NEW YORK STATE | Department of Health | Office of Mental Health

Adult Home Transition Initiative

Presentation to MISCC

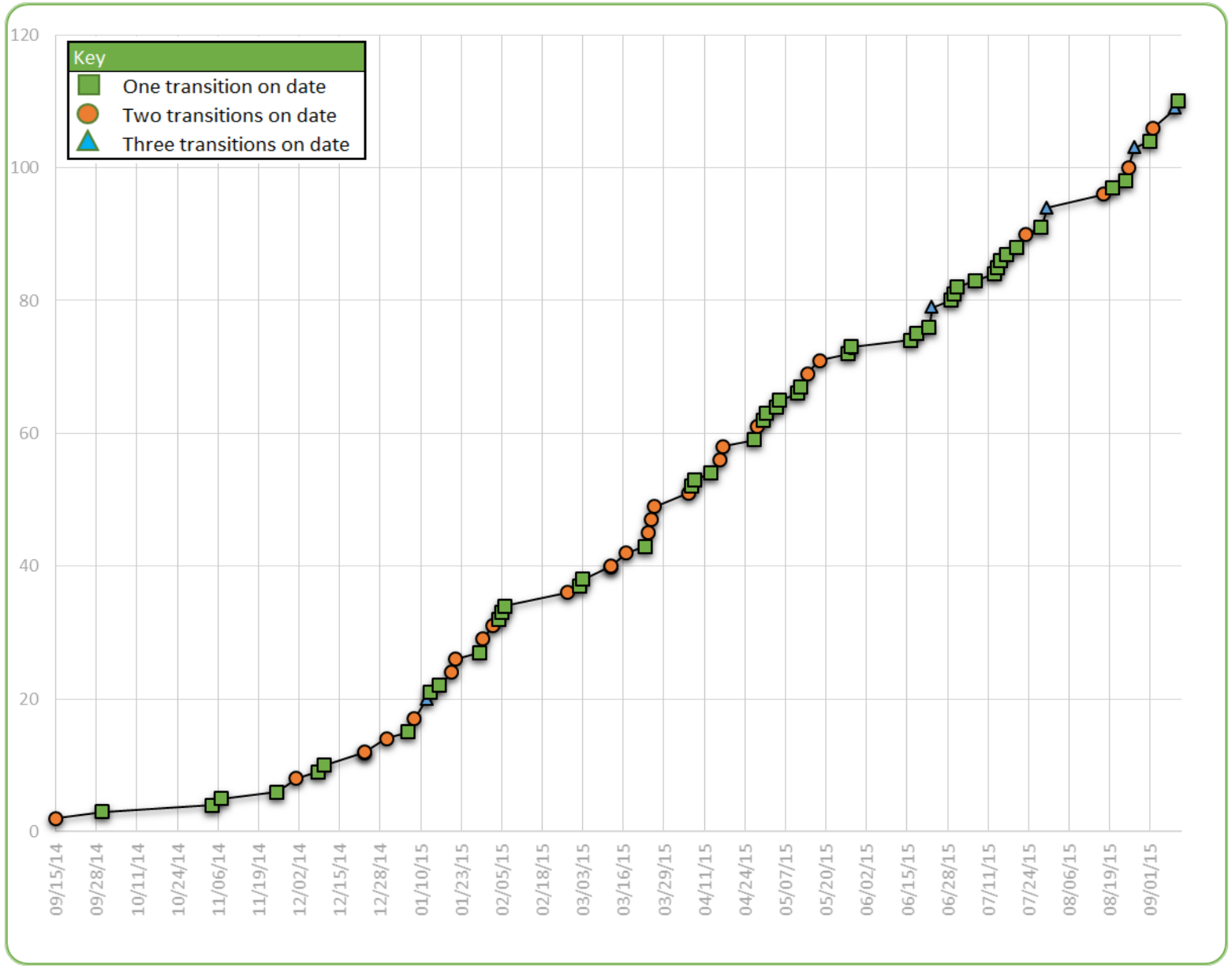
October 14, 2015

Overview of Settlement Agreement

- To provide NYC Adult Home residents with serious mental illness the opportunity to live in the most integrated setting, to provide them with the information necessary to make informed choices about this opportunity, and to transition them to the community if they wish to move.
- The Settlement requires:
  - The State to arrange for Housing Contractors to conduct in-reach to actively support AH residents in making an informed choice about moving to the community
  - The State to arrange for Health Homes and MLTC Plans, as appropriate, to conduct a comprehensive assessment and develop a person-centered care plan
  - The State to move class members who choose to transition
- The settlement was reached 7/23/13, signed by the judge 3/17/14, and first housing referral was received 7/7/14.
- By July 2018, assess and provide the opportunity to transition to all class members

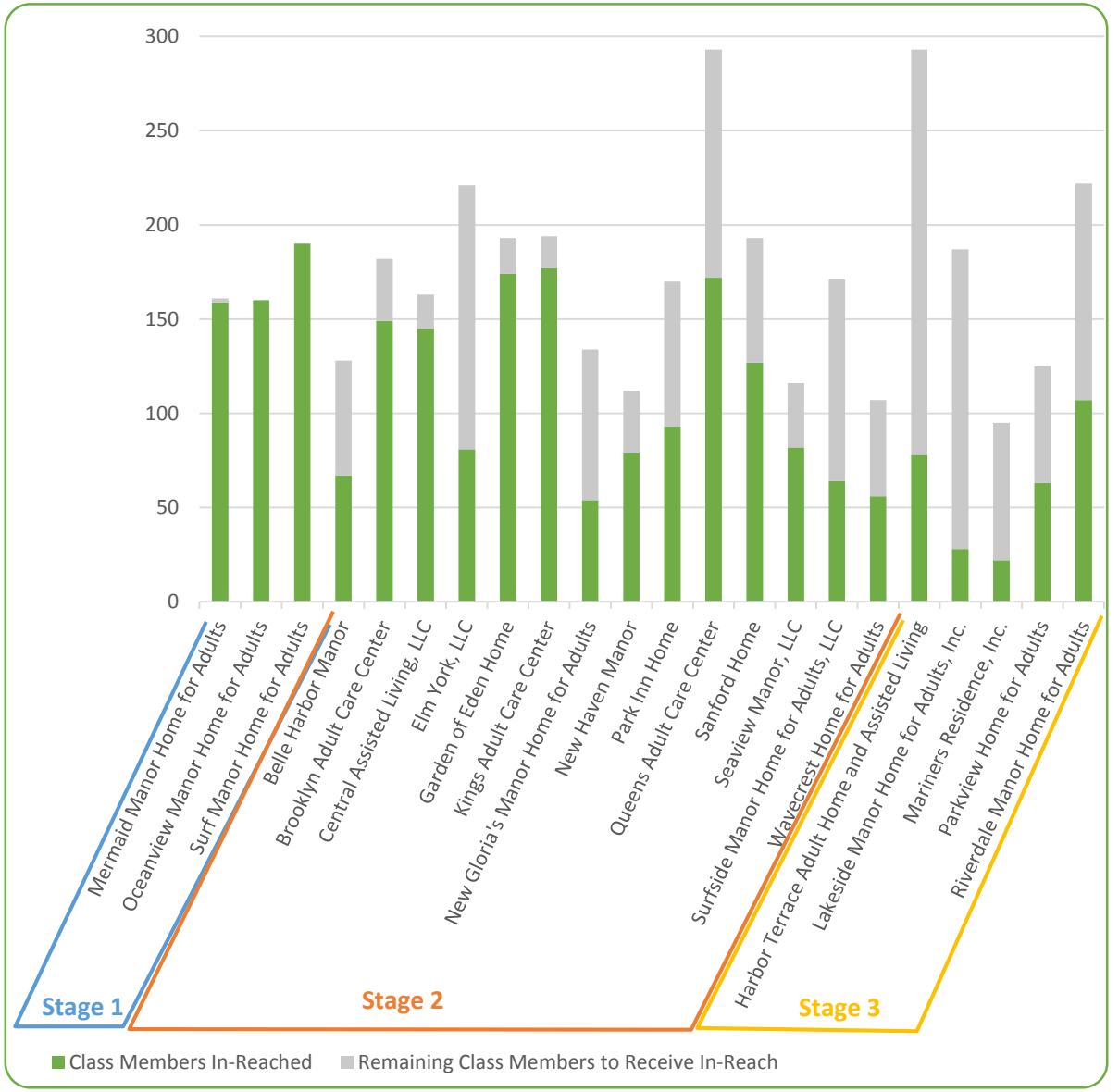
Transitions as of Quarter 6 (September 11, 2015)

Class members who have moved to the community: 126



Class Members Given the Opportunity to Transition as of Quarter 6 (September 11, 2015)

Class members who received in-reach: 2485



Stage 1: In-Reach began in three pilot homes in Brooklyn on March 17, 2014.

Stage 2: In-Reach was expanded to the rest of the Brooklyn and Queens Impacted Adult Homes on July 8, 2014.

Stage 3: In-Reach began for the rest of the Impacted Adult Homes located in Staten Island and the Bronx on April 27, 2015.

Adult Home Plus Program

Adult Home Plus Program (AH+)

- Concept: Lower case loads, more intensive care management support, experienced care managers, more individualized assistance
- Goal: To improve the class member experience, to increase the pace of transitions, and to increase the rate at which class members say “yes” to transitioning
- All class members who are eligible for Health Home enrollment and are interested in transitioning will automatically receive AH+
- Implementation began September 1, 2015

What does AH+ look like?

In addition to providing all required Health Home care management services, AH+ care managers will:

- Have caseload ratios no greater than 1:12
- Serve as the single point of contact for class members
- Provide face-to-face contact with the AH class member at a minimum of four times per month from the point of enrollment into the Health Home and after the AH class member expressed a desire to transition to supported housing
- Develop the class member's person-centered care plan and arrange for services necessary for discharge

Who can provide AH+?

AH+ care managers must be credentialed and have at least 4 years experience in:

1. Providing direct services to people with Serious Mental Illness; or
2. Linking individuals with Serious Mental Illness to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

ADULT HOME TRANSITIONS
AUGUST 2015

Process

ACRONYMNS
AH+: Adult Home Plus
AH+ CM: Adult Home Plus Care Manager
HH: Health Home
HC: Housing Contractor
MLTCP: Managed Long Term Care Plan
OCT: Office of Community Transitions
HRA: Human Resources Administration

STEPS IN THE TRANSITION PROCESS FROM ADULT HOME TO THE COMMUNITY

1	2	3	4	5	6	7	8	9	10	11
Enroll in HH	**In-Reach**	**Assessment**	**QA Review**	**HRA approval**	**Housing Intake**	**Tours**	**Accepts Apartment**	**Pre-Tran QA**	**Move Day**	**Post-Tran QA**
Class member enrolls in HH and if indicates a desire to move, receives AH+	HC conducts in-reach	Assessment package: 1. UAS-NY 2. Psychosocial 3. AHRAR	DOH OCT reviews assessment package	HRA approves application for housing	HC conducts intake interview	HC shows apartments to class member	Class member accepts apartment	DOH OCT organizes pre-transition call 3 weeks prior to move	Class member moves out of the Adult Home	OMH organizes post-transition call 1-2 weeks after move

ROLE AND SUPPORT OF AH+ THROUGH THE TRANSITION PROCESS

1	2	3	4	5	6	7	8	9	10	11
AH+ CARE MANAGER IS SINGLE POINT OF CONTACT FOR THE CLASS MEMBER THROUGHOUT THE PROCESS TO SUPPORT TRANSITION.										
Upon enrollment, AH+ CM will begin person-centered care planning,* focusing on transition, with a minimum of four face-to-face contacts per month.	AH+ CM will communicate directly with HC about class member's initial needs related to transition (e.g., need for I.D.s, SNAP benefits, etc.). AH+ attends in-reach when possible.	AH+ CM will schedule UAS-NY and psychosocial, simultaneously when feasible. AH+ CM will accompany the class member to their assessment and provide input as appropriate.	AH+ CM will coordinate the timely completion of the AHRAR and submitted to OCT for QA. Once approved, AH+ CM submits assessment package to HRA.	AH+ care manager sends HRA approval to HC and continues person-centered care planning.	AH+ CM attends intake meeting, when feasible. AH+ CM assists class member in articulating specific housing desires and needs and works with class member to set realistic expectations.	AH+ CM communicates with class member and HC about tours and the team continues to work with class members to identify an apartment.	AH+ CM works with class member and HC to sign lease and provide AH 30 day notice.	Three weeks prior to the move, AH+ CM facilitates the pre-transition call using the discharge planning tool. AH+ care manager is responsible for the coordination of all aspects of the transition.	AH+ Care Manager accompanies the class member to their new apartment to confirm services are delivered as planned.	AH+ CM reports progress at post transition call and continues to support the class member in the community for at least six months. At six months, the class member is assessed to determine if AH+ care management or HH care management is appropriate.

* For class members who are enrolled with an MLTCP and HH: The assigned HH care manager will be the lead and single point of contact providing care management services throughout the transition process. Once a class member is enrolled in the HH, signs a HH consent form, and expresses a desire to transition to the community from the Adult Home, the HH care manager (AH+) initiates person-centered care planning in collaboration with the MLTCP, which includes a focus on transitioning to Supported Housing.

Education and Outreach

Improved Education About Community Transition for AH Class Members

- Educating AH class members is critical so that class members are able to make a fully informed choice about moving to supported housing.
- Housing contractors will continue to work with class members that are undecided about moving.
- Class members will continue to receive re-in-reach through the life of the settlement.
- Each in-reach team has a peer member. Peers are people with similar experiences (many have moved from Adult Homes) who provide guidance and individual support to residents considering the move into the community.

Improved Education About Community Transition for AH Class Members

Examples of more robust in-reach that housing contractors employ:

- Facilitating monthly support groups for interested AH class members
- Offering groups outside the AH in the community
- Taking trips to model supported housing apartments
- Showing apartments that are presently occupied by former AH class members
- Arranging for an individual who has moved from an AH into the community to speak to current AH class members about their experience

Next Steps

Next Steps

The State will continue:

- Aggressive rollout of AH+
- Expansion of pool of assessors to complete assessments
- Provide trainings to Health Homes, Managed Long Term Care Plans, Housing Contractors
- Develop new tools for in-reach to educate class members
- MOVE PEOPLE WITH SERIOUS MENTAL ILLNESS OUT OF ADULT HOMES

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Thank you.

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