Office of
Mental Health

Statewide Comprehensive Plan

2014-2018

Message from the Commissioner

New York is a State under transition. This document aims to capture the major forces in play for the public mental health system, which are integrated with and driven by larger trends in the broader healthcare system, insurance markets, clinical advancements, and legal mandates. While many of these forces can be viewed as challenges—they can be translated into opportunities that will ultimately render a greater health and behavioral healthcare system than before. As such, the 2014-2018 Statewide Comprehensive Plan will lay out each of the major initiatives that "everyone is talking about" in order for the reader—local governments, providers, consumers, advocates, and the general public—to identify their roles and the opportunities for those respective roles as we continue to build and develop a stronger community healthcare safety net for all New Yorkers.

The repeated request to OMH, and likely its partner agencies, over the past years has been to "draw a picture" of how all of the national and State policy reforms fit together: the Affordable Care Act, DSRIP, managed care reform, the OMH Transformation Plan, etc. While the present document attempts to diagram some of the relationship between major New York State initiatives, the transformation is still underway—and therefore it is asked that the reader reflect on the interplay of these initiatives from their own perspective and use this to directly participate in this process.

We have been fortunate to have had the continuous and ongoing flow of communication from stakeholders across the State on what OMH (and New York State government at large) can do to accomplish the OMH mission: promoting the mental health of all New Yorkers with a particular focus on facilitating hope and recovery for adults with serious mental illness and children with serious emotional disturbance. However with the emerging opportunities for integration with healthcare systems, the impacts of expanded insurance eligibility, and care management for all—the opportunities and challenges in achieving this goal involves a broader set of partners whom we all must educate and learn from respectively to advance the Triple Aim of better health, better care, and lower costs across all healthcare settings.

Following an overview of the statutory mental hygiene planning process, this Comprehensive Plan will outline the following initiatives involving the State Office of Mental Health and the individuals we serve:

1. The OMH Transformation Plan
2. Integrated Managed Behavioral Healthcare
3. The Delivery System Reform Incentive Payment (DSRIP) program
4. The Statewide Prevention Agenda 2013-2017, and
5. The Population Health Improvement Program (PHIPs).

As the scale and complexity of many of these initiatives suggests, "planning" itself is in need of careful consideration, and of an evolving role to ensure alignment and rationality of the multiple reforms underway. And the reader will see in the forthcoming presentation that planning processes and structures are built into the designs of the initiatives- such as the Regional Planning Consortiums under Managed Care, and the PHIPs in themselves.

While this document reflects many of the current priorities and plans of OMH and the local governmental units, it should be seen as an evolving record to be continuously developed and adjusted as we hear from consumers, families, providers and other stakeholders across the State.

Ann Marie T. Sullivan, M.D.
Commissioner, NYS Office of Mental Health

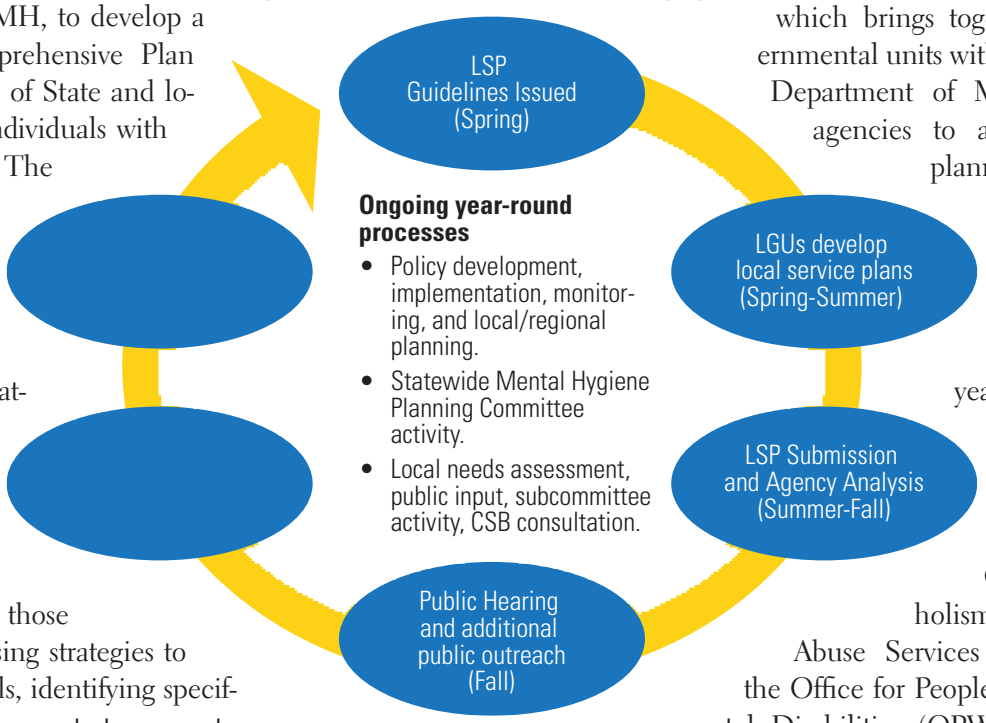
Table of Contents

Chapter 1

An Introduction to the State and Local Planning Process

Section 5.07 of Mental Hygiene Law requires OMH, to develop a Statewide Comprehensive Plan for the provision of State and local services to individuals with mental illness. The purpose of the 5.07 Plan is manifold, with some key objectives identified in the statute including: identifying statewide priorities and measurable goals to achieve those priorities, proposing strategies to obtain those goals, identifying specific services and supports to promote mental wellness, analyzing service utilization trends across levels of care, promoting recovery-oriented, state-local service development, and reporting progress on key children and family initiatives.

Figure 1-1: The State and Local Planning Cycle



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

> The statewide comprehensive plan shall be based upon an analysis of local services plans developed by each local governmental unit, in consultation with consumers, consumer groups, providers of services and departmental facilities that furnish behavioral health services in conformance with statewide priorities and goals established with recommendations of the behavioral health services advisory council and the advisory council on developmental disabilities.
>
> *— NYS Mental Hygiene Law §5.07(b)(1)*

The planning process begins in March of each year with the posting of planning guidelines issued jointly by OMH, the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office for People With Developmental Disabilities (OPWDD). The Local Services Plan (LSP) Guidelines project each agency's key policy developments and strategic direction, in addition to more technical survey tools and guidance for the submission of local plans. Utilizing the OASAS-operated County Planning System (CPS), LGUs develop their local services plans in consultation with their local Community Services Board and other local advisory bodies. The LGUs then submit their final local services plans by the end of June. In 2014 all local services plans were made fully available to the public without a CPS account, through the NYS Conference of Local Mental Hygiene Directors website, which will now allow for greater access to local services plans to help further educate and engage commu-

nity stakeholders. LSPs for 2014 and 2015 are available by selecting any county on the following web page: http://www.clmhd.org/contact_local_mental_hygiene_departments/

Once plans have been submitted to the State agencies, they not only drive the content and direction of the Statewide Comprehensive Plan, but are used by OMH staff across the agency in order to monitor the state of the public mental health system and drive changes and reforms, particularly when trends and themes emerge. Local plans also factor into the development of the annual SAMHSA Integrated Block Grant, a federal funding source supporting several initiatives between OMH and OASAS. For example, the current Integrated Block Grant includes significant set-asides for the expansion of First Episode Psychosis, OnTrackNY program.

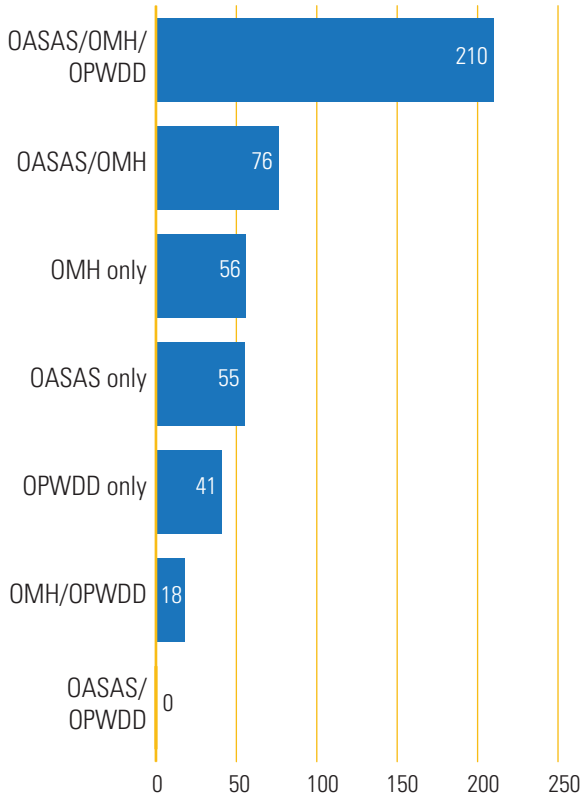
For the past two years, the local services plans have been used to develop regional recommendations for the investment of community based services and supports that will help transform the public mental health system by reducing inpatient psychiatric utilization and expanding the community safety net. In a rapid and iterative process that has involved OMH field offices and facility directors, local governmental units, and other key community stakeholders, the Office of Mental Health is making over $40 million annualized of investments that are driven by LGU plans and continuous consultation with local Directors of Community Services (DCSs, who are the chief executives of the local governmental unit). The Office of Mental Health sees this consultation process as the beginning of a longer-term enhancement of collaborative planning among this agency and local governments, providers, consumers, and other stakeholders in the transformation of the public mental health system.

At the same time that State and regional planning efforts are informed by local service plan analysis and consultation with LGUs and others at the community level, New York Staff must also incorporate macro-level sea changes in the public health and mental health systems that have emerged from broader State and federal policy initiatives. The need to incorporate local wisdom with broader legislative, regulatory, and administrative directives necessitates an organizing infrastructure to manage change in a manner that will improve quality of care, consumer health, and cost efficacy; the most recent planning efforts for the public mental health system build upon existing systems while advancing a more integrated and inclusive model for the future.

The 2015 Local Services Plans - A Discussion of Priorities and Themes

There were a total of 456 priorities identified in the 2015 local services plans submitted by 57 LGUs, up slightly from the previous year.[1] As Figure 1-2 shows, 360 priorities were associated with OMH, including 210 that were associated with all three mental hygiene agencies. Only 56 priorities were exclusively associated with OMH. This reflects in part the degree to which local planning priorities are targeting areas that require a more comprehensive cross-system approach.[2]

Figure 1-2: 2015 Local Services Plan Priorities by Disability Agency (N=456)



An analysis of county local services plans for 2015 portrays a system influx and an almost universal theme of managing, facilitating, coordinating, and succeeding in change. Nearly all LGU plans included a top priority that addressed the need for the counties and the State to increase cross-systems collaboration and communication, in large part to ensure that the individuals we serve will continue to have access to the services, supports, and self-directed resources to pursue recovery in their lives. Most plans spoke directly to the need for the LGU and local behavioral health providers to be engaged in the Delivery Sys-

tem Reform Incentive Payment (DSRIP) plan, integrated health and behavioral health systems, Medicaid Managed Care, and the Prevention Agenda. There is a wide recognition that while we are in a period of great change and opportunity with an influx of new community resources for individuals with mental illness, that we must pay close attention to how all of these opportunities fit together in order to achieve lasting reforms to promote better care, better health outcomes, and lower costs.

A second common theme was the need for the better utilization and coordination of existing resources and systems above the need to have just "more" of something. This is consistent with the theme of collaborative and coordinated care; because having more of a resource does not necessarily translate into achieving a positive outcome. While 18% of all OMH-related local services plan priorities were categorized under expanded/new services; nearly 50% of priorities were associated with improving existing services, or with greater coordination/integration of existing services and systems.[3] Again, with the Triple Aim goal of improving care, improving population health, and lowering per capita cost, the alignment and continuous improvement of existing and emerging systems and objectives is critical to managing such large scale change.

The emphasis on working with existing resources is not to take away the still significant emphasis on developing new or expanded services. The most frequently cited area for continuing expansion has been around housing, a theme also heavily emphasized in the regional planning work that localities and providers participated in with OMH Field Offices and facilities beginning in the fall of 2013 and which is ongoing. Local services plans called for all levels of residential opportunities, from supported housing to more intensely staffed or supported settings for older adults with chronic medical conditions to children in need of short-term stabilization and respite care. OMH has and will continue developing housing opportunities in order to address the consistent theme. OMH is also working statewide to make more efficient use of all levels of housing to increase the number of individuals served in the community and in the appropriate settings for their needs. See Chapter 2 for a regional breakdown of Supported Housing investments made through the current State Budget under the OMH Transformation Plan.

Figure 1-3 demonstrates a heavy focus on alignment and improvement of existing services as localities implement existing and plan for emerging systemic reforms. This theme also carried over into the work of the LGUs' partner agencies, local health departments (LHDs), which also submit plans to the State Department of Health. Under the Prevention Agenda initiative, local health departments and local governmental units worked together to identify common Prevention Agenda providers. Figure 1-4 exhibits that the topmost cited activity appearing in both LGU and LHD plans was supporting collaboration across systems (12), along with suicide prevention (12). The Prevention Agenda 2013-17 is discussed in greater depth in Chapter 4.

Figure 1-3: Local Services Plans Priority Outcomes by Type[4]

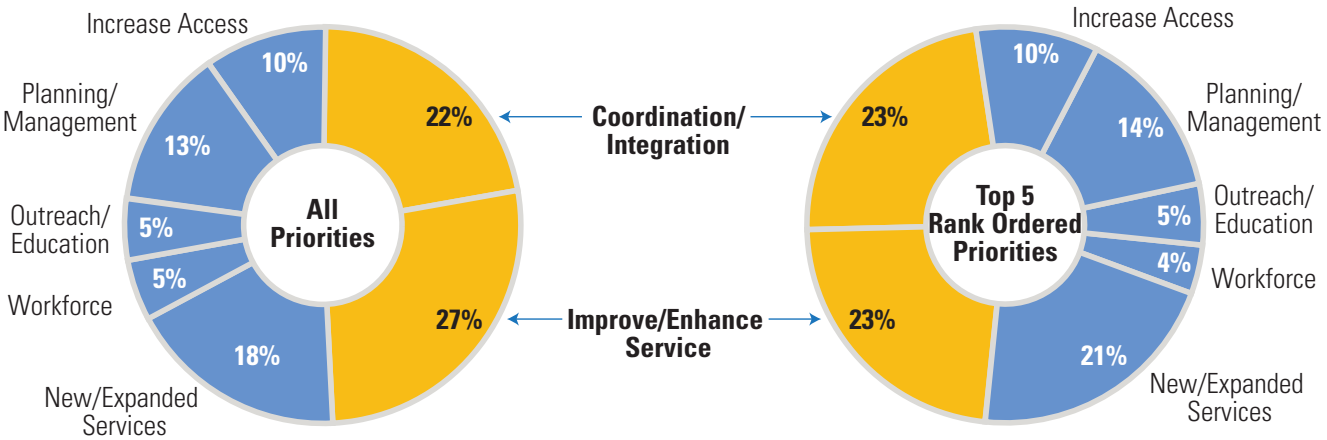
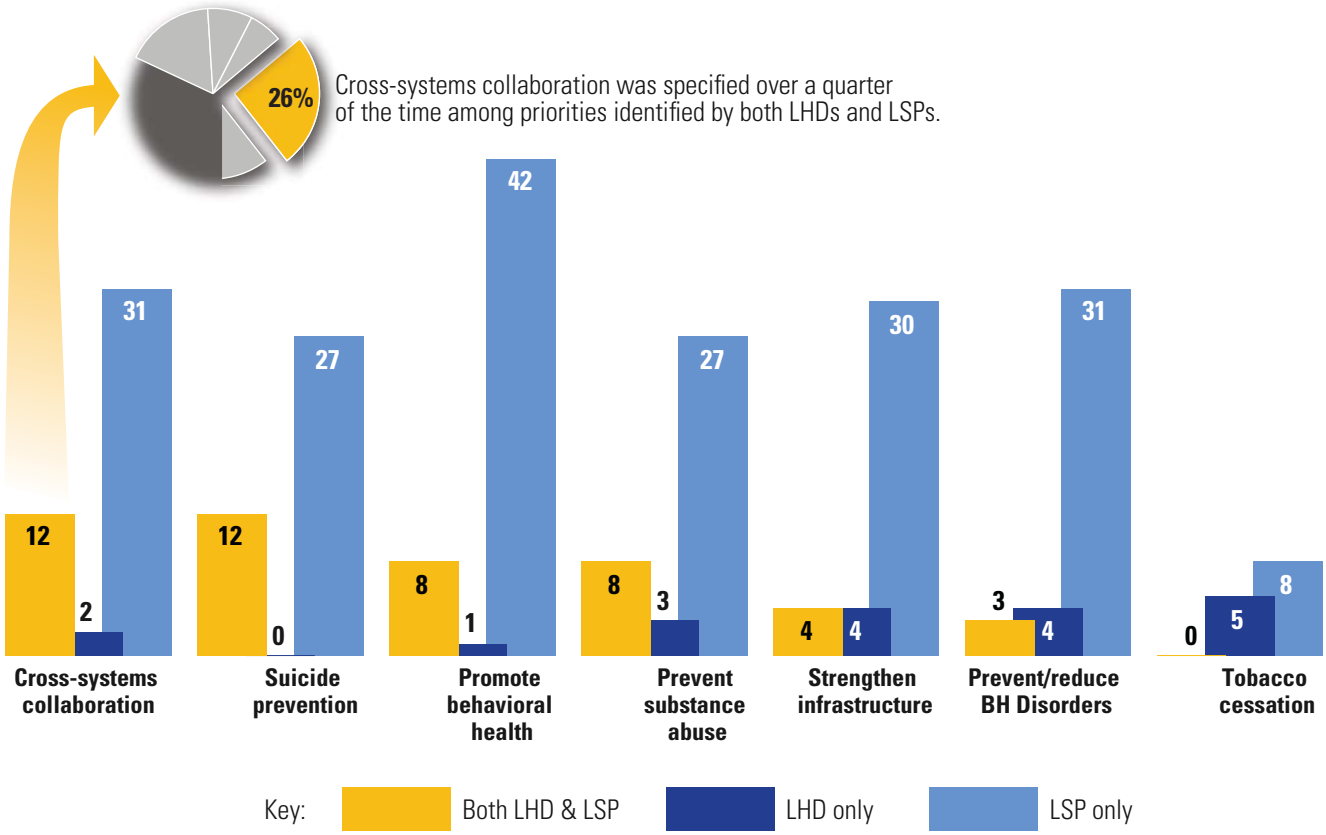


Figure 1-4: Prevention Agenda Priority Alignment for Local Health Departments and Local Governmental Units focused on the "Promote Mental Health and Prevent Substance Abuse Action Plan"



Joint Public Hearing for 2014

Following the submission and analysis of local services plans, each mental hygiene agency also holds a hearing or hearings to solicit general feedback and recommendations from the public on other priorities and recommendations for inclusion into each agency's respective 5.07 Plan. 2014 marked the third annual OASAS-OMH joint public hearing, in which the Commissioners of both agencies appeared together to receive recommendations and feedback on issues the agencies should focus their efforts in strategic planning. This year the hearing was held among nine locations via video teleconference technology which allowed for over 200 participants and 23 individuals and organizations who testified before the Commissioners. Hearing site locations allowed for the participation of members of the public in Albany, Buffalo, Rochester, Syracuse, Manhattan, Staten Island, West Brentwood, Ogdensburg, and Binghamton; covering all the major regions of the State. Copies of all testimony may be viewed on the OMH website.

As with the local services plans, public testimony this year focused significant attention around the multiple initiatives driving systems transformation, and the particular need for the Office of Mental Health to ensure that consumers and families are involved in the planning and implementation of reforms. These recommendations were a balance between caution over the complex technical and systemic components involved in such large scale change for the public mental health system, with a strong and constructive sense of optimism at the many opportunities presented.

In addition to the consumer and family perspective, many statewide organizations made detailed technical recommendations regarding fiscal, programmatic, and systems reforms, and provider sustainability during the ongoing statewide transformation efforts. Some examples include advocacy for continuing development of regional planning entities, reimbursement (particularly clinic) rate and workforce wage support, and the role of acute and intermediate inpatient services. Regulatory reform and relief is a regular theme in 5.07 hearings, however this year elicited more

structured and specific recommendations in testimony now that New York State has made substantive progress in implementing integrated clinic licensure and a formal process for regulatory waivers through the DSRIP program.

Finally, there were a few individuals who presented spontaneous testimony after hearing others voice questions, concerns and constructive recommendations; this to OMH was a positive sign that many of the critical stakeholders who will aid in the transformation of the public mental health system are identifying with one another and orienting around a common theme of recovery and resiliency for children, adults, and families impacted by behavioral health disorders.

Chapter 1 Endnotes

1 There are 58 LGUs in New York State (57 counties plus New York City). Only 57 are submitted because Warren and Washington counties are represented by one Director of Community Services who submits a single, unified Local Services Plan for both counties.

2 Some caution should be taken with the all-agency (OASAS, OMH, OPWDD) category as a careful reading of many local services plans will show that some priority outcomes coded this way appear to apply primarily or exclusively to one or two agencies. However, those priorities directed toward systems integration and coordination of multiple stakeholders as seen in the 2015 plans at least implicitly would apply to all three agencies.

3 See Appendix A for an overview of the local services plan priority selection process and the coding used to categorize local service plan priority outcomes.

4 This figure includes the categorization of all local service plan priority outcomes applicable to OMH regardless of rank (All Priorities chart), and the top five rank-ordered local service plan priorities (Top 5 Rank Ordered Priorities chart).

Chapter 2

The OMH Transformation Plan: Advancing a Progressive Behavioral System

New York currently exceeds both the national average inpatient utilization rate at state-operated psychiatric centers, and per capita inpatient census levels at state-operated psychiatric centers in other urban states and all Mid-Atlantic States. New York's extensive State PC inpatient capacity includes 24 facilities with nearly 4,000 budgeted beds.[1] Among these are a number of hospitals operating with fewer than 100 beds.

This situation had led to disproportionately high State-operated inpatient per capita costs as more individuals with mental illness are supported successfully with community-based mental health services, while the inpatient footprint has remained large. The evidence of this imbalance is clear: while New York's State-operated inpatient facilities serve approximately 1% of the total number of people served in the public mental health system, they account for 20% of gross annual system expenditures. With the inclusion of other acute inpatient facilities (Article 28 or 31 psychiatric hospitals), inpatient psychiatric costs amount to approximately half of the total spending on public mental health services.

Based on the analysis of the 2015 Local Services Plans, hearing testimony, and ongoing consultation with LGUs, providers, consumers, and family and peer representatives the following themes and priorities consistently arose in the context of the OMH Transformation Plan. These principles will continue to inform OMH statewide and regional planning efforts:

1. Pre-invest: Fund community services before reductions to inpatient capacity in order to have stronger continuum of services for individuals leaving facilities, and to have a meaningful preventive impact on inpatient demand.
2. Service design must be community-driven: Support local and regional forums to identify additional services and systemic reforms. These plans should engage community and provider stakeholders, and build upon Article 41 local service plan priorities.
3. Maintain resources in future by maintaining staff positions when needed and reprogramming funds that may not be effectively serving the communities as intended.
4. Align with DSRIP projects and Medicaid Managed Care HCBS services to the greatest extent possible for an understandable, integrated, and navigable service system.
5. Access is critical, and multi-dimensional: More than funding and developing new services and programs, they must be accessible, useful, and understandable to the people we serve. This includes having an understanding of what services are offered and where, the ability to "get there" or have them come to you (transportation, mobile service, or telecommunication), and their being culturally and linguistically accessible.

The OMH Transformation Plan aims to rebalance the agency's institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so the Plan will strengthen and broaden the public mental health system to enhance the community safety net; allowing more individuals with mental illness to be supported with high quality, cost effective services within home and community-based settings and avoid costly inpatient psychiatric stays. Beginning with the State fiscal year (SFY) 2014-15 State Budget, the OMH Transformation Plan "pre-invested" $25 million (annualized to $44 million) into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay. These pre-investment funds are based on a one year reduction of 399 psychiatric inpatient beds that will produce savings to help sustain and grow these community investments.

At the State level, the upcoming "carve-in" of most Medicaid beneficiaries into managed care, the Delivery System Reform Incentive Payment (DSRIP) program, and the Prevention Agenda 2013-17 are timely and direct drivers of reform to the State and community-based systems of care. Together these initiatives will further coordinate care across clinical modalities and levels of government by developing an integrated, recovery-centered service delivery system designed to improve patient care and population health—the means to achieve the "Triple Aim" of better care, better health and better lives for those whom we serve—at lower costs.

The OMH Transformation Plan is consistent with these ongoing reforms in health care policy and financing. As the market for health care services becomes more consumer-directed, integrated and community-oriented, OMH must advance in step with the people we serve in order to be relevant and sustainable in the future. The OMH Transformation Plan will create the mental health system that New York needs in the 21st Century—a system focused on prevention, early identification and intervention, and evidence-based clinical services and recovery supports. Finally, the Plan's rebalancing of the agency's institutional resources to further develop and enhance community-based mental health services is also consistent with the Americans with Disabilities Act (ADA). The US Supreme Court's 1999 Olmstead decision held that the ADA mandates that the State's services, programs, and activities for people with disabilities must be administered in the most integrated setting appropriate to a person's needs.

Reinvestment and Regional Planning Progress

With the passage of the SFY 2014-15 budget, planning for pre-investment funding began in all areas of the State: Western New York, the Rochester area, the Southern Tier, the North Country, the Syracuse area, the Hudson River region, New York City, and Long Island. Through this process, local government units, OMH field offices, and State-operated psychiatric center directors are working collaboratively to operationalize the goals of a broad set of community stakeholders who participated in regional advisory bodies which met through the summer and fall of 2013. The goals of the regional advisory bodies focused on the following resources: Supported Housing, Medicaid Home and Community Based Services (HCBS) waiver, State-operated community enhancements, and Aid to Localities funding—in addition to overall systemic reforms required to most effectively use these resources. State Fiscal Year 2014-15 allocations of these resources by State-operated facility and region are presented in Table 2-1.

Supported Housing and HCBS Waiver are established OMH programs for adults and children respectively. The

Table 2-1: OMH Transformation Plan SFY 2014-15 Investments in Community Services and Supports by Facility

		HCBS Waiver		Supported Housing				
Region	**State PC Service Area**	**Units**	**Funding**	**Units**	**Funding**	**State-Community**	**Aid to Localities**	**Grand Total**
Southern Tier	Greater Binghamton	12	$315,516	60	$470,263	$5,740,000	$805,000	**$8,050,743**
	Elmira	12	$315,516	48	$404,448			
North Country	St. Lawrence	12	$315,516	50	$383,750	$2,870,000	$281,000	**$3,850,266**
Long Island	Sagamore	54	$1,488,240	-	-	$2,100,000	$3,307,000	**$8,399,540**
	Pilgrim	-	-	100	$1,504,300	-		
Western NY	Western NY	24	$631,032	-	-	$1,050,000	$1,898,000	**$4,000,332**
	Buffalo	-	-	50	$421,300	-		
Rochester Area	Rochester	-	-	116	$977,416	$2,100,000	$2,823,000	**$5,900,416**
New York City	Manhattan & Bronx PCs	24	$661,440	154	$2,316,622	-	$4,323,000	**$7,301,062**
Hudson River	Rockland	12	$323,118	50	$622,276	-	$2,255,000	**$3,200,394**
Central NY	Hutchings	18	$473,274	-	-	$1,050,000	$177,000	**$1,700,274**
Statewide Forensic/Suicide Prevention								**$1,500,000**
	Total	**168**	**$4,523,652**	**628**	**$7,100,375**	**$14,910,000**	**$15,869,000**	**$43,903,027**

Article 28/31 Hospital Reinvestment and the Vital Access Provider (VAP) Program

In addition to the pre-investment funding for State PC reductions, the State Budget for 2014-15 also includes the authority for reinvestment of Medicaid savings associated with community hospital inpatient psychiatric services, and for the support of vital service providers with structural financial risks; these are the Article 28/31 hospital reinvestment and the VAP programs.

Article 28/31 Hospital Reinvestment

Over the past several years, there have been a number of closures of Article 28 and Article 31 inpatient and ambulatory programs, due to both programmatic and fiscal issues with the operation of the unit, or the overall fiscal viability of the institution. Given that such actions could leave gaps in the service delivery system in certain areas of the State, OMH is working with the Department of Health (DOH) to develop reinvestment plans to address the loss of psychiatric services in institutions that have closed, or will be closing in the near future. These plans are funded through the Medicaid state-share savings resulting from reductions in behavioral health capacity, with the primary program focus areas of these plans involve crisis assessment and admission diversion programs, respite services, and other alternatives to inpatient admission. As with the Transformation Plan pre-investment planning, the consultation and planning for Article 28/31 reinvestment involves the local governmental units impacted by the reductions and the OMH field office; the goal for such reinvestment is also consistent with the Transformation Plan, in reducing the need for inpatient services through the development of community supports and services.

Vital Access Provider (VAP) Program

For some other Medicaid providers of community mental health services that are at risk of closing or reducing services but are still operating, OMH is working prospectively with DOH to implement a targeted investment strategy to ensure critical access to behavioral health care in areas across New York State, through the Vital Access Provider program. VAP funds will be available to Article 28 inpatient and ambulatory providers, including inpatient psychiatric units, to support providers identified as providing a critical role to specific populations or geographic areas. Through recent regulatory amendments, VAP has also been expanded to include Article 31 licensed outpatient clinics, in recognition of the critical role of outpatient treatment, and of the fiscal issues facing several clinics throughout the State.

Among the factors that will go into the decisions made in determining VAP eligibility will be current geographic capacity, provider occupancy levels within the geographic area, overall financial viability of the institution, proximity to actions planned for State Psychiatric Centers, and programmatic need for the particular provider services. VAP funds will be used to enhance community care and to help providers achieve defined financial, operational, and quality improvement goals related to integration or reconfiguration of services offered by the facility.

Taken together, the Transformation Plan, Article 28/31 reinvestment, and Vital Access Provider program all engage local and regional stakeholders to examine the needs of communities in the context of the continually evolving infrastructure. As macro level forces such as the Olmstead Plan, and the recovery movement are driving a shift of resources into communities and away from large institutions, these targeted investment and reinvestment strategies will help pave the road to a more responsive, consumer-oriented, and cost effective support system to improve the health and well-being of more adults, children and families impacted by behavioral health disorders in New York State.

OMH Field Offices worked with LGUs to determine the geographic distribution in awarding these services; final awards were made in most areas by May 2014 for housing and June 2014 for HCBS waiver. Planning around State-operated community service expansion and Aid to Localities (State Aid) has been more deliberative and in-depth, since these resources allow for very specific levels of service design and geographic reach, based on each region and county's specific needs and assets.

OMH is committed to continuing to work with LGUs and other stakeholders to further develop community services intended to reduce inpatient hospitalizations and lengths of stay and optimize community living for the adults, children, and fami-

lies residing throughout New York State. The ensuing sections outline the progress of regional plans to date, including the services already funded and implemented across many areas of the State. All reinvestment progress described in the statewide and regional narratives is as of December 1, 2014. [2]

Western New York Reinvestment and Planning Progress

OMH has made funding available for the counties served by Western New York Children's Psychiatric Center and the Buffalo Psychiatric Center in an annualized amount of $4 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS Waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

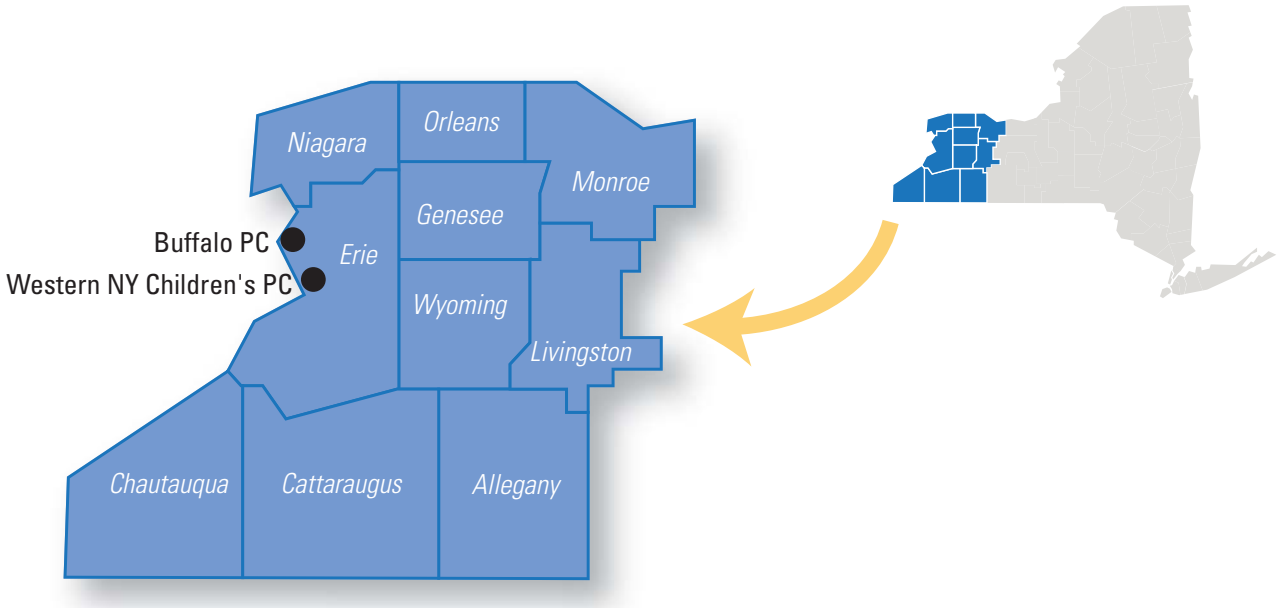
- *50 new Supported Housing units.*
- *24 new Home and Community-based Services Waiver slots.*
- A State-operated *Mobile Intervention Team (MIT)* for children and youth.
- State-operated *children's outpatient clinic expansion*.

Additional programs developed by the LGUs and funded through Aid to Localities grants to counties include:

- *Peer Respite Center Hospital Diversion Program*. These peer-run respite centers will provide recovery-based alternatives for adult consumers. The centers' services are designed to enhance engagement in community service supports, help maximize community tenure and avoid inpatient hospitalizations. The Chautauqua and Cattaraugus center will serve approximately 150-175 people annually in a four to six bed center. The Erie County respite center will serve approximately 225 people annually in a three to five bed center.
- *Mobile Transitional Support* will provide mobile clinical intervention and support with follow-up during the time when discharged individuals are transitioning to engagement in the community-based services and supports identified on their discharge plan. This program will provide mobile interventions during hours when community-based clinical services are largely unavailable, care management may not be immediately available, and crisis outreach is not appropriate.
- *Crisis Intervention Team*. This team will provide clinical intervention and supports to successfully maintain each person in his/her home or community by providing the level of clinical care, community-based supports and supervision that are needed to maintain community tenure.

In addition to these Transformation Plan services, OMH and the New York State Department of Health are funding the following services with reinvestment funds associated with the closure of inpatient psychiatric units at Medina Memorial Hospital ($199,030) and St. James Mercy Hospital ($894,725):

Figure 2-1: Western New York Reinvestment Area



housing, and provide other incidental services to support recovery.

- *Enhanced Crisis Outreach/Respite Programs.* Capacity expansion, after hour services and an increase in support staff will enhance existing mobile crisis and crisis intervention programs in Essex, Franklin and St. Lawrence counties.
- *Forensic Program.* This program will provide more direct services to inmates in Jefferson County who have been identified as mentally ill. This program aims to reduce the rate of inmates decompensating, reduce recidivism among this population and produce data for studies determining how to better divert individuals who enter the justice system from hospitals or jail.

Hudson River Region Reinvestment and Planning Progress

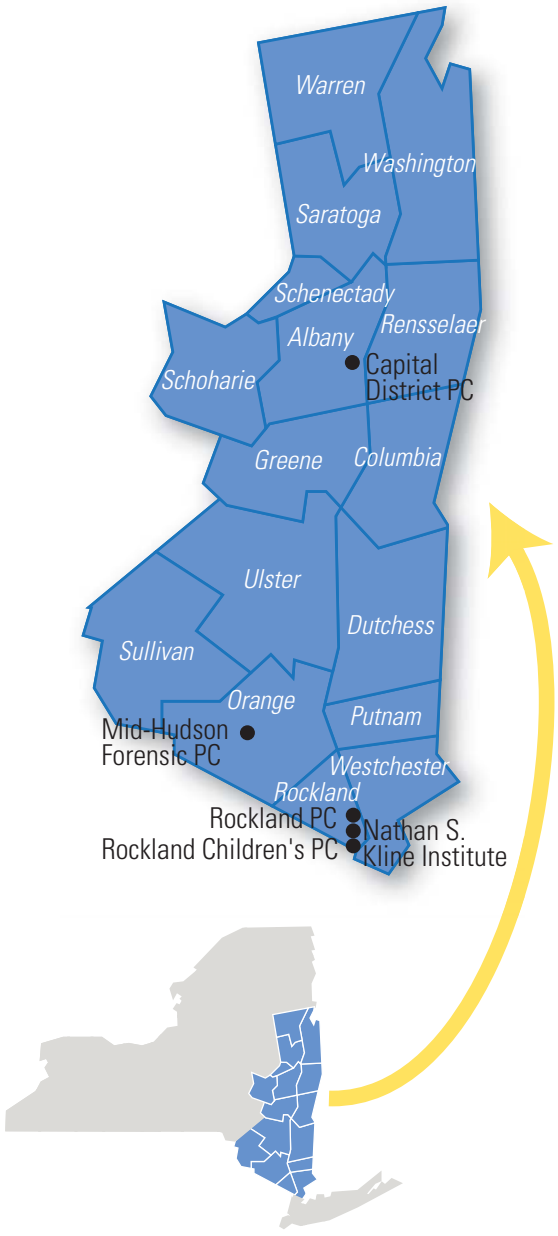
OMH has made funding available for the counties served by Rockland Psychiatric Center and Rockland Children's Psychiatric Center in an annualized amount of $3.2 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

- *50 new Supported Housing units*[5].
- *12 new Home and Community-based Services Waiver slots.*

Additional programs funded through Aid to Localities grants are under discussion with the local governmental unit and may include those listed below:

- *A Self-Help program* will offer short-term care and interventions in response to a behavioral health crisis event that creates an imminent risk for an escalation of symptoms without supports.
- *Supported Housing and Outreach programs* to assist in locating and securing housing of a service recipient's choice and in accessing the supports necessary to live successfully in the community. Outreach programs are intended to engage children, adults, and families who are potentially in need of mental health services.
- *Advocacy and Support Services.* Advocacy and support services assist consumers in protecting and promoting their rights, resolving complaints and grievances, and accessing services and supports of their choice. A self-help component of the program will provide rehabilitative and support activities based on the principle that people who share a common condition or experience can be of substantial assistance to each other. These programs include mutual support groups and networks, self-help organizations and/or specific educational, recreational and social opportunities.
- *Mobile Crisis Intervention programs* will provide the clinical intervention and support necessary to successfully maintain children in home or community-based settings and prevent inpatient hospitalizations.
- *Assertive Community Treatment (ACT) Team.* ACT Teams are evidence-based programs that deliver comprehensive and flexible treatment, support, and reha-

Figure 2-6: Hudson River Reinvestment Area



bilitation services to individuals in their natural living settings rather than in hospital or clinic settings. These teams have been found to improve recipient outcomes with studies showing greater reductions in psychiatric hospitalization rates, emergency room visits, and higher levels of housing stability after receiving ACT services.

- *Adult Outreach Services* are intended to engage and access individuals potentially in need of mental health services.
- *Children's Crisis Intervention/Mobile Integration Team* will provide the clinical interventions and supports necessary to successfully maintain children in home or community-based settings and prevent inpatient hospitalization.

In addition to these Transformation Plan services, OMH and the New York State Department of Health are funding the following services with $4.6 million in reinvestment funds associated with inpatient psychiatric reductions at the Stony Lodge Children's Psychiatric Hospital and the intermediate care Hospital at Rye.

- *Respite Services* to stabilize individuals in the community rather than utilize hospital or long term, out-of-home services.
- *Home Based Crisis Intervention (HBCI) Services* to provide intensive in-home crisis services to children aged 5-17.
- *Mobile Crisis Intervention* to prevent or limit inpatient hospitalization or emergency room use for adults, adolescents and children experiencing acute symptoms. This service will operate late in the day and in the evenings. Combined with the use of respite beds, it will reduce the use of inpatient beds.
- *18 additional Home and Community-based Services Waiver slots.*
- *Supported Housing and Community Supports* to enable people to live independently and reduce the utilization of more costly Medicaid services. These funds will support at least 10 additional supported housing units with community supports for targeted populations, including transitional youth (aging out) at risk of hospitalization.
- *Children and Youth Family Support* to provide core services of family/peer support, respite, advocacy and skill building, and educational opportunities. This is a cost-effective and evidence-based method of reducing the need for inpatient services.
- Self-Help Program. A peer-operated alternative to hospitalization that provides supports to individuals in crisis or emotional distress.

New York City Reinvestment and Planning Progress

OMH has made funding available for New York City in an annualized amount of $7.3 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the New York City Department of Health and Mental Hygiene.

- *154 new Supported Housing units.*
- *24 new Home and Community-based Services Waiver slots.*

Additional programs developed in consultation with the LGU and funded through Aid to Localities grants include:

- *Transitions in Care Teams* focused on State PC and acute care discharges. OMH is funding two types of transitions in care teams known as the Pathway Home (2) and Parachute teams (3), for a total of 5 teams, largely focused on assisting recipients in the transition from a State Psychiatric Center to a community setting. These teams will become a critical part of what is missing in the crisis management system in the City. Although largely focused on SPC discharges, these teams can also be used as a bridge service for individuals being discharged from an acute care hospital as a way to provide more intensive support while a recipient is being engaged in outpatient clinic and other services.

  Both teams are focused on recipient engagement through a multi-disciplinary mobile team consisting of Peer Specialists and nurses, social workers and part-time physician staff and have as their goal the collaboration with treatment and housing providers to facilitate timely, safe discharge to the community with ongoing support. Although run by different providers, the basic aim is similar – providing time-limited support in transitions in care to prevent future crises, and costly inpatient and psychiatric emergency services use. The team support is very patient-centered and depending on the recipient's needs can extend from 3 months to year. An important part of the engagement is the use of recipient wrap-around dollars.

In addition to these Transformation Plan services, OMH and the New York State Department of Health are funding the following services with $7.3 million in reinvestment funds associated with inpatient psychiatric reductions at Holliswood ($5,735,711) and Stony Lodge Hospitals ($1,600,000).[6]

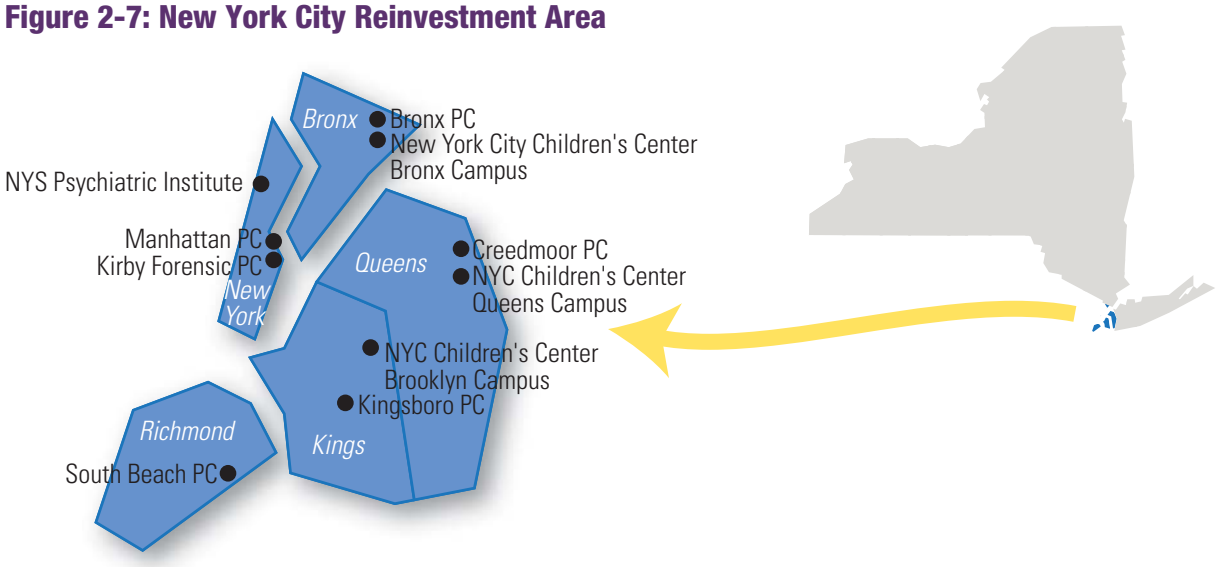
Holliswood Hospital:

- *54 additional Home and Community-based Services Waiver slots* for intensive home based services targeted at children who would otherwise require hospitalization or residential treatment. This funding adds 15 additional slots for the NYC Region. In addition, NYS will fund another 39 slots using Balancing Incentive Program (BIP) funds and support those slots using reinvestment savings from State PC reductions.
- *Crisis Respite Beds* to offer short term overnight respite of up to 21 days for relief from a current stressful living situation for children aged 4-18. This funding increases bed capacity in Queens and Bronx Counties from 16 beds to 21 beds.
- *Rapid Access Mobile Crisis Teams* to provide short term crisis response and management for children and adolescents aged 0-17 in Brooklyn, Queens, Staten Island, and Manhattan. This funding adds a total of 6.5 new teams.
- *Family Advocates* will work with children and families accessing community hospital emergency departments and inpatient and outpatient units by advocating for their needs and assisting them in accessing and navigating services and supports in the community. Family advocates are peers, or family members with a child with emotional challenges who have experienced firsthand the services offered through the community mental health system.
- *Inpatient Beds:* A 15-bed inpatient unit for children will be developed at Long Island Jewish Medical Center in New York City as part of the spectrum of community services under development to enhance treatment and supports for children and families.
- *Child Specialist Staff* to assess and divert children from inpatient admissions and develop linkages to Home Based Crisis Intervention and other intensive services in Queens.
- *Home Based Crisis Intervention (HBCI) Team.* Holliswood Hospital also provided services for children in Hudson River counties. These funds will be used to provide intensive in-home crisis services in those counties combined with reinvestment funds in the NYC Region.

Stony Lodge Hospital:

- *Home Based Crisis Intervention (HBCI) Team* to provide intensive in-home crisis intervention for families whose children are at risk of inpatient admission. These funds will be used to establish an HCBI team at Lincoln Hospital in Bronx County and to support the Bellevue HCBI Team in New York County.
- *Connection to Care (C2C) Team* to work with children and youth under 18 and their families while they are hospitalized to link them to appropriate services and

Figure 2-7: New York City Reinvestment Area



ongoing care in the community. C2C targets children and youth at high risk of re-hospitalization, as well as those experiencing first episode psychosis. The reinvestment plan is to fund one city-wide team.

- *Partial Hospitalization and Day Treatment Programs* to serve as an alternative to inpatient hospitalization and provide intensive services for children. This funding will enable Bellevue Hospital in New York County to convert its existing 25 slot day treatment program to a 27 slot Partial Hospitalization Program and retain 9 slots for Day Treatment. The program is the only existing Comprehensive Psychiatric Emergency Program (CPEP) for children in New York City and receives referrals from all five boroughs.

Long Island Reinvestment and Planning Progress

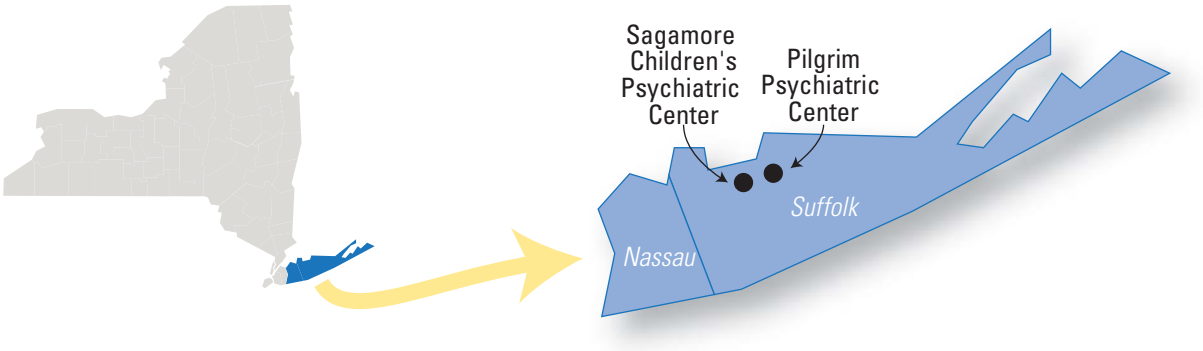
OMH has made funding available for Long Island in an annualized amount of $8.4 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

- *100 new Supported Housing units.*
- *54 Home and Community-based Services (HCBS) Waiver slots.*
- *Children's Crisis/Respite beds* to be developed through the conversion of existing inpatient units. Crisis/respite unit capacity will be developed only as a reduction of inpatient utilization is demonstrated.
- A State-operated *Mobile Intervention Team (MIT)* for children and youth.
- State-operated *children's outpatient clinic* expansion.

Additional programs developed by the LGUs and funded through Aid to Localities grants to counties include:

- *Assertive Community Treatment (ACT) Teams:* Two ACT Teams will serve 68 individuals each. ACT Teams are evidence-based programs that deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings rather than in hospital or clinic settings. These teams have been found to improve recipient outcomes with studies showing greater reductions in psychiatric hospitalization rates, emergency room visits, and higher levels of housing stability after receiving ACT services. One ACT team will serve individuals with significant mental health challenges, while the second team will be a "Forensic" ACT Team focusing on individuals who are re-integrating into the community after incarceration.
- *Non-Medicaid Care Coordination for Children:* 72 Non-Medicaid Care Coordination slots aimed at linking children with serious emotional disturbances and their families to the mental health service system and coordinating these services to promote successful outcomes with continuity of care and service. While children with Medicaid may receive services from this program, it is open to all children and families meeting the criteria for service provision.
- *Child and Family Intensive Case Management:* 18 Child and Family Intensive Case Management slots will promote optimal health and wellness for children diagnosed with severe emotional disturbance. These case management services will help children and families with linkages to and coordination of essential mental health services and community resources, allowing the children served to live successfully in the community.
- *Mobile Residential Support Teams* to focus on transitioning adults living in supported housing apartments into community living. Once these individuals are liv-

Figure 2-8: Long Island Reinvestment Area



ing in the community, the Mobile Residential Support Teams will visit them in their homes to help ensure that their basic needs are being met.

- *Hospital Alternative Respite Center* will provide a viable option to inpatient hospitalization for individuals experiencing psychiatric distress. In many cases, an individual with psychiatric challenges might not require inpatient psychiatric admission, but could benefit from a break from daily stressors in a non-hospital environment that supports recovery and allows for a renewed perspective and wellness plan. A respite setting will not only prevent avoidable emergency room and inpatient hospitalization usage, but also provide care in a less stigmatizing and low stress environment.
- A *Recovery Center* to be located in Eastern Suffolk County will be designed to help individuals living with psychiatric diagnosis to live, work and fully participate in their communities. This center will focus on programs that will build on existing best practices in self-help, peer support, and mutual support.

Statewide Initiatives

In addition to regionally developed services under the Transformation Plan, OMH is supporting and expanding several other initiatives recommended during the regional advisory process on a statewide basis. The initiatives as described below, include general policy development such as regulatory reforms, existing program expansions, and the development of entirely new services.

Suicide Prevention

Funding has been allocated to the Statewide Suicide Prevention Center to develop and promote evidence based practices in suicide prevention and identification of individuals at risk of suicide attempts. These efforts will help drive the strategic direction of OMH's newly created Suicide Prevention Office and its strategic planning efforts under the "Zero Suicide" initiative with the goal of zero suicides for individuals receiving health or behavioral health care.

Forensics

Funding has also been allocated for the expansion of community-based interventions to support individuals with mental illness in the criminal justice system through earlier identification and diversion to treatment, and more active discharge and service referrals to reduce recidivism and promote recovery. OMH is currently developing several initiatives funded in the 2015-16 budget that will enhance forensic services in the community, including expanded care coordination, Forensic Assertive Community Treatment (ACT), and supported housing units. Within State operations, OMH is expanding its clinical staff in prisons to conduct risk of violence assessments and violence reduction treatment, and to expand clinical treatment services and discharge planning. We will also be expanding civil capacity at State PCs for a 20 bed inpatient secure intensive care unit and a 20 bed transitional living residence (TLR).

Two current initiatives outside of the most recent budget funding that have already been implemented in several areas of the State are described in further detail below.

Justice Mental Health Collaboration Program

The overarching goals of the Justice Mental Health Collaboration Program include: (1) identification of opportunities for appropriate diversion of persons with mental illness into treatment and community supervision; (2) reduction of recidivism for individuals with serious mental illness; (3) long term cost savings for local and State justice and treatment systems; (4) better treatment outcomes and recovery for persons with mental illness under community supervision and leaving local/county jail systems; and (5) enhanced cross system collaboration.

The Collaboration Program activities in New York include the NYS Office of Parole and Correctional Alternatives (OPCA) and OMH working in 10 counties (Albany, Erie, Monroe, Nassau, Niagara, Onondaga, Orange, Rensselaer, Schenectady and Westchester) to conduct sequential intercept mapping of the system of care for persons with mental illness who are involved with the justice system. The mapping process explores the five "intercepts" where persons with mental illness may come into contact with the justice system (i.e., law enforcement, initial detention/court hearings, jails/courts, reentry, and community corrections) and identifies appropriate diversion opportunities, as well as general opportunities for enhanced services and system coordination. Following the sequential intercept mapping, OPCA and OMH are working with individual counties to provide training and technical assistance to address their identified needs and goals.

Evidence-Based System of Jail Mental Health Practices

The OMH Division of Forensic Services has established an Evidence-Based System of Jail Mental Health Practices

program to support the development and enhancement of evidence-based systems of care for persons with mental illness in local correctional systems. The program's goals are to: (1) enhance collaboration between the mental health and local correctional systems; (2) contribute to reductions in recidivism among those with mental illness who are involved with local justice systems; and (3) achieve better treatment outcomes for individuals with mental illness who are confined in and leaving local jails.

This program consists of both a planning and implementation phase with services provided to the following counties: Albany, Monroe, Nassau, Rensselaer, Schenectady and Westchester. Each county has established a steering team consisting of the local Director of Community Services, the Sheriff/Jail Administrator, the Probation Director, and appropriate medical and behavioral health care representatives from the jail. Each steering committee is charged with assessing their current practices with regard to this population and developing a strategic implementation plan to enhance practices with a particular focus on screening and assessment, provision of services and discharge planning.

First Episode Psychosis

In 2013, OMH launched OnTrackNY in collaboration with the Center for Practice Innovations at the New York State Psychiatric Institute and The Research Foundation for Mental Hygiene. OnTrackNY is an innovative, evidence-based team approach to providing recovery-oriented treatment to adolescents and young adults who are experiencing their first episode of psychosis (FEP). In order to be eligible for the program, participants need to be between the ages of 16 and 30 and have recently begun experiencing psychotic symptoms. OnTrackNY helps people achieve their goals for school, work, and relationships by following principles of care that include shared decision making, youth friendly and welcoming environments, and flexible and accessible recovery-oriented services.

By fall of 2014, OnTrackNY had been implemented at four partner settings in downstate New York that were identified in collaboration with county mental health departments. They are:

- Kings County Hospital Center
- Mental Health Association of Westchester
- North Shore Long Island Jewish Hospital
- The Washington Heights Community Service Center, New York State Psychiatric Institute

Each program has received some funds for staff, training, and technical assistance. Early evaluation of the four OnTrackNY sites indicates that they are operating to produce the desired outcomes. For example, among program participants the rates of participation in degree-granting school programs or competitive employment have increased from 30% at baseline to 60% after just three months of receiving OnTrackNY services.

In order to scale up FEP initiatives, the Center for Practice Innovations conducted an analysis of the number of OnTrackNY Coordinated Specialty Care (CSC) teams that would be needed to serve the population of New York State. The Center determined that approximately 30 CSC teams would be needed to address the current statewide needs.[7] In addition to these assessed needs, the Transformation Plan regional advisory meetings have emphasized the need and demand for FEP services in their respective regions.

As a result, in 2014-15 OnTrackNY will be expanded to more rural, sparsely populated areas that currently have no formal FEP interventions in place. Nine new OnTrackNY teams are presently being planned and implemented. The locations for each of the new teams are:

- Buffalo
- Albany/Rensselaer
- New York City
- Syracuse
- Farmingville
- Orangeburg
- Binghamton
- Ithaca
- Chautauqua County

Education and Employment: PROMISE

The NYS PROMISE program is a five-year initiative that strives to increase access to services for eligible youth and their families with the goals of improving academic and employment outcomes, increasing financial stability, and reducing reliance on Supplemental Security Income (SSI). It intersects the education and employment sectors with the hope of creating better employment outcomes for the youths served.

The NYS PROMISE intervention model was jointly developed by the U.S. Departments of Education, Health and Human Services and Labor, and the U.S. Social Security Administration in an effort to improve the service provision and coordination for youth with disabilities who receive

SSI and their families. New York State PROMISE is one of six PROMISE awards granted by the US. Department of Education in October 2013. Partnering agencies include: The Parent Center of Western New York, Wildwood Programs, Inc. in the Capital Region, and Resources for Children with Special Needs in the New York City area.

Telepsychiatry

Telepsychiatry, or telemedicine, is a specifically defined form of video conferencing that can provide psychiatric services to patients living in remote locations or otherwise underserved areas. It can connect patients, psychiatrists, physicians, and other healthcare professionals through the use of television cameras and microphones. Telemedicine offers an array of services, including but not limited to diagnosis and assessment; medication management; and individual and group therapy. It also provides an opportunity for consultative services between psychiatrists, primary care physicians and other healthcare providers. The technologies have proved reliable enough to allow for provider to patient direct treatment services. Recently, the Centers for Medicare and Medicaid Services (CMS) determined that telemedicine is equivalent to face-to-face encounters, and the majority of U.S. states have enacted parity laws requiring medical coverage and reimbursement for telemedicine services.

Given the rapid expansion and emphasis on telemedicine to address provider shortages and expand patient access to care, it is necessary for OMH to be responsive to the needs of the community providers and consumers of mental health care in New York State. Accordingly, OMH has filed a Notice of Proposed Rule Making to add a new Section 599.17 to Title 14 NYCRR – Clinic Treatment Programs. This rule will establish basic standards and parameters to approve the use of telepsychiatry in OMH-licensed clinic programs choosing to offer this service.

In addition, OMH recently received a grant from the United State Department of Agriculture Rural Development awarded a 2014 Distance Learning and Telemedicine Program Grant to the New York State Office of Mental Health. Only 5 applicants in New York State received this year's award. The Federal Award consisting of $219,650 will finance new videoconferencing technology for 26 State-operated mental health treatment sites and 5 local community mental health clinics/community centers. The award facilitates telepsychiatry access for patients in rural and poverty-stricken areas of New York State benefiting children, adult, and forensic populations. In the future, we expect a new revenue stream to soon emerge from telepsychiatry claims fully reimbursed by Medicaid for direct patient care. As well, the grant enables greater access to medical care and culturally relevant distance learning opportunities for the Seneca and Tuscarora Native Peoples.

Finally, under OMH leadership, an interagency telehealth workgroup is continuing to explore additional opportunities to support telehealth and telepsychiatry in the field and to identify additional opportunities to ease the adoption and use of technologies for communication, treatment, and supports that promote recovery.

Peer Workforce Expansion

Given the demand for more information on using peer staff, the OMH Office of Consumer Affairs has provided comprehensive in-person training in all New York State regions for both State and community providers. These trainings help agencies recruit, train, and support peer staff in a variety of program types and roles. They will continue through a series of webinars in 2015 and ongoing technical assistance for LGUs and providers as needed. Local governments, voluntary organizations, and other potential peer employers may also obtain resources on peer workforce development through a free federal resource called the Job Accommodation Network (JAN) located at https://askjan.org/.

In addition to increasing the size of the peer workforce, New York State has a strong commitment to ensuring a qualified peer workforce that provides evidence-based practices. To ensure continued opportunities for peer services, OMH worked with peer leaders to develop a Peer Specialist Certification process which is currently accepting enrollees. The Academy of Peer Services is a free online training platform for individuals delivering peer support services in New York State. The Academy was developed through the collaboration of peer leaders and the Rutgers University School of Health Related Professions. Enrollment in the Academy is available through its website at http://www.academyofpeerservices.org/.

For community programs that have not had the budget to hire peer staff or could only hire part-time staff, certification through the Academy will also allow programs to bill Medicaid for some of the services that peer staff provide in authorized settings. This Medicaid component is critical to the sustainability of peer supports across the service spectrum. With the impending movement of all

Medicaid mental health services into managed care, the expansion of peers in the workforce may grow even greater as a broader array of Home and Community Based Services (HCBS) become mandatory offerings for Health and Recovery Plan (HARP) enrollees (and optional for a much larger number of Medicaid beneficiaries). Another financial incentive for peer staff positions is the New York State Employment Services System (NYESS) administrative employment network.[8] Programs in the NYESS employment network that provide employment supports and services receive milestone payments through the federal Ticket to Work program. In OMH facilities, all milestone payments are reinvested in the facility through the hiring of peers to provide services; this practice can be applied to community programs as well.

Youth and Family Peer Support

As the New York State (NYS) Office of Mental Health positions to transition children's behavioral health services into Medicaid Managed Care, it is proposed that Family and Youth Peer Support Services delivered by Family and Youth Peer Advocates become a State Plan Medicaid billable service. When executed, this will not only expand the capacity for families and youth to receive these services but also position family and youth peer support services as a distinct discipline in the continuum of behavioral health services.

In preparation, the Division of Integrated Community Services has initiated numerous initiatives to assist Family and Youth Peer Advocates to successfully transition into the Medicaid Managed Care Environment. These include:

- The advancement of a Family and Youth Peer Support Service definition that is consistent across all programs in New York State. These definitions will be submitted to CMS as the program definitions for Family and Youth Peer Support Services for Medicaid Managed Care
- The implementation of an outcome tool, Family Assessment of Needs and Strengths (FANS) specifically for Family Peer Advocates (FPAs) delivering family peer support services.
- A credentialing process for FPAs delivered by Families Together of New York State (FTNYS) which is currently in the third year of implementation.[9] The New York State FPA Credential was developed to:
  - Recognize the expertise of family peer advocates;
  - Ensure that all Family Peer Advocates have common training that supports core competencies;
  - Provide a framework to improve outcomes through professional development;
  - Promote the formation of a professional community of practice; and
  - Promote an understanding of the unique contribution and value of Family Peer Advocates.

  Specific component include:
  - A five day face-to-face Parent Empowerment Program (PEP) training. Core competencies include:
    - Principles of Parent Support
    - Listening and Engagement Skills
    - Priority Setting
    - Boundary Setting Skills
    - Group Management Skills
    - Mental Health System
    - Working with Schools
  - 6 months consultation calls following PEP training,
  - 1,000 hours of documented service providing peer-to-peer family support and advocacy services to other parents/caregivers in either a paid or 'formal' volunteer capacity,
  - A Professional Development Plan, and
  - 30 hours of continuing education to maintain the FPA Credential
- The Division is working with YOUTH POWER! to develop a similar credential for Youth Peer Advocates. To date, YOUTH POWER! and Cornell Cooperative Extension are in the final stages of development of an online and in person YPA training curriculum. Components may include:
  - The Role of Youth Peer Advocate in the Waiver System
  - Peer Advocacy and Support
  - Group Facilitation Skills
  - Professional Expectations: Confidentiality
  - Supervision
  - Self-care and support
  - Systems navigation

The aforementioned curriculum will be piloted in 2015. Youth Peer Advocates will deliver the training via a train the trainer model. Simultaneously, in 2015 the Division will be working with YOUTH POWER! and other system stakeholders to develop credentialing standards for Youth Peer Advocates.

OMH's move toward a system focused on prevention, early identification and intervention, and evidence-based clinical services and recovery supports is motivated by the overarching idea that recovery and community reintegration is

not only possible—but they are likely.

While inpatient hospitalization can be useful, it is not always the best—nor should it be the only—option for an individual in need of assistance.

Many of the new services developed through the Transformation Plan planning process will strengthen the community safety net and provide more coordinated care for individuals before, during and after discharge from inpatient settings. While this will help equip consumers with the tools they need to seek integrated care, OMH also recognizes that coordinating one's own care can be a daunting task; hence the movement toward Managed Care described in the next chapter. With guidance from Health Home Care Managers and other facets of managed care, OMH can maintain, and advance the levels of support that contributes to recovery. Not only will this allow for more cost-effective spending; OMH also intends to have greater consumer outcomes to drive and sustain recovery and community reintegration.

Chapter 2 Endnotes

1 This count includes civil and forensic inpatient psychiatric facilities, and two OMH research institutes.

2 The regional maps in this section depict a general area of service expansion. Not all services listed in this chapter will be available to the entirely of each region.

3 The Rochester area is receiving a total of 136 new supported housing units under the Transformation Plan, with the inclusion of the 20 units that will be specialized for forensic individuals, pursuant to the county Aid to Localities plan.

4 $4.3 million are associated with Greater Binghamton Health Center reductions and $3.8 million for Elmira Psychiatric Center. State Operations and Aid to Localities resources will be planned for the entire Southern Tier region served by both facilities.

5 The Hudson River region is receiving a total of 56 new supported housing units under the Transformation Plan, with the inclusion of 6 additional units pursuant to LGU plans.

6 Stony Lodge reinvestment funds were divided between New York City and Hudson River regions in accordance with patient utilization patterns; the funding levels for each region are unduplicated amounts.

7 Humensky JL, Dixon LB, Essock SM: An Interactive Tool to Estimate Costs and Resources for a First-Episode Psychosis Initiative in New York State. Psychiatric Services. 64:832–834, 2013.

8 More information about the New York State Employment Services System is available at http://www.nyess.ny.gov/.

9 Family Peer Advocate information is available at http://www.ftnys.org/family-peer-advocate/.

Chapter 3

The Integration of Behavioral and Physical Health Care: Medicaid Managed Care Approaches

Medicaid Managed Care Approaches

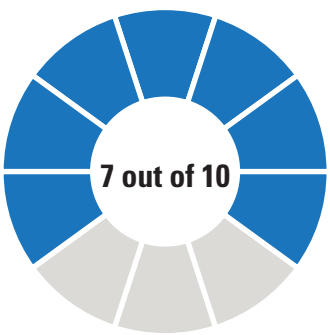
Physical health and mental health are inextricably linked. Data from the 2003 National Co-morbidity Survey Replication show that nearly 7 out of 10 adults with a mental disorder have one or more medical conditions, while 3 out of 10 adults with medical disorders experience at least one mental health condition.[1] Moreover, an estimated 70% of primary care visits have been attributed to psychosocial issues, suggesting that office visits by people with physical health ailments may often be prompted by underlying behavioral health issues.[2] The relationship between physical and mental health is further complicated by our knowledge that barriers to primary healthcare services—coupled with challenges in navigating intricate healthcare systems—represent a major obstacle to effective care for people with physical and behavioral health conditions.

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

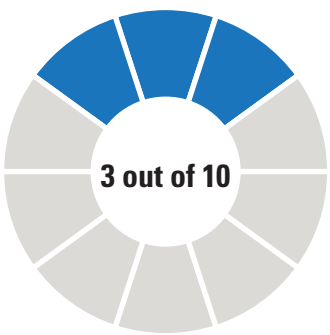
In NYS, the Medicaid Redesign Team (MRT) has been at the forefront of leading change and advancing the State toward the seamless integration of health and mental healthcare for beneficiaries of Medicaid. A cornerstone of healthcare transformation in the State public mental health system, Medicaid Redesign aligns with findings from research demonstrating that outcomes improve and healthcare dollars are saved when integrated care approaches are implemented effectively,[3,4,5,6,7] whether in primary care settings, behavioral health settings or health homes.

The charge of the MRT Behavioral Health Reform Workgroup has been to help establish a framework for the transition to care management for all New Yorkers with mental illnesses and substance use disorders. Its final report

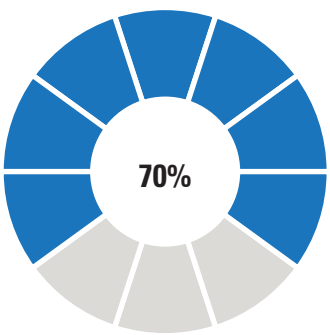
Figure 3-1: Physical and Mental Health Linkage



Adults with a mental disorder that have one or more medical conditions.



Adults with medical disorders who experience at least one mental health condition.



Estimated number of primary care visits attributed to psychosocial issues.

issued in October 2011 focused on facets of the charge, including consideration of delivery and payment mechanisms for the integration of substance abuse and mental health services, as well as their integration with physical healthcare services; examination of opportunities for the co-location of services and peer and managed addiction treatment services and their potential integration with behavioral health organizations (BHOs); and the provision of guidance about health homes and proposals of other innovations that lead to improved coordination of care between physical and mental health services.

When begun, the MRT process reflected the recognition that the State's behavioral health system (which is the system providing specialty treatment and care for individuals diagnosed with mental illnesses and substance use disorders) was large and fragmented, with then more than 700,000 people with mental illness being served at an estimated annual cost of $6.6 billion.[8] Approximately one-half the spending, the Behavioral Health Reform Workgroup noted, goes to inpatient care. For substance use disorders, the publicly funded system serves more than 250,000 individuals and accounts for about $1.7 billion in expenditures annually. However, despite the significant spending on behavioral healthcare; comprehensive care coordination for individuals receiving services, particularly those with the most intensive needs, has been lacking and accountability for outcomes and quality care have been insufficient.

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

When care is not well coordinated, there is greater risk that behavioral health needs will not be identified and people will receive suboptimal behavioral healthcare in primary care settings. Untreated or suboptimal treatment of behavioral health conditions is associated with lower adherence to prescribed medical treatment, higher medical costs, and poorer health outcomes. In particular, adults with mental disorders have a "twofold to fourfold elevated risk of premature mortality," largely due to poorer physical health status, as well as accidents or suicides.[9] Given the high prevalence of mental illnesses and co-occurring mental illnesses and substance use disorders among Medicaid beneficiaries,[10] the opportunity for improved clinical and financial outcomes through improved coordination of behavioral and physical health services is strong. The integration of behavioral and physical healthcare via managed care for individuals with substance use disorders, with or without serious mental illnesses is associated with improved access, better monitoring of quality outcomes and a better distribution of services across the entire care continuum.[11,12,13,14,15]

The final report produced by the MRT has provided NYS with a blueprint and action plan for reforming Medicaid services and optimizing health system performance through alignment with what the Institute of Healthcare Improvement calls the triple aim: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per person cost of healthcare.[16] Overall, the design and operational components of the newly configured behavioral health system for Medicaid beneficiaries address the State's advancement of the MRT vision and goals, including:

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

The centerpiece to the MRT vision is the expansion and redesign of the State's behavioral health Medicaid program through a broader managed care strategy and "carving in" previously managed care exempt Medicaid services and beneficiaries into a managed, coordinated benefit package. This multi-stage design is marked by four key opera-

Explanation of Initial Enrollment Process

1. Individuals initially identified by NYS as HARP eligible, who are already enrolled in an MCO with a HARP, will be passively enrolled in that Plan's HARP.
2. Individuals identified for passive enrollment will be contacted by the NYS Enrollment Broker.
3. They will be given 30 days to opt out or choose to enroll in another HARP.
4. Once enrolled in a HARP, members will be given 90 days to choose another HARP or return to Mainstream before they are locked into the HARP for 9 additional months (after which they are free to change Plans at any time).
5. Individuals initially identified as HARP eligible who are already enrolled in an MCO without a HARP will not be passively enrolled. They will be notified of their HARP eligibility and referred to the NYS Enrollment Broker to help them decide which Plan is right for them.
6. HARP eligible individuals in an HIV SNP will be able to receive HCBS services through the HIV SNP. They will also be given the opportunity to enroll in another HARP. They will be notified of their HARP eligibility and referred to the NYS Enrollment Broker to help them decide which Plan is right for them.

tional components:

1. Development of managed behavioral health organizations regionally, by entities with demonstrated expertise in managing behavioral health services for individuals with substance use disorders and serious mental illnesses[17] as well as networks of health homes statewide that are qualified to serve enrollees with behavioral health and/or chronic medical conditions (these health homes are not tailored for meeting the needs of people with developmental disabilities and long term care needs);[18]
2. Integration of Medicaid behavioral health benefits with the physical health benefit already under managed care in a multi-phase process. Beginning with adults in New York City, the first phase Health and Recovery Plan (HARP) enrollment letters will be distributed from July 2015 to October 2015, followed by staggered enrollments from October 2015 to January 2016. In October 2015, mainstream plans and HARPs will implement non-HCBS behavioral health services for enrolled members, and HCBS service implementation will begin for the HARP population on January 2016. In the remainder of the State, the first phase of HARP enrollment letters will go out beginning in April 2016, and in July 2016, mainstream plan behavioral health management and phased HARP enrollment will begin. Children's implementation will begin in New York City and Long Island in January 2017, followed by the remainder of the State in July 2017;
3. Qualification of managed care organizations (MCOs) and HARPs prior to the implementation, thereby ensuring adequate capabilities to manage behavioral health services and supports. Qualification includes verifying the program and financial management structures to support the transition to, and ongoing operation of, the newly integrated behavioral and physical health system and ensuring member continuity of care requirements from fee-for-service to managed care;
4. Integration of the behavioral/physical health premium and minimum medical loss ratio (MLR) for HARPs and a behavioral health MLR for qualifying MCOs.[19] All behavioral health capitation rates and health home reimbursements will flow through the Plans. Plans will be required to separately report behavioral health expenditures to ensure access to new behavioral health services and to work with health homes to ensure coordinated plans of care.

The Medicaid managed care program design takes a multi-pronged approach to raise expectations and improve the behavioral and physical healthcare outcomes for all members. Key elements of the design include:

- Providing all Medicaid State Plan services for physical health, behavioral health, pharmacy, and long-term care;
- Expanding and enhancing network capacity and the array of evidence-based treatment and support services accessible in the community so they facilitate recovery for adults and resiliency for children;
- Clearly specifying the expectation that the behavioral health benefit will result in high-quality care that has a positive impact on member outcomes;
- Requiring routine screening of members in primary care settings to identify unmet behavioral health needs and expedited, effectively made referrals to behavioral health services;
- Requiring routine screening of members in behavioral health settings to identify unmet medical needs and expedited, effectively made referrals to appropriate physical services;

- Stipulating data integration and predictive modeling approaches to identify individuals who are at high risk for, or have intensive and costly service needs, and facilitating program evaluation across systems;
- Instituting utilization management, medical management, and quality management protocols and other administrative methods to ensure that behavioral health service delivery, and associated financial and clinical outcomes, are appropriately managed;
- The NYS Department of Health (DOH), in conjunction with OMH and the Office of Alcoholism and Substance Abuse Services (OASAS), will pre-approve MCO behavioral health services criteria and practice guidelines for utilization review, prior authorization, and levels of care;
- Each MCO will be required to use an OASAS-approved substance use disorder level-of-care tool for all substance use disorder level-of-care decisions (to include, but may not be limited to, the agency's placement criteria system known as the Level of Care for Alcohol and Drug Treatment Referral [LOCADTR]);
- Utilizing specialized case management and care coordination protocols to improve the engagement of each person in care, promote self-care, and enhance cross-system coordination—including participation in health home innovations—for people at risk for or experiencing intensive and costly service needs;
- Facilitating system transformation through the provision of comprehensive and ongoing education, training and technical assistance programs for members, behavioral and physical health providers, and MCO staff;
- Developing a transition plan that delineates key milestones and time lines for transitioning behavioral services from fee-for-service to MCOs and implementing other key program components.

Because some MCOs may not have the expertise to manage specialty behavioral benefits, MCOs are being required to demonstrate their qualifications, subcontract with a specialty BHO, or partner with vendors and providers who demonstrate experience in serving the population.

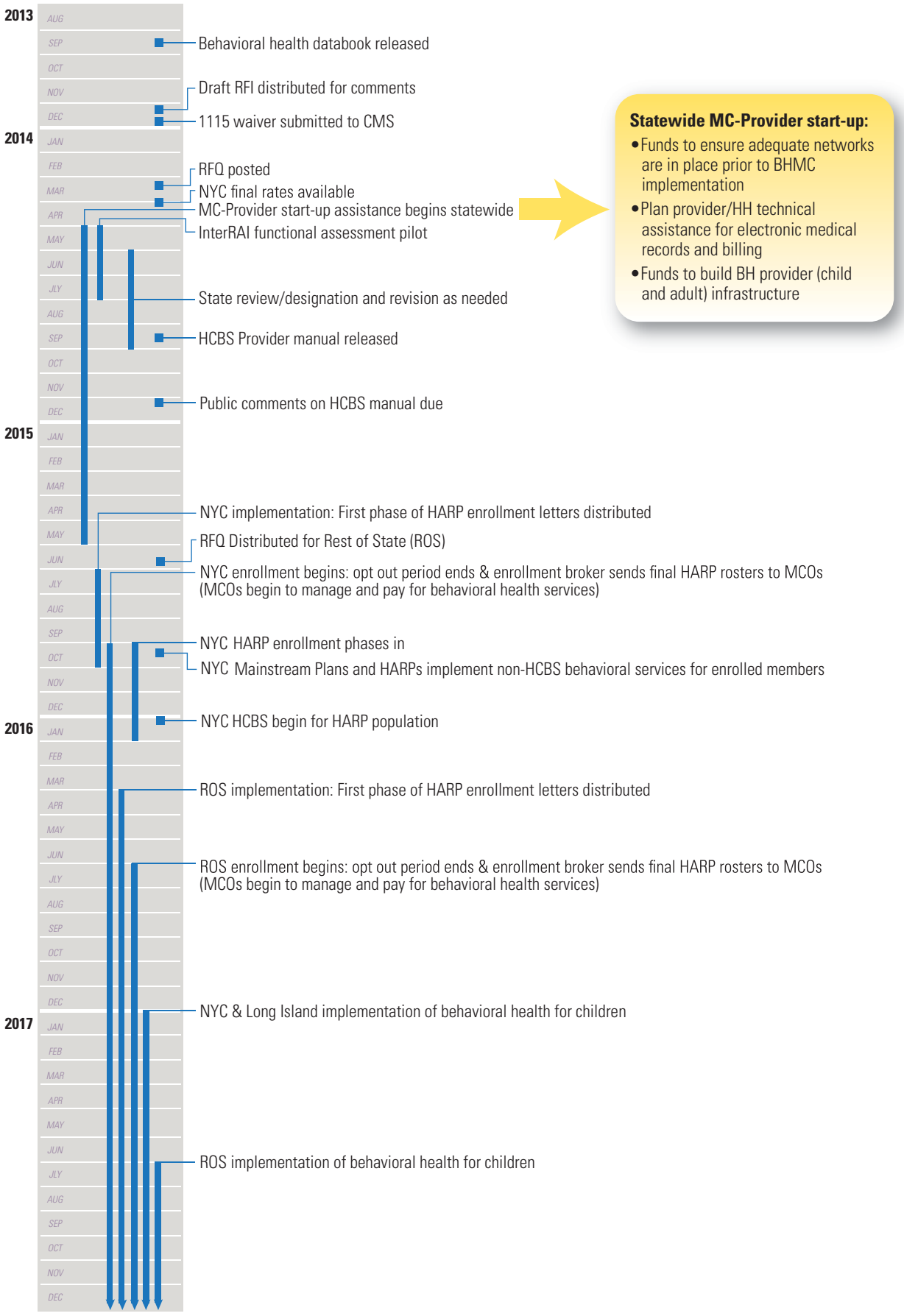
The Behavioral Health Reform Workgroup recommendations adopted by the MRT informed the State's December 2013 submission of an amendment to its current federal 1115 demonstration waiver20 to enable qualified MCOs statewide to comprehensively meet the needs of participants with behavioral health disorders—either by meeting rigorous standards (perhaps through a partnership with a BHO, as noted above) or under HARPs for those individuals with significant behavioral health needs. As proposed, specific features of Medicaid managed care include:

- Mainstream or conventional MCOs having responsibility for the integration of Medicaid-covered mental illnesses, substance use disorders, and physical health services for adult Medicaid beneficiaries and the use of performance measures specific to behavioral health.
- HARPs having responsibility for providing specialized services for adult Medicaid beneficiaries with significant behavioral health needs based on clinical/functional impairment eligibility requirements. The HARP benefits package will include rehabilitation, crisis intervention, educational and employment support, and peer and self-directed services; modeled under the Home and Community Based Services (HCBS) waiver.[21] These services will be available to beneficiaries based their detailed plan of care, which will be informed by a full functional assessment. Qualified HARPs will rely upon specialized medical and social necessity/utilization review approaches and beneficiaries will have care management through a Health Home.[22]
- Children in mainstream MCOs: Children's behavioral health services, including OMH's HCBS Waiver, The Office of Children and Family Services' (OCFS) Bridges to Health Waiver (B2H), and the Department of Health's Care at Home (CAH) I&II Waiver, will be included in the mainstream MCOs.

Overall, the goals of the various managed care models and qualification process aim to improve clinical and recovery outcomes for Medicaid beneficiaries diagnosed with serious mental illnesses and substance use disorders; reduce the growth in costs through a reduction in unnecessary emergency and inpatient care; and increase network capacity to deliver community-based, recovery-oriented services and supports. Activities to achieve these goals beginning in 2013 and planned for the next three years are highlighted in Figure 3-2.

As the figure shows, from September through December of 2013, OMH distributed the MCO Data Book, containing information on eligibility data, managed care encounters, and fee-for-service claims. The Book displays data summaries by region and premium group, provides a separate premium group for individuals eligible for participation in HARPs, delineates separate behavioral health

Figure 3-2: NYS Medicaid behavioral health transformation implementation time line



and physical health components of the HARP integrated premium, and shows utilization and dollars based on managed care encounters and on utilization and dollars from fee-for-service claims.

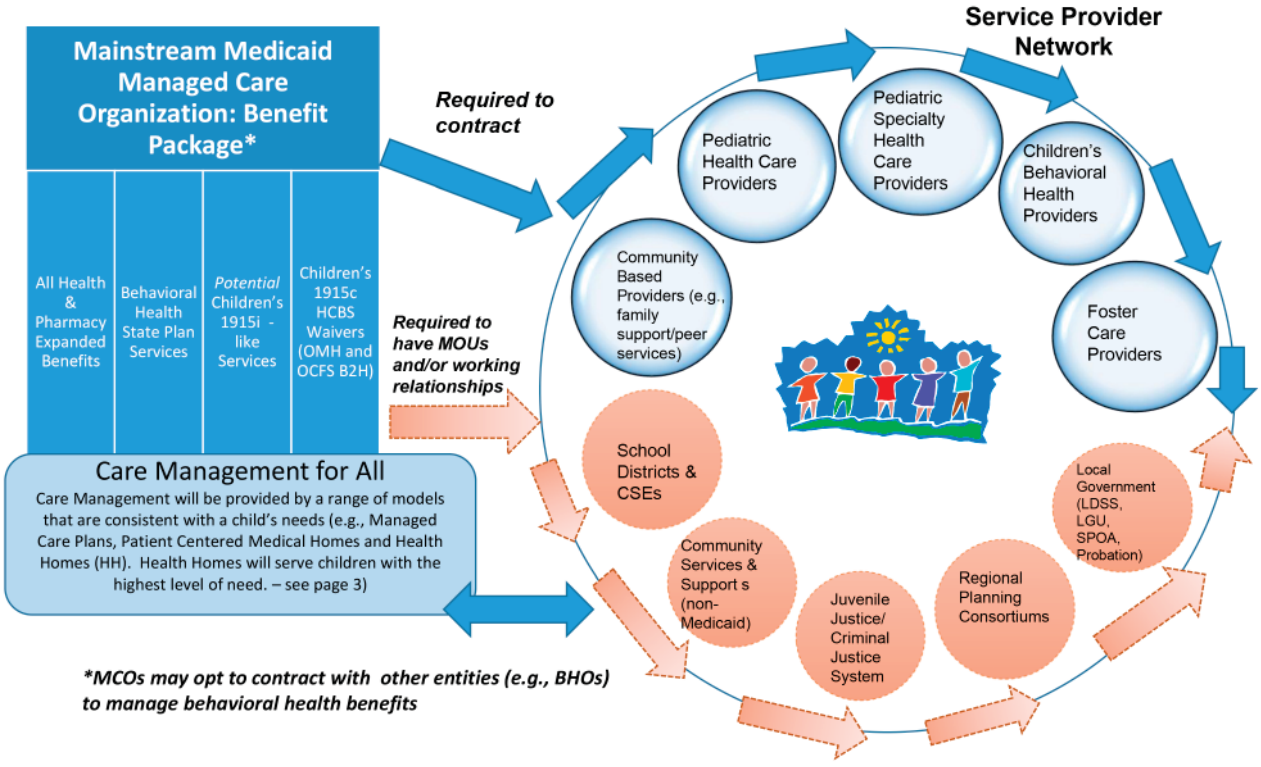
In December 2013, New York State released a Request for Information (RFI) regarding "New York's Request for Qualifications (RFQ) for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans." This RFI solicited input concerning New York's draft proposal to manage Medicaid substance use and mental health benefits for adults. The RFI also addressed planning and systems oversight under the concept of "Regional Planning Consortiums," which would consist of LGUs and other important stakeholders, and require collaboration between MCOs/HARPs and these regional entities. Comments in response to the RFI submitted through January 17, 2014 were reviewed, and the State released the final RFQ in March 2014 for MCOs applying to provide coverage in New York City.

The RFQ required all mainstream MCOs operating in NYC to provide a detailed account of their qualifications to provide the general behavioral health managed care benefit which effective in 2015 will include all OMH and OASAS specialty services for all adults enrolled in Medicaid Managed Care. The mainstream plans and the HIV Special Need Plans (SNPs) operating in NYC also had the opportunity to apply to be a HARP to serve persons with serious and chronic behavioral health conditions, which would include Home and Community Based Services to be available only to adults in the HARP. Seven of the ten eligible Medicaid Managed Care Plans in NYC did apply to operate HARPs.

Based upon the lessons learned through the NYC RFQ process, and due to the additional details required for statewide managed care implementation (e.g. multiple rate regions), a discrete RFQ for non-NYC Plans will be issued in the future.

With the submission in December of the 1115 waiver amendment to the Centers for Medicare and Medicaid Services, OMH, the Department of Health (DOH), and OASAS have continued to work with the federal government to refine the waiver submission and gain approval to implement integrated behavioral and physical healthcare across the State. Many of the implementation and plan readiness target dates indicated here and in Figure 3-2 are contingent upon federal approvals.

Figure 3-3: Proposed 2016 Children's Medicaid Managed Care Model for Children up to Age 20



Children's Managed Behavioral Health Redesign

The MRT Children's Behavioral Health Team has designed a separate framework for children's integrated health and physical health services under managed care, in recognition of the additional complexity of systems accessed by children and families, and of the nature and span of some children's behavioral health problems. The leadership of the group, which is shared between OMH, OASAS, DOH, and the Office of Children and Family Services (OCFS), has developed a model to guide design, as illustrated in Figure 3-3. This model takes into consideration the unique specialty behavioral health care services needs of children with serious behavioral health needs and their families. The model indicates the importance of:

- Early intervention;
- Evidence-based practices;
- Team based, family-centered approaches; and
- Family advocacy.

The vision of this design is consistent with a key priority of the OMH Children's Plan (2008) to ensure that children receive the right services, at the right time in the right amount.

At the beginning of the children's managed behavioral health planning process, the Children's MRT Behavioral Health Subcommittee identified themes to guide their work in addition to the overall goals of New York's Medicaid Redesign Team, namely:

- Intervening early in the progression of behavioral health disorders is effective and reduces cost;
- Accountability for outcomes across all payers is needed for children's behavioral/physical health;
- Solutions should address unique needs of children in a unified, integrated approach;
- The current behavioral health and healthcare system for children and their families is underfunded;
- Children in other public or private health plans should have access to a reasonable range of behavioral/physical health benefits.

To accomplish the vision and goals, the decisions made with regard to the design have not only focused on ensuring that existing services will be maintained under Medicaid managed care, but have recognized that the design should address our systems' collective capacity to intervene earlier and more effectively. For example, an integral part of the design includes the creation of new Medicaid State Plan services intended to address gaps in services for children, such as crisis intervention and psychosocial rehabilitation services.

For children who have more significant needs, but may not be at risk for institutionalization, the new design includes a capacity for children to qualify for a greater array of Home and Community Based Services by meeting "Level of Need" criteria. Currently, children have only been able to access HCBS services if they were determined to be at imminent risk for out of home placements or psychiatric hospitalization by meeting a higher "Level of Care" criteria. Therefore, by creating this new, lower eligibility threshold, children will be served earlier, and ideally avoid the need for higher level of care or more long term services.

Under this new design, it is the hope of New York State to improve access to a wider array of services for children and families at the point in time when they need them, and in the appropriate amount and frequency.

For more information on the progress of the Medicaid managed care design for children's integrated mental health and physical health, please go to the following link for the Children's MRT Behavioral Health Subcommittee: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm

The shift toward Managed Care and the implementation of the Medicaid Redesign Team's Triple Aim to improve patient experience of care, improve the health of populations, and reduce the per person cost of healthcare mark a turning point in the way health care services will be offered. This has resulted in the development of programs geared toward resource reinvestment and regional collaboration to meet the needs of a more recovery based and outcome focused approach. These efforts can be seen in the creation of the Delivery System Reform Incentive Payment (DSRIP) Program, the Prevention Agenda and the Population Health Improvement Program (PHIP). Chapter 4 discusses how each program encourages provider and facility collaboration to support the movement toward managed care.

Chapter 3 Endnotes

1 Kessler R, Chiu W, Demler O et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication.

Archives of General Psychiatry, 62, 617–627.

2 Robinson P, & Reiter J. (2007). Behavioral consultation and primary care: A guide to integrating services. New York: Springer.

3 Pirraglia PA, Kilbourne AM, Lai Z et al. (2011). Co-located general medical care and preventable hospital admissions for veterans with serious mental illness. Psychiatric Services, 62, 554–557.

4 Druss BG, von Esenwein SA, Compton MT et al. (2010). A randomized trial of medical care management for community mental health settings: The primary care access, referral and evaluation (PCARE) study. American Journal of Psychiatry, 167, 151–159.

5 Glied S, Herzog K, & Frank R. (2010). Review: The net benefits of depression management in primary care. Medical Care Research and Review, 67, 251–274.

6 Parthasarathy S, Mertens J, Moore C et al. (2003). Utilization and cost impact of integrating substance abuse treatment and primary care. Medical Care, 41, 357–367.

7 Chiles JA, Lambert MJ & Hatch AL. (1999). The impact of psychological intervention on medical cost offset: A meta-analytic review. Clinical Psychology, 6, 204–220.

8 This number includes funding from all payers.

9 Druss B, & Reisinger Walker E. (2011). Mental disorder and medical comorbidity. Princeton, NJ: Robert Wood Johnson Foundation.

10 Boyd C, Leff B, Weiss C et al. (2010, December). Clarifying multi-morbidity patterns to improve targeting and delivery of clinical services for medicaid populations. Available online at http://www.chcs.org/usr_doc/clarifying_multimorbidity_patterns.pdf.

11 Center for Health Care Strategies. (2012, October 1). Integrating Medicaid physical and behavioral health services: Lessons from Pennsylvania. Available online at www.chcs.org/publications3960/publications_show.htm?doc_id=1261427.

12 Kim J, Higgins T, Gerolamo A et al. (2012, May). Early lessons from Pennsylvania's SMI innovations project for integrating physical and behavioral health in Medicaid. Available online at http://www.chcs.org/usr_doc/PA-RCP_Early_Lessons_Brief051412.pdf.

13 Bella M, Somers SA, & Llanos K. (2009, June). Providing behavioral health services to Medicaid managed care enrollees: Options for improving the organization and delivery of services. Available online at http://www.uhfnyc.org/assets/619

14 Institute of Medicine. (2006). Improving the quality of health care for mental and substance-use conditions. Washington, DC: National Academy Press.

15 World Health Organization. (2003). Organization of services for mental health. Geneva: Author.

16 Berwick DM, Nolan TW, & Whittington J. (2008). The triple aim: Care, health, and cost. Health Affairs, 27, 759–769.

17 The first phase of development created five regional BHOs to monitor inpatient behavioral health services for Medicaid beneficiaries whose inpatient behavioral health services are not covered by a Medicaid managed care plan and who also are not enrolled in Medicare. The phase one BHOs became operational in 2012 and were phased out in April 2014, while the lessons learned and process improvement achieved by these entities will help inform the integrated management of behavioral and physical health benefits for Medicaid beneficiaries.

18 New York State Department of Health. (nd). NYS health home provider qualification standards for chronic medical and behavioral health patient populations. Available online at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm.

19 The Affordable Care Act requires health insurers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires health insurers to issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases.

20 Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP). The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible; providing services not typically covered by Medicaid; and using innovative

service delivery systems that improve care, increase efficiency, and reduce costs.

21 Under the Affordable Care Act, revised and new HCBS provisions were instituted in 2010 for removing barriers to offering home and community-based services through the Medicaid State plan; thus giving states an opportunity to provide services and supports before individuals need institutional care; importantly, it allows the provision by State plans of HCBS to individuals with mental health and substance use disorders.

22 Health Homes will provide care management services for Medicaid managed care members, through contractual partnership between the managed care plans in which a member is enrolled, and the Health Home to which they have been assigned

Chapter 4

Promoting Population Health and Delivery System Reform: DSRIP, PHIP and the Prevention Agenda

Delivery System Reform Incentive Payment (DSRIP) Program

With the implementation of dozens of Medicaid Redesign Team initiatives since its inception in 2011, New York State has saved approximately $17 billion in federal share Medicaid funds, and set the State on a more sustainable path for health and behavioral healthcare spending in the future. The Delivery System Reform Incentive Payment (DSRIP) Program is an $8 billion, five-year initiative supported through federal waiver amendments, Medicaid State Plan Amendments, and other State resources. DSRIP represents a broad effort to stabilize New York State's health care safety net by reducing inpatient utilization through the development of hospital and provider networks that will collaborate to redesign local and regional healthcare systems around common population health and program goals.

The central pillar of DSRIP is a $6.4 billion dollar Medicaid waiver that will fund dozens of different "projects" across the State, to be developed and implemented by large provider networks led by a single lead agency.[1] Under these provider networks known as "Performing Provider Systems (PPS)," projects will be selected across three domains of System Transformation, Clinical Improvement, and Population Health which are designed to drive the transformation of hospital systems in particular toward more broad based networks of community services and supports.[2]

DSRIP funding will be driven by process and outcome metrics, with the overriding goal of the initiative to reduce avoidable inpatient hospital admissions and emergency department utilization by 25% over five years. DSRIP applications will be filed by a lead applicant (the PPS) and will require a broad provider and stakeholder network to support the application, including behavioral health providers. PPSs will be led in most or all cases by an Article 28 hospital, though OMH and the Department of Health have emphasized the importance of behavioral health providers and stakeholders being part of DSRIP applications to ensure an integrated approach to individuals in any DSRIP coverage area.

The $8 billion DSRIP reinvestment will be allocated in the following ways:

- $500 Million for the Interim Access Assurance Fund – temporary, time limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without disruption.
- $6.42 Billion for Delivery System Reform Incentive Payments (DSRIP) – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP Administrative costs.
- $1.08 Billion for other Medicaid Redesign purposes – this funding will support Health Home development, and investments in long term care, workforce and enhanced behavioral health services.

Source: NYS Department of Health http://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm

As the name suggests, DSRIP will begin by driving "delivery service" reforms through "incentive payment" for projects aimed toward reducing inpatient and emergency room utilization. The first years of DSRIP implementation will concentrate incentive payments on process milestones; as each year passes payments will be weighted more heavily on outcome metrics, until by year five of DSRIP nearly all incentive payments will be outcome-based. Equally important are two major incentives for statewide systemic transformation under DSRIP: One, is that statewide outcomes will supersede those of individual PPSs— so even a PPS that hits or exceeds all its metric targets will not be rewarded if the State as a whole does not achieve the collective outcome goals of all PPSs combined. And second, DSRIP terms and conditions stipulate that 90% of Medic-

aid managed care payments made in New York State be value-based (rather than fee-for-service) by year five; meaning that managed care plans must work with providers on the purchasing of patient outcomes and service value, rather than simply for the provision of service itself. These two principles alone set a bold vision, and high bar, for the public health and behavioral health system of the future.

OMH is supporting behavioral health stakeholder involvement in PPS network and project development as this initiative is implemented. For example, OMH is encouraging local community provider involvement in PPS networks by having OMH community providers who claim Medicaid for services be included in PPS and be recognized as safety net providers. OMH has advocated with DOH to The Center for Medicare and Medicaid Services for OMH State Aid-funded providers who will begin to claim Medicaid as HCBS providers under HARPs, to be recognized as safety net providers under DSRIP. This is an important designation because safety net providers have the opportunity to participate in DSRIP payments as part of the 95% pool of incentive payments for other non-safety net PPS stakeholders, rather than the remainder (5%) pool which is demonstrably more limited. In addition, OMH-operated Psychiatric Centers have been partnering with potential (applicant) PPSs across the State in order to support the goals of DSRIP and reduce inpatient utilization across all settings. While the inpatient admission target under DSRIP does not apply to State-operated hospitals, and State PCs cannot be designated as safety net providers under the terms of DSRIP; they will still support a more vibrant, community-oriented system of care that will help reduce the need for inpatient and emergency visits through its Transformation Plan and ongoing outpatient reform efforts. Finally, OMH will continue supporting the data needs of PPSs, local governments, and providers as they perform community needs assessments and the oversight of formative service models and systems.

Beyond inclusion of stakeholders in Performing Provider Systems, behavioral health reforms are integrated into the DSRIP initiative in other ways. For example, each PPS is required to develop a number of projects across multiple domains, and each domain has requirements and/or parameters to address behavioral health. Any PPS selecting from the Clinical Improvement Projects domain will be required to develop a behavioral health project (Domain 3a), Systems Transformation Projects domain projects will require behavioral health providers to be included in any integrated delivery system developed (Domain 2a), while Domain 4 (Population Health/Prevention Agenda) includes a full set of projects to promote mental health in communities. Moreover, OMH is emphasizing that in every project, attention must be paid to the population of individuals with behavioral health disorders if the PPS is to be successful in meeting its outcomes for physical health conditions. New York State Medicaid data demonstrate that many individuals diagnosed with a behavioral health disorder have comorbid health conditions that will likely be targeted in most projects selected by PPSs; for an example of the prevalence of such comorbidities (which drive a volume of inpatient and emergency services) see Appendix B.

In addition to a focus on developing transforming broad-based service networks (patient care improvement) and reducing avoidable inpatient/ER admissions (cost reduction), there is a strong population health component to complete the nexus of the Triple Aim under DSRIP. The population health focus is driven through a couple central mechanisms: First, all PPS applicants are required to perform an extensive community needs assessment, the framework of which has been defined in large part by the New York State Prevention Agenda 2013-17. Secondly, of the four project domains in DSRIP (of which there are multiple projects in each area), one is fully dedicated to Prevention Agenda priorities. Behavioral health will be further infused into DSRIP by its integration with Prevention Agenda initiatives, and the key behavioral health metrics tracked in both the community health needs assessments and Prevention Agenda priorities.

Population Health and the Prevention Agenda

The focus on population health is not new for the State of New York, however its recognition of behavioral health through public health strategies (and the corresponding use of public health interventions by traditional behavioral health stakeholders) has increased significantly in the last several years. The Office of Mental Health continues to work with the State DOH and OASAS on implementing the New York State Health Improvement Plan known as the Prevention Agenda 2013-17. The Prevention Agenda is a 5-year effort to make New York the healthiest State in the U.S. by aligning local governmental units, local health departments, hospitals and partners from health, business, education other organizations around a series of population health goals.

The Prevention Agenda 2013–2017 has five overarching priorities,

1. Improve health status in five priority areas and reduce health disparities for racial, ethnic, disability, socioeconomic and other groups who experience them;
2. Promote attention to the health implications of policies and actions that occur outside of the health sector, such as in transportation, community and economic development, education and public safety;
3. Create and strengthen public-private partnerships to achieve sustainable health improvement at state and local levels;
4. Increase investment in prevention and public health to improve health, control health care costs and increase economic productivity;
5. Strengthen governmental and non-governmental public health agencies and resources at state and local levels.

Within the overarching priorities for the Prevention Agenda, five individual Action Plans were developed to effectuate the overall goals of this initiative:

1. Prevent chronic diseases;
2. Promote a healthy and safe environment;
3. Promote the health of women, infants, and children;
4. Promote mental health and prevent substance abuse;
5. Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases, and healthcare-associated infections.

While participating in all five priority areas as needed, OMH has taken a more central leadership role in the Promote Mental Health and Prevent Substance Abuse Action Plan, which is also included in the DSRIP Domain 4a. The goals formulated by the workgroup are outlined in Table 4-1 on the following page:

Figure 4-1: New York State Prevention Agenda Priorities Selected by Counties for 2013-2017

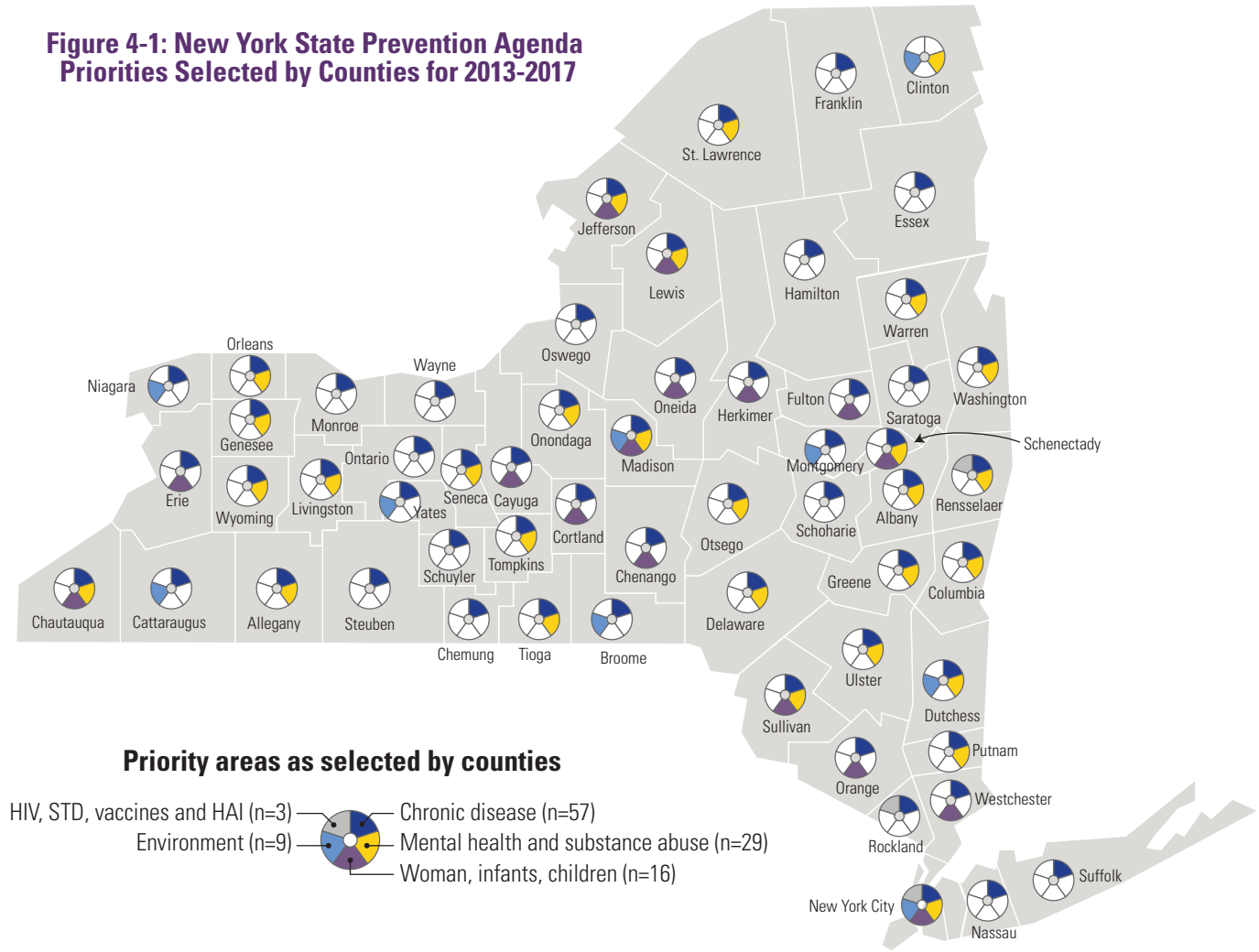


Table 4-1: Promote Mental Health and Prevent Substance Abuse Action Plan

Goal 1: Promote mental, emotional and behavioral (MEB) well-being in communities	Objective 1.1.1: Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults.
Goal 2.1: Prevent underage drinking, non-medical use of prescription pain relievers drugs by youth, and excessive alcohol consumption by adults	Objective 2.1.1: By December 31, 2017, reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days to no more than 34.6%. (Baseline: 38.4 per 100, 2011 YRBS) - Tracking Indicator Objective 2.1.2: By December 31, 2017, reduce the percentage of youth ages 12-17 years reporting the use of non-medical use of painkillers. (Baseline: 5.26% 2009-2010, NSDUH, Target: 4.73%) - Tracking Indicator Objective 2.1.3: By December 31, 2017, reduce the percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month to no more than 18.4%. (Baseline: 20.4 percent, 2011 BRFSS) - Tracking Indicator
Goal 2.2: Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.	Objective 2.2.1: By December 31, 2017, reduce the percentage of adult New Yorkers reporting 14 or more days with poor mental health in the last month by 10% to no more than 10.1%. (Baseline: 11.1%, 2011 BRFSS) - Tracking Indicator Objective 2.2.2: By December 31, 2017, reduce the number of youth grades 9-12 who felt sad or hopeless by 10% to no more than 22.4%. (Baseline: 24.9 %, 2011 YRBS) - Tracking Indicator
Goal 2.3: Prevent suicides among youth and adults.	Objective 2.3.1: By December 31, 2017, reduce suicide attempts by New York adolescents (youth grades 9 to 12) who attempted suicide one or more times in the past year by 10% to no more than 6.4%. (Baseline: 7.1 suicide attempts per 100, 2011 YRBS) - Tracking Indicator Objective 2.3.2: By December 31, 2017, reduce the age-adjusted suicide mortality rate by 10% to 5.9 per 100,000. (Baseline: 6.6 per 100,000, Bureau of Biometrics 2007-2009) - Tracking Indicator
Goal 2.4: Reduce tobacco use among adults who report poor mental health.	Objective 2.4.1: By December 31, 2017, reduce the prevalence of cigarette smoking among adults who report poor mental health by 15% from 31.2% in 2011 to 26.5%. (Baseline: 31.2%, 2011 Data source: NY Adult Tobacco Survey) - Tracking Indicator

Table continues on next page

Table 4-1: Promote Mental Health and Prevent Substance Abuse Action Plan (Continued)

Goal 3.1: Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.	Objective 3.1.1: Identify and strengthen opportunities for sharing data on access to care, identifying service gaps, studying cost-effectiveness strategies for integration and coordination, and the impact of interventions. Objective 3.1.2: Identify and strengthen opportunities for implementing MEB health promotion and MEB disorder prevention with individuals. Objective 3.1.3: Collaborate with the chronic disease community to identify opportunities to share and disseminate scientific information, implement evidence-based interventions, and provide cross-systems training and quality improvement. Objective 3.1.4: Support efforts to integrate MEB disorder screening and treatment into primary care.
Goal 3.2: Strengthen infrastructure for MEB health promotion and MEB disorder prevention.	Objective 3.2.1: By December 31, 2017, identify indicator data and establish baseline targets for data required to plan and monitor county-level, strengths-based efforts that promote MEB health and prevent substance abuse and other MEB disorders. Objective 3.2.2: Identify specific roles different sectors (e.g., governmental and nongovernmental) and key initiatives (e.g., Health Reform) have in contributing toward MEB health promotion and MEB disorder prevention in New York State. Objective 3.2.3: Collaborate with researchers and practitioners to develop and disseminate a compendium of evidence-based interventions and policies that promote MEB health and prevent MEB disorders. Objective 3.2.4: Strengthen training and technical assistance of primary care physicians, MEB health workforce and community leaders in evidence-based, including cultural sensitivity training, approaches to MEB disorder prevention and mental health promotion.

In promotion of the Prevention Agenda, the 2014 Local Services Plan Guidelines for Mental Hygiene Services strongly encouraged local governmental units (LGUs) to proactively reach out to their respective local health departments (LHD) to collaborate on the Promote Mental Health and Prevent Substance Abuse priority area. The most recent two years of local plans from LGUs and LHDs exhibit shared priorities and collaboration across departments in many counties on a series of core prevention agenda items. These planning efforts that take into account a broader view of the public mental health system and public health are helpful in paving the way for the implementation of managed care, DSRIP, the OMH Transformation Plan and other efforts to reorient care and support meaningful and sustainable change. As Chapter 1 shows, the most recent local plans for the 46 counties that chose promote mental health and prevent substance abuse as a focus area for local planning showed some promising overlap in priority activities, such as cross-systems collaboration and suicide prevention; building a foundation for ongoing and strengthened public health and behavioral health planning activities.

For more detailed information on the Prevention Agenda and the Promote Mental Health and Prevent Substance Abuse Action Plan, visit the Prevention Agenda 2013-2017 website, which also includes a population health metrics dashboard that is updated as current data are made available.

Population Health Improvement Program

One of the most recent tools introduced to the population health and behavioral health planning sphere is the Population Health Improvement Program which was introduced through the 2014-15 State Budget. The Population Health Improvement Program (PHIP) will promote the Triple Aim of better care, better population health and lower health care costs through regional efforts that reflect local needs, assets and capabilities. PHIP contractors will each work in one of several regions that together will serve the entire State. PHIP contractors will provide a neutral forum for identifying, sharing, disseminating and helping implement best practices and strategies to promote population health and reduce health care disparities in their respective regions. In particular, PHIP contractors will help support and advance ongoing activities related to the New York State Prevention Agenda 2013-2017 and the NYS Health Innovation Plan in addition to incorporating strategies to reduce health disparities.[3]

Each PHIP contractor will plan, facilitate, and coordinate many different activities required for the promotion of healthy communities and the successful transformation of the health and care system in the region to achieve the Triple Aim. Additionally, each contractor will make activities and findings transparent to the public. PHIP contractors will be expected to integrate and coordinate activities with regional health and human services planning agencies including, but not limited to, local public health departments, health care providers and payers, local departments of mental hygiene services, regional health information organizations, area agencies on aging, social services agencies, and behavioral health regional planning consortiums.

The relationship of PHIPs with some of the other large initiatives discussed in the Comprehensive Plan will be developed further as systems and stakeholders continue to establish and refine their roles in support of the broader public health and mental health system reforms. The Request for Proposals indicates a role for PHIPs in providing data to Performing Provider Systems as PPSs begin operating in the coming years of DSRIP; such arrangements would be made at the discretion of PPS.

The role and activities of PHIP contractors are in line with other initiatives such as the advancement of the Regional Planning Consortium concept under the integrated managed behavioral health care RFQ, the ongoing regional planning activities underway with the Transformation Plan reinvestment planning, and the Prevention Agenda collaboration among LGUs and LHDs. Information and updates on the Population Health Improvement Program can be accessed through the Department of Health http://www.health.ny.gov/community/programs/population_health_improvement/

As we transition into a new era of healthcare service delivery, the Office of Mental Health will remain focused and dedicated to wellness and recovery, which is reflected in standalone efforts—such as the Transformation Plan—and participation in collaborative efforts—such as DSRIP, PHIP and the Prevention Agenda. OMH is committed to mental health needs of the population, and embraces the changes to assess needs at a regional level. We encourage our community stakeholders to embrace of this shift toward reinvestment of resources to facilitate better clinical outcomes and greater recovery for all.

Chapter 4 Endnotes

1 DSRIP leads will in most or all cases be hospitals.

2 There are four DSRIP domains, but only the latter three apply to specific project areas. The first DSRIP domain is Overall Project Progress, which applies to all PPSs and projects, and the entire DSRIP waiver.

3 Funded through a grant from the Centers for Medicare and Medicaid Innovation, the NYSHIP is a broad health systems reform framework with one of its primary goals being the promotion of Advanced Primary Care across New York State.

Appendix A

Mental Hygiene Priority Outcomes Development, Rank-ordering, and Coding

Local Services Plans (LSPs) are constructed in part through the submission of "Mental Hygiene Priority Outcomes." The Mental Hygiene Priority Outcomes Form was introduced in 2008 as the first fully integrated county mental hygiene planning form, with the purpose of facilitating a more person-centered planning process that focuses on cross-system collaboration. The form was designed to provide counties with a process for developing priorities in a consistent manner across the three mental hygiene disabilities. It was intended to improve the ability of counties to conduct local planning and develop priorities consistent with State goals and priorities.

For the 2015 LSP submission process, after all priority outcomes were entered into the County Planning System (the CPS is the Local Service Plan online entry portal), local governmental units ranked the top five priorities in plan in order of importance. For plans with fewer than six priorities, all priorities were rank ordered.

In order for the Office of Mental Health to perform basic analysis on the overarching themes for the LSP priority outcomes, LGUs were required to indicate the single option that most accurately described the focus of each priority. Below are the categories that were provided. The full Local Service Plan guidelines document for the 2015 plan year can be accessed at http://www.oasas.ny.gov/hps/state/documents/2015LSPGuidelines.pdf

OMH Priority Focus: (check one)

Indicate the option that most accurately describes the focus of this priority.

- ❑ Service Capacity Expansion/Add New Service
- ❑ Service Improvement/Enhancement
- ❑ Increase Access to Services
- ❑ Service Coordination/Integration
- ❑ Service System Planning/Management
- ❑ Workforce Development
- ❑ Outreach/Education
- ❑ Other (specify)

_____

_____

_____

Appendix B

Health Home Highest Risk Population

Multiple Co-occuring Complex Disease so Care MUST be integrated

Chronic Episode Diagnostic Categories: Health Home Eligibles Adults 21+ Years with a Predictive Risk Score 75% or Higher (n=17,752)

Condition	Total	Severe Mental Illness	Mental Illness	Substance Abuse	Hypertension	Hyperlipidemia	Diabetes	Asthma	Congestive Heart Failure	Angina & Ischemic Heart Disease	HIV	Obesity	Osteoarthritis	COPD & Bronchectasis	Epilepsy	CVD	Kidney Disease
Severe Mental Illness	43.5	100.0	74.7	77.2	33.8	28.1	23.2	34.1	6.8	8.5	9.6	14.8	23.2	13.9	20.1	31.9	10.9
Mental Illness	46.2	70.4	100.0	70.9	42.0	33.7	28.0	35.8	11.0	12.6	8.7	16.9	29.9	17.8	19.4	41.0	16.4
Substance Abuse	54.4	61.9	60.3	100.0	35.4	25.9	21.4	32.8	7.5	9.4	11.2	10.7	23.1	14.5	16.4	34.4	11.2
Hypertension	37.6	39.1	51.6	51.1	100.0	47.4	41.4	30.7	28.2	22.1	5.6	17.8	29.3	22.6	13.9	62.2	30.8
Hyperlipidemia	29.8	41.0	52.2	47.1	59.8	100.0	54.9	37.7	27.8	33.4	5.6	23.6	30.9	25.1	15.0	70.4	31.5
Diabetes	27.8	36.3	46.5	41.8	56.0	58.8	100.0	35.4	25.7	25.3	5.4	24.3	28.1	22.8	13.2	64.9	34.3
Asthma	28.3	52.4	58.5	62.9	40.8	39.7	34.8	100.0	15.3	17.4	12.3	22.0	34.3	33.0	16.7	47.7	18.4
Congestive Heart Failure	13.4	22.1	37.9	30.6	79.5	61.9	53.5	32.3	100.0	41.2	4.1	21.1	26.1	33.9	8.9	100.0	50.3
Angina & Ischemic HD	12.2	30.5	47.8	41.8	68.2	81.5	57.6	40.3	45.1	100.0	4.6	24.1	33.8	31.5	11.7	100.0	41.9
HIV	8.3	50.2	48.4	73.5	25.2	20.0	18.1	41.9	6.7	6.8	100.0	4.9	26.6	16.4	13.2	31.1	17.9
Obesity	12.7	50.5	61.4	45.8	52.6	55.4	53.1	49.0	22.2	23.1	3.2	100.0	39.3	25.7	16.5	60.1	27.2
Osteoarthritis	22.1	45.7	62.7	56.8	49.9	41.8	35.5	44.0	15.8	18.7	10.0	22.7	100.0	25.5	15.1	52.0	24.9
COPD & Bronchiectasis	15.5	38.8	53.0	50.6	54.7	48.1	40.7	60.1	29.2	24.8	8.7	21.0	36.1	100.0	14.0	67.2	27.0
Epilepsy	13.5	65.1	66.6	66.3	38.8	33.2	27.2	35.1	8.9	10.6	8.1	15.6	24.8	16.2	100.0	41.1	16.3
CVD	41.9	33.2	45.3	44.6	55.9	50.2	43.1	32.3	32.0	29.2	6.2	18.3	27.4	25.0	13.2	100.0	35.4
Kidney Disease	18.8	25.2	40.4	32.4	61.5	49.9	50.6	27.6	35.8	27.2	7.9	18.3	29.1	22.3	11.7	78.6	100.0
Total	100.0	43.5	46.2	54.4	37.6	29.8	27.8	28.3	13.4	12.2	8.3	12.7	22.1	15.5	13.5	41.9	18.8

Note: Diagnosis History During Period of July 1, 2010 through June 30, 2011

Appendix C

An overview of the various efforts employed to achieve outcomes based on the NYS Health Innovation Plan and reflecting the triple aim of better care experience, better health and lower cost for services.