cost of obtaining required documentation the agency shall assume the financial responsibility for obtaining required documents.

CTI is 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
- 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
- Promote adherence to prescribed medications and treatment
- Promote harm reduction, linkage to recovery treatment, and support sustained recovery maintenance

Although the CTI model is time limited and has a prescriptive 3 phase approach, the number of contacts made by the CTI worker per week is tailored to the individual’s current needs. The CTI staff will provide multiple contacts per week as needed. CTI varies in intensity to meet the changing needs of the individuals served and contacts are expected to taper in volume and frequency throughout the duration of the three phases.

During Phase 1, a CTI worker must have at least six community-based meetings per month with an individual being served for a total of at least eighteen community-based meetings for Phase 1. Of the eighteen, two community-based meetings must be with an individual's provider and/or informal supports.

During Phase 2, a CTI worker must have at least two community-based meetings per month with an individual being served for a total of at least six community-based meetings in Phase 2. Of the six community-based meetings, two must be with an individual's provider and/or informal supports. During Phase 2, a CTI worker meets less frequently with an individual being served but phone and collateral contacts increases.

During Phase 3, a CTI worker transfers care and responsibilities to both the individual being served and the formal and informal caregivers. During Phase 3, a CTI worker must have a minimum of two community-based meetings with an individual being served. The CTI workers role during this phase shifts to monitoring via phone calls with the individual and the individuals provider/informal caregivers.

### **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 an individual.

An assessment is required for entrance into this service. The CTI team can obtain a Comprehensive Clinical Assessment (CCA) that has been completed in the previous 12 months and contains relevant current information or a licensed CTI team member can complete an abbreviated assessment and obtain any other available clinical materials upon referral to CTI.

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 problem;
- 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.

The CTI provider will be responsible for the development of a CTI Phase Plan or Person Centered Plan (PCP). 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 is 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 Prevention and Intervention Plan* published by the NC DMH/DD/SAS.

A signed service order must be completed by the fully Licensed Clinical Supervisor/Fieldwork Coordinator. Each service order must be signed and dated by the authorizing professional and must indicate the date on

which the service was ordered. A service order must be in place prior to or on the day that the service is initially provided in order to bill for the service. The service order must be based on an assessment of the beneficiary's needs.

### **Utilization Management**

Up to 10 hours (40 units) of Pre-CTI can be provided with no prior authorization for the purpose of assessment, engagement and enrollment of the individual into the service. Pre-CTI is provided prior to the actual start-up of Phase 1.

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 a three month period covering Phase 1, not to exceed 144 units (36 hours). As CTI is individualized, additional units may be requested for Phase 1 in order to provide necessary services to address the individual's transitional needs (for example, completing a SOAR application).

The concurrent authorization will be for the last six months of CTI covering Phases 2 and 3 and will not exceed 168 units (42 hours) total for the 6 month period. An example of how the concurrent authorization could cover services for Phases 2 and 3 is a team using 112 units (28 hours) for Phase 2 and the remaining 56 units (14 hours) for Phase 3.

Units will be authorized and billed in 15 minute units.

### **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 is making progress towards the initial goals of the CTI Service Plan, and additional goals are indicated as evidenced by documented functional impairments;
- b. The individual is unavailable or unable to be located but has previously demonstrated gains and benefits, and may be willing to re-engage with the CTI provider. The individual may re-engage if they return within nine months of their entrance date.

### **Discharge Criteria**

The individual is discharged 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 service.

### **Service Exclusions and Limitations**

An individual may not receive CTI services if they are currently receiving ACT or CST services.



CTI may be provided for an individual transitioning into ACT or CST for a period of up to 90 days when an individual has transitioned to Phase 3 only.

### **Fidelity Monitoring**

CTI teams will complete the CTI Self-Assessment every 6 months beginning from the date the team starts. Documentation of completed Self-Assessments must be made available upon request. The Self-Assessment is a quality improvement tool used to measure adherence to the CTI model.

Providers operating CTI teams will be evaluated according to a fidelity measure to evaluate the extent to which defining elements of the program model are being implemented. The CTI Self-Assessment Tool, or its successor as approved by DHHS, must be used to evaluate teams. The aim of these evaluations is not only to ensure that the model is being adhered to as intended, but also to provide a mechanism for quality improvement feedback and guided consultation.

NC DHHS shall track adherence to the CTI model and determine annual CTI performance outcomes from teams through their participation in the administration of the most current CTI fidelity assessment. Completed fidelity assessment will be shared with the CTI team's LME-MCO.

### **Expected 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 with providers and other support systems
- The individuals' utilization of community-based services will increase
- The individuals' hospital admissions will be reduced
- The individuals' 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

Teams will utilize a provided tracking tool to document outcomes. This tool is completed ongoing and the information must be provided to NC DMH/DD/SAS and DMA quarterly.

### **Documentation Requirements**

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

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

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.