**Revised Guidance Effective February, 2021**

**Assignment of Persons with Assisted Outpatient Treatment Court Orders**

**to Care Management in a Health Home Environment**

**Introduction:**

The New York State Office of Mental Health (OMH) recently developed standards for Specialty Mental Health Care Management. This new set of guidance outlines standards of care for persons with Serious Mental Illness (SMI) who meet certain indicators for high need, such as risk for disengagement from care and/or poor outcomes (e.g., multiple hospitalizations, incarceration, and homelessness). As part of the eligibility criteria for persons who meet this level of care, persons with an active Assisted Outpatient Treatment (AOT) order meet eligibility to receive HH+ services for up to 12 consecutive months. Health Homes and their Care Management programs should accordingly be familiar with the statutory basis of the AOT Program (Section 9.60 of the New York Mental Hygiene Law (MHL)), and all associated reporting requirements detailed in the law.
This includes policies by the mental hygiene department of the County or the City of New York, i.e., the Local Governmental Unit (LGU).

A description of the AOT Program, and the procedures under which a court may order an individual to AOT status, is detailed on the OMH website at: https://my.omh.ny.gov/bi/aot

This guidance will focus on individuals under active AOT orders who are assigned to receive health home care management services. Every individual with an AOT court order must either have a care manager or be assigned to an Assertive Community Treatment (ACT) team (in areas of the State where the ACT program is available).
As stated in the interim guidance cited above, an AOT court order may require that an individual participate in a Health Home for the purpose of receiving care management.

Under Section 9.60 of the Mental Hygiene Law, any AOT order must include either care management services or ACT services as part of a court-ordered treatment plan. This is true for all persons on AOT status, whether or not they are Medicaid recipients and whether or not they are enrolled in a Health Home.

**Care Management Agencies (CMAs) Eligible to Serve HH+ Individuals**
Effective March 8, 2021, only CMAs designated by the NYS OMH as Specialty Mental Health Care Management Agencies (SMH CMAs) will be eligible to enroll newly referred individuals meeting HH+ SMI eligibility criteria. Only Specialty MH CMAs with authorization by the State, LGU and lead Health Home(s) will have the ability to accept referrals, serve and bill HH+ for individuals on AOT.

**Assignment:**

For Medicaid recipients on AOT status who are already assigned to a Health Home:
The LGU/SPOA must communicate with the Health Home and health home care management program to let them know that their member is now on AOT status. This will prompt an assessment of need to assure that the individual is assigned to a designated specialty mental Health care management program and will be provided the appropriate level of intensity of care management services.

For Medicaid recipients on AOT status who are not yet assigned to a Health Home:

The LGU/SPOA will make a referral to a designated specialty mental health care management program that best meets the individual's needs. It will then be the responsibility of the health home care management program to assign that person to a Health Home.

For those recipients on AOT status who are not Medicaid eligible:

The LGU/SPOA shall assign the person to a designated specialty mental health care management program with a history of providing targeted case management services to individuals with serious mental illness.

**REMINDER: Funding for all individuals with mental illness who are not eligible for Medicaid services is provided by OMH via contract with the appropriate local government units. Since it is likely that some persons on AOT will not be Medicaid eligible, OMH will continue to support the health home care management providers with this funding.**

**Accelerated Access:**

The establishment of a good working relationship and an organized process is critical among the LGU/SPOA, Specialty Mental Health care management agencies who serve both Medicaid and non-Medicaid enrolled individuals, managed care organizations, DOH, and Health Homes. Continuing cooperation among these entities is essential to ensure that individuals receive care management services as required by the AOT order, and are able to access coordinated services pursuant to their AOT treatment plans without delay.

If localities are in compliance with the requirements of the AOT law, OMH will not prescribe a specific local process that must be followed by community partners to ensure that persons on AOT status receive care management and other coordinated services in a timely manner. OMH does suggest, however, that LGU/SPOAs consider creating the same or similar processes where Health Homes serve more than one county so the Health Home does not need to manage several different processes based on what county in which the individual on AOT status resides.

In addition, there are individuals who have agreed to an "enhanced service plan" as a less restrictive alternative to the formal AOT process. These individuals will not be on AOT status but will also need to have accelerated access to health home care management services. The process for this informal status may vary from county to county. Where this informal status is utilized it will again be important for the LGU/SPOA, health home care management program, managed care organization, DOH, and Health Home to partner and develop a process to expeditiously assign the individual to a health home care manager.

Accelerated access to care management also supports the evidence-based practice of critical time intervention (CTI). Individuals need support when they are in periods of transition. Individuals moving

from inpatient status or jail/prison to the community are far more likely to have a successful community tenure if they have rapid access to health home care management services and enhanced service planning.

**AOT Requirements:**

The need to comply with the AOT law is part of the spending plan guidelines[1] that OMH issued for the care management state aid (for non-Medicaid eligible individuals and for service dollars). OMH suggests that the county mental hygiene department director, known as the "Director of Community Services," should seek to include language in any agreements between the County and the health home care management agency ensuring appropriate compliance with the order and effective communication between the health home care management program, county, and the Health Home.

For individuals on AOT status, the requirements for documentation and reporting are specific and additional to expectations for those who are not on AOT status in the care management program. As stated above, the care management program is contractually obligated to comply with requirements set forth by the LGU or as required by OMH spending plan guidelines.

It is expected that individuals on AOT status will only be assigned to legacy health home care management programs. It is critical that the appropriate intensity of care be assessed, established and maintained by the care management program for all individuals on AOT. An AOT order may be prescriptive in specifying the level of intensity a recipient must receive from the care management program.

The following are a subset of Program Standards required for persons on AOT status that may be found at: https://my.omh.ny.gov/analytics/saw.dll?dashboard

- Care management programs are expected to have contact at least weekly with county AOT personnel regarding the individual's compliance or lack of compliance with treatment. Care management programs are expected to notify the Director of Community Services (DCS), or designee, immediately when a person under an AOT court order has an unexplained absence in a treatment program or place of residence. The program must also document the date and time he or she was notified by the treatment provider or housing provider that the individual was absent.
- Care management programs are expected to contact any person or persons who may reasonably have knowledge of the AOT recipient's whereabouts within 24 hours of being informed that a person subject to an AOT order's whereabouts are unknown. Efforts to contact persons who may have knowledge of the whereabouts of such individual should be documented, together with the results of that effort.
- If the recipient of AOT services has not been located within the initial 24 hour period, the care manager will be expected to continue trying to locate such individual, and contact the following, within 48 hours of being informed that such individual's whereabouts were unknown:
    - Local hospitals,

[1] Spending Plan Guidelines are located at: https://apps.omh.ny.gov/omhweb/spguidelines/

  - Morgues,
  - Shelters, and
  - Local jails.
- If a recipient of AOT services cannot be located, and has had no credibly reported contact within 24 hours of the time the Care Manager received either notice that the patient has an unexplained absence from a scheduled treatment appointment or other credible evidence that an AOT recipient could not be located, the person will be deemed Missing.
- Once the AOT patient is deemed Missing, it is expected that a Missing Person Report shall be filed by the care management program with local police within 48 hours after the initial notice of the AOT patient's unexplained absence, or receipt of any other credible evidence that an AOT patient may be missing.
- Once a person is determined missing, the care management program will be required to submit a Significant Event Report, consistent with OMH standards, to:
  - The AOT Program, and
  - The DCS.
- The care management program will be required to make daily calls to the residence of the missing AOT recipient for the first three days after the person is deemed missing, and weekly calls thereafter for the duration of the order, or until the missing AOT recipient is located. Such contacts may occur more frequently, to the extent appropriate, considering the circumstances of the particular case.
- The care management program will be expected to make weekly calls to local hospitals, shelters, morgues and jails in search of the missing person for the following 2-month period, and thereafter as appropriate, for the duration of the order.
- The care management program will be required to provide the AOT Program with weekly updates concerning efforts to locate the missing AOT recipient, and the results of such efforts.
- If and when the person is located, the care management program will be expected to promptly notify the AOT Program.
- The care management program will be expected to maintain contact with AOT recipients and the providers while they receive inpatient services. In an acute-care setting, the minimum one face to face check in per week is expected to continue. If the recipient is in a longer term setting, the care management program will be expected to have contact with the recipient once per month. The care management program is also expected to have weekly contact with mental health providers/staff at the facility where the AOT recipient is located.

**Summary:**

- All parties must become familiar with the AOT statute (MHL section 9.60) and OMH guidance regarding AOT.
- There are local partnerships that must be developed in order to facilitate assignment of AOT status individuals to health home care management.
- There are separate legal reporting and documentation requirements for individuals on AOT status that are different from the guidance provided by DOH for the general health home care management population.