Health Care Facility Discharge to NYC Department of Homeless Services (DHS)

Institutional Referral Decision Aid: Mobile Health Programs

Case management and treatment adherence services for people experiencing homelessness

Mobile Mental Health Programs for Serious Mental Illness

- Patients with serious mental illness (SMI) can benefit from supportive services to support treatment adherence. Mobile mental health programs aims to support patients with high services needs not engaged in traditional behavioral healthcare.
- If the individual has severe mental illness and is a chronic danger to self or other but lacks insight into their condition and declines mental health services, a referral can be submitted without patient consent and the program will outreach and attempt to engage in services over time. Please loop DHS into the referral to help advocate for expedited enrollment.
- Some programs may have waitlists. Programs that generally do not have waitlists include Sheltered Partnered Assertive Community Treatment (Shelter Partnered ACT), Medicaid Health Homes/Non-Medicaid Care Coordination, and Safe Options Support (SOS).

Mobile Mental Health Program	To refer patients
SPOA programs*	
Assertive Community Treatment (ACT) and Shelter Partnered ACT (SPACT) Treatment for people with SMI and high service needs not being met in traditional settings. People with SMI who are otherwise unable to connect to community treatment can receive clinical support from an interdisciplinary team, including medication management, behavioral health therapy, assistance with supportive housing applications, and advocacy for hospitalization. ▪ Shelter Partnered ACT (SPACT) for people assigned to designated mental health shelters ▪ Forensic ACT (FACT) for people with current/past criminal justice involvement	Online application via NYC DOHMH Single Point of Access (SPOA). A psychiatric and psychosocial evaluation are required. For SPACT only: if a psychiatric evaluation is not available, an observational mental health assessment can be submitted.
Intensive Mobile Treatment (IMT) For people with serious behavioral health concerns, very complex life situations, transient living situations and/or criminal justice involvement	Online application via NYC DOHMH Single Point of Access (SPOA). A psychiatric and psychosocial evaluation is required.
Non-Medicaid Care Coordination (NMCC) Care management services for high-need people with serious mental illness not eligible for Medicaid, including people with SMI not eligible for Medicaid waitlisted for ACT or IMT. (Clients eligible for Medicaid should enroll in Health Homes Plus/Health Homes, see next page.)	
Non-SPOA programs	
Pathway Home (Coordinated Behavioral Care) Provides day-of-discharge support and accompaniment, accompaniment to medical appointments, family conferences, benefits and entitlement support, expedited housing placement, enrollment in long-term case management services and other services. Learn more	Submit Pathway Home referral package. Contact PathwayHomeInfo@cbcare.org or (646) 930-8841 for questions.

*Psychotic disorder (schizophrenia, schizoaffective disorder), bipolar disorder and post-traumatic disorder are most appropriate for SPOA referrals.

Mobile Mental Health Program	To refer patients
Non-SPOA programs (continued)	
Health Homes Plus (HH+) Care management services for high-need Medicaid-eligible people with serious mental illness	Refer to CBC Health Home or another OMH Specialty Mental Health Care Management Agency.
Safe Options Support (SOS) Outreach and care coordination for patients experiencing street/subway homelessness. Services include: outreach and canvassing; assistance enrolling in housing/employment assistance, benefits, legal services; linkage to medical care, including substance use and behavioral health treatment	If client has a recent history of street or subway homelessness and is unlikely to enter shelter, refer to SOS. Email referral form to SOSInfo@cbcare.org, or call 1-866-SOS-4NYC to discuss referral

Primary and Specialty Care for People Experiencing Homelessness

If patient is unlikely to attend follow-up primary or specialty care appointment in a traditional health care setting, refer patient to clinical programs specialized in serving people experiencing homelessness.

Primary and Specialty Care	To refer patients
Safety Net Clinics Integrated primary care, addiction treatment and behavioral health care, care coordination, and linkage to specialty care for people with multiple chronic health conditions who are experiencing homelessness	Safety Net Clinic contact information for patient referrals
Street Health Outreach and Wellness (SHOW) vans Mobile clinic for health screenings and referrals; medical care, behavioral health resources, harm reduction, and material goods to people who are unsheltered or living on the street	Refer through Safetynet Clinic referral contacts

Other Mobile Health Programs

Other Mobile Health Program	To refer patients
Medicaid Health Homes People enrolled in a Health Home are assigned a care manager who will develop a care plan and connect enrollees to health care providers, behavioral health providers, medications, housing and social services. Eligible patients must have or more chronic conditions or one single qualifying chronic condition (HIV/AIDS, serious mental illness, sickle cell disease). Learn more	Contact a Health Home in the patient's borough of residence. To determine patient's borough of residence, contact the DHS Institutional Referral Program. Some Health Homes can accommodate multiple boroughs of residence.
Community health worker programs	Connect clients to a community health worker program at their facility.
Visiting health services or home care	Home care agencies can be found on the NYS Department of Health website.

For more information, contact the DHS Health Services Office at DHS-HCFReferral@dhs.nyc.gov.