SINGLE POINT OF ACCESS

Care Management, ACT, and AOT Referral Process

WHEN IS A REFERRAL APPROPRIATE?
CARE MANAGEMENT

- Individual is diagnosed with a serious mental illness (Schizophrenia Disorder, Schizoaffective Disorder, Delusional Disorder, Psychotic Disorder, Major Depressive Disorder, Bipolar Disorder, Post Traumatic Stress Disorder)
- Is in need of added support in the community due to high risk of further system utilization
- Unable to maintain community-based linkages and important supports

WHEN IS A REFERRAL APPROPRIATE?
ASSERTIVE COMMUNITY TREATMENT PROGRAM (ACT)

- Community based treatment—Treatment goes to the individual
- Care Management criteria
- Demonstrated difficulty in accessing or engaging with traditional service delivery models
- At least 2 of the following:
  - 3 inpatient hospitalizations in the past 12 months
  - At least 2 readmissions to a psychiatric hospital within 30 days
  - Utilization of crisis services 3 times in any 30-day period in the past 6 months
  - Intractable severe major symptoms (i.e. psychotic, suicidal)
  - Co-occurring mental illness and substance use disorder for more than 6 months
  - Involvement or high risk of being involved in the criminal justice system in last 6 months
  - Homeless, at risk of homelessness, or living in substandard housing

WHEN IS A REFERRAL APPROPRIATE?
ASSISTED OUTPATIENT TREATMENT (AOT)

- Assisted Outpatient Treatment (AOT)
- Criteria:
  - 18 years old or older and diagnosed with a mental illness
  - Unlikely to survive in the community without supervision, based on a clinical determination
  - Has a history of non compliance with treatment for mental illness which has led to either 2 hospitalizations for mental illness in the preceding 3 years, or resulted in at least 1 act of violence toward self or others, or threats of serious physical harm to self or others, within the preceding 4 years
  - Unlikely to accept treatment recommended in treatment plan
  - In need of AOT to avoid a relapse or deterioration that would likely result in serious harm to self or others
  - Will likely benefit from AOT

MAKING A REFERRAL

- Eriespoa.org
- Go to referral submissions on top banner
- Log in with existing sign in, or sign up
- Chose “create a referral”
- Upload the SPOA consent
- Chose care level (ACT or Care Management) & care status (general or AOT)
- Fill in all fields
  - Be thorough
  - More information is better than not enough
  - A risk score is generated on the information provided which helps in assigning to proper care in a timely manner
  - Instances of lethality: Is not a required field, but should be filed out even if the answer is “don’t know”
- Finish and submit referral (submit button located in top right corner of screen under the drop down arrow)
- Make sure consent is attached!

SPOA CONSENT

- SPOA consent must be filled out correctly, signed by the individual who services are being requested for, and uploaded to every submitted referral
- Can be located on eriespoa.org→ referral submissions→general consent form
- ** Referral will NOT be accepted without a completed consent**

Erie County Department of Mental Health
Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug treatment privacy regulations (42 CFR Part 2) and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment and health care operations. (See 45 CFR 164.506.)

1. I acknowledge that my information will be entered into an electronic record and I hereby give permission to [illegible] health, mental health, alcohol/drug and education records as described below.

2. The person whose information may be used or disclosed is:

   Name: John Doe   Date of birth: 01/01/2001

3. The information that may be used or disclosed includes (check all that apply):

   - ☐ Mental health records
   - ☐ Alcohol/Drug Records
   - ☐ School or Education Records
   - ☐ Health records
   - ☒ All of the records listed above

4. This information may be disclosed by:

   - ☒ Any person or organization that possesses the information to be disclosed.
   - ☐ The persons or organizations listed in Attachment A
   - ☐ The following persons or organizations that provide services to me:

   ______________________ ______________________

   ______________________ ______________________

5. This information may be disclosed to:

   - ☒ Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
   - ☐ The persons or organizations listed in Attachment A
   - ☐ The following persons or organizations:

   ______________________ ______________________

   ______

6. The purposes for which this information may be used and disclosed include:

   - Evaluation of eligibility to participate in a program supported by the Erie County Department of Mental Health;
   - Delivery of services, including care coordination and case management;
   - Payment for services provided; and
   - Health Care Operations such as quality assurance.

7. I understand that New York and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA privacy, drug, alcohol and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

Erie County Department of Mental Health
Permission to Use and Disclose Confidential Information (cont.)

8. This permission to use and disclose expires (check applicable box):

   - ☐ On (date)
   - ☒ One year from the date of the signature

9. This permission to re-disclose is limited as follows:

   - ☐ Permission only applies to records for the following time period: ________ to ________
   - ☐ Other limitation: ______________________

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.

Signature: John Doe   Date: 02/02/2023

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is

______________________ I give permission to use and disclose my records as described in this document.

Signature ______________________   Date ______________________

Print Name ______________________

Attachment A

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Erie County.

[illegible list of organizations, including: Child & Family Services; Erie County Department of Mental Health; Jewish Family Service; Salvation Army; Western New York; Other]

AOT CONSENT

- When making a referral specifically for AOT, an AOT consent is required in addition to the general SPOA consent.
- Must be filled out correctly, signed by the individual the referral is being made for, and uploaded into the referral
- AOT consent is located at eriespoa.org→referral submissions→more→AOT consent form
- **Referral will NOT be accepted without a completed consent**

Erie County Department of Mental Health Assisted Outpatient Treatment Program

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: John Doe		Date of Birth: 01/01/2001	SSN: 000-00-0000
Patient Address: 1 Main St Buffalo, NY 14000			

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in Item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE PERSON, ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED BELOW**

7. Name and address of person(s) or category of person to whom this information will be sent:
Erie County Department of Mental Health / Assisted Outpatient Treatment Program, 95 Franklin St., Buffalo, NY 14202

8. Specific information to be released:
X Medical Record from 48 months prior to (insert today's date) 2/2/2023 (or) from ________ to
Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records
X Admission & discharge summaries, CPEP/ER evaluations, Crisis Services assessments, psychiatric evaluations, Patient histories / core history, recommendations
Include: *(Indicate by Initialing)*
JD Alcohol/Drug Treatment
JD Mental Health Information

9. **NAME AND PHONE NUMBERS OF HEALTH CARE PROVIDERS OR ENTITY TO RELEASE THIS INFORMATION**

Kaleida-Buffalo General	Erie County Medical Center	Buffalo Psychiatric Center	TLC Lakeshore	Niagara Falls Memorial MC
P (716) 859-7734	P (716) 898-3257	P (716) 816-2152	P (716) 95_-7234	P (716) 278-4328
F (716) 859-2570	F (716) 898-5358	F (716) 816-2543	F (716) 934-4647	F (716) 278-4368

Other: ________ Other: ________

Brylin Hospitals
1263 Delaware Ave. Buffalo NY 14209
P (716) 886-8200

10. Reason for release of information:
For the purpose of ECDMH **Assisted Outpatient Treatment (AOT) Program: to obtain and include records in development of an AOT court order and for reference in any related hearing**

11. Date or event on which this authorization will expire:
2/2/2024

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions have been answered. I have been provided a copy of this form.

Signature of patient or representative authorized by law: John Doe Date: 2/2/23

Witness (signature): Jane Doe Date: 2/2/23

The above information has been reviewed with me and I decline authorization ________ Date: ______

ECDMH / AOT 9/11-9

Important notes:

- Demographic information should be filled out completely
- Box 8: We do NOT want the entire medical record. The first option, medical record from 48 months prior to (enter date) should be chosen along with admission discharge summaries, etc. Client should initial alcohol/drug treatment, and mental health information
- Box 9: Add any other relevant hospitals where records should be requested from (i.e. individual had an inpatient stay at Strong Memorial)
- Box 11: Don't forget expiration date! 1 year from date of signing is a good choice
- Client and witness signature needed

IMPORTANCE OF A COMPLETE REFERRAL

- Complete referral:
  - Accurate and detailed hospital information
  - Lethality section filled out fully
  - Up to date demographics and contact information
  - Referral source contact information
  - Diagnosis with verification (if available)
  - Collateral contacts
  - Consents completely filled out and accurate
- Incomplete referral
  - No hospital information, or incomplete information
  - Nothing filled out in lethality section
  - Incorrect contact information, or no contact information
  - Incomplete referral source contact information (what is your relationship to the referred? Phone number? Email?)
  - No diagnosis, or not a SPOA accepted diagnosis
  - No collateral contacts
  - Consents missing or filled out incorrectly

IMPORTANCE OF A COMPLETE REFERRAL

- The more information in the referral→ The higher the risk score
- Allows SPOA to know where to request records from (for AOT referrals)
- Give the ACT team/Care Management agency an accurate description of the client they will be serving
- The more information we have, the quicker we can assign, therefore bringing needed services to the client in a timely manner

I SUBMITTED A REFERRAL, NOW WHAT?

GENERAL CARE MANAGEMENT

- Referral is reviewed by a member of a team
  - Is all information filled out?
  - Consent attached?
  - Can diagnosis be verified in Psyckes, or was diagnosis verification uploaded?
  - Does the client have Medicaid?
- Once reviewed and determined it is appropriate, referral will be assigned to a Care Management providing agency
  - The assigned agency will then be in touch with you or the referred individual to schedule intake and move forward

NON-MEDICAID GENERAL CARE MANAGEMENT

- We have non-Medicaid slots available, so regardless of insurance anyone eligible can be assigned a care manager
- However, slots are limited, and your referral may end up on a waitlist

ASSERTIVE COMMUNITY TREATMENT (ACT)

- ACT spots are very limited and highly requested
- We are always on a waitlist
- If we can not assign to ACT right away, we will reach out to the referral source with other alternatives
  - Other community team options
  - General care management
  - Clinic information
- Waitlist is assigned when there are openings, based on risk score and need. We will reach back out when there is a possibility to assign
- When the referral is assigned, it will be up to the individual ACT team to accept or deny after completing a screening. Assignment does not equal enrollment.

ASSISTED OUTPATIENT TREATMENT (AOT)

- A member of our team will request hospital records based on information in the referral. It is important to be accurate and thorough so we know where to get them from!
  - It can take some time (up to a month or more) to get records
- Once records are received, we will investigate if the referral meets AOT criteria.
- If the individual meets criteria for AOT:
  - We will determine a treatment plan with your assistance. AOT individuals can be care management + clinic, or ACT (depending on history and need)
  - We will work to schedule an AOT evaluation which requires a physician willing to complete the evaluation, sign off on paperwork, and attend a court hearing.
- If the individual does not meet criteria for AOT:
  - We will reach out to see if assignment to general care management is needed

FAQ

- Why was my referral rejected or marked incomplete?
  - *We will usually provide a reason to the referral source. Likely it was because there wasn't a consent, the consent wasn't filled out appropriately, there isn't an SMI, or because the individual is already linked with services*
  - *When a referral is "marked incomplete" it goes into a separate category in the SPOA admin view. We won't see it until information needed is provided (a consent is attached)*
- Will I hear anything after I submit a referral?
  - *That depends. We will reach out if we need more information. Often we will just assign without reaching out personally, but you should get an email updating to the assignment.*
- How long will my referral be on a waitlist?
  - *There is no set time for someone to be on the waitlist for non-Medicaid or Act services. It depends on need and availability of services. Reach out if there are changes in the person's status or you have questions*

FAQ

- Can I request a specific agency to be assigned for CM or ACT?
  - *You can, and we will try to accommodate, but we assign based on availability of slots*
- What if I am having issues with the SPOA site?
  - *Hit "contact support" on the top of the referral under "more", or reach out to someone in the SPOA office via email or phone*
- Why can't someone with a personality disorder, or anxiety, or depression get services?
  - *Unfortunately services though SPOA have to be limited to those with an SMI (Schizophrenia, Schizoaffective disorder, Bi-polar disorder, MDD, PTSD). However, we want to help however we can and ask that you reach out if this is the case so we can explore other options and referrals available in the community*

SPOA AGENCIES

ACT

- Best Self Behavioral Health (including AOT)
- Spectrum Human Services (Including AOT)
- Buffalo Psychiatric Center (Including AOT)

Care Management

- BFNC (including AOT)
- Best Self Behavioral Health (Including AOT)
- Buffalo Psychiatric Center (Including AOT)
- Spectrum Human Services (Including AOT)
- Evergreen
- CINQ-NY
- Harmonia
- Hillside
- Horizon
- Monroe Plan
- TSI
- Venture Forth
- Community Services for Every1

SPOA CONTACTS

- care@eriespoa.org
- SPOA Coordinator:
  - Nicole Jordan
  - Nicole.Jordan@erie.gov
  - 716-858-7059
- Assistant SPOA Coordinator:
  - Andrea Tobias
  - Andrea.tobias2@erie.gov
  - 716-858-7357
- Assistant SPOA Coordinator:
  - Ellen Mills
  - Ellen.mills@erie.gov
  - 716-858-2893

- SPOA Housing
- https://www3.erie.gov/mentalhealth/erie-county-training-collaborative
- Go to past trainings and locate SPOA housing training from 7/26/2022
- Christine.Slocum@erie.gov
- Joshua.curry-bascome@erie.gov