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Governor

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Commissioner

New York State Office of Mental Health

# Statewide Comprehensive Plan

## 2012-2016

New York State
omh
Office of Mental Health

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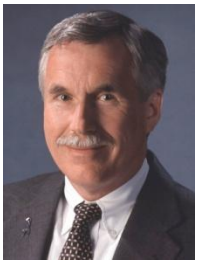
# Introduction from Commissioner Hogan



The Office of Mental Health's (OMH) core purposes, programs and mission have emerged from a nearly 175-year history of care to New Yorkers with serious mental illness, dating from the establishment of the New York State Lunatic Asylum in 1843. New York State's mental health system remains largely based on this "legacy system" of psychiatric institutions, with New York State continuing to operate nearly 10% of the nation's state-operated psychiatric centers (PCs) – more than twice as many as the next largest state – with many more inpatient psychiatric beds than comparable states. However, today, the vast majority of mental health services are now delivered in the community. While New York State once provided inpatient mental health services to more than 90,000 New Yorkers in the 1950s – constituting the vast majority of mental health care at the time – the current census of OMH-operated PCs is now less than 4,000; the remaining estimated 710,000 New Yorkers receiving OMH-funded or -operated services do so in the community.

The core mission of OMH remains management of the mental health safety net for New Yorkers with the most serious mental illnesses, yet that core mission and OMH's functions are rapidly evolving, with multiple forces for change. Development of community-based alternatives to institutions has been robust. However, care provided by these community alternatives has not been managed – not because of an absence of good leaders, but because there has been no single point of accountability at the community level. Counties, providers, health plans and OMH all played a role. This has resulted in poor outcomes for individuals, resulting from the lack of continuity and integration – and subsequently it has led to high costs as well. Like nearly all states, New York State turned to Medicaid to pay for community-based mental health care; however, Medicaid's coverage of mental health services has been uneven, often services were contorted to assure coverage, and care was "siloed." Until the Medicaid Redesign Team's recommendation to move to behavioral health managed care, there was no possibility of fixed accountability.

The absence of accountable systems meant that people with mental illness frequently "fell through the cracks," sometimes simply ending up in emergency rooms again and again, but sometimes with spectacularly tragic results – including suicide. The MRT vision and plan of "care management for all" allows New York State the opportunity to redefine the core OMH safety net mission, and to right-size OMH services. The biggest mental health challenge in a generation lies just ahead – getting the move to care management right.

The mental health safety net requires more than treatment services, however. Supports such as housing, supports provided by peers, and assistance gaining employment are needed as well. New York State is now positioned to address the needs of this modern mental health safety net: 1) care management for individuals in Medicaid will allow re-balancing from costly hospital services to community treatment, with modest reinvestment in supports; 2) OMH efforts, combined with the MRT Supported Housing initiative can help close the gap in affordable housing availability for people with mental illness; 3) leveraging New York State's historic Ticket To Work agreement with the Social Security Administration will create opportunities to offer competitive employment opportunities to many people with disabilities.

Yet, even with these advances, the safety net will also require efforts to assure adequate provisions for mental health care in other systems, such as corrections, children's services, and especially primary health care. The movement of mental health care into mainstream health plans and primary settings will necessitate a significant improvement in the ability to address mental health needs in primary health care. These settings have traditionally remained largely ill-equipped to this task, in fact, leading in part to the overdevelopment of institutional mental health care, along with the failure to apply early interventions that reduced the severity and duration of such disabling conditions. Now, most people with mental ill-

ness not only are not in hospitals, but they are not in specialty mental health settings, like those funded and operated by OMH. Psychiatrists write less than 1/3 of the prescriptions for psychiatric medications. The average nine-year gap between when an individual first experiences a mental illness and when they first begin receiving care demonstrates many missed opportunities. The majority of these opportunities for early intervention occur in primary care settings, but identification and treatment or referral for treatment is far too rare. Managed care for intensive mental health services must be coupled with improved integration with mainstream managed care, and especially with improved detection and treatment of mild-to-moderate mental health problems in primary care. This will require investment, supports, and standards. In collaboration with the Department of Health, OMH will offer focused and structured support to mainstream health care to provide services to people who need moderate levels of mental health treatment. Additionally, OMH is developing a First Episode Psychosis (FEP) capability to detect potentially disabling psychotic illness early, and to support young people in their families as they learn to manage these conditions in a fashion that will not lead to lifelong disability.

The public mental health safety net is perhaps in the final stages of a generation-long transition from the institutionally dominated system of another era. We are moving beyond the "casualty model" of mental health care that waits for problems to arise and then offers expensive and extensive treatment in inpatient settings. OMH is moving to an early intervention and coordinated care model that promotes wellness and aims to prevent the need for more extensive and expensive treatment through increased community-based services with the capacity to meet the needs. At the same time, we must redouble our commitment to assure adequate care for those who need it most, including people whose illness can block the recognition that they need help. The initiatives and efforts discussed in this document are profound changes from the past and will serve as catalysts to accelerate the movement from a mental health safety net focused on inpatient care – which too often has done more to perpetuate long-term disability than prevent it – toward community-based services that are focused on recovery, but never forgets those for whom recovery has not yet begun. These changes will help OMH fundamentally redefine priorities – moving away from long-term treatment toward supporting people in achieving independence, improved community functioning and substantially better lives.

This year's OMH Statewide Comprehensive Plan (2012-2016) serves as a guide to the efforts that will move mental health services toward a more prevention- and recovery-oriented system of services and supports. In this document, you will read about several key initiatives that are centerpieces of OMH's efforts to bring about such change:

1. Improving the quality of care through implementation of a care management approach via the Behavioral Health Organization [BHO] and Health Home initiatives;
2. Implementing a different approach to help people first experiencing psychotic symptoms avoid lifetimes of dependence on intense supports;
3. Installing a systemic approach to suicide prevention efforts;
4. Transforming inpatient OMH-operated services to focus on recovery and rapid transition to the community;
5. Using data to improve decision making, both at a clinical and systems level;
6. Improving access to safe and affordable housing; and,
7. Facilitating access to competitive employment opportunities.

In addition, these seven featured efforts are complemented by additional initiatives that further illustrate OMH's shift toward overall improvement in the quality of the lives of people with mental health conditions.

These efforts are reflective of an inevitable evolution of the mental health system. These changes are inevitable as they represent the "right thing to do" to help people experiencing symptoms of mental illness lead more fulfilling lives. In that regard, these initiatives take on an unprecedented level of importance, as their successful implementation will further that inevitable evolution.

While our system's ability to help people achieve recovery has improved dramatically, there is still much to be done. Collectively, these efforts provide stakeholders an unprecedented opportunity to shape the future of mental health services and supports.

*Change and improvement is not just a top-down proposition. The history of mental health is full of innovations led by individuals, and community and voluntary organizations. Be an agent for change. Get involved with the changes taking place. Decisions about the future delivery of mental health services are being made every day, throughout the year, and can only benefit from every stakeholder's involvement.*

# Chapter 1

## OASAS-OMH Common Chapter

This common chapter, contained within both the Office of Alcoholism and Substance Abuse Services (OASAS) and OMH Statewide Comprehensive Plans for 2012-2016, is just one of many efforts underway to improve coordination and collaboration between OASAS and OMH. This represents an initial step to integrating the OASAS and OMH statewide planning processes and reflects a strategic effort to bring about integration while recognizing that such efforts must be implemented carefully and wisely in order to avoid unintended consequences that could negatively affect access to care for vulnerable people. In bringing these processes together, there are a few themes that embody the commonalities between the OASAS and OMH systems.

The first is integration. Individuals receiving mental health or substance use disorder services should have access to such care regardless of a program's primary focus or license. Much has been done to improve this – through clinic reform, establishment of clinic guidelines for high quality care, and now through efforts to improve the integration of licensure requirements. For those individuals with more well-established mental health and substance use disorder needs, the movement toward Health Homes will help develop community networks that pull together medical, mental health, and substance use disorder services to provide a more person-centered, holistic form of care.

Secondly, the concept of "recovery" has now become common sense – no longer a radical or novel concept. While there are perhaps slightly different meanings of the word in mental health and substance use disorder services, they share the following principles: 1) individuals are the primary agent of their own healing and recovery process; 2) recovery no longer equates exclusively to the receipt of services, but is a process that takes advantage of services and includes family and natural supports in an explicit and meaningful way, wherever possible; 3) improved outcomes are possible for people, regardless of their circumstances; and, 4) peers play an important role in the recovery process. These common visions of recovery also include an understanding that more than health care or specialty health care is necessary – that securing employment or otherwise making a meaningful contribution to the community can dramatically improve one's well-being. Both fields also recognize that safe and affordable housing is a critical component in the recovery journey.

Lastly, OASAS and OMH are both moving toward care management for all individuals they serve. No longer shall services be absent some degree of care management to help people achieve positive outcomes in their life and reduce costs. Care management is not to be confused or mistaken for traditional managed care, which is too linear and too narrow to incorporate the full range of needs that must be addressed in a care management environment for people receiving mental health and substance use disorder services. The efforts of OASAS and OMH to develop a care management approach set us on a path to advance the integration of care, but recognize that care management must be driven by those with specialty behavioral health care expertise. OMH and OASAS will need to work very closely to help direct this new care management approach.

The two state agencies, local governments, and providers are operating in a health care environment where an expansion of benefits is occurring at the same time as initiatives move to control costs. The OASAS-OMH approach to integration is in its early stages. While care management is necessary, the leadership of both state agencies understands that this is a new and unfamiliar territory, necessitating our increased collaboration to move forward together from a position of

strength. All of this is taking place within the framework of recovery, which recognizes that housing, supports, and meaningful community participation are all essential to achieving wellness and improving the quality of life for individuals, families, and communities throughout New York State.

OASAS and OMH are collaborating on a number of initiatives to address the needs of individuals with mental health and substance use disorders – many of whom who have co-occurring disorders. The overarching goal of these initiatives is to provide more integrated patient-centered care that meets the needs of the whole patient, regardless of disability or primary diagnosis. A number of the most prominent initiatives in which OASAS and OMH are collaborating are discussed in this chapter. These initiatives include:

- State and Local Planning Process
- Behavioral Health Organizations (BHOs)
- Health Homes
- Behavioral Health Services Advisory Council (BHSAC)
- Integrated Licensure
- New York State Clinical Records Initiative (NYSCRI)
- Integration of the Federal Block Grant

## State and Local Planning Process

Section 5.07 of Mental Hygiene Law requires OMH, OPWDD, and OASAS to develop Statewide Comprehensive Plans for the provision of services to their respective populations. These plans are to be formulated from local services plans submitted by each local governmental unit (LGU) (57 counties and New York City), with participation from stakeholders.

The local planning process begins in March with the posting of planning guidelines from the Department of Mental Hygiene agencies outlining the agencies' directions for the submission of local services plans. Utilizing the OASAS-operated County Planning System (CPS), LGUs develop their local services plans, taking into consideration input from stakeholders at the local level, submitting their final local services plans by the end of June.

This year's public hearing was the first ever conducted jointly by OASAS and OMH, in which stakeholders from both systems were invited to jointly submit testimony to the two agencies. The hearing was part of a larger integration effort between OASAS and OMH that began with the integration of local planning and continued with the changes in the Mental Hygiene statute affecting statewide comprehensive planning authorized as part of the 2012-13 New York State Budget. The statute change authorized OASAS and OMH to begin working toward the future development of a joint OASAS-OMH Statewide Comprehensive Plan. However, the future development of such a plan is just one factor in the current evolution of the planning process taking place at the state and local levels.

Responding to the intensified pace and quantity of changes in the mental hygiene system, OASAS, OMH, OPWDD, and the Conference of Local Mental Hygiene Directors (CLMHD) have explored and implemented enhancements to planning processes. The goal of these efforts is to increase the ability of the state and LGUs to respond more quickly to emerging issues. As part of the ongoing collaboration between CLMHD and the Department of Mental Hygiene agencies, CLMHD initiated an experimental process to enhance the traditional planning process. This involved the rapid solicitation and collection of information from LGUs on a pertinent topic under consideration at the state level, with rapid analysis and dissemination of the analysis to the relevant state agencies. The subject of the first survey process, conducted over the summer, was Behavioral Health Organizations (BHOs).

Seneca County Director of Community Services and CLMHD Planning Committee Chair Scott LaVigne articulated details about the process particularly well in an email to the CLMHD members in August 2012:

"The Mental Hygiene Committee is seeking to create more opportunities for local input to be gathered and shared with leaders within state agencies at points in time when policy and practice changes are being contemplated. This survey was a pilot designed to be a complement to the annual planning process. … The survey was broken out into three sections and asked for demographic information, perceptions of the BHO experience to date and considerations for the next phase. …(T)he results of this pilot survey were (then) presented to … (an) OMH/OASAS … workgroup … comprised of senior staff from both state agencies that meet … to discuss relevant items that impact the implementation and development of RBHOs. The presentation prompted a good dialogue between LGU representatives and agency staff. Workgroup members were interested in the fact that the survey confirmed many of their conceptions of how BHOs are functioning statewide. Further discussion explored how the BROTs (BHO Regional Oversight Teams) were functioning, how Health Homes are rolling out and implications for non-Medicaid populations. The Mental Hygiene Planning Committee is encouraged by this feedback and will apply the same process to other policy and practice changes over the next several months. We believe that the 'rapid response' data which can be obtained in this process can provide an important perspective on the expertise and systems knowledge that resides at the local level."

An overview of the CLMHD "rapid-cycle" survey results on BHOs is available at http://www.clmhd.org/resources/resources.aspx?category=1384&parent=601&Title=CLMHD-RBHO/LGU-Survey-2012&anchor=true#1384.

Moving forward, OMH, OASAS, and OPWDD will continue to collaborate with CLMHD to refine this "rapid-cycle" response survey process and pursue additional opportunities to increase the usefulness of planning in shaping the future direction of mental hygiene services.

### *OASAS-OMH Public Hearing*

On September 6, 2012, OASAS and OMH held the first-ever joint public hearing on their statewide comprehensive plans. The hearing was conducted by videoconference among seven locations: Albany, Buffalo, Long Island, Manhattan, Staten Island, Syracuse, and Rochester. Commissioners González-Sánchez and Hogan gathered input for consideration in the development of their respective plans, anticipated integration of statewide planning efforts in the future, and ongoing planning initiatives. Recent changes in Mental Hygiene Law give OASAS and OMH the authority to develop a joint Statewide Comprehensive Plan and Interim Report. The joint public hearing was a significant step in moving the addictions and mental health systems toward the delivery of more integrated services and the potential development of a single Statewide Comprehensive Plan for both agencies in the future.

A total of 255 representatives from local governments, advocacy organizations, providers, family members, and recipients of services attended the hearing with 30 individuals presenting testimony. Other stakeholders who were unable to attend the hearing submitted testimony by e-mail. Those presenting testimony came from all parts of New York State and reflected a broad diversity of perspectives.

The importance of integrating services to meet the need of individuals with co-occurring substance use and mental health disorders was a significant theme of the hearing. As one stakeholder put it, "Integrated treatment for co-occurring disorders is a best practice." Another stakeholder praised the steps that OASAS, OMH, and DOH have taken to coordinate services. There was support for integrating licensing and acknowledgement that family support services have increasingly become cross-systems efforts. However, the need for continued improvement in these areas was also discussed in the hearing testimony received. Two parents, each of whom lost a child to suicide after

struggling with addiction issues, spoke movingly about the shortcomings in the continuum of care for adolescents and young adults, and the need for improved integration between OASAS and OMH.

Relatedly, a variety of perspectives were expressed regarding a potential future merger of OASAS and OMH. Most individuals who expressed an opinion supported the concept, as it would assist the efforts to integrate and improve coordination; at least one other individual expressed opposition to the concept. Some participants proposed quickly merging the two agencies into one behavioral health care state agency. Others advocated a more measured approach, recommending that the agencies move slowly toward a potential merger, with incremental steps to eliminate silos, provide more holistic care, and avoid allowing people to fall through the cracks during such a transition.

In addition, a number of other topics were discussed by individuals who testified. These included, but were not limited to the following:

- Behavioral Health Organization (BHO) implementation and the movement toward care management
- Health Home implementation and the conversion of case management services
- Importance of culturally competent evidence-based services for special populations, including veterans, children, adolescents, young adults, seniors, and those involved with the criminal justice system
- Need for safe and affordable supportive housing
- How children fit into the new care management environment
- Importance of peer-based services and family involvement
- Value of family support services
- Importance of Prevention Resource Centers
- Limitations on information access to parents with children in care
- Promoting movement toward electronic health records
- Reinvestment of system savings into community-based services
- Need to streamline funding mechanisms
- Review data collection for appropriateness and usefulness
- Importance of outcome/performances measures, and the use of data to drive performance
- Increasing screening for substance use disorder and mental health concerns
- Challenges related to transportation, particularly in rural areas
- Problem gambling
- Empowering people to move to less intensive services/care
- Research
- Helping primary care physicians address addiction and mental health issues
- Importance of not allowing managed care to dictate the terms of the treatment in the new care management environment

OASAS and OMH will continue to review the comments and testimony received from the September 6, 2012 public hearing. The two agencies will incorporate this input into their ongoing planning and service integration initiatives, and publish a more comprehensive analysis as part of a common chapter in the respective OASAS and OMH 2013 Interim Reports on their Statewide Comprehensive Plans in February 2013.

## Behavioral Health Organizations (BHOs)

In 2011, Governor Cuomo's Medicaid Redesign Team (MRT) was constituted and charged with finding ways to reduce costs, and increase quality and efficiency in New York State' Medicaid program. Among the major elements of the MRT's initial work was a finding that "unmanaged" care was no longer satisfactory for individuals with mental illness and substance use disorders, as illustrated through high Medicaid costs and a lack of coordination of services, which resulted in poor outcomes. Therefore the MRT recommended moving all Medicaid beneficiaries (including people with mental illnesses and substance use disorders, previously exempted from such requirements) into a managed behavioral health model, bringing fee-for-service payment arrangements to an end. Unfortunately, Medicaid managed care organizations have limited experience overseeing services for individuals with serious mental illnesses and substance use disorders. Therefore, the MRT's recommendation for people with serious mental illnesses and substance use disorders was to phase-in their transition over a three-year period. This resulted in the two-phase implementation of Behavioral Health Organizations (BHOs).

***BHO Phase I***

The first phase of the BHO initiative (BHO Phase I) is designed to improve care coordination for individuals with serious mental illness and substance use disorders, and provide OMH and OASAS the opportunity to learn more about what constitutes quality managed care for individuals with serious mental illness and substance use disorders, prior to moving into the managed care environment in the second phase (BHO Phase II). After the recommendations of the Behavioral Health Reform Workgroup of the MRT were submitted in November 2011, OMH and OASAS jointly entered into contractual agreements with specialty managed care entities (known as Behavioral Health Organizations) to assist with preparing the fields of mental health and substance use disorder services to transition from fee-for-service to care management, paying particular attention to helping develop techniques to improve coordination of services and thereby improve health outcomes. This first step resulted in five regional BHOs being selected:

- New York City Region: OptumHealth
- Hudson River Region: Community Care Behavioral Health
- Central Region: Magellan Behavioral Health
- Western Region: New York Care Coordination Program
- Long Island Region: Long Island Behavioral Health Management

These five BHOs are responsible for:

1. Monitoring, reviewing and assessing the use of behavioral health inpatient care. This includes conducting concurrent reviews of inpatient behavioral health services, sharing prior service history from Medicaid claims data to inpatient clinical staff, and monitoring hospital discharge planning.
2. Monitoring and tracking outpatient services for children with serious emotional disorders (SED).
3. Profiling the system of care to identify service gaps, barriers, and high-performing providers. In collaboration with OASAS and OMH, each BHO hosts quarterly stakeholder meetings to share profile data and review systems issues with providers.
4. Facilitating cross-system linkages to improve engagement, re-engagement, continuity of care, accountability and service integration across behavioral and physical health care services.

Contracted BHOs in Phase I are utilizing their tools and expertise, as well as collecting and submitting data, to help OMH and OASAS learn how to improve care in preparation for the transition to a care management environment in Phase II. Phase I also will help identify where improvements can be made in relation to: inpatient discharge planning; ambulatory engagement/continuity of care; and, utilization of Medicaid data to inform treatment and care planning. Lastly, Phase I will provide

the opportunity to test and develop dynamic, useful metrics for monitoring behavioral health system performance.

The Phase I population focus includes the following Medicaid fee-for-service beneficiaries (excluding Medicare dual eligibles):

- Admissions to OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals)
- Children and youth admitted to OMH-licensed psychiatric hospitals (Article 31 hospitals)
- Children and youth direct admissions (i.e., not transfers) to OMH State-operated children's PCs or children's units of PCs
- Children with a SED diagnosis covered by Medicaid and receiving care in and OMH-designated specialty clinic
- Individuals in OASAS-certified hospitals (Article 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services
- Individuals in OASAS-certified Part 816 Inpatient Detoxification Services (Article 28/32)

Data collected by BHOs is intended to help provide a more complete picture of the factors taking place concerning people with mental illness and substance use disorders, focusing primarily on inpatient utilization and connections to care after inpatient care. BHOs are collecting data and sharing all profiles with individual providers. In addition, BHOs are sharing aggregated data with all other providers and interested stakeholders. By August 2012, each of the BHOs had produced both a first and second quarter report, containing such data. Data collected by the BHOs complements the Medicaid claims data available to OMH and OASAS from the Department of Health, much of which will be made available in aggregate via the new BHO portal.

Each BHO is responsible for conducting regular meetings with stakeholders from their respective regions in an effort to establish a level of dialogue that will keep stakeholders informed and help the BHO gather valuable input regarding the experience of

**Principles for Behavioral Health Services in a Managed Care Environment**

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

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

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

recipients, family members, advocates, and providers impacted by the BHOs' efforts and activities. Among these meetings are the BHO Evaluation and System Transformation (BEST) meetings, intended to serve as a forum in which the BHOs can present data they have collected, discuss possible modifications to their operations/functions, and engage stakeholders in discussions about preparedness for Phase II. Among the topics discussed at the BEST meetings are: reasons for inpatient admission and the types of discharge planning activities being utilized; the value of prior service history data and mechanisms for providers to gain access to such information, including through the use of the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) database; and, care coordination strategies to improve engagement in care.

***BHO Phase II***

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

The MRT Behavioral Health Reform Work Group, co-chaired by OMH Commissioner Hogan and NYC Deputy Mayor for Health and Human Services, Linda Gibbs, developed parameters to guide the state agencies through this transition. This work group consisted of representatives of individuals receiving services, advocates, service providers, and health insurers in the mental health and substance use disorder fields. The Behavioral Health Reform Work Group submitted final recommendations to the MRT in November 2011, which were then accepted by the MRT and incorporated into the MRT's final report in 2012. Their recommendations included a set of principles (see insert) that should apply to the delivery of behavioral health services in a managed care environment in Phase II, regardless of the specific delivery design (e.g. full-benefit Special Needs Plans [SNPs], provider-based Integrated Delivery Systems [IDS], or behavioral health benefit carve-out BHOs).

**BHO Outcomes Vignette #1**

**Helping with a complicated linkage to housing services**

A provider from a residential treatment facility (RTF) contacted the BHO care manager for advice regarding a young man with schizophrenia who was aging out of the system. This consumer had no family support, was an immigrant with green card status, and had lived in the RTF for the prior 2 years. The RTF provider submitted a housing application but was told that the consumer was not eligible for services. The RTF provider explained to the BHO care manager that the only alternative was to discharge the consumer to a shelter. *The BHO care manager contacted the local Single Point Of Access (SPOA), reviewed the consumer's situation, and arranged for the SPOA representative to communicate with the RTF.* Within a few days, the consumer's application for housing was processed successfully. The BHO care manager received an email from the provider expressing appreciation for the assistance.

In addition, and perhaps more importantly, the BH Reform Work Group submitted a number of specific recommendations in the areas of finance and contracting with plans; eligibility; performance metrics/evaluation; peer services; Health Homes implementation; as well as some issues that were considered important for the Behavioral Health Reform Work Group to provide recommendations on, but that were outside the scope of the Work Group's mission. A few overarching concepts from the work group's recommendations include:

- Establish risk-bearing managed care approaches/entities – either as SNPs, IDSs or BHOs.
- Invest or reinvest into community-based systems of care in order to create the strong, well-functioning system of care necessary to meet the needs of individuals no longer utilizing in-

patient care. Such investments are needed in care coordination, affordable housing, health information exchanges and other non-clinical services and supports.

- Risk-bearing managed care approaches should bear responsibility to pay for inpatient care at OMH PCs and to coordinate discharge planning from these facilities, and other inpatient settings. As downsizing of these facilities continues, such resources would be reinvested into the community-based services mentioned above.
- Advance the core principle that managed care approaches for people with behavioral health care needs should assist enrollees in recovery and in functioning in meaningful life roles.
- Ensure access to front-line services/benefits to prevent, screen and treat behavioral health disorders by identifying the core elements of the benefit package, including those specific to children.
- Develop outcome measurements and standards to review performance that are meaningful, easy to measure, validated and readily available, and easy to use – for both adult and children's behavioral health services.

Given the unprecedented nature of this transition to managed care for individuals receiving mental health and substance use disorder services that are paid for by Medicaid, New York State is reaching out to other entities with similar experience to help determine the tasks necessary to successfully implement this initiative. These factors/tasks include background research on how BHOs / SNPs have been implemented in other places, State Plan Amendment (SPA) / waiver requirements that must be addressed to achieve program design goals, model payment approaches, and model the financial impact of the redesign initiative.

Moving into Phase II, contracted entities will indeed bear risk, be responsible, and be held accountable for the behavioral health services delivered through their network. OMH and OASAS, in consultation with DOH, will establish the behavioral health service delivery requirements and performance standards under Medicaid care management. These agencies will also jointly oversee and monitor contract performance related to care to people with mental illness and substance use disorders in the Medicaid program.

The BHO initiative is a transformational reform that provides a platform to address other areas where change is needed, including: reinvestment of inpatient savings into much needed targeted community supports and affordable housing; prioritizing recovery through reorientation of support programs; and, enhancing use of information to improve care coordination, performance, and development of an electronic medical record.

**BHO Outcomes Vignette #2**

**Care coordination to break the cycle of multiple detox admissions**

A 38 year-old woman with co-occurring substance dependence and mental illness was admitted to an inpatient detoxification unit. The provider was unaware of the consumer's 3 inpatient detoxification admissions in the prior 3 weeks. *The BHO care manager provided recent service use history and noted that the consumer had a 4-year period of sustained engagement in outpatient services that ended 7 months prior to the current admission. The BHO care manager suggested transfer to an inpatient co-occurring unit for continued treatment.* Following transfer, *the BHO care manager organized a case conference* with the consumer and inpatient staff. Several discharge planning options were formulated and the consumer agreed to a plan including OMH's Assertive Community Treatment program and outpatient substance abuse services. Follow-up indicated the consumer successfully engaged in community-based services.

## Health Homes

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

To improve coordination among the various medical, behavioral and long-term care needs of these populations – and thereby reduce costs – New York State is establishing Health Homes, as is authorized under the federal Patient Protection and Affordable Care Act (ACA), enacted in 2010. "A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner."[1] Health Homes will consist of a network of organizations that provide a variety of services, all working together to meet the needs of the individuals they serve. These services include: "comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and, the use of health information technology to link services, as feasible and appropriate. ...The use of the health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual."[2]

In essence, Health Homes are responsible for coordinating the various aspects of a Medicaid recipient's health care needs, paid through Medicaid managed care or fee-for-service Medicaid (until BHO Phase II is implemented), and promoting communication among caregivers. Health Homes will be responsible for directly providing or contracting for services to identify eligible beneficiaries. These services include comprehensive care management, health promotion, transitional care including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, and use of health information technology to link services. It is expected that Health Homes will develop networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services.

The Health Home will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's care manager will be clearly identified in the clinical record and have overall responsibility and accountability for coordinating all aspects of the individual's care. The Health Home will assure that communication is fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, changes in condition, etc., which may necessitate treatment change (i.e., written orders and/or prescriptions).

Health Homes are being developed, in part, through "conversion" of OMH's current Targeted Case Management (TCM) program and the OASAS Managed Addiction Treatment Services (MATS) pro-

[1] http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
[2] https://www.cms.gov/smdl/downloads/SMD10024.pdf.

gram. This will allow Health Homes to utilize the extensive expertise of former TCM providers in engaging and reaching out to people in the mental health system, but includes responsibility for coordinating all medical, behavioral and long-term care needs. Likewise, MATS case managers will lend their expertise in working with individuals in the treatment system and coordinating all aspects of care. This more comprehensive care coordination approach is anticipated to significantly benefit individuals with mental illnesses and substance use disorders by providing more integrated health and behavioral health service delivery. More information on this conversion is available at http://www.omh.ny.gov/omhweb/adults/health_homes/.

Health Homes will also be required to have policies and procedures in place with local government units, local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to ensure coordinated, and safe transition in care for individuals who require transfer to/from sites of care. They will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge. Also, they will be an active participant in all phases of care transition, including: discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of individuals who have become lost to care.

Peer supports, support groups, and self-care programs will be utilized by Health Homes to increase individuals' and caregivers' knowledge about the individual's medical conditions, promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment.

Health Homes will also need to identify available community-based resources and manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. To accomplish this, they must develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants. The plan of care will include community-based and other social support services, appropriate and ancillary health care services that address and respond to the individual's needs and preferences, and contribute to achieving the recipient's goals.

Health Home providers must meet Health Information Technology (HIT) standards and provide a plan to achieve the final HIT standards within 18 months of program initiation in order to be approved as a health home provider. To the extent possible, Health Homes will be encouraged to utilize regional health information organizations or qualified entities to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e., hospitals, TCMs). Health Homes will also be encouraged to utilize HIT as feasible to create, document, execute and update a plan of care that is accessible to the interdisciplinary team of providers for every patient. Lastly, Health Homes will be encouraged to utilize HIT as feasible to process and follow up on individual testing, treatments, community based services and provider referrals.

It is important to note that Health Home care managers will be required to make sure that individuals (or their guardian) enrolled in their Health Home play a central and active part in the development and execution of their plan of care, and that they are in agreement with the goals, interventions and time frames contained in the plan. Family members and other supports involved in the individual's care should be identified and included in the plan and execution of care as requested by the individual. The care plan must also include outreach and engagement activities, which will support engaging the individual in their own care and promote continuity of care.

After receiving more than 150 applications to become a Health Home from around the state, DOH established a three phase process for the Health Homes roll-out, with an increasing number of counties moving to the Health Home model in each phase. There are 10 counties included in Phase 1 (Bronx, Clinton, Essex, Franklin, Hamilton, Kings, Nassau, Schenectady, Warren, and Washington),

which had an implementation date of January 1, 2012. Phase 2 includes 13 counties (Dutchess, Erie, Monroe, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester) and has an implementation date of April 1; however, the Medicaid State Plan Amendment (SPA) authorizing these counties has not yet been approved by the Centers for Medicare and Medicaid Services (CMS). Over the summer, DOH designated a number of contingent Health Homes for the remaining counties participating in Phase 3 (Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming, and Yates), with additional designations anticipated soon after. However, as with Phase 2, the SPA for these counties has not yet been approved by CMS, despite the planned implementation date of July 1, 2012.

Community-based providers, including mental health organizations, have been strongly encouraged either to take the lead in establishing a Health Home or to partner with an organization taking the lead in establishing a Health Home network in their region. DOH has posted all the designated Health Homes on their website.

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

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

The State has provided each managed care plan with a Health Home eligible list of individuals sorted from highest to lowest predictive risk. The State is working on the development of Patient Rosters that take the factors above into priority consideration for initial health home assignment. The goal is to assign and outreach to the highest risk (based on a predictive model) and highest cost members with the lowest primary and ambulatory care connectivity in each health home area. Once those members have been assigned and enrolled then the State and health plans will move down the list using provider loyalty and geography as markers for initial health home assignment. The details of this algorithm will be approved by all the State partners (DOH, OMH, AIDS Institute and OASAS) and will be recommended to health plans as one means of distributing members through intelligent assignment to each of the State approved health homes."[3] Once individuals have been assigned to a Health Home, they will have the option to choose a different Health Home provider or opt out of Health Home enrollment altogether.

## Behavioral Health Services Advisory Council

As part of the 2012-13 New York State Budget enacted earlier this year[4], the OMH Mental Health Services Council and the OASAS Advisory Council on Alcoholism and Substance Abuse Services will

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

[4] Chapter 56 of the Laws of 2012, Part N

be replaced by a newly created Behavioral Health Services Advisory Council (BHSAC), constituted of individuals nominated by the Governor and confirmed by the New York State Senate. The BHSAC will comprise 28 individuals with varying degrees of experience and expertise, including consumers of behavioral health services, family members, non-providers, providers of mental health and substance use disorder services, individuals with experience serving veterans with mental health and substance use disorders, state/local governmental agency representatives, and members of DOH's Public Health and Health Planning Council.

The BHSAC's responsibilities include advising the Commissioners of OMH and OASAS on matters related to behavioral health service delivery, financing of behavioral health services, integration of behavioral health services with primary health services, services to people with co-occurring disorders, prevention of behavioral health disorders, and improvements in care to people served by the behavioral health system. In addition, the BHSAC will have responsibilities in relation to the annual comprehensive planning process, shall review applications seeking OASAS/OMH certification to provide behavioral health services, and review all proposed OASAS/OMH rules and regulations prior to enactment.

This initiative marks a significant step forward in enhancing the ability of the addictions and mental health systems to deliver more integrated services. This effort will have additional impacts down the road, through the BHSAC's development of statewide goals and objectives that will guide the respective OASAS and OMH planning processes and the potential merger of those separate planning processes into a single Statewide Comprehensive Plan for both agencies.

## Integrated Licensure Project

Physical and behavioral health problems often occur simultaneously. Individuals with behavioral health disorders frequently suffer from chronic illnesses such as hypertension, diabetes, obesity, and cardiovascular disease. These illnesses can be prevented and are treatable. However, barriers to primary care, as well as the difficulty in navigating complex health care systems, present major obstacles.

In addition, individuals with serious mental illness and substance use disorders often receive regular care in specialized behavioral health settings, but many do not routinely access primary care or care for their chronic physical health conditions. When they do receive physical health care, it is often segregated from their behavioral health services. As a result, they experience poorer health status and higher rates of emergency room and inpatient hospitalization. By facilitating the co-location and integration of physical health and behavioral health services, New York State is seeking to reduce preventable hospital utilization among people with mental illness and substance use disorders, and improve their overall health status and quality of life.

OASAS, OMH, and DOH have been working on an Integrated Licensing Project pursuant to authorization contained in the 2012-13 New York State Budget.

*Goals of the project:*

1. To streamline the approval and oversight process for clinics interested in providing services from more than one agency (OMH, DOH, and OASAS) at one location:
    - Providing an efficient approval process to add new services to a site that is not licensed for those services
    - Establishing a single set of administrative standards and survey process under which providers will operate and be monitored
    - Providing single state agency oversight of compliance with administrative standards for providers offering multiple services at a single site

2. To improve the quality and coordination of care provided to people with multiple needs:
    - Ensuring that appropriate compliance with applicable federal and state requirements for confidentiality of records
    - Incorporating the evidence-based treatment approaches to integrated dual disorders treatment outlined in the OMH/OASAS 2008 clinical guidance to the field. This initiative is not meant to replace this guidance, but rather to support providers in their evolution toward service integration.
    - Building on the efforts of OASAS and OMH on the New York State Clinical Records Initiative (NYSCRI).
    - Ensuring that optimal clinical care and not revenue drive the program model

Each agency (OMH, DOH, and OASAS) will work with a subgroup of pilot providers. The pilot will begin during fall 2012, and the interagency group will assess the progress and make a decision expanding the project beyond the initial participants.

## New York State Clinical Records Initiative (NYSCRI)

Initially developed on Long Island in 2009, the New York State Clinical Records Initiative (NYSCRI) offers licensed OMH and OASAS community-based treatment providers an opportunity to standardize and streamline their clinical records. Developed collaboratively among OMH, OASAS, Nassau and Suffolk County Mental Hygiene Departments, the Long Island Coalition of Behavioral Health Providers, recipients and families, NYSCRI offers providers a standardized set of clinical case record forms designed to enhance compliance with state, federal, and accreditation requirements. NYSCRI also offers providers a number of other benefits, including technical assistance in the use of the records, support for documenting medical necessity, and more efficient use of clinician time. Perhaps most beneficial, however, is the compatibility opportunities NYSCRI offers as movement toward the establishment of electronic medical record (EMR) systems continues. This capacity allows EMR system vendors to develop an electronic record certified as compliant with the NYSCRI requirements, thereby allowing providers to use NYSCRI as a means of data entry into an EMR system.

NYSCRI is now available throughout New York State, offering the same opportunity to create efficiency at no-cost to providers and on a voluntary/non-mandatory basis. The NYSCRI project team welcomes feedback, which is reviewed by the implementation team for potential changes to the record set. An advisory group consisting of behavioral health leaders, government representatives, and recipient representatives also provides project feedback related to their particular constituencies. The record set is updated at least annually to assure all promulgated OMH and OASAS regulations and other accrediting bodies' standards are represented accurately. By fall 2012, an updated version is anticipated to be completed, making the NYSCRI records set even more streamlined, compliant, person-centered and user-friendly.

## Integration of the Federal Block Grant Plan

The pending implementation of health care reform and affordable insurance exchanges has led the Substance Abuse and Mental Health Services Administration (SAMHSA) to encourage states to submit integrated mental health and substance use disorder Block Grant plans. In 2011, the OASAS Substance Abuse Prevention and Treatment (SAPT) Block Grant consisted of approximately $115 million coming into New York State and the OMH Mental Health Block Grant consisted of approximately $24 million.

OASAS and OMH have agreed to pursue this opportunity to integrate the respective Block Grant plans and subsequent reporting into one. To accomplish this, OASAS and OMH must have an inte-

grated process for review and approval of the integrated Block Grant. Through the recently created Behavioral Health Services Advisory Council (BHSAC), OASAS and OMH have a mechanism for Block Grant integration. OASAS and OMH have agreed to create a subcommittee/subgroup of the BHSAC to review and approve the integrated Block Grant Plan prior to its submission to SAMHSA, as required.

For OMH, this will constitute a significant change, as the OMH Mental Health Planning Advisory Committee (MHPAC) currently has responsibility for review and approval of OMH's Mental Health Block Grant application to SAMHSA. Once the new BHSAC is constituted and prepared to take on its responsibilities, including review and approval of the integrated Block Grant Application, the MHPAC will be dissolved.

*Changes to Block Grant Requirements*
The new integrated Block Grant Plan must reflect the following SAMHSA priorities:

- Primary health and behavioral health care should work together to support the individual. The use of health information technology and interoperable electronic health records are an indispensable tool to integrated care.
- SAMHSA has continued interest in understanding the evidence that supports the delivery of medical and specialty care (including care for substance use disorders and mental health disorders). OASAS and OMH fully support this direction. To determine which evidence-based practice will be most successful, SAMHSA promotes the use of the Strategic Prevention Framework (SPF), which uses a five-step process to assess the community needs, determine the capacity to meet the identified needs, plan to meet the needs, implement the plan, and evaluate the impact on the identified needs.
- Similar to primary health care, specialty health care for substance use disorders and mental health disorders must emphasize prevention and primary prevention, address health disparities, implement recovery-based approaches, address trauma, and ensure program integrity through quality services.
- SAMHSA encourages a "systems of care" approach to serving unique populations, particularly adolescents, criminal justice, juvenile justice, veterans and their families. This approach uses state and local interagency coordination centered on the unique needs of the individual and family being served.

# CHAPTER 2

## Integrating Care and Improving Accountability

For years, OMH has discussed the fact that while mental health services remain available for those in need, the care that is provided lacks accountability for outcomes and fails to adequately integrate with primary health care. This has been identified by advocates, recipients, and local governmental units as one of the most significant barriers to helping people achieve better outcomes in their lives.

In preparing this chapter, OMH considered input received from several sources, including:

- A participant at OMH's Central New York forum in May articulated that they believe it to be imperative that reinvestment of resources from the downsizing inpatient system resulting from the implementation of managed care be directed to community-based mental health services.
- A participant at OMH's Long Island forum in May recommended hiring peers to work in emergency departments to support people in crisis when they first arrive, continue to be supportive during a hospitalization, and assist with transitioning beyond the hospital setting.
- A participant at OMH's Western New York forum in May articulated that recreational activity and promotion of people having fun is an extremely important value/outcome that should be promoted.
- Monroe County Office of Mental Health's local services plan identified the following priority outcome: "Ensure that managed care development and implementation utilizes care coordination and care management approaches and service delivery models that are driven by person-centered, strengths-based and recovery oriented values to support individuals with mental illness and/or substance use disorders to reach recovery goals and improve outcomes." Furthermore, their implementation strategies included: "Through the New York Care Coordination Program (NYCCP), continue development work for Phase 2 BHO managed care model for behavioral health/physical health care integration based upon the principles of person-centered planning in support of recovery... Continue to work with the NYCCP to implement Health Homes in Monroe County that are structured to effectively provide integrated care management and that incorporate an array of community based recovery supports within the network… Work with OMH targeted case management providers to transition their services to Health Home care management services, ensuring that individuals in need who are not Medicaid eligible continue to have access to care coordination services."

### Behavioral Health Organizations, Health Homes, and Integrated Licensure

These initiatives, which are some of the key efforts underway at OMH to integrate care and improve accountability for care provided, are discussed in detail in Chapter 1.

### Co-Locating Children's Mental Health Clinics in Primary Care Settings

Co-location as a strategy for integrating mental health services within the primary care setting builds and strengthens existing natural networks and fosters collaborative relationships. Co-location can

further facilitate communication, early identification, care coordination and planning. Co-location serves to enhance the health and well-being of children through the promotion of a coordinated care model.

OMH has made funds available to promote the establishment of licensed children's satellite mental health clinics co-located within a pediatric or family practice primary care setting as part of a larger vision to identify children with social and emotional problems earlier, and to increase access to mental health services for those children and their families who are in need. Contracts for this program were recently awarded and twenty-six programs from across the state are beginning the journey to make this vision a reality.

Co-location of children's mental health care within the primary care setting is an approach to advance access to quality care. This partnership will provide a unique opportunity to identify those children and families who might not otherwise seek treatment and strengthens the capacity for earlier recognition and treatment options. Co-location fosters an atmosphere that recognizes the interconnectedness between physical and mental health and paves the way to improved outcomes.

Mental health referrals made directly within the same office can be less stigmatizing. The convenience and immediacy of care provided on-site, coupled with a warm handoff from the primary physician can support improved engagement rates. Co-location allows for the concurrent focus on both physical and mental health needs, giving support to the mitigation and prevention of disease burdens. The potential benefits of a coordinated care model utilizing the proximity that co-location offers are enormous.

In addition to the establishment of a co-located satellite clinic, awardees will work collaboratively with the associated primary care practice to develop a comprehensive approach for integrated care. This will represent a significant movement toward a comprehensive approach to the integration of children's mental health and primary care in New York State.

## Collaborative Care for Behavioral Health Disorders in Primary Care

Individuals with common mental disorders such as depression (which annually affects nearly 20% of the population of U.S. Medicaid recipients) and anxiety disorders typically do not receive treatment in specialty mental health settings licensed or operated by OMH, but in primary care settings. Efforts to foster screening in primary care settings and train primary care providers in the treatment of mild to moderate depression has not been successful; the result is diminished abilities by untreated individuals to care for themselves and adhere to treatment plans, producing significant medical morbidity and mortality, reductions in quality of life and increased health care costs.

To improve outcomes, OMH and DOH are engaged in an initiative to implement the *Collaborative Care* approach to addressing common mental health conditions in primary care settings. This team approach includes: 1) training primary care providers in screening for and treating common mental health conditions; 2) employing in the primary care setting care managers who engage, educate patients and provide basic counseling and medication support for the treatments initiated by a primary care doctor; and, 3) psychiatrists who consult with primary care physicians on those patients who need more intensive, specialty services. The *Collaborative Care* approach incorporates a standardized measurement of depression to detect and track the progress of depressed patients; this monitoring allows primary care doctors to change or intensify treatment if clinical improvements are not achieved as expected. Referrals to specialty mental health care are typically also reduced as effective care is delivered in the primary care setting, thereby sparing specialty mental health resources for those with the most significant mental health conditions.

Not only have the results of *Collaborative Care* approaches demonstrated improved mental health outcomes, there is evidence that the intervention improves other chronic health conditions, such as diabetes, hypertension and high cholesterol. In addition, individuals in the program have reported reductions in physical pain, improved functional capacity both socially and physically, and improved quality of life. This approach is now widely recognized as a best practice, including by SAMHSA.

Over the next two to three years, OMH and DOH will work together to fully implement a *Collaborative Care* approach here in New York State.

## Project TEACH

Pediatricians and family physicians are often the first place where families seek help or information about emotional or behavioral concerns with their children. While these pediatricians and primary care physicians (PCPs) provide mental health support and prescribe medications, they often do not have access to the necessary training or consultation to help them make treatment decisions for children with complex needs. To support the critical role that pediatricians and PCPs play in the early identification and treatment for emotional disturbances in children, OMH, in collaboration with the American Academy of Pediatrics (AAP), the New York State Chapter of the American Academy of Family Physicians (AAFP) and the Conference of Local Mental Hygiene Directors (CLMHD) is funding Project TEACH – Training and Education for the Advancement of Children's Health.

Project TEACH is a collaborative effort of State government and medical providers designed to link pediatricians and PCPs with child mental health experts across New York State. Project TEACH is committed to strengthening and supporting the ability of PCPs to provide mental health services to youth in their practices. Physicians participating in Project TEACH can access rapid consultation from child and adolescent psychiatrists, education and training, and referral and linkage services for their child and adolescent patients. One long-term goal of the project is to have more youth with mental health disorders treated in primary care. Its design also allows and facilitates referral to specialty mental health providers for those children requiring more complex care.

OMH has contracted with two entities, Child and Adolescent Psychiatry for Primary Care (CAP-PC), and the Four Winds Foundation, Child & Adolescent Psychiatry Education and Support (C.A.P.E.S.), to provide these consultation, training, and referral and linkage services. Services became available in June 2010 and the evaluation of the Project TEACH utilization, functioning, and development began in October 2010. Data collection and tracking efforts, reported on a quarterly basis, are focused on outcome measurement and assessment of change.

Since the program inception (data current as of 1st quarter 2012):

- 950 PCPs have registered with the program;
- CAP-PC and C.A.P.E.S., collectively, have received approximately 2,100 calls from primary care practices;
- Resulting in nearly 1,600 phone consultations by child and adolescent psychiatrists to practicing physicians;
- Of these, 359 youths were evaluated directly by a child and adolescent psychiatrist;
- 220 physicians completed a mini-fellowship training through CAP-PC; and,
- Over 150 physicians have attended C.A.P.E.S. training events.

This model of care envisions expanded and collaborative roles for both child and adolescent psychiatrists and PCPs. Project TEACH is in line with current efforts to encourage collaboration and integration efforts between primary care and the community mental health system along with other OMH initiatives that are paving the way toward more collaborative or integrated care, such as Health Homes and co-location of mental health clinics in primary care settings.

## Clinic Technical Assistance Center (C-TAC)

It is a challenging time for clinics, due to recent changes in regulations, financing, and overall healthcare reform. Clinics are required to be more productive, efficient, and business-savvy. To achieve these outcomes, clinics need support and technical assistance to negotiate this rapidly changing environment and to develop strong business and financial models to ensure sustainability. As a result, OMH has funded the Clinic Technical Assistance Center (C-TAC) to serve as a training, consultation, and educational resource for clinic providers throughout New York State.

C-TAC was originally created to assist children's clinic providers in the enhancement of the infrastructure necessary to support their evolution towards the new clinic model. It quickly became evident that adult-serving clinics could also benefit from C-TAC resources. Participation in C-TAC activities takes place on a project-by-project basis and agencies are invited to participate in projects that are relevant to their individual needs. C-TAC brings together finance, practice, and regulation in each project to help clinics adapt to the rapidly changing behavioral health landscape, with the overall objective of improving mental health outcomes.

The original target audience for C-TAC included approximately 350 child-serving clinics, which represent 246 agencies. Since C-TAC began in January 2011, its resources have consistently been utilized by more than half of all children's clinics. Now, with an additional investment, C-TAC will also target those adult-serving clinics that have been identified as a priority because of the population and/or the geographic region they serve, and because they are at risk financially.

**C-TAC Accomplishments to Date**

- 143 agencies have attended at least one C-TAC offering
- 195 clinics have attended at least one C-TAC offering
- 529 individuals have attended at least one CTAC offering

www.ctacny.com

The long-term goal is to provide clinics throughout New York State with an integrated set of resources that include the financial, clinical, and measurement tools necessary to ensure a highly effective, efficient, and sustainable provider organization.

# CHAPTER 3

## Early Identification and Intervention to Promote Mental Well-Being and Prevent Lifetimes of Disability

Increasingly, OMH is looking to help support efforts to identify and provide appropriate treatment for mental health conditions before they become more challenging, more disabling for individuals, and more expensive to treat.

In preparing this chapter, OMH considered input received from several sources, including:

- A participant at OMH's Hudson River region forum in May articulated that while the *First Episode Psychosis* initiative is an excellent step in the right direction, additional efforts are needed to engage individuals before they experience a "first break," including wrapping supports around the individual that they find helpful to allow them to explore their creative capacity and ingenuity without risking the safety of themselves or others.
- A participant at OMH's Long Island forum in May articulated that the concept behind collaborative documentation should be expanded to include ongoing management of the treatment regimen and modifications to the treatment plan.
- Another participant at the OMH Long Island forum in May articulated that trauma-informed approaches to mental health care are needed, as they are extremely effective, but can also promote shifts in perception about mental illness in society.
- A participant at OMH's Western region forum in May articulated that OMH should shift the focus of services and supports away from the prevention of mental illness and toward the promotion of mental wellness.
- Westchester County Department of Community Mental Health's local services plan articulated the following priority outcome: "Provide trauma informed care to improve outcomes." To implement this outcome, they will focus on increasing the number of providers who offer this evidence-based service and coordinate a Trauma Informed Committee, charged with creating a "trauma informed and trauma driven" approach throughout the County.
- Franklin County Community Services' local services plan articulated the following priority outcome: "Develop a county wide cross systems approach to Suicide Prevention." In order to achieve that outcome, the department plans to "establish a Suicide Prevention Coalition… (and) educate the community to reduce stigma associated with mental illness and suicide."

### *First Episode Psychosis* (FEP)

The time of first onset of psychosis generally is a traumatic event that typically visits individuals and families who are unprepared, confused and frightened by what is happening. For people experiencing symptoms of a psychotic disorder, the initial "psychotic break" often leads to hospitalization, which usually is quite successful at stabilizing the individual within one to two weeks, often through medication treatment. Unfortunately, this relief is often only temporary. As discharge from the hospital to community-based services takes place and the individual begins to feel better, without adequate services that acknowledge the trauma of what they have experienced, their struggle to

understand what has happened in their lives, information about the risks and benefits of medication and other recovery and youth-relevant services, individuals will often not receive any follow up treatment or choose to discontinue medication - often because of undesirable side effects (e.g. tardive dyskinesia, weight gain, sexual dysfunction). These circumstances can trigger a second decline of mental well-being, an increase in symptoms of a psychotic disorder, a second "psychotic break," and the need for hospitalization once again. This cycle is often repeated through a series of debilitating psychotic episodes that often involve repeat hospitalizations, the criminal justice system and incarceration, long-term disability, dependence on health care, poverty, homelessness, and too often, suicide.

Traditional approaches to treatment of psychotic disorders essentially fail, as they usually lead to lengthy durations of untreated psychosis and a myriad of negative outcomes, many of which are mentioned above. OMH is seeking to improve early identification and treatment for individuals with psychotic disorders such as schizophrenia through an approach currently referred to as *First Episode Psychosis* (FEP). Recent research, as well as national and international experience in mental health systems, indicates that reducing the duration of untreated psychosis, coupled with the provision of recovery-oriented psychiatric services and community supports, markedly improves short-term outcomes and may likely lead to life-long benefits. The ultimate goal of the FEP initiative is to minimize disability so often associated with schizophrenia and to maximize recovery.

The FEP initiative has two fundamental goals: (1) ensure that individuals experiencing a first episode of psychosis receive treatment as quickly as possible; the goal is to reduce the duration of untreated psychosis to zero months; (2) provide individuals experiencing their first episode of psychotic symptoms with cost-effective, recovery-oriented services, minimizing the disruption of illness and maximizing their capacity to return to meaningful lives. The Revised Network Episode Model[5] will inform OMH's FEP initiative with respect to problem recognition and treatment seeking. This model considers the structure, capabilities, content and functioning of the family, school and community, and treatment system. For example, consideration of family beliefs, knowledge, capabilities and experience with the medical system will be taken into consideration. Also, family size, configuration and functioning (e.g., "Is advice giving more prevalent than coercion?") will also be taken into consideration. The model forces consideration of each of these dimensions of the lives of individuals and their questions about seeking services.

The FEP initiative has three related components:

- Development of efficient and effective pathways to care far beyond the conventional acute care mental health service system to the community as a whole, who can then help identify the need for care and facilitate prompt access to services that are accessible and acceptable to individuals and their families.
- Delivery of affordable mental health and other community-based services that offer the best available treatment strategies. These include psychosocial approaches – especially

[5] Boydell KM, Volpe T, Gladstone BM, Stasiulis E, Addington J. Youth at ultra high risk for psychosis: using the Revised Network Episode Model to examine pathways to mental health care. Early Interv Psychiatry. 2012 Mar 5. doi: 10.1111/j.1751-7893.2012.00350.x. [Epub ahead of print]

those that enable an individual to remain in school or work – that are grounded in a philosophy of recovery, as opposed to disability, and can often include medication.
- Community education to enable individuals experiencing psychosis, their family members, supporters, teachers, friends, religious leaders, and neighbors to recognize symptoms of psychosis, the need for prompt psychiatric help, and to know where and how to turn for help. Knowledge and empowerment must replace the destructive impact of stigma and fear.

These components will require financing strategies and close collaboration with the evolving managed care initiatives, including Health Homes, Behavioral Health Organizations, etc., so that individuals experiencing a first episode of psychosis identified via these pathways have accessible and recovery-oriented services organized and financed so as to be viable fiscally for service providers.

OMH believes that through successful implementation of this initiative, individuals experiencing psychotic symptoms can avoid decades of cycling that have left many completely disenchanted with the mental health system. Enough has been learned about the disaster of "usual care" that we need not wait longer to try to improve treatment and support for people with early onset of psychosis and their families. Thereby, their expected trajectory can change from a lifetime of cycling in and out of hospitals and incarceration to an expectation that recovery will be achieved to allow individuals to become educated and become/remain employed. As more experience is gained, OMH intends to establish this new initiative on a statewide basis, making New York State the first state in the nation with a reliable network of *First Episode Psychosis* services.

## Suicide Prevention

In 2011, 1,492 New Yorkers are known to have died by suicide.

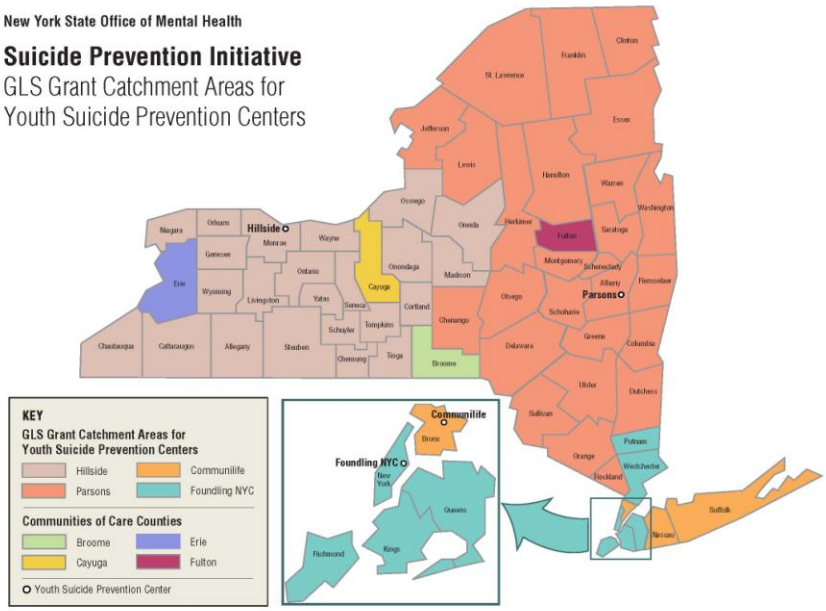
While this number is actually lower than in 2010 and lower than the national average, every single death from suicide is simply one too many. Suicide death rates vary significantly from community to community across New York State; regardless, major efforts are needed in every community to build a better suicide prevention safety net. Our efforts are timely. On September 10, 2012, U.S. Surgeon General Regina Benjamin released an updated National Strategy for Suicide Prevention that summarizes new knowledge and proposes new approaches to save lives.

Because of improvements in assessing the risk of suicide, better treatments and new knowledge about how to intervene, suicide deaths of individuals who are in our in care must be seen as system failure – analogous to people in hospitals that experience "wrong site surgery." Therefore, as part of its larger Suicide Prevention Initiative, which focuses on preventing suicide across the life span and across all communities, New York State – led by OMH – has developed and is implementing a plan to effectively manage suicide risk, eliminate suicide deaths and reduce suicide attempts by people receiving behavioral health care.

Some may ask why this special focus on people who are receiving behavioral health care. First, we know that serious mental illness and addiction elevates suicide risk by 6 – 12 times the rate of suicide amongst the general population. Second, we must elevate safety as the first responsibility of behavioral health settings.

OMH's plan is informed by the work of the National Action Alliance for Suicide Prevention. Its September 2011 Clinical Care Task Force report, *Suicide Care in Systems Framework*, makes the new point that a systemic approach can comprehensively address suicide risk. The report cites several examples demonstrating success in the use of a comprehensive suicide care systems framework –

the U.S. Air Force, Henry Ford Health Service (Michigan) and Magellan Health Services (Arizona) have all experienced remarkable successes in reducing the number of suicide deaths, suicide attempts, and hospital visits by utilizing this approach. Perhaps most poignant is the experience of the "Henry Ford Health System('s) (HFHS) *Perfect Depression Care* initiative…, (which) achieved steep declines in the suicide rate during the first four years and focused on a broader group than those diagnosed with depression, including persons at risk of suicide. More recently, HFHS has reported ten straight quarters without a suicide death for those enrolled in its Health Maintenance Organization. …the HFHS lesson is that culture change focused on a goal of zero errors (deaths) was the essential foundation for improving interventions. HFHS adopted these core values, which, in turn, catalyzed practices that have achieved unprecedented results."[6] The National Action Alliance for Suicide Prevention report points to the need for organizations to articulate and adopt a vision for suicide care, plan and to plement services that support that goal, build staff suicide care competencies, and to create and maintain quality improvement systems.




The OMH comprehensive systems framework includes three critical elements. First, leadership must assert core organizational values of safety and quality improvement. We hope that this leads to commitments to eliminate suicide deaths for people in care. The second element involves the development of a clinical system that structures risk assessment and service protocols to achieve the goal of eliminating suicides. Lastly, staff with the knowledge, skills, support and confidence to deliver excellent care for patients with suicide risk must be empowered to do so. Based on this framework of care, New York State has begun employing comprehensive strategies to implement a systems approach in selected communities and systems. Initially, these are focused on four areas:

1. Taking all needed steps to reduce and eventually eliminate suicide deaths in four state-operated psychiatric service systems, including both inpatient and outpatient care.
2. Piloting the suicide care model in two county systems: Broome and St. Lawrence counties. These pilots will involve the establishment of networks consisting of county leadership, inpatient hospitals, residential providers, and outpatient providers of mental health and sub-

[6] http://www.actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf

stance use disorder services – all focused on reducing suicide attempts, deaths, and repeated hospitalizations and emergency department visits. Implemented as part of the BHO initiative, this will bring a focus to the importance of transitions (e.g. inpatient and crisis to outpatient and aftercare), measuring success by reductions in suicide attempts and deaths, and recognizing efforts made and outcomes achieved.

3. Implementing a comprehensive approach to suicide care with FEGS, one of the largest nonprofit behavioral health care providers in the U.S., which serves New York City and Long Island.

4. Embedding suicide care in four major youth serving organizations across New York State - Hillside Family Centers; Parsons Child and Family Center; NY Foundling; Comunilife Latina/Latino Adolescent Youth Services Program. Using federal Garrett Lee Smith Memorial Act resources, OMH has funded each organization to become youth suicide prevention training centers, beginning with their own operational environments and expanding to sister providers within each catchment area. This effort adds to the progress previously made through the *Caring and Competent Counties and Communities* initiative, which helps develop local capacities for suicide prevention (create community buy-in, develop connections between schools and services), which will be expanded from the original four counties (Broome, Cayuga, Erie and Fulton) to an additional seven counties (Jefferson, Lewis, St. Lawrence, Tioga, Cattaraugus and Chautauqua).

While OMH has made suicide prevention a priority for over a decade, bringing a systems approach to suicide care reflects an evolution in policy and practice. The OMH plan comprises a six-point strategy, collectively designed to comprehensively improve suicide care and eliminate suicide deaths in the four aforementioned sites.

1. OMH will work with each organization to assist them with setting an organizational vision of reducing or even eliminating suicides for people under care. This will involve assistance raising the level of staff support and – with the assistance of Magellan Health Services – surveying staff on their knowledge and readiness for providing effective suicide care. Program performance in suicide care will be measured continuously and transparently in a quality improvement environment.

2. Each organization will receive assistance in developing improved clinical practices, including efforts to: create an expectation that suicide care is a shared responsibility delivered through team-based care; empower clinicians to work with patients productively and as a team; treat suicide directly - not as a symptom of underlying mental health and/or substance use disorder; and, incorporate suicide care protocols into policies and procedures.

3. All individuals receiving services will be screened for suicide risk. Screens indicating potential elevated risk will lead to specific suicide risk assessments that will trigger appropriate service responses in treatment plans. Staff will be trained in the Columbia - Suicide Severity Rating Scale (C-SSRS), an evidence-based screening tool with robust predictive validity for future suicide attempts. Available in 103 languages, C-SSRS can be administered to individuals in practically all settings and systems (i.e. military, criminal justice, emergency room, inpatient psychiatric, colleges, etc.), making it a versatile tool. Training on the use of C-SSRS will be provided to each organization by one of the instrument's developers from Columbia University.

4. For each individual with an identified suicide risk, a safety plan will be developed at intake to services and reviewed regularly. Using the model developed by Drs. Barbara Stanley (Columbia University) and Greg Brown (University of Pennsylvania), staff will receive training on how to develop and effectively use the safety plan. At the same time, OMH is working with Rensselaer Polytechnic Institute to develop a telephone application safety plan that will al-

low patients with certain cellular phone capacity to have their safety plan loaded on their phones – making it readily accessible.

5. Clinical staff with each organization will be offered the opportunity to upgrade clinical skills, specifically in Cognitive Behavioral Therapy, an evidence-based treatment modality that emphasizes the important role of thinking in how individuals feel and how they behave, which is effective for managing and treating suicide risk.
6. Staff will also be trained on appropriate follow-up protocols, including the critical importance of "warm handoffs" for patients with suicide risk (especially from inpatient to outpatient care). Staff will be educated about the community and other resources available for individuals with suicide risk, including the National Suicide Prevention Lifeline (1-800-273-TALK) and crisis centers.

In addition to the targeted training activities described above, OMH will institutionalize educational opportunities through the development of online learning modules, via the Center for Practice Innovations. The first two training modules, scheduled to be completed by January 2013, will address C-SSRS and safety planning. Afterward, a third module will focus on follow-up after acute/emergency department care and "warm handoffs." New York State will make these modules available nationally through the Suicide Prevention Resource Center.

OMH recognizes that many of the individuals who die by suicide each year in New York State are not engaged in behavioral health care. Based on dialogue with experts in suicide prevention and health care, we are agreed that a first crucial priority is that additional efforts are needed to improve basic behavioral health care in primary care settings. OMH is working with DOH to implement Collaborative Care in dozens of primary care settings and through efforts to improve integration of care via the implementation of Health Homes. To reach additional individuals at risk, expansion of specific suicide prevention competencies into primary care and emergency departments will be required. Implementing the comprehensive suicide care framework described above via BHOs will lead to safer and more effective care. Together, it is expected that fewer lives will be lost to suicide.

## Department of Health Prevention Agenda

OMH is very pleased to be working in collaboration with DOH on the development of the *New York State Health Improvement Plan 2013-2017*, otherwise known as the *Prevention Agenda*. This effort stems from the work of the DOH Public Health and Health Planning Council's Ad Hoc Committee to Lead New York Prevention Agenda 2013, which is charged with developing the next iteration of the *Prevention Agenda*. When complete, this plan will assess progress since the publication of the 2008-2012 Prevention Agenda toward the Healthiest State, identify new priorities and outline a plan for action to achieve those priorities.

The Ad Hoc Committee established five priorities for the 2013-2017 Prevention Agenda:

- Prevent Chronic Diseases: Focus on heart disease, cancer, respiratory disease, and diabetes and the shared risk factors of diet, exercise, tobacco, alcohol and associated obesity.
- Promote a Healthy and Safe Environment: Focus on environmental quality (air, water, etc.) and the physical environment where people live, work, play and learn.
- Promote Healthy Women, Infants and Children: Focus on improving the health of women and mothers, birth outcomes and child health, including oral health.
- Promote Mental Health and Prevent Substance Abuse: Focus on primary and secondary prevention and strategies for increasing screening to diagnose and connect people to needed services.
- Prevent HIV, STIs and Vaccine Preventable Diseases: Focus on preventing HIV, sexually transmitted infections and vaccine preventable diseases via immunization.

While advising on all five priority areas, OMH is taking a leadership role in the Promote Mental Health and Prevent Substance Abuse Workgroup. The workgroup is meeting several times throughout the summer/early fall of 2012 to identify the priority details, identify the appropriate metrics/indicators that will be monitored, and identify key stakeholders to provide the ongoing leadership and accountability for advancing each component of the prevention agenda.

While the workgroup's process remains underway, OMH has several items it is promoting for adoption in the final recommendations for this workgroup, including:

- Increase the identification and treatment of mothers with depression, as depressive symptoms in a child's primary caregiver are associated with increased risks of problems in development and learning
- Disseminate resources for families for guidance/education in raising healthy children and strategies to promote their child's social-emotional development
- Promote awareness of the impact of trauma and identify screening initiatives for exposure to trauma, as well as the use of trauma-informed approaches to care
- Continue statewide coordination efforts to further reduce and eliminate suicide and suicide attempts
- Reduce the prevalence of tobacco use among people with mental illness and substance use disorders, estimated to be 50%

## Early Childhood Initiatives

Until several years ago, the children's mental health system typically provided services to children starting at the age of five, leaving early childhood intervention efforts to the state health and education departments. However, research clearly now shows a critical link between young children's social-emotional development and later social adjustment, success in school and life, generally. With the development of The Children's Plan in 2008, OMH – along with eight other child-serving systems – acknowledged the need for universal awareness and involvement in the promotion and support for children's social-emotional development and wellbeing. Thereby, OMH began its foray into early childhood and early intervention efforts, helping to establish supports for young children's social-emotional development across a wide range of settings, including pediatric offices, community clinics, early childhood and home visiting programs, child welfare agencies and early care and learning centers. Since that time, early identification and intervention have framed OMH's efforts in this area, focusing on the promotion of positive social-emotional development, the provision of emotional wellbeing screenings and linkages to services and supports, and prevention efforts that provide evidence-based parent training.

Through acknowledgement of the importance of intervening at an early age to promote social-emotional development, OMH became a member of the ***Early Childhood Advisory Council (ECAC)***, which provides strategic direction and advice on early childhood issues. The ECAC supports the development of a comprehensive and sustainable early childhood system, defined as a unified network of public and private supports and services that, together, prepare young children for success in school and life. Essential components of New York State's system include early care and education, physical health, social-emotional development, and family support and education. OMH also became an active member of the ***Promoting Healthy Development (PHD) Work Group***, which is charged with the development and promotion of new training strategies for a wide range of professionals that work with young children and their families to promote health and social-emotional development.

OMH has also become involved in efforts to support parents in building their own children's social-emotional development, partnering with the New York State Council on Children and Families (CCF), New York State Office of Children and Family Services (OCFS), and Prevent Child Abuse New York (PCA-NY) to lead the ***New York State Parenting Education Partnership (NYSPEP)***. NYSPEP is a net-

work of parenting educators and colleagues from across the state committed to enhancing parenting skills, knowledge and behavior by developing a strong, statewide network that promotes, provides and improves parenting education.

An opportunity to provide direct services and supports to young children and their families in support for early mental wellbeing also came about through a federal SAMHSA grant initiative, ***Project LAUNCH ("Linking Actions to Unmet Needs in Children's Health")***. New York State was awarded two federally funded projects in neighborhoods in both Westchester County and New York City to expand and enhance the system of care for children, from birth to age eight. Using key strategies to promote young children's mental health (mental health consultation, home visiting, developmental screening, family strengthening, behavioral health into primary care and substance abuse prevention), this effort will help provide guidance to the field on what it takes to adopt a public health approach to young children's mental health.

A new initiative is underway to expand New York State's capacity to assist parents and teachers in supporting the development of children's social-emotional competencies and academic achievement. Through ***ParentCorps***, a culturally-informed, family-centered, evidence-based preventive intervention, parents can become better equipped to successfully implement positive practices at home and communicate with teachers so that they can be effective partners in their children's learning. This family intervention is designed specifically to be engaging and relevant for ethnically diverse families of preschoolers living in disadvantaged communities.

*ParentCorps* will target under-served communities through two other existing initiatives: ***QUALITYstars NY*** (QSNY), a quality rating system and comprehensive initiative to ensure that young children under age six have the opportunity for high quality early learning experiences; and, ***Promise Zones***, a cross-systems strategy to achieve New York State's goals of student engagement, academic achievement, dropout prevention, social and emotional competence, establishing positive school culture and school safety in three urban high needs communities. In an effort to better understand the impact of prevention on long-term health outcomes and the resulting cost analysis, *ParentCorps* will evaluate the long-term health and economic effects of this demonstration project. The findings will guide strategic planning and investment in population health efforts with other child serving agencies, including DOH, State Education Department (SED), OCFS, and CCF, as well as with the Early Childhood Advisory Council and other key stakeholders.

## Disaster Mental Health Collaborative Planning with Public Health

Mental health disaster response addresses psychological, emotional, behavioral and social issues which may arise from a disaster event. These services can help mitigate the severity of adverse psychological effects of a disaster and help restore social functioning for individuals, families, and communities. OMH is responsible for coordinating New York State's emergency mental health response and ensuring that mental health services are available for those in need. OMH continues the emphasis on disaster preparedness and response, which includes reviewing emergency mental health response systems through a comprehensive disaster preparedness planning process conducted in collaboration with other State and local agencies. OMH also coordinates with other State and Federal agencies, local governmental units, and the American Red Cross in New York State to plan for disaster mental health response capacity. Through these processes, OMH recognizes the complementary roles, shared commitment, and the mutual advantage of an integrated approach to improving emergency mental health services.

Toward this end, OMH has been engaged in building capacity to provide such services through the creation of a cadre of Disaster Mental Health responders to provide immediate response to survivors follow a manmade or natural disaster. To date, more than 800 mental health professionals

have participated in either the 2-day or 3-day versions of the *Disaster Mental Health: A Critical Response* training. The members of this network of responders are primarily OMH clinical staff working in PCs and OMH Field Offices. They provide assistance soon after the impact of a disaster to ensure a positive recovery environment, providing support to the survivors and limiting exposure to negative, blaming reactions from others. Therefore, survivors tend to need less long-term traditional therapy. The basis of these interventions is Psychological First Aid (PFA), an evidence-informed and pragmatically-oriented early intervention that addresses acute stress reactions and immediate needs for survivors and emergency responders in the period immediately following a disaster. The goals of this approach are to establish a sense of safety (objective and subjective), reduce stress-related symptoms, restore the ability to rest and sleep, create linkages to critical resources, and connect to social supports (NIMH, 2002).

OMH has been successful in the development of training material to educate and prepare competent mental health disaster responders. However, only modest accomplishments have been made toward the development of an operational plan to ensure that the necessary mental health support is available in a comprehensive manner across the state. To improve this situation, OMH has initiated a series of conversations with DOH and the New York City Department of Health and Mental Hygiene (DOHMH) in an effort to better integrate disaster mental health into existing planning mechanisms in the public health system. These discussions have led to several concrete outcomes, including: identification of disaster mental health contacts to participate in the DOH and DOHMH emergency planning and preparedness entities; collaboration toward the development of an integration of disaster mental health trained responders into the existing ServNY volunteer management system for disasters and emergencies; and, efforts to establish agreement on the definitions and competencies related to disaster mental health and such responders.

# CHAPTER 4

## Transforming Services and Supports to Promote Recovery

As discussed earlier, changes are constantly necessary to make continual improvements in the services and supports available to people with mental illness, including those provided directly by OMH or funded through OMH.

In preparing this chapter, OMH considered input received from several sources, including:

- A participant at OMH's Hudson River region forum in May articulated that OMH should do more to change the institutional environment of the PCs it operates in order to assist people to prepare for life in the community.
- Another participant at the Hudson River region forum articulated that OMH should do more to promote financial literacy amongst individuals, including those living in congregate settings, as it would assist them to realize that there are opportunities to become more self-sufficient.
- Yet another participant at the Hudson River region forum articulated that OMH should do more to focus on helping people develop an exit strategy from hospitalization as soon as they arrive in the hospital, rather than waiting until days or weeks have passed by first.
- Columbia County Department of Human Services' local services plan outlines a strategy to "Provide in-services to non-traditional professional staff who may interact with our disability populations while fulfilling their job responsibilities (i.e. law enforcement…)."
- New York City DOHMH's local services plan articulates the following priority outcomes: "Enhance access to timely and appropriate mental health treatment and support for children and youth" and "Improve the quality of care coordination for children and youth."
- Cattaraugus County Community Services Department's local services plan articulates the following priority outcome: "To link at risk and/or dually diagnosed individuals facing serious emotional disturbance (SED) and out-of-home placement with appropriate wrap around services."

### Outpatient Transformation

As discussed in the earlier sections on BHOs and Health Homes, the landscape of New York State's mental health service delivery system is undergoing seismic changes through the move to a care management environment. While there is no doubt these changes are challenging, these changes are also healthy, as they present a vital opportunity to examine the value of OMH-operated outpatient supports and ensure that these services provide individuals the necessary assistance to achieve recovery. As we move into this new managed care structure of mental health care delivery, it is clear that to be a responsive and responsible provider, OMH must realign its outpatient services and supports to better meet the needs and expectations of those we serve. Otherwise, despite all the best intentions, if these supports are of little value and benefit to individuals seeking recovery from mental illness and cannot be provided in a cost efficient manner, these service systems will be unable to compete and survive in the new marketplace being developed.

In order to address these issues, OMH convened a group of stakeholders from across the state to review literature and find out first-hand what individuals want and what service providers feel would assist individuals to move forward in recovery. While many needs surfaced, the most prevalent concepts were easily grouped in four key areas: housing, work, social relationships, and individualized support. A review of the "balance of services" suggests that as a system, OMH outpatient services tend to focus on treatment services in the clinic setting, but when rehabilitation staff is included, the focus shifts to rehabilitation/recovery services. This is instructive, as it points to the fact that OMH outpatient services must improve their ability to balance what is *important to* a person with what is *important for* a person if they are going to be successful in helping people achieve recovery in a care management environment.

This group also examined the different roles that are needed as services shift to meet the needs identified by recipients of services. The roles identified as most important were not those that have come to be accepted as non-negotiable in the traditional delivery of services, but those that are effective in helping people achieve recovery, such as 'engager,' 'coach,' 'skills trainer,' 'therapist,' 'community-connector,' and 'health/wellness-connector.'

The ultimate goal of launching the OMH Outpatient Transformation initiative is to move the state mental health system to the leading edge of the field of recovery. This means provoking a paradigm shift away from an acceptance of the current primary focus on treatment to a partnership between rehabilitation and treatment services and the individual receiving these services. This type of shift will require OMH-operated outpatient services to: 1) become more rehabilitation- and recovery-oriented; 2) become sought-after as a resource to achieve one's self-defined recovery goals; 3) utilize the most effective approaches to achieving recovery; and, 4) demonstrate outcomes measurable in the quality of life for those being served.

While some regional variations among the various OMH outpatient programs will continue to exist, all programs will be expected to:

- Identify staff to ensure that needed roles to promote recovery are fulfilled, recipients and families are involved, and staffing supports the services to be offered.
- Services to be offered will be balanced – treatment, recovery/rehabilitation, self help/empowerment, crisis, and support must all be offered consistent with the individual needs of those receiving services.
- Hours of operation will reflect the ability of individuals and families to obtain services outside of regular business hours.
- "Warm" services will be available to individuals who require assistance.
- Co-occurring treatment services will be provided in all OMH clinic sites.
- Environments will reflect recovery principles, be warm and welcoming.
- Documentation strategies will support recovery and collaborative documentation (clinician and client involvement) will be encouraged whenever possible.
- Assistance securing employment will be provided and employment goals will be a part of all interactions with those who desire these services.
- Knowledge of and connection to residential opportunities will be incorporated into the fabric of outpatient services.
- Services should be documented appropriately to assist with the measurement of productivity, the true costs of service, and to identify clinical progress.
- Individuals receiving services will be assigned to a team that will ensure all needed roles are available to assist in the recovery process.

In order to achieve these expectations, OMH outpatient services will need to undertake a number of steps. First, they will need to evaluate their current delivery system to determine what areas need to be changed to become more consistent with a recovery orientation. Program management will need to involve all program staff in reviewing programmatic issues that support or detract from achieving recovery goals. Realistic plans to develop the roles and services identified by recipients

and stakeholders will be created. Lastly, a written plan for each outpatient service location will be developed and submitted for approval by OMH's Central Office.

In order to help facilitate this Outpatient Transformation initiative, OMH's Central Office has engaged in a multi-step process that will provide the various OMH-operated outpatient programs with a number of resources and technical assistance to successfully make this transition. Teams from each of the adult facilities were developed to participate in the development of their specific Transformation Plans.

The first phase involved the development of a series of events aimed at increasing staff acceptance and knowledge related to developing a recovery-oriented system of care. An Executive Overview led this series, followed by a call to change led by Denise Bissonette and Connie Farrel, consultants on motivation and transformation. Carol Blessing of Cornell University led an introduction to Appreciative Inquiry – a leading best practice in organizational transformation with principles and methods parallel to the values of recovery, self-determination and community inclusion – to assist facility staff to look inward to the potential creative solutions necessary to create change. A recovery-oriented leadership workshop lead by Mark Ragins, M.D., the medical director of The Village Integrated Service Agency in Long Beach, California – a program built on a recovery model that Dr. Ragins developed and which serves as a national model – culminated the series.

The second phase involved the development of facility Transformation Plans. Supports were offered to the facilities as they developed their plans in collaboration with their staff. Regular conference calls with the facilities were held to offer clarification and share ideas and town hall-style meetings were held in several facilities to engage staff at all levels in the process.

By July 2012, all OMH-operated outpatient programs had submitted their Outpatient Transformation plans to OMH's Central Office and were beginning to work toward implementation. In the fall, facilities will once again come together to share the best of their plans. Learning communities will be established to promote collaboration between facilities and to identify and teach "best practices" to one another. These learning communities will provide a format to share successes, present effective recovery-based tools to staff, and to model recovery-based leadership.

Going forward, as the Outpatient Transformation plans become fully actualized, individuals receiving services in these settings will have a wider range of services available to them to assist in their recovery. Moreover, it is expected that these changes will secure OMH-operated outpatient services a role as a valued support that individuals with mental illness continue to desire as mental health services move into a care management environment.

## New York City Children's Center

Building on efforts such as *Achieving the Promise* and *The Children's Plan* beginning in 2006, OMH has shifted from a focus on high-end services for children with clinically complex disorders to early-recognition and evidence-based treatment approaches that respond to community needs. Local access to community-based services through programs such as Clinic-Plus and Single Points of Accountability (SPOA) have shown dramatic improvements in the ability to intervene earlier in a child's social and emotional development. This has been demonstrated through the creation of partnerships and service agreements between education, preventative service agencies, early childhood programs and primary care practices serving children and adolescents throughout New York State.

As such, in 2009 an initiative was launched to evaluate the role of state-operated services in the local system of care in New York City to determine how best to meet the ever-changing needs of children and families. In addition to an extensive review of data and analysis of client characteristics and service utilization, a variety of focus groups engaged local stakeholders – including acute child

and adolescent inpatient hospitals, youth, family members and other multi-system providers – to consider their recommendations for improvements to the local system of care.

Through this process, it was realized that there has been a decrease in referrals to state inpatient services by nearly 30%, the result of which stakeholders believe to be the success of new programs focused on early identification and intervention, such as Clinic-Plus and Home and Community-Based Waiver Services. These findings led to a comprehensive plan to reconfigure the state-operated services in New York City. This plan provided an opportunity to further reduce underutilized inpatient capacity and redirect funding to expand community-based mental health resources to provide more efficient, responsive supports that better serve the children and families in the New York City area.

The initial reconfiguration transformed the Brooklyn Children's Psychiatric Center (CPC) into the Brooklyn Children's Center, a unique state-operated comprehensive mental health center for children and families in Kings County. This comprehensive outpatient campus provides the capacity to serve more than 600 children annually, through proven evidenced-based state-of-the-art community mental health services. The closure of the Brooklyn inpatient units provided an opportunity to partner with the Office of Children and Family Services (OCFS) to address mental health needs of underserved population in their custody. This collaboration resulted in development of the first OMH-licensed Residential Treatment Facility (RTF-JJ) in New York State dedicated to serving youth with serious social and emotional mental health needs in the juvenile justice system. The new RTF-JJ is located on the Brooklyn Children's Center campus, however is operated and managed separately from state-operated programs. To ensure a full, comprehensive system of care throughout the metropolitan New York City region and address potential inpatient capacity concerns, some inpatient capacity from Brooklyn CPC was moved to Queens and Bronx CPCs and South Beach PC's Children's Unit. Additionally, outpatient programs were expanded and enhanced at Queens and Bronx CPCs. These changes then led to an opportunity to improve the coordination and operation of children's mental health services in the region. As of September 2012, the Brooklyn Children's Center, Queens CPC and Bronx CPC are known as the New York City Children's Center (NYCCC), which will provide one, unified operational structure that provides inpatient and outpatient services on all three campuses, and in Manhattan as well.

In preparation for the creation of the NYCCC, OMH embarked on an effort to reduce the wait time for admission and ensure timely access into Queens and Bronx inpatient children's mental health programs. Using the Six Sigma quality improvement process, OMH successfully reduced an extensive wait time averaging five weeks in length to an average wait of seven days. This improves the continuity of treatment for youth and minimizes disruption to families while significantly increasing the state's ability to serve more children and youth in this inpatient program.

The NYCCC now consists of a 172 bed inpatient program with capacity on two campuses (Bronx and Queens) and an outpatient program with capacity to serve 1,360 children operated on three campuses (Brooklyn, Bronx and Queens), as well as in Manhattan. These outpatient services include expanded Family Support Services, a youth drop-in center, a 21-day respite residential program, a vocational and educational tutorial service, a 400-slot children's clinic, expanded Intensive Case Management capacity, Day Treatment, a new short-term Intensive Day Treatment program, and additional clinic supports in two schools in Manhattan. These changes seek to streamline operations, improve patient care and expand program opportunities that deliver the appropriate level of mental health services and supports to children, youth and families in the New York City area.

## Changes to OMH-Operated Inpatient Care

As was discussed in the introduction to this Plan, the OMH-operated PC system is a hold-over from a previous era when institutions and asylums comprised the only formal provision of mental health care. New York State has twice as many of these institutions as the next closest state, with a census

that has dropped below 3,000 adult, non-forensic patients. This number lies in sharp contrast to the approximately 712,000 New Yorkers who receive outpatient, community-based supports through the OMH system. With improved treatment for mental illness and the momentum of health care reform, OMH will continue to pursue a rightsizing of its PC hospital system. The goal is to develop well-coordinated community care systems that will allow a smaller network of state-operated inpatient services – that are effective, efficient and high quality – to serve as a back-up. This transformation of the OMH-operated "safety net" from a predominance on inpatient care to a focus on community-based supports will allow current and future generations of individuals with mental illness to remain in their community, receive supports necessary to remain healthy and stable, and contribute to our society.

***Kingsboro Psychiatric Center (PC) Transformation***

In 2011, the Medicaid Redesign Team's Brooklyn Health Systems Redesign Work Group issued a report finding significant over-reliance on hospital care in Kings County, with significant gaps in community-based care. In its report, this Work Group recommended a number of wide-sweeping changes to the acute care hospital system in Brooklyn, including the closure of Kingsboro PC, with maintenance of its community-based service network. OMH originally embraced this recommendation, based in large part on a history of quality challenges at Kingsboro PC and lengths of stay which exceeded other OMH hospitals, thereby acting as a barrier to admission for people needing intensive psychiatric care. After extensive discussions with the Brooklyn community and a review of the recommendation as part of the 2012-13 budget process, the plan to close Kingsboro PC was modified into a plan to transform the facility into a smaller, shorter stay hospital with expanded community care service.

The transformation plan, initiated in April 2012, involves the appointment of a new interim-Executive Director experienced in hospital leadership, recruitment of new leadership talent for the facility and improving the quality of services. Improvements in quality at the facility are anticipated through a number of clinical initiatives while census management will be enhanced by strengthening linkages with housing and service providers in the community and targeting expanded supported housing bed capacity to individuals ready for discharge.

For longer-term patients currently at the facility, transitional services and a more gradual re-entry into the community will likely be necessary. Two temporary 25-bed Transitional Placement Programs will be developed in renovated space on the facility campus to accelerate the successful transition of such patients. In addition, a Community Support Team capacity will be developed to assist individuals with the transition from inpatient to transitional or outpatient settings, addressing issues related to discharge anxiety, acquisition of skills and providing support post-discharge. Community services will be expanded via a satellite clinic program incorporating self-help, empowerment, peer support and employment services to be established on the Kingsboro PC campus.

The workforce at Kingsboro PC is receiving an invigorated curriculum of training specifically targeted to helping staff manage change and learn new skills in rehabilitation and recovery-based supports. Residential staff have been taught to functionally assess the skill deficits of individuals in their care and provide treatment and supports to move individuals to more independent living settings. Facility staff will also receive training in Preventing and Managing Crisis Situations, strength-based treatment, and trauma-informed care. Retrained hospital staff will be deployed to provide support to individuals as they transition from patients at Kingsboro PC to persons in the community.

Last, but certainly not least, the presence and contribution of peers at the hospital will be strengthened, providing hope and role modeling in a way that professional and paraprofessional staff cannot.

In addition, as inpatient capacity decreases, another crisis residence program will be developed in collaboration with general hospitals with psychiatry programs in Kings County. The crisis service will provide short-term housing and supports, reduce emergency room wait times, and reduce admissions to inpatient programs. A final step will be the addition of an Assertive Community Treatment team.

When fully implemented, the Kingsboro PC transformation is anticipated to serve as a model for the future of mental health service delivery in New York State, with the ability to efficiently stabilize individuals experiencing symptoms of mental illness, discharge them quickly and safely to the community, and provide the supports to avoid the necessity of inpatient hospitalization in the future.

***Other Changes in Psychiatric Centers***

Consistent with the direction of right-sizing the inpatient PC system, in February 2012, OMH implemented a number of efficiencies in the delivery of mental health services included in the 2011-12 state budget, including the elimination of 600 beds from the statewide PC system. OMH waited until February to implement these reductions to allow staff attrition, retirements and transfers to take place, thereby reducing the number of job losses. The bed reductions were accomplished through the closure of one ward at Bronx PC, closure of one unit at Sagamore CPC, conversion of one ward at Creedmoor PC to a Transitional Placement Program, and – at Mohawk Valley PC – the closure of two wards serving adults and transfer of one ward to Hutchings PC in Syracuse.

At Mohawk Valley PC, these ward closures resulted in a complete reduction in adult inpatient capacity at the facility, leaving Mohawk Valley PC to operate a children's inpatient unit, adult outpatient programs and adult residential services. Even with the closing of Mohawk Valley PC's adult inpatient services, OMH continues to operate three PCs serving adults (Greater Binghamton Health Center, Hutchings and St. Lawrence), and one forensic PC (Central New York) in the Central New York region. As the adult inpatient census at Mohawk Valley PC has reduced in recent years, the ongoing need for OMH-operated adult hospital services in the Mohawk Valley PC area is estimated to be 25 beds – a capacity that can easily be met by Hutchings PC. OMH augmented Mohawk Valley's community-based care to include a Community Support Team that will work with individuals needing intensive assistance to succeed in community living. In addition, Oneida County is receiving a $500,000 grant from OMH to support expansion of community-based mental health services, bolstering the areas capacity to help support people in the community and avoid the need for inpatient hospitalization altogether.

## Training Correctional Officers on the "Experience" of Mental Illness

OMH has worked with the New York State Department of Corrections and Community Supervision (DOCCS) and the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD) to provide training to correctional officers in DOCCS facilities, "who regularly work in programs providing mental health treatment for inmates," as required under the Special Housing Unit (SHU) exclusion law of 2008.[7] The purpose of these trainings is to promote a collaborative approach to meeting the goals of the new policies, services and therapeutic units amongst all members of the mental health treatment team, including correctional officers.

[7] Chapter 1 of the Laws of New York, 2008

OMH is using these trainings to introduce the concept of recovery and improve understanding of the perspective of a person experiencing symptoms of mental illness. In order to accomplish this, the training was developed to include two modules. The first utilizes MP3 players in small group activities designed to afford staff the opportunity to experience a simulation of auditory hallucinations. The MP3 players have a pre-recorded track trainees listen to via headphones while attempting to respond to directions similar to those expected of an offender/patient, including movement of the group as a whole and completion of forms. The trainees are then debriefed on the experience and share insights with each other on the methods they found most useful in overcoming the auditory hallucinations in an attempt to complete the tasks.

The second module introduces the concept of recovery from mental illness and offers staff the opportunity to see what this might look like in a correctional setting. This module draws from research that demonstrates the possibility and likelihood of recovery from serious mental illness, utilizing video-recorded interviews with former offender/patients who are now in recovery in the community and some who work as peer advocates within the mental health forensic system.

Thus far, the results of the trainings have demonstrated effectiveness at helping staff who work with offender/patients with mental illness to learn new strategies of managing correctional situations and working together to improve each offender/patient's mental health so that they can return to the community better prepared to address their mental health needs.

## OMH Capital Plan

While the overall direction of the service system is toward a vibrant community system of care, state inpatient care remains an important component to the mental health safety net and must be maintained in accordance with all accreditation, and health and safety standards. OMH's capital budget includes the minimum level of funding necessary to complete capital projects and maintain the physical plant necessary to fulfill OMH's responsibilities to provide care to people with mental illness. OMH's responsibility for the provision of a safe and therapeutic environment concurrently protects the State's assets.

Accreditation, with its requirements of high quality care and resultant reward of federal financial reimbursement, remains the goal and benchmark of OMH. Good patient care requires a good quality physical plant. The Joint Commission (TJC) has implemented an accreditation process called Shared Vision-New Pathways, considered a "continuous improvement initiative" that requires facilities to maintain a constant state of readiness for inspection. OMH continues to implement the direction of this quality improvement initiative, which relies heavily on compliance with Life Safety Code requirements. As a result, perhaps the most significant measure of the quality of care provided by New York's PCs are TJC survey results, which include a comprehensive assessment of the therapeutic environment as well as medical care. TJC has been highly complimentary, and on most campuses the quality of the physical plant is no longer a cause for citations during their surveys.

Campus consolidation and efficiency improvements are underway at a number of OMH campuses. Significant work is underway at Bronx PC and NYC Children's Center (Bronx campus) and is planned for the campus of Kirby PC/Manhattan PC, Hutchings PC and South Beach PC. Capital work planned and underway at Kingsboro PC will facilitate the transformation of Kingsboro PC into a smaller, shorter stay hospital with expanded on-site community care outpatient services. An inpatient ward at Kingsboro PC is being modified to provide a Transitional Placement residential service. In Central New York, an inpatient ward at Hutchings PC was prepared to accommodate the transfer of patients from Mohawk Valley PC. At these locations, work is being completed to ensure compliance with Life Safety standards.

OMH has made vigorous efforts to improve energy conservation and environmental protection for years and remains a significant responsibility for the agency. OMH's Comprehensive Energy Efficiency Program has reduced the agency's energy consumption to a level that makes it a model for the rest of New York State government. The development and daily utilization of the Facility Management System (FMS) database is recognized as an innovative and resourceful tool for mitigating energy costs. Metering equipment has been installed on utilities (electric, natural gas, water, etc.) at each PC, which provides near-real time data and allows for continuous monitoring, trending of energy consumption, and ultimately leads to efficiency. For environmental protection, OMH continues to take a proactive, practical approach to environmental compliance and remediation, including issues related to indoor air quality and asbestos removal. Prevention and cleanup of fuel spills, upgrades and replacement of fuel storage tanks, upgrade and replacement of boiler facility equipment, landfill investigations and closures, and management, clean up and disposal of hazardous materials are common initiatives.

Maintenance and management of OMH campuses is facilitated by a comprehensive building commissioning process, which essentially test jobs performed and staff skills. Currently operational at most PCs is a preventative maintenance and work order application, which has greatly enhanced the planning and tracking of maintenance activities. OMH has also implemented a statewide Testing, Inspection, Maintenance and Repair (TIMR) or replacement contract for all fire protection and security systems.

## Adolescent Co-Occurring Disorders Training

Almost half of youth receiving mental health services in the U.S. have been diagnosed with a co-occurring substance use disorder. Research shows that these youth generally have poorer clinical outcomes than those without a co-occurring disorder. Despite this knowledge, many mental health clinicians are ill-equipped to handle youth with substance use disorders, and conversely substance abuse counselors are often unable to adequately address the mental health needs of the youth they serve.

In 2009, OMH and OASAS convened a Task Force on Co-occurring Disorders. From that, a subcommittee was formed to address the same in adolescents. The Task Force on Co-occurring Disorders Adolescent Subcommittee Report from the subcommittee addressed screening, assessment and treatment of this population, highlighting integrated treatment as the most effective means to address the complex needs of youth with co-occurring disorders.

As a result, OMH and OASAS partnered to move the field toward providing integrated services through training and guidance programs for mental health and addictions clinical staff. Beginning in early 2010, sixty professionals were trained as trainers in an introductory curriculum on adolescent co-occurring disorders. Trainees represented both substance use disorder and mental health agencies throughout New York State. In 2010-11, mental health and addictions clinicians received training and consultation in Motivational Enhancement Therapy and Cognitive Behavioral Therapy, a five-session treatment for adolescents with co-occurring disorders. This training targeted outpatient clinic programs in which 30 clinicians were trained.

Currently, OMH and OASAS are developing a training module on adolescent co-occurring disorders for inclusion in the **Focus on Integrated Treatment (FIT) initiative**, which provides free online training to help programs implement integrated treatment for co-occurring disorders (COD). The FIT initiative includes 35 half-hour online learning modules predominately focused on adult issues, with some applicability for youth. The specific module on adolescent COD, which directs trainees to other available modules that are relevant to the adolescent population, will be available in the fall of October 2012.

## "Life Coaching"

As part of the New York Employment Services System (NYESS), New York State expects to generate millions of dollars in Employment Network milestone payments from the Social Security Administration (SSA) through the Ticket-To-Work program. As required by SSA, these funds must be used to enhance employment services and supports for individuals with disabilities. Under the terms of the new NYESS system, Employment Network milestone payments will be distributed among providers of employment services and supports who helped individual job seekers with a Ticket-To-Work successfully achieve employment milestones, based on their percentage of effort. These providers will then be able to use these resources, in part, to support hiring of additional qualified individuals with disabilities. A small portion of funds will be held by New York State for continued operation of the NYESS system, but also for strategic investment into statewide initiatives to assist individuals with disabilities achieve employment goals. These investments include training and technical assistance to users of the NYESS system to assist them in supporting job seekers with disabilities, continuation of the New York State Department of Labor's Disability Employment Initiative after federal funding ends, and enhancement of a benefits advisement capacity to provide a "life coaching" capacity to individuals with disabilities seeking economic self-sufficiency.

The "life coaching" concept is based, in part, upon the current Work Incentive Information Network (WIIN), an informed and educated network of professionals and peers throughout New York State who understand public benefits and the various work incentives. This network was established to work one-on-one with individuals with disabilities entering the work force or returning to work. The goal of the WIIN is to increase the number of individuals with disabilities who choose to work, helping them navigate the complex systems of public benefits, providing them with information to make an educated and informed choice about work, and providing assistance to take the next step toward economic independence.

Conceptualizing the "life coaching" capacity in discussions with stakeholders, these individuals would first and foremost be individuals with disabilities themselves, providing firsthand proof that employment for people with disabilities is possible. Secondly, these "life coaches" would have significant training in benefits planning and advisement; using the NYESS system to determine when individuals are likely to need such support (i.e. end of the trial-work period), the "life coaches" could be deployed at strategic times when assistance is most likely needed. Third, similar to the resources available to many individuals making the transition from the work world to retirement, the "life coaches" would also be trained and available to assist people with disabilities navigate any and all of the complexities associated with the world of work and be available to assist with challenging transitions.

## Adult Homes

In 2010, a U.S. District Court in Brooklyn ruled in Disability Advocates, Inc. v. Paterson, et al. ("Adult Home case"), requiring New York State to implement a remedy for individuals with mental illness who were residing in, or at risk of entry into, "impacted" adult homes (defined as facilities with 120 beds or more, in which 25% or 25 residents - whichever is less- of the residents have a mental illness) in New York City. The Court ruled that New York State would be required to move virtually all of these adult home residents with mental illness into supported housing or independent apartments. In 2012, the lower court decision was overturned and the case was dismissed by the U.S. 2nd Circuit Court of Appeals.

New York State hopes to prevent future litigation on this matter through the implementation of an initiative to reduce the number of individuals with serious mental illness residing in "transitional" adult homes, defined as those adult homes with 80 or more beds in which at least 25% of the

residents have serious mental illness. This initiative involves the transition of residents to the most integrated setting that is appropriate to their needs, including Supported Housing. In August 2012, OMH announced a Request for Proposals (RFP) for the development of 1,050 units of Supported Housing in Brooklyn and Queens over a three-year period.

To improve care and health outcomes for individuals with serious mental illness currently residing in adult homes, these individuals will be enrolled in a Health Home linked with a Medicaid Managed Care Plan or a Managed Long Term Care Plan (MLTCP). Health Homes and MLTCPs will be responsible for assessing individuals' needs and developing integrated care plans for them, and will play a key role in any transition from a "transitional" adult home to community housing by ensuring that needed services are in place to facilitate the move.

The contractors selected under the OMH RFP will be responsible for providing "in-reach" services to the target population in the adult homes in their awarded group(s). The in-reach process will identify individuals with serious mental illness living in "transitional" adult homes who are interested in moving to alternative community settings, and document the residents' housing and service preferences. The selected housing will be required to engage and educate residents, who may be ambivalent about moving, about the various housing and service options available, including the opportunity to visit alternative community settings.

In addition, New York State will retain a Community Transition Coordinator (CTC) to help facilitate discharge efforts among adult home residents, including those that will be served by the selected housing contractors. The CTC will maintain a Community Transition List, which will include all adult home residents who are identified by the Health Homes and MLTCPs as appropriate for transition to other settings and will help facilitate efforts to transition such individuals to other settings.

Many adult home residents will be able to transition to the community with a moderate level of planning and connection to community services. Other adult home residents may need a more comprehensive service package, including a combination of behavioral and physical health services. These efforts are consistent with the U.S. Supreme Court's 1999 decision in Olmstead v. L.C. and will significantly enhance the quality of life for many individuals with serious mental illness currently residing in adult homes.

# CHAPTER 5

## Promoting and Ensuring High Quality in Services and Measuring Progress

OMH has maintained an emphasis on continuous quality improvement effort, whether that be from a clinical perspective or from a systems perspective – increasingly through the use of data and information to measure outcomes.

In preparing this chapter, OMH considered input received from several sources, including:

- A participant at OMH's Central New York forum in May articulated that greater emphasis and weight should be given to consumer assessment surveys conducted by OMH, as they provide data about basic needs and gaps people experience in pursuing a healthy lifestyle.
- A participant at the Hudson River region forum OMH hosted in May articulated that greater efforts are needed to improve diagnostic capabilities and provide effective treatment for mental illness. The individual stated that commonly un-identifiable conditions and treatments that provide little/no relief or improvement for years on end would be unacceptable in the primary health field and, likewise, should be unacceptable in mental health as well.
- A participant at the Long Island forum OMH hosted in May articulated that OMH should take additional steps to educate individuals about the dangers associated with stopping psychiatric medications abruptly.
- Allegany County Mental Health Services' local services plan articulates the following strategy: "Continue to take advantage of state initiatives available to The Counseling Center staff which will allow for increased staff training to improve the availability of evidenced based treatment."
- Erie County Department of Mental Health's local services plan articulates the following strategy: "The Erie County Department of Mental Health will engage in dialogue with the Regional Behavioral Health Organization and Managed Care Organizations regarding: Use of data analytics: Erie County will work on the development of a risk-based, predictive model to explain trajectory of deep-end system penetration. Primary focus is to make the results translatable to professionals so the results can impact administrative, supervisory and direct practices."
- Onondaga County Department of Mental Health's local services plan articulates the following priority outcome: "Implement data driven decision making." Further, they articulate the following strategy: "Develop strategies for enhanced use of data in contract management and provider projects, including access to CAIRS and PSYCKES to promote better planning."

### Using Data to Drive Performance Outcomes

OMH has a strong history of using data to improve organizational capability, meet goals and objectives, and deliver high-quality policy advice and program administration for New York State's public mental health system. The agency's commitment to using data to drive quality includes making a large amount of data and information publicly available on the Internet. The Statistics and Reports page on the OMH website includes numerous data portals that report on outcomes experienced by individuals served in the public mental health system and present critical indicators of OMH organizational performance. The OMH data portals are designed to improve accountability and transpar-

ency in New York State government by allowing anyone to use OMH data to make more informed choices about services that best meet their needs and to assess the progress the agency is making toward improving public mental health care. OMH's newest data portal is the BHO portal, which will support the BHO initiative, involving the transition to care management for Medicaid recipients receiving mental health and substance use disorder services. Important information about the BHO portal and each of the other OMH data portals is presented below.

***Historic OMH Data Portals***

Assertive Community Treatment (ACT) is an evidence-based practice designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. With small staff-to-recipient ratios, ACT is an intensive service that is available on a 24/7 basis and has a capacity to serve more than 5,000 individuals statewide. Using the ACT portal, individuals can find ACT teams in their geographic region and access up-to-date statistical data on program operations, the demographic and diagnostic characteristics of ACT recipients, and recipient outcomes. The ACT portal includes statewide, regional, county and program-level data.

OMH understands that individuals with mental illness need safe and affordable housing because having a home is such a critical component of achieving recovery. To that end, OMH currently funds and oversees nearly 33,000 units of housing in the community available to adults with mental illness. The Adult Housing portal includes the Residential Program Indicators report, which is a performance measurement tool for adult mental health housing programs throughout the state. The portal provides information on agency housing programs including congregate treatment, licensed apartments, single room residences, and supported housing. The data presented measure a number of factors related to housing provider occupancy rates, lengths of stay, priority admissions and discharges to state PC inpatient care. Viewers can use indicators in the report to evaluate agency residential programs, based on county, regional, and statewide averages.

Assisted Outpatient Treatment (AOT) is court-ordered outpatient treatment for individuals deemed to be at risk of causing serious harm to self or others and who are likely to have difficulty living safely in the community without close monitoring and mandatory participation in treatment. Also commonly referred to as "Kendra's Law," AOT was established in 1999. The OMH AOT portal offers statistics on the operation of the AOT program since its inception. In addition, the AOT portal describes the demographic and diagnostic characteristics of AOT recipients, and outcomes for AOT recipients. Statewide, regional and county-level data are available.

OMH's Balanced Scorecard portal measures and reports on outcomes experienced by individuals served in the public mental health system, results of public mental health efforts undertaken by OMH, and critical indicators of organizational performance. The Scorecard is designed to improve accountability and transparency, and assess the agency's progress toward achieving its strategic goals. This Balanced Scorecard portal includes definitions of its management objectives and descriptions of how they are calculated, explanations of statewide targets and how they are determined, data that can be used to compare across geographic locations, and trend analysis to demonstrate performance over time. Statewide, regional, county and facility-level data are available and updated on a quarterly basis.


Better information about consumer outcomes and what treatments work for whom – and under what circumstances – is essential to improving the quality of mental health care and the quality of life for persons who experience mental illness. OMH recognizes that consumer assessment of mental health care is a critical component of this information and uses the Consumer Assessment of Care Survey (CACS) to assess perception of care among adults in state-operated outpatient, non-residential programs. OMH makes this survey information publicly available in the CACS portal, with access to aggregated data on consumer perception of care in areas including service quality, access, appropriateness, individual outcomes, and changes in quality of life. The CACS portal also displays consumer feedback on recent OMH initiatives, such as efforts to promote tobacco cessation. Data are presented at the state, region, facility and program/site level and are available for each year beginning in 2009.


The County Mental Health Profiles portal offers consolidated, at-a-glance, and comparative views of key county community characteristics, mental health service expenditures, and outcomes. Its purpose is to enable planners and others to identify service gaps and disparities, and plan improved service delivery. This portal's reports on utilization statistics, service needs, outcomes and expenditure data allow comparisons to be made across agencies, between different groups of recipients, and across geographic locations. Other reports include snapshots on inpatient service use and readmissions, community residential programs, specialty treatment programs (e.g. AOT, ACT), medication utilization, and indicators of wellness. Medicaid claims data for mental health services and other (non-mental health) services provided to individuals receiving mental health services through Medicaid are also included, as are enrollment rates in Medicaid managed care. A complete update of the County Mental Health Profiles Portal occurs annually.


OMH developed the Children, Teens and Families Indicators portal to advance the recommendation in the 2008 New York State Children's Plan for data-driven measures that can be used to better understand and improve the quality of services and service outcomes for youth and families. This portal includes data submitted by providers of services to children and their families reported through the OMH Child and Adult Integrated Reporting System (CAIRS), as well as information collected through the OMH Youth Assessment of Care (YACS) and Family Assessment of Care (FACS) Surveys. The CAIRS indicator reports provide over-time comparisons of rates of occurrence and outcomes for youth behavior/symptoms and functioning, family stressors and length of stay, with data from 2002 forward. The Assessment of Care survey data provides demographic information, as well as details on the survey results dating back to 2007. Lastly, the Child and Adolescent Needs and Strengths (CANS) indicator reports provide data on the prevalence of strengths and needs and youth outcomes in terms of change in mental health needs over the course of a service episode. CANS data reports are cumulative from 2002 forward.


The Patient Characteristics Survey (PCS) is conducted every two years, and collects demographic, clinical, and social characteristics for each person who receives a public mental health service during a specified one-week survey period. All programs licensed or funded by OMH are required to complete the survey, which is the only agency data source that describes all of the public mental health programs in New York State. The PCS receives data from approximately 5,000 mental health programs serving 175,000 people during the survey week. The Patient Characteristics Survey portal presents aggregated PCS results with the most recent data available from the November 2011 survey administration. PCS information is used for planning and program evaluation

by OMH and local governmental units. Survey results are also used to describe the state public mental health system to state and federal funding agencies and legislative bodies.

***New OMH Behavioral Health Organization Portal***


New York State's BHO initiative involves phasing out Medicaid fee-for-service behavioral health services in favor of a managed system designed to encourage appropriate utilization of services, improve care coordination, and reduce costs. Beginning in January 2012, New York State contracted with BHOs in an effort to identify where improvements can be made in relation to care and discharge from acute settings (inpatient mental health, and substance use disorder inpatient detoxification and inpatient rehabilitation), post-hospitalization engagement and continuity of care to prevent readmission. This constitutes Phase I of the BHO initiative, which is designed to provide the opportunity to make improvements in the delivery of behavioral health services in advance of moving into a managed care environment in BHO Phase II. BHOs are collecting data on many factors related to provider performance, which will be useful in preparation for Phase II.

OMH's new BHO portal includes aggregated Medicaid claims data information received from DOH pertaining to the provision of mental health and substance use disorder services. The BHO portal provides access to a number of reports that track 35 performance measures derived from Medicaid. The 35 BHO performance metrics span eight domains:

- Continuity of medication
- Length of stay
- Mental health continuity of care
- Mental health engagement in care
- Mental health readmission
- Substance use disorder engagement in care
- Substance use disorder continuity of care
- Substance use disorder readmission

Performance metrics in the BHO portal are calculated quarterly showing data for the given calendar quarter and year-to-date, allowing for the ability to monitor changes in performance over time.

When considered together, the Medicaid claims data from the BHO portal and the data collected by the BHOs provide a more complete picture of performance than either data set can provide independently. OMH and OASAS will examine the BHO portal's Medicaid performance measurement reports in conjunction with the data collected by the BHOs to determine what a better functioning behavioral health system can deliver within the care management environment. BHOs, providers of services, families and recipients are afforded the opportunity to do the same, utilizing the data collected by the BHOs and available via the BHO portal to make informed analyses about potential improvements to care.

## Justice Center for the Protection of People with Special Needs

In 2011, there were more than 10,000 allegations of abuse and neglect against New Yorkers with special needs and disabilities – including those with mental illness – in state operated, certified or licensed facilities and programs. Unfortunately, New York State has never had a consistent and comprehensive standard for tracking and investigating complaints of abuse and neglect, or for punishing those who commit such conduct.

In an effort to address this long-standing issue, Governor Cuomo introduced legislation to create the *Justice Center for the Protection of People with Special Needs*, an entity that would have primary responsibility for tracking, investigating and pursuing serious abuse and neglect complaints for facilities and provider agencies that are operated, certified, or licensed by DOH, OPWDD, OCFS, OASAS, SED, and OMH. This legislation, which was passed by both houses of the New York State Legislature in 2012, would establish a Special Prosecutor and Inspector General for the Protection of People with Special Needs who would be responsible for investigating reports of abuse and neglect, and prosecuting those allegations that rise to the level of criminal offenses. When signed into law, this new agency would also establish a hotline run by trained professionals, establish a comprehensive statewide database that will track all reports of abuse and neglect, and create a statewide register of workers who have committed serious acts of abuse who are prohibited from working with people with disabilities or special needs. The information obtained by the Justice Center will also provide the means to analyze abuse pattern and trends in order to prevent future abuse and provide a basis for the training and supports that program managers and direct care workers need to meet their critical responsibilities. All functions and responsibilities of CQCAPD, with the exception of the Federal Protection and Advocacy and Client Assistance Programs that will be designated to a qualified non-profit, would be absorbed by the Justice Center. The new law would also replace inconsistent definitions of abuse and neglect in various laws and regulations with a single consistent standard applicable to human services systems.

The new Justice Center would also include:

1. A substantial staff of trained investigators, lawyers and administrators, with authority concurrent with district attorneys, to prosecute abuse and neglect crimes against people with special needs
2. Authority to develop common standards for investigations and requirements to be used to train investigators
3. Authority to develop a code of conduct containing the basic ethical standards to which all individuals working with people with special needs and disabilities would be required to subscribe and would be held accountable
4. Ability to consolidate background check procedures, including review and evaluation of criminal history for any individual applying to become an employee, volunteer or consultant at any facility or provider agency operated, licensed or certified by OMH, OPWDD, and OCFS in a position where a background check is required
5. A required annual report to the Governor and the Legislature concerning its work during the preceding year, to include data on central register reports, results of investigations, types of corrective actions taken, results of its review of patterns and trends relating to abuse and reporting of abuse, suggested corrective actions and training efforts

Under the legislation, a new level of transparency will be created for non-state operated facilities and programs licensed or certified by the State to serve people with disabilities and special needs. These entities, working with the Justice Center, will need to follow transparency guidelines based on the freedom of information law for information requests regarding abuse or neglect of the people they serve. The new law also would enhance criminal penalties for endangering the welfare of people with disabilities and special needs and strengthen a prosecutor's ability to prove that any individuals in a facility operated, licensed or certified by the State were the victims of sexual abuse.

Upon passage of the Justice Center legislation, Governor Cuomo said, “The Justice Center for the Protection of People with Special Needs will give New York State the strongest standards and practices in the nation for protecting those who are often the most vulnerable to abuse and mistreatment. This new law will help us protect the civil rights of the more than one million New Yorkers with disabilities and special needs who for too long have not had the protections and justice they deserve. This legislation recognizes the dedication and good work of the many employees who care

for the disabled, and we will continue our commitment to providing proper training and support for those who work in these facilities."

The Justice Center legislation was developed, in part, from recommendations outlined in *The Measure of a Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse and Neglect*, a special report prepared by Mr. Clarence Sundram, the Governor's Special Advisor on Vulnerable Persons.

## Electronic Medical Record

Through advances in technology that provide the capacity to track individual health diagnoses, treatments and outcomes, and make such information available to all clinicians who are providing services to an individual, significant improvements in health outcomes, reductions in redundancies and mistakes, and improvements in health care efficiency are expected. Consistent with the direction of the Affordable Care Act and numerous initiatives at the state level to develop such capacity, OMH is currently in the process of developing an EMR that will serve as the source for all clinical information concerning all individuals receiving services and supports from OMH-operated facilities and programs.

Key aspects of the OMH EMR include development and support for a coordinated, comprehensive, public mental health system. By implementing this EMR, OMH seeks to improve:

- tracking of individuals' mental health care records
- flow of EMR data among OMH facilities and outpatient locations
- efficiency and effectiveness of OMH mental health services

The EMR Project is based upon a system the U.S. Department of Veterans Affairs (VA) implemented – the Veterans Health Information Systems and Technology Architecture (VistA). Second only to the VA, the OMH EMR will be largest implementation of such a system yet attempted in the country. Planned as a two stage process, OMH will initially implement an EMR modeled after VistA, without any significant modifications. The second stage will involve a customization of the EMR to meet all of OMH's requirements. These two stages are anticipated to take up to 5 years to complete.

## SHAPEMEDs

SHAPEMEDs, an innovative electronic antipsychotic medication prescribing checklist, is now in its second year as a New York State OMH best practice dedicated to improve patient's behavioral and physical health. Developed to improve patient safety and foster evidence-based prescribing practices for patients receiving anti-psychotic medications, SHAPEMEDs asks providers to systematically review six key clinical elements involved in prescribing:

1. Side effects
2. Health issues
3. Adherence
4. Patient Preference
5. Expense
6. MEDication monitoring

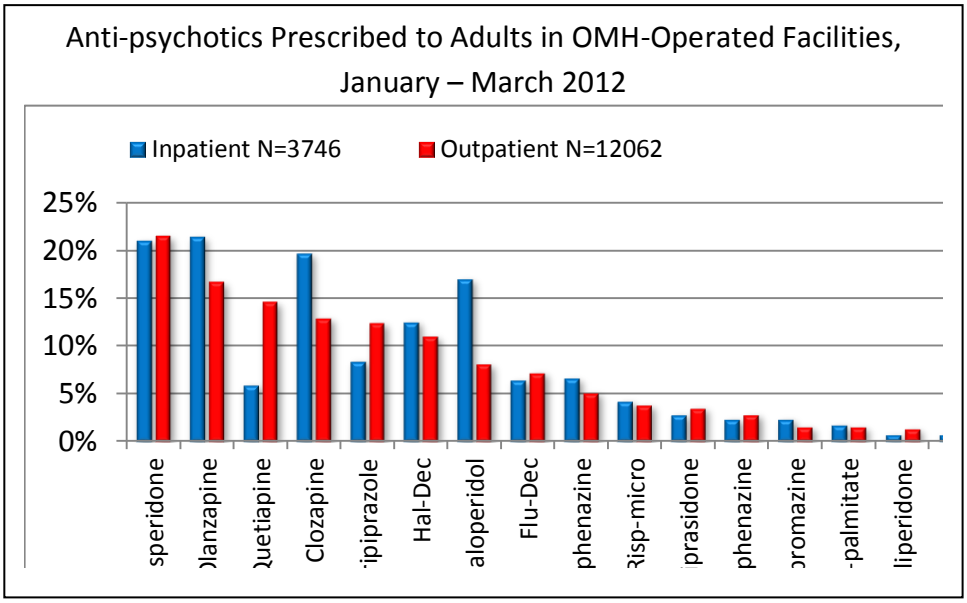
The SHAPEMEDs checklist endeavors to assist clinicians in their clinical decision making – and assist patients in their shared decision making – when discussing the prescription of anti-psychotic medications. SHAPEMEDs enables the clinician to have information regarding the clinical status of their patients and the choice of anti-psychotic medications in a clear online checklist form. This innovative design helps to foster a productive dialogue with consumers regarding expectations, concerns, and goals towards improved health, wellness, and recovery. As the treatment of mental illness is com-

plicated, SHAPEMEDs streamlines the traditional "checks" on medication prescribing (i.e. justification before authorization) with a tool that guides clinicians to consider relevant clinical factors, reduce poly-pharmacy, improve clinical outcomes and avoid unnecessary health-related side effects (e.g. weight gain) associated with many anti-psychotic medications.

First initiated as a pilot involving seven of the PCs in 2010-11, within the last year, SHAPEMEDs has been implemented across the state to all OMH statewide adult, child, and forensic inpatient and outpatient facilities. Use of SHAPEMEDs is required upon both initial prescriptions of an anti-psychotic medication and at regular follow-up intervals of treatment (every 3 months for outpatients, every 6 months for inpatients). As part of the implementation, OMH utilized a learning collaborative approach around SHAPEMEDs with local champions, whereby information and updates were easily disseminated at a local level, challenges could be proactively identified, and collaborative discussions were facilitated to identify potential – and productive – solutions.

The SHAPEMEDs electronic checklist is a crucial tool for clinicians to employ shared-decision making and guide anti-psychotic medication prescribing practices. Moreover, results from the SHAPEMEDs checklist are now a keystone for the OMH Best Practices Initiative on Clozapine (which was launched in 2012), an exciting program that will assist clinicians in their efforts to promote recovery-based care and wellness through the increased use of the anti-psychotic medication, clozapine.

## Cardio-Metabolic Indicators



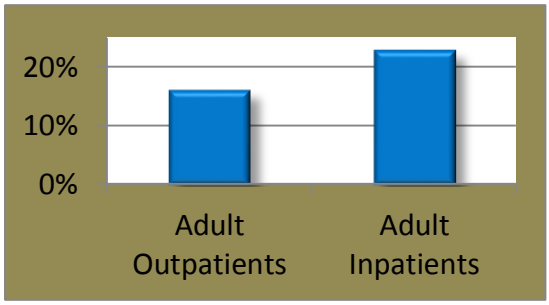

In an effort to address the 25-year lower life expectancy among people with mental illness – caused in part by smoking, poor diet, sedentary life-style and a lack of preventative health care – OMH has been monitoring three health indicators for all adults and children in OMH-operated outpatient clinics. For adults, these indicators are body mass index (BMI), blood pressure, and smoking status – measured quarterly; for children, these indicators are BMI, smoking status and exercise status – also measured quarterly. The data is being collected electronically and is available at all OMH-operated treatment sites across the state. OMH is utilizing this data as part of the risk evaluation and screening process for patients, which is then being used by facilities and clinics to develop targeted interventions for the populations they are serving. In addition, a number of independent efforts focused on wellness, prevention and overall health have grown out of this initiative at several of OMH's PCs.

## Optimal Utilization of Clozapine

Medications to treat the symptoms of schizophrenia and other psychotic illnesses have been available for decades and fall into three primary "generations" of anti-psychotic medications. Clozapine, which is typically considered a "second generation" anti-psychotic medication, has been available for over 20 years with a high degree of efficacy for individuals who have not responded to other anti-psychotic medications, as well as for improving functioning, reducing violence and reducing suicidal thoughts. Moreover, clozapine appears to substantially lower mortality associated with physical illnesses, when compared to other anti-psychotic medications. Despite its notable potential benefits, clozapine, however, remains underutilized.

Like many medications, including anti-psychotics, use of clozapine is associated with risks and side effects, including a reduction in infection-fighting white blood cells. To address this, use of clozapine requires regular blood draws to monitor white blood cell counts and avoid potentially life-threatening illness. Importantly, with individualized monitoring, use of clozapine and its side effects can be managed quite effectively.

**Use of clozapine among people with schizophrenia or schizoaffective disorder – January – March 2012**




*While Clozapine use in OMH-operated programs is higher than most comparable programs, further increasing these rates will improve the ability of individuals with psychotic disorders to achieve recovery.*

OMH believes that many individuals with diagnoses of schizophrenia and other psychotic illnesses served in OMH-operated facilities could realize significant steps toward recovery and wellness through an increased use of clozapine. Therefore, OMH initiated the *Best Practice Initiative on Clozapine Task Force* to increase the use of clozapine, where appropriate, in OMH-operated inpatient and outpatient settings. OMH is pursuing this initiative through development of a "toolkit" that provides guidance to clinicians in managing side effects, phone consultation services and clinical site visits. Additionally, the Clozapine Task Force provides technical support and clinical information for recipient and family outreach and engagement.

The *Clozapine Initiative* is supported by OMH's SHAPEMEDs electronic checklist, which provides guidance to clinicians in their evidence-based prescribing practices for patients receiving anti-psychotic medications and assists clinicians and consumers with shared decision-making with respect to medication administration, behavioral health needs, and physical health issues.

OMH considers the increased utilization of clozapine a good target for closing the "science to service gap" that too often limits the opportunity for consumers to achieve recovery. The *Clozapine Initiative* seeks to engage individuals and their families in their consideration of clozapine. OMH is dedicated to helping individuals succeed with the demanding challenges of recovery and realize their full and productive lives – and clozapine is a cornerstone of this outreach.

## Center for Practice Innovations

Stemming from OMH's research efforts and the affiliation between OMH's New York State Psychiatric Institute and Columbia University, the Center for Practice Innovations (CPI) assists OMH in promoting the widespread availability of evidence-based practices to improve mental health services, ensure accountability, and promote recovery-oriented outcomes. CPI has four main initiatives currently:


The ACT Institute provides training, support, and consultation to providers of Assertive Community Treatment (ACT) – a specific treatment approach that offers support services, treatment, rehabilitation, and case management delivered by a mobile, multi-disciplinary team. The training is based upon national standards offered either in person or via distance learning focusing on the core principles of ACT, evidence-based practices that can be applied as part of the ACT model, and offering team consultation to improve practice.


Focus on Integrated Treatment offers free online training intended to assist programs integrate services for individuals with co-occurring disorders, proven as an effective approach to help people achieve recovery. The training helps practitioners assist individuals receiving integrated treatment set their own recovery goals and incorporate peers with similar experiences into the recovery process.


Individual Placement and Support is a highly respected approach used to support individuals in becoming and remaining employed. CPI offers providers of IPS in OMH Personalized Recovery-Oriented Services (PROS) programs training and support, ongoing technical assistance and consultation in an effort to help individuals attain economic self-sufficiency.


CPI supports Wellness Self-Management, a practice designed to assist individuals with effective management of mental health issues contained within a curriculum that covers knowledge, information and skills individuals necessitate to make decisions that support their recovery goals. The curriculum is organized into a 57-lesson personal workbook geared to help people understand factors that assist in their recovery, facts about symptoms of mental illness and treatments that work, and how varying supports can assist in finding recovery.

In addition, CPI is providing assistance with OMH's efforts to prevent suicide through the development of online training modules on the use of the Columbia-Suicide Severity Rating Scale, safety planning, and eventually on follow-up after acute/emergency department care to promote connections with community-based services. Also, CPI is working to promote the use of Clozapine through the development of training modules aimed at helping clinicians maximize use of this effective medication.

# CHAPTER 6

## Promoting Full Community Participation

OMH continues to make significant efforts to provide individuals with mental illness the opportunity to participate as complete members of our communities and society as a whole.

In preparing this chapter, OMH considered input received from several sources, including:

- A participant in OMH's Central New York forum in May articulated that the most recent "Priced Out" report indicates that individuals receiving SSI must pay 112% of their monthly income to rent a modest one-bedroom unit – pointing to the need for OMH to do more to make affordable housing available for people with mental illness.
- A participant in OMH's Hudson River region forum in May articulated that employment and other meaningful community activity provide individuals with a sense of self-worth and positive self-image, which can help promote the acquisition or maintenance of independent housing.
- Another participant in OMH's Hudson River region forum articulated that OMH should make additional efforts to promote the use of peer support, as it provides a level of independence that other supports cannot provide and serves to inspire individuals to follow the lead of their peers to work hard toward self-sufficiency.
- A participant in OMH's Long Island forum in May articulated that providers of mental health services should be required to meet a quota of employees who receive mental health services and that providers unable or unwilling to do so should have their funding withheld.
- A participant in OMH's New York City region forum in May articulated that OMH does little to promote recovery, other than to pay lip service to the concept.
- Broome County's local services plan articulated the following priority outcome: "Explore opportunities for consumer fulfillment via participation in work, vocational, educational or volunteer activities to promote productivity and social connectedness for individuals with behavioral health issues." Their plan went on to articulate the following strategy: "Increase awareness of networking opportunities and resources that promote restoration, remediation and rehabilitation in order to improve functioning and independence as well as to reduce the effects of illness or disability."
- Chenango County Department of Mental Hygiene's local services plan articulated the following priority outcome and strategy: "Increase residential opportunities in the community; Access to safe and stable housing is an essential element for successful living in the community and is a key component in the recovery process. In order to fully participate as a member of a community, an individual with a mental disability must have a place to live and grow…"

### Employment

There is perhaps nothing more effective at helping people with disabilities acquire the capacity to make their own decisions about their own lives and empower them to do so than helping them find meaningful employment. Through employment, people acquire money, which is the foundation of how people in the U.S. are able to direct their own destiny. Without money generated through employment, people are beholden to government systems, dependent on government subsidies, and allowed to remain in a perpetual state of permanent disability. Nonetheless, OMH has a long history of telling people with mental illness that "you can't work," "you're too sick to work," and "you'll

be disabled for the rest of your life." That culture and expectation is rapidly changing with the initiatives to promote competitive employment opportunities for people with mental illness underway at OMH.

### *Sheltered Work*

Sheltered workshops, which group individuals with disabilities together to perform job functions, once offered the only work opportunities to people with mental illness. In more recent years, sheltered work has become an out-dated model, viewed as an unnecessary segregation of people with disabilities from the rest of the "non-disabled" community. Instead, many people with mental illness and other disabilities have found significant success finding employment opportunities in the marketplace as businesses/employers have become more willing to hire people with disabilities and providers of employment supports have successfully identified and successfully marketed the skills of people with disabilities to businesses/employers.

Therefore, OMH is committing to end funding for sheltered work for individuals with mental illness. That commitment is already underway, as funding for these services has been scaled back starting in 2012 and will be completely phased-out by 2014.

### *The New York Employment Services System*

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

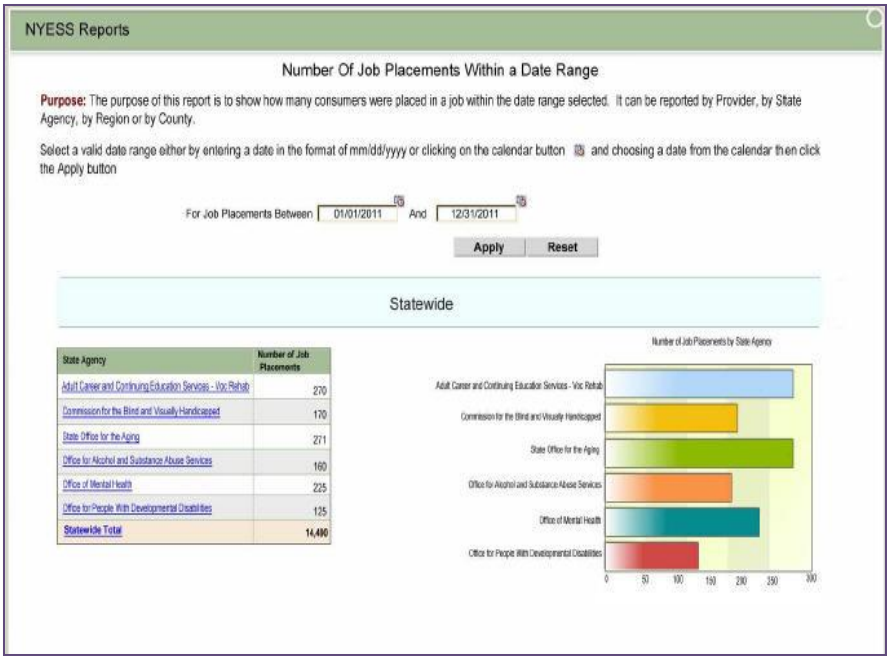
NYESS will enhance New York State's ability to improve employment outcomes for New Yorkers with disabilities, and prove greatly beneficial to businesses/employers and providers of employment supports. Among the many benefits, this new employment system will:

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

- Provide public access to employment-related performance reports generated by data entered into the system

Implementation of the NYESS system will take place in a number of phases over the next several years, the first of which began in the fall of 2011. More than 3,500 individual employment support staff, working for more than 350 organizations, are now utilizing the NYESS system to provide employment services and supports to people with disabilities.

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




For providers, data collected through NYESS will help to address a long-standing issue regarding documentation for employment services rendered, which is necessary for providers to claim milestone payments under the Social Security Administration's (SSA) Ticket-To-Work (TTW) program. TTW allows providers of employment services to people with disabilities to claim milestone payments from SSA for successfully helping an individual achieve designated employment outcomes. However, documentation of continued employment and earnings has been a long-standing challenge for providers looking to claim such milestone payments. Data collected by NYESS will include proof of continued employment and the providers who helped the individual achieve an employment milestone. Under an agreement reached with SSA, NYESS will directly interface with the SSA to document employment milestones for individuals served and automatically qualify providers who served that individual for a milestone payment. Such payments will be centrally administered and then distributed among the providers who helped that individual achieve an employment milestone, based upon percentage of effort. A small percentage of these funds will be held for continued operation of the NYESS system and for reinvestment into strategic employment supports – including a benefits counseling/"life coaching" capacity employing individuals with disabilities to assist other individuals with disabilities to make the transition to economic self-sufficiency.

With the initial development and first phase implementation of NYESS underway and nearly completed, DOL and OMH are seeking to explore additional opportunities for NYESS to be used to bene-

fit both individual job seekers and to advance policies that promote healthy living, community involvement and economic self-sufficiency. Among the future plans for NYESS are to:

- Integrate each currently participating state agency's (ACCES-VR, CBVH, DOL, NYSOFA, OASAS, OMH, OPWDD) service delivery tracking systems in order to determine eligibility for various services, expedite eligibility determinations, streamline enrollment for qualifying individuals and track longitudinal outcomes for individuals
- Integrate data from the Office of Temporary and Disability Assistance to expedite benefits eligibility screening and enrollment, eliminate duplication of data entry for staff and ease the burden on individual applicants
- Incorporate volunteer and other non-paid opportunities (e.g. internships), allowing NYESS to assist in identifying non-paid opportunities/experiences in which individuals can acquire skills necessary to become competitively employed
- Provide the Office of Children and Family Services access to NYESS, thereby allowing youth involved with the juvenile justice system to explore employment/career/volunteer opportunities, develop marketable skills and pursue employment/non-paid opportunities
- Generate reports on employment service provider performance to eventually move toward performance-based contracting, enhancing overall outcomes and improving results for taxpayer funded services
- Generate a series of reports to inform policy decisions (e.g. trend analysis of the impacts of employment-related supports on Medicaid service utilization and expenditures)

In addition, future plans for NYESS include an effort to streamline and expedite the process for any individual with a disability to apply for the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program. In essence, MBI-WPD allows individuals with disabilities who are working to maintain their Medicaid eligibility beyond the maximum income and asset limits for Medicaid eligibility, allowing them to retain their health benefits and avoid the untenable position of having to choose between continuing to work and maintaining health benefits. Difficulties in applying for MBI-WPD through local Departments of Social Services has caused enrollment in the program to remain artificially low, at approximately 10,000 – despite estimates that approximately 150,000 New Yorkers currently qualify for MBI-WPD. Using the NYESS data warehouse, a majority of determinations about MBI-WPD eligibility could be performed automatically, with any unclear applications sent directly to DOH for a determination – easing the burden on local DSS offices. This action alone would likely exponentially increase the number of New Yorkers enrolling in MBI-WPD. In addition, this would also result in a significant cost savings to government, as a recent study performed by Cornell University's Employment and Disability Institute demonstrates that enrollment in the MBI-WPD program (and thereby, employment) results in a reduction in Medicaid expenditures of approximately 43% compared with "regular" Medicaid enrollment.

The NYESS system effectively eliminates the segregated systems of employment supports for people with disabilities that have traditionally existed in New York State. In that regard, the NYESS system has gained considerable attention nationally and is being considered a potential model worthy of replication by SSA and other states. It is widely expected that NYESS will significantly open up employment opportunities to individuals with disabilities, allowing them to make true strides toward economic self-sufficiency, which is perhaps the purest form of independence.

# Housing

Identified by the Affordable Housing Work Group of the Medicaid Redesign Team as a necessary component to maintaining and improving health outcomes for Medicaid beneficiaries, the MRT recommended increasing the availability of affordable supportive housing for high-need Medicaid recipients who are homeless, precariously housed or living in institutional settings as a significant opportunity to reduce Medicaid cost growth. As a result, Governor Cuomo recommended, and the Legislature approved, $75 million in the 2012-13 New York State Budget to support the MRT housing recommendation. A portion of this $75 million appropriation has been allocated to OMH to support the development of 700 new Supported Housing Units. 350 of these units are targeted to support individuals with serious mental illness who are high-end users of Medicaid services in Brooklyn – in line with the efforts to improve mental health care in Kings County through the transformation of Kingsboro PC. First priority for these units in Brooklyn will be provided to individuals who are inpatients of Kingsboro PC or who reside in housing operated by Kingsboro PC. The remaining 350 units will be targeted for individuals with serious mental illness who are high-end users of Medicaid services residing in the remaining regions of the state. Consistent with the MRT recommendation, $25 million has been targeted for capital development of supportive rental housing, further demonstrating the State's commitment to develop supportive housing under the NY/NY III Agreement with the City of New York.

Separate from the MRT recommendations, OMH is also moving ahead to award capital projects to develop community housing that were originally targeted for implementation in 2008, but were held due to the State's financial situation. Of the total 500 units, 150 units are allocated for the Hudson River region, 175 units are allocated for New York City, 75 units are allocated for the Western New York region, 50 units are allocated for the Central New York region, and 50 units are allocated for Long Island (20 of which are specifically dedicated to serve veterans with mental illness). In addition, OMH has 600 Supported Housing units statewide and 570 units of capital originally planned for 2008 to be awarded statewide; Request for Proposals are in various stages of development and are scheduled to be issued within the next year.

Specifically targeted toward individuals with mental illness residing in nursing homes, OMH has made awards of 200 units of Supported Housing in the downstate region to support people who wish to make this transition. This was developed to fulfill the obligations agreed to by New York State as part of the settlement in the Joseph S. and Stephen W., and Disability Advocates, Inc. (DAI) v. Hogan et al. litigation, which requires alternate placement for such individuals in a community-based setting with necessary mental health services provided in the least restrictive setting. Both OMH and DOH have recently announced conditional awards for contracts to support individuals seeking to transition from nursing homes, with DOH selecting a Community Placements Assessment provider and OMH selecting Supported Housing providers to develop the 200 Supported Housing units, with an additional 400 units planned for future years. The state has also hired a Community Transition Coordinator to work closely with contractors from both agencies and to track the progress of the individuals moving into community settings.

OMH also continuously works with housing providers on capital improvement projects. Providers need adequate funding to keep housing options available for individuals living with a serious mental illness. These individuals have some of the lowest documented incomes and are often priced out of safe, decent, affordable housing. "Approximately 4.4 million adults with disabilities between the

ages of 18 and 65 who relied on the federal Supplemental Security Income (SSI) program had incomes of less than $8,500 per year – low enough to be completely priced out of every single rental housing market in the country"[8].

OMH also works with not-for-profit sponsors to develop housing units for individuals with mental illness, providing development, capital and operating funding in order to create opportunities to access a range of good quality, affordable housing. This can include assistance with start-up, establishing a residence, development, supportive services, building operations or rent stipends, and if necessary, capital for acquisition and construction. The ongoing operation and management of such housing is the responsibility of the not-for-profit sponsor, contracted with OMH.

Acquisition, renovation and associated capital costs to develop OMH housing for persons with mental illness are financed through the sale of tax exempt bonds by either the Dormitory Authority of the State of New York (DASNY) or New York State Homes and Community Renewal (HCR). OMH and HCR have established a solid collaboration which has resulted in several successful projects. HCR is responsible for the supervision, maintenance, and development of affordable low-income housing in New York State, providing oversight and regulation of the State's public and publically assisted rental housing; administration of the State's rent regulations and protection of rent regulated tenants; and administration of housing development and community preservation programs, including State and Federal grants and loans to housing developers to finance construction and renovation of affordable housing.

## Recovery Centers

Recovery Centers build on the existing best practices already established in self-help/peer support/mutual support. Utilizing specific staff competencies, Recovery Centers are designed to both model and facilitate recovery. They may be seen as a superb example of promoting the principles of the Supreme Court's 1999 Olmstead v. L.C. decision (services to individuals with disabilities provided in the "most integrated setting"), helping individuals to truly become integrated within their communities.

To help individuals find opportunities for community integration, Recovery Centers assist individuals in identifying, discovering or re-discovering their own passions in life. For so many people with mental illness, their interests and passions have atrophied through years of disengagement. Each individual's passion or "spark of life" becomes the key for the Recovery Center to link the person to naturally occurring community organizations and opportunities that embrace the individual's self-development. In order to link individuals with organizations that support their goals, Recovery Centers need to serve as a clearinghouse of community participation opportunities. As such, each Recovery Center provides the resources necessary to support individuals, linking them to community groups, organizations, networks or places that will nurture and feed an individual's interests. This begins with social/recreational events that present a variety of opportunities for participation within a specific community for individuals to explore. These events expose individuals to a variety of experiences in order to assist in the identification or discovery of the individual's "spark of life," using dynamic learning experiences (not lectures or presentations) to engage the individual.

[8] 2010 Priced Out, June 2011

Recovery Centers have an important distinction from previous day programs or drop-in centers for people with mental illness. They have been described not as a place one goes *to*, but a place one goes *through* – in that they serve as the opportunity to connect with naturally occurring organizations based on people's interests, rather than artificial communities of people based solely on one's status of having a mental illness. But Recovery Centers serve systemic functions as well - they can provide a welcoming place for individuals who may be reluctant to pursue traditional clinical treatment, and they model a peer-governed alternative to traditional services. They will thus help "keep traditional providers honest," and also serve as a resource for engagement of people who may desperately need support but are reluctant to seek it.

Each Recovery Center also has staff appropriately trained and competent in a number of core areas to support its mission. Competencies include (but are not limited to) staff with knowledge of: the Americans with Disabilities Act; Section 504 of the Rehabilitation Act; the Voting Right Act; Social Security Administration entitlements, including SSI and SSDI; Medicaid; Medicare; employment supports; work incentives; the Fair Housing Act; Wellness Self-Management; Wellness Recovery Action Plans; Crisis Self-Management Plans; advanced directives; energy assistance programs; substance use disorder services; housing options/programs; motivational interviewing; veterans supports; parenting supports; financial literacy training; nutrition and food programs/supports; literacy training/education support; forensic/jail diversion programs; crisis support; and peer support.

Over the past year and a half, more than 15 Recovery Centers have become operational though support from OMH, with additional Recovery Centers becoming operational into the future. Recovery Centers are an excellent example of OMH's efforts to provide people with mental illness the opportunities to completely integrate into their communities, in line with the *Olmstead* decision.

# Appendix

# Central New York
# Regional Planning Input Forum

On May 14, 2012, OMH staff facilitated a video-conference between the OMH Central Office in Albany and the OMH Central New York Field Office in Syracuse for interested individuals from OMH's Central New York region to provide their recommendations and input into the development of the next OMH 5.07 plan. The topics of discussion ranged from issues surrounding the availability of housing and housing assistance to competitive employment supports to how OMH can help to provide people with hope.

**People First**

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

- A greater focus on recovery-based mental health care is needed, as envisioned by Mark Ragins and recently adopted by the state of Connecticut.

**Person-Centered Decision Making**

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

- Develop mechanisms by which to promote the Independent Living Center's "people first" philosophy in schools, programs and services.
- OMH should ensure that a full array of choices remain available for individuals with mental illness, as the system transitions into a managed care environment. Such choices have traditionally been about which organization to receive services from, but the move into managed care may provide opportunities to provide additional choices – for different kinds of services, different partners to work with, and different ways in which to arrange supports (including natural supports).

**Basic Needs Are Met**

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

- Develop the capacity to have disability advocates in a variety of settings (e.g. local departments of social services) to assist people with disabilities understand and enroll in the benefits and services that would assist them in living a life with improved quality (e.g. applications for housing assistance). The entities that already do this and could easy expand this capacity are Independent Living Centers.

- Additional capacity to provide opportunities for continuing education – like that provided through the MIG grant to create experts in benefits counseling – should be created.
- As the most recent "Priced Out" report indicates that a person receiving SSI needed to pay 112% of their monthly income to rent a modest one-bedroom unit, OMH needs to do more to make affordable housing available for people with mental illness.
- Moving into a managed care environment, additional attention needs to be paid to the use of the Medicaid Buy-In program for Working People with Disabilities, as that can help to reduce the costs for Medicaid-funded healthcare by promoting employment.
- Consumer assessment surveys should hold greater weight in OMH's policy development process, as they provide statistical data about basic needs and gaps in the road to a healthy lifestyle.

**Relationships**

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

- OMH should explore efforts to promote the participation of families and recipients on community service boards and train individuals to serve in this function and provide assistance to individuals and families.
- The state should pay additional attention to the rights of parents within the family court/social service systems, as well as the rights of children in foster care.

**Living a Healthy Life**

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

- OMH's trainings (e.g. SSI/SSDI Myths, Tips and Tricks), which provide educational opportunities for individuals to move closer to recovery and become more independent, are indispensible and should be expanded in both numbers and covered topics.

**Treatment and Supports**

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

- Family support services for children with serious emotional disturbances and their families is a crucial level of support that often prevents the need for more intensive services and should be expanded. This could greatly help families as they wait for services pre-admission and post-discharge during transitional periods

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

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

- Hope being such a crucial element of wellbeing and the journey to recovery, more must be done to promote the involvement of people with lived experience, as it demonstrates the prospect for others who are struggling with mental illness. This concept should be incorporated into a larger philosophical transformation of the mental health system to focus on involvement of people with lived experience, which could start with changes to the educational process for professionals in mental health and educators. Incorporating peers and family members would help acclimate these future professionals to the values of recovery from mental illness, the value of lived experience, and the need for respect.
- Professionals must bring additional excitement and enthusiasm to their approaches of working with individuals experiencing symptoms of a mental illness in an effort to help provide motivation and model the inherent hope we look to promote for a better future.

**System of Care, Workforce and Accountability**

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

- Ensure that printed materials and information transmitted verbally are easily understood by individuals with limited literacy – whether they are literacy skills with a language other than one's native language, or literacy within an individual's native language.
- With the move to managed care, responsibility for the maintenance and operation of the single point of access (SPOA) should remain with the local governmental unit.
- Building upon OMH's efforts contained within the outpatient transformation initiative, OMH should ensure that peers are afforded an active and integral role, and that resources are made available to advocate for educational opportunities for recipients.
- Moving into a managed care environment, it is imperative that reinvestment of resources from the downsizing inpatient system to community-based mental health services be fully embraced.
- Moving into a managed care environment, OMH should maintain maximum flexibility in the design and delivery of services, as individualized services are most often the most effective in promoting recovery and the most cost effective.

# Hudson River Regional Planning Input Forum

On May 30, 2012, OMH staff facilitated a video-conference between OMH's Central Office in Albany and Rockland Psychiatric Center to receive input from individuals in the OMH Hudson

River region regarding the OMH 5.07 Plan. Following below are the recommendations that were received:

**People First**

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

- There has been a great increase in the number of children receiving mental health medications, often times at very young ages. This is often not beneficial for the child in the long run. Disturbingly, some parents have been forced to medicate their children with mental health medications in order for them to attend public school – this practice is unacceptable and should not be allowed.
- OMH must do more to change the institutional environment of psychiatric centers to help people get ready for life in the community. The outpatient transformation effort is a good step in the right direction.
- Culture change is necessary to make sure everyone understands the importance of treating others the same way you would want to be treated if you were in the same circumstance. One way to accomplish this is to remind people that everyone is just one step away from needing some level of support.
- It is unacceptable that individuals with mental illness are regularly subjected to a relinquishing of their rights – taken away by police absent any charges being brought against them and having committed no crime, through Assisted Outpatient Treatment known as Kendra's Law, and through the involuntary commitment process involving 2 physicians allowed by state mental hygiene law.

**Person-Centered Decision Making**

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

- 'Professionals in mental health services and treatment must work for the expressed interests, not necessarily the best interests, of people receiving treatment.'
- OMH must do more to promote a strengths-based philosophy that encourages people to transform their weaknesses into strengths through focused attention and work.
- There are many and significant barriers to participation in mental health services evidenced most prominently by the fact that people vote with their feet. Additional efforts are needed to attract individuals to mental health services and programs and making it easy for people to become involved, rather than difficult. This requires a multi-faceted approach to getting news out, including getting out to where people are, with information about major initiatives underway. Failing to engage people with lived experience would constitute a major lost opportunity to gain insight regarding the implementation of complex initiatives, such as Health Homes.
-

**Basic Needs Are Met**

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

- Employment and other meaningful community activity that provides a sense of self-worth is good for everyone and should be promoted to the maximum degree. These types of activities promote a positive self-image, increased rates of recreation and healthy living, and even help to promote the acquisition or maintenance of independent housing.
- OMH should do more to develop additional capacity to help people currently living in psychiatric centers to transition to housing with supports. The vast majority of people with mental illness can live successfully in the community with these types of supports.
- More must be done to demonstrate to people with mental illness the path to economic self-sufficiency, particularly with regard to education regarding personal finances.
- Financial literacy amongst people living in group homes receiving a Personal Needs Allowance from SSI via a representative payee is greatly needed. This would help people realize there are opportunities for becoming more self-sufficient.
- The mental health housing model tied to supports is not the right model. Instead, NYS should utilize a housing-first approach. Greater expansion of this housing model would prevent housing programs from holding people back from getting a job, making money, transitioning to a new living situation for the benefit of the provider.

**Relationships**

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

**Living a Healthy Life**

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

- Greater efforts are needed to assist people with addressing issues related to low self-esteem and help motivate people to make positive changes in their lives. Such low self-esteem issues make it very difficult to break the institutionalization mentality and negative effects of institutionalization. More must be done to shift from the traditional messages of "you'll be sick/disabled for the rest of your life" and "you're too sick to work" to messages that promote full community participation and inclusion.
- While the First Episode Psychosis capacity is a step in the right direction, more must be done to engage individuals before they experience a "first break," including wrapping supports around the individual they find helpful. This type of engagement will help people explore their creative capacity and explore their ingenuity without risking the safety of themselves or others.
- Additional efforts must be made to teach young people about mental wellness when they are in the formative years.

- OMH should focus on helping people develop an exit strategy from hospitalization as soon as they arrive in the hospital, not days later.

**Treatment and Supports**

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

- Additional efforts are needed to improve diagnostic capabilities and provide effective treatment for mental illness. Individuals seeking physical health treatment and services from their primary care doctor don't put up with unidentified conditions and treatments that don't provide relief of improvement for years on end. The same should be unacceptable for people with mental illnesses.
- OMH should make efforts to improve the level of specialization necessary to provide treatment to individuals who have witnessed trauma.
- Trauma-informed care is a much more effective means of support than more traditional methods, like Cognitive Behavioral Therapy. NYS must find ways in which to ensure that these types of services are readily accessible as more services become funded via Medicaid.
- OMH's Transitional Placement Program is not functioning as it was designed, in that it is not doing enough to train people to move on with their lives in the community.
- A recommendation for a new name for the First Episode Psychosis team capacity is Psychotic Episode Response Team (PERT).

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

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

- More must be done to promote self-help and peer support, as this type of help is more powerful and effective than any help from a clinician.
- OMH must make additional efforts to promote the use of peer support, as it provides a level of independence other supports cannot provide and provides inspiration for individuals to follow the lead of their peers to work hard toward self-sufficiency.

**System of Care, Workforce and Accountability**

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

- Unfortunately, involvement of individuals with lived experience with symptoms of mental illness appears to be dwindling. Improvements in communication, both from OMH and to OMH, regarding all of the changes taking place in the mental health system are necessary.
- Additional efforts, beyond bribing individuals with food to attend meetings, must be make to promote the involvement of individuals with mental illness. New opportunities

offered through email and social media can help promote involvement, even if only virtually.

# Long Island Regional Planning Input Forum

On May 8, 2012, OMH staff facilitated a video-conference between OMH's Central Office in Albany and OMH's Pilgrim Psychiatric Center in West Brentwood to receive input from individuals in the OMH Long Island region regarding the OMH 5.07 Plan. Following below are the recommendations that were received:

**People First**

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

- More needs to be done to promote involvement of people with mental illness in the systems and decisions that impact them – to promote the "nothing about us without us" philosophy, as it is a truly empowering experience.
- NYS should explore and promote the use of self-directed medical care, similar to what parts of Europe have done.

**Person-Centered Decision Making**

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

- There is a great need to get people with mental illness more involved in their own treatment planning and management, and to promote shared-decision making. The First Episode Psychosis initiative is an excellent step toward addressing this need. OMH should use the Grand Rounds series to promote the use of collaborative medical documentation with patients.
- While collaborative documentation is focused on development of a treatment plan, this concept should be expanded further to include ongoing management of the treatment regimen and modifications to the treatment plan.
- Wellness Recovery Action Plan was recently granted evidence-based practice recognition by SAMHSA and should become a mainstream approach used in all settings.
- The Health Home initiative fails to provide any inclusion of the concept of shared decision making – similar to what the First Episode Psychosis team capacity envisions. NYS should build an advocate role into the Health Home model.

**Basic Needs Are Met**

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

- Additional resources for housing are needed.
- Long Island's significant public transportation challenges require additional attention.
- While the New York Employment Services System initiative is a good start, additional efforts are needed to promote employment amongst people with mental illness.

**Relationships**

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

- Faith communities are ripe grounds for educational efforts about mental health and promotion of recovery, and resources should be dedicated to this approach.

**Living a Healthy Life**

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

- More needs to be done to promote complimentary alternatives to traditional care approaches, including medication. For example, nutritional blood analysis prior to a prescription for a psychiatric medication could help identify whether there truly is a need for such medication and whether alternative approaches may be warranted.
- Additional efforts are needed to educate individuals about the dangers associated with stopping psychiatric medications abruptly.

**Treatment and Supports**

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

- In an effort to improve discharge planning efforts from inpatient facilities, OMH should penalize hospitals (e.g. the complete cost of the primary hospitalization) if their discharge planning efforts are weak and cause re-hospitalization.
- There is a great need to promote the use of trauma-informed approaches to mental health care, as this is not only an extremely effective form of treatment/care, but this approach also can help to promote shifts in philosophy about mental illness and the stigma associated with mental illness in our culture.
- There is great need for peers in emergency departments, as they can support people in crisis when they first arrive, continue to be supportive during a hospitalization, and can play an essential role in transitioning beyond the hospital setting.
- The current survey questions posed to individuals prior to discharge from a hospital could be much more effective if they were designed and conducted by peers. Not only

could this approach ensure anonymity where desired, the compilation and publication of these surveys could be used a selling point to attract individuals necessitating hospitalization.
- The Health Home initiative is fertile ground for the development of a peer employment initiative.
- Respite care housing is a cost effective and clinically effective approach to dealing with people in crisis, and should be expanded statewide.

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

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

- Additional training for consumers of mental health services in peer advocacy is necessary, and technology-based approaches can make such training extremely cost-effective. Such assistance would greatly enhance the effort underway to develop a Recovery Center at Pilgrim PC, getting individuals involved who understand the potential this initiative has to offer.
- Individuals with mental illness must be afforded greater access to technology in order to participate in processes that impact them and have their voice heard. Additional efforts, including the Governor's recent Executive Order requiring the state's surplus computers to be made available to the community, are needed.
- Additional funding is necessary for peer services, including recovery centers.
- Providers of mental health services should be required to meet a percentage of people employed who are peers. Providers unable or unwilling to meet this quota should have their budgeted funding withheld.

# New York City Regional Planning Input Forum

On May 21, 2012, OMH staff facilitated a video-conference between OMH's Central Office in Albany, OMH's New York City field office in Manhattan, and South Beach Psychiatric Center on Staten Island to receive input from individuals in the OMH NYC region regarding the OMH 5.07 Plan. Following below are the recommendations that were received:

**People First**

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

- OMH does little to promote recovery other than pay lip-service to the concept.

- While cultural competence in mental health care has been a focus for a long time, there is a need to consider other populations with disparities in mental health outcomes, particularly those who are seniors.

**Person-Centered Decision Making**

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

- OMH needs to do more to promote self-directed services and move to a values-based outcome measurement system.

**Basic Needs Are Met**

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

- OMH should no longer fund provider-based housing, which are nothing more than mini-institutions. Instead, NYS should provide people with mental illness in need of housing with a voucher for housing that is non-negotiable and non-transferrable, which would allow individuals additional choice as to where they want to live.
- There are great disparities in the employment of people with mental illness, illustrated by the deplorable employment rates amongst this population. Additional resources and efforts are necessary on this front.

**Relationships**

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

- Additional resources for family support services are necessary, which could go a long way to support parents with children with emotional disturbances and avoid the termination of parental rights.

**Living a Healthy Life**

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

- NYS needs additional peer-operated crisis services, including the need for crisis residential services. This model, successfully implemented in Canada, Arizona and in New York's Warren/Washington counties promotes the maintenance of daily living skills, rather than take such skills away from people through institutionalization.
- OMH should develop a "warm line" capacity.
- Due to concerns about the effects of psychiatric medications, OMH should explore and promote additional alternatives to psychiatric medication.

- OMH should develop strategies to prevent/avoid individuals from becoming lazy and content after joining a mental health program, instead engaging people in their interests and promoting involvement with community activities.

**Treatment and Supports**

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

- While transitional youth respite capacity has not been fully utilized, no such service capacity exists and is available for the aging population.
- NYC should develop a Crisis Intervention Team capacity to more appropriately engage people with mental illness in crisis or violent situations. Police escorting people to emergency rooms is an outdates option and should only be used as a last – not a first – resort.
- NYS should end the Assisted Outpatient Treatment program as it is discriminatory against people with mental illness.
- There is a need for additional senior citizen-specific mental health services. There remains a dearth of psychiatrists with a geriatric specialization, which could be addressed through a tuition reimbursement program to draw psychiatrists into this specialty field.
- The Health Home concept is a solid one, but caseloads for case management must be kept manageable. In order to assist with this, peer advocates should be employed by Health Homes and play an active role in assisting with case management.

# Western New York Regional Planning Input Forum

On May 3, 2012, OMH staff facilitated a video-conference between OMH's Central Office in Albany, Rochester Psychiatric Center and Buffalo Psychiatric Center to receive input from individuals in the OMH Western New York region regarding the OMH 5.07 Plan. Following below are the recommendations that were received:

**People First**

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

- OMH's language, in the 5.07 plan and in all other documents and publications, should be more family-centered and youth-oriented.
- An effort is needed to ensure that professionals currently being trained are receiving the most state-of-the-art education about the most effective means of providing mental health services and supports. This education must begin with the fundamental premise

in the belief in recovery, because without that believe, practitioners don't practice from that perspective or have that expectation for those they are serving.

- Emulating an initiative started elsewhere, OMH should require nurses (and other professionals) currently in school/training to undergo a mentorship in which peers serve as the mentees.
- A study of previous disability and civil rights movements should be undertaken to inform OMH on the best strategies to use in the civil rights movement for people with mental illness.

**Person-Centered Decision Making**

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

- Significant differences between the perspective of youth and adults with mental illness exist, and additional efforts should be made to ensure that parents and other natural supports are fully incorporated into service plans for individuals in the transitional age group.

**Basic Needs Are Met**

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

- In an effort to instill a greater appreciation for work/employment amongst young adults, additional resources are necessary to be able to provide young adults with opportunities to explore and experience the work world. Such experience will help them develop/acquire the skills necessary to be successful in the marketplace.

**Relationships**

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

- There are opportunities to include families that are not fully utilized and could be improved through increased efforts to train families about resources and how to effectively advocate for their loved ones. Natural supports offered by families are necessary for care and treatment to be successful and to assist in breaking through difficult times to allow care and treatment to be effective.
- Normalizing experiences dealing with mental illness, just like any other life challenge or transition, is perhaps the most effective anti-stigma technique.
- Additional efforts must be made to educate and empower parents to be able to provide their children with the supports or resources to intervene at an early stage of mental illness and prevent more long-term disabling mental health conditions.
- Parents who provide care should be reimbursed for the supports and care they provide to their children.

**Living a Healthy Life**

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

- Engaging directly with the peer community at an early stage in the First Episode Psychosis team initiative will help ensure the success of the project.
- The focus of services and supports should be shifted from the concept of prevention of mental illness to the promotion of mental wellness.
- The First Episode Psychosis team capacity should be renamed the Comprehensive Access to Responsible Early Treatment (CARET).
- Recreational activity and promotion of people having fun is an extremely important value/outcome that must be reinforced for people dealing with mental illness.

**Treatment and Supports**

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

- OMH's Assisted Outpatient Treatment program should be expanded, as it serves as an important tool for many families to successfully access mental health services and it serves to protect everyone's civil rights.

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

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

- For the population of individuals transitioning from childhood/adolescence to adulthood, additional opportunities in the western region of the state are needed to develop youth advocates.
- Additional efforts must be made to tap into young adults to develop them as peer resources. Additional resources for family support programs are needed in order to help develop youth advocates.
- Ensuring that youth have access to and a voice in the planning process is extremely empowering. Engaging with the counties that have started youth initiatives would be an excellent opportunity for soliciting input and promoting the empowerment OMH seeks to instill in individuals.
- Peer operated programs and initiatives are the most effective way in which to promote the development of hope amongst people living with a mental illness and present the most promising attempts to initially engage and provide ongoing treatment/support.
- Peers and families must take it upon themselves to inform and educate the public when they witness inaccurate or inappropriate depictions of people with mental illness.

- Now that the Wellness Recovery Action Plan (WRAP) has been endorsed as an evidence-based practice by SAMHSA, payment for this support should be included in all payment mechanisms.
- OMH should take additional efforts to get individuals out of inpatient/institutional settings as quickly as possible, as this is the environment in which individuals lose their social skills most quickly.

**System of Care, Workforce and Accountability**

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

- Individuals with lived experience with mental illness should be directly employed to deliver provider trainings and continuing educational supports.
- The "High Fidelity Wraparound" program is a good model for consideration as the effort to develop a children's Health Home continues.