The Vital Role of Behavioral Health: Driving Better Health Outcomes by Integrating Services

By John Coppola, Executive Director
New York Association of Alcoholism
and Substance Abuse Providers (ASAP)

Behavioral and physical healthcare in New York State are going through an unprecedented transformation. Medicaid redesign, implementation of a health benefit exchange, a transition from fee-for-service to managed behavioral healthcare, integration of behavioral health with primary healthcare, implementation of health homes, and a variety of additional innovations and transformations are among the most prominent component parts of that transformation. Critical elements of our healthcare system are being transformed at a dizzying pace and will evolve in ways that significantly impact how services are delivered, the outcomes that are achieved, and the level of consumer satisfaction. Integration of behavioral health with primary care is vital to the success of healthcare reform in New York State.

Medicaid Re-Design

During the first meeting of the Medicaid Re-design Team, an array of stake-

John Coppola

holder groups that included consumers, services providers, and payers were given an overview of New York State's Medicaid program and a mission to transform it to improve health outcomes, make better use of resources, and drive down the cost of care. It was noted at this first Medicaid Re-design Team meeting that New York

State spent way more than any other state per capita for healthcare and that, in spite of the significant variance in cost when compared with the rest of the country, we ranked only 26th in health outcomes. Anticipating the obvious question, Department of Health staff came to the meeting prepared with an answer to how we could rank so low when we spent so much: New York State was ranked 50th in un-necessary hospitalizations. It was noted during the discussion about the high cost of un-necessary hospitalizations and other un-necessary use of expensive healthcare services that 80% of the patients who were un-necessarily hospitalized had an untreated substance use disorder and a slightly lesser number had a mental health disorder.

As the Medicaid Redesign Team (MRT) began to grapple with how to improve New York's Medicaid program, it quickly came to the conclusion that behavioral health experts had to play a major role in the re-design. A MRT Behavioral Health Work Group was formed and asked to provide recommendations that would help the MRT to achieve its goals. Those recommendations have been incorporated into the implementation of re-design. Of paramount concern to workgroup participants was how New York could reduce un-necessary hospitaliza-

tions while simultaneously improving health outcomes and consumer satisfaction. Consequently, as New York moves forward with Medicaid re-design, behavioral health services providers are expecting to play a significant role.

Healthcare Reform

With passage of the Affordable Care Act, states were encouraged to establish health benefit exchanges as a marketplace for uninsured persons to get coverage for their healthcare. The New York Coalition for Whole Health, a diverse network of advocates and stakeholders, worked closely with key state government officials to ensure that a comprehensive continuum of behavioral health services was included on the menu of benefits required by the New York State of Health, New York's newly created health benefit exchange. The New York Coalition for Whole Health's advocacy efforts were successful and, with recent guidance from the New York Department of Financial Services about implementation of parity for behavioral health services, access to services for substance use and mental health disorders is much improved.

Population Health: Transforming Health Care to Improve Our Health

By Lloyd I. Sederer, MD
Medical Director, New York State
Office of Mental Health

As the debate about improving health in the United States wages on, it turns out that only 10 percent of our health status and longevity, experts declare, derives from health care.

What Makes Us Sick?

As the Determinants of Health pie chart reveals (see page 36), it is our behaviors, our habits (like excessive and poor eating, more than moderate drinking, smoking, physical inactivity, high salt and processed food intake), that drive the lion's share (40 percent!) of our ill health and early demise. It is also mental health

conditions that often disable people and keep them from effectively managing their illnesses (2). While 30 percent of our health may be attributable to our genes, we now recognize through the science of epigenetics that genes are turned on or off by their exposure to our environment and what we do and don't do -- which helps to explain the rapidly growing rates of certain illnesses in this country.

Understanding the determinants of health is more than academic because of what it means to the quality of our lives and because the U.S. spends $2.7 trillion annually on health care services (18 percent of the GNP). Yet, this vast sum of money appears to influence only 10 percent of the health outcomes we achieve. Citizens of the U.S. may live longer than we did two decades ago, but we suffer from higher rates of morbidity (where functioning is limited by disease) and

death when compared with 34 other developed nations (3). While we greatly outspend other countries for health care we have far too little health to show for it.

Of course, we want a top notch emergency room to go to if we have chest pain. We want skilled surgeons to operate on our vital organs and joints to sustain life, relieve pain and enhance mobility. We want (and need) scientifically proven disease management programs to slow the progression of the chronic diseases (like diabetes, heart disease, asthma, depression) that afflict our lives.

But it is *population health*, a growing movement in health policy and practices, that considers the wellbeing of a group of people and offers an approach that extends beyond the 10 percent of determinants managed by medical care delivered at hospitals, emergency rooms and even doctors' offices. Population health ex-

tends to the 90 percent of factors that make us sick.

What Can be Done?

Going beyond the pie chart of determinants of health leads us to the pyramid of factors that can improve our health.

This graphic (see page 36), courtesy of the CDC and work by Dr. Thomas Frieden, depicts a graded approach of the actions a society can take to impact its health. But no level of the pyramid is meant to be primary or exclusive. The more levels affected the better we will mitigate disability and death.

Achieving success on any level of intervention in the pyramid depends upon partnerships among public health proponents, medical centers, business entities, communities and citizens.

Table of Contents

Behavioral Health News
2015 Theme and Deadline Calendar

Winter 2015 Issue:
"Mental Illness and Substance Use Issues In Older Adults"
Deadline: October 14, 2014

Spring 2015 Issue:
"Caring for Our Veterans and First Responders"
Deadline: January 14, 2015

Summer 2015 Issue:
"Understanding and Addressing the Opioid Epidemic"
Deadline: April 14, 2015

Fall 2015 Issue:
"Caring for Depression in Integrated Settings"
Deadline: July 15, 2015

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The Pathway to Integrating the Healthcare System:
Integrated Licensure and Health Homes

By Arlene González-Sánchez, MS, LMSW
Commissioner, NYS Office of Alcoholism
and Substance Abuse Services (OASAS)

New York's Medicaid program serves over 5 million enrollees with a broad array of health care needs and challenges. The Medicaid program serves many population groups with complex medical, behavioral, and long term care needs that drive a significant volume of high cost services including hospitalizations, inpatient stays and long term institutional care. Appropriately accessing and managing these individuals through service integration and improved care coordination is essential to improving overall health outcomes and to controlling future health care costs for this population.

Integrated Licensure

Individuals with substance use disorders and mental illness often receive regular care in specialized behavioral health settings, but many do not access any basic primary care or routinely manage their chronic physical health conditions. When they do receive physical health care, it is often segregated from their behavioral health services leaving primary care practitioners unaware of the full scope of their patients healthcare needs. Likewise, individuals who are engaged with a primary care practitioner are frequently treated only for chronic and preventative medical issues, leaving behavioral health issues unaddressed and unidentified. This fragmented care causes many of these individuals to experience poorer health status and higher rates of emergency room visits and inpatient admissions.

New York State is seeking to reduce preventable inpatient stays and hospital utilization among people with substance use disorders, mental illness and chronic health conditions and improve their overall health status and quality of life by the co-location or programs which integrate physical health and behavioral health services.

The New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), and the state Department of Health (DOH) have been working together on the Integrated Licensing Project. The key goal of this project is to facilitate the delivery of integrated care in outpatient clinic settings to improve the quality and coordination of care provided to people with multiple needs. Participating providers benefit from reduced administrative burden because their programs are monitored by one of the state agencies using integrated standards. A single clinical record, integrated program staff and one set of Medicaid billing rules all contribute to better care and less burden.

There are currently seven providers with fifteen sites participating as integrated clinics in the pilot stage of the Integrated Licensure Project. These providers are operating in different regions of the state under varying models. All models involve providing at least two of the three permitted services; substance use disorder treatment, mental health treatment, and primary care. The state agencies are gathering information and data from each provider's programs that is being used to guide the expansion of this project.

To facilitate statewide expansion, the state agencies have begun drafting an integrated regulation that will be adopted by all three state agencies and provide a single comprehensive set of standards to guide provider application, survey requirements, service delivery, physical plant requirements, clinical delivery and billing. The regulation and associated expansion is slated to begin in early 2015.

Health Homes

While integration of behavioral health and physical health is a significant step towards improving care for individuals who suffer from multiple physical and behavioral health conditions; improving coordination among all service providers, including medical, clinical, supportive, and recovery based organizations is another critical component to reducing the utilization of more costly inpatient and hospital services. Coordinating care is especially critical for those who suffer from more complex and/or chronic conditions, including substance use disorders and serious mental illness. Medicaid recipients who suffer from substance use disorder and another chronic condition or serious mental illness are eligible for enrollment in one of New York's 32 health homes located throughout the state.

A health home is a care management service delivery model whereby all of a member's providers and caregivers communicate with one another to ensure that the member's needs are addressed in a comprehensive manner. The model recognizes that individuals often require more than medical services to maintain their health and recovery. Coordination of supportive services such as housing, peer supports and recovery services are also critical to ensuring long term stability.

A health home member is assigned to a "care manager" who oversees and provides access to all needed services. Care managers engage their members in varying degrees of frequency and intensity to ensure that members receive whatever is necessary with the goal of staying healthy and out of emergency rooms and hospitals. Health records are shared among providers so that services are not duplicated or neglected and providers are able to have a real-time, comprehensive understanding of a member's needs.

Health home services are provided through a network of organizations that includes providers, health plans and community-based organizations. The designated health home provider is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs. Where an inpatient or hospital stay occurs, the health home is also expected to provide timely post discharge follow-up to ensure connection to necessary aftercare, improve patient outcomes and avoid further readmissions.

The overall goals of the health home service delivery model are to lower rates of emergency room use, reduce hospital admissions and re-admissions, reduce health care costs, foster less reliance on long-term care facilities, and improve the experience of care and quality of care outcomes for the individual members.

While integrated licensure and health homes are only in their early stages, initial response is encouraging. It is only through system change and innovative new service delivery models such as these that New York will succeed in its goals of providing better care and reducing the state's growing Medicaid expenditures.

**OASAS Commissioner
Arlene González-Sánchez, MS, LMSW**

Preparing the Workforce to Improve Health and Wellness

**By Peggy Swarbrick, PhD, Director
CSPNJ Wellness Institute, and
Pat Nemec, Independent Trainer and
Consultant in Psychiatric Rehabilitation**

Health disparities facing people served by the public mental health system are well known and remain a significant concern. In the 1990s, following recognition a 15-year loss of life for people served by the public mental health system, Peggy Swarbrick, formalized a holistic wellness dimension model (eight overall dimensions and six physical domains) to help people remember to view themselves holistically, as mind, body, and spirit. When we learned that the early mortality figures can be as high as 25-32 year loss of life in some states, we organized a series of projects and workforce initiatives to help mobilize and prepare the workforce to assist effectively and act proactively. Here, we highlight some efforts we have spearheaded: defining wellness, health and wellness screenings, wellness coaching, health literacy, and health and wellness self-care resources.

Wellness Defined

Wellness is a conscious, deliberate process that requires a person to become aware of and make choices that help promote a more satisfying lifestyle. A wellness lifestyle includes a balance of health habits, such as adequate rest and sleep, good nutrition, exercise, productivity, participation in meaningful activity, and seeking social contact and supportive relationships (Swarbrick, 1997). Unfortunately, many people encounter physical, emotional, and social challenges that impact their well-being. Modifiable lifestyle factors, including smoking, poor nutrition, poor access to quality healthcare, and a sedentary lifestyle, often contribute to preventable illnesses, diseases, and premature mortality. The eight dimensions of wellness are physical occupational social emotional, intellectual, environmental, financial and spiritual. This dimensional model has been adopted by the SAMSHA Wellness Campaign.

Health and Wellness Screenings

In 2009, Peggy and her colleagues at Collaborative Support Programs of New Jersey began to helped organize health screenings at large conferences in New Jersey and at the national Alternatives Conference. We were pleasantly surprised to see how many people were interested in learning about their blood pressure, glucose levels, and other risk factors for diabetes and cardiovascular disease. We mobilized and trained peers interested in health and wellness to be available to conduct such screenings. We then worked with the UIC Center on Psychiatric Disability and Co-Occurring Medical Conditions to create a new integrated health tool called, *Promoting Wellness for People in Mental Health Recovery: A Step-by-Step Guide to Planning and Conducting a Successful Health Fair.* Health fairs help people in mental health recovery better man-

The 8 Dimensions of Wellness

Emotional
Developing skills and strategies to cope with stress.

Environmental
Good health by occupying pleasant, stimulating environments that support well-being.

Financial
Satisfaction with current and future financial situations.

Intellectual
Recognizing creative abilities and finding ways to expand knowledge and skills.

WELLNESS

Social
Developing a sense of connection and a well-developed support system.

Physical
Recognizing the need for physical activity, diet, sleep, and nutrition.

Spiritual
Search for meaning and purpose in the human experience.

Occupational
Personal satisfaction and enrichment derived from one's work.

Adapted from Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal,* 29,(4) 311-314.

age medical conditions that can be improved with screening, education, and support. Health fairs also help people learn about their health and support them in making choices that lead to a satisfying lifestyle. From this study is a new publication (Swarbrick et al., 2013), highlighting peers' unique perspectives about how health fairs motivated them to take steps towards a healthier lifestyle.

Wellness Coaching

Given the large contribution of lifestyle factors to early mortality (Schroeder, 2007), interventions focused on lifestyle modification are key to addressing existing health disparities. One such intervention is wellness coaching, which offers support to regain balance and restore wellness.

The *wellness coach model* is an approach that can be helpful for someone who wants to make a lifestyle change (anything from smoking cessation, to exercise, to career exploration, to relationship building) or for someone who needs support in managing a chronic health condition, such as diabetes, metabolic syndrome, a mental illness, arthritis, or fibromyalgia. Wellness coaching is based on the premise that individuals can learn to promote their own health, contributing to the self-management of their health and/or illnesses. Wellness coaches apply principles and processes of professional life coaching to the goal of lifestyle improvement (Swarbrick et al., 2008).

Wellness coaches are trained to apply health promotion strategies through education, guidance, and support, designed to promote successful, positive, and durable behavior change. The aim is to empower the person seeking change to assume responsibility for his or her own individual, healthy lifestyle patterns. The wellness coach helps a person to set and achieve a wellness or health goal by offering support and encouragement and by exploring what would be most helpful. Coaching is not counseling or therapy; therefore a coach is not a therapist, counselor, or mentor. Coaching does not require that a person explore his or her past experiences

nor gain insight into problems or challenges encountered. A coach does not provide a prescription, wisdom, or advice, but rather helps the person seeking coaching to define what is important and to set a plan to accomplish a personally valued goal.

Coaching is a positive supportive relationship between the coach and the person who wants to make a change. This positive supportive connection empowers the person seeking change to draw upon his or her own abilities and potentials to achieve lasting lifestyle changes. A critical aspect of coaching is self-responsibility. Through coaching, people can determine what they are responsible for and become empowered to take action to improve their wellness status, in terms of the many dimensions of wellness: spiritual, emotional, physical, environmental, intellectual, financial, occupational, and social.

CSPNJ, in collaboration with Rutgers University, has offered wellness coaching training in multiple states to peer workers, case managers, nurses, and supported housing workers. Training requires a significant investment, four to five full days, and extended follow-up, ideally for at least six months. The best success implementing the wellness coaching model occurs when agencies train and support administrators and supervisors as well as direct care staff, and conduct agency-wide campaigns to infuse wellness into the agency culture.

Health Literacy

One barrier to improving physical health through mental health services is that direct service providers often lack knowledge about common medical conditions, interpretation of lab values, the importance of regular screenings, and basic disease management strategies.

Health literacy training helps frontline staff feel prepared to address the health disparities facing persons served. Typically, training content focuses on the areas of health literacy, physical health and wellness, and motivational enhancement techniques to engage persons served in health dialogues and, ultimately, health behavior improvement. Staff learn about

common health issues and risks and how they are best addressed, including, but not limited to, pulmonary conditions, metabolic syndrome, cardiovascular disease, diabetes, obesity, and tobacco use. Staff increase their awareness of how and why health literacy and motivational strategies can improve quality of life. We have worked with agencies in two states and are beginning to see a positive impact.

As with wellness coach training, health literacy training needs to be followed by time-limited technical support mentoring phone sessions, designed to help staff apply skills and information in their day to day encounters with persons served. On the calls, staff actively engage in team problem solving and began to compile health information they could consider using with the people they serve. We have found the training and technical support process increases staff comfort in addressing health issues over time, and increases their confidence and proficiency applying heath literacy skills. In one training project, a notable outcome was that every person served who was invited to participate in the pilot completed the project. This is significant, as many of these individuals encountered challenges that may have led to dropout.

In one training project, the entire team is now placing attention to persons served needs in a very holistic manner, despite implementation challenges. At times, the immediate crisis (potential loss of housing, exacerbation of psychiatric symptoms, substance use relapse, etc.) impact the efforts of the person served and temporarily limited progress. However, staff remained supportive and attentive throughout to be sure physical health needs were supported equally to maintain focus and balance. Staff did an excellent job engaging people who had not been following up with important doctor /medical appointments. In addition, staff worked to empower persons served to work with their pharmacists. Staff developed a trusting rapport with persons served, which helped them consider important health issues to improve or change.

In addition to engaging persons served through daily or weekly outreach, staff were able to connect with and link people to local community resources (local parks, gyms, etc). Some other notable outcomes include:

- Decreased use of emergency room use for physical health problems, increased interested in smoking cessation, and increased involvement in physical activities.

- Mental health symptoms were less impacted by physical health problems.

- Many individuals are following up with primary care providers and medical specialists. Many are participating on groups addressing addiction issues, enhancing community and social awareness. According to staff reports, persons served have developed a proactive attitude towards health/wellness, as evident in the

Integrated Treatment for Successful Aging

By Michael B. Friedman, LMSW
Behavioral Health Policy Advocate

Contrary to the ageist assumptions of modern society, it is possible to age well. This being so, physical and behavioral health providers ought to ask themselves what they can do to promote successful aging.

Part of the answer, of course, is just to provide good treatment for physical and behavioral health conditions experienced by older people. But this is just part of what health providers can and should do, particularly now that the American health care system is becoming increasingly comprehensive.

In what follows I will discuss what successful aging is and then suggest a number of ways in which large physical health care groups—including group private practices as well as community health centers—and behavioral health practices, programs, and centers can organize to promote successful aging. Integrating care, I will suggest, is a key component of this.

Successful Aging

In a recent review of the research literature on successful aging, Dillip Jeste and his colleagues say that they found 28 research studies that met their standards of research and that within these studies they

Michael B. Friedman, LMSW

found 29 definitions of successful aging. Obviously, the science of successful aging has a long way to go. Nevertheless, they found it useful to classify the definitions into two fundamental types—"objective" and "subjective." [1]

Objective concepts of aging well focus on measurable physical and mental characteristics. Basically, a person is regarded as aging well objectively if they are physically and mentally healthy, not disabled, and cognitively intact. We all know such

people, particularly at the younger edge of aging—people who are in great physical shape (for their age), are still highly functional at work and/or play, and generally are still energetic and active.

Subjective definitions of successful aging are drawn from what older people say about themselves when asked how they are doing. Recent research indicates that most older people, especially as they get closer to the older edge of aging, are not aging well objectively; they are experiencing significant declines in physical and mental functioning, if not outright, disability. But most of them—even those with functional impairments--feel good about their lives.

People who are aging well subjectively generally share a number of characteristics including a positive attitude, a sense of optimism, resilience, and adaptability, traits they were fortunate to acquire as they were maturing. They also have active relationships with people they care about and who care about them, and they engage in activities that they find enjoyable, engaging, and—in many cases—meaningful. These activities may include paying work, although most working people retire eventually. They often include volunteer work for a cause they care about. They also can include new active roles in the family, such as being grandparents who share caregiving with their children. Older people who are happy with their lives

also get great satisfaction from hobbies, such as golf; from creative activities, such as painting; from travel; from learning put off due to busy lives, from being an appreciative spectator of sports and the arts; and so forth.

It is important to note—although fairly obvious—that people with depressive disorders usually don't feel good about their lives, that people with anxiety disorders find it difficult to form trusting relationships or to do something new and different, and that people with substance use disorders are not likely to get the most out of their lives. (Overuse of alcohol and of prescription and over the counter drugs—especially painkillers—are the core substance use problems for older adults.)

Younger people in our youth-oriented society often find it difficult to understand that most of those of us who are older are happy with our lives despite the typical declines we experience as we age. But the fact of the matter is that we are at a different developmental stage, in which many of us experience a state of consciousness that is different from and alien to the experience of younger people.

For example, I have eight chronic conditions and slightly limited mobility. I simply don't have the amount of energy that I had in the days when I routinely worked 12 hours a day and had ambitious goals for myself and the organizations

Integrating Primary Healthcare and Behavioral Health Services Improves Outcomes and Reduces Hospitalizations: But is it Financially Sustainable?

By Anna Ivanova-Tatlici, LMHC, PROS
Team Leader, and John Javis, MDiv,
Director of Special Projects, Mental Health
Association of Nassau County

The Mental Health Association (MHA) of Nassau County Gathering Place PROS (Personalized Recovery Oriented Services) program recently completed a two year pilot project funded by the New York State Office of Mental Health to integrate primary healthcare into a behavioral health setting. The project produced concrete outcomes for consumers who utilized the service in regards to hypertension and obesity. Also impressive was the fact that of the consumers who utilized the primary care physician, none were hospitalized for medical issues during the two year pilot.

The New York State Medicaid Redesign Team (MRT) reported that a high percentage of mental health consumers receive minimal, or no primary healthcare services in the course of a year. Prior to the implementation of the pilot project, many MHA PROS consumers indicated that they "did not remember" the last time they had undergone a physical exam, nor could they even recall the name of their primary care physician.

To address that issue, the MHA collaborated with Nassau Medical Associates (NMA), who provided a primary care

physician one day a week to the MHA PROS Program. NMA is an affiliate of Nassau University Medical Center; which serves as the local "safety net" hospital. Over the two years, the pilot project provided approximately 70 consumers with over 400 primary healthcare visits.

The project enabled MHA to offer a "one stop" service center for consumers who could access the PROS rehabilitation services, Clinical Treatment (PROS Clinic), and primary medical care all within one program. As an added benefit, MHA also provides Health Home / Care Coordination and Peer Services in the same building.

The integrated care pilot focused on screening and treatment for six chronic health conditions: hypertension, obesity, diabetes, tobacco use, depression and substance use. The data indicated that 90% of the PROS members who participated in this pilot were at risk for at least one of these health conditions.

The project had concrete impacts on hypertension and obesity. The primary care physician alarmingly found that 73% of members with a history of hypertension were not receiving proper treatment, and were in need of pharmacological interventions. After receiving medications and improving their diet, 63% were able to reduce their blood pressure to below 140/90.

In terms of obesity it is well-documented that a side effect of some

psychotropic medications is weight gain. The data showed that 47% of the PROS members with obesity who worked with the primary care physician and the nutritionist lost weight. It is important to note that of the members with obesity who refused the nutrition consult, 100% of them gained weight during the project.

An added benefit of the project was the improved coordination of care. The primary care physician attended the morning PROS staff meeting, to review the status of consumers enrolled in the pilot. Several times a year the primary care physician and the PROS Psychiatrist met face-to-face to coordinate care for common consumers. These efforts paid off in that none of the members enrolled with the primary care physician were hospitalized for medical conditions during the two year pilot program.

The project, however, also experienced its share of challenges. A particular challenge arose when the primary care physician referred PROS members to outside specialty appointments such as a gynecology, cardiology, and gastroenterology, with the result that there was a high percentage of non-compliance. While members felt comfortable with the primary care physician in the familiar surroundings of the PROS, they felt uncomfortable with unknown medical providers outside of PROS. This was a particular issue for

members with a trauma background who were fearful that the exam might be invasive. Other members admitted to not going to the appointments because they were afraid that the test might find something "wrong" with them.

The PROS program was also unsuccessful in motivating members to partake in a free gym membership in an effort to help members lose weight, and improve cardiovascular fitness. Transportation was also provided. The effort was unfortunately halted due to minimal use of the benefit.

A third challenge involved attempts to expand the project to Article 31 clinics in the area. While the "milieu" of the PROS Program was conducive to the integrated medical services, efforts to duplicate the effort in outpatient clinics, which have a more fluid consumer base, were not successful.

The final challenge with the integrated care pilot program involved sustainability. The cost of providing the medical service was offset by the two year OMH grant. Under the "Fee for Service" billing mechanism, the rates paid by Medicaid / Medicare / Managed Care do not adequately cover the cost of providing the care. Even in the commercial sector, many private medical practices must affiliate with hospital systems in order to

Sleep Issues: An Opportunity for Integrated Care

Lied Metcalf, BSN, Director of Nursing for Behavioral Health, FEGS, and Amanda Saake, LMSW, CPRP, Senior Program Associate, Center for Rehabilitation and Recovery, Coalition of Behavioral Health Agencies

Who should take the lead when issues of sleep problems come up? Is the sleep problem a physical or a behavioral health issue? If a client only has diabetes, there is no question that the lead in the integrated team needs to be the primary care provider (PCP) or endocrinologist. If a person only has bipolar disorder, no one questions that the psychiatric provider should be leading treatment. But when sleep issues occur, it is not always clear if it is a physical or a behavioral health disorder. It may fall in between and, as a result, risks getting lost.

Up to 80% of patients in psychiatric settings report chronic sleep problems. Up to 90% of people with depression report sleep problems. Three-quarters of people with bipolar disorder experience insomnia or reduced need for sleep, and in direct contrast, 50% of those with bipolar depression experience excessive sleeping. Compare this to 10-18% of people in the general population experiencing sleep problems. Many people assume that the behavioral health problem is the cause. But this is not always the case. People

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Amanda Saake, LMSW, CPRP

with sleep problems are up to four times more likely to develop depression and sleep problems pre-date anxiety disorders 25% of the time. ("Sleep and Mental Health" *Harvard Mental Health Letter* (July 2009): Vol. 26, No. 1, pp. 1-3).

The interaction between sleep and behavioral health is a complex one. We know that even when mental illness is not

present, sleep deprivation can cause hallucinations, irritability and difficulty concentrating. When mental illness is present the effects of sleep deprivation can multiply. Many antipsychotic medications leave people feeling sedated, and some anti-depressants have the opposite effect, and keep people awake.

Sleep issues are also prevalent among

people with substance use disorders. In fact, sleep problems are 5-10 times higher in people with substance use disorders than in the general population (Vimont, Celia. "Sleep Problems and Substance Use Disorders: An Often Overlooked Link" *Partnership for Drug Free Kids* 26 July 2013. Web 3 July 2014). For many, "nodding off" can be a symptom of substance use, and many people use alcohol and/or other drugs as a sleep aid. But while alcohol helps people fall asleep, it interrupts the sleep cycle and many people wake up just a few hours later. For the newly abstinent, sleep can be disrupted for weeks; long after other initial withdrawal symptoms have subsided.

Sleep problems can take several forms, and neither too much sleep, nor too little, is healthy. The brain requires an appropriate amount of sleep to rest, refresh, and reorganize. Not enough sleep can result in memory problems, a weakened immune system, dysfunction in social settings, and of course, low energy.

When there is a problem, the first step is an evaluation. Whether the complaints are first heard by the behavioral health specialist or the medical provider, it is likely that primary care physicians and psychiatric providers will be involved. Depending on the initial findings, in addition to consulting with the behavioral health team, other specialists such as sleep

Integrating Physical and Behavioral Health Care Systems: Lessons Learned in New York City

By Trish Marsik, Assistant Commissioner, and Andrew Fair, Project Manager and Analyst, Bureau of Mental Health, New York City Department of Health and Mental Hygiene (DOHMH)

In New York City, as elsewhere, people with mental illnesses have worse physical health outcomes, on average, than the rest of the population. An estimated 239,000 New Yorkers live with serious mental illnesses, or SMI (Community Mental Health Survey 2012). They are significantly more likely to report fair or poor health compared to other New Yorkers (44% versus 20%), as well as hypertension, high cholesterol, and suffering from two or more chronic illnesses. While the causes of these health disparities are complex and varied, there are several consistent themes: people with SMI tend to smoke at a much higher rate than the rest of the population (in NYC, 44% versus 15.5%), and it is therefore not surprising that smoking-related diseases such as heart disease, respiratory disease, and cancer have been found to account for approximately 50% of deaths in people with SMI; psychotropic medications, including antipsychotics, can lead to substantial weight gain and an increased risk of diabetes; lifestyle factors, such as poor diet and physical activity, contribute as well; and, in spite of having worse health,

people with SMI are less likely to receive the medical care they need. Studies show that high numbers of people with SMI who have diabetes or heart disease do not receive treatment for their physical ailment.

The health disparities faced by people with mental illnesses, combined with gaps in treatment, point to an urgent need for better coordination and integration of physical and behavioral health care. For the purposes of this article, *coordination* means communication between behavioral and physical health providers to arrange consistent care for their shared clients and to exchange referrals. *Integration* means incorporation of physical health care expertise and capability into behavioral health practices. Both are essential to ensuring people with mental illnesses receive proper treatment for their physical health conditions, and to identifying risk factors and preventing physical illnesses from occurring.

DOHMH's HEAL 17 Experience

In 2010, the New York City Department of Health and Mental Hygiene (DOHMH) was awarded a State Department of Health grant, referred to as HEAL 17, to expand care coordination through the use of health information technology for individuals with schizophrenia and other psychotic disorders and/or major depression. The focus of this article will

be a behavioral health quality improvement project conducted as part of the HEAL 17 implementation. DOHMH worked with 17 different behavioral health programs (mostly mental health clinics, but also some PROS programs and clubhouses) from five different agencies to collect physical health integration data. DOHMH measured the extent to which individuals received an appropriate clinical service within a certain timeframe. For instance, one quality measure was the percentage of adults whose current body mass index (BMI) had been documented in the past six months. The other measures included tobacco use and treatment, diabetes screening and monitoring, primary care provider visits, cholesterol screening, and alcohol and drug use screening. These measures were selected to represent the physical health conditions and risk factors most relevant for people with SMI, and were calculated every month for one year.

As one might expect, the data varied greatly. For the most part, behavioral health programs reported high rates of screening for alcohol, tobacco, and other substance use. This was unsurprising, because screening for these addictive behaviors is broadly considered to be within the domain of behavioral health care. The programs reported a moderate level of tracking whether their clients had a recent primary care visit, whether tobacco users

were actively offered a cessation intervention, and whether clients had a documented BMI screening. These areas might be considered slightly outside the comfort zone of some behavioral health providers. Finally, the programs by and large struggled to report whether laboratory values were documented for cholesterol screening and diabetes screening and monitoring. Most of these behavioral health programs lacked their own integrated lab operations, and did not succeed in obtaining information on lab completion from their clients' physical health providers. In addition, the programs were often hampered by limited communication with their clients' physical health providers. This made it difficult for them to determine if their clients were overdue for diabetes and cholesterol screening.

While it remained a challenge for some, several programs reported increased information exchange with physical health providers, often owing to persistent efforts at establishing a communicative relationship. Some very simple infrastructure changes, like purchasing scales, allowed several programs to keep up with their clients' BMI and report this measure more consistently, while also paving the way for on-site weight-loss initiatives.

Many programs identified the importance of having on-site nursing support. Some

Towards Seamless Integration: Advocating for Reform

By Jeanie Tse, MD, Jason Cheng, MD,
Marc Manseau, MD, and
David Woodlock, ICL

Many people with serious mental illnesses have difficulty accessing primary care or do not feel comfortable in primary care settings, for a host of reasons. Often, they have experienced trauma, resulting in trust issues that impact their ability to form relationships with new providers. As a result, they use emergency services to obtain needed care, or allow health conditions to worsen to the point of requiring high-cost inpatient care. At the same time, many of these people are engaged in a behavioral health program. For this group, the natural solution is to provide physical health services within behavioral health settings, leveraging the relationships they have with existing providers with the goal of improving outcomes and reducing costs.

To encourage development of integrated services, the Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded grants for Primary and Behavioral Health Care Integration (PBHCI). Analysis of data from New York State grantees has already turned up promising results. For example, New Yorkers participating in PBHCI services with at-risk blood pressure (BP) readings at baseline had average reductions of 9 points on systolic BP and 5 points on diastolic

David Woodlock

BP. Research on blood pressure medication shows that similar reductions result in a 41% reduction in stroke and a 22% reduction in coronary heart disease events such as heart attack (Law MR et al 2009. BMJ. 338:1245-1253.).

As a NYS PBHCI grantee agency, ICL has implemented primary care in two mental health clinics and in a NYS Personal Recovery Oriented Services (PROS) program. ICL

has identified a number of challenges and potential solutions in the following categories, discussed below: (1) Reimbursement, (2) Health Records, (3) Physical space, (4) Staffing, and (5) Care Coordination.

Challenges and Solutions

Reimbursement: Part 599, Article 31 of NYS Mental Health Law allows state-licensed mental health clinics to bill Medicaid for health physicals, health monitoring, and complex care management. Health physicals can be billed once a year per patient. Otherwise, physical health visits with physicians, nurses, and nurse practitioners are billed as health monitoring. The health monitoring rate is about half the rate of social work clinician services for the same amount of time, making these services financially unsustainable. In addition, peer health coaching services and multi-disciplinary team meetings, both so central to the integration efforts of SAMHSA-funded agencies, are not reimbursed at all in the current structure. And while Part 599 has moved clinics forward, the NYS PROS and Assertive Community Treatment (ACT) models have not moved towards sustainable reimbursement for primary care services, even though these models often serve people with the most severe physical and mental illnesses.

Fee-for-service rates will become less important as the state Medicaid system

transitions to a managed care environment for behavioral health. Under more bundled payment models including capitation, it will be vital to ensure the financial sustainability of primary care and behavioral health providers working in fully integrated, ideally co-located teams, with open and frequent communication.

Health Records: Currently, many integrated care systems use one electronic health record (EHR) for behavioral health care and another one for physical health care. This situation commonly occurs when a behavioral health agency partners with a Federally Qualified Health Center (FQHC) that provides medical services at the behavioral health site and bills for these services at the enhanced FQHC rate. While this enhanced rate encourages partnership with FQHC's, having two agencies involved usually means two separate EHR's. For individuals choosing to access both physical and behavioral health care in the same location, information-sharing is more integrated and efficient if both types of care can be documented in the same system. The adaptation of reimbursement structures that make it more feasible financially for behavioral health agencies to provide physical health services would be one solution to this issue. The state's efforts to promote interagency communication via PSYCKES and the Regional Health Information Organizations

Partners in Integration: Addressing Need by Supporting NYC Workers

By Laura Bercuson, MSW
Project Manager/Analyst, ICL

In today's evolving healthcare system, there is a growing need for an integrated healthcare workforce to better address the needs of patients with complex and interrelated medical and behavioral health conditions. However, workforce development supporting skills enhancement around integrated practice are imperative to meaningful collaboration across systems. The home health care workforce in New York City provides essential services, and is in need of additional training and certification in order to meet the demands of a changing system. According to District Council 1707 (DC 1707), there are currently thousands of employed home attendants in New York City who are at risk of losing their jobs or not being able to secure new employment with home health care agencies unless they receive 35 hours of additional training to become certified as Home Health Aides (HHAs). Training opportunities that fail to meet workers' personal and professional demands puts them at risk of job loss. This would significantly impact the quality and availability of services to individuals with chronic health and behavioral health conditions. To address this need within the New York City healthcare workforce, ICL has recently secured funding from the New York

Laura Bercuson, MSW

State Departments of Health and Labor as part of the Healthcare Workforce Retraining Initiative to work with DC 1707 and the City University of New York (CUNY) to provide the 35-hour Home Health Aide (HHA) upgrade training to 500 or more DC 1707 members currently working as Home Attendants (HAs).

Through collaboration with CUNY's continuing education and workforce programs department and Lehman College, ICL will incorporate its expertise on

Trauma Informed Care to develop a trauma-infused framework into the 35-hour course. A Curriculum Committee consisting of representatives from CUNY, DC 1707, and ICL will be established to address this focus and to add an optional enrichment section that provides basic training on racial, ethnic and culturally-based health disparities, as well as simple but effective tools for helping patients self-manage chronic disorders such as diabetes. Finally, we will work with CUNY to embed a trauma-informed framework into the existing curriculum – reflecting ICL's leadership and expertise in Trauma Informed Care. We have made a steadfast commitment to the implementation of Trauma-Informed Care in all of our programs. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional approaches to care may ignore, so that these services and programs can be more supportive and avoid re-traumatization. Further, trauma has a profound impact on overall health outcomes and health-related behaviors, and enhancing the existing curriculum will provide prospective HHAs an opportunity to take a more holistic approach to their work. Though the curriculum for HHA upgrade is standardized, CUNY instructors will be encouraged to emphasize how trauma impacts health. By informing Instructors to address a trauma lens to care, HHA's
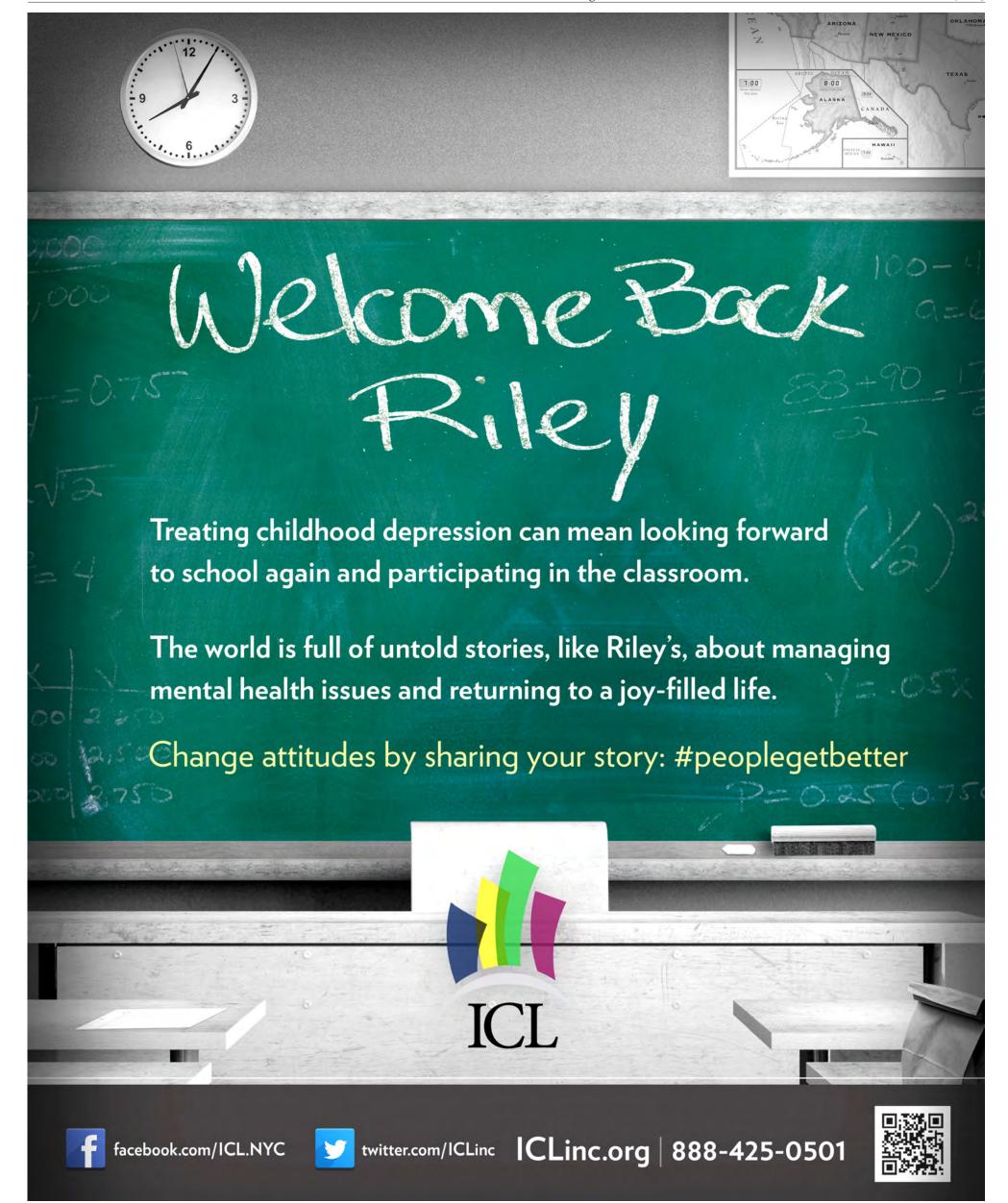
will better grasp how to provide sensitive care that addresses the whole person's past and present experiences.

Each year, there are approximately 240,000 registrations in CUNY's Adult and Continuing Education (ACE) programs, which are an important focus of workforce development activity at CUNY. ACE programs encompass literacy, GED preparation, English for Speakers of Other Languages (ESOL), and a large number of short-term training programs in areas such as health care, technology, business and office administration, buildings and construction, education and others.

District Council 1707 organizes New York City workers, and is a bargaining agent for NYC home attendants in need of the HHA upgrade training. ICL, through its own direct support personnel, has a growing relationship with DC 1707. DC 1707 will work collaboratively with ICL and CUNY to identify members who need and want the upgrade training, assist members in enrollment preparation, and facilitate enrollment at CUNY. The Healthcare Workforce Retraining Initiative grant has allowed this partnership to be established.

Through this collaboration, ICL, CUNY and DC 1707 will work to enhance the New York City healthcare workforce and ensure that a sizable group

Integrated Care Models to Improve Health Outcomes and Reduce Poverty

By Jorge R. Petit, MD
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FEGS Health & Human Services, in partnership with the Institute for Family Health (IFH), Health-first, Bronx-Lebanon Hospital, McSilver Institute of New York University, Mount Sinai Hospital, and Promoting Specialized Care and Health (PSCH) has been awarded a $925,000 grant from the Robin Hood Foundation to develop a new, integrated care model to improve health outcomes and reduce poverty among adults and children with mental illness living in New York City.

This transformative initiative aims to improve patient access to quality healthcare and social support by integrating the services of historically separate and distinct service providers. Additionally, the grant supports the development of a blueprint for citywide implementation of this model with a financially sustainable model through Medicaid. The grant partners will work collaboratively to improve the overall health of 2,000 adults and 3,000 children living in poverty in NYC. Importantly, this work will advance integrated care models among hospitals, Federally Qualified Health Centers (FQHC), non-profit agencies and Managed Care Organizations leading to true "population health" in the New York Metropolitan area. Finally the grant will require that all partners (and eventually the entire health and social service delivery sector) redefine the core focus of its collective efforts…which is about improving the lives of all our citizens.

Not only is this critical but it is time sensitive. As a nation we spend 2 ½ times more than any other developed country on health care services, which means U.S. health care costs consume

Jorge R. Petit, MD

about 18% of GDP and growing; yet we rank below 16 other countries in overall life expectancy. Moreover we under-invest in social services: for every dollar spent on health care, only 50 cents is invested in social services, whereas other developed countries spend roughly $2 on social services for every dollar spent on health care. In addition, we know that a small percentage of Medicaid recipients, especially those with complex health and social problems, drive more than 50 percent of all program costs; too many of them have chronic complex medical, behavioral health, and/or social service needs. Given the limited social service supports available through the current healthcare settings and the lack of coordination among the different service providers, these patients tend to end up in emergency rooms, have high rates of avoidable hospital admissions, and have

harder times engaging in and being adherent with treatment .

Mental health disorders are all too common and oftentimes mis- or under-diagnosed and/or inappropriately treated. In any given year, 1 in 4 New York adults have a diagnosable mental disorder. Untreated mental illness is connected to poverty, unemployment, academic failure, homelessness and poor health. The resulting impacts have been catastrophic; 90% of adults in New York with serious mental illness are unemployed, an estimated one-third to one-half of people who live with serious mental illness live at, or near, the Federal poverty level, 30% of young new Yorkers with a serious emotional disturbance graduate with a standard diploma, and approximately 35% of the homeless have untreated mental illness.

Moreover, lack of access to critical mental health services and care comes at unreasonably high costs, despite the fact that not only do we know how to treat mental illnesses but there are effective treatments for the major mental health disorders. Regrettably, the mental health system has operated in isolation from the general health care system, utilizing a "casualty model," where patients typically need to have very serious mental illness symptoms before they receive treatment and support; further enhanced by misaligned financial incentives, archaic State regulations and a separation between health and mental health care.

Something has to change in how we approach these issues; the current traditional healthcare system does not do a great job at effectively treating physical and behavioral health conditions due to a limited reach into the non-health care services such as supportive housing, vocational training and transportation, among others. This groundbreaking grant and its partners are poised to be transformative and ultimately show that delivering integrated care is feasible and makes clinical

and financial sense. The grant will address many of these challenges and barriers that have such negative consequences on New Yorkers by creating an Integrated Delivery System (IDS) among the grant partners across the continuum of care. The IDS will be based on the implementation of collaborative care at several clinical sites (hospital-based as well as within FQHCs) as well as the creation of a "promising practice" in the delivery of integrated care for children and their families in the South Bronx. Additionally, the grant partners will work closely to develop standards of work, processes, and practices for the development of the IDS as well as performance and outcomes metrics with clear lines of accountabilities across the partners.

Another important component of this grant will be an intensive impact analysis of the integrated care pilot for children will be conducted with a sub-set of 200 children, using rigorous methods designed by the New York University McSilver Institute for Poverty Policy & Research in collaboration with FEGS, Bronx Lebanon Hospital and Healthfirst. The McSilver Institute for Poverty Policy & Research oversees numerous applied research studies aimed at addressing the root causes of poverty, as well as examining approaches to reduce its effects.

The grant partners are confident that this grant will provide New York with the needed tools to replicate and scale IDS throughout the city and state as well as demonstrate a return on investment for this type of collaborative care service model(s) that Managed Care Organizations will want to fund and promote. Lastly, the grant will provide direct medical and specialty services to a large number of New Yorkers and will track overall outcomes… with the aim of improving the lives of these New Yorkers, their families and communities…which should be our # 1 priority.

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in which I played leadership roles. But I'm OK with that. I'm still active and involved. But I have different expectations, desires, and goals.

Understanding developmental changes is a critical aspect of understanding subjective, successful aging.

Implications for Providers

Health providers generally pay attention to the factors that contribute to **objective** successful aging—good physical and mental health, absence of functional disability, and cognitive capacity. Subjective successful aging is another matter.

Health Care To Promote
Objective Successful Aging

Unfortunately, physical health providers usually don't pay enough attention to behavioral health issues, and historically behavioral health providers have not paid enough attention to physical health issues. These facts are now well-known and have led to a widespread call for enhanced

"integration" of treatment for people of all ages, including older people. Proposed improvements include:

- Routine screening by physical health providers for behavioral health conditions such as depression, anxiety, and substance misuse.

- Routine monitoring of health and health care by behavioral health providers.

- Improved quality of care, built on the use of evidence-based practices

- The use of care managers for outreach and engagement and to promote adherence to treatment regimens

- Improved communication and coordination among physical health, mental health, and substance abuse providers especially through the use of computerized information systems

- More co-location of physical and behavioral health services

- Greater connection between acute

and long-term care for both physical and mental conditions

- Greater attention to improved functioning in the community rather than just to treatment of disorders

- Ideally, increased use of integrated treatment team models.

It is important to note that most care for older adults is provided by people with no special knowledge about geriatric medicine or behavioral health. This is generally problematic, but it is of particular concern because of the changing risks of certain medications and dosages as people age. For example, some anti-depressant medications increase risks of disability and mortality in older people. And some antipsychotic medications can have a perverse effect on people with dementia.

Clearly, there's a significant need for development of a knowledgeable workforce in geriatric physical and behavioral health as well as for more extensive use of tele-medicine to spread the limited expertise that exists.

In addition, "wellness" has become an

increasing focus for healthcare providers. This basically means helping people to maintain and improve their physical and mental health. It includes: weight control, smoking cessation, limited use of alcohol and other addictive drugs, good nutrition, and adequate exercise.

Of course, there's nothing new about this in standard medical practices. Doctors have been telling their patients to lose weight, stop smoking, get exercise, etc. for many, many years. For the most part patients ignore their doctors' advice.

Wellness is relatively new for behavioral health providers, who historically ignored their patients' physical health. Now it is a major focus of psychiatric rehabilitation.

The key to effective wellness is helping people to do what they mostly know they should do. It can be helpful to engage people in group approaches to smoking cessation, weight control, exercise, and confronting addictions.

But a great many individuals simply aren't joiners. Lifestyle changes happen when people are motivated to change.

Integrated Care Supports Improved Outcomes for Individuals With Chronic Illnesses and Behavioral Comorbidities in Health Home Settings

By Sandra L. Forquer, PhD
Senior Vice President, State
Government Programs, Optum

The prevalence of comorbid chronic physical and behavioral health conditions is high. Treatment for mental health and substance use conditions have historically been provided in systems of care that are separate from primary care and physical health. Optum recognizes that these fragmented approaches are not as effective. Integrated care promotes a person-centered approach with a whole-health focus. This also fosters the inclusion of social and community resources in the development of systems of care that promote well-being and resiliency.

The Affordable Care Act and other health reform initiatives to improve the quality and outcome of care have also promoted new service delivery models. These include Accountable Care Organizations (ACOs), Health Homes/Patient-Centered Medical Homes (PCMHs), Federally Qualified Health Centers (FQHCs), and Federally Qualified Behavioral Health Centers (FQBHCs), among others. Each of these systems of care have built their own solutions for providing services for physical and behavioral health conditions. The Health Home model of care has

been endorsed by the Centers for Medicare and Medicaid Services (CMS) as an approach that fosters integrated care for chronic physical and behavioral health conditions.

Historically, models of collaboration between primary care and behavioral health providers have been in use for many years. For instance, five levels of collaboration have been described by Doherty, McDaniel, and Baird (1996). These include: 1) Minimal collaboration; 2) Basic collaboration from a distance; 3) Basic collaboration on site; 4) Close collaboration in a partly integrated system; 5) close collaboration in a fully integrated system. Druss (2011) has described three models of behavioral health and primary care integration. These include a *fully integrated* medical and behavioral health staff model where providers equally participate within a single organization; a *partnership model* in which primary care and behavioral health providers are embedded within a medical or behavioral health clinic or organization; and a *facilitated referral* model where staff are not physically present, but formal arrangements support information sharing and referrals.

Most evidence-based approaches for addressing comorbid chronic physical illnesses and behavioral health conditions have been built from the framework developed in the Chronic Care Model

(Druss, 2011). Six core elements of this approach include self-management support; decision support; delivery system design; clinical information systems; health care organization; and community resources. Optum recognizes the importance of health homes in comprehensive systems of care and has also identified several similar keys for the integration of care in health homes and other organized systems of care. These include; cross-training primary care and behavioral health clinicians on common medical comorbidities; emphasizing wellness and preventative care across provider systems; sharing medical and behavioral health information through electronic health records; increased measurement and monitoring of treatment pathways and outcomes; and sharing decision-making with consumers. Treating patients from a combined behavioral and medical perspective is respectful of their choices and empowers them to take an expanded role in directing their own care.

Optum provides a range of services through a Network Administrator model to support Health Homes in their coordination of care. This scalable approach provides newly emerging groups of providers with the necessary infrastructure resources to begin to aggregate service and coordinate care. For more mature health home organizations, the Health

Home Network Administrator (HHNA) framework can be tailored to meet the specific requirements of states and other payer systems to assume responsibility for population health management and outcomes.

Optum has implemented the HHNA framework in Washington. Some of the core components of the model include support for shared information and clinical responsibilities. The Optum Washington Health Home System provides a common platform for this shared information. A single web-enabled management information system supports these health homes. This is used to communicate, document, monitor and track, and support administrative functions across provider systems. Utilizing this portal, interdisciplinary treatment teams are able to support beneficiaries and their families. The access to and sharing of information is controlled by appropriate release of information documentation. Care planning and documentation are provided through paper copy, fax, secure e-mail, and electronically on the web portal.

Shared care coordination responsibilities are also promoted through the HHNA model. Services are provided by a combination of licensed clinicians and wellness coaches. Care coordinators have primary responsibilities for assisting beneficiaries

Upgrading Skills in a Changing Mental Health Care Environment

By Carolyn Castelli, MSN, RN-BC
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Westchester Division

As healthcare has changed over time, so too has the knowledge and expertise required of the practitioners. Computer literacy for electronic medical records, knowledge and application of research and evidence-based best practices, and patient satisfaction are but a few of the most recent requirements. And, as information is more accessible, consumers are demanding more information about their providers and treatments; they are choosing providers based not only on their credentials, but on their advanced degrees, certifications, and their ability to empathize.

At NewYork-Presbyterian Hospital/ Westchester Division (NYP/WD), the ways and means in which mental health professionals upgrade their skills in a constantly changing mental health care environment have historic roots. With roots dating back to 1808 and the original New York Hospital Asylum, we have provided continuous inpatient services to those with mental illness. We value our responsibility to continue the legacy passed on to us. As part of a teaching hospital, over the years we have trained medical students, nursing students, social work, psychology, and psychosocial rehabilitation specialists, and do so to this day.

Our primary focus is putting patient care first above all else. We respect patients and families by keeping them at the center of their treatment and recovery. Interdisciplinary teamwork is hard-wired as we provide empathetic care, ensure excellent quality and service, and find innovative, cutting edge solutions to treatment planning and work-flow. To ensure that staff provides the highest quality care, NYP/WD has developed a number of initiatives to increase knowledge and competencies, including formal education, certifications, ongoing training and real world practice. According to Linda Espinosa,

Carolyn Castelli, MSN, RN-BC

MS, RN, Vice President of Patient Care Services and Nursing, "We've seen the quality of care, patient satisfaction and employee engagement increase as our staff has become more educated and leaders in their respective fields." By emphasizing the importance of education and reinforcing it, our clinicians are able to provide care according to current best practices. When available, staff can participate in established programs; if not, we create our own to address the need.

NYP has partnered with a number of schools to create an RN to BSN Program, Executive Master of Science Public Administration: Concentration for Nurse Leaders (EMPA), a Master's in Nursing Education, and a Doctorate in Nursing Practice for nurse leaders. An education stipend is available so an advanced degree is attainable rather than a burden. For areas where no formal program is available, we create our own to fill the need. Due to shorter lengths of stay for patients, our Department of Social Work responded by enhancing skills in the area of brief treatment. They created a curriculum for social

workers to learn about creating narratives with patients, treatment contracting, assessing risk, stabilization of acute symptoms, developing safety plans, as well as empowerment and recovery.

When staff members receive their degrees, they are encouraged to continue their education and pursue certifications in their respective fields. More than a third of our nurses are nationally certified in their specialty. Many of our Psychosocial Rehabilitation therapists completed Cognitive Behavior Training and went on to become licensed. Staff Chaplains are increasingly required to become certified as Board Certified Chaplains and/or Clinical Pastoral Educators. These certifications show a commitment to becoming experts in every field in order to provide the best quality care to patients.

After receiving a degree and/or license, the hospital encourages maintaining and updating skills on a regular basis. Through ongoing in-service training, grand rounds, seminars, management training and mandatory yearly education requirements, staff remain current on behavioral health treatment methods and learn about best practices from the literature and other institutions. Additionally, staff is encouraged to publish their work, to participate in poster presentations, and attend and present at conferences.

One of the most important parts of education is putting it into practice. The Department of Nursing has an established Shared Governance Model, which encourages nurses in direct patient care with a mechanism to change practice based on research evidence. The clinical Career Pathway program fosters professionalism, leadership, consultation, and teaching by the direct care nurses. Our Primary Nurse model for direct care nurses enhances the development of the therapeutic relationship of the nurse and nursing support staff team with their primary patients. Nurses endorse the recovery model by allowing patients to direct their care with the guidance and advocacy of their Primary Nurse. By modeling certain techniques and behaviors, our

patients see firsthand how to utilize skills they are being taught.

Yet education goes beyond the classroom and peer training. In some ways, updating very basic skills is what is needed. According to Beth Harris, RN, MA, PMHCNS-BC, Coordinator of Health Education, "We've moved from self-learning (hard copy) manuals to online manuals and in some cases to interactive online learning. We allow employees to complete required educational materials electronically from home when they prefer. All staff members have 24/7 access to the Medical Libraries from all hospital computers which translates to staff members being able to search the literature for research and evidence 24/7." By embracing technology, we are better able to adhere to current requirements. Our staff reduces errors by inputting all patient information into electronic medical records to better track the patient's progress, medication, and status. While basic, these skills are necessary to ensure a better and safer patient experience.

With rapid changes occurring in healthcare on a regular basis, all healthcare providers in acute care settings, including mental health, must upgrade the professional skills in their treatment-toolbox. On-going professional growth, education, and teamwork, in addition to partnering with clients and families in their recovery, provide the best outcomes with the most efficient, cost-effective means possible. Healthcare professionals cannot be inflexible and reluctant to learn new evidence-based ways and means of caring for patients. The ability to be engaged, flexible and innovative, to seek evidence in the research for best practices, to be a life-long learner, to take the next generation under their wing – these are essential skills. Preceptors, mentors, supervisors, managers, and leaders should encourage their protégés and supervisees to develop and apply these skills. Herein resides the best hope for acute care hospitals and their constituents to not only survive the future, but to thrive.

Lessons Learned from page 10

programs hired nurses to direct or assist with wellness initiatives; others re-dedicated nurses already on staff to take charge of groups for smoking cessation or weight loss; and others still made plans to hire nursing staff to help meet the needs identified through their quality reporting project.

Finally, all programs made progress with their routine assessment of tobacco dependence and assistance with cessation. Thanks to a partnership DOHMH arranged with the New York State Tobacco Cessation Centers, each program received tailored training and technical assistance on tobacco dependence treatment. Consequently, the reported quality measures for tobacco screening and intervention demonstrated marked improvement over the year.

Recommendations

Drawing from the challenges and strategies identified by our behavioral health

partners, we arrived at a set of recommendations for integration and coordination of behavioral health and primary care.

1) Build stronger relationships between behavioral health and primary care providers. In order to coordinate effectively around client care, behavioral health and primary care providers must make a greater effort to communicate directly with each other as a virtual care team. This means both reaching out (for instance, about changes in health status or medication regimen), and being receptive to feedback from one another. Those who were able to most effectively coordinate care had made special effort to establish relationships with an array of providers from "across the fence" of health specialty. This included both those already treating their own clients for a separate health concern, as well as providers they relied on for exchanging referrals. Relationship-building strategies include making extra phone calls and arranging "meet

and greets." While time consuming, there is long-term benefit to these efforts—the behavioral health providers who most consistently communicated with their clients' primary care physicians reported that they felt better able to manage their clients' whole health.

2) Hire new staff and/or train existing staff to address basic physical health concerns such as diet, physical activity, and smoking cessation. As mentioned above, several programs saw considerable benefits from incorporating nursing staff. These nurses measured consumers' vital signs, conducted groups on smoking cessation and weight reduction, and helped manage their clients' diabetes care by following up with physical health providers. Some behavioral health programs have even co-located physicians to provide primary care services right on site, allowing consumers who have difficulty keeping primary care appointments to receive these services at the same setting

where they already get their behavioral health care. Unfortunately, current reimbursement structures do not motivate the incorporation of primary care medical services into behavioral health settings, so outside funding has been required to support such efforts. However, even training existing behavioral health staff in physical health integration can have far-reaching benefits. Behavior change efforts around smoking cessation, physical activity, and nutrition can be championed by social workers and psychiatrists. Indeed, when behavioral health providers take the lead in these areas, it sends a message to consumers that they are invested in their whole health.

3) Improve the use of health information technology systems both for management of consumers' health and for information exchange between physical and behavioral health care providers. While some

Mental Health Integration in Pediatric Primary Care Practices in NYC

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The primary goal of mental health integration in pediatrics is prevention and early intervention. Mental health integration in pediatric primary care is increasingly recognized as a key approach to support children's healthy social and emotional development and intervene early to prevent more serious problems from developing later. Mental health conditions are common in pediatric populations (about 20%) yet are often unidentified and untreated (Perou et al., 2013). Over time, untreated mental health disorders are associated with impaired functioning, troubled family and peer relationships, substance use, and school failure (National Academy of Sciences, 2009). The pediatric practice is an accessible, non-stigmatizing setting for mental health screening and integration of mental health services because children have regular well-child visits during which parents/caregivers expect developmental guidance and expertise from pediatricians and form trusting relationships with them over the long-term (SAMHSA-HRSA CIHS, 2013).

Successful integration of mental health into pediatrics should include screening and promotion of healthy development, addressing risk factors, assessing how social-emotional and other developmental domains are intertwined, and working with parents/caregivers.

Developmental and Behavioral Screening

One important goal of integrating mental health into pediatrics is to identify children with behavioral health challenges. Screening during routine well-child visits provides an opportunity to ensure that children with mental health challenges are identified as early as possible when intervention is most effective and cost-efficient (American Academy of Pediatrics, Committee on Children with Disabilities, 2011). While it is standard practice for pediatric care providers to ask about developmental and behavioral concerns at every well-child visit (referred to as surveillance), few use a formal screening instrument. Without a validated screening instrument, however, providers in one systematic review were only able to correctly identify 14% to 54% of children with a developmental-behavioral problem (Sheldrick, Merchant, & Perrin, 2011). A screening tool completed by a parent prior to a pediatric visit improves early recognition by identifying far more children with developmental and social emotional needs than surveillance alone, even performed by a seasoned clinician (Guevara et al., 2013). The American Academy of Pediatrics (AAP) recommends use of standardized valid developmental and behavioral screens as an integral component to well-child care (AAP Committee on Psychosocial Aspects of Child and Family Health, 2009), and the American

Academy of Child and Adolescent Psychiatry (AACAP) supports the integration of mental health in pediatric primary care (AACAP Committee on Health Care Access and Economics, 2009).

Models of Mental Health Integration in Pediatric Practices

Successful integration of mental health in pediatric care practices depends on a number of factors. A Substance Abuse and Mental Health Services Administration (SAMHSA) framework describes a continuum of integration with increasing degrees of collaboration, co-location of services, and medical record and system integration (Heath et al., 2013). For integrated teams to work effectively, team members need skills and competencies in interpersonal communication, care planning, collaborative teamwork, and informatics, among others. On-site mental health clinicians are available to address developmental and behavioral concerns, and can function as a consultant or even as a primary therapist. These clinicians need to have flexible schedules so that they can be available for same-day consultations, brief follow-up interventions, supervision of screening, and informal consultations (Stancin & Perrin, 2014).

One evidence-based model for integrating physical and behavioral health services within adult primary care is the collaborative care model; it has been found to improve health and mental health outcomes while reducing health care costs (Unutzer, Harbin, Schoenbaum, & Druss, 2013). The key clinical activities are care

coordination, monitoring patient progress to treatment targets, and "step up" of treatment to specialty care, using a care manager and consulting psychiatrist as part of the integrated team. The collaborative care model is increasingly used in pediatric community clinics to target Attention Deficit Hyperactivity Disorder and anxiety disorders. Studies show the model reduced child behavioral and anxiety symptoms as well as parental stress, and was well accepted by parents (Kolko et al., 2014, and Myers et al., 2010).

The NYC Department of Health and Mental Hygiene (DOHMH), through a SAMHSA grant, Project LAUNCH, funds a model that co-locates an early childhood mental health psychologist and a primary care assistant within pediatric clinics at a Federally Qualified Health Center and a municipal hospital. This model includes conducting routine social-emotional (mental health) screening, and providing assessment, short-term treatment, referral and follow-up when needed. The mental health clinician works with the child and caregiver together during assessment and treatment. Several other NYC programs provide mental health consultation to young children and their families through city and state funding mechanisms so that mental health clinicians from behavioral health agencies are co-located in various pediatric clinics that serve high-needs children.

To better understand models, and successes and challenges of mental health integration in NYC pediatric clinics, in

Integrating Screening Brief Intervention and Referral To Treatment (SBIRT) into School Based Health Centers (SBHCs)

By Gerry King, LMSW, MPA,
Prevention Supervisor, New York State
Office of Alcoholism and Substance
Abuse Services (OASAS)

Adolescence is a time of dramatic physical, mental and emotional growth and development but also a time when significant risks exist. Adolescence is the time when many youth begin to experiment with alcohol and other drugs (AOD). Research has shown the brain is still developing until age 25, and is more vulnerable to the harmful effects of alcohol and other drugs. Cognitive functioning of the brain can be permanently impaired even if the adolescent stops using (Schweer, 2009). It is important to prevent and/or delay as long as possible the onset of AOD use as individuals are four times more likely to develop alcohol dependence if they begin drinking before the age of 14 compared to those who wait until age 21. The data is similar for early onset of regular marijuana smoking (Hingson, 2006).

Substance use is a major contributor to the three leading causes of death among adolescents: motor vehicle accidents,

homicides and suicides. (American Academy of Pediatrics, 2010). 32.5% of New York State (NYS) high school students, grades 9-12 are current drinkers (reported drinking in the last 30 days), 21.4 % current marijuana smokers (reported smoking marijuana in the last 30 days) and 18.4% report binge drinking (five or more drinks of alcohol in a row in past 30 days) (2013 NYS YRBS). Binge drinking results in increased risk for: riding with a driver who had been drinking; smoking cigarettes or cigars; being a victim of dating violence and using illicit drugs. Teens that use alcohol, marijuana or other drugs are more likely to be sexually active, to engage in risky sexual behavior and to experience the negative consequences of risky sex e.g. unintended pregnancy or contracting a sexually transmitted disease, compared to those who do not use substances. Adolescent substance users are also twice as likely to have poor grades and drop out of high school. (Bryant, 2003). Lastly, the costs of underage drinking, (youth violence, youth traffic crashes, high risk sex, youth property crime, youth injury, poisoning and psychoses, FAS (mothers age 15-20) and youth alcohol treatment) in NYS are substantial with

underage drinking costs estimated in 2010 to be $3.3 billion annually. (Pacific Institute for Research and Evaluation, 2011).

Overview of SBIRT

Fortunately there is an evidence based healthcare intervention called Screening, Brief Intervention and Referral to Treatment (SBIRT) that can provide early intervention services to adolescents who have begun to use AOD. SBIRT can be provided in a variety of healthcare settings e.g. emergency rooms, primary health clinics, college campus health centers, school based health centers (SBHCs) etc. Individuals undergo Screening, using a valid and reliable screening instrument to assess their level of alcohol and drug use. If they're determined by the screen to be at risk, they receive a Brief Intervention that focuses on raising their awareness of their substance use, identifying existing or potential consequences of their use and motivating them to change their behavior. Individuals who need more extensive treatment receive Referrals to Treatment. SBIRT is ranked among the top five most beneficial and cost-effective preventive health services by the US Preventive Services Task Force (Solberg, 2008). SBIRT is rated higher than screening for high blood pressure, high cholesterol, breast, colon, or cervical cancer, and osteoporosis. SBIRT has been shown to reduce both alcohol and other drug use and the consequences associated with both. Research shows a savings of $4.30 for every $1 spent on SBIRT. Center for Substance Abuse Treatment (CSAT) has the goal to help integrate SBIRT throughout the entire health care system.

Effectiveness of SBIRT With Adolescents

SBIRT is a good fit for adolescents as they tend to not have a long history of AOD abuse, many times are ambivalent regarding changing their substance use, desire autonomy, and often resist authority. The self-guided structure of SBIRT does not force adolescents to admit having a problem. This approach avoids confrontation and instead allows adolescents to develop their own goals. Abstinence from alcohol and other drugs may not necessarily be the initial goal, but by

— The NYSPA Report —
New Medicaid Restrictions on the Prescription of Benzodiazepines

By Rachel A. Fernbach, Esq.
Deputy Director and Assistant General
Counsel, New York State Psychiatric
Association (NYSPA)

Late last year, the New York State Medicaid Drug Utilization Review Board (DURB) recommended new protocols in connection with the prescribing of benzodiazepines under the Medicaid program. Benzodiazepines, a controlled substance, are a class of psychotropic medication used to reduce symptoms of anxiety as part of the treatment of many mental illnesses. This class of psychoactive medications includes, for example, Valium®, Ativan®, and Xanax®. The new protocols went into effect on March 20, 2014 and include, among others, a requirement for anti-depressant step therapy prior to initiation of benzodiazepines in the treatment of generalized anxiety disorder and social anxiety disorder and a requirement for anti-depressant therapy concurrent with benzodiazepines in the treatment of panic disorder.

The New York State Psychiatric Association (NYSPA), the state medical specialty association of psychiatrists, is concerned that these new restrictions on benzodiazepine therapy do not reflect generally accepted psychiatric practice, may disparately impact access to necessary psychiatric care and treatment for Medicaid beneficiaries, and will significantly increase the burden on psychiatrists and other physicians choosing to prescribe these medications.

For example, one of the new protocols requires that a benzodiazepine used in the treatment of panic disorder be prescribed concurrently with an antidepressant, unless the prescriber contacts the Medicaid managed care plan and successfully advocates for coverage of the benzodiazepine on its own. Mandatory concurrent use of an anti-depressant along with a benzodiazepine is not supported by well-established guidelines for the treatment of panic disorder. The American Psychiatric Association Practice Guidelines for the Treatment of Panic Disorders (the "Practice Guidelines") do not advocate for concurrent or step therapies in connection with benzodiazepines because benzodiazepines provide an effective opportunity for rapid symptom reduction. Even though certain anti-depressants are considered effective therapies for the treatment of panic disorder, they are not appropriate or indicated in all cases for a variety of reasons.

Another protocol creates a new step therapy requirement in connection with an initial benzodiazepine prescription for generalized anxiety disorder (GAD) or social anxiety disorder. In this case, the initial benzodiazepine prescription will not be approved absent a previous anti-depressant trial, unless the prescriber intervenes and successfully demonstrates that the step therapy would not be clinically recommended. In fact, this new protocol directly conflicts with generally accepted psychiatric practice, which provides for the use of a benzodiazepine for short term relief with the possible subsequent introduction of an anti-depressant for long term symptom reduction. Under no circumstances would a psychiatrist treating a patient with acute GAD or social anxiety symptoms prescribe a trial of anti-depressants to be followed up with a benzodiazepine. In fact, this approach represents the direct opposite of generally accepted treatment protocols for patients with acute GAD and social anxiety disorder.

Under both the step therapy and concurrent therapy recommendations, if prescriber intervention and advocacy is not successful, providers would be required to either take patients off their current benzodiazepine in order to "try" an anti-depressant or add an anti-depressant to current medication regimes even if the patient is clinically stable. However, if a patient is doing well on a benzodiazepine and is showing no evidence of tolerance or dependence, there is no clinical reason to take them off their medication. Many individuals experience withdrawal symptoms in connection with tapering of benzodiazepines and to subject them to these possible symptoms in favor of an unwarranted anti-depressant trial seems clinically inappropriate. Further, all anti-depressants are not effective for all individuals and many have undesirable side effects. As noted in the Practice Guidelines, benzodiazepines represent an excellent treatment option for individuals with severe symptoms that need to be controlled rapidly and should not be compromised by step or concurrent therapy requirements that fail to conform to generally accepted psychiatric practice and appear to have no actual clinical benefit.

Further, these new protocols may place a disproportionate burden on outpatient mental health clinics that treat Medicaid beneficiaries with chronic mental illness. Prior approval protocols such as these expend valuable clinical time and resources, taking time away from patient care and resulting in reduced access to necessary services. This is at a time when, due to increased regulation of controlled substances and a documented reluctance among primary care physicians to prescribe benzodiazepines, more and more patients with chronic mental illness including anxiety related symptoms are seeking care at mental health clinics, only further burdening an already overburdened system of care.

These new restrictions on benzodiazepine therapy come close on the heels of New York's I-STOP program, which went into effect on August 27, 2013 and requires that physicians consult an online database to review a patient's controlled substance prescribing history prior to writing new prescriptions for Schedule II, III or IV controlled medications. To the extent that the DURB recommendations in question were intended to address concerns regarding overutilization of benzodiazepines, it seems clear that the State has already taken steps to address the problem of abuse and diversion of controlled substances. NYSPA strongly supports efforts to reduce doctor shopping and illegal diversion of controlled medications, including an additional DURB protocol that requires prescriber involvement in connection with concurrent opioid and benzodiazepine prescriptions. However, where a prescriber has already consulted the I-STOP registry to confirm that diversion or misuse is not a concern and the use of other opioids is not contemplated, the proposed step therapy and concurrent therapy protocols represent unnecessary additional restrictions on the prescription of essential psychiatric medications.

NYSPA has already written to the DURB and the Department of Health to express its concerns regarding these new restrictions and the need for prescriber involvement, which will likely cause a significant delay in patient access to necessary medications. These proposals clearly subject Medicaid patients to an inferior standard of care and NYSPA strongly supports a stay in implementation pending further review and input from the provider community.

Rachel A. Fernbach, Esq.

Give the Gift of Hope to Someone in Need: A Gift Subscription to Behavioral Health News

One Runner at a Time: We Are Slowly Eroding the Stigma of Addiction

By John Tavolacci, LCSW, CASAC,
Executive Vice President
and Chief Operating Officer,
Odyssey House

Recovery from substance use disorders often resembles training for a marathon. It's a long process that requires discipline, focus, and ongoing effort. As addiction experts and mental health professionals gain greater insight into the behavioral-physical health connection, fitness programs are proving to be important components of long-term recovery.

This is particularly true at Odyssey House, where recovery includes engaging in regular physical activity and taking responsibility for your health. Research shows that exercise not only improves cardiovascular function and has other physical benefits but can also elevate mood, alleviate stress, and even improve brain function.

Exercise makes us feel better, both mentally and physically, and that is why physical fitness is such a big part of the Odyssey House experience. In my 25 years of clinical experience, I have personally seen the positive impact physical well-being has on the recovery process. Recreational activities, like running, help residents stay fit, develop self-confidence by achieving personal goals, and feel like they are a part of something larger.

A Perfect Antidote to Addiction

At Odyssey House, we encourage people in recovery to participate in physical fitness programs as varied as long-distance running, weight training, basketball, softball, Pilates, and yoga. Facilities are outfitted with exercise equipment and weights. In 2001, I founded "Run for Your Life," a program that brings residents of all ages together several times a week in New York's Central Park to walk or run. We have since had more than 300 clients and staff members complete the NYC Marathon.

The most widely understood benefits of regular exercise include weight loss, improved strength and enhanced cardiovascular health. And while physical health is an important reason for following a personal fitness plan, the effects of exercise aren't limited to speed, strength and endurance. It also addresses the negative breakdown of the human spirit and provides those in recovery with a constructive, healthy way to spend their time. Addiction is time-consuming – a constant cycle of using and searching for the next fix. Training for a marathon, or embarking on a fitness program, fills that time. It requires long-term planning and commitment, necessary qualities for sustaining a lasting recovery and making exercise, in many ways, a perfect antidote to addiction.

John Tavolacci, LCSW, CASAC

Many of our clients enter treatment with decimated self-esteem and exercise gives them something to feel good about. The sense of accomplishment from completing a marathon or reaching a fitness milestone is powerful – it can help carry clients through the difficult stages of early recovery and gives them a reason to stay in treatment when they get discouraged.

Exercise Can Boost Treatment Goals

Although exercise regimens are not yet part of traditional recovery programs, new research is lending evidence-based support to the potential for exercise to boost traditional treatment. A study at Butler Hospital, an affiliate of Brown University, found that individuals in early recovery who participated in regular exercise were more than twice as likely to be abstinent from alcohol as the control group (Sejourne, 2014).

Exercise can also improve the brain's ability to resist the temptations of addictive drugs. Two independent studies funded by the National Institute on Drug Abuse indicate that exercise does more than simply provide an alternative activity that reduces the time available for drug seeking; both exercise and addictive drugs raise levels of dopamine in the brain's reward system, and as a result, exercise may compete with cocaine as a source of pleasurable sensations (Whitten, 2012).

Power of Team Building

Social interaction is also crucial to recovering addicts, who must learn to build relationships without the help of drugs or alcohol. In addition to the direct physical and mental impacts of addiction, many recovering addicts and alcoholics have found organized exercise to be a source of camaraderie and support. Our marathon runners, for example, depend on each other to get them through the long training runs and past mental road blocks, both on the road and in treatment. And it's not just our clients who are united in recovery. When our staff and clients train together, it establishes a mutual respect that evolves into improved therapeutic relationships.

Running also helps our clients reintegrate back into their community. People struggling with substance use disorders are often seen as a lost population. But our marathon team is changing the stereotype. Over the years, as Run for Your Life has become known in Central Park, I have seen the difference in how people respond to our clients. Once a source of concern, our clients are now a source of inspiration. One runner at a time, we are slowly eroding the stigma of addiction.

As our clients reintegrate, they become active members of their community and give back. Our marathon team is involved with Achilles Track Club, an organization that provides support, training, and technical expertise to people with disabilities. The Run for Your Life team volunteers at Achilles races and acts as guides for their runners. By giving back to the community, our clients reinforce their commitment to recovery.

Join us on September 20, 2014 for the 9th Annual Run for Your Life 5K Run & Recovery Walk. This event brings together individuals in treatment, their families and friends, and supporters of recovery services to promote the societal benefits of prevention, treatment, and recovery for mental health and substance use disorders. Visit odysseyhouseinc.org for more information and to register.

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Behavioral Health Medical Homes: An Approach to Integrated Care

By Jason Cheng, MD, Rosemarie
Sultana-Cordero, MA, LMHC, Jeanie
Tse, MD, and Zelma Muhammad, ICL

"At first I was scared. I started skipping my appointments with my therapist and also Dr. Levy. I did not want to deal with it. But then my therapist and the doctor called me at home. They told me I was not alone and they wanted to help me. That made all the difference. I came in. The doctor took time to explain it to me. Everyone wanted to know how I was doing. Even the director of the program. I'll never forget that. I wasn't alone."

This is the story of Zelma Muhammad, an ICL client newly diagnosed with pulmonary sarcoidosis, an inflammatory lung condition. She asked to be identified by name because she wanted to help break the stigma around mental illness. Having moved from Baton Rouge to New York City, she was overwhelmed by the transition and began suffering from depression, often feeling isolated and angry. She consulted providers for both her depression and physical health but found the experiences disappointing: "Doctors and staff acted like they didn't care if I came or went."

It's the story of many: struggling with physical health diagnoses compounding behavioral health issues, the urge is to withdraw and ignore. The unsympathetic response of a fragmented health care system only worsens the problem. However, Zelma's own situation began to change. She says, "When I came to Rockaway [Parkway Center], it was different. Here someone really cares. They know my name from the front desk on up. This is my family." With the efforts of a caring multidisciplinary team, a behavioral health clinic can become a welcoming "home" where the needs of the whole person can be addressed.

Rosemarie Sultana-Cordero, MA, LMHC

It's no longer news: people living with serious mental illness (SMI) die 25 years younger than people in the general population, mostly due to common preventable medical conditions such as heart disease, stroke and diabetes. In response, providers across the nation are integrating primary and behavioral health care to achieve the triple aim of producing better outcomes, improving consumer satisfaction, and decreasing costs, including those associated with ER and inpatient visits.

The Behavioral Health Medical Home (BHMH) Model

ICL's BHMH model was an outgrowth of efforts over more than a decade to integrate physical health care into a range of behavioral health programs. New mental health clinic regulations allowing limited primary care services helped ICL implement the BHMH model in its clinics in the last few years; the model has also been adapted for ICL's Personal Recovery Oriented Services (PROS) program. The BHMH model uses behavioral health programs as a gateway to integrated health services, reaching people who would otherwise not access primary care.

The BHMH model uses the unique strengths of a behavioral health program to reach people at risk. Behavioral health counselors (including therapists, case managers and peers) can have a very close relationship with individuals living with mental illness. They may see their clients more frequently than any other provider. With training and resources to better understand physical health conditions, as well as accessible consultation with nurses, behavioral health counselors can be equipped to support close monitoring of an individual's physical health. In addition, behavioral health counselors have expertise in behavior change, which is key in management of chronic medical conditions, for which behaviors such as physical activity or and tobacco use affect outcomes.

Two pillars of the BHMH model are disease management and nursing-supported care management, detailed below. With access to these interventions, ICL BHMH participants had significant improvements in self-rated health status and medication adherence over time. There were also decreases in the proportion of people with at-risk body mass index and blood pressure.

Disease Self-Management

An important aspect of the treatment of any chronic condition is self-management, which involves individuals learning about their health conditions and the steps they can take to manage them. ICL has created toolkits to support this learning, including a Healthy Living Workbook and Toolkit, a similar Diabetes Self-Management Toolkit, and a series of other disease-specific modules. Written at a fifth grade reading level, the tools cover a range of health topics, including diet, exercise, sex, smoking, and how to best use medical resources such as primary care and the ER. Staff members have access to these resources at any time through the agency's intranet system to share with individuals in one-on-one and group counseling. These resources have also been shared with other agencies in New York.

The disease-management workbooks borrow from motivational techniques to encourage individuals to discuss changes they have been thinking about making, in addition to the pros and cons of the changes. Readiness for change is assessed, and if there is enough commitment, Action Step pages facilitate the development of specific, concrete, and achievable plans for change. Action Step Review pages encourage self-evaluation of the change process. Small steps successfully taken accrue to generate momentum towards lasting change.

Each quarterly treatment plan requires a review of individuals' health behaviors, including attendance at health care appointments, medication adherence, healthy eating and physical activity. Individuals are then prompted to develop health self-management goals as a part of the treatment plan, with the support of behavioral health counselors; progress on these goals is reassessed quarterly. At ICL, the number of individuals setting health self-management goals has increased over time.

Nursing-Supported Care Management

In the BHMH model, although the behavioral health counselors are at the front line of integrated health work, they are supported by nurses who help them

Keeping Recovery Real – and Healthy

By Marylee Burns, LMHC, CRC,
and Gita Enders, CPRP, New York
City Health and Hospitals Corporation

A well-known fact -- mental health consumers die 25 years earlier than the general population and if an individual has a co-occurring substance use disorder, their life expectancy is further reduced. Responding to the need to integrate health care services and to promote a smooth transition from inpatient to ambulatory services, NYC Health and Hospitals Corporation initiated a project featuring a wellness tool, *Guide to Keeping Healthy after the Hospital*©, available in seven languages. The *Guide* is used in both inpatient and ambulatory settings and targets mental illness and substance abuse and medical issues such as hypertension, diabetes, and smoking. Emphasis is placed on how each disease impacts the other and cannot be treated separately.

The *Guide* was developed to help consumers better understand and appreciate the importance of taking responsibility for their recovery. Studies have shown that self-management – or a person's determination to get better, manage his/her illness (which includes managing physical well-being and any concurrent substance use), take action, face problems, and make choices – facilitates recovery. In fact, it can be argued that self-management of illnesses is at the heart of person-centered care.

To super-charge the project, peer counselors were hired to work on inpatient units and in outpatient services to assist consumers in using the *Guide* and to help them when transitioning to the community. The project has expanded to chemical dependency inpatient detox units and outpatient clinics, again with peer counselors conducting groups, emphasizing whole health and recovery.

The material in the *Guide* is adapted from models such as the stages of change and motivational interviewing, SAMHSA's dimensions of wellness, the concept of disease management used in medicine, and principles and practices of psychiatric rehabilitation and person-centered care, to mention just a few. Strategies in group health coaching address ambivalence about taking medication, making lifestyle changes in diet and exercise, stopping smoking and substance use while emphasizing the notion of recovery and resiliency. It teaches that it is normal to feel conflicted about change and also encourages consumers to think about how they can stay out of the hospital and focus on their recovery and wellness.

Consumers are given their *Guide/ workbook* to take home, along with their portable health plan that they can carry with them for future use. Because consumers were requesting to have similar groups available in the clinic, ambulatory groups were initiated. In fact, HHC had discharged consumers wanting to come back to visit the inpatient unit just to participate in the groups.

Peer counselors provide a friendly face while consumers transition to the clinic setting. Peer counselors help consumers engage in ambulatory services through their role-modeling, by sharing tips about keeping healthy, reinforcing the message of hope and offering information about community resources. HHC believes philosophically that peer-run groups support engagement in aftercare. It is clear that their presence and participation on the units and in ambulatory settings is helping to change the culture of service delivery at HHC; their contribution is immeasurable.

From March 2013 through to July 2014, 1,976 groups were conducted by peers, and 11,505 consumers participated in these groups both in mental health and chemical dependency treatment programs, inpatient and ambulatory settings.

Marylee Burns, MA, MEd, LMHC, CRC is Senior Director, and Gita Enders, MA, CPRP, is Assistant Director/ Consumer Affairs Coordinator, at the NYC Health & Hospitals Corporation, Division of Medical and Professional Affairs, Office of Behavioral Health

Peer Leadership and Workforce Development

By Jennifer M. Padron, MEd, ACPS, CHW and Pamela G. Hardin, MBA, MEd

The future is here. 2014 is the year of the peer. In economics, the cycle of poverty is the "set of factors or events by which poverty, once started, is likely to continue unless there is outside intervention." (Wikipedia, 2014) People with mental health, substance abuse and physical health challenges represent a large portion of individuals living in chronic poverty. The implementation of the Affordable Care Act (ACA) and the health activated social movement provide the integrated health community an exceptional opportunity to provide outside intervention.

Background and Problems: People living with serious mental illness in the United States die, on average, twenty-five years earlier than those without a serious mental illness, largely due to preventable medical conditions and suboptimal medical care (Brekke, J., Siantz, E., Pahwa, R., Kelly, E., Tallen, L. and Fulginiti, A., 2013). Studies are finding higher incidences of certain physical disorders and addictions, among people with serious mental illnesses including: diabetes, obesity, high cholesterol or dyslipidemia, metabolic syndromes, cardiovascular problems and cancer.

When combined with a serious mental illness, physical illness can lead to other

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health conditions and to a quality of life lower than that of both the general population and individuals with mental illnesses alone. These negative health consequences affect other recovery goals such as housing, vocational training, and education (Brekke, J., Siantz, E., Pahwa, R., Kelly, E., Tallen, L. and Fulginiti, A., 2013)

Peer providers bring their own experiences of living with mental illnesses, addictions and/or community health problems to light the path to recovery for oth-

ers. Creating a recovery based peer driven and delivered workforce creates training and employment opportunities providing peers with a stronger role and voice in integrated care plus the opportunity to break the cycle of poverty with employment in this emerging new healthcare field.

The Affordable Care Act and its implementing regulations, building on the Mental Health Parity and Addiction Equity Act of 2008, expands coverage of mental health and substance use disorder benefits

and federal parity protections in three distinct ways:

- By including mental health and substance use disorder benefits in the Essential Health Benefits;

- By applying federal parity protections to mental health and substance use disorder benefits in the individual and small group markets; and

- By providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services (Stateline, C., 2013).

CMS is developing new programs and tools as a result of the Affordable Care Act. The ACA is based on a wellness model rather than a fee for service model, changing the landscape of health care.

This new landscape is paving roads for peer provided services. 2014 is being coined as the Year of the Peer; the timing is right and integrated innovation and emergent solutions are expected.

A US Peer Workforce Development Plan: Creating a national Lived Experience Workforce Development plan can establish and legitimize the lived experienced service provider as a healthcare occupation and should be recognized by

Kimberly A. Williams, LMSW Joins MHNE Board of Directors

Staff Writer
Behavioral Health News

At its June meeting, the Board of Mental Health News Education, Inc. (MHNE), publishers of *Behavioral Health News* and *Autism Spectrum News* elected two new members: Dianne Zager, PhD, Michael C. Koffler Professor in Autism at the Dyson College of Arts and Sciences of Pace University, and Kimberly A. Williams, LMSW, from the Mental Health Association of New York City (MHA-NYC). Dr. Zager's election to the MHNE Board was just announced in Autism Spectrum News summer 2014 issue.

Kimberly A. Williams, LMSW is Vice President of Policy and Program Solutions at the Mental Health Association of New York City. In this role she oversees MHA-NYC's efforts to advocate for better behavioral health policies, to provide educational opportunities for providers and members of the public, and to strategically maximize MHA-NYC's direct service programs in the changing health care environment.

Ms. Williams directs the Geriatric Mental Health Alliance of New York, a 3,000 member advocacy and education organization that she co-founded in 2004. She also directs a TBI and Emotional Wellness Alliance, which was founded in 2011 and aims to drive awareness, science-based information, and policy reform on the convergence of traumatic brain injury and its emotional impact. Ms. Williams also oversees the Veterans' Mental Health Coalition of New York City, co-founded by MHA-NYC in 2009. Additionally, Ms. Williams spearheaded and oversees an MHA-NYC integrated care technical assistance project to help patient centered medical homes (PCMHs) integrate behavioral health services.

Ms. Williams serves on a number of advisory and planning committees including the New York State Interagency Geriatric Mental Health and Chemical Dependence Planning Council and the National Coalition on Mental Health and Aging, which she currently chairs. She also recently served on the National Committee on Quality Assurance's (NCQA)

Kimberly A. Williams, LMSW

Patient Centered Medical Home Advisory Committee.

Ms. Williams earned her Master's Degree at Columbia University School of Social Work, and Bachelor's Degree at the University of North Carolina at Wilmington. She is an adjunct lecturer at the Columbia University School of Social Work.

MHNE's new Board Chairman, Jorge Petit, MD stated, "We are delighted to welcome Kim to our Board. She has been a strong advocate and educator for many of the behavioral health community's most important causes. She brings a wealth of experience with her that I believe will be an enormous benefit to MHNE's educational mission."

Ira Minot, Executive Director of MHNE stated, "I am very pleased that Kim has been elected to our Board of Directors. I have had the pleasure of working with her for many years in bringing the important work she has been involved with at MHA-NYC to the attention of the readers of *Mental Health News* and now *Behavioral Health News*. I know I speak on behalf of the entire Board at MHNE in praising her work and welcoming her to the Board."

the United States Department of Labor (DOL) as a billable healthcare provider category through the Centers for Medicare and Medicaid Services (CMS) and managed care organizations (MCO).

OptumHealth, an innovative MCO, implemented a Peer Services project in New York and Wisconsin both of which are producing remarkable outcomes. The Peer Services preliminary program evaluation results (July 2013) show members who received Peer Services:

- Have a Significant Decrease in the number of behavioral health hospital admissions

- Have a Significant Decrease in the number of behavioral health inpatient days

- Have a Significant Increase in outpatient behavioral health visits

- Have Significantly Decreased total behavioral health care costs.

An integrated study with funding and support from both the National Institute for Mental Health (NIMH) and the National Institute for Health (NIH) is needed. Health outcome measures should reflect the whole person. Physical and mental health are equally important components contributing to an individual's quality of life.

We need research funded to study the outcomes for both the individual serviced and the peer providing services to legitimize the impact of including and developing this emerging workforce. We need quantifiable evidence from studies examining to what degree implementing a peer workforce career ladder: Increases access to care, Reduces cost, Improves participant outcomes, and Improves provider outcomes.

Certified Peer Specialist, Recovery Coach, Community Health Worker Promotora: Certified Peer Specialists (CPSs), Recovery Coaches (RCs) and Community Health Workers (CHWs) are all essential components for implementing ACA driven physical and behavioral integrated systems of care. Increasingly, peer services are being embedded in healthcare delivery, helping to inform and transform those systems through an emphasis on whole health, wellness, social inclusion, cultural competency and the professionalizing of a peer-led and peer driven workforce. A key goal of the peer workforce is to prevent co-optation and the diminution of critical peer support values and practices.

The entry level paid position on the recovery career ladder starts with a health activated CPS, RC and/or CHW who wants to share their recovery message with others. Health activated people represent a new approach to healthcare focusing on prevention and wellbeing instead of the medical model of disease treatment. These people are able to implement their own recovery and wellness so effectively that they learn and hone specific skills that increase their subsequent resiliency (Manderscheid, 2014). This proposal focuses on leadership development for the future of a truly integrated approach to recovery and rebirth for millions of Americans trapped in this cycle of poverty. Evidence based practices with

CPS, RC and CHW all demonstrate improved health outcomes when interventions are delivered by individuals with shared life experience.

Peer roles in mental health, substance abuse and community health are evolving, as people with lived experience offer a potent resource to help other peers who are facing these health concerns through education, support, and coaching. Peer roles are evolving within the context of emerging "recovery-oriented" integrated health systems (Tucker, S. J., Tiegreen, W., Toole, J., Banathy, J., Mulloy, D., & Swarbrick, M., 2013).

The International Association of Peer Supporters, Inc. is currently developing national practice guidelines focusing on competencies, ethics, and implementation for peer workforce roles (INAPS National Practice Standards, 2014). Faces and Voices of Recovery is developing a credentialing process for organizations that deliver peer services (de Miranda, 2014). This work is supported financially by SAMHSA and will create the cornerstone for the emerging peer workforce. The International Certification & Reciprocity Consortium (IC&RC) has developed and is currently piloting a Peer Recovery Credential after having a thorough job analysis conducted by Schroeder Measurement Technologies, Inc., in order to identify essential job functions for peer services.

We are introducing the development of a workforce of professionals whose shared life experience opens the door to end the cycle of poverty by creating a recovery based workforce who have empowered themselves using the principles of Recovery Based Practices. A great deal of important work has been done toward integrating mental health and substance abuse peer support services. The next phase of integration is to include physical health concerns including preventative services and wellness planning; thus the need for the Licensed Integrated Care Professional (LICP).

Other factors also compel further development of the peer workforce. The ACA requires Medicaid and all other health plans to cover behavioral health care on par with health care for physical services. It also will add an estimated 8 million people to the Medicaid rolls in the first year, many of whom will have untreated mental illnesses. Another 7 million people are expected to get federal tax subsidies to purchase health insurance, many for the first time. This surge in demand, combined with an already severe shortage of mental and community health workers not only supports but demands the need to expand the peer workforce and create a career ladder including Licensed Integrated Care Professionals and a certification process for licensed medical professionals to add Lived Experience Professional credential as a specialty.

Licensed Integrated Care Professional: We propose using national/international mental health and substance abuse standards developed in conjunction with SAMSHA and cross walking those standards with national CHW standards to filter for cross program required competencies. We are not trying to compete with current plans for CPS, RC or CHW certification programs. Our goal is to build upon existing work and establish an infrastructure which values and supports

The Challenges of Integrated Health Care

By Natalie Huntley, Director of Quality Assurance and Debbi Witham, Chief Program Officer, VIP Community Services

One of the most talked about issues in both the behavioral health and medical field is the integration of behavioral and physical health services. In fact, SAMHSA has reworked their definition of recovery to include physical health: A process through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. This shows that recovery is no longer just about achieving abstinence or taking your psychotropic medications. It is about the person as a whole.

To understand and best provide services under this new model of recovery, it is important to understand the history and the challenges facing individuals with mental health and substance use disorders. Research conducted in the last decade indicates this population dies 15-25 years earlier than the rest of the population *(Approaches to Integrating Physical Health Services into Behavioral Health Services, Lewin Group, 2012 (1))*.

Individuals with behavioral health needs often don't access traditional healthcare. They cite feeling uncomfortable and judged and many feel the service maze is large and complicated. In addition, many primary care physicians struggle to understand how to treat this population as they may not identify the behav-

ioral health as a medical disorder creating a relationship of distrust for both sides *(Merrill, Joseph O et al, Mutual Mistrust in Medical Care of Drug Users, J Gen Internal Medicine, May 2002 17(5) 327-333).*

Further complicating matters are that many individuals struggling with mental health and substance use disorders have histories of trauma. The very act of going to the doctor and being asked to undress or being touched can recreate trauma. In addition, many providers are not trained in managing trauma and through the best of intentions may cause additional trauma *(National Council, Linda Ligenza, Trauma Informed Care in an Integrated World, 2012).*

Finally, most that have behavioral health issues lack many basic Activities of Daily Living (ADLs) such as making appointments, managing a schedule, and interpersonal communication. All of these deficits can create serious challenges for individuals to make and keep medical appointments. Often compounded with this is that these individuals do have real struggles to meet basic needs and thus medical care falls low on the priority of survival.

As a result of these many challenges, it has become critical that all medical and behavioral health services become integrated in order to provide individuals with high quality services to improve health outcomes and reduce healthcare spending.

Like any major shift in business, the integration of health care will encounter some fundamental challenges. For years, the areas of health, mental health and substance use treatment have practiced in their own silos.

It can be understood that a client can have a physician in all three entities; however, the sharing of information and the collaborative effort to treat the client never structurally existed. Each profession has functioned and operated within their rights of their respective practice. Now with the integration of health care system, breaking down those dividers which section off each practice can pose some challenges.

One of the simplest barriers to this shift in health care is the lack of understanding amongst the disciplines. This integration will require practitioners from all areas to learn the core fundamentals of their new cohorts. A learning curve must be anticipated, as these practices have never shared or traded information in the realm that is to come. For health care providers, they must now understand all the nuances of addiction and treatment. Unlike the common cold, there is no prescription to be written to cure addiction. Healthcare providers will have to learn the elements of counseling and group therapy. On the reverse, behavioral health providers will now have to broaden their scope of treatment to include monitoring of any health related issues that can conflict with a client's treatment.

With sharing information, there comes the question of "how" do we go about doing this? Today, the use of electronic health records (EHR) is now a best practice in most fields. The use of technology to share information might seem to be the most practical way to co-treat a client; however it can be the very exigent. Most

fields have tailored their EHR systems to fit their needs, and it can be problematic to get systems, with different purposes to talk to one another.

When we start to talk about sharing information through the use of technology, we expand our list of collaborators to include our technology vendors. Technology vendors emphatically function in their own silos within the technology world, so there will be multiple layers of collaboration to consider. Additionally, we must consider each integrated entities governing source. Each field has their own local, state and governmental responsibilities that are often not transparent to their counterparts.

While the list of challenges might seem difficult, the solutions to combat these barriers pose some relief. With any change, there will be hurdles, however, with a well thought-out strategic plan; there will be minimal ripples in the current. A starting point would be to cross train practitioners in evidence based practices that have proven to be effective within each discipline. A unified understanding of all practices allows for a seamless integration. Developing linkages and co-locating programs between disciplines is another way to foster a more cohesive health care system. The collective goal of all areas of treatment is to treat the client's basic needs which will then allow the client to focus on their health, be it general health, mental health or substance abuse disorders. The ultimate goal of an integrated health system is to treat the client from a holistic approach.

Alcoholism and Substance Abuse Providers of NYS Announce Formation of New York Certification Board

By John Coppola, Executive Director New York Association of Alcoholism and Substance Abuse Providers (ASAP)

Alcoholism and Substance Abuse Providers of New York State (ASAP) is pleased to announce a new project, formation of the **New York Certification Board (NYCB),** and the launching of two timely and important credentials, the Certified Addiction Recovery Coach and the Certified Recovery Peer Advocate. As the behavioral health services system transforms itself to incorporate healthcare reform, Medicaid redesign, and the transition from fee-for-service to managed care,

peer services and peer certification will become much more in demand.

The New York Certification Board has as its mission to strengthen health and human services outcomes and enhance the recovery-oriented skills and capacity of the workforce by providing high quality testing, credentialing, and technical assistance. The New York Certification Board is made up of a diverse group of peers/professionals from across NYS who have expertise in Recovery, Recovery Coaching, Recovery Advocacy, Peer Relationships Supporting Recovery and experience serving on credentialing boards.

The New York State Office of Alcoholism and Substance Abuse Services

(OASAS) approved the New York Certification Board to offer the Certified Recovery Peer Advocate (CRPA) credential in NYS. Once certified by ASAP's New York Certification Board, Certified Recovery Peer Advocates will be able to offer peer services in OASAS approved outpatient treatment settings and the services they provide will be able to be reimbursed by Medicaid.

ASAP has been developing the infrastructure to offer peer credentials in New York State since 2011 when they convened a group of recovery experts and stakeholders to develop competencies and qualifications for recovery coaches. ASAP did this work in collaboration with certification boards that offered peer cre-

dentials in other Northeast states. In 2012, the NYCB became operational and has since approved approximately 250 Certified Addiction Recovery Coaches and Certified Recovery Peer Advocates.

ASAP and the New York Certification Board have established a relationship with IC&RC and will be using the IC&RC test as part of the certification process. The NYCB Certified Recovery Peer Advocate credential will have reciprocity in all states that have IC&RC boards. For those who are interested in contacting the New York Certification Board to find out more about the Recovery Peer Advocate or Recovery Coach certification process, please contact Sherry LaFountain at (518) 426-3122 or via e-mail at slafountain@asapnys.org.

This Fall Issue of

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Integrated Health Care:
A Life Saving Concept In Search Of a Functional Reality

By Mary M. McKay, PhD
and Peter C. Campanelli, PsyD

Integrated health care has become the new "buzz word" of an era ushered in by the passage of the Affordable Care Act (ACA) and its associated elements of health care reform. More than a buzz word it signifies an approach to medical care for high risk people faced by multiple life threatening co-morbid conditions that could literally save their lives. The fundamental underlying presumption is that if integrated health care can be achieved then health care costs will decrease and quality health outcomes will increase. Reductions in healthcare costs and improvements in healthcare outcomes are two of the three triple aims of the ACA and arguably important issues for a country that spends more than any other industrialized nation on the health care of its citizens, yet ranks dead last in terms of most health care quality indicators. Although the concept of integrated health care likely could provide considerable improvement for both coast and outcome how does one achieve an approach to integration across multiple disorders and for a diverse group of people all presenting person centered idiosyncrasies. After all, many life threatening chronic medical conditions are linked, for example metabolic disorders like diabetes can lead to cardiovascular disorders and smoking, a personal behavior choice, leads to a vast array of chronic diseases including cancer, repertory ailments, and hypertension to name just a few. So, the challenge is how is integrated health operationally defined for people with much different co-morbidity, all of whom have person centered differences, taking into account different levels of disease progression spanning premorbid disease development through chronic disease development?

Making matters more complex, medication treatment choices made for one issue may have profound iatrogenic effects in other body systems, the most frequently cited example being depression and weight gain secondary to some medications which is especially problematic if the person is also struggling with type II diabetes. The social determinants of health and disease also do undoubtedly exert and influence on health cares' effort to improve the health and well- being of people particularly if they come from high poverty communities. No one would argue with the fact that most people with SMI are living within the federal definition of poverty.

Behavior is notoriously resistant to change and so nutritional and lifestyle habits that provide immediate gratification like consumption of sugars and carbs as well as sedentary activities like sitting around all day watching TV as well as addictive behaviors like smoking all contribute to the poor health outcomes associated with people with SMI. Stable housing; access to continuous medical care that provides continuity and proper nutrition are among the important social determinants of health that will help to mitigate poor health outcomes.

A safe and stable place to live that provides reasonable geographic access to consistent and continuous community based health care as well as access to nutritional food sources and the knowledge and skill to prepare meals certainly play an important role in facilitating the goals of integrated health care. Further, each individual's response patterns to all of these issues is different making a person centered approach to health care integration essential. These are complicated interactive issues that make the concept of integrated health care difficult to define and elusive to programmatically structure.

However, the public health crisis presented by people with serious mental illness (SMI) and co-morbid medical disorders represents the "perfect storm" that integrated health care can address best if clearly operationally defined and implemented properly within the array of mental health program assets that can be leveraged. Recent population health fiscal analysis of the public burden of this health crises published on the Commonwealth website and in the Journal of Health Affairs suggest that over 80% of the dollars consumed in Medicare and Medicaid combined are spent because of the impact of SMI and comorbid medical disorders including secondary substance use disorder (SUD) by dual eligible clients that are younger than 65 years old. There is both a fiscal and life preservation imperative to the search for a functional programmatic reality that can help structure integrated health care.

The Programmatic Landscape

We have made tremendous strides in the community based treatment and support of people with SMI. Thirty years ago deinstitutionalization was in full swing with little more than flop houses, adult homes and a few community based mental health clinics available to support people leaving psychiatric hospitalization. Since then the social and treatment circumstances have changed considerably for people with SMI as a result of the development of a number of innovations in program design. These have included various specialty forms of supported housing, assertive community treatment and supported competitive employment programs. Additionally, many community based mental health clinics have introduced cognitive behavior therapy, empirically supported family and child therapies and some innovative providers have developed a set of best practices geared toward adaptation to cultural and ethnically diverse populations. Most recently a full understanding of the role of trauma in the development of SMI and a trauma informed care model has emerged. Finally, we have come to the realization that housing is not just housing but may serve multiple important functions such as crisis intervention, admission diversion, and avoidance of re-traumatization.

During this virtual explosion of community based support program development people with "lived experience" found a voice and used it to communicate the important contributions they could make in the treatment and support of people with SMI. Theirs has been an important force in the development of self-help, advocacy and peer support programs. However, studies focusing upon the health and well- being of people with SMI found significant gaps in the system not addressed by the development of community mental health support programs .

During the decades following deinstitutionalization there was a preoccupation with the development of mental health support systems. So much so that we failed to recognize the importance of health care. So, when it was reported in a research study some years ago that people with SMI were dying 25 years sooner than people who did not have SMI it really came as no surprise to people working in the field. However, what was shocking was that people with SMI were not dying prematurely of psychiatric related causes but rather they were dying from the physical diseases most of us will suffer and die from eventually including hypertension, diabetes, cardio vascular disorder and the like. The dramatic difference was that these premature deaths were avoidable and were the result of very poor continuity and quality of physical healthcare received by people with SMI. As one provider once commented when talking about this state of affairs, it is as though all the advances in community care for people with serious mental illness over the last 30 years were focused on issues "from the neck up and between the ears."

Toward a Functional Reality

While everyone can agree that integrating health and mental health from a clinical treatment and support perspective is most desirable and the most likely intervention to improve health care outcomes for people with SMI the real challenge is how one best accomplishes this programmatically.

Several different strategies have emerged to accomplish integrated health. These can be categorized into site based strategies, clinical treatment strategies, and collaborative strategies. Site based strategies have involved co-location of health and mental health treatment access imbedded within a mental health or a health care clinic. Integrated clinical

Integrated Settings: An Opportunity
For Advancing the Care of Patients at Risk for Suicide

By Virna Little, PsyD, LCSW-R, SAP
Senior Vice President, Psychosocial
Services and Community Affairs
Institute for Family Health

The integration of primary care and behavioral health affords settings the ability to better identify and manage patients at risk for suicide. Each year in the United States 35,000 people die by suicide, a large majority of whom are not engaged in the mental health system and who saw their primary care provider within the month. With the suicide rates on the rise across New York, the time to develop better systems has never been more urgent. Integrated care settings provide opportunities for all disciplines to save lives through workforce training, the use of technology and established clinical pathways for patients at risk.

With the implementation and utilization of electronic health records, integrated settings have ways technology can help care for their population at risk for suicide. The development of decision supports as a reminder for screening and safety planning, "flagging" or specialized banners to identify patients and imbedding tools for assessment and risk, are critical steps that should be a priority for integrated care organizations as they develop their electronic systems. Even the placement of suicide risk on the problem list, which will draw attention to the risk by placing the problem in every provider encounter, is a way integrated settings can begin to use technology to care for their at-risk patients.

Unfortunately, thus far training systems have not adequately trained providers, of either behavioral health or primary care, to adequately address the needs of patients at risk for suicide. Continued use of antiquated "contracts" in many settings is a prime indicator that current workforces need to be trained in patient-centered and evidence-based approaches to the care and treatment of individuals at risk for suicide. Primary care providers feel un-equipped to ask, especially in a fifteen minute visit with patients who have multiple chronic medical illnesses. Likewise, behavioral health providers often lack the "clinical confidence" needed to assess for suicide. Integrated settings offer the opportunity to train primary care providers to ask the right questions, identifying patients who would not have been previously identified as at risk, and then conducting a "warm hand off" to behavioral health or asking the behavioral health provider to join the visit to engage the patient in care, in a setting they identify as their clinical home. Equally critical to training primary care providers to ask the right questions and reinforce safety planning is having a behavioral health workforce that is adequately trained to manage patients at risk for suicide. A behavioral health provider trained in Assessing and Managing Suicide Risk (AMSR), XXXX (CAMS), specialized Cognitive Behavioral Therapy (CBT) or Dialectical Behavioral Therapy (DBT) has the tools to treat patients at risk. The combination of trained providers in an integrated setting can mean the identification of those patients who are currently completing suicides not being identified in primary care or engaged in behavioral health treatment.

Integrated settings offer the ability to develop truly comprehensive clinical pathways to identify and treat patients at risk for suicide. Organizations who develop a screening process to help identify patients can clearly define a process, involving all disciplines, for the care and management of patients at risk for suicide. A clearly defined workflow is critical not only for staff clarity, but for the prevention of patients at risk "falling off the radar". All staff in integrated settings can play a role in the management of patients at risk and have a place in the pathway. A team approach, the availability of providers of all disciplines, the ability for joint visits involving both primary care and behavioral health, and shared records common in integrated settings allow for the development of comprehensive clinical pathways for patients at risk.

The diversity of staff in integrated settings offers a unique opportunity to identify and treat patients at risk for suicide in a way that could effectively decrease the numbers of individuals who die by suicide each year. Through leveraging technology, training the workforce and developing clinical pathways, integrated care organizations could provide the ability to identify patients seen in primary care settings not previously identified as well as engage patients in behavioral health services previously not known to or engaged in behavioral health services. Integrated care settings, or those moving on a path to developing an integrated setting, should prioritize the identification and treatment of patients at risk for suicide. The ability to save lives offers a clinical crisis providers of all disciplines can recognize and rally around. As organizations strive for improved internal systems around suicide prevention the setting as a whole will advance, further creating a truly integrated care system for all patients, making sure to include those at risk for suicide.

If You are Feeling Hopeless, Alone and In Despair, Never Give Up Hope.
There are Many Behavioral Health Organizations in The Community That Can Help,
Several of Whom are Listed in This Issue. It is NOT a Sign of Weakness to Ask For Help.
— A Message From the Board and Staff of Behavioral Health News —

Reality from page 30

treatment strategies typically involve imbedding treatment capacity within ether the medical or mental health specialty thereby insuring that medical and mental health treatment can occur in one location and making a single treating professional within the integrated site responsible for the integration process. This approach can be found in medical homes and mental health clinics with medical monitoring and assessment capacity. Finally, collaborative care is best exemplified by the Health Home (HH) networks that have been developed pursuant to the ACA and with federal subsidy. New York Department of Health has implemented HH development enabling multi-disciplinary teams to emerge to attend to the complex needs of eligible people within these networks. Care navigation is provided by individuals through network based case management services. These virtual service systems are inter-connected by hi-tech electronic record systems (EHR) and regional health information exchanges (RHIO).

While we have developed a sophisticated array of community based treatment and support programs for people with SMI and in some instances have empirically proven their efficacy on a pilot basis, an "array" of services and an integrated system with common standardized approaches are quite different in their impact and outcome. It could be argued that what is lacking from the current discourse on integrated care is a common organizing philosophy that can transcend programmatic boundaries and provide a common organizing principle. Prevention methodology may very well provide the common platform upon which the concept of integrated health could come to rest.

Prevention activities have never been a reimbursable service by Medicare or Medicaid insurance in the past. The gold standard was always that the treatment rendered must be "medically necessary" in order to be reimbursable. However, it has become clear that waiting for a person who is at risk for serious medical complications to become sick is simply not the best way of improving medical outcomes or avoiding costly emergency care.

Prevention is a concept that the Center for Medicaid Services (CMS) has become very comfortable with in the wake of the passage of the ACA. In fact, the previous Secretary of Health is on record as endorsing prevention efforts and CMS has established a rapid evaluation system for examining innovative cost effective prevention strategies. Providers are less comfortable with prevention because of the previously held standard that only permitted Medicaid reimbursable services for the treatment of disease that was deemed of "medical necessity". However, developing an understanding of a tiered prevention based approach to population management would be very helpful from the perspective of primary, secondary and tertiary prevention efforts that are both clinically and educationally based and imbedded within various programmatic assets that exist to serve people with SMI.

Diabetes is perhaps the best disease profile to illustrate the point. The type II diabetes rate has been climbing at an alarming rate within the US population and nowhere is that more the case than among people with SMI. An integrated primary prevention approach to this disorder among adults with SMI would involve standardize screening procedures in clinics, housing, ACT teams, school based mental health programs etc. Early identification, especially for pre-diabetic conditions, nutritional and life style counseling within program environments such as housing, and primary, secondary, and tertiary preventive education protocols with a person centered focus as well as within the individuals living environment that addresses warning signs and symptoms, teaches frequent monitoring and medical management and targeted consultation with one's physician could go a long way toward integrating health care. Important elements of the educational approach for people with SMI could include evidenced based strategies that have been shown to be effective when applied by peers such as motivational interviewing (MI). The goal of a tiered prevention approach would be to prevent the onset of the disease or more serious complications once the disease is diagnosed. Specific standardized prevention based approaches could be structured for people who have already acquired the disease (secondary prevention) and people who have the disease as a chronic condition with secondary damage (tertiary prevention). Further, a prevention approach offers a metric methodology to measure effectiveness of comprehensive protocol driven integration efforts from a disease measurement standpoint. Indeed, Druss (2010) and colleagues report on preliminary pilot results that are hopeful in this area.

Conclusion

The concept of a competent community was developed decades ago to characterize the positive synergistic impact that can be harnessed when various support elements of a community have a common understanding and support a common intervention plan in support of a community member in need. Primary, secondary, and tertiary prevention may

with developing treatment goals and care plans, and overseeing and tracking their progress. They also provide oversight of the wellness coaches. Trained to support beneficiaries and their families, the wellness coaches provide outreach and engagement, and are active in the development and support of treatment goals. These coaches are individuals who have lived with chronic conditions themselves, and they are trained in peer support and chronic illness self-management.

Through a network administrator approach Optum is able to provide the resources and services necessary to support the custom development and design of integrated clinical systems of care. Using integrated data, Optum is able to help identify individuals with chronic physical and behavioral health conditions. Working with states, provider systems, and community stakeholders, Optum's approach helps identify which individuals are at highest risk for poor health outcomes and helps coordinate resources to support their care. Implementing chronic care management programs for payers and providers helps high-need/high-risk members receive the care they require. This can also coordinate care across multiple systems and community resources to foster improved outcomes.

Developing networks of providers who have demonstrated outcomes of evidence-based care and chronic illness management are facilitated within Optum's network administration model. Technical assistance is also provided to emerging health home organizations and other integrated systems of care. This approach promotes integrated care for physical and behavioral health needs. It also provides necessary population health management tools to support existing clinical operations and resources.

As integrated systems of care evolve and health homes play an increasingly larger role in delivery systems, new payment models are also being developed. The Optum network administrator program has the capacity to support a variety of reimbursement models. Case rates, capitation, and population based outcome models of reimbursement are supported through claims tracking and adjudication, and contract monitoring and compliance. As providers join in organized systems of care like health homes, the capacity to monitor services and adjudicate a comprehensive range of services is necessary.

As a network administrator, Optum is also able to help establish quality monitoring and improvement programs. These can be based on standardized national and state indicators, as well as custom designed resources that meet the specific needs of individual providers and systems of care. Quality management can also support outcomes management and clinical and contract reporting requirements.

Optum does not recommend or endorse any treatment or medications, specific or otherwise. The information provided is for educational purposes only and is not meant to provide medical advice or otherwise replace professional advice. Consult with your clinician, physician or mental health care provider for specific health care needs, treatment or medications. Certain treatments may not be included in your insurance benefits. Check your health plan regarding your coverage of services.

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medicine experts, neurologists, pulmonologists, and pain management specialists may be involved to help rule out medical problems. If a medical disorder is identified, such as sleep apnea, restless leg syndrome, or a circadian rhythm disorder, it should be treated by the medical team, keeping the behavioral health providers apprised and involved. Similarly, if the cause is psychiatric, substance use, or other behaviorally derived issues, these should be addressed by the behavioral health team, keeping the medical providers in the loop.

One of the first responses to sleep issues, whether the problem is medical or behavioral, is sleep hygiene education, a preventive tool and treatment strategy. Sleep hygiene (or habits) refers to a set of practices that contribute to a restful night's sleep. At their most basic, these "healthy" sleep habits are common knowledge: establish and follow a regular bedtime routine, minimize use of drugs and alcohol, maintain a healthy diet and exercise regularly. Other practices are less intuitive such as ensuring adequate exposure to natural light to help balance the sleep-wake cycle, isolating the sleep environment to ensure it's primarily associated with sleep, and establishing a pleasant and relaxing sleep environment.

A more involved behavioral response to sleep is Cognitive Behavioral Therapy for Insomnia, or CBT-I. CBT-I focuses on helping people avoid anxiety about not falling asleep by building confidence that a good night's sleep is possible. CBT-I participants maintain sleep diaries, and may be placed on sleep restriction (where they are not allowed to go to bed earlier initially to recover from exhaustion). The practice involves sleep hygiene education and incorporating cognitive changes such as identifying and challenging irrational thoughts that cause or worsen sleep problems. It also stresses providing education to reframe or replace problematic thoughts and/or feelings related to sleep. Many people report that initially, CBT-I participants get even less sleep than before starting, but after several weeks, they are able to resume normal sleep habits. ("Cognitive-Behavioral Treatment of Insomnia" *Penn Sleep Centers Newsletter* (Winter 2006): Web 5 March 2014.)

For some people, resolving sleep issues requires medication. There are a number of medications that prescribers may use to promote sleep. These include zolpidem, eszopiclone, ramelteon, zaleplon, doxepin, quetiapine, trazodone, mirtazapine, and benzodiazepines such as

One Mental Health Clinic's Journey into Integrated Care

By Aaron Newman, LCSW, Regional Administrator of Mental Health Services for Southern Westchester, Westchester Jewish Community Services (WJCS)

We have heard the statistic countless times over the past few years, yet they are still shocking. People with serious mental illness will die, on average, 25 years sooner than the general population. WJCS, like many mental health providers, has predominantly focused on the area of the human body "above the neck," concerning ourselves with the mind, behaviors, emotions, and cognitions. Inadvertently, we have not focused on the total person. At the same time, it can be surmised that many traditional medical facilities have not focused on the psychological challenges and behaviors experienced by their patients.

Over the past two years, WJCS has successfully launched a series of initiatives that more realistically recognize the need to look at the whole person - to "connect" the minds and bodies of our clients to more fully address their complex physical and mental health needs. To conquer the troubling statistics and best serve our clients, WJCS has embarked on the journey to establishing an integrated model of client care through a partnership with the pediatric clinic of Hudson River Health Care in Yonkers (HRHCare).

The Yonkers Family Mental Health Center of Westchester Jewish Community Services (WJCS) is a busy urban clinic which provides mental health services to over a thousand consumers annually in the southwest corner of Yonkers, a community of very high need and distress. Half of our clients are children and many have experienced trauma in their lives. The vast majority of children designated as seriously emotionally disturbed within Westchester County live in this community.

In the spring of 2012 WJCS submitted two very different and seemingly unrelated proposals to the NY State Office of Mental Health. Both were funded. An "Early Recognition Screening" initiative, now in its third year, supports universal social/emotional wellness screenings to children in community settings, such as schools, pediatric medical clinics, and other natural environments. The goal is to intervene early and reach children who need and would often not receive mental health services in a timely manner. As part of that proposal we partnered with our local Federally Qualified Health Center (FQHC), Hudson River Health Care, to provide screenings for social and emotional wellness to children on site in their Valentine Lane pediatric clinic, located a half a block from the WJCS Yonkers Family Mental Health Clinic. At the same time, WJCS also received start up funding from the NY State Office of Mental Health to co-locate a mental health clinician in a Federally Qualified Health Center to provide mental health services to children on-site. Again, the WJCS

Yonkers Family Mental Health Clinic partnered with Hudson River Health Care at their Valentine Lane pediatric clinic. These two initiatives have led to the development of a close partnership between our two institutions, ensuring that children entering the physical health side of care can get free confidential emotional wellness screenings and referrals as well as on-site mental services without being referred out to a clinic. We did not realize the potential of these collaborations to foster positive systemic change and move us towards a more integrated model of care.

From the logistics of obtaining MOU's, working out releases, developing the work flow, obtaining a satellite clinic license, and figuring out two computer systems with two electronic medical records to bringing two different organizational cultures and disciplines together, the initial startup presented a variety of challenges. However, these challenges were met by the commitment of both partners to the community, high standards of excellence, and a willingness to roll up our collective sleeves and tackle the issues we faced.

Meetings with a variety of staff including administrators of each organization, medical directors, and line staff needed to be done to work out details and to develop protocols. Despite changing personnel on both sides, starts, stops and slow downs, an exciting and successful collaborative effort emerged. The WJCS "early recognition screener" and co-location therapist have been valued welcomed and integrated into the staff of the Valentine Lane Pediatric Clinic of HRHCare. From the ground up, we have forged strong relationships and have been able to resolve concerns and challenges in a collaborative spirit of honesty and mutual respect.

Out of this initial collaboration, other mutually beneficial practices have emerged. Referrals for behavioral health services from HRHCare to the WJCS mental health center, for both adults and children, have been prioritized and this year we received over 162 referrals from HRHCare in Yonkers. At the same time, our mental health center has been more focused on the overall health needs of clients. As part of the health monitoring performed on all clients in the WJCS mental health center by our Licensed Practical Nurse (LPN), we provide referrals to HRHCare for any clients who do not have a primary care physician.

Each organization has learned more about what specialized services the other offered and how they worked with clients. The cultures and demands of a busy FQHC and a mental health clinic can be very different. Professionals participated in interagency meetings and staff trainings and our collaboration was greatly enhanced by consultations of the clinical professionals. Psychiatrists and physicians on the working on the physical health side were talking directly to each other between the organizations and consulting on shared cases. Vital health and

Medical Homes from page 24

triage and manage medical risk. The behavioral health intake includes screening for physical health conditions and risk factors. Nurse care managers review the charts of individuals who screen positive and determine whether additional medical monitoring or follow-up is needed. The nurse may advise the behavioral health counselor on how to support an individual's self-management or which members of the health care team may need to be involved. Individuals with increased medical risk are discussed at regular multidisciplinary staff meetings, and their status is tracked using an electronic registry.

Nurse care managers provide support in other ways as well. They may directly assess and monitor an individual's health status. Their multi-faceted nursing training enables them to be an effective liaison between individuals, behavioral health counselors, the on-site primary care provider, and outside medical providers. The nurse care manager also provides training on physical health topics for the behavioral health staff, with a focus on common medical conditions and their relationship with mental health. The nurse care manager also works closely with a peer health coach, who is trained to use lived experience of an illness to engage individuals in treatment.

Integrated Primary Care

Many people living with SMI are most comfortable in mental health settings and are best engaged with primary care services provided in those settings. A SAMHSA grant supported the development of a medical office and hiring of primary care staff at two of ICL's clinics and its PROS program. A separate article in this issue (Towards Seamless Integration: Advocating for Reform) describes some of the challenges and solutions involved in integrating primary care into behavioral health services. With the addition of primary care, these Behavioral Health Medical Homes were complete and ready to provide the full circle of care for people who might otherwise be lost in the system.

For Zelma, the hub of her health care team was her therapist at the ICL Rockaway Parkway Center, in whom she confided every week. With the support of a nurse care manager, Zelma's therapist helped her to self-manage her medical conditions and to access appointments with the clinic's internist and psychiatrist. The clinic's peer health coach also supported engagement and team meetings provided a forum for the successful coordination of Zelma's inte-

grated care. Ultimately, Zelma has experienced improvements in both her physical and mental well-being.

Back home, Zelma enjoyed writing poetry. She says, "My depression took that away from me. I loved to write. But at Rockaway, the staff helped me so much. I started to feel better. I see a change in me. So does my family. I am more social. I don't hide stuff and I am not embarrassed to ask for help. I wanted to give something to the staff. I don't have money for a gift so I wrote a poem." Here it is:

Many vow this election year to help New Yorkers– though it sometimes appear that their promises are somewhat insincere.

Though there are some, who act, not speak and are at their highest peak in healing the sick and strengthening the weak.

ICL is the one welcoming and helping all that come. They offer help where there is none.

In Brooklyn, NY on Rockaway Parkway is the branch in which I'll continue to stay I'm satisfied with the service and am glad to say Even the receptionist staff happily makes my day!

I know they perform quality care. Many members of my health team are working there. Because the treatment given to all patients is very fair.

My psychiatrist and psychotherapist keep me ever aware that solutions do exist. Many effective treatments are used to assist vulnerable populations that are at risk.

Mental and medical conditions, they do address. I must say, they serve me best. I'm treated well on each and every visit.

While others vote this election year, I vote for a place that keeps me healthy and in good cheer and where workers are competent, courteous and most sincere !!

For more information on the Behavioral Health Medical Home model, please visit ICL's webpage at www.ICLinc.org/behavioral-health-medical-homes.

Jason Cheng, MD, is Director of Integrated Health, Rosemarie Sultana-Cordero, MA, LMHC, is Program Manager, Integrated Health, and Jeanie Tse, MD, is Vice President for Integrated Health, at ICL. Zelma Muhammad is a consumer at ICL.

multidisciplinary teams with specialized training to lead/manage a recovery based peer workforce and provide integrated care services to populations served.

A LICP position adds a step to the new career ladder. LICPs are trained across disciplines; they are the third leg of a stool helping people become health activated and strive for wellness. LICPs are cross trained in mental health, substance abuse and physical/community health recovery and resiliency issues. They will mentor, support and manage the peer provider workforce lending value-added supports by integrating the strengths of the CPS, RC and CHW career paths and a step up and out of poverty for a large group of disenfranchised people.

Lived Experience Professionals (LEP): Establishing a Lived Experience Professional (LEP) certification for licensed healthcare professionals who embrace recovery practices, promote self-directed care models and are open to identifying as a person with lived experience is an additional board certification a medical professional could receive. Empowering licensed professionals to earn a LEP certification demonstrates they are recovery and self-directed care experts in their field of licensure. Healthcare customers will benefit by having additional information to use when selecting a licensed professional. Society as a whole benefits when lived experience and taking personal responsibility for health and wellness are respected instead of stigmatized.

Currently, there is limited coordination between roles and responsibilities for the three different types of peer providers. Essential competency requirements are different between types of peer providers although many competencies are the same for all types of peer providers. A structured approach is needed to integrate the strengths of each type of peer provider. Standardization of peer provider certification is out of scope for this proposal; however we seek to gather the data necessary to discover the overlapping competencies among peer providers and to define and develop the occupational category of Licensed Integrated Care Provider.

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Pam Hardin is a mental health advocate who also happens to be a peer with lived experience as both a consumer of mental health services and as a family member of mental health and substance abuse recovery. She has many years of project management experience implementing major governmental agency innovative project initiatives with proven skills in planning, development, implementation and evaluation. She is a talented forward thinking instructional designer, with 17 years of experience in public service, transforming how and where training is developed and delivered. In her "day job," Pam is an Instructional Designer with the Texas Health and Human Services Commission. Ms. Hardin is collaborating with Jennifer Padron and Ron Manderscheid preparing for a major change in the delivery of integrated healthcare services. They propose creating a career ladder for peer providers by establishing an Integrated Care Professional (ICP) credential for Certified Peer Specialists, Recovery Coaches and Community Health Workers focusing on the recovery model.

Stable and safe housing, even without health care, can stabilize chronic disease and reduce unnecessary emergency room and hospital care. Smoke-free environments can reduce respiratory illnesses and cancer. Early detection of cancer, colon and breast cancers for example, allows for earlier intervention and reduces death. Early detection in primary care or community settings of hypertension, diabetes, high cholesterol and depression improves lives and saves money. Self-care with diet, exercise and stress management are at the heart of healthy communities and nations.
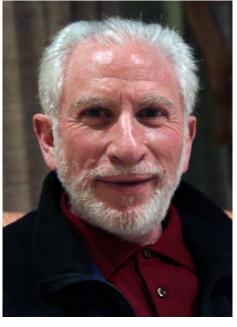
Is Population Health Possible?

What makes us think that population health can be achieved? The natural act of self-interest may answer that question. We are far more apt to do something if it is shown to be in our self-interest or the interest of those we care about -- and when it is built into the routines of medical care and our lives.

We now have inescapable evidence that illness is bad for business. We know that illness produces absenteeism, presenteeism (showing up but being unproductive), and greater rates of disability. We also know that wellness ("... a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." -- The World Health Organization) increases worker (from the factory floor to the corner office) productivity and is associated with higher corporate earnings (so says IBM).

We know that 1 percent of patients in a large group of people account for about 20 percent of medical costs; that 5 percent of patients account for 50 percent of costs; and that 10 percent of patients account for 75 percent of costs. But if only 10 percent of their health is determined by the provision of health care we are talking about a tiny fraction of what can reduce costs.

Enter population health: Unless we change behaviors and the environments people live and work in there will be limited impact on the economic burden a society and a community face. In other words, we can't afford to still primarily focus on medical care.

We also have a sea change underway in the financing of health care. Buyers of health care (federal and state governments and large employers in the private sector -- the vast predominance of the purchasers of medical services) are now putting in place payments that will reduce reimbursing medical providers for doing more and instead incentivize them to economically contain the health costs of their subscribers. When health plans and medical practices are put at financial risk for not managing to a fixed budget or, even better, create arrangements where savings are shared by purchasers and providers together, the marketplace can add its muscle to achieving health. Penalties like not paying for inpatient readmissions within 30 days also drive better health. They force hospitals to be partners with communities and with patients (and families)

Lloyd I. Sederer, MD

since what happens after a hospital stay usually has little to do with what happened in the hospital and everything to do with follow-up care and the attention patients give to their health.

Privacy concerns notwithstanding, we also are seeing an explosion in information technology -- the nervous system of health care. We are positioned to place a cortex, an IT cortex, to inform and help improve the health of patients and populations. Information need not stop at the grounds of a hospital. Patients, primary care clinicians and medical practices can (and are doing so in demonstrations underway) be linked to information about what consumers buy in the supermarket, the fitness they pursue with pedometers and in clubs, and their smoking and drinking habits. If Netflix and Amazon can know so much about you and influence what you buy and do, so can health IT. What's more, insurance premiums paid by subscribers may come to reward, or not, those whose habits are less costly to society. Using information to shape public behaviors may be called the "nanny state" but it is also a way by which individuals can take control of their health while businesses as well as state and municipal governments save money and lives.

Who is Leading the Way?

I recently attended a meeting, a Population Health Summit, in New York City, hosted by the NYS Department of Health with the support of the NYS Health Foundation, the NYC Department of Health and Mental Hygiene, hospital associations, NYS county governments, community health care providers, researchers, global and local companies, universities, and the NY Academy of Medicine. We met at the headquarters of the NY Academy of Sciences.

Attendees were there to advance the cause of population health: to assert the evidence for it and to provide examples of what can and is being done. The message throughout the day was that it is possible to reduce illness and death, improve quality of lives and "bend" the curve of (if not di-

minish) budget breaking health care costs by attending to more than the 10 percent that has dominated our health care heretofore.

To do so, however, requires unprecedented collaboration among the varied groups assembled -- who need proof that they can achieve results consistent with their respective interests. Hospitals have had to fill beds and do complex procedures to remain financially viable. Governments have had to regulate to try to control costs and quality. Businesses, large and small, have struggled with the growing burden of health insurance costs and have done what they need to do to limit them. Researchers have had little opportunity -- or support -- to move from controlled, university settings into the barrio, the supermarket aisle, domestic dysfunction and damaging human habit disorders.

Among the prominent public health experts at the Summit were Drs. Tom Frieden (head of the CDC), Nirav Shah (NYS Health Commissioner) and Tom Farley (NYC Health Commissioner). Their message to the diverse interests in attendance was that population health can be financially sustainable and can get NYS (and this country) out of the global cellar of rates of morbidity and mortality.
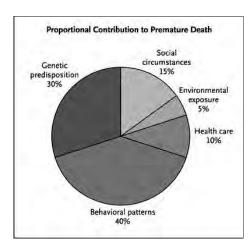
But experts, government officials and corporate buyers cannot succeed without individuals and families coming to believe that their interests will be served, their lives improved and their personal budgets spared by taking their health seriously. Changing habits is among the most daunting of endeavors for any of us. But we now have behavioral interventions like Motivational Interviewing (4) and Screening and Brief Intervention and Referral for Treatment -- SBIRT (5). We have smart phone apps (and other technologies) for monitoring and managing just about everything human from the food we ingest to the moods we have. Peer influences are helping to reduce smoking and excessive sugary drinks. Insurance incentives to live healthy can add leverage for prevention and self-care. No single intervention works here either but when bundled together people do change.

Population Health

Population health will not be achieved by a few missionaries. But it can be led by a confederation of public health advocates, organized medicine, government, independent businesses, and patients and families. What seems out of reach is possible when so many players are on the same team.

As individuals, we can benefit from new medicines and more frequent MRIs, surgery or other procedures. In fact, we have an amazing health care system in this country that does just that for those who have good medical insurance. We don't want to lose that capability; we want to add to health care the needed attention to the 90 percent of determinants that impact our health, our longevity and our pocketbooks.

To paraphrase President John F. Kennedy, changing the public's health will not be easy -- it will be hard. Those gathered at this Summit on Population Health were

Proportional Contribution to Premature Death

Factors that Affect Health

there for the sake of our generation and the generations to come. Let's wish them well and lend our collective support for they surely will need it.

This article first appeared in the Huffington Post on 12/16/2013 and is reprinted with permission from Dr. Sederer. The opinions expressed are solely his as a psychiatrist and public health advocate. He reports no support from any pharmaceutical or device company.

Dr. Sederer's book for families who have a member with a mental illness is "The Family Guide to Mental Health Care" (Foreword by Glenn Close). To learn more about Dr. Sederer please visit his website www.askdrlloyd.com.

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stay financially viable.

A positive outcome from the Medicaid Redesign Team is the recognition

that mental health, substance abuse and physical healthcare must be integrated. The concept is also crucial to the success of new initiatives such as FIDA (Fully Integrated Dual Advantage),

HARP (Health and Recovery Plans) and DSRIP (Delivery System Reform Incentive Payment).

Integrated care, while somewhat costly "up front," saves money in the long run

by improving health and reducing and eliminating hospitalizations. Early mortality among persons with serious mental illness has been well documented. Integrated care saves money and lives!

Behavioral Health News
2015 Theme and Deadline Calendar

Winter 2015 Issue:

"Mental Illness and Substance Use Issues In Older Adults"

Deadline: October 14, 2014

Spring 2015 Issue:

"Caring for Our Veterans and First Responders"

Deadline: January 14, 2015

Summer 2015 Issue:

"Understanding & Addressing the Opioid Epidemic"

Deadline: April 14, 2015

Fall 2015 Issue:

"Caring for Depression in Integrated Settings"

Deadline: July 14, 2015

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Increased use of motivational interviewing in physical and behavioral health practices could make a big difference.

That said, health education is surely useful for some people. For example, people diagnosed with diabetes frequently haven't a glimmer what they can and can't eat. Intelligible classes and literature could be helpful for many such matters.

Health Care To Promote
Subjective Successful Aging

What physical and behavioral health care providers can and should do to promote successful **subjective** aging is far from obvious. Is it really the responsibility of health care providers to promote self-esteem? Is it really the responsibility of health care providers to help their patients maintain or develop social connections and to engage in activities they find pleasurable, engaging, and/or meaningful? Don't health care providers have more limited responsibilities for health promotion, prevention of illness, treatment of disorders, and rehabilitation? Aren't they already too busy with their traditional responsibilities without taking on more?

These are, I think, reasonable questions. But they strike me as more reasonable in the context of solo, private practice, which was the norm until recently. Now that solo practices are disappearing into large groups that are able to hire staff for health education and wellness, it seems to me that the social roles and responsibilities of these practices (most of which aspire to be "medical homes") should be extensively reviewed.

So, what can large practices and community health and mental health centers do to promote subjective successful aging?

1. Integrative Medicine: Dillip Jeste and his colleagues at the Center for Healthy Aging of UC San Diego (www.aging.ucsd.edu) have developed an approach to promote well-being in old age that they all "Integrative Medicine" (IM).[2]It "evaluates physical, emotional, mental, social, spiritual, and environmental influences in order to optimize well-being. IM includes non-pharmacological and less invasive interventions when appropriate, thereby incorporating many complementary and alternative medicine treatments in practice (e.g. acupuncture, aromatherapy, massage, meditation, tai chi, yoga). They are finding that this integrative approach promotes "compassion, optimism, and wisdom" in old age. [3]

2. *Respect:* All interactions between staff and older patients (younger too) should be insistently respectful. Core to this is engaging patients in decision making. But minor matters also make a difference. For example, if my doctor is going to call me by my first name, I want to do the same. And I certainly don't want to be called "honey" or "sweetie," especially by kids who are wet behind the ears.

3. *Asking About Life:* Questions about what and how an older patient/client is doing not just medically but also in life in general should be a routine part of the provider-patient interview. Since having pride in the past as well as being active in the present is a key component of aging well, it would be great for providers to let their patients/clients reminisce a bit.

As I write this, I hear some providers respond, "You think I have enough time for this? Give me a break." And "What am I going to do if a patient begins to open all sorts of issues in their lives that I don't have time, skill, or resources to deal with?"

4. *Concierge Services:* Although these are perfectly reasonable concerns in the context of solo practices, is it really unreasonable to expect large group practices, to have someone on staff—as they have nutritionists and social workers—who can help a person who is isolated and inactive to connect with local resources? It strikes me that they could have a "concierge" available, as they do in good hotels and VIP units in some hospitals, to help people to make connections in their community.

5. *Alternative interventions:* Jeste's concept of integrative medicine includes an emphasis on non-pharmacological and even non-medical approaches. A large group practice could provide access to, or even provide directly, alternative interventions such as yoga, exercise, acupuncture.

6. *Community Education:* Health and mental health centers and group practices could provide education related to successful aging similar to the community health education most now provide for smoking cessation, weight loss, diabetes management, etc.

7. *Life Planning:* A practice that wants to present itself as a go-to place for successful aging could also add a life-planning division. Obviously this is not a medical service, but it is a service that many older adults want and some will pay for

8. *Volunteers:* Since volunteering is a major way in which many older adults get meaningful roles in their lives after they have retired and no longer have childrearing responsibilities, community based practices, programs, and centers might add roles for volunteers. Inpatient facilities have done this for years. Why not in

The Workforce from page 6

number of times certain individuals are now meeting with primary care physical and other specialists. In the past some individuals would not regularly follow up with appointments and disregarded serious health symptoms are now regularly attending appointments and following up with health routines.

- Some persons served are using harm reduction strategies for smoking cessation.

- Some individuals are increasing accessing to social support (including sponsor, reconnecting with family for the holiday).

Health literacy training has been conducted at two large community based psychosocial agencies and it is a key component of the wellness coaching training.

Wellness Self Care Resources

Because each person defines wellness in his or her own way and has different risks, needs, strengths, concerns, and preferences, we have created self-care resources available for people in recovery

and their supporters. Our all-time "reader favorite" document is the 24-page *Wellness in Eight Dimensions*. Each dimension is defined, includes an opportunity for the reader to assess and score strengths, suggests ways to focus on wellness, and provides space to identify relevant personal goals. An 18-page Physical Wellness booklet is organized into six physical wellness domains: (1) Physical Activity, (2) Sleep/Rest, (3) Relaxation/ Stress Management, (4) Eating Well, (5) Habits & Routines, and (6) Screenings. This booklet provides definitions for each domain, a self-assessment, and a space to identify wellness goals and next steps.

Not only have these and other resources been used effectively by individuals on their own, they have been used in peer run and traditional community and hospital programs that run wellness-related groups. Given the limits of current availability of staff training in health and wellness, such resources provide an opportunity for learning as well as guidance for beginning the important conversations that will help address poor health, health risks, and the abbreviated lives experienced by people in the publicly funded mental health system.

We are passionate and committed to improve the lifespan and quality of life among

people served by the public mental health system. We hope these training efforts and resources can empower the workforce to share our passion and commitment.

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Pat Nemec is an independent trainer and consultant in psychiatric rehabilitation. She has an appointment as an Adjunct Associate Professor at Rutgers University (SHRP), and collaborates with CSPNJ on a number of wellness-related projects. She can be contacted through her website at www.patnemec.com.

Resources

1. Promoting Wellness for People in Mental Health Recovery: A Step-by-Step Guide to Planning and Conducting a Successful Health Fair, http://www.cmhsrp.uic.edu/health/designing_health_screening.asp.

2. Wellness in the 8 dimensions and other

wellness booklets, http://www.cspnj.org (go to articles, then wellness resources; scroll through "older entries")

3. SAMHSA Wellness Campaign, http://www.promoteacceptance.samhsa.gov/10by10/wellness_tools.aspx

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Behavioral Health from page 1

New York State of Health enrolled close to a million individuals during its initial enrollment period, giving newly insured persons and their families better access to the behavioral and physical healthcare they need.

Transition from Fee-For-Service to Managed Behavioral Healthcare

With the prevalence of untreated substance use and mental health disorders among persons who have been unnecessarily hospitalized or otherwise used a disproportionate amount of healthcare resources, most typically for a physical health concern, Medicaid re-design is very focused on the delivery and management of behavioral health services. Medicaid re-design will soon transition behavioral health services from a fee-for-service model to managed care. As of January 1, 2015 in NYC and as of July 1, 2015 in the rest of New York State, all Medicaid behavioral health services in will be managed by a health plan or behavioral health organization. The economic and health impact of the failure to treat substance use and mental health disorders has been an unacceptable and unnecessary expenditure of healthcare resources and unacceptable health outcomes. Access to and utilization of treatment for substance use and mental health disorders drives down the unnecessary use of expensive healthcare services and helps to significantly improve health outcomes. Medicaid re-design is counting on the management of behavioral health to drive this improvement of health and behavioral health outcomes and to decrease unnecessary healthcare expenses.

Integration of Behavioral and Physical Healthcare

Less than 20% of persons with substance use disorders ever get treatment for their drinking or drug use. The unnecessary hospitalizations associated with untreated substance use disorders are most frequently for other health conditions that are exacerbated by the addiction. Persons with untreated substance use or mental health disorders frequently experience a decline in their health status when health conditions such as diabetes, heart disease, HIV/AIDS, hepatitis, liver disease, and other chronic diseases also go untreated or when, because of the behavioral health symptoms, the individual is not following recommended physical health treatment protocols. Recent monitoring of inpatient care revealed that in only about 10% of the cases are patients successfully referred to behavioral health services when their untreated behavioral health disorder is identified when they are receiving care for a physical health problem. It was also found that the converse was true. People getting treatment for a behavioral health issue are connected with primary care services in only about 10% of the cases when they have a physical health issue. This disconnect between behavioral and physical health care is a major target of health reform initiatives such as the DSRIP program that is currently being developed across New York State. DSRIP is an excellent example of an initiative that seeks to bridge the disconnect between behavioral and physical health services.

Hospitals, community health centers, health homes, and other primary care practices are all being asked to incorporate behavioral health services into their

health services offerings. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is being promoted as a science-based tool that can be easily implemented in healthcare settings with the goal of helping people with untreated substance use disorders to get the treatment they need. The use of mental health peers and certified recovery coaches in emergency departments is another strategy that seeks to connect people with the behavioral healthcare that they need while ensuring that physical health needs are also addressed.

National and state healthcare reform presents a tremendous opportunity to improve public health outcomes, reduce costs, and ensure coverage and access to necessary care for all New Yorkers. Improving the connection between behavioral and physical health services is vital to the improvement of health outcomes. Behavioral health providers working across systems with primary care and in collaboration with health plans and managed care organizations have a unique opportunity to positively influence health outcomes in the months and years ahead if the transformation and reform of healthcare properly recognizes the vital importance of substance use and mental disorders prevention, treatment, and recovery support services.

The New York Association of Alcoholism and Substance Abuse Providers (ASAP) will provide significant attention to issues related to healthcare reform, integration of behavioral health and primary care, and the transition to managed care at our 15th Annual Conference with presenting sponsor, LabCorp, on October 19-22 in Saratoga Springs, New York. Our conference theme, *The Vital Role that Community Substance Use Services Play*

in the Success of Healthcare Reform is intended to encourage participation from behavioral health, health insurance, managed care, health home, primary care, and other professionals who are vital to improving health outcomes in New York State. With the technical assistance of ASAP Corporate Affiliate Members Cohn & Resnick, Millin Associates, SAE & Associates, and Brown & Weinraub, the conference will feature a special luncheon for CEOs and their Executive teams focused on services and business transformation. Please join ASAP and our Platinum Sponsors SAMHSA and Alkermes for this important conference.

About ASAP

New York Association of Alcoholism and Substance Abuse Providers, (ASAP) represents the interests of the largest substance use disorders and problem gambling services system in the United States. Through advocacy at the state and federal levels, ASAP champions the urgent message that substance use disorders and problem gambling are public health issues that can be effectively addressed with adequate resources.

ASAP offers professional development, program development, technical assistance, and community education to strengthen and increase access to prevention, treatment and recovery support services.

ASAP serves as a catalyst for cross-systems collaboration with public health, mental health, criminal justice, juvenile justice, child welfare, and social services policy makers and service providers. We represent the field on numerous policy development and implementation work groups with a regional, statewide and national focus.

Reform from page 12

help with multi-agency partnership, but where feasible, the greatest integration is still afforded by a single health care team.

However, even when a single agency provides both behavioral health and physical health services, integrating the EHR can be challenging. Behavioral health agencies in NYS often use specialty EHR's that meet NYS Office of Mental Health (OMH) clinic regulations for treatment planning. In general, such systems can be unwieldy for medical staff members. For example, they often do not integrate physical health information such as lab results into the clinical record in useful ways, in contrast to most EHR's oriented toward physical health care. It would be helpful for the state to facilitate EHR integration either by aligning mental health and primary care documentation requirements more closely or supporting the development of the next generation of EHR systems that are well-suited to meet both sets of requirements.

Physical Space: Clinic licensing regulations can also make it challenging to provide integrated care. Behavioral health spaces are generally designed to provide offices with a desk and two chairs. Given limited space, many behavioral health clinics have had difficulty meeting NYS Department of Health (DOH) architectural requirements for medical clinics, such as having a soiled holding room. ICL was able to obtain a waiver request stating that soiled holding is not needed for the scope of physical health services provided at its mental health clinics, since linens used are disposable and regular hazardous waste pickup is sufficient for the clinics' needs. The consequence of the waiver request process was a substantial delay in the application for a DOH license. For many agencies, some of the requirements could be a deterrent to integrating primary care into their behavioral health programs. Given that providing physical health services in mental health settings will be an important way to increase healthcare access, we strongly promote regulatory change to make it easier to implement, while still maintaining appropriate standards.

Staffing: Integrated health staff members usually have either a physical or a mental health background, not both.

Jeanie Tse, MD

Therefore, many agencies have difficulty finding employees with the flexibility and willingness to work in integrated settings. Frequently, there is high turnover in these positions. Given the growing importance of integration in healthcare, some social work, primary care, and psychiatric training programs now offer experience in integrated settings. The state can encourage more integrated care training in clinical and peer programs, via both financial support and licensing requirements

Care Coordination: An important aspect of integrated care is the use of health home care coordination services made possible by the Affordable Care Act. Unfortunately, there are limits to the level of care coordination that health homes can provide, since the care managers often do not have any medical training. They experience difficulty effectively triaging the medical needs of the individuals they serve, and at the same time, they have caseloads much larger than were carried in traditional case management programs. Many health home care managers lack access to consultation with medical clinicians such as nurses and doctors. We believe that the coming capitated care system should pay for either 1) care managers with medical training or 2) ready access to supervision

Jason Cheng, MD

or consultation from medical clinicians.

Conclusions and Recommendations: Providing physical health services in behavioral health settings is essential to improving the health of individuals with mental illness. Many NYS agencies are making efforts to move along the spectrum of levels of integration, from care coordination to co-locating services, with the final goal of true, seamless integration. Some organizations are already making changes in measurable health outcomes that are large enough to significantly decrease heart attacks and strokes.

Based on ICL's ground-level experience integrating physical health care into behavioral health settings, we support the following:

1. Revision of the Article 31 codes and rates to reimburse needed primary care services, including follow-up visits, peer health coaching, and multidisciplinary risk review, with a health monitoring rate that reflects the cost of service.

2. Revision of PROS and ACT reimbursement models to include funding for primary care services.

3. Requirement of managed care organizations to support fully integrated services in a bundled payment and capitated environment.

Marc Manseau, MD

4. Alignment of regulatory documentation requirements, with advocacy to strongly encourage EHR vendors to adapt systems to meet both sets of requirements.

5. Adaptation of architectural standards for Article 28 clinics to reflect the reality of behavioral health clinics offering onsite primary care.

6. Inclusion of integrated care competencies in training and licensing standards for social workers, physicians, nurses, and peers.

7. Rates that facilitate provision of medical supervision and/or support for health home care coordinators to enhance quality of care and utility of the service.

Changes such as these will promote movement towards integrated care throughout the behavioral health system, to the benefit of thousands of New Yorkers, and with the potential to save costs related to utilization of high-end services.

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SBIRT from page 20

taking on a more flexible approach toward goal attainment, adolescent clients appear more receptive to the change process.

Most of the research on the effectiveness of SBIRT has been conducted with adults but more studies are being done on SBIRT with adolescents and show similar positive results. Studies show lower past 90-day alcohol and other drug use comparing SBIRT to usual care (Harris, 2010), decreased marijuana use after 3 months, (Grenard, 2007), and reduced risk of drinking and driving (Knight, 2005).

SBIRT in School Based
Health Centers (SBHCs)

The American Academy of Pediatrics' Bright Futures and the American Medical Association's Guidelines for Adolescent Preventive Services both recommend that youth aged 11 years and older should be screened for AOD use at each annual pre-

ventive health visit. Unfortunately pediatricians rarely screen for alcohol and other drugs as a part of routine adolescent healthcare visits and relatively few pediatricians who do screen do so according to guidelines or use evidence-based screening tools (American Academy of Pediatrics, 2002.). Even if youth screen positive, intervention and/or referral to specialty care are not common (Bethell, 2001). The most common reasons given for pediatricians' failure to routinely screen and intervene were: time constraints; adolescent confidentiality policies and regulations; belief that patients would not tell the truth and uncertainty regarding whether treatment was effective (Sterling, 2012).

In contrast, SBHCs provide a convenient location where SBIRT services can be delivered and services can reach a large number of at-risk students statewide. SBHCs can help address the unique needs of adolescents, including enhancing access to behavioral health services (Weinstein,

2006). Visits at SBHCs were twenty-one times more likely to be initiated for behavioral health reasons than at other healthcare facilities. Adolescents and their families have been found to be receptive to screening and intervention in SBHC settings, and in fact perceive the quality of care to be higher when AOD is addressed (Yoast, 2007). Students receiving behavioral health care in SBHCs had significantly lower total health and behavioral health costs than students outside of SBHC care. [Guo, 2008].

Providing SBIRT in SBHCs provides the convenience of the school with the confidentiality of healthcare clinics. In NYS, parents sign an enrollment form for the SBHC that gives permission for the SBHC to provide "Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol and smoking abuse…". This policy has encouraged students in SBHCs to be willing to discuss substance use with their healthcare provider and students reported

not feeling judged (Grenard, 2007).

There are 227 SBHCs in New York, the largest SBHC network in the country. There are 104 SBHCs that serve middle and high school students. In the 2011-2012 school year, there were 212,620 students attending the schools with an SBHC; 80% of these students (170,096) were enrolled in an SBHC. A large proportion of these students are minority, uninsured or insured by Medicaid. SBHCs offer an environment where SBIRT services can be delivered to a large number of youth.

OASAS Experience
With SBIRT in SBHCs

In New York State the billing codes for SBIRT have been activated for Medicaid allowing SBHCs to bill Medicaid for SBIRT services. With the belief that SBIRT could be effectively delivered in

2013 DOHMH conducted interviews with medical and behavioral health directors of 16 NYC pediatric clinics practicing elements of integrated care. The telephone interviews included questions about mental health screening and services for children and parents/caregivers; integration (e.g. staffing, referral sources, linkages to outside services); communication (between mental health and primary care providers, with children and families); and financing and reimbursement.

Common characteristics across the sites are that mental health clinicians are typically onsite, yet when offsite they are readily available to the pediatric site. Informal consultation between medical and mental health providers is a frequent method of communication, rather than integrated treatment plans or joint case conferences. Almost all of these sites use integrated electronic medical records for pediatric and mental health providers. Developmental surveillance with clinician generated questions from the American Academy of Pediatrics' Bright Futures guidelines is commonly used. Routine use of formal screening tools is less common, although some sites will formally screen young children when the mental health clinician is onsite.

Perceived benefits of co-location include improved communication between medical and mental health providers, a 'warm handoff' of families to mental health staff, as well as quicker appointments and reduced stigma for families who receive their mental health care in the familiar primary care setting. Overall, integration was thought to lead to improved effectiveness of the primary care practice, child health and mental health outcomes, and experiences for families.

Perceived challenges to integration include the need for various combinations of sources of payment and funding to cover costs because insurance collections alone are not sufficient to support the services. Agencies generally require a combination of sources to cover costs, including revenue from Medicaid (most patients are insured by Medicaid in these interview sites) and private insurers, grant-funding, and the agency's internal operating budgets. Financing limitations make it harder to recruit and maintain adequate numbers of mental health professionals as these positions are not fully supported by insurance reimbursement, and therefore additional resources are required. Further reported challenges include merging professional cultures within medical and mental health teams, and the need for additional resources such as administrative staff time and clinical office space.

This exploratory study points to the importance of adequate payment and funding, infrastructure support, and strong, integrated medical and mental health teams to achieve sustainable mental health integration.

Future Directions

Current federal and state health care reform initiatives present an opportunity to promote mental health integration and closely monitor results and successes. Implementing and sustaining mental health integration in primary care is a challenging endeavor but critically important given the prevalence and potential long term impacts of childhood mental health conditions. Pediatric primary care providers have an essential role in identifying these conditions, intervening early, and improving the health, mental health and developmental outcomes of children.

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provide the common platform around which integrated health care competence can be organized.

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SBHCs, and with the added incentive of having the services reimbursed, the NYS Department of Health, NYS Department of Education, NYS Office of Alcoholism and Substance Abuse Services (OASAS), NYC Department of Health and Mental Hygiene (NYC DOHMH) and the NYC Department of Education all supported a pilot to implement SBIRT in selected SBHCs.

In 2012 OASAS, in cooperation with NYC DOHMH, began an SBIRT pilot project at five sites in two SBHCs, Winthrop University Health Center located on Long Island and Morris Heights Health Center, located in the Bronx. The CRAFFT, a valid and reliable screening tool for adolescents, was selected as the screening instrument. Training was provided onsite to staffs from the two SBHCs. Between January and May of 2012, 401 screens were conducted among 388 unique students. Of those, 140 (35%) reported alcohol or drug use in the past 12 months: 113 (28%) reported alcohol use, and 64 (16%) reported marijuana use. Fifty-seven, or 14% screened positive based on score of 2 or more on CRAFFT. 21 received a brief intervention, and 8 received both a brief intervention and a referral to treatment.

Lessons learned from that pilot were used to help inform the planning and implementation of an upstate demonstration project with 3 SBHCs at 6 sites in 2013-2014. Two of the SBHCs were located in Rochester and the third in the Cooperstown area. Site visits were conducted at each site to meet the staffs and to understand the patient flow. Meetings were arranged between staffs from the SBHCs and regional substance abuse providers. The purpose of the meetings was to have staff from the SBHCs and substance abuse programs meet each other, learn about each other's services, and to facilitate the referral process between the SBHC and substance abuse program. Monthly conference calls were held with the three upstate SBHC directors to discuss successes challenges, possible solutions, and establish an environment where the 3 SBHCs could learn from each other. A focus group was conducted in June of 2014 (and other focus groups to be scheduled) with staff from one SBHC to identify lessons learned and identify improvement opportunities that OASAS can utilize in future implementation SBIRT efforts.

Between October 2013 and June 2014, screens were conducted and data entry forms were submitted for 316 students. Of those, 39 (12%) reported alcohol or drug use in the past 12 months: 25 (8%) reported alcohol use, and 32 (10%) reported marijuana use. Twenty-seven, (9%) screened positive (based on score of 2 or more on CRAFFT). 24 received a brief intervention, and 9 received a referral to the on-site mental health staff.

The percentage of positive screens for the upstate SBHCs was lower than expected and significantly lower than those for the downstate SBHCs. There were varying opinions why this was the case, e.g. adolescents screened were looking to "give the right answers" in the school setting, but further analysis would be needed to confirm the causes.

Successes and Challenges

In speaking with staff from the various SBHCs there were consistent positive results. The SBIRT screenings and interventions were not found to be time consuming. SBIRT had been well integrated into Well Child Checks, sports physicals and annual check-ups. There was the belief, even with the low numbers upstate, that by using the CRAFFT standardized screening tool more students would be identified with potential substance abuse problems. SBIRT was well-received by students, there was an increased number of referrals to in-house mental health staff, and delivering SBIRT services provided the opportunity for the SBHCs to bill and be paid for SBIRT services.

Challenges/improvement opportunities included billing and receiving payment for SBIRT services. SBHCs also considered the data collection and reporting to OASAS for the purpose of this demonstration project to be a burden to their staff so not all of the data was completely reported.

In conclusion, SBHCs provide a convenient location where healthcare services are already being provided to large numbers of youth and adolescences. This unique opportunity to deliver SBIRT services should reduce the level of use of AOD for students and the accompanying negative consequences and benefit the school, the SBHCs and most importantly, the students who receive SBIRT services.

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clonazepam or temazepam. Additionally, some people use over the counter medications such as diphenhydramine or other non-prescription strength anti-histamines for sleep. Many can have potentially dangerous side effects when used with other medications. Moreover, some of these medications can be habit forming, and therefore need to be carefully monitored when prescribed. This underscores the importance of information sharing between the medical and behavioral health teams: while doctors routinely ask about other medications, many patients do not consistently report *all* medications they are using. Providers who share this information (with consent) can help avert future problems.

On top of other behavioral health issues, there are other risk factors that can result in elevated risk for sleep issues. Teens, the elderly, and menopausal women are three age cohorts that often don't get enough sleep. Menopausal women, in particular may not be aware that insomnia is associated with changing hormones and may blame sleep problems on an escalation of pre-existing conditions.

However, being "sleep aware" with vulnerable groups is no different from being sleep aware with other populations. Everyone on the team should be alert for sleep concerns. Specific questions about sleep should be a part of assessments, and medical and psychiatric evaluations, work-ups, and histories. Groups focused on health and well-being should include discussions about sleep. Sleep hygiene education can be offered. Brochures and posters providing information about sleep can be displayed. And programs should routinely ask clients to sign HIPAA or other confidentiality waivers allowing the behavioral health team to communicate with medical providers to facilitate information sharing and collaboration. Finally, information on local sleep resources, including sleep labs and other sleep specialists should be kept on hand.

FEGS has taken significant steps to become more "sleep aware." In looking into the sleep habits of clients, it was learned that many clients had sleep disturbances but were unaware of all the tools available to help them. So FEGS launched a comprehensive campaign in some of its programs, providing education, treatment and referrals for sleep problems. As a result of this campaign, prescribers began to initiate conversations about sleep issues more with their clients. The offering of comprehensive treatment brought together the entire team to work with the client for the best outcomes possible.

To best address sleep problems, physical and mental health providers need to share information and coordinate interventions. Yet despite the need for integrated, coordinated care, providers continue to operate in silos. After all, confidentiality waivers fail to get signed, it is difficult to find time to talk, and providers don't consistently speak the same language. But when done right, like diabetes and hypertension, sleep problems benefit most from collaboration between physical and behavioral health. The interventions may be simple, but the payoffs are great.

mental health information began flowing more regularly, allowing the different providers to have more knowledge of the health or mental health needs of their consumers, regardless of which "door" (mental health or physical) was entered.

For the families agreeing to be screened through the early recognition screener or referred to the co-located mental health provider, mental health needs are assessed in a preventive manner and early detection of concerning behaviors can occur in a trusted, non – stigmatizing environment. Children are seen at their pediatrician's office and receive mental health services more quickly. Historically, a high number of referrals for children to mental health services were not successful due to the barriers of stigma, limited access and fear. Mental health services are slowly being understood by families as one of the supports they may need to help ensure their child's overall well being.

As the partnership between WJCS and HRHCare moves toward a fully inte-grated model, there are more and more signs of reciprocal "warm handoffs" between the two agencies, often reducing the need for more intensive behavioral health interventions. .We plan to have all children within our community screened for emotional wellness as part of the well visit at the pediatric clinic; and we plan to provide mental health care to all children who need services either through the co-located WJCS mental health satellite clinic at HRHCare, the mental health counseling available through HRHCare's article 28 services, or the WJCS Mental Health Center down the block. As a result of this journey, children in southwest Yonkers are receiving a higher level of quality care and those who need behavioral health care are receiving it in a more holistic and timely manner, with inter-agency sharing of both knowledge and information.

WJCS is a member of CBHS, Consolidated Health Behavioral Services, a group of 9 behavioral health and disability service providers committed to achieving the "triple aim" in health/mental health care - improving the experience of care, improving health and reducing cost.

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community settings as well?

Clearly, I am proposing substantial additions to current community-based physical and behavioral health practices. I imagine that one initial response will be, "How will we pay for the new services? I confess that I have not yet worked out the details of this, but there are several general responses.

- First, some of these services are covered by health insurance for older adults including Medicare and Medigap plans.

- Second, some patients/clients can and will pay for these services. In fact, many already pay for similar services such as membership in a gym, yoga classes, elder care management, and more.

- Third, some of these services will attract well-insured older people, not a minor matter in environments where market share is so competitive that health care providers spend a lot of money for advertising.

I am optimistic that over time health and behavioral centers and practices will realize that a very substantial and growing portion of their clientele are old and that it is both good health care and good business to focus on helping older adults to age successfully. It would be nice to be right and to live to see these changes take place.

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communication barriers could be removed through stronger business relationships (as discussed above), better use of health information technology is also key. More providers than ever are currently using electronic health records (EHRs), including both primary care and behavioral health providers. However, interoperability (meaning the ability of different systems to communicate and exchange data) is lacking, and many providers do not optimally use their health information technology. Until regional and statewide health information exchange systems become adequately functional and resourced, and until providers go fully electronic (i.e., eliminating paper charts and using EHRs to document all client information), there will be only incomplete information available for electronic exchange. Once the state of behavioral health information technology matures, instant access to health information by all the providers who need it will give them the ability to provide the best services possible.

Additionally, HEAL 17 revealed the need for more behavioral health expertise in EHR-supported quality improvement. By using EHRs to monitor their own activity, behavioral health programs can provide better care leading to improved client outcomes. For example, using EHR reporting capabilities, a program could instantly flag the charts of all consumers who have not had a physical checkup in a specified time frame, so they could be reminded at their next visit. Or, a report could be run to identify all consumers who are smokers, for individualized outreach to a smoking cessation group. By fully utilizing EHR capabilities, behavioral health providers can provide more integrated care and ensure better health outcomes for consumers.

Conclusion

Our health care system has been historically, and notoriously, fragmented, and nowhere is that fragmentation more apparent than in the divide between physical and behavioral health care. However, the time is ripe for a paradigm shift towards integration. The health disparities faced by persons with mental illnesses are now more broadly acknowledged than ever before. Advancements in health information technology are on the verge of making the exchange of health information among providers truly seamless, and quality management using EHR data is easier than ever. Even funding structures are evolving, with health reform making managed care organizations responsible for addressing and maintaining the whole health of their members. It truly is an exciting time as we continue to move in the direction of integrated care.

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of individuals can continue working in a field where there is a great need for committed, caring individuals. In addition, the incorporation of an integrated, trauma-informed framework into the current curriculum will support the meaningful acknowledgement of the inextricable link between physical and mental health, and the importance of integrating this framework into all health care settings. Further, research continually highlights the detrimental impact of trauma on mental health and on many health-related behaviors. This is in line with the tenets of the Affordable Care Act (ACA), which stresses the importance of increasing provider competency in the provision of integrated care. Integrated care "enhances usual care and decision-making for people with medical and behavioral health conditions and is a critical factor in quality, patient experience, and cost" (Croft and Parish, 2012). The elements of the ACA that may lead to greater integration between provider systems "are organized into three domains: increasing access, financing and reimbursement changes, and infrastructure enhancements (Croft and Parish, 2012). This project seeks to support infrastructure enhancements through workforce development. Indeed, building a knowledgeable workforce that is attuned to the value of integrated care will help build bridges across providers. Through the addition of an integrated and Trauma Informed Care component to the existing curriculum, prospective HHAs will be positioned to provide high-quality, person-centered, integrated care to New Yorkers in need of these essential services.

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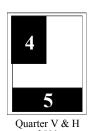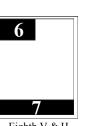
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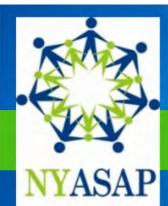**Summer Issue - April 14, 2015**
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