Implementing Critical Time Intervention (CTI) to Enhance Care Coordination for Veterans Leaving GPD Programs

Supervisors Session

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Introductions

- Housing Innovations
  - Suzanne Wagner
  - Andrea White
- Goals for the Training
- Housekeeping
  - **PLEASE TURN YOUR CAMERAS ON AS MUCH AS YOU CAN**
  - **Please put your first and last name as your screen name**
  - **The website has all the CTI materials**
  - **We love interaction – please raise hand, indicate in chat box that you would like to comment or just unmute and talk!**

Agenda

- Introduction and Brief Review of the CTI Model
- CTI Implementation Planning
- Self-Assessment Discussion
- CTI Practice Shifts
- Supervisory Structure and Tools
- CTI Tools for Staff
- Planning for Next Steps on Implementation

Introductions – Who is in the zoom room?

Please put in the chat:

- Your Name and Title
- Your Department/Program Type and Location
- What is your favorite thing about the winter?

Poll: Were you able to participate in the CTI Trainings that Housing Innovations conducted ?

How is CTI Different?

- Structured and time limited intervention
- Goal focused - not symptom based
- Transition is the focus of the work
- Depends on community connections to services and supports for sustainability (including landlord)
- Community and home-based service
- Staff step back and adjust their roles with each phase
- Adjust documentation to reflect areas of assessment and no more than 3 goals in service plan

CTI Key Model Characteristics

- Client-driven partnership that respects choices, rights and dignity
- Time limited
  - 6 months for Care Coordination for Veterans
- Four phases of decreasing intensity of contact
- Manualized intervention - most intense in the early phases
- Highly focused assessment and service plans
- Small weighted caseload
- Weekly team supervision and modifications to documentation
- Uses other evidence-based practices

CTI Phases Chart	Pre-CTI (In Outreach, Shelter or Interim Housing Pgm)	Phase I: Transition (Begins when person moves into housing)	Phase II: Try- Out	Phase III: Transfer
Time frame/Intensity of Contact	Flexible	2-3 Months/Intense Weekly	2-3 Months/Moderate Bi-weekly	2-3 Months/Low Monthly
Objective	Relationship Building Assessment	Complete Identification of Resources and connect client	Monitor resource impact and client connection/access	Complete transfer of services to the community
Action Steps	Educate/Advocate Begin Phase Specific Plan Begin connection to resources Begin accessing benefits and income	Accompany each Veteranto appointments, follow up to ensure connection Phase I Specific Plan Work on tenancy skills, income. Maintain motivation	Make adjustments to plan in collaboration with client Phase II Specific Plan	Meet with new service providers or others in the support system; reflect on work with client Phase III Specific Plan
Potential Barriers	Housing placement may be delayed due to multiple challenges Often challenge to maintain motivation	Lack of resources; Veteran hesitant to engage Several competing “priorities”	Client may not be ready to assume rent for RRH or tenancy in PSH; resources may be inadequate	Both Veteran and worker may have difficulty ending, especially if goals aren’t met.
Strategies	Collaborate with Housing Specialist to teach/model housing location process; present services as a helpful resource, not an obligation	Do advance work of creating resource networks Prioritize needs based on relevance to housing stability	Empower client to do what they can on their own; create alternative plans if necessary Use skill building techniques	Reduce involvement gradually and inform Veteran early on about the length and nature of CM support

CTI Implementation Self-Assessment Tool

- Tool to assess your program's progress on implementing CTI practices
- 30 domains scored on scale of 1 to 5
- Overall score is an average w/max 5
- Conduct post-implementation as check in

Reviews the following Areas:

- CTI Main Components
- Engagement
- Initial Assessment
- Linking Process
- CTI Worker Role
- Clinical Supervision
- Fieldwork Coordination
- Documentation

PDF

Implementation Self-Assessment

Go to: CTI Implementation Self-Assessment Tool

Implementation

In the Action Planning polls in Session 4, these types of implementation strategies resonated for staff

- Use of tools/sample forms/resources provided in the training
- Discuss adopting some or all of the model with my teammates and in staff mtg
- Discussion of adopting some or all of the model with my supervisor/manager

Goals for the Supervisors Sessions

- Discuss ideas for implementation by CTI elements
- Identify resources and supports needed, barriers to and questions about implementation
- Share input on what type of structure(s) will help support implementation

Poll CTI Integration

Small Group Discussions on Strategies

Join a breakout group

Say “Hello” to each other

Identify a recorder and reporter

Discuss for 10 minutes

- What you interests you about implementing CTI? What ideas do you have for implementation?
- What doesn’t interest/excite you about CTI?
- What questions/concerns do you have?

CTI Practice Emphases/Shifts

- Maintaining Engagement
- Working the person's plan (as opposed to staff's)
- Focused Assessment and Service Planning
- Home Visits and Community Based Fieldwork
- Community and Landlord Coordination
- Stepping Back
- Moving to Crisis Prevention Orientation
- Using Motivational Interviewing Techniques
- Adjustments to Documentation and P &P

Support for CTI

Supervision and agency support key to implementation

Focus

- High quality services consistent with the practice
- Achievement of program goals and outcomes
- Support and resources for staff and participants
- Complex needs and challenges posed by participants
- Development of staff skills and knowledge of CTI and other EBP's
- Supervision is delivered weekly through group and individual sessions

Focus Areas for CTI Supervision

- Proper weighting of assignments
- Timely movement throughphases
- Assisting workers with making decisions/problem solving
- Sharing of resources between workers
- Proper documentation (Phase Plans, Progress Notes, Closing Notes)
- Safety on home visits
- Highlighting best practices, common barriers, patterns and challenges in implementation
- Arranging specialized consultation
- Looking at the practice critically, assessing implementation and working on program planning

Team Caseload Management

Weighted
Caseload Tracker

- Varies by Phase - **Standard Caseload Equivalents** (SCE's)
  - Phase 1 – each person/family counts as 2
  - Phase 2 – each person/family counts as 1
  - Phase 3 – each person/family counts as ½
- Example
  - 10 people in Phase 1 = 20 cases
  - 10 people in Phase 2 = 10 cases
  - 10 people in Phase 3 = 5 cases

Weighted Caseload Tracker

CTI Worker Name: Jane Smith **Date:** 2/28/2021

	Pre-CTI		Phase 1		Phase 2		Phase 3		
Client Initials	Start Date	"1" if client in Pre-CTI	Start Date	"1" if client in Phase 1	Phase 2 Start Date	"1" if client in Phase 2	Phase 3 Start Date	"1" if client in Phase 3	**End CTI Date**
AB	[redacted]		9/1/2020		11/1/2020		1/1/2021		3/1/2021
CD			9/8/2020		11/8/2020		1/8/2021		3/8/2021
EF			9/15/2020		11/15/2020		1/15/2021		3/15/2021
GH			9/22/2020		11/22/2020		1/22/2021		3/22/2021
IJ			9/29/2020		11/29/2020		1/29/2021		3/29/2021
KL			12/1/2020		2/1/2021		4/1/2021	1	
MN			12/8/2020		2/8/2021		4/8/2021	1	
OP			12/15/2020		2/15/2021		4/15/2021	1	
QR			12/22/2020		2/22/2021		4/22/2021	1	
ST			3/1/2021		5/1/2021	1			
UV			3/8/2021		5/8/2021	1			
WX			3/15/2021		5/15/2021	1			
YZ			3/22/2021		5/22/2021	1			
AZ			6/1/2021	1					
BY			6/8/2021	1					
CX			6/15/2021	1					
DW			6/22/2021	1					
	Category Total	0		8		4		2	
							Total Weighted Caseload	**14**	

Structured Supports

Individual and Team Supervision:

- Weekly staff supervision meetings
- Caseload tracking though the phases

Case Conferencing:

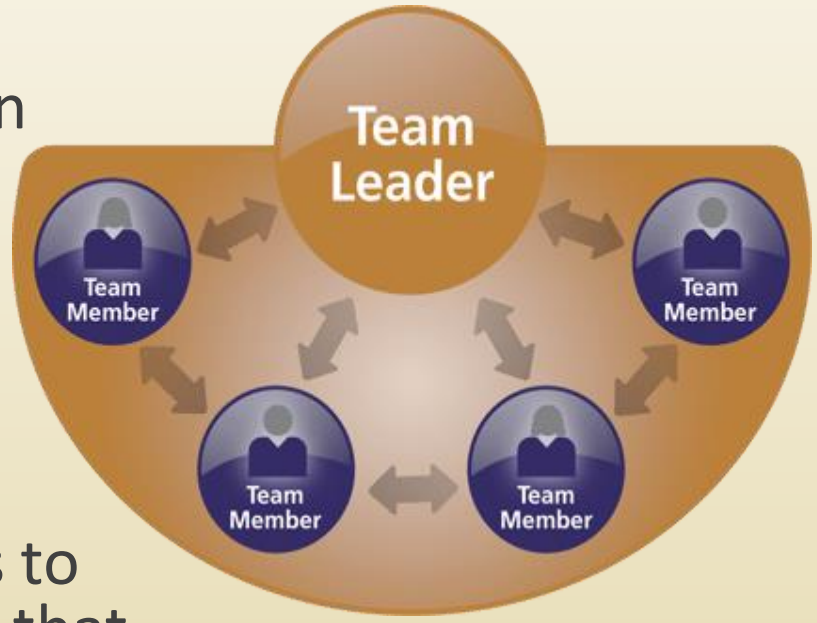
- Highlight best practices, identifies themes around barriers, highlights resources, provides clinical consultation

Team Meetings:

- Team meetings have an informational, monitoring and support function, track where people are in the transition and identify common barriers, share information and resources among team members, alert team to people in distress or crisis, identify best practices, review everyone at least briefly

Focusing Team/Group Supervision

- Case presentation of each new client
- Review of cases that will end intervention within the coming month
- Review of cases that are facing major crisis or cannot be located
- Review of cases that have experienced major success or positive change
- Brief review of entire caseload every two weeks to ensure that phase changes are on schedule and that cases are not overlooked



CTI Team Supervision Form

This form is filled out <u>every week</u> during the team supervision meeting to document in-depth discussions about the highest priority clients (use reasons listed below as a guide).

Before the meeting, the case manager fills in the names of clients with highest priority, based on past week's fieldwork and any change to client status and records explanation and one reason code.

The supervisor places a **√** mark in the far right column next to each client who has been discussed.

Client's name	Worker's initials	Explain why it is important to discuss this client at today's meeting. Record the **reason code** in the box. 1=ready to give new case presentation 2=client faced with a crisis or big change 3=cannot be located 4=discuss whether refusal is permanent 5=time to prepare for a new phase 6=time to prepare for end of intervention 7= difficult problem with support network 8= positive occurrence to share with team	Place **√** mark in box when team discusses client

An Effective CTI Supervisor….

Ensures case manager practice is consistent with phase-specific activities and foci of the CTI model

Encourages open communication and demonstrates a willingness to support, as well as instruct, supervisees

Ensures that model-specific case planning and recording documents are being completed correctly and are up to date for all workers

Carefully monitors workers to ensure that phase transition dates are observed

Monitors and manages caseload to ensure there is reasonable time to provide services as intended

CTI Tools for Staff

- The Assessment Domains and Housing Plan provides focus on domains that most effect housing retention, limits goals, defines roles
- The *Participant/Tenant Resource Guide* structures work around community resources and supports
- The *Harm Reduction Plan* helps participants think through options to mitigate behavior that is threatening tenancy/creating risk for eviction
- The *Closing Note* outlines the process for the end of the transition and provides guidance for final meetings and handoffs to network of care.

Small Group Discussions

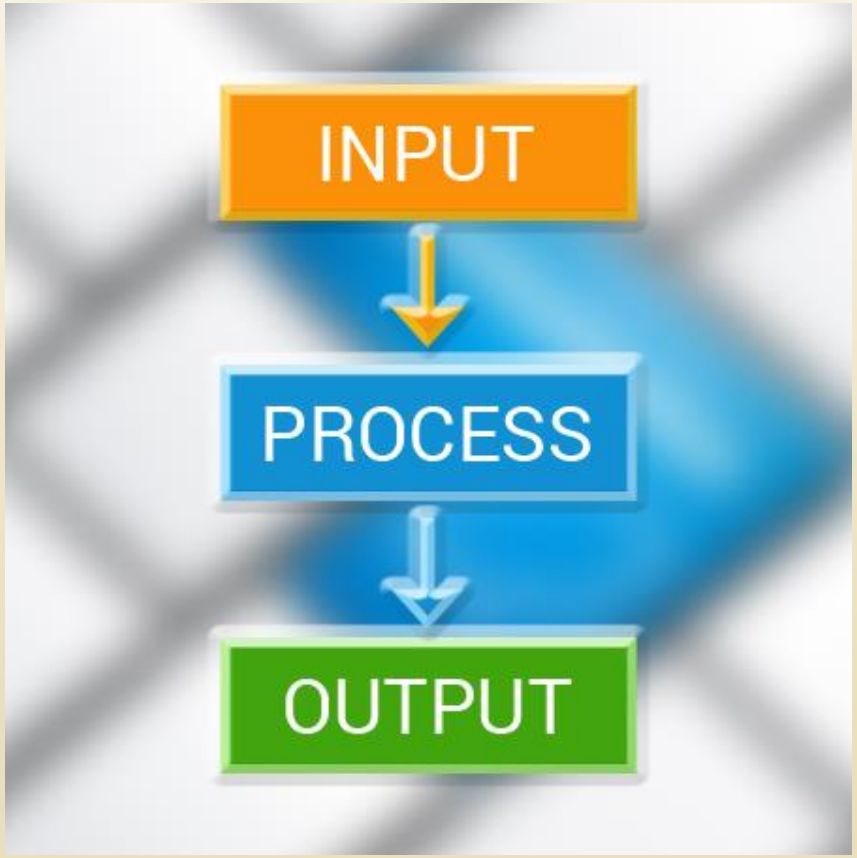
- Join a breakout group according to your program type
- Identify a recorder and reporter
- Discuss for 15 minutes
  - Which of the tools/resources/strategies discussed most resonates with you?
    - What would you like to implement tomorrow if you could?
    - What barriers/obstacles would you anticipate?
    - What support could help to overcome these barriers?
- Large Group Report Back: Top 3 tools/resources and supports that could help with implementation/overcoming barriers

Action Planning

Poll: What support might help you to integrate CTI into your program/unit/ department?

Please type in the chat, speak out, raise your hand with elaborations on your suggestions or “other” if you selected that.

Final comments/questions



Please type in the chat, speak out, raise your hand with any final comments or questions

Implementing CTI will be a process that will be supported by Housing Transitions Queri.

Communities of Practice and Website with all the Materials

Wrap up

Many thanks!

Complete evaluation for CEU’s

PLEASE TURN ON YOUR CAMERAS TO SAY GOOD-BYE

Practice Shifts: Reference Slides

Focused Assessment and Service Planning

Areas of Focus for Assessment and Planning

- Housing and homelessness history and barriers to stability
- Income and financial literacy, education/training and employment
- Life skills
- Family, friends, and other supports
- Psychiatric and substance abuse issues
- Health and medical issues

Assessment looks at history, current, strengths, barriers, motivation and GOALS

Service plans limit goals to 3 and reflect the participant's goals and connect housing success to personal goals

Home Visits and Field Work

Teaching the skills to be in a person's space, structuring the visit and addressing safety concerns

- Home visits challenge boundaries
- First home visit modeled by the supervisor or seasoned colleague
- Must have P+P for safety in the field

Supervisor can periodically accompany staff on home or field work to observe and assess competencies

Pandemic considerations

Working with Community Resources

- Core to the practice
- Part of worker's job is to ensure resources are working for each Veteran, frequent check-ins with the service.
- Staff new to community services will need training on community resource options, application and enrollment processes.
- Staff should visit community and VA programs to get a feel for them.
- Sometimes meetings with senior staff to negotiate roles and responsibilities and an MOU (Memorandum of Understanding) and troubleshoot issues

Working with Housing Providers

- Clarify expectation about roles
- Education of staff on:
  - Working with landlords to support lease compliance and stable tenancy
  - Role and transition process when people move into supported housing or other options that provide ongoing support
  - Tenant's rights, housing subsidy process and rules, reasonable accommodations, fair housing, eviction process

Stepping Back

- Identify services and supports needed to maintain community living
- Focus on connecting to community resources and building skills
- The worker remains involved but must step back and allow person to try on their own
- This can be difficult for workers
- Give permission for extra time to teach skills
- Monitor movement through phases

Adjustments to Documentation

- Paperwork can help shape and reinforce CTI practices
- Can adapt forms currently in use to be CTI-informed
- Ensure community stabilization goal is central
- Limit goals to two or three
- Use areas of focus for assessments
- Assessments connect to service plan
- Provide sample chart notes and review in supervision
- Sign off by supervisor on notes and plans
- Supporting documentation: Participant Resource Guide and Harm Reduction Plan were well-received by staff during training