ADULT SINGLE POINT OF ACCESS (A-SPOA) GUIDANCE MANUAL

FOR THE

ERIE COUNTY DEPARTMENT OF MENTAL HEALTH (ECDMH)

COUNTY OF ERIE

PURPOSE OF THIS GUIDANCE DOCUMENT

The purpose of this Guidance Document is to provide the purpose and function of the Erie County Adult Single Point of Access (A-SPOA), the services available, referral process, and information for contract agencies related to reporting requirements.

OVERVIEW:

The Adult Single Point of Access (referred to as "A-SPOA" or "Adult SPOA") is a New York State Office of Mental Health (OMH) initiative designed to provide a more cohesive and coordinated system. The Erie County Adult SPOA Referral system has established a uniform process for receiving and evaluating referrals for individuals with a serious mental illness (SMI) diagnosis. The goal was to create a system that promotes recovery-oriented services, that are widely available, flexible, personally tailored and responsive to an individual's needs.

This entry point's function is to assess/screen those referred and facilitate connection to the services that best meet the consumer's needs and the community's priorities. These centralized referrals facilitate linkage to services, triage access for high needs, and monitoring outcomes. Referrals are made through an online system at: www.eriespoa.org. This website provides instructions for users on how to complete and submit an A-SPOA referral. A signed A-SPOA consent from the individual to be served must be submitted in order for the referral to be processed.

A-SPOA ELIGIBILITY REQUIREMENTS:

Each A-SPOA service has unique eligibility requirements, and many services are based on the diagnosis of Serious Mental Illness (SMI). The definition of Serious Mental Illness according to the New York State Office of Mental Health "**Definition of Serious and Persistent Mental Illness (DSM-V)**,"(*please see this definition copied herein or visit the online link below.*

Definition of Serious and Persistent Mental Illness (DSM-V):
https://www.omh.ny.gov/omhweb/guidance/serious_persistent_mental_illness.html)

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

Designated Mental Illness (DSM-V):
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

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

Or

2. **Extended Impairment in Functioning due to Mental Illness:** Documentation that the individual has experienced two (2) of the following four (4) functional limitations due to a designated mental illness over the past twelve (12) months on a continuous or intermittent

basis:

a. Marked difficulties in self-care (personal hygiene, diet, clothing avoiding injuries, securing health care or complying with medical advice);
b. Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services);
c. 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)
d. 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

3. Reliance on Psychiatric Treatment, Rehabilitation and Supports:

A documented history shows that the individual at some prior time met the threshold for number 3 (listed 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.

SERVICES AVAILABLE THROUGH ADULT A-SPOA:

CARE MANAGEMENT:

General Case Management/Care Coordination:

Consumer's needs are chronic in nature and mental health issues require enhanced community services (*Ssee referral assessment form for criteria*). Referrals are made directly to the A-SPOA and the A-SPOA will assign to the most appropriate Care Management Agency and/or Health Home.

Assertive Community Treatment (ACT):

Mobile mental health treatment is required due to the inability to link with traditional treatment and has had no other successful linkages. The individual has not been successful with previous care coordination programs. Referrals are made directly to the A-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

HOUSING PROGRAMS:

Non-Licensed Housing

Supportive Housing Programs (SHP):
These programs provide a partial rental subsidy for a private apartment selected by and leased by the consumers themselves. The supportive housing programs provide rental payment assistance and supportive services. Staff provide services designed to assist consumers to obtain or refine skills necessary for more independent living and increased self-sufficiency. Staff generally meet with the consumer at a minimum of once a month depending on individual needs of the consumer. Consumers are expected to develop individual goals which focus on living more independently. Referrals are coordinated through the Adult Single Point of Access (A-SPOA). The New York State Office of Mental Health (OMH)-funded supportive housing programs require verification of significant impairment in functioning due to a mental disability.

HUD-funded permanent supportive housing programs also require verification of homelessness at the time of admission. HUD defines homelessness as being in a place not meant for human habitation, in an emergency shelter or transitional housing program exclusively intended for people who are homeless or fleeing domestic violence or human trafficking. The demand for these programs typically exceeds the availability of open beds; therefore referrals are placed on a wait list prioritized by a risk score that is auto-generated by the circumstances entered into the A-SPOA referral. The Erie County Housing Coordinator and Assistant Housing Coordinators facilitate this process.

Supportive Housing Program Agency Providers Include:
- Transitional Services, Inc.;
- DePaul Community Services (Living Opportunities of DePaul);
- BestSelf Behavioral Health;
- Spectrum Health & Human Services;
- Southern Tier Environments for Living;
- Buffalo Federation of Neighborhood Centers;
- Restoration Society, Inc.; and
- WNY Veterans Housing Coalition.

Critical Time Intervention (CTI):
CTI are goal-oriented case management programs that support the transition into housing out of an institutional setting such as a hospital, prison, jail, substance abuse treatment facility, or homeless shelter. CTI offers one (1) month of financial assistance towards the cost of housing. The following months are then focused on helping participants build their support system and accomplish person-centered goals. A six-month (6-month) program is offered for people who

experienced homelessness and are transitioning from an institution. There is also a twelve-month (12-month) program for those who are transitioning from a substance abuse treatment facility. Restoration Society, Inc. facilitates the CTI program for homeless individuals and BestSelf Behavioral Health operates the CTI program for people transitioning from substance abuse treatment facilities.

Emergency Housing Services (EHS):
EHS is a ten-bed (10-bed) setting for people with serious mental illness (SMI) who are also experiencing homelessness. Services are focused on transitioning people who are experiencing homelessness into permanent housing. Transitional Services, Inc. facilitates this program.

LICENSED HOUSING:

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

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

Treatment/Supervised Apartments (TSA):
TSA provides transitional housing in shared (one (1), two (2) or three (3) bedroom) apartments within the community. These apartments are either located at a single site that has staff onsite 24/7, or there are scattered site apartments where the staff visit them anywhere from three (3) to seven (7) days each week but remain on-call for emergencies 24/7. Staff provide services that are designed to assist residents in either obtaining or refining the life skills necessary for independent living. Cash allowances for groceries and clothing are provided by some of the offered programs. TSA residents are expected to develop individual goals with the focus on them living more independently. The typical length of stay is eighteen (18) to twenty-four (24) months. TSA housing services are facilitated by Buffalo Federation of Neighborhood Centers; DePaul Community Services; and Transitional Services, Inc.

MICA Housing (MICA):
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 facilitated by Transitional Services, Inc. which operates a ten-bed (10-bed) supervised apartment program.. Single bedrooms are available.

Young Adult Housing (YAH)
YAH is a group home and supported housing program, providing specialized services for individuals aged eighteen (18) to twenty-one (21) years of age, who are transitioning from Residential Treatment Facilities or congregate living environments for adolescents. The service provided are similar to other group settings. YAH has the staffing capacity to provide more intensive services for individuals participating in the supported housing component of the program. YAH services are facilitated by Transitional Services, Inc.

Single Room Occupancy (SRO'):
SRO provides 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 that are 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 facilitated by DePaul Community Services.

INFORMATION FOR AGENCIES PROVIDING A-SPOA LINKED SERVICES

Agencies that are providers of A-SPOA linked services should adhere to the following guidance as applicable. The following sections cover AOT Reporting Guidance and A-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 A-SPOA MIS no later than the 10th day of each month. A monthly report is to be submitted for each, individual AOT client that is court ordered or on a Diversion Agreement (voluntary). 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 24-hour period.
Link to Missing Persons Protocol:
https://my.omh.ny.gov/analyticsRes1/files/aot/AOTGuidanceforProgramOperation2017.pdf

PHYSICIAN AVAILABILITY GUIDANCE:
Agencies accepting and providing treatment inclusive of, but not necessarily limited to, medication management and/or psychiatric treatment to those individuals enrolled in Assisted Outpatient Treatment whose AOT court order is subject to renewal are required to provide a Board-certified physician to complete the renewal evaluation, prepare a treatment plan, and when a hearing is

required provide court testimony and associated testimony preparation in accordance with the requirements and deadlines of the Court.

A-SPOA HOUSING LANGUAGE DEFINITIONS AND INSTRUCTIONS

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 A-SPOA office:

Engagement:
Begins once the provider agency receives a referral from A-SPOA and extends 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 the next plan of action.

72-Hour Bridger Housing:
It is an expectation that the individuals who are referred to unlicensed housing will be screened and housed, at least within 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 A-SPOA who will then collaborate with coordinated entry.

The Screening Process:
Once the A-SPOA referral is received, it is expected that within 24-hours of receiving the referral from A-SPOA, that the receiving agency should contact the referring person and the client to initiate the screening intake appointment. This should be indicated in the "Housing Engagement" section of the A-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 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 A-SPOA within one (1) business day.

Disengagement:
This includes referrals in which the client refuses services, client is unable to be found (the ECDMH standard of time spent looking is for at least ninety (90) days, if chronic), client needing a higher level of care, referrer withdraws, client is currently with another housing provider, client found other housing, etc. The ECDMH should be notified when a housing disengagement is needed as ECDMH A-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, A-SPOA is to be notified as soon as a disposition occurs.

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

Enrollment:
Enrollment means that the individual has been housed. It is expected that an individual will be enrolled in housing within forty-five (45) days of receipt of the referral. Once the individual is housed, the provider agency needs to document this in the A-SPOA MIS System by clicking "Enrollment" located below the A-SPOA Notes section in the referral.

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

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

A-SPOA 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. A-SPOA sends referrals to providers based on the information per the A-SPOA Cpacity Table.

Running of Reports:
A-SPOA will regularly compile reports that will measure the following:

- Length of time from agency receiving referral to enrollment in housing;
- Reasons for disengagements and denials; and
- Capacity based on capacity boards.