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Safe Options Support (SOS) Program: Older Adult & Medically Fragile Support Team

Request for Proposals
Bidder's Conference

May 14, 2024

New York State's Expanded Homeless Initiative

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

NYS Expanded Homeless Initiative

- The Safe Options Support Team initiative launched in NYC in April 2022 with 4 teams located in Manhattan.
- There are 14 SOS Teams now operating throughout Manhattan, Bronx, Brooklyn and Queens, and 2 additional teams expected to launch in Queens and Staten Island in Summer 2024.
- 7 SOS Teams are now operating in areas outside NYC, and 4 additional teams were recently awarded in locations across NYS.

SOS CTI Award Information

- The SOS initiative is now expanding to offer specialized services for older adults and individuals with existing chronic medical conditions.
- OMH intends to issue one (1) award through this RFP for a team to serve individuals enrolled in SOS services in the Bronx, Brooklyn, Manhattan, and Queens.
- The team award will be made in the amount of $3,589,000 for five (5) years. Annual funding for each of the five (5) years is $717,800.

Safe Options Support (SOS) CTI Teams: Overview

SOS CTI Teams Overview

- The SOS CTI Teams use an evidence-based Critical Time Intervention (CTI) approach to provide intensive outreach, engagement and care coordination services to unsheltered individuals for up to 12 months, pre- and post-housing placement, with an intensive initial outreach and engagement period.
- The teams provide coordinated care transition activities and support, starting from the time of referral through transition to community housing, treatment and supports.

SOS CTI Teams Overview

- CTI promotes community integration, self-advocacy, and continuity of care by ensuring that the participant has strong ties to their professional and nonprofessional support systems during critical periods of transition.
- The teams work with members and their professional and natural support networks to build skills and strengthen supports so that care can successfully be transferred within 12 months.

Older Adult & Medically Fragile Support Team

Older Adult & Medically Fragile Support Team

- Approximately 42% of current NYC SOS members are age 51+, many of whom are living with unmanaged chronic disease and limited access to healthcare.
- Older adults with histories of homelessness often have greater functional impairments and behavioral health challenges, as well as increased social isolation and limited connection to their communities.

Older Adult & Medically Fragile Support Team

- The Older Adult & Medically Fragile Support Team will work collaboratively with the NYC SOS CTI Teams to offer short-term interventions and specialized services to older adults and medically fragile individuals who are enrolled in SOS services.
- The target population is adults 50+ with unmet age-related needs, and individuals with existing chronic medical conditions who are currently unsheltered, in temporary shelter settings, or recently transitioned into stable housing.

Older Adult & Medically Fragile Support Team

- The Older Adult & Medically Fragile Support Team will work in close collaboration with primary care physicians, specialty care providers, hearing/vision providers, and housing providers to ensure that SOS members are receiving all services and supports needed to live in the least restrictive environment possible.
- Services will be delivered both in the member's home and in the community, including shelter settings, temporary housing placements, or other settings of the member's choice.

Older Adult & Medically Fragile Support Team

- The Older Adult & Medically Fragile Support Team is expected to be well versed in trauma responsive approaches and communications, culturally responsive and inclusive, and to show sensitivity toward individuals' personal stories.
- The team must also be well versed in the various Medicare and Medicaid Health Plans (e.g., Managed Long-Term Care Plans, Medicaid Advantage Plans, etc.) for older adults and able to establish collaborative relationships with health plans.

Referrals to Older Adult & Medically Fragile Support Team

Referrals

- Referrals will be made by the NYC SOS CTI teams in coordination with the SOS Referral Hub. The Referral Hub and the Older Adult & Medically Fragile Support Team will work closely with the NYC SOS CTI Teams to identify enrolled members in need of this enhanced level of support.
- The Older Adult & Medically Fragile Support Team will work in close collaboration with the SOS Referral Hub, SOS CTI Teams, NYC's Street Homeless Outreach Teams, hospitals, and others to coordinate efforts and prevent any duplication of services.

Staffing & Hours of Operation

Hours of Operation

- The Older Adult & Medically Fragile Support Team will have hours of operation that match the unique needs and availability of the individuals whom they serve.
- Flexible work schedules, including early morning and evening hours, may be necessary to facilitate better engagement.

Team Staffing

- The Older Adult & Medically Fragile Support Team will be comprised of 5.0 FTE's:
    - 1.0 FTE Team Leader
    - 1.0 FTE Occupational Therapist
    - 1.0 FTE Geriatric Registered Nurse
    - 2.0 FTE Licensed Social Worker with expertise in gerontological social work

Startup Activities

- Team start-up will include the involvement of OMH and other key agencies to provide support around the development of the team.
- Monthly calls and/or meetings will be held to provide technical assistance and ensure the delivery of services consistent with programmatic objectives.

Objectives & Responsibilities

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- The Older Adult & Medically Fragile Support Team will have a clear understanding of the service needs of older adults, including but not limited to older adults living with Serious Mental Illness, as well as a demonstrated ability to coordinate services internally and externally.
- The Team should be knowledgeable about the complex interplay between physical health and mental health experienced by older adults with co-occurring complex medical conditions.

Objectives & Responsibilities

Team responsibilities include, but are not limited to:

- Assessing for specific risk factors associated with aging;
- Completing evaluation of members to determine priority areas of occupational performance/participation;
- Assisting in implementing environmental, adaptive, and compensatory modifications;
- Providing support to help individuals adapt to the physical or cognitive mental disabilities that occur later in life;
- Assessing for mental status and cognitive skills, understanding acute and chronic health issues, and discussing common health concerns;

Objectives & Responsibilities

- Connecting individual to a primary care physician and/or coordinating with primary care physician on supports needed to maintain highest level of physical, cognitive, mental, and emotional wellbeing;
- Providing support for individuals with visual or hearing impairments;
- Assisting with applying for/accessing long-term care options available through Medicaid, Medicare, and local Offices for Aging, including skilled home health services, home health aide services, personal care, and the consumer-directed personal assistance program (CDPAP);
- Assisting with linkage to social adult day services, non-Medicaid transportation, meals and nutrition services, Medicare options, and NY Connects;

Objectives & Responsibilities

The team will also work in collaboration with OMH and the NYC SOS Hub to increase the education and knowledge of SOS CTI Teams in areas including, but not limited to:

- Community resources available specifically for older adults;
- Ways that serious mental illness manifests in older adults;
- Mental health problems among older adults, such as: substance use, dementia, psychosis, sleep and behavior disorders, cognitive decline;
- Impacts of social isolation/loneliness, bereavement, family dynamics, and loss of independence;
- Trauma responsive approaches for aging adults and individuals experiencing multimorbidity.

Quality Infrastructure and Reporting Requirements

Quality Infrastructure / Reporting Requirements

- Provider will be expected to participate in a SOS CTI Team active learning community, in collaboration with OMH, to review progress, outcomes and develop best practices.
- Submission of regular reports to OMH is required, including but not limited to length of service, characteristics of individuals served, diagnosis, services provided, disposition, and follow up.
- Provide information regarding performance indicators demonstrating continuity of care and improved social determinants of health and community tenure.

Quality Infrastructure / Reporting Requirements

- Ensure ongoing quality improvement, including analyzing utilization review findings and recommendations.
- Measure timeliness of services, disposition, and outcomes to inform the agency's overall quality improvement plan.
- Participate in site visits and ensure regular monitoring and evaluation of outcomes.

Documentation & Use of Technology

Documentation and Use of Technology

- All applicants should have an electronic health record (EHR) that can document referrals, assessments, and each encounter with the recipient.
- Applicants must describe how they will utilize digital technology to support client engagement in care and describe digital tools available to staff, as well as those available to clients.
- Providers should maximize the use of technology to help support the team's communication and quality improvement efforts, as well as each member's wellness and recovery goals.

Proposal Narrative

Proposal Narrative & Population

Proposal narratives must address all components listed in the RFP including, but not limited to:

- Understanding of service needs of older adults who are homeless or unstably housed, including those who have SMI or co-occurring disorders;
- Clinical approaches and/or best practices in treatment and care for older adults who have SMI, co-occurring substance use disorders, physical health conditions, history of complex trauma and extensive complex medical needs;
- Familiarity with NYC housing options for older adults, including senior housing, assisted living, and skilled nursing facilities, and experience accessing these levels of care.

Description of Program

- Description of services to be provided and efforts to ensure continuity of care;
- Partnerships with internal and external systems of care;
- Practices and approaches to assess for specific risk factors associated with aging;
- Collaboration with housing providers on the use of assistive devices, home modifications, and wrap around services;
- Collaboration with health plans, including managed long-term care (MLTC) plans, to coordinate services and improve access to long-term care options.

Implementation

- Startup and phase in activities, including timeframes;
- Physical space and equipment;
- Roles and responsibilities of staff and plans for providing supervision;
- Recruitment and training, including specialized trainings for this target population;
- Use of data and technology to promote best care and achievement of recovery goals.

Agency Performance

- Agency mission, services provided, and populations served;
- Achievements in quality, fiscal stability, and mission of the agency;
- Experience in providing culturally and linguistically relevant services.

Utilization Review, Reporting, and Quality Improvement

- Methods of ensuring confidentiality;
- Plans for integrating the Older Adult & Medically Fragile Support Team into the overall quality improvement infrastructure;
- Participation in OMH's active learning community.

Diversity, Equity, Inclusion and Recipient Input

- Diversity, inclusion, equity, cultural and linguistic competence plan for the program;
- Involvement in committees/workgroups that focus on reducing disparities;
- Efforts to recruit, hire and retain staff from prevalent cultural group of service users, and staff with lived experience;
- Efforts to meet the language access needs of the clients served.

Financial Assessment

- 5-year budget for the team;
- Plan for how agency will manage its operating budget, including detailed expense components and the calculation or logic that supports the budgeted value of each category.

Timeline and Questions

Key Events/Timeline

• RFP Release Date	04/16/24
• Bidders Conference	05/14/24
• Questions Due	05/21/24
• Questions and Answers Posted on Website	06/04/24
• Proposals Due by 2:00 PM EST*	06/25/24
• Anticipated Award Notification	07/23/24
• Anticipated Contract Start Date	01/01/25

Questions?

- Questions and requests for clarification will now be taken in the chat box on the right side of your screen.
- The questions and official answers will be posted on the OMH website on 6/4/2024.
- Additional questions or requests for clarification concerning the RFP must be submitted in writing to the Issuing Officer by e-mail to OMHLocalProcurement@omh.ny.gov by 2:00 PM EST on May 21, 2024.