Health Home Implementation Webinars

Session #24– September 25, 2013

The Role of SPOA in Health Homes

NEW YORK state department of HEALTH

Agenda

- Introduction
- Presentation: Brian Hart, DCS of Chemung County; Darcie Miller, DCS of Orange County; and James Dolan DCS of Nassau County

Role of SPOA in Health Homes:

Where County and State governments meet individual's needs!

September 25, 2013

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Role of SPOA in Health Homes

Agenda

- Article 41 MHL
  - Local Government Unit (LGU) Statutory Role
  - Director of Community Services (DCS)
  - Duties of the LGU
- SPOA Process
  - Chemung County
  - Orange County
  - Nassau County
- Standard SPOA Elements

Article 41-Establishes Local Governing Unit (LGU)

- Article 41 MHL establishes the process that governs the joint effort between the state and the LGUs for the planning and financing of mental hygiene services in NYS
- LGU has statutory responsibility for oversight, fiscal and programmatic management and monitoring of the local mental hygiene system. (OMH/OASAS/OPWDD)
- The design reflects the needs of individuals across services providers, housing, rehab, criminal justice, courts, state PCs and ATCs etc.
- Recognizes the population has complex needs and requires a local, integrated oversight by an entity that his embedded in the moving parts of the community which is the LGU

Article 41-Establishes Director of Community Services as CEO of the Local Governing Unit (LGU)

It is designed **to enable and encourage** local governments

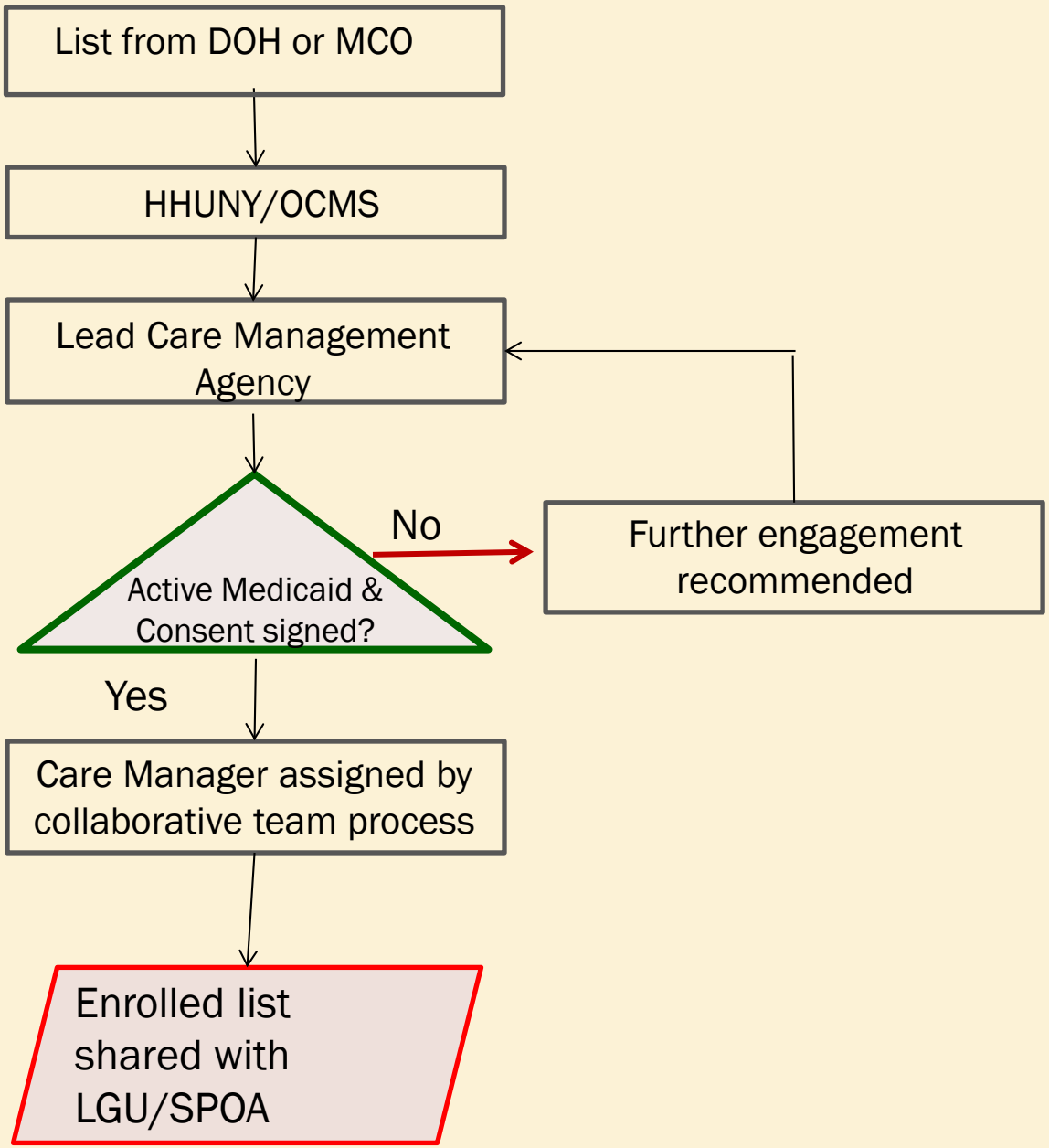
- **to develop the community** preventive, rehabilitative, and treatment **services offering continuity of care**;
- **to improve and to expand existing community programs** for the mentally ill, the mentally retarded and the developmentally disabled, and those suffering from the diseases of alcoholism and substance abuse;
- **to plan for the integration** of community and state services and facilities for the mentally disabled; and
- **to cooperate with other local governments** and with the state in the provision of joint services and sharing of manpower resources."

Powers and Duties of Local Governmental Units -41.13

- " ...seek to assure that under the goals and plans required pursuant to this subdivision, all population groups are adequately covered, sufficient services are available for all mentally disabled within its purview, that there is coordination and cooperation among local providers, that the local program is integrated and coordinated with the provision of community services..."

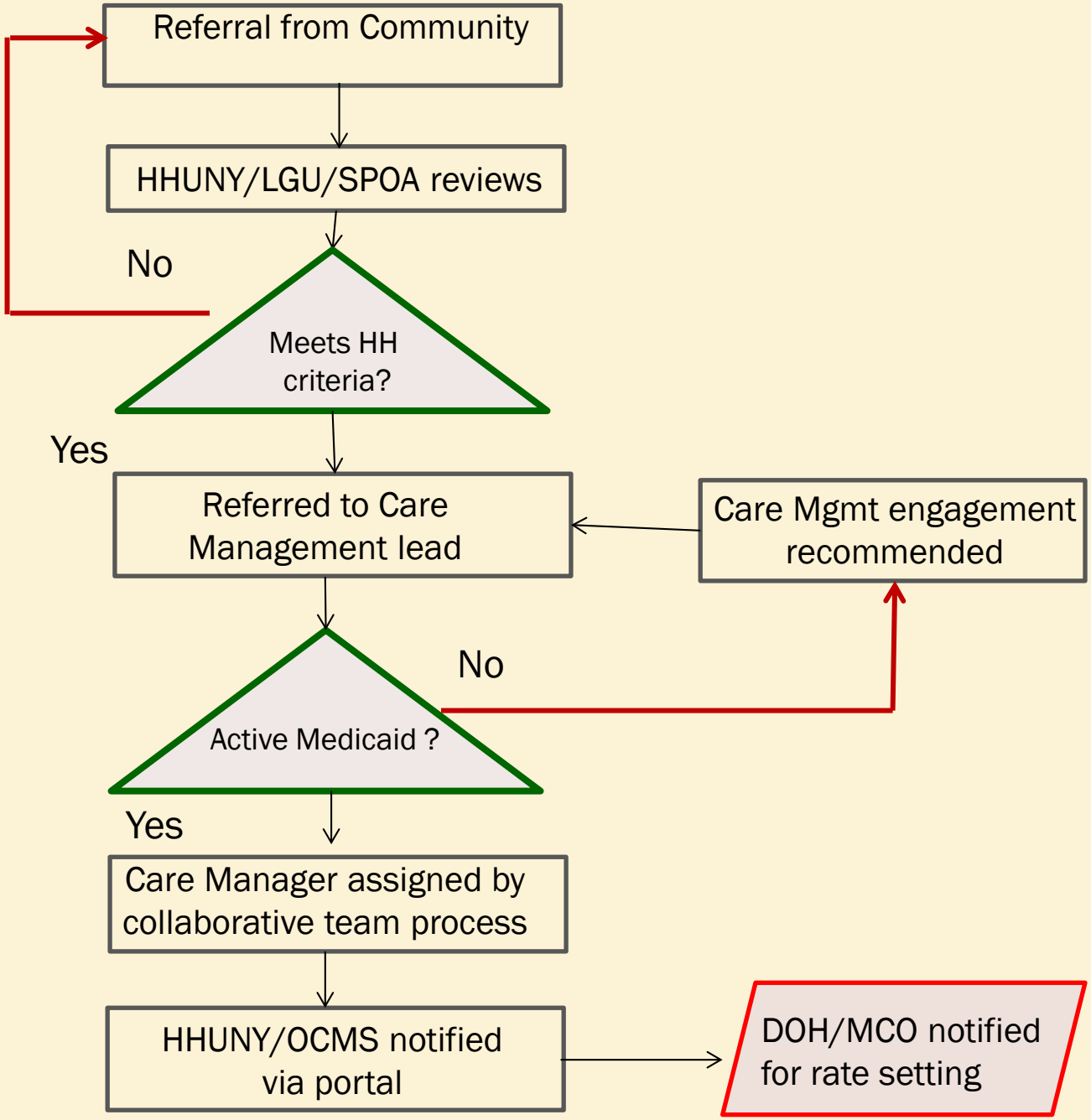
- "...identify and plan for the provision of care coordination, emergency services, and other needed services for persons who are identified as high-need patients..."

Chemung County
Top Down Referrals



NYS Conference of Local Mental Hygiene Directors, Inc.

Chemung County Ground Up Local Referrals



NYS Conference of Local Mental Hygiene Directors, Inc.

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Orange County
Single Point of Access (SPOA)

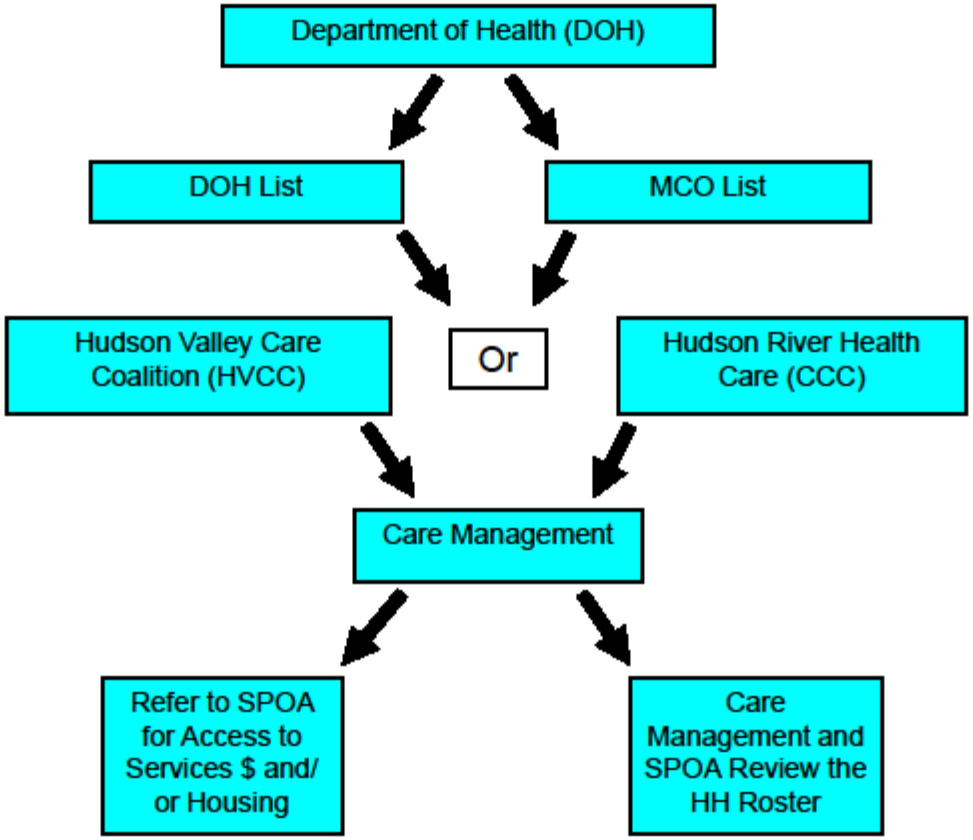
- Our SPOA committee is an integrated collaboration of care management, housing providers, family partners & peer specialists who work diligently to improve access & foster engagement with individuals who are at high risk of system usage and future deep end, high cost usage such as ER's, homelessness & incarceration. SPOA's goal is to have the right person, in the right services, at the right time, achieving the right outcomes.

- We are a collaboration of professionals who know the clients, know the system, know the resources and know each other.

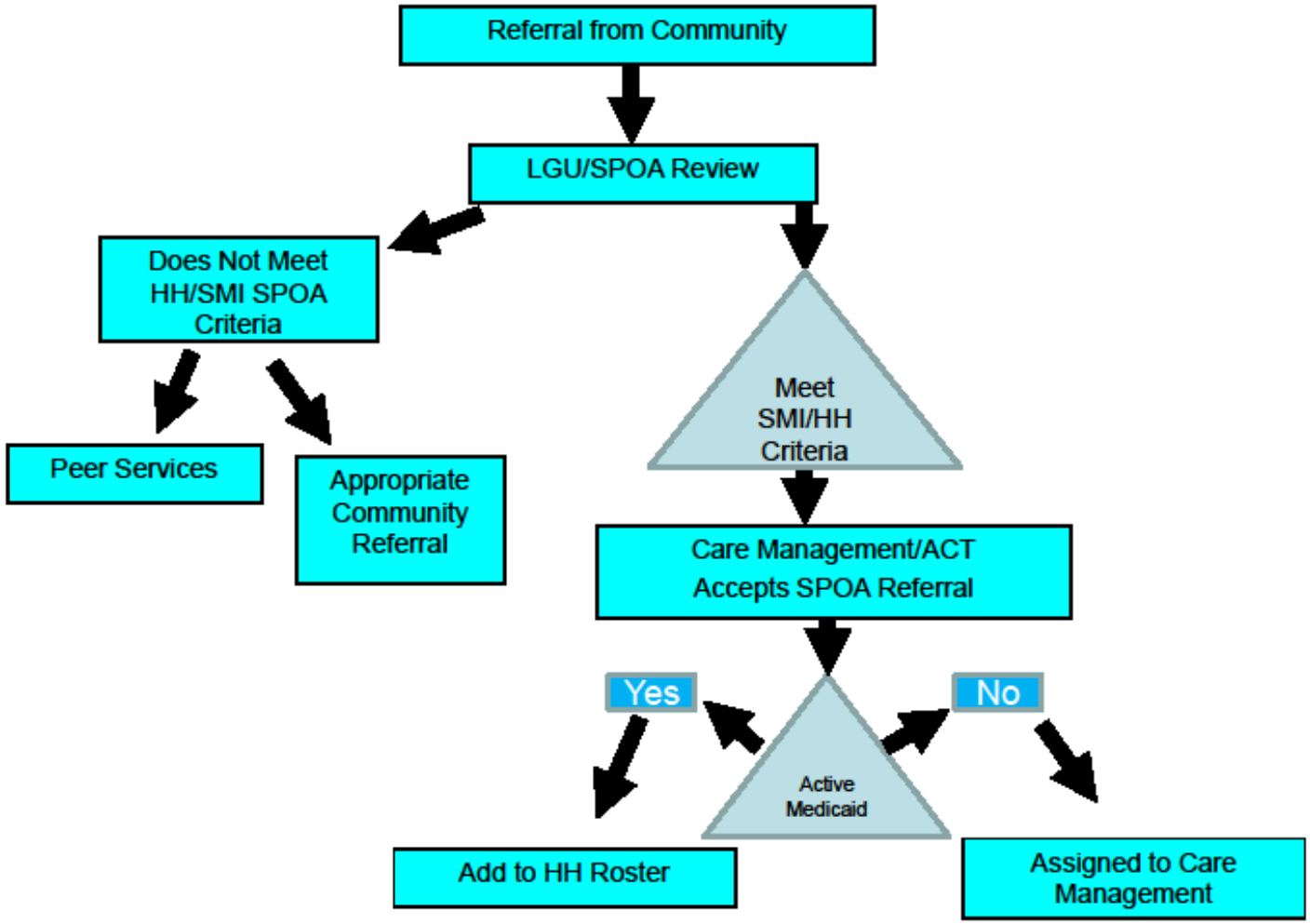
Orange County SPOA continued

- We help the mental health consumer achieve & maintain stability through linkage with the most effective and least restrictive services available.
- We utilize peer supports whenever requested or when ever possible to enhance the consumer's engagement and involvement in services.
- We serve the local hospitals, jails & state prisons as a resource in their discharge planning, and we assist the consumers in making a positive transition between levels of care.
- We work together as a team to identify gaps in the services and to promote creative ways to better respond to the ever changing needs of the consumer.
- We continually strive to improve services through evaluation of service delivery initiatives.
- Most of all, we value our ability to assist the consumers and families in our community to live safe successful lives

Orange County Top-Down Referrals



Orange County Bottom-Up Referrals



Nassau County

- The Nassau County Local Government Unit (LGU) is the Single Point of Access (SPOA) for the two Health Homes in Nassau County.
- The LGU is a co-lead with the agency FEGS in the operation of one of two Nassau County Health Homes. This Health Home is named "Nassau Wellness Partners" (NWP).
- The LGU is also an active partner with the other Nassau County Health Home, which is operated by NS-LIJ Health Systems.

Nassau County

- Each Health Home receives client lists from NYS DOH and from the Managed Care Organizations. The Health Homes share these lists with the LGU, since the LGU has signed a DEAA agreement with each Health Home.
- As the SPOA for both Health Homes, the LGU assigns Health Home clients to care management providers within 48 hours after receiving the referral from the Health Home.
- Each Health Home contracts with other agencies to provide care management and outreach services that are not provided by the Health Home lead agency.

Nassau County

- The SPOA also processes “ground up” referrals for potential Health Home enrollment.
- If the client appears to meet HH criteria, but is not on a DOH or MCO list, the referral is sent to one of the HH’s for a determination of their HH eligibility, based on a loyalty algorithm
- If the HH agrees to serve the client, the LGU is notified and then assigns the client to the HH.
- If the individual needs mental health care management, but does not quality for HH assignment, such person will be assigned to OMH funded care management.

Nassau County

- The LGU established the Assessment and Referral Center (the ARC) which is co-located with the Nassau County Department of Social Services (DSS). The ARC is staffed with clinicians from the LGU.
- The ARC staff receive referrals from DSS when a person comes to the DSS site and the person has been identified by DOH or an MCO as eligible for Health Home services.

Nassau County

- To allow for this referral process, the LGU signed DEAAs (Data Exchange Application Agreements) with both Health Homes. The LGU also arranged for DSS to sign a DEAA with both Health Homes.
- Since DEAA's are signed by the LGU and DSS, it allows DSS to notify the ARC when a Health Home eligible client is at the DSS site.

Nassau County

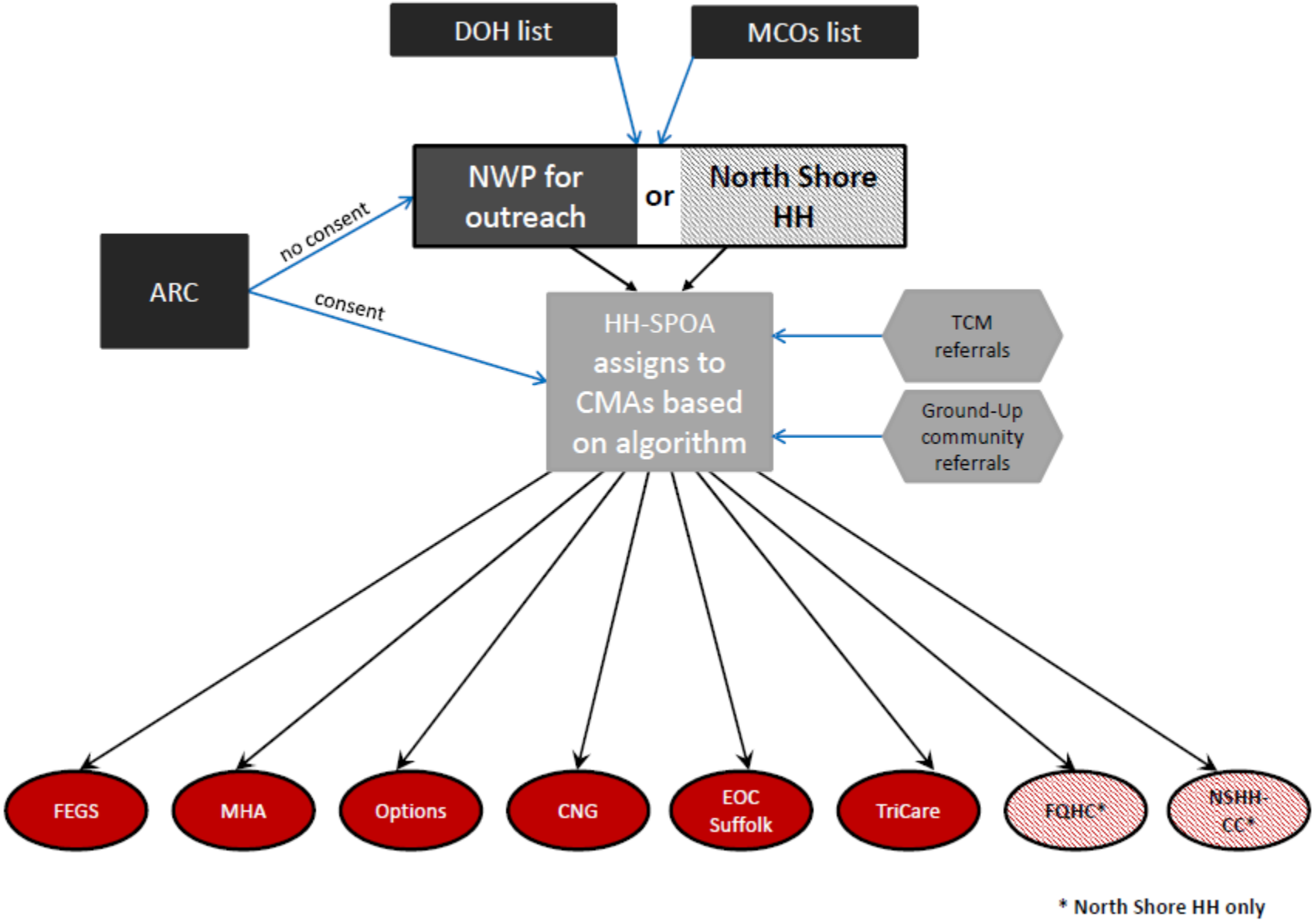
This notification system works as follows:

- All DSS recipients who come to the DSS site are registered at a "Welcome Desk".
- The Welcome Desk worker uses a software program that looks for a match for the DSS recipient with the list of Health Home eligibles.
- If a match occurs, an electronic message is sent to the ARC that a Health Home eligible client is in the building.
- The ARC worker then reaches out to the client, attempts to engage with them, and seeks to get their consent to join either the FEGS or NSLIJ Health Home.

Nassau County

- In many instances, after the client agrees to receive Health Home services, a representative from the Health Home is alerted, and they come to the DSS site to meet the client.

- An added responsibility of the ARC is to conduct behavioral health assessments of DSS recipients who are deemed by DSS staff as likely to benefit from ARC services. Clients can then be connected to outpatient treatment and, when deemed HH eligible, are referred to SPOA.


DOH list
MCOs list
NWP for outreach
or
North Shore HH
ARC
no consent
consent
HH-SPOA assigns to CMAs based on algorithm
TCM referrals
Ground-Up community referrals
FEGS
MHA
Options
CNG
EOC Suffolk
TriCare
FQHC*
NSHH-CC*
* North Shore HH only

SPOA Eligibility

In order to be eligible for services through OCDMH, applicants for Housing, Care Management or ACT Services must be diagnosed with severe and persistent mental illness. Please complete the checklist below to determine if the applicant is eligible for services.
A must be met. In addition, B, C, or D must be met:

A. The individual is 18 years of age or older and currently meets the criteria for a primary DSM-5 diagnosis other than alcohol or drug disorders, developmental disabilities, dementias, or mental disorders due to general medical conditions, except those with predominantly psychiatric features, or social conditions (V-codes).

B. SSI or SSDI Enrollment due to Mental Illness. The applicant is currently enrolled in SSI or SSDI DUE TO A DESIGNATED MENTAL ILLNESS.

C. Extended Impairment in Functioning due to Mental Illness.

SPOA Eligibility - continued

1. 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. (Documentation in psychosocial assessment required.)
    a. Marked difficulties in self-care
    b. Marked restrictions of activities of daily living
    c. Marked difficulties in maintaining social functioning
    d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home of school setting.
2. The individual has met criteria ratings of **50 or less** on the Global Assessment of Functioning Scale due to a designated mental illness over the past twelve months on a continuous or intermittent basis.

SPOA Eligibility - continued

D. Reliance on Psychiatric Treatment, Rehabilitation and Supports. (Dates and facility must be documented in Referral Form)

- One six month stay in an inpatient psychiatric unit
- Two stays of any length in an inpatient psychiatric unit in the preceding two years
- Three or more admissions to an OMH operated or licensed mental health outpatient program or forensic satellite unit operated by OMH
- Three or more contacts Crisis or emergency mental health services or a combination of any 3 contact within the preceding 18 months.
- Six months consecutive residency in a designated Adult Home
- Six months consecutive residency in a Residential Care Center for Adults (RCCA)
- Six months consecutive residency in a Residential Treatment Facility (RTF)

SPOA Elements – Adult Care Management & Housing

- Full time SPOA Coordinators to facilitate SPOA Committee meetings
- A Process to define and identify individuals with greatest needs with a priority rating scale
- Protocol to connect all ineligible referrals to other case management service, peer services, housing services, or cross system links
- Data Base that records all SPOA activity and collects pertinent clinical and continuum of care information for all referrals
- Quality improvement and performance based monitoring of care management service housing services
- Utilization management process including periodic reassessment of individuals needs for transition planning to appropriate level of care based on their needs
- Client satisfaction surveys

SPOA Elements – Adult Care Management & Housing

- Collect statistics on a monthly basis from all care manager providers.
- Collect performance based measures and monitor for appropriateness of referral, timeliness of placement, and client outcomes.
- Manage integration/coordination between assisted outpatient treatment adult housing and care management activities.

Questions?

Useful Contact Information

- Visit the Health Home website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

- Get updates from the Health Homes listserv. To subscribe send an email to: listserv@listserv.health.state.ny.us (In the body of the message, type SUBSCRIBE HHOMES-L YourFirstName YourLastName)

- To email Health Homes, visit the Health Home Website and click on the tab "Email Health Homes" http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

- Call the Health Home Provider Support Line: 518-473-5569