Statewide Comprehensive Plan

2016-2020
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Introduction from the Commissioner

I am proud to present the Office of Mental Health (OMH) Comprehensive Plan for the years 2016-2020, outlining the significant transition and transformation underway across the agency and the New York State public mental health system. Six years have gone by since the passage of the federal Affordable Care Act and Governor Cuomo’s Medicaid Redesign initiative, and the resulting system changes have had some time to develop and mature, while the wheels of change are still in full motion.

This report provides a snapshot of the current State of the public mental health system in New York, including a profile of the diverse populations we serve, a description of the principal initiatives transforming the mental health system, and a review of the workforce challenges and opportunities for serving a diverse and growing consumer population. It is my hope that the information provided in this report will be informative for the general public, and also useful for planners and program leaders who must put all the pieces of the healthcare transformation together, in order to sustain and expand access to quality prevention, support, and treatment services for the 21st century.

While change and transformation have become a constant in the world of health and behavioral health planning, the core mission of OMH - 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 – is still fundamental in our day to day work, and our planning for the future.

Given the increasing and diverse demands and opportunities for the mental health system, it has been helpful to revisit and reaffirm the mission, vision, and values of this agency in order to maintain our obligations to the children, adolescents, adults, and families of New York. The statements below reflect the agency’s steadfast commitment to individual and population health, informed by values and a vision for New York where health is promoted, disability is prevented, and illness is treated using the most clinically effective and person centered interventions. As these statements also reflect, we must ensure that the services and systems that individuals interact with are stable, competent, and accessible. In short, these principles should drive everything that we do.

OMH Mission

The Mission of the New York State Office of Mental Health 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.

OMH Vision

In order to accomplish the broad mission of this agency, we need to know what success will look like at many levels, including systems, programs, communities, and individuals. The Office of Mental Health envisions a future for the public mental health system and our citizens that will result in:

1. Integrated, accessible, and sustainable systems of high quality, person-centered, resiliency-and recovery-focused health and behavioral health supports and services.
2. Mental and physical wellbeing, and community and social environments that reduce the incidence of disorders, eliminate stigma, and foster community inclusion.
OMH Values

Informing the vast portfolio of work under the Office of Mental Health is a set of core values that are infused in the regulation and direct provision of services, research, planning, consumer empowerment, and quality advancement. These values can help the OMH and broader community mental health workforce at all levels relate together to a basic set of principles to drive excellence in a modern, progressive mental health system.

1. Person-centered care and systems.
2. Recovery is individual, and possible for everyone.
3. Community inclusion and positive environments for social and emotional development and resiliency.
4. Excellence in the design and delivery of mental health services and supports.
5. Cultural competence and reduction of disparities in care and health status.
6. Safety for consumers, staff, and community.
7. Respect for the worth and dignity of every person, including the prevention and rejection of stigma.
8. Scientific discovery and the translation of science to practice.
9. OMH has a fundamental role in ensuring a safety net for all people in need.

As you read through this report, I hope that our vision and values are reflected in the programs and priorities as they are described throughout. I am pleased that in the upcoming chapters we are able to extensively review the many areas where OMH has developed prevention and early intervention initiatives, and expanded regulatory and technological tools for integrating services with health and substance use disorder treatment. We also provide updates to the ongoing transition of Medicaid behavioral health into managed care statewide, and the continued transformation of the State-operated and community service footprint through reinvestment and regional planning. Finally, we look at the challenges in staffing State and local mental health programs, along with the tools available to support the cultural competence of our existing workforce and access for underserved cultural groups. In sum, the contents of this report should not only give New Yorkers a better understanding of the public mental health system as it currently operates, but also a sense of the future direction for this agency and the entire health care delivery system, for a stronger, healthier tomorrow.

Ann Marie T. Sullivan, M.D.
Commissioner, NYS Office of Mental Health
Chapter 1
The New York State Public Mental Health System

Chapter 1 is an overview of the New York State public mental health system. It describes individuals receiving services in the system by their demographic characteristics, severity of diagnoses, incidence of co-occurring disorders, employment status, and where they receive services. This chapter also reviews the programmatic footprint of all OMH operated and regulated programs, and a summary of State mental health expenditures.

Section 1
People Served:
Estimated Number of Individuals Served

The characteristics of adults and children served in New York’s public mental health system are described here using data from the OMH Patient Characteristics Survey (PCS). OMH conducts the PCS during a one-week period on a biennial basis to gather clinical and demographic information for people who receive mental health services from programs the agency operates, funds or licenses. The most recent PCS includes over 200,000 survey submissions by programs providing direct services during a one-week period in October 2015. Unless otherwise indicated, all data presented is annualized data from the 2015 PCS.

OMH estimates the number of people served annually in the public mental health system using data from the PCS. Annual estimates are prepared using a statistical methodology developed at the Nathan Kline Institute for Psychiatric Research. Annual estimates are valuable for local and State-level decision making, and for directing the development of policy in the areas of planning, service delivery, resource management, finance, evaluation and ongoing monitoring.

In 2015, an estimated 772,000 individuals were served in the New York State public mental health system. This estimate is a significant increase from those based on prior PCS surveys, which estimated annual service numbers of 729,000 in 2013 and 717,000 in 2011.
What Are Annualized Estimates?

The PCS collects information on consumers of mental health services for a one-week period and standard PCS reporting provides counts of individuals for this one-week timeframe. OMH recognizes the utility of having some of these weekly numbers “annualized”. Hence, OMH employs an annualizing algorithm developed at the Nathan Kline Institute (Laska, Meisner, Wanderling, Siegel, Statistics in Medicine, 2003; 22:3403-3417) to estimate the number served annually from these weekly numbers. Each point estimate has a range of uncertainty referred to as a “confidence interval”. Confidence intervals are disproportionately larger when the number of persons in the interest group is relatively small. For simplicity, only the point estimates are presented here.

Analysis of Medicaid data suggests that the number of people served in the public mental health system may be higher than what is captured by the PCS data. Possible reasons for this data limitation include the one-week survey period, and individuals served before or after the survey period not being captured in the data. Another explanation is that not all individuals who receive mental health services access them in primary mental health settings, and instead may be receiving them in primary care settings. Finally, there are people in need of mental health services that have not engaged in them and are not captured in the PCS data. Therefore, the annualized number of people served reported in this chapter represents a subset of individuals in need of and/or accessing mental health services.

Sex and Gender Identity

Figure 1-1 describes the sex of persons served in the public mental health system. Overall, males were served at a rate of 391 per 1,000 males in the general population, and females at a similar rate of 390 per 1,000 females in the general population. In an effort to more accurately capture data on gender identity, OMH included additional measures in the 2015 PCS to identify the number of transgender individuals who are served. OMH will make these data available in the near future.
Age

The age distribution of individuals served per 1,000 persons in that age group in the general population is displayed in Figure 1-2. The highest annual rate of service utilization is among individuals 25 to 64 years of age (42.3 per 1,000). In comparison, the rate of service utilization is lowest for adults ages 65 and older (19.6 per 1,000). This lower service rate may be related in part to older individuals receiving services in primary care and long-term care settings when they present with signs of mental disorders, rather than receiving services in primary mental health settings.¹
Race & Ethnicity

Figure 1-3 presents the race and ethnic distribution of people served per 1,000 persons of that race or ethnicity in the general population. By race, the highest annual rate of service utilization is among Black/African Americans (52.8 per 1,000), followed by Pacific Islanders (51.6 per 1,000), Multi-Racial (36.0 per 1,000), Whites (29.5 per 1,000), Native American/Alaskan (22.2 per 1,000) and Asians (9.1 per 1,000). Among those identifying as Hispanic/Latino, the rate is 47.8 per 1,000.

Rates of service by race should be read with some caution due to the small size of some racial groups in the general population and fluctuations in these rates identified through analyses of past PCS populations.

However, since rates for most racial groups (e.g., White, Asian, and Black/African American) and for Hispanic/Latino ethnicity have been relatively stable across multiple PCS collection years, there do appear to be real differences in rates of service between racial groups.

Differences in service rates may be explained in ways that are both directly and indirectly related to race and ethnicity, including factors that influence access to public mental health services rather than settings such as primary care and private practices. These factors may include insurance type (private, public, or uninsured), language access, and cultural differences.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Rate (per 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African American</td>
<td>52.8</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>51.6</td>
</tr>
<tr>
<td>Multi-Racial</td>
<td>36.0</td>
</tr>
<tr>
<td>White</td>
<td>29.5</td>
</tr>
<tr>
<td>Native American/Alaskan</td>
<td>22.2</td>
</tr>
<tr>
<td>Asian</td>
<td>9.1</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>47.8</td>
</tr>
</tbody>
</table>

![Graph showing rates of individuals served annually by race & ethnicity](image-url)
Services by Program Auspice

Figures 1-4 and 1-5 show the distribution of access to services in the State-operated and voluntary service sectors during the 2015 PCS one-week survey period. As shown in Figure 1-4, State-operated programs account for approximately one-tenth of individuals served in the public mental health system, while voluntary programs (including county-operated) account for the vast majority of utilization of public mental health services statewide. As indicated in Figure 1-4, there is a small degree of overlap in program auspice access, indicating individuals who received services in both State-operated and voluntary programs.

Figure 1-5 compares the percentages of people served by program type in the State-operated and voluntary service sectors. Individuals may access more than one type of service within a sector.

While the State-operated and voluntary service sectors have similar percentages of people accessing emergency and residential program services, there are substantial differences in the utilization of inpatient, outpatient, and support services between the sectors. For example, nearly three quarters (72.3 percent) of people utilizing voluntary-operated programs are in outpatient programs compared to less than half (44.8 percent) of persons utilizing State-operated programs. Outpatient programs include major program types such as clinic, PROS, and ACT.

The percentage of people in the State-operated sector utilizing inpatient programs (19.1 percent) is far greater than the percentage of persons in the voluntary sector utilizing these programs (4.2 percent). Finally, 29.4 percent of people served in the State-operated sector receive support services compared to 18.5 percent of persons utilizing services in the voluntary sector. This signifies a newer trend in the growth of State-operated share of support programs which has occurred since the last PCS survey, and appears to be largely due to increases in State-operated forensic transition services and Mobile Integration Teams, which together served thousands of new individuals in 2015.3

<table>
<thead>
<tr>
<th>Auspice</th>
<th>Residential</th>
<th>Support</th>
<th>Outpatient</th>
<th>Inpatient</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>4.2%</td>
<td>4.2%</td>
<td>44.8%</td>
<td>12.8%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Local</td>
<td>2.5%</td>
<td>2.5%</td>
<td>72.3%</td>
<td>18.5%</td>
<td>12.1%</td>
</tr>
</tbody>
</table>
Severity of Diagnosis: 
Serious Emotional Disturbance and 
Serious Mental Illness

Many adults and children served in the New York State public mental health system are engaged in services because they experience symptoms that impede their ability to function day-to-day. Serious mental illness (SMI) occurs in individuals diagnosed with mental illness who experience significant impairment in functioning. Serious emotional disturbance (SED) in children is characterized by a diagnosable mental disorder and impairment that substantially limits their functioning in school, family or community activities.4

By applying prevalence rates supplied by the U.S. Department of Health and Human Services to the State’s population, it is estimated that there are approximately 264,000 children and youth (ages 9 to 17) with SED and 865,000 adults with SMI in New York State.5 SED is not estimated for children under nine years of age. Based on annualized PCS data, it is estimated that 71 percent (N=550,424) of individuals who received services in the public mental health system have SMI or SED (Figure 1-6).

It is important to note that actual prevalence levels may not be wholly consistent with estimates derived by applying a standard rate to whole populations, and there may also be differences in rates and actual prevalence by region.6 Additionally, the estimated number of individuals with mental illness receiving care in the public mental health system may be underestimated because not all individuals receiving care would be captured during the PCS one-week survey period. Finally, individuals who receive mental health services in primary care or other settings not considered part of the public mental health system are not included in these analyses.

Estimated Percentage of 
SMI/SED Population 
Served by Auspice

Figures 1-7 and 1-8 describe the percentages of people with SMI/SED served by program type in the State-operated and voluntary service sectors. In State-operated settings (Figure 1-7), the majority of clients served are part of the SMI/SED population, with the exception of those served by support programs (41 percent).

In voluntary-operated settings (Figure 1-8), the percentages of persons with SMI/SED served in inpatient and residential programs are similar to those served in these program types in State-operated settings.

Voluntary-operated emergency and outpatient programs tend to serve a lower percentage of SMI/SED individuals compared to these program types in State-operated settings while voluntary support programs serve a significantly higher percentage of persons with SMI/SED (68 percent) than do State-operated support programs (41 percent).
### Percentage of Persons with SMI/SED Served in State-Operated Settings

<table>
<thead>
<tr>
<th>Service Type</th>
<th>SMI/SED</th>
<th>Non SMI/SED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>12.0%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>10.4%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>6.2%</td>
<td>93.8%</td>
</tr>
<tr>
<td>Support</td>
<td>59.0%</td>
<td>41.0%</td>
</tr>
<tr>
<td>Residential</td>
<td>3.6%</td>
<td>96.4%</td>
</tr>
</tbody>
</table>

### Percentage of Persons with SMI/SED Served in Voluntary-Operated Settings

<table>
<thead>
<tr>
<th>Service Type</th>
<th>SMI/SED</th>
<th>Non SMI/SED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>27.0%</td>
<td>73.0%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>11.5%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>27.5%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Support</td>
<td>32.0%</td>
<td>68.0%</td>
</tr>
<tr>
<td>Residential</td>
<td>3.3%</td>
<td>96.7%</td>
</tr>
</tbody>
</table>
Mental health diagnoses do not exist independently of other diagnoses that service recipients may have. Approximately 28 percent of individuals served in the public mental health system have a co-occurring diagnosis of mental health and substance use disorder or a dual diagnosis of mental health and developmental disability (Figure 1-9).

Figure 1-10 describes where service recipients with co-occurring or dual diagnoses are treated in the public mental health system by auspice. State-operated and voluntary settings treat similar percentages of individuals with a dual diagnosis of mental health and developmental disability.

However, the percentage of people in the voluntary sector with a co-occurring diagnosis of mental health and substance use disorder (36.8 percent) is more than twice the percentage in the State-operated sector (17.1 percent). In contrast, the percentage of service recipients in the State-operated sector with a mental health diagnosis only is substantially larger (73.9 percent) than the percentage in the voluntary sector (55.1 percent).
Thousands of individuals receiving services in the public mental health system have a co-occurring diagnosis of substance use disorder and/or a dual diagnosis of developmental disability. The data presented here support the continuation of collaborative, interdisciplinary efforts across New York State Department of Mental Hygiene agencies; a theme that is also strongly communicated through the local services plans developed by local governmental units.

**Employment Status**

Mental health and mental wellness models emphasize recovery-oriented treatment that support opportunities for individuals with mental illness to transition from inpatient mental health settings, and return to and thrive in their communities. Employment in the community is a key component of recovery. Individuals with severe mental illness who hold competitive jobs for an extended period of time frequently experience a number of benefits, including improvements in their self-esteem and symptom control.

In New York State, approximately 535,000 individuals 18–64 years of age receive services in the public mental health system, and 93,000 of them (17.4 percent) are competitively employed. This competitive employment rate has remained relatively steady over the years, with only small amounts of growth over time.

Figure 1-1 shows the New York State regional competitive employment rates for adults receiving services in the public mental health system. Competitive employment rates range from a low of 15.4 percent in New York City to a high of 21.4 percent in the Long Island region. By continuing to expand recovery-oriented services and confronting stigma, OMH is optimistic that a greater amount of progress will be made in coming years to increase rates of competitive employment among adults with mental illness.
Section 2
The Office of Mental Health and the statewide Public Mental Health System

The State Office of Mental Health (OMH) mission is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults diagnosed with serious mental illness and children diagnosed with serious emotional disturbance. In order to promote this mission OMH has a role as the State’s lead mental health authority in managing, regulating, and funding the public mental health services, and directly operating services. Two other primary lines of business of the agency are to advance research and to promote overall prevention of mental health.

As a regulatory agency, OMH maintains oversight of over 4,500 State, voluntary, and county-operated mental health service and support programs. Pursuant to Article 31 of the NYS Mental Hygiene Law, the Commissioner of the Office of Mental Health has the authority and responsibility to set standards for the quality and adequacy of facilities and programs that provide services for the treatment and recovery of persons who suffer from mental illness. The standards governing the operation of facilities and programs are contained in various sections of Title 14 of the Codes, Rules, and Regulations of the State of New York or the 14 NYCRR.

As a provider of services, the Office of Mental Health operates 24 State inpatient facilities for civil, forensic, and research populations, serving approximately 10,000 inpatient individuals each year. OMH also operates dozens of residential, outpatient, and support programs that serve thousands of children, adults, and families in communities across the State.

The following section describes the various programs that make up the NYS public mental health system.

The Mental Health Service System

The NYS public mental health system is comprised of mental health programs that are licensed, funded or operated by OMH. Currently, OMH oversees over 2,000 licensed and 2,600 unlicensed programs which fall into five major categories: inpatient, outpatient, emergency, residential and support programs.
delivered in community settings. OMH operates 24 State Psychiatric Centers\(^8\), and licenses over 100 other inpatient programs that collectively operate nearly 10,000 psychiatric inpatient beds statewide.\(^9\)

Overall, OMH accounts for 16 percent of the inpatient programs in the State, including adult and children’s facilities.\(^10\) Inpatient services are also provided on inpatient psychiatric units of general hospitals, at private psychiatric hospitals, and in residential treatment facilities.

State Psychiatric Centers are 24-hour psychiatric inpatient treatment programs that are operated by the New York State Office of Mental Health and are often referenced as “State PCs.” Most OMH Psychiatric Centers are accredited and regulated by the Joint Commission and the Centers for Medicare and Medicaid Services (CMS); they are not licensed by the State. OMH State PCs account for a smaller share of the total inpatient facilities statewide than they do when measured by bed capacity, where they represent a larger share of beds for both adults (32 percent) and children (22 percent). In addition to the nearly 3,000 budgeted adult and child beds, OMH also operates over 700 adult beds in forensic facilities, which are not included in the bed counts in Figure 1-13.

Inpatient psychiatric units of general hospitals, also referred to as Article 28 hospitals, are licensed, 24-hour inpatient treatment programs that are operated

### Find a Mental Health Program

Want to find a program in your county described in this chapter? The OMH website houses the Mental Health Program Directory which includes both State-operated and voluntary programs regulated by the agency. The directory includes program details such as county of operation, hours of operation, and program contact information. The directory is maintained by the Office of Mental Health through the CONCERTS program database. All programs discussed in this section can be found at [https://my.omh.ny.gov/analytics/saw.dll?PortalPages](https://my.omh.ny.gov/analytics/saw.dll?PortalPages)

### Unlicensed Programs

There are 2,600 unlicensed programs which are programs such as care coordination, crisis services, education, forensic programs, general support and education, specific types of housing, self-help, vocational and some emergency programs. Unlicensed programs are usually directly contracted between local governmental units and providers using State Aid funds, while some are directly contracted by OMH.
in a medical hospital, and include full-time medical, psychiatric services, social services and around-the-clock nursing services for individuals with mental illness. Jointly licensed by OMH and the New York State Department of Health, there are approximately 100 Article 28 psychiatric inpatient units operating over 5,000 beds throughout New York State.

Private psychiatric hospitals, also known as Article 31 hospitals, are 24-hour inpatient treatment programs that are licensed by OMH and operate in private hospitals that exclusively provide behavioral health services. There are currently six Article 31 hospitals statewide, operating a total of 864 beds.

Another type of inpatient psychiatric facility are Residential Treatment Facilities (RTF). RTFs provide fully-integrated mental health treatment services to seriously emotionally disturbed children and youth between five and 21 years of age. These services are provided in 14-61 bed facilities which are certified by both OMH and either the Joint Commission or the Council on Accreditation (COA). Sometimes classified as residential, RTFs are less intensively staffed than inpatient units, but provide a much higher level of services and staffing than community residences, group homes, or child care institutions. There are currently 18 RTFs operating approximately 500 beds throughout the State.

Outpatient

OMH operates and regulates nearly 800 outpatient programs. Assertive Community Treatment (ACT) teams, Personalized Recovery-Oriented Services (PROS) programs, Article 31 clinics, and Day Treatment provide treatment and rehabilitation to service recipients in need of community based support to maintain mental health. The most common, largely utilized outpatient services are clinic treatment services which make up 63 percent of all outpatient services as shown in Figure 1-15.

Emergency

Emergency programs provide rapid psychiatric and/or medical stabilization. They ensure the safety of persons who present a risk to themselves or others. The program types range from crisis counseling and residential services to Comprehensive Psychiatric Emergency Programs (CPEP). Home-based crisis intervention services for children are designed to provide crisis services to families when a child is imminent risk for psychiatric hospitalization. For a more detailed description of the CPEP program, including service-level data for all programs statewide, see Appendix B.
Residential

Residential Services are provided to maximize access to housing opportunities, particularly for persons with histories of repeated psychiatric hospitalizations, homelessness, involvement with the criminal justice system, and co-occurring substance abuse. Residential services are also offered to children to provide short-term residential assessment, treatment, and aftercare planning. There are approximately 600 residential programs, amounting to nearly 40,000 beds statewide.

Support

Support programs are based in the community and help adults diagnosed with serious mental illnesses to live as independently as possible and help children with serious emotional challenges to remain with their families. These services include family support case management and vocational, self-help and other support services. While the array of services varies between adults and children, the goal is to support successful and full community living.

For a full list of each program described above, visit the Mental Health Program Directory on the OMH website at: https://my.omh.ny.gov/analytics/saw.dll?PortalPages
Section 3
New York State Mental Health Spending

Gross Expenditures:
State and Local Programs

Statewide mental health expenditures from all sources have grown over the most recent five-year period of data available, from $6.7 billion to $6.8 billion, and the share of spending by State and local auspices has remained relatively stable. There was moderate growth in local services, while State operations spending declined slightly in dollars and in the relative share of the total.

Expenditures Service Category:
State and Local

The following tables provide a more detailed one-year view of expenditures by service category, within State and local auspices respectively. When viewed at this level, the large proportion of inpatient spending within State-operated settings is notable, comprising nearly 70 percent of all OMH operations, or $1.3 billion per year.
Expenditures on local inpatient services make up a plurality of spending by service category at 42 percent, and exceed State inpatient in raw dollars at $2 billion. However the local system is generally more balanced between community and hospital-based settings.

Under both the OMH Transformation Plan, and the Delivery System Reform Incentive Payment (DSRIP) program, New York State will continue to direct a greater share of our resources to community-based services through savings from avoidable and unnecessary inpatient utilization. In future years, we continue to expect growth in the total expenditure amounts, but with an increasingly greater share of such growth in community-based, non-inpatient service settings.
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Chapter 2
Mental Hygiene Law Section 5.07 Background and the Local Planning Process

Section 5.07 of Mental Hygiene Law requires OMH to develop a statewide Comprehensive Plan for the provision of State and local services to individuals with mental illness. Some key objectives identified in the statute include: identifying statewide priorities and measurable goals to achieve those priorities, proposing strategies to obtain those goals, identifying specific services and supports to promote behavioral health wellness, analyzing service utilization trends across levels of care and promoting recovery-oriented State-local service development.

This statewide Comprehensive Plan is developed in part from the analysis of local services plans submitted by each local governmental unit (LGU) (57 counties and New York City), in addition to a considerable amount of outreach and discussion with other stakeholders across the State, including consumers, families, providers, and other State, local, and federal agencies. Facilitating the process of county-State communication is the New York State Conference of Local Mental Hygiene Directors Mental Hygiene Planning Committee, which brings together LGUs with the three State Department of Mental Hygiene agencies to address ongoing planning needs.

The planning process begins in March of each year with the posting of planning guidelines issued jointly by OMH, the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office for People With Developmental Disabilities (OPWDD). The Local Services Plan (LSP) Guidelines project each agency’s key policy developments and strategic direction, in addition to more technical survey tools and guidance for the submission of local plans. Utilizing the OASAS-operated County Planning System (CPS), LGUs develop their local services plans in consultation with their local Community Services Board and other local advisory bodies. The LGUs then submit their final local services plans during the month of June. All local services plans are fully available to the public without a CPS account, through the NYS Conference of Local Mental Hygiene Directors website, allowing for greater access to local services plans to help further educate and engage community stakeholders. LSPs for 2016 are available by selecting any county on the following web page: http://www.clmhd.org/contact_local_mental_hygiene_departments/.

Due to both county and State-level decisions, local needs priorities have changed over the past several years to reflect the rapidly changing landscape of healthcare reform. Statewide initiatives to improve population health, transform health care delivery, and eliminate healthcare disparities are reflected in local priorities and strategies that focus on service integration and care coordination. In addition, most counties are addressing service needs and gaps through activities around the Medicaid Delivery System Reform Incentive Payment (DSRIP) Program, the Population Health Improvement Program (PHIP), the State Health Innovation Plan (SHIP) and the Prevention Agenda 2013-2018.
2016 Local Services Plans
Priority Outcome Analysis

Summary analysis from the 2016 Mental Hygiene Local Services Plans (LSPs), which were submitted to the State in the summer of 2015, included identification of mental health service priorities in the community, in addition to county and regional needs assessments. In the 2016 LPS Guidelines, LGUs were asked to state their local priorities by addressing their needs and progress on those priorities. The plurality of county priorities included in the 2016 plans were associated with multiple mental hygiene service systems. Priorities that address cross-system collaboration, service integration, and care coordination represent a common theme also identified in the needs assessment data, while the expansion of services accounted for one-fifth to one-quarter of priorities.

One larger narrative uncovered in the local priority outcome data was that as managed care and DSRIP implement statewide, there is a need for a continuing role and relevance of specialty mental health providers. There is concern that many providers need more support to keep up with the changes and requirements of the healthcare delivery and payment systems of the future in order to be sustainable in the new health care financing environment. Some counties’ priorities focus even solely on “keeping up” with what is happening locally, now that other large health care systems are moving into the behavioral health arena and changing the dynamic in mental health planning and local service development.

As Figure 2-4 shows, 57 local services plans included a total of 457 priorities. Of those, 220 (48 percent) were associated with OASAS, OMH and OPWDD systems; 71 were associated with OMH and OASAS; and 22 that were associated with OMH and OPWDD.
Chapter 2: Mental Hygiene Law Section 5.07 Background and the Local Planning Process

2-5a  LGU Assessment of Needs for Adults, Statewide

2-5b  LGU Assessment of Needs for Children & Youth, Statewide
Chapter 2: Mental Hygiene Law Section 5.07 Background and the Local Planning Process

The local services planning process and the priorities identified in county plans, particularly the cross-system priorities, inform each State agency’s policy, programming and budgeting decisions in a way that is more timely and comprehensive than previously possible. To help ensure that policies supporting people with mental illness are planned, developed and implemented comprehensively, OMH will continue to look to the local services planning process and the annual plan submissions as important sources of input.

**Needs Assessment Analysis**

As discussed above, OMH included a subjective needs assessment survey in the 2016 LSP Guidelines to identify unmet needs in several areas. The survey tool used in the 2016 LSP Guidelines was developed jointly with OASAS and OPWDD, with general categories developed to apply to all agency populations. LGUs were asked to assess the level of need for several areas of need related to service access, and additional areas such as workforce and transportation. The survey guidance directed LGUs to consider each category’s need level against the other categories, in order to determine the spectrum of unmet needs within an area. Given that the survey is a subjective assessment of need, no definitive conclusions can be drawn on the results by themselves, however they do provide some utility in comparing regions’ areas of need, and also help in providing a starting point for data analysis and validation, to support regional and statewide planning efforts.

The results of the 2016 needs assessment have in part validated many of the areas that are already priority areas for the State; but they also identified less visible themes. In the former category, there are indications of a high need for more housing and transportation for people with mental illness, and a serious need for more psychiatry workforce availability in most areas across the State. A few unique themes that came through in the open-ended portion of the survey were related to difficulties in navigating Medicaid transportation services and the need for a more comprehensive and organized crisis response system within counties, including crisis capacity for people with developmental disabilities and the dually diagnosed. Many needs assessment narratives also focused on the need to better align and coordinate service delivery systems to better support individuals and families with complex needs.

While the survey included needs assessment questions to be answered at both the county and regional level, the recent analysis focused on the county-level responses which were then “rolled up” for presentation at a regional level. Efforts to parse differences in individual counties’ assessments of need between their own county and that of the Regional Planning Consortium (RPC) region in which they reside did not deliver enough of a response to include in this analysis. The figure presents local needs aggregated at the statewide level. A copy of the survey questions with full category names is provided in Appendix C, along with analyses of these need categories at the RPC regional level.

Given the richness of the data provided through the 2016 plans, OMH developed a series of 2-page summary briefs that provide an overview of those areas that a county identified as “high need” for their mental health population/system locally and for their region, in addition to summaries of the county top five priority areas for 2016. Copies of the individual LGU documents are included in Appendix F of this report.

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1 There are 58 local governmental units, but only 57 LSPs are submitted due to the joint leadership of two LGUs (Warren and Washington) by a single DCS.
Chapter 3
Public Health and Clinical Strategies to Prevent and Intervene Throughout the Trajectory of Mental Health and Wellness

This chapter describes several initiatives aimed at building our capacity as a State to promote mental wellness, prevent disorders, and intervene earlier in the trajectory of mental illness. These efforts can be identified as a progression across the left and central portion of the Institute of Medicine (IOM) mental health intervention spectrum (depicted below) which ranges from the general promotion of mental wellness, prevention of and early intervention with illness, the treatment of conditions, and maintenance and recovery.\(^1\) The Institute of Medicine, and New York State through the DOH Prevention Agenda 2013-18\(^2\) have indicated the importance and value of focusing on promotion and prevention strategies across larger populations, in order to reduce future incidences of mental health disorder. The following sections summarize efforts underway at OMH to reach larger populations earlier in the trajectory of mental wellness and illness in order to improve New York State population health.

Section 1 provides an overview of two strategies to promote mental health and prevent disorders by focusing on early childhood. Section 2 details the OnTrackNY initiative, a targeted strategy to identify and assist individuals at the earliest onset of psychotic symptoms to help better manage the illness, and reduce recurrence and negative impacts in the future. Finally, Section 3 outlines a series of transformational efforts across behavioral health and primary care treatment settings to identify and treat health and behavioral health conditions using a more integrated approach. Together these efforts reflect statewide, interagency collaboration to earlier and more holistically address a range of needs in the total New York State population.
Section 1
Early Childhood Prevention and Pediatric Connections

Scientific evidence over the past 30 years shows that behavioral health problems can be prevented. Research has also identified positive attributes and protective environmental influences that buffer or minimize the adverse effects of exposure to risk. In 2010, the Surgeon General issued the following National Prevention Strategy Recommendations:3

1. Promote early identification of mental health needs and access to quality services.
2. Promote positive early childhood development, including positive parenting and violence-free homes.
3. Facilitate social connectedness and community engagement across the lifespan.
4. Provide infants, toddlers, young children and their families with the support necessary to maintain positive mental well-being.

The NYS Office of Mental Health has made significant investments in advancing evidence-based prevention interventions and mobilizing across disciplines and communities to unleash the power of prevention across New York State. Several OMH initiatives outlined in this section will advance the Surgeon General’s preventive strategy recommendations: Healthy Steps and ParentCorps target communities throughout New York State to advance OMH’s prevention policy of intervening early to strengthen families and promote children’s social-emotional wellbeing, and Project TEACH offers child psychiatry consultation services to pediatric providers in order to build primary care capacity for serving children with mental health disorders.

Healthy Steps for Young Children

Primary care settings offer an important opportunity to intervene before a problem has fully manifested and to provide prevention and intervention strategies such as universal screening, early identification, integrated treatment, and parental education and support. In the coming year, OMH is advancing Healthy Steps for Young Children. The Healthy Steps model offers families enhanced primary care visits for children by promoting children’s development, addressing parental concerns, and providing supports and linkages as needed from birth to age five.

A recent national study of pediatric practices identified the persistent inability to achieve better linkages with community-based resources as a major challenge yet, pediatric primary care provides a key opportunity to offer families information and support on their child’s social-emotional well-being and growth in a non-stigmatizing environment.4 Healthy Steps builds this capacity and breaks down these barriers to needed supports and linkages for families.

Healthy Steps for Young Children is an evidence-based primary care preventive intervention that enables the primary care practitioner to expand the primary focus of physical health to emphasize social-emotional and behavioral health and to help support family relationships. Healthy Steps infuses mental health and trauma-informed care into the primary care setting and is facilitated by the addition of the Healthy Steps Specialist who is a professional with expertise in child and family development.

Primary care providers are a natural contact for families. Typically an infant has seven well child visits within the first year of life, often before families have contact with other systems of care. This provides many touch points for the Healthy Steps Specialist to support the health care provider in promoting early healthy social and emotional wellbeing. This early access provides opportunities to integrate social-emotional wellbeing with physical health for the youngest of New York’s children at a critical time in brain development.

Three related themes inform the Healthy Steps approach to primary care for young children:

1. The first five years of life are critically important for both the child and the family.
2. Key to a young child’s healthy growth and development are nurturing relationships between the family and the child and between the practice and the family.
3. Medical care for young children can be enhanced by including the promotion of child development, focusing on the whole child and the whole family.
Healthy Steps has been implemented at numerous sites across the country, and is standardized in its goals in increased caregivers’ understanding of development and behavior using a range of tools and strategies. An evaluation by the Johns Hopkins Bloomberg School of Public Health found that Healthy Steps families were more likely than control families to:

- Practice safer and more responsive parenting.
- Avoid harsh disciplinary tactics.
- Openly discuss feelings of sadness with a health care professional.

Given the important correlation of feeling loved and safe to a child’s healthy development, these findings are powerful indicators of Healthy Steps’ highly desirable effects on parental behavior. The study also reported that Healthy Steps children received regular developmental screenings and were more likely to have current immunizations. Even more impressive, researchers followed Healthy Steps children to age five and a half and found that families continued to use more appropriate disciplinary methods and remained more sensitive to the child’s behavioral cues.

Below are the key components of service delivery:

- Staff offers enhanced well child care through well child office appointments where parents can get answers to questions about child development and take advantage of “teachable moments.”
- Healthy Steps Specialists make home visits at key developmental points.
- Healthy Steps Specialists staff a child development telephone information line.
- Staff provides child development and family health checkups, with screens to detect signs of developmental or behavioral problems and screen for family health risks such as maternal depression.
- Parent groups offer social support as well as interactive learning opportunities.
- Staff provides linkages to community resources and facilitate parent to parent connections.

Another important component of service delivery is the addition of a parental trauma screen, since caregiver childhood trauma may help to identify children at risk for impaired social-emotional development at a very young age. Given the foundational nature of social-emotional development for future success, it is anticipated that interventions specifically targeting the parenting of caregivers with childhood trauma and the social-emotional development of their children may represent a promising approach to prevent behavioral health challenges.

Implementing Healthy Steps in New York

The Office of Mental Health has selected seventeen pediatric and family medicine practices to implement the Healthy Steps program across New York State. These practices will engage new parents to enroll their infants in the Healthy Steps program by four months of age, and follow them through five years of age. These Healthy Steps sites will have the combined capacity to impact the lives of thousands of children and their families.

The Healthy Steps sites are committed to advance the Healthy Steps model. They are distributed across the State and represent diverse populations and geographical areas. The sites range from Federally Qualified Health Centers, hospital-based clinics, community health centers, and private practices. The sites primarily serve communities in poverty where on average 85 percent of their practices see children that are covered by Medicaid, Child Health Plus or are uninsured. The children served will come from high need communities and are disproportionately at risk for social and emotional concerns.

Healthy Steps brings the opportunity to prevent mental health problems though anticipatory guidance and promotion of healthy lifestyles. While prevention is emphasized, Healthy Steps also incorporates mechanisms to identify and intervene potential problems early on. Universal screening for the child and consideration of the well-being of the family though maternal depression screening and attention to past adversities is included. When needed, facilitated referrals to community resources are provided.

Each site brings a unique and rich perspective to build upon and the collective shared knowledge gained through ongoing learning collaboratives will help to strengthen each program’s ability to excel in implementation, to promote the mental health and well-being of our young children. The OMH partnership with
this diverse range of primary care practices will inform our efforts and work to bring together multi-payer support to sustain this universal prevention model.

**ParentCorps**

Advances in neuroscience, developmental psychology, and prevention science provide compelling evidence that the foundation for healthy development is established in early childhood. Interactions between biological processes and home and early care environments can impact learning, behavior, and health across the lifespan. The stress of poverty constrains caregivers’ ability to provide positive behavior supports, and jeopardizes the development of social, emotional and self-regulatory skills. Collectively, these skills impacting executive functioning are recognized as core components of readiness for school, and a necessary foundation for achievement and well-being. By identifying communities where children are disproportionately exposed to factors that can compromise development, OMH is better able to align and mobilize resources from various service systems to intervene early and make an important public health impact.

ParentCorps is implemented as a universal intervention (i.e., for all children) in early childhood education or childcare settings (collectively referenced as “school”). The school-based delivery model and intervention process were developed to be relevant and engaging for all families as children enter school, recognizing the breadth of diversity found in urban areas. To effectively mitigate the impact of poverty, ParentCorps combines multiple approaches to strengthen parenting, classroom quality, and child self-regulation:

- Family program (14-week behavioral parenting intervention and concurrent group for children);
- Professional development for early childhood educators; and
- Consultation for school leadership.

![ParentCorps: 5-Year Project Plan](image-url)
Two randomized controlled trials with young children entering school in New York City provide evidence in support of ParentCorps’ impact on vulnerable children, with replicated studies concluding that ParentCorps engages parents and teachers at very high rates, and strengthens parenting and early learning environments necessary to improve children’s learning, behavior and health.\(^7\)

Outcome indicators are also very promising: ParentCorps substantially altered the negative developmental trajectory to serious conduct problems for high-risk boys, potentially reflecting an important shift off the early-starter pathway to antisocial behavior. For this high-risk group, ParentCorps also resulted in lower rates of obesity in both girls and boys. In addition, ParentCorps substantially increased each child’s quality-adjusted life expectancy.

In 2011 the NYS Office of Mental Health commissioned a cost-benefit analysis to estimate the long-term health and economic effects of ParentCorps, in order to inform policy and investment decisions. This analytic project also supported feasibility testing for ParentCorps implementation model in six NYC schools with Universal Pre-K programs. The results of the cost benefit analyses estimated that ParentCorps can save more than $2,500 per child in health care, criminal justice and productivity expenditures, after factoring in the costs of capacity building and annual programming.

The projected cost savings and increased quality of life are primarily attributable to ParentCorps’ benefits for children who are at the highest risk for long-term problems, including impacts on obesity and subsequent diabetes, behavioral problems, criminal justice system involvement, and unemployment.

In 2015, OMH awarded a grant to expand a family-centered, school-based preventive intervention to foster healthy development and school success among young children (ages three to six) living in disadvantaged neighborhoods throughout NYC. ParentCorps was the successful applicant. To scale its impact, ParentCorps developer Dr. Laurie Brotman leveraged foundation dollars with a five-year OMH contract to expand partnerships with policymakers and practitioners to translate findings into broader practice, and advance the model for independent and sustainable implementation. Figure 3-2 highlights the projected growth of ParentCorps throughout New York City.

At the end of the contract, the 36 schools will have the capacity to serve 2,376 Pre-K students annually. Together with the nine schools currently implementing ParentCorps, 45 schools will have the capacity to serve nearly 3,000 Pre-K students and nearly 1,800 families annually. This prevention intervention aligns with State initiatives to support quality in pre-k programs in high-need communities and will yield valuable information to guide practice change to advance a public health approach for promotion, prevention and earlier intervention of children’s social emotional development.

### Project TEACH

Pediatric primary care provides an enormous window of opportunity to offer families information and support on their child’s social-emotional well-being and growth in a non-stigmatizing environment. Further, many children receive mental health counseling and support through their primary care providers (PCPs) with no additional services. PCPs provide mental health support and can prescribe medication, but they may not have access to consultation or the training needed to make decisions for children with mental health needs.

Additionally, while New York State has among the largest number of child and adolescent psychiatrists of any State; there is a significant disparity in distribution. Rural and underserved areas in NYS and elsewhere are particularly hard hit. In a recent study, Kaye and colleagues found:

- 20 percent of 58 counties surveyed reported having no child and adolescent psychiatrist.
- 15 percent reported only one child and adolescent psychiatrist.
- Nearly all counties (53 of 58 surveyed) reported the need for additional child and adolescent psychiatrists.

The American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the National Institute for Health Care Management support providing primary care providers with access to consultation with child and adolescent psychiatrists as a strategy to mitigate the shortage of child and adolescent psychiatrists.

To address many of these issues, in 2010 OMH created a statewide child and adolescent psychiatric consultation...
and training initiative called Project TEACH. TEACH is a collaborative model that is committed to strengthening and supporting the ability of PCPs to provide mental health services to children, adolescents and their families. This statewide program is comprised of three interrelated services for primary care providers: rapid access to child and adolescent psychiatric consultation, referral and linkage to assist families and primary care providers to access community mental health and support services and educational based training.

Figure 3-3 highlights the two regional entities that contract with the Office of Mental Health to deliver Project TEACH services in three regions of the State.

Child and Adolescent Psychiatry for Primary Care (CAP-PC) is a collaboration between the Departments of Psychiatry at the University at Buffalo, University of Rochester, Columbia University Medical Center/NY State Psychiatric Center, State University of New York (SUNY) Upstate, and Hofstra Northwell School of Medicine.

Child and Adolescent Psychiatry Education and Support Program for Primary Care (C.A.P.E.S) The C.A.P.E.S. Program, through the Four Winds Foundation, has been active since 2005.

Since its inception, Project TEACH has provided nearly 10,300 consultations with over 2,300 primary care providers. Additionally, Project TEACH has provided over 3,100 linkage and referral services and over 110 trainings to pediatric PCP providers.

In order to assess the impacts of the Project and any improvements that should be made, OMH in collaboration with key stakeholders began an evaluation in 2012. The evaluation identified positive trends such as improvement in trained PCPs’ perception of their ability to address mental health issues. The report cited an increased ability in trained PCPs to initiate and select appropriate psychotropic medications and to adjust doses as well as an increase in the identification of children diagnosed with mental/behavioral health issues following the PCPs participation in Project TEACH trainings. Moreover, a reduction in the utilization of psychiatric emergency services by children prescribed psychotropic medications was noted post PCPs participation in Project TEACH trainings. The recent evaluation findings supported the need to not only continue, but to expand Project TEACH.

Expansion of TEACH: Regional Providers and Statewide Coordination Center

In 2015, funding for Project TEACH was increased by $1.4 million to $2.5 million annually and the Office of Mental Health re-bid contracts for the Regional Provider services through 2020. Additionally, OMH instituted other improvements to Project TEACH including an increase of child and adolescent psychiatry staffing from 2.0 to 5.25 full time equivalents statewide.

The increased funding will enable Project TEACH to triple the number of consultations with pediatric primary care providers provided by child and adolescent psychiatrists, increase trainings for primary care providers, and add
staff to provide children and families with linkages and referrals to community supports and services. The increased funding will also support a new site for the program—the seventh site statewide. Additionally, other providers who offer ongoing treatment to children, such as general (non-child) psychiatrists, may now request a consultation—further improving the quality of care available to New York children already engaged with psychiatric treatment providers.

In addition to expansion of the Project TEACH Regional Provider services, OMH has established the Project TEACH statewide Coordination Center (SCC) to oversee the successful expansion of Project TEACH. The SCC will promote Project TEACH, strengthen the coordination of consultation services to ensure that utilization is at full capacity, expand training on a statewide basis, add specialty consultation for identified areas of need, and oversee the evaluation of services provided by Project TEACH. The SCC will work with other prevention and early identification initiatives, such as suicide prevention and first episode psychosis initiatives (described later in this report) to bring training to pediatric PCPS.

Additionally, the SCC will be a New York State leader in advancing prevention science by serving as a clearinghouse and resource for promising and evidence based practices in promoting children’s social-emotional health and preventing and treating disorders, and will support the continued integration of pediatric primary care and behavioral health at a systems level.

Upon full implementation of the expansion, OMH estimates they enroll an additional 3,800 providers and conduct an additional 24,500 consultations over the next five years.

For more information about Project TEACH, including information on how primary care providers can take advantage of this program, please visit: https://www.omh.ny.gov/omhweb/project_teach/.

Section 2
The OnTrackNY First Episode Psychosis Program

OnTrackNY is New York’s model early psychosis intervention program, which was built on the National Institute of Mental Health-funded Recovery After an Initial Schizophrenia Episode (RAISE) Implementation and Evaluation Study. The RAISE Connection program study developed and tested the outcomes and implementation challenges of a team-based approach to providing an array of pharmacologic and psychosocial services to help young people with recent-onset psychosis keep their lives on track after an initial psychotic episode. The RAISE Connection program had very high rates of engagement, doubled rates of participation in school and work, and increased rates of remission from psychotic symptoms. In collaboration with OMH leadership, RAISE is a model of how scientific research can be swiftly implemented, or “translated,” into community based treatment programs.

OnTrackNY provides recovery-oriented treatment to young people ages 16 to 30 who have recently begun experiencing psychotic symptoms, helping them achieve their goals for school, work, and relationships. This model is now called Coordinated Specialty Care and is being promoted nationally by a funding increase in the Mental Health Block grant to states. In this type of program, a team of specialists work with clients and their families to create personal treatment plans that are based on their individual needs and preferences.

The OnTrackNY program treatment teams consist of a team leader, primary clinicians, a supported employment/education specialist, an outreach and enrollment specialist, a psychiatrist and nurse. Each team serves up to 35 individuals and provides a range of services, including relapse prevention, illness management, medication management, integrated substance use treatment, case management, family intervention and support, supported employment, and education. Results from the OnTrackNY program include improvements in engagement, functioning and symptoms that are comparable to the RAISE Connection program findings.

OnTrackNY is currently operating at 12 sites throughout the State, with additional locations planned in the future in
order for this service to be available across most areas in the State. The 12 currently operating programs are located in the following areas: Buffalo, Rochester, Syracuse, Albany, Yonkers, New York City (six sites), and Farmingville.

Participating agencies work with county and municipal mental health departments, and receive funds for staff, training, and technical assistance. OnTrackNY will continue to track participants’ recovery, including staying in or returning to school or employment, improved control of mental illness, and reducing the duration of untreated psychosis.

OnTrackNY was developed, and continues to operate under the direction of the Center for Practice Innovations (CPI), which assists OMH in promoting the use of evidence-based practice by using innovative approaches to build collaborations between stakeholders, strengthening the skills of practitioners, and helping agencies develop the means to support such initiatives.

CPI was established in November 2007 with the goals of:

- Promoting the widespread availability of mental health evidence-based practices in New York State.
- Promoting innovations related to emerging promising practices, cultural adaptations, and organizational change approaches that support the implementation of quality services for individuals with serious mental health problems.
- Creating informational and educational resources for the general public as well as users and providers of mental health services.

CPI is located within the New York State Psychiatric Institute (NYSPI) on the New York Presbyterian Hospital/ Columbia University Medical Center campus. NYSPI is one of the Office of Mental Health research institutes, which is also affiliated with Columbia University.

For more information on OnTrackNY and the Center for Practice Innovations, visit http://practiceinnovations.org

Section 3
Integrating Care for Earlier Identification and Treatment of Behavioral and Physical Health Conditions

Since the passage of the federal Affordable Care Act, and the creation of the New York State Medicaid Redesign Team (MRT) shortly thereafter, there has been increasing recognition of the value of integrated behavioral and primary/physical healthcare treatment. This section outlines three of the most significant efforts underway in New York State to more build behavioral health capacity for primary care, and to build primary care capacity for behavioral health. They include Integrated Outpatient Clinic services regulations, Collaborative Care, and the State Innovation Model grant initiative for Advanced Primary Care. This section will also provide an overview of recently adopted telepsychiatry regulations, which are an additional tool to enhance psychiatry services in behavioral health and primary care settings.

Integrated Outpatient Clinic Services

On January 1, 2015, New York witnessed the culmination of a four-year effort to further the integration of physical and behavioral health services in clinic settings across the State. The new authorization establishes the licensure category “Integrated Outpatient Services” (IOS) and appears identically within regulations for OMH-licensed providers (14 NYCRR Part 598), OASAS-licensed providers (14 NYCRR Part 825), and DOH-licensed providers (10 NYCRR Part 404).

Over the past four years, the Office of Mental Health, the Office of Alcoholism and Substance Abuse, and the Department of Health have uniquely partnered in the development, implementation and oversight of the “Integrated Licensure Project.” This collaboration resulted in the development of clinical and physical plant standards, staffing requirements, and a single application and review process – all with the goal to reduce the administrative burden on providers and to improve the quality of care provided to consumers with multiple needs by improving the overall coordination and accessibility of care.
Participating facilities in the Project have been overseen by a single State (“host”) agency, which monitors for compliance with standards at the single site. Therefore, though an agency may have multiple licenses, they are only subject to one survey. Further, the Project has promoted the use of an integrated physical and behavioral health record for recipients.

The now-established IOS regulations further the core principles of the Project, which are:

1. Allowing a provider to deliver the desired range of cross-agency clinic services at a single site under a single license;
2. Requiring the provider to possess licenses within their network from at least two of the three participating State agencies;
3. Allowing the site’s current license to serve as the “host”; and
4. Facilitating the expansion of “add-on” services through a request to the State agency that is principally responsible for oversight of such services.

### Applicable Sites for Integrated Outpatient Services

Providers eligible to become IOS providers under the uniform regulations must already possess licenses within their network from at least two of the three participating State agencies, as indicated above. In addition, the provider must be in “good standing” with the agencies for whom it will be operating integrated services, and must be affiliated with a Health Home (DSRIP Performing Provider System network status is not a sufficient substitute for Health Home affiliation).

Integrated outpatient clinics fall into three main categories that are organized under “host” models. The host model refers to the lead agency which oversees and is the primary point of contact for all of the integrated services:

1. **Primary Care Host Model**: The State Department of Health is the lead oversight agency, and behavioral health services (substance use disorder (SUD) and/or mental health (MH)) are provided in addition to primary health care.
2. **Mental Health Behavioral Care Host Model**: The State Office of Mental Health is the lead oversight agency, and primary health care and/or substance use disorder services are provided in addition to mental health care.

### Licensure Threshold Crosswalk for DSRIP Project 3.a.i. Clinics

<table>
<thead>
<tr>
<th>Existing Licensure Thresholds</th>
<th>DSRIP Project 3.a.i Licensure Thresholds</th>
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</thead>
<tbody>
<tr>
<td>A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if it has more than 10,000 annual visits for mental health services or more than 30 percent of its total annual visits are for mental health services.</td>
<td>A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if more than 49 percent of its total annual visits are for mental health services.</td>
</tr>
<tr>
<td>A PHL Article 28 provider may not provide substance use disorder services without being certified by OASAS pursuant to MHL Article 32.</td>
<td>A PHL Article 28 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services.</td>
</tr>
<tr>
<td>A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 5 percent of its total annual visits are for primary care services or if any visits are for dental services.</td>
<td>A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 49 percent of its total annual visits are for primary care services or if any visits are for dental services.</td>
</tr>
<tr>
<td>No existing Licensure Threshold. A MHL Article 31 provider or MHL Article 32 is able to integrate mental health and substance use disorder services pursuant to a Memorandum of Agreement between OMH and OASAS.</td>
<td>A MHL Article 31 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services.</td>
</tr>
<tr>
<td>A MHL Article 32 provider must be certified by OMH if more than 49 percent of its total annual visits are for mental health services.</td>
<td>A MHL Article 32 provider must be certified by OMH if more than 49 percent of its total annual visits are for mental health services.</td>
</tr>
</tbody>
</table>
3. **Substance Use Disorder Behavioral Care Host Model**: The State Office of Alcoholism and Substance Abuse Services is the lead oversight agency, and primary health care and/or mental health services are provided in addition to substance use disorder care.

Applications to become an IOS provider are made on a clinic-specific basis, and therefore the agency under which the applicant clinic is originally licensed determines the host site status. For example, an Article 31 mental health clinic applying to become an IOS clinic providing substance use disorder services in addition to those on its original license, will have the State Office of Mental Health as its primary State oversight agency and point of contact.

**Services Provided by Integrated Outpatient Clinics**

Any clinic that operates as an IOS provider must continue to offer those services required under their host model agency regulations, in addition to those services required under the regulations of the secondary and tertiary licensing agencies.

Any behavioral health care host model must also complete treatment plans for clinic enrollees, which must include physical health, behavioral health, and social service needs. Treatment plans must be completed within 30 days of admission to the clinic. Primary care host models must complete treatment plans for behavioral health services only after a patient has been advanced beyond assessment and pre-admission services. In such cases, a treatment plan is required within 30 days after a decision has been made to begin post-admission behavioral health services.

**Adoption of Integrated Outpatient Services by Clinics statewide**

Since the final adoption of the IOS regulations on January 1, 2015, those clinics that were included in the pilot project for integrated outpatient services have continued providing integrated services consistent with the regulations. Additional providers that were not included in the pilot have also since received approval to provide integrated services. The following statistics reflect the number of IOS sites by type, including both grandfathered sites and those approved under the new IOS regulations (as of August 26, 2016):

- **14 OMH host sites total**
  - 7 with SUD
  - 6 with primary care
  - 1 with both
- **8 OASAS host sites total**
  - 6 with MH
  - 2 with primary care
  - 0 with both
- **0 DOH host sites total**

**Integration of Primary and Behavioral Health Care under DSRIP: Project 3.a.i.**

In addition to the opportunity to provide integrated behavioral health and primary care services under the IOS regulations, the DSRIP Program has provided another avenue for clinics within Performing Provider Systems (PPS) to integrate care under DSRIP Project 3.a.i.

OMH, OASAS, and DOH collectively agreed to raise the current licensure thresholds associated with clinics in order to allow a greater number of secondary and tertiary services at existing sites, for those clinics that are part of a DSRIP Project 3.a.i. (which was chosen by all 25 PPSs). However, it is important to note that any clinic providers operating within the existing licensure thresholds or the DSRIP Project 3.a.i. licensure thresholds must also meet certain regulatory requirements outlined by the host model.

Approved DSRIP 3.a.i. integrated clinic sites (as of October, 2016):

- **14 OMH host sites total**
  - 7 with SUD
  - 6 with primary care
  - 1 with both
- **8 OASAS host sites total**
  - 6 with MH
  - 2 with primary care
  - 0 with both
5 DOH host sites total
- 4 with MH
- 0 with SUD
- 1 with both

Collaborative Care

Behavioral health disorders such as depression, anxiety, and substance use disorders are major drivers of disability and health care costs, but only three in ten adults living with a mental health or substance use disorder currently receive care from a mental health specialist. At a time when policy makers and payers are tasked with quickly moving from volume to value-based purchasing of healthcare, there is strong evidence that effectively integrated behavioral health services can help achieve the health care Triple Aim for better care, better outcomes, and lower costs.

Among models of behavioral health integration, Collaborative Care (also known as the IMPACT model) stands apart through a large evidence base, and a significant potential impact on population health. This model of care brings the individual together with the primary care provider, a care manager, and a consulting psychiatrist to treat depression and other common mental health diagnoses in the primary care environment, and utilizes an electronic registry to track each individual's progress and monitor outcomes on the whole patient population. Collaborative Care helps the practice build in-house capacity to treat behavioral health conditions, as well as enhances the ability to manage co-morbid chronic diseases such as diabetes or hypertension by addressing some of the behavioral factors impacting physical health outcomes. Rigorously evaluated over the last 20 years, there are now more than 80 randomized controlled trials that have shown Collaborative Care to be significantly more effective than the usual process of referring out to specialty behavioral healthcare.

New York State has been a leader in implementing Collaborative Care, beginning with a two year implementation for depression in 2014 through 19 academic medical centers and 32 primary care training clinics as part of the NYS Department of Health Medical Home Demonstration Project. This project provided grant funding and technical assistance to a limited number of sites to build their capacity and implement Collaborative Care, however the lack of a sustainable financing mechanism to support Collaborative Care had initially threatened the infrastructure developed during the grant.

A critical development in advancing Collaborative Care in New York has been the Governor and Legislature’s agreement to allocate at least $11 million to support the model for Medicaid recipients. Using this allocation, OMH created the Medicaid Collaborative Care Depression Program. This program has been offered to sites that demonstrated success in the grant project in order to allow them to both continue and expand the work they have done, while new programs that are equipped to implement Collaborative Care, such as Federally Qualified Health Centers (FQHCs), have also been included. The Medicaid Collaborative Care program continues to provide technical assistance and training to participating practices to help them continue to grow their programs.

Additionally, practices that meet certain process and outcome standards are able to receive a monthly case rate for each program enrollee. Practices submit quarterly outcomes reports to OMH to demonstrate progress and show the model is functioning as designed. OMH will be evaluating the program to support the case for continued expansion of the Collaborative Care model, as well as the case rate financing method. To date, there are 36 active sites, with an additional 18 expected under Delivery System Reform Incentive Payment (DSRIP) project technical assistance efforts.

Many other NYS initiatives are encouraging the implementation of Collaborative Care as part of the increasing emphasis on behavioral health integration including the DSRIP project 3.a.i. and Advanced Primary Care. In conjunction with the Medicaid program, these programs will allow more New Yorkers access to integrated and coordinated care so that behavioral health conditions can be recognized earlier and treated more efficiently, thereby reducing the burden of disease statewide. For information on the Collaborative Care model or the Medicaid program, contact nyscollaborativecare@omh.ny.gov.
Advanced Primary Care and the State Innovations Model

In December 2014 New York State DOH, in coordination with Health Research, Inc. was awarded a four-year, $100 million State Innovations Model (SIM) grant by the Centers for Medicare and Medicaid Services. As part of the broader State Health Innovation Plan (NYSHIP), SIM will help New York State integrate care and services by improving access to primary care, and also by integrating primary care into long-term care, behavioral health, specialty care and community supports.

One key strategy and requirement of the SIM grant is the implementation of the Advanced Primary Care (APC) model. The NYS APC model is consistent with principles of NCQA\(^2\) Patient Centered Medical Home criteria; but seeks to move beyond structural criteria to achieve durable, meaningful changes in processes and outcomes. APC seeks to provide patients with access to high quality, integrated care, delivered by teams of providers with the capacity to manage the care of patients with chronic illnesses. SIM support will enable the State to achieve three core objectives within five years:

1. 80 percent of the State’s population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral healthcare;
2. 80 percent of the care will be paid for under a value-based financial arrangement; and
3. Consumers will be more engaged in, and able to make more informed choices about their own care, supported by increased cost and quality transparency.

To support practices in the evolution to APC status, NYS will support practice transformation including goal-setting, leadership, practice facilitation, workflow changes, measuring outcomes, and adapting organizational tools and processes to support new team-based models of care delivery over the three year implementation period. Operationally, practice transformation expanded clinical prevention services will be driven in party by SIM-funded Public Health Consultants. These consultants will work closely with regional Population Health Improvement Programs (PHIPs), SIM-funded practice transformation teams and Medicaid DSRIP Performing Provider Systems.

Behavioral health integration will be achieved under APC in part through the broader adoption of depression screening and Collaborative Care, and the addition of screening and interventions for substance use disorders, such as SBIRT (Screening Brief Intervention, and Referral to Treatment).

The hallmark of APC is support from payers, including private insurers, in order to reach all populations. Ultimately, primary care practices will have to negotiate alternative payment models with plans to support value-based payment structured around the APC elements. Two proposed metrics related to behavioral health that will be tracked as well are 1) depression screening and management and 2) initiation and engagement in alcohol or substance use treatment.

In December 2015, the State Department of Health submitted the SIM Year Two Operational Report,\(^{13}\) with detailed project deliverables and core metrics associated with APC. This report makes it clear that the large scale adoption of APC across settings and payers is a multi-level, long term, and complex endeavor that requires significant and sustained attention by practitioners, planners, and policymakers alike. However, the planning underway places New York on a strong footing to advance the behavioral health competencies in primary practice, and impact thousands more individuals who have not previously been identified or treated for mental health conditions.

Telepsychiatry

Technology has made it possible to increase access to healthcare, including behavioral health care, by utilizing secure interactive communications. Telepsychiatry is the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance. Telepsychiatry is appropriate in situations where on-site services are not available due to distance, location, time of day, or availability of resources. The many advantages offered through telepsychiatry have led to a rapid expansion of such programs across New York State and the rest of the country. While clinical practice standards are developing along with this proliferation, OMH regulations currently address the use of telepsychiatry only in OMH licensed clinics.
Recently adopted regulations (Part 596 of the New York Codes, Rules and Regulations Title 14) expand the types of arrangements/sites eligible for telepsychiatry in New York State. Under these new regulations, only one site needs to be a licensed Article 31 program (ACT and PROS programs are excluded), while the other site must only be enrolled as a provider in the Medicaid program.

OMH advises sites seeking approval to utilize telepsychiatry to review all OMH regulations and guidelines, and incorporate relevant provisions into their plans. Additionally, before starting to offer telepsychiatry, policies and procedures should be in place at both the originating/spoke site and the distant/hub site to address:

- General clinic procedures.
- Physical environment.
- Site and check-in procedures.
- Emergency procedures.
- Quality review.
- Prescriptions, labs and orders.
- Patient enrollment for telepsychiatry and informed consent.
- Collaborating with patient’s interdisciplinary treatment team.
- Care between telepsychiatry sessions.
- Confidentiality and privacy of health information.

The new regulations now permit telepsychiatry in settings such as Comprehensive Psychiatric Emergency Programs, Emergency Departments, and OMH licensed inpatient hospitals and units. However, the regulations will continue to prohibit the use of telepsychiatry for Mental Hygiene Law Article 9 commitments, medication over objection, and the ordering of restraint and seclusion.

As the adoption and use of telepsychiatry develops and grows, it is important to remember that such technology is to be used in combination with, but not as a replacement for, a broader program and plan for direct treatment and support services. However, with that in mind, the possibility that this technology can and will provide increased access to psychiatric services for individuals and communities across the State, is very promising.

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9 Table from link in note below.

10 The host model can be found on the Department of Health website at [http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_thresholds.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_thresholds.htm).

11 Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. Arch Gen Psychiatry, 62 (6) 629-40.

12 NCQA is the name commonly used by The National Committee for Quality Assurance.


14 The Office of Mental Health is piloting the use of telepsychiatry for Article 9 commitments in a small numbers of sites, after which a review and findings will inform any broader use of the technology for these purposes.
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Chapter 4
New York State’s Suicide Prevention Plan 2016-17 from the OMH Suicide Prevention Office

Suicide is a significant public health problem in the United States and New York State. The most recent data available indicates that in 2014, 42,773 persons died by suicide in this country. Over the last decade, the nation witnessed the number of annual suicide deaths surpassing deaths by motor vehicle accidents, homicides, and most recently breast cancer. Since 1999 rates of leading causes of death, such as heart disease, stroke, and cancer, have been decreasing, but according to a recent report by the Centers for Disease Control and Prevention (CDC), the suicide death rate in the US increased by 24 percent.

New York State itself has one of the lowest suicide rates in the nation, at 8.6 suicide deaths per 100,000 (vs. 13.4 per 100,000 nationally), however this still reflects an increase of 32 percent over the past decade, amounting to 1,700 deaths by suicide in 2014.

In consultation with a panel of national and State experts on suicide, public health, and prevention, The New York State Office of Mental Health Suicide Prevention Office (SPO) recently developed a comprehensive Suicide Prevention Plan that addresses the problem at three levels:

1. Implementation of the Zero Suicide strategy for preventing suicide for individuals in health and behavioral health care settings;
2. A lifespan prevention approach to foster competent and caring communities; and
3. Suicide surveillance and data-informed suicide prevention.

This chapter provides a brief statistical summary of suicide in New York and nationally, followed by an overview of the Suicide Prevention Office strategic plan to prevent suicide in New York State. The full version of the SPO’s Suicide Prevention Plan 2016-17 is available at https://www.omh.ny.gov/omhweb/resources/publications/suicide-prevention-plan.pdf

The Data on Suicide in New York

**Geography:** New York City and the surrounding metropolitan areas (Mid-Hudson and Long Island) have the lowest suicide rates in the State, with Kings County representing the lowest county-level rate at 4.7 deaths per 100,000. The North Country has the highest suicide rate, at 13.8/100,000. The highest suicide rates are in predominantly rural counties.

**Means:** For 2014, the most prevalent means of suicide lethality in New York are suffocation (37 percent), firearms (28 percent), and poisoning (17 percent). The

The Seven Elements of the Zero Suicide Strategy

These seven core elements or processes that drive Zero Suicide systems of care are:

1. Leadership-driven, safety-oriented culture committed to reduce suicides among people in care.
2. A workforce with suicide specific expertise.
3. Suicide risk among people receiving care is identified and assessed.
4. Individualized pathway of care, including safety planning with lethal means reduction.
5. Evidence-based treatments are used to target suicidal thoughts and behaviors.
6. Care transitions include follow-up contact and support, especially after episodes of acute care.
7. Data-driven CQI (continuous quality improvement) processes are applied to inform systems.
firearm rate of suicide lethality is significantly below national trends, where more than half of all suicide deaths are by firearm.

**Demographics:** Demographic trends for suicide death in New York are consistent with national data. Based on the CDC data\(^3\) for New York State in 2014:

- Men accounted for 75 percent of all suicide deaths.
- Whites have the highest rates of suicide.
- The 45-64 age group has the highest rate of suicide.

Due to broader national trends consistent with the data above, the middle-aged white male demographic group has come under increased attention since the publication of a major study on the mortality rates that showed escalating rates of death by suicide, drug overdose, and alcoholic liver disease for this population.\(^6\) As suggested by the individual demographic data profiles, New York State rates are consistent with the United States as a whole, with a suicide rate for middle-aged males at 22.3 per 100,000—nearly three times the rate in the general population.\(^4\)

**Risk factors:** While suicide is relatively rare, and very difficult to predict, there are a few major factors associated with statistically higher risks of suicide, including:

- People with mental illness are more likely to die by suicide than the general population. For New York State, an analysis of individuals receiving services in the licensed mental health system revealed a suicide rate of 38.8 per 100,000; nearly five times greater than the general population.\(^7\)
- Alcohol and drug use is estimated to be associated with as high as 63 percent of all suicides nationally.\(^8\)
- Trauma is associated with up to a twenty-time greater likelihood of suicide.\(^9\)
- History of suicide: A previous suicide attempt indicates a risk of future suicide 30-40 times greater than for people without a past attempt.\(^10\)
- Self-injury: A history of non-suicidal self-injury increases suicide risk more than two-fold.\(^11\)

**The NYS Suicide Prevention Strategy**

New York’s 2016-17 Suicide Prevention Strategy uses a multifaceted systems approach that targets both health/behavioral healthcare and community settings, with a commitment to continuously use data to inform and evaluate the effort over time. Building on the strength of the current foundation for suicide prevention, the New York State strategic framework is divided into three domains or strategies:

1. Prevention in health and behavioral healthcare settings—Zero Suicide in New York State,
2. Lifespan prevention approach in competent, caring communities, and
3. Suicide surveillance and data-informed suicide prevention.

This section provides a brief overview of each domain of the Suicide Prevention Plan. A more thorough description of all sections is included in the full report.

**Strategy 1: Prevention in Health and Behavioral Healthcare Settings—New York State Implementation of Zero Suicide**

Developed under the National Action Alliance for Suicide Prevention, Zero Suicide depends on successfully re-engineering healthcare systems in order to identify those in distress and at risk for suicide, and deliver timely intervention.\(^12\) The model is based on three basic observations:

1. Most suicide deaths occur among people recently discharged from care.
2. New knowledge about detecting and treating suicidality is not commonly used.
3. Suicide prevention in healthcare requires a systematic clinical approach.

Zero Suicide implementation in New York State offers a strategic approach for reaching many high-risk populations, given their contact with the health and behavioral healthcare systems. The Suicide Prevention Office developed six guiding principles that will help promote and accelerate the transformation required of health and behavioral health systems to truly integrate Zero Suicide. These principles, which are described in detail in the full report, are summarized below.

**Zero Suicide Guiding Principles:**

A. Start with the public mental health system, beginning with outpatient clinic care.
B. Invest in trainings that utilize the latest clinical knowledge.
C. Target culture change to move the system towards population-based preventive engagement.
D. Provide a clear definition for “suicide safer care.”
E. Integrate lived experience into policy and planning.
F. Capitalize on opportunities to broaden Zero Suicide beyond the public mental health system through government and private sector alliances.

Strategy 2: Prevention across the lifespan in competent, caring communities

Community settings offer opportunities to detect and intervene with high risk populations, including some of which may not be easily reached through the health and behavioral healthcare system. New York State is seeking to develop programming that covers the lifespan. From school-aged children to young and middle-aged adults to seniors, the collective goal is to reduce risk factors and bolster protective factors among those at risk.

Primary prevention strategies (those that prevent individuals from becoming suicidal in the first place), and secondary prevention strategies (those that intervene at the earliest stages of suicidal crises) offer critically important avenues for reducing the number of suicide deaths in New York State. By targeting the antecedents of suicide and broadly promoting mental health and supportive social connection, several lines of evidence suggest that “upstream” interventions can potentially leave large populations less vulnerable to suicide.

This expanded focus on addressing “upstream” risk and protective processes—before individuals develop entrenched problems or become suicidal—represents a meaningful expansion of the suicide prevention paradigm. Evidence is growing that suicidal behavior can be reduced by successful interventions that promote emotional, social and behavioral health. For example, the Good Behavior Game, implemented by teachers in first and second grade classrooms, reduced suicide attempts fifteen years later by nearly one-half, showing the potential suicide prevention impact from enhancing children’s skills for managing their behavior and emotions. Upstream approaches may be particularly important for older adults because of the lethality of suicidal behavior in that segment of the population. Among this population, interventions targeting social isolation seem promising and are currently under investigation for suicide prevention effects.

Four principles guide New York State’s approach to develop competent, caring communities with the ultimate goal of leaving community members less vulnerable to suicide across the lifespan. These are explored in detail in the full Suicide Prevention Plan 2016-17, and summarized below.

Guiding principles for “Prevention across the lifespan in competent, caring communities”:

A. Develop, support, and strengthen community coalitions as the “backbone” of local suicide prevention infrastructure.
B. Create suicide safer school communities.
C. Utilize postvention as prevention.
D. Deliver targeted gatekeeper trainings.

Strategy 3: Surveillance and Data-Informed Suicide Prevention in New York State

Preventing suicide is difficult, in part, because of the inherent challenges of measuring progress. First, statistics are most powerful when applied to large populations. While shockingly common, suicide remains statistically rare; what statisticians refer to as a low base-rate phenomenon. Second, population-derived suicide risk factors have not translated readily into accurate prediction at the individual level. Third, the one to two years it generally takes for states to release the most definitive counts of suicides in a given year is too much of a lag for quality improvement initiatives, which require much faster data collection and reporting cycles in order to allow timely mid-course corrections. Finally, while the agency has made great strides in recent years, there is still no clear consensus within the field of suicide prevention on how best to measure progress, and the metric used may depend on the setting and a number of other factors.

All of the above challenges underscore the need to continuously enhance and improve suicide surveillance data. The success of both healthcare and community-based suicide prevention initiatives depend on leveraging the best information available and presenting it to stakeholders in a readily “actionable” form. New York State is fortunate to have a good foundational surveillance infrastructure on which to build.

The following principles illustrate the New York State approach to enhancing and improving suicide surveillance:

A. Develop, support, and strengthen community coalitions as the “backbone” of local suicide prevention infrastructure.
B. Create suicide safer school communities.
C. Utilize postvention as prevention.
D. Deliver targeted gatekeeper trainings.
data and using it to guide quality improvement initiatives:

Guiding principles for “Surveillance and Data-Informed Suicide Prevention:”

A. Enhance and improve suicide surveillance data.
B. Disseminate surveillance data to stakeholders in readily usable forms to support quality improvement work.
C. Perform in-depth reviews of suicides occurring within the public mental health system.
D. Promote a research agenda that leverages the use of technology and large scale trials.

The NYS Suicide Prevention Infrastructure

The New York State Office of Mental Health has played a central role in suicide prevention in the State. In order to most effectively advance our efforts as an organization, OMH conducted a review of all OMH supported suicide prevention activities across the agency and our affiliates in 2014. In addition to providing a comprehensive overview of projects, which included a well-established community and gatekeeper training infrastructure, this comprehensive review made recommendations to improve the organizational infrastructure for suicide prevention in New York State, including:

1. Improved coordination and alignment of statewide initiatives,
2. Additional investment in suicide prevention clinical trainings, and
3. The establishment of the Suicide Prevention Office, within the Office of Mental Health.

These recommendations have informed the organizational frameworks for suicide prevention under the Office of Mental Health. Each of the entities described below will fulfill and advance specific components of the Suicide Prevention Plan 2016-17, and in years beyond.

The OMH Suicide Prevention Office

The Suicide Prevention Office (SPO) was created in 2014 to coordinate all OMH-sponsored suicide prevention activities. SPO aims to strengthen suicide safer care across health care settings starting with behavioral health, followed by primary care, emergency rooms, and substance use disorder treatment settings, while continuing to support and strengthen the existing community-based infrastructure. SPO’s main partners include:

- Office of Performance Measurement & Evaluation
- New York State Incident Management Reporting System (NIMRS)
- Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)
- Center for Practice Innovations (CPI)
- Suicide Prevention-Training, Implementation and Evaluation Program (SP-TIE)
- Suicide Prevention Center of New York (SPC-NY)
in this endeavor are the Suicide Prevention—Training, Implementation, and Evaluation (SP-TIE) program within the Center for Practice Innovations and the Suicide Prevention Center of New York (SPC-NY).

SPO’s efforts to date have focused on:

- Collaboration and coordination across the OMH system, including licensing, State operated facilities, and field offices;
- Review of suicide deaths of individuals served by OMH;
- Improved use of existing suicide surveillance data; and
- Establishing a learning collaborative to provide technical assistance to early adopter provider systems interested in implementing current best practices of the Zero Suicide model.

Suicide Prevention Center of New York (SPC-NY)

Founded in 2009 by OMH, SPC-NY is the community-based presence of suicide prevention within the State. It advances statewide and county-specific suicide prevention initiatives. SPC-NY has developed a strong community-based infrastructure that supports local efforts to prevent suicide, including promoting suicide prevention in schools, early identification through gatekeeper trainings, and local support for individuals through fostering competent caring communities.

SPC-NY has supported the development and growth of suicide prevention coalitions in 44 counties across the State and the training of over 30,000 individuals as gatekeepers since 2012. When a community is affected by a suicide death, SPC-NY, through its collaborative efforts with local OMH field offices and local organizations, facilitates postvention responses and activities to address the loss, and limit contagion effects.

Suicide Prevention-Training, Implementation, and Evaluation (SP-TIE)

Established in 2014 at the New York State Psychiatric Institute, SP-TIE is an initiative within the Center for Practice Innovations (CPI), a joint program of OMH and Columbia University. SP-TIE’s mission is to increase the capacity of clinicians in the State to assess, manage and treat suicidal individuals. In coordination with the SPO, SP-TIE selects, develops, implements and evaluates evidence-based suicide prevention clinical interventions. It is responsible for developing suicide safer care, clinical training approaches and materials for clinicians across the State (e.g. risk assessment, safety planning, and evidenced-based interventions), identifying and targeting gaps in expertise and training, and conducting ongoing evaluation for both SP-TIE and SPC-NY training offerings.

Summary

New York State OMH has an ambitious goal for suicide prevention across the State in the coming years. The 2016-17 strategic plan outlines the short-term strategy for making progress toward longer-term goals. This strategy focuses on suicide prevention in health, behavioral health, and community settings and will leverage State data and the unique expertise of each of its partners to achieve its goals. The plan was first presented during the first annual statewide suicide prevention conference in September 2016, where presenters highlighted current initiatives within OMH’s Suicide Prevention Plan, garnered support among stakeholders, and established an agenda for the coming year.

New York State has one of the lowest suicide rates in the nation. OMH believes it is a reflection of all the collaborative work that has been conducted by communities, providers, public health professionals, suicide prevention experts and policy makers across the State. However, the burden remains high, and 1,700 suicide deaths each year is too many. More coordinated action must be taken to address the significant public health problem of suicide in our communities. This plan represents an important step toward materially reducing the burden of suicide in New York State.

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1 This chapter is excerpted from “1,700 Too Many: New York State’s Suicide Prevention Plan 2016-17,” by the NYSOMH Suicide Prevention Office, issued in September 2016.


5 Suicide lethality by poisoning is likely underestimated due to the difficulty in distinguishing between accidental and intentional drug overdoses. There were 1,937 overdose deaths in 2014 that were classified as accidental; some may have been undetected intentional overdose.


7 New York State Office of Mental Health Incident Management Reporting System (NIMRS), 2015.


12 The Suicide Prevention Resource Center includes a comprehensive overview of the Zero Suicide strategy, at [http://zerosuicide.sprc.org/](http://zerosuicide.sprc.org/)


16 Crosby, A., Han, B., Ortega, L., et al. (2011) Suicidal thoughts and behaviors among adults aged 18 years and older—United states, 2008-2009. Centers for Disease Control and Prevention MMWR. [http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6013a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6013a1.htm)
Chapter 5: Managed Care of Integrated Behavioral and Physical Health Services

Physical health and mental health are inextricably linked. Data from the 2003 National Co-morbidity Survey Replication show that nearly 7 out of 10 adults with a mental disorder have one or more medical conditions, while 3 out of 10 adults with medical disorders experience at least one mental health condition. Moreover, an estimated 70 percent of primary care visits have been attributed to psychosocial issues, suggesting that office visits by people with physical health ailments may often be prompted by underlying behavioral health issues. The relationship between physical and mental health is further complicated by our knowledge that barriers to primary healthcare services—coupled with challenges in navigating intricate healthcare systems—represent a major obstacle to effective care for people with physical and behavioral health conditions.

In response to these data and emerging evidence about the importance of integrated healthcare, health organizations are striving to shift resources from systems in which care often has been poorly coordinated to ones where the delivery of physical and behavioral healthcare is systematic, well-coordinated and integrated. In New York State, the Office of Mental Health’s State and community-based service Transformation Plan is just one example of an effort aimed at addressing the fragmentation of healthcare, improving outcomes, and holding down the costs of care. Nationally, such efforts have been spurred in part by the passage of the federal Affordable Care Act, which is providing incentives and support for the integration of mental health, substance abuse and primary care services for millions of Americans, as well as their integration with physical healthcare services;

- Examination of opportunities for the co-location of services and peer and managed addiction treatment services and their potential integration with behavioral health organizations (BHOs); and
- The provision of guidance about health homes and proposals of other innovations that lead to improved coordination of care between physical and mental health services.

The MRT process reflected the recognition that the State’s behavioral health system was large and fragmented, with then more than 700,000 people with mental illness being served at an estimated annual cost of $6.6 billion. Approximately one-half the spending goes to inpatient care. For substance use disorders, the publicly funded system serves more than 250,000 individuals and accounts for about $1.7 billion in expenditures annually. However, despite the significant spending on behavioral healthcare, comprehensive care coordination for
individuals receiving services (particularly those with the most intensive needs) has been lacking and accountability for outcomes and quality care have been insufficient.

The MRT report also documented the lack of clinical, regulatory and fiscal integration and effective care coordination for behavioral health and physical healthcare. While behavioral health is funded primarily through fee-for-service Medicaid funding, a substantial portion of physical healthcare for people diagnosed with mental illnesses and/or substance use disorders is financed and arranged through Medicaid managed care plans. The result of these funding arrangements is that they inadvertently contributed to fragmented care and a lack of accountability for care. Moreover, this fragmentation and lack of accountability extend well beyond physical healthcare into the education, child welfare, and juvenile justice systems for children and youth under the age of 21, as well as adults who are homeless or involved in the criminal justice system.

When care is not well coordinated, there is greater risk that behavioral health needs will not be identified and people will receive suboptimal behavioral healthcare in primary care settings. Untreated or suboptimal treatment of behavioral health conditions is associated with lower adherence to prescribed medical treatment, higher medical costs, and poorer health outcomes. In particular, adults with mental disorders have a highly elevated risk of premature mortality, largely due to poorer physical health status, as well as accidents or suicides. Given the high prevalence of mental illnesses and co-occurring mental illnesses and substance use disorders among Medicaid beneficiaries, the opportunity for improved clinical and financial outcomes through improved coordination of behavioral and physical health services is strong. The integration of behavioral and physical healthcare via managed care for individuals with substance use disorders, with or without serious mental illnesses is associated with improved access, better monitoring of quality outcomes and a better distribution of services across the entire care continuum.

The MRT has provided NYS with a blueprint and action plan for reforming Medicaid services and optimizing health system performance through alignment with what the Institute of Healthcare Improvement calls the “Triple Aim:“ improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per person cost of healthcare. Overall, the design and operational components of the newly configured behavioral health system for Medicaid beneficiaries address the State’s advancement of the MRT vision and goals, including:

- Improved access to appropriate behavioral and physical healthcare services for individuals with mental illnesses and/or substance use disorders;
- Better management of total medical costs for individuals diagnosed with co-occurring behavioral and physical health conditions;
- Improved health outcomes and increased satisfaction among individuals engaged in care;
- Transformation of the behavioral health system from one dominated by inpatient care to one based in ambulatory and community care;
- Enhanced service delivery system that supports employment, success in school, housing stability and social integration.

The centerpiece of the MRT vision is the expansion and redesign of the State’s behavioral health Medicaid program through a broader managed care strategy and “carving in” previously managed care exempt Medicaid services and beneficiaries into a managed, coordinated benefit package.

**Adults Transition for Mainstream and Health and Recovery Plans**

For adults aged 21 and older, the integration of all Medicaid behavioral health and physical health benefits under managed care will be delivered through two behavioral health managed care models:

**A. Qualified Mainstream Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid State Plan covered services for mental illness, substance use disorders and physical health conditions.

**B. Health and Recovery Plans (HARPs):** HARPs will manage care for adults with significant behavioral health needs. These specialized Plans will facilitate the integration of physical health, mental health and SUD services for
individuals requiring specialized expertise, tools and protocols which are not consistently found within most medical plans. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of Behavioral Health Home and Community Based Services (BH HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan. BH HCBS are available to beneficiaries based on their detailed plan of care, which will be informed by a full functional assessment. In order to qualify as HARPs, Plans were required to demonstrate that they have the organizational capacity and culture to ensure the effective management of behavioral health care and facilitate system transformation.

Beginning with adults in New York City, the first phase HARP enrollment letters were distributed between July 2015 and October 2015, followed by staggered enrollments from October 2015 to January 2016. In October 2015, mainstream plans and HARPs implemented non-HCBS behavioral health services for enrolled members, and HCBS service implementation began for the HARP population in January 2016. In the remainder of the State, the first phase of HARP enrollment letters were distributed in April 2016, and in July 2016, mainstream plan behavioral health management and phased HARP enrollment began. Children’s implementation will begin in New York City and Long Island in July 2017, followed by the remainder of the State in January 2018. The State agencies are working with plans to ensure that they are ready to implement the requirements included in the request for proposals. Access the full timeline on the DOH website.

The ultimate goal of this transition is to provide New Yorkers with fully integrated behavioral health and physical health services offered within a comprehensive, accessible and recovery oriented system.

Mainstream and Health and Recovery Plan Qualification Process

NYS, in conjunction with the New York City Department of Health and Mental Hygiene (“NYC DOHMH”), engaged in a thorough “Request for Qualification” (“RFQ”) Process. The RFQ required all mainstream MCOs operating in NYC to produce a detailed account of their qualifications to provide the general behavioral health managed care benefit. It also required Plans who applied to offer the HARP product line to demonstrate their ability to manage the specialty benefit. NYS evaluated the adequacy of plan capacity to arrange and manage the delivery of covered behavioral health services during a readiness review process. In July 2015, NYS issued an RFQ for plans in the Rest of State, with reviews completed by spring of 2016.

The RFQ required all plans to show how they will, among other requirements:

- Develop a behavioral health network based on the anticipated needs of special populations;
- Maintain a network of physical health providers that meets the physical health needs of people with serious mental illness and substance use disorders;
- Provide primary care screening for anxiety, depression and substance use disorders; and
- Include a sufficient number and array of providers to meet the diverse needs of the member population, including geographic accessibility, cultural competence and physical accessibility for people with disabilities.

In addition, Plans must comply with the following requirements:

- Contract with behavioral health agencies licensed or certified by OMH or OASAS who serve five or more Medicaid managed care enrolled beneficiaries. Mainstream MCOs and HARPs must offer to contract with these behavioral health agencies for at least the first 24 months of operation;
- Contact with all Essential Community Behavioral Health Programs including offering contacts to all OASAS Certified Opioid Treatment Programs in plan service regions;
- Contract with a sufficient array of BH HCBS providers to meet network adequacy. Submit their network plan to the State to ensure adequacy of network. NYS will also review
network compliance on an ongoing basis; and
• Demonstrate that their managerial staff have expertise in network development.

**HARP Behavioral Health Home and Community Based Services (Adult BH HCBS)**

The Centers for Medicare and Medicaid Services (CMS) authorized various BH HCBS under Medicaid waiver authority. BH HCBS are designed to help adults (21 and over) with serious mental illness and/or Substance Use Disorder remain and recover in the community and reduce preventable admissions to hospitals, nursing homes, or other institutions.

BH HCBS address isolation and promote integration by providing a means by which individuals may gain the motivation, functional skills, and personal improvement to be fully integrated into the community and achieve life goals. The goal of integrating BH HCBS into the managed care environment is to promote significant improvements in the behavioral health system of care and move toward a recovery-based managed care delivery model. The recovery model of care, as envisioned in the HARP and HIV Special Needs Plan (SNP) models, emphasizes and supports an individual’s recovery by optimizing quality of life and reducing symptoms of mental illness and Substance Use Disorders through empowerment, choice, treatment, education, employment, housing, and health and well-being.

HARPs and HIV SNPs provide BH HCBS as a covered benefit for qualified members. HARPs and HIV SNPs must create an environment where the plan, service providers, plan members, families and other significant supporters, and government partner to assist members in prevention, management, and treatment of physical and behavioral health conditions, including serious mental illness and Substance Use Disorders.

The following BH HCBS are included in the HIV SNP and HARP benefit package:

• Psychosocial Rehabilitation
• Community Psychiatric Support and Treatment
• Habilitation
• Family Support and Training
• Short-term Crisis Respite
• Intensive Crisis Respite
• Education Support Services
• Empowerment Services - Peer Supports
• Pre-vocational Services
• Transitional Employment
• Intensive Supported Employment
• Ongoing Supported Employment
• Non-Medical Transportation

The initial designation process for behavioral health HCBS providers was completed in March 2015 for New York City (NYC) and December 2015 for the rest of State. All agencies wishing to provide BH HCBS must apply to be designated for each service they would like to provide. Applicants may apply at any time for a designation, however the State will only update the designation lists quarterly for each area on a periodic basis. Information on providing BH HCBS can be found in the BH HCBS Manual on the OMH website. As of early 2016, NYS had designated approximately 430 adult BH HCBS providers across the State, each for different combinations amounting to nearly 2,400 HCBS program types.

**HARP BH HCBS Eligibility and Assessment, and Plan of Care**

HARPs and HIV SNPs will coordinate with Health Homes (HH) or another State-designated entity to complete a brief eligibility assessment for BH HCBS for all HARP enrollees or HARP eligible HIV SNP enrollees as required by CMS. The BH HCBS Eligibility Assessment contains some elements from the NYS Community Mental Health Suite of the InterRAI Functional Assessment tool.

For HARP and HIV SNP members receiving HH care management, the HH care manager utilizes the information in the full assessment to work with the individual to develop a plan of care that meets CMS requirements for HCBS. As part of development of the plan of care, the HH care manager is responsible for assisting the member in selecting providers from his or her HIV SNP or HARP provider network for each BH HCBS in the individual’s plan of care. All BH HCBS provider selections are to be included in the plan of
Chapter 5: Managed Care of Integrated Behavioral and Physical Health Services

Behavioral Health Transition Timeline

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- **1.2016**: NYC Adult Behavioral Health HCBS start date
- **10.2015**: NYC Adult Managed Care (Mainstream & HARP) Rollout
- **7.2016**: Rest of State (ROS) Adult Managed Care Rollout
- **10.2016**: NYC & Long Island Transition of Existing Children’s BH Medicaid Services to Managed Care
- **10.2016**: Statewide Implementation of Additional FFS and Managed Care SPA Services for Children/Youth
- **7.2018**: Eligibility Expansion of HCBS to Children/Youth with Medicaid With Level of Need
- **1.2019**: Eligibility Expansion of HCBS to Medicaid Eligible Children/Youth With Level of Need
- **1.2019**: Transition of Voluntary Children in Foster Care Agencies to Managed Care
- **12.2016**: Implementation of Children’s Health Home
- **3.2017**: Statewide implementation of Other Licensed Practitioner SPA Services for Children/Youth
- **1.2018**: ROS Transition of Existing Children’s BH Medicaid Services to Managed Care

Children’s Transition

The MRT Children’s Health and Behavioral Health Team has designed a separate framework for children’s integrated health and behavioral health services under managed care. The separate framework is due to recognition of gaps in the current service system, the complexity of multi-systems involvement by children and families, and the fluidity of children’s needs and challenges as they develop.

The Children’s BH MRT Subcommittee made a recommendation in 2011 that the children’s system needed improvement with respect to service access, funding and earlier intervention for children and families. Since then, the Children’s Medicaid Redesign Leadership team, with representation from OMH, OCFS, OASAS, and DOH, has been using the transition of behavioral health services to Medicaid Managed Care to achieve significant reforms in the children’s behavioral healthcare system. OMH recognizes that, generally, our system in its current form fails to recognize children soon enough to consistently apply effective intervention. Early identification, accurate diagnosis, and effective intervention of behavioral health problems can help keep children and youth on track developmentally, which in turn prevents expensive, ancillary problems from developing, such as school dropout or involvement in the juvenile justice system. OMH also recognizes that, while we currently offer care, including provider selections for other physical and behavioral health services, and non-Medicaid services. The HH care management provider is responsible for ensuring that the individual is given choice of providers in the network.
Chapter 5: Managed Care of Integrated Behavioral and Physical Health Services

a continuum of behavioral health services, there are significant gaps in our children’s service delivery system, particularly in the area of home and community-based preventive and step-down services.

The leadership team has put together a proposed benefit package which will address these gaps and weaknesses. This package, once approved and implemented, will enable New York State to serve more children and to prevent the need for more restrictive, more expensive services. The design will also break down some of the system’s walls that have historically been built up around services, particularly in the Home and Community Based Services (HCBS) that three State agencies offer through 1915c waivers. OMH envisions building a service delivery system in which children and families can access the services they need, when they need them, and in the right amount, regardless of the door through which they have entered.

OMH knows that today, many opportunities are missed early in a child’s trajectory of challenges that could prevent a costly path for the child and their family’s future. A child and their family, in many cases, must fail through a variety of programs, services and interventions before being determined eligible for an HCBS Waiver. By that time, a child and their family have likely developed a more complex array of challenges which, had they been addressed earlier, may not have occurred.

The shortcomings of our current systems, combined with the vision of earlier intervention, led to a decision to develop a new set of State Plan Medicaid (SPA) Services. This new set of services will enable our providers to focus on prevention and wellness, will allow for better integration of behavioral health services and early pediatric care, and creates improved opportunity for the delivery of evidence-based practices statewide. The proposed services will be available for all children on Medicaid under the age of 21 who meet medical necessity criteria. Delivery of the new services may take place in natural settings where children live and go to school. The six proposed services are:

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

In addition to adding State Plan services, we plan to align and transition the existing 1915c Waiver services into one array of HCBS services available for children with measurable functional impairment. This includes all existing children’s waivers – OMH HCBS Waiver, OCFS Bridges to Health, and DOH Care At Home.

Unlike the proposed State Plan services, which will be universally available to all children with Medicaid who meet medical necessity, the proposed array of HCBS will be available to children eligible for Medicaid who meet specific target population and functional limitations criteria. The proposed HCBS array was developed by aligning all the services currently offered to children enrolled in the existing 1915c Waivers – services which OMH knows to produce good outcomes, keep children out of long term institutional care, and provide the supports that families need to recover and become more resilient.

New York’s vision for the children’s system of care integrates physical and behavioral health services within mainstream Medicaid Managed Care Plans. There will be no HARPS for children. When the transition is implemented, services that were previously carved out of managed care and paid on a fee-for-service basis will be included in the Medicaid managed care benefit available to children.

Consistent with the Medicaid Redesign Team’s Care Management for All goal, every child that receives Medicaid will be enrolled in a high-quality, fully integrated care management program. Care management will be provided by a range of care management models including Plans, Patient Centered Medical Homes and Health Homes. Children with the highest level of needs, who meet the criteria, will be enrolled in Health Homes.

In an effort to best integrate all care and services, Plans will be required to contract with behavioral health, foster care agencies, and specific community based providers, as well as pediatric health care and specialty health care providers already in network. OMH anticipates a designation process for providers similar to the adults, with a two year government fee schedule requirement.

Children and their families are involved in a variety of systems and in order to ensure that all care is coordinated,
OMH will require Plans to develop and maintain working relationships with school districts, non-Medicaid funded community services and supports, Regional Planning Consortiums, and local governments.

This entire design and plan has been created, discussed, and initiated under the collaboration of the four agencies and in partnership with the Children’s Health & Behavioral Health MRT Subcommittee.

Regional Planning Consortiums: Facilitating Oversight and Implementation

In preparation for both the opportunities and challenges the expansion of behavioral health services in Medicaid Managed Care will present at the local level, the State and the counties/New York City collaborated to develop 11 Regional Planning Consortiums throughout the State where key stakeholders can discuss and monitor issues inherent to this type of transition. Each RPC represents natural local patterns of access to care and include representatives from LGUs, the State, mental health, SUD, and primary care service providers, the child welfare/criminal and or juvenile justice/housing/social service systems, Health Homes, hospitals and MCOs, as well as Medicaid recipients and behavioral health service recipients, peers, families, and advocates.

The RPCs are a necessary mechanism for the State and the MCOs to obtain vital, real-time feedback and recommendations for improving the implementation of behavioral health managed care. In addition, the RPC in each region will help align Medicaid managed behavioral healthcare with other system redesign initiatives aimed at improving the quality and integration of the physical and behavioral healthcare delivery systems, as well as strategize ways to use potential future reinvestment funding. The role of RPCs is to complement the existing work of their respective and participating LGUs by guiding behavioral health policy as it relates to Medicaid Managed Care in each region.

The following further outlines the specific role and function of all RPCs, in relation to the MCOs, and describes where the New York City RPC (NYC RPC) and the remaining ten New York State RPCs henceforth referred to as the Rest of State RPCs (ROS RPCs), diverge in structure and scope, as relevant to MCO planning and participation.

Scope and Function of RPCs

The core focus areas within the scope of RPC function are:

1. Service access and capacity: monitoring the timely access to services, including BH HCBS, for Medicaid recipients of behavioral healthcare, as well as service gaps.
2. MCO performance: observing MCO actions with respect to their responsibilities to behavioral health service recipients and providers of Medicaid services.
3. System stability and improvement: facilitate collaboration among any and all regional sectors that touch the Medicaid behavioral health system.
4. Service quality, efficiency, and efficacy: improving care of behavioral health service recipients overall by voicing concerns as they arise and making recommendations to State Partner Agencies (DOH, OMH, and OASAS).

All New York State RPCs will share three primary functions:

1. To be the early warning system for locally occurring issues which data would not immediately or necessarily show (such as access to needed services, gaps in services, timeliness of eligibility determinations, and engagement or disengagement in care, etc.); and for ongoing monitoring, deliberation, and forming recommendations to the State in response to issues that arise from stakeholders at the table:
   a. Members will be expected to give status updates from the field, especially regarding payment and billing; data needs and Informational Technology (IT); and training and education. Based on issue analyses, the RPC will recommend next steps to the State, which may include:
      i. Identifying systemic and contract related issues, either between the State and the MCOs or the MCOs and service providers, to State partners and recommendations for improvement.
ii. Convening topic or issue based meetings with MCOs, including HARPs, MMCPs, and HIV SNPs, to address issues at the MCO and local level.

iii. Establishing and participating in workgroups to address local systems issues in collaboration with the MCOs and State partners.

b. RPCs will make any request for data related to the MCOs’ performance to the State partners. Such data might include payment and billing, data and IT needs, and training and education.

2. To understand and improve the parallel process and intersection of the expansion of behavioral health services under Medicaid Managed Care with other system redesign initiatives, especially the Delivery System Reform Incentive Payment (DSRIP) Program and Population Health Improvement Program (PHIP):

a. All RPCs will include representatives from the DSRIP Performing Provider Systems (PPSs). The RPC, together with the LGU (or in the case of NYC, the NYC RPC), will help create as much continuity and efficiency as possible across multiple MCOs and PPS projects serving the counties and the regions. ROS RPCs will address downsizing and closure of State psychiatric centers.

3. To work with their respective LGUs, which are the points of accountability for MCOs in identifying and addressing local system issues:

a. In the case of the NYC RPC, the DOHMH will function both as both the LGU and RPC convener. DOHMH will systematically analyze problems identified through the RPC, data reviews, and feedback from other stakeholders, and provide appropriate recommendations to the State via the Quality Steering Committee (QSC).

b. In the ROS RPCs, the LGUs in each region will participate on the RPC. The ROS RPC shall be the primary point of interaction between the LGUs and the MCOs.

**Status and Progress of RPCs**

Given the phased schedule of managed care implementations, the New York City RPC began its operations in 2015, integrating many different advisory structures into the RPC process, making this body an integral point in the behavioral healthcare transformation in this area.

Rest of State RPCs began operation in mid-2016 with a series of regional kick-off meetings, to educate all community stakeholders and prospective RPC members on the role and procedures of these bodies. Under the administrative direction of the New York State Conference of Local Mental Hygiene Directors, ROS RPCs were populated with membership and staff throughout the summer of 2016, and are expected to become fully operational across the State by the fall. More information on the Rest of State RPCs can be found at [http://www.clmhd.org/rpc/](http://www.clmhd.org/rpc/).


2 Non-Medical Transportation will be carved out of the MCO benefit, managed by a Medicaid Transportation Manager based on the Plan of Care, and paid FFS directly to the transportation provider. In addition to Non-Medical Transportation, transportation to BH HCBS included in an individual’s Plan of Care will be treated the same way as medically necessary Medicaid Transportation. Please see Managed Care Transition Manual for additional plan requirements for this service.

3 Not all designated providers will necessarily ultimately opt to provide the HCBS services they indicated during the designation process.
Chapter 6: The OMH Transformation Plan: Advancing a Progressive Behavioral Health System

Background

New York currently exceeds both the national average inpatient utilization rate at State-operated Psychiatric Centers, and per capita inpatient census levels at State-operated PCs in other urban states and all Mid-Atlantic states. New York’s extensive State PC inpatient capacity includes 24 facilities with over 3,500 budgeted beds. Among these are a number of hospitals operating with fewer than 100 beds.

This situation had led to disproportionately high State-operated inpatient per capita costs as more individuals with mental illness are supported successfully with community-based mental health services, while the inpatient footprint has remained disproportionately large. The evidence of this imbalance was demonstrated in the utilization and financing data from Chapter 2 of this report: While New York’s State-operated inpatient facilities serve approximately one percent of the total number of people served in the public mental health system, they account for 20 percent of gross annual system expenditures. With the inclusion of other acute inpatient facilities (Article 28 or 31 psychiatric hospitals), inpatient psychiatric costs amount to approximately half of the total spending on public mental health services.

The OMH Transformation Plan aims to re-balance the agency’s institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so the Plan will strengthen and broaden the public mental health system to enhance the community safety net; allowing more individuals with mental illness to be supported with high quality, cost-effective services within home and community-based settings and avoid costly inpatient stays.

Beginning in State Fiscal Year (SFY) 2014-15 and continuing through present, the OMH Transformation Plan has “pre-invested” $81 million annualized in State-operated inpatient savings into priority community services and supports, with the goals of reducing State and community-operated facilities’ inpatient psychiatric admissions and lengths of stay. Nearly $19 million in additional Article 28 reinvestment funds have also been directed across the State as the result of unnecessary community inpatient bed reductions over the past several years. These funds have further developed the critical community services and supports needed to prevent inpatient hospitalization, transition individuals from inpatient settings, and strengthen the community mental health safety net.

In the current State fiscal year, OMH is also dedicating a share of pre-investment funding to support transitions for State long-stay inpatients to the community through Managed Long Term Care and Skilled Nursing Facility bridging. Nearly 50 percent of OMH adults on census have been at a State PC for over a year, and a large portion have even been with us for several years. By helping move long-stay individuals with complex medical and behavioral health needs to more integrated and less restrictive community settings, OMH will free up inpatient capacity that has otherwise been unavailable for admissions from the community; this will effectively increase our capacity to provide intermediate care.

In addition to financial resources, the Transformation Plan has also convened groups consisting of local governmental units, OMH Field Offices and psychiatric centers, providers, and other stakeholders to engineer other systems changes in order to better serve individuals in communities and hospital settings. These systems-level planning efforts have worked to improve pathways through levels of housing, increase engagement in clinic and other outpatient services, and expand access to existing and new children’s Home and Community Based Services (HCBS) waiver capacity.

The recent carve-in of most Medicaid behavioral health services into managed care, the Delivery System Reform
Ten Areas of Transformation Plan Pre-investment*

These are ten major service areas supported through the Transformation Plan investment:

1. 1,105 units of Supported Housing with appropriate wrap-around services to ensure individuals can be served safely in the community, and avoid potential future homelessness.

2. 246 additional Home and Community Based Services Waiver slots which provide children and their families with respite services, skill building, crisis response, family support, intensive home support and care coordination.

3. Twelve State-operated Mobile Integration Teams (MIT) which provide an array of mobile services and supports for youth and adults, including on-site crisis assessment, skill building, family support, and respite. Additional existing State-operated community support services will also be converted to a MIT model. MITs can serve hundreds of individuals each month, and are scaled and located to community need. To date, MITs have provided critical supports to over 4,500 individuals statewide.


5. Expansion of State and voluntary-operated clinic programs, State-operated school-based clinic satellites, and extended clinic hours to provide services when they would be otherwise unavailable or inaccessible.

6. Staffing support for two of the First Episode Psychosis programs being implemented statewide under the nationally recognized OnTrackNY initiative.

7. Sixteen new and expanded crisis intervention programs, many with extended hour coverage, mobile capacity, and peer-support components in order to best meet the needs of individuals in times of crisis.

8. Over a dozen new advocacy, outreach and bridger programs, to guide individuals through transitions from inpatient settings into integrated, clinically-supported community living, and linking them to various community based supports.

9. Ten new or expanded Assertive Community Treatment (ACT) teams, accounting for a capacity expansion of 572 slots.

10. Forensic programs for both adult and juvenile offenders, developed to link individuals with mental health services, provide specialized assessments for probation and courts, and reduce future recidivism and hospitalization.

*NOTE: As of December 2016.

Incentive Payment (DSRIP) program, and the Prevention Agenda 2013-2018 are timely and direct drivers of reform to the State and community-based systems of care. Together these initiatives will further coordinate care across clinical modalities and levels of government by developing an integrated, recovery-centered service delivery system designed to improve consumer care and population health—the means to achieve the “Triple Aim” of better care, better health and better lives for those whom we serve—at lower costs.

The OMH Transformation Plan is consistent with these ongoing reforms in health care policy and financing. As the market for health care services becomes more consumer-directed, integrated and community-oriented, OMH must advance in step with the people we serve in order to be relevant and sustainable in the future. The OMH Transformation Plan will create the mental health system that New York needs in the 21st Century—a system focused on prevention, early identification and intervention, and evidence-based clinical services and recovery supports.

Regional Planning, Service Development, and Outcome Measures

OMH has made significant investments in every region of the State in the current, and past two fiscal years to enhance community mental health services designed to reduce the need for unnecessary inpatient hospitalizations at State Psychiatric Centers. The investments were made with input from a broad set of community stakeholders and advisory bodies in every region of the State. The sections below summarize the investments made to date, and exhibit some of the outcomes associated with these investments.

More comprehensive and timely reports are available on the Transformation Plan homepage at http://www.omh.ny.gov/omhweb/transformation/. The monthly and annual reports posted on this page include State Psychiatric Center performance metrics, descriptions and status of community service investments, and psychiatric readmissions to hospitals and emergency rooms for State PC, Article 28, and Article 31 hospital discharges.

Service investments to date have focused on the following areas to be described separately below: State-operated community services, Supported Housing,
State-Operated Community Services: Mobile Integration Teams, Crisis Respite and Outpatient Clinic Expansion

Mobile Integration Teams

As the State inpatient footprint has slowly shifted, OMH has directed an increasing number of State-operated supports toward community based services and support programs. One program model developed out of the Transformation Plan is the Mobile Integration Team (MIT). MITs provide an array of mobile services and supports for youth and adults, including on-site crisis assessment, skill building, family support, and respite. MITs can serve hundreds of individuals each month, and are scaled and located to community need. To date, there are thirteen State-operated MITs in operation, and several other existing State-operated community support services being converted to the MIT model.

Examples of services include, but are not limited to, health teaching, assessment, skill building, psychiatric rehabilitation and recovery support, in-home respite, peer support, parent support and skills groups, crisis services, linkage and referral, outreach and engagement. Populations served include children and adolescents, families, and adults. Staff make these services available in a variant of settings including an individual’s residence, schools, or integrated with other program settings as needed. Depending on their staffing and service intensity, MITs can serve hundreds of individuals within a State PC catchment area in any given month. A cumulative statewide count of interventions provided by MITs through SFY 2015-16 is presented in Figure 6-1. Additional data from the same time period on MIT referral sources, service duration, and location are also presented in Figures 6-2 to 6-5.

![Interventions Provided by MIT (November 2014-March 2016): Count of Services Provided by MIT](image-url)
Another State-operated program developing through the Transformation Plan is the Child & Adolescent Crisis Respite House which provide short term care residential crisis and respite services in a homelike environment. The purpose of this program is to provide support in a trauma sensitive, safe and therapeutic environment, with the goal of stabilizing the crisis situation, and supporting the family and service provider's efforts to maintain the youth in his or her current residence.

Youth served in this program typically transition back to their home and community after a brief stay at the respite house, lasting up to two weeks. The program is designed to serve youth who currently receive mental health services or who are at risk of, or are currently experiencing, an emotional/behavioral crisis due to events in their environment. Examples of such events include, but are not limited to, family problems, loss of relationships, abuse, neglect and problems in school. This is a voluntary and free service for families. The family and the youth must agree to the admission.

Four new Crisis Respite Houses are now operating on the grounds of Elmira PC in Elmira (eight beds), Hutchings PC in Syracuse (six beds), and Sagamore CPC in Dix Hills (eight beds), and St. Lawrence PC in Ogdensburg (six beds). An additional six bed Crisis Respite beds are currently in development on the grounds of St. Lawrence PC in Ogdensburg, with an anticipated opening in fall 2016.

**Targeted Outpatient Clinic Expansion**

Additional State-community reinvestments supported the expansion of State-operated clinic programs and school-based clinic satellites, and extended clinic hours to provide services when they would be otherwise unavailable or inaccessible. Adult clinic expansion has occurred in the Greater Binghamton, Elmira, Pilgrim, and Rochester PC catchment areas. Children & youth clinic expansion has occurred in Elmira and St. Lawrence PCs and Sagamore and Western New York CPC areas.
Critical Time Intervention Dissemination

CTI is an evidence-based care management model focusing on high need individuals during key care transitions. For most individuals, the transition from institutional to community living is an extremely vulnerable period during which increased support is vital. CTI is a time-limited intervention, lasting nine months. The phases of CTI, Transition to Community, Try-Out, and Transfer of Care, are each roughly three months; this period should conclude with a network of supports in place to help the individual stay in the community and pursue their recovery goals.

In April 2015 OMH began a large scale adoption of CTI across State-operated Mobile Integration Teams, care management teams, residential programs, and clinics. By December of the same year, over 180 staff across 15 facilities have been trained in the model. Of those trained, approximately 115 have served or are actively serving 270 individuals across 23 counties. Of the 270 individuals who began receiving services using the CTI model, 57 percent or 155 individuals began receiving the CTI model while still admitted to inpatient hospital level of care.
The CTI approach has been effective at supporting a number of individuals in their transition from State operated transitional and residential programs to Supported Housing. The OMH implementation of the CTI model has shown to be an effective strategy, supporting individuals transition to less restrictive and more integrative and independent living opportunities.

**OMH Inpatient and Residential Transitions to Long Term Care Settings**

The New York State Office of Mental Health SNF Project effective April 1, 2016 is expanding upon OMH Psychiatric Centers’ ongoing efforts to refer and place long stay individuals who require and are eligible for skilled nursing facility (SNF) level of care or enrollment in a Managed Long Term Care program. Through resources included in the SFY 2016-17 Enacted Budget, OMH has allocated $5.5 million (annualized) to provide the resources for the implementation of enhanced discharge and support services for individuals requiring long term care. The enhanced supports are targeted to facilitate the timely discharge of approximately 100 individuals during the first year of program operation. Supports are also intended to provide the SNFs with supports necessary to successfully aid individual recovery, and prevent avoidable hospitalizations.

The project includes the provision of enhanced support services to the SNF to assist their staff in meeting the needs of individuals referred from OMH PCs. The enhanced supports and consultations will be in effect during the transition period, and extended as needed on a case-by-case basis for each individual identified by the State PC.

OMH PCs are establishing and strengthening existing relationships with local SNFs, outlining expectations of both parties, and identifying the supports and services facility staff will provide to aid in these transitions, based on the needs of individuals identified by the State PC.

As this process is further implemented in 2017, OMH will provide updated information on the successes and challenges in serving such high need populations as they move to more appropriate levels of care in communities across the State.

**Innovative Locally-Operated Community Programs**

In addition to State-operated services, OMH has made significant investments directly through counties, supporting expanded and new services in voluntary-operated, community based settings. Areas of reinvestment include:

- Crisis intervention and mobile crisis programs, many with extended hour coverage, mobile capacity, and peer-support components in order to best meet the needs of individuals in times of crisis.
- Advocacy, outreach and bridger programs, to guide individuals through transitions from inpatient settings into integrated, clinically-supported community living, and linking them to various community based supports.
- New or expanded Assertive Community Treatment (ACT) teams, accounting for a capacity expansion of 572 slots.
- Forensic programs for both adult and juvenile offenders, developed to link individuals with mental health services, provide specialized assessments for probation and courts, and reduce future recidivism and hospitalization.
- Peer-supported crisis-respite residences (congregate) and short term crisis transitional residential units (scattered) for adults, to help prevent avoidable ER and hospital use. These program provide a safe and supportive environment for adults who require brief crisis intervention and/or respite services on a short term basis.
- Family support and outreach programs to help families and children better manage and address mental health and psychosocial issues that lead to escalation and hospitalization.
- Mobile residential support teams to provide targeted supports for individuals in congregate and scattered site residential programs when a need is indicated. Recent investments have developed specialty support teams to help long stay individuals (one or more years at a State PC inpatient or residential program) transition and remain in supported community environments.

OMH recently issued surveys to all local governmental units through the county planning system to identify impacts of locally-developed services under the Transformation Plan; particularly as it relates to inpatient service demand. After processing, the results will be
used by our facilities, field offices, and planning staff to inform future service development and to identify opportunities for improving existing services and system processes.

Home and Community Based Services (HCBS) Waiver & Supported Housing

The HCBS waiver program is a program designed for children and youth under federal CMS waiver authority with the goals to:

- Enable children to remain at home, and/or in the community, thus decreasing institutional placement.
- Use the individualized care approach to service planning, delivery and evaluation. This approach is based on a full partnership between family members and service providers. Service plans focus upon the unique needs of each child and builds upon the strengths of the family unit.
- Expand funding and service options currently available to children and adolescents with a diagnosis of serious emotional disturbance and their families.
- Provide services that promote better outcomes and are cost-effective.

The target population for waiver are children with a diagnosis of serious emotional disturbance who without access to the waiver would be in psychiatric institutional placement. Parent income and resources are not considered in determining a child’s eligibility.

The HCBS waiver includes six services that are managed by a care coordinator:

- **Individualized Care Coordination** includes the components of intake and screening, assessment of needs, service plan development, linking, advocacy, monitoring and consultation.
- **Crisis Response Services** are activities aimed at stabilizing occurrences of child/family crisis where it arises.
- **Intensive In-home Services** are ongoing activities aimed at providing intensive interventions in the home when a crisis response service is not enough.
- **Respite Care** are activities that provide a needed break for the family and the child to ease the stress at home and improve family harmony.
- **Family Support Services** are activities designed to enhance the ability of the child to function as part of a family unit and to increase the family’s ability to care for the child in the home and in community based settings.
- **Skill Building Services** are activities designed to assist the child in acquiring, developing and addressing functional skills and support, both social and environmental.

A total of 246 Home and Community Based Services Waiver slots were funded under the Transformation Plan in SFY 2015-16. In addition to funding new capacity, OMH has also focused attention on the waiver program in order to move more children through the program’s existing capacity, and increase connectivity between inpatient programs and waiver providers.
Figure 6-6 presents 30-, 60- and 90-day Medicaid HCBS waiver program utilization rates for children discharged from State PC settings from January 2014 to September 2015. During this period, HCBS waiver utilization rates for children discharged from State PC settings increased. Further increases in HCBS waiver utilization are expected as OMH continues its work with localities and providers to identify and improve access for children and families in need.

**Supported Housing**

Supported Housing is a category of community-based housing that is designed to ensure that individuals who are seriously and persistently mentally ill may exercise their right to choose where they are going to live, taking into consideration the recipient’s functional skills, the range of affordable housing options available in the area under consideration, and the type and extent of services and resources that recipients require to maintain their residence with the community. Supported Housing is not as much considered a “program” which is designed to develop a specific number of beds; but rather, it is an approach to creating housing opportunities for people through the development of a range of housing options, community support services, rental stipends, and recipient specific advocacy and brokering. As such, this model encompasses community support and psychiatric rehabilitation approaches.

The unifying principle of Supported Housing is that individual options in choosing preferred long term housing must be enhanced through:

- Increasing the number of affordable options available to recipients;
- Ensuring the provision of community supports necessary to assist recipients in succeeding in their preferred housing and to meaningfully integrate recipients into the community; and
- Separating housing from support services by assisting the resident to remain in the housing of his choice while the type and intensity of services vary to meet the changing needs of the individual.

Recognizing the statewide need for additional Supported Housing to assist with transitions from State-operated settings, OMH has allocated over 1,100 additional units of reinvestment housing through SFY 2016-17 while continuing to expand the pipeline development outside of reinvestment. In addition to the new capacity, OMH has strengthened the process for referrals from inpatient settings directly to Supported Housing, while working with LGUs, Health Homes, hospitals, and residential providers on a regional basis to improve referral and care management processes across all residential levels. This process has helped strengthen provider communications and improve residential stability for individuals with serious mental illness living in the community.

Figure 6-7 displays the percentages of admissions to supported housing from Quarter 1 2014 to Quarter 4 2015 who were individuals discharged from State PCs and individuals discharged from acute psychiatric settings. During this period of time, utilization of Supported Housing increased in both populations. The spike during the second quarter of 2015 is likely due the convergence of an infusion of additional housing resources,
Vital Access Provider Program: Maintaining Inpatient and Clinic Access

For some Medicaid providers of community mental health services that are at risk of closing or reducing services but are still operating, OMH and the State Department of Health have coordinated a targeted investment strategy to maintain critical access to behavioral health care in areas across New York State, through the Vital Access Provider (VAP) program. VAP funds have been available to Article 28 inpatient and ambulatory providers, and more recently to Article 31 licensed outpatient clinics in recognition of the critical role of outpatient treatment and of the fiscal issues facing many clinics throughout the State. VAP funds are used to enhance community care and to help providers achieve defined financial, operational, and quality improvement goals related to integration or reconfiguration of services offered by the facility.

In the State Fiscal Year 2014-15 budget, the Office of Mental Health initiated the first round of targeted investments under the VAP Program by awarding grants totaling over $30 million over the course of four years to the following Article 28 hospitals: United Health Services Hospitals, Inc. (Binghamton General Hospital), St Joseph’s Hospital Health Center (Syracuse), Mary Imogene Basset Hospital, Oswego Hospital, Claxton Hepburn Medical Center and St. Joseph’s Hospital (Arnot). The grants are used to stabilize the inpatient mental health services available in areas of minimal geographic capacity, and set these hospitals on a more sustainable footing by the completion of the grant period.

Fiscal year 2015-16 expanded the VAP program for preservation of critical access Article 31 mental health clinic services, with a wide distribution of awards across the State to 40 voluntary and county-operated mental clinics that met the VAP eligibility criteria. A table with all clinic VAP awardees is in Appendix D. The main goals of the clinic VAP initiative are to:

1. Preserve geographic access and clinic services for specialty populations.
2. Financially stabilize at-risk Article 31 freestanding clinics, and restructure financing and operations to attain overall fiscal viability.
3. Improve clinic operations and increase efficiencies; including higher productivity and revenue collection, cross agency consolidation of administrative functions, and inter-agency mergers.
4. Reduce clinic program costs
5. Improve quality and patient outcomes.

$43 million (gross, assuming federal financial participation) has been allocated for VAP Article 31 clinic preservation for over a four year period.

Key criteria providers met for inclusion in VAP program:

1. Financial Viability. For provider agency and/or clinic program:
   - OMH evaluated fiscal viability need using Consolidated Fiscal Report, audited financial statements and Medicaid billing.
   - OMH’s determination factored in demonstrated fiscal challenges in the operation of the provider agency in the past three years, and demonstrated fiscal challenges in the mental health clinic in the past three years.

2. Community Service Need: Limited geographic access, special populations.
   - OMH evaluated community service need using Medicaid billing, county data book, Patient Characteristic Survey, and licensing information.
   - OMH’s determination factored in the following: Existing service capacity, Market share, minority and special populations served by the applicant, and child and youth and criminal justice populations served by the applicant.

3. Actionable Plan. To preserve services and achieve fiscal viability:
   - The actionable plan was the primary focus of the VAP mini-bid application.
   - VAP application was evaluated to determine the commitment to institute changes and reasonableness of the plan to attain overall fiscal viability.
   - Favorable consideration was given to proposals which include plans for mergers, cross-agency consolidation of administrative functions, and/or demonstrated interest to engage in such activities.

Data and Reporting Requirements:

VAP awardees are required to submit quarterly reports for the life of the award (typically three to four years) in order to demonstrate whether or not the awardee is achieving their performance target. Metrics are reported for three key areas:

- Financial (e.g., increase net revenue, increase collection rate)
- Operating (e.g., increase visit volume, improve billing practices)
- Quality (e.g., improve patient coordination of care, improve consumer satisfaction)
and reformed discharge processes between PCs and housing providers early in 2015; the subsequent drop still represents a general trend of increased discharges from all inpatient settings to Supported Housing.

Transformation Plan Services
Consumer Feedback

From September 14, 2015 through October 9, 2015, OMH assessed consumer satisfaction with OMH Transformation Plan services by directly surveying adults, youth and their families in targeted programs and counties. Questionnaires were customized for each service population and included the following domains: access to services, appropriateness of services, cultural sensitivity, participation in services, outcomes of services, overall satisfaction with services, and quality of life.

Adult consumers receiving Mobile Integration Team services in St. Lawrence PC, Elmira PC, Greater Binghamton Health Center (GBHC) and Rochester PC service areas, and locally-operated Community Transition and Crisis Services in Bronx, Erie, New York, Queens, Rockland and Steuben Counties were administered the Adult Service Assessment Survey. The survey response rate for adults was 43 percent overall (N=185) and varied by county.

Youth and family members of youth receiving crisis/ respite services in Elmira PC, Hutchings PC and Sagamore CPC service areas, Mobile Integration Team services in GBHC, Western New York CPC and Sagamore CPC service areas, and Community Transition and Crisis Services in Erie county were administered the Youth and Family Service Assessment Surveys. The survey response rates for youth and family members were 44 percent (N=52) and 43 percent (N=55) respectively.

Adult Survey Respondents
Demographics

Half (50 percent) of adult respondents were women and three percent of adult respondents identified as transgender. More than half (53 percent) were above 44
years of age. A majority (65 percent) of adult respondents were White, 22 percent were Black/African American, and 6 percent Multiracial. Twelve percent were of Hispanic/Latino ethnicity.

**Assessment of Care**

Overall, adult respondents reported a positive assessment of care they received. The percent positive responses to each domain are displayed in Figure 6-8. Findings showed that the average of the percent positive rating for items in the Overall Satisfaction with Services domain was 92 percent. Average item scores for other domains ranged from 85 percent for Outcomes of Services to 93 percent for Participation in Services. The Quality of Life domain showed an average percent positive rating of 71 percent, which is consistent with prior OMH program survey results, but indicates the ongoing need to focus on supporting individuals personal recovery goals and social connections at the same time that we focus on crisis, treatment, and stabilization.

**Youth and Family Members Survey Respondents**

**Demographics**

Half of youth respondents were male (50 percent). Similarly, more than half (54 percent) of children of family respondents were male. The age distribution of youth respondents was 14 percent aged 9-11, 37 percent aged 12-14 and 49 percent aged 15-18. Seventeen percent of children of family respondents were 5-8 years old or 9-11 years old while 83 percent were 12-14, 15-18 or 19-21. Most responding youth (69 percent) were White, 8 percent were Black/African American and 12 percent Multiracial. Similarly, 78 percent of children of family respondents were White, 6 percent Black/African American, and 9 percent Multiracial. 14 percent of youth respondents
were of Hispanic/Latino ethnicity, although a very small percentage (4 percent) of children of family respondents were of Hispanic/Latino ethnicity.

**Assessment of Care**

Like adult consumers, youth and family members of youth served reported a positive assessment of care they received (Figure 6-9). Findings showed that the average of the percent positive rating for items in the Overall Satisfaction with Services domain was 88 percent for youth and 96 percent for family members. For youth respondents average item scores for other domains ranged from 87 percent for Appropriateness of Services to 94 percent for Cultural Sensitivity and Access to Services. A similar pattern is seen for the Family Assessment of Services where the average of the percent positive rating ranged from 88 percent for Outcomes of Services to 97 percent for Cultural Sensitivity. The average percent positive rating for items in the Quality of Life domain was 82 percent for youth and 79 percent for family members, both of which are consistent with prior survey results.

**Conclusion**

Altogether the results from our community pre-investments during the past two years have been very promising. The average daily inpatient census in OMH civil adult and children’s Psychiatric Centers reduced by 166 (5.7 percent) during calendar year 2015. Meanwhile, the new and expanded Transformation Plan services have already reached over 18,000 new individuals. These efforts will help put New York State firmly on the path toward balancing our institutional resources more equitably in order to serve more people in more appropriate, effective, and modern community treatment and support programs.

More comprehensive survey results, along with additional impact measures associated with the OMH Transformation Plan are available in the most recent Transformation Plan annual report, which is available at http://www.omh.ny.gov/omhweb/transformation/.

1 Most MITs listed here have been funded with reinvestment resources, while some teams are conversions of earlier State-operated community support teams.
Individuals with mental illness who are justice-involved or at risk for adverse incidents must be supported during critical transitions in care to ensure their safety and that of our communities. OMH is focusing on the fundamental role as a provider of safety net and forensic services for the most seriously ill and underserved, to continue to build a stronger, safer State of New York. This Chapter outlines three major forensic initiatives underway to support individuals with mental illness who are also involved with the criminal justice system.

**SMI-V Initiative**

The SMI-V initiative seeks to enhance treatment services provided to inmate-patients who suffer from serious mental illnesses and have histories of violence. The new enhanced treatment services offered by OMH Central New York Forensic Psychiatric Center’s (CNYPC) Corrections-Based Operations (CBO) will focus on addressing criminogenic needs with the ultimate goals of:

1. A reduced risk of future violence, and
2. Successful community reintegration through enhanced discharge planning services and community partnerships.

In order to accomplish these goals, a Screening and Assessment unit is being established at Downstate Correctional Facility. This unit will evaluate, for risk of violence, all incoming State prison inmates who have serious mental illness. These individuals will receive enhanced treatment planning that includes programming to reduce their risk of violence. In addition, three Intermediate Care Programs (ICP) will provide specialized violence reduction programming as well as programming to address participants’ mental health needs.

The target population for these enhanced ICPs (E-ICPs) are imprisoned individuals with serious mental illness who require an ICP level of care and have histories of interpersonal violence. In addition, two other ICPs will be identified as enhanced discharge ICPs and will provide both specialized violence reduction programming and reentry planning for this high-needs population. The discharge ICPs will provide services to ICP individuals with histories of violence who are within 12 months of their anticipated prison release date. Treatment for individuals identified as SMI-V will be augmented by the services of specialized licensed regional psychologists. These regional psychologists will work in collaboration with the primary treatment providers to assess treatment progress, provide psychological testing services, offer clinical consultation, direct treatment, and other resources, as needed.

Specialized training will be provided to all SMI-V staff to ensure access to evidence-based treatment for violence reduction. Specific training initiatives in the current fiscal year include motivational interviewing, Core Corrections training, interactive journaling, Seeking Safety trauma intervention, START Now, and trauma-informed care. Additionally, SMI-V staff will be trained in specialized assessment tools such as the HCR-20, Violence Risk Appraisal Guide (VRAG), and the Violence Risk Scale (VRS).

**Forensic Supported Housing Initiative**

OMH is committed to insuring that SMI individuals leaving prison have appropriate housing in the community. The SFY 2015-16 State budget authorized funding for the development of 200 units of Supported Housing allocated to eight Upstate counties (Erie, Oneida, Onondaga, Monroe, Nassau, Suffolk & Westchester) and NYC based on the distribution of SMI inmates returning to the community. In addition, OMH is allocating an additional 200 Supported Housing units for individuals discharged from NYS prisons to a psychiatric hospital for access once the individualized is stabilized for release to the community.
The OMH Forensic Housing Initiative provides support to participating housing providers through access to: enhanced services funding; transitional care coordination; dedicated mental health parole officers; and specialized staff training through the Academy for Justice-Informed Practice. Staff training opportunities include but are not limited to: understanding violence and staff safety; understanding the criminal justice system; working with parole; trauma-informed care for justice-involved individuals; reducing recidivism and promoting recovery; and the clinical impact of incarceration. The OMH Forensic Housing Initiative also offers targeted technical assistance upon request and convenes quarterly meetings with all funded providers and stakeholders to discuss cross-systems coordination challenges and to share information regarding program resources for the target population.

**Crisis Intervention Team Initiative**

The Crisis Intervention Team (CIT) is a criminal justice diversion model designed to create partnerships between law enforcement, behavioral health professionals, service recipients and their families, and to provide a forum for effective community problem solving and communication. In 2014, the CIT Initiative was implemented in eight local jurisdictions with an additional ten local jurisdictions targeted in 2015.

Implementation of the CIT model includes “systems mapping,” which brings together key stakeholders to detail how the criminal justice and behavioral health systems identify and handle individuals experiencing mental health-related crises. After strengths and gaps in the current system are identified, a model action plan is developed. In each jurisdiction, a 40-hour CIT training is provided to law enforcement personnel who are then assigned to a Crisis Intervention Team.

Additionally, Mental Health First Aid (MHFA), an international training program that teaches participants to identify, understand, and respond to signs of mental illnesses and substance use disorders, is provided to first responders and officers who do not receive the full 40-hour CIT training in each of the participating jurisdictions. To broaden the geographic impact of the initiative, regional Mental Health First Aid trainings also are conducted statewide and are thus available to officers in jurisdictions that have not received CIT training.
A recent snapshot of the New York State licensed mental health workforce shows a total of 88,194 licensed and/or certified professionals within a mental health specialty. Of this group, licensed master social workers (LMSWs) and licensed clinical social workers (LCSWs) comprise approximately 65 percent of the total licensed mental health workforce, followed by much smaller numbers of psychologists, psychiatrists, licensed mental health practitioners, and nurse practitioners in psychiatry.

These workforce levels adjust to 45 mental health professionals per 10,000 residents statewide; however the uneven distribution of professionals among New York’s 62 counties means that workforce availability can range from around ten to one-hundred professionals per 10,000 residents, depending on the county. Many areas across the State have severe shortages of all licensed mental health professionals.

The data presented in Figure 8-1 are based on New York State licensing and specialty board certification information, and do not necessarily reflect the number of professionals practicing in clinical settings in direct or clinical supervisory capacities. However, even with the inclusion of non-practicing mental health clinicians, these numbers translate into many areas of New York State falling within State and federally designated mental health professional shortage areas. For example, as of January 2014, 40 of New York’s 62 counties (65 percent) were designated as mental health professional shortage areas under either State or federal designations.

Overall, approximately 3.1 million people in the State live in designated federal and/or State mental health shortage areas. Geographically, the professional shortage is most acute in the OMH Central New York Region, with 77 percent of its population living in areas designated as mental health professional shortage areas.
mental health professional shortage areas. The Central New York Region is followed by the Western New York (39 percent), and Hudson River Regions (17 percent) for percentage of population living in shortage areas. New York City and Long Island counties do not meet any such shortage designations at the county level, however there are census tracts and institutions within these areas that do meet such shortage designations.

As federal healthcare reform drives the expansion of community behavioral health services, and parity increases individuals’ eligibility for such services, the demand for New York’s existing mental health workforce has increased. Meanwhile, the aging demographic of our mental health workforce is expected to concurrently decrease the supply of qualified practitioners in the labor force, making few short-term solutions to the...
workforce shortage viable. 54 percent of the New York State mental health workforce is over the age of 50, and nearly 30 percent are over age 62. For the highly demanded psychiatry workforce, the demographics are even starker: 64 percent are over 50 and 38 percent are at or beyond retirement age.

Addressing the Critical Need for Psychiatry

The New York State public mental health system is particularly challenged by an acute shortage of psychiatrists in many areas across the State, which constrains our ability as a State to meet the current and growing demand for mental health services. While the statewide ratio of residents to psychiatrists falls below the Health Resources and Services Administration (HRSA) health professional shortage areas (HPSA) criterion for psychiatrists, it remains immensely challenging to recruit psychiatrists for the salaries and demands associated with many public mental health settings. As such, the psychiatry workforce available to public mental health providers is likely significantly smaller than the numbers suggest. Without an adequate psychiatry workforce, programs are limited in their ability to meet ongoing demands for diagnosis, treatment planning, and prescribing, in which psychiatrists in particular play a critical role across treatment settings.

Illustrating some of the forces at play in the psychiatry labor market, the SUNY Albany Center for Health Workforce Studies recently published a report providing evidence of both symptoms and causes of shortages in this profession. Data collected each year from 2010 through 2014 show significant wage gaps between psychiatrists (adult and child) and other medical specialties entering the workforce in New York State, while at the same time the relative demand for psychiatrists is far above most other medical specialties (Figure 8-2). Compared to other specialties and markets in general, where incentives will correspond with demand, the intersection of supply and demand curves for psychiatry have not caught up.

Additionally, during the ten year period between 2004 and 2013 there has been only a minor growth trend in medical school graduates entering adult psychiatry (6.4 percent), with a more positive trend for entrants into the child psychiatry workforce (25.1 percent). However the healthy growth in child psychiatry is nearly outweighed by the still meager size of the highest graduate cohort in 2013: 429 child/adolescent vs. 1,155 adult psychiatrists graduating from Graduate Medical Education (GME) programs nationwide. In total there are 1,063 child and adolescent psychiatrists registered with the American Board of Psychiatry and Neurology as of June 2016.

In order to improve access to timely mental health services, OMH is adopting a multi-tier strategy that will focus both on the full public mental health system, and directly on our State-operated safety net programs.

- Salary enhancements for psychiatrists and nurse practitioners in psychiatry aimed at increasing both recruitment and retention of these essential service providers in OMH;
- Loan repayment program expansion, including eligibility for psychiatrists in all OMH facilities under the Doctors Across New York OMH Psychiatrist Loan Repayment Program;
- Development of affiliation agreements between OMH and academic programs for nurse practitioners pursuing a psychiatry track;
- Peer credentialing for adult and children and family services in order to leverage the unique expertise of individuals with lived experience, while also adding to the mental health workforce.
- Expansion of telepsychiatry through additional reimbursement mechanisms and regulatory expansion.
- Expansion of psychiatric consultation services for primary care practitioners through Project TEACH.

Project TEACH and the expansion of telepsychiatry regulations to additional practice settings are described in detail in Chapter 3 of this report. Additionally, many of the current efforts to integrate behavioral health services with primary care will also help build mental health treatment capacity by leveraging a large, existing primary care system. While primary care itself faces workforce shortages, there are significant opportunities for synergy when we add competency and capacity for PCPs to identify, treat some mental health disorders—while simultaneously building some physical health assessment and treatment capacity to existing behavioral health providers. All of these efforts are described in Chapter 3, which addresses a series of initiatives that will transform and integrate health and behavioral health practice settings.
Beyond the efforts described in this report, New York State is engaged in long term workforce planning efforts through the DSRIP program and the State Innovation Model grant, and OMH will continue its efforts to ensure that mental health workforce and mental health treatment competencies, are included in these plans.

1 Licensed mental health practitioner encompasses the professions of licensed mental health counselors (LMHC), licensed marriage and family therapists (LMFT), licensed creative arts therapists (LCAT), and licensed psychoanalysts (LPsy), which are all licensed under Article 163 of the NYS Education Law.

2 Psychiatrist data source: American Board of Psychiatry and Neurology, Inc. (ABPN). Data as of June 29, 2016 from https://application.abpn.com/verifycert/verifycert.asp. A small number of psychiatrists in this dataset were listed as “uncertified” at the time the data was accessed. Data for all professions other than psychiatrists is as of January 1, 2016 and was provided by the Office of the Professions at the New York State Education Department.


4 A primary Health Resources and Services Administration criterion for mental health provider shortage areas is a ratio of residents to psychiatrists exceeding 30,000:1 in a “rational area for the delivery of mental health services,” or 20,000:1 in areas with “unusually high needs for mental health services.”


6 The number of certified child and adolescent psychiatrists is duplicative of the number of certified psychiatrists in New York, and should not be added to the base number of psychiatrists in this section.
Chapter 9: Cultural Competence

OMH is dedicated to promoting effective policy, procedure, and practice by integrating cultural and linguistic competence throughout New York State’s public mental health system. Through the Bureau of Cultural Competence (BCC), OMH seeks to eliminate disparities in care and access to care for people of diverse backgrounds. At an operational level, this mission is active through ongoing training and technical support to all (local and State) providers, and through broader general efforts to promote mental health for all and disparities for none.

OMH integrates cultural and linguistic competence through the following functions:

- Conducting comprehensive trainings on the importance of infusing cultural and linguistic competence throughout agency policies and clinical practices.
- Engagement across all agency functional units to ensure that cultural competence is implemented across all OMH programs and policies.
- Monitoring the advancement of research through the two OMH Research Institute Centers of Excellence for Cultural Competence.
- Providing technical assistance to OMH operated and regulated providers.
- Providing cultural and linguistic program evaluations.

This chapter is presented in two sections. Section 1 explains the infrastructure within OMH to promote cultural and linguistic practices, and Section 2 outlines efforts to increase cultural competence through language access, training, assessment, and evaluation in the public mental health system.

Section 1
OMH Infrastructure for Promoting Cultural Competence

The infrastructure for developing, promoting, and integrating cultural competence across the public mental health system is supported in New York State through the State and Regional Multicultural Advisory Committees and the Centers of Excellence for Culturally Competent Mental Health. The advisory committees facilitate communication between stakeholders and OMH about community, regional and statewide needs of diverse cultural groups; and the Centers facilitate research on mental health disparities to identify and develop best practices needed to effectively engage diverse groups into treatment, and subsequently reduce disparities.

State & Regional Multicultural Advisory Committees

The State and Regional Multicultural Advisory Committees are comprised of various stakeholders that seek to address racial, ethnic and other cultural disparities that exist within the service system.

The State Multicultural Advisory Committee (SMAC) advises the Commissioner of OMH on the development of policy, programs, and activities that foster recovery and resiliency for individuals with mental illness and families from diverse cultural backgrounds. The SMAC meets quarterly and makes recommendations to improve understanding of the clinical needs specific to diverse populations to ensure that services promote health while eliminating disparities. This is accomplished through efforts to design, develop, and evaluate culturally and linguistically appropriate client and family-centered treatment and support services. In addition, the SMAC creates an annual work plan with goals and objectives that the committee seeks to accomplish during the year.

The Regional Multicultural Advisory Committees (RMACs) are comprised of consumers, peers, family members, providers and other vested stakeholders within specific regions, and are organized to stimulate community action and create systemic change for diverse cultural groups within the mental health system. RMACs are engaged with OMH Field Offices to support effective collaborations and supports to enhance community-based services in their region. Additionally, the RMACs inform the SMAC about the disparities that are unique to a county or region, and about the recommended strategies to address these challenges.
RMACs currently exist in the following areas, while work is ongoing to develop and support capacity statewide:

- New York City
- Broome County
- Westchester County
- Suffolk County
- Nassau County
- Western New York

**Centers of Excellence for Culturally Competent Mental Health**

In 2007 NYS Mental Hygiene Law was amended to establish two Centers of Excellence for Culturally Competent Mental Health. The legislation charged these Centers to identify and disseminate best practices for behaviors, policies, and structures to support culturally competent care. OMH designated its two research institutes, the Nathan Kline Institute for Psychiatric Research and New York State Psychiatric Institute, to house the Centers and conduct research that focuses on disparities in service delivery for marginalized and minority populations.

The Nathan Kline Institute (NKI) Center of Excellence for Culturally Competent Mental Health performs research that identifies and develops culturally competent mental health practices, identifies disparities and culturally competent strategies to reduce these disparities, and creates valid and reliable measures of the cultural competence of practices and organizational structures. NKI also serves as an informational resource on cultural groups and cultural competence to OMH bureaus, State planners, providers and consumers. Community representatives, consumers, and family members serve on an advisory panel and have input into the Centers projects.

The New York State Psychiatric Institute (NYSPI) Center of Excellence for Culturally Competent Mental Health addresses the growing need for culturally and linguistically appropriate mental health care and service integration, including physical and mental health care integration. This Center collaborates with mental health providers, consumers and families, community and faith-based organizations, policy makers, and mental health service researchers to develop, adapt, and evaluate evidence-based approaches aimed at improving access to and the quality of mental health services to underserved populations throughout the State. In addition to its focus on integrated care, the Center is studying cultural brokering and language interpreter services and striving to enhance early intervention, engagement for culturally diverse families whose children have serious emotional disturbances.

**Understanding the Four Levels of Cultural Competence**

Cultural competence can be broken into four basic levels for providers of mental health services: organizational, program, client-provider, and community:

1. The organizational level refers to the broader administrative structure of an agency, and the extent to which its budget, vision and mission statements, and policies embed culture and linguistic competence into practices, rules, and procedures. This includes an organization’s commitment to language access services, promoting workforce diversity, and implementation of specialized training for the delivery of services to a diverse client population.

2. The program level applies to the organization or agency’s provision of diverse programs and services that reflect the needs of the diverse cultural groups that are served, such as spirituality, LGBT or adolescent support groups.

3. The client-provider includes how cultural and linguistic competence is embedded within the client and staff therapeutic relationship in the areas of engagement, outreach and assessment, treatment planning and clinical practices. A cross-cultural exchange occurs when both the client and provider/staff person take into consideration each other’s cultural views of mental illness and behavior as it applies to helping clients and their families develop a recovery plan.

4. The community level is the extent to which local community organizations and agencies such as churches, drop-in centers, housing agencies, and food pantries, are utilized as supportive services to the diverse cultural groups served in that geographic region. These stakeholders are valuable community cultural resources and supports for the community to access, and can be integrated into the community’s mental health system by establishing relationships and fostering collaboration with these organizations.
Section 2
Creating Culturally Competent Environments through Language Access, Assessment, Evaluation and Training

Language Access Services

New York State is one of the most diverse states in the nation. According to the 2010 U.S. Census data, 21 percent of the U.S. population and 30 percent of the NYS population reported speaking a language other than English at home. Based on this same data, nearly one in five New Yorkers identified their English-speaking ability as “not well” or “not at all”, indicating significant Limited English Proficiency (LEP) among the general population. For LEP mental health service recipients, their needs and problems cannot be fully assessed or understood if they are unable to communicate, or if they are not provided with information in their preferred language, leading to treatment attrition, lack of engagement, and reduced utilization of necessary mental health resources.

Research conducted by the Office of Mental Health and by the New York State Psychiatric Institute speak to the disparities in health care related to race and ethnicity, as it relates to the lack of effective communication. The NYSPI Center of Excellence for Cultural Competence has also provided research on the importance of providing appropriate language access services in mental healthcare.

It is essential for mental health providers to establish effective communication with LEP recipients and their family members, in order to provide appropriate and accurate assessments, evaluations, treatment planning, and treatment. When mental health care providers take into consideration the diverse cultural, ethnic and racial groups’ views on mental illness, they are able to understand practices that are more effective for diverse populations.

Mental health providers can serve LEP speaking individuals by integrating Language Access Services (LAS) into their practices. This includes having interpreter and/or translator services available in languages that are used by the population in the areas served. Interpreter services consist of a person who provides direct oral interpretation of communication that is spoken between two or more people, and translator services consist of a person providing direct and/or written translation of documents in another language.

Agencies that receive federal funding such as Medicaid or SAMHSA Block Grant funding, are regulated at both a State and federal level to provide LAS at no cost to individuals receiving care. In order to select the vendor that will meet a provider’s language needs, the language population groups of the area should be determined by using U.S. Census Bureau or other data sets, including the OMH Patient Characteristics Survey. Providers and agencies looking for assistance in acquiring LAS that meet the needs of individuals and their families can visit the OMH website.

Types of Interpreter Services

Telephone Interpreter Services are interpreter services that are provided over the phone by a vendor to provide oral interpreter services between two or more people. This is the most commonly used service by providers and it is the least preferred by recipients and family members of mental health services.

Face-to-Face interpreter Services are interpreter services in which an interpreter is present to provide oral interpreter services between two or more people. This is the most preferred service that recipients and family members support.

Virtual Interpreter Services are interpreter services in which an interpreter is present through video remote process to provide oral interpreter services between two or more people. This is the second most preferred service that recipients and family members support.

American Sign-Language (ASL) Services are interpreter services that are provided to deaf and/or hard-of-hearing individuals who communicate through sign-language. ASL services can be found on the Sign-Talk Link http://www.signtalk.org/Professional-Development-Series.html
Cultural Competence Assessment & Evaluation

Community mental health providers can promote and implement cultural and linguistic competence within organizations and programs, but must also foster a culturally competent environment for diverse populations to access services. This can be done by first assessing and evaluating the level of cultural competence, and by providing training consistent with best practices in developing cultural competence among clinical and clerical staff.

OMH’s Bureau of Cultural Competence (BCC) provides cultural and linguistic competence review, assessment, and evaluation at both an individual and programmatic level. Individual assessments consist of clinical and clerical staff completing self-report surveys to score their own degree of cultural self-awareness and indicate the extent to which they identify with their own cultural background, values, and of cultural biases. Program assessment and evaluation activities includes assessing the availability of language access services, or surveying the physical environment to determine how child friendly an agency is that generally serves young mothers, or the availability of materials that include images of people who appear similar to the clients being served.

Following an assessment, the BCC provides recommendations to promote and enhance cultural and linguistic competencies and training based on its findings. Providers are then able to receive training in areas identified for growth.

Cultural competence consultations are offered free of charge to OMH licensed mental health providers. Providers that are not OMH licensed, but are seeking to develop and enhance culturally competent mental healthcare settings can find a list of resources on cultural and linguistic competence, best practices, programs, and service delivery for diverse cultural groups at http://www.omh.ny.gov/omhweb/cultural_competence/assessment_tools.html

Training

The BCC provides regular trainings for State and local providers licensed by OMH. These trainings are available to psychiatrists, psychologists, nurses, social workers, residential counselors, and other direct care staff.

In addition to agency training, the Bureau of Cultural Competence has web-based trainings, which explain the difference between diversity and cultural competence, address how to implement culturally sensitive programs into mental health agencies, and discuss strategies to serve and engage members of specific populations, such as the LGBT community.

It is vital that providers develop and implement cultural and linguistic competence training plans to meet the demographic needs of their service recipients and staff. Training should promote and implement cultural and linguistic competence skills into daily practices to create more person centered care into mental health recovery.

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1. These four layers of cultural competence are based on the “Dilemmas of Mono-Cultural Service Design” model presented in Cultural Competence & African-Americans with Mental Illness, cited below. The original model has been modified with the permission of the author.


3. LEP refers to individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.


5. New York State Psychiatric Institute (2014). Language Access Needs in NYS Office of Mental Health Facilities prior to implementation of Expanded Language Access Strategies in 2011-2012. The NYSPI link is provided to review the Center’s language access research as a best practice for mental health providers: http://nyculturalcompetence.org/

6. The BCC utilizes individual and program assessments provided by Georgetown University National Center of Cultural Competence and Nathan Kline Institute Center of Excellence for Culturally Competent Mental Health

7. Mental health providers who are interested in assessing their staff and programs for cultural competence should contact the BCC for additional information: http://www.omh.ny.gov/omhweb/cultural_competence/

8. CEU and CASAC credit is offered to staff in State and local settings. OMH licensed providers can contact the BCC to request training by visiting the BCC website: http://www.omh.ny.gov/omhweb/cultural_competence/training/
Appendix A: OMH Facilities, Article 28/31 Hospitals and CPEPs in New York State

New York State Office of Mental Health | 2016-2020 OMH Statewide Comprehensive Plan
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The Comprehensive Psychiatric Emergency Program (CPEP) program is a set of hospital-based services that include emergency observation, evaluation, and care and treatment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further evaluation or treatment activities, or discharge to another level of care. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination.

Program objectives include providing timely triage, assessments, and interventions; controlling inpatient admissions; providing crisis intervention in the community; and providing linkages to other services. CPEPs are designed to directly provide or ensure the provision of a full range of psychiatric emergency services, seven days a week, for a defined geographic area. Brief and full emergency visit services are Medicaid reimbursable.

The four CPEP service components are:

1. Hospital-Based Crisis Intervention Services: The psychiatric emergency room is the setting for CPEP hospital-based crisis intervention services and is available 24 hours per day, seven days a week. Services offered in the emergency room include triage, referral, evaluation and assessment, stabilization, treatment, and discharge planning. These services are provided by a multi-disciplinary team consistent with CPEP regulations. Enhanced staffing is necessary for timely and thorough assessments and more appropriate clinical decision making, especially as high risk or high cost decisions are frequently made. CPEPs help ensure individual and community safety and appropriate inpatient admissions and outpatient referrals.

2. Extended Observation Beds are intended to provide recipients a safe environment where staff can continue to observe, assess, diagnose, treat, and develop plans for continued treatment as needed in the community or in a hospital or other setting. By regulation, CPEPs may be licensed for up to six extended observation beds. The number of beds per site varies based on geographical need and the CPEP’s physical plant. Extended observation beds are usually located in or adjacent to the psychiatric emergency room, allowing recipients to remain in the emergency room area for up to 72 hours. Extended observation beds enable staff to assess and treat recipients who need short term care and treatment rather than inpatient hospitalization. In addition, the availability of extended observation beds assists in diverting avoidable short term inpatient admissions.

3. Crisis Outreach Services are designed to provide mental health emergency services in the community. The two objectives of this component of service are to provide initial evaluation, assessment and crisis intervention services for individuals in the community who are unable or unwilling to use hospital-based crisis intervention services in the emergency room, and to provide interim crisis services for emergency room recipients who require follow up. Interim crisis services are mental health services provided in the community for recipients who are discharged from a CPEP emergency room, and include immediate face-to-face contacts with mental health professionals to facilitate community tenure while waiting for a first visit with a community-based mental health provider.

4. Crisis Residence Services are designed to offer residential and other necessary support services for up to five days to recipients who recently experienced a psychiatric crisis or were determined to be at risk of an emerging psychiatric crisis. Most CPEPs have provided crisis residence services through linkages with State psychiatric centers or other local service providers.

CPEP Provider Performance Data

In addition to providing or ensuring the provision of required services, each CPEP is also responsible for submitting quarterly reports to OMH including: the number of visits or admissions to each of the four required components of service; timeliness/length of stay and disposition data related to emergency room evaluations and extended observation beds;
disposition data related to crisis outreach and crisis residence services; discharge diagnoses; and recipient demographic characteristics. As of July 2016, there were 22 CPEPs operating in four OMH Field Office regions; there are no CPEPs in the Hudson River region.

CPEP Regional Count:
- 3 in Western New York
- 2 in Central New York
- 16 in New York City
- 1 on Long Island

The following table provides statewide aggregated CPEP data for the 2015 calendar year.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Total 2015 Annual Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPEP Component Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ER</td>
<td>Brief Visits</td>
<td>7,727</td>
</tr>
<tr>
<td></td>
<td>Full Visits</td>
<td>122,659</td>
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<tr>
<td></td>
<td>Total Visits</td>
<td>130,386</td>
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<tr>
<td>Extended Observation Beds (EOBs)</td>
<td>Admissions</td>
<td>12,844</td>
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<tr>
<td></td>
<td>Total Bed Days Occupied</td>
<td>21,408</td>
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<tr>
<td>Crisis Outreach</td>
<td>Initial Visits</td>
<td>16,436</td>
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<td></td>
<td>Interim Visits</td>
<td>8,342</td>
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<tr>
<td></td>
<td>Total Visits</td>
<td>24,491</td>
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<tr>
<td>Crisis Residence</td>
<td>Admissions</td>
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<td></td>
<td>Total Bed Days</td>
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<td><strong>Waiting and Retention Times</strong></td>
<td>1st Contact with Clinical Staff</td>
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<tr>
<td></td>
<td>Less than 1 hour</td>
<td>107,526</td>
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<td></td>
<td>1+ to 2 hours</td>
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<tr>
<td></td>
<td>Over 2 hours</td>
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<tr>
<td></td>
<td>1st Contact with MD</td>
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<td></td>
<td>Less than 2 hours</td>
<td>81,805</td>
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<tr>
<td></td>
<td>2+ to 4 hours</td>
<td>15,929</td>
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<td></td>
<td>4+ to 6 hours</td>
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<td></td>
<td>Over 6 hours</td>
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<td>Entry to Discharge (Non-EOBs)</td>
<td>Less than 8 hours</td>
<td>55,017</td>
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<tr>
<td></td>
<td>8+ to 16 hours</td>
<td>20,343</td>
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<td></td>
<td>16+ to 24 hours</td>
<td>17,149</td>
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<tr>
<td></td>
<td>Over 24 hours</td>
<td>16,562</td>
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<td>Entry to Discharge (EOBs)</td>
<td>Less than 24 hours</td>
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<tr>
<td></td>
<td>24+ to 48 hours</td>
<td>5,296</td>
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<td></td>
<td>48+ to 72 hours</td>
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<td></td>
<td>Over 72 hours</td>
<td>1,335</td>
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<td><strong>Diagnosis on Discharge from CPEP Services</strong></td>
<td>Schizophrenia, Other Psychotic Disorders and Mood Disorders</td>
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<td></td>
<td>Substance-Related Disorders</td>
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<tr>
<td></td>
<td>Personality Disorders</td>
<td>4,888</td>
</tr>
<tr>
<td></td>
<td>Dementia &amp; Other Cognitive Disorders</td>
<td>3,163</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>32,804</td>
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<tr>
<td></td>
<td>Total</td>
<td>143,006</td>
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<tr>
<td><strong>Client Demographics</strong></td>
<td>Age Reported for All CPEP Components</td>
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<tr>
<td></td>
<td>Under 18 Years Old</td>
<td>19,935</td>
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<tr>
<td></td>
<td>18 to 34 Years Old</td>
<td>50,894</td>
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<tr>
<td></td>
<td>35 to 64 Years Old</td>
<td>60,674</td>
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<tr>
<td></td>
<td>65 Years Old and Over</td>
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<tr>
<td></td>
<td>Gender Reported for All CPEP Components</td>
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</tr>
<tr>
<td></td>
<td>Male</td>
<td>77,786</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>59,779</td>
</tr>
</tbody>
</table>
Appendix C: Local Services Plan 2016 Needs Assessments

LSP Survey Question 4:
Assessment of Local Issues Impacting Youth and Adults

For each issue listed in this section, indicate the extent to which it is an area of need at the local (county) level for each disability population listed on the right. The online form will have a drop down menu in each box with the options: High Need; Moderate Need; and Low Need. For each issue that you identify as either a “High” or “Moderate” need, answer the follow-up questions to provide additional detail.

<table>
<thead>
<tr>
<th>Issue Category</th>
<th>Youth (Under 21 years)</th>
<th>Adults (21+ years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CD</td>
<td>MH</td>
</tr>
<tr>
<td>a) Access to Prevention Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Access to Crisis Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Access to Treatment Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Access to Supported Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Access to Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Access to Home/Community-based Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Access to Other Support Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Workforce Recruitment and Retention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Coordination/Integration with Other Systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Other (specify):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Other (specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If any of the issue categories listed above is identified as either a “high” or “moderate” county need to be addressed, additional follow-up questions will need to be completed. Provide a brief description of the issue and why it is important to address it at the county level. Identify any strategies that could potentially be pursued to address the issue. If this issue is also included on the Priority Outcomes Form, the outcome statement and strategies should be copied here.

**Issue Category:** Will automatically appear if a high or moderate need is indicated.

4a1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here.

4a2. Identify strategies that could potentially be pursued to address this local issue.
Appendix C: Local Services Plan 2016 Needs Assessments

LGU Assessed Need for Children & Youth Services, Long Island Region

LGU Assessment of Need for Adult Services, Long Island Region
Appendix C: Local Services Plan 2016 Needs Assessments

LGU Assessed Need for Children & Youth Services, Mohawk Valley Region

LGU Assessment of Need for Adult Services, Mohawk Valley Region
Appendix C: Local Services Plan 2016 Needs Assessments

LGU Assessed Need for Children & Youth Services,
Tug Hill Seaway Region

LGU Assessment of Need for Adult Services,
Tug Hill Seaway Region
Appendix D: Clinic VAP Awards

Listed below are the 40 recipients of the Clinic VAP awards

Central
Cayuga County Community Mental Health Center
Chenango County Community Service Board
Clinton County Community Service Board
Delaware County Community Services
Essex County Mental Health Services
Madison County Mental Health Clinic
The Children’s Home of Jefferson County
Upstate Cerebral Palsy, Inc.

New York
Community Association Progressive Dominicans, Inc.
Hamilton-Madison House Inc.
Lexington Center for Mental Health Services, Inc.
Northside Center for Child Development Inc.
Puerto Rican Family Institute
Safe Space NY
Service Program for Older People, Inc.
Staten Island Mental Health Society, Inc.

Hudson River
Albany County of Mental Health
Astor Children and Family Services
Family Services of Westchester, Inc.
Mental Health Assoc. of Westchester County
Northeast Parent & Child Society
Access Support for Living
Schoharie County Community Mental Health Center
Sullivan County Department of Community Services
The Guidance Center Inc.
Westchester Jewish Community Services

Western
 Allegany Rehabilitation Associates, Inc.
Catholic Family Center of the Diocese of Rochester
Child & Adolescent Treatment Services, Inc.
Ontario County Department of Mental Health
Schuyler County of Mental Health
Steuben County Community Mental Health Center
Tioga County Department of Mental Hygiene
Tompkins County Mental Health Services
Wayne County Mental Health Department

Long Island
Angelo J. Melillo Center for Mental Health
Catholic Charities of the Diocese of Rockville Center
Central Nassau Guidance and Counseling Services, Inc.
NorthShore Child & Family Guidance Association, Inc.
Suffolk County Department of Health Services
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### Appendix E: Database/Terms Glossary

| MHARS | Mental Health Automated Record System (MHARS) is an electronic clinical patient record system for New York State psychiatric center programs (inpatient, outpatient & residential). |
| CONCERTS | Certificate of Need Certification (CONCERTS) application processes information gathered by the Bureau of Inspection and Certification (BIC) on local service providers that are licensed and/or funded by OMH. It captures provider information at the sponsor, agency, facility, program and site levels. Site-specific information includes program capacity, services, population served, and counties served. |
| CAIRS | Child and Adult Integrated Reporting System (CAIRS) application is a web-based information tracking system that facilitates the processing, managing and coordinating of on-going mental health services to children and adults. It integrates the reporting requirements of state and local level providers in consolidating their reporting needs as well as tracking statewide outcomes. |
| NIMRS | New York State Incident Management Reporting System (NIMRS) is a secure, web-based, quality management tool used by OMH providers to report incidents. NIMRS allows for reporting of incidents and restraints in a real-time environment and it eliminates the need for excessive paper-based incident management processes. NIMRS features a report generator that can be used to examine trends, providing risk management staff the ability to make program changes and better the quality of the lives of the individuals serve. |
| PCS Survey | The Patient Characteristics Survey (PCS) is conducted every two years, and collects demographic, clinical and social characteristics for each person who receives a public mental health service during a specified one-week period. The PCS receives data from approximately 5,000 mental health programs serving 178,000 people during the survey week. All programs licensed or funded by the OMH are required to complete the survey. |
| Transformation Plan Services Consumer Satisfaction Survey | OMH assessed consumer satisfaction with public mental health transformation services by directly surveying adults, youth and their families in targeted counties. The Transformation Plan Services Consumer Satisfaction Survey was administered from September 14, 2015 through October 9, 2015. Tailored questionnaires were developed for each service population and included the following domains: access to services, appropriateness of services, cultural sensitivity, participation in services, outcomes of services, overall satisfaction with services, and quality of life. |
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