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# Statewide Town Hall – November 2016

## A Vision for the NYS Public Mental Health System

**November 16, 2016**

Ann Marie Sullivan, M.D., Commissioner

# Presentation Outline

- OMH Mission and Vision – What drives the work
- OMH Strategic Framework- 5 key priorities
- Open questions, comments, testimony/ formal remarks

# OMH Mission

The Mission of the New York State Office of Mental Health (OMH) is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances.

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# OMH Vision

The Office of Mental Health envisions a future for the public mental health system and the citizens of New York State that will result in:

- Integrated, accessible, and sustainable systems of high quality, person-centered, resiliency-and-recovery-focused health and behavioral health supports and services.
- A strong continuum of institutional and community systems to support at-risk individuals, and promote individual and public safety.
- Mental and physical wellbeing, and community and social environments that reduce the incidence of disorders, eliminate stigma, and foster community inclusion.
- Population health, without disparities.

# Ultimate Goal to Achieve the "Triple Aim"

- **BETTER HEALTH OF THE POPULATION**:
  - Prevention and maximizing wellness and health promotion
- **BETTER CARE FOR EACH PERSON**:
  - Quality Care focused on patient choice, engagement, and satisfaction; clinical best practices; integrated care between medical and psychiatric services (mind and body); coordinated care; access to care when and where the individual needs it.
- **LOWER COST OF CARE**:
  - Performance based payment; value-based payment; more efficient and effective care that provides comprehensive ambulatory care (PCMH) and behavioral care and utilizes high cost inpatient care only when needed; risk based models such as the Accountable Care Organization (ACO); parity for mental health care

# Five Points of OMH Strategic Framework

1. Greater prevention, support and service access for children and families across the spectrum.
2. Expand early intervention and prevention statewide.
3. System Transformation to make community-based, community-integrated recovery a reality.
4. Provide appropriate housing for all individuals in need.
5. Improve safety, reentry, and recovery for at-risk individuals.

# Supporting Children and Families: Prevention, Promoting Wellness and Resiliency

The right services, at the right time, in the right amount

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# Many systems and approaches involved

- Promoting wellness and preventing disorders starts before birth- maternal health, family system strengths
- Interventions and events at earliest stages have lifetime impact
- Building capacity and competency beyond the “mental health system” required: OB/GYN, pediatric primary care, schools, social services
- OMH and wider NYS efforts to support children and families requires a coordinated strategy among multiple providers, systems, and stakeholders

# ACE (Adverse Child Experiences Study): The Need for Prevention

- Adverse Experiences: Childhood Abuse: sexual, physical, emotional; Household: substance abuse, mental illness, violence, imprisonment
- Prevalence: > 50% had one adverse experience; 25% 2 or more
- Mental Health : If 4 or more experiences 4 to 12 fold increase in alcoholism, depression, suicide attempts, drug abuse
- Physical Health: Strong dose response relationship with ischemic heart disease, cancer, lung disease, fractures and liver disease
- Recognition of importance in NYS: DOH including ACES questions in Behav. Risk Factors Surveillance System (BRFSS) survey for first time this year

ACE Study, Felitti MD et al, AM J Prev Med 1998:14(4)

# Healthy Steps for Young Children

- Enhanced well child care through PCPs Healthy Steps Specialist home visits at key developmental points.
- Healthy Steps development telephone information line.
- Staff provides child development and family health checkups
- Parent groups offer social support and interactive learning
- Staff provides linkages to community resources and facilitate parent to parent connections.
- Current pilot to implement in 19 offices

# Project TEACH: MH competencies in pediatric primary care

- First launched in 2010, Project TEACH has enrolled nearly 2,200 pediatric PCPs, providing consultation for 8,900 children.
- Through a $1.4 million expansion, Project TEACH is set to:
  - Enroll an additional 3,800 providers
  - Provide an additional 24,500 New York children with behavioral health consultations by 2020
- New contracts help support this goal:
  - Expanded scope and duties of regional providers of consultation services (psychiatry)
  - New Statewide Coordination Center (Mass General) to promote and increase utilization of TEACH by practitioners, expand training opportunities, and add specialty consultation

# Maternal Depression Screening

- OMH working with State DOH on implementation and promotion of maternal depression screening among pediatric and women's health care providers, pursuant to Chapter 199 of 2014 (NYS).
- NYS Insurance Circular Letter No. 1 (2016) issued by DFS asserts the legal requirement that insurers cover maternal depression screenings for pregnant and postpartum women at their OB/GYN or a pediatric office with no cost sharing - built on foundation of MH parity laws, and Chapter 199 of 2014.
- The screening and early interventions driven by these policies are highly effective in reducing costly and lengthy maternal and postpartum depression. Positive long term impact and savings for both mother and child health.

# Treatment and Support: Children's Managed Care

**Children's State Plan Amendment (SPA) – Major expansion for <u>all</u> <21**

- Crisis Intervention
- Community Psychiatric Support & Tx
- Psychosocial Rehabilitation Services
- Family Peer Support Services
- Youth Peer Training and Support
- Other Licensed Practitioner Services

**Children's HCBS (Proposed for 2017)**

- Habilitative Skill Building
- Caregiver/Family Support Services
- Prevocational Services
- Supported Employment
- Community Advocacy and Support
- Non-Medical Transportation
- Day Habilitation
- Respite (planned and crisis)
- Adaptive and Assistive Equipment
- Accessibility Modifications
- Palliative Care
- Care Coordination

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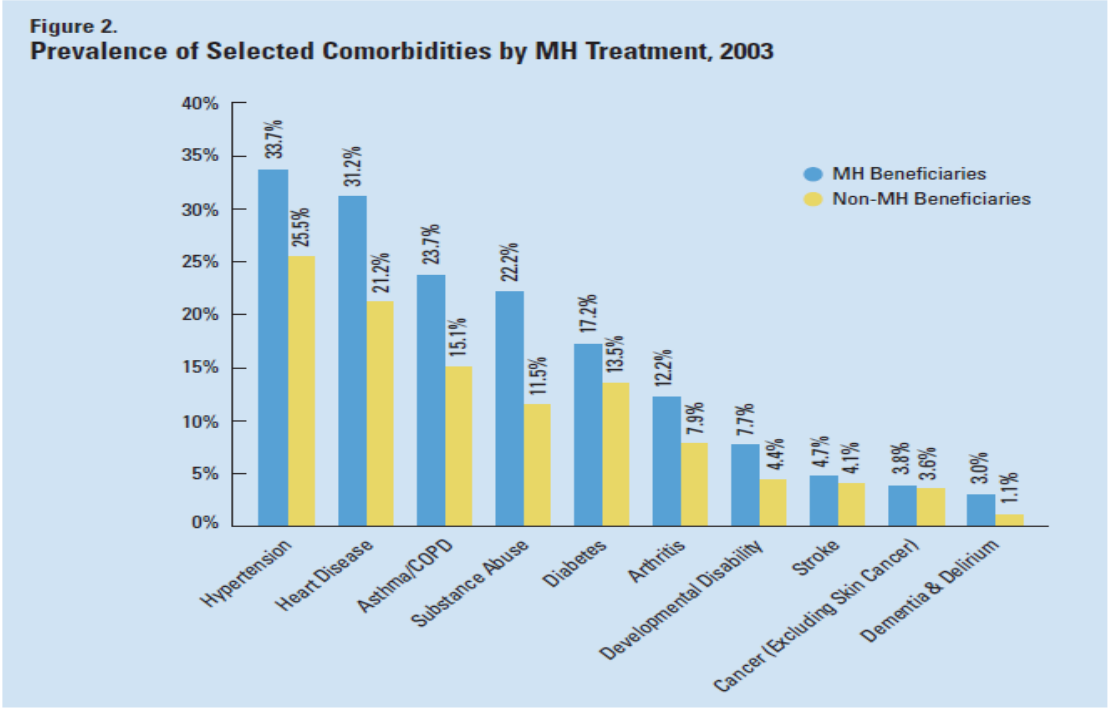
# Clinical Improvements for Prevention, Early Identification and Intervention, and Integration

# Making the case: Comorbid health conditions among Medicaid beneficiaries with mental illnesses




Source: United Hospital Fund, New York Beneficiaries with Mental Health and Substance Use Conditions, 2011

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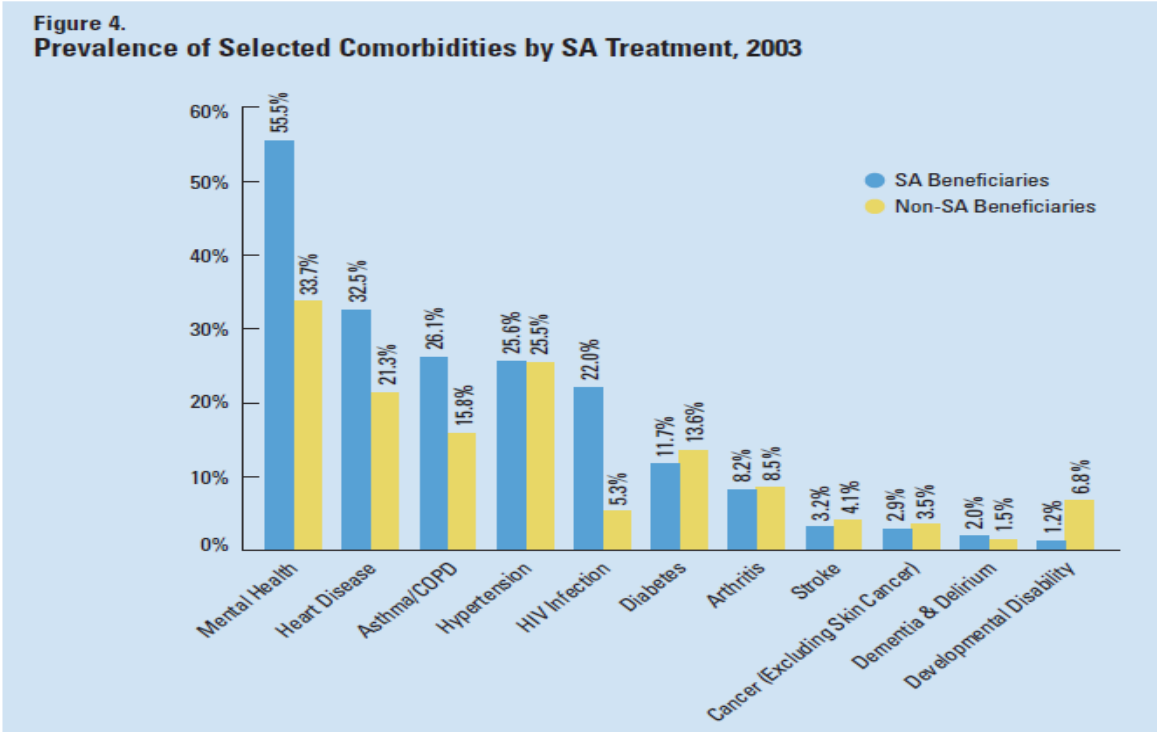
# Making the case: Co-occurring disorders among Medicaid beneficiaries with substance use disorders




Source: United Hospital Fund, New York Beneficiaries with Mental Health and Substance Use Conditions, 2011

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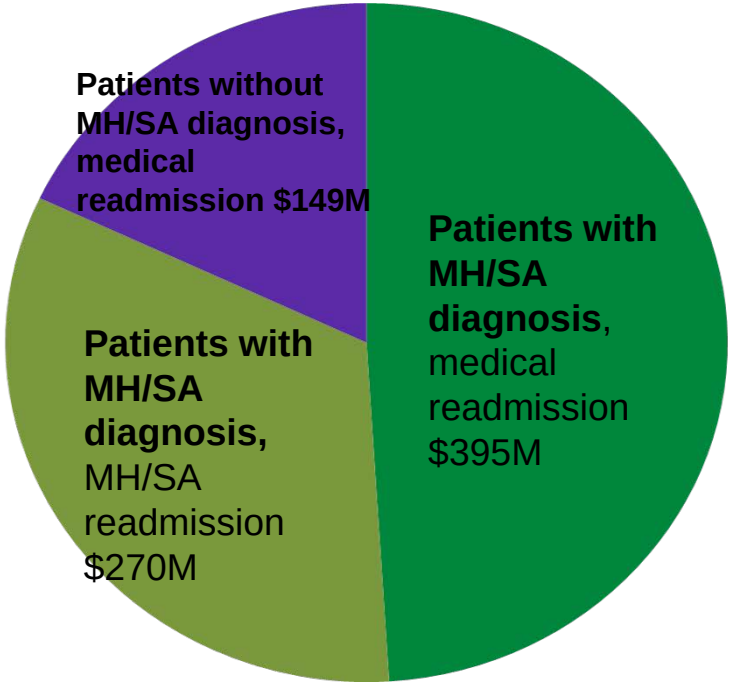
# The Need for Transforming and Integrating Systems of Care:
## Potentially Preventable Readmissions (PPR's)
## NYS Costs $814M (2007)

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# Population Health: Unipolar Depression

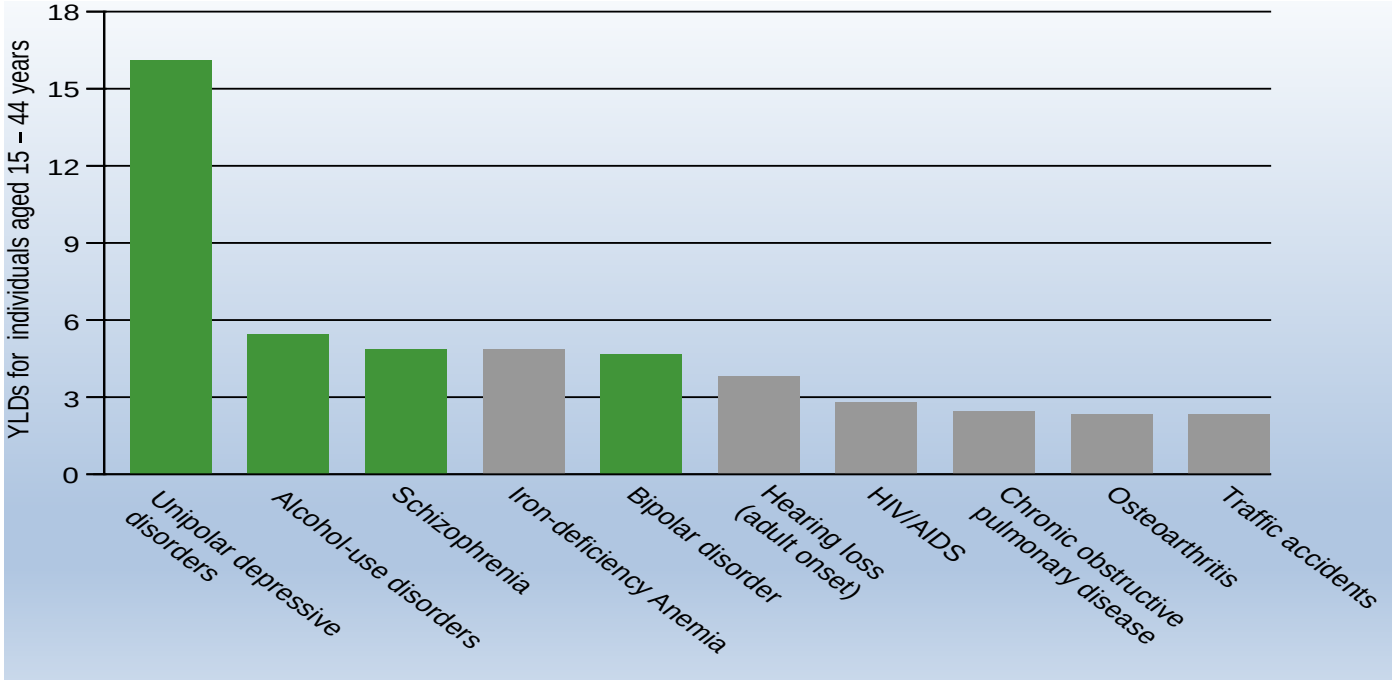
**Depression in US**

- Lifetime prevalence of significant depression in NCS (2001-2) 16%; 12 month prevalence 6.6%
- 42%-50% of significant depression in US is still untreated
- Still only 22% of patients treated receive evidence based care
- Lack of treatment increases inpatient days; results in poor compliance for chronic illnesses and poor outcomes
- High cost of depression functional disability in all societies; in US direct (care) costs and indirect (workplace costs) $ 210 Billion dollars in 2010.

**Primary Care in US**

- 6 to 9 % of primary care patients have a significant treatable depression
- Co-morbid depression increases morbidity and mortality in heart disease, diabetes, stroke
- Treatment: Impact Model Works

# Population Health: Neuropsychiatric diseases are among the top 10 causes of disability worldwide (ages 15-44)



# IMPACT Program

- Collaborative Care for late life depression
- Primary Care patients 60 and older with major depression or dysthymia
- Randomized trial 8 health centers and 18 clinics
- Treatment: Pharmacologic and Care Management
- Outcomes: >50% drop in SCL-20 depression scores at 6 months and 12 months

# Collaborative Care in New York State

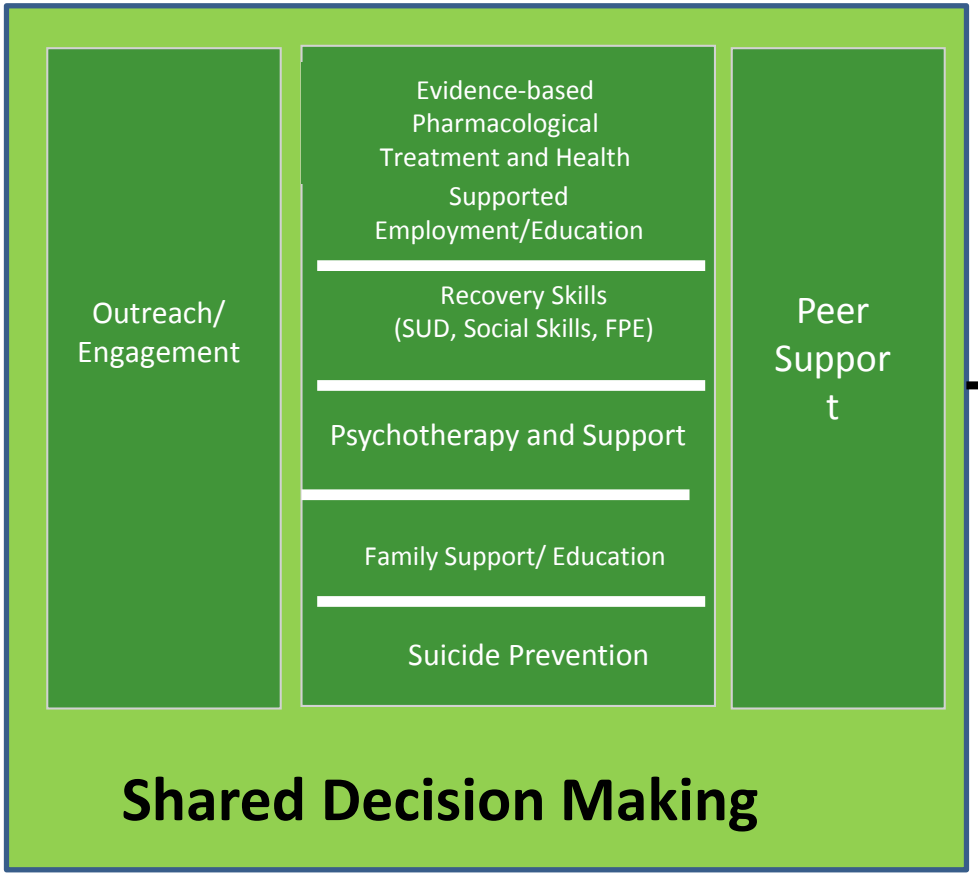
- FQHC's: 25 across the state have implemented collaborative care for depression in primary care; supported by grants CHCANYC and MHANYC
- NY State OMH/DOH 2 year funding to establish collaborative care in 20 Academic Medical Centers and 31 primary care clinics
- Geriatric demonstration Project: over 20 sites collaborative care in primary care and behavioral health
- DSRIP: all 22 PPSs chose collaborative care treatment for depression/substance use in primary care; 5 for integrated in behavioral settings
- Challenges: Rate/payment/structure to sustain these and other programs (e.g., rate increase for implementing collaborative care for depression); regulatory relief for collaborative care in primary care and BH settings.

# OnTrackNY

My health. My choices. My future.

OnTrackNY is an innovative treatment program for adolescents and young adults who recently have had unusual thoughts and behaviors or who have started hearing or seeing things that others don't. OnTrackNY helps people achieve their goals for school, work, and relationships.

# OnTrackNY Team Intervention




4.0 FTE

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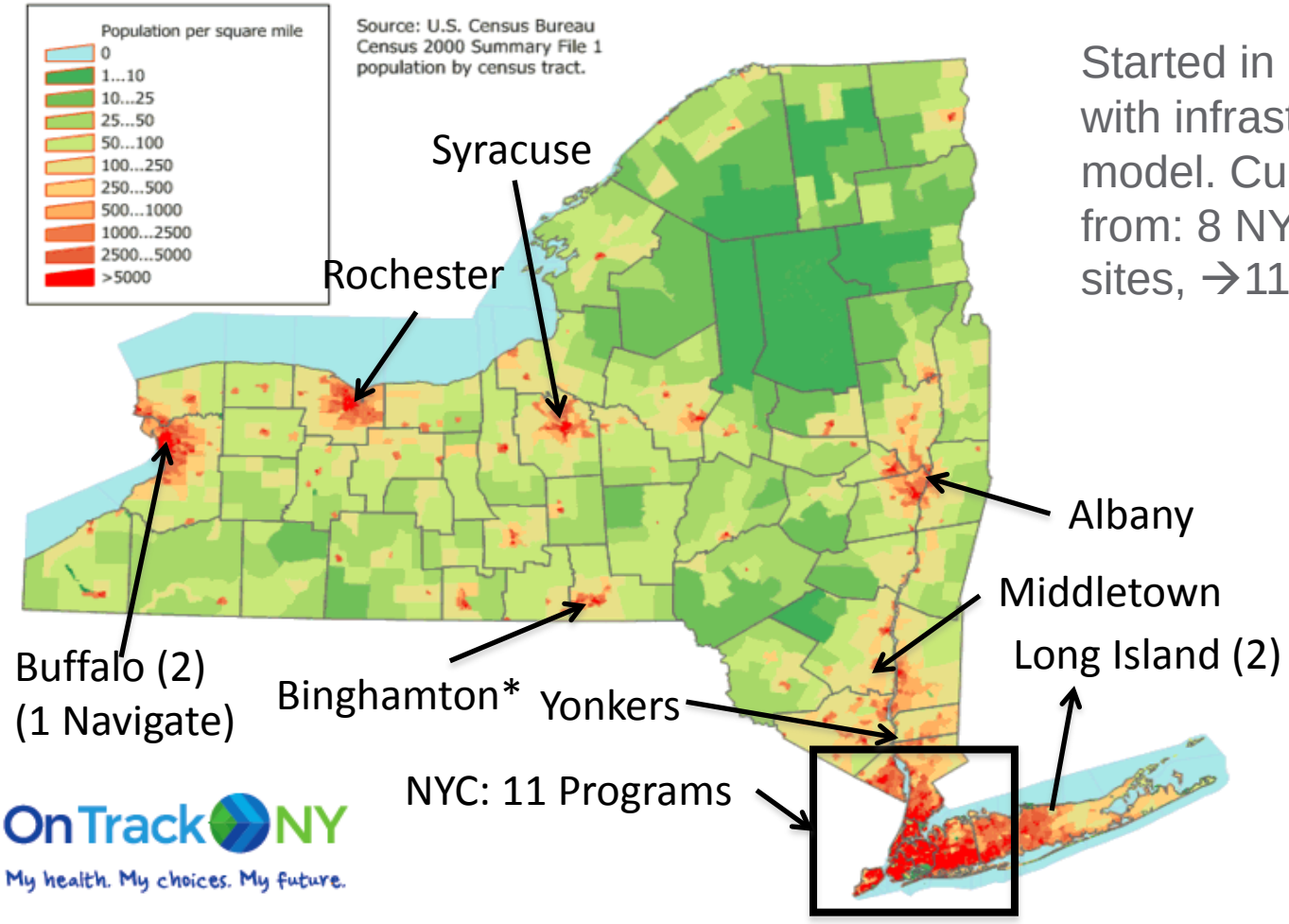


Started in population centers with infrastructure to support model. Currently Expanding from: 8 NYC and 6 ROS sites, →11 NYC and 10 ROS

OnTrackNY
My health. My choices. My future.

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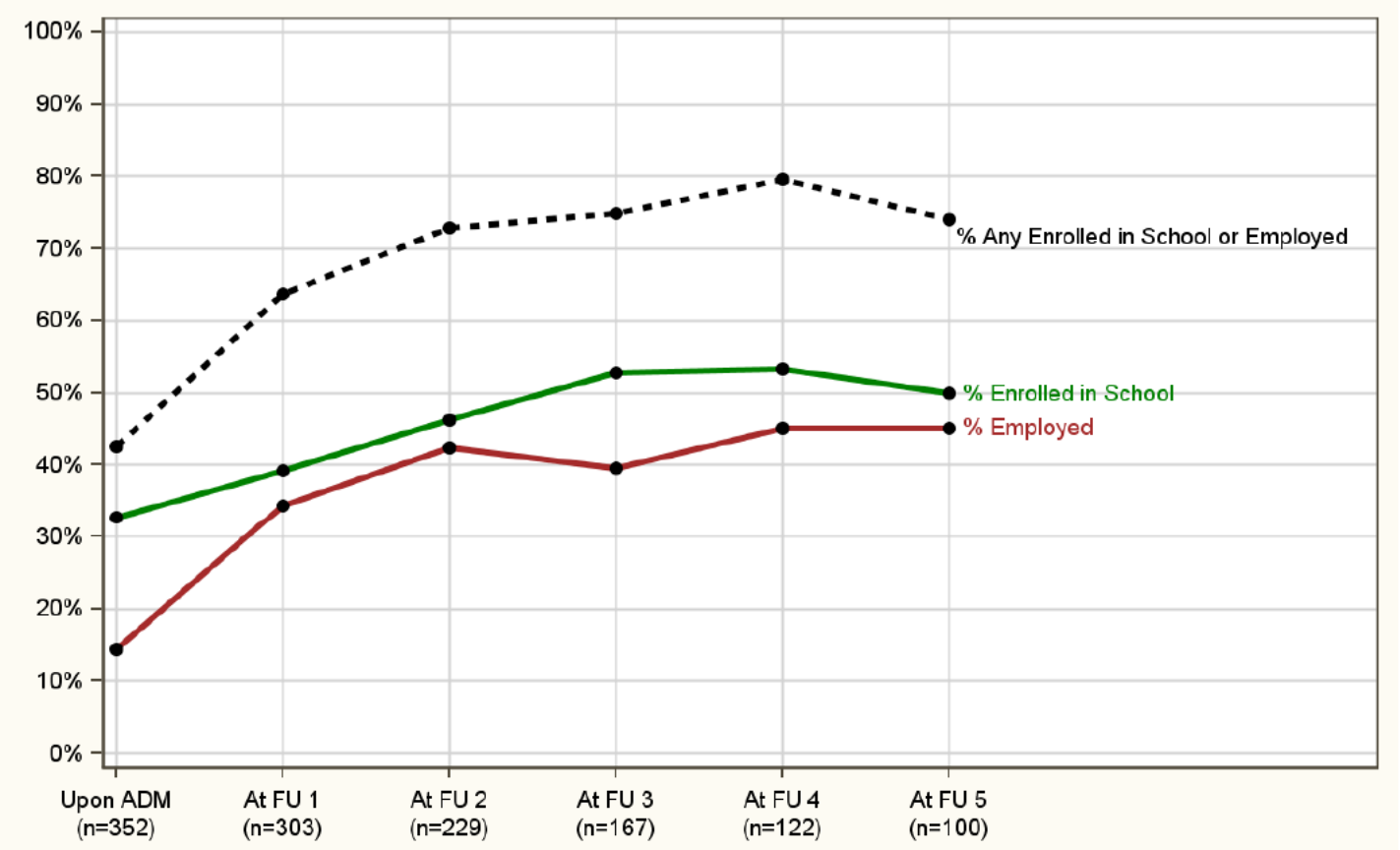
# % of OnTrackNY Clients Working or in School in Last 3 Months through 6/16

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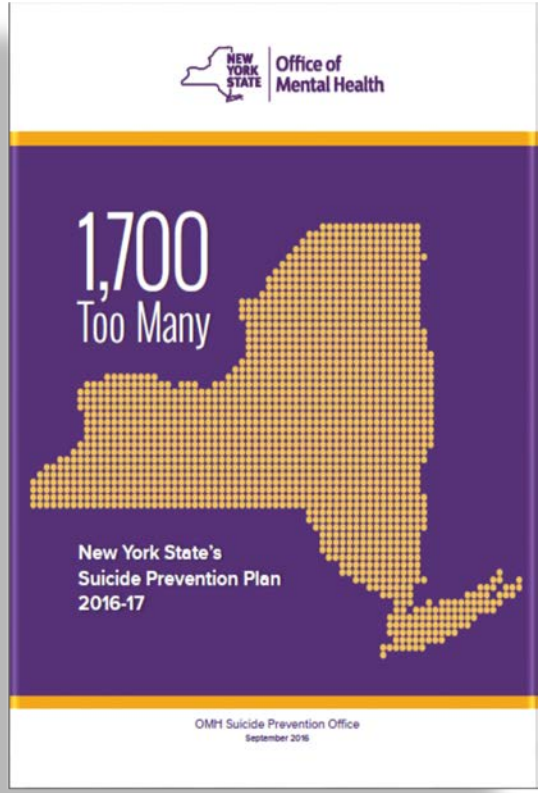
# NYS Suicide Prevention Plan 2016-17
# 3 Core Strategic Domains :




1. Integrating a systemic approach to suicide prevention into health/BH care systems
   - Advancing Zero Suicide implementation

2. Community(non-clinical) interventions:
   - Schools
   - Community Coalitions
   - Gatekeeper Training

3. Making better use of existing and new surveillance data

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# Zero Suicide Implementation and Evaluation in Outpatient Mental Health Clinics

- 1 of only 3 NIMH awarded grants nationally (PI: Stanley at NYSPI)
- $3.8M over 5 years
- Part of a larger CQI project involving > 180 clinics
- PSYCKES, a web-based application, used to support data collection and performance measurement
- Integrates Zero Suicide principles of screening, assessment, and a high risk pathway with safety plans and increased engagement & monitoring for those screening positive
- Evaluating 2 different implementation strategies

# System Transformation: Rebalance, Integrate, and Stabilize Inpatient and Community Service Systems


Reinvest in Community Services

Medicaid Managed Care

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# Medicaid Managed Care Benefit Redesigns: Integration of Mind and Body

**Mainstream MCO Integration**

- Medicaid BH services now integrated into mainstream plans
- Supports more integrated, less fragmented care and increases plan accountability for whole care

**Health and Recovery Plans (HARPS)**

- Targeting population with higher indicated need/acuity
- 72,000 enrolled in HARP to date;
- Ensuring true integration of physical and behavioral health
- Integration of Health Homes: care coordination; 30,000 enrolled to date
- Waiver /Wellness services: employment support, education support; peer services, cognitive skills training, respite and crisis services; family support
- Self-directed care plans

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# Value Based Payment for BH Care: Pay for Outcomes

- DSRIP and the State Innovations Model (SIM) are driving NYS providers to a value-based payment environment and integrated care will be measured and a key part of outcomes and payment

- Outcome Measures used to determine payments for value based arrangements in the HARP benefit will include: behavioral health outcomes such as engagement after psych hospitalization and physical health outcomes such as hypertension and diabetes control for people with schizophrenia

- Value based payments in the mainstream plan will include measures for depression in primary care such as screening and treatment outcomes; depression is one of the chronic illnesses to be managed and followed for outcomes in the mainstream plans

- Pursuing VBP Incentive Pool for meaningful inclusion of BH community providers in new payment arrangements, linked to primary care and/or community based arrangements

# Medicaid Managed Care: Challenges

- Ensuring dollars and savings remain in behavioral health services
- Ensuring true integration of physical and behavioral health: outcome measures to include both
- Integration of Health Homes and the special needs of those with serious mental illness
- Assessment process for HARP enrollee eligibility for HCBS
- Implementation of waiver services: certification (eg. peers); billing infrastructure; sufficient local and statewide capacity/coverage; managed care plans use of services; health and wellness services; tracking and measuring effectiveness (lack of functional measures).
- Ensuring quality care: effective oversight at State, regional, and local levels
- Ensuring stability of the continuum of care during the transition: clinic government rate for 2 years; Vital Access Program (VAP) support for inpatient units and clinics

# State Hospital Transformation

# State Operations and Community Service Transformation

Balancing the OMH inpatient institutional footprint with expanded network of community supports, services, residential expansion across the State. Pre-invest and redesign systems.

- Through September 2016, $60 million of the full annual pre-investment funds have been allocated expanded local and State operated community services, with savings of reduced inpatient beds
- Additional $19 million in Article 28/31hospital reinvestment allocated
- Over 20,000 adults, children, and families have been served by these new community-based services

# Re-investment continued:

- 16 new or expanded crisis intervention programs, many w/extended hour coverage, mobile capacity, and peer-support
- 4 new State-operated, campus-based children's crisis/respite units
- Over a dozen new advocacy, outreach and community transition programs
- Several PC long-stay transition support teams
- 10 new or expanded Assertive Community Treatment (ACT) teams, expansion of 572 slots
- 1,100 additional supported apartments with appropriate wrap-around services
- 246 additional Home and Community Based Services Waiver slots
- 13 (and growing) State-operated Mobile Integration Teams (MIT)

# Current Year (2016-17) Reinvestment

- Additional reduction of 200 beds statewide this fiscal year, as well as completion of last two years 536 beds.
- $22 million annualized to continue $110,000 in community services for each bed closed.
- Half of current year bed reductions will be based on SNF/MLTC-eligible long stays transitioning from PC inpatient beds.
- Over 500 State PC long stay individuals in have moved to the community in past year, enabling more admissions to PCs from community, while still slowly decreasing beds
- Similar reinvestment for additional services depending upon community need and local input (planning underway statewide).

# Desired Outcomes for Transformation

- **Recovery:** Independence, Community Integration, Well-being (not just reduction of symptoms)
- Some areas of focus/measures:
  - Residential stability
  - Employment
  - Life satisfaction, social & family engagement
  - Continuity and engagement in care
  - Reduction in crises and need for emergency care
- Defining and incentivizing recovery outcomes is critical, and a work in progress toward Value-based Payment

# Expanding Residential Opportunities for All Individuals with Mental Illness in Need

Reinvestment, MRT, Adult Home, and other housing funds

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# Scope of OMH Housing

- 41,688 units of housing for adults and children with an additional 5,956 units of housing in pipeline.
    - Of these units 19,403 are supported permanent housing and 5,402 are single site supported SRO (some of which are mixed use).
    - All supported single site SRO will be mixed use in future.
    - Currently in the pipeline there are 2,605 units of mixed use affordable housing/SP SRO.
        - Roughly 653 of these units are targeted to the final completion of NY/NY 3. Building in collaboration with sister agencies at State and City level.

# Changing Roles of State Agencies

## Medicaid Redesign:

- **Enriched Crisis And Transitional Housing Pilot**
  - Funding provided to 10 Housing Providers throughout State to create 30 additional units of housing.
  - As of September 2016 212 individuals have been served.
  - This pilot is being extended for 2 more years as it have showed initial success

**Supplemental Support Services Funding Pilot**

  - Enhanced reimbursement of $5,000 per client is provided for the expansion of eligible rehabilitation services to facilitate the movement of individuals from institutional settings to community settings.
  - This pilot is being evaluated and adaptions will be made from lessons learned in the first 2 years.

# Changing Roles of State Agencies

## Governor's Housing Initiative:

- Plan to build 6,000 units over the next five years

- The first year's commitment has been released and New York State will award service and operating funding for units of housing developed with capital funding to support the needs of residents. Up to $25,000 per unit/year in services and operating funding.

- 8 state agencies: Department of Health (DOH) – including the AIDS Institute, NYS Homes and Community Renewal (HCR), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Children and Family Services (OCFS), Office of Mental Health (OMH), Office for the Prevention of Domestic Violence (OPDV), and Office of Temporary and Disability Assistance (OTDA) have come together to form an interagency workgroup for the implementation of the Governors Homelessness Plan.

# Improving Safety, Reentry, and Recovery for At-risk Individuals

# Special Population: Criminal Justice Involved Individuals with Mental Illness

- Impacts on State and local criminal justice systems: High human cost, high local and state costs
- Focus on diversion, treatment, discharge planning, and post-discharge transitions
- Partnering with criminal justice agencies and localities

# Addressing Forensic and Individuals at Risk – Diversion and Community Capacity

- $22 million NY State investment and $4 million legislative grants to:
  - Prevent Incarceration: sequential mapping and CIT training for police across NY; connection of police to services and county partnerships; jail diversion programs with courts and DAs
  - Prisons: specialized transition to community units for the seriously mentally ill 6 to 18 months before leaving prison; increased training and programming for high risk individuals
  - Community: investment in specialized treatment and support teams that work with parole such as Forensic ACT, specialized housing supports, rapid connection to Medicaid at discharge and care coordination services with community providers prior to discharge.
- Building capacity and partnerships in localities and with local providers
- Supporting more stable transition upon return to community

# Before Concluding: A Comment on Workforce

# Workforce: A Challenge We Must Face

- Workforce recruitment for behavioral health (esp. psychiatry, nursing, social work) a theme across NYS, acute in many Upstate counties
- OMH understands from provider community, and faces itself, major workforce recruitment challenges
- Statewide strategy underway to build BH and healthcare workforce
- Development of new workforce takes time
- Must adopt strategies to expand competency and capacity of existing providers as long term planning develops. e.g.: integrated health/MH/sud models, collaborative care, TEACH…

# Summary: A Major Opportunity to Transform the System

Major investment over the next 3-5 years in system redesign that will transform how we provide care

There must be coordination in planning and implementation of all the moving parts:

- Prevention focus on children and youth
- Integration of Medical and Behavioral Health: Integrated Care
- State Hospital redesign , DSRIP redesign and Medicaid Managed Care that supports Triple Aim goals
- Growing residential capacity and flow through levels of care
- Move individuals with mental illness away from the criminal justice system to integrated care in the community

# Thank You!

Questions, Comments, Remarks

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