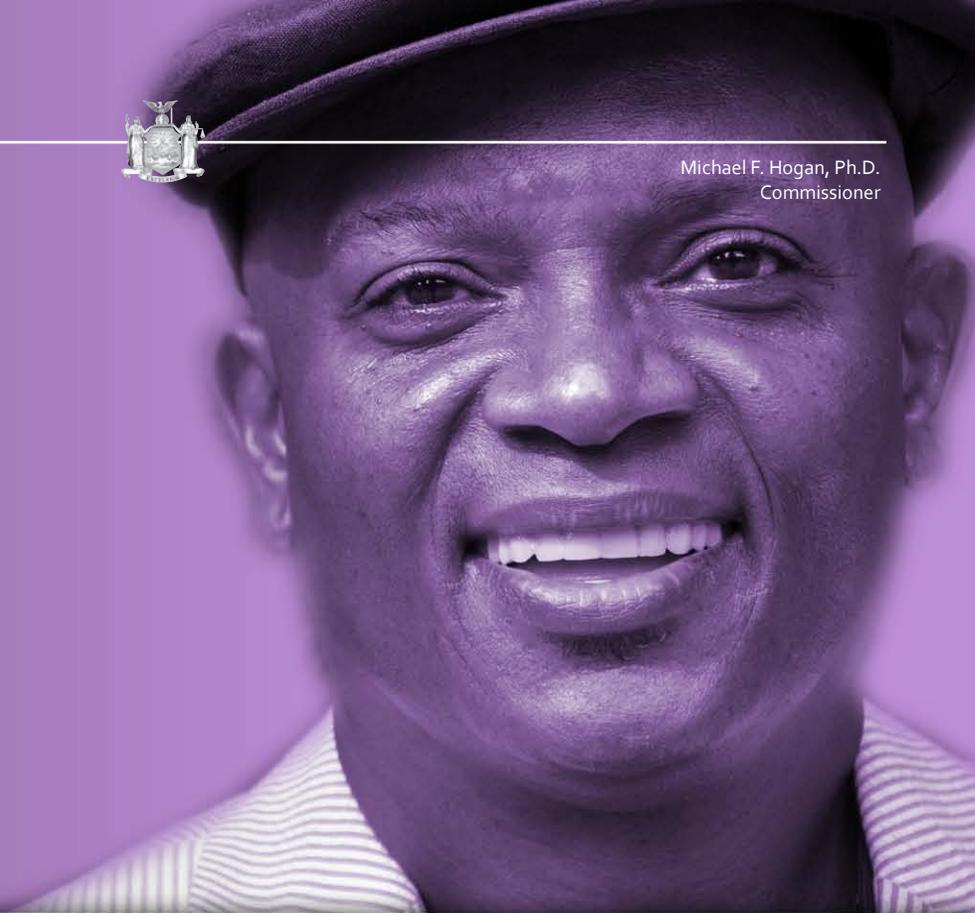


Andrew M. Cuomo  
Governor



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New York State Office of Mental Health

# Statewide Comprehensive Plan

2011-2015



New York State  
**omh**  
Office of Mental Health

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# Challenges to Transforming Care

Without a doubt, the field of mental health faces some of the greatest challenges ever. As New Yorkers, we strive to overcome the economic conditions around us, adapt to the unfolding elements of the Affordable Care Act (ACA), respond to the effects of natural disasters that have hit our communities, redesign and improve the quality of Medicaid services, and structure our State and local governments for greater efficiency. Within this environment, the Office of Mental Health (OMH) works assiduously to sustain clinical treatment so people, particularly the most vulnerable people we serve, receive necessary mental health services and supports.

This year's *Statewide Comprehensive for Mental Health Services* primarily addresses the many changes all taking place at the same time:

- The ACA, signed into law in March 2010, put in place comprehensive health insurance reforms that are being rolled out continuously, with most changes implemented by 2014. On the heels of mental health parity legislation, these efforts hold promise for early intervention and treatment as well as for mental health and behavioral treatment on par with that for physical ailments.
- While ACA components are introduced, a caucus within Congress makes

## Challenges to Transforming Care in New York State

- Mental illness leads as the cause of disability from illness, contributes to death through suicide, and drives school failure, poor health, incarceration and homelessness.
- Decentralized and fragmented approaches to care coordination persist in New York State.
- When people do not get early assistance, problems often worsen and add to the responsibility of an already overburdened mental health safety net.
- Schools struggle to create environments that support learning for students with mental health and behavioral problems.
- A lack of safe, affordable housing for people with serious mental illness stands in the way of productive community living.
- Unemployment continues at unacceptably high rates for individuals with serious mental illness.
- When compared to the general population, people with serious mental illness are over-represented in the criminal justice system.
- A lack of coordinated care and policies between agencies has reinforced barriers to care and contributed to diminished accountability.
- New York is overly reliant on expensive inpatient psychiatric care.
- Medicaid is the single largest payer of mental health services in New York State.
- This need for restructuring and redesign are urgent in the face of the Great Recession, large State budget gaps, the end of federal stimulus funding, changing federal Medicaid regulations and the introduction of the federal ACA.

repeated attempts to chip away and roll back provisions of the ACA, for example, proposing legislation to repeal the requirement that states maintain current Medicaid eligibility standards for adults until 2014, and in mid-September, introducing draft legislation to remove consumer protections from the ACA.

- While the number of suicides is up nationally, in New York State (NYS) the number has declined by about 10%. Nonetheless, data show that the overall suicide rate generally rises during recessions and falls during times of economic expansion.<sup>1</sup> These findings make more compelling the necessity for unremitting public health suicide prevention approaches.
- Clinic restructuring continues to align fiscal and clinical policy and drive improvements in care (e.g., increase access to clinic services with more timely first visits following hospitalization or emergency care, better engage people in care with welcoming environments and staff responsive to concerns).
- Under the Governor’s leadership, much activity is under way with the Medicaid Redesign Team (MRT), Spending and Government Efficiency (SAGE) Commission, and Mandate Relief efforts to advance government service that is more efficient and effective.
- The State Department of Health (DOH), localities and stakeholders are preparing for the implementation of health homes for people with chronic health conditions.
- OMH, DOH, Office of Alcoholism and Substance Abuse Services (OASAS), local governmental units (LGUs), and stakeholders are developing a set of recommendations to guide the design of specialty health homes, called behavioral health homes, for the provision of integrated health, mental health, and substance abuse care for people with the most serious behavioral health issues. Since the announcement of notices of conditional awards in September, OMH and DOH have been working with the designated organizations in preparation for their behavioral health organization (BHO) administrative and management duties.<sup>2</sup>

In this changing, dynamic environment, it is clear that developing a five-year plan is challenging at best, since so much is changing simultaneously. Collaboration and shared understanding become essential to adapt to change and to set the groundwork for others to adapt.

## **Change and Growth**

Creating the circumstances for change requires that we educate stakeholders outside of the mental health system—particularly providers of primary care services—about the unique health and cultural needs of adults, children, and families dealing with mental health challenges, especially those with the most serious and complex behavioral/ physical health conditions. Gathering input from within the public mental health system—from individuals engaged in or previously engaged in services, families, stakeholders, providers, LGUs—is necessary to

Transformation of the mental health delivery system rests on two principles articulated in the 2003 *New Freedom Commission on Mental Health* final report. The first is that services and supports must be more clearly centered on the person and family members engaged in care, rather than oriented toward the “requirements of bureaucracies.” This is no small task in a time when insurance coverage—especially Medicaid—has become how most care is paid for. The second is that services and supports cannot just help with symptoms, but must also enhance abilities to cope successfully with life’s challenges, facilitate recovery, and build resilience.

*2010–2014 Statewide Comprehensive Plan for Mental Health Services*

ensure that the next five-year Plan is firmly rooted in the principles of recovery and resiliency and incorporates much of the good work under way in the public mental health system.

This Plan, therefore, is a transitional document that bridges to the next five-year planning cycle set to begin with the 2012–2016 Plan. It builds on the successes and transformational changes described in the Plans of the past several years. The themes outlined and brought to life in these Plans—recovery, resiliency, cultural competence, evidence-based practice and transformation—must continue to serve as the basis for change. They incorporate hope and recovery, respect and compassion, and support for health and well-being. Examples of ongoing

initiatives, programs and research efforts essential to quality care include:

- The recognition that good care rests on accessibility; personal and continuous healing relationships; integrated primary and behavioral health care that is focused on the person and family (from the early to older years) and based on scientific evidence; culturally and linguistically appropriate approaches that help people to adapt to health challenges and figure out how to live their lives by calling on their strengths and managing their symptoms.
- Care based on a recovery framework and its elements of hope, respect, personal responsibility, inner directedness, and empowerment. Also, care that is holistic, draws upon strengths, incorporates peer supports, and takes into account the natural ebbs and flow of life.
- For children, youth and families, care anchored in the Child and Adolescent Service System Program (CASSP) values (e.g., child and youth guided, family driven, individualized) and the cross-systems New York State Children’s Plan.
- Initiatives for adults that promote wellness (LifeSPAN), cultural and linguistic competence (e.g., Centers for Excellence for Cultural Competence, development of regional multicultural advisory committees), competitive employment (New York Makes Work Pay, New York Employment Services System), Clinic and Ambulatory Restructuring (more responsive clinic services, incentives for quality care), public-private housing collaborations, recovery-oriented services (Personalized Recovery-Oriented Services, Recovery Centers), and use of integrated care for older adults, co-occurring behavioral disorders, evidence-based practices and trauma-informed care (support for military and families)

- Initiatives for adults involved with criminal justice system that promote an improved mental health crisis response (informed by public-private collaboration), evidence-based wellness self-management for persons in State correctional facilities, and expanded comprehensive care (residential mental health units)
- Initiatives for children and their families that build on a public health approach to care (prevention of mental health problems and early intervention when problems are suspected), family and peer support, social and emotional development (Project LAUNCH), enhancement of the youth voice in strengthening recovery-oriented services (Regional Youth Partners), effective training and education of primary and mental health providers (Project TEACH), interventions for at-risk youth (Promise Zones), and trauma-informed care (Positive Alternatives to Restraint and Seclusion [PARS], trauma training through the Evidence-Based Treatment Dissemination Center)
- Research that helps to alter the course of schizophrenia (care informed by NYS Psychiatric Research Institute’s “Recovery after an Initial Schizophrenia Episode”), understand the prevalence of post-traumatic stress disorder (PTSD) among 9/11 first responders, uncover genetic mutations linked to schizophrenia, reveal differences in the language center of the brains of children with and without autism, and explain the possible role of lysosomes in the development of Alzheimer’s and other neurodegenerative diseases

These are a number of initiatives, programs, and research results that are part of the everyday operations at the State and local levels. Within the input described in Chapter 4, you will read how many stakeholders value these efforts and wish to see them carried forward under Medicaid redesign. Information in Chapter 4, and the appendices accompanying it, is presented largely from the perspective of the OMH Strategic Plan Framework. Created in partnership with stakeholders of the public mental health system and local government units, it serves as the starting place for ensuring accountability, enhancing operations through structural, fiscal, regulatory and other mechanisms, and improving outcomes for children, youth, adults, and families served by the public mental health system. The Framework is always available on the OMH web site under the [Planning Resources](#) section found within the gray box under “Highlights” of the home page.

## Primary Functions of OMH

As the State mental health authority, OMH has two main strategic directions: assuring access to services of the highest quality for children with serious emotional disturbance and their families and adults with serious mental illness; and promoting the mental health of all New Yorkers through a public health approach. The State public mental health system each year serves approximately 695,000 individuals.

To effectively meet its responsibilities, OMH organizes daily operations along four functional administrative lines:

- **Regulating, certifying and overseeing New York’s public mental health system**  
OMH regulates and licenses all mental health facilities and programs in the State, with the exception of private practices and federal facilities. The agency oversees 57 LGUs, and the LGU that encompasses New York City in its entirety.

Within the five regions of the State, more than 2,500 mental health programs are operated by local governments and private agencies. The services offered by these programs include inpatient, outpatient, emergency, residential, and community support. While certain policy, funding, regulatory, and management functions are centrally administered, actual program administration takes place on the local government level.

- **Providing State-operated inpatient and outpatient mental health services**  
OMH is a major provider of intermediate and long-term inpatient as well as outpatient treatment services. It operates 25 psychiatric centers, including six serving children with serious emotional disturbance and 16 serving adults with serious mental illnesses, and three serving adults with mental illness who have contact with the criminal justice system. State-operated outpatient services are designed to serve children and adults who use State-operated inpatient services. Additionally, OMH provides mental health services in 25 sites around the State to inmates incarcerated in Department of Corrections and Community Supervision facilities. OMH also operates three secure treatment programs for the care and treatment of sex offenders requiring civil management and oversees community-based treatment of sex offenders determined to be in need of strict and intensive supervision and treatment in the community.

- **Conducting mental health research to advance prevention, treatment, and recovery**

Scientific research conducted by OMH is critical in identifying treatment and clinical practices that are effective in improving outcomes of services and integrating these practices into the public mental health and general medical care systems.

Researchers from the Nathan S. Kline Institute (NKI) in Orangeburg and the NYS Psychiatric Institute (PI) in New York City conduct clinical trials to develop and evaluate new treatments and services and basic research to better understand behavioral, molecular, biochemical, neurological, neurobiological and genetic mechanisms underlying mental illness. These researchers participate in consortia, clinical trials, and other scientific collaborations that are leading to the development of new medications, technological methods, and clinical therapeutic approaches to treating schizophrenia, bipolar disorder, depression, anxiety disorder, and Alzheimer’s disease, and other psychiatric disorders. OMH research and evaluation staff members also examine service outcomes, conduct data-driven analyses of pressing mental health issues, and develop sound recommendations and approaches for improving service quality and access.

- **Promoting mental health through public education**

OMH promotes mental health through education and advocacy for all New Yorkers. Mental health promotion activities are targeted toward expanding public awareness and knowledge of mental health, particularly for persons at risk for, or living with, mental health problems. Specifically, mental health promotion focuses on enhancing individual resiliency, making communities stronger, and diminishing structural barriers that impede access to housing and gainful employment. Through OMH, many New Yorkers are being educated and given information on the nature and impact of mental health and mental illness, effective treatments and services, preventive and coping strategies, and how to get help when needed.

## **This Year's Statewide Comprehensive Plan**

Because of the enormous change we are experiencing in health care, we are using this year's annual planning process to take stock of where we are and to lay a foundation for a new five-year plan in 2012. Accordingly, the next two chapters provide an overview of the imperative for change and Medicaid redesign in NYS. They are followed by a snapshot of the current public mental health system and data resources to inform planning and decision making. The last chapter summarizes an abundance of input from the LGUs, better known as our counties, and stakeholders of the public mental health system. This information is proving valuable as the Medicaid Redesign Team and its subcommittees continue to guide planning for care management opportunities for New York's Medicaid beneficiaries and other citizens.

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<sup>1</sup> Luo F, Florence CS, Quispe-Agnoli M et al. (2011). Impact of business cycles on US suicide rates, 1928-2007. *American Journal of Public Health, 101*(6), 1139-46.

<sup>2</sup> More information and detail about Medicaid redesign, health homes, and behavioral health homes appears in Chapter 3.

# The Imperative for Health Care Reform

A number of forces have converged to create a climate for change in health care. National, state and local resources are limited and opportunities for more efficient and effective health care are two crucial forces at play.

## National Economics

Our nation has suffered the deepest economic downturn since World War II. Known as the Great Recession, the decline from December 2007 hit bottom by February of 2010, with a resulting loss of 9 million jobs, a near doubling of the unemployment rate, lengthening in the duration of unemployment, and cuts to incomes and work hours for millions of Americans. Added to these stresses, many families experienced losses to personal wealth from declining home prices.<sup>1</sup> The recovery from the crisis has been much less robust than hoped for.<sup>2</sup>

This year, economic growth continues to be much slower than anticipated and the somewhat improved employment picture shows deterioration. Contributing to the sluggish economic growth is flat household spending, higher food and energy prices, a depressed housing sector, and weak corporate investment.<sup>3</sup> The slower pace of recovery is expected to continue into 2012.

As our nation struggles with a recession and prepares for the implementation of rapidly changing health care reforms, it does so with the understanding that its public and private health expenditures are growing at rates outpacing those of comparable countries. Moreover, the higher levels of spending are not translating into better health outcomes.<sup>4</sup>

Nationally, the prevalence and disabling effects of mental illness and substance abuse disorders (collectively termed “behavioral health disorders”) contribute to the escalating cost of health care. Nonetheless, research shows that, for mental health and substance abuse spending in the United States, growth has been at a slightly slower rate than gross domestic product and has shrunk as a share of *all* health spending.<sup>5</sup> The slight decline in spending may continue with the introduction of Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act (ACA) of 2010, as people with behavioral disorders and their families experience improved access and better integrated behavioral health care. This outlook, however, is tempered by the reality of the current recession and the challenges states and localities are facing in its midst.

## How the States Are Faring

According to an analysis by the Center on Budget and Policy Priorities, states' newly enacted budgets for fiscal year 2012 (beginning July 2011) show four successive years of slowing revenues and budget cuts of historic proportions. Depressed revenues, higher costs of providing services such as Medicaid, and the depletion of emergency federal stimulus funding have all contributed to states' deep spending cuts and a slowing pace to the economy. Of 44 states providing the Center with data, for example, 36 projected less state revenue in 2012 (adjusted for inflation) than they did during the fiscal year when the recession began. As with previous recessions, the effects are expected to be more profound and to persist for several years.<sup>6</sup>

In addition to the loss of federal stimulus funding to fill budget gaps, states now face the threat of sizeable reductions by Congress in "non-security discretionary" spending, which goes to states in the form of funding for critical areas such as education, health care, and human services. In coping with such adverse economic conditions, states are enacting significant cuts to spending—particularly in education and health care where states typically spend the most—and many are looking to preserve or improve essential public services through operational efficiencies.<sup>7</sup>

### Recessionary Pressures in New York State

Under Governor Cuomo's leadership, our State has created a plan in partnership with many stakeholders to address serious fiscal challenges. The plan calls for fundamental transformation of government by putting the State's fiscal house in order, radically redesigning governmental structures and operations, restoring integrity and performance to state government, and strengthening the State for future generations. Key components of the plan include:

- An emergency financial plan to close the \$10 billion deficit in the 2011–12 budget, without borrowing or raising taxes
- Redesign and rightsizing of State government through the newly created State Agency and Government Efficiency (SAGE) Commission
- Redesign of the State Medicaid program via the newly created Medicaid Redesign Team (MRT), to save money initially as part of the 2011–12 budget and thereafter to identify efficiencies and cost savings in the Medicaid program

#### Vision for Reform

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."

*Governor Andrew M. Cuomo  
January 5, 2011*

- Provision of mandate relief by review of unfunded and underfunded mandates imposed by the State government on school districts, local governments, and other local taxing districts so they may better control their expenses
- Redesign of education to create incentives that reward school districts for student performance and the adoption of management efficiency policies
- Transformation of the economy through an ambitious economic development agenda that seeks to help government facilitate job creation<sup>8</sup>

The budget contained no new taxes, included two-year appropriations for education and Medicaid, and set a ceiling for the growth of both education and Medicaid spending.

## **Efficient and Effective Health Care for Medicaid Beneficiaries**

### **Providing Good Care to Adults with Serious Mental Illness**

Nationally, about 50 percent of people experience some mental illness in their lifetime. About one-quarter of these individuals have some mental illness (e.g., anxiety, mild depression, attention deficit/hyperactivity disorder [ADHD]) within a given year. About 10 to 15 percent of this cohort are mildly affected, yet most get no care even though an adequate “dose” of brief therapy would be indicated. When care is received, it often involves self-help and medication and most of care is provided by primary care physicians.

For the approximate 6–7 percent of Medicaid beneficiaries in NYS who receive specialty care each year:

- About 5–7 percent has mild impairment (e.g., moderate depression, well-controlled bipolar disorder and schizophrenia). About half of these individuals receive care, which generally should include combined therapy.
- About 5 percent of children and 3–5 percent of adults experience severe impairment (e.g., schizophrenia, bipolar illness, serious posttraumatic stress disorder [PTSD], obsessive-compulsive disorder, multiple trauma) that require continuous, integrated and mobile treatment with services aimed at engagement in care, rehabilitation, medication therapy and peer support. Most of this treatment takes place in the public mental health system.

The importance of care is illustrated by what we know about depression, for example, among women who bear children and children of mothers who are depressed. About 10–15 percent of women experience depressive episodes during pregnancy (about 7–10 percent major depression) and about 15 percent experience depression in the first three months following delivery,<sup>9</sup> with 25 percent of women having an onset of depression between six months and one year after delivery.<sup>10</sup>

For mothers who receive Temporary Assistance to Needy Families support, the rates of depression are even greater, estimated between 30–45 percent.<sup>11</sup> A majority of children whose

mothers are depressed develop mental health problems. Fortunately, though, when the mothers receive treatment, the mental health problems of about half of the children resolve. Given that depression, while serious, is treatable and improves functioning for mothers and their children, it is troubling that up to two-thirds of the depressive episodes are not recognized by providers and less than one-third receive treatment.<sup>12,13</sup>

Currently, care received by people with mental illness is not well integrated. Often mental health care itself is fragmented and discontinuous, with a person receiving medications, psychotherapy, rehabilitation, support, and addiction treatment in different locations by different providers. Such care often takes place in the absence of health information technology that would enable more coordinated care. Education, employment, and housing supports—all crucial to sustaining recovery in a person's community and natural environs—are available only to a minority of people in need.

Integrated primary health and mental health care for high-risk adults with serious mental illness, when done well, has significant potential to improve overall health and quality of life, while reducing the costly disabling effects of illness.<sup>14</sup> Helping these individuals and their families toward recovery requires:

- Team-based, continuous and titrated treatment based on the best scientific evidence
- Integrated care:
  - One master care plan of care supported by integrated health information technology and care management approaches
  - Medication treatment and management, for many people an important adjunct to coping successfully with symptoms
  - Relevant psychosocial support (e.g., wellness management, peer support, respite services to avoid hospitalization)
  - Substance abuse treatment when indicated, relying upon integrated dual disorders treatment
  - Assured provision of resources and supports that sustain recovery and productive community living:
    - Stable housing
    - Benefits/benefits counseling
    - Employment/education
    - Medical care

Such treatment addresses clinical characteristics unique to serious mental illness. Psychiatric illnesses can be marked by periods of intermittent wellness and illness, and by disordered thinking and behavior. When people are most in need of care the very symptoms of illness impede their abilities to obtain treatment. Moreover, the symptoms can impair a person's abilities to carry out day to day (e.g., bathing, eating poorly) tasks, as well as other critical functions (e.g., taking medications, keeping medical appointments, paying rent). The nature of

serious mental illness, therefore, requires effective clinical interventions (e.g., case management, peer outreach and engagement, electronic medical records) to help people navigate through such periods.

Another clinical characteristic unique to serious mental illness and of priority for the mental health system is preventing and reducing the risk of suicide. For people with serious mental illness, suicide prevention measures are critical following emergency psychiatric care and inpatient care—the times when the risk of suicide is greatest for these individuals.

### ***Necessity of Integrated Primary Care in Mental Health Treatment***

Many adults with serious mental illness experience difficulty in navigating the broad array of service options. Added to this, the current service system does not always ensure access to individuals with the highest needs, services provided by different clinicians are not always well-coordinated, and payments for services are not always structured to provide incentives that promote recovery.

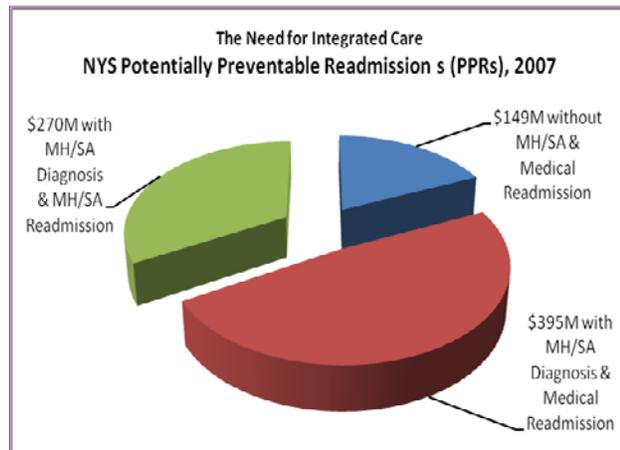
In 2008, New York City and State government leaders, faced with a number of tragic events linked to fragmentation of care, convened a panel to examine and recommend actions to improve the public safety while enhancing the care of high need individuals with serious mental illness. The Panel found that the system in place was not as effective as it might be in coordinating care across agencies or in engaging people who dropped out of or had been lost to care. It recommended creating “care monitoring” teams to improve accountability and reduce service failures.

Teams were piloted in Brooklyn and expanded citywide. They used Medicaid claims and other State administrative data to identify people with high need and serious mental illness who were at risk for lapses in care, overused inpatient and emergency services, and had poor outcomes. The pilot showed success in using claims data to identify individuals with serious mental illness and high service needs who may have been in need of outreach and engagement. Many were found not to be engaged in adequate and appropriate services, and re-engaging them in care was impeded by limits on information sharing across systems of care. Of note is that people enrolled in full-benefit managed care plans were just as likely to be identified by the pilot as those in fee-for-service Medicaid.

The NYS experience with care monitoring highlights the critical nature of integrated, coordinated care for people living with serious mental illness. And, for people with serious mental illness, “integrated care” demands that we treat the whole person and family with the core of essential elements noted in the previous section.

**Figure1: The Need for Integrated Care**

Other data from the State Department of Health (DOH) reinforce the need for integrated care. Potentially preventable readmission data from 2007 show higher costs for medical hospital readmissions for people diagnosed with behavioral disorders, suggesting that good management of behavioral disorders might help in avoiding readmissions and realizing substantial savings from possibly preventable readmissions<sup>15</sup> to medical or behavioral inpatient settings for people identified as having behavioral disorders.



People with serious mental illness have higher rates of medical co-morbid conditions than the general population. The prevalence of diabetes, high lipids, hypertension, and obesity, for example—all modifiable risk factors for cardiovascular disease—is approximately 1.5 to 2 times more than for the general population.<sup>16</sup> Nonetheless, people with serious mental illness receive fewer routine preventative services, less-than-adequate diabetes care, and lower rates of treatment for cardiovascular disease (e.g., cardiac catheterization, drug therapy of proven benefit following heart attack).<sup>17</sup> A number of barriers to integrated care may be at play, from poor access to mainstream health care, the effects of poverty, stigma and discrimination, and cultural issues.

### **Providing Good Care to Children with Serious Emotional Disturbance and Their Families**

The data describing the scope of serious emotional disturbance for children and society are compelling:

- Worldwide, neuropsychiatric disorders are the main cause of disease burden in high-income countries for children and young adults between 10 and 24 years of age.<sup>18</sup>
- More children in the United States suffer from psychiatric illness than from cancer, blindness, autism, developmental disability and autoimmune deficiency syndrome (AIDS) combined.
- Only 3 out of 10 children with a special education label of serious emotional disturbance graduate with a standard high school diploma.<sup>19</sup>
- Adverse experiences in childhood (e.g., recurrent abuse, parent has mental illness, parents' divorce) are seen as drivers of a majority of adult chronic illnesses.<sup>20</sup>
- Approximately 20 percent of children with an emotional disturbance receive specialty treatment.<sup>21</sup>

- A majority of children in youth and juvenile justice settings and many children in foster care are diagnosed with serious emotional disturbance.<sup>22</sup>
- Among 15- to 24-year olds, suicide accounts for 12.2 percent of all deaths annually.<sup>23</sup>

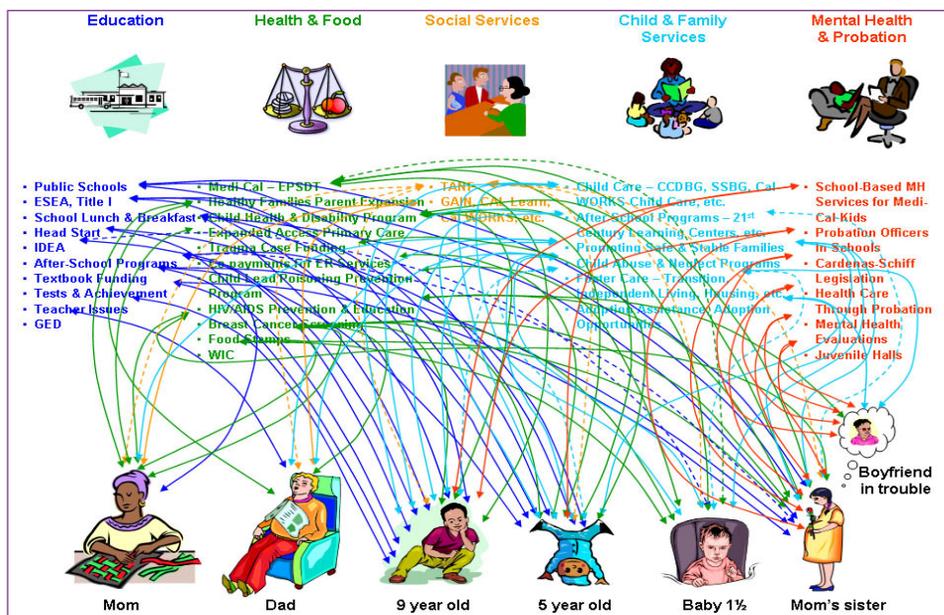
Increasing rates of childhood chronic conditions (with obesity, asthma and ADHD highly prevalent) portend of large increases in disease burden into adulthood. Rising rates result in greater private and public healthcare and disability expenditures, less ability for those affected to participate fully in the workforce, and a diminished quality of life<sup>24</sup>

Developmental and environmental risks that present early in a child’s life (e.g., child abuse, learning problems) reduce a child’s ability to develop healthy relationships and to function independently. As children move through the middle and teen years, problems may manifest as depression, anxiety, conduct disorder, PTSD, and substance abuse.

Without intervention in the early years (e.g., treating maternal depression) and targeted therapies thereafter, when clinically indicated (e.g., treating depression, ADHD), the impacts can be great. Youth may then require more use of emergency behavioral services and residential treatment, become involved in the juvenile justice system, fail to stay in school, and be at risk for suicide.

**Figure 2: Challenges to Integrating Care across Service Systems**

In NYS, the [Children’s Plan](#) provides a strong foundation for more integrated care across the child-serving agencies. Nonetheless, formidable barriers to integrated care continue to exist. Margaret Dunkle of George Washington University provides more than a hint of just how challenging



it can be to provide integrated care in her depiction showing how 40+ programs might touch one Los Angeles family (see Figure 2).<sup>25</sup> The illustration underscores the importance of ensuring that State agencies and service providers are accountable to individual families for more integrated and effective care. Medicaid redesign provides a natural opportunity for such a return through investments in early preventive and therapeutic interventions that forestall the development of school failure, suicide, criminal justice involvement, and homelessness into adulthood.

**Promoting Care Management for Children and Families**

Specialized approaches that should be included in care management affecting children and families should be premised on the principles of the Child and Adolescent Services System Program (CASSP)<sup>26</sup> and the domains of priority outlined in the Children’s Plan as summarized in Figure 3.

**Figure 3**  
**Principles and Domains of Priority underlying Care for Children and Families**

<b>The Children’s Plan Domains</b>	<b>CASSP Core Principles</b>
Social and emotional development and learning form a foundation for success in school, in work and in life.	Child-centered services meet the individual needs of the child, consider the child's family and community contexts, and are developmentally appropriate, strengths-based and child-specific.
Every action should strengthen our capacity to engage and support families in raising children with emotional health and resilience.	Family-focused services recognize the family as the primary support system for the child and that it participates as a full partner in all stages of the decision-making and treatment planning process.
One-family, one-plan: Ensuring integrated and effective services and supports.	Community-based services, whenever possible, are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community.
The right service is available at the right time and in the right amounts.	Multi-system services are planned in collaboration with all the child-serving systems involved in the child's life.
An adequately sized workforce that is culturally competent and steeped in a new paradigm of integrated, family-driven care must be developed and sustained.	Culturally competent services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, languages, rituals, and practices characteristic to the family's cultural group.
	Least restrictive/Least intrusive services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive to meet the needs of the child and family.

Consonant with these values and principles, ongoing planning for care management for children and families in New York should:

- Employ targeted, focused prevention efforts such as positive parenting programs
- Reduce the nine-year gap between when behavioral problems first show up and when treatment starts through enhanced pediatric and mental health clinical partnerships

- Provide specialty behavioral treatment to children with serious emotional disturbance and their families using current evidence-based interventions
- Draw on effective, less costly and highly valued expertise of youth and family support services
- Take into account the complexity of children’s mental health financing and more closely align payment and care strategies

Medicaid redesign offers opportunities to anchor care for children and families in integrated, multidisciplinary approaches that realize efficiencies, effective use of clinical treatment, and support for emotional well-being and resilience.

<sup>1</sup> Dudley WC. (2011, June). *Road to recovery: Remarks by President Dudley at the Brooklyn Chamber of Commerce*. Federal Reserve Bank of New York. Available online at <http://www.newyorkfed.org/newsevents/speeches/2011/dud110610.html>.

<sup>2</sup> Bernanke B. (2011, August 26). The near- and longer-term prospects for the U.S. economy. Available online at <http://www.federalreserve.gov/newsevents/speech/bernanke20110826a.htm>.

<sup>3</sup> Dudley, WC. (2011, August 19). *The national and regional economic outlook. Remarks at the Meadowlands Chamber of Commerce*. Available online at <http://www.newyorkfed.org/newsevents/speeches/index.html>.

<sup>4</sup> Kaiser Family Foundation. (2011, April). *Health care spending in the United States and selected OECD countries*, April 2011. Available online at <http://www.kff.org/insurance/snapshot/OECD042111.cfm>.

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# Redesigning Medicaid Health Care in New York State

The Medicaid Redesign Team (MRT) was tasked by Governor Cuomo to find ways to



reduce costs and increase quality and efficiency in the Medicaid program. The MRT is addressing the realities that our State spends more than twice the

national average on Medicaid per person, and spending per enrollee is the second highest in the nation. At the same time, New York ranks 21st out of all states for overall health system quality and ranks last among all states for avoidable hospital use and costs.

The work of the MRT affects the system of care directed by the Office of Mental Health (OMH), because like most states, New York uses Medicaid to pay for almost all mental health care, even that which once was wholly a State responsibility. So changes in Medicaid mean changes in mental health care. Less spending and wiser use of resources set the direction for Medicaid redesign.

For New York State (NYS), improving service efficiency and effectiveness presents opportunities. The specialty mental health system overseen by OMH requires a big safety net. This is due mostly to a systematic failure to address mental health problems in the general health system, where most of us go when we need help. Data show, for example, that although the average age of first mental health symptoms is 13, the average delay until getting care is nine years. Such a delay in general medical care would be unacceptable. Moreover, only about one-half of all physicians report feeling comfortable with diagnosing and treating depression, the most common and reliably

Two major developments will disrupt our lives, affecting almost everyone who receives services or works in our vast system. Both of these developments (Medicaid Redesign and the most challenging budget in years) will force change, upset the status quo, and force us to think hard about priorities. There's nowhere to hide from these realities. My view is that we have to engage, adjust and adapt.

*Commissioner Hogan  
January 2011*

diagnosed mental illness. The weakness in care for mental health problems exists across the general health system from primary care to health plans.

One provision of the Affordable Care Act (ACA) this year illustrates how changes in Medicaid affect the delivery of local health care. Under the ACA, states now have the option under their individual Medicaid State plan to receive additional federal reimbursement for the enhanced integration and coordination of care for people with chronic illnesses, across the lifespan. The goal is better integrated primary, acute, behavioral health (mental health and substance use), and long-term services and supports.

To address the realities of Medicaid spending and opportunities to realign services to be more efficient, the MRT is following a two-phase approach to drive efficiencies that lead to improvements in quality, safety, and effectiveness of patient care:

- Phase 1: The primary goals included the establishment of the MRT to find solutions for lowering Medicaid costs in the 2011–12 State fiscal year budget, without compromising care for New Yorkers, and to develop a set of recommendations for the Governor’s consideration and approval.
- Phase 2: The major goal of this phase calls on the MRT to create a coordinated plan to ensure that the Medicaid program functions within a multi-year spending limit, while sustaining and improving the quality of services delivered.

## **Phase 1 of Medicaid Redesign: Setting the Foundation**

Beginning in January 2011, upon appointment of the MRT, the Team held public forums and sought reform ideas from health experts and diverse shareholders from every region of our State. From the more than 4,000 suggestions made by New Yorkers, the MRT reviewed, synthesized and prioritized reform proposals into a single package of recommendations to Governor Cuomo.

Through legislative approval, the resulting proposals in the budget bill introduced structural reforms that helped the State to achieve its current fiscal year Medicaid budget target, without cuts to eligibility. The implementation of proposals ([descriptions of the MRT proposals](#)) began an orderly shift in redesign of the Medicaid payment system in the State to one oriented toward better outcomes and quality care.

Specifically, major elements of reform undertaken in Phase 1 included:<sup>1</sup>

1. Effecting a three-year phase in of “care management for all” Medicaid beneficiaries and ending fee-for-service (FFS) payment arrangements
2. Planning for the expansion of patient-centered medical homes, launching health homes, and enrolling Medicaid beneficiaries in these care management models
3. Initiating development of regional behavioral health organizations (BHOs) to meet the goal of full integration of physical and behavioral care within innovative care management arrangements (see glossary of common terms being used in relation to Medicaid redesign in Figure 1).
4. Enacting a “global Medicaid cap” that links growth to the medical consumer price index, challenges providers to control costs, and requires monthly reporting of Medicaid spending compared to projected State fund expenditures

**Figure 1**  
**Innovative Health Care Management and Service Delivery Models Glossary**

**Managed care** describes a health insurance plan or health care system that coordinates the provision, quality, and cost of care for its enrolled members. Each managed care enrollee selects a primary care practitioner from the plan's network of professional and hospital providers. A primary care practitioner holds responsibility for coordinating an enrollee's health care and making referrals for specialty care. There are many different types of Medicaid managed care funded in the State (e.g., Medicaid managed care, Family Health Plus, Medicare Advantage) serving residents in all age groups and various income levels.<sup>2</sup>

An **accountable care organization (ACO)** represents a local health care organization and collaborating primary care physicians and other health providers, specialists and hospitals that are held accountable for the cost and quality of care delivered to a defined population of individuals. The performance of the ACO is linked to financial incentives or penalties based on valid and reliable measures of individual- and system-level outcomes.<sup>3</sup>

An **integrated delivery system (IDS)** is a well-structured, coordinated, and collaborative network of organizations (e.g., Kaiser Permanente) that either provide or arrange provision of a continuum of services to a defined population or community. The IDS is accountable clinically and fiscally for the health outcomes of the population or community served.<sup>4</sup>

A **special needs plan (SNP)** model of care management provides clinical service planning, service acquisition, service delivery and coordination by a designated medical case manager and/or case management team. SNP services (currently available to individuals with HIV in NYS who receive Medicaid) are client-centered and promote timely, coordinated access to medically appropriate levels of care and services that support engagement in care and wellness through education, care advocacy, and health promotion.<sup>5</sup>

**Behavioral health organizations (BHOs)** are administrative entities in New York State that will assist regionally in the management of behavioral health services for individuals not enrolled in managed care for their behavioral health services and for those whose services are not covered by a Medicaid managed care plan, regardless of whether a person is enrolled in a managed care plan that includes behavioral health services or not. Chief activities during the three-year transition to care management for all Medicaid beneficiaries will be assessing the use of behavioral inpatient care and reducing readmission rates, monitoring and contributing to understanding conditions of children diagnosed with serious emotional disturbance and treated in OMH-licensed clinics, monitoring key performance indicators, and facilitating linkages across systems of care.<sup>6</sup>

A **patient-centered medical home (PCMH)** is a model for care, provided by physician-led practices, that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and individual's complaints with coordinated care for all life stages, acute, chronic, preventive, and end of life, and a long-term therapeutic relationship. The physician-led care team is responsible for coordinating all of the individual's health care needs, and arranges for appropriate care with other qualified physicians and support services.<sup>7</sup>

The **health home** model expands on the traditional patient-centered medical home concept. The health home is a provider or team of health care professionals who provide integrated care based on a "whole-person"

philosophy where care is provided to meet physical, emotional, behavioral, social, family and community needs. A health home further enhances the integration and coordination of medical and behavioral health care for people who are living with multiple chronic illnesses and includes links to other essential community and social supports that foster healthy, productive community living.<sup>8,9</sup> A variation of the health home for people with serious mental illness that could emerge is the behavioral health home described below.

The **behavioral health home** could be modeled after the patient-centered medical home to address the distinct behavioral and health care needs of individuals with serious mental illnesses/substance abuse disorders and reduce the likelihood that they will fall through the cracks. Particular attention is paid coordinating and integrating health care that fosters a consistent relationship with the primary clinician, a single care plan where changes are clearly communicated to others providing care, post-hospital discharge services that emphasize continuity of care in the community, and intensive outreach to individuals who stop participating in care.<sup>10</sup>

Within three years, all Medicaid beneficiaries will be in some form of managed care in our State. The implementation of care management for Medicaid beneficiaries by the end of 2013 or early 2014 clearly impacts the strategic directions of OMH and the Office of Alcoholism and Substance Abuse Services (OASAS). Among the proposals receiving the intense focus of the two agencies are one calling for the implementation of “health homes” for Medicaid beneficiaries who have high health care needs and costs, and another, Number 93, which requires the development of an interim managed FFS model, known as regional BHOs, which will help to bridge the transition to managed care for people who receive behavioral health services not “covered” under the State’s existing various Medicaid managed care plans. The goals are to improve the coordination of care between services and across service systems, strengthen accountability for care, reduce unnecessary behavioral health and physical inpatient care, and enhance discharge planning to avoid preventable readmissions to inpatient care.

Together, the two proposals have been described somewhat like a two-stage rocket. Movement toward managed care arrangements for Medicaid beneficiaries identified as “high-need, high-cost” builds on both proposals, with one atop the other and launched in succession. The Phase 1 regional BHO model that makes up the first stage is jettisoned, while the Phase 2 cabin of the rocket—the health home initiative—continues on its mission. The jettisoned behavioral health organization structure, however, is conserved, “re-conditioned” and reused for Phase 2. The phased launch is designed to help individuals with complex behavioral conditions reach the highest level of integrated physical and behavioral health care and full, productive community living.

### **Behavioral Health Organizations**

The concept of the BHO and the creation of regional BHOs build on the experience of the New York City–State care monitoring initiative.<sup>11</sup> The development of BHOs represents the next natural step in moving the statewide system toward enhanced recovery-focused accountability and reduced system fragmentation.

As part of the first phase of the BHO initiative (not to be confused with the first phase of the MRT), OMH and OASAS met with stakeholders, delineated major BHO functions, and formed a preliminary time line for implementation. In late June, the agencies jointly released a

request for proposals to seek applications for the provision of Medicaid FFS administrative and management services in five regions of the State (see Figure 6) aimed at concurrent review of inpatient behavioral health services and the coordination of behavioral health services.

**Figure 6: BHO Regions**



BHOs will assist recipients, providers, families and localities across five regions of the State to prepare for the transition from the current unmanaged FFS to a managed behavioral health services environment. Essentially, OMH and OASAS will contract with the BHOs and, in conjunction with local governmental units, all will work together toward successful implementation.

Specifically, BHOs will aid in the management of behavioral health services for individuals whose services are currently covered under the FFS

system. The major functions of BHOs during Phase 1 include:

- Monitoring behavioral health inpatient length of stay
- Reducing unnecessary behavioral health inpatient hospital days
- Reducing behavioral health inpatient readmission rates
- Improving rates of engagement in outpatient treatment following discharge from inpatient care
- Adding to our understanding the clinical conditions of children diagnosed as having a serious emotional disturbance
- Monitoring provider performance
- Testing metrics for assessing system performance

BHOs have been tasked with adding to our understanding of the clinical conditions of children diagnosed as having a serious emotional disturbance to help achieve the goal of having all Medicaid recipients receive managed services by the end of three years. As such BHOs will monitor OMH-licensed specialty clinics to determine when children in Medicaid managed care are diagnosed with serious emotional disturbance and to capture clinical characteristics to aid planning. In this first phase of activity, while health homes may not exclude children, the focus will be on better understanding the characteristics of children who are already enrolled in managed care and are diagnosed as having serious emotional disturbance. The data will help to shed light on how care management can be arranged for children and families to meet their unique needs.

Phase I also provides OMH and OASAS with the opportunity to test and evaluate various systems metrics—those relevant and quantifiable attributes of BHO system performance over time—to monitor quality and identify trends. The initial set of metrics centers on measures of access to and appropriateness of services, engagement in treatment and continuity of care, and acceptability of care. Within each of these three domains, the following performance expectations will be used with a defined set of performance indicators, which may be modified or expanded by OMH and OASAS as indicated:

- **Access.** Access to appropriate behavioral health services will be maintained as managed care strategies are implemented (e.g., metrics focus on outpatient, and inpatient and emergency services).
- **Engagement and Continuity.** Individuals who have been ill enough to be hospitalized will be engaged in appropriate follow-up services promptly upon discharge (e.g., metrics focus on time from discharge to outpatient/non-crisis service visits, confirmation of post-discharge outpatient appointments documented in plan of care, outpatient visits completed over a defined period, re-engagement in appropriate level of care such as assertive community treatment following hospitalization, prescriptions filled and re-filled post-discharge, receipt of physical health services as prescribed).
  - Inpatient length of stay will be of appropriate duration (e.g., metrics focus on mean days, proportion of long stays).
  - Readmission rates will decline (e.g., metrics focus on 30- and 90-day readmission rates).
- **Acceptability.** Post-discharge persons will be referred to services offered by providers that individuals find useful enough to come back a second time (e.g., metrics focus on second appointments kept, prescriptions filled).

To foster quality care, each regional BHO will share aggregate information on provider patterns of care with local governmental units, as well as with stakeholders that include physical and mental health and substance abuse providers, insurers, consumer groups, family groups, health homes and other appropriate organizations in the BHO region.

Upon completion of the review of requests for proposals, OMH and OASAS in September announced notice of conditional awards for the BHOs. Implementation of Phase I is targeted to begin on October 1, with all regional BHOs scheduled to be fully operational by January 1, 2012.

## Phase 2 of Medicaid Design: Toward Comprehensive Reform

As part of the MRT Phase 2 activities, work is under way to develop specialized, comprehensive care plans capable of managing behavioral and physical health services for individuals who have considerable behavioral and physical health needs. The specific populations of individuals who receive Medicaid in New York State are described in Figure 2.

**Figure 2**  
**Populations Served by Medicaid Health Care in New York State**

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| <p>1. People who receive Temporary Assistance to Needy Families (TANF) and Home Relief (“Safety Net”) recipients. TANF and Home Relief recipients voluntarily or mandatorily enrolled in Medicaid managed care are assigned to comprehensive managed care plans. Behavioral health benefits include inpatient psychiatric and mental health clinic services. Children identified as having a serious emotional disturbance (SED) and served by OMH-licensed specialty clinics receive clinic services on an FFS basis. In addition, mental health services in OMH-licensed outpatient programs other than clinics, continuing day treatment, intensive partial rehabilitative treatment, children’s day treatment and partial hospitalization are not covered by Medicaid managed care.</p> <p>2. People who receive Supplemental Security Income (SSI) are assigned to “health only” Medicaid managed care plans. Currently, people who receive SSI and most children in foster care in New York City do not receive any mental health services through mainstream Medicaid managed care plans.</p> | <p>3. People who are enrolled in Medicaid and Medicare have dual coverage and are not covered under Medicaid managed care and are excluded from this care management process for the initial term of the contract.</p> <p>4. All other persons NOT enrolled in Medicaid managed care might include people living in smaller counties who have been exempted from mandatory enrollment in Medicaid managed care, children in foster care, people who are homeless and people identified as having serious mental illness. Behavioral health inpatient admissions for these individuals are FFS.</p> <p>Medicaid managed care plans cover inpatient rehabilitation services for people not enrolled in SSI and inpatient detoxification (Part 816) services for all enrollees of Medicaid. Many FFS claims are paid for detoxification services provided to individuals not enrolled in Medicaid managed care; often these individuals are not enrolled in Medicaid managed care because they meet exemption criteria.</p> |
|--|--|

In Phase 2, all care for people with serious mental illness will be managed in each region by one of three options: integrated delivery systems, special needs plans, and behavioral health organizations (see glossary). What’s important about each of these arrangements is that the entities are responsible for the provision of defined health services while working to keep costs in check and to sustain quality care.

To accomplish the MRT goal of developing a multi-year plan for care management that meets the unique needs of Medicaid beneficiaries, the MRT subdivided into several work groups in June. Once the work groups were determined, membership was rounded out to ensure broad stakeholder representation. The work groups are addressing, in a complementary fashion, a series of multifaceted issues carried over from the initial work of the MRT. With the exception of the first work group, which is described here, summaries of the charges of the other active groups are available in Appendix 1 (and also on the MRT website).

### **Behavioral Health Reform Work Group**

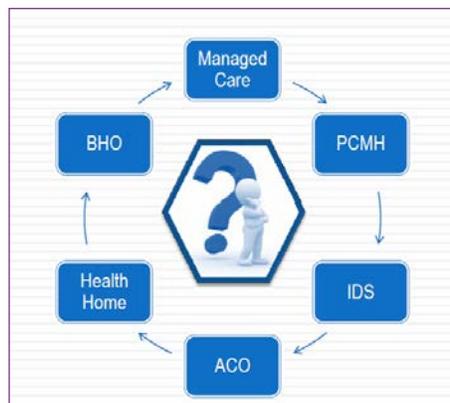
The Behavioral Health Reform Work Group is of utmost importance to the individuals with the most serious behavioral conditions and families served by the public mental health and substance abuse systems of care. Chaired by OMH Commissioner Hogan and Linda Gibbs, Deputy Mayor of Health and Human Services in New York City, the Work Group has been

meeting since June 30, 2011, and slated to complete its final report by October 15. The time line leaves sufficient time for the MRT to consider and submit its recommendations to the Governor for development of the 2012–13 State budget.

The Behavioral Health Reform Work Group is taking this opportunity to examine care management models that best match the needs of individuals and local systems of care within the framework of integrated health and behavioral health where the divide between the mind and body no longer exists.<sup>12</sup> The work group's three major areas of attention include:

**Figure 3: Examining Options for Managing Care**

- Considering principles and performance standards for the provision of integrated behavioral and physical health services for likely incorporation into one of three types of Medicaid care management delivery and payment models—integrated delivery system, special needs plan, and behavioral health organization models
- Exploring strategies for improving the integration of behavioral and physical health care, including peer support services, while identifying ways to reduce administrative and regulatory burdens
- Providing guidance to DOH on the implementation of the health homes initiative, which is set this fall to begin enrolling Medicaid beneficiaries



Inherent in efforts to address all three areas is the recognition that while primary care has a significant role in integrated care management strategies, the mental health system has a clear and understandable stake in the design of care management approaches for children, adults and families with serious mental health challenges. The push to streamline care to be more efficient and effective presents an extraordinary opportunity to reshape policy, practice and financing mechanisms and ultimately the way behavioral health care is provided.<sup>13</sup>

An example of how the Behavioral Health Reform Work Group is taking advantage of the opportunity to reshape care and promote recovery is through its examination of proven peer and family support approaches, discussion of the unique contributions that peer and family support providers offer people who are in recovery, and study of peer and family support strategies that protect the integrity and fidelity of the service model, while ensuring the availability of these cost-effective services to individuals and families.

The work group also formed a Children's Subcommittee of stakeholders in late July to consider a minimum set of behavioral health standards for children that public and private insurance plans ought to meet; admission criteria, benefits under specialty behavioral care for children, medical necessity, and provider network attributes; and key outcome indicators to use in anchoring quality within regular and specialty care plans. The Subcommittee completed its

work by mid-September and submitted its final recommendations to the Behavioral Health Reform Work Group.

In October the work group will present its set of recommendations to the MRT, spelling out steps it advises for the transition to specialty care for people with complex primary care and behavioral health disorders and strategies for systemic changes necessary for successful care coordination and integration (e.g., engaging primary providers in assuming responsibility for behavioral care, ensuring primary and other health services in behavioral health homes). Overall, the recommendations should reflect the commitment of the health care system to meet any health need in an integrated, coordinated fashion.

### **Health Homes and Care Management for People with Serious Mental Illness**

Just how is the health home concept being developed in New York? Who will be assigned to health homes and how what happens to people with complex mental health and physical health needs?

DOH leads the effort in NYS to develop the health home model of care and to partner with OMH and OASAS to ensure appropriate and quality care for individuals with the most complex psychiatric and chemical dependency needs. Health homes, including behavioral health homes, are expected to provide continuous, interdisciplinary medical and behavioral care and social services for people living with chronic conditions. Such services would not necessarily be delivered at one location, but rather they would be the responsibility of a network or team of health care professionals and providers who integrate primary care, behavioral health and other health services that meet the needs of each person served. Health homes are intended to expand the concept of the patient-centered medical home into the community so each person may receive additional support (e.g., assistance in keeping a doctor's appointment) to cope effectively with complex illness and to lead as healthy and full a life as possible. Health homes will help to improve outcomes, reduce unnecessary hospitalization and emergency department use, and diminish long-term care costs.

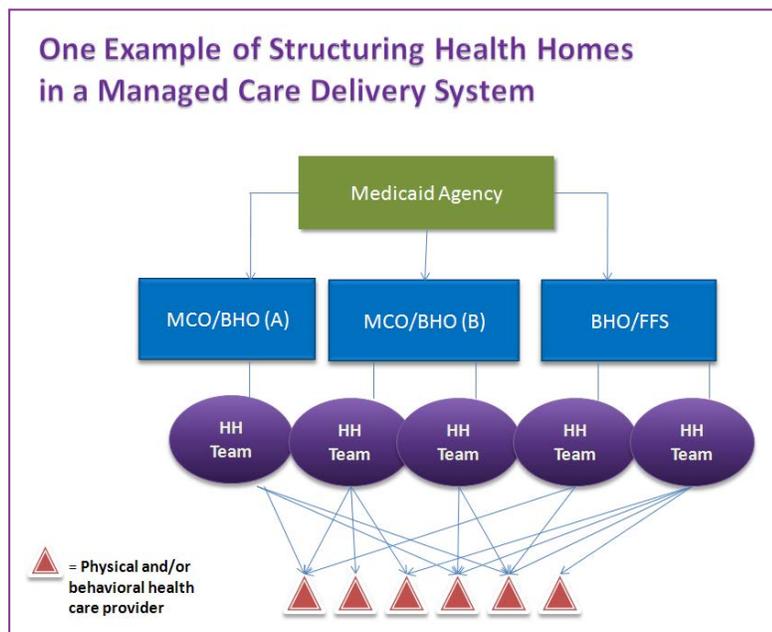
Under the terms of the federal health home initiative, New York and other states must meet specific requirements, such as limiting health home services to Medicaid beneficiaries with at least two chronic conditions, one chronic condition and the risk of another, or one serious mental health condition. One limitation of the law, however, is that beneficiaries of both Medicare and Medicaid may not participate in the initiative. NYS's consultation with the federal Substance Abuse and Mental Health Services Administration, a requirement of states submitting amendments to their federal State Plans, has already taken place.

The goal in NYS is to begin enrollment in health homes for the identified populations this fall. In late September, DOH announced a three-phase implementation plan, with health homes starting in 13 counties as of January 2012; the start of health homes in the remaining counties is anticipated to occur during the last two phases, in April and June 2012.

Planning currently includes a tiered approach to intensity of health home services, with regular assessments of need for continuation in health home services. Homes providing services for people with moderate need (e.g., one chronic condition and at risk for another)

would be the first level, followed by homes for individuals with multiple complex needs, and a third level for people with intensive complex needs, including people with the most serious behavioral health conditions. New Yorkers interested in following the progress of health home implementation may go to the [DOH Medicaid Health Homes Web Page](#) for additional information.

**Figure 4: Example of Home Health Structures**



The Behavioral Health Reform Work Group, among other responsibilities, is considering recommendations on a number of fronts, but not limited to:

- ***The structuring of health homes in managed care delivery systems.*** Figure 4 illustrates just one example of a structure, where managed care and behavioral health organizations would each report to the State Medicaid agency and have a series of health home teams where providers of those teams have

an ability to participate flexibly. Whatever structures are developed for organizing health home services, the regional BHOs will be involved in the assignment of Medicaid beneficiaries who qualify for health homes. Moreover, DOH recognizes that health homes and regional management structures composed of the BHO/MCO/Health Home may be necessary.

- ***The evaluation of the effectiveness of care management as models form and strive for integrated, coordinated and effective care.*** The Work Group is considering necessary performance indicators related to housing, employment, and recovery; the quality of care as measured by the percentage of services based on sound scientific evidence; the provision of prevention services; the continuity of treatment for people who have the greatest clinical and social needs; care coordination across treatment domains; and, importantly, whether disparities are present in access to and the outcomes of care.
- ***The need to address the unique characteristic of mental illness: it can impair a person's ability to seek needed help.*** The work group is examining lessons learned from the care monitoring initiative in New York City designed to identify at-risk people with high service needs who have become disengaged from and possibly in need of care. The experiences gained from this crucial initiative are helping to set care coordination expectations for outreach and engagement. Among these would be welcoming environments; open scheduling and immediate access to urgent care;

embrace of shared decision-making approaches; peer outreach, wellness coaching and support; peer-operated alternatives; mobile outreach services to reach those unable or not willing to go to a services location; and a regard for the principle of procedural justice to help people be safe.

## Wrap Up of MRT Activities

Upon completion of its consideration of work group recommendations, the MRT will provide summary documentation of the approved recommendations from the work groups. Out of the documentation and recommendations and under Governor Cuomo's leadership, the State will advance a comprehensive action plan for true Medicaid reform.

As this Statewide Plan readies for publication and before the MRT wraps up its work, the Behavioral Health Reform Work Group has sought input into recommendations being prepared for the MRT. It urges stakeholder to stay abreast of its ongoing deliberations by visiting its page on the [Medicaid Redesign web site](#)<sup>1</sup>.

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<sup>1</sup> There are many aspects to the budget bill reform proposals not included in this narrative that are important to the overall success of the Medicaid redesign, but beyond the scope of detailed discussion in this Plan. To learn about the comprehensive package of reforms, the reader is referred to the Medicaid Redesign website at [http://www.health.ny.gov/health\\_care/medicaid/redesign/](http://www.health.ny.gov/health_care/medicaid/redesign/)<sup>2</sup>.

<sup>2</sup> See the State Department of Health Managed Care page online at [http://www.health.ny.gov/health\\_care/managed\\_care/index.htm](http://www.health.ny.gov/health_care/managed_care/index.htm)<sup>3</sup>.

<sup>3</sup> Devers K & Berenson R. (2009, October). *Can accountable care organizations improve the value of health care by solving the cost and quality quandaries?* Available from the Robert Wood Johnson Foundation at <http://www.rwjf.org/files/research/acosummaryfinal.pdf><sup>4</sup>.

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<sup>5</sup> See the New York State Department of Health "HIV Special Needs Plan" page online at <http://www.health.ny.gov/diseases/aids/resources/snps/><sup>6</sup>.

<sup>6</sup> New York State Office of Alcoholism and Substance Abuse Services and Office of Mental Health. (2011, June). *Behavioral health organizations selection process document instructions*. Available online at [http://www.omh.ny.gov/omhweb/rfp/2011/bho/selection\\_process\\_document.pdf](http://www.omh.ny.gov/omhweb/rfp/2011/bho/selection_process_document.pdf).

<sup>7</sup> See the Health Home Q&As on the New York State Department of Health website at [http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/2011-08-09\\_questions\\_and\\_answers.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/2011-08-09_questions_and_answers.htm)<sup>8</sup>.

<sup>8</sup> See "What is a health home," available on the Substance Abuse and Mental Health Administration blog at <http://blog.samhsa.gov/2010/12/04/what-is-a-health-home/><sup>9</sup>.

<sup>9</sup> See the Health Home Q&As on the New York State Department of Health website at [http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/2011-08-09\\_questions\\_and\\_answers.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/2011-08-09_questions_and_answers.htm)<sup>10</sup>.

<sup>10</sup> Smith TE & Sederer LI. (2009). A new kind of homelessness for individuals with serious mental illness? The need for a mental health home. *Psychiatric Services*, 60, 528–533.

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<sup>11</sup> More information on the Care Monitoring Initiative appears in the January 2010 OMH News available online at <http://www.omh.ny.gov/omhweb/resources/newsltr/2010/jan/#med>.

<sup>12</sup> Strosahl K. (1997). Building primary care behavioral health systems that work: A compass and a horizon. In *Behavioral Health in Primary Care: A Guide for Clinical Integration*, N. Cummings, J. Cummings, and J. Johnson, Eds, pp. 37–58. Madison, CT: Psychosocial Press.

<sup>13</sup> Collins C, Hewson DL, Munger R et al. (2010). *Evolving models of behavioral health integration in primary care*. New York: Milbank Memorial Fund. Available online at <http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf> .

# Public Mental Health System Highlights

As the Office of Mental Health (OMH) prepares for the introduction of national and State health care reform and the redesign of services, particularly for people who receive Medicaid, it focuses on the provision of efficient and effective behavioral health services and the preservation of the safety net for New York's most vulnerable citizens and families. Planning for the future builds on the underpinnings of good care:

- Early and ready access to appropriate treatment and supports
- Clinically and culturally competent care that considers individual needs
- Continuous, personalized and integrated physical and behavioral health and support services from trusted caregivers
- A focus on helping people to live, learn and work productively in their communities
- Services and supports that are consonant with the values of recovery and resiliency

As reforms are considered and planned, OMH remains committed to providing treatment and supports based on quality, scientific evidence, safety, fairness and accountability. The necessity for data-driven planning has never been greater.

This chapter provides a snapshot of the current public mental health system of care in New York State (NYS)—a view of where we are now. It also provides indications of why integrated behavioral and physical health care matters, and ends with a picture of data resources that inform ongoing planning and monitoring, with an eye toward the changing system of care.

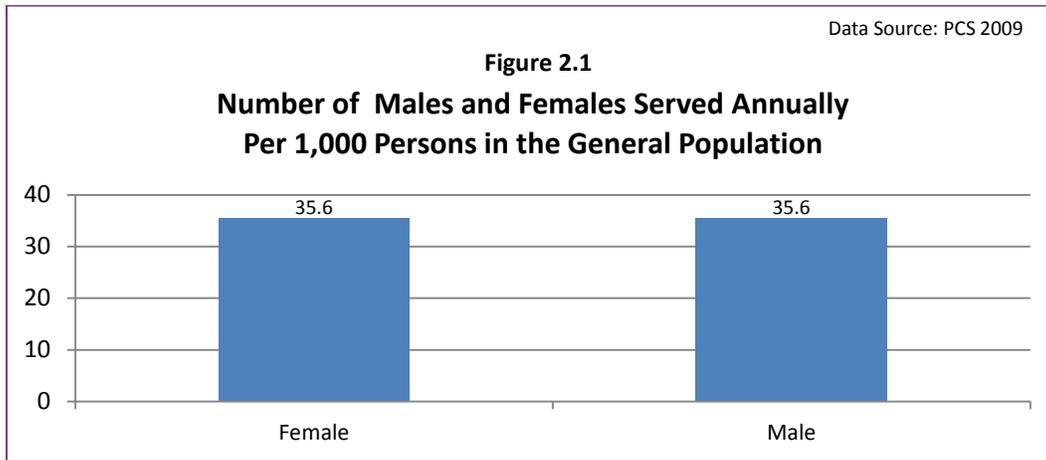
## Snapshot of the State Public Mental Health System

### Who is Served?

The Patient Characteristics Survey (PCS) captures the characteristics of children and adults served in the public mental health system. Conducted every other year, the one-week-long survey gathers clinical and demographic information for people who receive mental health services from programs operated, funded, or certified by OMH. The most recent survey includes 173,682 individuals served during a one-week period in October of 2009.

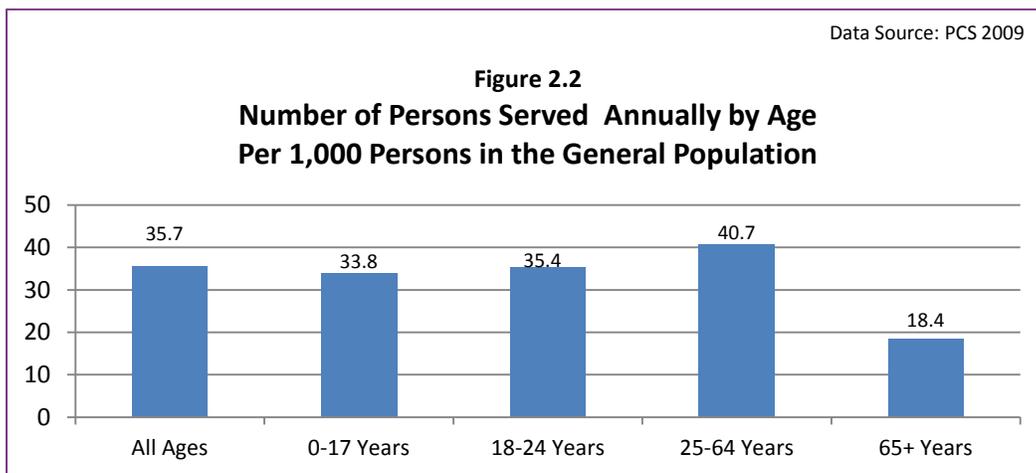
OMH estimates the number of people served annually in the public mental system from the PCS. Annual estimates were prepared using statistical capture-recapture methodology developed by researchers from the Nathan Kline Institute for Psychiatric Research.<sup>1</sup> Such estimates prove valuable for local- and State-level decision making and for directing the

development of policy in the areas of planning, services delivery, resource management, financing, evaluation and ongoing monitoring.

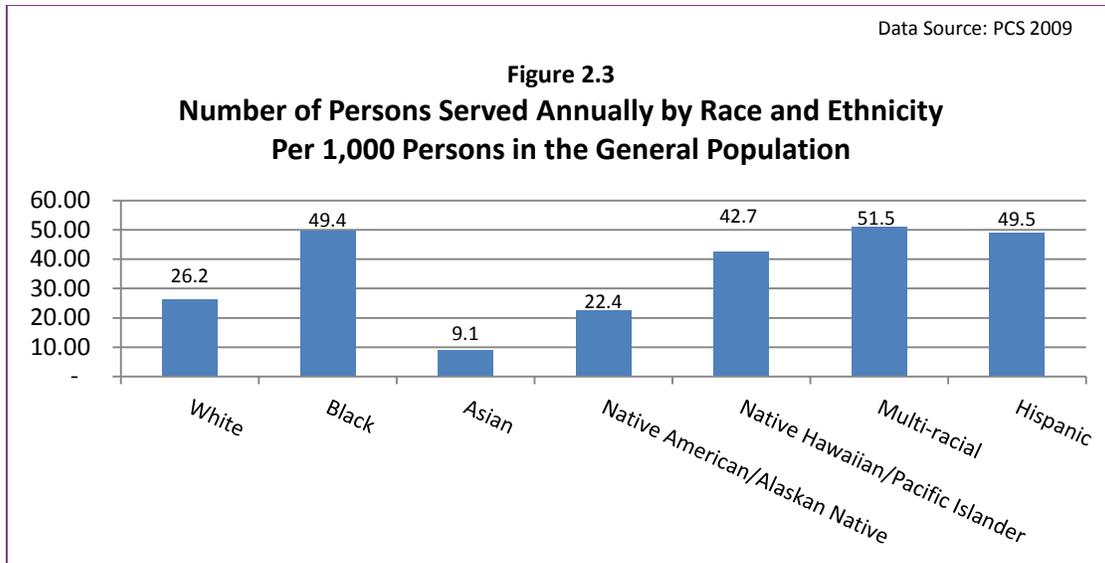


The NYS public mental health system provides services annually to an estimated 695,000 persons.<sup>2,3</sup> Among them (see Figure 2.1), 35.6/1,000 males and an equal number of females in the general population receive mental health services.

Figure 2.2 illustrates that the highest annual rate of utilization is in the 25–64 year old age group. By comparison, the rate of utilization is lowest for older adults (65 years of age and above).



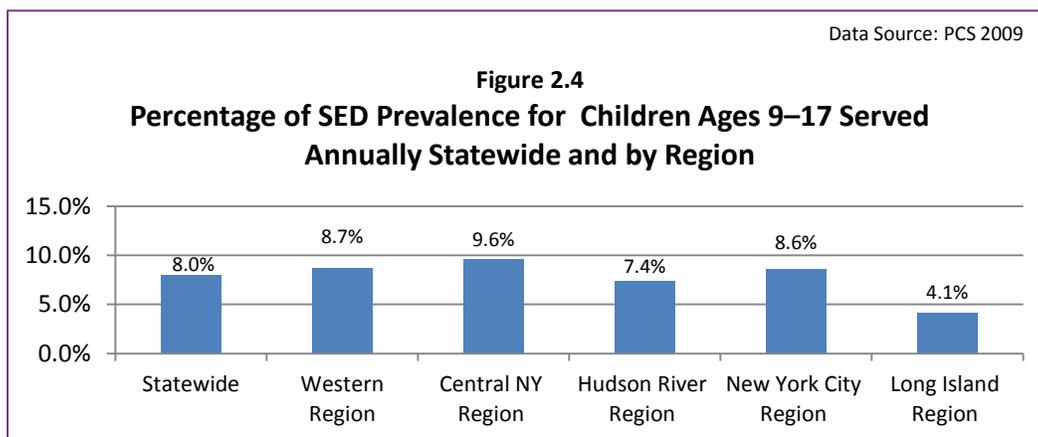
By race and ethnicity, as shown in Figure 2.3, the rates of services annually are highest among people who are Multi-racial, Black, Hispanic, and Native Hawaiian/Pacific Islander and lowest among people who are Asian. The rates for Black and Hispanic persons served are nearly the same, with annual rates of 49.4 and 49.5 respectively.



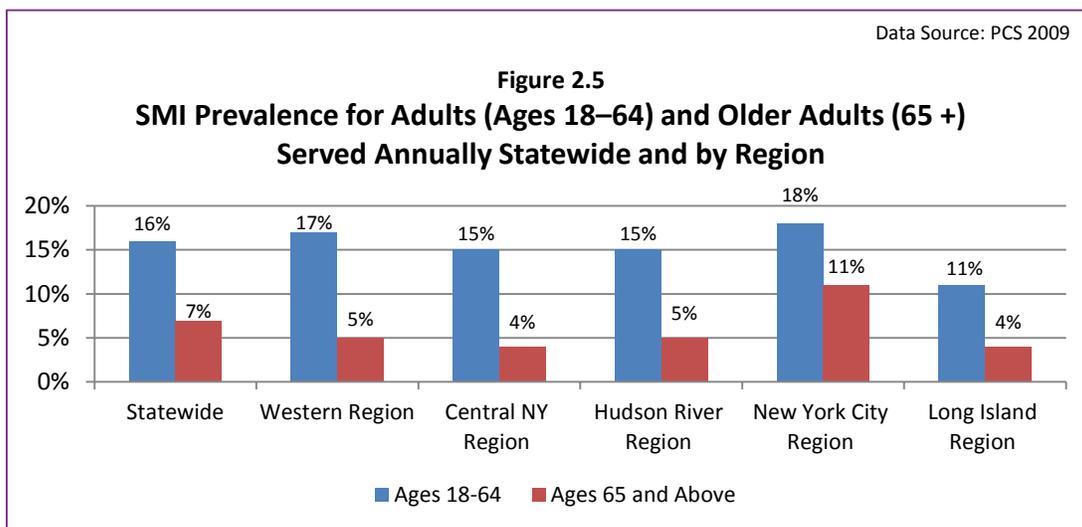
### Disability Status and Diagnoses of People Served

Most children and adults served in the NYS public mental health system are engaged in services because of symptoms that impede their ability to function day to day. Serious mental illness (SMI) occurs in individuals diagnosed with mental illness and with significant impairments in functioning, while serious emotional disturbance (SED) in children is characterized by a diagnosable mental disorder and impairment that substantially limits functioning in school, family, or community activities.<sup>4</sup>

Figure 2.4 depicts that among children served annually, the serious emotional disturbance prevalence is about 8 percent, with the lowest percentage of serious emotional disturbance prevalence found in the Long Island Region.<sup>5</sup> A prevalence rate for children between ages birth to 8 years of age has not been estimated.



For adults between 18 and 64 years of age and older adults age 65 and above, the percentage of serious mental illness prevalence is sometimes two to four times higher in adults than in the older adults. Also illustrated in Figure 2.5, the percentage of serious mental illness prevalence across regions for older adults is two times higher in New York City than in any of the other regions.



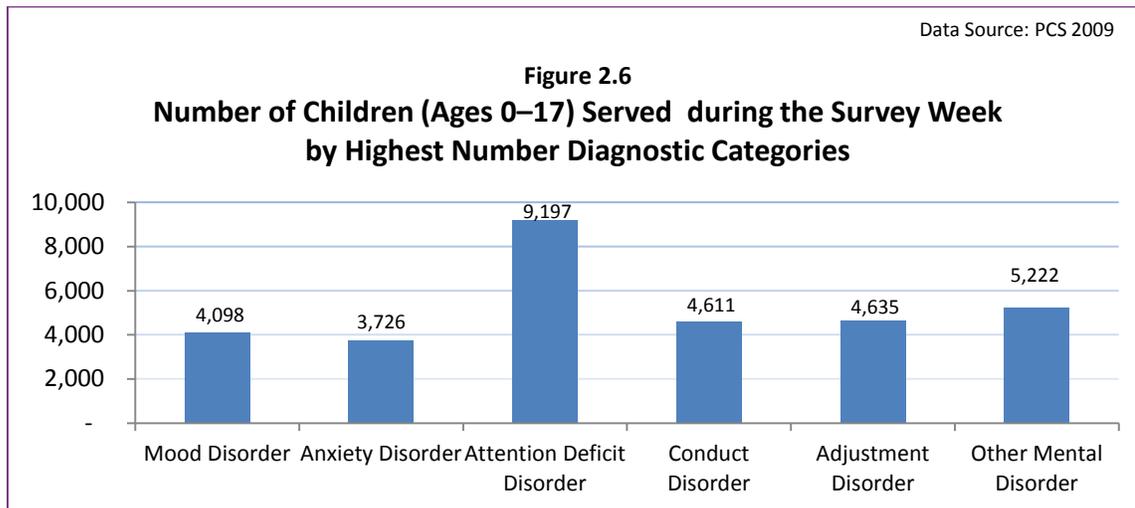
Across the United States only one-half of the individuals who are in need of mental health treatment actually receive the treatment. The societal results are readily apparent.<sup>6</sup> The disabling effects of mental illness in adults can result in incarceration, homelessness, joblessness, chronic physical health problems, social isolation, and suicide. Half of all lifetime cases of mental disorders begin by age 14, with long delays, sometimes decades, between the first onset of symptoms and when people seek and receive treatment. The incapacitating effects are often serious and extended, leading to poor academic achievement, failure to complete high school, substance abuse, involvement with the juvenile and criminal justice systems, lack of vocational success, higher health care utilization costs, inability to live independently, and suicide.<sup>7,8,9,10</sup>

Specific mental health diagnoses reported in 2009 for New Yorkers served in the public mental health system during the survey week are broken out by population for children 17 years and younger, young adults 18 to 24, adults 25 to 64 years, and older adults 65 years of age and older.

### ***Children 17 Years and Under***

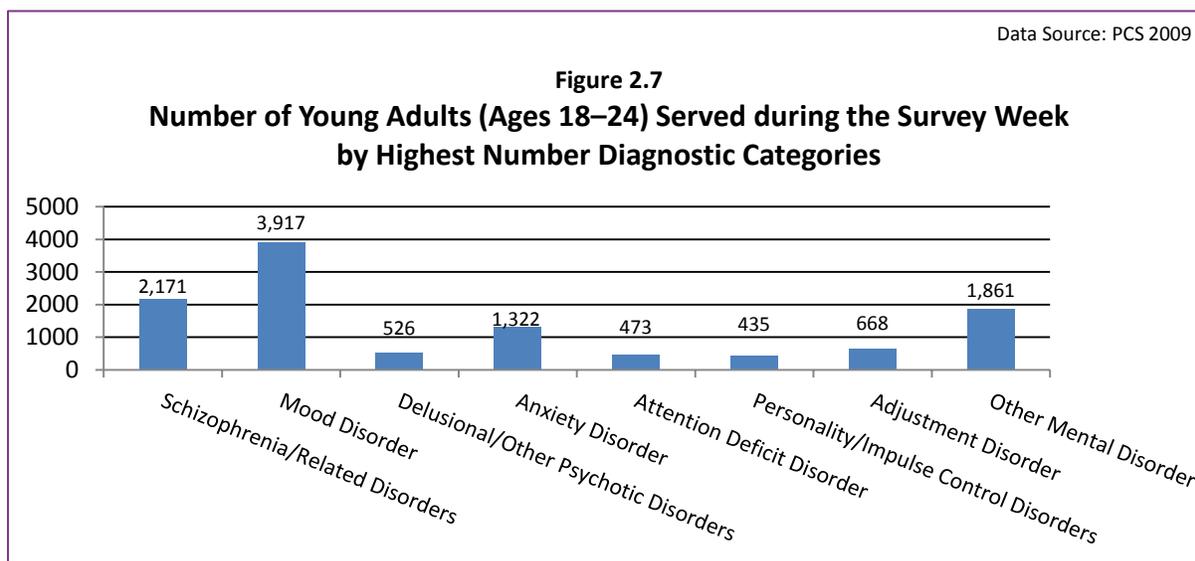
As illustrated in Figure 2.6, attention deficit disorder leads the diagnostic categories for children served during the one-week survey. The other diagnoses seen most often for children during that week are adjustment, conduct, mood (all types of depression and bipolar disorder) and anxiety disorders. “Other” mental disorder is defined by the survey as a mental health diagnosis that does not fit into any of the diagnostic categories identified for survey reporting; some examples of “other” diagnoses would be eating disorder, somatoform disorder or

dissociative disorder. About 5,200 children served during the survey week had other mental health diagnoses.



### ***Young Adults between Ages 18–24***

Figure 2.7 shows that mood disorders are highest in number among the diagnoses given to young adults during the survey week. Schizophrenia and related psychotic disorders, when combined with the delusional disorder diagnoses, accounts for the next highest number of young adults served during the survey week. Smaller numbers of young adults served were diagnosed with adjustment, personality/impulse control, and attention-deficit disorders.



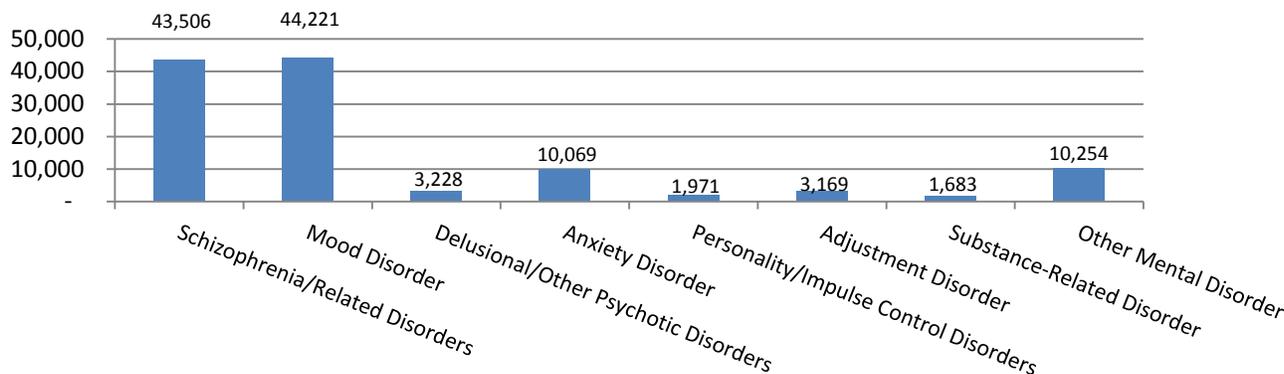
### ***Adults between the Ages of 25 and 64***

As illustrated in Figure 2.8, the two diagnoses with the highest numbers for adults served during the survey are schizophrenia and related disorders and mood disorders. When the number of delusional disorder diagnoses is combined with the schizophrenia and related

disorders number, then the combined diagnostic category edges in number slightly over mood disorder. The third most frequent diagnosis from the one-week survey for adults is anxiety disorder.

Data Source: PCS 2009

**Figure 2.8**  
**Number of Adults (Ages 25–64) Served during the Survey Week**  
**by Highest Number Diagnostic Categories**

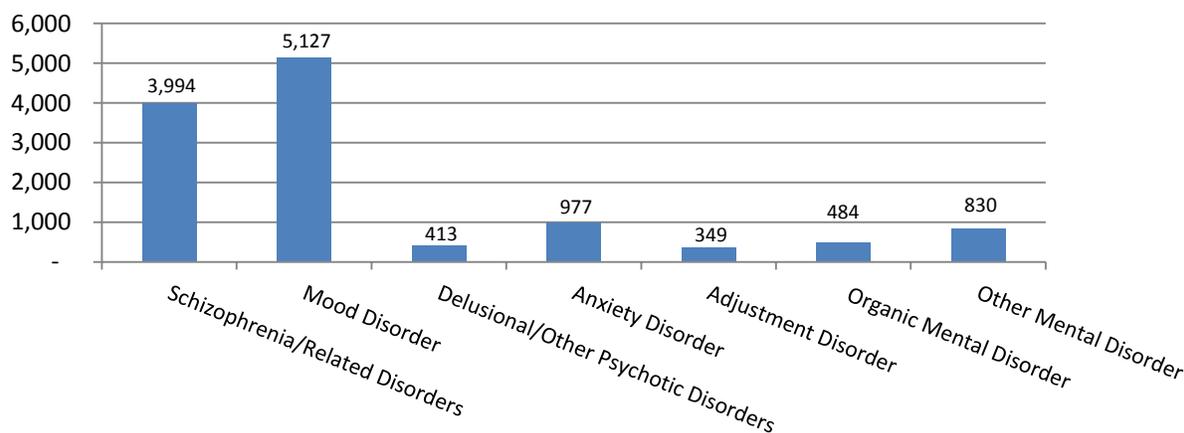


### **Older Adults 65 Years of Age and Above**

Among older adults served during the survey week, the category of mood disorders is highest in number, followed closely by schizophrenia and related disorders (see Figure 2.9). As with the adult population, anxiety disorder is also third highest in number. One difference between the other populations and the older adults is the presence of organic mental health disorders, which is consistent with research findings that the risk of Alzheimer’s disease, vascular dementia and other dementias rises with age.<sup>11</sup>

Data Source: PCS 2009

**Figure 2.9**  
**Number of Older Adults (Ages 65 +) Served during the Survey Week**  
**by Highest Number Diagnostic Categories**



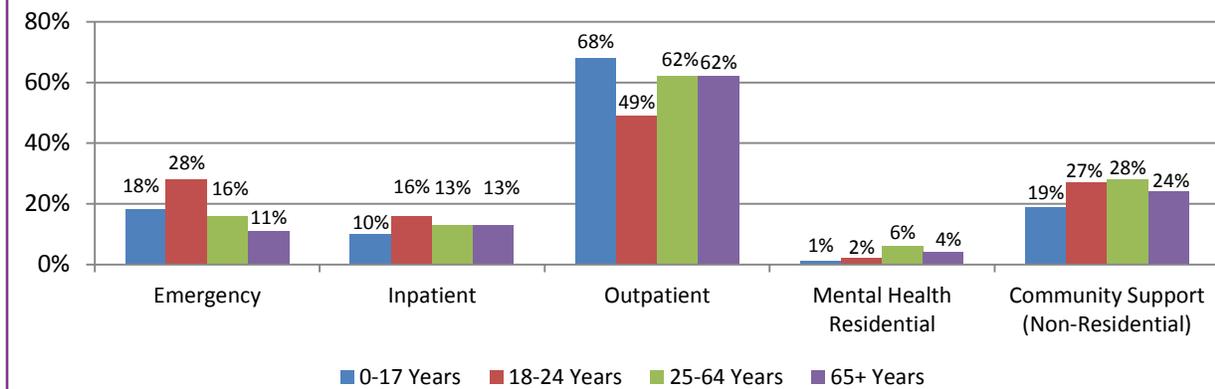
## Where People Engage in Services

Public mental health services cluster in five major categories across the health care continuum: emergency, inpatient, outpatient, residential and community support. Both State and locally operated programs provide services in each of these categories and people may receive services from more than one category.

- Emergency services bring rapid psychiatric and/or medical stabilization for individuals and families, thereby supporting their safety and well-being. These programs include a range of mobile crisis counseling and residential services, as well as comprehensive psychiatric emergency programs.
- Inpatient services provide acute psychiatric stabilization, intensive treatment and rehabilitation within 24-hour controlled care environments. They are the programs of choice only when the required services and supports cannot be delivered in community settings.
- Outpatient treatment and rehabilitation services take place in ambulatory settings, including clinics, partial hospital programs, ACT, prepaid mental health plan (PMHP) and personalized recovery-oriented services (PROS).
- Residential services provide basic housing services that enable individuals to live in their community settings. Congregate treatment, apartment treatment, and supported housing are among residential services provided.
- Community support services assist individuals diagnosed with serious mental illness to live as independently as possible in the community, and help children with serious emotional disturbance to remain with their families. These programs provide case management, vocational/employment, self-help/peer, residential and other support services.

Figure 2.10 reveals that the highest proportions of persons in the public mental health system are served in outpatient programs, ranging from 49 percent for young adults to 68 percent for children receiving outpatient services. Of those served in non-residential community support programs, the range is from a low of 19 percent for children to 28 percent for adults between ages 25–64; in mental health residential programs, between 1 percent for children and 6 percent for adults (ages 25–64); in inpatient settings, from 10 percent for children to 16 percent for young adults; and in emergency programs, the highest proportion of persons served is young adults (28 percent). Totals for each age group across the five program categories exceed 100 percent because people attend more than one program during the course of the year.

**Figure 2.10**  
**Percentage of Persons Served Annually by Program and Age Categories**



### Other Characteristics of People Served

PCS data describe characteristics of people served in the public mental health system. Among them are data on basic needs, employment, and the appropriateness of grade levels for the ages of children.

#### Basic Needs

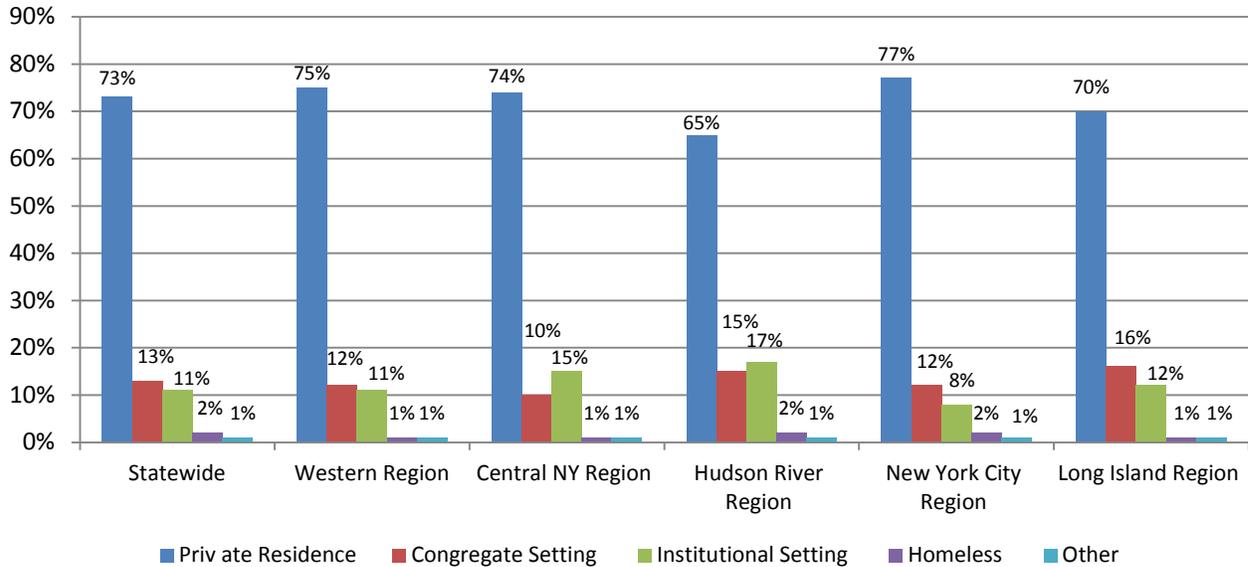
As Chris Koyanagi of the Bazelon Mental Health Center notes, good health is among a set of basic needs—secure and safe place to live, income for necessities, recreational and social opportunities, and a sense of purpose—required for community integration and recovery for people with serious mental illness.<sup>12</sup> As illustrated in Figure 2.11, the PCS offers a view of how people served in the public mental health system are faring in terms of basic needs.

Community integration and recovery for people with psychiatric disabilities, while unique for each individual, require that a set of basic needs be met. A safe, secure place to live, enough income for life's necessities, recreational opportunities, social contact and a sense of purpose are all part of recovery. High on the list, and affecting most of the other areas, is good health.

*Chris Koyanagi*  
*Will Health Reform Help People*  
*with Serious Mental Illnesses?*  
*Bazelon Center for Mental Health Law*

At the top of the basic needs list is safe and secure housing. Figure 2.11 shows that nearly three-quarters of individuals served annually and across the five regions live in a private residential setting such as a home, apartment, rooming house or hotel room. While the level of homelessness among individuals served is at 1 percent across four of the regions, in the large urban NYC region and the Hudson River regions, the percentage is doubled to 2 percent each.

**Figure 2.11**  
**Percentage of Living Situations for All Ages Served Annually**



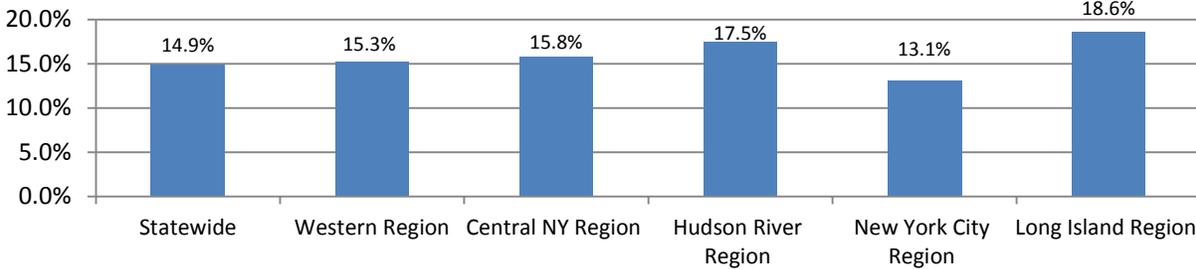
### ***Employment Status***

Most individuals who cope with serious mental illness want to work; some with the most serious conditions hold positions that require high levels of functioning.<sup>13</sup> Work is essential to most of our lives, provides monetary compensation and reward, and offers benefits not measured by dollars alone, such as a social identity, social support, constructive use of time, community engagement, and personal satisfaction. A vital link to community living and active citizenship, work helps us in maintaining our overall health and in staying on the path toward recovery.

Despite this, people with serious mental illness experience significant barriers to work, many linked to prejudice, stigma, and discrimination. National survey data indicate an employment rate of 17 percent for working age adults with schizophrenia, paranoia or delusional disorder, compared to 33 percent for persons with other mental health disorders and 77 percent for the population not living with disabilities.<sup>14</sup>

In the State public mental health system, the rates of competitive, full- or part-time employment in community settings for adults (ages 18–64) served annually (Figure 2.12) range from 13.1 percent in NYC to 18.6 percent in the Long Island Region. The rates include individuals who receive supported employment services.

**Figure 2.12**  
**Percentage of Adults (Ages 18–64) Served Annually Who Are Employed in the Community Setting**



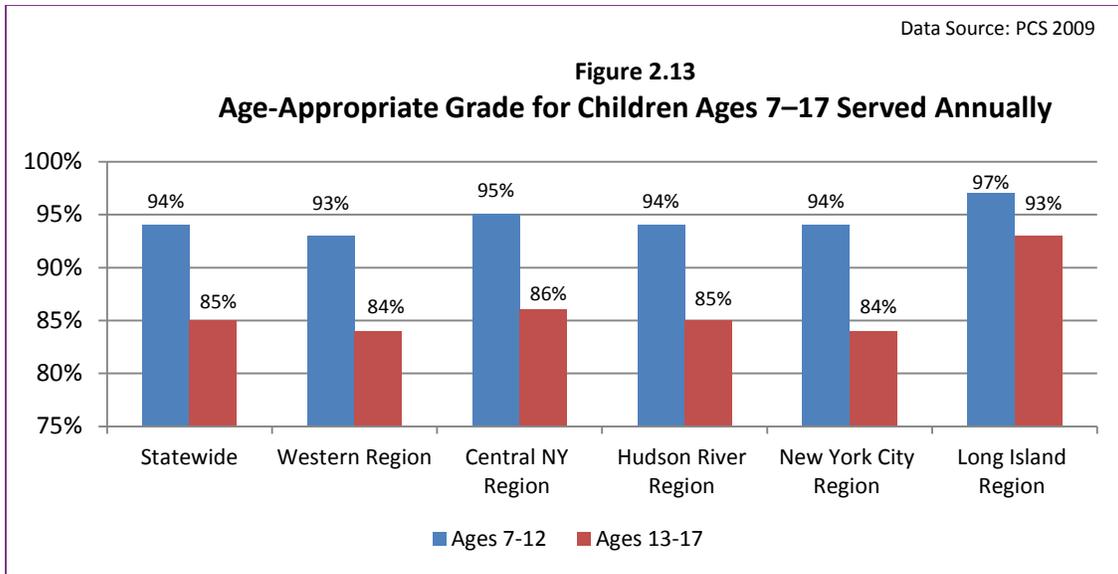
Helping people with serious mental illness find and keep work is a priority for OMH, with a focus over the last year on the development of a cross-agency comprehensive job matching/employment supports coordination and data system. The new system is designed to support competitive employment opportunities and outcomes for all New Yorkers with disabilities. A part of the “New York Makes Work Pay” federally funded grant initiative, which is administered by OMH, the system serves as a single point of access for each New Yorker seeking employment and employment supports, regardless of individual abilities and regardless of the state agency (e.g., children and family services, substance abuse, vocational rehabilitation) serving the individual.

### ***Child Age-Appropriate Grade Levels***

Directly connected to employability is educational attainment. A fundamental part of the American dream is the belief that educational achievement leads to future economic well-being. Data support this view and show that at most ages of the adult years, more education equates to higher earnings.<sup>15</sup> Data also show that education pays off in terms of lower unemployment rates.<sup>16</sup>

Understanding that children and youth with mental health problems have lower educational achievement, greater involvement with the criminal justice system, and fewer stable and longer-term placements, OMH remains committed to monitoring and addressing how children do at home, in school, and in their communities. For children served in the State public mental health system, the PCS gathers data on the percentage of children from ages 7–17, for example, whose education level is age-appropriate. A child is considered in an age-appropriate grade when the difference between the child's age (in years) and current grade level is less than or equal to 6. For example, a child in the first grade should be 7 years old or less, to be age appropriate for that grade.

As Figure 2.13 shows, the age-appropriate grade for children from ages 7–12 is higher than for youth between ages 13–17. In the Long Island region, the gap between children and youth is narrower than for the other regions of the State.



### Data Informing Improved Integration of Physical and Behavioral Healthcare

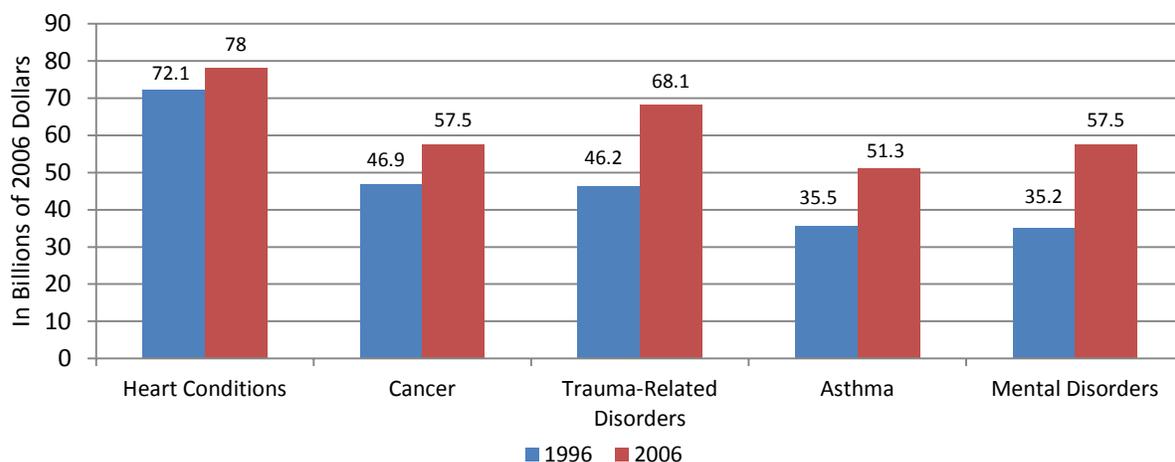
National and state health reforms concentrate to a large degree on improving the quality of healthcare by strengthening care coordination and the integration of physical and behavioral health care.

Neuropsychiatric disorders, including mental illnesses, rank first among illnesses in our nation that cause disability, surpassing cancer and cardiovascular disease.<sup>17</sup> The cost of this disability is also staggering. In 2006, total direct expenditures for mental health services totaled \$57.5 billion, making them the third most costly medical condition in the United States, tied with cancer and behind heart conditions and trauma.<sup>18</sup>

Poor coordination generally leads to less effective and more costly care, and more importantly, can result in potential errors, misdiagnoses and expensive complications, as well as increased mortality and morbidity rates.

*Complex Chronic Illness: An Essential Target in Health Cost Management*  
*World at Work Journal, 3<sup>rd</sup> Quarter 2009*

**Figure 2.14**  
**Expenditures for the Five Most Costly Conditions, 1996 and 2006**



Data Source: Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality, Household Component of the Medical Expenditure Panel Survey, 1996 and 2006

These data become even more compelling when considered within the context of what we now know about the burden of chronic medical conditions:

- Nearly one-half of Americans have a chronic medical condition
- Health care spending for a person with a chronic condition, on average, is four times that for a person without a chronic condition
- About one in two people with a chronic condition have more than one chronic condition
- Average spending in yearly medical plans is 15 times more when a person has five or more chronic conditions.<sup>19</sup>

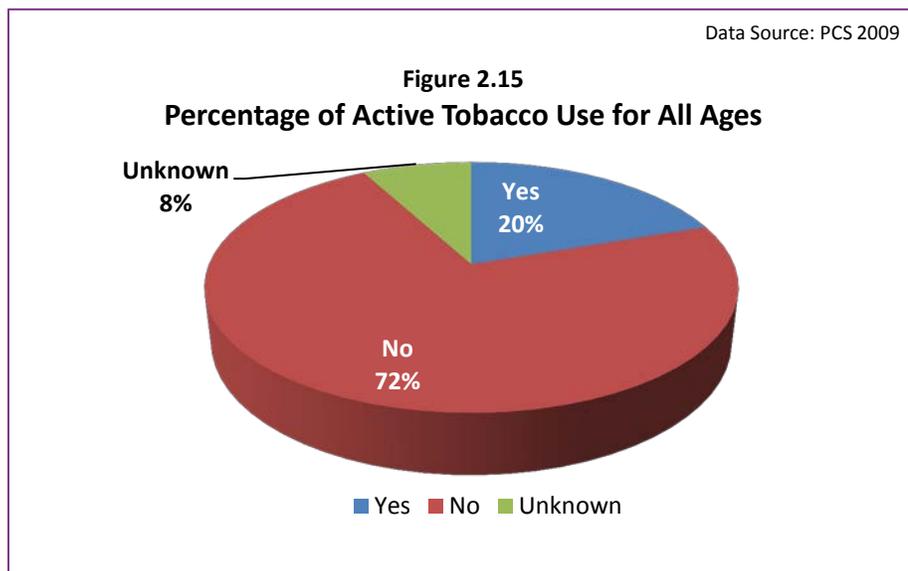
Ongoing PCS data collection is taking into account this knowledge and will continue to be of value in monitoring health care trends as OMH moves toward behavioral managed care arrangements. Two data points illuminate how PCS data are informing ongoing care aimed at reducing behaviors that contribute to poor health outcomes: the use of tobacco and the presence of chronic medical conditions.

### **Active Tobacco Use**

Among people with serious mental illness, high rates of smoking are associated with increases in physical illness (e.g., coronary heart disease, peripheral vascular disease, chronic obstructive pulmonary disease) and mortality. People with serious mental illness, on average, die 25 years younger than the general population—largely from conditions caused or worsened by smoking, according to a 2006 report by NASMHPD.<sup>20</sup> People with psychiatric disorders consume nearly one-half (44.3 percent) of all cigarettes smoked in this country, causing them to be at greater risk for the adverse consequences of tobacco use.<sup>21</sup>

The 2009 PCS survey week is the first time that OMH is reporting on active tobacco use among all people served in the public mental health

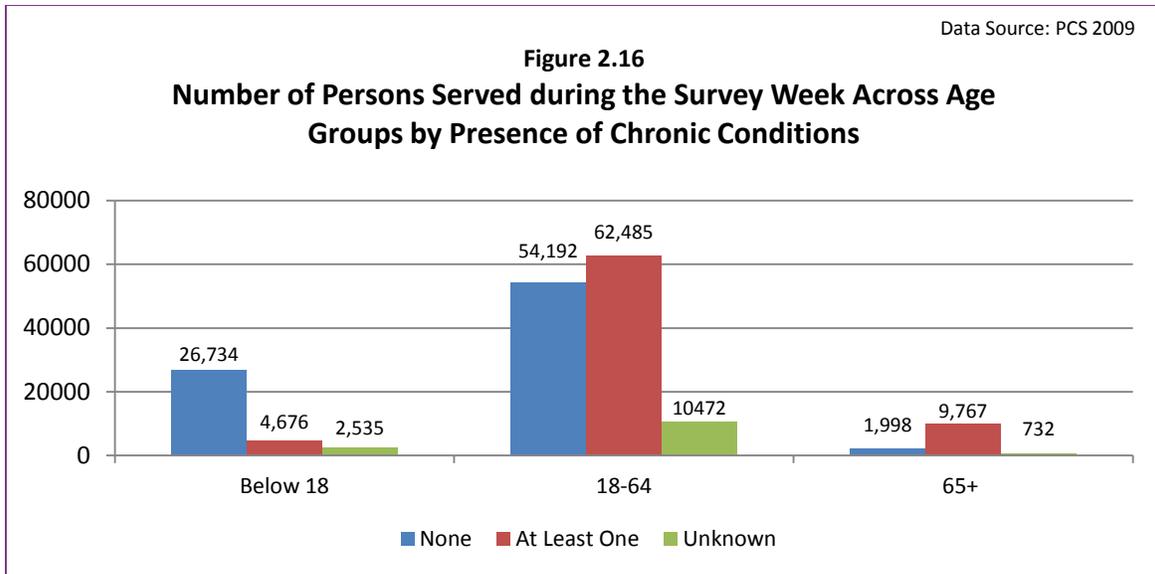
system. During the survey week in 2009, percentage of active tobacco use for all ages is 20 percent.



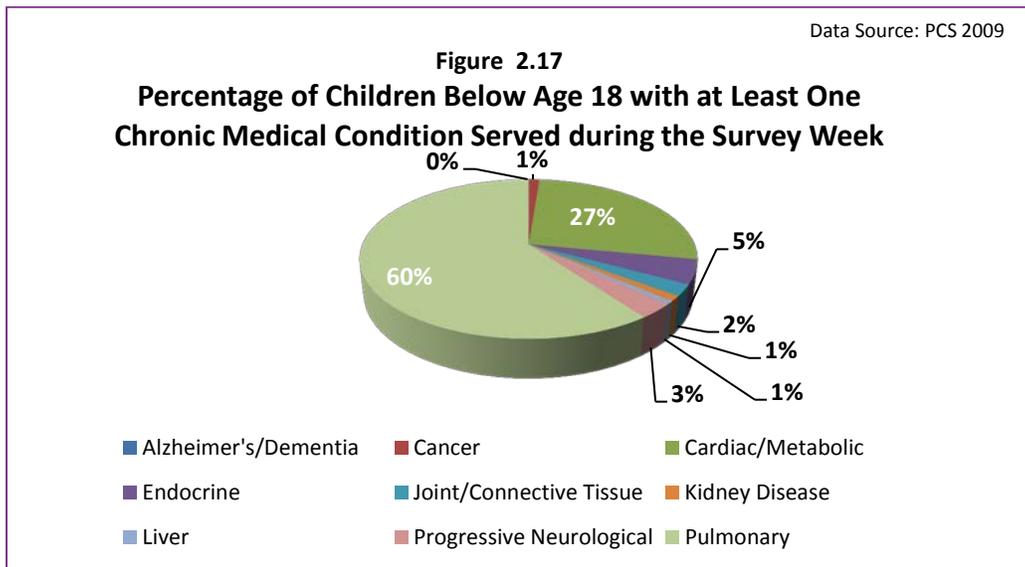
### **Chronic Medical Conditions**

For the 2009 PCS Survey, another new question aims to identify the presence of chronic medical conditions experienced by people served during the survey week. The question asked about the existence of any chronic medical conditions, including cardiac and metabolic (e.g., high blood pressure, elevated cholesterol), pulmonary conditions (e.g., emphysema), tobacco use, Alzheimer’s disease or dementia, kidney disease, liver disease (e.g., hepatitis), endocrine disorders (e.g., thyroid disease), progressive neurological disorders (e.g., multiple sclerosis) traumatic brain injury, joint and connective tissue disease (e.g., arthritis, lupus), cancer. Also included among choices is “none of the above,” and “unknown.”

Of the 173,682 individuals served during the survey week, 44 percent had at least one chronic medical condition. As noted in Figure 2.16, the proportion varies by age group. Children and youth have the lowest rate, with just 14 percent having one or more chronic medical conditions compared to 49 percent for adults and 78 percent for older adults.

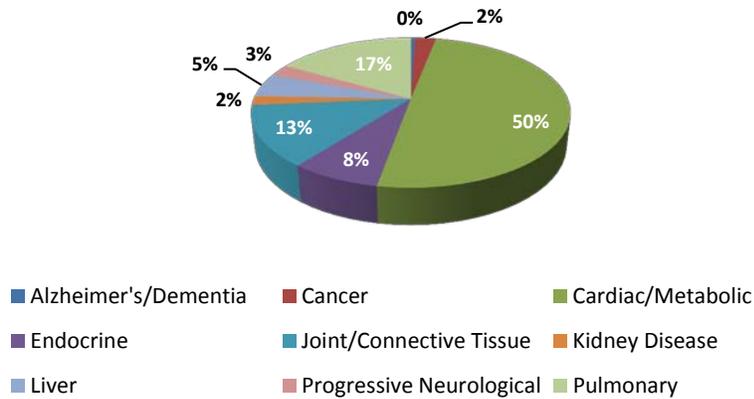


The percentages of people served with at least one chronic medical condition are displayed by condition and age group in Figures 2.17 to 2.19. For children and youth under 18 years of age, more than one-half have pulmonary illness (60 percent), followed by cardiac and metabolic illnesses (27 percent) and endocrine disorders (5 percent).



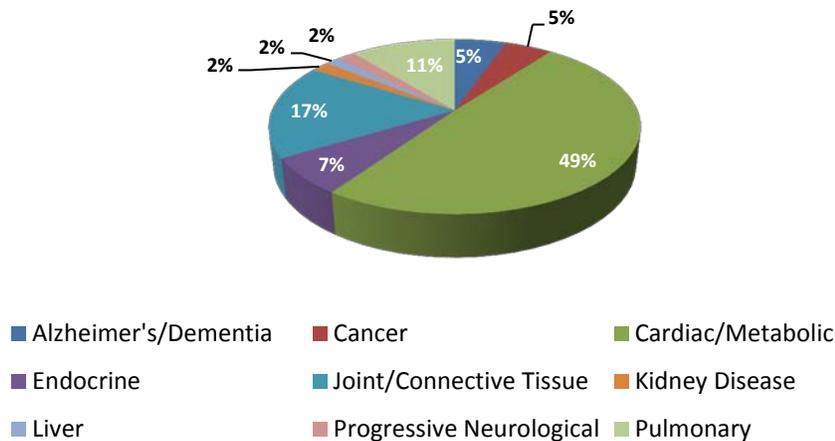
Among persons 18 years of age and older served during the survey week, one-half (50 percent) have cardiac and metabolic illnesses, followed by pulmonary illnesses (17 percent) and joint and connective tissue diseases (13 percent).

**Figure 2.18**  
**Percentage of Adults (Ages 18-64) Served during the Survey Week with at Least One Chronic Medical Condition**



For older adults, the category of cardiac and metabolic disease is the highest, followed by joint and connective tissues and pulmonary disease. Alzheimer’s and dementias, seen most often in people more than 65 years of age, accounted for 5 percent of chronic conditions reported during the survey week.

**Figure 2.19**  
**Percentage of Older Adults (Ages 65+) Served during the Survey Week with at Least One Chronic Medical Condition**



The large presence of co-morbidity amongst individuals served and the types of conditions seen most often in the age cohorts highlight the importance of managing mental health and physical health in a culturally competent manner to improve overall health and well-being.

Data such as these are key to future planning and meeting the needs of New York's most vulnerable citizens in efficient and effective ways and require OMH to sustain and improve data and information resources.

## Strengthening the Planning Infrastructure

### State–County Planning

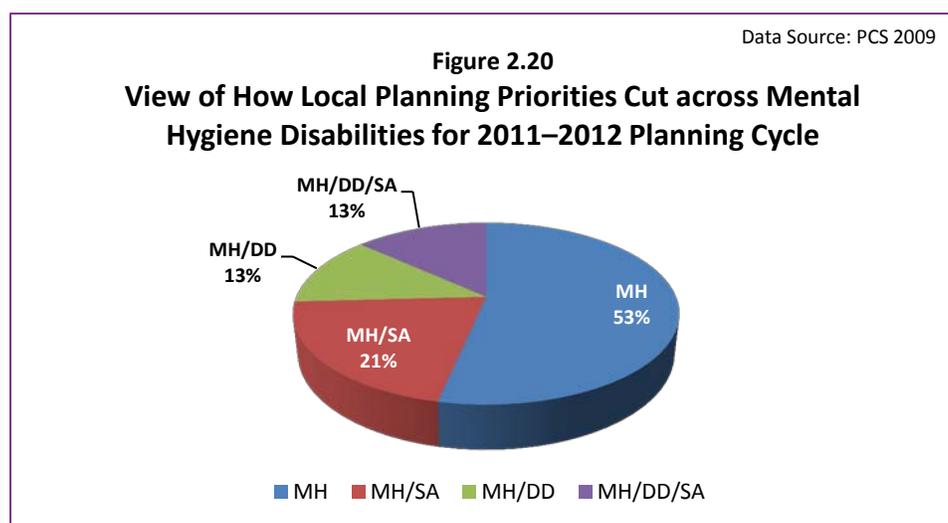
State Mental Hygiene Law requires that OMH as well as its sister agencies, the Office of Alcoholism and Substance Abuses Services (OASAS) and the Office for Persons With Developmental Disabilities (OPWDD), guide and facilitate local planning. It also requires each LGU to develop and annually submit to each mental hygiene agency a local services plan that establishes long-range goals and objectives consistent with statewide goals and objectives. In addition, statewide comprehensive plans are expected to reflect local priorities.

In 2007, the three mental hygiene agencies, in collaboration with the Conference of Local Mental Hygiene Directors (CLMHD), established the Mental Hygiene Planning Committee to strengthen planning efforts between the State and localities. Before the Committee formed, each agency conducted its own local planning process, followed its own timetable, and established its own planning requirements for the LGUs. At the county level, planning for each disability was often conducted independent of the other disabilities.

As a result of the Mental Hygiene Committee's work, counties today enjoy a more integrated mental hygiene local planning process. The Committee, which is formally a subcommittee of the Inter-Office Coordinating Council, instituted an annual planning calendar that aligns local services planning with State planning and budgeting processes. Annually, it creates and refines integrated cross-agency planning documentation. This documentation is stored in an online County Planning System (CPS) hosted by OASAS, with support from OMH and OPWDD. Many of the improvements to the local planning process, plan guidelines, and CPS result from county and service provider collaboration and input.

First developed and piloted by OASAS in 2004, the CPS was redesigned and implemented statewide the following year. CPS quickly became an innovative, state-of-the-art platform from which counties documented needs assessment and planning activities, completed required planning forms, and

submitted online their entire chemical dependency plans to OASAS. In 2007, OMH utilized CPS on a pilot basis for gathering mental health priorities and in 2008 fully integrated their local



planning requirements into CPS. OPWDD followed suit, making CPS a tool for comprehensive mental hygiene local services planning. Rather than submitting three separate plans, each county now submits a single integrated mental hygiene local services plan to all three State agencies at once.

An important achievement of the integrated planning process has been the ability to identify local planning priorities that cut across the three disability areas. Figure 2.20 highlights the breakdown of mental health and cross-disability priorities for the current planning cycle. As shown, 47 percent of priorities cut across two or more disability areas, up from 43 percent last year. This suggests that the integrated planning process and CPS continue to foster more coordinated and focused planning across multiple systems of care. (More findings from this year's local planning activities are presented in Chapter 5.)

### **State and Local Data-Informed Decision Making**

In 2010, OMH introduced its County Mental Health Profiles portal online to facilitate local planning. The portal is the result of an ongoing collaboration between the OMH Offices of Information Technology, Performance Management/Evaluation and Planning with CLMHD and Mental Hygiene Planning Committee members. The portal aims to aid county planners in identifying mental health service gaps and disparities and in using the data provided to improve the quality of service delivery. The portal reports consolidate utilization, services need, and expenditure data from an array of OMH and non-OMH data systems. These reports present content in a standard format that enables planners to make comparison across agencies and between consumer cohorts. Sections of the portal include:

- ***Medication Utilization – Mental Health Services***  
The reports on this page provide summary information on Medicaid mental health services utilization and expenditures for Local Fiscal Years, beginning in 2007 for adults and 2010 for children and updated yearly thereafter. Program totals are based on date of service. Because data are refreshed on a monthly basis, values in the same report may change over time. Prepaid Mental Health Plan (PMHP) data are included in these reports as recovery services (RS). Medicaid managed care capitation payment data, however, are not included. Expenditures include comprehensive outpatient program services (COPS) and community support program (CSP) add-on payments, where applicable.
- ***Medicaid Utilization – All Medicaid Services***  
These statewide and County-level reports offer an OMH perspective of Medicaid service utilization and expenditures for mental health and other Medicaid services (e.g., alcohol and substance abuse, pharmacy, general health, long-term care) based on reimbursement claims paid by the Medicaid fee-for-service billing system to OMH-licensed providers for services delivered in a State Fiscal Year (SFY), i.e. from April 1, 2008 to March 31, 2009, labeled SFY 2009. A similar report is available from OASAS. In addition to aggregate data on mental health inpatient, outpatient and residential service utilization, the profile report aggregates data by the county of fiscal responsibility and by the county where services are provided.

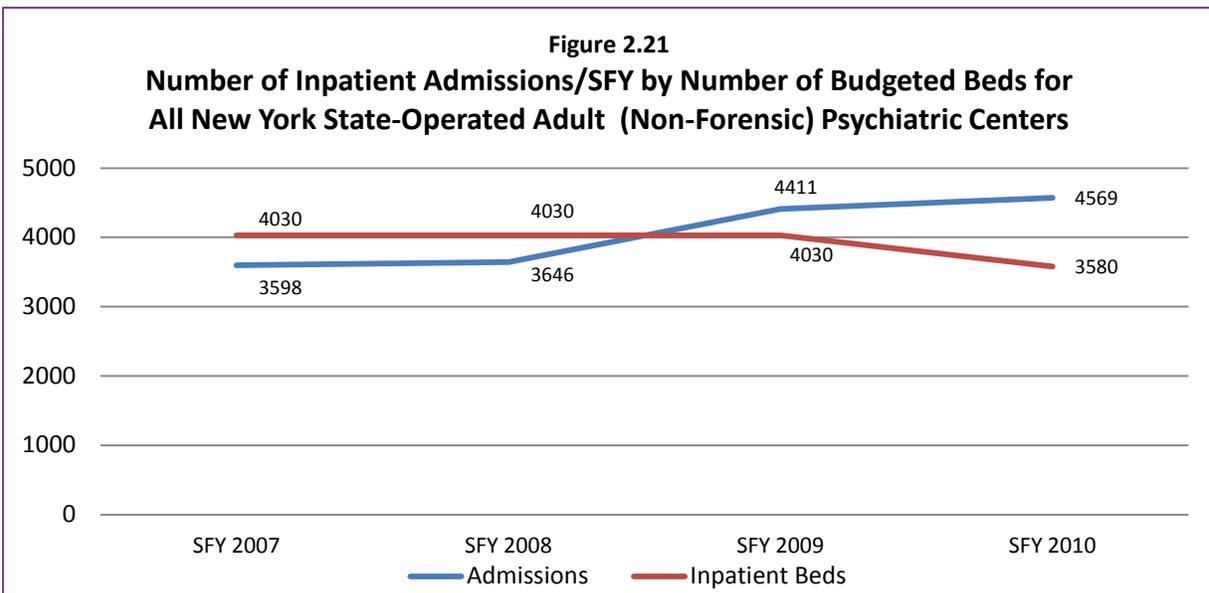
- **Dashboard**

The Dashboard includes summary reports focused on key County community characteristics, mental health services, expenditures, and outcomes. The reports provide quick, at-a-glance views and offer comparative statewide statistics in a number of relevant domains (e.g., community characteristics, service use, inpatient readmission rates, wellness and community integration). Each domain tab brings you to an individual report that displays summary data and, for most, a corresponding chart. The time frame for data is displayed.

- **Managed Care Reports**

With the changing health care system and movement to managed care arrangements, OMH has added its first report that specifies for each county managed care enrollment and penetration rates.

With ongoing data infrastructure development, OMH continues to monitor services across time, as well as provider outcomes to enable performance assessment and quality improvements in critical areas such as admissions and readmissions to inpatient psychiatric hospital care. Since 2008, for example, OMH has focused on improving efficiency and productivity within its adult psychiatric hospitals (not including forensic hospitals) by increasing access to acute inpatient care. During state fiscal year (SFY) 2009, OMH adult psychiatric hospitals admitted 4,411 individuals into 4,030 beds (Figure 2.21). The SFY 2009 admissions included 765 more admissions than the prior year and represent an increase of 19 percent in admissions per inpatient bed over SFY 2008.



The trend continued in SFY 2010 when 4,569 individuals were admitted into 3,580 beds. The SFY 2010 admissions included 158 more than in the prior year and represent an increase of 19 percent in admissions per inpatient bed over SFY 2009. Overall, between 2008 and 2010 the number of beds in OMH adult psychiatric hospitals has declined by 11 percent (N=450),

while the number of admissions per budgeted bed increased 38 percent. This gain in admissions occurred with no significant change in readmission rates (as illustrated in Figure 2.22), reflecting increased productivity and efficiency in hospital operations.

Discharge Year	Cumulative Readmission Rate by Days after Discharge						
	7 Days	14 Days	21 Days	30 Days	60 Days	90 Days	180 Days
SFY 07	3%	6%	8%	12%	18%	23%	31%
SFY 08	2%	6%	9%	11%	18%	22%	32%
SFY 09	3%	7%	10%	13%	20%	24%	35%
SFY 10	3%	6%	9%	12%	19%	23%	31%
<b>SFY 07–10</b> <b>Change</b>	0%	0%	1%	0%	1%	0%	0%

The role of performance measurement, monitoring, and quality improvement initiatives remains crucial as the system of care moves toward the introduction of behavioral managed care (e.g., regional behavioral health organizations (BHOs) and, later, health homes) under the leadership of Governor Cuomo and the Medicaid Redesign Team.

During the first phase of preparing for managed care, BHOs will be charged with employing data to monitor psychiatric inpatient lengths of stay, reducing unnecessary inpatient hospital days and readmission rates; improving rates of engagement in outpatient treatment following discharge; better understanding clinical conditions of children diagnosed as having a serious emotional disturbance; and profiling provider performance. Data will play a central role in assessing the strength of discharge planning and successful community living after hospitalization.<sup>22</sup>

Region	Admissions		Length of Stay			
	# of Persons	# of Admissions	Mean	Lower Quartile	Median	Upper Quartile
Western	3,480	4,922	11.4	4	7	13
Central	2,289	3,349	8.6	3	6	10
Hudson River	5,101	7,135	17.5	5	10	20
New York City	14,954	23,237	20.1	6	13	22
Long Island	3,328	4,870	22.5	7	12	23
<b>Statewide</b>	<b>28,047</b>	<b>43,514</b>	<b>18.0</b>	<b>5</b>	<b>11</b>	<b>20</b>

For the very small number of admissions that had not resulted in discharge by 6/30/2010, length of stay was computed as if discharge occurred on 6/30/2010. The number of persons admitted is an unduplicated count of persons admitted in calendar year 2009.

Figure 2.23 exemplifies baseline admission and length of stay data from the OMH Medicaid data warehouse, which has been made available to the regional BHOs and will serve as a basis for such analyses. As the data show, for calendar year 2000, there is a moderate degree of regional variation in admissions and lengths of stay for adults and children covered by Medicaid and admitted to non-OMH-operated hospitals during calendar year 2009.

The data underscore the importance by BHOs to account for those factors that explain regional and local variations and to foster the development of strategies tailored to the needs of people, particularly those with the most complex conditions, to support such persons in recovery and successful community living.

## **Data-Informed Decision Making**

In an environment of fiscal stress and budget reductions, and where it is complex to sustain the financing, operation and maintenance of behavioral prevention, treatment and supports, OMH relies upon data to sustain the safety net of mental health treatment services for New York's most vulnerable citizens and to promote public safety and well-being.

It provides data resources additional to the ones already described in the chapter that are essential to the ongoing planning, delivery, monitoring and evaluation of care. Links to other data resources appear on the [Statistics and Reports](#) page of the OMH website. There you can find portals that offer information and statistical data on housing; ACT; assisted outpatient treatment (AOT); children, teen and family indicators; consumer assessment of care; and the balanced scorecard.

Over the last year, in particular, the balanced scorecard has helped to highlight progress toward achieving priorities. The scorecard uses up-to-date quantitative data to compare actual performance against specific measurable targets. Content areas include outcomes experienced by individuals served in the NYS public mental health system, results of public mental health efforts undertaken by OMH, and critical indicators of organizational performance.

An example of how the scorecard helps to reflect the quality of care is in the area of restraint and seclusion. As described in a previous Statewide Plan, the Positive Alternatives to Restraint and Seclusion (PARS) initiative, led by the OMH Office of Quality Management, occurred over three years with federal funding and focused on a set of core strategies for reducing the use of restraint and seclusion: commitment of leadership to organizational change; use of data to inform practice; workforce development; use of seclusion and restraint reduction tools; involvement of consumers in the planning development and implementation of programming; and post-event debriefing techniques.

While the formal initiative has ended, the work of reducing restraint and seclusion continues. The balanced scorecard helps to maintain attention to transforming the system of care to one that is free of coercion and violence and one where the goal is to reduce and eventually eliminate the use of restraint and seclusion in the State public mental health system. It provides quarterly reports of restraint and seclusion in adult, children's and forensic settings. OMH and stakeholders regularly monitor progress toward the goal of eliminating restraint and seclusion.

It is only through such efforts that we can obtain the best outcomes possible. As OMH continues to provide inpatient and residential services and moves toward implementing BHOs and behavioral health homes, its data resources will play a pivotal role in the comprehensive monitoring and management of the delivery of care and the operations of the behavioral system of care at the State and regional levels.

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<sup>1</sup> OMH derives its estimates of the number of people served annually by the public mental health system from its PCS using a population-based approach based on the 2008 U.S. Census data. The PCS gathers information about the demographic and clinical characteristics of persons receiving mental health services in programs operated, funded, or certified by OMH during a one-week period. The one-week data are then used to estimate the total number of people served annually and their characteristics. OMH uses estimates rather than actual counts because the variety of administrative data systems does not allow a complete enumeration across all service sectors of the number of persons served.

<sup>2</sup> Using the methodology described in the first footnote, an estimated 695,162 persons (95 percent confidence interval of 629,712 to 773,559) were served in the public mental health system in 2009. .

<sup>3</sup> Services provided in New York's public mental health system are those delivered by programs funded, certified or operated by OMH. They do not include mental health services provided by private practitioners or by programs operated by other State agencies.

<sup>4</sup> Adults with serious mental illness are persons ages 18 or older who currently have, or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-RE) and the diagnosable disorder must result in functional impairment that substantially interferes with or limits one or more major life activities. Children with serious emotional disturbance are persons ages 17 or younger who currently have, or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV-TR and the diagnosable disorder must result in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

<sup>5</sup> OMH regions are include **Western**: Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, and Yates; **Central**: Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, and St. Lawrence; **Hudson River**: Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, and Westchester; **Long Island**: Nassau and Suffolk; and **New York City**: Bronx, Kings, New York, Queens, and Richmond.

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<sup>8</sup> U.S. Department of Health and Human Services. (2008, July 8). *Mental health 101*. Rockville, MD: Office of Minority Health. Available online at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=81> .

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- <sup>17</sup> World Health Organization's *Global Burden of Disease Statistics*. Available online at [http://www.who.int/healthinfo/global\\_burden\\_disease/en/index.htm](http://www.who.int/healthinfo/global_burden_disease/en/index.htm) .
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# Local Governmental Unit and Stakeholder Input for Behavioral Health Care Redesign

A major goal of this year's Plan was to seek broad input from local governmental units (LGUs) and stakeholders for consideration in the redesign of Medicaid health care and for maintenance of other critical features of the public mental health system (e.g., unique needs of children and families, of people who do not have health insurance). From March–September, the Office of Planning gathered this input from a number of perspectives:

- Annual LGU mental hygiene plans
- Policy analysis of LGU responses to a set of questions addressing Medicaid redesign, spending and government Efficiency (SAGE), and mandate relief
- Recommendations to Commissioners Hogan and González-Sánchez from the Conference of Local Mental Hygiene Directors (CLMHD)
- Recommendations from the New York City (NYC) Department of Health and Mental Hygiene's (DOHMH) Bureau of Mental Health
- Meetings with individuals and family representatives who are engaged or were previously engaged in receiving services, including notes taken by OMH at the DOHMH's annual hearing held by the Bureau of Mental Health
- Meetings with mental health advocacy groups
- Yearly public hearing and dialogue with the Commissioner and comments and hearing testimony submitted

This chapter offers summaries of data and information gathered. (Detailed reports make up Appendices 2–9). As with previous Statewide Plans, the information was mapped, where possible, to the OMH Strategic Framework domains as follows:

## 1. **People First**

Respect individuality by demonstrating hope and positive expectations, a belief in recovery, and regard for diversity.

## 2. **Person-Centered Decision Making**

Provide supports and treatment based on self-defined needs, while enhancing personal strengths.

**3. Basic Needs Are Met**

Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.

**4. Relationships**

Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.

**5. Living a Healthy Life**

Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.

**6. Mental Health Treatment and Supports**

Foster access to treatment and supports that enable people to lead satisfying lives in their communities.

**7. Self-Help, Peer Support, Empowerment**

Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.

**8. Mental Health System of Care, Workforce and Accountability**

Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.

## Annual Plan Priorities of LGUs

This year, 60 of 62 (96.8 percent) counties submitted and certified their priorities in time for analysis in the online County Planning System (CPS). The majority of the 120 priorities (64, 53.3 percent) relate to mental health. Co-occurring mental health and substance abuse priorities account for 20 percent, while co-occurring mental health and developmental priorities total 13.3 percent. In all there were also 13.3 percent of priorities that crossed all three disability areas. The distribution is similar to previous years, where cross-systems, comprehensive, integrated person-centered services and supports are designated by counties as essential to effective service provision.

Across the State, priorities fall largely into Domain 6, Mental Health Treatment and Supports, with (56, 46.6 percent), rising 3.3 percent since last year. Also rising slightly from a year ago is the number of priorities focused on Basic Needs (Domain 3), largely the need for housing with supports to promote successful community living. Compared to 19.8 percent last year, Basic Needs priorities are at 22.5 percent. Priorities related to the System of Care, Workforce and Accountability (Domain 8) ranked third at 14.2% and reflect ongoing concern with fiscal viability of community programs and other effects of regulatory reform.

Overall, the data appear to indicate the crucial role counties play in overseeing, operating, managing and evaluating resources and resource needs in a time of serious fiscal constraint. Counties are striving to ensure quality mental health treatment and supports with no new monies, while at the same time responding to a changing service system, including

implementation of clinic restructuring and reforms being introduced in preparation for Medicaid managed care. While top-two priorities largely fall into the three domains described here, counties are clearly committed to the goals described in the other domains (e.g., person-first, recovery-oriented services and supports, peer support), thereby enabling adults, children and families to live productively in their communities. Features that describe the nature of top priorities by OMH region are included in Appendix 2.

## **Policy Analysis of LGU Responses to Questions on Medicaid Redesign, Spending and Government Efficiency (SAGE) and Integrated Mental Hygiene**

Last year this year also, the interagency Mental Hygiene Planning Committee asked LGUs to respond to policy concerns in relation to changes under way at the local level. The Policy and Planning Activities Report section of this year's mental hygiene planning cycle, therefore, provided localities with the opportunity to weigh in on substantive policy and planning issues affecting the mental hygiene disability areas at the State and local levels. In all, 36 counties responded fully or partially to questions 2 (Medicaid redesign), 3 (mandate relief) and 4 (integration of mental hygiene services) on the Planning Activities Report. Responses were considered by region within the same geographic framework being used for the creation of the regional behavioral health organizations (BHOs).

Counties answered any or all parts of the three survey questions. Eighty percent of all responses came from counties in the Central and Western New York regions. Question 4 drew the highest number of responses, reflecting in part the emphasis on integrated planning across the three mental hygiene agencies and impending changes under Medicaid redesign. Of note, NYC, which comprises the five boroughs (counties) of the NYC Region, did not respond to any of the survey questions.

As indicated in Appendix 3, most of the concerns related to the planning, financing, delivery and evaluation of mental hygiene services centered primarily on mental health/chemical dependencies (defined under Medicaid redesign as "behavioral health") and physical health. Counties uniformly pointed out ways they wished to see tighter integration between the mental health and substance abuse systems of care and provided numerous recommendations for reducing regulatory and statutory barriers to effective care. Counties also highlighted areas where improved coordination and integration of care could occur between mental health and developmental disabilities.

Broadly, counties across the state offered recommendations on the movement toward Medicaid managed care and ultimately toward the provision of the most effective services, while reducing costs and making the best investment of Medicaid funding. These priorities include:

- Implementing the integration of chemical dependence and mental health services and ultimately integrating behavioral health services with physical health services and related supports for successful community living

- Incorporating case management services and care management for people with complex conditions, while strengthening community linkages along the recovery continuum of care to reduce unnecessary inpatient care and detoxification admissions, as well as readmissions, among Medicaid beneficiaries who are identified as “high use/high cost”
- Providing integrated physical and behavioral health care based on the values of person-centered, recovery-oriented care, and utilizing models of co-located care that help to reduce stigma and improve the outcomes of care
- Engaging with the State agencies to identify areas for regulatory and statutory relief, enabling better alignment between the goals of Medicaid redesign and the on-the-ground operations (e.g., billing models that incentivize integrated care rather than contribute to siloed care) as well as fostering implementation of integrated services and care management with the least administrative and clinical burden
- Implementing electronic medical records and having access to robust Medicaid data to better manage the care of Medicaid beneficiaries with the most serious and complex conditions, monitoring outcomes of care, identifying people who may need treatment but have been lost to care so providers may reach out and engage them in care, and examining indicators of overall system of care performance
- Having the ability to access flexible funding to provide critical support services (e.g., peer, housing, employment) not funded under Medicaid but proven by science to be essential to successful community life for individuals with serious behavioral conditions

Appendix 3, which offers a qualitative review of regional concerns, sheds light on variation across regions as well as differing geographic features of counties (e.g., rural vs. urban).

## **Recommendations to Commissioners Hogan and González-Sánchez from the CLMHD**

In May 2011, CLMHD advanced a set of recommendations for modifying the roles of stakeholders, including providers, consumers, and the LGU. It noted the current LGU’s responsibility for managing the local system for all consumers—not just those enrolled in Medicaid—and the need to institute new and enhanced core functions and responsibilities in a regional behavioral healthcare organization (RBHO) and managed care environment.

CLMHD outlined a framework for the core functions and responsibilities of the LGU in advising and monitoring the impact of care management arrangements for the system and consumers with mental illness and substance abuse disorders and families during Phase I.

The role of the LGU is pivotal in determining the impact of statewide policy decisions and managed care operations on local systems of care. The core functions and responsibilities of the LGU in a BHO/managed care environment are anchored in Article 41 of Mental Hygiene

Law, which vests in the LGU the responsibility to develop plans to meet the needs of people diagnosed with mental illness and alcohol or substance use/abuse conditions. The statutory role of the LGU makes it an important change agent in the role of moving each county toward Medicaid managed care arrangements (e.g., planning for the needs of all residents, not just those receiving Medicaid services, ensuring a continuum of care to meet residents' needs, facilitating court-ordered services, and financing services).

Given its role in statute, CLMHD offered a series of recommendations to ensure full participation by LGUs in developing, monitoring, and governing BHOs. Specifically, for Phase 1 of BHO implementation, CLMHD calls for LGUs to be:

- Participating in defining key elements of redesign, including advice on benefit plan, development of networks that ensure a comprehensive, responsive, recovery-oriented behavioral health care for members
- Monitoring quality for impacts of change on the entire local system of care (e.g., non-Medicaid recipients) and on member services (e.g., monitoring access to care, provider choice, member satisfaction)

More details associated with the CLMHD recommendations, including suggestions for steering committee oversight, are available in Appendix 4.

## **Recommendations from the New York City Department of Health and Mental Hygiene's Bureau of Mental Health Services**

In August, the Bureau of Mental Health Services provided a written response to questions posed by OMH for stakeholders and LGUs to consider in preparation for its yearly public hearing (see Appendix 5).

It offered suggestions for the Phase 1 of BHO implementation and urged that this period be used to obtain an accurate picture of the regional inpatient behavioral health services utilization and the quality of care coordination taking place for people with behavioral disorders. It noted that BHOs will be well positioned to inform the State and LGUs about service gaps and unmet needs that are contributing to readmissions and multiple emergency health services utilizations. Through information sharing and data exchange, BHOs will also have the ability to keep everyone abreast of opportunities for improvement and lessons learned.

The Bureau urged that the Behavioral Health Subcommittee of the MRT prioritize essential recovery-oriented elements, including health information technology (HIT) to serve as a “lynchpin of integrated care delivery”; the integration of peer supports into health care delivery, with a set ratio of peers to consumers to ensure access; integration of care for dual disorders; and establishment of quality health home operational standards and guidelines.

Truly integrated care will evolve from attention to positive outcomes achieved through basic screening/prevention and well-coordinated referrals, improved collaboration among primary and specialty providers, effective care management that enables people to link to

providers best able to meet their overall health needs, improve communication among care providers, and staff cross-trained at all levels of primary and specialty care, particularly for mental health screening and chronic disease indicators.

Care management networks should provide consumers with behavioral health conditions seamless access to physical health services and/or rehabilitative services (e.g., education, employment, housing, social service benefits) or well-connected access to such services. HIT, it adds, should be an essential component of integrated care, with built-in care planning functions that foster holistic health care.

All of these components should be supported by guidelines for the implementation of recovery and resiliency practices at the systems level such as the inclusion of peer-run agencies in services provision and support for community integration, for example, through social, employment and educational opportunities. Additionally such guidelines should include the promotions of prevention and wellness strategies such as advance directives, alternative approaches (e.g., peer respite to avoid hospitalization) that show promise in helping people manage their conditions.

At the program level, the Bureau urges the development of recovery-oriented performance indicators to monitor individual and program outcomes, and recovery-oriented program evaluation. It calls for holding programs accountable for producing positive outcomes. Importantly, it notes, programs must provide services in culturally and linguistically competent ways from promoting wellness, to addressing trauma, economic-self-sufficiency and self-agency.

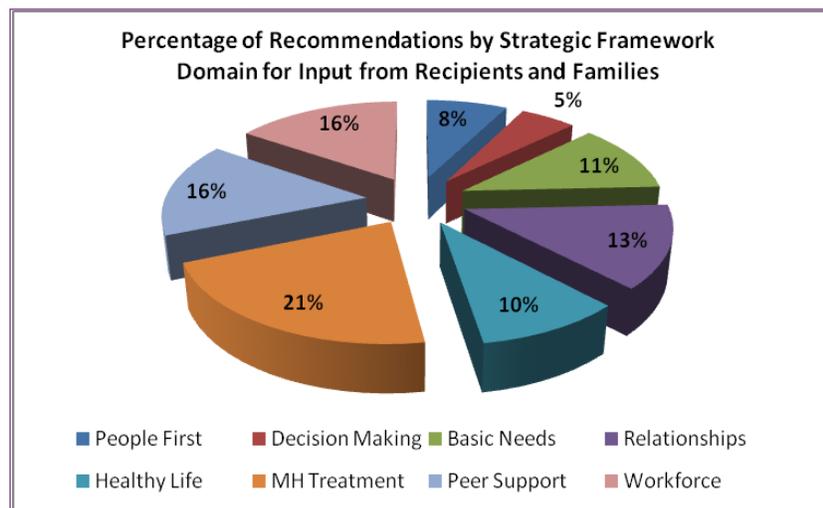
To ensure a well-prepared work force for care management, the Bureau calls for certification of the peer specialist role in NYS, the creation of professional education guidelines to ensure recovery education, and include tenets of recovery, integrated care and evidence-based practices in such guidelines.

## Recommendations from Recipients and Families Who Are or Were Previously Engaged in Mental Health Services and from Recipients Hospitalized in Forensic Psychiatric Centers

### Recommendations from Recipients and Families Who Are or Were Previously Engaged in Mental Health Services

As illustrated in Figure 1, among the recommendations from recipients and families, the highest percentage occurred in the domain of mental health treatment and support, followed by the domains of peer support and workforce/ system/ accountability issues. Common themes in these three areas include:

**Figure 1. Percentage of Recommendations by Framework Domain**



#### ***Mental Health Treatment and Supports***

Overall, there appears to be a sense that the health home option provides new opportunities for recreating community mental health treatment and support so that physical and behavioral health care are well integrated and reduce the stigma and discrimination associated with mental health care. Essentially recipients and families urge health home environments that are welcoming and staffed with individuals, including peers, who “love working with people who are dealing with serious mental health conditions.” Health homes need to “attract providers to their network who truly believe in and have a demonstrated commitment to recovery and wellness.” They should employ physician assistants and nurse practitioners as much as possible because “they take time to listen” and they assume with ease the role of coaching people to reach their wellness goals.

Part of a health home’s role is to be attractive and “hip” to people who are leaving inpatient care, thereby having a greater degree of success in engaging people in care and connecting to community supports when indicated. They should foster self-direction, enable people to determine approaches that enable them to be healthy, and never force treatment.

Health homes should “match the level of care to a person’s needs” and identify recovery-oriented, culturally competent approaches that promote rehabilitation following hospitalization (e.g., peer visiting, crisis diversion). Care should be comprehensive and tailored to clinical need (e.g., expertise in trauma-informed care, warm lines, community crisis response, management of metabolic disorders) and informed by close connections to the community (e.g., use peers to train first responders and law enforcement personnel in empathy and strategies for maintaining

calm). Health homes should aid in building collegiality among public and private network providers and community agencies, rely upon health information technology to strengthen communications between providers and strive for well-integrated care.

Health homes should work closely with inpatient providers to have robust discharge planning that avoid unnecessary readmissions by taking each person's needs into account (e.g., Has social security paperwork started? Have connections to peer services been made? Where will the person be living?) Moreover, health homes should support efforts to reverse a culture of dependency created by hospitalization by embracing peer services and fostering each person's confidence and strengths.

Health homes should also prioritize care for special populations (older adults, people being released from jails) by building on resources available across the State (e.g., mental health courts, geriatric demonstration projects, programs that help to modify living environments for older adults).

Primary care, behavioral care, and other specialty providers all require training to understand the roles and responsibilities, and promote mutual respect for the strengths and contributions that each member brings to the health home team. Professional and ancillary staff will likely require education about the role peers play in promoting health and well-being and help them to incorporate peers and their expertise into integrated health teams (e.g., treating peers as members of the team who bring peer expertise and knowledge, not as "patients."). Another area of education for health home teams will be in increasing sensitivity and knowledge about cultural groups in network communities, to ensure that beliefs and values are seen within the context of culture rather than misinterpreted as signs and symptoms of mental health challenges.

While children will not be enrolled into health homes during the transitional Phase 1, health homes serving children and families already enrolled should provide care based in the values of the Child and Adolescent Services System Program (CASSP) and the NYS Children's Plan and assure essential community and family support services for children and their families, including case management, school-based clinic services, mobile services, crisis management and outpatient treatment.

### ***Self-help, Peer Support, and Empowerment***

There was widespread support for incorporating authentic peer support and peer-run services into BHOs and health homes, where peers are not employees of, but rather providers of services via contracts with health homes. There is an expectation that health homes will have an adequate array of peer support services as part of the services mix. Recipients also voiced that peer support training should be standard and include certification and that peer services be a billable rehabilitation service under Medicaid.

Peer services are urged at every point in the care continuum, from early on when behavioral challenges are identified, to avert the need for emergency department services, to assist treatment planning, and to provide bridge services and ongoing community support following discharge from the hospital. Recipients and family members expressed widespread agreement that peer services are vital in emergency departments. They asked that individuals

seeking psychiatric emergency intervention be offered the opportunity to talk with a peer while awaiting professional psychiatric assessment, ensuring that people in crisis are not isolated and alone with their thoughts and feelings. There was strong support for making peer support a standard of emergency psychiatric care and for helping people to head off crises using peer respite, peer empowerment centers, and warm lines. In NYC, recipients requested a 24/7 peer warm line for empathic, cost-effective support. Mobile peer services should also be provided in the community, and include outreach, engagement, and responsiveness to individual need (e.g., for people isolated due to behavioral conditions).

Health homes should also rely upon peers to mentor people in care, helping them to find their strengths, manage symptoms, and gain stability in community living (e.g., support employment goals, connect to natural community supports, benefits counseling). Recipients underscored the value of contracting with peer providers, noting that their presence conveys the powerful message that recovery is possible and gives hope to people who would otherwise not have it.

### ***Mental Health System of Care, Workforce and Accountability***

Recommendations strongly endorsed the need to help recipients and families understand features of BHOs, health homes and educate them about the choices they may need to consider during Phase 1 of BHO and health home implementation. Recipients asked for clear direction and access to information about whether to enroll in a managed care plan or continue to receive Medicaid on a fee-for-service basis. As implementation occurs, people who receive or have received services and their families should be engaged in identifying recovery outcome measures and the use of valid and reliable measures of primary and behavioral health care as well as data to identify gaps in services and quality health care.

Provider education is another area with a number of recommendations from recipients and providers. A primary focus of provide education should be on changing the culture of care from one focused on what is wrong with an individual to one that seeks from individuals their personal stories that tell what happened to them. Sharpening the engagement skills of physicians will be crucial to achieving positive outcomes for people with behavioral challenges. Cross-training of primary and specialty care providers, increasing their knowledge and understanding of behavioral disorders and recovery approaches, will be key to the success of health homes, recipients also advise.

A number of dimensions of accountability and system of care issues were also addressed by recipients. Most important is the recommendation that people engaged in services and their families must be involved in policy and decision making and included in planning the design of BHO oversight and health home services and supports.

Incentives need to be created for health homes to work with individuals who have the most complex medical and behavioral health conditions and not turn them away from care. Incentives also need to be created to attract psychiatrists and psychiatric nurse practitioners into health homes in more rural and underserved areas of the five OMH regions. Incentives also need to be provided to recipients that promote self-directed health goals (e.g., flexible funding to cover the cost of gym membership, running shoes or a bicycle).

Health information technology needs to be employed, recipients say, to improve communication between primary and behavioral providers, to avoid errors (e.g., medication interactions, alerts to physicians that a medication waiver is needed), to reduce the burdensome paperwork currently used for each provider visit, and to monitor the program and fiscal effects of clinic restructuring and changes under way in the service system (e.g., impact of 30/50 reduction for children with serious emotional disturbance and their families).

More details for these three domain areas as well as detailed re commendations for the other domains appear in Appendix 6.

## **Recommendations from Recipients Hospitalized in OMH Forensic Psychiatric Centers**

In support of integrated care across forensic settings and hospitals, recipients overwhelmingly recommended more family involvement. They urge that facilities hold family days, offer education programs that help family to support wellness of their loved ones (to the degree the recipient desires), and more integrated treatment planning with family members. Moreover, they point out that upon admission to a forensic psychiatric center, families may benefit from education on what to expect and how they can support recovery.

Integrated care, they recommend, may also be achieved by supporting hospitalized inmates to strengthen their skills to cope with stress and chaos in their immediate environment as well as programs to promote wellness, recovery action planning, and work skills development. Recipients also asked for more peer-run programming to increase learning and vocational development opportunities. Of note, recipients urged that their environments be infused with hope, a focus on bringing out each person's strengths, and a staff educated to understand the value of person-centered care and therapeutic support for recovery.

Using non-treatment time productively is of concern to recipients and they made recommendations in a number of areas. They asked for balance between treatment/group time and non-treatment time so they obtain the most therapeutic benefit from treatment and are not "worn down" by nonstop structured treatment or, for people with bipolar disorder, experience symptoms from too much stimulation. They urged that time be provided to maintain physical health (e.g., strength training). They pointed out the chance for wellness through positive non-treatment individual, group and social opportunities such as karaoke, Latin music, movies, lectures on recovery and resiliency, concerts, board games, video games, drumming, and spiritual counseling.

Recipients also pointed out the role of people in recovery in supporting their peers during hospitalization. They emphasized the importance of improving one's community, sharing insights and reinforcing rehabilitation and recovery, aiding people in special housing units through peer support, and helping their peers to reflect upon actions and genuinely make amends.

Recommendations from recipients hospitalized in forensic psychiatric centers also appear in Appendix 6.

## Input from Advisory and Advocacy Groups

Input from advisory and advocacy groups reflects in part the perspective of each group and its priorities. Of note, because of OMH was involved in the procurement for Phase 1 of the implementation of the BHO initiative, the Office of Planning was unable to meet with a number of advocacy groups during the period of restricted communications. Groups were invited to submit feedback in writing during this period.

Given the extensive input received across the Strategic Framework domains, the summary here focuses on treatment and support recommendations for Medicaid redesign. These include:

- Having standards of care rooted in the values of recovery, resiliency and the rights and dignity of individuals and developing within each health home a therapeutic milieu focusing on strengths rather than deficits
- Relying upon the most accepted therapies that are proven or informed by scientific evidence.
- Not losing sight of the treatment and support needs of all New Yorkers diagnosed with mental illness regardless of who pays for services
- Attending to the critical nature of discharge planning and providing bridger services during the transition from hospital to rehabilitation in the community
- Utilizing performance indicators that show outcomes following discharge and for monitoring engagement in treatment and supports (e.g., re-hospitalization rates)
- Ensuring that services provided under BHOs for children, youth and their families are based upon the principles espoused in the Child and Adolescent Service System Program (CASSP) and Children's Plan
- Supporting the development and recognition of family/peer competencies and credentialing that builds on the recognition that peer and family support build trust, improve engagement in treatment, and improve outcomes
- Ensuring that children's services under BHOs respect the principle that children are not little adults, but rather they are individuals who require a much different approach than adults and require the participation of parents and families in treatment and support
- Strengthening the LGU Coordinated Children's Services Initiative (CCSI) infrastructure and provide incentives for the delivery of integrated and coordinated treatment and supports across systems of care
- Increasing mental health courts serving rural areas and diverting people with serious mental health conditions from the criminal justice system
- Working toward the creation of a BHO managed "carve-out plan" that has at its core the integration and improved coordination of behavioral health (mental health and

substance use) treatment services that are linked to appropriate health, housing and social support services

- Ensuring that people who become engaged in behavioral health treatment in health homes have good access to treatment and services when indicated **and** good access to leaving treatment and services when they no longer are necessary (providing the right dose of treatment at the right time)
- Structuring peer services so they are provided through independent peer providers, with expertise in connecting people to appropriate supports and also helping people to connect to medically necessary treatment services
- Fully integrating trauma-informed care into the service array of health homes
- Advocating with the federal government for greater state flexibility in using client-directed services funding (i.e., Money follows the Person) for improved community care
- Having dialogues to reframe safety and risk by drawing upon the work of Mead and relying upon approaches that build on our strengths and not our deficits (e.g. seeking safety through mutually responsible relationships in which people feel safe disclosing discomfort and sharing risk).
- For people at risk for negative consequences of not receiving behavioral treatment, meaningfully engaging them in services without the use of force or coercion

See Appendix 7 to review recommendations across the Strategic Framework domains.

## **Written Public Input Received via the Transformation Mailbox or the Statewide Public Hearing**

In late July, OMH invited the public to provide input into this year's Statewide Comprehensive Plan for Mental Health Services. Stakeholders were encouraged to submit their concerns and recommendations in writing and also to attend the public hearing and dialogue with Commissioner Hogan on September 13.

OMH requested that individuals and organizations across the five OMH regions declare their priorities for our changing health care environment. Specifically, OMH posed the following questions to elicit input:

- As New York moves toward managing mental health and addiction treatment services and increasing integration of behavioral and physical health care, interim regional BHOs will be established beginning in Fall 2011 to facilitate the transition to care management and to improve appropriateness and continuity of inpatient care. What suggestions do you have for this interim period?
- What should OMH and members of the Behavioral Health Subcommittee of the MRT take into account as it considers strategies for integrated, managed behavioral

(mental health and substance abuse) services, for co-locating behavioral services with physical health care, for integrating peer supports, for guiding the development of health homes, and for other innovative approaches to improving the coordination of physical and behavioral health care?

- What do you suggest to ensure truly integrated care? That is, what recommendations do you have to bring physical and behavioral health care together to improve the health and quality of life for people engaged in care?
- What elements would you like to see included—or not included—as part of managed networks of behavioral care, as well as in health homes?
- What suggestions would you offer to move New York closer to evidence based, person-centered, family

What follows is a summary of a number of recommendations from the public hearing and written submissions:

- While the current operating environment is changing and OMH awaits approval of clinic restructuring provisions, the three mental hygiene agencies and Department of Health should articulate how the Medicaid managed care BHO and health home approach all fits together. Reform, for example, is not just for Medicaid, but impacts care for people not receiving Medicaid. Reform efforts must be seen within the context of the entire delivery system and attention must focus on access to care for people lacking health insurance.
- Attention needs to be given to the culture of change; it will take more than “care coordinators” to significantly change the interactions among consumers with multiple co-morbidities, primary care providers, specialists, and hospitals and to achieve the kinds of behavioral changes needed to assure adherence to complex medical regimens.
- Don’t lose the focus on early identification, screening, assessment, and engagement of children and families in clinic care. Look to success among the cohort of clinic plus providers and lessons learned.
- Continue planning to meet the needs of children and their families with more interagency planning, particularly the roles played by other child-serving systems, including education, child welfare, and juvenile justice, which are not funded by Medicaid dollars.
- Ensure that new payment models respect the independent nature of family-run peer-to-peer, family support and compensate these programs, which are as important as the traditional “medical” model services.
- Provide a child in crisis or in need of hospital care with a friendly, peaceful, and caring facility, where the child can be monitored while the proper medications are found and the family can readily be close by and aid recovery.

- Ensure that health services to homebound individuals are addressed under reform so that their needs are adequately met.
- Build in peer services to the contracting process and include peer-led support and education programs, including wellness management and health coaching, in health homes now and as part of NYC special needs plans when they are established in two years.
- Maximize the integration of primary and behavioral health care by (1) educating primary care physicians and other network providers about mental illness; (2) training primary medical staff to care for people with mental illness (e.g., working effectively with people who have behavioral disorders, avoiding relapses, managing medications); and (3) improving access to medical information through electronic medical records at all points of care.
- Prepare the workforce to value and bring its behavioral health expertise to the primary care environment.
- Improve the integration of mental health and substance abuse care so providers do not just talk about providing such care, but actually do address both mental health and substance abuse needs comprehensively and holistically.
- Ensure that services are culturally and linguistically competent.
- Look to proven programs such as Compeer to meet the social need for friendship using the needs of individuals.
- Ensure that gaps in care for youth in transition to adulthood with serious emotional challenges are addressed.
- Continue to work with other State agencies to leverage resources that lead to housing opportunities for people with serious behavioral disorders and particularly to address the need for diversion and crisis housing.
- Look to lessons learned in other managed care systems and adopt those that fit well with providing integrated care (e.g., call center to triage care, folding primary care practices in mental health, developing a network of preferred provider hospitals, incorporating behavioral billing codes into primary care settings, using the Patient Health Questionnaire-9 (PHQ-9) to measure symptoms over time).
- Base clinical interventions on the best scientific evidence (e.g., treating first episodes of psychosis with safe, caring environments, ongoing coaching, careful medication management) and continue research efforts that help to narrow the gap between science and practice.
- Reduce the regulatory burdens that impede the ability of providers to work collaboratively.

Appendix 8 provides a full overview of recommendations received from the public via the OMH mailbox and the yearly public hearing.

## **Behavioral Health Care Recommendations from the Medicaid Redesign Public Hearings**

The MRT, created by Governor Andrew M. Cuomo, conducted a comprehensive examination of New York's Medicaid system, holding six regional public hearings in January and February of 2011. The hearings were designed to solicit suggestions from the public and stakeholders on ways to eliminate waste and inefficiency while improving quality in the Medicaid program. The Medicaid Redesign Team invited public input directly in writing, via the web site, or during these hearings. The Team received more than 800 recommendations, a number specific to mental health and behavioral care.

Suggestions and recommendations related to behavioral health care were elicited as part of the public hearing process. Across all regions, these recommendations organized into the following content areas: care coordination, service quality, service access, reimbursement setting and rates, and oversight and regulatory reform.

Overall, many of the recommendations offered in February have become more developed over time by stakeholders, as evidenced by the preceding summaries. Importantly, however, what came through in the recommendations is the importance of preserving the safety net for the State's most vulnerable citizens in a culturally and linguistically competent manner, ensuring that regions of the State have flexibility for designing BHOs that reflect local need, and learning from the lessons of other states that have experience with redesign of integrated Medicaid and other behavioral health services.

Appendix 9 provides behavioral health recommendations gleaned from the MRT public hearings.

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# Phase II MRT Work Groups and Summary of Charges

As of September 28, 2011

## Affordable Housing

- Develop a statewide plan for increasing access to affordable housing, so that New York State Medicaid beneficiaries are not forced into institutional settings because they cannot access affordable housing. The plan should:
  - Be multiyear and identify options for financing the construction
  - Provide input regarding assisted living redesign
  - Be related to MRT recommendation # 196, Supportive Housing Initiative
  - Be created in consultation with New York City and other governments

## Basic Benefit Review

- Examine current covered benefits under State Medicaid and current co-payment, coinsurance and premium levels.
- Examine cost-effectiveness research and value-based benefit design initiatives to glean lessons learned.
- Recommend modifications to Medicaid benefit package and cost-sharing policies for improved health care quality lower program costs.
- Recommend strategies for monitoring the impact of budgetary changes on access to care and services.

## Behavioral Health Reform

- Consider integrated substance abuse and mental health services, as well as the integration of these services with physical health care services, through 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 BHOs.
- Provide guidance about health homes and propose other innovations that lead to improved coordination of care between physical and mental health services.

## **Health Disparities**

- Advise the Department of Health (DOH) on initiatives, including establishment of reimbursement rates, to support providers in offering culturally competent care and addressing health disparities.
- Advise DOH on interpretation and translation services for patients with limited English proficiency/hearing impaired.
- Address health disparities among people with disabilities, including people with psychiatric disabilities and substance use disorders, and their need for equal access to primary and preventive health care services.
- Explore issues related to charity care and the uninsured.

## **Health Systems Redesign: Brooklyn**

- Assess the strengths and weaknesses of Brooklyn hospitals and their future viability.
- Make recommendations in support of a high quality, financially secure and sustainable health system in Brooklyn.

## **Managed Long-Term Care Implementation and Waiver Redesign**

- Advise DOH on the development of care coordination models to be used in the mandatory enrollment of persons in need of community-based long-term care services.
- Ensure sufficient patient protections and promulgate network development guidelines so contractual benefit package services are sufficient to ensure the availability, accessibility and continuity of services.
- Examine ways to promote access to services and supports in homes and communities so individuals may avoid nursing home placement and hospital stays.

## **Payment Reform and Quality Measurement**

- Develop a series of payment reform and quality measurement recommendations to facilitate health care transformation consistent with, to the extent practicable, reform imperatives of both the MRT Phase 1 work and the Patient Protection and Affordable Care Act.
- Recommend ways the State can encourage innovative payment and delivery models, including accountable care organizations, bundling, gain sharing, clinical integration, and other shared savings and/or risk-sharing arrangements.
- Explore and identify evidence-based quality indicators to benchmark the State Medicaid program and the provider delivery system.
- Explore State disproportionate share program issues and indigent care funding mechanisms in compliance with federal law and Health and Human Services/Centers

- for Medicare and Medicaid Services (HHS/CMS) requirements; recommend needed work to ensure long-term viability.
- Consider criteria that can be used to identify "safety net" providers, and the implications of such a designation on local planning, financing, care delivery and oversight.
  - Assess the implications of other MRT work group deliberations on payment for workforce education, including graduate medical education; workforce shortages; information technology investment; and access to capital financing.

### **Program Streamlining and State/Local Responsibilities**

- Identify administrative impediments that prevent New York residents from accessing the health care services they need.
- Explore ways to streamline enrollment, ease administrative requirements, while ensuring consistency between efficiencies and federal health care reform and health insurance exchange operations.
- Consider streamlining and centralizing long-term care administration and services.

### **Workforce Flexibility and Change of Scope of Practice**

- With membership to include the State Education Department, New York State Nurses Association and other interested stakeholders, develop a multi-year strategy to redefine and develop the workforce, to ensure that the comprehensive health care needs of New York's population are met. This may include:
  - Redefining the roles of certain types of providers and aligning training and certification requirements with workforce development goals, formulating consensus recommendations, and identifying areas in statute, regulation and policy that would require changes prior to implementation
  - Considering proposals for implementation in Fiscal Year 2012–2013 that would increase workforce flexibility and changes to the scope of practice of advanced practice clinicians, (see MRT #200, Change in Scope of Practice for Mid-level Providers to Promote Efficiency and Lower Medicaid Costs)
- Utilize smaller groups within this work group to focus on several issues:
  - Permitting nurses (under their scope of practice exemption) to orient/direct home health aides (HHAs) and primary care workers to provide nursing care as currently allowed in the consumer-directed personal assistance program
  - Allowing licensed practical nurses (LPNs) to complete assessments in long-term care settings
  - Extending the use of medication aides into nursing homes
  - Expanding the scope of practice of HHAs to include the administration of pre-poured medications to individuals who are and are not self-directing

- Expanding the scope of practice to allow dental hygienists to address the need for services in underserved areas

To learn more about the MRT work groups, including work group charge, membership and meeting dates, visit the [Medicaid Redesign website](#) .

# Analysis of Top Two Mental Health Priorities

July 2011

Sixty of 62 counties have submitted and certified their priorities in the County Planning System (CPS) as part of their annual planning efforts. Counties have declared varying numbers of priorities, but for the purpose of this analysis, the top two for each county were examined through the lens of mental health to understand more fully general areas of emphasis across counties. Moreover, the analysis provides an overview of areas of concern mapped to the Office of Mental Health (OMH) Strategic Framework. OMH regions are used for the analysis of priorities and mapping to the framework.<sup>1</sup>

## Distribution of Mental Health Priorities

The analysis takes into account the top two priorities that counties indicated were of chief concern for the delivery of mental health services and supports. The number of priorities reported by counties is 120, representing an overall response rate of 96.8 percent.

Region	MH	MH/SA	MH/DD	MH/DD/SA	YET TO RESPOND	Total
Central	14	13	5	6	2	38
Hudson River	18	7	5	2	0	32
Long Island	2	0	1	1	0	4
New York City	10	0	0	0	0	10
Western	20	4	5	7	2	38
<b>Total</b>	<b>64</b>	<b>24</b>	<b>16</b>	<b>16</b>	<b>4</b>	<b>124</b>

The majority of the 120 priorities reported to date in the CPS relate to mental health (64, 53.3 percent). A number of counties also indicate that their mental health priorities are shared either with one of the other two mental hygiene areas or among all three. Mental health/substance abuse disability priorities account for 20 percent. The percentage of priorities between mental health/developmental disabilities and all three disability areas are the same, with rates of 13.3 percent each. While the distribution reflects much attention to priorities that

<sup>1</sup> Regions as defined by the New York State Office of Mental Health: **Hudson River:** Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, Westchester. **Western:** Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates. **Central:** Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, St. Lawrence. **Long Island:** Nassau, Suffolk. **NYC:** Bronx, Kings, New York, Queens, Richmond.

relate to mental health services alone, it also reinforces findings from previous years, where cross-systems, comprehensive, integrated person-centered services and supports are designated by counties as essential to effective service provision.

### **Priorities in Relation to Strategic Framework**

Priorities for each county have been mapped to the OMH Strategic Framework domains and major goals, permitting a closer look at priorities. The framework brings structure to the values and principles guiding recovery-oriented, person-centered, and family-driven services and supports. They include:

- 1. People First**  
Respect individuality by demonstrating hope and positive expectations, a belief in recovery, and regard for diversity.
- 2. Person-Centered Decision Making**  
Provide supports and treatment based on self-defined needs, while enhancing personal strengths.
- 3. Basic Needs Are Met**  
Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.
- 4. Relationships**  
Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.
- 5. Living a Healthy Life**  
Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.
- 6. Mental Health Treatment and Supports**  
Foster access to treatment and supports that enable people to lead satisfying lives in their communities.
- 7. Self-Help, Peer Support, Empowerment**  
Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.
- 8. Mental Health System of Care, Workforce and Accountability**  
Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.

Across the State, priorities fall largely into Domain 6, Mental Health Treatment and Supports, with (56, 46.6 percent), rising 3.3 percent since last year. Also rising slightly from a year ago is the number of priorities focused on Basic Needs (Domain 3), largely the need for housing with supports to promote successful community living. Compared to 19.8 percent last year, Basic Needs Priorities are at 22.5 percent. Priorities related to the System of Care,

Workforce and Accountability (Domain 8) rank third at 14.2 percent and reflect ongoing concern with fiscal viability of community programs and other effects of regulatory reform.

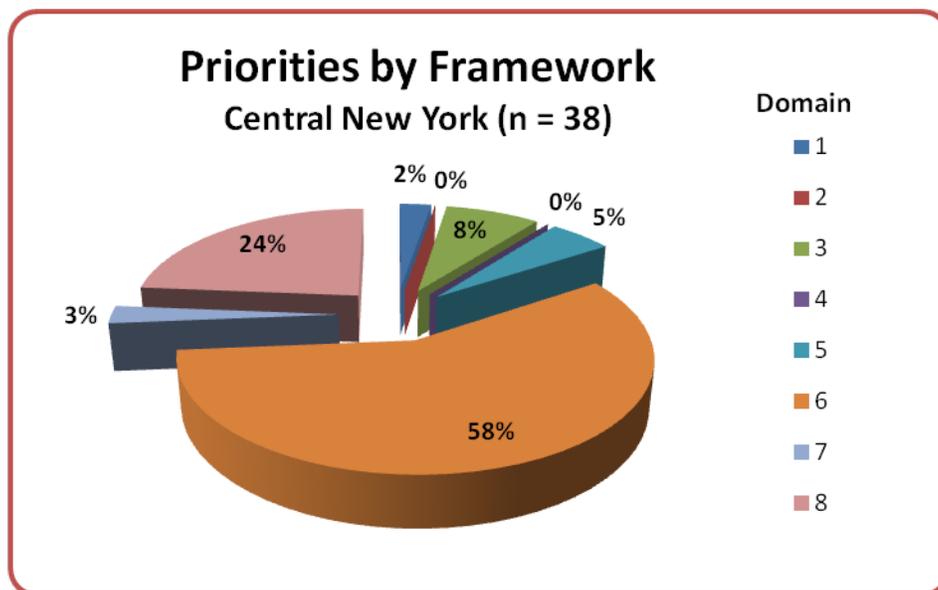
**TABLE 2**  
**Regional Priorities by Framework Domain**

<b>Region</b>	<b>1 People First</b>	<b>2 Person- Centered Decision Making</b>	<b>3 Basic Needs are Met</b>	<b>4 Relation- ships</b>	<b>5 Living a Healthy Life</b>	<b>6 MH Treatment &amp; Supports</b>	<b>7 Self-Help, Peer Support, Empowerment</b>	<b>8 MH System of Care, Workforce &amp; Accountability</b>	<b>Yet to Respond</b>	<b>Total</b>
Central	1	0	3	0	2	22	1	9	2	40
Hudson River	0	0	11	3	2	10	2	4	0	32
Long Island	0	0	2	0	0	1	0	1	0	4
New York City	0	0	0	5	0	5	0	0	0	10
Western	0	1	11	2	1	18	0	3	2	38
<b>Total</b>	<b>1</b>	<b>1</b>	<b>27</b>	<b>10</b>	<b>5</b>	<b>56</b>	<b>3</b>	<b>17</b>	<b>4</b>	<b>124</b>

Overall, the data appear to indicate the crucial role counties play in overseeing, operating, managing and evaluating resources and resource needs in a time of serious fiscal restraint. Counties are striving to ensure quality mental health treatment and supports with dwindling resources and no new monies, while at the same time responding to a changing service system, including implementation of clinic restructuring and reforms being introduced in preparation for Medicaid managed care. While top-two priorities largely fall into the three domains described here, counties are clearly committed the goals described in the other domains (e.g., person-first, recovery-oriented services and supports, peer support), thereby enabling adults, children and families to live productively in their communities. Features that describe the nature of top priorities by OMH region follow.

## Central New York Region

Top priorities fall largely between Domains 6 and 8, Mental Health Treatment and Supports and System of Care, Workforce and Accountability.



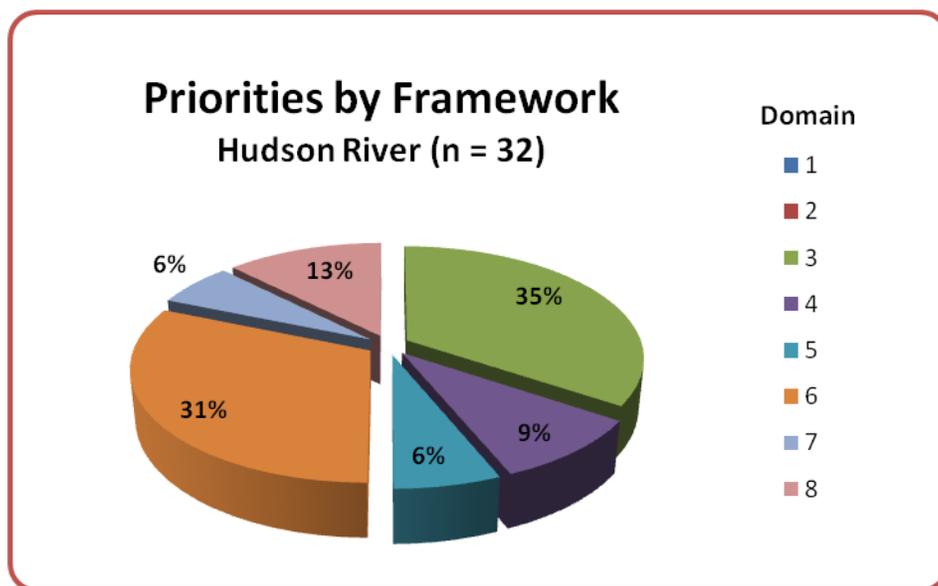
Most of the priorities that fall under Mental Health Treatment and Supports (Domain 6) highlight the importance of improving access to an array of integrated services that meet the needs of persons with co-occurring mental health and chemical dependency disorders and to ensuring well-integrated, coordinated care within the mental health and across the other mental hygiene systems of care. Rural issues were evident by priorities focused on assessing unique rural challenges and planning to address them as well as the need to increase psychiatrist services.

System of Care, Workforce and Accountability priorities (Domain 8) address fiscal and regulatory reform concerns. Counties are striving to operate efficiently and effectively as they deal with the fiscal impacts of the current fiscal climate in New York and nationally. While some are in the midst of reconfiguring services, others are also beginning to consider system changes on the horizon related to State Medicaid Redesign and national health care reform.

Other priorities fall mostly under Basic Needs (Domain 3) and include housing and housing supports for people across the three disability systems and transportation services for a rural county that wishes to improve access to services and supports for its residents.

## Hudson River Region

In the Hudson River Region, counties have identified priorities mainly in Domains 3 (Basic Needs) and 6 (Mental Health Treatment and Supports), which is consistent with the priorities declared during last year's planning cycle.



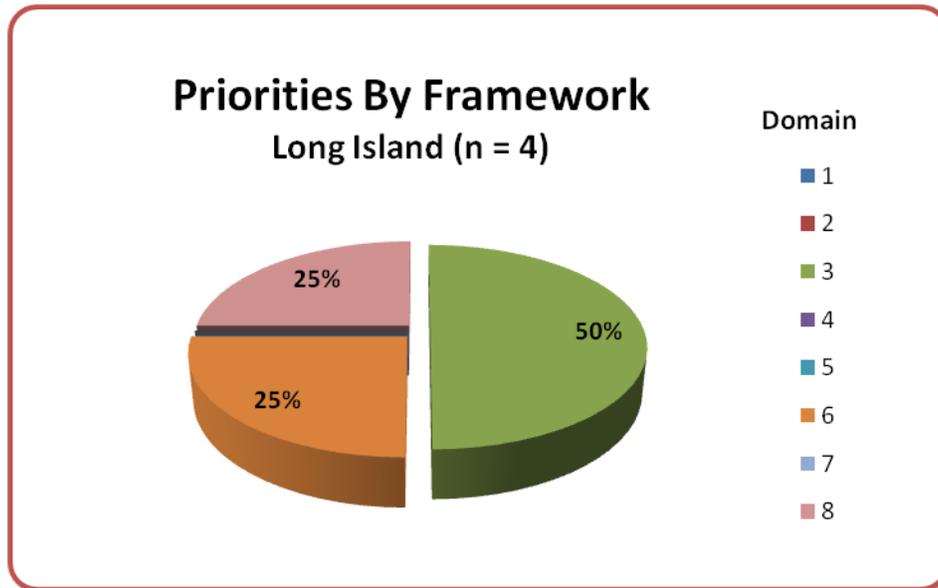
Under Basic Needs, the priorities deal with safe, affordable housing and related supports (e.g., employment, educational opportunities) necessary for successful community living. Three counties cite the importance of providing safe, affordable housing opportunities specifically for people with co-occurring mental health and substance abuse disorders, such as sober housing;; another county indicated work in the area of housing with supports for people with mental health and developmental disabilities.

Integrated, coordinated, and collaborative treatment and supports is a main concern across the mental hygiene and other service systems. Counties are working to improve care coordination for youth in transition in the mental health system as well as across the mental health and developmental disability systems. Other counties are focusing on integrated health care in the substance abuse/mental health and across all three mental hygiene areas. Priorities also address the need for healthy living, self-help and peer support services, and efforts toward stronger local systems of care as the transition to clinic restructuring occurs.

Other priorities aim at more fully integrating health and mental health treatment and supports into the fabric of the community, with the aid of peers and peer support; adding more crisis and respite capacity for adults, children and families; more fully developing and strengthening peer leadership and peer services; and addressing fiscal viability and restructuring concerns.

## Long Island Region

On Long Island, two priorities are aimed at Domain 3, Basic Needs, and one each for Domains 6 and 8, Mental Health Treatment and Supports and System of Care, Workforce and Accountability, respectively.

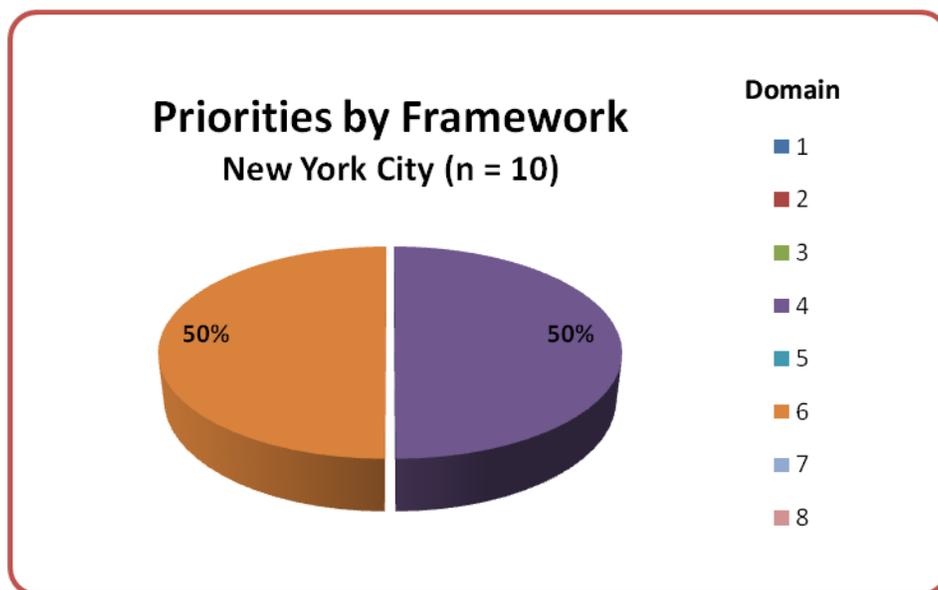


The Basic Needs priorities are intended to increase the supply of housing with related supports. One effort focuses on sufficient housing to meet the needs of people with serious mental illness and the other for people served across the three mental hygiene disabilities. Long Island continues to be challenged by very high housing and living costs and a lack of housing to meet specific needs, including the needs of people who are difficult to place.

The two other main areas being addressed are the provision of evidence-based treatment services and care coordination for persons with multiple disabilities and attention to regulatory and fiscal issues related to restructuring, billing, and inadequate reimbursement rates impacting operations and barriers to clinic access for individuals who do have insurance coverage. An important finding is that people with health insurance who lack the skills and resources to challenge insurance companies (e.g., insufficient provider network, service denials) tend to find their way to public services as a result.

## New York City Region

New York City has declared two priorities that fall into Domains 4 (Relationships) and 6 (Mental Health Treatment and Support), covering each of the City's five counties. (The priorities were given the weight of two for each of the five counties comprising the City, totaling to 10.)

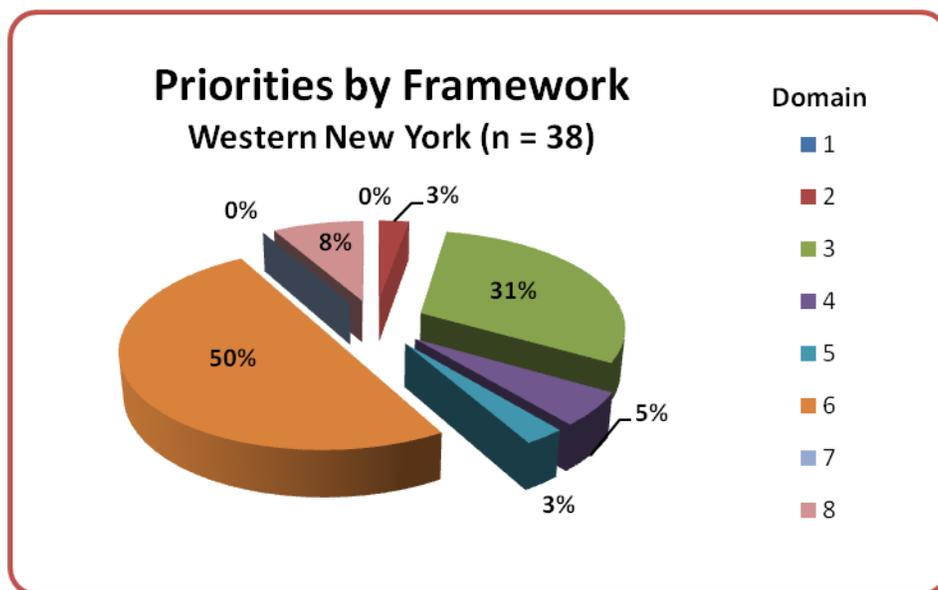


The priorities are expressed broadly, and, in particular, with respect to Domain 4, the City has placed a strong emphasis on services and supports that help people to reach their full potential and lead personally meaningful lives in their communities through employment, recreational activities, community involvement, and significant relationships. The City's goal is to provide a full range of supports that are oriented toward recovery and enable people to make informed decisions and manage their lives as well as they can.

The second priority is a continuation from the previous year and includes striving to have children from birth to eight years of age reach their optimum developmental potential through assessment and early mental health intervention, when indicated. The priority aligns with the goals of the Children's Plan to promote the social and emotional growth and development of New York's children and aims to continue building capacity among parents, caregivers and others responsible for children's education, health, safety, and well-being.

## Western New York Region

Priorities for Western New York cluster mainly around domains 3, 6 and 8, and focus on Basic Needs, Treatment and Supports, and the System of Care, Workforce and Accountability, respectively.



Priorities addressing basic needs primarily involve safe, affordable housing and supports for people served by OMH and also for people served by OMH and OASAS. One rural county continues to work on improving transportation to health appointments, jobs, classes and recreational activities for people with disabilities across the systems of care; another is concerned with better meeting the needs of youth in transition served by the three mental hygiene disability areas; and two counties are particularly interested in strengthening vocational and employment opportunities for people with disabilities.

Mental Health Treatment priorities tend to concentrate on the specific needs of populations served by mental health and other providers. The priorities call for strengths-based, person-centered care coordination and integrated services across systems of care for high-need, high-risk populations (e.g., dual disorders, multiple disabilities, criminal justice contact) and for strengthened System of Care efforts on behalf of children with serious emotional disturbance and mental health challenges and their families.

System, Workforce and Accountability priorities vary, with three counties noting the need to expand psychiatry services through recruitment of child psychiatrists and/or use of tele-psychiatry. Another county indicates that it will be assessing the level of services needed for children and families, while another will be examining how it can increase access to children's services. Staff development is another theme to emerge, with one county focusing on use of screening tools to improve care across disability areas and another looking at how it can

improve provider education for providers serving people with co-occurring mental health and substance abuse disorders.

# 2012 Policy and Planning Activities Report from LGU Mental Hygiene Planning

August 2011

The Policy and Planning Activities Report section of this year's mental hygiene planning cycle provided localities with the opportunity to weigh in on substantive policy and planning issues affecting the mental hygiene disability areas at the State and local levels. Specifically, the Policy and Planning Activities Report this year sought feedback in three major areas—Medicaid redesign, mandate relief, and the integration of mental hygiene services—across the Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), and the Office of Alcoholism and Substance Abuse Services (OASAS).

In all, 36 counties responded fully or partially to questions 2 (Medicaid redesign), 3 (mandate relief) and 4 (integration of mental hygiene services) on the Planning Activities Report. Responses were considered largely within the geographic framework being used for the creation of the regional behavioral health organizations (BHOs), which will guide overall health care management and coordination for Medicaid beneficiaries in New York State.

The breakdown of these regions includes:

- **Central New York Region**

Broome, Cayuga,  
Chenango, Clinton,  
Cortland, Delaware, Essex,  
Franklin, Fulton, Hamilton,  
Herkimer, Jefferson, Lewis,  
Madison, Montgomery,  
Oneida, Onondaga,  
Oswego, Otsego, St.  
Lawrence

- **Hudson River Region**

Albany, Columbia,  
Dutchess, Greene, Orange,  
Putnam, Rensselaer,  
Rockland, Saratoga,  
Schenectady, Schoharie,  
Sullivan, Ulster, Warren,  
Washington, Westchester

- **Long Island Region**

Nassau, Suffolk



- **New York City Region**  
Bronx, Kings, New York, Queens, Richmond
- **Western New York Region**  
Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuylar, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates

Additionally, responses were considered in terms of the geographic nature of each county, using the OASAS epidemiological regions based on the U.S. Census classification of NYS counties.

- **New York City:** Bronx, Kings, New York, Queens, Richmond
- **Suburban Downstate:** Nassau, Rockland, Suffolk, Westchester
- **Suburban:** Dutchess, Ontario, Orange, Putnam, Saratoga, Sullivan, Tompkins, Ulster
- **Upstate Urban:** Albany, Broome, Erie, Monroe, Niagara, Oneida, Onondaga, Rensselaer, Schenectady
- **Rural:** Allegany, Cayuga, Chenango, Cattaraugus, Chautauqua, Chemung, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Orleans, Oswego, Otsego, St. Lawrence, Schoharie, Schuylar, Seneca, Steuben, Tioga, Warren, Washington, Wayne, Wyoming, Yates

Data tables used for the analysis, which are included with the report, detail the regional and geographic breakdown for each county. Counties had the option to answer any or all parts of the three survey questions. As Table 1 shows, 80 percent of all responses came from counties in the Central and Western New York regions. Question 4 drew the highest number of responses, reflecting in part the emphasis on integrated planning across the three mental hygiene agencies and impending changes under Medicaid redesign. It should be noted that, because the survey was optional and some large urban and suburban counties opted not to respond to some or all of the questions, findings should be viewed cautiously in light of their underrepresentation in the results.

**TABLE 1**  
**Breakdown of Survey Responses by Region**

Region	Question 2 Medicaid Redesign				Question 3 Mandate Relief	Question 4 Mental Hygiene Integration		
	2a	2b	2c	2d		4a	4b	4c
	Central New York	8	5	7	7	5	7	6
Hudson River	3	2	3	3	2	5	4	3
Long Island	0	1	0	0	0	2	1	1
New York City	0	0	0	0	0	0	0	0
Western New York	9	7	8	9	4	12	12	9
<b>Total</b>	20	15	18	19	11	26	23	21

The following analyses demonstrate that most of the concerns related to the planning, financing, delivery and evaluation of mental hygiene services center primarily on mental health/chemical dependencies (defined under Medicaid redesign as “behavioral health”) and physical health. Counties uniformly pointed out ways they wished to see tighter integration between the mental health and substance abuse systems of care and provided numerous recommendations for reducing regulatory and statutory barriers to effective care. Counties also highlighted areas where improved coordination and integration of care could occur between mental health and developmental disabilities.

Broadly, counties across the State, counties offered recommendations on the movement toward Medicaid managed care and ultimately toward the provision of the most effective services, while reducing costs and making the best investment of Medicaid funding. These priorities include:

- Implementing the integration of chemical dependence and mental health services and ultimately integrating behavioral health services with physical health services and related supports for successful community living
- Incorporating case management services and care management for people with complex conditions, while strengthening community linkages along the recovery continuum of care to reduce unnecessary inpatient care and detoxification admissions, as well as readmissions, among Medicaid beneficiaries who are identified as “high use/high cost”
- Providing integrated physical and behavioral health care based on the values of person-centered, recovery-oriented care, and utilizing models of co-located care that help to reduce stigma and improve the outcomes of care
- Engaging with the State agencies to identify areas for regulatory and statutory relief, enabling better alignment between the goals of Medicaid redesign and the on-the-ground operations (e.g., billing models that incentivize integrated care rather than

contribute to siloed care) as well as fostering implementation of integrated services and care management with the least administrative and clinical burden

- Implementing electronic medical records and having access to robust Medicaid data to better manage the care of Medicaid beneficiaries with the most serious and complex conditions, monitoring outcomes of care, identifying people who may need treatment but have been lost to care so providers may reach out and engage them in care, and examining indicators of overall system of care performance
- Having the ability to access flexible funding to provide critical support services (e.g., peer, housing, employment) not funded under Medicaid but proven by science to be essential to successful community life for individuals with serious behavioral conditions

What follows is a summary of recommendations and concerns in response to each question.

### **Question 2: Medicaid Redesign (optional)**

In January 2011, Governor Cuomo established the Medicaid Redesign Team. Its objective is to find ways to reduce costs and increase quality and efficiency in the Medicaid program. Part of this effort includes seeking ideas from the public at large, as well as experts in health care delivery and insurance, the health care workforce, economics, business, consumer rights and other relevant areas. These guidelines provide counties with an additional opportunity to provide input into this process. Resources you may find particularly helpful in completing this item include: [OASAS Detailed Medicaid Recipient Profiles \(2007-09\)](#), [OMH County Mental Health Profiles \(Adult Medicaid Expenditures\)](#).

- 2a. What specific *system or program reform/changes* have you enacted or are proposing to enact during the reporting period that will improve quality and reduce costs to the Medicaid program?
- 2b. What specific regulatory or administrative changes have you implemented locally (in partnership with Medicaid managed care companies or Local Commissioners of Social Services/Human Services) to lower costs and/or improve quality within the Medicaid program?
- 2c. What current elements of your local Medicaid program or system of care do you find have truly worked to control costs and enhance quality and that you feel should be preserved or expanded?
- 2d. What other recommendations do you propose to restructure the State Medicaid program that could "... achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure"?

In all, 24 counties across four regions responded to one or more parts of this question. Concerns expressed by counties often reflect their geographic nature. In this regard, with respect to counties responding to any part of survey question 2:

**2a. What specific system or program reform/changes have you enacted or are proposing to enact during the reporting period that will improve quality and reduce costs to the Medicaid program?**

Across three regions, counties described reforms and changes already enacted or being proposed in several major areas. The changes under way reflect attention on preparations for BHOs, integrated behavioral and physical health care, and health homes. Below are some of the common themes among those counties responding to this part of the survey question:

- Ensuring that services are medically necessary and of the right amount and duration
- Improving single-point-of-access (SPOA) processes so that intervention occurs early for persons identified as having high need and that care management strategies are employed to provide continuity of care during critical transitions in care
- Strengthening discharge planning, especially for individuals with high readmission rates, with “warm hand-offs,” accessible clinic hours, follow up for no-show appointments, care manager involvement in discharge planning)
- Fostering collaborations among hospitals, clinics, and providers across the mental hygiene systems of care to identify people whose service use and costs are high and to establish comprehensive treatment plans that will improve outcomes while at the same time lower costs associated with care for people with high risk and/or clinically complex conditions
- Improving the integration of primary and behavioral health care by providing behavioral health onsite consultation in primary care settings
- Providing training to improve care for persons with co-occurring mental illness and chemical dependency services (e.g., screening tools, motivational interviewing techniques, cognitive behavioral therapy, trauma-informed care)
- Utilizing peer-run and peer support services to help engage people with treatment needs who have dropped out of or who have become lost to care or to promote skills development that aids daily living (e.g., benefits counseling, employment support)
- Removing regulatory and statutory restrictions that impede the ability of localities to co-locate and effectively integrate services (e.g., substance abuse, physical health, mental health)
- Improving mobile and crisis services to address urgent needs more effectively and reduce the need for emergency department utilization
- Utilizing electronic medical records to improve the ability of clinicians to provide effective, integrated care

Regional examples of reforms include:

### ***Central New York Region***

Eight counties in Central New York responded to Question 2a. Seven of the eight affirmed that they are integrating physical health and behavioral health care. In some counties, primary care providers are in the same physical location as behavioral healthcare providers. Other counties have integrated substance abuse treatment with mental health services, providing screening for addiction and mental health disorders at the same time. Onondaga County is an active participant of the New York Care Coordination Project (NYCCP).<sup>1</sup>

Staff members in Otsego County are dually trained to participate in treatment courts and social services case conferences and evidence-based interventions such as motivational interviewing. Crisis intervention enhancements are in place in Clinton County and include using community residences as crisis respite, involving an intensive case manager at treatment team meetings and discharge planning, developing risk assessments and safety plans and using a “warm hand-off at discharge. Others are providing phone crisis intervention using trained clinicians, phoning “no-show” individuals, initiating phone contact with persons on wait lists, and developing evidenced-based group therapies to provide a greater diversity of services. One county simply declared the local governmental unit (LGU) has no say in enacting reforms because Medicaid is a federal/state program.

### ***Hudson River Region***

In the Hudson River Region, three counties responded to this question. Dutchess County is experiencing diminished bed capacity, with rising transportation costs. It formed a weekly “Community of Solutions” team involving all providers to move clients from inpatient to community care, which increases access to inpatient beds while helping people to receive services in their own communities. Greene County placed a mental health clinician in five primary care offices, which has reduced stigma and improved outcomes. The county involvement in the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) has also improved outcomes for individuals. Sullivan County is in the process of discussions with physical health providers to coordinate care for their common consumers. The introduction of Recovery Centers is also being discussed to assist individuals with housing, employment and illness/wellness management.

### ***Western New York Region***

A number of counties in this region are part of NYCCP (Chautauqua, Erie, Monroe and Wyoming). Chautauqua County implemented county-wide public health models to identify at-risk youth and intervene early. It is also a “System of Care” community and uses high fidelity wraparound services and evidence-based treatment models. Its clinics participate in PSYCKES to reduce polypharmacy and manage medications across providers. In addition, the county plans to redesign its behavioral health crisis model to avoid unnecessary emergency room visits.

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<sup>1</sup> NYCCP is a collaborative undertaking by county governments, providers and consumers who share interests in promoting recovery and conserving resources for the support of children with serious emotional disturbance and adults with serious mental illness. The web site address is [NYCCP](#) .

Monroe and Erie Counties are planning to improve their SPOA processes for better care of high-cost, high-need individuals. Erie County will implement Critical Time Intervention (CTI) to enhance continuity of support for persons with serious mental illness during periods of transition. The county has also partnered with the Department of Senior Services to provide services to older adults to avoid placements in nursing homes or institutions. Monroe County plans to simplify access for high-need individuals, provide outreach and engagement, and use short-term intensive care management for people with physical and behavioral health needs, develop level of care guidelines for mental health and chemical dependence services, and analyze Medicaid data to identify high-need/high-cost individuals to inform health home planning and physical and behavioral health integration. Wyoming County is using a Co-occurring Disorders Task Force to track people with dual diagnoses to better integrate care.

Cattaraugus County plans to strengthen discharge planning for individuals with high readmission rates. The county will provide co-occurring services training to its providers across services. Engagement of people lost to services will be assisted through the use of peers.

Several counties are identifying high need/high cost individuals either through using Medicaid data or collaborating with physical, behavioral, and substance abuse providers. Chemung County is encouraging provider groups to assess medical necessity at intake and via utilization review. It is also working to improve outcomes while shortening lengths of stay in case management and to identify people with co-occurring disorders to establish comprehensive plans of care while improving outcomes. Niagara County is shifting from long-term outpatient treatment to a model that provides episodic care as needed. Wayne County is employing a clinical operations team to conduct a risk review and identify consumers who have potential for relapse. Seneca County is conducting a mental hygiene cross-disability assessment to better understand how physical, behavioral and developmental disability services are being delivered and plans to offer primary medical services (e.g., physicals) within the mental health and substance abuse clinics upon approval of the Centers for Medicaid and Medicare Services.

**2b. What specific regulatory or administrative changes have you implemented locally (in partnership with Medicaid Managed Care companies or Local Commissioners of Social Services/Human Services) to lower costs and/or improve quality within the Medicaid program?**

Counties in four regions outlined regulatory and administrative changes they have implemented to improve the quality of care for Medicaid beneficiaries, while reducing costs. Common changes cited across regions include:

- Participating in NYCCP to integrate physical healthcare and behavioral healthcare through its complex care coordination functions that are helping to reduce emergency department use and inpatient stays
- Relying upon proven quality improvement initiatives (e.g., Six Sigma) that enhance care processes and lead to better outcomes and pilot projects, such as the Rapid Engagement Demonstration, which are successfully linking at-risk individuals with substance abuse disorders to services and supports (e.g., housing) and ongoing care coordination

- Establishing collaborations with Medicaid managed care companies to address the high Medicaid costs associated with treating physical and behavioral health issues, and with local Social Services to reduce residential youth placements and address community living needs of youth in transition
- Strengthening collaborations across the systems of care so that care is more holistic and better integrated
- Improving access to and engagement in care through enhanced SPOA processes (e.g., data-informed decision making)
- Monitoring data trends and implementing clinic restructuring

Regionally, counties described regulatory or administrative changes that have led to cost-effective quality care, including:

### ***Central New York Region***

Across the Central Region, most of the changes implemented by the five counties responding to this question have been administrative. Four counties have been concentrating on strategies aimed at concurrent care for persons with co-occurring disorders and staff training, a greater emphasis on recovery-oriented services and supports, strong collaborations between adult and child-serving agencies (e.g., breaking down silos through good communications), and management of resources (e.g., improving access to housing services for youth in transition, reducing no-show rates for appointments through outreach, improving SPOA and hospital communications to reduce inpatient and crisis services utilization). St. Lawrence County notes that regulatory relief at the State level across the mental hygiene agencies will be crucial in the development of fully integrated physical and behavioral health services.

### ***Hudson River Region***

In the Hudson River Region, Greene County identified making administrative changes like examining Medicaid costs in conjunction with the Social Services Department and looking at specific costs like the financial impact of housing youth in motels. Sullivan County is focusing on care coordination using wraparound services to allow individuals to remain at home and calls for data sharing and cross-systems care coordination.

### ***Long Island Region***

Nassau County points to the need for timely high-need, high-cost client data to help the county manage care coordination for this population.

### ***Western New York Region***

Chemung County is on the leading edge of health care reform among the seven counties responding, having already formed a medical care home model to enhance care for individuals with co-morbid conditions. The county is monitoring outcomes and anticipates cost savings from reductions in hospitalization and readmissions. Counties participating in NYCCP (Chautauqua, Erie, Monroe, and Wyoming) describe a successful collaboration with a managed care organization to implement complex care management strategies (reductions in inpatient stays) for individuals identified as utilizing high amounts of inpatient and emergency services.

Other changes include shifting from an “individual meets admission criteria” orientation to single point of access reforms in Erie County that focus on assessment and triage to appropriate services. Of note is the implementation of a rapid engagement demonstration project in Monroe County, where at-risk individuals with substance abuse problems are being linked quickly to services and ongoing care coordination.

**2c. What current elements of your local Medicaid program or system of care do you find have truly worked to control costs and enhance quality, and that you feel should be preserved or expanded?**

Those elements that work to control costs and enhance quality most commonly cited by counties in three regions include:

- NYCCP
- Complex care management
- Substance Abuse and Mental Health Services Administration (SAMHSA) supported Systems of Care for children, youth and families.
- SPOAs
- Person-centered planning and recovery-oriented care
- Accessible Medicaid data to inform planning, evaluation and performance management efforts
- Co-occurring Disorders Task Force
- Cross-systems collaboration and planning

By region, counties described those elements they believed should be preserved or expanded as follows:

***Central New York Region***

Of the seven counties responding to this question, Clinton County indicated that case review to determine treatment dropout and readmission trends as well as emergency department psychiatric assessments appear to be having a positive effect, with fewer hospital admissions, more emergency room assessments, and more outpatient admissions. The county advocates for Medicaid data to monitor care for high-need, high-cost individuals and expansion of SPOA monitoring for lengths of stay in case management and housing and for doing community outreach. Otsego County reports that it is also exploring ways to follow up with people who use crisis services but do not keep appointments; this population is of concern because case management, SPOA and housing make a significant difference in preventing hospitalizations and promoting recovery. Onondaga County is an active participant in NYCCP and points to the value of the program in delivering services efficiently and effectively.

The other counties responding to this question indicated that they would like to see the following to help control costs:

- Establishing clinical profiles and trends to monitor outcomes and costs

- Establishing a countywide care coordination model for people with behavioral conditions
- Having a close-knit provider community that communicates frequently around client needs, coordinates individualized services, and is granted waivers from burdensome regulations
- Providing person-centered, recovery-oriented care
- Shifting toward reimbursement for peer services, implementing options for step-down care for people who have had long institutional stays, and focusing on training in evidence-based treatments

Montgomery County indicates that it is simply trying to survive in a system of care it does not own, but rather is owned by the federal and state governments.

### ***Hudson River Region***

Putnam County explained that case management serves to reduce repeat hospitalizations and connects consumers with supports, treatment, and additional services such as housing. The county also noted the value of Section 8 programs, additional housing assistance programs, and access to a safe house for a person in supporting his or her recovery. It also called for allowing providers to flexibly serve people with needs who may or may not be Medicaid eligible (e.g., pay offline for prescriptions when Medicaid benefit cards are not available or to ensure payment for medications when a non-Medicaid eligible person lacks funds to pay for those medications). Dutchess County also points to the success of its Community of Solutions group to increase inpatient capacity and provide community services.

### ***Western New York Region***

Of the eight counties in the region that responded to the question, three were involved in NYCCP (Chautauqua, Erie, and Monroe). The three point to a number of successes in controlling costs and preserving quality through adherence to utilization management, quality improvement practices, a prescribed matrix and benchmarks. Among these are SPOA for adults and children as a gatekeeper to high-end services through triaging and prioritizing access to services; practice to outcome models / fidelity to practice; quality improvement mechanisms; utilization management performance; accountability; access to real-time data that is used to monitor outcomes, quality improvement, utilization management and performance accountability; and the sharing of aggregate data and data dashboards with partners. Under the NYCCP complex care management program, a more intensive, short-term care management approach, counties are showing promising results. Moving forward under care management and Medicaid redesign, the counties have requested Medicaid managed care encounter data, data to identify individuals on a trajectory to high use, an ability to drill down OMH data by race and ethnicity and an ability to drill down to OASAS data by provider; and expansion of care coordination for high risk/high cost consumers with addictions.

Chemung County is monitoring the effect of the health home in reducing readmissions and improving care. Livingston County is has adopted a team concept for addressing each individual's needs, with identified points of access and more collaborative care. Wayne County

reported that child and adult SPOAs, the Coordinated Children’s Services Initiative (CCSII) Tier 2, Co-occurring Disorders Task Force, cross-systems planning, and a leadership group are all working.

**2d. What other recommendations do you propose to restructure the State Medicaid program that could “... achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure”?**

Across three regions, counties offered suggestions for restructuring State Medicaid programs. Among the common recommendations are:

- Implementing utilization management and quality improvement practices that provide the right treatment in the right amount at the right time
- Ensuring strong vendor networks and use of electronic medical records
- Providing regulatory review and relief, where possible, between OASAS and OMH that leads to more integrated treatment (e.g., single treatment plan, New York State Clinical Records Initiative [NYSCRI])
- Taking into account that the cost of providing services in rural counties, while relatively small in comparison to most counties, is significantly higher per individual and making certain that such counties are given regulatory flexibility to the degree possible
- Ensuring alignment between Medicaid billing requirements and the structure of care (e.g., treatment options limited for people with dual diagnosis because Medicaid billing does not recognize this as a “primary diagnosis”)
- Facilitating county access to Medicaid managed care data that enables effective systems management
- Supporting Medicaid reimbursement of treatment that focuses on the health needs of the “whole person” such as recovery-oriented, peer support and offsite services
- Being certain that the people with the most serious behavioral health conditions do not fall through the cracks

Within each of the regions, specific recommendations include:

***Central New York Region***

Two of the seven counties responding to this portion of the question called for more effective and efficient service provision between OMH and OASAS. Clinton County called for the establishment of a single treatment plan template along with a relaxation of some of the more stringent OASAS requirements that are difficult to master, particularly with a co-occurring population; the establishment of a sound "harm reduction" model (e.g., less rigidity with abstinence); the development of medication clinics that provide maintenance rather than clinical care relaxing the accompanying documentation needed to maintain that level of care for those who cannot be referred back to a primary care physician for follow up; and the provision of off-

site visits (e.g., in physicians' offices) without establishing satellite sites has the potential for much better integrated behavioral and physical health care. Franklin County asked for more streamlined regulations and consolidation, particularly consolidation of documentation procedures via NYSCRI.

Hamilton County added that it would like to see the rural nature of counties considered in regulatory reform. The county noted that the key to maximizing efficiency in such settings is having the flexibility to continually right size staffing configurations to target populations through combinations of mobile staffing and contracting staff on an as needed basis. Otsego County, on the other hand urges a "warm hand" linkage to providers and services. Rather than spending time on the phone trying to manage outpatient services, it recommends that we think locally and remember that systems work together because of the relationships people have and act upon the importance of support services a (e.g., housing, transportation, employment) because they matter when it comes to outcomes.

Lewis County recommended an expansion of the use of information technology, which is essential to enhance the coordination of care, reduce the duplication of services, and assist the flow of information to the benefit of the treatment for clients. The county also calls for the certification of peer service providers to ensure proper reimbursement of these services.

### ***Hudson River Region***

Columbia County called for regulatory reform to permit integrated care of individuals with dual diagnoses (mental health disorders/chemical dependency issues or mental health disorders/ developmental disabilities). The county also noted that current Medicaid billing parameters that focus on a "primary diagnosis" do not recognize such persons and arbitrarily limit treatment options. Dutchess County stressed the need for protections and a safety net for people with the most serious mental illness so they do not fall through the cracks as the system orients toward integrated health and mental health care.

### ***Western New York Region***

Chautauqua County would like to see genuine collaboration among the agencies. It points out that under NYSCRI, the integrated approach of using unified forms is being threatened by the OASAS approach of developing its own forms. "Time wasted, dollars wasted. Providers could be back to separate forms." The county also would like to see family and peer services as reimbursable under Medicaid, and suggested that off-site services be covered under Medicaid, as they are proven to be effective in improving outcomes at a lower cost. Monroe County recommended that regional BHOs be established in a way that recognizes the need for local county oversight and allows for the designation of regions that local counties believe to be the best configuration to achieve the desired results. The county also noted that the simultaneous establishment of health homes for those with serious mental illness and serious substance use disorders would present an opportunity to better organize the system of care and provide care management and care coordination within a structure that maintains oversight at the local level. Among the four NYCCP counties responding to this question, Wyoming recommended accountability for each individual with high needs that takes into account a partnership between managed care organizations and the locality so that community integration can truly occur. The county also points out the importance of regional attention to specific

county needs in system design (e.g., needs of large counties vs. unique needs of small counties).

Seneca County suggested allowing OASAS-licensed treatment clinics to provide treatment for nicotine dependence to Medicaid clients. Livingston County recommended dual licensure for OMH and OASAS providers, while Cattaraugus County requested that localities have some local controls when it comes to BHOs.

### **Question 3: Mandate Relief Redesign (optional)**

In January, Governor Cuomo established a Mandate Relief Redesign Team to review unfunded and underfunded mandates imposed by the New York State government on school districts, local governments, and other local taxing districts. Unfunded and underfunded mandates drive up costs of schools, municipalities, and the property taxes that support them. The team is looking for ways to reduce the costs of mandated programs, identify mandates that are ineffective and outdated, and determine how school districts and local governments can have greater ability to control expenses.

Given the objectives of the Mandate Relief Redesign Team described in these guidelines and the categories in which it is soliciting recommendations, identify potential mandate relief actions that you would like passed on to the team for consideration. For each recommendation, indicate whether the recommendation is for statutory or regulatory relief.

The State Mandate Relief Redesign Team includes representatives from private industries, education, labor, and government and will look for ways to reduce the costs of mandated programs, identify mandates that are ineffective and outdated and determine how school districts and local governments can have greater ability to control expenses. The team is charged with looking for ways to reduce the costs of mandated programs, reasons for State delays in reimbursements, and the practice of cost shifting of mandated programs. It is also charged with identifying opportunities for eliminating or reducing unfunded and underfunded mandates imposed by State government on local governments and local school districts.

Eleven counties responded to the Mandate Relief Redesign question. In the Central New York Region, all five counties reporting (Chautauqua, Chemung, Hamilton, Lewis and Montgomery) are rural counties. In the Hudson River Region, Columbia County is rural, while Sullivan County is classified as a suburban county. Two of the four counties in the Western New York Region are upstate urban counties (Erie and Niagara), while the other two are rural in nature (Seneca and St. Lawrence).

**Given the objectives of the Mandate Relief Redesign Team described in these guidelines and the categories in which it is soliciting recommendations, identify potential mandate relief actions that you would like passed on to the team for consideration. For each recommendation, indicate whether the recommendation is for statutory or regulatory relief.**

The counties responding to this question recommended potential mandate actions for consideration by the Mandate Relief Redesign Team that fell into several areas: criminal justice (public safety), local government operations, professional practice, quality of care, State/federal compliance, and supported housing. By region, specific recommendations are described by content area:

### ***Central New York Region***

#### **Criminal justice**

- Pass the Chargeback Bill, which would control the costs to counties related to those found incompetent to stand trial. The costs to the counties, which come with no county control or input, can be in the hundreds of thousands of dollars.
- Develop an infrastructure that supports every county's ability to provide intensive sex offender treatment programs to meet the demands of Article 10 civil confinement cases<sup>2</sup> for discharge to communities, rather than placing these individuals primarily in those communities that have created such capacity, thereby overburdening these communities because a comprehensive infrastructure is absent statewide.
- Support legislation that permits social workers and other appropriately licensed clinicians to conduct 730 and 330.2<sup>3</sup> evaluations.

#### **Local government operations**

- Remove redundant and ineffective legislative mandates that require children and adult SPOA committees, while not entrusting them with decision-making authority and funding to assure access.
- Eliminate the pre-approval certification committee (PACC), and the need for agency specific intake/admissions processes, and support SPOA in a more uniform manner in both regulatory and fiscal manner.

#### **Professional practice**

- Provide relief to scope of practice regulations that restrict service delivery by requiring specific licensed personnel to deliver treatment services. Reimbursement rates do not adequately compensate the required licensed professionals,

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<sup>2</sup> The Sex Offender Management and Treatment Act (SOMTA), enacted as Chapter 7 of the Laws of 2007, became effective April 13, 2007. The centerpiece of the legislation was the creation of a new Article 10 of the Mental Health Law.

<sup>3</sup> Criminal Procedure Law (CPL), Section 730, covers "not competent to stand trial as a result of mental illness," while CPL Section 330.20 covers "not responsible for criminal conduct by reason of mental disease or defect."

effectively discouraging individuals from pursuing professional careers in human services.

### **Quality of care**

- Look at the proliferation of evidence-based practices (EBPs), which are primarily proprietary, and the profit motive costs to everyday practice.

### **State/federal compliance**

- Fund fingerprinting compliance officers and their training; make sure reciprocation of this requirement occurs across systems.
- Modify the Office of the Medicaid Inspector General (OMIG) requirement to screen new employees and contractors to determine if they have been excluded or terminated from participation in federal health or State Medicaid programs; and reduce the burden associated with monthly re-screening of all employees, vendors, and referral sources.
- Reduce the burden associated with the Department of Labor guidelines for written notice for rate of pay and pay date (Wage Theft Prevention Act 4/9/11).
- Relieve burdens from Health Care Reform that require employers to provide all employees with notices of updated information and federal employee Health Plan Required Notices.
- Eliminate the impending change to the W-2 form that is being instituted to add the reporting of cost to the employer.

### **Supported housing**

- Provide more flexibility in the use of this resource (not just for downsizing State psychiatric units).

### ***Hudson River Region***

#### **Criminal justice**

- Support the bill proposing mandate relief pertaining to Criminal Procedure Law 730 to include licensed certified social workers and nurse practitioners in the definition of "psychiatric examiners."

#### **Professional practice**

- Examine intent of new OASAS regulatory requirements covering the qualifications of medical directors in 822<sup>4</sup> outpatient clinics in relation to the physician shortage.

#### **Quality of care**

- Ease 42 CFR, which serves as a barrier to identifying and engaging high-use people in integrated care management.

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<sup>4</sup> Part 822 refers to general service standards for chemical dependence outpatient and opioid treatment programs.

**State/federal compliance**

- Support regulatory restriction of the degree to which OMIG can extrapolate take backs.
- Support the right of providers to correct some errors before fines are assessed against them.

**Western New York Region****Criminal justice**

- Support mandate relief for the provision of mental health services in the local correctional facility.
- Address the demand for mental health services in correctional facilities while reimbursement continues to decrease.

**Local government operations**

- Shift payment of Medicaid entirely to the State and require its agencies to work together on the care of people with multiple disabilities.
- Eliminate CBRs, CFRs, CCR, quarterly claims, budget approvals, MHPD, petty review of certificates.
- Address issues unique to rural counties that impact the cost of care (e.g., lack of mass transit, high unemployment).

**Quality of care**

- Address underpayment by insurance companies to outpatient treatment providers for treatment services vitally needed to help people avoid costly care and to live successfully in their communities.

**State/federal compliance burdens**

- Allow no regulatory changes without first obtaining the appropriate funding to support them.
- Provide regulatory relief that reduces silos between state agencies to truly provide person-centered planning changes are needed (e.g., OPWDD regulatory issues are causing delays in the implementation of respite care for children).

#### **Question 4: Integration of Mental Hygiene Services (optional)**

Given the current fiscal climate and dire budget projections for the years ahead, and given the ongoing efforts of LGUs to find more efficient and effective ways to meet the needs of people with co-occurring disabilities or to meet common needs across the different mental hygiene service systems, and given the priority of the governor to reduce the cost of needed services, identify potential strategies that will meet these objectives.

- 4a. Identify efforts the county has undertaken, or plans to undertake, that will lead to efficiencies and improved quality of care.
- 4b. Identify strategies for service integration and for care coordination.
- 4c. Identify potential strategies beyond the Medicaid redesign and mandate relief strategies covered in the two previous questions that can or should be employed at the state government level that will create a more favorable environment for the county and providers to provide more efficient and quality services.

Overall, 29 counties responded to one or more portions of the question focused on the integration of mental hygiene services. The majority of responding counties in the Central New York Region are rural, while Onondaga County is an upstate urban county. In the Hudson River Region, three of the counties are designated as suburban (Dutchess, Putnam, and Sullivan), while Albany and Rensselaer are designated as upstate urban counties and Columbia County is rural. Nassau and Suffolk Counties in the Long Island Region are considered suburban counties. Three counties in the Western New York Region are upstate urban counties (Erie, Monroe and Niagara), while the other eight are rural.

#### **4a. Identify efforts the county has undertaken, or plans to undertake, that will lead to efficiencies and improved quality of care.**

Efforts leading to efficiencies and improvements in the integration of care commonly described by the counties in the four regions include:

- Co-locating, sharing, and merging services and integrating services functionally rather than by disability, particularly in rural counties
- Developing focused collaborations with mental hygiene (e.g., co-occurring disorders task forces) and other agencies serving people with disabilities
- Seeking expert guidance and support from entities with experience in care management and care coordination for people with complex conditions
- Strengthening the workforce to provide integrated physical and behavioral health care, as well as evidence-based treatment and support for co-occurring mental illness and substance abuse disorders, through education, training and expert consultation and educational opportunities

- Redesigning systems of care so they are “integrated” in a fashion that supports integrated care for the people and families being served.
- Beginning to develop networks of care that draw on the expertise of individual providers in an integrated care setting, including recovery centers and peer providers (e.g., peer respite)
- Conducting screening, brief intervention, referral and treatment (SIBRT) in emergency and primary care settings and participating in medication supported recovery training opportunities

Specific efforts toward integrated physical and behavioral health care among the counties include:

### ***Central New York Region***

Four of the seven counties responding to question 4a described efforts under way to improve care efficiencies and quality of care for people with co-occurring mental illness and chemical dependency disorders. Cortland County has created a co-occurring mental illness and chemical dependency taskforce to address service needs, capacity and related issues, encourages educational opportunities aimed at best practices for integrated care, and looks for grant-funded projects to foster integrated care. Hamilton County is striving for integrated treatment plans and noted how helpful it would be to have OASAS waive the application process for the provision of chemical dependency services in an OMH-approved mental health site. Otsego requests regulatory relief (e.g., requirements related to staffing, documentation, physical plant, safety) to help it better achieve integrated care. Of note, the North Country Directors from St. Lawrence, Franklin, Essex, Clinton, Jefferson, Lewis and Hamilton counties are beginning to engage in discussions with the NYCCP to determine the benefits of partnering with the coalition to better manage Medicaid costs.

### ***Hudson River Region***

Dutchess County noted how difficult it is to plan and prepare budgets in an environment of such uncertainty, one in which parts of the clinic restructuring effort are still not settled at the federal level, BHO activities are under way, and movement from a fee-for-service to capitated system and the introduction of health homes are to occur. Albany County is finding that consultation by the CEIC, in conjunction with the FIT curriculum, is leading to improved retention in services and outcomes for people with mental illness and chemical dependency disorders. Putnam County is also working on the integration of care for co-occurring disorders and preparing for the introduction of managed behavioral health and physical health services; preliminary planning is in progress for the development of a health home that provides behavioral, physical, crisis services, peer respite, and joint provider meetings focused on cross-system cases.

### ***Long Island Region***

Nassau County is focusing on sharpening staff skills and knowledge in assessing and identifying the services needs of individuals with co-occurring substance abuse and mental illness conditions. Building from lessons learned in a pilot co-occurring disorders treatment

program, administrative leadership is ensuring the success of ongoing integration efforts using integrated dual disorder treatment (IDDT) protocols and performance monitoring. In Suffolk County, the community mental hygiene system and Pilgrim Psychiatric Center have been working on the treatment and management of depression in primary care settings, using the Patient Health Questionnaire.

### ***Western New York Region***

Chemung County is continuing its work to integrate services across systems (e.g., expand beyond the three mental hygiene disabilities and bring in the Office of Aging and Long-Term Care into efforts to integrate and manage care). It is now setting up a memorandum of agreement between mental health and developmental disability entities that focuses on doing the right thing for the individuals being served rather than assuming that all services can be provided in any one system; activities have begun and are inclusive of county, not-for-profit agencies and State-operated administrators. The CEIC and Community of Solutions initiative have also aided the county in evaluating the degree of integration being achieved for people with co-occurring mental health and substance abuse disorders.

Erie County is strategically advancing care for co-occurring disorders under the direction of a Dual Recovery Coordinator, who is helping the department to reframe mental health and chemical dependency dual recovery services to include assessment and utilization of research informed practices, fidelity measures to practices, development of standardized performance measures and quality improvement planning/management related to the integration of care. In 2010, the Monroe County Office of Mental Health began reorganizing its structure to align with the core functions of the LGU— policy and planning, contract management, quality and accountability and priority services. Within these areas, all disability and age-related services are combined into a system that enables comprehensive, integrated approaches to care. Most other counties in the region are also attending to the integrated of care for dual disorders. Tioga County points to the need to not have regulatory requirements impede the integration of care for behavioral disorders and notes that the paperwork required of primary care providers is far less than that for behavioral health providers.

#### **4b. Identify strategies for service integration and for care coordination.**

Across four regions, counties responding to this part of question 4 described a number of strategies that are similar:

- Co-locating services, particularly for co-occurring mental illness and chemical dependency disorders, and integrating related functions such as treatment planning, case reviews, quality assurance, and staff training
- Participating in local discussions and planning for BHOs and health homes
- Utilizing shared educational resources to strengthen staff skills to provide care management and integrated behavioral and physical health care
- Tapping into care management resources to strengthen integrated care and related support activities (e.g., dual recovery coordinators, SPOAs, NYCCP)

- Considering what is necessary to meet the needs of adults and children with the most serious behavioral health issues and their families

Examples of strategies aimed at service integration and care coordination are:

### ***Central New York Region***

Counties responding to this part of the survey question are primarily working on the integration of co-occurring mental health and substance abuse disorders, with a number looking toward integrated care management under a health home model. In Otsego County, for example, county-operated mental health and addiction services are co-located, with integrated quality assurance activities, staff training, incident review and billing; discussions are taking place about integrated care under health homes and behavioral health homes and shared medical staff is being considered as a bridge across systems.

### ***Hudson River Region***

Similar strategies are being employed in the Hudson River Region, where, in Columbia County, the local government is pursuing a co-located mental health and chemical dependency treatment clinic, while a dual recovery coordinator is promoting the use of the FIT web-based training curriculum. Other approaches to integration in Columbia County include partnerships between human services and the Office of Children and Family Services to better serve youth at risk of detention or placement and co-locating a satellite clinic licensed for mental health and chemical dependency services. Putnam County, on the other hand, is striving to improve communications and strengthen integrated care through conferences for complex cases and monthly provider meetings.

### ***Long Island Region***

Nassau County is taking several steps to improve treatment for co-occurring disorders. It is collaborating with CEIC to evaluate and enhance integrated care and to overcome barriers to care coordination; identifying training needs and addressing them through a partnership with the Nassau County Mental Health Association, OASAS and OMH to deliver relevant training (e.g., motivational interviewing, cognitive behavioral therapy, stage-wise interventions).

### ***Western New York Region***

Much work in the Western New York Region focuses on improving care under BHOs and preparing for the transition to capitated care management through health homes and behavioral health homes for people with serious mental illness. Erie County, for instance, is working with NYCCP to design and implement a specialized health home services program for children with serious emotional disturbance and adults with serious mental illness. The County and NYCCP have a documented record of success implementing person-centered service planning and care coordination programs in diverse service environments, with improved individual outcomes and significantly reduced Medicaid and other government costs. The specialty health homes the County is considering would be a critical structural support for any managed care program that serves children with serious emotional disturbance or adults with serious mental illness. (Other Western New York counties responding to this question are taking similar actions.)

As with the other regions, counties responding to the survey question in the Western Region are concerned with improving care for persons with dual diagnoses and exploring improved care models that provide primary care services and other essential supports for recovery.

**4c. Identify potential strategies beyond the Medicaid redesign and mandate relief strategies covered in the two previous questions that can or should be employed at the state government level that create a more favorable environment for the county and providers to provide more efficient and quality services.**

Twenty-one counties, mostly large rural, responded to Question 4c, which asked what other strategies than those mentioned in parts a and b of the question would counties recommend they State address to create a more favorable environment for successful care management and integrated care.

Strategies recommended across the three regions fall into several categories; collaboration, fiscal, flexibility, information/technology/data, regulatory, and workforce. In the collaboration category, a number of counties asked for greater involvement of counties in the design, implementation, and evaluation of managed care initiatives. Additionally, among counties responding, a number acknowledge the importance of consolidating functions and operations wherever possible, thereby freeing up dollars for reinvestment in critically needed services. The recommendations include:

***Central New York Region***

**Collaboration**

- Clear communications with stakeholders about new initiatives, regulatory requirements and policy changes.
- Seek local input as part of the monitoring and evaluation of Medicaid redesign.
- Involve providers and practitioners in discussion of SAGE, mandate relief and Medicaid redesign.
- Consolidate the disability agency administrative, planning, and fiscal operations to better serve high-cost, high-need individuals with dual disorders and those in correctional settings.
- Consolidate mental health and chemical dependency system operations.

**Fiscal**

- Streamline reimbursement procedures to allow co-location/integration of mental health services and reimbursement in primary care settings.

**Flexibility**

- Ensure that the unique needs of rural counties are taken into account during the development of regional behavioral organizations.

**Information technology/data**

- Provide technical support and financial incentives for the adoption of electronic medical records in behavioral health settings.

- Support the adoption of electronic medical records that are simple, flexible, and not redundant.

### **Regulatory**

- Streamline licensing procedures to allow co-location/integration of mental health services in primary care settings.
- Reduce regulatory barriers across the systems of care so that integrated care may be realized (x3).
- Continue to consolidate State-operated psychiatric centers and reinvest savings into community programs that enable people with serious behavioral conditions to live successfully in their communities.

### **Workforce**

- Provide technical and financial support for training of medical and mental hygiene (all three disabilities) staff for provision of integrated services.
- Address scope of practice issues that impede the delivery of quality care.

### ***Hudson River Region***

#### **Collaboration**

- Ensure that OMH and OASAS synchronize system management so they do not work against each other and create more work for providers, ultimately compromising the quality of care.

#### **Housing support**

- Assure special housing options for people with disruptive behavioral disorders.

#### **Regulatory**

- Invest in federally qualified health centers.

### ***Long Island Region***

#### **Collaboration**

- Create strong local-State partnerships by including LGU personnel in decisions affecting local service delivery systems and fully utilizing their knowledge of community needs and priorities.

### ***Western New York Region***

#### **Collaboration**

- Provide flexibility to providers at the county level in determining eligibility for OPWDD services in the same manner as the OMH system, eliminating state barriers to access.
- Provide directors of community services with more opportunities to plan for change before major policy changes are instituted.
- Ensure clarity in responsibilities of field offices and DDSOs in relation to LGUs to avoid duplication and/or gaps.

## **Fiscal**

- Support consistent/common practices across mental hygiene agencies that permit counties to allocate funding in a more flexible manner (current practice of some state agencies is to allocate funds by provider/by program).
- Ensure the success of managed behavioral health care by enabling counties to manage resources while maintaining fidelity to clinical standards of care and other indicators of performance.
- Support consistent consolidated budget review practices and timely consolidated fiscal report closeouts.

## **Flexibility**

- Be sure to fund those necessary recovery services and supports not covered under Medicaid, thereby keeping health care costs down through the provision of supports essential for healthy community living.

## **Information technology/data**

- Make data compiled by the State available to counties to assist them in planning and services oversight, management, and quality improvement activities.

## **Regulatory**

- Consolidate operations wherever possible to save dollars (e.g., human resources, information technology) and reinvest savings so that individuals obtain only the care needed to maintain health and well-being.
- Allow for the dual licensure (OMH and OASAS) of all staff within an agency such that all staff are part of the OMH and OASAS clinic, eliminating the need for separate waiting rooms, case conference rooms, data bases (servers), support staff, record storage and all the other duplicative things that agencies with both a substance AND mental health clinics now have to do.
- Support consistent/common practices across mental hygiene agencies for county involvement in certification review processes.
- Reduce unfunded mandates and burdensome regulations.

## **Conclusion**

The statewide policy questions included in the local services plan guidelines provide the counties with an opportunity to influence State policy by offering their opinions, experiences and knowledge on important topics regarding the mental hygiene service system. The three policy questions that cut across all disabilities focused on Medicaid redesign, mandate relief and the integration of mental hygiene services. Responses to the policy questions were not mandatory and most reflected the views of Western and Central Region counties, with some responses from counties in the Hudson River and Long Island Regions. The 36 counties that answered the statewide policy questions provided valuable information to the OASAS, OMH and OPWDD. Given the changes to Medicaid and the mental hygiene system, this portion of CPS may be

required in future years so the county perspective is sufficiently represented in State policy decisions.

The most consistent theme throughout the responses was the need for the ability to integrate mental hygiene services to realize improved service quality and cost efficiencies. Successful implementation of NYCCP, Complex Care Management, SPOA, PSYCKES, CTI model, and Rapid Engagement Demonstration pilot are all examples of the counties incorporating the integrated care service model by using techniques such as person-centered care, enhanced case management, complex care coordination, peer recovery services and the employment of off-site services.

Most county recommendations centered on having State agencies provide more efficient access to Medicaid managed care data, integrated electronic medical records and more regulatory relief.

# Recommendations from the Conference of Local Mental Hygiene Directors (CLMHD)

May 24, 2011

Submitted to Commissioners Hogan and Gonzalez-Sanchez  
by Philip Endress, Erie County Commissioner of Mental Health and CLMHD Chair  
and Kelly Hansen, CLMHD Executive Director

CLMHD welcomes the opportunity for positive changes to the behavioral healthcare system in New York under the proposals adopted by the Governor's Medicaid Redesign Team (MRT).

We are optimistic that through collaboration among the state, counties, providers and consumers, New York can meet its objective to redesign and integrate the delivery of mental hygiene and physical health services to consumers in a cost-effective way.

Enrolling consumers with serious persistent mental illness in Medicaid managed care in 2013 and including substance abuse services in managed care are cornerstones of the system redesign. Moving to managed care, coupled with the redesign of behavioral healthcare under the MRT, allows for a new of approaching treatment, services and recovery for consumers.

This effort will require modifications to the existing roles of all stakeholders, including providers, consumers, and the local governmental unit (LGU). From the local perspective, LGUS' responsibility for managing the local system for all consumers—not just those enrolled in Medicaid—will require new and enhanced core functions and responsibilities in a regional behavioral healthcare organization (RBHO) and managed care environment.

In this context, the following provides a broad framework for what the Conference views as the core functions and responsibilities of the LGU in advising and monitoring the impact to the system and consumers with mental illness and substance abuse disorders during Phase I.

The Conference will continue its discussions of the priority elements of the behavioral health organization (BHO), the redesign of the behavioral healthcare system and Medicaid managed care as additional information is available. We look forward to working with the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) to improve the treatment and services for consumers with mental illness and substance abuse disorders in the state.

## **The Role of the LGU in a Managed Care Environment**

The role of LGUs/counties is an important component of managed care in other states, e.g., the counties in Pennsylvania, the local management entities (LMEs) in North Carolina, etc.

In New York State (NYS), local involvement provides a vehicle for determining the impact of statewide policy decisions and managed care operations on local systems of care. The core functions and responsibilities of the LGU in a BHO/managed care environment are anchored in Article 41 of Mental Hygiene Law (MHL), which vests in the LGU the responsibility to develop plans to meet the needs of people diagnosed with mental illness and alcohol or substance use/abuse conditions. What makes LGUs unique and an important change agent in the move to Medicaid managed care is that they are statutorily responsible to:

- **Plan for the needs of ALL LGU residents**, not just Medicaid managed care plan members. The LGU, not unlike the OMH/OASAS, is responsible for addressing the treatment and service needs of all individuals needing mental hygiene services, regardless of the payer source.
- **Plan for an essential array of services and supports** whether those services are a covered benefit in the managed care plan or the provider is in the network.
- **Facilitate forensic and court-ordered services** provided for under Criminal Procedure Law (CPL) and assisted outpatient treatment (AOT), including involuntary commitments, emergency admissions, and competency evaluations.
- **Finance services** through county tax levy and the approximately 20 percent Medicaid local share.

### **CLMHD Recommendations and Requests for LGU in Phase 1**

Included within the authority conferred LGUs by Article 41 of MHL is an explicit role and responsibility for oversight of quality mental health and chemical dependency services. This oversight of the delivery system will require modification in a managed care environment wherein the locus of authority for Medicaid recipients is shifted to private entities. As such, CLMHD recommends and requests the following considerations for the role of LGUs as we move into Phase 1 of RBHOs:

- LGUs will participate in the development, with the state and BHOs, of mutually agreeable service access and quality measures, and will monitor adherence to such measures through the use of data reports provided by the BHOs to LGUs and State oversight entities. Monitoring will be done on quality issues related to timely and appropriate access, clinical outcomes, and quality of care of the managed care program.
- A role for regionally and demographically representative LGUs in each of the steering Committees of the BHO/Medicaid managed behavioral healthcare plans. Steering Committees (or similar governance structures) would comprise representatives of the plan, the State, LGUs, mental health and substance abuse providers, consumers and family members to monitor and oversee the project and bring the local perspective to the group.
- Facilitate access to timely and comprehensive data and information, including access to data and performance reports from the managed care organizations that reflect standards included in the managed care contract with the State

- LGU consultation and participation in BHO contract deliverables, via the CLMHD as the facilitator (except in New York City [NYC]) to convene and coordinate LGUs impacted by each regional contract.

### Conceptual Design of LGU and BHO in Phase 1

The new responsibilities of LGUs in Phase I of the project in an RBHO model and ultimately managed care environment include:

- **Participation** in the definition of key elements of the design, implementation and redesign of managed care. This would include, but not be limited to providing advice on benefit plan design, network development to ensure that a comprehensive, responsive, recovery oriented behavioral health system of care is available to members
- **Monitoring quality** from the perspective of the LGU's overall system of care and the impact of managed care activities on all county residents in need of behavioral health services. Quality monitoring will include but not be limited to an active review of:
  - **System impacts:** Provide feedback to the state and the managed care company regarding the impact of managed care on the local service system and the people served by that local system including the plan members as well as the medically indigent, non-Medicaid recipients, etc.
  - **Member services:** Monitor data reflecting timely access to care, provider choice, appeals and member satisfaction for managed care plan members and provide feedback from a local perspective.

Each of these broad-brush elements includes several varied and important aspects of the system which require planning and focused implementation to meet the objectives the state is seeking from BHO and managed care models. The clinical outcomes, data, and other findings collected in Phase I under the RBHO will inform the foundation for the design of the full-risk managed care system in Phase II. It is crucial that stakeholders are equal partners in the process to design, implement and monitor a behavioral healthcare system that is effective in producing improved outcomes for consumers through access to clinically-appropriate services, and the cost-effective use of limited resources.

### Steering Committees

The Conference strongly recommends that each RBHO be required to create a Steering Committee that is responsible for oversight and evaluation of if and how the RBHO with stakeholders is meeting the objectives of the project. The Steering Committee concept is an accepted model in other states with Medicaid managed care programs. The Steering Committee in each region would be comprised of representatives of:

- BHO
- OMH/OASAS

- LGU : The Conference would facilitate identifying a specific number of representatives to each RBHO region (except for NYC) to participate on the steering committee based on the number of counties in the RBHO and with consideration for urban/rural geographic differences.
- Mental health and substance abuse providers
- Consumers/families/peers

The Steering Committee would be responsible for oversight of various aspects of the RBHO project, such as:

- Identifying the population, i.e., outliers, underutilizers
- Monitoring inpatient hospitalization length of stay to identify appropriate utilization and outliers
- Overseeing the availability and access to community-based services. Are extended hospital lengths of stay caused by lack of appropriate community services?
- Quality of the services in the community
  - Are specific mental health or substance abuse community services more effectively preventing re-hospitalization?
  - How is care coordination working in the region?
- Reviewing mental health and substance abuse policy, financing or regulatory issues that may impact on the functioning of the RBHO
- Reviewing data provided by the BHO that is real time and actionable in order to monitor the project and make necessary adjustments or enhancements
- Identifying opportunities for better treatment integration for the co-occurring population and between behavioral health and physical health
- Developing and advising on indicators and outcome measures

The quality oversight component is a crucial piece of the Steering Committee activities as this portion will answer the question, “Is the RBHO meeting the objectives?” The LGU provides the boots on the ground perspective through planning, contracting, and knowledge of community providers and resources. Counties will work in partnership with the state, managed care companies/behavioral health organizations and stakeholders to build the local service systems that provide access, choice, person-centered planning, quality care, innovative treatment and supports, and overall oversight of the system.

Over the years the LGUs have worked as a partner with the State of New York to develop statewide behavioral health policies and implement them at the local level, a role that should continue in the move to managed care.

# New York City Department of Health and Mental Hygiene Bureau of Mental Health Recommendations

August 2, 2011

**As New York moves toward managing mental health and addiction treatment services and increasing integration of behavioral and physical health care, interim regional behavioral health organizations (BHOs) will be established beginning in Fall 2011 to facilitate the transition to care management and to improve appropriateness and continuity of inpatient care. What suggestions do you have for this interim period?**

- The interim regional BHOs should (to the extent possible) obtain an accurate picture of the regional inpatient behavioral health service utilization and the quality of care coordination for people with behavioral health needs.
- Through its proposed role in data review and communication with hospital discharge planning staff, the BHOs will be in a good position to inform the State and relevant localities about service gaps and unmet needs that may result in readmissions or multiple emergency room visits by some consumers.
- Through its role in facilitating cross-system linkages, the BHOs will likely be able to learn about opportunities for improvement and share information that would be pertinent to developing an effective care coordination strategy for individuals who will be enrolled in managed behavioral healthcare under Phase 2. This information and data should be shared widely among all relevant entities including local counties, providers and the public.

**What should OMH and members of the Behavioral Health Subcommittee of the Medicaid Redesign Team (MRT) take into account as it considers strategies for integrated, managed behavioral (mental health and substance abuse) services, for co-locating behavioral services with physical health care, for integrating peer supports, for guiding the development of health homes, and for other innovative approaches to improving the coordination of physical and behavioral health care?**

- All elements and process within New York's new system of care must be consumer-friendly such that care is easily accessible, flexible, seamless and related to the specific needs of people with serious mental illness.
- Prioritize the adoption of health information technology (HIT) as a lynchpin of integrated care delivery.
  - HIT will foster inter-provider communication and collaboration, and enable accountability for the quality care delivery.

- Integrate peer supports to the fullest extent possible.
  - People receiving behavioral health care should have access to peer specialists at various points in their involvement in the behavioral health system.
  - Peers should play an important role in facilitating service engagement, linkages to social services and promoting/ providing self-management skills.
  - Each health home should have an acceptable ratio of peers to consumers that would enable peers to be involved in an array of activities related to consumer care.
- Integrate mental health and substance abuse treatment.
- OMH should collaborate with the MRT to establish quality operational standards and guidelines for health homes.

**What do you suggest to ensure truly integrated care? That is, what recommendations do you have to bring physical and behavioral health care together to improve the health and quality of life for people engaged in care?**

- Providing people with mental illness in New York City with high-quality, integrated care and facilitating appropriate outcomes requires the following. (These priorities can be advanced by promoting integration in a setting that serves as the point of accountability for an individual's health care.)
  - More use of basic screening/prevention and successful referral strategies across all care settings
  - More meaningful collaboration between the primary and specialty health care disciplines to help promote most effective care for individuals with mental illnesses
  - Greater emphasis on care management to help individuals identify appropriate providers and take appropriate actions to promote their well-being
  - Better communication of relevant clinical information among all providers involved in an individual's care
- Cross-train provider staff at all levels in medical and mental health care practices, particularly on mental health screening tools and chronic disease indicators.
  - These indicators should be incorporated into the use of evidence-based practices around health/wellness and mental health treatment.

**What elements would you like to see included or not included as part of managed networks of behavioral care, as well as in health homes?**

- People who receive behavioral health care should have seamless access to physical health services as well as necessary rehabilitative services such as education, employment and housing and social service benefits.

- While these services do not necessarily need to be part of the managed network of the Plan that handles behavioral healthcare, the Plan and/or its provider network should establish strong linkages with such service providers to ensure seamless referrals and service engagement.
- Prioritize the adoption of HIT as an essential component of integrated care delivery.
- Develop standardized care plans that incorporate all physical and behavioral health needs of individuals and will foster a holistic approach to care.
  - Monitor these plans for quality assurance and use them as a tool to foster provider accountability.

**What suggestions would you offer to move New York closer to evidence-based, person-centered, family focused care based on the principles of recovery and resiliency?**

**Systems Level**

- Create guidelines regarding implementation of recovery practices within healthcare reform.
- Provide opportunities for consumer education on healthcare reform and solicit consumer input.
- Include peers at all levels of system, program and policy planning and research.
- Create more peer run services, peer run agencies and include more peers in the provision of services.
- Support individual recovery by providing opportunities for community integration and stability such as home ownership, employment, education, social integration, etc.
- Adopt a change in language that is more recovery oriented when describing consumers and services.
- Support activities that promote prevention such as promoting advanced directives and providing comprehensive crisis services (e.g., peer run alternatives to hospitalization).

**Programming**

- Develop recovery-oriented indicators to measure individual and programmatic outcomes.
- Strengthen recovery-oriented program evaluation based on recovery-oriented outcomes in the areas of employment, community integration, number of healthy days, attainment of desired life goals, obtaining and performing meaningful roles, and etc.
- Hold programs accountable for producing favorable outcomes.
- Ensure all programs are able to provide culturally and linguistically competent services that address wellness, employment, family integration, harm

reduction/substance use, mental health, trauma, economic self-sufficiency, and self-agency.

### **Education/Workforce Development**

- Create certification of New York State Peer Specialist role to maximize peer workforce development.
- Create guidelines for social work schools and licensing entities to follow that require recovery education.
- Include tenets of recovery, integrated care and evidence-based practices such as motivational interviewing within these guidelines.

# Input from People and Families Engaged in or Previously Engaged in Receiving Mental Health Services

This Appendix includes input from people and families who are engaged in or were previously engaged in mental health services from each OMH region. It also offers the perspective of individuals who are hospitalized in OMH forensic facilities across the State. Finally, OMH attended the public hearing held by the New York City (NYC) Department of Health and Mental Hygiene (DOHMH) and took notes regarding issues, concerns and recommendations. The summary notes, which have been reviewed by DOHMH, also appear in this appendix.



## Central New York Recipient and Family Meeting Recommendations

April 20, 2011

Advocate Specialist Tony Trahan from the Office of Mental Health (OMH) Central Office facilitated a videoconference with individuals and family members from the Central New York Region and OMH Planning staff. The meeting focused on planning for this year's Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of "ideal" elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

## **PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Provide education to people and families engaged in substance abuse programs about the role psychiatric medication can play in working toward recovery

## **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Encourage the use of tools and approaches that are proven to support recovery, such as wellness recovery action planning (WRAP), where individuals can include natural supports in helping them (e.g., to manage their own triggers and their choices for dealing with them).
- Ensure that WRAP is part of the support services available in behavioral health homes.

## **BASIC NEEDS ARE MET**

**Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.**

- While difficult to attain, continue where possible to provide affordable, safe housing.
- Promote work opportunities for people who wish to work and supplement their social security income benefit.
- Rather than build more prisons, provide more safe, affordable housing that promotes a person's abilities to engage in work and feel a sense of dignity and worth.
- Strive to make sure that individuals with serious mental health challenges who have criminal histories (e.g., felony) are not placed at greater risk for victimization and greater symptom development secondary to stress because they are locked out of safe, affordable housing and left to live in very bad buildings and neighborhoods.
- Improve access to "safe" buildings for people with mental illness who will benefit from living in environments with "honest working people."
- To ensure stable community living for ex-felons who are now excluded from federally funded housing, seek a waiver from the federal government that would allow ex-felons to access and utilize such housing after demonstrating for a certain length of time (e.g., two years) that they have no new legal entanglements.

## **LIVING A HEALTHY LIFE**

**Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Understand that when people with serious mental health challenges experience frustration in accessing services, they may lessen their efforts and risk becoming disconnected from care.

- Increase engagement in services for individuals and families by providing education on mental health early to help with symptom recognition, and increase understanding of effective treatments, including medication management.
- Include effective alternative medicine approaches as part of the continuum of care (e.g., reiki, chiropractor, yoga, pain management).
- Know that when people have access to medications and care, they are able to “stay on track” and do better.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

### **Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- Strengthen provider-to-provider communications within the same organization or between organizations to reduce the probability of harm and to improve care coordination and outcomes.
- Build a sense of collegiality and team among providers in an organization and across organizations so the best outcomes can be achieved.
- Assess the degree to which independent substance abuse and mental health providers are taking seriously the importance of treating both substance abuse and mental health disorders and encouraging dual recovery and integrated care.
- In responding to crises, providers should try, whenever possible, to avoid police involvement and the community and personal trauma associated with police intervention, which carries over after recovery and may show up as fear of the police.
- Realize that the police and first responders (e.g., ambulance personnel) have assumed the role of filling a mental health support and safety void in communities and use peers in helping them improve their understanding of mental health issues and empathic responses that will help to maintain calm or de-escalate situations.
- Rather than referring people to emergency departments for crisis care, encourage providers to have a crisis response that begins with having a person answer the call for help rather than an answering machine.
- Avert the need for emergency department care by having a range of crisis services available to people, such as a respite setting where people can go to talk with people who are supportive and understanding, using much less costly hospital diversion programs such as respite homes where the change in environment removes a person from a crisis situation.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

### **Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

- Understand that when providers are connected by computers and they are used effectively, care is improved and helps to set a foundation for good self-advocacy.

- Encourage peer advocates to be involved in strengthening communication skills and teaching individuals how to make the most of their visits to hospitals, clinics, and other care providers.
- Encourage positive mentoring experiences, similar to that seen in programs where people with a cancer diagnosis serve as mentors for people newly diagnosed with cancer.
- Separate out peer mentoring services so they are provided “authentically” by peers who are not employed by the organization in which services are received.
- Utilize standardized peer support training so that peers are able to effectively help people in crisis and at risk for going over the edge.
- Use peer services earlier in the course of a person’s trajectory toward crisis and avert the need for emergency department services.
- Make peer support services and diversion initiatives the first line of intervention before emergency department care is sought.
- At the point a person does seek emergency department services for a psychiatric crisis, ask if he or she would like to talk with a peer while awaiting professional psychiatric assessment, provide a supportive and caring environment away from the hubbub of the department, and make certain that people in crisis are not isolated and alone with their thoughts and feelings.
- Realize the power of peer support services to people seeking emergency department care for crisis because peers are trusted and effective in using their own knowledge and experience (e.g., having walked in their shoes) to provide comfort and help allay fears.
- Place emphasis on the integration of authentic peer support services into all levels of the system of care.
- Call upon peer specialists to help with care coordination when there is a waiting time for emergency department services.
- Use peer bridger services to avert crises.
- Include peer support in standard emergency department care, whether accompanying people in crisis to emergency departments and providing ongoing support or being on hand when a person in crisis arrives at the emergency room.
- Employ the use of crisis lines staffed by peers who can be responsive and compassionate.
- Encourage the use of peer support for people who feel as though they are heading toward crisis, and include preventive options such as peer hospital diversion, peer empowerment centers, peer drop-in centers, crisis lines, and warm lines.
- Look to peer-run services to strengthen employability such as the Intern Work Program (IWP), which offers 1-to-2 year internships and opportunities for strengthening confidence, respect, and credibility.

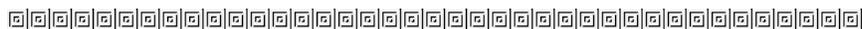
- Ensure that peer services are billable under Medicaid as well as the resources necessary to support this work (e.g., family education, medication management classes).
- Use research findings to strengthen the case for the value of peer services and compensate peers for their expertise and knowledge and as valued members of the health care team.
- Push out more peer support resources into rural areas so that these areas receive the same resources as more urban areas.

#### **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

##### **Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- Ensure that people engaged in services and their families are involved in policy and decision making and are included in planning to shape the design of services and supports.
- Provide education and training that will enable mental health and primary care providers to work more effectively together.
- Help people to understand their current options under fee-for-service or managed care and what services are covered and not covered (e.g., bus passes not covered by Fidelis, but are under Medicaid, supportive housing from Medicaid).
- Address the problems caused by individuals who are covered by Medicaid, yet on psychiatrist waiting lists because too few are available to meet need.
- Know that emergency department visits are the least effective use of mental health dollars for people in crisis, in addition to contributing to negative experiences for people with mental health issues.
- Understand that while substance abuse and mental health agencies are charged with providing care for dual diagnosis, people are not getting integrated care (e.g., Double Trouble does work and should be available whether a person seeks mental health *or* substance abuse care).
- To achieve more cost-effective care, set a goal for diverting emergency department visits (e.g., reduce by 10%), while ensuring that appropriate services and supports (e.g., peer support, bridger services) are in place.
- Provide a place where people engaged in services can ask questions about Medicaid managed care, which continues to be introduced in counties by the Department of Health, and ensure that people have access to the information about whether to en-roll in a managed care plan or continue to receive Medicaid on a fee-for-service basis.
- Under Medicaid, make the expectation that doctors cannot turn people away who have complex medical and behavioral health conditions.

- Address the problem that burdensome paperwork required by Medicaid serves as a barrier to providers participating in the Medicaid program and reduces access to care.
- Because prescription drug copayments come out of pocket under managed and serve as a barrier to obtaining medication, people are not able to obtain their medications as ordered.
- Help people to understand the limits to participating in managed care (e.g., no taxi or bus fare for appointments) and help people who have signed up for managed care and not having their needs met to switch back to straight Medicaid coverage.
- Understand the problems associated with the limit on the number of prescriptions permitted by Medicaid in one year (e.g., once threshold is met people cannot get prescribed medications and end up hospitalized from complications of seizures, diabetes), particularly for people with mental health problems who have other serious chronic health conditions such as seizure disorders, diabetes, newly diagnosed cancer.
- Put in place a warning system for people requiring many medications under Medicare to let them and their physicians know when the threshold for medications is near so that waivers may be requested in a timely way that does not cause untoward effects associated with a lapse in medications.



### **Hudson River Recipient and Family Meeting Recommendations**

April 29, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference with individuals and family members from the Hudson River Region and OMH Planning staff. The meeting focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

## **PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Keep an open door policy in health homes, so that wherever people go they will be helped.
- Ensure that every behavioral health homes has an “open-door” policy.
- Ensure truly integrated general medical and behavioral health services (mental health and substance abuse) that treat the whole person, and make certain that care is not provided in silos.
- Focus behavioral health care on enabling people to be better citizens than patients.
- When working with people who have had very long stays in psychiatric hospitals, remember that their lives are like the Flintstones, while life in the community is in the Jetsons age.
- Understand that people need to be in recovery to recover.
- Wherever possible, avoid institutional models of care; rather help people to express and fulfill their hopes, dreams, and goals.

## **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- If PROS programs will be part of health homes, examine how to move them to a more recovery-oriented orientation, even replacing staff not supportive of recovery concepts.
- Use tools to help prevent re-hospitalization and to identify preferences for care, such as relapse prevention plans and advance directives.
- Begin preparing people to return home from hospitals at the point they are admitted, emphasizing self-directed approaches to treatment, education, and supports for regaining life roles.
- Understand that remarkable things can occur when people care and promote partnerships with providers that are committed to recovery and resiliency.
- Provide the opportunity for people to select their own health coaches, and offer their natural supports who agree to do so, training to be effective health coaches.
- Do not allow “cases to close” in health homes; recognize that as with physical illness, exacerbation and remission can occur with mental health problems; and ensure that access to health care is facilitated through an ongoing relationship with a primary physician who takes responsibility for coordinating and working with each person to manage all aspects of health care.
- Work with people who have behavioral and physical health problems to identify their fears about their conditions and to help them hook up to resources in the community that

they desire and will be critical to maintaining health (e.g., practicing yoga and exercising in the gym to help manage hypertension).

### **BASIC NEEDS ARE MET**

**Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.**

- Ensure financial education counseling services (e.g., to address IDA, PASS funds, EITC) to offer sound advice, enable people with serious mental health conditions to access resources within reach, and aid people in financial planning and management
- Help people to identify barriers to care and supports in the community (e.g., money, a lack of internet access for independently identifying resources for community living).
- Make certain that strategies are in place to enable community living for people who have been hospitalized for long periods and have become too dependent on the system.
- Offer access, when appropriate, to the Medicaid Buy-In program, which permits people with disabilities the opportunity to earn more income without the risk of losing vital health care coverage.
- Create community resource liaisons within health homes to aid providers and people being served so they may identify community resources that will aid overall health, including accessible transportation options.
- Help people to achieve independent community living by helping them to get and keep employment.

### **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Support the creation of recovery-oriented peer-led groups that are based on member interests.
- Have strong linkages in health homes to natural support opportunities in the community.
- Pay attention to “social wellness,” particularly with peer bridger support, so that people can pursue lives they see for themselves (e.g., friendships, healthy romantic relationships), experience full community integration (e.g., with ties to natural social opportunities such as book nights at the book store), and break a reliance on the mental health system to have social needs fulfilled.
- Aid people to live successfully in the community by helping them to explore and become engaged in interests and hobbies.
- Ensure that health home providers have strong ties to and knowledge of community resources to support wellness.

## **LIVING A HEALTHY LIFE**

### **Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Use marketing approaches to convey the shift in health care from illness to wellness and the positive benefits wellness approaches bring to us.
- Rely upon marketing approaches to engage people in learning how to use health homes and get away from old approaches to seeking health care (e.g., rather than using an ER, using peer services as a first step for getting support).
- Encourage a full array of wellness approaches in health homes, from yoga, meditation and other alternative therapies that people can use to support wellness.
- Have health homes engage recovery planners or health coaches to work with people on developing and implementing wellness plans.
- Knowing that people return to hospitals because they lack connections and support in the community, provide an array of services that help people to live successfully following discharge (e.g., peer warm lines, education re: recognizing and managing symptoms).
- Utilize mobile crisis services that emphasize listening, problem solving, and stabilization.
- Think of the emergency department as a place to promote the health home option by having a person who seeks emergency care immediately engaged with the health home, and strengthening engagement in this care with empathetic, respectful care givers (e.g., the health home should be seen as a five-star hotel that people desire to go to rather than an emergency department).
- Borrow practices from traditional medical practice management such as, based on a person's choice, reminder calls for health home behavioral care appointments, helping to foster engagement in care and optimal health.
- Seek providers to join health home networks who have the passion for helping people recover by fostering resiliency, and providing tools and helping people to learn how to use them in living productive lives in their communities.
- Help people to transition from hospital care to outpatient services, where they are supported in their abilities to regain important life roles (e.g., student, father, secretary).
- Encourage the use of natural community supports rather than reinventing the wheel (e.g., the 211 support system is rich with information about community resources that can aid in linking people to the resources that best meet their need).

## **MENTAL HEALTH TREATMENT AND SUPPORT**

### **Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- Strive to maintain the quality of care while making changes during challenging economic times.

- Don't divide services that will be offered in health homes by the degree of illness.
- Ensure that people who are "less sick" receive the services and supports that help them to maintain health independent living.
- Call upon health homes to do outreach to hard-to-reach populations (e.g., people who are homeless).
- Understand that for health homes, the goal is not necessarily to create new services, but rather to help people access what is already available in the community.
- Encourage options for care that foster self-direction, health choices, and no forced treatment (e.g., peer-run services)
- Ensure that forced treatment, paternalistic care-giving attitudes, and coercive approaches are not be part of any health home; rather design approaches to encourage the use of tools to enable people to determine approaches for wellness, self-care etc.
- Ensure that recovery centers providers are attractive to the people being discharged from hospitals so "they are hip to them" and use them upon discharge.
- Break the cycle of repeated hospitalizations, working with people to avoid having them be lost to the system of care or have their conditions worsen and to focus on community connections.
- Match the level of care to a person's needs and rely upon crisis diversion programs to help people avoid hospitalization and even as places where people can go as part of a plan to transition back to their homes in the community.
- Utilize physician assistants and nurse practitioners as much as possible in providing behavioral health care because they take more time to listen.
- Look to successful models like the one being employed in Rockland County where physician assistants assume the role of "wellness assistants," and help people to access the care they desire.
- Encourage comprehensive health care approaches for persons who are living with serious mental health conditions (e.g., meet with nutritionist to assess and implement dietary modifications to manage diabetes).
- Encourage behavioral health homes to attract physicians and providers who love working with people who are dealing with serious mental health conditions.
- Attract providers to the health home network who truly believe in and have a demonstrated commitment to recovery and wellness.
- Ensure that health home networks have expert services for people who have experienced trauma and provide them with clinical care (e.g., wellness action recovery planning) that helps them move toward wellness.
- Avoid the use of the term "health homes," which unfortunately does not convey the concept of coordinated care through an integrated network of physical and behavioral care providers.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

**Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

- To engage people in the range of services to be offered by health homes, make the health home concept an attractive one by stressing care coordination, choice, and education in how to use the health home effectively.
- At the heart of the health home, give priority to having providers teach people how to live self-determined lives.
- In health homes, focus on wellness and wellness approaches that do not necessarily take place in the mental health system (e.g., cooking class in the community center that features good nutrition).
- Provide peer support as a standard part of care in emergency departments and continue to educate and encourage professional providers to tap into the expertise of peers.
- Offer supportive alternative care environments such as the Rose House that provide respite, offer peer support and avert hospital care.
- Use peer-run “safe houses” as places for people to receive support and come and go.

## **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

**Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- As is happening in primary care, change the culture that hospitals are not the place to go unless acute care (e.g., a person is dangerous to self or others) is required.
- Make certain that health homes are cohesive networks of providers and they do not have walls.
- Within the package of services offered, make sure a set amount of flexible funding (e.g., \$1,000 of unrestricted funding) is available for the purchase by the health home of self-directed wellness services in the community that would otherwise not be possible for each person to have (e.g., bicycle, running shoes, gym membership).
- Attract and retain a sufficient number of good therapists in each health home network, to ensure, particularly for children and parents, consistency in care and to minimize gaps in services when providers leave the network.
- Require participation by independent peer-run providers in the network mix of health homes.
- Do not have health homes directly employ peers, to avoid having peers be co-opted into roles not designed for them (e.g., assistant case managers), thereby valuing the independent status of the peer specialist and ensuring effective peer services.
- Educate providers, including hospitals, and promote system change about alternatives to hospitalization and diversion of care to the community.

- Encourage provider education aimed at effective treatment for co-occurring mental health and substance abuse disorders (e.g., participation in the Focus on Integrated Care (FIT) learning curriculum).
- Educate and give providers tools to enable them to offer comprehensive, integrated care.
- Incentivize and attract physicians and other health professionals in short supply (e.g., nurses) to become home health by instituting educational loan forgiveness programs for those who agree to practice for a set number of years in health home serving areas that lack adequate medical care such as remote and/or economically depressed regions.
- Realizing that one of the most important factors in engaging people in integrated care will be the engagement skills of physicians, ensure that preparation for health homes includes a focus on engagement in services and its importance to positive outcomes.



### **Long Island Recipient and Family Meeting Recommendations**

April 19, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference with individuals and family members from the Long Island Region and OMH Planning staff. The meeting focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

#### **PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Ensure that individuals in the lesbian, gay, bisexual, and transgender (LGBT) community are provided with culturally competent care.

- Ensure cultural and linguistic competence education and training of providers, direct-care staff, and volunteers, especially so that care is premised upon respect for the individual and his or her culture and values.
- Reaffirm with providers how critical hope is to recovery and encourage use of this knowledge so they do not give up on people, rather they continually offer them options for growth and know when the time is right these individuals will move along in their recovery journeys.

### **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Provide family education on mental health issues and develop mechanisms for individuals and families to work together toward recovery.
- Educate providers that mental health treatment and supports are most effective when offered with empathy and caring, are designed to allay fears and help people cope effectively, take the whole person into account, and not provided in a way that people engaged in care sense that providers “are just going through the motions.”

### **BASIC NEEDS ARE MET**

**Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.**

- Provide the option for a home through single residency housing (SRO), which offers onsite medical and mental health services that promote health and well-being and have the potential for coordinated and integrated care.
- Provide more integrated, affordable community housing.
- Make certain transportation services available so that people may access care.
- Assess and strengthen, where indicated, daily living skills that enable individuals to sustain productive community living (e.g., cooking, writing checks and balancing check books, paying bills, doing laundry, managing chronic physical conditions such as diabetes, maintaining orderly and clean residences, navigating the public transportation system).

### **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Help providers to understand that maintaining a person’s privacy—even when a people have not provided staff with a release under the Health Insurance Portability and Accountability Act (HIPAA) to discuss their cases with their families—does not mean that staff should ignore families nor listen to their concerns. Rather, they should tap into families’ knowledge of their loved ones to help foster recovery.

- Educate communities about the importance of housing for people dealing with mental health challenges and the options that are available, to help enhance public knowledge about what helps people to be stable, productive members of the community.
- Particularly for individuals engaged in mental health care who are incarcerated, ensure supportive family involvement as much as possible.
- Address the stigma and discrimination associated with mental illness through general education that emphasizes the abilities of people with mental health challenges, including the ability to recover.
- Help to bridge the gap between when people first experience symptoms to when they seek care by incorporating a curriculum, such as an adapted “Breaking the Silence,” program for the early elementary grades that engages children, fosters compassion and caring, eliminates fear through education regarding early signs and symptoms, encourages children to ask for help when needed, and eliminates the stigma associated with mental health challenges and illness.

## **LIVING A HEALTHY LIFE**

### **Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Ensure that young adults dealing with serious mental illness are engaged in the normal developmental work of the young adults—discovering who they are as individuals and separating from their families of origin—by supporting young adults to gain access to housing, rather than forcing their families to evict them, possibly to be homeless, before they can be considered for housing support services.
- Recognize the needs of families that are providing housing to their loved ones with serious mental health challenges and aid them in supporting their loved ones (e.g., respite care, respect for the role families play in helping their loved ones recover).
- Help communities to identify people at risk for mental health problems (e.g., homeless individuals) and develop strategies to intervene (e.g., crisis intervention teams during nights and weekends, strong connections to community care) so they do not end up in the criminal justice system where they do not get the treatment they need.
- Educate providers, from physicians to case managers, about recovery-oriented resources that are naturally available in their communities and promote the integration of such resources into strengthening a person’s ability to use natural supports in coping with mental health challenges.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

### **Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- When care is provided through a “network,” it must truly help people to manage their own care and navigate the system successfully.

- Ensure that people who need case management services have access to them.
- Ensure case management services for individuals who find it difficult for, or may be incapable of, navigating behavioral and physical health services.
- Help increase sensitivity and knowledge about cultural groups in a provider's community, to ensure that beliefs and values are seen within the context of culture rather than misinterpreted as signs and symptoms of mental health challenges.
- Ensure that mechanisms are in place in behavioral health homes that foster communication between physicians.
- Redirect funds from inpatient care to services that support vocational and educational programs for persons engaged in services.

### **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

#### **Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

- Make sure that OMH gives attention to education on advance directives and other aspects of self-directed care during licensing visits, and invite people engaged in services and their families to participate in licensing visit debriefings.
- Focus client and family education on different approaches to personal safety and wellness such as the use of advocates, wellness recovery action planning, advanced directives, and power of attorney.
- Provide information to individuals engaged in care and family members on how to designate legal proxies, so that individuals have a way to protect their self-interests.
- Encourage people engaged in services and their families to be involved in advocacy at all levels of the system of care.
- Ensure that natural community services are incorporated into a behavioral health home's network of services and increase the level of awareness about how these services support recovery.

### **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

#### **Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- Make certain that physicians, nurses and other professionals are knowledgeable and current about wellness recovery action planning and other tools that aid people engaged in care to be mindful about what helps and hinders recovery, while providing structure and support.
- Educate providers on the importance of programs such as Family-to-Family, National Alliance on Mental Illness (NAMI), In our Own Voices, and Federation of Organizations to recovery and resiliency.

- Work with providers to change the culture of care from one that is focused on what is wrong with an individual to one that seeks from individuals their personal stories that tell what happened to them.
- Mandate training of first responders and law enforcement officers so they may intervene more effectively with individuals who have psychiatric histories or are demonstrating behaviors that may indicate mental health problems.
- In the forensics mental health system, ensure that clear, accessible grievance processes are in place.



### **New York City Recipient and Family Meeting Recommendations**

April 26, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference with individuals and family members from the New York City Region and OMH Planning staff. The meeting focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

## PEOPLE FIRST

Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.

- Incorporate recommendations from [Infusing Recovery-Based Principles into Mental Health Services](#) ☞ the 2004 white paper into every aspect of health home development.

Ten Rules for Quality Mental Health Services in New York State  
(from *Infusing Recovery-Based Principles into Mental Health Services, 2004*)

### Care must:

1. Be based on informed choice
2. Be recovery focused
3. Be person centered
4. Cause no harm
5. Ensure free access to records
6. Be based on trust
7. Have a focus on cultural values
8. Be knowledge based
9. Be based on a consumer-provider partnership
10. Accessible, regardless of ability to pay

- Incorporate recommendations from the *Infusing Recovery-Based Principles* white paper into training of professional staff members.

- Develop public education strategies to address cultural barriers to treatment based on a culture's long-held values and beliefs (e.g., medications are not good to take) and provide education on how to be sensitive to cultural values while getting people the help that will help them to be healthy and well.

- To engage people in services and supports when they would be helpful, make

sure that outreach and engagement strategies are culturally competent and produce dialogue between people who may benefit from services and the people who are trying to help (e.g., to better understand how stigma may be expressed, what helps to deal with symptoms, how is "recovery" understood and integrated or not culturally, how cultural beliefs impact treatment and response to treatment).

- Guide development of health homes using the 10 components that comprise the [National Consensus Statement on Recovery](#) ☞ as well as recommendations contained in the Institute of Medicine 2001 [Crossing the Quality Chasm](#) ☞ report.



- Address the issues related to the disproportionate number of persons of color with mental health problems involved in the criminal justice system and community impact (e.g., more people going to jail than college).
- Understand that a system of care truly based on the values of recovery and resiliency is essential to aiding hard-to-engage people to stick with treatment and support.
- Always keep in mind that the individual and family being served are at the core of good health care, which is enhanced by close connections between members of interdisciplinary teams.

- Given that with any illness other than mental illness second opinions are valued, work to engender respect and turn around the attitude that people engaged in care “don’t” know what’s best for them.”
- Remember that what works in one community will not necessarily work in another, so tailor approaches to the community and its culture.

### **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Work with clinicians to help them understand the importance of not discouraging hope for recovery.
- Have processes in place to support consumer choice (e.g., how to change your physician without a hassle) and effective care.
- Provide good education and support for medication management so that people engaged in services are able to work with physicians collaboratively to fine-tune medications so they are most effective.

### **BASIC NEEDS ARE MET**

**Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.**

- Increase the availability of training opportunities for peers so more of them can be actively involved in health homes and available to help each other live, work and socialize fully in their communities.

### **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- To engage people in services earlier in the course of having psychiatric symptoms, create community partnerships that help to foster engagement in services in ways that are culturally sensitive and appropriate.
- Address the substantial barrier to care due to the stigma and discrimination associated with mental health care by improving community and family education and by engaging people and their families in care without stigma.
- Provide a great deal of well-advertised public education that helps link people to support and treatment services, helping to reduce the stigma through normalizing messages (e.g., Feeling stressed? Call xxxx to speak with a supportive person).
- Don’t wait for people to come to behavioral health homes for help; rather, reach out in communities to where people who need help are.
- Realize that one of the best ways to break down the stigma and discrimination associated with mental health problems is wide community involvement in health homes.

- Be instrumental in conveying facts and information about mental health, mental health conditions and what works, about the essential nature of recovery, and about how important it is to give people a chance to try and, when they fail, to learn from their experiences.
- Help to correct public misunderstandings and perceptions about mental health conditions by taking us “out of the closet,” and telling it like it is (e.g., we can recover, we can take care of ourselves and, given the opportunity, take care of others).
- Provide ongoing and regular family education to people who are just entering the health home and newly diagnosed or identified as in need of mental health treatment and supports.

## **LIVING A HEALTHY LIFE**

### **Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Educate people enrolled in health homes to seek help when symptoms worsen, thereby helping to reduce the window of time between the onset of disabling symptoms and treatment.
- Provide an array of tools that help prevent mental health conditions from developing or for early intervention when symptoms become problematic:
  - Peer-staffed warm lines for support (not emergency care) 24 hours a day, seven days a week that take into account coverage to meet cultural and linguistic needs
  - A central way for community agencies to be better connected across the system of care in a community
  - Advertising resources aimed toward eradicating stigma and discrimination and promoting mental health wellness
  - Educational resources for individuals and their families to help them understand mental health conditions, treatments, supports, recovery, etc.
  - Certification as peer counselors
  - Incorporation of peers as valued members of health teams in health homes
  - More peer guidance counselors and youth peer advocates in schools, particularly to work with adolescents
  - Support for youth peer networks
- Provide public education on the common signs and symptoms of psychiatric conditions (e.g., with schizophrenia, person goes to college, has a breakdown, receives diagnosis) so that people can recognize when a loved one or friend may be in need of help.
- Among groups offered in health homes, make sure there are groups devoted to education and support for integrated physical and behavioral health care (e.g., a group where people discuss interactions between physical and mental health).

## **MENTAL HEALTH TREATMENT AND SUPPORT**

### **Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- Make sure that primary health care and behavioral providers are aided in communicating effectively with each other so that people engaged in care do not get mixed messages or conflicting information.
- Make certain that behavioral health homes provide a range of recovery services within the context of comprehensive behavioral and primary medical care.
- To the degree possible, make medical health homes “one-stop shopping” places.
- Build into health homes mechanisms to foster good communications between primary care providers and behavioral providers so that individuals receive care from providers who are “on the same page.”
- Provide an array of specialty care in behavioral health homes, from peer to clinical expertise.
- Make MyPSYCKES available online within health homes so that people engaged in care and providers can discuss medication decision making.
- To engage people with serious mental health conditions who have become disconnected from care, rely upon peer support, which will be critical in avoiding treatment failures that may have been experienced by individuals in the past.
- Make sure that behavioral health homes are welcoming environments in which people feel comfortable in obtaining care.
- Set the expectation that mutual respect for the varied strengths and contributions of peers and professionals will be central to cohesive health home teams.
- Make sure that at the heart of every health home are integrated teams of health care providers offering treatment and support services.
- Work with professional and ancillary staff to help them understand the role peers play in promoting health and well-being and help them to incorporate peers and their expertise into integrated health teams (e.g., treating peers as members of the team who bring peer expertise and knowledge, not as “patients.”)
- Make certain that health homes have peers as essential clinical health team members, in a way similar to the integration of peers into assertive community treatment teams.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

### **Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

- Employ peers to provide employment, socialization, benefits counseling, transportation, and advocacy services in each health home.
- Employ peer bridgers to avoid costly institutional care.

- In health homes, rely upon professional staff to provide cognitive treatment and medication therapy and use peer to do everything else.
- Seek to employ peers in promoting good communications among behavioral health home providers.
- Use trained peers to provide support services such as groups for co-occurring disorders.
- In preparing to develop health homes, have ongoing communications and meet frequently with peers to seek guidance and their expertise.
- To ensure that people get the best care possible at the onset of psychiatric symptoms, be sure peers are part of the care team, which not only helps individuals feel hopeful but also helps to allay the stigma and discrimination associated with seeking mental health services.
- Know the power in having peers be part of health home teams, where by their presence they convey that recovery is possible and give hope to people who would otherwise not have it.
- Made sure that one-to-one peer counseling by well-trained peers is available on demand.
- Provide warm line telephone support services around the clock.
- Involve peers at pivotal points in a person's journey through a health home (e.g., intake, treatment planning).

#### **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

##### **Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- Monitor and evaluate what happens as health homes are introduced, engage people who receive or have received services and their families in identifying indicators of progress (e.g., recovery outcome measures), use valid and reliable measures of primary and behavioral health care, and use the data obtained to ensure quality health care.
- Ensure that regular training of health home providers, including HIPAA training and data sharing rules) is driven by a core curriculum designed for professional and peer staff.
- Include peers in training for professional staff members as well as professional staff in training for peers, thereby facilitating mutual understanding and respect for what each contributes to a multidisciplinary health team.
- Provide sufficient funding for peer training.
- Provide good education and training of health home staff so they are able to provide quality care based on best practices.
- Consider having health homes offer clinical treatment and medication therapy and contract with peer-run services to meet support needs, ensuring sufficient financial support to meet goals and objectives.

- Ensure that the voice of people who have been or are engaged in services and family members is represented in the assessment, development, operations and evaluation of health homes.
- Realize that electronic records can be vital in helping with physical and behavioral care coordination, improving communications between providers and the people they serve, and ensuring safe care (e.g., documentation of medication side effects helps providers in decision making).



## **Western New York Recipient and Family Meeting Recommendations**

April 21, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference with individuals and family members from the Western New York Region and OMH Planning staff. The meeting focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

### **PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Make certain that care is individualized and guided by each person’s personal choices.
- Ensure that behavioral health homes are organizations that are integrated into the fabric of communities and reflect that people who use their services are respected, and valued citizens.

## **BASIC NEEDS ARE MET**

**Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.**

- Look closely at the [Veterans Administration recovery services model of psychosocial support](#)  to promote full community living for people dealing with serious mental health conditions.

## **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Educate primary care physicians about mental health conditions, the value of mental health services and supports, and the types of interventions proven effective in promoting mental health and well-being; at the same time, work on the stigma associated with mental health conditions that exist among medical practitioners, which will help people to be open with their physicians about their mental health challenges and facilitate more effective and integrated care.
- Use strategies for engaging people in mental health care much like the strategies used for other health conditions (e.g., as cancer centers tout their experts, mental health centers could do the same; people with mental health problems do have enjoyable lives; remind people that they are not alone and empower them to seek help).
- Understand that marketing provides a road map for people who wish to have better integrated physical and behavioral (mental health and substance abuse) care, particularly services that are holistic in nature.
- Understand that one of the best ways to engage people in getting mental health care is to market these services well.
- Look for places to get the word out about mental health symptoms (reaching people affected, families, loved ones, friends, and co-workers) and what to do about them (e.g., signs at bus stops that ask, “Are you depressed? Don’t be alone. Go to xxxx for help.”)
- With peer outreach and engagement, make sure that peers visit homeless shelters and help people to make appointments that help them with recovery (e.g., doctor’s visit, AA meeting) and build relationships that help people to see opportunities for recovery.
- Provide peer outreach and engagement services in soup kitchens and houses of worship and advertise them (e.g., church bulletins, coffee shop listings, bus stops, public service announcements, social clubs).
- Make certain that care is truly integrated under managed care and reflected by robust community connections and activities that help to address trauma, depression, and other challenges for communities.
- Keep the messages about how mental health is treatable out there constantly, because people are in various stages of readiness about when to seek help; continual messaging may catch them when they are ready to seek help.

- Keep literacy in mind when creating mental health messages for marketing purposes (e.g., public service announcements).
- Provide resources that enable peer networking groups to showcase people's strengths and engage people with mental health conditions in using their talents to foster community living and participate in valued community events.
- Realize that when people with mental health problems become active members of their community, the connections they make may be helpful in times of crisis, especially when a community member contact peer network members to intervene rather than calling police.
- Realize the importance of social activities, in concert with treatment, in preventing isolation and promoting a good life in the community.
- Encourage behavioral health organizations to tap into natural support systems, such as houses of worship that often link to resources that are used by people who are disconnected from care (e.g., church sponsors AA meetings) and work with spiritual leaders to increase knowledge of trauma and trauma treatment.
- Work with schools and houses of worship to reduce violence and offer resources to youth who wish to deal with mental health and substance abuse problems.
- See the opportunities in community activities to help people with mental health challenges become more fully integrated into the life of the community.
- Realize that stigma is reduced and public education about mental health enhanced when people with mental health challenges are engaged productively and fully in their communities.

## **LIVING A HEALTHY LIFE**

### **Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Design innovative marketing campaigns that sends the message that people with mental health conditions desire to be alright (e.g., "It's all about us being alright), much like the "Got Milk?" campaigns (e.g., "Got Depression?").
- Promote the abilities of each person to be seen as person with strengths, to gain citizenship, and to lead a full life in the community.
- Teach children how to deal with anger issues by providing more positive alternatives.
- Teach children in the early grades about mental health challenges, focusing on the basics of mental health and wellness, how to be supportive of people with mental health conditions, and how to seek help when experiencing symptoms because early intervention and prevention are so important.
- Provide scholarships to people who are homeless so they can be involved in community events that link them to peer support (e.g., HA-HA conferences), expand their

knowledge about the wide array of services available traditionally and nontraditionally), and help to foster positive views of mental health).

## **MENTAL HEALTH TREATMENT AND SUPPORT**

### **Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- Enable providers to educate people and families desiring care on available programs, particularly peer-run and peer-operated programs.
- Encourage providers to help people engaged in care to explore the different programs available to them.
- Help general medical practitioners to understand that help seeking for mental health symptoms sometimes gets expressed through physical conditions (e.g., accidents) and encourage physicians, when indicated, help patients to attain mental health treatment when indicated.
- Expect that hospitals will move from a culture of fostering dependency to promoting discharge planning that embrace peer services, fostering each person's confidence and strengths, and building skills for community living.
- Help people with mental health challenges to embrace life more fully by making life outside an institution more attractive (e.g., peer services immediately upon admission to a hospital, peer bridgers who work with individuals well ahead of hospital discharge).
- Have health homes provide counseling services in schools and deploy grief counseling services in times of community need (e.g., school shooting).
- Promote programs such as [Fathers who Care](#)  in high schools, where young men have the opportunity to learn healthy approaches to managing feelings as well as good parenting skills.
- Ensure that health homes provide prevention and early intervention services, so that people can avoid the development of mental health challenges and avoid life-long disability and functioning.
- Make sure that peer outreach services are part of the behavioral health organization efforts and behavioral health homes.
- Ensure that holistic health services are options offered in behavioral health homes.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

### **Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

- Use knowledge about the value and proven effectiveness of peer support services to make certain that the role of peer is respected as A member of the health care team.
- Be sure to promote peer networking groups because they help people to find their strengths and build upon them.

- Rely upon peers to serve as mentors to people who wish to learn how to manage symptoms and gain stability in community living.
- Realize that peer services give people struggling with mental health problems hope for the future, most notably by the very presence on the health care team of people who have dealt with mental health issues and are in recovery.

**MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

**Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- Strongly advocate for Medicaid-billable peer outreach and engagement services that provide essential education and support.
- Fund integrated services that focus on autism and provide teacher and ancillary health professional (e.g., occupational therapists) education on autism and strategies for dealing with autism spectrum disorders.



**Forensic Peer Network Group (PNG) Meeting Recommendations**

March 30, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services between OMH Planning staff and recipients from Kirby Forensic Psychiatric Center, Mid-Hudson Forensic Psychiatric Center, Central New York Psychiatric Center, Rochester Psychiatric Center Regional Forensic Unit, and Buffalo Psychiatric Center. The goal of the meeting was to obtain feedback from individuals receiving forensic mental health services in OMH facilities for use in planning mental health services that help people on their recovery journeys and promote mental health and well-being. As with the many stakeholder meetings held in preparation for the development of the yearly statewide plan, the recommendations are not meant to be prescriptive, but rather to serve as guidance to OMH as it develops strategic priorities for the entire public mental health system.

Mr. Trahan began the session by pointing out that every state in our nation is required to help people who are elderly and/or have disabilities to live in the most integrated community setting possible. The community for individuals served by OMH forensic settings is the secure forensic hospital or civil psychiatric center. Mr. Trahan posed the question, “Until you are able to physically leave the facility, what can OMH do to help you be integrated into the community.” During the meeting, he explained an integrated setting for people in secure forensic hospitals who are managing mental illness would include being more involved in the hospital community or, even to the degree possible, the community outside the hospital.

To help people consider this larger question, Mr. Trahan also asked a series of related questions:

1. What does most integrated care look like for people in secure forensic hospitals (Kirby/Mid-Hudson/Rochester)?
2. What does most integrated care look like for people in civil facilities (Buffalo)?
3. What does most integrated care look like for people at Central New York who don't seem to fit into the other two categories?
4. What happens in your facility during non-treatment times?
5. Are there trainings that may be helpful for you as you plan for the future?
6. What can we do to increase positive family involvement?
7. For people sentenced to lengthy sentences, up to and including life, or who have not been sentenced but will be here for a while and have recovered from their mental illness, what role could you see yourself in helping people?
8. The traditional path to the community from a secure hospital is to a civil facility, then community residence. All of these are big changes. What can we do to help with the transition at each stage?

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down their recommendations under each of the first seven questions. The summary groups responses from questions 1, 2 and 3 together and from questions 4 and 5. While time ran out for discussion of Question 8, Mr. Trahan noted that he and Mr. Allen will be discussing this question during upcoming Peer Network Group meetings this year.

### **QUESTIONS 1, 2, AND 3**

#### **Recommendations for supporting integrated care across secure forensic settings and hospitals**

- Support forensic wellness and recovery action planning to integrate recovery into forensic mental health treatment and strengthen a person's abilities to manage mental illness as he or she moves through the forensic process from secure to civil to community placement.
- Support family days and encourage Recipient Affairs Committee members to be active in sharing information and educating families on a range of issues, from becoming involved in legislative days to learning how to support behavioral health recovery.
- Offer family visiting hours that take into account and accommodate a person's work hours, which would help improve community integration.
- Hold family days, consider more social events during the year other than holidays (e.g., movie nights) and offer education programs that would bring people receiving care in the secure forensic facilities together with their families and treatment team members in a more general way than happens with treatment team meetings (more programs like these would be a win-win for everyone).

- Help to strengthen the quarterly education meetings for family members by having ones that are more issues oriented, for example, with medication and mental health education being offered as in the past.
- When concerns about ensuring a safe environment are of chief importance and visiting hours are not permitted within the first month of admission, consider permitting phone contact with family members to help people receiving services to maintain their connections to their families.
- Consider having social workers reach out and connect with families more, providing information and support that encourages family involvement in care.
- Make the computer room available so that people receiving care in the facility can responsibly access recovery information via the internet and visit other authorized web sites having to do with mental health treatment and recovery.
- Provide access to a public law library that will enable people who are receiving forensic psychiatric care to participate in their own defense.
- Consider the use of technology (e.g., skype) to permit people receiving services to connect with family members, which would help in overcoming a barrier to telephone communications resulting from the costly charges associated with using the phone.
- Continue work skills' program to help people develop skills that are marketable in today's society (e.g., providing clerical services, stripping and waxing floors, planting vegetables and flowers for the upcoming season), recognizing that these programs are very therapeutic, provide a sense of pride in work accomplished, permit people to make a contribution to the facility, gain experience in working and dealing with mental illness, help them to do things they thought they would never be able to do, and earn valuable volunteer and paid work experience.
- When possible, maintain the stable nature of the living environment, and help to increase each person's abilities to cope with stress and chaos when this is not feasible (e.g., people boarded on units as new admissions who don't shower, don't behave).
- Sponsor peer-run programs to come into the facility, such as Howie the Harp, to discuss ways to bring sheltered workshop activities (e.g., a frame shop) to the facility and increase learning and vocational development opportunities.
- Promote informal information sharing and community integration by inviting into the facility groups that could offer concerts, shows, vocational presentations, 12-step meetings.
- Encourage donations to the library that would increase vocational knowledge and options (e.g., books on auto mechanics).
- For individuals who enter secure forensic psychiatric centers for "tune ups" and return to prison, continue to work closely with DOCS to promote more recovery-oriented approaches for engaging with people in prison who have psychiatric disorders.

- As persons prepare for discharge from a facility, begin well ahead of time to put in place supports (e.g., SSI, medication access) that will help individuals to make a successful transition into the community.
- As persons prepare for transition from inpatient civil psychiatric centers back into the community, help to prepare them using approaches such as tiered privileges that allow the individuals to progress step-by-step through various stages of reintegration (e.g., passes to adult education classes, weekend visits to home, group home on the grounds of the psychiatric center, single-room occupancy).
- Strive to create environments that provide hope, help to bring out each person's strengths and help staff to understand the value of person-centered care and therapeutic support for recovery, realizing such approaches help shackles to go away.

#### **QUESTIONS 4 AND 5**

##### **Recommendations for non-treatment times, desired training and effective use of treatment**

- Recognizing that hospitalization is focused on treatment, strive to have balance between treatment/group time and non-treatment time so that people can get the most benefit from and are not “worn down” by nonstop structured treatment.
- Look at the mix of treatment groups and see where redundancies can be omitted or limited.
- Engage people receiving care in helping to shape group treatment, thereby increasing its potential to engage participants in relevant content.
- Consider the structure of the day for diagnoses (e.g., a day of nonstop treatment may not be indicated for a person with bipolar disorder who is striving to strike a balance in life's activities).
- Use groups as opportunities to help people strengthen social skills that are needed inside and outside of forensic settings.
- Allow some time on weekends for “reflection” on thoughts and activities from the previous week.
- Provide opportunities for physical activity and strength training, which are essential to good physical and mental health and help to improve recovery.
- Encourage groups that people can join optionally (e.g., stress management, current events) and use to help structure their own time.
- Increase positive non-treatment individual, group and social opportunities such as karaoke, Latin music, movies, concerts, board games, video games, drumming, and spiritual counseling.
- Take a look at how the groups by nursing students can be freshened (they tend to “border on boredom”) and more engaging.

- Authorize guest speakers to come in and speak to persons receiving services on recovery and resiliency.
- Offer training to persons engaged in services who desire to learn how to run groups, enabling these individuals to use these skills and knowledge as they move into the community (e.g., yoga, knitting circle to knit blankets for children in hospitals).
- Help people to integrate into their community more effectively through attention to personal hygiene (e.g., bring in nursing students to provide basic hygiene classes, hand washing technique).

## **QUESTION 6**

### **Recommendations for increasing positive family involvement**

- Recognize and incorporate, where possible, families in therapy so that they better understand their role in promoting health and well-being, providing education so families do not encourage unhealthy behaviors (e.g., encourage a loved one to stop medication because of a lack of knowledge about its therapeutic effect and benefits), and gaining skills to support the recovery of a loved one who is returning to the community.
- Engage the person receiving services in determining the degree of family involvement he or she wishes (e.g., email, participate in family day, visiting privileges) and support each person's choices.
- Work with the individual and family to identify values that may be at odds with treatment approaches and develop strategies for dealing with them.
- Educate people receiving forensic services so they can, in turn, educate their families.
- Provide families with education on medications, discharge planning, what to expect when a family member enters the forensic system (length of stay issues), and how to be supportive through long incarcerations.
- Use the treatment plan as a tool to engage families in supporting recovery and following a person's progress toward it.
- Particularly for facilities in remote areas or those with limited visiting hours, recognize that a lack of family contact and involvement in treatment can be discouraging, limit a family's engagement in the treatment process, and serve as a barrier to recovery.
- Support family participation in treatment as a way to boost morale and strengthen individual spirituality.
- Use the internet (email, skype, VTC, access to mental health sites) as tool to help keep families involved and help persons engaged in care to connect with each other for peer support and education.
- Hold family education days that focus on specific topics (e.g., stigma, treatment planning) and help to engage families in participating.
- Encourage the development of a family support network so that families can share information and support each other in supporting their loved ones.

- For people without immediate family, allow other supportive people visitation privileges.

**QUESTION 7**

**Recommendations for helping others, by people sentenced to lengthy terms of incarceration, or who have not been sentenced but will be here for a while, and have recovered from their mental illness**

- As people enter the system, support them in serving their terms and never returning to prison.
- Use personal knowledge and talents to help others, for example by tutoring others.
- Genuinely being involved in groups, opening up and sharing individual insights, and reinforcing one's rehabilitation and recovery in positive ways.
- Contribute to improving one's community and environment through work actions.
- Talk with people who are readying to leave prison, help them to see that there is a future, inspire hope and encouragement, and affirm the reality that it will be challenging to succeed on the outside because of having mental illness and having a criminal record.
- Encourage people about to leave prison to think about making amends for past actions and remembering what it feels like to lose family and freedom.
- Encourage people sentenced to long terms of incarceration and who have learned to handle their illness in day- to-day life to use their knowledge to help prisoners in the special housing unit better cope.
- Help people receiving services to come to terms with their illness and manage it as best they can.
- Use some symptoms of illness in a positive way, e.g., OCD can help people organize, stay on task, and keep things orderly on the wards.
- Encourage participation in activities such as the RAC and the PNG to reach the forensic mental health community as a whole.
- Encourage the work of peer advocates and peer specialists in helping to keep people receiving services and their families linked in supportive ways (e.g., family education, stigma reduction).



**Information Gathered by OMH during the Public Hearing  
sponsored by the  
New York City Department of Health and Mental Hygiene  
May 11, 2011**

The New York City Department of Health and Mental Hygiene (DOHMH) invited in May 2011 peers, families, service providers and other stakeholders from the Bronx, Manhattan, Queens, Brooklyn and Staten Island to a mental health planning forum. As noted by DOHMH, the goal of the City forum, which was held in a public testimony format, was to aid DOHMH in determining systematic goals and priorities to improve the City's mental health service system. While the forum focused on the adult system of care, DOHMH provided participants with the opportunity to comment on any aspect of mental health planning.

As part of its effort to collect broad stakeholder input into the development of the annual statewide comprehensive plan, OMH attended the public forum held by DOHMH and noted concerns and ideas expressed by forum participants. The OMH summary below is intended to capture participants' ideas relevant to planning and to convey them in actionable language. The summary also shows participant suggestions and recommendations within the context of the OMH strategic framework content domains.

**PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Place people engaged in care and their families at the center of service delivery.
- Recognize that one of the biggest challenges to mental health care today is to not destroy hope, increase learned helplessness, hinder the abilities of people to get on with their lives, and create an “us” and “them” system of care.
- Rather than concentrating on building new programs and new ways to offer services, work with people individually, nurture their hopes and dreams, and help them to move forward in achieving their own recovery.
- Support the partnership forged between with the Citywide Lesbian, Gay, Bisexual and Transgender Committee of the New York City Federation for Mental Health, Mental Retardation and Alcoholism Services, particularly for its ability to find collaborative solutions to issues.
- Respect individual rights of each person and not label every person who chooses to engage in services as a “consumer.”
- Strive to understand what it is like to be in another person's shoes and support the capabilities of people dealing with mental health challenges.

## PERSON-CENTERED DECISION MAKING

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Read Vega's piece, [Self-Determination and Responsibility in Transformation](#) <sup>4</sup>, to gain a fuller understanding of the importance of having power over one's own life to proceed toward recovery and the role professionals can play as transformation agents.
- Truly understand HIPAA and its intent; avoid having it become a barrier to including the family in an individual's plan of care.
- When people engaged in care desire to have their families participate in care planning, try to accommodate the needs of working families by scheduling family meetings for evening and weekend hours.
- Recognize that listening to families of children with mental health needs and being respectful of their understanding of their children's needs will go a long way toward producing positive outcomes for the child's growth and development.
- Find creative ways to help people express their hopes and dreams and create environments that allow them to pursue them.
- Listen carefully to what people engaged in services say helps and hinders recovery and understand how crucial it is for people engaged in services to be heard and have this demonstrated through the words and actions of providers.

## BASIC NEEDS ARE MET

**Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.**

- Preserve the community safety net for vulnerable New Yorkers, redirecting savings from state-operated service reductions to maintain and protect the safety net.
- Recognize that the persistence of mental illness is linked to poverty.
- Understand that recovery is not a cure and, when it persists as a chronic condition, it is important to protect the benefits that enable people to live productive lives.
- Recognize that safe, stable housing is essential to recovery.
- Recognize that decent, affordable housing and the stigma and discrimination associated with mental health problems are formidable obstacles to recovery.
- Promote each person's ability to advocate for himself and herself in meeting and sustaining basic needs (e.g., housing).
- Understand the importance of supported housing to recovery.
- Increase the supply of supported housing for people with serious mental illness.
- Understand that the intensity of services expected from housing providers makes it difficult for them to attract skilled staff within funding provided.

- Understand that, as housing is being priced out, housing providers are being forced to find opportunities in marginal neighborhoods.
- Know that under NY/NY III, people being served have much higher levels of co-morbidity and serious mental illness than seen under previous NY/NY initiatives.
- Ensure that people engaged in services living independently in the community who experience deterioration in mental health functioning and require a higher level of care have access to supported housing, thereby avoiding homelessness and attendant costs associated with it when supported housing would have been the appropriate level of care.
- Look for subsidized housing opportunities as new projects such as luxury apartments are introduced.
- Ensure access to low-income, public housing for people with mental health conditions.
- Provide supported housing with on-site support, particularly support that enables older adults to live independently.
- Reserve 40 percent of housing units for people with mental illness.
- Provide diverse housing opportunities to meet individual need.
- Give SPOA priority for meeting the supported housing needs of people residing in adult homes and who seek community living.
- Work more collaboratively with the Department of Housing and Urban Development so it can better respond to the housing needs of people with serious mental health challenges.
- Help people with mental health challenges in overcoming barriers to employment.
- Counter effects experienced by people living with psychiatric challenges in for-profit homes (e.g., indignities, lack of privacy, loss of choices, low morale, lack of initiative, learned helplessness).
- Support people in working toward their educational and vocational goals.
- Support people with mental health conditions to pursue their vocational and educational goals.
- Encourage consumer-run business ventures through partnerships with not-for-profit agencies that can serve as training grounds.
- Promote vocational and employment support opportunities (e.g., training support, on-the-job-training) for people with mental health challenges.

## RELATIONSHIPS

### **Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Rather than losing sight of the people with mental health challenges who need help but do not stay engaged in services, reach out to them in nurturing ways.
- Provide better outreach to people underserved by or not served by the mental health system who display clear mental health needs (e.g., people who are homeless and showing symptoms of mental health conditions).
- Work with communities to fund and engage people with mental health challenges who would otherwise be isolated from participating in community activities.
- Educate families about mental health disorders and challenges and aid them to facilitate the recovery of their loved ones.
- Respect the work of the Federation and its committees to be voice for people with mental health challenges who deal with stigma and discrimination, experience abuse, and are driven out of care because of their harmful experiences.
- Realize that Federation plays a crucial role in fostering communications among stakeholders of the mental health, developmental disabilities, and substance abuse systems.
- Encourage greater participation of peers in Borough Councils, where people dealing with mental health issues have the opportunity for collegial interactions rather than being seen as in need of services.
- Do not undermine the structure that is critical to good communications, public input and consultation between the NYC DOHMH and boroughs by withdrawing DOHMH staff from Borough Council meetings, but rather foster the robust relationship between the Borough Councils that advise DOHMH.
- Realize that after DOHMH decided to no longer send representatives to Borough Council meetings, it was perceived as a lack of interest in hearing feedback from people engaged in services, family members, advocates and other interested community members.
- Foster collaboration between the DOHMH and Borough Councils to address serious challenges in the boroughs (e.g., closure of mobile crisis teams, reduced ACT capacity, increased reporting of child abuse).
- Provide public school teachers and support staff with training and education about mental well-being and mental health challenges.
- Recognize that the stigma and discrimination associated with mental illness dramatically affects recovery.
- Educate primary and specialty care providers to effectively work with people and not stigmatize people because of their mental health challenges.

- Work to eliminate the stigma and discrimination experience by people with mental health issues who seek housing and community living.
- Combat stigma and discrimination regarding people with mental illnesses and promote public education opportunities that increase awareness and understanding of where and how to access services and supports.
- Develop strategies to deal with the stigma and discrimination experienced by people with mental health challenges upon discharge from incarceration so they do not encounter barriers to care and are aided in community living.

## **LIVING A HEALTHY LIFE**

### **Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Enhance the ability of each person to work toward his or her self-determined goals, recovery, well-being and good mental health.
- Ensure strong support services that promote independent community living (e.g., peer services, crisis intervention, police training).
- Promote hope, encourage people with mental health challenges to persist, and help them to advocate for themselves effectively.
- Support the abilities of people living in adult homes to live full, productive lives in their communities via affirmative processes that bring together all stakeholders to find solutions to providing community living options.
- Widely implement preventive, early intervention techniques and strategies supported by research to build emotional resilience.
- Provide community crisis interventions and ensure mental health training for police at the academy level and regularly thereafter.
- Support the plan of Rights for Imprisoned People with Psychiatric Disabilities (RIPPD) for the New York Police Department to implement Community Crisis Intervention Teams (CCITs) in New York City in 2011.
- Support community crisis intervention teams and diversion programs that help people obtain needed mental health services and stay out of the criminal justice system.
- With cuts to Medicaid affecting providers and people engaged in services, help providers and people seeking services to keep abreast of service system changes and referral resources in their communities.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

### **Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- Ensure effective integrated mental health services through strong coordination and collaboration among behavioral, primary, specialized, and long-term mental health providers, both public and private.
- Promote providers' integration of primary and specialty health and mental health services.
- Ensure a robust discharge planning process that takes into account how each person's needs will be met upon discharge (e.g., Has SSI paperwork started, has a psychiatrist's visit been scheduled for follow-up after discharge? Where will the person be living? Has the family been involved in discharge planning per the wishes of the individual receiving services?)
- Recognize that inadequate discharge planning is a primary contributor to the "revolving door" seen in mental health care.
- Strive at the City and State levels to improve communications among the child- and family-serving systems so professionals can better understand each other and work collaboratively to serve children and families.
- Provide developmentally appropriate treatment and support options for children who no longer have day treatment available to them.
- Help realize the intent of the Children's Plan with better coordination of care across the multiple child- and family-serving systems.
- Continue to strengthen collaboration and service integration between the mental health system and other systems serving children and their families.
- Increase public health efforts to prevent suicide and identify effective interventions for reducing suicide among adolescents and young adults, among adults with serious mental illnesses, and among older adults.
- Provide more resources for comprehensive community-based system of care for children and adolescents with serious emotional disturbances and their families.
- Continue to provide essential community support services for children and their families, including case management, mobile services, crisis management and outpatient treatment.
- Provide in-home and in-community case management and crisis services for older adults and for people whose mobility is limited by a lack of transportation.
- Attend to the broad needs of older adults with mental health challenges (e.g., ensure that homes are constructed or modified to meet their physical needs) and provide ongoing community monitoring for older adults in need of mental health services.
- Attend to the behavioral health needs of New York's aging population.

- Help people who have lost access to drop-in centers to adapt and not become disengaged from care because of the feelings of loss they are experiencing.
- Foster comprehensive care for people with mental health challenges who are involved in the criminal justice system.
- Recognizing that three times as many people with mental health problems are in jails and prisons compared to people with mental health problems in hospitals, make it a priority to build on success to date (e.g., diversion programs, mental health courts) to better meet the needs of persons with mental health conditions involved in the criminal justice system.
- Use tools and resources available from the national GAINS Center to promote diversion from the criminal justice system and movement as early as possible of individuals already in contact with the criminal justice system out of it and into treatment.
- Ensure a smooth transition to community services and continuity of care for people with mental health conditions in prisons and jails by planning for discharge as early as possible.
- When clinically indicated, place people with mental health conditions into supported housing upon discharge from the criminal justice system and ensure ready access to treatment services.
- Ensure that police receive good training and know that responding to a person having a mental health crisis does not equate to dealing with an “emotionally disturbed person.”
- Provide first responders with training that enhances their abilities to be empathic and handle crisis situations in ways that help to de-escalate situations and possible arrests or hospitalization for people with psychiatric disabilities.
- Create community crisis intervention teams.
- Know that the systemic problem of cycling in and out of emergency departments can be remedied with empathic, less costly crisis care approaches.
- Strive to reduce the harmful effects associated with polypharmacy.
- Recognize that services provided under Kendra’s Law lead to positive outcomes for the people engaged in care.
- Recognize that forced treatment, such as that under Kendra’s Law, is a failure of the system.
- Do not support or strengthen Kendra’s Law.
- Replace assisted outpatient treatment (AOT) in Queens with a mental health diversion program.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

### **Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

- See the value of peer services, especially because peers have “been there” and strongly believe in recovery.
- Promote peer opportunities that strengthen individual resilience and well-being and enable people to draw on their experience and strengths to help others.
- Protect “authentic” peer-driven, peer-run services.
- Support peer services.
- Ensure that recovery-oriented care and peer support are given priority regional behavioral health organizations.
- Ensure the delivery of peer respite services in the five City boroughs.
- Engage peer providers in delivering services and supports when and where they are needed.
- Implement a citywide 24/7 peer support line.
- Provide empathetic, cost-effective, and humane support services through a 24/7 peer warm line in New York City.
- Recognize the limits of LIFENET and make sure a 24/7 peer hotline is instituted.
- Expand peer support provided in emergency rooms beyond Kings County so that emergency rooms around the City have peers available to individuals in crisis.
- Improve the quality of emergency department services through peer services.
- Provide peer-run hospital diversion services.
- Fund alternative approaches to hospital care for people in crisis such as the Rose House peer respite program sponsored by People Inc., which costs about \$160 per day compared to hospital care of \$1,700 per day.

## **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

### **Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- Examine the structure of the City Department of Mental Hygiene to determine points at which it can reduce complexity and foster better access to and engagement in services.
- Prioritize serious mental illness and use this as a criterion for making budgeting decisions.
- Provide adequate reimbursement for the delivery of evidence-based treatment and supports to ensure quality care.
- Ensure careful monitoring of the implementation of clinic restructuring and how small agencies are able to manage the change.

- Recognize that the 30-visit limitation before reduced reimbursement under clinic restructuring is likely to be a barrier to care for people with the most serious mental illnesses.
- Monitor the impact of the 30/50 visit reduction for children with serious emotional disturbance especially when evidence-based interventions may require up to three visits per week.
- Know that under clinic restructuring, it will be hard to provide quality care and cover the costs of licensed professionals.
- Recognize that highly flexible rehabilitation services by supported housing providers requires additional funding.
- Monitor closely the impact of budget cuts on the quality of care and ensure that adequate resources are available for providing quality care.
- Recognize that budget cuts that reduce staffing can lead to increased costs elsewhere (e.g., hospitalization, incarceration, residential care).
- Recognize that permitting multiple visits in one day, while important for engaging people in and providing quality care, does not change the need for quality care, which is much more difficult to provide when multiple services in a day are discounted.
- Capitalize on the opportunities for integrated care in health homes as the system of care moves from a fee-for-service to a managed care environment.
- Monitor changes associated with the shift to managed care to identify unintended consequences that could result from shorter hospital lengths of stay and insufficient and inadequate discharge planning.
- Remove standards and unfunded mandates that needlessly make it difficult for housing providers to implement services and are not consistent with best practices.
- In supported housing programs, avoid regulating wellness approaches such as smoking cessation and good nutrition.
- Have behavioral health organizations create financial incentives for the use of peer services.
- Maximize the use of peer services by contractually including these services in the benefits package offered by the behavioral health organization.
- Enhance training of staff responsible for working with children ages 0 to 5/older teens.
- Ensure that people who seek public services and have mental health challenges are served by individuals who have good knowledge of how to work collaboratively with people who are coping with serious mental health problems.

# Input from Advisory and Advocacy Groups

This Appendix includes input from advisory and advocacy groups. Of note, because OMH was involved in the procurement of BHOs (BHO) for Phase 1 of the implementation of the BHO initiative, the Office of Planning was unable to meet with a number of advocacy groups during the period of restricted communications. As an alternative, groups were invited to submit feedback in writing during this period.



## Mental Health Planning Advisory Council Recommendations

June 23, 2011

Office of Mental Health (OMH) Central Office Planning staff met with members of the OMH Mental Health Planning Advisory Council (MHPAC) to discuss the Council's planning priorities for inclusion in this year's Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from MHPAC members about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participating Council members were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of "ideal" elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

### PEOPLE FIRST

#### **Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Reflect more comprehensively in the agency strategic framework that children and families are central to the treatment and support provided within the public mental health system.
- Regard individuals who provide mental health treatment and supports for whom they are and the knowledge and experience they bring to their roles, rather than focusing on titles and the responsibilities (e.g., a "peer" is a person first and someone who brings vast knowledge and experience to his or her role in helping people recover).

- Serve children and youth in the context of their families, paying particular attention to services that build on child and family strengths, foster resilience, and promote family units where children grow up healthy and well.

#### **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Provide a care environment that encourages people in care and their primary health care providers to develop trusting relationships that lead to open discussion of treatment options, and respect for choices that could produce less than optimal outcomes, giving people the opportunity to fail, with regard to safety, and using that experience to grow and be well.
- Recognize that in-home services by the Office of Children and Family Services (OCFS) are provided to about 4 in 10 persons 18 years and older who have serious mental health issues affecting their abilities to meet basic needs, do not engage in traditional mental services, and could benefit from flexible, nontraditional mental health services that would strengthen the capacity of OCFS to care for these individuals, most of whom reject or are unwilling to go to clinic and program sites.

#### **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Call upon experience and authentic, skillful communication to engage people living with serious mental illness to find their strengths, tap into them, and be hopeful about recovery.
- Recognize families as the experts for their children/youth and engage them in care as fully as possible.

#### **LIVING A HEALTHY LIFE**

**Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Understand that access to complementary and alternative therapies proven to be effective (e.g., meditation, yoga) is core to helping people identify and rely upon healthy strategies for maintaining mental health and well-being.
- Make sure that complementary and alternative therapies are accessible to enrollees and their health care practitioners in developing and putting in place plans for wellness and healthy living.
- Encourage people in health homes to identify supports for healthy community living, integrate them into a plan of care, and assess over time the helpfulness of the supports.
- Develop mental health screening for social- emotional wellness in pediatric practices and encourage pediatric health care providers to utilize such screenings as part of each

child's ongoing medical assessment and, particularly at the point the child is readying to enter school for the first time.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

### **Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- Base mental health treatment and support upon the best medical evidence available and rely upon the most accepted therapies that are proven or informed by scientific evidence.
- While attention is focused on creating managed care options that will serve people receiving Medicaid, do not lose sight of the treatment and support needs of all New Yorkers diagnosed with mental illness regardless of who pays for services.
- Provide data on the use of electroconvulsive therapy.
- Recognize that the biggest stumbling block to effective treatment occurs at the point of care—the handoff—where an individual leaves inpatient setting and returns to the community, and use BHOs to bridge this gap.
- Ensure that BHOs have standards that specify when “warm touch” follow-up in the community occurs with a person who has been discharged, to assess how he or she is doing and aid in successful community living (e.g., help people navigate the system to obtain necessary supports and treatment).
- Make certain that BHOs set realistic standards, risk assessment and objective criteria for judging suitability for hospital discharge and monitor over time how well people do following discharge.
- Develop performance indicators that show outcomes following discharge and for monitoring engagement in treatment and supports (e.g., re-hospitalization rates).
- Be sure the values and principles upon which treatment and support are based are honored (e.g., advance directives indicate a focus on managing one's illness, treatment that is not coercive indicates respect for working closely with an individual to create a plan of care that keeps him or her safe and well).
- Specify the full range of resources (e.g., crisis services, diversion beds) upon which BHOs will rely to ensure that people return to the community with resources necessary for rehabilitation and recovery that foster successful community living.
- Develop a culture and safeguards under BHOs where the clinical experience and expertise of practitioners are respected and where the needs of the person in care are balanced carefully against the desire for avoiding costly, more intensive services so that the best outcomes are achieved effectively.
- Ensure that services are of the right intensity (e.g., in the same way as when visiting nurses follow up in the community for people who leave the hospital after open-heart surgery.)

- Ensure that services provided under BHOs for children, youth and their families are based upon the principles espoused in the Child and Adolescent Service System Program (CASSP) Guidelines.
- Make certain that children are not seen as “little adults,” and ensure that families are always involved in care.

#### **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

##### **Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

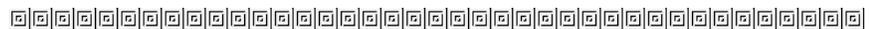
- Involve peers and case managers in assisting adults and children and youth and their families before they are discharged from inpatient settings and follow these individuals out into the community, helping to bridge the transition from hospital to community.
- Ensure that bridger services are offered in managed care benefits packages.
- Compensate peers with salaries/benefits commensurate with their responsibilities.
- In creating titles and job descriptions for “peers,” have a clear definition and understanding of “peer.”
- Recognize that for children services the notion of peer support is defined by the terms “family support,” “parent partners” or “parent or family advocates.”
- Support the development and recognition of family/peer credentialing.

#### **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

##### **Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- Provide more guidance to the field on the scope and authority of regional BHOs.
- Provide technical assistance to localities in identifying tensions and gaps in their systems of care and to find solutions to address them.
- Create effective mechanisms to help BHOs, State psychiatric centers and the communities to which people will return after hospitalization to reduce pressures (e.g., individuals whose independent living skills are not well developed) that make it difficult for people to live successfully in their communities upon hospital discharge.
- Invest in BHOs the authority to hold providers and localities accountable for quality discharge planning and community reintegration following hospitalization.
- Rely upon the experiences from other states in implementing Medicaid managed care for people with the most serious mental health challenges and use best practices in developing behavioral managed care arrangements and health homes.
- Have BHOs clearly articulate the process for and implement that process for grievances and complaints.

- Operate under the assumption that managed care is about managing care and outcomes first, not costs.
- Create incentives for positive outcomes into Medicaid behavioral managed care.
- Understanding that care to people with the most serious illnesses sometimes leads providers to avoid working with individuals with challenging conditions, ensure that providers receive incentives to serve these individuals and not turn them away.
- Be clear that care to children with serious emotional disturbance is challenged by the need to engage other service systems in a child's overall plan of care (e.g., individualized education plan).
- Recognize the tensions inherent in hospitals being pressured to discharge individuals and providers who are charged with post-hospital care and have processes in place to address issues that may arise from differing perspectives of the care needed.
- Ensure that in regard to health homes, the Department of Health (DOH) is respectful of regional variations in communities and not hamstringing localities, rather allow them to operate with flexibility in meeting the integrated health care needs of the people with serious mental illness and children with serious emotional needs and their families.



## **Recommendations Families Together in New York State**

June 22, 2011

Members from Families Together in New York State (FTNYS) met with members of the Office of Planning to provide feedback about impending changes to the system of care: behavioral health networks and behavioral health homes.

FTNYS participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

### **PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Honor the distinctly different health care needs for children and their families by ensuring that the whole family is included in peer and family support services (i.e., adult peer

support does not necessarily have this requirement) and ensure that health homes develop contracts with community-based family support programs that are skilled in facilitating treatment planning.

#### **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Ensure that families and youth are full participants in planning at the family, local, and state levels.
- Rather than investing in foster care, target dollars and resources toward the use of proven interventions that strengthen the family unit and parents' abilities to deal with challenging behaviors, be effective parents, and help their children to grow up emotionally and physically healthy and strong.

#### **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Because peer and family support foster healthy, trusting working relationships, strengthen community connections, and empower youth and families on their path to recovery, ensure that health homes develop contracts with independent peer and family support agencies.
- Knowing that continuous healing relationships are key to wellness and recovery, ensure that family support serves an important vehicle for continuity of care for the child and family.

#### **LIVING A HEALTHY LIFE**

**Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Ensure that health homes serving children provide access to a wide range of flexible services that provide parents with a foundation for fostering healthy growth and development (e.g., parenting education, family respite, evening and off-hours appointments for working parents, in-home visits, in-school behavioral services, school visits).

#### **MENTAL HEALTH TREATMENT AND SUPPORT**

**Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- Provide children and their families with timely, affordable access to appropriate treatment services and supports.

- Develop within each health home a milieu that focuses on strengths rather than deficits, and make certain that services are consistent with strengths-based approaches to health care.
- Ensure that treatment services and supports are provided in a flexible, coordinated fashion across the systems of care.
- Make certain to maintain fidelity to the cross-systems Children's Plan.
- Recognize that peer support, including family support, is valuable in building trust, improvement engagement in treatment, and improving outcomes and make certain that peer and family supports (i.e., trained, credentialed, and supervised independent peer and family support specialists) are central to any coordinated health care plan.
- Preserve family support programs.
- Continue state funding in partnership with Columbia University and FTNYS for developing family support competencies expected of family support providers and the credentialing of these providers, which will enable them to bill Medicaid and private insurances for essential family support services.
- Ensure that planning for children's services under BHOs follows a path separate from adults, respecting the principle that children are not little adults, but rather they are individuals who require a much different approach than adults and require the participation of parents and families in treatment and support.
- Call upon the Commissioner and Department of Budget to reinvigorate at the county level the infrastructure once known as the Coordinated Children's Services Initiative (CCSI), while providing incentives for the delivery of integrated and coordinated treatment and supports across systems of care.
- Look to successful models of treatment and care coordination across the systems of care (e.g., Broome County) to identify elements that are essential to coordinated cross-systems care (e.g., invested leadership, key CCSI county and parent coordinators).
- Ensure the success of coordinated care cross-systems treatment and supports through joint funding by each child-serving system and having such funding managed by the Council on Children and Families.
- Reinvest funds in community services and supports for children and their families as inpatient and residential capacity is consolidated.
- Structure entry into children's services so that it occurs at one single point at the county level, in conjunction with CCSI, providing a foundation for well-integrated and coordinated treatment and support services across systems of care.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

**Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

- Indicate preparations under way in anticipation of the threat to independent family support with Medicaid billing (i.e., already shrinking budgets and overextended family support staff working with needy families will be stressed to the point that these safety net services will no longer be available).
- While the transition to managed behavioral care is being made, continue to provide fiscal support for safety net family-run, peer-to-peer, and peer support services.
- While the transition to managed behavioral care is being made, continue to provide fiscal support for the work of Youth Power!, youth peer advocates, and youth leadership development for youth who not only provide peer-to-peer advocacy, but also provide agency Commissioners with direct access to the perspective of youth served across the systems of care.
- As the community system of care is strengthened with the transition to behavioral managed care, be sure that cross-systems respite care is included in the family support benefits package.
- Continue to work with the Peer Support Stakeholder group to provide the Medicaid Redesign Team (Proposal #541) with findings from the peer support survey to ensure the adoption of peer supports and services for families engaged in services.

## **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

**Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- Articulate how care financed by Medicaid for children and families will fit in with the Children's Plan and 5.07 planning and consider whether the health homes charged primarily with serving adults is the appropriate place for meeting the unique treatment and support need of children and families.
- Ensure that family interests are represented during deliberations of the Behavioral Health Reform Workgroup of the Medicaid Redesign Team.
- Work with DOH to understand the enormous value of child and family peer-to-peer services in delivering cost-effective services.
- Lay out plans for how children's services will fit in with other reform efforts (e.g., Spending and Government Efficiency [SAGE], which calls for co-location of mental hygiene Field Offices) and how input will be sought into this decision making.
- Require health homes to specify in request for proposals' responses and include in contracts with health homes how peer and family support will be incorporated into the array of service options.
- Ensure that peer and family services are a billable support service under health homes.

- Specify if the co-location of Field Offices is anticipated to affect the waivers in place under OCFS, Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism and Substance Abuse Services (OASAS) and OMH.
- With the transition to BHOs and health homes, do not lose sight of the important needs of children and families and ensure continued funding for vital services (e.g., renew contract to fund regional youth partners set to end in December 2012).
- Ensure that joint child-serving agency funding for integrated, coordinated treatment and support via the Council on Children and Families goes to support parent and CCSI coordinators in each count, with disincentives for not participating in the collaboration.
- Create structures so that counties are incentivized to serve children in the community and discouraged from placing kids in out-of-home care (e.g., charge counties a larger share for each out of home placement).
- Make certain that entities charged with overseeing operations and the planning, assessment, delivery and evaluation of care by health homes include peer and family representation.



**National Alliance on Mental Illness – New York State  
Meeting Recommendations**  
June 2, 2011

Office of Mental Health (OMH) Central Office Planning staff met with Donald Capone, Executive Director, and Sherry Grenz, Board President, of NAMI –New York State (NAMI-NYS) to discuss the organization’s planning priorities for inclusion in this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from NAMI-NYS about impending changes to the system of care: behavioral health networks and behavioral health homes. In addition to providing feedback on NAMI–NYS priorities, Ms. Grenz and Mr. Capone provided input from their affiliates.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

## **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Understand the role of families in caring for people with the most serious illness, many whose parents and caregivers are aging and ensure appropriate supports (e.g., respite care, transportation services) that enable successful community living.

## **BASIC NEEDS ARE MET**

**Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.**

- Promote access to decent, safe, affordable housing and access to appropriate treatment and support for New Yorkers with the most severe and disabling mental illnesses, thereby promoting the independence and dignity of these individuals.
- Provide decent, safe, affordable housing to individuals living with mental illness and having the greatest need, which will provide the stability required to enable people to receive in-home and community services and achieve better outcomes at a small fraction of the cost compared to emergency and institutional care costs.
- Do not appeal or delay the provision of appropriate housing and supports for adult home residents who desire and are able to move into community living.
- Institute funding to start in 2010, a New York/New York IV agreement that will enable 4,000 units of supportive housing per year over three years to become available for the growing number of homeless people living with mental illness who live on the streets of, or in shelters in, New York City.
- Understand that in the current economy, opportunities for employment for persons with the most serious mental illnesses who have not worked in years are very limited and seek to avoid providing assistance that may place individuals at high risk for failure (e.g., avoid creating false hopes and the attendant mental health issues created by them).

## **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Continue to correct the misperception that violence is more prevalent among people with mental illness by promoting public understanding of the reality that people who have mental illness are at much greater risk of being victims rather than perpetrators of violent acts.

## **LIVING A HEALTHY LIFE**

**Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Understand that education, early intervention and prevention are central to minimizing the effects of mental illness and, in all likelihood, to eradicating mental illnesses.

- Build upon proven and successful classroom educational initiatives that meet national health education standards, de-stigmatize mental illness and increase knowledge, awareness, and attitudes of mental illness and health.
- Incorporate mental health education in NYS school curricula.
- Understand that for individuals for whom taking a shower may represent a good day that the milieu offered by clubhouses provides individuals with the most severe illness the opportunity for socializing and receiving assistance with vital daily living skills.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

### **Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- Continue to work toward the creation of a behavioral health managed “carve-out plan” that has at its core the integration and improved coordination of behavioral health (mental health and substance use) treatment services that are linked to appropriate health, housing and support services.
- Ensure that Medicaid managed care mental health dollars are directed toward the provision of treatment and supports by specialized health care providers that understand the complex needs of people with serious mental illness.
- Strive for a carve-out managed care model of treatment and support that ensure individuals and their families with access to quality, effective and focused care from specialized doctors.
- Do not make certain antipsychotic medications subject to a prior authorization requirement and do not lift the “prescriber prevail” protections currently in place.
- Provide unrestricted access to evidence-based psychiatric medications and do not eliminate fee-for-service reimbursement for pharmacy services.
- Ensure that case management focuses on helping people with the most serious illness to engage in and stay engaged in care and monitor how well engagement in treatment and services is occurring in health homes.
- Increase funding for mental health and medical treatment for veterans with serious mental illness and their families.
- Employ tools such as the Sesame Street videos and educational materials to aid families and young children in coping with the effects of deployments, re-deployments, homecomings, and grief secondary to the death of a loved one.
- Continue working toward full implementation of the special housing unit (SHU) bill so that people with mental illness who are incarcerated receive proper care for their mental illness, thereby not exacerbating psychiatric symptoms and breaking the cycle of going in and out of SHU because of psychotic breaks.
- Increase the number of mental health courts serving rural areas.

- Make certain that individuals with mental illness who are incarcerated and readying for release from jail/prison are linked to services before release (e.g., immediate access to medications upon release) and provided with strong transitional support services upon release.
- Ensure that the mental health treatment and support needs of children and families remain a top priority at the same time attention is focusing primarily on the care of adults in health homes.
- Make the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) available to community providers so they can better coordinate care.

#### **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

**Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

- Involve family members in policy making at all levels of the system of care to the same degree that people who are engaged in treatment are involved.

#### **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

**Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- Continue to invest in the crucial biomedical, services, disparities and comparative effectiveness research to provide the basis prevention, recovery, and cure from serious mental illness.
- Require the NYS Veterans Affairs Commission to develop and update, in consultation with OMH, OASAS, DOH, and Department of Labor, a State interagency plan to improve outreach, assessment, and care for veterans and their families coping with mental health and/or substance abuse problems.
- Provide direction on how child and family mental health treatment and supports will be provided and coordinated in a Medicaid managed care environment and explain how this care will relate to health homes.
- Ensure that savings from the consolidation and closure of State hospital beds are reinvested into the provision of community treatment and support services that enable people to live independently and successfully in their communities.
- Ensure a full continuum of care in the community, funded by savings from the closure of hospital beds, particularly those services that help during crisis and avert emergency room and inpatient care.
- Work to increase the number of child psychiatrists by creating incentives (e.g., loan forgiveness) for child psychiatrists to practice in underserved areas.
- Make certain that the 1-800 line within OMH Central Office has Spanish-speaking capability (e.g., available access to Spanish speaking employee, create agreement with vendor such as LIFENET to take such calls).

- Provide social work students of the City College of New York with access to internships that not only benefit the students, but also the clients they serve.
- Understanding that health care costs must be controlled, be sure that critical services are not targeted for cost-cutting measures and that Medicaid provides the right services at the right time for the most vulnerable New Yorkers.



**Recommendations from Coalition to Protect  
the Integrity of “Peer Support” Members**

June 16, 2011

A small group of members from the Coalition to Protect the Integrity of “Peer Support” met with members of the Office of Planning to provide feedback about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. Their points of view reflect individual perspectives and not necessarily the views of the Coalition as a whole. The following summary breaks down recommendations by the strategic framework content domains.

**PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Ensure that there is recognition on the part of providers that people are viewed as a commodity in the health market; provide safeguards to having people and their behavioral needs fall into becoming sources of revenue rather than be people who are provided with necessary health care when indicated.
- At every stage of health home development, make certain that the rights of people are taken into consideration, integrated into program design, and monitored through the use of performance indicators.
- Pay attention to what is being taught in academic institutions about mental health and recovery re: effective and proven alternatives and how they can complement traditional medicine.

- Respect people’s rights by doing away with restraint and seclusion and forced treatment and medication.
- Deal with the really tough issues surrounding the use restraint and seclusion and not allow this to be a practice of the public mental health system.
- Be sure to take into account gender identification for effectively meeting the needs of individuals.
- Urge anyone involved in the public mental health system to be guided by the work of the New Freedom Commission, which put emphasis on greater access to opportunities for people with disabilities, including civil rights as well as treatment concerns.

### **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Ensure that the values of a health home encourage a trauma-informed approach to care where the clinician does not start by determining what is wrong with a person and assigning a label, but first asks, “Can you tell me what is going on?”
- Ensure that families play a central role in the treatment of their children.
- Ensure that adults engaged in treatment have the right—to the degree they desire—to involve families in their treatment.

### **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Before instituting aggressive peer outreach, have providers start with families as the first step in the process of helping people diagnosed with mental health challenges to live successfully in their communities.
- Strive for true community integration, where services and supports are interconnected with entire communities (e.g., having people help to rehab a home in the community, live in that home, and maintain it as good citizens of the community).
- Be respectful of the different relationships and roles that families and people engaged in services play in advocating for what they desire to see in a mental health system, and provide opportunities at the state level for each constituency to advocate for their unique needs.
- Rely upon peer advocacy approaches based on Kretzmann & McKnight’s “Building Connections from the Inside Out” model,” which promotes individualized peer-to-peer outreach and support to individuals who may find it difficult to reach out and connect to community clubs and/or organizations that can promote their gifts, talents and skills and meaningful lives in the community.

## **LIVING A HEALTHY LIFE**

### **Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.**

- Advocate strongly for changes in Medicaid that lead to reimbursement for holistic approaches to wellness.
- Ensure that people are aided in preparing advance directives and that the directives are respected by service providers.
- Be certain that people, particularly individuals who are hospitalized or in crisis, have access to independent peer services when requested, to help them in maintaining and preserving their rights (e.g., advance directives).

## **MENTAL HEALTH TREATMENT AND SUPPORT**

### **Foster access to treatment and supports that enable people to lead satisfying lives in their communities.**

- Ensure that people who become engaged in behavioral health treatment and services in health homes not only have good access to treatment and services when indicated, but also good access to leaving treatment and services when they no longer are necessary.
- Examine how not to have medical homes become the primary source of behavioral support for individuals and rather become a vehicle for helping people to develop sources of community support that enrich their lives.
- Rather than having peer services be embedded in health homes where there will be a tendency to use peers to connect people to support services of the health home, structure peer services so they are provided through independent peer providers, with expertise in connecting people to appropriate supports and also helping people to connect to medically necessary treatment services.
- Ensure that health homes embrace a culturally competent, trauma-informed treatment and support philosophy.
- Make sure that structures are in place to fully integrate trauma-informed care within BHOs and health homes and not seen as an add-on service.
- When a person is about to be engaged in behavioral services offered by a health home, document whether the person has an advance directive and ensure that all team members have access to and use this information appropriately.
- Aspire to the philosophy of Dr. Dan Fisher not to create “medical homes,” but rather to build “green wellness villages, where whole health in the whole community is promoted throughout community members' whole lives under the motto "It takes a village to live a full life."
- Evaluate whether the Personalized Recovery Oriented Services program has truly created the shift in culture to a recovery-oriented approach and whether this program model is one that should be part of a health home.

- Determine how children will be served in a health home model (e.g., Medicaid waiver) so that sufficient, diverse treatment choices are available in the community.
- Advocate with the federal government for greater state flexibility in using client-directed services funding (i.e., Money follows the Person), which has the potential for individualized care that is community connected.
- Advocate with DOH for use of the Money follows the Person funding for people diagnosed with serious mental health conditions.
- Within health homes, track how often individuals are offered alternatives to traditional medical treatment as a way to raise awareness of effective alternatives and change provider behaviors.
- Ensure that we invest in keeping families together by supporting projects such as the Parents with Psychiatric Disabilities Project that is making a difference through provider education as well as crucial training to family court judges, social services workers.
- Hold dialogues across the state to reframe safety and risk by drawing upon the work of Mead and relying upon approaches that build on our strengths and not our deficits (e.g., seeking safety through mutually responsible relationships in which people feel safe disclosing discomfort and sharing risk).
- Look to the Nathan Kline Institute Center to Study Recovery in Social Contexts, particularly the work of Hopper, to inform approaches to safety and risk (e.g., the right to make choices and fail) and ultimately break down the connection between violence and psychiatric disabilities.
- For people identified as being at risk for negative consequences of not receiving mental health treatment (e.g., person with multiple admissions to an emergency room over a short period), strive to engage them meaningfully in services without the use of force or coercion.
- Ensure that the Health Insurance Portability and Accountability Act (HIPAA) guidelines do not become a barrier to services by ensuring that the person in care is involved in decision making related to confidentiality and privacy.
- Ensure that treatment is based on the rights and dignity of each person.
- Have BHOs and health homes work in collaboration with peer-run services providers to make sure that people have available a full continuum of treatment and support services and that independent peer services are valued for their role in promoting recovery and well-being.

#### **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

#### **Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.**

- Ensure that peer support is the means of connecting people to their lives rather than the primary mode of connecting people to behavioral health services.

- Build in protections to individual rights to be certain that peer services are not a means to seeking compliance with treatment, but instead they enable people to exercise their rights in navigating the system of care and obtaining the best health care possible.
- While it is accepted that peer support can save health care dollars, be sure not to degrade the value of this critical service as simply a way to save money and make certain that peer advocates receive a living wage and health care benefits for the services they provide.
- Have BHOs and health homes build into their service options a peer-run respite home in each county.
- Recognize the crucial role of advocates who have incorporated living with a disability into their own lives of their contribution in inspiring hope, empowering people to work toward their own recovery, and building resiliency (e.g., respect begets respect).
- Examine the effectiveness of independent peer services (peer advocates) and peer services that are provided as part of a mental health program (peer specialists) and use these findings to procure and provide evidence-based peer support that truly connects people to lives in their communities.

#### **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

##### **Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.**

- Target funds for the design of recovery services at the State level to the regional BHOs, where the BHOs are charged with building capacity through formal request for proposals that lead to recovery services that meet the unique needs of their populations and geographic localities.
- Ensure that regional BHOs, and ultimately health homes, seek input from families and individuals served within these entities, so the voices of each group are heard and so they are represented in oversight (e.g., sit on boards) activities.
- Develop performance indicators to monitor the quality of peer services to and ensure that peers are true advocates for the people they serve and not experts in helping people to be compliant.
- Make certain that providers have incentives to promote the use of peers who understand free and informed consent and who understand how to support healthy decision making and support individuals in developing plans of wellness.
- Extend to state outpatient settings the same ability afforded state psychiatric hospitals to contract with independent advocacy agencies.
- Avoid merging the OMH and OASAS systems so that people who receive services for alcoholism are not stigmatized.
- Continue to conduct quality research into finding medications that have fewer side effects and examine the research base on the effectiveness of alternative medications and promote their appropriate use in managing symptoms.

- When peers are working as members of a team in a clinical setting, be very clear about their role and monitor how peers are functioning to be sure they are not being utilized inappropriately (e.g., serving in a case manager rather than in a supportive peer advocacy role).
- Investigate racial and ethnic disparities within the context of treatment options (e.g., Are white people underrepresented among people engaged in assertive outpatient treatment?).
- Monitor the effectiveness of engagement in care with a performance indicator that asks each person whether he or she feels coerced into treatment.
- Promote accountability of the mental health system by creating and employing a set of indicators based on the 10 principles outlined in the White Paper, [\*Infusing Recovery-Based Principle into Mental Health Services\*](#).
- Find mechanisms to hold providers accountable for care based on the OMH Strategic Framework.
- Foster a sense of public accountability from members of a network of care (e.g., hospitals, providers) by having them seek input formally from the individuals and families they serve and use that input to improve services and supports.
- Expect that BHOs will promote and fund at all levels independent advocacy aimed at quality services and supports.

# Written Public Input to Statewide Comprehensive Plan Submitted to the Office of Mental Health

June–September 2011

## CENTRAL NEW YORK

***Dr. Bharati Desai***  
***Hudson River Psychiatric Center Medical Director***

Please consider medical home model where patients can see a psychiatrist, internist, dentist, or podiatrist and get blood work done if needed. Having pharmacy on the premises will be even better. This will save money, give coordinated care and avoid many duplicated services for patients not following up. I strongly feel that after working in the Office of Mental Health (OMH) system for 31 years.

***Mary Jane O'Connor***  
***Parent, Family Tapestry Board Member***

Five years ago in April, I spoke about the lack of psychiatric hospital beds for children in the Syracuse area because we personally experienced it with our daughter having to be treated out of town. Today the problem still lingers even more so because I'm speaking for hundreds of children and their families who have had to deal with this issue. Did you know that in 2009 over 200 children were sent out of town because there were no beds available here? Our own facility here at Hutchings has added a 30-bed child/adolescent psychiatric unit and it has been maxed out on several occasions.

I am on the board of "Family Tapestry" an advocacy group for families and children suffering from mental illness. We have been fortunate to have been invited to attend "Pediatric Mental Health Roundtable Meetings" with Dr. Mantosh Dewan at Golisano Children's Hospital (GCH), Comprehensive Psychiatric Emergency Program (CPEP), Hutchings, and Blue Cross Blue Shield to address the urgent need to have beds available locally for our sick children. Having a child with mental illness at home is stressful and disruptive enough but to have a child admitted to a psychiatric hospital far away is horrible and puts even more of a strain on families.

I know New York State is currently looking for better ways to expand on behavioral homes, treatment plans, etc., but the problem lies currently right from the start that children have to wait months for the initial diagnosis and then have to be treated out of town away sometimes hundreds of miles from their families. Initial diagnosis is crucial to recovery and treatment planning. Onondaga County was recently awarded 5-year Substance Abuse and Mental Health Services Administration (SAMSHA) Grant allowing us the opportunity to establish and streamline appropriate services needed once a diagnosis has been made.

Our children with mental illness desperately need to be treated **locally** just like children with physical illness currently do. They do not need costly operating rooms or the staffing that goes with it, nor do they need an expensive intensive care unit (ICU) and all those related costs. They need a friendly, peaceful, caring facility where they can be monitored while the proper medications are found and their families can be close by their side during this most difficult time aiding in their recovery. Hopefully, with the combination of Upstate and Community General Hospitals a space can be found for a 12-bed psychiatric ward for our children.

Please, please approve GCH the funding needed to provide **local** treatment to our children with mental illness.

**Linda M. Wagner**

I strongly encourage Dr. Hogan and others at New York State (NYS) OMH to read the book *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* by journalist Robert Whitaker. His review of research literature indicates that the psychiatric profession has taken the wrong approach to mental illness for many decades, resulting in a dramatic increase in the rate of long-term permanent disability among people with mental illness. NYS could and should be a leader in new approaches that reduce suffering and disability while increasing effective treatment and productive lives over the long term.



**HUDSON RIVER**

**Wilma Alvarado-Little, MA**

There are two areas where there is a need to better concentrate efforts. The first involves the provision of quality cultural and linguistic services. With approximately 29 percent of New Yorkers speaking a language other than English at home, it is imperative for these services to be part of the care plan. By providing a means of effective communication in an area that is challenging to navigate when the consumer and provider speak a common language, it would benefit the NYS OMH to develop strategies for the implementation and delivery of these services. In addition to the implementation of these services, there should also be a component to measure outcomes that could then determine the success of the use of these services along with an evaluation component to identify areas of challenge for the delivery of services.

The second area involves issues confronted by our youth when attempting to access services. Young adults who are in the mid to final years in high school or entering college do not have the resources to support these major life transitions. The lack of resources or direction complicates their ability to perform successfully in an academic setting, therefore compromising their ability for success.

It becomes an even more difficult journey if these young adults are individuals of color or children of immigrants who are under pressure to become "successful" as defined by the host society.

**Jacki Brownstein, MPS**  
**Mental Health America of Dutchess County**

We are very concerned about the transitioning of our caseload of over 1,000 individuals in targeted case management (TCM) to health homes. Although we applaud the integration of physical and mental health services and the concept of a health home, we worry about the transition time table and the possibility that mental health behavioral care will become secondary to physical health treatment. Unfortunately, historically non clinical behavioral health care is not well understood and its provision has often been subsumed under the better understood medical model. Stronger regulations must be put in place to ensure that behavioral health organizations (BHOs) and health homes utilize the experience of TCM programs in the provision of services. Also, consumer choice must be protected under the State Plan.

**Dr. Andrew Kirsch**  
**Recovery Center, Rockland Psychiatric Center**

1. Regional unified electronic medical record systems that can be accessed from various clinics.
2. Training in medical clinics about the work done in mental health clinics, including #3 below.
3. Recovery focused services including peer specialists running groups and assisting patients with wellness/health management; groups focusing on wellness, recovery and employment; more vocational specialists helping people at all phases of returning to work, including the pre contemplation and contemplation stages.

**NAMI-FAMILYA of Rockland County**

**Overview:** NAMI-FAMILYA recognizes the need for expanding and coordinating health and mental health services for Medicaid recipients in New York State. In Rock land County only a very limited number of health care providers accept Medicaid and only a handful of clinic services exist to serve the estimated 11 ,978\* individuals with serious mental illness in our county who receive Medicaid. Some of the most serious gaps in services are in the areas of health specialties such as gynecology, urology, endocrinology, dental specialties (including exodontists, periodontists), audiology, cardiology, pain management, ophthalmology and optometry, etc. Mental health "homes," as we understand them, would provide needed health services for many of these individuals who are currently underserved or not currently receiving health services at all, and would refer those who need specialized services not available to appropriate providers, (\*Based on estimated 20% of 59,874 Medicaid eligibles in Rockland County as of March 2010 from County of Rockland Budget & Management.)

**Accessibility:** Sufficient number and types of services are essential to ensure accessibility if we are to meet the needs of all Medicaid recipients. Health "homes" must be located in accessible areas.

**Transportation** is an essential component of health care for many Medicaid patients. In many communities public transportation either is non-existent, undependable and inadequate. If people on Medicaid can't get to a health home, they can't get health services. There also needs

to be provision for home health care for some patients who are severely disabled or homebound.

**Quality of Care, Compensation of Clinicians, Oversight:** One of the serious flaws in many currently existing managed care health services is the fact that physicians and other health professionals must see a large quantity of patients in order to pay high salaried administrators and frequently spend little time with each patient. Adequate compensation of physicians, physician assistants, and nurses must be a component of health "homes" in order to attract and keep well trained, competent, and caring "hands on" staff. Often "quotas" in number of patients required to be seen limit time and attention to individual patients. There also needs to be an oversight mechanism to ensure that services are adequately and efficiently provided, clinicians can devote time on an "as needed" basis to patients. Outcomes, perhaps, could be measured in terms of successful interventions, rather than number of patients seen.

**Transition to Managed Care, Continuity of Care:** We are concerned that the vulnerable populations we serve not experience constant shifts in health care providers and mental health clinicians. Continuity of care and the relationships developed between clinicians and consumers is particularly important for patients with psychiatric and psychological issues. Patients who have already established relationships with health and mental health providers who do accept Medicaid should be allowed to maintain those patient/doctor connections, which can be so important for recovery.

**Flexibility and Choices for Patients:** There needs to be some provision for choice of managed care network providers by patients, both for convenience of location and good relationship to clinicians. Randomly assigning patients to health homes will lead to dissatisfaction, failure to follow up on medical regimens, take medications, etc. Especially in behavioral health care, the relationship between the consumer and his therapist is a critical component of successful treatment and rehabilitation.

**Multicultural sensitivity:** In Rockland County, which has one of the most ethnically diverse populations in northeastern U.S., we are very sensitive to the varying cultural needs of individuals we serve. In setting up health homes, both the regional and the multicultural needs of the community should be addressed. Both health and mental health providers with varying language and cultural background are needed to serve the Medicaid population.

**Care Coordination, Prevention:** There needs to be mechanisms in place to educate people to the importance of health care, to help link people with psychiatric disorders to preventive health care and medical services, as well as behavioral health care, and to coordinate their health care services and their mental health care. Existing assertive community treatment (ACT) teams need to be expanded and can act as liaisons between health homes and the high risk consumers they serve. Trained peer coordinators can also be helpful in educating and linking individuals with psychiatric disorders to health services. We believe that professional expertise must be a part of all services provided to consumers

**Support Staff sensitivity training:** Receptionists (greeters), clerical and support staff should be trained, sensitive people who can recognize the humanity of all individuals, and treat them with respect and dignity. So often, we have witnessed staff in settings such as clinics, social services, etc. who treat people receiving entitlements in a demeaning, insensitive

manner. Staff members who come in contact with patients can contribute greatly to engage people, motivate them or, on the other hand, discourage their participation and cooperation.

**Integration of Behavioral Health Care and Health Care:** Although we recognize the importance of coordinating health care with behavioral health care, we also see the need to utilize trained professionals familiar with all aspects of mental illness. There already exist in many local areas mental health (including Rockland County) providers who have track records in successful treatment and rehabilitation of patients. We, therefore, feel that it is essential in providing contracts to behavioral health providers to utilize the expertise and experience of these providers. We believe a network of behavioral health providers makes sense with care coordinators to link and integrate health and mental health care.

***Paige Pierce***

***Executive Director of Families Together in New York State***

#### General Themes

- Families and youth must be full participants in planning of services on each level (state, local and family levels).
- No Wrong Door ... All children and their families must have timely, affordable access to appropriate services within their community. Services must be seamless and not dependent on payment models.
- Services must be cross-system and flexible to meet needs of family, child-centered, strength-based, family-focused, individualized, and culturally competent.
- Coordinated Children's Services Initiative (CCSI) is the model. It begins the Children's Plan and was developed with input from families, youth and providers. It reflects a cross-systems approach.

#### Medicaid Redesign, Behavioral Health Organizations (BHOs), Health Homes, Spending and Government Efficiency (SAGE) Commission

- We need a separate plan for children, based on the Children's Plan and CCSI.
- Kids BHO Work Group has prepared comprehensive recommendations that we support.
- The service models that are most flexible, able to deal with cross-system, and are most liked by families are family run, peer to peer family support, waiver and respite.
- New payment models need to respect independent nature of family run peer to peer, family support and find mechanisms that compensate these programs for their services. These services are as important as the traditional "medical" model services.
- We support peer-to-peer family run family support as a Medicaid billable service and we support requirements that contracts with peer services be required in contracts with BHOs and health homes.
  - We support credentialing of Family Support Specialists.

- Transparency and oversight are important and must include consumers in the oversight body.



## LONG ISLAND

***Marc Ducker***

***Consumer Link, Mental Health Association of Nassau County***

Try to add or replace many segments of the service system with peers and peer-run services. Peers should be seamlessly integrated whenever possible, for example, transportation for nondangerous patients; emergency room intake process/support; on-ward support; crisis respite emergency room diversion; longer-term respite housing; assertive community treatment (ACT) teams; inpatient and outpatient individual support, case management, and support groups; peer mediation (housing disputes, etc.); peers in personalized recovery-oriented services, rehabilitation, and benefits counseling, etc.

***Dr. John Kastan***

***Executive Director, Peninsula Counseling Center***

While it's clear that reducing State Medicaid expenditures (and expenditures, in general) are at the core of many of the initiatives that are being given high priority by the MRT, I do believe that many of the individuals on the task forces are truly interested in improving the system of care for individuals on Medicaid. I do think there is a need for OMH, the Office of Alcoholism and Substance Abuse Services (OASAS), and the Department of Health (DOH) to articulate how the various initiatives being pursued fit together. To those of us in the field attempting to 1) keep up with the new initiatives and 2) maintain viability as providers, the more information we have the better in order to develop strategic approaches to continue to be able to serve the State's most vulnerable residents.

The sole focus on reform of the Medicaid system—the State's priority— without recognition that providers serve New Yorkers regardless of their payor status is problematic for providers. To dismiss the needs of non-Medicaid individuals as “not the State's problem,” is bad policy, bad politics, and bad public health. There needs to be in a statewide planning document recognition that the mental health of all New Yorkers is a priority and focus. To view OMH-licensed agencies as merely Medicaid providers is short-sighted and does not reflect the reality that such entities are the safety net for a whole host of individuals, and is part of our not-for-profit missions.

The effort to integrate physical and mental health is of course laudable. I hope that it is informed by the reality of care delivery on the ground, the economic incentives at work, the culture of medical specialty care, and the like. I believe it will take more than “care coordinators” to significantly change the interactions among consumers with multiple co-morbidities, primary care providers, specialists, and hospitals, and to achieve the kinds of behavioral changes needed to assure adherence to complex medical regimens, etc.

I am pleased that the State has recognized the unique needs of children and adolescents, and is developing a separate focus on children's services. I hope that there are sufficient resources provided to address the complex care coordination and assessment needs of children, as well as recognition of the dearth of child psychiatrists in the public-oriented system. While I understand the decision to eliminate the clinic plus program, I do hope that the focus on early identification, screening, assessment, and engagement is not lost. Despite the overall poor performance against unrealistic targets of the clinic plus program, there are, in fact, success among the cohort of clinic plus providers, and lessons learned that should not be lost.

I am troubled that there is no provision in the Medicaid regulations for mental health services for homebound individuals. Particularly in the face of changing demographics and the desire for aging at home, both to save dollars and improve quality of life, it seems short-sighted of CMS. Perhaps the State needs to take it upon itself to fund this service, which, if utilized correctly, can improve adherence, reduce emergency room and inpatient stays, and improve quality of life for those who cannot be expected to travel to a provider location.

***Jeanne McGough***

***Outreach Coordinator, Mental Health Association of Nassau County***

Please take into account the historical territoriality long known and unfortunately defended by the separate mental health and substance abuse service providers, which needs respectful and firm dismantling for a segue into co-locating behavioral services with physical health care. Peer supports should guide the development of health homes and other innovations in approaching overall recovery.

Vigorously recruit peers, including young people and their families, to help move New York closer to evidence based, person-centered, family focused care, based on the principles of recovery and resiliency that they practice daily.

***Barbara Roth***

***President, Board of Visitors, Pilgrim Psychiatric Center***

Given the fact that a large number of individuals occupying inpatient beds no longer need that level of intense care a new and innovative program has been developed. Restoring confidence and giving individuals the tools necessary to work toward their recovery has been extremely successful in the new Transitional Placement Program. Providing a less restrictive level of care coupled with developing strong community living skills results in enhancing the desire to work harder to reach all their recovery goals.

The fact that these transitional wards are unlocked and the residents are able to walk in and out freely affords the individuals the ability to make their own decisions and settle on the goals they wish to complete in order to fulfill their dream of returning to their community. Just the freedom (to go out in the fresh air and be able to walk around instills in each person the desire to continue on the path to complete freedom. Some of the skills and services needed to foster success are medication management, assertiveness, symptom management, vocational planning and peer support to mention a few.

For our staff the challenge of working on a new program requires many changes in their thinking. However knowing the dedication and deep commitment to those they serve they leave no stone unturned. Nothing is ever too much for them to tackle no matter how difficult the transition may be. Establishing workgroups to address the issues individuals may face living outside in their community are well defined and are reinforced during the day in an open ward. Changing their perspectives from inpatient to community based services is needed for them to meet with success.

Recognizing the changes necessary to be made on the part of the individuals and the staff as well to create a positive atmosphere; one can feel very optimistic about the future of those who will be able to regain a life that has been on hold for some time.



## **NEW YORK CITY**

### ***Robert Brassell, Jr.***

Promptly conduct level-4-equivalent background checks on each and every homeless shelter “resident” within and without New York City (NYC) so as to at least know who and what you are dealing with.

### ***Wendy Brennan, Director***

#### ***National Alliance on Mental Illness of New York City (NAMI-NYC Metro)***

New York State’s mental health system is undergoing an unprecedented transformation at a time of severe budget deficits and fiscal scarcity. Health care reform is a reality, at least for the present, through the Affordable Care Act (ACA), which holds the promise of expanding health care coverage for millions of Americans and includes a provision to establish health homes to more effectively coordinate the care of Medicaid recipients with chronic illnesses. At the same time, a new federal mental health parity law aims to improve access to mental health treatment for people with employer-based health insurance, while a Medicaid Redesign effort will change the way adults with serious mental illness and children with serious emotional disturbance on Medicaid receive services over the next two years.

The need to improve the current health care system is great, particularly for those impacted by mental illness. We are concerned, however, that some of these changes are being implemented at lightning speed—too quickly to produce the best outcomes.

The New York State mental health community, specifically children, youth and adults and their families who are impacted by mental illness directly, are extremely fortunate that Commissioner Hogan is providing leadership in this dynamic environment. He has a great capacity to understand the details of a complicated system, and the vision and passion to imagine what transformation at its best might look like.

I would like to focus my comments on the importance of peer-led mental health services and integrated health and mental health care as essential components to promote recovery.

**Peer-led services:** By November 2011, New York State expects to establish health homes, through a provision of the ACA that aims to improve care coordination for people with serious mental illness and to integrate delivery of their health and mental health services. We are very concerned about the speed of the health home implementation process and the lack of sufficient dedicated resources to ensure that health homes are able to provide quality recovery-oriented services. We are also concerned that the rhetoric about the importance of inserting consumers and families in treatment may not have a corresponding action. The current reality is that the mental health system rarely allows people with mental illness and their families to participate in treatment in a meaningful way. A dramatic change in culture will be required to make the rhetoric a reality, but culture is stubborn and very difficult to change.

To help facilitate real change, we reiterate our support for including peer-led support and education programs in health homes now and as part of the special needs plans when they are established in two years. When consumers and family members provide psycho-education to their peers, the stigma associated with participation decreases and the utilization of this essential information increases. Consumer-led education programs reduce stigma and isolation. They give individuals tools to understand and manage their illness more effectively, and they promote recovery. Family-led education and support help relatives to understand their loved one's illness and better care for themselves, and ultimately allow them to provide more support for their loved one.

**Integrated care:** One of the essential goals of the health home provision is to integrate health and mental health care. Integration is essential to eradicate stigma, improve outcomes, and promote wellness and recovery. In the mental health community, we continue to quote from the 1999 U.S. Surgeon General's report by saying that "there is no health without mental health." But the converse is also true: there is no mental health without good health.

To maximize integration, we recommend the following:

- Education about mental illness should be required for all primary care physicians and other health providers who are part of the health home network.
- Hospitals in health home networks should be required to train their medical staff to care for people with mental illness, providing information about psychotropic medications and how to appropriately interact with someone with mental illness. We have heard from our members that patients often do not receive their psychiatric medications when they are hospitalized for a physical health reason, which can trigger a relapse.
- One of the essential aims of the ACA is to improve access to medical information through electronic medical records. Access to accurate and complete information is essential for all quality health care treatment, but is particularly important for people with mental illness. We recommend as part of care coordination a provision to require that information about an individual's mental **and** physical health follows him/her from the community to the hospital and back. Hospitals in the health home networks should be required to train their psychiatric staff to address consumers' physical health needs, including providing appropriate medications in the hospital to address conditions such as heart disease and diabetes.

- Peer-led wellness programs must be an integral part of health home networks to address consumers' health needs and help them to set achievable wellness goals. People with mental illness are much more likely to address their physical health needs, including smoking cessation, weight reduction and exercise, with support from a peer. As an example, the health coaching program developed by the Department of Consumer Affairs at the New York City Department of Health and Mental Hygiene is a very effective model, one we have brought onsite to NAMI.

Finally, NAMI-NYC Metro has advocated strongly for establishing a Medicaid Redesign Team (MRT) subcommittee to address the needs of children with serious emotional disturbance and their families. We are pleased that children's health homes will not be implemented immediately. The needs of children and their families are different from those of adults, and we believe that more inter-agency planning is required to ensure the best outcomes for children with serious emotional disturbance. We cannot improve those outcomes, however, without taking into account the roles played by other child-serving systems, including education, child welfare, and juvenile justice, which are not funded by Medicaid dollars.

Through our family support programs, NAMI-NYC Metro annually serves more than 1,100 families with children under the age of 24, many of them referred through the Administration for Children's Services, New York City's child welfare agency. We have found that at least 15% of the parents we serve have serious mental illness themselves and need treatment. Health homes designed to treat adults with serious mental illness and future health homes established for children with serious emotional disturbance must make provisions to address parents' mental health needs. Finally, we believe that health homes for adults must include developmentally appropriate services for transition-age youth (18- to 24-year-olds).

**Ms. R**

The only person or entity that has the responsibility for and right to make decisions for my mind my body or my healthcare is **me**.

No one has the license to make decisions about my mind and body **for** me. Health homes should have responsibility to make services **available**.

**ONE: Increased information access alone may provide (more economically) the improvements aimed for with the health homes model.**

I believe that the regional health information organization (RHIO) efforts to allow doctors to access most computer records for their patients would solve many of the problems that health homes aim to solve. Most doctors want their patients to be as healthy as possible. And doctors already know they must work within a budget. And they try to avoid lawsuits. The health homes model doesn't change doctors' behavior. Many general practitioners did not go the medical school to become administrators.

**Two: Problems with wording could lead to forced or coerced health and psychiatric care.**

**re-spon-si-ble** adjective 1. answerable or accountable, as for something within one's power, control, or management (often followed by to or for)

(<http://dictionary.eference.com/browse/responsible> )

The words “responsible” and “accountable” may or may not imply control. By when contained in a legal or regulatory document there is no protection against one or another interpretation. After all, it makes sense that health homes cannot assure health or savings if patients refuse care, can they? Hence these words beg qualifications and/or footnotes whenever they appear. The footnote should read: “patients retain inalienable decision making rights over their minds bodies and care thereof.”

These words “accountable” “responsible” and “for” appear frequently in literature on health homes. Some samples:

<p><a href="#">“That home then becomes accountable for all the individual’s care”</a> </p>	<p>My comment: It can be argued that one cannot be held accountable without the ability to control.</p>
<p>“To achieve the goal to have an accountable entity managing behavioral health services and promoting the integration of medical and behavioral health services“ Proposal to redesign Medicaid Proposal No. 93 MRT No. 171.1</p>	<p>My comment: Accountable does not always give control. But a word with multiple meanings can lead to a future definition that would harm many people.</p>
<p>“In addition, consumers and caregivers will have the benefit of having a single entity that is responsible for assessing, implementing and monitoring plans of care.” Proposal to redesign Medicaid Proposal No. 90 MRT No. 54</p>	<p>My comment: Please add the clause, “in conjunction with the consumer’s wishes.”</p>
<p><a href="#">“Health Homes must develop a care plan for each individual...”</a> </p>	<p>My comment: The word “for” should read “with”: “for” insults.</p>
<p><a href="#">“Develop a person-centered care plan for each individual...”</a> </p>	<p>My comment: The fact that the author uses the word “for” shows their opinion of consumers.</p>
<p>Impacted Stakeholders:  <ul style="list-style-type: none"> <li>• Providers and administrators of services to Medicaid beneficiaries</li> <li>• Industry associations</li> <li>• Social community support and service providers.</li> </ul>           Proposal to redesign Medicaid Proposal Number: 89 MRT No. 57</p>	<p>My comment: Observe failure to include people receiving the services as stakeholders. This author demonstrated a lack of respect for people with serious mental illness and should therefore never make any decisions or design any programs <b>for</b> them.</p>

I believe that the people who put these words in the health home documents did **not** intend to impose control of people diagnosed with serious mental illnesses. They did not intend that health homes nor any other health insurance entity could retaliate or deny medical needs to or housing to anyone on the basis of their refusal of services or complaints. To assure their objective, kindly remove all words that give responsibility, accountability or other words implying this to all documentation about health homes.

**Three: Some misconceptions that may have led to the wording. Some people have the impression that everyone diagnosed with a serious mental illness is less capable than everyone not so diagnosed.**

Most people diagnosed with serious mental illness have the competence to make decisions for ourselves at least as wisely as the average citizen. Many of us have high IQs, common sense, experience and personality way above average. But even those of us who struggle in one or more ways have the human right to self-determination.

Moreover, every person in the world is an individual and should be perceived as such not as merely part of groups.

I think some innovators of health homes may have forgotten the above concepts.

*Different language in accountable care organizations (ACOs).* By contrast to health homes, discussions of [ACOs](#) (also part of the ACA) had phrases like “People with Medicare will have better control over their health care” and, “We envision that [successful ACOs will honor individual preferences](#) and will engage patients in shared decision making.” Why such a difference? The difference in terminology may come from the unfortunate opinions about people with mental illness that too many people who work in the mental health field have. By nature health homes see people with mental illness as a group rather than as individuals with the same variance in personalities, intelligence, and talent as the whole population. I wish OMH would demand that people whose jobs influence the lives of people with mental illness would have an enlightened point of view.

**Four: Evaluating health homes**

All health home evaluations should include patient evaluation based on patient values. The State evaluates based on the State’s priorities:

But the State’s goals of reducing “hospital readmission rates” may diverge from the goals of the patients. If people need to return to the hospital, health homes could deny that need in order to pass its own evaluations. If a health home denies a client’s request to return to an inpatient unit and someone hurts themselves, then this goal to reduce hospitalization **must** disappear. Conversely, if a person already hospitalized has their stay unjustifiably prolonged so as to perhaps diminish the chance of return that violated the right to freedom. The health home should not have these as goals. And, if the health home system does make a difference it will do so **naturally** without a need for stating these as a goal.

When health homes come up for evaluation, the benefits of improved information exchange should **not** count toward the benefits of health homes. Otherwise health homes may appear more useful than reality. All benefits of the RHIO should be attributed to the RHIO. (Wikipedia defined RHIO as “motivating and causing integration and information exchange among stakeholders that region’s revamped healthcare system.”)

What if the health home evaluation comes while receiving extra federal dollars and when those allocations finish the health home performs poorly?

What if these health homes do not provide us with better care?

How many years before patients can leave health homes to find better care?

If health homes provide poor service and little improvement, will they discontinue?

How easy and quick will the appeals process be? What may I appeal? What may I demand? What if I must wait a longer time for an appointment than those outside my health home?

*Regarding consumer evaluations:* Please remember that when a person with serious mental illness would like to complain his/her disability and a fear of retribution make this difficult. So you should never assume that few complaints mean few problems.

#### **Five: Health home control over me**

If health homes in fact receive the legal right to control my body and mind—they will decide my medications—both what I must take and what I may not have. In fact these homes might eventually argue that they have a right to control what we eat and my lifestyle choices. Patients could lose privacy so they can be monitored. If a patient does not follow the health homes directions they could lose their medical care and medications and even housing. You will basically be putting all of us under assertive community treatment (ACT) without having to go to a judge, despite our competence. In many ways health home will have broader control than ACT.

What you propose doing with health homes will make me feel like a criminal under house arrest. This is my body and my brain and the only person who has the right to make choices for it is **me**.

I am not stupid nor a baby nor do I lack common sense or lack motivation. No one has the moral right to disable me by taking away my autonomy. Maybe some people might choose this service for a limited time when they are very sick. This phrase, “the whole person,” often used benevolently, here means I will lose 100% of jurisdiction over my mind and body.

The health home might **not** go to extremes when first augmented, but it will have the legal right to if it is accountable.

Adverse reaction to repression: Ironically, of all the groups to try to control, a high percent of this population is significantly adverse to suppression, especially from staff with obviously lower IQs. Some may have a reaction leading to immediate hospitalization others will internalize their frustration increasing their depression or anxiety, decreasing their functioning and requiring more medication.

So, all implementations of health homes must guarantee that nothing in the laws/regulations/wording in any way gives the homes legal rights to any person, their body their health their lifestyle. Not can any law take a person’s responsibility for him/herself away and give it to any other person or entity, except by a judge on a person-by-person basis and only if he or she is indeed incompetent.

#### **Six: If a health home is tied to one’s physical address**

If a health home is tied to one’s physical address it will ghettoize people. Those of us in housing do not have control over where we live. My program moved me from one area of the City to another against my will. I take the subway all the way back to my old health care provider because it is infinitely better than my neighborhood options.

If I had been told when I moved that I would have to change my doctors I would have appealed on the grounds that it would damage my physical and mental health. Removing me from the therapy group I have participated in for nine years would not improve my mental health. Health homes should first “Do no harm.”

**Seven: You won’t save money because health homes pay for decisions**

Health home structure will require “decision makers.” When I make a decision about my healthcare I do not bill Medicaid for that decision. But health homes will take Medicaid money **away** from actual healthcare and use it to pay people to make decisions for me. And those decision makers can’t work without supervisors and managers and cost accountants and lawyers and computers and their own healthcare **all** for something that currently **costs** nothing. Health homes should only use 10% of their government money for all their administration.

And will they make better decisions? Better is an opinion. Heated debates take place over health and medical issues. People are so different—including culturally different—so how can sweeping decisions meet the best needs of all these people? And each person has the right to act in accordance with their own option. Just provide (unbiased) healthcare education, give them a budget and allow them to choose their priorities.

No one says people should have a right to the most expensive healthcare for free. But within what Medicaid can pay for exists room for a vast number of combinations. And patients should make those decisions, **not** a very expensive administrative decision committee.

**Eight: Checks and balances**

Currently, if I have a problem with my housing I can tell my psychotherapist who works for a different entity. And if I want to change psychiatrists I ask my housing agency for assistance. But if they belong to the same agency, where can I turn to for help? I could have a major imminent complaint about my care . . . .

**Nine: Additional concerns**

- I believe that the health homes will not provide quality care for disorders unrelated to mental illness, e.g., cancer, hip replacements, allergies, stroke, lupus, etc.
- How will I know whether the Medicaid “comparability” requirement waiver has allowed for fair care? How can I demand fair allocation?
- What if I must return to an inpatient mental hospital and I do not like the hospital my health home has?
- Can recipients choose between discretionary services?

No one has the license to take my rights away from me and give them to another person or entity without a judge.

***Marguerite Harder, LCSW-R***

The plan should include regulations and financing, to facilitate existing agencies in developing and providing services to high-needs individuals. Recognition of programs that provide services to a majority of high utilizers, as determined by the severity or complexity of

their illness, should be provided financial supports. This could be achieved by including flexible dollars to allow targeted financing to support the utilization level of high-needs individuals.

**Jayette Lansbury**

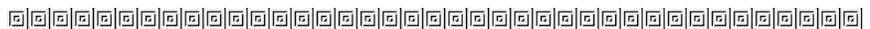
- We need to have more family involvement allowed at the forensic facilities.
- We need to move the patients through forensic facilities more quickly for those that are stabilized!!!
- We need more transparency at forensic facilities.
- The forensic facilities should be family friendly.
- More visitation days are needed in forensic facilities.

**Edward Ross**

Suggestion: Increase the amount of benzodiazapines that can be prescribed to a patient at a time. Presently, our psychiatrists say that they are limited by NYS to providing only a 30-day supply. This means that they must see the patient and bill Medicaid for monthly visits—even if there is no medical necessity for such frequency, for stable patients assessed as at minimum abuse potential. Other states allow prescribers to provide greater amounts than New York, a two- or three-month supply.

**Benjamin Sher, MA, LMSW**  
**Director of Training & Staff Development for Institute for Community Living**

I think it crucial to prepare the workforce as much as possible for the many changes that are coming for the behavioral health system. We need to especially focus on case managers, whose roles will really change in a health home and BHO environment. At least at our agency, these are often staff with the least amount of formal training who will now be asked to coordinate care for persons with serious and mental illness. I think OMH should conduct a competency analysis and survey study as part of its next plan.



## WESTERN NEW YORK

### ***Karen Albanesi***

#### ***Intensive Case Manager in Niagara County***

I find that when you are dealing with youth you cannot make a family whole without including the caregivers. Many of our families lack parenting skills, or had babies at very young ages and do not have the life experience of having a stable family life to nurture children. We see from the get-go what goes on in the family structure and find it ironic that our services do not include linking families to parenting classes and the like. We have a Family Support Group within our agency and we could assist families by using service dollars, but we cannot access that service for the family in need as it is not in our regulations for case management. I hope you would address this issue in your planning.

### ***Johanna Ambrose, Director***

#### ***Compeer – New York State Region***

Thirty-eight years ago, during an earlier time of change, a concept was born to help people who were inpatients reintegrate into their communities. This concept became known as Compeer, and introduced the simple idea of friendship into the complex mental health system.

The Compeer model incorporates the three elements of support—autonomy, relatedness, and competency. In implementing this model, we collaborate with many community partners. Caring, trained community volunteers are matched in one-to-one supportive friendship and mentoring relationships with adults in mental health recovery and youth with emotional challenges. The adaptability of the model allows Compeer to create programs serving youth with an incarcerated parent, the elderly, and a new one-to-one model program serving veterans, CompeerCorps, now operating in Utica, Rochester, and Buffalo with plans for more locations in New York.

Compeer programs are not only best-practices based, but evidence based. Our annual survey, filtered for the 21 community-based programs in NYS, reports by the numbers:

- Nearly 3,000 individuals, and their families, are served every year.
- Last year Compeer volunteers contributed nearly 85,000 hours in service. Because of this strong volunteer base, our services remain highly cost-effective -- \$1,275/match /year.
- Overall, respondents agree that the Compeer relationship has a 92 percent-plus impact on the client's life.

Additionally, Compeer programs are driven to positive outcomes, including:

- Independent living
- Positive change or stability in housing
- Positive change in employment status
- Greater engagement in community

- Improved resistance to drugs and alcohol
- Decreased need for crisis services

The real Compeer story, though, is not in the numbers. It is the story of personal success occurring in individual lives.

- The client who became a volunteer and says of the original match, “The friendship we shared was a life changing experience...that allowed me to evolve into the confident woman I am today.”
- Bonnie, a teacher, who mentored 10-year-old Kate, who now holds a bachelor of arts degree in sociology. Bonnie says, “Ours is a wonderful story of mutual growth...of two people meeting, and having their lives equally enriched.”
- The volunteer with diabetes and her friend with diabetes who support each other in illness management, such as diet and exercise regimens.

Compeer is a transformative model for engagement using natural supports in natural settings. It was relevant 38 years ago, it is relevant during this time of change, and it will continue to be relevant as long as people need the healing support of each other.

### ***Lucille Sherlick***

Behavioral, mental, physical health services housed in one space along with educational, vocational and social services would recognize that human health is multi-dimensional and the best approach is a holistic one where the needs of the whole person are addressed. We know that when people have work and feel productive their health improves and that when preventative services are readily available, the outcomes benefit the person, the community and the financial well-being of the State.

### ***Tamre S. Waite, Director, Schuyler County Office for the Aging Community Input from Schuyler County***

1. Medicaid redesign must not leave those most vulnerable without services!!
2. Rural Counties do not have multiple providers, and ancillary programs are also scarce, so the loss of a program due to funding cuts will lead to individuals not served.
3. People with serious mental illness in rural areas already lack options for treatment, and a portion goes without any treatment.
4. Transportation problems are significant and lead to no shows, cancellations, and drop outs. Even with public transit issues, individuals may not be able to independently navigate the system and may not have the supports available for assistance.
5. Local governments have had to cut back and curtail support of mental health treatment over the last three years. This has led to individuals going to the hospital,

- and emergency rooms for care at a crisis level and sometimes even prior to a crisis thus driving up costs of treatment.
6. Further cuts to local services will reduce the endangered safety net and lead to increased use of higher level services, and the criminal justice system.
  7. Lack of mandate relief reduces the local funding available for people with mental illness, developmental disabilities, and substance abuse disorder.
  8. Integration of primary and behavioral healthcare requires careful consideration regarding the rural community environment and culture.
  9. Care management design must consider the assets available in the rural community and the deficits.
  10. Administrative and fiscal issues related to integration must be developed and allow for success in the rural community.
  11. Support for peer worker development in the rural community needs to be encouraged and supported.
  12. The ability to share information, especially treatment plans, and progress documentation within an integrated care system is paramount.
  13. Serious effort to balance the medical model with one of a relapse recovery is essential if the Medical Home is to be successful.
  14. The holistic approach to the person in need is something the behavioral health system can bring to the medical table that is much needed in the rural setting.
  15. The funding, capacity and competency to do assessments and deliver care in a person's home is a key to building and strengthening individual resiliency.
  16. Evidence-based care is a laudable goal that should remain in the forefront; however, the rural community does not have the kinds of talent, training and array of evidence-based practices necessary given the full range of needs. Support must be provided in this area to bring the right treatment to bear.

# Summary of Behavioral Health Care Recommendations from the Medicaid Redesign Public Hearings

February 2011

The New York State Medicaid Redesign Team, created by Governor Andrew M. Cuomo, conducted a comprehensive examination of New York's Medicaid system, holding six regional public hearings in January and February of 2011. The hearings were designed to solicit suggestions from the public and stakeholders on ways to eliminate waste and inefficiency while improving quality in the Medicaid program. The Medicaid Redesign Team invited public input directly in writing, via the web site, or during these hearings.

The Team received more than 800 recommendations, a number specific to mental health and behavioral care.

The following summary takes into account suggestions and recommendations related to behavioral health care that were elicited as part of the public hearing process. Across all regions, care coordination, service quality, service access, reimbursement setting and rates, and oversight and regulatory reform were the predominant themes related to behavioral health care to emerge. Specific recommendations include:

On February 24, 2011, Governor Cuomo accepted a report from the Medicaid Redesign Team, which met the Governor's Medicaid spending target contained in his 2011–2012 budget. The report included 79 recommendations to redesign and restructure the Medicaid program to be more efficient and get better results for people receiving care under Medicaid. More information can be found on the [Medicaid Re-design website](#) .

## Care Coordination

- Use other states' successful programs as models for New York.
- Implement behavioral/medical healthcare homes.
- Consolidate the oversight function of agencies.
- Reduce misuse of emergency department and other costly services.
- Provide incentives for care coordination the provision of integrated care.
- Include use of peer support services.
- Increase use of technology and tele-health services.
- Increase and improve the training and qualifications of providers and physicians by including education and pay incentives.
- Redefine the role of county involvement.

- Expand substance abuse integrated services.
- Incorporate the use of “health coaches.”

### **Service Quality**

- Use evidenced-based practices.
- Improve preventative care in the behavioral health and medical health sectors (diabetes care/tobacco cessation).
- Improve and increase family planning.
- Improve diversity, especially linguistic competence.
- Increase available housing within the most integrated setting.
- Improve self-directed, individualized consumer-driven care.
- Reduce needless, repetitive paperwork and reporting by treatment providers.
- Streamline paperwork requirements and develop a universal assessment tool.
- Review residency restrictions.
- Reduce waste and unnecessary services (e.g., readmissions, emergency department visits).

### **Service Access**

- Expand hours of service.
- Provide more day service options.
- Expand community-based care.
- Increase access to community based- housing.
- Increase waiver programs.
- Streamline paperwork requirements and develop a universal assessment tool.
- Increase case management services.
- Increase the timeliness of eligibility determinations.

### **Reimbursement Setting and Rates**

- Eliminate reimbursement disparities amongst different regions and providers.
- Do NOT carve in behavioral health services; rather, keep them in the carve-out.
- Decrease provider reimbursement rates.
- Reform nursing home system of care and reimbursement.
- Increase home, community-based and long-term care reimbursement rates.
- Consider regional difference when looking at ways to redesign the system.

- Incentivize long-term care insurance.
- Reinvest savings back into communities.

### **Oversight and Regulatory Reform**

- Increase audits and reduce waste and fraud.
- Allow greater transparency.
- Do NOT cut services; rather keep the safety net in place for vulnerable populations.
- Reform the pharmacology component by recycling medications and relying upon generic formulations.
- Institute regulatory reform to reduce the burden of unfunded mandates and provide regulatory relief for providers.
- End the spousal refusal loophole.
- Reduce and standardize provider paperwork requirements and eligibility standards.

### **Regional Differences**

Although there were commonalities throughout the five regional hearings, there were also recommendations for Medicaid Redesign made that more clearly took into account regional differences experienced by participants. Below are those more prevalent recommendations by region.

#### ***Buffalo Regional Hearing***

- Carry out a comprehensive redesign to reduce waste and inefficiencies (e.g., unnecessary visits, readmissions), streamline paperwork requirements, and improve care coordination.

#### ***Rochester Regional Hearing***

- Include nursing homes in the redesign of long-term care.

#### ***Long Island Regional Hearing***

- Implement regulatory reform, including reimbursement rates, waste and fraud.

#### ***New York City Regional Hearings***

- Avoid cuts, expand access, and maintain the safety net.

#### ***Queensbury Regional Hearings***

- Use behavioral health organizations and expand patient-centered medical homes.