OnTrackNY
Fidelity Criteria

Overview: This Fidelity Criteria document includes program domain names, definitions and the program expectations that further define the domain and are considered essential components of the OTNY model.

<table>
<tr><th>Program Domains and Definitions</th><th>Program Expectations</th></tr>
<tr><td>1. <u>STAFFING</u>
Team is fully staffed with credentialed persons filling all roles (Team Leader, Primary Clinician(s), Outreach and Enrollment Coordinator, Peer Specialist, Prescriber, Nurse).</td><td>
• <u>Staffing</u>: Team is staffed with no less than 4.0FTE dedicated time, given program maturity and careload, and consists of persons meeting at least the minimum credentialing requirements fulfilling the following roles:
<table>
<tr><th>Role</th><th>Credentials</th><th>FTE</th></tr>
<tr><td>Team Leader</td><td>NYS licensed master’s level clinician</td><td rowspan="3">2.0</td></tr>
<tr><td>Outreach and Recruitment Coordinator</td><td>NYS licensed master’s level clinician</td></tr>
<tr><td>Primary Clinician</td><td>NYS licensed master’s level clinician</td></tr>
<tr><td>Supported Employment and Education Specialist</td><td>Bachelor’s level</td><td>1.0</td></tr>
<tr><td>Psychiatric care provider (prescriber)</td><td>Licensed psychiatrist, psychiatric nurse practitioner, or physician assistant</td><td>0.3</td></tr>
<tr><td>Nurse</td><td>Registered nurse</td><td>0.2</td></tr>
<tr><td>Peer</td><td>State certified as Peer Specialist within 1 year of hire</td><td>0.5</td></tr>
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• <u>Staffing</u>: Vacancies do not exceed 4 weeks.
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<tr><td>2. <u>TEAM INTEGRATION</u>
Providers function as a team: providers know and work with all clients and the team leader provides intensive role-specific supervision.</td><td>
• <u>Team-Based Approach</u>: At least 75% of clients meet with 2 or more team members: PC, Prescriber, SEES, Peer Specialist, and Nurse.
• <u>Supervision</u>: TL provides administrative supervision which includes managing staff time on the team, making sure there is seamless communication across team members, finding coverage, and ensuring that program elements are compatible with agency requirements.
• <u>Supervision</u>: Team leader provides supervision of role-specific responsibilities, issues and strategies at least bi-weekly:
○ during PC supervision, clients are reviewed for progress, interventions attempted, and next steps;
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	○ during SEES supervision, each client is reviewed with respect to education and employment outcomes to discuss strategies and ideas to help clients in their school and work lives; ○ during ORC supervision activities related to outreach, referrals, evaluations, and intakes are reviewed and strategies are discussed; ○ during Peer supervision, there is a review of engagement strategies for new clients and review of work with current clients. ○ team leader collaborates with the team prescriber and nurse regarding implementation of the medical aspects of the model.
3. **TEAM COMMUNICATION** Team meets weekly as a team to discuss each client and has developed an efficient communication system.	• Team Meeting: Full team meets at least weekly and each client's status (clinical status and progress toward recovery goals) is reviewed at least briefly at each team meeting. • Team Meeting: Each team member attends at least 80% of team meetings. • Team Communication: Team has developed a system for team communication, as needed, outside of team meetings.
4. **ELIGIBILITY** Eligibility evaluations and decisions meet program criteria (including age, date of onset, diagnosis) and are clearly documented.	• Eligibility: The team has a consistent process for screening incoming referrals. • Eligibility: Enrollment decisions follow explicit OnTrackNY inclusion/exclusion criteria and only clients meeting inclusion criteria are enrolled i.e. age, diagnosis, date of onset, IQ and location.
5. **COMMUNITY OUTREACH** Active and regular outreach to likely settings is conducted to develop referral networks and encourage more appropriate and frequent referrals.	• Team (led by ORC) conducts outreach: The team conducts regular outreach and recruitment activities (face to face, telephone, electronic) to at least two mental health setting (including inpatient units, outpatient clinics, mobile crisis teams and emergency rooms), and to at least two community settings each quarter (including community organizations, schools, colleges, law enforcement settings, etc.) each quarter except for the quarters during which the team was within 90% of capacity or was closed to referrals. • Community Education: Education about early psychosis is routinely provided to referral sources in the community. Education is provided to at least two community settings each quarter.
6. **MANAGING REFERRALS** Rapid engagement (including families), screening, and evaluation procedures support timely enrollment and increased engagement.	• Admission: For at least 65% of individuals admitted to the program, the time from eligibility determination to admission is </= 1 week. • Admission: At least 85% of individuals deemed eligible enter/enroll in the program.
7. **CARELOAD** Teams maintain an appropriate census,	• Careload: Team's careload is small to ensure optimal delivery of services and does not exceed 40-50 clients per 4.0 FTE staff ratio (10-12.5:1).

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which grows proportionately based on community need, but remains small enough to ensure optimal delivery of services.	• Careload: For teams open more than one year: As of the last day of each quarter, team enrolled at least 70% of the expected census.
8. **FLEXIBILITY OF SERVICES** Delivery of services in the community and flexible hours are provided to support engagement and service utilization.	• Services in the Community: At least 10% of clients are seen in the community by at least one team member (excluding services provided by the Supported Education and Employment Specialist). • Scheduling: The team is available weekly for routine appointments outside of the regular workday e.g., early morning, evening, or weekend hours (can be regularly scheduled, as-needed, or via phone).
9. **ASSERTIVE OUTREACH** Proactive and diversified outreach strategies are designed to engage clients, reduce missed appointments, and minimize drop-outs.	• Assertive Outreach: Team has a concrete strategy to promote client engagement when clients miss appointments or show disinterest in services, which includes reaching out to people by various methods (e.g., phone, text, email, and home visits) to promote engagement. • Engagement: At least 70% of individuals are still enrolled after 1 year of enrollment.
10. **CRISIS SERVICES** 24/7 phone service and information on this service is available and clearly communicated so that clients and family members are aware of crisis support services and can access them easily. The crisis services system is adapted to the host agency's specific policies, resources, and organizational linkages (e.g. medical back-up) to manage crises optimally.	• 24/7 Availability: At least one team member (a licensed mental health professional) is available 24/7 to clients and family via phone/pager/other means of coverage and the policy is posted at the site in a location visible to clients/family members and distributed to each client and family member (if participant consented to contact with family). • Crisis Services: The team is involved in providing live (in-person/phone) crisis support and coordinating linkages to crisis services, including medical back up, to manage crises on a timely basis.
11. **CARE PROCESSES** Clinical training and supervision on core care processes are provided throughout treatment planning and delivery to support clients and families in making informed decisions and utilizing services. The team provides person-centered, recovery-oriented, and culturally competent care. Providers and clients	• Core Sessions: Clients receive core sessions on each of the following topics: Introduction to the OnTrackNY Program and Team, Early Intervention and Recovery, Shared Decision Making Around Client Goals, the Impact of Culture, Identifying and Using Personal Strengths and Social Supports (1-5). At least 35% of clients receive core sessions 1-5 within one year of enrollment. • Care Processes: Clinicians report receiving training on core care processes including recovery, person-centered care, shared-decision making, and cultural competency from OnTrackNY Central or other sources. • Care Processes: The team is delivering person-centered care, using recovery principles, shared-decision making and cultural competency in the past year.

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use SDM when making decisions regarding medication, family involvement, and other psychosocial interventions (e.g., substance use, trauma, social skills training).	
12. **INITIAL ASSESSMENT AND TREATMENT PLANNING** Comprehensive assessments are conducted to inform diagnosis (e.g. co-occurring mood problems, substance use, or trauma) and individualized treatment decisions, including care planning and identifying supports (e.g. pharmacotherapy, psychotherapy, substance use treatment, trauma-informed care, suicide prevention, and weight management).	• Treatment Plan: Individualized assessments are conducted and clinical treatment plans are created after intake: assessment includes safety screening; client, family and staff develop individualized treatment plan using evidence-supported treatments addressing client needs, goals and preferences (e.g. pharmacotherapy, psychotherapy, care management, substance use treatment, trauma-informed care, suicide prevention, weight management). • Psychosocial Evaluation: Comprehensive evaluation is conducted (starting from the time of referral through intake/initial meeting), which includes: 1. Time course of symptoms, change in functioning and substance use; 2. Recent changes in behavior; 3. Risk assessment risk to self/others; 4. Mental status exam; 5. Psychiatric history; 6. Premorbid functioning; 7. Co-morbid medical illness; 8. Co-morbid substance use; 9. Family history. • Needs Assessment: Psychosocial needs in the following areas are assessed and incorporated into care plan: 1. Housing; 2. Employment; 3. Education; 4. Social support; 5. Finances and insurance; 6. Basic living skills; 7. Primary care access; 8. Social skills; 9. Family support; 10. Past trauma; 11. Legal issues.
13. **SAFETY PLANNING** Safety assessments using a standardized tool are conducted for all clients: assessments use all resources available to inform an understanding of risks and documentation of the risk assessment should be on record. The safety plan intervention is used for all participants with evidence of increased risk.	• Safety Planning: For those who meet or exceed the specified threshold indicating a risk of suicide based on a screening assessment, a safety plan is created, revised, and used during that same assessment period. • Safety Assessment: The CSSR or equivalent structured screening tool is completed with every client at admission and whenever safety concerns are raised. • Safety Planning: For those for whom a safety plan has been created the client has been given a copy and it is used in treatment.
14. **PRESCRIBING PRACTICES** Antipsychotic medication is prescribed following recommended guidelines based on empirical support and side effects are regularly monitored.	• Antipsychotic Medications: At least 75% of clients have at least one trial of an antipsychotic medication prescribed for at least 4 continuous weeks within the recommended dosage range, i.e., within the lower half of the FDA-approved dosage range for each respective medication, for each quarter. • Antipsychotic Medications: At least 1 antipsychotic medication is prescribed for at least 75% of clients on the last day of the reporting period of each quarter. • Antipsychotic Medications: Psychiatrist, nurse practitioner, or nurse assesses for side effects for each client prescribed psychotropic medication and uses standardized assessment scales at a minimum of quarterly (SAS,

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	AIMS, ESRS, BARS) for at least 80% of clients. • Antipsychotic Medications: For programs that have been open for one year or more: At least one client is on clozapine.
15. **CARE MANAGEMENT** Comprehensive assessments are conducted to assess for concrete needs and care planning and management, including identifying supports, is done on an individualized basis.	• Care Management: Primary Clinicians routinely assess clients' and families' concrete needs and provide care management services.
16. **METABOLIC RISK FACTORS** Metabolic risk factors are assessed for and monitored regularly; clients are provided with information to inform decisions around wellness.	• Weight Assessment: For at least 80% of clients prescribed an antipsychotic medication, weight is assessed each quarter in each year. • Monitoring of fasting glucose/HbA1c and lipids: For clients at least 75% of clients prescribed an antipsychotic, assessment of fasting glucose/HbA1c and lipids is conducted at least annually. • Medical or other staff work with clients to promote wellness: At least 50% of clients meet individually (i.e., not as part of a group) with the medical or other staff for medication education or support, health care coordination, nutrition/ exercise, smoking cessation, substance abuse, or sexual health or resources at least once within 12 months of their admission. • Medical staff work with clients to promote wellness: At least 35% of clients have completed a Core Session with the medical staff about health and wellness services available via OnTrackNY within the first two quarters following admission.
17. **PSYCHOEDUCATION** Psychoeducation that includes biological, pharmacological, social, cultural, and familial perspectives is provided to support engagement, self-efficacy, recovery and to inform treatment decisions.	• Core Sessions: At least 50% of clients who have been enrolled in the program for at least 1 year participate in Core Session 2 (for psychoeducation) with the Primary Clinician. • Psychoeducation: Primary Clinicians are providing psychoeducation routinely in care.
18. **COGNITIVE BEHAVIORAL THERAPY/MOTIVATIONAL ENHANCEMENT-BASED INTERVENTIONS** CBT and MI are provided to reduce	• Primary Clinician provides flexible, motivational interventions: At least 70% of clients participate in at least one of the following skills building interventions with the Primary Clinician: coping skills, social skills, substance use treatment, behavioral activation. • CBT Interventions: Primary Clinicians are using empirically-validated CBT-based interventions to match client problems based on client preferences.

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symptoms, increase readiness to change, target individual needs (e.g., substance use) and develop and strengthen coping and social skills.	
19. **SUBSTANCE ABUSE TREATMENT** Motivational interviewing is used to increase readiness to change and reduce substance abuse	• Substance Use Treatment: Of clients using substances, at least 50% of such clients are provided substance use treatment (includes skill-building or other interventions, such as motivational interviewing) by at least one clinician. • Substance Use Treatment: If substance use reduction is a treatment goal, it is documented in the treatment plan and the client record reflects that this is being worked on collaboratively with clients and the team using interventions like motivational interventions, shared decision making, and harm reduction strategies.
20. **Trauma Assessment and Treatment** Providers assess for PTSD and deliver trauma-informed care and trauma specific interventions based on client preferences.	• Trauma Assessment: Routine assessments of trauma are performed for all clients at the time of intake, and for those who indicate a trauma history, a structured PTSD assessment tool is completed in the past year. • Trauma Intervention: Interventions for trauma such as the Brief PTSD intervention are delivered based on client preferences.
21. **WORKING WITH FAMILIES** Team assesses family needs and meets with families regularly, individually and in groups, to provide psychoeducation and discuss family involvement strategies.	• Family Participation: The team reviews options for family involvement with the client, client preferences are discussed (at admission and follow-ups), the PC offers meetings reflecting preferred frequency/content, and services are delivered flexibly, in the past year. • Family Participation: For at least 50% of clients, at least one team member has contact with at least one member of the client's family in the past year. • Family Participation: At least 15% of family members attended any groups offered by OnTrackNY staff for each quarter.
22. **SUPPORTED EMPLOYMENT AND EDUCATION SERVICES** The SEES assesses client goals for competitive paid employment and education and spends time in the field providing services and creating employment and education networks.	• SEES Services: SEES primarily provides employment and education services. At least 90% of the SEES' meetings with clients are devoted to assisting clients with working on employment or education goals each quarter. • SEES Services: At least 50% of SEES' time is spent in community settings (outside the mental health center), devoted to engagement, employer and educational institution contacts, providing follow-along support, etc. each quarter. • SEES Services: SEES helps clients find competitive jobs and mainstream education: At least 65% of enrolled clients are competitively employed, in a competitive internship, or attend school as part of a degree-granting program each quarter. • SEES Team Integration: At least 40% of clients meet with the SEES during each quarter for the purpose of school or employment.

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	• SEES Services: At least 40% of clients who meet with the SEES have the Career Profile Form completed during the quarter when the goal was first expressed. • Work and School Goals: Client records reflect work and school goals in the treatment plan and indicate whether clients are enrolled in school or have jobs.
23. **PEER SPECIALIST SERVICES** Peer Specialist works with clients using their own recovery story and providing supports.	• Peer Specialist Services: The Peer Specialist works with clients using their own recovery story and providing support individually and in groups. • Peer Specialist Services: Clients and families are being offered meetings with the peer specialist. At least 50% of participants meet with the peer specialist. • Peer Specialist Services: Peer Specialist is engaged with team outreach activities, initial and continued client engagement, discharge and linkage to resources.
24. **DISCHARGE** Discharge plans are created with clients and families to ensure that follow-up services are identified, in place, and occur as planned.	• Discharge Follow-up: At least 80% percent of discharged clients attend their first pre- or post-discharge appointment with a mental health or substance use treatment provider within 30 days of discharge in the past year. • Discharge Follow-up: At least 90% of discharged clients who are prescribed an antipsychotic medication at the time of discharge keep a follow up appointment with a psychiatrist or psychiatric nurse practitioner within 30 days of discharge. • Discharge: There is a protocol for outreaching participants who are non-responsive (e.g. team is unable to contact client) and steps are taken to refer non-responsive participants to appropriate treatment providers and appropriate follow up (e.g., sending a letter with referral information). • Discharge: Interviews with Primary Clinicians, clients and a review of client records (when possible) indicate that Primary Clinicians identify and provide linkages to community supports that clients and families may need for a successful transition (e.g., NAMI, social-groups/activities, school support) in the past year. • Discharge: Interviews with Primary Clinicians, clients and review of client records indicate that discharges are planned and documented: teams use SDM to plan and perform discharges and have a system for following-up to make sure clients attend initial appointments with new provider in the past year.

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25. **TIME-LIMITED SERVICES** The team communicates to clients that the program is a critical time intervention (CTI), and the team provides service to clients for specified time period (an average of 2 years).	• Time Limited Services: The average length of program enrollment is 2 years, with flexibility, based on clinical circumstances. For at least 90% of clients, individual length of stay for enrolled clients does not exceed 42 months. • Time-Limited Services: Providers communicate to clients and family members at the time of enrollment that this is a time-limited service beginning at the time of enrollment.