

January 2010

Legally Speaking

Federal HITECH Act: Protecting Patient Privacy and Data Security

from OMH Counsel's Office

Today, the acronym "HIPAA" is very familiar to everyone in the health care industry. Although the federal law known as HIPAA was primarily designed to promote the use of standardized electronic transactions by the health care industry (thus creating savings and efficiencies), the push toward putting health care information into electronic form raised many concerns about privacy and security. This is why the HIPAA Privacy and Security Rules were enacted back in 2003. For OMH, these federal regulations did not represent sweeping new change, but they complemented the privacy protections for mental health treatment records that have been in place for decades under the New York State Mental Hygiene Law.

On February 17, 2009, President Obama signed the [American Recovery and Reinvestment Act](#) (ARRA), as a stimulus vehicle for the troubled economy. Included within ARRA is the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH was intended to provide funding for electronic health records and related activities, with a primary goal of increasing the use of electronic systems for healthcare use. HITECH sets the standards and encourages physicians and healthcare organizations to adopt and use Electronic Health Records (EHR) in a meaningful way. But, once again, because of the concerns about the privacy and security of health information, HITECH also makes changes to certain provisions in HIPAA, some of which are quite significant.

While HITECH makes many changes to the HIPAA rules, the following are important to highlight:

- **Security breach notification requirements:** HITECH requires HIPAA covered entities to notify individuals, and Business Associates to notify covered entities, in the case of a "breach" of protected health information. A "breach" includes all "unauthorized acquisition, access, use, or disclosure of" unencrypted or otherwise readable protected health information (both electronic and hard copy). There are very limited exceptions to this definition. Breaches affecting fewer than 500 persons in one state must be reported annually to the Secretary of Health and Human Services (HHS). If more than 500 individuals in a state are affected by a breach, notice

must be immediately provided to HHS, as well as to prominent media outlets.

- **Business Associates:** Before HITECH, business associates were not directly subject to the HIPAA Privacy and Security Rules. Instead, HIPAA applied indirectly to them contractually through a Business Associate Agreement (BAA) between the covered entity and business associate. Thus, business associates were not subject to the HIPAA penalties if they failed to comply with the Privacy and Security Rules - they were only subject to damages resulting from breach of the BAA. This is all changed under HITECH. Business associates will now be directly responsible for compliance with the HIPAA Security Rule, as well as some provisions of the Privacy Rule, with most new requirements taking effect on February 17, 2010.
- **Accounting for Disclosures:** Patients will be allowed to request an audit trail showing all disclosures of their **electronic** health records for a three-year period. In addition, patients are also entitled to receive a copy of their electronic health record if requested.
- **Penalties:** HITECH amends the penalties established in HIPAA. Civil penalties now range from \$100 to \$50,000 per violation, with caps of \$25,000 to \$1,500,000 for all violations of a single requirement in a calendar year. The amount of the civil penalty imposed varies, depending on whether the violation was unknowing, due to reasonable cause, or due to willful neglect. Criminal penalties include fines up to \$50,000 and imprisonment for up to one year. HITECH also provides that State Attorneys General can bring civil lawsuits to enforce HIPAA.

Although federal guidance in several areas is still forthcoming, significant portions of HITECH have a compliance date of February 17, 2010, OMH is actively working to restructure its privacy policy, security policy and Business Associate Agreements. In July 2009, OMH organized an agency-wide Data and Information Governance (DIG) Board to govern the quality, security, and use of health information. OMH has also decided to revamp its data and information security infrastructure to enhance the safeguards already in place that are designed to protect the health information we create or maintain for individuals we serve. Included in this security infrastructure are the capabilities for data loss protection (DLP), security incidence and event management (SIEM), network vulnerability scanning, and secure endpoints for computing. As OMH continues to work toward the adoption and use of an electronic

medical records system (EMR) statewide, our security initiative will support our EMR initiative in the encryption of protected health information (PHI) and the development of detail audit trails of activity on patient electronic health records.

To reinforce the critical need to protect the privacy of our patients and safeguard their protected health information, as well as to inform staff about the new HITECH requirements, OMH is currently developing HITECH awareness training that will be provided to all members of the OMH workforce.

For additional information, please see an [overview of the American Recovery and Reinvestment Act of 2009](#).

Medical Updates



The New York City Mental Health Care Monitoring Initiative

by Thomas Smith, Medical Director, NYC Care Monitoring Initiative

In 2007-2008 there were several incidents in New York City involving individuals with serious mental illness (SMI) as either victims or perpetrators of violence. At the request of the NY Governor and NYC Mayor, a panel was convened in February 2008 to recommend actions to improve mental health services and promote the safety of all New Yorkers. The [NYS/NYC Mental Health-Criminal Justice Panel report](#) noted a common theme of individuals experiencing gaps in services prior to adverse events.

The Panel recommended that the NYS Office of Mental Health (OMH) and NYC Department of Health and Mental Hygiene (DOHMH) jointly establish a Mental Health Care Monitoring Initiative to monitor services provided to high-needs individuals with SMI and work with providers to ensure service needs are being met. The Panel recommended that this Care Monitoring Initiative use Medicaid claims data to improve care by identifying patterns of service use, especially those indicating gaps in services, suggesting the need for prompt intervention.

The NYC Care Monitoring Initiative focuses on individuals with SMI living in NYC who have recently received or been referred for intensive services. The following groups of individuals have been identified:

- Individuals currently or having ever received Assisted Outpatient Treatment (AOT) services
- Individuals referred to Assertive Community Treatment (ACT) or Case Management services in the prior 12 months

- Individuals with 2 or more emergency room visits/inpatient admissions in the prior 12 months
- Individuals receiving forensic services in the prior 36 months: This population includes individuals with SMI discharged from prison satellite units as well as individuals discharged to the NYC community from state psychiatric facilities after receiving inpatient care under one of several forensic designations including: not competent to stand trial; not guilty by reason of insanity; or long-term inpatient civil commitment.

Medicaid claims data are reviewed for individuals in these groups every month, with notification flags designed to identify those whose pattern of service use (or non-use) indicates they may not be receiving needed services. The notification flags include:

- No ambulatory mental health care or substance abuse services in the prior 120 days
- No psychiatric medication prescriptions filled in the prior 60 days
- Two or more emergency room visits or psychiatric inpatient hospitalizations in the prior 120 days

The Care Monitoring Initiative includes clinically trained care monitors who review the monthly notification reports and establish contact with providers who last served the identified individuals. The care monitors discuss procedures used by providers to outreach to and retain individuals in services. The recently disseminated [OMH Mental Health Clinic Standards of Care](#) serve as a guideline for discussions about appropriate provider outreach and engagement strategies. The care monitors help providers formulate appropriate plans for outreach and monitoring of individuals when indicated, and follow-up to ensure re-engagement into appropriate care.

OMH and DOHMH are jointly supervising Community Care Behavioral Health, a managed care company owned by the University of Pittsburgh Medical Center, that is staffing the Care Monitoring Initiative. The first Care Monitoring team started at Kingsboro Psychiatric Center in Brooklyn, in October 2009, and a second team will begin in the fall 2010 in the Bronx. Dr. Thomas Smith is the OMH project co-director and can be reached at (212) 543-5976. Ms. Doreen Thomann-Howe is the DOHMH project co-director and can be reached at (212) 219-5455. Ms. Kelly Corkhill-Lauletta is Community Care's regional director and can be reached at (718) 221-7921.

Comings and Goings

Henry Fernandez Appointed OMH Assoc. Commissioner for Adult Services

Henry A. Fernandez has returned to the New York State Office of Mental Health (OMH) as Associate Commissioner for Adult Services. Mr. Fernandez previously worked at OMH from 1981 to 1986 as Assistant Counsel in the Office of Counsel, and from 1986 to 1988 in the Capital District Psychiatric Center as Director for Administration. Prior to leaving the OMH in 1988, he organized the newly established Bureau of Investigation & Audit and served as its first Director.

Mr. Fernandez was appointed Deputy Commissioner for the Professions with the New York State Education Department where he served from 1988 to 1993. In 1991, the Ford Foundation and Harvard University recognized his Nursing initiative at SED as one of the nation's top innovative programs in State and Local government. While at SED he established the Office of State Review and served as the first State Review Officer on appeals from parents or school districts on the placement of Children with Handicapping conditions pursuant to federal law.

Prior to returning to OMH he served in several private sector leadership and executive positions, and managed international and domestic health care engagements and management training programs in the Newly Independent States of the former Soviet Union, Central and Eastern Europe, and Latin America and in the public and private health care sectors throughout the United States.

Mr. Fernandez holds a Bachelor of Arts from St. John's University and a Juris Doctor from Brooklyn Law School. He is admitted to the New York State bar and the federal courts. He is an elected Fellow of the New York State Bar Foundation and he is also an elected Fellow of the New York Academy of Medicine. He has also completed the National Institute for Trial Advocacy Program at Cornell University and the Program for Senior Executives in State and Local Government at Harvard's John F. Kennedy School of Government.

Promoting Quality Services

Western New York Care Coordination Program Goal: System Transformation

by Don Zalucki, Director, Bureau of Program and Policy Development, Adult Services

The [Western New York Care Coordination Program](#) (WNYCCP) is a collaborative undertaking by county governments, providers and

consumers who believe in recovery of individuals with serious mental illness. The WNYCCP has a goal of system transformation to change the manner in which mental health care is delivered. Stakeholders from Erie, Monroe, Onondaga, Wyoming, Genesee and Chautauqua counties actively participate in program planning, governance, work groups, and training initiatives. The program has had several major accomplishments including:

- Establishing a culture for system change by utilizing continuous participation of all stakeholders including peers, families and providers in the program's design and decision-making since its inception;
- Implementation of person-centered planning for the delivery of care to individuals with serious mental illness in which the individual's life goals provide the basis for a plan of care and treatment plan development;
- Development of a Pay-for-Performance initiative for deficit-funded programs that creates fiscal incentives for the achievement of programmatic performance milestones agreed to by the counties and OMH (e.g., access to care for priority populations, fidelity to person-centered practices, achievement of recovery outcomes); and
- Development of a [secure online SPOA application](#) that allows providers, consumers and families to complete and submit an application for case management and housing services.

To date the WNYCCP has achieved some impressive results including the reduction of self harm, suicide attempts, emergency room visits, and days spent in the hospital, all contributing to a reduction of the mental health costs for program enrollees.

The program is currently developing a care management system designed to be responsive to the behavioral and physical health needs of individuals with serious mental illness. In 2009, WNYCCP contracted with Beacon Health Strategies, LLC to assist in the development of this initiative and has taken steps to create a foundation for care management in the six counties:

- Level of Care Criteria – Development of mental health program admission standards and criteria for continued treatment. These standards will form the basis for voluntary utilization management of services which should help ensure individuals receive an appropriate level of care, increase system flow and assist providers to avoid Medicaid disallowances.

- **Complex Care Management** – To improve coordination of behavioral and physical health care, 400 high-need individuals with co-occurring mental health, chemical dependency and/or physical health disorders will receive complex care management. Care managers will work with behavioral health providers, primary care physicians and HMOs to develop an integrated person-centered plan of care, arrange access to needed services, and monitor the overall health of the individual. While improving the quality of care delivered is the primary goal, it is anticipated cost savings will be achieved through reduction of unnecessary emergency room utilization and inpatient treatment.

In the coming months, the program will start using the level of care criteria and initiate a voluntary managed fee-for-service system that will be progress to further moving the WNYCCP toward its goal of system transformation.

For further information on the WNYCCP contact [Adele Gorges, Project Director](#) or visit their [website](#).

Reforming and Transforming Mental Health Services

Children and Family Services: Hope, Optimism & a Positive Outlook



The following article briefly summarizes Chapter 4 of [OMH's Statewide Comprehensive Plan for Mental Health Services](#). For more detail, see the unedited plan on the [OMH website](#).

Investments in children's social and emotional development today produce success, and avoid costly, long-term failures in the future. Research has demonstrated that prevention and early recognition, intervention of children's mental health problems, and treatment in natural settings, yield better results.

However, making effective investments in children's mental health is challenging. Even though the research strongly supports the value of prevention and early intervention, funding has been targeted toward more traditional and expensive services such as residential care.

In the face of such challenges, OMH continues its transformation of children's services, most recently with the creation of the Children's Plan. These efforts and a strong network of family advocacy and support have resulted in a system that is concentrating on home and community care, while striving to provide inpatient and residential

care for children in need of intensive services.

When nurtured and supported, resilience enables young people to do well in school, maintain friendships and other relationships, and find success in employment, even when they may be struggling with significant mental health challenges. It also equips youth to handle transitional experiences like moving to a new school, going into a residential placement or breaking up with a boyfriend or girlfriend. Long-term studies have shown that at least 50 percent – and often close to 70 percent – of youth growing up in high-risk situations develop the resilience to go on to live successful lives.

The children's system in New York is taking a public health approach through a sustained focus on children's social and emotional development, or promoting good mental health and working to prevent mental health challenges. It involves supporting healthy development and well-being, identifying challenges when they arise, and intervening early. Parents, partners, family members, teachers, doctors, clergy, social group leaders and friends all contribute to the social and emotional well-being of children.

With research now pointing to the importance of intervening early in the course of a child's problems, the children's system has adopted an emphasis on proactive action. Endorsed by nine New York State Commissioners of child-serving agencies, the Children's Plan recognizes that systems of care – education, child welfare, juvenile justice and others – share responsibilities for policies and practices for the social and emotional well-being of New York's children. It reflects a cooperative goal to break down barriers between systems and achieve social and emotional well-being for all children across the State.

Joint initiatives cover distinct efforts to increase community awareness of social and emotional development; enhance youth, family and parental involvement and education; provide consultation and training on children's mental health in other service systems; and expand our collective capacity to provide effective mental health services. They aim to reverse patterns such as child neglect, preschool expulsion, in-school violence and institutionalization. The goal is to help prepare youngsters for adulthood with supportive families and communities, effective schools and high-quality health care. This unified commitment across agencies to the common goal represents an unprecedented partnership for change.

From the Field



[Enlarge](#)

Hudson River Field Office: Success Through Collaboration

by Tara McDonald, Residential Treatment Facility Specialist

According to the Encarta Dictionary, the meaning of the word “collaboration” is ‘the act of working together with one or more people in order to achieve something.’ Traditionally the spirit of collaboration between sister agencies, the Office of Mental Health (OMH) and the Office of Mental Retardation and Development Disabilities (OMRDD), has been easy to intermittently summon but more challenging to successfully infuse into routine activities.

On October 1, 2008, the Commissioners from all of the child-serving New York State agencies submitted a copy of the [Children’s Plan](#) to Governor David Patterson. The plan calls upon these agencies to [Engage](#) in ongoing collaborative efforts in order to achieve better and more effective outcomes for New York State’s children and families. The Children’s Plan, in conjunction with the Children’s Mental Health Act of 2006, takes the idea of collaboration out of the realm of simply good practice and elevates it to a legal mandate.

In the Hudson River Field Office (HRFO) we follow the fundamental tenet of ‘positive change...one person at a time,’ which drives our daily work. In 2009, staff spent a significant amount of time assisting providers to identify (and at times create) paths for youth “stuck” in levels of care that were no longer appropriate due to evolving treatment needs. One such youth was Chantelle B., who had been a resident of a Hudson River Residential Treatment Facility (RTF).

At the time of Chantelle’s discharge she was 12 days shy of her 8 year anniversary as a resident. Prior to her admission into an RTF, Chantelle had a long history of psychiatric hospitalizations due in large part to a serious emotional disturbance. Chantelle also exhibited symptoms of a developmental disability, evidenced by her low cognitive functioning and limited social abilities. During most of Chantelle’s residency, she struggled with emotional stability and routinely fought the urge to bring harm to herself. However toward the end of year six, the clinical staff began to broach the subject of discharge with Chantelle, as a result of sustained success in treatment. Chantelle and her family were responsive to the discussions and participated in planning for Chantelle’s next steps.

Next steps for Chantelle hinged on her receiving an intensive level of services from OMRDD. Chantelle’s treatment needs had traditionally focused on her mental health disabilities, and entry into the OMRDD

world of services proved challenging. However, the spirit of collaboration came alive for the sake of achieving a better outcome for Chantelle. That collaborative spirit was present through consultative meetings between the Capital District DDSO representatives and the RTF Transition Coordinator for the purpose of submitting an appropriate OMRDD certification packet. That spirit was also present for monthly conference calls between the DDSO, the RTF and the HRFO to discuss progress, challenges and next steps. Finally, collaborative efforts culminated into Chantelle's discharge from the RTF on 9/8/09 into an OMRDD IRA. The IRA provides Chantelle with the appropriate level of service and support to match her current need.

The discharge process for Chantelle took two years and many staff hours. At times, it was frustrating and tedious, but ultimately it was extremely rewarding. It also proves that successes through collaboration between OMRDD and OMH can happen; especially one youth at a time.

Promoting Cultural Competence

NKI Center of Excellence Supports Culturally Competent Mental Health Services

by Carole Siegel, PhD, Director, NKI Center of Excellence in Culturally Competent Mental Health

The [NKI Center of Excellence in Culturally Competent Mental Health](#) website maintains a series of [cultural profiles](#) reviewing the professional literature and government reports on various cultural groups in New York State. These profiles highlight cultural traits that can impact access to and outcomes of mental health services, including demography and immigration information, prevalence rates and views of mental illness, cultural values that impact mental health service use, care seeking patterns, barriers to service and the impact of the acculturation processes. These profiles can be used by mental health providers to guide service adaptations in order to provide meaningful services that meet the mental health needs of diverse populations. Featured groups include Chasidim, Chinese Americans, Hispanics/Latinos, Korean Americans, Sexuality and Gender-based Identity cultures, Muslim Americans, Native Americans, South Asian Americans and Rural Americans.

What follows is an abstract of a [cultural profile of African Americans](#), based primarily on research studies of those who are descendants of Africans who entered the US as slaves, but because of lack of specificity in recording ethnicity, studies may have also included data on Caribbean Blacks and recent Black immigrants.

Treatment of African Americans needs to respect their history, understand their values, be aware of existing strengths within the individual, family and community, and anticipate the role of racial differences between providers and consumers.

African Americans traditionally turn to family, friends, neighbors, voluntary associations and religious figures for help with psychological challenges. Spirituality appears to serve a protective role; women tend to seek help from ministers and those who contact clergy first are less likely to seek help from other professionals. In a study of women in recovery from substance abuse, those who scored higher on a „Spiritual Well-Being Scale’ had more positive self-concepts, an active coping style, and healthier perceptions of family climate and parenting attitudes.

Adaptive behavior and the psychological well-being of African American men can be affected by discrimination, creating what has been called “an invisibility syndrome,” a psychological experience where racial identity and self-abilities have been undermined by episodes of racism occurring in interpersonal circumstances. While many women have achieved successful roles and live in intact families, others are in single family households, are un- or under-employed and live in impoverished conditions. Extended families frequently care for unrelated children and increasingly, the elderly are becoming caregivers of their grandchildren. Strained family living conditions can impact youth behaviors.

The percentage of African Americans receiving needed services is only half that of the general population. They are more likely to discuss mental health problems in general medical settings than with mental health specialists. Many use emergency rooms for crises. Location and time barriers also impede access to appropriate clinical services. Agencies may not locate services close enough to population centers of African Americans, and may offer restrictive hours of operation that do not accommodate working individuals or mothers with children. Greater use of services was found among those with self-reported substance abuse problems, and those with friends or family who have used mental health services.

**From the Facilities:
Transitional
Placement Programs**

Mohawk Valley Psychiatric Center's Transitional Living Center (TLC)

from Mohawk Valley Psychiatric Center staff

The Transitional Living Center (TLC) at Mohawk Valley Psychiatric Center is a twenty-five bed residential option based on the Transitional Placement Program model developed by the Office of Mental Health. Specifically, the TLC accepts adult inpatients into this residential model that would otherwise have obstacles to community placement because of lengthy hospitalizations or a history of unsuccessful community placements.

The philosophy of the TLC is a "Good Morning" approach to engagement of individuals during their recovery from mental illness and in the development of skills necessary for successful community reintegration. The residence embraces a psychiatric rehabilitative model of care to help individuals attain their optimal level of functioning and choose from a number of future residential options following an average length of stay of two to nine months on the TLC.

Licensed by OMH, this setting emphasizes the principles of normalization by offering services in the areas of assertiveness/self advocacy training, community integration services, daily living skills training, health services, medication management and training, rehabilitative training, skill development services, and activities to improve socialization and symptom management. Residents are engaged in a menu of services offered by the MVPC Rehabilitation Services Department that focus upon living, learning, working and social opportunities.

Common characteristics of a person referred to the TLC include a significant history of psychiatric problems that has adversely impacted the individual's pattern of compliance with treatment, motivational level, attention to personal care needs and limited his or her interpersonal and social skills. Individuals may also have a past history of criminal behavior, alcohol and drug abuse, limited intellectual functioning and/or co-morbid medical issues.

Involvement of family members and other outpatient providers is key to the individual's recovery and overall success on the TLC. Discharge plans are developed upon admission into the TLC Program with future residential goals documented within the first 30 days in the

initial Service Plan.

Since its opening on June 1, 2009, the Transitional Living Center at Mohawk Valley Psychiatric Center has successfully admitted 38 individuals and discharged 16 residents with an average length of stay of 130 days!

Mission

The Mission of the Transitional Living Center (TLC) is to provide a person-centered path that leads to successful experiences which support each resident's vision for a quality of life in the community.

Core Values

- Integration: To be a part of something meaningful
- Compassion: The heart must enter into everything we do
- Partnership: The journey of recovery cannot be traveled alone
- Potential: There are no limits
- Hope: The belief that life can be better

Upon discharge each resident is asked to put into words how the TLC has helped in their recovery. Here are a few of their statements.

“The Transitional Living Center not only gave me greater independence but also provided me fantastic aftercare with the York St. Clinic. They have given me everything I need to function after discharge. Thanks to all OMH personnel.” William D.

“The TLC helped in my recovery. The staff went out of their way to make sure that they helped me in any way that they could, and gave me the confidence I needed to move on.” Lisa T.

“The TLC gave me the independence I needed to get into the community. Also the staff was very helpful on answering my questions and was there when I needed someone to talk to when I become overwhelmed with thoughts and feelings. Thank you for your support, it was a pleasure to be part of the TLC program.” Carolyn M.

South Beach Psychiatric Center’s Ocean View Lodge Transitional Placement Program

from South Beach Psychiatric Center staff

South Beach Psychiatric Center (SBPC) serves a population of more than two million individuals in the greater New York City, providing

inpatient, community, and residential services. The SBPC Ocean View Lodge Transitional Placement Program (OVL-TPP) is located on the main campus, and serves consumers discharged from one of 11 inpatient units who are transitioning to comprehensive community care. The OVL-TPP is part of the OVL Service which includes inpatient, outpatient, and supported housing services. With the addition of the TPP, the OVL Service is well positioned to bridge the transition to community care for long-term consumers of inpatient services. The OVL-TPP is the second 24 bed TPP implemented by SBPC and follows many principles of the Fairweather Lodge model, stressing peer supports in a unique and caring residential environment.

OVL-TPP consumers receive treatment, wellness, and recovery services, including medical case management, through the OVL or other SBPC outpatient departments. Consumers work from a strengths-based perspective on increasing skills, readiness, and options for community living. Program design was guided by the NYSOMH plan for system transformation and the OVL-TPP was implemented in January 2009. Establishment of the OVL-TPP permitted a realignment of SBPC services, reducing inpatient beds by 25 and increasing residential beds by 24. The OVL-TPP addresses system transformation on two levels, first by providing a short-term living option for consumers ready for discharge from inpatient but awaiting placement, and secondly by facilitating consumers' community integration, in close coordination with SBPC OPDs.

The OVL-TPP provides 24-hour coverage for residential, rehabilitation and clinical services, by both paraprofessional and professional staff. The OVL-TPP also provides a graduated training program medication administration which culminates in self-administration as an essential community readiness skill. The program also prioritizes treatment for co-occurring substance abuse disorders, prevocational/employment programming, and the management of co-morbid health conditions.

Interventions and tasks performed by OVL-TPP staff:

- Transition consumers to residence at the OVL-TPP from inpatient care.
- Educate consumers and families about housing options, help consumers select housing that best optimizes their recovery.
- Help residents establish SSI/SSD and other financial benefits.
- Help residents to enroll in the optimal Medicare D plan based on their medication regimen and the plan formularies.

- Nutrition training, meal planning, shopping and cooking skills.
- Budget planning reflecting and aligned with projected income.
- Travel training to access community resources.
- Medication training for tracking renewals and reliable self administration.
- Help residents make and keep mental and physical health appointments.
- Help residents learn to organize their living space.
- Help residents build interpersonal skills.
- Education of residents and families regarding mental illness and community resources.
- Training in laundry, ironing, and personal care.
- Training in interview skills.
- Develop referral packets for housing, case management and program referrals.
- Liaison with mental health clinic, general health providers, case management programs, legal system, and family.

Outcomes

The chief outcome measures of the OVL-TPP include 1) attainment of community-based housing and 2) substitution of residential services for inpatient services, minimizing length of stay at both levels of care. Based on one year of data, the OVL-TPP has admitted 58 intermediate and long term inpatient consumers (inpatient median LOS=252 days, mean LOS=367 days), representative of diverse demographic and diagnostic groups. There have been 39 discharges from the OVL-TPP (median LOS=88 days), with consumers selecting from an array of housing options, including supportive apartments and community residences. Among those discharged, six have had a readmission to inpatient services, five of those six have returned either to the OVL-TPP (n=3) or been discharged to other community housing (n=2), one readmitted consumer remains on inpatient. These outcomes indicate that the establishment of the OVL-TPP has 1) facilitated system transformation at SBPC and 2) significantly increased the number of former intermediate and long term inpatient consumers who are successfully maintaining community tenure.

Vignette:

John Doe (pseudonym) is a 35 year old single male who chose to reside at the OVL-TPP in January 2009 after a slow progression through SBPC inpatient services. He presented with significant challenges including serious mental illness and an active history of substance dependence and abuse. The OVL-TPP and OVL-OPD

worked with John and his mother to recognize that new housing arrangements would likely facilitate his recovery and reduce the chance of relapse. John was able to secure supported employment on the grounds of SBPC which then transferred to a paid position in the community during his OVL-TPP stay. He became actively involved in a Narcotics Anonymous home group and identified a sponsor. As he became more confident in his ability to manage his own life, he decided he wanted to live in a supportive apartment. The OVL-TPP and OVL-OPD teams recognized this as breakthrough and also recommended intensive case management as part of John's individual service plan. John successfully transitioned to the supportive apartment in May 2009, and has consistently maintained treatment, recovery services, and employment in the community.

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