**OnTrackNY**
**Fidelity Criteria**
**Considerations during the COVID-19 health crisis**

This document includes questions to consider when thinking through how to implement the model during the current COVID-19 health crisis. This document also includes ideas on how to deliver essential component of the model in light of barriers.

Please note, OnTrackNY teams must follow their agency policies.

| **Program Domains and Definitions** | **Program Expectations** |
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| 1. **STAFFING**<br>Team is fully staffed with credentialed persons filling all roles (Team Leader, Primary Clinician(s), Outreach and Enrollment Coordinator, Peer Specialist, Prescriber, Nurse). | **Consider:**<br>Which team roles are vacant or have reduced staff time (e.g. due to illness, deployment and/or personal staff reasons such as childcare issues)?<br>If applicable, which current team members will provide coverage?<br>Is additional coverage being provided by other agency staff? How will coverage be facilitated?<br>How are coverage policies or changes in availability being communicated to clients and family members?<br>How will covering clinicians be updated on client statuses and key issues and communicate with team members?<br>What is the hiring status for vacant roles?<br>If clients have moved out of state and team is continuing to work with the individuals on a temporary basis, how are licensing issues being considered?<br><br>**Ideas:**<br>Inform each client/family unit of interim coverage policies or any changes in availability.<br>Facilitate “warm” hand-offs to covering providers when possible (virtually). |
| 2. **TEAM INTEGRATION**<br>Providers function as a team: providers know | **Consider:**<br>How are team members meeting and connecting with clients e.g. phone, video, email, text?<br>How are team members coordinating /encouraging clients to meet with other team members? |

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| and work with all clients and the team leader provides intensive role-specific supervision. | How are meetings being tracked so that TL and team members are aware of who is being met with and how often?<br>What systems is the TL using to provide administrative supervision to the team?<br>How is individual supervision held e.g. phone, video? How often?<br><br>**Ideas:**<br>When meeting with a client virtually, offer to conference in other team members (the virtual version of walking a client down to a team member's office).<br>For individual supervision, add in relevant topics e.g. telehealth capabilities and increased case management needs. Keep a supervision log to help ensure all topics are covered as needed. |
| 3. **TEAM COMMUNICATION**<br>Team meets weekly as a team to discuss each client and has developed an efficient communication system. | **Consider**:<br>How is team meeting held e.g. phone, video? How often (weekly or more often)? Who is updating the master client list and where is it kept (in accordance with agency policies)?<br>What are the team's policies/practices regarding day to-day communication. For example, if an issue of concern comes up, is it relayed by email, text, phone, and/or progress notes, etc.?<br><br>**Ideas:**<br>Some teams currently:<br>Hold a daily morning or afternoon virtual meeting to review upcoming team activities and client needs e.g. risk assessment and planning<br>Have each team member send a secure email update at the end of each day to the TL or whole team.<br>Maintain a master list or spreadsheet of each client's status and team activities in real-time that can be securely accessed by all team members. |
| 4. **ELIGIBILITY**<br>Eligibility evaluations and decisions meet program criteria (including age, date of onset, diagnosis) and are clearly documented. | **Consider**:<br>For teams that have capacity to accept referrals, what accommodations need to be considered to support rapid screenings, eligibility evaluations, and enrollments e.g. conducting services virtually?<br><br>**Ideas:**<br>Always follow agency guidelines regarding telehealth and remote communication with potential participants.<br>Some teams have been conducting remote assessments of participants on inpatient units or at home. |

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| | Keep in mind difference between a "referral" and an "inquiry", referrals generally involve the exchange of PHI or specific info about the individual.<br>Get as much collateral information as possible from referring source; if possible, speak with family members<br>Assess for suicidal ideation and behavior: keep in mind that post-hospital discharge is a high-risk time for individuals; assess and maintain contact even during the evaluation and enrollment period.<br>Since you may not be able to see the individual, it is important to do a thorough assessment (assess for risk factors, ideation, plan, intent, access to lethal means). |
| 5. **COMMUNITY OUTREACH**<br>Active and regular outreach to likely settings is conducted to develop referral networks and encourage more appropriate and frequent referrals. | **Consider**:<br>If open to enrollment, what is the plan for outreach to mental health settings and community settings, and for providing community education?<br>Has the contact information for referrals changed and if so, where does this need to be updated (e.g. website, email signatures, voicemail, etc.) and who needs to be informed (e.g. existing referral sources)?<br><br>**Ideas:**<br>Consider outreach to mobile crisis teams, ERs, and inpatient units to inform them that you are still accepting referrals and provide any updates regarding contact infomation.<br>Update contact information on websites, email signatures, and regular listserv emails. Consider sending a mass email/ calling referring providers with updated contact information. |
| 6. **MANAGING REFERRALS**<br>Rapid engagement (including families), screening, and evaluation procedures support timely enrollment and increased engagement. | **If open to referrals, consider**:<br>What procedures are in place to support enrollment following an eligibility determination?<br>What strategies are in place to support that individuals deemed eligible enter/enroll in the program?<br>What are other options that individuals have for treatment and supports in order to do full SDM process regarding enrollment (these may have changed due to pandemic).<br><br>**Ideas:**<br>Communicate the intake process to clients and family members. Explore options for introductions and initial meetings with all team members e.g. phone, video, etc.<br>When meeting with a client virtually, offer to conference in other team members to facilitate introductions (the virtual version of walking a client down to a team member's office). |

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| 7. **CARELOAD**<br>Teams maintain an appropriate census, which grows appropriately based on community need, but remains small enough to ensure optimal delivery of services. | |
| 8. **FLEXIBILITY OF SERVICES**<br>Delivery of services in the community and flexible hours are provided to support engagement and service utilization. | **Consider:**<br>What is the policy on which services are provided in-person and/or in the community versus telehealth?<br>For teams that are teleworking, how can staff members be reached by clients and families e.g. on a cell phone, via email, text?<br>How is the team communicating these policies to clients and family members?<br>If different than usual, what hours is the team available for appointments outside of the regular workday and how is this communicated to clients?<br><br>**Ideas:**<br>Communication about policies and hours should be delivered both verbally and in writing, when possible, so that clients and families can ask clarifying questions and have a written copy for reference.<br>When meeting virtually instead of in the community, agree to both walk outside during the call (keeping social distance from others). This strategy can be particularly useful for participants who are focused on health.<br>Some teams are largely doing telehealth with some in-person or community visits (keeping social distance where possible) if there are concerns about the participant's well-being, if participant is in crisis, or if LAI's need to be administered. |
| 9. **ASSERTIVE OUTREACH**<br>Proactive and diversified outreach strategies are designed to engage clients, reduce missed appointments, and | **Consider:**<br>How is the team tracking client engagement in treatment e.g. response to outreach attempts, keeping appointments?<br>In addition to usual strategies, what strategies are being used to promote client engagement when clients miss appointments or show disinterest in services? Or, when clients share concerns about phone/virtual meetings (if applicable)?<br><br>**Ideas:**<br>Contact information: |

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| minimize drop-outs. | ○ Confirm all client and family member contact information is current. If client has refused family contact in the past, consider re-exploring this preference (if appropriate) to ensure multiple avenues of contact.<br>○ Clarify client and family preferences for methods of contact, especially if new methods of contact are being used e.g. telehealth services. Use SDM approach to discuss options, preferences, and a plan.<br>○ If new methods of telehealth are used, provide clear instructions and troubleshooting services for clients and family verbally and in writing. Identify technical capabilities (access to phone/video/internet and ability to use technology).<br>Method of contact:<br>○ Use SDM approach to discuss options for meeting remotely e.g. texting, emailing, brief phone/video check-ins, full phone/video meetings, individual meetings vs. group meetings (with other team members and/or family), pros and cons based on values, and identify a plan.<br>○ Have concrete discussion re: access to phone (smartphone or other), computer, and internet access; as well as space (inside or outside) where participant feels that they can speak privately.<br>Frequency of contact:<br>○ Increase contact via phone; more frequent contacts.<br>○ Make contact predictable (schedule times) and bi-directional (schedule times that participant is willing to initiate contact/reach out to team for routine check-ins)<br>○ For some people, a daily contact with a team member (M-F) may be helpful, coordinated and spread out among team members.<br>○ If someone is not connecting with PC, consider other team members reaching out.<br>○ Plan for PC to have 1 contact w/ every person weekly |
| 10. **CRISIS SERVICES**<br>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 | **Consider:**<br>Have there been any changes in the way the team's 24/7 policy is being implemented?<br>Have there been any changes in the way participants and family members can call and/or leave message during regular office hours (e.g. a new service that answers calls rather than the receptionist who would have answered in the past)<br>If there are any changes, how is the current 24/7 policy being communicated to clients and family members?<br>In addition to live in-person/phone crisis support, how is the team coordinating linkages to crisis services including medical back-up?<br><br>**Ideas:**<br>Ways to contact the team, and the 24/7 policy, and contact information should be re-communicated verbally and in writing to all clients and their approved family member contacts – this gives clients and families the opportunity to ask clarifying questions and ability to refer to the written copy. |

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| policies, resources, and organizational linkages (e.g. medical back-up) to manage crises optimally. | |
| 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 use SDM when making decisions regarding medication, family involvement, and other psychosocial interventions (e.g., substance use, trauma, social skills training). | **Consider:**<br>How can core session information be tailored and delivered by phone and/or video? How is delivery being tracked to ensure continuity?<br>How might the team access trainings on core care processes that are tailored to current events?<br>How is the team approaching working with clients/families who are on different pages in regard to treatment goals or activities?<br>How is the team using cultural competence frameworks to explore client/family understanding of current events and treatment decisions e.g. level of concern regarding illness, quarantining, job loss, virtual meetings with the team?<br><br>**Ideas:**<br>Convey hope: "You are not alone," "This won't last forever."<br>Focus on individual strengths e.g., ways they have shown resilience in the past; areas of purpose in their lives, ex: taking care of the family dog; support networks and how they can stay connected; hobbies/interests e.g. fitness, reading, writing, playing music, painting, gaming, etc.<br>Identify "personal medicine" that can be used in addition to pill medicine (see Pat Deegan's recoverylibrary.com)<br>Review the SDM steps with clients and families, explore how it can help with finding common ground and problem-solving.<br>Track core session delivery in client charts or a master list that is updated regularly e.g. at team meeting.<br>When discussing cultural implications, target youth culture, family culture, religious background, ethnic identity, race, sexual orientation, etc.<br>Use video and written resources to help facilitate education and decision-making:<br>Written resources can be emailed: core session handouts, decisional balance worksheet, psychiatric medication and me, designated observer, preparing to talk about symptoms, finding personal motivation to use medication, and the medication option grid<br>Video/other resources: OTNY website recovery videos, the Recovery Library and the OTNY Facebook page |
| 12. **INITIAL ASSESSMENT AND TREATMENT** | **Consider:**<br>For eligible clients, how has the initial assessment protocol changed to meet needs (if at all)?<br>For enrolled clients, given current events, how can the team work with participants/families to re-examine what to focus on in |

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| **PLANNING**<br>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 e.g. revising the treatment plan, doing a short term versus long term treatment plan<br><br>**Ideas:**<br>Follow agency guidelines for completing intake/enrollment paperwork e.g. getting signatures.<br>Consider other ways to explore participant views about family involvement in treatment in light of COVID-19 (e.g., "Since most people are living together and spending even more time together than usual, it may be a good idea to consider involving someone else in your life – who you actually see on a regular basis - as a person to support you in achieving your goals. Are you interested in talking more about this?") |
| 13. **SAFETY PLANNING**<br>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 | **Consider:**<br>In light of current events, how often is the CSSRS (or equivalent) conducted with each client?<br>How might you be able to assess risk and protective factors on phone and/or video that might be different than in-person?<br>For those who meet or exceed the specified threshold indicating a risk of suicide based on a screening assessment, how are safety plans being created or updated? How is a copy of the plan provided to clients?<br><br>**Ideas:**<br>At the beginning of each session, confirm where participant is/address in case you need to call for additional support/crisis services<br>Given the current health crisis and its implications, it is recommended that the CSSRS be used more frequently than usual with all clients, and particularly with those at elevated risk.<br>Safety planning should take into account that outside crisis services providers (ambulances, ERs) might experience delays depending on local factors related to the health crisis. |

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| evidence of increased risk. | Safety and wellness plans may need to be updated to reflect changes in coping strategies that are available while people must stay at home.<br>Include client support people in safety planning (with permission), particularly those when clients are quarantined with support people. |
| 14. **PRESCRIBING PRACTICES**<br>Antipsychotic medication is prescribed following recommended guidelines based on empirical support and side effects are regularly monitored. | **Consider:**<br>Are there any barriers to getting medications filled given the current situation?<br>For participants on clozapine, how are blood draws being managed?<br>How are side effects being assessed for remotely?<br>How are LAI's being managed?<br><br>**Ideas:**<br>Discuss with participants options for medication delivery if needed (e.g. Capsule in NYC, mail order, or other delivery services).<br>Conduct screening for movement side effects via telehealth when possible. If the participant provides consent, consider involving an on-site family member or other support person in the assessment of side effects (i.e. explain the assessment and what to look for, and ask the family member/ support person to share observations).<br>For individuals on LAIs, conduct screening for movement side effects in person at the time of LAI administration. |
| 15. **CARE MANAGEMENT**<br>comprehensive assessments are conducted to assess for concrete needs and care planning and management, including identifying supports, is done on an individualized basis. | **Consider:**<br>What is the protocol for re-assessing concrete needs?<br>What outside supports are providing resources and how can the team help clients access them?<br>What are changes in resources (food, shelter, other basics) as well as re unemployment or entitlements/benefits that your participants and family members may be able to access.<br><br>**Ideas:**<br>Revisit each client/family's concrete needs, in light of high unemployment rates.<br>Identify emergent social support resources.<br>Consider program capacity to provide for some basic needs, to meet those needs and to help facilitate trust and engagement (e.g., delivering to people's doorsteps/apartments along with a note from the team - box of canned food items, paper products, vitamins, other toiletries, etc).<br>Gather information on recently created or modified government assistance services, for example, those listed on this website: |

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| | https://osc.state.ny.us/covid-19/financial-toolkit.htm?utm_source=weekly+news&utm_medium=email&utm_term=financial+toolkit&utm_content=20200419&utm_campaign=fiscal+oversight<br><br>See outreach domain re discussion about phone, computer, internet access |
| 16. **METABOLIC RISK FACTORS**<br>Metabolic risk factors are assessed for and monitored regularly; clients are provided with information to inform decisions around wellness. | **Consider:**<br>What resources are available at home to support metabolic monitoring (scale, possibly a blood pressure cuff)?<br><br>**Ideas:**<br>Ask clients if they have a home scale that can be used to record weight.<br>Inquire about how clothes are fitting.<br>For individuals on LAI's, assess weight and blood pressure at the time of LAI administration<br>Discuss with participants strategies for staying active while at home and strategies for healthy eating.<br>Inquire whether those who use nicotine/ tobacco have any interest in reducing or stopping their use and provide support for those who do.<br>Ensure that individuals have information on how to protect themselves against COVID-19 (e.g. use of masks, social distancing) based on current guidelines/ recommendations.<br>For any individuals who have possible symptoms related to COVID-19, support communication with the individual's primary care provider as needed. |
| 17. **PSYCHOEDUCATION**<br>Psychoeducation that includes biological, pharmacological, social, cultural, and familial perspectives is provided to support engagement, self-efficacy, recovery and to inform treatment decisions. | **Consider:**<br>How can core session information on psychoeducation be tailored and delivered?<br>How is core session delivery being tracked to ensure continuity?<br><br>**Ideas:**<br>Refer to the biological factors/environmental stress model for understanding psychosis and discuss how increased stress might impact symptoms and coping strategies.<br>In addition to PC core session 2 which focuses on recovery with a psycho-ed component, also refer to PC core session 5 re personal strengths and supports. |
| 18. **COGNITIVE** | |

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| **BEHAVIORAL THERAPY/MOTIVATIONAL ENHANCEMENT-BASED INTERVENTIONS**<br>CBT and MI are provided to reduce symptoms, increase readiness to change, target individual needs (e.g., substance use) and develop and strengthen coping and social skills. | **Consider:**<br>How are CBT frameworks being used to understand how participants are thinking/feeling/responding to the current health crisis and quarantine?<br>What skills have clients used before and can be applied to this current situation?<br>What new skills can clients learn that might be helpful during this period?<br><br>**Ideas:**<br>Identify relaxation techniques and practice together virtually: deep breathing, progressive relaxation, guided imagery<br>Explore options for activity scheduling and behavioral activation within the home e.g. cooking, cleaning, doing work/school work remotely, exercising, leisure activities, socializing with family, socializing virtually with friends etc. Discuss whether a family member can partner with the young person to create the schedule and/or do activities together.<br>Journal or track thoughts e.g. ruminating vs problem-solving<br>Discuss social skills for virtual socialization e.g., creating group chats with friends/family and identifying potential topics of conversation.<br>Re-visit skills for managing hallucinations- skills that were not appealing/did not work in the past might be useful in this new context<br>Some teams have created a "wellness-packet" with information on CBT-strategies, relaxation techniques, information on how to move one's body, gratitude exercises, etc. |
| 19. **SUBSTANCE ABUSE TREATMENT**<br>Motivational interviewing is used to increase readiness to change and reduce substance abuse | **Consider:**<br>How is substance use being assessed?<br>How are goals for substance use being re-visited and explored?<br>If substance use reduction is a goal, what interventions are being used?<br>If substance use is increasing, what other harm reduction strategies might be used?<br><br>**Ideas:**<br>As substance use is often initiated or increased during disasters such as the COVID-19 health crisis, assess substance use by all participants on a regular basis.<br>Revisit substance use goals e.g. reducing or stopping use. Focus on safety and harm reduction if there are increased barriers to stopping. Ex: can they use gloves or limit the amount of hand-to-hand contact with other people who may be using? Can they buy enough to reduce contact with dealer? Can they avoid using cash?<br>Stay connected; maintaining engagement and relationships are particularly important during this time. |

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| | Create online/video group or join an existing group focusing on Harm Reduction; gives space for peers to share helpful strategies<br>Connect participants with shared interests or with shared substance use histories; focus on creating healthy strategies (not increasing use)<br>Consider focusing on participant's other goals and interests or challenges; helping the participant move forward in one area can help create momentum for changes in addressing substance use (ex: working on controlling distress from voices, generalize the learning to developing strategies of control with substance use)<br>Build/practice stress relaxation techniques; explore mindfulness phone apps that can help during times of increased anxiety/distress<br>Identify and help participants connect on a regular basis with their existing social support network including family members |
| 20. **Trauma Assessment and Treatment**<br>Providers assess for PTSD and deliver trauma-informed care and trauma specific interventions based on client preferences. | **Consider:**<br>For participants with a history of trauma, is the current situation exacerbating trauma-related symptoms?<br>Are individuals being exposed to new trauma (e.g. domestic or dating violence)?<br><br>**Ideas:**<br>Ask individuals if they are in a location where they are able to speak privately and feel comfortable doing so.<br>Consider re-evaluating all clients for trauma and PTSD symptoms, since current situations can exacerbate trauma and trauma-related symptoms.<br>For individuals with current/recent trauma, discuss safety planning and consider referral to other resources as needed (e.g. local resources or hotlines related to dating or domestic violence).<br>For individuals with trauma related symptoms, discuss strategies and skills for coping with distress. |
| 21. **WORKING WITH FAMILIES**<br>Team assesses family needs and meets with families regularly, individually and in groups, to provide psychoeducation and discuss family involvement strategies. | **Consider:**<br>What options for family involvement are being provided?<br>To what extent are teams continuing to provide psychoeducation via core units even in midst of COVID? How is approach to sharing this information being modified?<br>Are teams members collaborating with one another to have contacts jointly with family (e.g., PC and SEES together talking with participant and family? PC and psychiatric care provider? SEES and Peer Specialist?)?<br><br>**Ideas:**<br>Revisit participant and family preferences for family involvement at regular intervals and as-needed.<br>Consider whether family consultation and/or problem-solving interventions may be helpful for families dealing with new |

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| | stressors related to home confinement, economic stressors, etc.<br>Consider whether family groups can be offered remotely by phone and/or videoconference. Assess family members' preferences and technological capabilities.<br>Consider informal family engagement strategies for bringing in family members during contacts with participants (e.g., "is there anybody else around you that you'd like me to say hello to?")<br>Consider shifting focus, if needed/wanted, on family self-care overall in midst of social distancing. [e.g., what is family doing to stay healthy, physically and emotionally/mentally? How are they staying connected with one another? Managing stress of sheltering in place?]<br>Tie into SEES concepts but with family. Are family members losing jobs? Family stress from working at jobs with unsafe COVID practices? Is this being discussed? Is this impacting overall family and participant?<br>Hold open office hours for families to use to contact team members. |
| 22. **SUPPORTED EMPLOYMENT AND EDUCATION SERVICES**<br>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. | **Consider:**<br>How are SEES re-visiting client needs for work/school, including those who they have not been contacted recently?<br>How can SEES try to build relationships with people who do not have current work/school goals? [in the event that goals/perspectives change over time]<br>How can the SEES work with employer contacts to explore any job opportunities being created at this time?<br>How can the SEES and clients work together to understand the position/actions of their current employer e.g. furlough, reduced pay, layoffs? How can they work together to respond appropriately, based on client needs and preferences?<br>For participants whose educational programs have shifted to distance learning, how is the SEES getting familiar with how different educational institutions are implementing distance learning?<br>What supports and accommodations may be needed, at school and work?<br>How can the SEES help provide technical assistance for remote learning and working?<br>How can the SEES encourage multi-disciplinary teamwork (i.e., with OTNY team and family or other natural supports) to support people with work/school goals?<br><br>**Ideas:**<br>Keep in touch with employers and continue to be a resource – keep connections.<br>Find out about temporary employment opportunities.<br>Schedule regular calls (e.g., 30-minute) with participants weekly.<br>Provide practical help with figuring out technology. Consider making a checklist – do people have: phone/ smart phone? computer? printer? webcam? internet access? photo ID? Social security card? |

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| | Collaborate on practical activities: Accessing transcripts; passing resumes back and forth to update them<br>Contact schools/colleges to try to figure out how they are doing distance learning; be prepared to assist participants with any distance learning activities and expectations so they can keep momentum with school/college; students may need additional support with organizing their space and time<br>Inquire about how people are staying active and productive – discuss, explore, brainstorm<br>Talk about the Career Profile – complete with participant; take this opportunity to do a deeper dive and get to know people even better<br>Maintain (and even increase) contact with families – help with any needed next steps (e.g., how to withdraw from classes for a person who was just hospitalized) |
| 23. **PEER SPECIALIST SERVICES**<br>Peer Specialist works with clients using their own recovery story and providing supports. | **Consider:**<br>How is the peer specialist connecting virtually with clients to discuss their recovery story?<br><br>**Ideas:**<br>Survey participants to learn what they need from the peer specialist and how they would like remote support<br>Provide extra support opportunities:<br>○ Provide flexible connection: set up regular check-in times and offer spontaneous check-ins. Topics can be serious or "fun" conversations e.g. sharing memes via text<br>○ Offer "trial period" of remote connection- try video chat with someone once before they decline, same with phone contact or any other remote option<br>○ Virtual Activity sessions (cooking groups, workouts, tours etc.)<br>○ Replica□ng in person events virtually (video game group, movie night using ne□lix party)<br>○ Community Building (connecting to virtual mutual aid communities, having interest specific sessions for 2 or 3 participants and allowing them to lead)<br>○ Supporting other team members (connecting with participants about how they would like to work with the team remotely through survey or discussion and sharing back that information, having collaborative sessions with other team members on video chat)<br>○ Regular "office hours" e.g. 2 x a week, available in webex room for an hour<br>○ Create a digital peer support group in addition to individual meetings. Discuss relevant topics and/or have a content review and discussion similar to a book club: review content individually then come together to discuss.<br>○ Phone- have consistent phone check-ins plus regular appointments<br>○ List of online resources, notably Recovery library. If participants don't have internet access and cannot view videos in |

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| | recovery library, read transcripts of videos or print them out and mail them.<br>○ Newsletter with updates from team, activity suggestions, ways to stay connected |
| 24. **DISCHARGE**<br>Discharge plans are created with clients and families to ensure that follow-up services are identified, in place, and occur as planned. | **Consider:**<br>How is the team supporting clients in attending their first pre- or post-discharge appointment with a follow-up provider within 30 days of discharge? If they are virtual appointments, how is the team providing tech support to help the client connect with the provider? If in-person, how is the team helping the client to keep themselves and others safe from COVID-19? How is this being tracked?<br>How is the team supporting clients who are prescribed an antipsychotic medication at the time of discharge to keep their follow-up appointment with a prescriber within 30 days of discharge (virtually or in-person)? How is this being tracked?<br>Are there revisions to the protocol for outreaching clients who are non-responsive e.g. team is unable to contact client? What steps are taken to refer non-responsive participants to appropriate follow-up treatment e.g. sending a letter with referral information?<br>Given social distancing, what services are community supports providing and how can they be accessed safely to help clients/families with a successful transition (e.g., NAMI, social-groups/activities, school support)?<br>How is the team using SDM to re-visit planned discharges e.g. re-evaluating options and newly arisen pros/cons?<br>How are individuals that have had to relocate being supported in transitioning to local services?<br><br>**Ideas:**<br>For clients who were approaching discharge, re-assess the timing of discharge. Use SDM to re-explore client needs and discharge options, including reassessing pros and cons of discharge at this time.<br>For clients who are proceeding with planned discharges, the team should connect with follow-up providers to ensure that they are still accepting new clients and to learn about new protocol for onboarding clients so that the team can support clients in a successful discharge.<br>For clients who are non-responding to outreach efforts, the team and agency should work together to re-assess the length of time needed to discharge non-responsive clients. New protocols might include increasing assertive outreach via various methods e.g. sending multiple letters, confirming that the typically recommended referrals are accepting clients, including information on how to connect with referrals virtually.<br>Encourage family involvement in transition planning conversation and processes – especially in light of COVID-19 as families may be key supporters (if client wishes) of the transition plan. |

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| 25. **TIME-LIMITED SERVICES**<br>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). | **Consider:**<br>How is enrollment being tracked?<br>How are needs being considered and clinical appropriateness assessed in regard to discharge planning?<br><br>**Ideas:**<br>Discharge plans should be re-visited given that increased stress among clients might impact clinical appropriateness for discharge; there might be barriers to successfully connecting clients with follow-up services; or follow-up services might no longer be accepting new clients. |