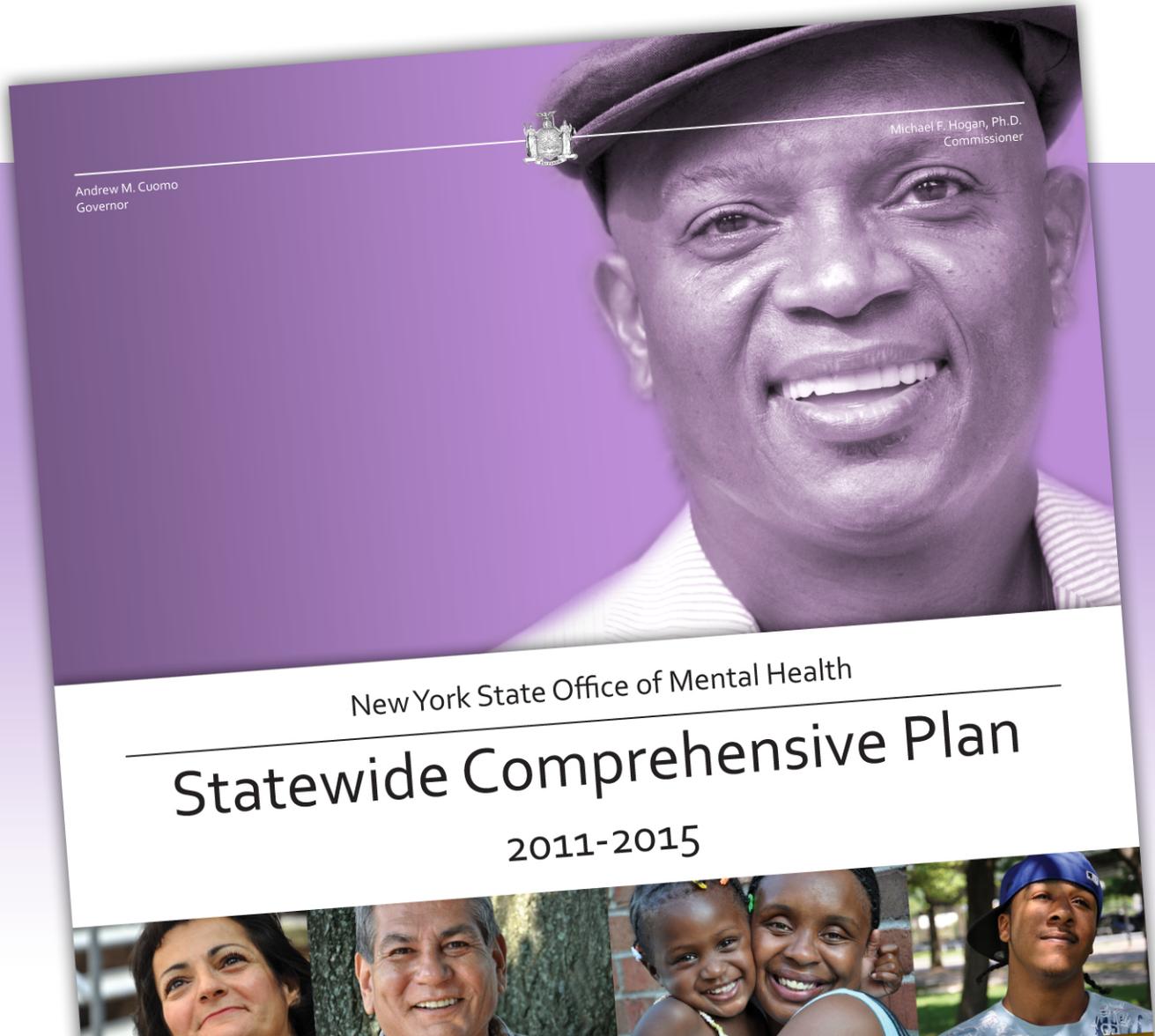




New York State Office of Mental Health

2012 Interim Report



February 15, 2012

I. Message from the Commissioner

Mental illness is now the leading illness-related cause of disability, a major cause of death from suicide, a significant driver of school failure, poor overall health, incarceration and homelessness. Yet, never before has the prospect for substantial improvements to the system of mental health services, the promise of recovery, or the possibility for full and meaningful participation in one's community ever been greater for New Yorkers with mental illness.

In an effort to both develop efficiencies in the delivery of services and bring about life-altering improvements for New Yorkers with mental illness, NYS is currently undergoing a number of transformational changes that will drastically alter the future of mental health services and supports. Such reforms, if managed well and implemented properly, will bring about improvements in the quality of mental health services that will drastically improve the quality of life and increase the overall life expectancy for individuals with mental illness. OMH is most focused on successful implementation of the transformational reforms discussed in this report.

There are commonalities amongst these reforms: moving away from institutional, inpatient services that too often have done more to perpetuate long-term disability than prevent it; moving toward community-based, outpatient services that appropriately address mental health issues when they first appear and allow individuals to continue living their lives; and, creating accountability for outcomes, as measured by the quality of life amongst those receiving services. It is also important to note the fact that these reforms represent a significant course alteration further in the direction of services and supports that allow individuals the opportunity to live as part of society – rather than segregated from it – and to contribute meaningfully to their community.

This Interim Report since the publication of the 2011-2015 Statewide Comprehensive Plan for Mental Health Services in October, 2011 focuses on the efforts to ensure that these most impactful, transformational changes are implemented properly, and the anticipated benefits to individuals with mental illnesses and the systems that serve these individuals are realized. OMH will leverage the reforms underway as part of Medicaid redesign, creation of the New York Employment Services System, development of *First Episode Psychosis* teams, and continued implementation of the NYS Children's Plan to create an accountable framework for systemic change. These transformational changes will drastically re-shape our mental health care delivery system over the next several years, guiding us further toward goals of realizing the promise of recovery, independence, and full community participation for New Yorkers with mental illness.

The central implication of the changes we will discuss is that all participants in New York's mental health system must be actively engaged in the changes that will affect them, and all of us. OMH cannot direct all these changes on its own. Success is not possible without your involvement. To paraphrase Mohandas Gandhi: "Change is happening in our world. You must seek it."



Michael F. Hogan, Ph.D.

II. Transformational Changes in Mental Health

MEDICAID REDESIGN



In early 2011, Governor Andrew Cuomo established a Medicaid Redesign Team (MRT) consisting of various stakeholders with expertise in Medicaid and charged the MRT with finding ways in which to reduce costs, and increase quality and efficiency in NYS' Medicaid program.

In the first few months of 2011, the MRT's work focused on development of a series of reform proposals focused primarily on achieving financial savings in the Medicaid program; these reforms were officially adopted as part of the 2011-12 NYS budget in March. Among the major elements of these reforms most pertinent to OMH and individuals with mental illness were: 1) commitment to a three-year phase-in of care management for all Medicaid beneficiaries and bringing fee-for-service payment arrangements to an end; 2) preparing for the expansion of patient-centered medical homes and implementation of Health Homes; and, 3) initiating regional Behavioral Health Organizations (BHOs) to bring about an integration of physical and behavioral health care.

Beginning in June and continuing through the end of 2011, the MRT's work focused on the development of recommendations for redesigning the Medicaid program so that it can function within a multi-year spending limit and to improve the program's quality. To achieve these goals, a number of MRT work groups were established to focus more specifically on issues within the Medicaid program. These work groups submitted recommendations to the full MRT, for their use in developing their report to Governor Cuomo.

Behavioral Health Organizations (BHO)

Incorporated within the 2011-12 NYS Budget was the authority for OMH and OASAS to contract with regional BHOs. This authority is the first step toward transitioning from a fee-for-service environment to a care management environment, following the growing recognition that "unmanaged care" is no longer satisfactory for individuals with mental illness and that mental health care integrated with other physical and substance use services is preferable. However, little experience with these managed care arrangements involving individuals with the most severe mental health conditions exists.

This first step, commonly referred to as "BHO Phase 1," resulted in five regional BHOs selected (Western NY, Central NY, Hudson River, Long Island and New York City) to:

- Monitor behavioral health inpatient lengths of stay
- Reduce unnecessary behavioral health inpatient hospital days
- Reduce behavioral health inpatient readmission rates
- Improve rates of engagement in outpatient treatment post discharge
- Improve understanding of the clinical conditions of children diagnosed as having a Serious Emotional Disturbance (SED)
- Profile provider performance

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In essence, the goal of Phase I is to successfully move to Phase II; therefore, the focus of Phase I is on readiness. Contracted BHOs in Phase 1 are utilizing their tools and expertise, as well as collecting and submitting data, to help OMH and OASAS learn how to improve care in preparation for the transition to a care management environment in Phase 2. This will provide OMH and OASAS the opportunity to learn more about effective care management practices for populations of individuals with serious mental illnesses and substance use disorders who have never before been included in a managed care structure in NYS. Phase 1 also will help identify where improvements can be made in relation to: inpatient discharge planning; ambulatory engagement/continuity of care; and, utilization of Medicaid data to inform treatment and care planning. Lastly, Phase 1 will provide the opportunity to test and develop dynamic, useful metrics for monitoring behavioral health system performance.

As of February 2012, all five regional BHOs had started their monitoring, reviews and data collection work to assist providers and OMH/OASAS to find way in which to improve care.

MRT Behavioral Health Reform Work Group and BHO Phase II

In 2013, BHO reform will begin moving to Phase II, involving contracting with specialty managed care plans that will bear financial and clinical risk for establishing and managing systems that address the needs of individuals whose benefits have been “carved out,” in integrated plan arrangements.

In an effort to develop parameters for this transition, the MRT established a Behavioral Health Reform Work Group (BH Reform Work Group). Co-chaired by OMH Commissioner Hogan and NYC Deputy Mayor for Health and Human Services, Linda Gibbs, this work group consisted of representatives of individuals receiving services, advocates, service providers, and health insurers in the mental health and substance use disorder fields. The BH Reform Work Group’s official charge was to:

- “Consider the integration of substance abuse and mental health services, as well as the integration of these services with physical health care services, through the various payment and delivery models.
- Examine opportunities for the co-location of services and also explore peer and managed addiction treatment services and their potential integration with Behavioral Health Organizations (BHO).
- Provide guidance about health homes and propose other innovations that lead to improved coordination of care between physical and mental health services.”¹

The BH Reform Work Group met from June through September. Almost immediately, the need for additional concentration on issues specific to children with serious emotional disturbances and substance use disorders was recognized. Thus, a subgroup of experts was formed to develop child-specific recommendations as well.

In October, after a series of presentations on topics pertinent to the BH Reform Work Group’s charge and discussion, they submitted final recommendations to the MRT. Their report outlined a set of recommended principles (see insert) that should apply to the delivery of behavioral health services in a managed care environment, regardless of the specific delivery design (e.g. full-benefit Special Needs Plans [SNPs], provider-based Integrated Delivery Systems [IDS], or behavioral health benefit carve-out BHOs).

¹ http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm

In addition, and perhaps more importantly, the BH Reform Work Group submitted a number of specific recommendations in the areas of finance and contracting with plans, eligibility, performance metrics/evaluation; peer services; Health Homes implementation; as well as some issues that were considered important for the Work Group to provide recommendations on, but that were outside the scope of the Work Group's mission. While the BH Reform Work Group's entire set of recommendations are too voluminous for the purposes of this report (see http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf for the complete set of recommendations), a few overarching concepts from the recommendations merit mention here:

**Principles for Behavioral Health
 Services in a Managed Care Environment**
*Recommendations from the MRT
 Behavioral Health Reform Work Group*

- There should be mechanisms at multiple levels for connecting and coordinating all of the different participants, including healthcare providers, payers, and care managers. The delivery of clinical care should be coordinated and efficient.
- Payment for services should be tied to patient/consumer outcomes.
- Patient/Consumer input and choice is critical.
- Attention should be paid to social factors that influence individual behavior and outcomes, such as employment and financial status.
- Housing resources need to be available directly for timely use to avoid lengthy or repeat admissions, and to provide stability for patients/consumers in the community.
- Money saved should be reinvested smartly to improve services for behavioral health populations.
- Distinction in design and operation must be made to address the unique needs of children and their families.
- The needs of older adults are unique and require special attention.
- Regulatory burden should be minimized.
- The diversity of NYS' communities should be taken into account.
- Key outcomes should include factors at individual, provider, and system levels.

Complete listing at

http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

- Establish risk-bearing managed care approaches/entities - either as Special Needs Plans (SNPs), Integrated Delivery Systems (IDS) or BHOs.
- Invest or reinvest into community-based systems of care in order to create the strong, well-functioning system of care necessary to meet the needs of individuals no longer utilizing inpatient care. Such investments are needed in care coordination, affordable housing, health information exchanges and other non-clinical services and supports.
- Risk-bearing managed care approaches should bear responsibility to pay for inpatient care at OMH Psychiatric Centers and to coordinate discharge planning from these facilities, and other inpatient settings. As downsizing of these facilities continues, such resources would be reinvested into the community-based services mentioned above.
- Advance the core principle that managed care approaches for people with behavioral health care needs should assist enrollees in recovery and in functioning in meaningful life roles.
- Ensure access to front-line services/benefits to prevent, screen and treat behavioral health disorders by identifying the core elements of the benefit package, including those specific to children.

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- Develop outcome measurements and standards to review performance that are meaningful, easy to measure, validated and readily available, and easy to use – for both adult and children’s behavioral health services.

The BH Reform Work Group’s entire set of recommendations were approved and accepted by the MRT during their November 1, 2011 meeting.

Moving into Phase II, contracted entities will indeed bear risk, be responsible, and be held accountable for the behavioral health services delivered through their network. OMH and OASAS, in consultation with DOH, will be the stewards of this transition to a care management environment.

While the BHO initiative, in itself, is a transformational reform, it will also act as a fulcrum to bring about additional transformative efforts, including: replacement of excess institutional capacity with targeted community care and affordable housing; re-orientation of community care staffing to prioritize use of trained/credentialed peer staff to promote recovery; and, the expanded use of data for care coordination, performance measurement and in electronic medical records.

Health Homes

Amongst the population of Medicaid recipients are those with complex and/or chronic conditions, including those with mental health and/or substance use disorders, developmental disabilities, those in long-term care, and those with conditions such as asthma, diabetes, heart disease, HIV/AIDS and obesity. Together, these populations total nearly \$26B in costs in NYS’ Medicaid program annually, with nearly \$6.3B accounting for services to 400,000 individuals with complex/serious mental illness and/or substance use disorders.

In an effort to improve coordination amongst the various medical, behavioral and long-term care needs of these populations – and thereby reduce costs – NYS is establishing Health Homes, as is authorized under the federal Patient Protection and Affordable Care Act (ACA), enacted in 2010. “A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner.”² Health Homes will consist of a network of organizations that provide a variety of services, all working together to meet the needs of the individuals they serve. These services include: “comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and, the use of health information technology to link services, as feasible and appropriate.”³ “...The use of the health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual.”⁴

² http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

³ <https://www.cms.gov/smdl/downloads/SMD10024.pdf>.

⁴ <https://www.cms.gov/smdl/downloads/SMD10024.pdf>.

In essence, Health Homes are responsible for coordinating the various aspects of a Medicaid recipient's health care needs, paid through Medicaid managed care (or fee-for-service until BHO Phase II is implemented), and

**Health Home Implementation Recommendations from the
MRT Behavioral Health Reform Work Group**

- Health homes must include behavioral health expertise and leadership.
- A transitional strategy must be in place to assure the smooth transition of behavioral health services (especially "case management" services) from the 2 year enhanced FMAP stage into the SNP/BHO/IDS environment that will be put in place for 2013.
- All Health Homes should include networks providing both physical and behavioral health care and rules should not distort spending on category of care, whether in health homes with a specialty capacity to serve individuals with SMI and SUD, or other health homes.
- Health homes must coordinate with non-health service providers and have explicit relationships with local governments that often coordinate these services.
- Screening and Brief Intervention for Referral to Treatment (SBIRT) and standard depression screening should be a mandatory element of every Health Home patient assessment.
- The State must clarify the roles and responsibilities of health homes participants.
- The State should work to preserve patient/consumer choice.
- If patients/consumers are automatically assigned to health homes, the State should take steps to ensure that assignment is appropriate.
- The State should incentivize health homes to reach culturally diverse communities and measure performance in this domain.
- Clearer timelines and paths for the implementation of health homes are needed.
- Both the State and health homes should present consumers with user-friendly information.
- Health home employees should be held to appropriate qualification standards, in which the standards of the state BH agencies should be considered.
- The State should implement health homes in a fashion that reduces regulatory burden while improving the quality and continuity of care.

Complete descriptions available at

http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

promoting communication amongst caregivers. Health Homes are being developed, in part, through "conversion" of OMH's current Targeted Case Management (TCM) program. This will allow Health Homes to utilize the extensive expertise of former TCM providers in engaging and reaching out to people in the mental health system, but includes responsibility for coordinating all medical, behavioral and long-term care needs. This more comprehensive care coordination approach is anticipated to significantly benefit individuals with mental illnesses by providing more integrated health and behavioral health service delivery.

To fulfill part of their charge, the MRT BH Reform Work Group submitted recommendations to the MRT and DOH on the implementation of the Health Homes initiative (see insert). Recognizing the unique needs of children and families served by multiple systems of care, the BH Reform Work Group's Children's Subcommittee also submitted a recommendation for a comprehensive and integrated model approach that can be

established through the creation of care coordination entities, a model of which is currently under development by the child serving state agencies.

After receiving more than 150 applications to become a Health Home from around the state, the Department of Health (DOH) established a three phase process to the Health Homes roll-out, with an increasing number of

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counties moving to the Health Home model in each phase; Health Homes are scheduled to be fully implemented in all counties by July 1, 2012. A full listing of the counties that will participate in the respective Health Home roll-out phases can be found at

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/index.htm.

Community-based providers, including mental health organizations, have been strongly encouraged either to take the lead in establishing a Health Home or to partner with an organization taking the lead in establishing a Health Home network in their region. A full listing of all the designated Health Homes participating in Phase 1 can be found at

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/prov_lead_designated_health_homes.htm.

“Eligible health home members will be assigned directly to approved (Health Home) networks by the State and will be assigned through health plans for members enrolled in Medicaid Managed Care. Initial assignment to State approved Health Home providers will be based on:

1. Higher Predictive Risk for Negative Event (Inpatient, Nursing Home, Death)
2. Lower or no Ambulatory Care Connectivity
3. Provider Loyalty (Ambulatory, Case Management, ED and Inpatient)
4. Geographic Factors

The State has provided each managed care plan with a Health Home eligible list of patients sorted from highest to lowest predictive risk. The State is working on the development of Patient Rosters for each county in the wave one rollout that take the factors above into priority consideration for initial health home assignment. The goal is to assign and outreach to the highest risk (based on a predictive model) and highest cost members with the lowest primary and ambulatory care connectivity in each health home area. Once those members have been assigned and enrolled then the State and health plans will move down the list using provider loyalty and geography as markers for initial health home assignment. The details of this algorithm will be approved by all the State partners (DOH, OMH, AIDS Institute and OASAS) and will be recommended to health plans as one means of distributing members through intelligent assignment to each of the State approved health homes.”⁵ Once individuals have been assigned to a Health Home, they will have the option to choose a different Health Home provider or opt out of Health Home enrollment altogether.

After recently receiving approval from the Centers for Medicare & Medicaid Services (CMS) for the State Plan Amendment that will allow the first phase of Health Home implementation to proceed, NYS is now working to commence assignment of individuals into provider-led Health Homes in March and allow programs to bill for patients they are already serving under Health Homes retroactive to January 1, 2012.

The BHO and Health Home initiatives, when considered together, are designed to accomplish common goals: to improve healthcare delivery and integration of care; to improve outcomes for Medicaid beneficiaries; to reduce or eliminate unnecessary state expenditures; to facilitate recovery; and, to improve the capacity of communities

⁵ http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-01-24_preliminary_hh_rollout_plan.pdf

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to achieve those goals. Together, these initiatives will create fundamental changes in the way in which mental health and substance use disorder services are delivered and usher in a new era of accountability and integration.

MRT Affordable Housing Work Group

In an effort to address the many issues related to housing for Medicaid recipients, the MRT established an Affordable Housing Work Group charged with evaluating NYS' current supportive housing programs and capacity, making recommendations to overcome barriers to development and utilization of supportive housing, and identifying opportunities for investment of additional resources for supportive housing, including from the private sector.

Likewise with the BH Reform Work Group's recommendations, the Affordable Housing Work Group's recommendations are too voluminous for the purposes of this report (see http://www.health.ny.gov/health_care/medicaid/redesign/docs/final_draft_recommendations.pdf for complete set of recommendations). However, some concepts of particular interest/impact to individuals with mental illness and the mental health system merit mention here:

- “Develop a NY-NY IV agreement with New York City and other interested counties to jointly commit to funding for capital, operating expenses/rent and services in new supportive housing units targeting high-cost, high need users of Medicaid, especially those transitioning out of restrictive institutional settings.
- Establish a formal mechanism to set aside a portion of Medicaid and non-Medicaid savings related to any reduction of inpatient hospital or nursing home capacity to a fund dedicated to housing development.
- A portion of the MRT funding allocation should be transferred to OMH, the Office of Temporary and Disability Assistance (OTDA) and Homes and Community Renewal (HCR) for distribution through a variety of programs operated by these agencies in order to allow for leveraging additional public and private investments.
- OMH capital and operating funding should be unfrozen for supportive housing for SFY 2012-13 and SFY 2013-14 (see 2012-13 Executive Budget & Reform Plan section below for additional details).
- Set-asides and incentives for supportive housing construction in HCR Qualified Allocation Plan should be evaluated and considered for an increase when awarding federal Low-income Housing Tax Credits.
- Include in MRT 1115 Medicaid waiver funding for ongoing housing services and supports, and operating costs.
- Explore the creation of a pilot program of “social impact investment bonds” that would pay for development, operations and services in supportive housing.”⁶

⁶ http://www.health.ny.gov/health_care/medicaid/redesign/docs/final_draft_recommendations.pdf

THE NEW YORK EMPLOYMENT SERVICES SYSTEM



For nearly four years, OMH has lead the efforts designed to support competitive employment opportunities and outcomes for people with disabilities that comprise the *New York Makes Work Pay* (NY-MWP) program (www.nymakesworkpay.org), funded through NYS' Medicaid Infrastructure Grant from CMS. Among the NY-MWP initiatives is the development of a new, comprehensive job matching/employment supports coordination and data system – the New York Employment Services System (NYESS) (www.nyess.ny.gov). NYESS will serve as a single point of access for all New Yorkers seeking employment and employment supports, regardless of an individual's abilities/disabilities and regardless of the state agency system from which they receive employment services/supports. NYESS consists of the NYS Department of Labor's *One-Stop Operating System* (OSOS), which connects job seekers with employment opportunities in the NYS Job Bank (www.jobcentral.org/ny/), as well as a data warehouse of employment-related information operated by OMH. Providers of employment-related supports and services licensed by/contracted with Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR), Commission for the Blind and Visually Handicapped (CBVH), Office for the Aging (NYSOFA), Office of Alcoholism and Substance Abuse Services (OASAS), Office for People with Developmental Disabilities (OPWDD), OMH and the NYS Department of Labor (DOL) will begin using this new system in the first phase.

NYESS will enhance NYS' ability to improve employment outcomes for New Yorkers with disabilities, and prove greatly beneficial to businesses/employers and providers of employment supports. Among the many benefits, this new employment system will:

- Centralize employment service/support information, greatly improving the ability to coordinate employment supports and services among multiple providers and across multiple systems
- Identify individual job seekers' skills, assist with resume development, and match skills sought by businesses/employers for specific jobs with the skills possessed by job seekers
- Assist with benefits screening and enrollment
- Generate tax credit claiming documentation for businesses/employers that hire individuals with disabilities through the system
- Generate Ticket To Work milestone payments associated with helping individuals with disabilities achieve certain employment outcomes
- Provide public access to employment-related performance reports generated by data entered into the system

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Implementation of the NYESS system will take place in a number of phases over the next several years, the first of which began in the fall of 2011. More than 200 organizations providing employment services and supports to people with disabilities have now been trained on the NYESS system and are beginning to use the resources NYESS offers.

As employment-related service information is entered into NYESS, aggregated outcome data for individuals served through the system will be collected in the OMH data warehouse and made publicly available on the NYESS website. Such transparency will allow individuals seeking employment services and supports and their families to make truly informed choices about the provider of employment related services with whom they may choose to work. It is anticipated that such transparency in outcomes will drive not only the individual job seekers to find the provider of services best able to assist them, but also drive service providers to compete to maintain high rankings in the NYESS system.

In addition, the data collected by NYESS will help to address a long-standing issue that providers of employment-related supports to people with disabilities have long faced regarding documentation for services rendered, which are necessary to claim milestone payments under the Ticket To Work program (<https://yourtackettowork.com/web/ttw/home>). All documentation necessary to claim such milestone payments – including proof of continued employment – will be collected in the NYESS system, which will then directly interface with the Social Security Administration to verify milestone payment eligibility for Ticket To Work holders who achieve an employment milestone. Such payments will then be distributed amongst all providers of employment services based upon percentage of effort. A small percentage of those funds will be held for continued operation of the NYESS system and for reinvestment into additional employment supports – including a benefits counseling/life coaching capacity employing individuals with disabilities to assist individuals with disabilities to make the transition to economic self-sufficiency.

This is a transformational project as it is not only an excellent example of inter-agency collaboration, but also by virtue of the fact that NYESS will effectively eliminate the segregated systems of employment supports for people with disabilities. The NYESS system is gaining considerable attention nationally and is being considered a potential model worthy of replication in other states. It is widely expected that NYESS will open up employment opportunities to individuals with disabilities, allowing them to make true strides toward economic self-sufficiency, which is perhaps the purest form of independence.

FIRST EPISODE PSYCHOSIS TEAMS

Often, for people with psychotic disorders such as schizophrenia, an initial "psychotic break" leads to hospitalization. Usually, with medication treatment, symptoms are largely stabilized in one to two weeks, but this relief is transitory. Discharge from the hospital to some level of community-based service follows. Yet, without an adequate plan, supports for recovery, and continuous care, most people begin to feel better and prematurely discontinue medications. This often leads to repeated and debilitating psychotic episodes, multiple hospitalizations, and a descent into long-term disability, poverty and dependence on health care. Sometimes the results are even worse; the risks of suicide, homelessness and incarceration are high for people with a diagnosis of schizophrenia.

The "good news" is that people are resilient. As a study from Vermont and other long term follow-up studies have shown, after years of revolving door experiences, many people develop coping techniques and figure out how to manage life with a psychiatric disability. But decades may be wasted with hospitalizations, incarceration, etc., and often leave individuals with these conditions completely disenchanting with the mental health system.

An acute illness model for treatment of people with schizophrenia is badly broken and is no longer acceptable. It is past time to move from the current episodic, "casualty" model of care that waits for problems to arise and then offers expensive and intensive treatment, to a model that emphasizes early and continuous recovery-oriented care. This approach has been proven effective in scores of demonstration programs around the globe, including in the U.S. A national research program called Recovery After Initial Schizophrenia Episode (RAISE) has been launched by the National Institute on Mental Health and is led by John Kane, MD at Zucker Hillside Hospital.

OMH believes that enough has been learned about the disaster of "usual care" that we need not wait to try and improve treatment and support for people with early onset of a psychotic disorder and their families. OMH will work to establish *First Episode Psychosis* teams with the expertise and capacity to provide early and effective care that offers hope and opportunities for recovery for people with psychotic disorders. As more experience is gained, OMH intends to establish this new initiative on a statewide basis, making NYS the first state in the nation with a reliable network of *First Episode Psychosis* services.

CHILDREN'S INITIATIVES

The Children's Plan

The Children's Plan, developed in October 2008 by nine state agency Commissioners from child-serving agencies in NYS, represents a blueprint for how to support the social and emotional well-being of children and their families. Under the leadership of the Council on Children and Families, the heads of the child-serving state agencies, with the active participation of family and youth partners and other stakeholders, work towards following paths that demonstrate fidelity to the values and principles underlying the Children's Plan. Two exciting efforts initiated in The Children's Plan include Promise Zones and various Early Childhood initiatives.

NYS Promise Zones

In recognition of the multiple and complex needs of children and their families, Promise Zones (<http://www.ccf.state.ny.us/Initiatives/ChildPlan/cpPromPrac.htm#pz>) were developed as a strategy to achieve New York State's goals of student engagement, academic achievement, dropout prevention, social and emotional competence, establishing positive school culture and school safety. This nationally recognized initiative formalizes partnerships among local school districts and child-serving state and local agencies, with initial sites located in Syracuse, Buffalo and New York City (updates on the progress in each site can be found at <http://www.ccf.state.ny.us/Initiatives/ChildPlan/cpResources/PromiseZoneUpdateMarch2011.pdf>). The goals of these efforts is to increase positive engagement in the instructional process measured by improved academic outcomes, attendance and other indicators of an increase in instructional time, including reduced absenteeism, truancy and incidents resulting in discipline; and to identify a replicable model for collaborative planning and service delivery to improve educational and health outcomes for children in high need districts/schools statewide.

Early Childhood Initiatives

Historically, the children's mental health system has not played an active role in early childhood programs and services for children under the age of five and their families. As a result of *The Children's Plan*, OMH has since become an active participant, including membership on the steering committee of the Early Childhood Advisory Council (ECAC), which provides advice to the Governor on issues related to the development of a comprehensive system of supports and services for young children and their families.

In addition, OMH serves as the co-chair of the Promoting Healthy Development Workgroup of the ECAC, which is a cross-systems collaboration to promote optimal health and development in all domains, including social-emotional development for young children. Out of these efforts, the workgroup developed recommendations for Social and Emotional Development Consultation in Early Childhood settings. These recommendations have led to the creation of a focus on increasing awareness and understanding of social-emotional development through trainings, supports and resources throughout the state. For more information on ongoing early childhood initiatives go to <http://www.ccf.state.ny.us/NavPages/early.htm>.

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Addressing the Quality and Vitality of Children's Clinic Services

Currently, it is a challenging time for clinics due to recent changes in regulations, financing, and the overall environment. Clinics must be more productive, more efficient, and more business-savvy. As a result, they need support and technical assistance to negotiate this rapidly changing environment. Two efforts are underway to support clinics in reaching policy objectives centered around early identification, comprehensive assessment, family engagement, and improved access to effective treatment.

Redesigning Child and Family Clinic-Plus

Child and Family Clinic-Plus (Clinic-Plus) was OMH's effort to establish social and emotional development as a statewide priority through early identification and evidence-based treatment. Over time, it became clear that stigma associated with seeking mental health services, as well as challenges in effective business planning, were contributing to provider's inability to meet performance targets associated with Clinic-Plus program elements.

Therefore, OMH has redesigned the Clinic-Plus program to focus on performance-based early recognition, coordination and screening, for which contracts were recently awarded. Selected providers will be required to screen at least 1000 children annually in order to retain their contract and are encouraged to develop partnerships with other children serving entities in the community in order to maximize the number of children who are identified and served. In addition, Clinic-Plus redesign includes one-year incentive grants to support the development of new mental health satellite clinics located in primary care settings, which will help develop a comprehensive approach to integrated care that OMH is seeking to establish. This partnership will provide a unique opportunity to identify those children and families who might not otherwise seek treatment and strengthens the capacity for earlier recognition and treatment options in an atmosphere that recognizes the interconnectedness between physical and mental health.

Children's Technical Assistance Center

As a result of clinic restructuring and the lessons learned through Clinic-Plus, it became apparent that children's clinic providers would benefit from ongoing support and technical assistance aimed at the development of strong business and financial models to ensure sustainability.



The Children's Technical Assistance Center (C-TAC) initiative assists children's clinic providers in enhancing the infrastructure necessary to support their evolution towards the new clinic model. C-TAC engages a number of organizations to provide training and support on quality improvement strategies, including clinical and organizational skills, and evidence-based practices, to all interested NYS child-serving mental health clinics with the overall goal of improving mental health outcomes for children and their families. Participation in C-TAC activities takes place on a project-by-project basis and agencies are invited to participate in projects that are relevant to their individual needs.

III. APPENDIX - 2011 LEGISLATIVE SUMMARY

SUMMARY OF LEGISLATION OF INTEREST TO THE NEW YORK STATE OFFICE OF MENTAL HEALTH (OMH) ENACTED DURING THE 2011 LEGISLATIVE SESSION

NYS OFFICE OF MENTAL HEALTH

DECEMBER, 2011

Acknowledgement

The summaries in this document are based on the latest available information from the Legislative Retrieval System (LRS) operated by the State of New York Legislative Bill Drafting Commission (LBDC). Status of legislation, copies of bills, veto messages, chapter laws, and other related information is available free to the public on the LRS web site: <http://public.leginfo.state.ny.us>

These summaries should not be used or relied upon without actual review of the underlying statute or without consultation with Counsel. If you have any questions, please contact David Wollner, New York State Office of Mental Health (OMH) Counsel's Office, at coledvw@omh.state.ny.us or 518-474-1331.

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CHILDREN'S SERVICES

Prohibiting Co-mingling of Children and Adults in Psychiatric Hospitals

A.4731 and A.8357

APPROVED

Chapters 157 and 188

Effective July 20, 2011

Together these bills amend section 7.09 of the Mental Hygiene Law to require OMH to promulgate regulations generally prohibiting the co-mingling of children and adolescent patients with adult patients in psychiatric hospitals licensed by OMH.

Specifically, this legislation requires OMH to promulgate regulations governing psychiatric hospitals licensed by OMH, to prohibit children and adolescents from being placed in residential areas of such hospitals with adults, or from receiving services in groups which include adults. However, under extraordinary circumstances, OMH may issue a waiver to permit such co-mingling, after consideration of the clinical needs of patients, and applicable health and safety concerns.

This legislation is consistent with current OMH regulations that prohibit co-mingling of children under the age of 18 and adults in licensed wards and wings of general hospitals and freestanding inpatient psychiatric hospitals. Also, the chapter amendment recognizes that there may be extraordinary circumstances where the ability to permit commingling on a situational and time limited basis is necessary for clinical reasons, or to protect the health, safety or welfare of patients.

COMMUNITY SERVICES

The 2011-12 Budget includes legislation to implement recommendations proposed by the Governor's Medicaid Redesign Team (MRT). The MRT was tasked by Governor Cuomo to find ways to reduce costs and increase quality and efficiency in the Medicaid program for the 2011-12 Fiscal Year. OMH will be working closely with the Department of Health (DOH) and the Office of Alcoholism and Substance Abuse Services (OASAS) on several of these initiatives including:

Behavioral Health Organizations (BHO's)
S.2809-D, Subpart H, sections 42 – 42-d, pages 143-146.

APPROVED

Chapter 59

Chapter 59 of the Laws of 2011 (included in the Enacted 2011-12 Budget) adds a new §365-m to the Social Services Law to authorize the Commissioner of OMH and the Commissioner of the Office of Alcoholism and Substance Abuse Services, in consultation with the Department of Health, to contract with Regional Behavioral Health Organizations (BHOs) to provide administrative and management services for the provision of behavioral health services. Consistent with the recommendations of the Medicaid Redesign Team, OMH and OASAS have the authority to contract jointly with Managed Behavioral Health Organizations (BHOs). These BHOs are charged with managing behavioral health services for individuals with substance abuse issues and serious mental illness.

2012 Statewide Comprehensive Plan Interim Report

The BHO implementation will occur in two phases. Phase 1 consists of five regional BHOs that will monitor inpatient behavioral health services for Medicaid-enrolled individuals whose inpatient behavioral health services are not covered by a Medicaid Managed Care plan and who also are not enrolled in Medicare. Four of the BHOs became operational on January 1, 2012 (Long Island will be operational early in 2012).

Phase 1 BHOs will be responsible for:

- Concurrent review of behavioral health inpatient length of stay;
- Reducing unnecessary readmissions;
- Improving rates of engagement in outpatient treatment following discharge;
- Gathering information on the clinical conditions of children with a Serious Emotional Disturbance who are covered by Medicaid Managed Care and receiving treatment in an OMH licensed specialty clinic;
- Profiling provider performance; and
- Facilitating cross-systems linkage.

To accomplish these goals, the BHOs will interact with providers to review treatment and discharge aftercare plans for Medicaid fee-for service admissions to inpatient mental health, detoxification, and substance use rehabilitation units.

In 2013, BHO reform will begin moving to Phase II, involving contracting with specialty managed care plans that will bear financial and clinical risk for establishing and managing systems that address the needs of individuals whose benefits have been “carved out,” in integrated plan arrangements.

Health Homes
S.2809-D, subpart H, section 37, pages 131-133

APPROVED

Chapter 59

The 2011-12 Enacted Budget adds a new §365-l to the Social Services Law to establish Health Homes for providing care management services for high cost, high need enrollees. Provider networks meeting Federal and state health home standards will be assigned high risk patients to improve the integration of service delivery and care outcomes while reducing unnecessary inpatient hospitalizations and emergency room visits. Under the federal Patient Protection and Affordable Care Act (ACA), enacted in 2010 a Health Home is “a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner.” Health Homes will consist of a network of organizations that provide a variety of services, all working together to meet the needs of the individuals they serve. These services include: comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; referral to community and social support services; and the use of health information technology to link services.

Notice of Investigations of Patient Abuses
Effective January 21, 2012
S.5793

APPROVED

Chapter 588

The bill amends section 5.05 of the Mental Hygiene Law (MHL) to require the OMH, the Office of People with Developmental Disabilities (OPWDD), and the OASAS to have “all new contracts with agencies and providers licensed by the offices” include a clause requiring that notice be provided to all current and new employees of such agencies and providers stating that all patient abuse investigations will continue even if an employee leaves employment prior to the conclusion of the investigation. The bill also stipulates that the provisions of this legislation shall not diminish the rights, privileges, or remedies of any employee under any other law, regulation, collective bargaining agreement or employment contract.

STATE OPERATIONS AND FACILITIES

Sale of Property on the Campus of Buffalo PC
Effective April 13, 2011
S.1406

APPROVED

Chapter 14

Chapter 14 of the Laws of 2011 authorized the sale and conveyance of a portion of the campus of Buffalo Psychiatric Center (Buffalo P.C.), from OGS to the Richardson Center Corporation (RCC), upon the consent of the Commissioner of Mental Health. The parcel includes the vacant H.H. Richardson Complex, a National Historic Landmark which was designed in the late 1860’s through a partnership between noted architect H.H. Richardson and landscape architect Frederick Law Olmsted. The mission of RCC is to stabilize and rehabilitate the Richardson Complex in order to reuse this property for new community development.

Since Buffalo P.C. and RCC will be sharing the same campus together, OMH is negotiating a Memorandum of Understanding with the RCC to address issues such as utility easements, ingress/egress, and shared use. The OMH is very supportive of the mission of the RCC and anticipates that the RCC will also be supportive of the ongoing mission of the Buffalo Psychiatric Center.

Closure, Consolidation and Reducing Inpatient Capacity
Effective April 1, 2011 and deemed repealed March 31, 2012
S.2809-D, Subpart G, sections 1 and 2, pages 109-111

APPROVED

Chapter 59

The 2011-12 Enacted Budget includes Article VII legislation which authorizes OMH to close, consolidate, reduce, transfer or otherwise redesign services of hospitals, other facilities and programs operated by OMH to achieve the necessary State Operations cost savings measures including the reduction of up to 600 inpatient beds with 30 days notice and the closure, consolidation or merger of one or more facilities with 60 days notice.

**Compliance with Operational Standards by Hospitals
Effective March 31, 2011
S.2809-D, Subpart Part H, section 55, pages 156-157**

APPROVED

Chapter 59

Chapter 59 of the Laws of 2011 authorized the OMH to accept accreditation by The Joint Commission or any other hospital accrediting organization to which the Centers for Medicare and Medicaid Services has granted deeming status, as evidence of compliance with operational standards for OMH-licensed psychiatric units of general hospitals. The new law authorizes OMH to exempt hospitals from the annual inspection and visitation requirements, provided that: such hospital has a history of compliance and a record of providing good quality care, a copy of the survey report and certificate of accreditation is provided to OMH, in conducting the survey the accrediting organization evaluates any minimal operational standards established by OMH, and there are no constraints placed upon access by OMH to the survey reports, plans of corrections, reports, notice and other documents related to the survey.

**State Reimbursement for Costs of Prosecution of CNYPC Patients
Effective July 24, 2011
S.5856, Subpart C, section 5, page 54**

APPROVED

Chapter 97

This new law adds a new section 29.28 to the Mental Hygiene Law requiring the Department of Corrections and Community Supervision to reimburse a county's reasonable costs associated with the prosecution of an offense alleged to have been perpetrated by an "inmate-patient" in OMH custody at Central New York Psychiatric Center.

STATE EMPLOYEES

**State Employees who Engage in Sexual Contact with Inmates
Effective November 1, 2011
S.5455-B**

APPROVED

Chapter 205

Chapter 205 of the Laws of 2011 amended section 130.05 of the Penal Law to impose criminal liability upon certain State employees, including certain OMH employees, who engage in sexual conduct with persons, who are deemed incapable of consent by virtue of their commitment, (1) to DOCCS "care and custody or supervision," (2) to OMH care, treatment or supervision at a State correctional facility or a "hospital" for State prisoners under sentence (i.e., Central New York Psychiatric Center (CNYPC)), or (3) to Office of Children and Family Services (OCFS) care, custody, treatment or supervision.

Additionally, the new law amended and expands the definition of "employee" to provide that offending employees no longer need to perform "professional" duties in the above listed facilities in order to be considered employees under section 130.05. Accordingly, employees subject to the provisions of this law would be expanded to include certain nonprofessional staff who provide care,

The Marriage Equality Act
Effective July 24, 2011
A.8354

APPROVED

Chapter 95

Chapter 95 of the Laws of 2011 known as “The Marriage Equality Act,” amended the Domestic Relations Law (DRL) providing that: (1) no application for a marriage license shall be denied on the ground that the parties are of the same, or a different, sex and a marriage that is otherwise valid shall be valid regardless of whether the parties to the marriage are of the same or different sex; (2) no government treatment or legal status, effect, right, benefit, privilege, protection or responsibility relating to marriage shall differ based on the parties to the marriage being or having been of the same sex rather than a different sex; and, (3) all relevant gender-specific language set forth in or referenced by New York law shall be construed in a gender-neutral manner.

As a result of this new law, OMH must ensure that it does not discriminate against, nor treat people differently on the basis of a marriage being of the same sex or a different sex. Furthermore, OMH must amend forms to insure that all gender specific language in forms, manuals, applications, etc. are gender-neutral (e.g., "husband" or "wife" should read "spouse").

Extending Waivers for the Practice of a Profession
Effective July 20, 2011
A.8298

APPROVED

Chapter 187

Chapter 187 of the Laws of 2011 amended the Education Law to extend the deadline by which entities providing services by certain licensed behavioral health professionals may apply for a waiver from the restrictions on the corporate practice of a profession, issued by the State Education Department (SED). Specifically, the new law extends (from June 16, 2011 until February 1, 2012) the date for corporations to apply to the SED for a corporate practice waiver.

Missing Vulnerable Adults Clearinghouse
Effective July 25, 2011
A.676-B

APPROVED

Chapter 222

Chapter 222 of the Laws of 2011 added a new section 837-f-1 to the Executive Law establishing a Missing Vulnerable Adults Clearinghouse within the Division of Criminal Justice Services (DCJS) which would be authorized to issue an alert to the general public and otherwise assist in the recovery of missing “vulnerable adults,” defined to include persons with mental illness. This new law authorizes DCJS to issue alerts” similar to “Amber Alerts” to search for missing vulnerable adults. DCJS will also operate a toll-free hotline, create a clearing house, and provide educational materials, training and planning with other State and local agencies regarding the prevention and search for missing vulnerable adults.

In regard to missing persons, OMH already has in place extensive procedures, policies and protocols concerning when individuals leave without notice to a facility. Specifically, when a patient leaves without notice from a facility, staff are required to follow the procedures outlined in OMH Official Policy (QA- 520).

**The Public Integrity Reform Act of 2011
S.5679**

APPROVED

Chapter 399

Portions effective on various dates beginning August 15, 2011

Chapter 399, a Governor's Program Bill, created the Public Integrity Act of 2011 which includes:

- **A New Joint Commission on Public Ethics:** On December 13, 2011 the Joint Commission on Public Ethics replaces the existing Commission on Public Integrity with jurisdiction over all elected state officials and their employees, both executive and legislative, as well as lobbyists.
- **Greater Financial Disclosure:** Financial disclosure statements filed with the new Joint Commission on Public Ethics from elected officials will now be posted on the internet and the practice of redacting the monetary values and amounts reported by the filer will be ended. The Act also includes greater and more precise disclosure of financial information by expanding the categories of value used by reporting individuals to disclose the dollar amounts in their financial disclosure statements. The Act requires disclosure of the reporting individual's and his or her firm's certain outside clients and customers doing business with, receiving grants or contracts from, seeking legislation or resolutions from, or involved in cases or proceedings before the State as well as certain of such clients that were brought to the firm by the public official.
- **Increased Access to Who is Appearing Before the State and Why:** The Act establishes a new database of any individual or firm that appears in a representative capacity before any state governmental entity.
- **Additional Disclosures for Registered Lobbyists:** The new law expands lobbying disclosure requirements, including the disclosure by lobbyists of any "reportable business relationships" of more than \$1,000 with public officials. It also expands the definition of lobbying to include advocacy to affect the "introduction" of legislation or resolutions, a change that will help to ensure that all relevant lobbying activities are regulated by the new Joint Commission.
- **Forfeiture of Pensions for Public Officials Convicted of a Felony:** Certain public officials who commit crimes related to their public offices may have their pensions reduced or forfeited in a new civil forfeiture proceeding brought by the Attorney General or the prosecutor who handled the conviction of the official.
- **Clarifying Independent Expenditures For Elections:** The Act requires the state board of elections to issue new regulations clarifying disclosure of Independent Expenditures.
- **Increased Penalties for Violations:** The Act substantially increases penalties for violations of the filing requirements and contribution limits in the Election Law, and provides for a special enforcement proceeding in the Supreme Court. The bill also increases penalties for violations of certain provisions of the State's Code of Ethics that prohibits conflicts of interest.

Making Records Available Prior to an Open Meeting

APPROVED

Chapter 603

A.72-B

Effective: February 2, 2012

The bill amends section 103 of the Public Officers Law to require public bodies, including State agencies, to make records available to the public under the Freedom of Information Law (FOIL), as well as other relevant resolutions, laws, regulations or policies, which are scheduled to be the subject of a discussion conducted by a public body. The new law requires that these records be made available to the public upon request “prior to or at the meeting” during which the records will be discussed “to the extent practicable as determined by the agency or department.” The legislation requires copies of these records be made available for a reasonable fee in the same manner as a FOIL request. The records must also be placed on the public body’s website if one is a regularly updated and maintained.

Procedures and Practices of the OMIG

VETOED

VETO #72

S.3184-A

This bill would have amended the Public Health Law (PHL) and Social Services Law relating to certain procedures, practices and standards employed by the Office of Medicaid Inspector General (OMIG) in exercising its audit responsibilities under the Medicaid program. Specifically, the legislation stipulated that the recovery of overpayments from providers because of the issuance of a final audit report or monetary penalty assessed by the OMIG shall occur not less than sixty days after the final action, after providing at least ten days advance written notice to the provider.

The bill would have also restricted the OMIG from undertaking new audits or reviews of contracts, cost reports, claims, bills or expenditures of a provider, if a review of the provider had occurred within the last three years, unless there is new information or good cause to believe that the previous audit or review was erroneous, or where the scope of the OMIG review is significantly different. The legislation also stipulated that in conducting audits, the OMIG would be required to apply the laws, regulations, policies, guidelines, standards and interpretations of the appropriate agency that were in place at the time the claims arose or other conduct took place. Any disallowances or other action could only be imposed for non-compliance with those measures. Additionally, the bill would have restricted the OMIG from making a recovery from a provider based on “an administrative or technical defect in procedure or documentation made without intent to falsify or defraud.” In such circumstances the provider would be given an opportunity to correct the defect and resubmit the claim within thirty days of notice of the defect.

OMIG would also be required to furnish a provider with a detailed written explanation describing the sampling and extrapolation methodologies that were used by the OMIG in conducting the audit and in any draft audit findings. The sampling and extrapolation methodologies used by OMIG would be required to be “statistically reasonably valid for the intended use and ... established in regulations.” Further, the bill would have required the OMIG to provide the recipient with at least five days written notice prior to the commencement of any interview of the recipient.

The Governor’s Veto Message stated that “in attempting to address these issues, the bill seeks to make changes to the law that are too far-reaching and would potentially allow fraudulent and abusive activity to go undetected or unprosecuted.” Instead, the Governor directed OMIG to conduct a thorough review of OMIG's policies and methods and to convene a working group, comprised of representatives of provider associations and others, to work through the issues attempted to be addressed by the bill.

Reporting Crimes

APPROVED

Chapter 558

S.5795

Effective November 22, 2011

Chapter 558 amends the Mental Hygiene Law (MHL) to reduce the maximum time period by which psychiatric hospitals licensed or operated by OMH and other programs under the jurisdiction of OMH must report certain crimes. The maximum time period for reporting crimes to the district attorney or other appropriate law enforcement is reduced from 72 to 24 hours for crimes that include an “employee, intern, volunteer, consultant, contractor, or visitor and the alleged conduct caused physical injury or the patient was subject to unauthorized sexual contact, or if it appears the crime is endangering the welfare of an incompetent or physically disabled person or if the crime was any felony under state or federal law.”

Generally, statutory and regulatory requirements require mental health programs to report to law enforcement authorities when it “appears that a crime may have been committed.” Specifically, section 7.21 (b) of the MHL requires directors of OMH-operated hospitals to provide “notice to the district attorney or other appropriate law enforcement official as soon as possible and in any event within three working days.” Similarly, MHL section 31.11 requires programs licensed, funded or administered by OMH to notify the district attorney or other law enforcement official and the Commissioner of Mental Health, or designee, “as soon as possible or in any event within three working days” if it appears that a crime may have been committed against a client. This new law reduces the above reporting times for certain crimes to no more than 24 hours.