ADULT SINGLE POINT OF ACCESS (A-SPOA) GUIDANCE

Purpose of this Guidance Document

The purpose of this Guidance Document is to provide an overview of what the Erie County Adult Single Point of Access (SPOA) is, the services available through the SPOA, when and how to make a referral, and information for contract agencies related to reporting requirements for these services.

OVERVIEW:

Single Point of Access (SPOA) is a New York State Office of Mental Health initiative designed to expand the county's existing community based mental health system and helps make it a more cohesive and better coordinated system. The Erie County Adult SPOA has established a uniform process for receiving and evaluating referrals, matching individuals to the services they need, triaging access so that those most in need get priority access, and monitoring the results. A standardized on-line referral has been developed which includes relevant clinical and social history and will assist in determining the appropriate level of care an individual's needs. The goal is to create a system that promotes recovery-oriented services, which are widely available, flexible, personally tailored and responsive to individual needs. Individual preferences will be integrated into the process. Referrals and transitions between programs and services will be entered into a database, in order to monitor who receives services, who does not, alternative recommendations, and the actual mental health residential and case management needs.

The Erie County Adult Single Point of Access (SPOA) provides timely access to community-based Care Management, Assertive Community Treatment (ACT), and/or Housing services and supports for adults with severe mental illness. An integrated SPOA (Care Management, ACT and Housing) improves access, fosters early engagement with individuals and provides priority services to individuals at high risk of system penetration. High risk individuals are those who are transitioning from institutional settings back into the community (i.e. psychiatric hospitalization or incarceration), have frequent hospital visits, homelessness, or incarceration. The goal of SPOA is to have each person linked with the appropriate services to achieve successful outcomes.

SPOA accepts referrals from individuals, families, and agencies. The SPOA process has established a uniform referral procedure which assists the referring party in determining the appropriate level of care coordination services, and the team which could best meet the needs of the consumer referred. One program is selected and serves as the entry point to services. This entry point's function is to assess/screen those referred and make a further determination as to the acceptance within that specific program or another program which may better meet the consumer's needs.

Erie County Department of Mental Health (ECDMH) SPOA process has been developed in Erie County for adults (18 and over) with severe mental illness. Care Coordination/Case Management Services are intended for the high need consumer who has had difficulty maintaining linkages to

mental health services and other important supports, such as; benefits, housing, advocacy, health care, peer services or vocational services. The overall goals include fostering independence and improving the quality of life for consumers of mental health services. The development of the Single Point of Access coupled with the expansion of community services, will achieve integration, improve access, and provide priority services to high need individuals.

Referrals are made through an online system at: www.eriespoa.org. This website provides instructions to users on how to submit a referral. A signed SPOA consent from the individual to be served must be provided in order for the referral to be processed.

SERVICES AVAILABLE THROUGH ADULT SPOA:

Case Management/Care Coordination:
Consumer's needs are chronic in nature and mental health issues require enhanced community services (*See referral assessment form for criteria*). Referrals are made directly to the SPOA and the SPOA will assign to the most appropriate care management agency and/or Health Home.

Assertive Community Treatment (ACT):
Mobile mental health treatment required due to inability to link with traditional treatment and has no other successful linkages. Individual has not been successful with previous care coordination programs. Referrals are made directly to the SPOA.
See ACT eligibility criteria at:
https://www.omh.ny.gov/omhweb/act/program_guidelines.html

Assisted Outpatient Treatment (AOT):
For individuals who meet the specific criteria under Kendra's Law and may need mandated services after other alternatives have been diligently attempted.
https://my.omh.ny.gov/analyticsRes1/files/aot/Outpatient_Treatment_Brochure_Revised.pdf

DESCRIPTIONS OF SPOA HOUSING PROGRAMS:

NON-LICENSED HOUSING
Supported/Supportive Housing Programs - SHP these programs operate scattered site apartments selected by and leased by the consumers themselves. The SHP programs provide rental payment assistance and supportive services. Staff provides services designed to assist consumers to obtain or refine skills necessary for more independent living and increased self-sufficiency. Staff generally meets with the consumer two or more times per month depending on individual consumer needs. Consumers are expected to develop individual goals which focus on living more independently. The typical length of stay is 3-4 years. Referrals are coordinated through the Centralized Housing Placement System and the Erie County Housing Coordinator. OMH funded SHPs require verification of significant impairment in functioning due to a mental disability. HUD

funded SHPs also require verification of homelessness at the time of admission. The Erie County Housing Coordinator is responsible for agency assignment. The SHP providers include Transitional Services, Inc., Living Opportunities of DePaul, BestSelf Behavioral Health, Spectrum Human Services, Southern Tier Environments for Living, Recovery Options Made Easy, Buffalo Federation of Neighborhood Centers, Restoration Society, and WNY Veteran's Housing Coalition.

LICENSED HOUSING

Supervised Community Residences - SCR are congregate care facilities (group homes) which house 8 to 24 residents 18 years of age or older. These Programs are considered transitional and rehabilitative in nature, as the resident's goal is to move to a less restrictive living environment within 24 months. Bedrooms are often shared but some programs have single bedrooms. Residents participate in the upkeep of the house which includes meal planning and preparation. Recreation activities are provided. Some group homes include an attached training apartment (TSI) for residents ready to test independent living skills. Staff is on site 24/7. SCR services are provided by The Buffalo Federation of Neighborhood Centers, DePaul Community Services, Southern Tier Environments for Living, and Transitional Services, Inc.

Supervised Senior Community Residences - SSCR operate the same as Supervised Community Residences but are for consumers who are 55 years of age or older. Residences are encouraged to identify independent living goals but there is less emphasis placed on moving to an apartment. SSCR are provided by Greenwood Residences (all single bedrooms), Southern Tier Living Environments and Transitional Services, Inc.

Treatment/Supervised Apartments - TSA provide transitional housing in shared one, two- and three-bedroom apartments in the community. The apartments are either located at a single site which has staff on site 24/7 or scattered site apartments which staff visit from 3 to 7 days each week and are on call for emergencies 24/7. Staff provide services designed to assist residents obtain or refine skills necessary for independent living. Cash allowances for groceries and clothing are provided by some programs. Residents are expected to develop individual goals which focus on living more independently. The typical length of stay is 18 to 24 months. TSA housing services are provided by The Buffalo Federation of Neighborhood Centers, DePaul Community Services, Southern Tier Environments for Living, and Transitional Services, Inc.

MICA Housing – MICA are Group Home and Treatment Apartment Programs capable of providing specialized staffing and services for consumers who are diagnosed with an addictions disorder as well as a psychiatric disability. MICA Group Homes are operated by Transitional Services, Inc.

Young Adult Housing - YAH is a group home and supported housing program providing specialized services for individuals 18 to 21 years of age who are transitioning from Residential Treatment Facilities or congregate living environments for adolescents. Services are similar to other group settings. There is staffing capacity to provide more intensive services for individuals

participating in the supported housing component of the program. YAH services are provided by Transitional Services, Inc.

Single Room Occupancy - SRO's provide housing that is specifically designed to offer permanent housing in a service-enriched setting. These programs are intended to provide housing and services for individuals capable of living independently. A social service team provides services on-site which includes case management, interactive groups, activities, medication management, money management and vocational linkage. SRO housing is provided by DePaul Community Services.

ELIGIBILITY REQUIREMENTS:

Each service has unique eligibility requirements. Many refer to Serious Mental Illness (SMI). The definition of Serious Mental Illness according to New York State Office of Mental Health follows. Definition of Serious and Persistent Mental Illness (*see below or visit link*):
https://www.omh.ny.gov/omhweb/guidance/serious_persistent_mental_illness.html

Serious and Persistent Mental Illness

In order to be considered an adult with a serious and persistent mental illness, "1" below must be met, in addition to either "2", "3", or "4":

1. Designated Mental Illness
   The individual is 18 years of age or older and currently meets the criteria for a DSM-V psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD-CM psychiatric categories and codes that do not have an equivalent in DSM-V are also included mental illness diagnoses.

And

2. SSI or SSDI due to Mental Illness
   The individual is currently enrolled in SSI/SSDI due to a designated mental illness.

Or

3. Extended Impairment in Functioning due to Mental Illness
   a. Documentation that the individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:
      i. Marked difficulties in self-care (personal hygiene, diet, clothing avoiding injuries, securing health care or complying with medical advice).
      ii. Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).
      iii. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).
      iv. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings, individuals may exhibit limitations in these areas when they repeatedly are

unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

Or

4. Reliance on Psychiatric Treatment, Rehabilitation and Supports
   A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder; e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings (e.g. Congregate or Apartment Treatment Programs) which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

INFORMATION FOR AGENCIES PROVIDING SPOA LINKED SERVICES

Agencies that are providers of SPOA linked services should adhere to the following guidance as applicable. The following sections cover AOT Reporting Guidance and SPOA Housing Language.

AOT REPORTING GUIDANCE:

The following reporting is required for all HH+ Care Management agencies and ACT teams that serve AOT clients:

Monthly Reports:

AOT Monthly reports are to be submitted via SPOA MIS no later than the 10th of each month. A monthly report is to be submitted for each individual AOT client that is court ordered or on a diversion (voluntary) agreement. Reporting is required for each category of service listed on the court ordered treatment plan. The monthly report is designed to capture compliance (or non-compliance) for each category of service.

Clinical Risk Information: Sound clinical decision-making requires accurate risk specific information. It is widely recognized that past violent behavior is a significant predictor of future behavior. Comprehensive risk specific information promotes the development of treatment plans that are attentive to both the management of risk and the quality of clinical services.

Coordination of Care: The coordinated interrelationship of service providers is critical to the successful delivery of the array of services offered to AOT recipients. Integration of inpatient, outpatient, residential, Care Manager, ACT, and community support staff, centered around an individualized service plan, provides a stage for coordinating services critical to risk reduction, quality of care, and positive clinical outcomes for recipients.

Significant Event Reports: The AOT statute requires the OMH Regional AOT Program Coordinator, as appointed by the Commissioner of the NYS Office of Mental Health, to ensure that a mechanism exists for the care management entity serving an individual who is under an

AOT court order to regularly report the assisted outpatient recipient's compliance, or lack of compliance with treatment, to the Director of the County's/NYC's AOT Program (MHY§ 7.17 (f)(2)(iv)). Therefore, each County's/NYC's AOT Program should have a procedure in place for the care management entity to report to the County's/NYC's AOT Director within 24 hours of being made aware of one of the significant events listed below. In addition, each County's/NYC's AOT Program should have a procedure in place for the Director of the County's/NYC's AOT Program or designee to report specific significant events (marked by an asterisk (*), to the OMH Regional AOT Program Coordinator within 24 hours. To provide guidance on how care management entities (ACT or HH Care Managers) can meet this reporting requirement, OMH has updated the previously re-issued May 2004 and posted on the OMH website, which outlined how OMH Case Management Programs and ACT teams could report non-compliance and other significant events to the Director of the County's/NYC's AOT Program. This Significant Event Report can be used for reporting Significant Events, and provides the County's/NYC's AOT Programs with information that can be used to complete the Quarterly AOT Reports (MHY§ 9.48 (b)(i-ix)). Additionally, it is recommended that AOT recipients who are members of HHs ensure that the HH network is made aware of significant events to partner with Care Management or ACT to ensure appropriate services are in place to prevent future events.
Link to the Significant Event report:
https://my.omh.ny.gov/analyticsRes1/files/aot/AOTGuidanceforReportingSignificantEvents11012017.pdf

MISSING PERSONS GUIDANCE:

Analysis of the AOT data set related to persons designated as missing indicates a significant correlation to previous violent incidents and homelessness. AOT is a strategy to reduce risk and every effort must be made to locate individuals who are deemed missing while under the AOT court order. Missing person for AOT is defined as a person who has had no credible contact within the last 24 hours or cannot be located within a 24hr period.
Link to Missing Persons Protocol:
https://my.omh.ny.gov/analyticsRes1/files/aot/AOTGuidanceforProgramOperation2017.pdf

SPOA HOUSING LANGUAGE:

In an effort to have well-defined communication among all contracting agencies the following definitions have been established for reporting to the Erie County Department of Mental Health SPOA office:

Engagement: Begins once agency receives referral from SPOA until the individual has been permanently housed. All engagement activities should be documented in the Housing Engagement section of the referral including activity type, who engagement is with as well as a detailed note related to the activity and next plan of action.

72 Hour Bridger Housing: It is an expectation that individual will be screened and housed at least in a suitable safe and temporary setting other than the street or a shelter, within 72 hours of receipt

of the referral (72-hour Bridger Housing notification will be located under Housing Engagement in the "Type" drop down box).

No Decline Admission Policy: Housing acceptance and enrollment are not contingent on compliance with the following: treatment, substance abuse history, participation in services, criminal conviction (arson, assault), poor financial ability, and/or rental history. All HUD contracted programs must follow a Housing First Model. All disengagements must be cleared with SPOA who will then collaborate with coordinated entry.

The Screening Process: Once the SPOA referral is received, it is expected that within 24 hours of receiving the referral from SPOA, that the receiving agency should make contact with the referring person and the client to initiate the screening intake appointment. This should be indicated in the "Housing Engagement" section of the SPOA MIS referral. All engagement activities should be documented in the Housing Engagement section of the referral including activity type, who engagement is with as well as a detailed note related to the activity and next plan of action.

- Please be advised that an email notification will be sent to program intake supervisors indicating that a SPOA referral has been sent for your review.

Disposition: Once the screening disposition is made by the housing agency, the decision must be posted in SPOA within 1 business day.

Disengagement: This includes referrals in which the client refuses services, client unable to be found (ECDMH standard-looking for at least 90 days if chronic), client needing a higher level of care, referrer withdraws, currently with another housing provider, client found other housing, etc. ECDMH should be notified when a housing disengagement is needed as ECDMH SPOA is the only entity that has the ability to disengage referral. Disengagement reason should be provided for notation purposes. In order to maximize capacity, SPOA is to be notified as soon as a disposition occurs.

Denial: An agency not accepting the SPOA referral. If an agency is denying an individual, a formal letter needs to be submitted to the ECDMH SPOA office through email identifying the client name and specific reason for the denial. As a reminder, HUD providers have a "No Decline Policy".

Enrollment: Enrollment means the individual has been housed. It is expected that an individual will be enrolled in housing within 45 days of receipt of referral. Once the individual is housed, agency needs to document this in the SPOA MIS system by clicking "Enrollment" located below the SPOA notes section in the referral.

- Please do not enroll unless the client has actually moved in the unit.

***It is mandatory that the SPOA System is updated as each disposition event occurs to reflect current activity on the assigned case.**

Capacity Table: Agencies need to ensure that their capacity table is accurate and reflective of the individuals that are in each phase related to the status of the referral. SPOA sends referrals to providers based on the information per the SPOA capacity table.

Running of Reports: SPOA will be running reports that will measure:

- Length of time from agency receiving referral to placement in Bridger housing (per HUD RFP)
- Length of time from agency receiving referral to enrollment in housing.
- Reasons for disengagements and denials.
- Capacity based on capacity boards