

Appendix C

Presentations to New Models Workgroup

Presentation	Discussion
<p><u>Traumatic Brain Injury (TBI) Waiver</u></p>	<ul style="list-style-type: none"> • The TBI Waiver is a Home and Community Based Services Medicaid waiver, created in 1995 to increase the opportunity for individuals with TBI to live in a community-based setting rather than institutions. The waiver brings back to New York individuals with TBI who have been living out-of-state because comprehensive services were not available here. The waiver currently serves ~1050 individuals. • Eligibility for the Waiver: 18-64 yrs of age; diagnosed with a TBI or related condition; eligible for nursing level of care; enrolled in Medicaid program • The following services are supported by the waiver program: Service Coordination; Independent Living Skills Training; Substance Abuse Treatment Programs; Intensive Behavioral Programs; Community Integration Counseling; Home & Community Support Services; Rental Subsidies & Housing Support Program
<p><u>Office of Mental Retardation & Developmental Disabilities (OMRDD) Waiver</u></p>	<ul style="list-style-type: none"> • The OMRDD Waiver is a Home and Community Based Medicaid waiver, initiated in 1991 to foster independence, integration, individualization, and productivity. The waiver currently serves ~45,000 individuals. 40% of those live in Individual Residential Alternatives. The Waiver has 3 priority levels of need: 1) Emergency, 2) Emergent, 3) All Others. • Eligibility for the Waiver: Children and adults with mental retardation and developmental disabilities • The following services are supported by the waiver program: Service Coordination; Residential Habilitation; Day Habilitation; Prevocational Services; Supported Employment; Respite Services. Services may be provided to people living at home, in OMRDD sponsored family care, in Individualized Residential Alternatives (IRAs), or in supportive/supervised community residences.

Presentation	Discussion
<p><u>AIDS Institute HIV Special Needs Plan (SNP)</u></p>	<ul style="list-style-type: none"> • The AIDS Institute has a SNP that has been in development since 1994 in an effort to provide a significant and sophisticated infrastructure of AIDS care. The SNP is based on a primary care model and is headed towards an incentive for integrated care. Potential enrollment = ~50-70,000. • Eligibility for a SNP: HIV positivity • The following services are supported by the SNP: Case Management (case managers have specialized training in regulation with AIDS Institute guidelines); Primary Care Services; Treatment Plans (medical, mental health, substance abuse, case management assessment). • Under the SNP model, individual adult home operators would only be responsible for housing and meals. • To date, SNP has not been implemented.
<p><u>Coalition for the Homeless: Supportive Housing</u></p>	<ul style="list-style-type: none"> • Supportive Housing is a type of housing offering on-site supportive services to help people live successfully in community settings. The Coalition has various housing-plus-services configurations to meet this need. Supportive Housing came about as a way to address the needs of people who were never “institutionalized” and were relegated to life in shelters. New York/New York is a well-known example of a supportive housing finance mechanism through which the city and state share the cost of housing. • Supportive Housing projects range in size from 10 units to more than 600 units in one building. • Eligibility: Homeless with Mental Illnesses; AIDS population; Seniors; Low-Income Persons Who Work. • Services and themes of Supportive Housing: Permanent Housing; Voluntary Supportive Services; Integrated Housing; A flexible service package that changes as one’s needs change; Concrete Amenities (kitchenettes, private baths, community cooking & laundry facilities); Recovery-Oriented Approach. • Services are often offered by outside providers.

Presentation	Discussion
<p>Primary Care Case Management Model, Office of Mental Health</p>	<ul style="list-style-type: none"> • The PCCM Model is one utilized by the Office of Mental Health as a mechanism for implementing managed care for the Medicaid population, an alternative to the standard managed care programs. • Eligibility for PCCM: Medicaid eligible • Services covered by PCCM: PCCM contracts are established between PCCM providers and the State, and must minimally address primary care. Primary care includes: all health care services & laboratory services provided by a general practitioner, family medicine physician, internal medicine physician, obstetrician/GYN, or pediatrician. • Reimbursement to PCCM providers may be fee-for-service, capitation, or other method approved by CMS.
<p>Assertive Community Treatment (ACT)</p>	<ul style="list-style-type: none"> • ACT is a Fundamental Mental Health Service that has a mobile team based approach with low client-staff ratios (10 clients per 1 staff member). ACT operates on a shared caseload approach. • Eligibility for ACT: ACT serves persons that have not been successfully treated in other programs and those with the most serious symptoms of mental illness. • Services supported by ACT: Comprehensive & flexible treatment, support & rehabilitation services. ACT teams consist of people experienced in psychiatry, psychology, nursing, social work, rehabilitation, substance abuse treatment. All staff have a shared responsibility of care. ACT allows individuals to learn skills in housing, empowerment, daily activities, money management, medication support, problem solving. Program staff work closely with each individual to develop a plan that helps the recipient reach his/her goals.

Presentation	Discussion
<p>Peer Bridging</p>	<ul style="list-style-type: none"> • The purpose of peer bridging is to adapt a model of peer supports for adult home residents that helps support individuals to capably move towards recovery and transition successfully from institutions into their home communities. • Population of focus for Peer Bridging: Adult home residents with psychiatric disabilities. • Services supported by Peer Bridging: Peer Bridgers lend personal experience, skill and training to offer adult home residents: personalized support services in support of newly developed recovery goals; individual and group self help support; community escort services; linkages to community services and natural supports; independent living skill training; empowerment training and advocacy support to residents; crisis support services. Peer bridgers provide both intensive support to specific adult home residents and also offer in-home self-help groups to all residents.
<p>Bazon Center for the Mental Health Law</p>	<ul style="list-style-type: none"> • Restructuring of resources throughout the state is necessary. Financing approaches to this restructuring include: <ol style="list-style-type: none"> 1) Reallocation of Medicaid money: redirect money that is financing adult homes to other models, at least the state supplement portion if SSI. 2) Opportunities of the Waiver Program: Create more integrated settings; assist people in adult homes with case management; provide rehabilitation services; assistance accepting community housing. <ul style="list-style-type: none"> - The Managed Care waiver is the traditional approach since it targets the population wanted: <ol style="list-style-type: none"> a) at risk of being admitted into an adult home; b) in an adult home; c) leaving an adult home. • Homes with smaller numbers of residents tend to be more beneficial for the residents. Negotiate with homes and make it more attractive to reduce in size. Evidence shows that the medically frail population and individuals with behavioral disorders benefit from smaller homes. • Re-defining services provided the homes would increase services provided by community-based service providers.

New Models Workgroup Site Visits

Model	Type	Resident Eligibility	Services	Site Themes/Values
<u>The Kelly</u>	<u>SRO Transitional Housing</u> <ul style="list-style-type: none"> • 40 Transitional Beds <ul style="list-style-type: none"> - 21 beds – MI long-term shelter users - 19 beds – MI living in public places • Shared bathrooms, Community Dining Area • Some private bedrooms 	<ul style="list-style-type: none"> • Long-term shelter stayers • More serious psychiatric problems (SPMI) • Co-occurring chemical dependency, medical conditions, etc. 	<ul style="list-style-type: none"> • Performance based contracts • Case Manager assigned to each resident. Assists with medical/MH stability • Med. Room staff in charge of meds. • Recipient expected to clean own room • Group Activities 	<ul style="list-style-type: none"> • 6-9 month stays • Goal to improve quality of life • Strong recovery culture • Outcome oriented standards • Low demand, high reward service model • Culture of encouragement
<u>The Euclid</u>	<u>SRO – Mixed Housing</u> <ul style="list-style-type: none"> • 292 Single Rooms with a sink and refrigerator 	<ul style="list-style-type: none"> • Age 50 and over • Must be able to live independently • Low income • Single • 6 months sobriety 	<ul style="list-style-type: none"> • 2 teams: including a team leader and 3-4 program aides. (18 total staff) • Case management services • Individual counseling • Recreation programs • Psychiatric consultation • MH services off-site 	<ul style="list-style-type: none"> • Permanent supportive housing for single, low-income adults • Age 50 and above

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<u>DePaul</u>	<p><u>Service Enriched SRO</u></p> <ul style="list-style-type: none"> - Cornerstone (former adult home) 100 beds - Edgerton – 85 beds • Private rooms/apts (Studio-type), with sink, microwave and refrigerator (kitchenette) • Private bathrooms (Edgerton) 	<ul style="list-style-type: none"> • Chronically mentally ill • Includes formerly homeless persons with mental illnesses 	<ul style="list-style-type: none"> • 2 Case Managers in Cornerstone, 2 in Edgerton • Medication room • Cafeteria style meals • Director of Dietary Maintenance • Recreation Director • MH treatment plan designed w/ resident upon admission 	<ul style="list-style-type: none"> • 100% impacted home • Support for success in goals • Housing as a right
Pathways to Housing	<p>Supported Housing Program</p> <ul style="list-style-type: none"> • Scattered-site, integrated, individual apts. • Studio Apts., one & two bedroom 	<ul style="list-style-type: none"> • Homeless individuals with severe psychiatric disabilities • Homeless, co-occurring substance abuse 	<ul style="list-style-type: none"> • ACT Team Support Services (24 hr. coverage). Each team has a leader, 6-7 service coordinators, 1 psychiatrist, 1 nurse practitioner (either family or psychiatric) , 1 nutritionist, 4 nurses, family therapist, substance abuse specialist, and vocational director. • Nurses package meds as needed/service coordinators deliver meds to residents. 	<ul style="list-style-type: none"> • Housing is a right • Gives immediate access to an apartment of one's own • Uses “harm reduction” model • Consumer choice is key • 85% success in keeping people in housing.

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			<ul style="list-style-type: none"> • Meals on own: nutritionist available • Complete MH status exams • Residents are expected to do own housekeeping once skills are developed • Some consumers are employed by agency to gain employment skills 	
129th Street Residence	<u>Licensed Adult Care Facility</u> <ul style="list-style-type: none"> • 82 residents 	<ul style="list-style-type: none"> • minimum age of 40 • ambulatory • in need of level of service offered by a congregate adult residence • firm source of income 	<ul style="list-style-type: none"> • 24-hr staffing & security • housekeeping services • on-site nursing services by outside agency • benefits and entitlements assistance • full meal program • medication supervision • on-site psychiatric services • most MH treatment is received off-site 	<ul style="list-style-type: none"> • Continuing pro-active commitment to serving homeless persons and persons with serious mental illnesses. • Every staff member and resident is treated with dignity and respect. • Ultimate goal of building a community of respect and trust, promoting each person's independence & safety.

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The RIO	Permanent Supportive Housing <ul style="list-style-type: none"> • 82 Units including 75 efficiency units for single adults and 7 two-bedroom units for families 	<ul style="list-style-type: none"> • homeless single adults • low-income working people and families • population includes mentally ill, substance users, HIV/AIDS, and other special needs 	<ul style="list-style-type: none"> • On-site services: education & employment assistance, relapse prevention services, assistance with daily living, health care services, parenting groups, recreation activities, recovery support groups. • Services are flexible and individualized to meet each resident's need. 	<ul style="list-style-type: none"> • RIO offers permanent, affordable housing with supports designed to maximize residential stability and assist with community integration to function as independently as possible. • Strong emphasis on resident participation in management of the building.
Times Square	Permanent Supportive Housing <ul style="list-style-type: none"> • 652 studio apartments <ul style="list-style-type: none"> - 326 units are reserved for formerly homeless individuals - 200 units are reserved for individuals with a psychiatric disability - 50 units are reserved for individuals with AIDS 	<ul style="list-style-type: none"> • Population includes: formerly homeless with physical and psychiatric disabilities, AIDS, low-income working individuals 	<ul style="list-style-type: none"> • On-site services: education & employment assistance, relapse prevention services, health care services, assistance with daily living activities, parenting groups, recreational activities • Numerous specialist positions, part-time nurse and psychiatrist • Services are flexible and individualized Job training and employment program 	<ul style="list-style-type: none"> • Permanent, affordable housing with supports designed to maximize residential stability and assist with community integration to function as independently as possible.