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FALL 2015 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 3 NO. 1

Substance Use and Mental Health Services at a Crossroads

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

Behavioral health services must be strengthened to meet community needs. All too often, people with substance use and mental health disorders do not get the help they need. Behavioral health services are not available on-demand across New York State. A comprehensive continuum of prevention, treatment and recovery support services is not available in some communities.

Advocates maintain that resources for substance use and mental health disorders prevention, treatment, and recovery supports are inadequate, resulting in significant gaps in the service delivery system. Waiting lists with hundreds of persons seeking treatment for their opiate addiction exemplify the unfortunate reality that treatment is not available on-demand in New York State. Finding adequate mental health or substance use disorders services for children, adolescents, or young adults is extraordinarily difficult in many parts of the State. Unfortunately, as demand for services is increasing, the infrastructure for

John Coppola

New York's behavioral health system is experiencing troubling fiscal challenges; including the failure of some of our cornerstone service providers and a widespread lack of fiscal viability. These have been trying times for service providers and for individuals and families seeking help.

Community-based mental health and substance use disorders service providers are burdened by increased regulations, increased business costs, resources that do not keep pace with inflation, an underpaid workforce, and the limitations created by significant stigma. Persons and families with behavioral health needs are at wits-end when they cannot find services, are turned away because they have no insurance or inadequate insurance, or they experience some other barrier.

Because behavioral health services are under-funded and so many people never get the prevention, treatment, or recovery support services they need, New York State must strengthen its service delivery system if it wants to successfully achieve the goals of its new policy and program initiatives. Recent policy shifts and projects developed collaboratively by federal and New York State officials may be a cause for optimism.

Fragmentation of Services and Policy are Part of the Problem

It is a cause for significant concern that most people who are repeatedly hospitalized for physical health problems also suffer from substance use and mental health disorders. Especially alarming is the percentage of people who are frequently hospitalized for physical health concerns that also have a serious and persistent behavioral health need but are not engaged with any services or peer supports.

At the very first meeting of New York's Medicaid Redesign Team, when it was noted that New York State had the highest rate of un-necessary hospitalization in the nation, participants were informed that 80% of the people who were un-necessarily hospitalized suffered from an *untreated* substance use or mental health disorder … or both. Because of the fragmentation that exists between primary healthcare and behavioral healthcare, many people presenting and representing themselves at hospitals are *never* successfully referred to a substance use or mental health disorders service provider. Because of this failure, people with untreated (and sometimes un-diagnosed) behavioral health issues are likely to have difficulty taking care of their other chronic health conditions (heart disease, diabetes, hypertension, etc.) and see their health deteriorate unnecessarily.

More than 80% of persons incarcerated in New York State prisons and county

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Insurance Models to Achieve The Triple Aim

By Kristan McIntosh, LMSW
Joshua Rubin, and Meggan Schilkie
Health Management Associates

Most people think that the reason for bringing behavioral health services under managed care—a "carve-in"—is to save money. They're partially right. Carving in services has resulted in savings for the Medicaid program and for States in many instances. In a carve-in, behavioral health benefits are managed within the existing managed care structure along with all other health care benefits (i.e., medical, pharmacy, inpatient, dental, etc.) and included in the same per-member-per-month (PMPM) rate. This results in one locus of accountability for all healthcare needs. Beyond just saving money, integrated payment can drive integrated care.

According to the Kaiser 50-State Medicaid Budget Survey completed by Health Management Associates in partnership with the National Association of Medicaid Directors an increasing number of states are moving toward carved-in benefits. In this year's survey, the number of states reporting benefit cuts or restrictions fell to the lowest level since 2008. A far larger number of states, 21 states in FY 2014 and 22 in FY 2015, reported enhancing or adding new benefits. The most common benefit enhancements or additions reported were for behavioral health services (10 in FY 2014; 5 in FY 2015).

New York's current plan is to enroll 95% of Medicaid recipients in managed care and to reduce fee-for-service spending to less than 4%. How this transition to managed care occurs will have a tremendous impact on whether people have access to high quality, integrated, comprehensive, and person-centered care. While there are certainly pros and cons to carving in behavioral health services, this article will focus on how carve-in can impact care integration.

The Triple Aim

The Centers for Medicare and Medicaid Services (CMS) have embraced the triple aim of better population health through the provision of better quality services at a lower overall cost of care. Achieving any one of these ambitious goals would be a heavy lift. Two at the same time would be extraordinary. All three together would be Herculean. Thanks to the hard work of dedicated researchers, creative practitioners and passionate advocates, we have learned some valuable lessons that—if we put them to use properly—will help us achieve the triple aim. Three critical lessons we have learned that will make this possible:

(1) Health outcomes are determined by behavior patterns. These behaviors "represent the single most prominent domain of influence over health prospects in the United States." Behaviors that impact health outcomes include diet, exercise, drug and alcohol use, tobacco use, suicidality and many others. (see chart #1 on page 32)

(2) Social determinants like housing, education, employment, trauma and socioeconomic status have a profound impact on health outcomes. (see chart #2 on page 32)

(3) Integrated health and behavioral healthcare improves outcomes, reduces costs and increases provider satisfaction.

Notably, all three of these fundamental lessons point to the essential work of the behavioral health field. The behavioral health sector has decades of experience helping people change their behavior and we are well ahead of the rest of the healthcare community in understanding the critical importance of housing, jobs and supporting those affected by trauma. We have been leading the way in providing care for the whole person, from both the

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Mental Health News Education, Inc.
460 Cascade Drive
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The Pathway to Integrating the Healthcare System: Integrated Licensure and Health Homes

By Arlene González-Sánchez, MS, LMSW, Commissioner, New York State 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.

OASAS Commissioner Arlene González-Sánchez, MS, LMSW

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

see Pathway on page 30

Trauma-Informed Care Leads to More Integrated Care

By David Woodlock
Chief Executive Officer
ICL, Institute for Community Living

Our inattention to the emotional dimensions of health and illness is a public health perfect storm, especially for the mentally ill. This group of people experiences high rates of illness, suffers greatly, uses an enormous amount of our precious healthcare dollars, and dies 25 years earlier than the rest of us. We have the ability to unlock one of the most profound drivers of successful chronic disease management—namely the influence of traumatic experience and toxic stress and what healthcare providers can do about it.

Trauma impacts almost everyone. Its nature may vary—natural disasters, illness, death of a loved one, neglect, or at its most extreme levels, physical and/or sexual abuse. Yet there is strong evidence to suggest one thing in common: many of our seemingly intractable and most costly public health challenges can be traced to the emotional distress ultimately grounded in a traumatic experience, whatever its foundation.

The Milbank Memorial Fund study in 2010 found that "when symptoms and trauma related behaviors are left unaddressed, individuals often experience lower productivity, failed relationships,

David Woodlock

significant distress and dysfunction, difficulty caring for their children, and difficulty caring for themselves in health-promoting ways." It went on to note that "as many as 70 percent of visits to primary care sites stem from psychosocial issues and although patients typically present with a physical health complaint, data suggests that underlying mental health or substance abuse issues are often triggering these visits."

Need more proof? The seminal Adverse Childhood Experiences (ACE) study provides evidence of profound negative consequences of trauma on overall quality of life and clearly demonstrates that traumatic experiences are predictive of poor health outcomes in later life. In fact, multiple experiences of trauma can greatly affect the intensity of both physical and psychological symptoms. The study, conducted by Kaiser Permanente and the CDC, focused on a commercially insured population in California and began as an effort to understand obesity. The study focused in particular on the often-inextricable link between childhood maltreatment, family dysfunction, trauma, and later-life physical and mental health status and harmful health-related behaviors.

There are a number of negative ways that people cope with the emotional distress associated with traumatic experience: smoking, alcohol and drug use, unsafe sexual behaviors, overeating, and more. Each of these compensatory behaviors provides some relief—in the short term. In fact, traumatic experiences are associated with behavioral health issues and, perhaps more important, can lead directly to the behaviors that result in chronic health conditions, not necessarily because those behaviors reflect an individual's intention but rather because they are a means by which people cope with the emotional pain caused by trauma.

Moving forward with the body of knowledge we have on traumatic experiences and its impact on health, we have the option of intervening to address the underlying cause of the person's health impairing behaviors, to look beyond what is being presented as the "problem." By doing so, there is a greater likelihood of addressing the person's overarching health as well as the condition of immediate concern. To do so, however, medical training will need to become more holistic, taking on the phrase most associated with trauma-informed care—*"What happened to you?"* rather than the more expedient *"What's wrong with you?"*

Despite every indication that the health burden of trauma exposure is high, this remains a difficult topic to address for health care providers, who often do not assess for trauma histories with their patients. Part of the reason is that trauma is a sensitive topic, almost as painful in the hearing as it is in the telling. But we must bridge this gap. Our deepening understanding of trauma and its consequences demands that providers not only understand the links between traumatic experience and health outcomes, but also begin to work collaboratively to address an individual's whole health needs.

What we at ICL are doing is a paradigm shift in the provision of integrated

see Trauma-Informed on page 33

Changing Physician Roles and Relationships in Integrated Care

By Jeanie Tse MD, Associate Chief Medical Officer and Vice President of Integrated Health, and Jason Cheng MD, Director of Integrated Health
ICL, Institute for Community Living

Unacceptably high mortality and morbidity among people with serious mental illness have prompted a call to action for behavioral health providers from all disciplines. Included among these providers are physicians and other prescribers, who have an important part to play in the integration movement.

Implementing integration has involved training large numbers of peer health coaches, social workers and paraprofessional case managers to identify and support self-management of physical health risks. In earlier issues of this newsletter, ICL has described dissemination of its Diabetes Self-Management and Healthy Living toolkits to support transformation of the behavioral health workforce across New York City to better take into account physical health. However, very few physicians were able to participate in these trainings, and the material did not specifically address the learning needs of people with a high level of medical training.

For physicians, integrating primary and behavioral healthcare has involved an expansion of scope of practice and development of engagement and motivational enhancement skills, as it has for other behavioral health providers. However, the new scope and skills are quite specific and require more training than most physicians have accessed at this time. Dr. Lori Raney, an expert on this kind of integration, has contributed very important curricula specifically designed to prepare primary care providers and psychiatrists to work in integrated settings. Supporting physician access to these trainings should be a priority for behavioral health agencies. She and others have also worked to support and legitimize the shift in scope that many physicians have had to undertake in order to provide the best care for people with complex health needs.

This article focuses on physicians, but many of the ideas are applicable to other prescribers, including advance practice nurses and physician assistants.

Psychiatrists in Primary Care Settings: The Collaborative Care Model

Providing behavioral health care in primary care settings is called "forward co -location," and the best-known model is collaborative care. In this model, primary care clinics screen people for mental illness, most commonly depression or anxiety. Those who screen positive can choose psychotropic medication prescribed by the primary care provider (PCP) and/or brief, evidence-based psychotherapeutic interventions provided by an on-site behavioral health clinician. Both types of staff are supported by a consultant psychiatrist who is available to answer questions and who may also meet with patients to help direct care. The status of the mental health symptoms are tracked regularly, with timely treatment adjustment for those who are not responding. More than 80 randomized controlled trials have been conducted on collaborative care, demonstrating improved depression and anxiety outcomes (http://aims.uw.edu/collaborative-care/evidence-base).

The advent of this model has created a new role for psychiatrists and a new type of relationship between PCPs and psychiatrists. The practice of primary care has always involved management of people with mental illnesses, since over 50% of people have a diagnosable mental illness at some point in their lifetimes (http://www.hcp.med.harvard.edu/ncs/ftpdir/NCS-R_Lifetime_Prevalence_Estimates.pdf). In addition, as many as 70% of visits to primary care sites "stem from psychosocial issues" (http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf). However, the great demands on PCPs' time have meant that, in most cases, only people whose chief complaint is a psychiatric symptom have received treatment. Many PCP's have voiced frustration at being unable to find a psychiatrist for people who have more complex psychiatric needs. Therefore, greater access to psychiatry has been welcomed by PCPs who have been able to participate in the collaborative care model, and generally the feedback has been very positive. It may require PCPs to develop more skill in psychiatric diagnosis and the use of psychotropic medications, but does not require a major shift in scope of practice.

However, this model requires a certain type of psychiatrist: one who is willing to "share care" with another prescriber, in a role halfway between a supervisory and consultant role. On top of the uncertainty that comes with consulting on cases with limited information, liability is less well defined. Few psychiatry residents have participated in this model in training. The closest experience for many would be the consultation-liaison experience, in which residents typically consult on inpatients on medical/surgical units, rather than consulting on people receiving continuous outpatient care over time. Greater exposure to the collaborative care model would prepare more psychiatrists to take on this important role and expand access to behavioral health care.

Primary Care Providers in Behavioral Health Settings: Reverse Co-location

"Reverse co-location" puts primary care in the behavioral health settings where people with serious mental illness are already engaged in care. Behavioral health counselors can have very close relationships with individuals, often seeing them more frequently than any other

see Changing Roles on page 31

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Although statistics show that people with serious mental illness are dying 25 years earlier than the general population, by exploring the impact of past negative experiences, ICL treatment focuses on the whole person (not their symptoms) and on life goals to determine the best path to mental and physical health recovery. Treatment outcomes have shown a reduction in emergency room visits as well as hospitalizations for mental and physical health reasons.

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Building an Integrated Healthcare System: Blending Public Health and Prevention Models

By Peter C. Campanelli, PsyD
Senior Scholar, McSilver Institute for Poverty Policy and Research

The very first time I ever thought about physical and behavioral healthcare together was when I heard of a psychiatrist who wanted to do complete blood chemistry before prescribing medication to new patients within a mental health clinic, a unique situation some 20 years ago. Clearly, this psychiatrist was a visionary and if her insight had translated into public policy, who knows how many incipient chronic medical conditions would have been diagnosed. Instead, Medicaid denied the claim for the blood work because it could not be used as a "…diagnostic criteria for schizophrenia," sadly missing the point and an important opportunity.

We may be at a similar crossroads in our discussion of integrated health being too narrowly focused on where care is delivered. It seems that the current focus on integrating healthcare as "placed-based," rather than "context- based" may well become another opportunity lost. While integrating health care into behavioral health locations (and vice versa) may in fact improve medical monitoring and adherence, that level of integration remains at the patient-practice level and fails to elevate the discussion to the social context. Put more directly, healthcare generally is about a person's health status and the treatment that can be offered to improve a presenting problem, rather than how the person managed to develop the disorder and what secondary and tertiary interventions can be applied to mitigate the effects of the disease.

There is a common thread that ties the domains of health care and public health together. There are nine preventable diseases that account for 50% of all deaths in the United States. Evidence indicates that prevention targeting the root causes of these diseases account for an 80% reduction in mortality, while direct treatment accounts for less than 20%, (Hardcastle, Record, Jacobson, & Gostin, 2011). This fact alone argues for the development of an integrated healthcare system that gives equal importance to the development of the science of prevention, as well as continued development to improvements in treatment and service delivery.

Peter C. Campanelli, PsyD

The Changing Landscape

The Affordable Care Act (ACA) came into being for three simple, but interconnected reasons. These were: (1) the country had over 35 million people without health insurance, 16 million of whom were poor, but did not qualify for Medicaid; (2) while America spent more than any other industrialized nation for health care, our healthcare outcomes placed us at a dismal 37% ranking; and (3) over 18% of the nation's gross national product (GNP) was being spent on healthcare with an upward trajectory being projected for the future. Put simply, the situation was not economically sustainable, nor was it acceptable from a quality outcome perspective. While the United States has built an exceptional healthcare system for the acute treatment of complex disorders, pioneering innovative developments in pharmacology and surgical procedures, on the one hand, the country has spent enormous resources on unnecessary, inefficient, and expensive interventions, often ignoring improvements in care and efficiencies in cost that could be gained by a more community-based prevention focus. It is estimated that approximately 60-75% of the cost on chronic care could be saved if a full prevention agenda were to be implemented.

Nowhere is this truer than among people who are challenged by serious mental illness (SMI) and complex chronic physical diseases. Indeed, over 50% of people with SMI have at least one, indeed many have multiple, chronic diseases such as repertory, metabolic, and cardiovascular conditions which complicate their care. Added to this level of complexity is the fact that these individuals frequently lack access to specialty care required by these conditions and likewise, lacked the self-care knowledge they need to help self-manage these conditions.

Health Care Through The Lens of the Social Context

In 1979, Surgeon General Julius Richmond established the first national prevention agenda. His ambitious report led to the creation of the Healthy People National Vision, a strategic framework for health promotion and disease prevention using data driven outcomes to motivate, guide and focus action. While the Healthy People framework has accomplished a great deal with regard to population health, it has not focused on the social determinants of health, which are generally defined as social context variables that can lead to negative health outcomes including: (1) health care access/literacy; (2) stable housing; (3) poverty/financial stability; (4) education; and, perhaps most importantly, (5) avoidance and resilience to trauma.

The first iteration of integrated health care placed emphasis on co-location of primary care into behavioral health and behavioral health into primary care utilizing an acuity index predicated on the four quadrant model of acuity. The second iteration has shifted, while keeping co-location as a core principle, to understanding the social context which results in negative healthcare outcomes. Examples of this shift include NYS Performing Provider Systems (PPS) being asked to incorporate social determinants in care planning/delivery; the immediate past NYS Commissioner of Health not only publishing an article stating that "…housing is healthcare,"(Doran, Misa, & Shah, 2013), but also funding supported housing with Medicaid dollars; and the Immediate past HHS secretary Kathleen Sibelius stating that "…the most lasting legacy of the ACA is its focus on prevention as a national priority" (Koh & Sebilius, 2010). Further, New York State Health Foundation (NYSHF) President James Knickman titled one of his blogs, "It's time we get serious about Social Determinants [of Health]". Today, there is a confluence of professional opinion on the importance of social determinants in population health and the need for strong, targeted prevention initiatives.

What is not well known is how health care and social systems can intervene strategically around social determinants in order to positively impact healthcare outcomes. We lack assessment strategies and prevention applications for social determinants that can be marshaled in the prevention arena in concert with evidenced based practices (EBPs) for disease management and a compendium of self-help skills to promote "healthy behaviors" all designed to improve population health.

Epigenetics, Social Determinants And the Role of Prevention

The Adverse Child Experiences (ACE) study (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998) was an early glimpse into the devastating impact that child abuse and neglect has on child development and later adult life. A retrospective application of the ACE scale not only tied the experience of adverse and traumatic events to negative healthcare outcomes, but it was suggested that there was a dose response relationship between trauma frequency and negative outcomes. Subsequent research done in Texas (Dube, Cook, & Edwards, 2002) found that found that people with childhood adversities were more likely to be adults who were poor, less educated, and have difficulties maintaining employment. Moreover, these adults were more likely to be burdened with health problems such as smoking, obesity, substance and alcohol abuse. The emerging science of epigenetics (Lester, Marsit, Conradit, Bromer, & Padbury, 2012) , the study of changes in organisms caused by modification of gene expression, rather than alteration of the genetic code itself, is beginning to suggest that exposure to adverse life experiences not only has an inter-generational expression, but may indeed have a trans-generational expression as well.

These new developments have important implications for the development of the science of prevention. First, Hardcastle (2011) suggests that when we think about integrated health, we consider the development of a *Health Care System* consisting of appropriately co-located services coordinated by patient care navigators for complex cases where evidenced based treatment, as well as trauma informed care and social determinant intervention and assessment are available. Secondly, the clinical science of prevention requires considerable developmental work in order to produce targeted assessment and intervention strategies that promote resilience for the mental, emotional, and behavioral health (M-E-B) of children and young adults (Yoshikawa, Aber, & Beardslee, 2012). Thirdly, difficult decisions concerning re-allocation of resources to the various priorities of a reconfigured Health Care System will need to be made that keeps the focus on improved healthcare outcomes for the population. Finally, a renewed interest in community development by community based organizations (CBOs) helping communities become places that foster rehabilitation and support for community members. There is a natural synergy that should exist between CBOs and their host communities.

Preparing the Workforce

Admittedly, this is a hugely complicated, multi-component transformational shift. The ACA has offered a number of tools that can be used to help in the transformation. These include expanded insurance coverage, care navigation, expanded community based health care through federally qualified health centers and medical homes, and an emphasis on prevention; research resources to promote rapid system transformation; and the development of accountable care organizations to oversee system and payment transformation. System transformation will only succeed to the extent that we develop innovative strategies to fully engage and re-train the workforce. Creating an integrated healthcare system will involve the development and learning of complicated new concepts and implementation strategies. Success will be totally dependent on engaging and re-tooling the workforce to not only adapt, but to also help shape these changes. Experience in workforce re-tooling, thus far, clearly indicates the workforce understands the importance and wants to be engaged. A colleague once remarked that re-tooling the work force for the requirements of the ACA will be a bit like trying to fix the transmission of an automobile as it is going down the road at 60 MPH. Everyone in the car realizes how important it is that we be successful and that failure is not an option.

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Zero Suicide: Working Together to Save Lives

By John Draper, PhD, Director, and Shari Sinwelski, MS, EdS, Associate Director, National Suicide Prevention Lifeline

The death of Robin Williams in 2014 was an event that stunned the nation. He was a beloved man who brought laughter to so many people's lives. His suicide stirred emotions in people as they pondered a myriad of questions.

- How could someone who had such a full life want to kill himself?"
- "Did anyone know how much pain he was in? Why didn't they help him?"
- "If Robin Williams' life isn't worth living, why would someone like me stay alive?"
- "His death reminds me of when I lost my sister to suicide."
- "I have a friend who has been saying he wants to end his life too. How do I help him?"

These are a few examples of what people were saying when they called the National Suicide Prevention Lifeline after Robin Williams death. Calls to the line increased by 40% in the initial week after his death and to remain higher than baseline to this day. Perhaps the only solace in such a great loss was the conversations it sparked and the media's focus on directing people to resources such as the Lifeline where open conversations about suicide are encouraged. Finally, people knew they had somewhere to turn.

John Draper, PhD

Shari Sinwelski, MS, EdS

Talking about suicide is a key strategy in its prevention. It's important that people who are considering suicide are able to find someone with whom they can talk to about their feelings. It is also important that health and behavioral care systems talk about it as well. The Suicide Prevention Resource Center and the National Action Alliance for Suicide Prevention are challenging health and behavioral health care systems to do just this with the Zero Suicide Initiative. Based on the tenet that suicide is preventable, this initiative sets the bold goal of creating systems of care where no one is lost to suicide.

The concept grew from work at the Henry Ford Health System in Michigan where they set out to create a "perfect system" for depression care. It wasn't long before the question was asked, how will we know if the system is successful and someone responded, "When no one dies by suicide." This aspirational thinking caused changes in systems at Henry Ford that resulted in an 80% reduction in the suicide rate amongst their health plan members.

The success of the Henry Ford model can be attributed to a systems approach to suicide prevention that requires a commitment to patient safety and to the safety and support of the clinical staff responsible for providing care to those at risk for suicide. The National Action Alliance for Suicide Prevention recognizes seven essential elements for health and behavioral health care systems to adopt in order to close the gaps in care that can lead to an unintentional loss of a life to suicide. The tenets include:

1. Lead: Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.

2. Train: Develop a competent, confident, and caring workforce.

3. Identify: Systematically identify and assess suicide risk among people receiving care.

4. Engage: Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.

5. Treat: Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.

6. Transition: Provide continuous contact and support, especially after acute care.

see Save Lives on page 33

A New Model for Integration of Care: The Ambulatory ICU

By Jeffrey M. Levine, MD, FACP
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Bronx-Lebanon Hospital Center

DSRIP and the Ambulatory ICU

Patient Centered Medical Homes (PCMH) are built upon access, communication, continuity and ongoing performance improvement. Health Homes have been most successful in engaging marginalized difficult patients with little primary care utilization but falter when successful treatment requires care by multiple physician specialists, who most often cannot directly communicate; on the other hand, stable patients with chronic disease could frequently be cared for more efficiently in the community by non-physician providers. We at the Bronx-Lebanon Hospital Performing Provider System in the Bronx are building a new model: the Ambulatory Intensive Care Unit. The objective of the Ambulatory ICU is to develop a model of care that combines the virtues of the PCMH and the Health Home: Multi-provider team-based visits (Ambulatory ICU's) for patients with complex medical, behavioral, and social morbidities.

Jeffrey M. Levine, MD, FACP

Models of Care Integration

The integration of medical and mental health is promoted in several of the projects of the Delivery System Redesign Incentive Payment (DSRIP) projects. Most attention has been given to instituting Collaborative Care models for general medical patients with anxiety or depression. Primary care has been expanded through Patient Centered Medical Homes (PCMH) to include the provision of mental health screening and treatment. In the PCMH, primary care patients with depression receive enhanced follow-up and education through a Depression Care Coordinator (either an RN or social worker) within the medical practice. A psychiatrist consults regularly about problematic patients or those who are not improving as anticipated. The key point is that the primary care practice takes primary responsibility for initial treatment. The mental health system supplies support for these efforts through consultation and acceptance of referrals for patients with severe mental illness.

Improvements in the health care of patients with more severe mental illness have been more problematic. As is well known, patients with persistent mental illness have a markedly shortened life expectancy. Integration of general health care into mental health treatment sites is less developed than Collaborative Care for primary care. Patients with mental illness often have multiple debilitating medical illnesses requiring the care of multiple specialists. Not infrequently, there is little communication among these specialists. Health Home care coordinators make excellent alliance with patients, but they cannot be expected to repair a disorganized system.

High Utilizing Patients

Containment of health care costs has driven the development of the Ambulatory ICU. Because a relatively small number of patients account for a disproportionate share of health care utilization and cost, considerable attention is focused on improving the coordination of health care for such high need, high cost patients. The challenges posed by high utilizing patients with multiple co-morbidities are especially acute among poor inner city residents insured through Medicaid.

There have been several attempts to improve care for high utilizing patients. Programs in six counties in California were designed to address the needs of high cost Medi-Cal (Medicaid) patients and identified three key components of comprehensive care for high cost patients:

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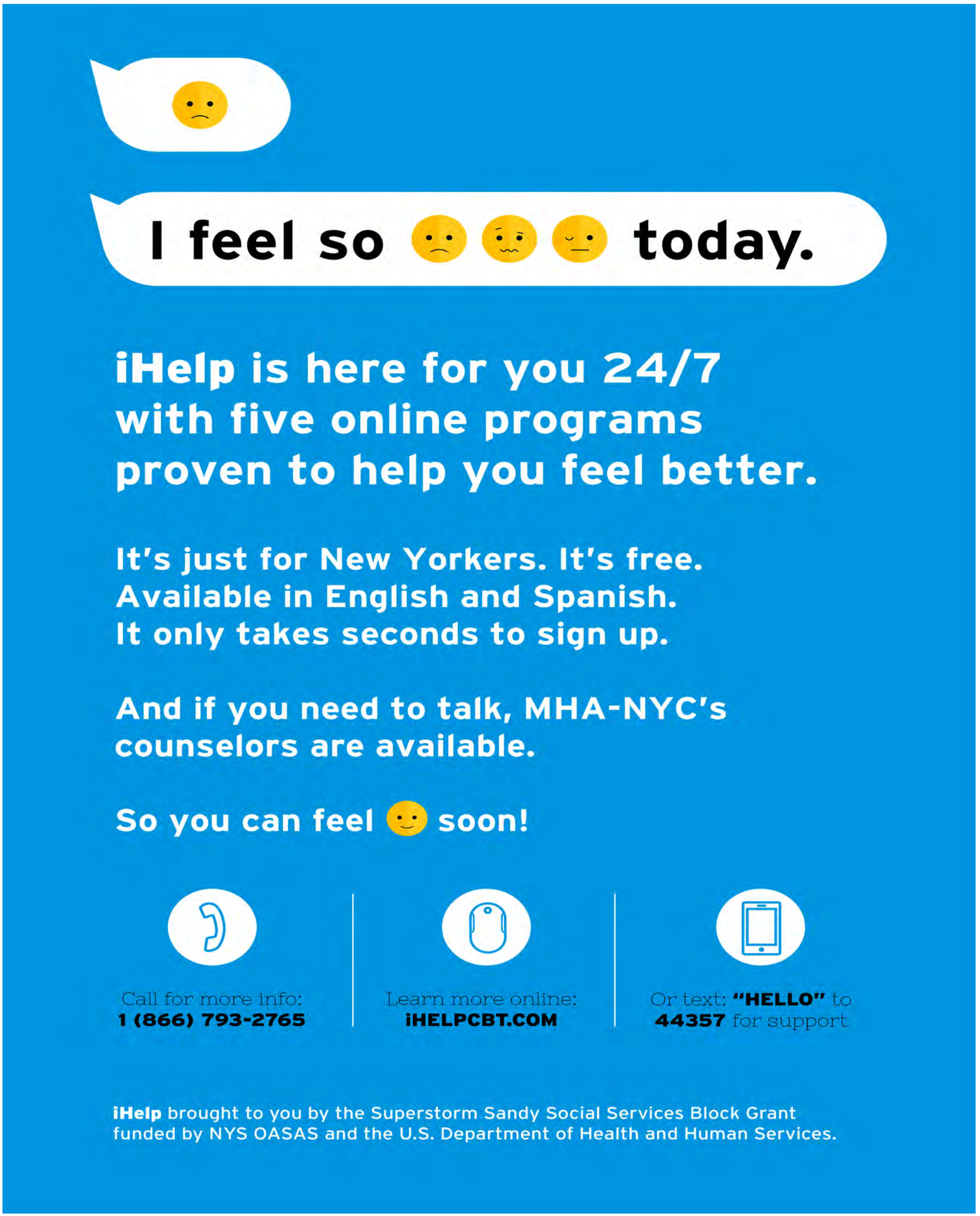
I feel so today.
iHelp is here for you 24/7
with five online programs
proven to help you feel better.
It's just for New Yorkers. It's free.
Available in English and Spanish.
It only takes seconds to sign up.
And if you need to talk, MHA-NYC's
counselors are available.
So you can feel soon!
Call for more info:
1 (866) 793-2765
Learn more online:
iHELPCBT.COM
Or text: "HELLO" to
44357 for support
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Integrated Care At Last?

By Michael B. Friedman, LMSW
Behavioral Health Policy Advocate

This issue of *Behavioral Health News* is devoted to current efforts to integrate care for people with behavioral health conditions. So many complex mechanisms are being created that I get lost in the maze of confusing names and acronyms. "Health home", "medical home", "HARP", "DSRIP", and more. I confess I know little about the specifics. I considered sitting this issue out or writing about something else. But having been involved in efforts to achieve integration for over 40 years, maybe I can offer a couple of observations that will be useful to the architects of today's new systems.

The "fragmentation" of the mental health system has been a matter of concern at least since the early 1970s, when—for example—New York State passed the Unified Services Act in an effort to end the fragmentation of the state hospitals and local mental health services. That effort collapsed (except in 5 counties) because it shifted financial risk to local governments without giving them full control of the state hospitals. Since then, there have been numerous efforts to integrate care, including the federal Mental Health Services Act, the Community Support Systems initiative begun in the late 70s, Child and Adolescent Service System Program (CASSP)

Michael B. Friedman, LMSW

and Intensive Case Management in the 1980s, the Special Needs Plans in the 1990s, and many more. Over this period of time, more and better services in the community have been developed, but complaints about the fragmentation have not abated in the least.

There are many lessons to be learned from the failures or very limited success of prior efforts to integrate care. One of the most important, I think, is that the meaning of "integrated care" has varied over the years.

The 1970s

In the 70s the primary meaning of integration" was building effective working relationships between state hospitals and local mental health services. In New York State, the Unified Services Act and the long-forgotten Triangle Plan were aimed at solving that problem of fragmentation. Neither succeeded, but over time there was some improvement in working relationships depending largely on the particular people who were directors of state hospitals and those who were directors of community services for local governments.

The 1980s

By the early 80s, it was clear that there was also fragmentation among local mental health providers. A person admitted to a hospital generally was not followed there by providers in the community, and a person discharged from a hospital (even with a decent discharge plan) was not followed by anyone at the hospital. People in community residences went to day programs where they might or might not get their clinical services so that some people had three or more sets of providers (housing, rehabilitation, and clinics) who rarely communicated. Case managers were supposed to coordinate their care, when they had case managers. This was no doubt helpful to some people. But complaints continued that people in various programs were largely left to drift on their own, with no provider taking overall responsibility for their care.

"Intensive case management" and, later, Assertive Community Treatment were important and somewhat successful responses to this form of fragmentation. (It strikes me that the concept of "care coordination" at the heart of several of the new integrative mechanisms is an effort to build on the partial successes of ICM and ACT.)

During the 1980s concern also emerged about integrating care for people with both mental and substance use disorders. Battles of treatment philosophy as well as conflicting service, administrative, and financing structures plagued efforts to integrate treatment for people sometimes called MICA (mentally ill chemical abusers) and sometimes called "dually diagnosed", (although it was clear that most were dually undiagnosed). During the late 90s NYS and SAMHSA developed a grid to clarify which system was responsible for whom, but that did little to increase the number of people actually receiving integrated treatment. Apparently, the vast majority still do not get integrated treatment.

Also during the 1980s much concern emerged about the failure to integrate services for children with serious emotional disturbances. Overcoming fragmentation in this context meant primarily that different systems serving children need to work together. This includes mental

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It's All About Engagement

By Yves Ades, PhD
Principal
Ades Integrated Health Strategies

Our new managed care lexicon is full of buzz words like "integration," "coordination," and "person-centered." I'm sure that by now we all have a sense of the practices associated with these words. There are plenty of websites and webinars to walk us through what integrated, coordinated and person-centered care should look like.

My work as a provider of behavioral healthcare along with my current consulting practice has allowed me vast opportunity to witness active, "on the street" efforts at implementation of integrated, coordinated and person-centered services. What astounds me is that with all the earnestness and good intention going into the effort, there are still a significant percentage of service recipients who don't benefit. This is the segment of the individuals who, while in need of good integrated and coordinated care, succeed in evading all provider attempts to engage them with our new models of service delivery. I hear this all the time in morning meetings and service utilization conferences. Despite all the training service coordinators have gone through, they come up against a wall of rejection and non-responsiveness, and

Yves Ades, PhD

often from the service recipients who are the most in need of integrated and coordinated care. In that scenario everyone loses: the provider, the service recipient and the healthcare system.

So, what's the answer? Better yet, what's the question? Perhaps it is this: How do we sell care integration and coordination to the "uninterested?" While we may believe that what we are offering is wonderful, what do we know about how it is perceived by those to whom we are trying to sell it? How do we know whether our sales force is adequately trained to sell our product? Other industries spend huge amounts of time and money on teaching their salespeople about their products and how to represent the value of their products to would-be consumers. Simply believing that care integration and coordination is good will not make the sale.

One effective "tool" we've been using to engage the skeptical consumer is the peer---the person with lived experience--who has both empathy and credibility for the job. Yet, when it comes to anything "integrated" or "coordinated" the product is too new for anyone to give it a genuine personal endorsement. The Peer is therefore counting entirely on his/her prior experience with the mental health system, and cannot genuinely vouch for the benefits of our new redesigned healthcare menu of services.

So then, what are the best practices with which we can equip our "sales force" to engage potential beneficiaries? There are lots of approaches, a number of which come from the work on trauma informed care, which readily acknowledge the person's prior experience as the starting point for engagement in treatment, i.e. "What happened to you?" instead of "What's wrong with you?" This may be central to successful engagement, but not without the willingness to stay the course, which is another less talked about best practice. Here, it is time and effort that matter; Time and effort to develop trust through open, empathic and motivational dialogue. Note that this is no small investment for Care Managers and the Health Homes under whose auspices they operate. Yet the "system" has only minimally acknowledged the need to "front load" resources so that care management providers can develop the talent in their staff to engage beneficiaries with the effort, and over the time, it requires.

If our evolving and re-designed healthcare system is going to achieve the Triple Aim with disengaged "super-utilizers," the reimbursement rates for engaging and enrolling them in Care Management and the HCBS menu of services will have to be adjusted to allow for staff training, and for the time and effort it takes to effectively engage and enroll. A sound investment at the front end with reasonable incentives for providers will better ensure that the right people receive the services and supports they need. Otherwise these would-be beneficiaries will be "dropped" from the recruitment lists, remain in the margins of care, and defy the objectives of this unprecedented healthcare reform initiative.

Integration on a Continuum: Models for Integrating Behavioral Health and Primary Health Care

**By Alan Trager, LCSW,
Amy Anderson-Winchell, LCSW,
Amy Kohn, DSW,
Andrea Kocsis, LCSW,
Andrew O'Grady, LCSW-R,
Elizabeth Kadatz,
and Stephanie Madison, LMSW**

CBHS Behavioral Health Partners: (Front) Amy Kohn, CEO, Mental Health Association of Westchester; Andrea Kocsis, Executive Director, Human Development Services of Westchester; Amy Anderson-Winchell, President and CEO, Access: Supports for Living; (Rear) Elizabeth Kadatz, Director of Operations, Rehabilitation Support Services; Alan Trager, CEO, Westchester Jewish Community Services; Andrew O'Grady, Executive Director, Mental Health America of Dutchess County; Stephanie Madison; President and CEO Mental Health Association of Rockland

In the recent years of Medicaid Redesign in New York State, community-based mental health agencies who serve persons with serious and complex psychiatric conditions have addressed the evolving transformation of health care in a variety of ways. Much of the response has been reactive, with agencies reorganizing and adapting their services and supports to conform to the opportunities and contend with the challenges presented first by the roll-out of Health Homes, and then of DSRIP (the Delivery System Reform Incentive Payment program). While these initiatives have been fraught with the stresses of continually changing operational time frames and procedural requirements, they are now launched and are proceeding at various stages in their development.

The next phase of the NY State Medicaid Redesign includes the carving in of mental health services into the Medicaid managed care system. Once again, this portends major changes in agency services, operations and billing procedures, and again, is proceeding in fits and starts.

Many of these changes have been stimulated by the federal Affordable Care Act (ACA), with its goals to increase access to quality care, to improve population health, and to do so at a lower cost. A major thrust of the ACA has been to encourage and incentivize increasing integration of behavioral and physical healthcare, which historically have been provided in silos of care. Community mental health agencies have embraced these noble goals and are striving to serve an expanded pool of people needing services. Some of these agencies have organized into partnerships in an effort not simply to *respond* to the challenges, but to *innovate* within the new climate of change, to create new models of integration, to more effectively assist people to move forward in their recovery.

In 2012, a group of eight leading behavioral health and developmental disability nonprofit community-based agencies serving the Lower/Mid-Hudson River Region of New York State partnered to move proactively into this new and challenging environment. They incorporated to form Coordinated Behavioral Health Services (CBHS). (CBHS IDD agencies have also partnered with the New York Integrated Network (NYIN), a group of leading providers of services to persons with developmental and intellectual disabilities to pursue innovative approaches within the similarly challenging and evolving IDD world.) The history of the CBHS partnership has previously been described in the Spring 2014 edition of *Behavioral Health News.*

Since that time, the CBHS behavioral health agencies have formed an IPA (Independent Practice Association), and have added new partners, the group now comprising Access: Supports for Living, Human Development Services of Westchester (HDSW), Mental Health America

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A New Approach to Service Integration and Variation on a Proven Theme

**By Ashley Brody, MPA, CPRP
Chief Operating Officer
Search for Change, Inc.**

Ashley Brody, MPA, CPRP

Policy developments within federal, state and local governments are compelling providers to pursue the "Triple Aim" of healthcare reform and to continually reevaluate their systems and services to this end. Notwithstanding the complexities of the Affordable Care Act (ACA), Delivery System Reform Incentive Payment (DSRIP) program, universal Managed Care and other industry forces, the successful integration of primary (physical) and behavioral healthcare across service domains and its provision in non-institutional, community-based settings is a denominator common to all initiatives and a key metric by which providers' success will be measured.

The conceptualization of integration is anything but integrated, however. It has been differentially defined in both the research literature and clinical practice, and new models of integration continue to evolve in accordance with available technologies, resources and stakeholder demands. The Agency for Healthcare Research and Quality (AHRQ) offers no fewer than nine definitions of integration, some of which include both quantitative and qualitative dimensions (Agency for Healthcare Research and Quality, 2008). For instance, one definition refers to "any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting" (Institute of Medicine, 2006) whereas another suggests integrated approaches must "have medical and behavioral health components within one treatment plan for a specific patient or population of patients" (Blount, 2003). Integration may be achieved among service settings, populations, treatment interventions, diagnostic classifications and innumerable other dimensions, but the overarching goal of integration remains largely consistent across disparate approaches. Each endeavors to apply increasingly holistic methods to the management of comorbid health conditions in order to enhance the quality and coordination of care, reduce expenditures associated with inefficient and duplicative services and improve healthcare outcomes.

To this end the Westchester County Department of Community Mental Health (DCMH) has secured support from the New York State Office of Mental Health (OMH) for the implementation of a novel approach to service integration for members of an especially vulnerable target population. The DCMH has funded three community-based organizations to deliver mobile outreach, peer support and respite services to recipients with histories of treatment at state-operated psychiatric facilities and others at risk of admission to them. This approach is expected to reduce the incidence of emergency department visits and inpatient hospitalization among service recipients and to effect measurable improvements their overall health status.

The mobile outreach component of this project includes two care managers and a Licensed Practical Nurse (LPN), and they maintain modest caseloads in order to maximize their capacity to deliver intensive support services for recipients with complex and comorbid health conditions. Although the Mobile Outreach Team (MOT) does not retain as comprehensive an array of clinical supports and credentials as an Assertive Community Treatment (ACT) Team, it nevertheless employs a multidisciplinary approach in its attention to both behavioral and primary (physical) health conditions. It also leverages existing community support services in order to achieve integration across various clinical and service domains and to address the innumerable social determinants of health for its target population. Peer support services are delivered by two agencies with proven expertise in this modality, and these services are provided in concert with mobile outreach as needed in order to ensure recipients may benefit from the support of others with lived experience in the recovery process. Care managers, peer support providers and an LPN routinely conduct "inreach" activities in a state-operated psychiatric center in order to cultivate relationships with prospective recipients and to develop individualized support plans. Principles consistent with a Critical Time Intervention (CTI) approach are applied in order to promote recipients' resilience during precarious periods of transition. In addition, respite services are available to individuals who have been discharged and secured housing in the community but require

see Variation on page 36

The NYSPA Parity Enforcement Project: New Tools for Patients and Providers in The Fight Against Parity

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

The passage of the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) represented a landmark moment for those fighting for parity in behavioral health benefits. In the years since MHPAEA and its implementing regulations went into effect, many of the financial restrictions and treatment limitations previously imposed on behavioral health benefits have disappeared. However, some insurance carriers continue to employ discriminatory practices, particularly in the context of utilization review and medical necessity review of ongoing behavioral health care and treatment.

In response, the New York State Psychiatric Association (NYSPA) is working on a new initiative called the Parity Enforcement Project, a joint project of NYSPA and the American Psychiatric Association. The Parity Enforcement Project is designed to educate and assist behavioral health providers, patients and their families in challenging adverse benefit determinations with respect to mental health and substance use disorder benefits. Through the Project, we hope to provide individuals with easy access to tools already available under federal law to fight back against discriminatory practices by health plans.

Some of the health plan practices we hope to target include:

- Reductions in the frequency of covered or reimbursed visits;
- Pre-payment medical record reviews;
- Requests for peer interviews;
- Requirements for outpatient treatment reports;
- Imposition of prior authorization requirements on behavioral health treatment;
- Imposition of numerical visit limits;
- and Notification that behavioral health treatment will no longer be covered by the health plan.

The Project focuses on provisions of federal law that address disclosure of information in connection with compliance by health plans. Under MHPAEA as well as the federal Employee Retirement Income Security Act (ERISA), plans are required to provide access to certain documents that govern the way the plan is operated and the way benefits are administered.

Under MHPAEA, current or potential plan participants may request copies of medical necessity criteria used by the health plan to make determinations regarding mental health or substance use disorder (MH/SUD) benefits (29 C.F.R. §2590.712(d)(1)). Current or potential contracting providers are also entitled to

Rachel A. Fernbach, Esq.

this same information (29 C.F.R. §2590.712(d)(1)). In addition, MHPAEA mandates that plan participants be provided with the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits (29 C.F.R. §2590.712(d)(2)).

Under ERISA, plan participants and beneficiaries have the right to request copies of "instruments under which the plan is established or operated (ERISA Section 104(b)(2) and 29 C.F.R. §2520.104b-1)." This information must be provided by the plan to the requesting party within 30 days. Certain provisions of ERISA, which also apply to MHPAEA, permit individuals to designate their health care provider or other third party as an authorized representative. The authorized representative would then act on the patient's behalf to request plan documents, request reasons for denials, or otherwise communicate with the health plan.

An initial goal of the Project is to gain access to health plan documents to ensure that plans are actually following their own internal policies and procedures when making benefit determinations regarding MH/SUD benefits. In order to do this, providers, patients and family members may request information from a health plan in writing. To facilitate such document requests, NYSPA has prepared form letters that have been posted on the NYSPA website (www.nyspsych.org) and may be downloaded and personalized by providers, patients or family members. The document request letters may take one of two general approaches, a general inquiry letter or a letter following an adverse action.

General Inquiry Letter

The general inquiry letter may be sent at any time, in advance of any adverse action, to request access to plan documents under ERISA and/or MHPAEA. A general inquiry letter might be useful if a patient is considering switching to a new health plan and wants to find out more about the plan's internal policies and procedures. Another reason to use a general inquiry letter might be in response to a plan's request for treatment notes or a plan's request for a telephone interview with the provider in connection with continued processing of behavioral health claims. In these situations, while no adverse action has yet been taken, the plan appears to be engaging in utilization review of the patient's benefit and a document request may be considered preventively.

If the patient participates in a health plan that is subject to ERISA, the patient or the patient's authorized representative may request copies of any instruments under which the health plan is established or operated. This is a broad request power because it applies both to plan documents relating to medical/surgical benefits and plans documents relating to MH/SUD benefits.

However, if the patient participates in a health plan that is not subject to ERISA, for example, individual plans or ACA exchange plans, the request must be made under MHPAEA. A MHPAEA request is limited to a copy of the medical necessity criteria used by the plan to make determinations regarding MH/SUD benefits only.

Following An Adverse Action

The second approach to a document request would be following an adverse action already taken by the health plan, for example, a denial of benefits or a reduction in the frequency or amount of covered services. Following the adverse action, a plan participant or provider may make two kinds of requests under MHPAEA. First, the plan participant or provider can request copies of the medical necessity criteria used by the plan to make the instant determination. Examination of the documents provided should assist in determining whether the plan has followed its own internal policies and procedures regarding benefit determinations. Second, under MHPAEA, the patient or an authorized representative may request that the plan provide a written reason for the adverse action, taking into account the patient's particular medical circumstances.

Failure of a health plan to provide complete and prompt responses to any of the document requests outlined above is a possible violation of law and may serve as a basis for complaints to federal and state regulatory authorities.

At this point, the focus of the Project is primarily on the policies and procedures of commercial insurance carriers. However, we expect that final regulations regarding the application of MHPAEA to Medicaid plans will be issued in the coming months. We hope to include more information about disclosure requests to Medicaid fee-for-service and Medicaid managed care plans in a future column.

The next phase is to compile and review plan responses to provider and patient document requests, with patient identifying information redacted. Through this process, we hope to identify benefit determinations that lack clinical support and detect ongoing patterns and practices of discrimination that may be forwarded on to governmental regulators for further investigation. The Parity Enforcement Project is not limited to New York State and we hope that it will be expanded nationally in the future.

For more information on the Parity Enforcement Project, please visit the New York State Psychiatric Association website (www.nyspsych.org) or contact us at (516) 542-0077 or centraloffice@nyspsych.org.

Building the Amazon Prime Experience in Health Care

By Linda Rosenberg
President and CEO
National Council for Behavioral Health

Mike Hogan, former Mental Health Commissioner of New York, predicts that in 45 years, distinct public mental health systems with state-operated and state-funded specialty services will no longer exist in their current form. He says, "Almost all the new service models unleashed by the Affordable Care Act — from Medicaid health homes to accountable care organizations (ACOs) to patient-centered medical homes — cannot succeed without integrating behavioral and general medical care…Yet the mainstream is not prepared. They need our help."

Being part of the mainstream will mean offering all health care anywhere and anytime the customer needs it. How often have you wished you could just text or email your doctor for a quick consultation? Imagine the savings, and the convenience for all.

Community behavioral health organizations have led the way by pursuing all avenues for integrated care delivery — thoughtful engineering of staff roles, intensive community outreach, exploration of public and private and funding options, and creative collaborations and partnerships.

If we consider where "the mainstream needs our help," behavioral health offers three distinct advantages.

First, we know more about person-centered care and patient engagement. Behavioral health providers spend more

Linda Rosenberg

time with each patient than primary care providers, building relationships, nurturing trust, and helping them navigate life in the community. We build customized, long-term treatment plans with patients based on their preferences and with the involvement of family and caregivers. We've modeled care that extends beyond clinic walls, into the community and into people's lives (such as assertive community treatment).

Second, we know that partnerships and collaborations are crucial to success. To factor in all the social determinants of health, behavioral health providers collaborate with a range of community institutions and systems — criminal justice, hospitals, schools, faith communities, homeless shelters, supported housing and employment, veterans services, child welfare, and more.

Third, the roles and responsibilities of community behavioral health staff have primed them for population health management. Care managers are in demand in the world of population health, and they're really just taking on existing case management skills and integrating them with health care. They're becoming experts in health behavior change and building relationships.

However, we are not lacking in areas for improvement. If behavioral health organizations want to be effective in population health management, we must focus on building strengths that have traditionally not been high on our priority list. Here are three ways we can do better.

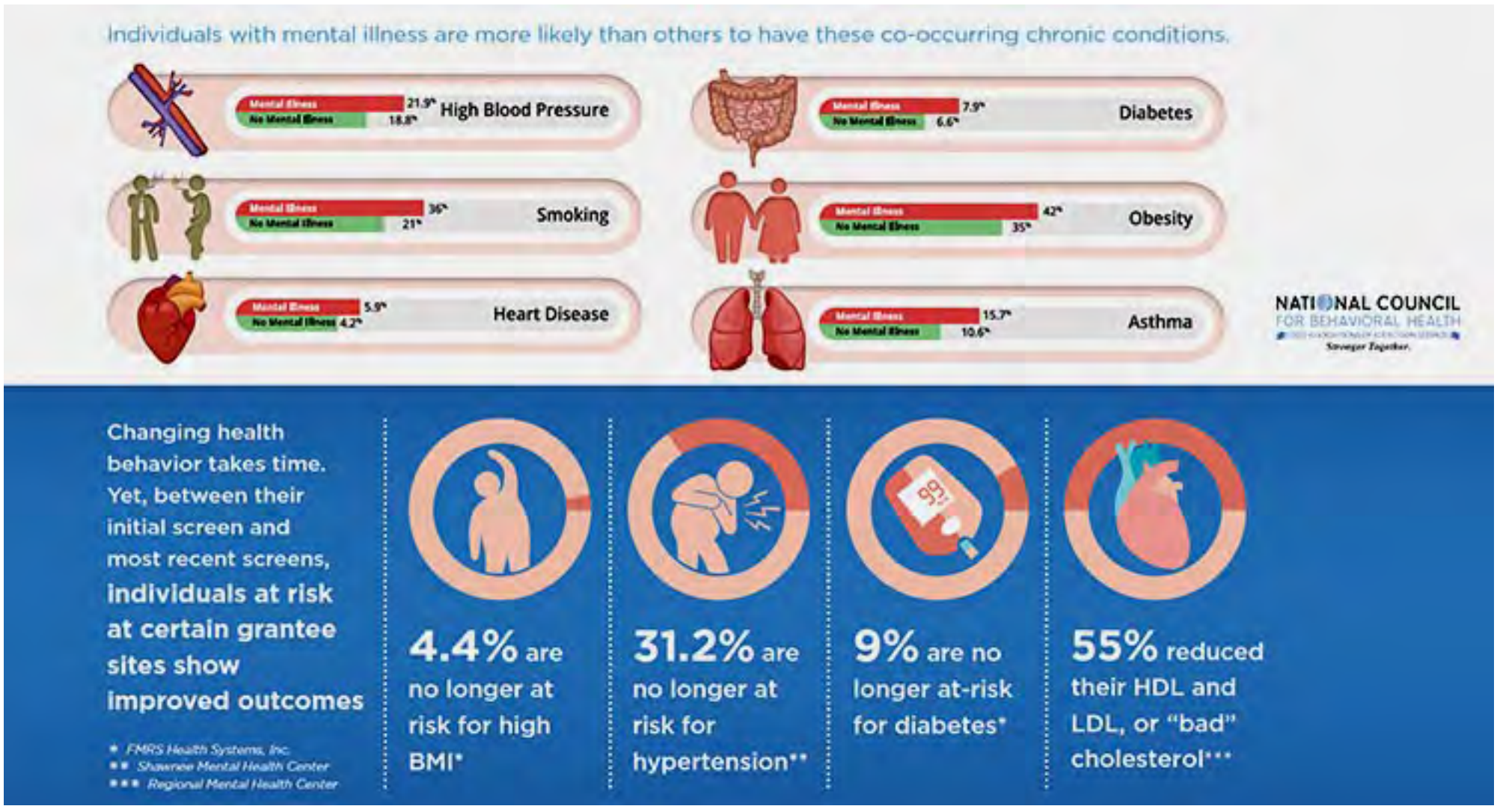
First, we need to focus on public education and on prevention/early intervention. We need literacy and early intervention programs like Mental Health First Aid to touch every community, every home, every school, and every corporation in America. And we need the spread of initiatives like the Felton Institute's Prevention and Recovery in Early Psychosis program, where early intervention and targeted treatment for schizophrenia achieve dramatic results — more than half of people in the program are employed or in school by the sixth month of treatment.

Second, we must embrace measure-based care. Henry Chung, the chief medical officer at Montefiore notes, "There's too much treatment inertia in all of healthcare. We keep doing the same thing over and over again. When we don't measure, how can we tell if we're really helping the patient or not? We must have goals, and when we don't meet them, we must look at what else we can do."

Third, we must capitalize on the power of technology to extend the reach of staff, empower self-management, and offer the customer centric experience technology can deliver. Consider for instance the Health Buddy — a simple clock radio-sized device designed to help individuals manage their physical and mental health needs on a daily basis in the comfort of their homes.

We're driven by the desire — and need — for one-stop care, instant access, informed choices, reasonable prices, good quality, and discernible results. Chris Murphy, editor of InformationWeek, argues that health care providers should benchmark their online engagement against other industries. He quips, *"How come a retailer such as Amazon or Apple can remember I bought an Ace of Base recording the last time I visited, but the people who help keep me alive or healthy have to ask about my allergies every time I show up at the doctor's office? Why can I book a flight, hotel and car from three different companies on one website but not schedule doctor appointments online and see all of my upcoming medical visits in one place?"*

Behavioral health can lead the way in population health management if we think from the outside in. If we commit to building the Amazon Prime experience for the millions of people who depend on us for better health and better lives.



How Much Money Are You Losing By Ignoring Behavioral Health? Interoperability Thoughts From HIMSS 2015

By Marlowe Greenberg
Founder and Chief Executive Officer
Foothold Technology

For the last few years, I've had the pleasure of participating in large events like the HIMSS Conference and the InterSystems Global Summit, both of which gather techies and healthcare policy leaders from around the world to discuss issues of interoperabilty and connected care. When compared to some of the giant Electronic Medical Record (EMR) companies in attendance, Foothold Technology might be seen as the little guy, even though our Electronic Health Record (EHR) is used by several hundred behavioral health organizations across the nation.

At the InterSystems Global Summit for example, very few of the EMR presenters had thought of, or were working with, Behavioral Health providers. For many of them, "coordinated care" meant only coordinating the various providers of physical healthcare. Most participants expressed astonishment at the idea that Foothold, working exclusively with Behavioral Health, Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse providers, was even able to share data through HL7 or C-CDA formats. And yet, all expressed interest in accessing such data and putting it use to help improve care across the continuum. Primarily, this is because everyone sees the payment models changing. The success of a given healthcare organization will increasingly depend on their ability to arrange coordinated care between different providers and create value by offering the right service at the right time at the lowest cost. Increasingly, the healthcare world will begin to realize this means working with providers like the agencies

Marlowe Greenberg

in the Foothold community.

As noted in my blog post* this past spring, we are also constantly seeking answers to two overarching questions about the state of our industry. First, how much money is being lost by our healthcare system because Behavioral Health hasn't been properly integrated and leveraged? And second, when will the primary care community begin the process of actually integrating Behavioral Health services into its workflow? With that in mind, I wanted to share some thoughts about interoperability I originally wrote on our blog while attending the HIMSS Conference:

Day One – 10 AM

HIMSS always amazes when you first walk in. The sheer size of the conference, 40,000 attendees, hundreds and hundreds of vendors. Exhibit hall displays that tower to two and three stories. Electric cars and mobile wi-fi trucks, video games and open bars; some vendors throw happy hours where they actually barbecue food for guests – right here in the hall. If you were to walk long enough to see every vendor, you would walk for miles…

But more impressive is the fact that this isn't just a sales opportunity for vendors. Most companies bring their top executives and it's not unusual to see and be able to speak to the CEOs of billion dollar companies. All the CEOs know that all the other CEOs are here at HIMSS, so meetings that can take months to set up outside of HIMSS, and that usually result in phone calls, actually take place face to face. In some respects, HIMSS is one of the last testaments to the power of offline business networking. We still like to see each other, and in our industry, HIMSS is where we do that.

Day One – 4 PM

This year our work at the Interoperability Showcase is included in the Health Story where we use data to tell the story of a woman with breast cancer and her resultant depression. Our Cancer Care and Depression Management booth tracks all the data associated with a fictional woman who decides to undergo surgery and has follow-ups with her oncologists and psychiatrists. AWARDS receives data files from the other service providers involved in her care and we can now take the data from those services and parse them directly into the AWARDS database. That means that medications, for example, that are prescribed by an oncologist can be imported into AWARDS and put directly into the medication module for this consumer without direct data entry by AWARDS users. This is just one of the many ways that participation in this conference helps to direct and drive the development of AWARDS.

Day Two

HIMSS 2015 is, in many ways, similar to 2014. The players look the same, many of the conversations seem similar. Even our participation in the Interoperability Showcase feels, not routine exactly, but the level of intensity and technical complexity of our Health Story aren't surprises this year.

But This is Kind of Amazing

Foothold Technology now regularly plays with the largest EMRs in the world. From GE, to Greenway, to Epic, to McKesson…technically and functionally, these systems are our sisters and brothers. We track different data, yes, and Behavioral Health is usually chronic, while medical care is usually episodic. But the underlying capabilities of the systems are not materially different. That is astonishing when you think about it. From a home in community mental health, supportive housing, developmental disabilities, and drug rehabilitation, Foothold has launched itself into the stratosphere of technical prowess and functional capability in the Health Information Technology world. There simply are not systems that can do things we cannot — or at least not for very long. Indeed, AWARDS can now do things that some of these billion dollar EMRs cannot!

In many cases, of course, our clients are less concerned about when we are going to implement a FHIR exchange than they are in getting AWARDS to

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Picturing Your Interoperability: The HIE Comic

By Sarah Morrison
Marketing
Foothold Technology

Coordinated care is becoming a reality, and interoperability is the key. Interoperability, in simplest terms, is the ability to exchange data automatically with other data management systems. In the not-too-distant future, healthcare providers, whether they offer behavioral or physical services, will need an Electronic Health Record (EHR) that is interoperable with other systems in their respective networks. AWARDS is one of very few EHRs that have achieved interoperability and are actively participating in data exchanges today.

When terms like "interoperability" and "health data exchange" began bubbling up in the national healthcare conversation, we were excited and in-

Sarah Morrison

trigued, but to be quite honest, we knew we were all in for a huge challenge. There was an air of confusion as legislators and advocates grappled with the concept—and logistics—of sharing a patient's health information electronically. We wanted to demystify these concepts by explaining them in a simple and fun way, so we created this comic strip to illustrate how health exchanges work, and why interoperability is so important for agencies.

The story centers on a patient who, like many of our clients' clients, has a complex background of medical and behavioral health issues. At the hospital, our patient's doctor opens his chart and is able to see his entire health history—because it includes notes entered by providers at other facilities. The HIE (Health Information Exchange) is the hub that controls traffic of the data, with an EHR (like AWARDS) as the conduit providing secure and confidential delivery. This seam-

less coordination results in better treatment, money saved, and an overall better recovery. In a nutshell, that is Interoperability – the exchange of patient data across providers that allows for a full view of a patient's health history.

Opportunities for Improved Services with Integrated Care

By Peter Provet, PhD
President and Chief Executive Officer
Odyssey House

The key component of integrated care – coordination of primary and behavioral health services in a way that is accessible from one place – is not a new concept for many substance abuse treatment organizations, such as Odyssey House in New York City, that operate Article 28 licensed medical and dental services as part of comprehensive residential and outpatient treatment.

Odyssey House opened its first NYS Department of Health-licensed primary medical clinic in 1992. Staffed by primary care physicians, psychiatrists, and registered nurses, this clinic, co-located in a residential treatment center, was an early model of integrated care. For close to 25 years, our residents have benefited from accessible, on-site services that provide coordinated medical, dental, and behavioral health care across a multi-site system of treatment and housing services.

Early on, substance abuse treatment professionals realized bringing primary care into the treatment community offers clients significant benefits including: integration of medical, psychiatric, pharmacy, prevention, and social work services, and less missed time from treatment. On-site medical clinics were found to reduce use of emergency rooms for non-urgent care, improve management of preventable conditions such as asthma, diabetes, and hypertension and treatment outcomes by encouraging clients to stay in long-term programs.

A 2013 report by the Center for Integrated Health Solutions, published jointly by the Substance Abuse and Mental Services Administration (SAMHSA) and Human Resources Administration (HRA), looked at integrated primary care services and substance abuse treatment and convincingly found that the integration of physical health and addictions care not only helps reduce barriers to primary care, it also enhances recovery from substance abuse.

"In fact," the report states, "two or more primary care visits in a 6-month period have shown to improve abstinence by 50 percent in individuals with substance abuse disorders, and those with medical conditions related to substance abuse are three times more likely to achieve remission over 5 years. Regular health and addictions care for people with substance abuse disorders also decreased hospitalizations by up to 30 percent. Lastly, substance use screening and services improve the general health of individuals with co-occurring substance abuse and physical health conditions and reduce the overall costs to the healthcare system."

Today's model of integrated care, ushered in by passage of the Affordable Care Act (ACA) in 2010 and the earlier Mental Health Parity and Addictions Equality Act (MHPAEA) in 2008, provides opportunities for behavioral health care organizations to further develop integrated care services. According to SAMHSA, ACA expands benefits to approximately 60 million Americans. This legislation mandates coverage of certain preventive services and, together with MHPAEA, ensures health insurers provide the same level of benefits for behavioral health.

Peter Provet, PhD

This, as we know, is all good news for people in need of substance abuse and mental health treatment who also have physical health needs. Studies have shown that individuals with substance use and mental health disorders who also receive treatment for medical conditions demonstrate improved outcomes in both behavioral and physical health. The demand for medical services is further supported by advances in addiction treatment medication which require appropriately trained staff to administer and monitor these medications for opioid and alcohol addictions.

With the expansion of services comes significant changes to the way Odyssey House, and other behavioral health organizations, must deliver care. Chief among them in New York is a restructuring of Medicaid under the DSRIP (Delivery System Reform Incentive Payment) as part of the Medicaid Redesign Team's mandate. This effort is charged with reducing avoidable hospital visits by 25 percent over five years by transforming systems and clinical management, and improving population health. Achieving these goals requires the integration of several systems of care from community-based clinics and hospitals, to supportive housing and rehabilitation services.

Positioning for the New Health Care Marketplace

As we prepare for, and participate in, the restructuring of health care services, Odyssey House is gearing up to expand community-based primary, behavioral health, and dental services located at our Family Center in East Harlem and outpatient center in the South Bronx. We are currently included in three Preferred Provider Systems (PPS) that include Mount Sinai, Bronx Lebanon, and Health and Hospital Corporation of New York, and have executed numerous contracts with managed care companies for primary and behavioral health care.

Our services are aligned with the core Health and Recovery Plan (HARP) principles that require Medicaid beneficiaries with mental illness and/or substance use disorders be provided with services in their own communities. These include an array of mandated Home and Community-Based Services (HCBS) that are:

- Person-centered
- Recovery-oriented
- Integrated
- Data-driven
- Evidence-based
- Trauma-informed
- Peer-supported
- Culturally competent
- Flexible and mobile
- Inclusive of social network
- Coordinated and collaborated.

As an HCBS provider Odyssey House is designated to provide the following behavioral health services:

- Community psychiatric support and treatment
- Psychosocial rehabilitation
- Habilitation/rehabilitation support services
- Family support and training
- Pre-vocational services
- Ongoing supported employment
- Educational support services
- Empowerment services – peer supports.

Another way we are preparing for changes in the integrated behavioral health care environment is by exploring an FQHC Look-alike designation at our Family Center in East Harlem. While FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits, they must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have ongoing quality assurance programs, and have an independent governing board of directors.

The criteria demanded to provide integrated primary and behavioral health care are aligned with the 48 year-old mission of Odyssey House to provide high-quality, holistic, treatment impacting all major life spheres: psychological, physical, social, family, educational and spiritual.

While the new regulatory environment brings challenges to how we manage our limited resources, who we partner with, and how we monitor the health needs of the individuals we serve, the benefits of an integrated system promise improved care for underserved Americans, not least among them the millions of individuals with substance use and/or mental health disorders.

Integrated Care Supports a Whole-Person Approach to Improved Health Outcomes

By Michelle Berthon, LPC MHSP
Clinical Director, Behavioral Health Care
Optum

About one in six adults will experience a mental health illness and medical condition within a year — and among those receiving Medicaid, the percentage is likely higher.[1] Since medical and behavioral health conditions tend to overlap, research shows that the most effective way to treat this vulnerable and growing population is by integrating their care.[2]

An integrated approach to health care recognizes that an individual's health is influenced by a combination of many complex factors. These go way beyond the biological and psychological components of illness, and include social, community, cultural, and other determinants of health and well-being. Strategies to improve health outcomes must be person-centered and support the engagement and activation of people to improve their own health and wellness. Provider systems and networks of care must also foster the coordination of care and integration of services.

Optum recognizes these challenges and works to develop health care solutions that address the comprehensive needs of individuals, their families, and the communities in which they live. In Tennessee, Optum has partnered with United Healthcare in their TennCare Medicaid program. Covering over 450,000 beneficiaries, this integrated health care program employs a comprehensive health risk assessment that accounts for a person's medical and behavioral health needs — plus social, family, and other environmental challenges — in order to develop a single comprehensive treatment plan. This extensive approach to the whole person supports the integration of their health service needs, and all of the providers and health service resources involved in their care.

A major obstacle for effective and efficient health care treatment — and especially for comorbid conditions — is poor communication among clinicians.[3] Integrated care enhances communication and collaboration not just among providers but also with community resources. In the TennCare program, Optum and UnitedHealthcare have developed a clinical team of physical and behavioral health care coordination staff, including peer specialists, to help coordinate the care of those covered by the plan. The care team is led by a designated clinical staff member who integrates both physical and behavioral health resources and promotes a whole-person approach to care and services. Members and their providers also have access to the care team 24/7 for immediate help with routine, urgent, and emergency physical and behavioral health needs including crisis intervention. All care coordination records are integrated into a single data system, and this supports improved coordination among team members. Additionally, the care team meets weekly to address the complex health care needs of covered beneficiaries.

In order to support the integration of care, Optum and UnitedHealthcare have developed networks of clinical services that promote the co-location of physical and behavioral health providers. In partnership with a national community mental health agency, they have supported the availability of behavioral health providers in a medical home system that is available to TennCare members. By providing behavioral health clinicians who are a part of the overall medical home team, timely screening, assessment and consultation services are available to the primary care providers and members. This promotes timely resolution of many behavioral health problems and effective referrals for others that require higher levels of service.

Optum also recognizes that many of their covered members with behavioral health conditions are most comfortable receiving their medical care in the settings where they receive their behavioral care. Therefore, primary care services have

An Integrated Model of Care and Education: Wellspring and the Arch Bridge School

By Richard Beauvais, PhD
Director
The Wellspring Institute

"Residential Treatment" has been under assault for some time, as you may know. Critics have made claims about its shortcomings, many of which are absolutely true. But residential treatment is not just one model. There have been several models available to families that have been successful, time tested and outcome supported. Sadly, many of these programs have failed to survive or have been forced into dramatic changes from the pressures they face.

The unsuccessful and even hurtful residential programs have been the "warehouse" models that provide a long-term living situation for large groups of children. These programs typically offer behavior modification along with recreational activities and socialization. By necessity, educational programs are connected to them, but they usually have lower expectations and are able to avoid teacher credentialing in meeting state licensing requirements.

So, does an "ideal" care model actually exist with clinically intensive residential treatment and quality education for children suffering from psychiatric illnesses?

Richard Beauvais, PhD

Everyone can agree these young people need a safe, well-supervised environment when struggling with suicidal behaviors, manic episodes, psychotic thinking, or post traumatic stress. What would prevent us from offering them and their families a private school experience in a clinically focused residential setting? If you have an ample, well-trained staff and require parents to participate as part of the solution, wouldn't this be an ideal model of "Integrated Care"?

Integrated Care can have many dimensions, but the question with each is – what is being brought together and for what purpose? The care model I'll describe was developed at Wellspring, a multi-service mental health and educational agency in Bethlehem, Connecticut. It offers three levels of integrated care: Intensive residential treatment combined with special needs education; the use of different treatment modalities acting in concert; and a blend of transitional step-downs, day school and outpatient services in a continuum of care. All of this is contained in a private school environment, with the personal integration of the resident-student woven through each level. I'll begin with the integration of treatment and education. At Wellspring, clinically intensive residential treatment is integrated with education in a way that is unique in the realm of therapeutic schooling. Each component is accredited by top-flight agencies – Wellspring by the Joint Commission (JCAHO) and its Arch Bridge School by the New England Association of Schools and Colleges (NEASC) – the same agency that accredits Harvard and Yale. The Arch Bridge School serves Wellspring's residential programs – children's, adolescent, and young adult – and also functions as a Day School for students bussed from surrounding districts. Since its accreditation by NEASC in 2012, the Arch Bridge School has been designated each year as a School of Excellence by the National Association of Special Education Teachers (NASET).

Outcome studies have continually verified the effectiveness of both components. In 2014, an independent evaluation survey of Wellspring by the CT Department of Children and Families found that 100% of residential students answered "Yes" to the statement – "I like being in this program since it's helping me and my family." Wellspring's internal survey of parents, residents and day students asked – "Would you recommend the Arch Bridge School to others?" Over a five year period ending in 2014 the mean response on a scale of 1-7 was 6.7.

In 2012, the NEASC survey team made the following statements in its evaluation:

"Educationally and emotionally, the Arch Bridge School is on the leading edge in many of their philosophies and designs. Culturally, Arch Bridge's family atmosphere and unyielding commitment to excellence would be the envy of most schools."

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Integrated Care Models in Managed Behavioral Healthcare Organizations

By Rebecca Murow Klein
Association for Behavioral Health and Wellness

The Association for Behavioral Health and Wellness (ABHW) represents specialty behavioral health and wellness companies that provide services to treat mental health, substance use, and other behaviors that impact health. ABHW members have long histories with integrating behavioral health care and a lot can be learned from their experience. Whether carve-out entities or health plans with their own internal specialty organization for behavioral healthcare, managed behavioral healthcare organizations (MBHOs) are experts in blending services to meet the needs of individuals with complex behavioral health conditions.

Integrated care produces better outcomes and provides better care to individuals with multiple health care needs. ABHW member companies employ a variety of models to clinically align behavioral health and primary care for individuals receiving care in their networks.

Training for Primary Care Practitioners on Identification and Treatment of Behavioral Health Conditions and Screening for Behavioral Health Conditions in Primary Care Settings: Training and consultation from behavioral health providers and MBHOs can assist primary care practitioners (PCPs) in improving their identification of behavioral health concerns and conditions. Behavioral health specialists can assist primary care practices in initiating Screening, Brief Intervention, and Referral to Treatment (SBIRT) and develop systems for warm handoffs for patients who require substance use disorder (SUD) treatment. In Colorado, Beacon Health Options provides training on depression screening to primary care practices; and in Maryland, they will train PCPs on SBIRT, alcohol screening for pregnant women, and suicide risk assessment.

Since there are patients with mental health and/or substance use disorders (MH/SUD) who prefer to remain in medical settings for treatment, partnerships with PCPs are critical to improving health outcomes. Beacon Health Options' Psychotropic Drug Intervention Program uses aggregate data and scaled clinical insight to promote integration of care at the provider level. Analyzing integrated behavioral health, medical, and pharmacy claims data, this MBHO identifies target events and intervenes with members and prescribers to educate them on best practices and changes to pharmacological treatment. Evidence-based practices drive the algorithms in the technology platform that identifies prescription-related problems. Peer-to-peer consultation staffed by psychiatrists utilizes the best available clinical guidelines to coach physicians on practice improvement while health coaches educate members and provide care coordination. As a result of this program, hospital admissions and emergency room visits decreased by 30% and inpatient spending was reduced by $90 PMPM.

Providing Consultation Services to Primary Care Practitioners: Primary care practices and the patients they serve benefit from consultation and connection with behavioral health providers, as demonstrated in various psychiatric liaison and consultation programs that support pediatricians in identifying children with MH/SUD needs and in collaborating with psychiatrists on their treatment. The long-standing Massachusetts Child Psychiatry Access Project encourages and supports PCPs integrating behavioral health resources into their practices and provides quick access to psychiatric consultation and facilitates referrals for accessing ongoing behavioral health care. The project has been so effective that it is now available in 22 states.

Co-Locating Behavioral Health and Primary Care Services and Creating Strategies for Increasing Patients' Health Literacy and Activation: The co-location model of coordinated care involves behavioral health specialists providing services at a primary care site or PCPs working in behavioral health settings. Co-location increases communication across practitioners and significantly increases the likelihood of referrals from primary care to behavioral health. Since two-thirds of PCPs report that they are not able to access behavioral health treatment for their patients [i], and 30 to 50% of referrals from primary care to behavioral health do not make the first appointment [ii], co-location can open access substantially.

Healthfirst is contracting with a pediatric primary care practice that includes behavioral health clinicians. The behavioral health clinicians can be accessed in several ways: calling to make an appointment; scheduling an appointment prior to exiting the site, as a recommended follow-up to a PCP visit; meeting immediately following a PCP visit; visiting simultaneously with a behavioral health clinician and a PCP within the exam room, in more urgent cases. The full integration of the behavioral health clinicians under one practice, which is an enhanced co-location, means full service needs can be met and the practice has the ease of single claims submission.

Cenpatico has supported the development of integrated services in several of its core behavioral health agencies in Arizona. These integrated clinics are housed in behavioral health agencies, allowing persons with severe mental illness to access physical health care in the settings where they are already comfortable. Cenpatico's support has included successful

see Models on page 32

Super Storm Sandy is Over but the Problems Are Not: A Creative Community-Based Integrated Health Care Initiative

By Michael Skinner, LCSW
Program Director, Sandy Relief Services
Staten Island Mental Health Society

The Staten Island Mental Health Society, Inc. (SIMHS as lead agency) and Community Health Action of Staten Island (CHASI) partnered, in April 2014, to form a Mobile Integrated Health Team (MIHT) to provide in-home health and mental health services to Staten Island residents still suffering the effects of Super Storm Sandy.

The MIHT is modeled on the research findings from Hurricanes Katrina and Rita and data from Super Storm Sandy's FEMA-sponsored Project Hope Crisis Counseling Program (Norris 2009). Findings suggested that communities experiencing the most destruction tended to have the highest rates of untreated health and mental health concerns, while the corresponding use of formal health/mental health services was low (Madrid 2007).

On Staten Island, the model developed demonstrated clients accepted into the program exhibited at least one major medical condition along with at least one mental health condition. The model verified that clients could address their health and mental health concerns with the goals of reconnecting with their family, friends, community resources and service providers. While the MIHT was designed for

Michael Skinner, LCSW

post-disaster services, the model can easily be adapted and utilized to assist other high-risk and underserved populations.

The MIHT is designed to provide integrated health and mental health care to high-risk residents who remain seriously affected 1½ years post-Sandy. Each of the MIHT's three teams is comprised of a licensed Registered Nurse (RN) and a Master's-level mental health professional (MHP). These teams stay constant throughout the program and change only if a team member resigns from the MIHT. The MIHT also utilizes a Nurse Manager and an overall Program Director. All nursing staff are CHASI employees, while mental health professionals and the Director are SIMHS employees. When psychiatric services are required, a SIMHS staff psychiatrist is available for evaluation and medication therapy.

Following the storm, due to the level of destruction to their homes and communities, residents were not leaving their homes/neighborhoods for health care appointments. Residents were focused on rebuilding their homes, their families' safety and then their own safety and survival. Most residents who owned cars lost them in the flood waters. Traveling to health care appointments via public transportation was exhausting and time consuming. Attempting to get residents to attend scheduled clinic appointments for their health or mental health had failed.

This is why all MIHT services are designed to be home-based. However, if a team cannot see a client in the home, services are provided in the community at a relief "hub," a coffee shop, house of worship, park bench, etc.

It was important at the outset of the program to address the relationship between the mental health and nursing philosophies of treatment. Simply put, nursing can be seen as direct and scientific, versus "exploratory" for mental health. The team concept was designed with the goal of each discipline functioning in a complementary manner. Each member of a team was to have an active, concurrent part in the treatment process. The RN does not sit quietly for 30 minutes while the MHP explores, nor does the MHP sit quietly while the "vitals" are taken. Team members become involved in each other's disciplines in the course of treatment.

To help develop this model, In-Service Trainings were instituted in weekly staff meetings with the MIHT staff, Nurse Manager and Program Director. The RN staff trained the MHP in such disciplines as Understanding Blood Pressure, Diabetes, Obesity and Cardiovascular Disorders. The MHP trained the RN staff in Understanding Anxiety, Depression, Traumatic Stress Disorder, Resistance and Therapeutic Questioning. The weekly staff meetings continue to address the team's development.

The entire MIHT staff completed two full days of training in Hamblen (2009) Cognitive Behavioral Therapy for Post Disaster Distress (CBT-PDD), a community-based treatment program developed from work with Hurricane Katrina survivors. This training experience helped the RN staff feel more connected to the

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Integrated Care Model: Progress for Young Adults With Autism and Mental Health Issues

By Dennis Feuerstein, LCSW
Coordinator Compass Bridges Compass Project, Jewish Child Care Association

As the number of young adults with autism increases, Jewish Child Care Association's Compass Project's model programs are successfully helping their specific psychological, medical and social needs. The program includes individual counseling, social and life skills groups, activities and overnight trips and internship and paid employment. Jewish Child Care is a comprehensive child and family services agency vulnerable helping children of all backgrounds.

Autism today presents a prevailing concern in the field of developmental disabilities. The CDC currently estimates that about 1 in 68 children in the United States is diagnosed with autism spectrum disorder (ASD). There is a marked increase of diagnoses. Yet there are few opportunities for independence or employment among young adults on the spectrum. According to Autism Speaks: at least 70% of adults with special needs never leave home, for lack of options, 80% of adults don't have adequate employment opportunities, and 62% of families do not have a life plan in place for their loved one.

The DSM 5 (Diagnostic Statistical Manual of Mental Disorders 5th Edition) by the American Psychiatric Association, defines the criteria for neuro-developmental disorders including ASD. There are two domains in which a person with ASD must show persistent deficits. This includes 1) persistent social communication and social interaction, and 2) restricted and repetitive patterns of behavior.

More specifically, people with ASD must demonstrate (either historically or currently) deficits in social-emotional reciprocity, deficits in nonverbal communication and the non-verbal nuances needed for social interaction, and deficits in developing maintaining and understanding personal and professional interaction. Additionally, they must show at least two types of repetitive patterns of behavior including repetitive motor movements, a need for sameness with little to no flexibility with routines, showing a fixation on specific interests and/or sensitivity to sensory input.

In addition to these deficits it has been a rising concern that individuals with ASD also exhibit, in increasing numbers, co-morbid issues in the areas of mental health, specifically; depression, anxiety and bi-polar disorder.

According to a study by White et al; "Anxiety disorders are common among children with ASD, although there is no firm data. Symptoms are likely affected by age, level of cognitive functioning, degree of social impairment, and ASD-specific difficulties. Many anxiety disorders, such as social anxiety disorder, are not commonly diagnosed in people with ASD because such symptoms are better explained by ASD itself, and it is often difficult to tell whether symptoms such as compulsive checking are part of ASD or a co-occurring anxiety problem. The prevalence of anxiety disorders in children with ASD has been reported to be anywhere between 11% and 84%; the wide range is likely due to differences in the ways the studies were conducted" (White SW, Oswald D, Ollendick T, Scahill L (2009). "Anxiety in children and adolescents with autism spectrum disorders." Clin Psychol Rev 29 (3): 216–29. doi:10.1016/j.cpr.2009.01.003. PMC 2692135. PMID 19223098).

Bi-polar disorder is now also being identified in the realm of mood issues associated with ASD. "Pediatric bipolar disorder, or manic-depression, is a highly controversial diagnosis and is itself often claimed to be co-morbid with a number of conditions, including autism. Autism includes some symptoms commonly found in mood and anxiety disorders" (Towbin KE, Pradella A, Gorrindo T, Pine DS, Leibenluft E (2005). "Autism spectrum traits in children with mood and anxiety disorders." Journal of child and adolescent psychopharmacology 15 (3): 452–64. doi:10.1089/cap.2005.15.452. PMID 16092910).

One of the foremost issues in mood disorders is depression. In a study of 64 children and adolescents with autism referred to a tertiary clinic, Ghaziuddin et al. (1992) found that depression was the most common psychiatric disorder, affecting about 2% of the total sample. Recent studies have shown that rates of depression and anxiety symptoms re elevated among individuals with autism spectrum disorders (ASDs) of various ages and IQs and that depression/anxiety symptoms are associated with higher IQ and fewer ASD symptoms (Depression and Anxiety in Children with Autism Spectrum Disorders without Intellectual Disabilities. John F. Strang Et Al. Research in Autism Spectrum Disorders vol6 jan-mar pg 406, 2012).

It is reported that there is a rate as high as 65% diagnosed with co-morbid conditions of anxiety and depression among ASD individuals.

Young adults growing out of the surge of numbers of infants and children diagnosed with some form of autism are now entering adulthood. They are challenged by the same issues as any emerging adult, developing independence. This includes social, vocational and independent living.

Developing programs for young adults

see Young Adults on page 29

Care Management Model for Integrated Settings

By Stanley W. La Forest, LPN
Transitional Care Coordinator
The Institute for Family Health

The Care Management model in an integrated health care setting is rapidly evolving and expanding. Although there have been many improvements in coordination of health care, barriers persist for patients and medical providers which diminish the quality of care being delivered. Primary health care centers have developed into a single point of access for both physical and behavioral health services. Care Managers collaborate with behavioral and medical providers within their respective care teams in order to assist in the provision of care. Care management plays a crucial role within this integrated care setting by connecting patients with access to services tailored to the individual patient through coordinated care planning increasing health literacy and improving communication between patients and providers.

Individuals with a mental health diagnosis have an increased mortality rate resulting from untreated and preventable chronic illnesses such as: hypertension, diabetes, obesity, and cardiovascular disease. These conditions are usually aggravated due to a lack of physical activity, poor nutrition, smoking, and substance abuse (Bartels S, Desilets R. Health Promotion Programs for People with Serious

Stanley W. La Forest, LPN

Mental Illness Pg7. Prepared by Drathmouth Health Promotion Team. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. January 2012).

Colton and Mandersheid surveyed mortality data from eight states and concluded that, on average, Americans with major mental illness die 13 to 30 years earlier than the general population. The average life expectancy of individuals that were examined with mental illnesses was from 49 to 60 years. Care Managers work to remove the barriers that exist in access to primary care and meaningfulness in their interactions with their providers (Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states,2006).

Colton and Mandersheid's study illustrated that the delivery of quality care to patients with behavioral disorders is hindered because of fragmentation between the patient's primary care providers and the mental health provider that the patient may be seeing. Often these high risk patients' PCPs and mental health clinicians are not communicating with each other. In some instances, the patient is not linked to a PCP at all. This can create many barriers to care and cause a lot of confusion especially when it comes to medication management, palliative care, and disease management.

The Care Management program provides care coordination for these patients by ensuring that the PCP is aware of all the specialty providers that the patient is seeing and further, linking patients to missing services. Care Managers are the crucial link between providers to ensure that there is an open line of communication between all members of the interdisciplinary team. Care Managers play an integral role in linking patients with behavioral issues to primary care in order to address underlying health issues. Care Management is oftentimes referred to as "the glue that holds all the pieces of the puzzle together."

While linking patients to care, Care Managers are also mindful of teaching opportunities to promote autonomy and to get patients involved in their own care. This can be a very challenging task due to many unforeseen variables such as physical and social determinants that hinder successful engagement. Care Managers are trained to assess patients holistically, in order to identify any barriers and fill any gaps that may exist.

As a Transitional Care Manager in a family medicine care center, I have encountered many different situations where implementation of Care Management has demonstrated positive outcomes. One of the issues that occur commonly with patients who are diagnosed with a mental illness is a high rate of avoidable emergency room utilization. Many of these patients are known to be receiving mental health services and not primary or vice versa.

One example of this is with a patient I have worked with at the 16 St. family clinic at The Institute For Family Health. Mr. J, a 58 year old patient who is diagnosed with schizophrenia and depression had 10 emergency room visits from June

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Governor Announces New Text Messaging Feature on NYS HOPEline

By the Office of New York State Governor Andrew M. Cuomo

New Yorkers can now text State HOPEline for support and referral to services for alcohol and drug addiction, and problem gambling. Governor Andrew M. Cuomo today announced that New Yorkers can now contact the New York State HOPEline addiction referral and support service by texting 1-877-8-HOPENY. The HOPEline is a free and confidential 24-hour service that connects people who are struggling with substance abuse and problem gambling to specially-trained behavioral health professionals for assistance in times of need.

"This new feature will make it even easier for those struggling with addiction to get the help and support they need," Governor Cuomo said. "I encourage anyone who may be dealing with substance or gambling addiction to reach out to us today and let us help them build a safer and healthier future."

By texting 1-877-8-HOPENY, individuals can get help connecting with a treatment provider in their community as well as across the state, and obtain resources and information about substance use disorders and problem gambling. The New York State Office of Alcoholism and Substance Abuse Services (OASAS) has contracted with the Mental Health Association of New York City (MHA-NYC) to expand existing HOPEline services to include this texting feature.

Tatiana Green; NYS OASAS Commissioner Arlene González-Sánchez; NYS Assemblymember Linda B. Rosenthal; Giselle Stolper, President and CEO, Mental Health Association of New York City; with the NYS HOPEline Team at NYS HOPEline Text Line Service Launch held on May 21, 2015

MHA-NYC President and Chief Executive Officer Giselle Stolper said: "For many years, MHA-NYC has been utilizing ground-breaking technology to give people access to help wherever and whenever they need it. This enhancement to the HOPEline service gives young people and their families, and all New Yorkers, an important new communications tool which can directly link them to life-changing services and put them on their way to recovery."

In 2014, the HOPEline received nearly 30,000 calls and made nearly 9,000 outbound follow-up calls. The HOPEline currently handles nearly 2,700 calls monthly. The HOPENY texting service is expected to handle nearly 5,000 text messages per year.

"By enhancing the HOPEline service with the capacity to provide text message support, the HOPEline will be able to reach even more New Yorkers, especially young people, who increasingly rely on text messaging as their primary means of communication," said OASAS Commissioner Arlene González-Sánchez. "As we see the rise of prescription opioid abuse and heroin abuse continue to affect young people and adults across our state, it is vitally important that New Yorkers can easily text HOPENY or call the HOPEline to find addiction treatment services. With treatment, recovery from addiction is not only possible, it can be a reality."

Parents, caregivers, and others who are seeking help for a loved one or someone they know with an addiction problem can also text or call the HOPEline.

The HOPENY text line service will provide confidential support via text message

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Behavioral Health News First Annual Leadership Awards Reception Honors Phillip Saperia, Alan Siskind and Andrew Solomon

Staff Writer
Behavioral Health News

Over 200 guests gathered at NYU Kimmel Center's beautiful Rosenthal Pavilion to honor three champions of the behavioral health community: Phillip A. Saperia, MAT, CEO of The Coalition of Behavioral Health Agencies, Alan B. Siskind, PhD, former CEO of the Jewish Board of Family and Children's Services, and Andrew Solomon, PhD, journalist, advocate, and award-winning author of "Far From the Tree: Parents, Children and the Search for Identity," and "The Noonday Demon: An Atlas of Depression."

Jorge R. Petit, MD, President of Quality Healthcare Solutions, and Chairman of the Board of Mental Health News Education, Inc. (MHNE), which publishes *Behavioral Health News*, was master of ceremonies for the evening. Dr. Petit stated, "This event is a wonderful tribute to our outstanding honorees and draws attention to the vital mission of *Behavioral Health News* in providing essential news, education, and community resources to thousands of individuals, families, treatment professionals and service providers."

The evening's speakers included Ann Sullivan, MD, Commissioner of the New

Phillip A. Saperia, MAT

York State Office of Mental Health, Arlene González-Sánchez, LMSW, Commissioner of the New York State Office of Alcoholism and Substance Abuse Services, Mark Herceg, PhD, Commissioner of the Westchester County Department of Community Mental Health, and Gary Belkin, MD, Executive Deputy Commissioner of the New York City Department of Health and Mental Hygiene.

Alan B. Siskind, PhD

Constance Y. Brown-Bellamy, MPA, Vice President of Community and Government Relations at ICL, and a member of the MHNE Board said, "I know I speak on behalf of our entire Board when I say how grateful we are for the many guests, sponsors, and volunteers who helped make this evening possible. We are all very proud to be part of the vital work MHNE is doing for our community."

Andrew Solomon, PhD

Ira and David Minot, the father and son team behind MHNE, remarked, "Our greatest joy is to share this evening with our many friends, colleagues and supporters. In our hearts, all of them are being honored tonight for the vital work they are doing for the community."

The photos, sponsors and journal of the event can be viewed on our website at: www.mhnews.org/AwardsReception.htm.

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jails, including Riker's Island, suffer from substance use and mental health disorders. New York's failure to integrate treatment more effectively into its public protection policy and program agenda has had numerous unintended consequences like unnecessary incarceration or hospitalization. Our prisons and jails have become the holding facilities for persons needing treatment, further stigmatizing them. Reforming drug laws or implementing I-STOP without strengthening community-based services leads to overdoses, deaths, poor health, stress on families, and wasted years in a cell. De-institutionalizing persons with mental health challenges, moving people out of substandard housing and adult homes back to the community without an adequate continuum of services results in a similar outcome. Fragmentation in policy development and implementation, where a meaningful role for behavioral health services providers and consumers is not included, produces costly, unacceptable health and social outcomes.

When we examine the challenges faced by persons working in a cross section of health and human service sectors or the consumers of services in the child welfare, domestic violence, social services, juvenile justice, homeless shelters, and countless other services, untreated substance use and mental health issues are a common denominator. To the extent that these service systems are not meaningfully connected with behavioral health prevention, treatment, and recovery support service providers, unnecessary suffering will be experienced by persons with behavioral health challenges and their families. This fragmentation is costly and damaging to individuals, families, and communities.

Integration and Adequate Resources Are Part of the Solution

The Delivery System Reform Incentive Payment Program (DSRIP) is a new health initiative that could significantly change the value placed on behavioral health services as a critical driver in the achievement of New York's public health goals. DSRIP has as its singular outcome target: reducing unnecessary hospitalizations by 25% over the next five years. One of the extraordinary dimensions of this innovative project is that it is supposed to rely heavily on behavioral health interventions and recovery supports. DSRIP will use 25 Performing Provider Systems, which are designed to be the new physical and behavioral health service delivery mechanisms for all New Yorkers on Medicaid, to reduce unnecessary hospitalizations. These new Performing Provider Systems will receive $6.42 billion over a five year period to get the job done.

DSRIP is designed in a manner that requires each of the 25 Performing Provider Systems to have a strong behavioral health services component. In the early stages of development, behavioral health advocates are concerned that some Performing Provider Systems are not doing a good job of incorporating a strong behavioral health component while others are. If these new systems of services delivery do not stick to the DSRIP blueprint, they will not achieve their performance targets and New York State will lose. The behavioral health component of DSRIP has to be real, meaningful, and strong if we are to reduce unnecessary hospitalizations by 25% in 5 years.

The goals that drove passage of I-STOP, the data system put in place to reduce dangerous prescribing behaviors related to opiate pain medications and other potentially addicting medications, will only be achieved when prevention, treatment and recovery support services are strengthened. Unnecessary expense associated with the incarceration of persons with untreated mental health and substance use disorders will not decline until there is an investment made in community-based behavioral health services. It is only when behavioral health service providers are meaningfully engaged in policy development and corresponding services delivery reform that unnecessary confinement, unnecessary expense, unnecessary death, and poor health outcomes can be effectively addressed.

Behavioral health integration is imperative across health and human services sectors. An engaged behavioral health, substance use *and* mental health, services system can help to reduce homelessness, unemployment, child abuse and neglect, domestic violence, and a myriad of other health and social problems. When substance use and mental health disorders go untreated, the consequences impact the individual, their family, and the community. By fragmenting substance use and mental health prevention, treatment, and recovery supports and failing to integrate them across health and human service sectors, we continue to create a problem of unnecessary hospitalization, unnecessary, incarceration, and unnecessary pain and suffering.

When substance use and mental health services providers, consumers, and people in recovery are meaningfully incorporated into cross-systems policy conversations, meaningful change can occur leading to better health and social outcomes, increased integration, and better use of resources; three goals articulated by Governor Cuomo in his first State of the State address.

Funding should not be in a silo. Currently, for the most part, savings generated in one silo (health) by services providers paid from a different silo (behavioral health) is not reinvested in the system that created the savings. Where behavioral health programs achieve results that include savings, those savings should be reinvested in those behavioral health programs so that they can do more good work.

DSRIP has the right idea. Untreated substance use and mental health disorders are costly. They result in poor health and declining ability to address co-occurring health challenges like hypertension, diabetes, and heart disease. Integrating behavioral health services across systems of care is the answer.

Integration: Nuancing The OASAS – OMH Discussion

Community Forums are being convened this summer to get the input of individuals, families, community members,

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on the spectrum with co-morbid mental health issues requires a balance between respecting individual freedoms and providing the necessary supportive clinical/social/vocational interventions.

Jewish Child Care Association's (JCCA) Compass Program provides just this type of balance. Having the support of WJCS (Westchester Jewish Community Services) and QSAC (Quality Services for the Autism Community), JCCA has been able to establish 3 programs for these young adults in Westchester, Queens and Manhattan.

Each program, Pursuing Our Independence Together - POINT (Westchester), Queens Independent Living Program - QILP (Queens), and New York City Independent Living Program - NYC-ILP (Manhattan) have their own special distinctions due to location. Each provides the necessary structure for these individuals to develop successes. The model for our independent living program provides residential services to young adults on the spectrum and others with neurological developmental disabilities. These individuals are then able to live in self rented apartments within the community. All the supports are individualized not a one size fits all approach. The focus is on community integration. JCCA addresses the major issues challenging these young adults; life transitions and associated stressors such as entering and completing college, obtaining meaningful and sustaining an occupation. Family support and being seen by parents and family members as self sufficient become equally challenging components. The disenfranchisement of these youth all through their school years and entering college contributes to the significant correlation of symptoms of social anxiety, depression, and aggression. These individuals feel less satisfaction in college and in day to day living, overall, despite being academically successful.

"The goal of the Compass Program," according to Elise Hahn Felix, Compass Director, "is to engage our youth, build on their strengths and enable them to be as independent and productive as possible." Each individual is assessed for vocational interest, aptitude and ability related to executive functioning when entering the program. They are then matched according to interest and emotional strengths with a peer for living arrangements. Each applicant goes through an interview process and takes part in social outings to confirm the clinical findings and supportive information obtained during the screening process.

The focus is to build social and emotional reciprocity and encourage their ability to be challenged. Daily these residents are supported to find work or schooling to better their self esteem and make them more connected to the fabric of the community. They are counseled by licensed social workers and mental health counselors to develop their strengths. The program provides services of NYS ACCES-VR to provide employment supports.

Social skills groups and outings are planned regularly and encouraged to build camaraderie and friendships. They receive life skills training in: cooking, cleaning, laundry, money skills/budgeting, travel training to increase satisfaction. The program also provides on campus college supports to help build satisfaction and success.

Equally important is helping the individual and families recognize the emergence of co-morbid issues that arise during these transition years. Mental health issues are sometimes difficult to separate out from the frustrations faced by an Autism Spectrum Disorder. Having clinical staff who are able to recognize symptomology and develop supportive interventions is critical to maintaining well-being. Medication management and crisis intervention are a crucial part of the supports offered. Having each person connected to a local therapist and psychiatrist, as needed, is part of the agreement the residents make in order to remain connected to the program.

M is a young man, who was enrolled in a prestigious university learning to make his mark in the world. His autism was not going to stop him. He wanted to belong to the larger world. But this desire caused such stressors that M had to be hospitalized for his depression. Once his rehabilitation was done through hospital programs M rejoined The Compass Program and began working on his social skills. He was steered towards running to help ease his anxiety. Today M is a multi-time marathon participant completing the NYC marathon's 26.2 miles. His words are that "running in the Marathon freed my life. It made me feel like a super athlete." He continues to participate in social events creating more independence and working on career goals.

Compass Project provides supports and answers for these critical life demands, as our clinical expertise focuses on the wholeness of each individual.

In addition, family's involvement is a critical part of creating the supportiveness to make the program a success. The Compass Project unties with families to help develop and enhance program services. The families also advise on the goals and direction of growth for the program. Compass Project ties braid government funding with private fees and since fundraising is vital part of maintaining the life blood of the program.

Jewish Child Care Association (JCCA) is a comprehensive child and family services agency. We work with those who need us most, including children who have been neglected or abused, immigrant Jewish families, and those building new lives. Most of our clients come to us because they struggle with poverty or family crises, and because they are working to create an independent future. JCCA helps more than 16,000 children and families every year and is consistently rated at the highest levels for the quality of our programs. In all our work, we are motivated by *tikkun olam*, the value within Jewish tradition that calls upon all of us to repair the world, and by our belief that every child deserves to grow up hopeful.

The Jewish Child Care Association is located at 858 East 29th Street Brooklyn, New York, 11210. You can visit them

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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.

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to New Yorkers who seek information on the risks associated with alcohol and opioid abuse, how to recognize signs of addiction, and how to connect to additional resources and information. HOPENY professionals offer supportive listening, risk assessment, motivational interviewing, crisis de-escalation, safety planning, and connecting New Yorkers with Emergency Medical Services when an imminent health risk is identified, in addition to their primary function of providing referrals to services.

This expansion of the HOPEline will help address the rise in heroin and prescription opioid abuse, which continues to be a persistent national problem that is also reaching deep into communities across New York and is heavily affecting young adults. According to the Centers for Disease Control, nearly 25,000 people nationwide died in 2013 from overdoses involving prescription painkillers or heroin. In 2014, there were more than 118,000 admissions into New York State-certified treatment programs for heroin and prescription opioid abuse – a 17.8 percent increase over 2009. The largest increase in opioid admissions during that time was among 18- to 34-year-olds.

Governor Cuomo has made this issue a priority and implemented aggressive measures to help New Yorkers address heroin addiction and prescription opioid abuse. The Governor launched the #CombatHeroin campaign in September 2014 to inform and educate New Yorkers about the risks of heroin and prescription opioid use, the warning signs of addiction, and the resources available to help. Additionally, the Governor has expanded efforts to offer naloxone anti-opioid overdose medication training in areas all across the state. Approximately 55,000 New Yorkers are now trained to properly deliver naloxone in an emergency and more than 1,500 lives have been saved.

To reach the State's HOPEline 24-hour, confidential help line text or call: 1-877-8-HOPENY. Your phone service plan's standard texting rates will apply. Starting in July, New Yorkers can also reach the HOPEline by texting the short code HOPENY (467369).

For more information and resources to help people struggling with substance abuse, visit the NYS OASAS website at: http://www.oasas.ny.gov/accesshelp/index.cfm. A list of addiction treatment providers is available at: http://www.oasas.ny.gov/providerDirectory/index.cfm?search_type=2.

For information about combating heroin use and prescription opioid drug abuse, visit the #CombatHeroin website: http://combatheroin.ny.gov/. Information about anti-opioid overdose training is available at: http://www.oasas.ny.gov/atc/atcherointraining.cfm.

Changing Roles from page 6

provider. For individuals whose traumatic experiences have made trusting new providers difficult, being able to access primary care in a place where they already feel safe can facilitate management of health risks. While the literature on reverse co-location is currently at a younger stage than for forward co-location, there are nevertheless some promising research findings. In particular, Benjamin Druss's group has demonstrated improved primary care linkage, rates of diagnosis of medical conditions, and quality of medical treatment for people with mental illness.

Finding PCPs who are willing and able to work in behavioral health settings, including clinics, rehabilitation programs and outreach teams, is not an easy task. As it is, there is a dearth of PCPs to serve the general population. A PCP who takes on this new role needs to be highly collaborative, flexible and open to creating a new model, not to mention having a commitment to working with people who have high behavioral health needs. Whereas PCPs are generally accustomed to working in group or private practices where they are team leaders, this new role makes them consultants and minority members of a multidisciplinary team that is usually led by non-physicians. And since reverse co-location is still being developed, with federal (SAMHSA) and other grants supporting innovations in this area, the pioneer PCPs doing this work need to be willing to try out different workflows with their colleagues, provide constructive feedback, and continue to develop new ways of working together to improve outcomes. Given the promising results demonstrated by the Druss group, behavioral health agencies and departments would do well to support family medicine and internal medicine trainees to engage in experiences that develop their interest and skill in reverse co-location.

Psychiatry's Role in Management of Physical Health Conditions

For psychiatrists working in behavioral health settings, the main shift in scope has been to include not only cardiometabolic monitoring but also management of basic cardiometabolic conditions as part of routine patient care. Many psychiatric medications, including second generation, or "atypical" antipsychotics, have metabolic side effects including increasing weight, glucose levels and cholesterol levels, all of which are risk factors for heart attacks and stroke. Screening guidelines were introduced over a decade ago by the American Diabetes Association and American Psychiatric Association for people on atypical antipsychotics. These guidelines include regular measurement of weight, waist circumference, blood pressure, fasting glucose and fasting lipid profile at baseline and at intervals after starting an antipsychotic medication. The development of standards for non-fasting glucose and cholesterol measurement have made good screening more accessible for people whose psychiatric symptoms have made fasting for bloodwork difficult. Many psychiatric offices now have scales, tape measures and blood pressure cuffs available to make routine measurement possible, and some practices have nursing or medical technician support as well.

For people who develop metabolic side effects with a medication that has been effective for psychiatric symptoms, the risks of switching medications need to be weighed against the metabolic risks. Behavior changes to reduce risk should be discussed. Medication side effects are only one of the reasons why obesity, diabetes and high cholesterol are prevalent among people with serious mental illness. Symptoms of mental illness such as avolition and low energy lead to reduced physical activity. Tobacco or substance use can also affect health (e.g., alcohol causing weight gain) and worsen self-care.

When medication changes and/or behavior changes are not adequate to address metabolic risk, medications that reduce weight, blood pressure, glucose levels and cholesterol levels may be needed. Sometimes psychiatrists may prescribe these medications when access to primary care is difficult. For example, metformin can be used to reduce weight in people with schizophrenia and obesity, even if they do not have diabetes. Metformin is generally well-tolerated and has few risks. Psychiatrists can also prescribe amlodipine for hypertension, statins for elevated cholesterol levels, or aspirin to prevent heart attack if high risk, as the risk-benefit ratio for these medications is usually favorable. However, since this practice was not part of most psychiatrists' residency training, and since major associations and regulatory bodies have not yet made a clear position statement on the issue, many psychiatrists are still reticent to prescribe these medications and manage basic cardiometabolic conditions.

What may be required is an integrated care model that is a reverse version of the collaborative care model, in which psychiatrists could manage a basic set of physical health conditions for people with serious mental illness, using the support of a primary care provider who is available for doctor-to-doctor consultation but also to examine people in person if needed. This would require development of another primary care role, which has not yet been investigated to any great extent.

Towards a More Continuous Continuum of Care

The health care system is moving toward a continuum of care that includes quality psychiatric care for people in the general population on one end, and quality primary care for people with the highest level of behavioral health needs on the other. This transition will require a greater supply of different types of psychiatrists and primary care providers to work in different roles. Expansion of scope of practice, and regulatory support of this expansion, will be needed to allow integration to flourish. Training physicians to work in these different roles should begin in residency or even before, with continuing medical education helping physicians in practice to keep up with changing models of integration. Ultimately, this increased flexibility in physician roles is needed to achieve better outcomes for the people we serve.

Insurance Models from page 1

neck up and the neck down.

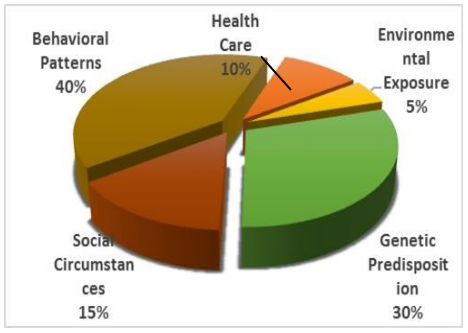


Chart #1: Health Outcome Patterns

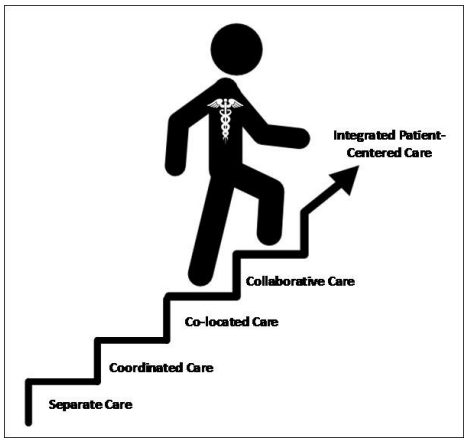
Chart #2: Social Determinants

The Problem of Poorly Integrated Care

Separate systems of health and behavioral health care have led to terrible outcomes for people with serious mental illness (SMI), who have mortality rates up to four times as high as those of their peers without mental illness and life expectancies up to 25 years shorter. Even moderate mental illness diagnoses correlate with premature death, and people with SMI die even earlier than people with moderate mental illness. People with SMI are more likely to be diagnosed with cancer and are less likely to survive when they get it. In addition, people with mental illness are more likely to engage in unhealthy behaviors like smoking, overeating, insufficient exercise, and excessive consumption of alcohol and other drugs.

The Promise of Integrated Care

State of the art clinical care is integrated care, whether through Patient Centered Medical Homes, Advanced Primary Care or some other model of collaborative, integrated, patient-centered care. The benefits of collaborative care have been broadly demonstrated in over 70 randomized controlled trials, which have shown it to be—across a wide range of practice settings and patient populations—more effective and more cost effective than usual care for common mental disorders such as depression.



The Promise of Integrated Care

Integrated care has produced better outcomes for many prevalent and costly chronic medical diseases including asthma, hypertension, congestive heart failure and diabetes, and has been shown to be more effective for many of the most common mental illnesses, including anxiety disorders, depression, bipolar disorder and schizophrenia.

Importantly, the financial case for integrating behavioral health and primary care is profound. Studies have estimated $15 billion in savings per year for the Medicaid system. Others have estimated savings from $26.3 billion to $48.3 billion annually, of which between 34% and 40% would accrue to Medicare and Medicaid. Savings are generated in pharmacy, inpatient and outpatient medical and mental health specialty care, and long-term analyses have shown a return on investment of $6.50 for every $1 spent on integrating care. And as an added bonus, integration achieves a fourth aim – increased provider satisfaction.

Incenting Integration with Insurance

Whatever insurance scheme is put into place, one key indicator of its likely efficacy will be the extent to which it promotes integrated care at the level of clinical practice. In a carved-out environment, the behavioral health benefit is paid for and managed separately from all other health and benefits, leading to disjointed service delivery and oversight. In a behavioral health carve-out, accountability for physical and behavioral health needs is fragmented. With different payers managing care, it is difficult to align financial incentives across physical and behavioral health systems or share information in real-time across systems.

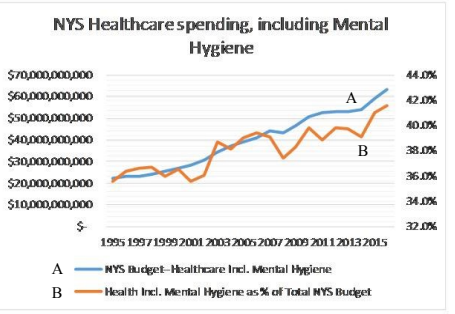
Under a carve-out model the behavioral health expenses for the entire managed population remain under a fee-for-service (FFS) payment model. Clinical services are differentiated by type and are assigned either to the managed care organization (MCO) responsible for the person's medical/surgical care or paid directly by the Medicaid program. Some carve-out models also exclude the total healthcare needs of people with SMI from any care management at all and leave them in an entirely FFS environment. This gives MCOs greater predictability of healthcare costs, but it prevents them from developing the expertise necessary to manage behavioral health conditions. As well, unmanaged behavioral health costs can drive huge and unpredictable expenses for state Medicaid programs, and the bifurcation of responsibility can lead to duplication and lack of clear accountability. It is extremely difficult to incent integrated care with a dis-integrated insurance scheme.

In a carve-in model, on the other hand, participating MCOs are given responsibility for the total health and wellbeing of their members. All medical/surgical, inpatient, outpatient, specialty mental health and other services are covered by the participating MCOs. Carve-In models can also exclude people with SMI, who can either be covered FFS or by a Special Needs BH Plan (SNBHP); their distinguishing characteristic is that those who are covered are fully covered by a single plan. This creates challenges for MCOs. They need to develop behavioral health expertise, expand their networks to include behavioral health providers, and respond to a landscape with less cost predictability. However, it drives greater cost savings for the state, makes clear to whom savings are attributable, incents integrated care, provides a single point of accountability and oversight for state regulators, and reduces duplicative tracking, monitoring and quality assurance.

Under a carve-in, MCOs are still able to access the support of specialized Behavioral Health Organizations (BHO) to help them build the behavioral health network they need to serve their members, and provide the expertise in behavioral health that they need to effectively manage care while supporting community living, implementing person-centered practices, supporting family caregivers, promoting employment, and meeting people's diverse needs across the whole lifespan. The key is that there is a single locus of accountability and a single entity that is ultimately responsible for someone's care.

New York State's Plans

New York State (NYS) has chosen to transition to a carved-in model of managed care, with plans to carve Medicaid-funded behavioral health services into managed care. Governor Cuomo launched the Medicaid Redesign Team (MRT) initiative in 2011 in order to identify strategies to reduce ever-growing healthcare costs and address multiple issues related to care quality (i.e., despite the high cost of the Medicaid program, New York State ranked last in avoidable hospital admissions for Medicaid members in 2009).



New York State Healthcare Spending

In order to achieve the goal of managing 96% of all Medicaid spending, and improve and integrate care, the MRT proposed carving in behavioral health services into the Medicaid Managed Care program. To accommodate the specialized needs of specific high need populations, adults in New York with SMI and/or significant substance use disorders (SUD) will be eligible for specialized plans called Health and Recovery Plans (HARPs). HARPs will be fully integrated, similar to mainstream plans, but they will also offer an enhanced benefit package of additional home and community based services (HCBS) designed to keep people with SMI out of institutionalized settings and in the community.

Establishing the system is not a guarantee of success, and it's true that a bad carve-in may be worse than a carve-out, but by investing in an integrated, carved in Medicaid system, NYS is positioning itself to integrate care and generate positive health outcomes on a population health level.

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advocacy at the state level to change statutes/regulations that were barriers to embedding physical health services within behavioral health agencies, technical assistance to access physical health funding streams managed by other payers, and seed funding for exercise equipment, community gardens, and green space.

In Colorado, Beacon Health Options is a partial owner of two behavioral health organizations that have carve-out contracts but are operationalizing the state's goal that 80% of Coloradans have access to co-located healthcare by 2019. This MBHO has developed a provider self-administered survey to measure movement along the integration continuum, building on the Vermont Integration Profile (VIP). The MBHO also provides targeted disease and care management using evidence-based supports for self-care and improved health outcomes, tailoring health coaching to each member based on their response to the Patient Activation Measure (PAM).

Delivering Integrated Team-Based Behavioral Health and Primary Care: One particularly effective model for integrated treatment is the Collaborative Care Model (CCM), developed by Unutzer and patterned after Wagner's work on the Chronic Care Model. CCM operationalizes five principles of effective patient-centered integrated behavioral healthcare: 1) Team and collaborative care so that all members of the treatment team are working in concert on whole health; 2) Population-based care that identifies cohorts of patients with common clinical conditions and tracks outcomes for each group; 3) Measurement-based (treatment to target) so that treatment effectiveness is continually monitored against targets and adjustments are made based on results; 4) Evidence-based care that has demonstrated outcomes for specific populations; and 5) Accountable care in which results are shared with patients, practitioners, and purchasers so that future treatment protocols are informed by practice-based evidence. [iii]

Involving a collaborative team of a PCP, behavioral health care manager(s), and psychiatric consultant, CCM is more effective for depression and anxiety than care as usual.[iv] Based on Unutzer's model, the Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) model for depression treatment has had large scale implementations across health plans, community health clinics, and PCPs.

Cenpatico's program for depression treatment is based on the IMPACT model and uses depression symptom scales, behavior activation, and relapse prevention to improve treatment outcomes. Training is provided to PCPs on stepped care and IMPACT's tenet of "treatment to target". Predictive modeling allows the MBHO to identify members newly diagnosed with a chronic medical condition, to

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health, child welfare, education, juvenile justice, and more. The Child and Adolescent Service System Program (CASSP) was largely devoted to building "systems of care" that would bring together all the child caring systems to coordinate care case by case. Various interesting models emerged around the country including the Coordinated Children's Services Initiative (CCSI) in New York State. These had some success, largely depending on the interest and cooperative nature of particular people from different service systems.

The 1990s

During the 1990s the first efforts were made to integrate care via Medicaid managed care. In New York and some other states, serious mental and substance abuse conditions were excluded from managed care. But by the mid-1990s many experiments were underway around the country to provide managed care for people with serious, long-term mental and substance use disorders on Medicaid. All such efforts envisioned the use of care coordinators to plan and authorize a broad range of services, including some social services such as housing, for people who would likely be hospitalized without such services in the community. In NYS, an effort was made to develop "Special Needs Plans". It failed largely because it did not include people covered by Medicare as well as Medicaid (about half of all people with serious and persistent mental illness) and because the state legislature was persuaded (correctly, I think) that it was not financially viable as proposed. (Current Medicaid managed care approaches have been designed to include people covered by Medicare as well as Medicaid.)

The 2000s

Towards the beginning of the current century, integration of physical and behavioral health care emerged as a major goal due to research that revealed that people with serious mental illnesses have comparatively low life expectancy (largely due to physical illness), that people with co-occurring serious and chronic physical and behavioral disorders are the major drivers of Medicaid costs, and that people with untreated mental disorders, especially depression, and physical health conditions, such as heart disease, are at high risk for disability and premature death.

Integration of care, therefore, has come to mean integrating "behavioral health" care (treatment for mental illness and/or substance use disorders) with physical health care. This is a huge conceptual leap that adds enormously to the complexity of integrating care if only because the separation of the roles of mental health and substance abuse providers and physical health care providers is well-entrenched in the tradition of medical practice.

Complexity is also increased because the current goal of "integrated" care does not focus only on people with severe, long-term behavioral disorders but also on the general population, 50% of whom will have a diagnosable mental or substance use disorder in their lifetime. That's a very large target population.

So, in the first 5 decades of the shift from institution-based care to community-based care, several meanings of "integration" have driven several quite different approaches to achieving integration. This has included attempts to (1) develop effective working relationships between state and local mental health providers, (2) develop collaboration and clear responsibility among local providers, (3) integrate treatment for mental and substance use disorders, (4) build "systems of care" for children and for adults including service systems outside the mental health system, (5) extend Medicaid managed care to people with severe, chronic mental and/or substance use disorders, and (6) integrate the treatment of behavioral and physical health conditions for **all** people with diagnosable co-occurring conditions, roughly 50% of the American population.

There is, I think, much to be learned from this history, which is largely a history of brilliant ideas crashing on the rocks of reality. It is a history that makes me skeptical that the complex systems now being put in place can work. I would be delighted to be wrong. Integrated care at last? That would be wonderful.

Michael Friedman is retired but continues to teach at Columbia University and to write about behavioral health and about aging. He is the founder and former director of the Center for Policy, Advocacy, and Education of the Mental Health Association of New York City. He can be reached at: mf395@columbia.edu.

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medical and behavioral health care. We know that traumatic experiences are often an inevitable part of human experience. Therefore, our interventions must address the broader implications of the current mind/body split approach to care and the need for more meaningful integration. The next generation of integrated care will be one that incorporates the critical role that emotional distress plays in our lives and in our health, with services that recognize and honor an individual's life experience and how compensatory behaviors are linked to earlier traumatic experiences.

ICL is spearheading the integration of primary and behavioral health care, as well as care coordination, throughout our multiservice agency. From care coordination to housing to PROS services, our goal is to ensure that more people with serious mental illness (SMI) have access to quality behavioral health *and* medical services. ICL's model for integrated care puts consumers at the forefront, making decisions about their healthcare based on personal values and goals. ICL also works tirelessly to train our clinical and frontline staff in evidence-based, trauma-informed interventions that will support clients in receiving fully integrated care that addresses both their behavioral and medical health needs.

Through our research and firsthand experience, it has become clear that implementing trauma-informed, integrated care will lead to better client outcomes and reduced cost of care. When healthcare providers honor and acknowledge the degree to which health-related behaviors are connected to experiences of trauma, they can work with all patients, regardless of conditions or expense of treatment, to identify better ways of coping with these feelings to turn reactive habits of the heart into healthy habits that sustain the body. We have the potential to break the legacy of trauma's impact across the spectrum of healthcare users and to facilitate more responsive outpatient care and improved overall health outcomes.

We have the potential to save lives and it is imperative that we take action now.

Crossroads from page 28

and services providers on the topic of the potential consolidation of the missions of the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and the New York State Office of Mental Health (OMH). This inclusive conversation is an important conversation. The content of these Forums will be collected by OASAS and OMH with the help of a Steering Committee made of 20 stakeholders and communicated to the Governor's staff as they consider what is best for New Yorkers.

Following the lead of the extraordinary policy work currently being done in New York State in the areas of healthcare, corrections and criminal justice, juvenile justice, and other sectors of the human services system, it might be a productive pursuit to broaden the conversation and examine integration of substance use and mental health services into the continuum of health and human services funded by New York State. This broader discussion could be rooted in better outcomes, better integration and better use of resources with emphasis on paying for performance; all priorities of Governor Cuomo.

Integration of competent and effective substance use and mental health disorders prevention, treatment, and recovery support services into other systems, especially where desired outcomes are not being achieved, would be a policy shift that could truly revolutionize New York's health and human service delivery system. Let's have the discussion about OASAS and OMH, but let's contextualize the discussion in the best way to integrate both specialized services systems, substance use *and* mental health, across systems to dramatically improve outcomes, collaboration, and use of resources.

Blending from page 8

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Save Lives from page 10

7. Improve: Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

The timing for the Zero Suicide initiative is perfect as the nation strives to integrate health and behavioral health care systems. Instead of the "don't ask, don't tell" mentality that kept life-saving conversations about suicide from happening in these settings in the past, Zero Suicide prompts these systems to see how and where they can integrate practices that can open up conversations about suicide and implement interventions to save lives. And while the initiative is young, decreases in suicide rates from 30%-60% are being seen.

The National Action Alliance has created a toolkit to help those who are committed to Zero Suicide start their work. There are many free tools there to get started. To learn more visit them on the web at http://zerosuicide.sprc.org/.

Wellspring on page 22

"One of the most outstanding resources of the Arch Bridge School is their staff. They are exceptionally well-trained and deeply passionate about helping and teaching this population. The Arch Bridge School staff experience their mission as transforming, and in many cases, saving lives. This was confirmed time and again by staff at all levels, parents, and the students themselves."

At the second level of integrated care – that of program – the reason for success is apparent. The basic approach to treatment and education is personal and relational, which is integrative in its own right. The personal dimension is based on a cultivated awareness and response by staff to the unique nature and gifts of each resident or student. This involves a deeper look at the individual than diagnosing a disorder or a learning disability. It is a concerted effort to see, affirm and foster this "personal" core through staff relationships. Joined with clinical experience and skill, this approach gives depth to how behavioral and learning issues are addressed and helps stabilize the treatment and educational process.

Examples abound. Debbie's deep response to animals in the animal program awakened a self-discovery that led her to become a veterinary assistant upon graduation, with the hope of someday becoming a vet. Gina's love for cooking was apparent when her mother discovered her avidly watching the food channel when she was four years old. She rediscovered this passion at Wellspring, where it became the basis for her entire educational program. With graduation she enrolled in culinary school. Shauna was mired in negativity and treatment resistance when she hacked into Wellspring's computer system to read her clinical chart. To her surprise, after some initial uproar, she was lauded for her audacity as a detective and for her evident gift for computer science. Though initially expressed in "bad" behavior, the recognition and affirmation of her underlying gift opened the door to active involvement in treatment and a positive discharge. Each of these residential students had been stuck in negativity, hopelessness and depression; suicidality was part of that. Yet through the recognition and affirmation of a unique gift each found a practical lifeline to a future that supported the hard work of change.

At Wellspring, the personal and relational approach is fully integrated into program design. Disorders and learning disabilities are complex; but so are people. Because each person responds differently to different media, no single modality or approach can meet all the needs of a given individual. Program design must be comprehensive to address the different aspects of a disorder, but it should also be holistic to touch the mind, heart, body and spirit of a person.

Treatment is centered by individual therapy twice a week and family therapy once a week. Milieu therapy in the school and residence supports this work with particular attention to peer and staff relationships. As parental relationships become transferred to the milieu staff in their "parenting" roles, the acting out of these patterns is focused back into the individual and family therapy. Multiple interactive group therapies concentrate on developing self-assertion, caring feedback, caring confrontation and conflict resolution. These skills in turn funnel back into the family therapy and the bi-weekly parent support and multi-family groups to address problems and reconstitute family relationships. In these different ways, the interpersonal world of the resident becomes a practical school of relational development.

The integration of different modalities can have a synergistic effect on treatment, but this is accomplished only through close collaboration – no small matter to achieve. An essential part of the mix is the twice-weekly Emotional Expressive group, designed to evoke and express the blocked emotions of sadness, anger, pain so basic to affective disorders and PTSD. Primary therapists are present in these groups to integrate these basic emotions through follow-up individual work. This becomes a bridge in turn to convert raw emotional expression into effective and appropriate communication of feelings in family therapy.

Creative-expressive groups – art, sand tray, and drama improvisation – evoke and reflect a sense of self, a sense of "who I am." Surprisingly, these creative media work in concert with the physical activities of animal therapy, garden therapy, work therapy, and adventure program for the same end. The individuality expressed through creative media has its embodied counterpart in the instinctual self revealed by the resident side by side with staff and peers in hands-on work. These land-based media also build ego-strength through learning how to work and developing a work ethic to meet the challenges real life presents.

Land-based programs are often thought of as a clinical luxury, but at Wellspring they are considered essential. Richard Louv, in his book The Last Child in the Woods, has coined the phrase "nature deficit disorder" to characterize the unhealthy effects of young people's increasing disconnection from nature through fixation on virtual reality. Camping, canoeing, ropes course, and the camaraderie of shared work and play experiences, make involvement with nature inviting and help correct this imbalance.

From a belief in the whole person, Wellspring is intentionally countercultural in this regard. Immersion into soil that grows vegetables and flowers is different than just getting dirty, though in an adolescent's mind it may start out the same. Getting to know a chicken, a lamb, a goat, or a rabbit can be a revelation to an adolescent otherwise cut off from direct experience. So can camping out in the woods. Most adolescents have never engaged in community service – never helped in a soup kitchen or washed cars to raise money for a local ambulance service that also serves them. They discover satisfaction in helping others.

Not to forget the medical dimension of integrated care. Each residential program is supported by quality psychiatric care and 24 hour nursing coverage. Both are supported in turn by nutritional consultation and guidance. Unlike outpatient care, a supportive residential setting can test medications to see what's actually needed and what helps, in contrast to medication add-ons for symptom control. As the resident becomes healthier through treatment, medications can be either discontinued or diminished.

This brings us to the third level of integration – the continuum of care available to residents, students and families as they progress in treatment. This continuum is multi-faceted and situational. As a resident-student progresses in the residential context, they may step down to less intensive treatment similar to a typical therapeutic school. If living locally, they may attend the Arch Bridge Day School while participating in some residential groups and meeting with their primary therapist in individual and family work. Young adults may attend college classes while in residence, preparing for eventual return to full-time college. Or they can take a part-time job while in residence as preparation to live independently nearby. They can then be in partial care and spend two or three days a week at Wellspring, connecting with friends in residence while seeing their primary therapist as an outpatient.

In other words, a care continuum is fashioned individually based on readiness and flexibly blended services to provide the necessary support. Residential step-down opportunities include day-school, therapeutic schooling, part-time employment, outpatient therapy, and off-campus living as available options. The intent is to provide support through established relationships, because continuity of relationship is a crucial factor in managing transitions. While the goal is always to make these transitions as seamless as possible, change is never seamless. It can, however, be made less bumpy and disjointed.

Wellspring's model of integrated care provides clinically intensive residential treatment in a private school environment. It fosters personal integration with continuity of relationship to stabilize the process. But a model differs from the work required to make it reality. This work is arduous and never-ending, but having the right framework focuses right action, and the results support the continued effort. The Wellspring model of integrated care ascends through four levels beginning with the person, extending through comprehensive and holistic programming, to the integration of treatment with education, to a continuum of care suited to the individual and family. Although it is always a work in process needing continual adjustment, for young people with psychiatric problems – it works!

Models from page 32

conduct depression screenings and assign targeted members to health coaches embedded within the primary care practice. Coaches assist patients to develop behavior activation plans to increase treatment adherence and improve outcomes. Preliminary data shows improvements in depression scale scores and lower emergency department and inpatient costs.

The CCM has shown both reduced healthcare costs and improved patient functioning. In the largest trial, IMPACT, participants were twice as likely as patients in usual care to have a substantial improvement in their depression over a 12-month period[v] and to have less physical pain. [vi] Additional studies have shown the model to be effective with adolescents with depression [vii], cancer patients with depression, [viii] and patients with diabetes. [ix] Analysis of the cost and savings of collaborative care produces a return on investment of $6.50 per dollar spent. [x]

In Arkansas, Humana At Home (HAH) and Humana Behavioral Health (HBH) launched a collaborative pilot focusing on members experiencing the highest complexities in both behavioral and medical disorders. The pilot is demonstrating the efficacy of partnering medical and behavioral health clinicians to conjointly provide support to the member. Structured communication channels and processes have been built into the model to ensure consistent real time collaboration between the clinicians and the member. The HAH care managers report being much better equipped to identify and address behavioral health contributions to members' overall health challenges by partnering with the HBH. As a result, they have reported that it is easier to engage the member with the most beneficial resource or intervention to address the behavioral need. This collaboration has demonstrated improved health outcomes for Humana members while reducing costs. By synchronizing or combining existing behavioral health resources within chronic care management even further, gains in extending life-long wellbeing and cost reduction could be achieved.

To encourage medical-behavioral integration, Anthem promoted the use of the Health and Behavior Assessment and Intervention procedure codes. These codes were added to behavioral health provider fee schedules and the claim systems set up such that they could be submitted with a medical diagnosis. PCPs can refer patients with physical illnesses/ailments that either were being provoked by a behavioral health condition or can assist in providing psycho-educational consultation/intervention to assist members to manage and adhere to their medical condition treatment plans. In Maine, where the provider community engaged quickly with these codes, a study was done looking at members who were eligible for Anthem benefits over a three-year period and compared the baseline to year one for members with diagnoses of sleep disorders, headaches, chronic pain, and morbid obesity. While behavioral health costs increased, medical and pharmacy costs decreased with a net overall healthcare cost reduction of 3.2%.

One of the many ways Humana has approached integration is with the Humana Chronic Care Program (HCCP). HAH developed HCCP to improve the health of the top 25% of its sickest, most costly members with chronic illness and functional challenges, while also reducing costs. Predictive Analytic Tools were used to stratify members into four Quadrants of member need and utilization; types and frequency of care management intervention were designed for each Quadrant. The program uses a holistic approach with a primary care manager working with an interdisciplinary team of social service professionals, nurses, pharmacists, dieticians, community health educators, and a consulting geriatrician. Individuals in HCCP have had success maintaining their chronic illnesses and mental health disorders at home; hospital admissions have decreased by 51%, and the patients' two-year odds for survival

see Models on page 35

New Model from page 10

(1) Instrumental outreach and engagement (e.g., use of incentives such as phone cards, grocery vouchers or transportation assistance); (2) multidisciplinary, ethnically diverse teams that met regularly for care planning and coordination with other agencies and hospitals; (3) partnerships among agencies, including hospitals, mental health and substance abuse providers, housing agencies, pain management specialists and legal services. Initial analysis suggested substantial cost savings.

Ambulatory ICU Sessions

The key points of the Ambulatory ICU team based care sessions are: 1) Patients registration by a familiar team member; 2) Review of visit agenda with team members in advance of the physician visit; 2) RN symptom review, vital signs, and delineation of need for specific tests for chronic disease management on this visit; 3) Generalist physician or Nurse Practitioner visit; 4) Psychotherapist visit when scheduled; 5) Psychiatrist or Psychiatric Nurse Practitioner visit; 5) Visit with social service expert, if needed; 6) Review of day's findings and recommendation with the patient by one or more team members to be certain that the patient understands the plan; 7) Meeting with the community care coordinator to set up follow-up visits and schedule for community resource appointments (e.g., housing, exercise, NA/AA, Weight Watchers, or others); 8) Team review of care plan on a regular basis or whenever the patient has an Emergency Department visit or hospitalization. In addition to these activities, we plan to reserve specialist time (Endocrinologist, Gastroenterologist, Infectious Diseases specialist, Surgeon, others) for on-site or telemedicine consultation with the team and patient whenever indicated. We also will work intensively with inpatient teams should a patient be hospitalized and institute intensive transitional care that will involve a phone conversation within 24 hours of discharge, a home visit within 48 hours and a follow-up visit within 3 working days.

Disruptive Innovation

The Ambulatory ICU has roots in the theories of Disruptive Innovation as described by Clay Christensen and his colleagues at the Harvard Business School. In his terms, the Ambulatory ICU is a "Solution Shop" rather than the usual assembly line primary care, which Christensen calls a "Value Adding Process" (VAP). Solutions Shops address complex, unstructured and unique problems. Success depends largely on the training and expertise of the employees involved and access to sophisticated technology. An example of a solution shop business model includes the work of a consulting group when it brings expertise from multiple experts to bear on the problems of an enterprise. Those experts evaluate the unique problems of that one organization, hold extensive discussions among the consulting team, and offer an individualized set of recommendations. In healthcare, a solution shop might include the kind of detailed consultation offered at the Mayo Clinic, when a patient with a complex illness that has not been easily treated at other institutions is examined and discussed among a cross-disciplinary panel of experts, relevant tests performed, and a report discussed with a patient – all in one day.

A VAP business model uses predictable and routine processes to improve a product step-by-step and is most appropriate for routine, standardized procedures. Success depends primarily on the quality of the process. An example is a Toyota assembly line where each step is completed and perfected before moving onto the next task. Each stage of assembly is carefully documented and done the same way each time, rendering it suitable for Continuous Process Improvement. In healthcare, an example of a VAP problem would be the routine care of diabetes, wherein the hemoglobin A1c, eye examination, foot examination, dietary and exercise counseling, and use of appropriate hypoglycemic medications all need to be performed at prescribed intervals and in a reproducible manner.

Medical Assembly Lines

Think of the Emergency Department. The focus is on processing a particular patient as quickly as possible "up or out". In either event, the ED physician then turns to the next "case". Handoffs are rushed. If the patient is admitted, there is a brief discussion with the resident on call "on the floor". That resident will leave the following evening or morning, signing out to the next resident who will discuss the patient with the inpatient attending physician. By that point, the patient's primary care plan is a distant memory, if it were ever known. The patient's primary care physician, even if notified, seldom has the time to be involved in the inpatient care. Care coordinators try to make sure that the patient keeps follow-up appointments. Medications are reconciled. A continuing care document is sent to the primary care physician. Perhaps a "Transitions Coach" nurse even makes a follow-up call. But who has really considered the meaning of this hospitalization in the patient's life course? Who notices that this is the fourth admission for abdominal pain this year and that the CT scans obtained in the ED all show the same abnormalities? Who discovers that the abdominal pain recurs whenever the patient relapses on alcohol? Who understands that the patient relapses on alcohol whenever her son relapses on drugs and steals her medications and money? Can a Health Home Care Coordinator possibly know that the abdominal pain admissions were medically avoidable or that the radiological studies were excessive? Can a primary care doctor figure this out in twenty minutes? Can a psychiatrist possibly evaluate the patient's abdominal pain? (This scenario is taken from a patient in our Health Home, whose history was elucidated only in our case conferences, which are similar to Solution Shops.) Or if a different patient visits different medical emergency departments with varying pain complaints and leaves each time against medical advice, who notes that her medical complaints and irritability relate to her worsened depression and opiate dependency? Who shares the insight and with whom?

The Ambulatory ICU will endeavor to go beyond coordination of current care and beyond the integration of primary and mental health care. It envisions a system in which the most complex patients get careful attention from the best experts, allowing care coordinators to do what they do so well: Engage patients on a rational journey toward better health.

Improved Health from page 21

been integrated into some of the larger network behavioral health service settings. This team-based approach brings primary care clinical resources to the sites of behavioral health providers to support whole-person care. Optum and UnitedHealthcare's care coordination staff are available to support this integration of care and help direct appropriate services as needed.

Improving health outcomes for TennCare members requires attention to a range of factors that are broader than just physical and behavioral health conditions. Social and community factors also influence an individual's health and well-being. One example is the availability of stable housing. The TennCare program includes partnerships with supported housing providers to create stable community living supports. These alternatives are available to individuals with both physical and behavioral health needs who are transitioning from facility-based care back to the community. These supported community living resources are a cost-effective means to promote stability and improve community engagement and tenure. Peer services also help support the engagement and activation of covered members.

Through these integrated approaches to care and community services, the TennCare program has been able to demonstrate improved health outcomes and reduced care costs. Effective partnerships with providers have resulted in a 12% statewide reduction in service utilization.[4] In behavioral health there has been a concurrent reduction in psychiatric readmissions of 8.3%.[5] The coordination of care has also demonstrated better follow-up after hospitalization, as evidenced by a 42% increase in follow-up with providers within 7 days, and a 32% improvement in follow up after 30 days.[6] Improved housing alternatives have also resulted in reduced costs and improved community tenure.

Optum and UnitedHealthcare have demonstrated in the TennCare program that the integration of care for physical and behavioral health conditions must include the coordination of care across all levels of the system and a commitment to whole-person care. This integrated approach improves quality of care while reducing unnecessary service use and overall health care costs.

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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4. Results from Optum's analysis of inpatient admission reports from TennCare for FY2011 to FY2012. Cost savings is based on a daily average TennCare unit cost of $525. Results include reductions in psychiatric readmission rates in West Tennessee during the same period.

5. Results from Optum's analysis of state quarterly psychiatric readmission reports for the West Tennessee region, from FY2011 to FY2012 (psychiatric readmissions statewide decreased overall). Cost savings is based on a daily average TennCare unit cost of $525.

6. Based on Optum's comparison of HEDIS rates for the West Tennessee region from FY2009 to FY2012 (three-year period).

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have improved by 26%.

New Directions Behavioral Health is now piloting team-based, member-centric programs in primary care settings. The programs involve the selection of a unique type of behavioral health professional who can adapt his or her services to the pace and culture of a primary care environment. These practitioners become a member of the primary care team providing brief assessment, brief intervention, referral and case management, physician consultation, stepped care, and group work with members who have medical and behavioral comorbidities. Physicians involved in these pilot programs describe the impact as "transformational" for their practices.

In carve-in and carve-out environments, MBHOs are using their experience and expertise to make significant contributions to the growth of integrated healthcare. They are creating integrated delivery systems; managing integrated benefits for persons with serious mental illness and Medicare/Medicaid beneficiaries; and partnering with health plans on integrated management of medical and behavioral health services. The result empowers

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providers to more effectively engage members in their own treatment and deliver integrated models of care that promote overall improvements in health status and outcomes.

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Variation from page 13

more intensive support than is available to them in their permanent living arrangements. The flexible and coordinated provision of mobile outreach, peer support and respite services, individually or in combination, is designed to address the myriad clinical, medical, psychosocial and emotional support needs of individuals for whom unmet needs have often been precipitants of relapse.

Inasmuch as these and similarly holistic approaches address both clinical and social determinants of health they constitute meaningful steps toward a fully integrated approach to health management. Conventional definitions of integration, such as those described above, refer to the coordination of primary and behavioral healthcare services but they seldom address other influencing factors of nutrition, stable housing, and social and emotional support resources. This is hardly surprising in view of the nation's myopic management of its healthcare resources. The United States ranks first in healthcare spending among industrialized nations and 25th in social service spending (Harris, 2015), and this disparity is tragic in view of the relatively modest role healthcare delivery plays in overall population health. By some estimates only 10% of our health status should be attributed to healthcare interventions. Individual behavior, genetics and social circumstances are significantly greater determinative factors (McGinnis, Williams-Russo, & Knickman, 2002).

Although it is premature to assess the efficacy of our mobile outreach, peer support or respite initiatives in reducing preventable hospital readmissions or emergency department visits, an emerging body of research suggests truly effective approaches to integrated care must attend to the medical, behavioral and social determinants of health. Approaches that achieve only partial integration are unlikely to fulfill the Triple Aim of healthcare reform. We applaud the DCMH and OMH for their vision and abiding commitment to complete integration and we thank our partners for their support in the implementation of this promising project.

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Sandy from page 24

mental health field. Each team manages a caseload of up to 20 clients with weekly appointments for 45-60 minutes per session. All client sessions are conducted by the team; clients are never seen by just the RN or MHP.

At the initial intake interview, and every three sessions thereafter, clients are asked to complete the Adult Self-Report (Osofsky & Osofsky, LSUHSC-NO, 2013). The Report rates clients in five areas: anxiety, physical problems, depression, suicidality, and alcohol abuse.

The MIHT is an integral part of the Staten Island community recovery and resiliency building process that quickly became relied-upon as a valuable resource. The MIHT maintains close working relationships with the various grassroots disaster relief and recovery groups including the Island's Long Term Recovery Organization (LTRO), Coalition of Organizations Active in Disasters (COAD), and Connect to Recovery. MIHT teams incorporate into their weekly assignments visiting relief hubs and recovery centers and talking with residents and workers/volunteers.

Community outreach also targets houses of worship/community centers, elected officials, schools, and health care centers in the heavily affected areas. MIHT teams were present at the many community disaster preparedness trainings and health fairs providing health/mental health screenings and information.

The MIHT treatment model can be viewed as successful on four levels: team design, treatment services provided, community rebuilding, and resiliency and continuity of care. The integrated RN and MHP team approach proved successful. Initially uncomfortable in the conjoint treatment team approach, the RNs and MHPs, through supervision, training and practice, learned to work together and support each other in the treatment sessions and grew to respect and become involved in each other's treatment philosophies and practices.

For example, after taking K's blood pressure, the RN reported, "K, your pressure is high, 160/90." The MHP spontaneously, and to her own surprise, responded, "K, it's never been this high. What do you think is going on?" As the program progressed, the team members coalesced to effectively address both health and mental health issues in each session.

To reiterate, all treatment services are provided in the client's home, although when that is not possible, community relief "hubs," such as coffee shops or park benches are utilized. Home-based services allow the MIHT teams to reach the most vulnerable populations and provide services within severely damaged neighborhoods and homes. The home-based model allows the teams to experience the smells, sounds, sights, chaos, despair and life-as-they-live-it views (Trout, 1987) of clients. This direct experience of clients' living conditions aid in the teams' connections to individual residents, families, and the community, ensuring continuity of care.

One year post-startup, the MIHT had opened 72 cases, provided 1,240 individual and/or family sessions and completed over 500 outreach screenings.

When analyzing the health and mental health conditions, upon admission, of Sandy-affected residents of Staten Island, New York, the MIHT team found clients exhibited a pronounced co-occurrence of health and mental health problems. The most common behavioral health diagnoses were depression, anxiety, and PTSD. The most frequent medical conditions were Hypertension, High Cholesterol and Chronic Obstructive Pulmonary Disease. These data mirror the findings from the aftermath of Hurricanes Katrina and Rita.

Health Conditions: 87% had one serious medical condition; 67%, two medical conditions; and 50% had three medical conditions. Mental Health Conditions: 100% received a positive screening score on the Adult Self Report for a mental health condition; 90%, two positive screenings scores; and 65% three positive screening scores.

Analysis of the Adult Self Report data indicates a significant decrease over time in the Anxiety, Depression and Physical Problems scores resulting in improvement in the client's symptomology.

Case Example: Kay, age 42, and Rob, age 46, along with their three children, ages 13, 10 and 6, are clients of the MIHT. Kay applied for services in May 2014 due to increased anxiety and fears related to Super Storm Sandy. Kay was also concerned about her husband's depression and fears, as well as anxiety evident in her children related to the hurricane. The family lives in the Midland Beach section of Staten Island, which was severely impacted by the storm. The family did not evacuate the night of the storm, and witnessed the flood waters approach and encircle their home. The couple reported watching neighbors and relatives escaping the rising waters while they remained in their home. The children often speak about hearing fearful screaming and yelling the night of the storm. Kay and Rob report fearing for their lives when the waters came in. Fortunately, after the flood waters receded, their home was damaged but livable. However, both Kay and Rob's parents' homes were severely damaged and unlivable, creating extra pressure on the entire family. When the MIHT team went to Kay and Rob's home for an initial assessment they found Kay and her children in good physical health, but experiencing increased fears and anxiety, while Rob was depressed, with high blood pressure, diabetes and obesity. The team began weekly meetings with them to address both the post-Sandy mental health issues, and Rob's health concerns. At one meeting, Rob was having difficulty breathing, with high blood pressure, abnormal heart rate and increased sugar levels, necessitating immediate transfer to the ER. However, because Rob became anxious and fearful of going to the hospital, the MHP began addressing these symptoms, while also working with Kay, in a relaxed, calm manner to arrange child care while the couple went to the hospital. The MHP also provided support to the children, who had become fearful and anxious regarding their father. Rob was admitted to the hospital with possible heart failure due to a leaky heart valve and pneumonia. The MIHT team remained in contact with Kay while Rob was hospitalized and visited the couple after he returned home the following week. Both Kay and Rob told the team that they "saved his life."

Four months into the MIHT program, several clients independently requested the formation of a "social" group to facilitate meeting and mingling with other MIHT clients. The MIHT Community Support Group was launched. The group meets monthly for 2½ hours in a community center in the heavily damaged Oakwood Beach section of Staten Island. All MIHT clients and their families are invited. The format is casual, with food, games, crafts, music and relaxation/stress reduction exercises including yoga, breathing techniques or "ice breaker" exercises. This group is an asset for the clients where they can re-connect to their community and develop new friendships

The MIHT has proven to be an essential resource in the post-Sandy disaster recovery and community resiliency rebuilding process on Staten Island, New York. Providing home-based health and mental health services to the most medically and psychologically at-risk residents is successful. The model confirms that community based health and mental health care can be comprehensive, culturally sensitive, stigma-reducing, family-centered, resiliency-based and continuous.

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of Dutchess County (MHAD); Mental Health Association of Rockland County (MHAR), Mental Health Association of Westchester County (MHAW), Rehabilitation Support Services (RSS), and Westchester Jewish Community Services (WJCS). These organizations provide a vast array of services to multiple populations and are licensed by OMH, OPWDD, OASAS, DOH and OCFS in seventeen counties in the Hudson River Region.

However, as CBHS agencies moved to increase the integration of behavioral and physical healthcare internally within their organizations, they acknowledged that to best serve their clients, to more fully address complex physical and mental health needs, they needed to access additional high-quality and comprehensive physical health resources. CBHS found those in a partner, Hudson River HealthCare (HRHCare), a network of federally qualified community health centers providing primary, preventive, oral and behavioral health care in the Hudson Valley region and Long Island. HRHCare equally wished to strengthen its access to behavioral health expertise for its patients who had serious psychiatric conditions, and in 2014, HRHCare and CBHS partnered to form an IPA specifically to address the integration of their respective services. This new corporation, CBHCare IPA, has consulted with numerous national experts on models of integration of behavioral and physical health services over the course of a year, as it worked to shape its integration strategies. We have learned that integration is not an occurrence, it is a process; that it can take up to two years for organizations to meld their cultures, operations and experience so that a successful strategy may emerge that meets the objectives of the Triple Aim. CBHCare partners have contributed countless hours of administrative and direct care practice to the development of a variety of integration models and configurations, some of them highly successful and exciting ventures, and others that have struggled to evolve. A clinical subcommittee works on establishing and evaluating pilot metrics, interagency protocols, integrated record keeping, broader interoperability, risk stratification and care coordination. Following are brief descriptions of some of these endeavors:

CBHS - IDD Partners

Abilities First

Access:
Supports for Living

Crystal Run Village

Human Development
Services of Westchester

Mental Health America of
Dutchess County

Mental Health Association
of Rockland County

Mental Health Association
of Westchester County

New Hope Community

Rehabilitation Support Services

Westchester Jewish
Community Services

• CBHCare partners, WJCS and HRHCare, have long had the common goal of improving the quality of life, including the health and mental health of residents of Southern Yonkers. Located on the same street, the two institutions had served the same community and often the same patients, separately in the past. That changed in 2012, when WJCS received funding from the NYS Office of Mental Health to embed a social worker in the HRHCare pediatric practice. Starting out as co-located services, the joint venture has evolved to full integration, with the WJCS social worker working side by side with the pediatricians in addressing the overall health of youth seen in the practice. The social work and medical professionals regularly "huddle," discussing high risk patients, interventions, and the significant overlap of problems with health, mental health and trauma. They creatively work together to bring their collective strength and knowledge to the team and enrich the lives of children served at the HRHCare practice. Recognizing the significant impact of trauma on the lives of these young patients, HRHCare was fortunate in being selected, through a SAMHSA initiative, as one of 11 teams nationwide to participate in a Johns Hopkins University Learning Collaborative "to improve pediatric primary care's capacity to provide trauma services to young children and their families." The pediatric team, including the WJCS integrated social worker, the pediatrician, the practice manager and a family advocate/consumer from WJCS have together attended learning sessions at Hopkins and utilized the expertise of the Hopkins leadership in moving toward trauma-informed care. The expertise of WJCS' Treatment Center for Trauma and Abuse will further the goals of this initiative with staff from WJCS providing training and guidance to the entire pediatric clinic on becoming "trauma informed" in their practice.

• Two Licensed Clinical Social Workers (LCSWs) employed by Access: Supports for Living, have started in January 2015 to provide behavioral health consultation and services at HRHCare sites in Walden and in Monticello, Orange County. The social workers have extensive backgrounds in working with clinically complex individuals and families and have embraced the opportunity to expand their skills and knowledge during this new venture. The Access clinicians often start their day in a "morning huddle" with the primary and specialty care providers and nursing staff to discuss patients who are scheduled to be seen that day. For part of the day, the social workers are in previously scheduled appointments, but always expecting and welcoming an interruption for a warm handoff from a physician or nurse practitioner to start to engage the patient. Whenever possible, the social workers meet with the patient right away, but often after a brief introduction, schedule an appointment for the next day. Both clinicians are recognized as members of the treatment team, most often referred to by their first names in order to reduce the stigma that often follows behavioral health challenges. They follow-up with a variety of patients who struggle with headaches, sleep problems, etc., and when the medical causes have been ruled out, the social workers then step in and start to explore psychosocial stressors that might contribute to the discomfort of the patient and identify coping skills by utilizing Evidence Based Assessment Tools and Practices. If a patient is in need of longer term behavioral health services, a referral to CBHS clinic services is initiated.

• MHA of Dutchess County, has partnered its care managers with medical professionals in a pilot project at an HRHCare center in Poughkeepsie to improve outcomes through strengthened Health Home teamwork.

• HRHCare centers are hosting Meet & Greet open houses so that CBHS Health Home, residential, PROS and clubhouse staff can familiarize themselves with HRHCare primary care and specialty services in support of increased integration and to facilitate positive transitions of care.

One of the lessons learned in the course of the last three years, is that although the relevant state departments are conceptually on board regarding integration of physical and behavioral healthcare, it has been difficult for healthcare organizations to obtain the regulatory relief that would support that integration.

Throughout the CBHCare experience, CBHS behavioral health agencies continue to be impressed with the medical expertise and the deep caring of HRHCare staff for the people we serve in common. We will continue to strengthen our alliance and improve and expand the integration of our services as the CBHCare IPA moves forward into value-based contracting with managed care organizations. We anticipate that such contracting will support the opportunity to create additional integration projects focused on the DSRIP goals of reducing avoidable emergency room and hospital admissions and readmissions in the service of the Triple Aim.

Alan Trager, LCSW, is CEO of Westchester Jewish Community Services; Amy Anderson-Winchell, LCSW, is CEO of Access: Supports for Living; Amy Kohn, DSW, is CEO of the Mental Health Association of Westchester County; Andrea Kocsis, LCSW, is Executive Director, of Human Development Services of Westchester; Andrew O'Grady, LCSW-R, is Executive Director of Mental Health America of Dutchess County; Elizabeth Kadatz, is Director of Operations at Rehabilitation Support Services; and Stephanie Madison, LMSW, is CEO of the Mental Health Association of Rockland County.

Interoperability from page 18

produce a report that looks exactly like the one their funder is expecting. But that doesn't mean that what we do with the Interoperability Showcase at HIMSS, with our Meaningful Use Certification, with our participation in events like the Connectathon are irrelevant. On the contrary, the one difference between this HIMSS and the last one is that a lot of the things we used to just talk about, like data exchanges, the shifting of funding streams to some kind of value-based alternative payment model, those things are beginning to actually happen. That means that Foothold Technology will be there when our clients get there.

** http://footholdtechnology.com/think-tank/interoperability-thoughts-from-himss-2015/*

Care from page 25

2014 to December 2014. His top 4 diagnosis for ER visits were pneumonia, asthma, hypertension, and diabetes mellitus. I was unable to contact the patient because he does not have a telephone so I visited him at the hospital upon receiving an electronic emergency room visit notification through the electronic health record system. I spoke to his mental health clinician and she stated that they have attempted to set up many appointments for the patient to follow up with a PCP; however, the patient has failed to show up to any of the appointments. During the visit, I was able an important barrier to care of homelessness for the last 2 years and no access to communication (i.e. telephone). The patient stated this was the reason that he does not attend any of the appointments was because he is very forgetful and would like someone to remind him.

In care management we were able to address the patient's main concerns which were housing and access to a telephone. I was able to work with a Social Worker to get the patient into a three quarter house upon discharge and I also applied for a telephone through a grant-funded program. The patient was appreciative and we agreed to a hospital follow up date after ensuring to him that he would receive a reminder call prior to his appointment.

Prior to the appointment I set up a case conference with the PCP and mental health clinician and we were able to make up a plan of care for the patient. We were also able to get the diabetes educator and nutritionist involved to offer additional support to the patient. During the appointment I was able to assist the patient in communicating concerns that patient had with his PCP and explained concerns that the PCP had to the patient. As a result of a collaborative effort, ER utilization drastically decreased and his overall health has improved.

This one example of how a patient can "slip between the cracks" when navigating through our complex health care system. As the previous example clearly portrays, Care Management is a vital component of the integration model of care which ensures high quality care is delivered in a patient-centered manner.

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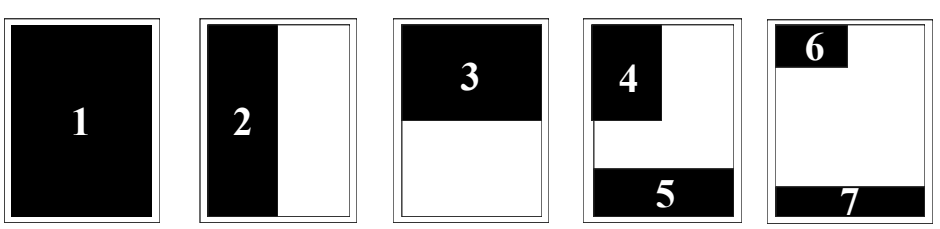

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