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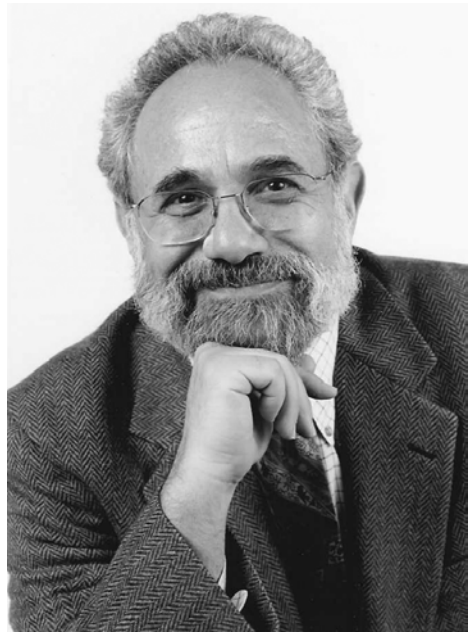
Perspectives on the Transition to Managed Care

Will Managed Care Advance the Goals of Community Mental Health?

By Michael B. Friedman, LMSW
Behavioral Health Policy Advocate

In the middle of the 20th century, when American mental health policy switched from institution-based to community-based, the primary goal was to enable people with severe, chronic mental illness to live freely and safely in the community with the same rights as other Americans. Considerable progress has been made. Mental institutions are gradually becoming a vestige of the past with plans in place to virtually eliminate them. Community-based services and supports have expanded considerably, helping hundreds of thousands of people to have better lives in the community than they would have had in institutions. The Americans with Disabilities Act and the Supreme Court's Olmstead Decision explicitly grant rights to people with mental disabilities that were not respected in the past.

But much remains to be done to achieve the original goal of community



Michael B. Friedman, LMSW

mental health policy. For many, many people, community mental health policy has at best not been useful and at worst may have exposed those in need of great support to dangers that have taken a terrible toll on them. These people have been left behind—not in mental institutions, perhaps, but living with families struggling with the burdens of caring for a disabled family member or living on their own but without safe, stable housing or living in other institutions such as shelters, adult homes, nursing homes, jails, or prisons. In addition, people with serious, long-term mental disorders are much more likely to abuse drugs or alcohol, to be victims of crime, to be in jails and prisons, to commit suicide, and to die long before their time than people without such disorders. They are also unlikely to be employed, and are, in general, not fully welcome in mainstream American society.

These lingering problems should define the primary agenda of American mental health policy in the early decades of the 21st Century. Safe and stable housing for all people with severe, prolonged and disabling mental disorders should be a primary goal. Good health and survival into old age should be a primary goal. Leading independent lives that they find personally satisfying and meaningful despite continuing mental illness should be a primary goal. And full integration into mainstream society should be a primary goal.

Rhetorically they are primary goals. Mental health policy is now supposed to be "person-centered" and "recovery-oriented." That's jargon, which no one outside our field understands, for providing community-based services and supports that are relevant to each individual's needs and for helping individuals with serious, long-term mental illness to have satisfactory lives in the community.

But, in truth, mental health policy is now dominated by the expansion of Medicaid managed care to people with long-term psychiatric disabilities. This reflects decisions made by the top policy makers in the United States—especially by Governors determined to contain the cost of

see Advancing the Goals on page 28

Collaborative Care: An Integral Part of Psychiatry's Future

By Jürgen Unützer, MD
and Jeffrey Lieberman, MD

In 1974 the music critic Jonathan Landau penned a classic article in which he stated, "I have seen the future of rock and roll and its name is Bruce Springsteen." Landau was commenting on his impression of the debut album of the then-fledgling rock star. If you will permit my imaginative analogy, I believe that the same can be said about the collaborative care model with respect to the future of psychiatry. For this reason I invited Jürgen Unützer to co-author this column for Psychiatric News.

With the enactment of the Affordable Care Act, the rise of accountable care organizations and patient-centered medical homes, and the increased national attention on mental health, psychiatrists and primary care providers have an unprecedented opportunity to join together and work collaboratively on increasing the overall health of millions of Americans. APA recognizes this opportunity and has been actively involved in efforts to improve integration and collaboration with our primary care colleagues.

Jurgen Unützer, MD

Jeffrey Lieberman, MD

As one of the largest medical specialties, psychiatry is an important component of the physician workforce in the United States, but psychiatrists are distributed unequally around the country. More than half of the counties in the United States don't have a single practicing psychiatrist. Only about 1 in 10 adults with a diagnosable mental disorder receives care from a psychiatrist in any given year and patients are much more likely to receive mental health treatment from their primary care provider than from a psychiatrist. It is well known and often said that 40 percent of primary care (adult and pediatric) involves dealing with psychiatric problems. Our colleagues in primary care are well aware of the substantial challenges related to treating the millions of patients who present with mental health problems in their offices every year and report serious limitations in the support they receive from psychiatrists and other mental health specialists.

Although we have effective pharmacological and psychosocial treatments for most common mental disorders, they are not widely accessible, and only a minority of patients receive them. Many patients are not on medications at therapeutic doses or for long enough to see positive effects, while others continue to use medications even if they are not effective. As few as 20 percent of patients started on antidepressant medications in primary care show substantial clinical improvements. The situation is not much better for those referred for psychotherapy.

see Collaborative Care on page 30

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Perspectives on the Transition to Managed Care

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

The year 2014 will provide opportunities for OASAS and the other behavioral health agencies in New York as we prepare for the transition to Medicaid Managed Care beginning in 2015. The goal of this change is to create a system that provides New Yorkers with fully integrated behavioral health services within a comprehensive, accessible and recovery-oriented system.

I am excited about the transition as I believe we can capitalize on the Medicaid Managed Care experience to move our treatment system from a program-based to a more flexible community-based treatment system focused on person-centered approaches with expansion of recovery support services in all communities in New York State.

We will seek to leverage the experience and efforts of managed care to reduce unnecessary inpatient care and to place patients in the most appropriate setting, which in many instances will be community based.

We will use managed care to reduce the number of Medicaid participants who continually cycle in and out of hospital-based detoxification programs and are never linked to the next level of care or diverted beforehand, where appropriate to do so.

OASAS Commissioner
Arlene González-Sánchez, MS, LMSW

We can use managed care to help us expand the number of providers who offer recovery support services and to broaden the use of peers supports.

As part of our plan, OASAS is seeking federal approval to move to a rehabilitative Medicaid reimbursement model which would allow our certified programs to provide Medicaid reimbursable services outside the four walls of their clinics.

OASAS is also seeking approval for home and community-based recovery support-type services to be Medicaid reimbursable. We will move to a system where Medicaid reimburses for clinical and medical services, regardless of the treatment modality.

For too long we have focused on volume of services to support programs. The move to Medicaid managed care will allow us to focus on patient needs and support for long term recovery.

We will change how patients are treated in our system of care with a new focus on outcomes and value. We will move away from procedure-driven treatment episodes in clinic settings to value-based reimbursement for episodes of care that meet the patients needs for long–term success as close to their own community and family as possible.

No longer will we focus on discreet treatment episodes with a narrow focus on substance use disorder care. We will have opportunities to reward programs that offer integrated care that provide for recovery of physical, mental health and social needs of the individual and family.

While I believe that there are tremendous opportunities with the transition, I also have concerns which we must account for. We need to move away from the use by managed care of medical necessity and level of care tools that ask whether a person has failed at outpatient care before they are allowed to access inpatient treatment. There is no clinical foundation for such criteria. This is why OASAS will mandate the use of our new level of care tool or LOCATDR, which is a clinically-driven instrument focused on the needs and risks of the patient.

We will protect reimbursement rates and will require broad provider networks during the transition, so that we enable the new system to develop by allowing providers to show their ability to produce good outcomes.

We will also spend time in 2014 working with providers and managed care plans to provide information and opportunities to network and develop relationships so that when January 2015 rolls around, both stakeholder groups are prepared to operate in the new system.

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New York State Office of Alcoholism and Substance Abuse Services
Commissioner Arlene González-Sánchez

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Health Care Reform: Empowering the Workforce Through Outcome Focused Education

By Peter C. Campanelli, PsyD, Evelyn Kleinbardt, LMSW, Mary M. McKay, PhD Lynn Videka, PhD, Eileen Wolkstein, PhD, McSilver Institute, Office of Global & Life Long Learning, Silver School of Social Work, New York University

The Affordable Care Act of 2010 (ACA) unquestionably began a process that potentially could lead to a total transformation in the health and behavioral health care delivery system of the United States. The ACA is fundamentally a regulatory reform effort that is guided by the triple aim of expanding health insurance coverage; lowering the cost of health care; and improving the quality of the care provided as measured by improved health outcomes. The ACA does not provide a government sponsored public option for insurance coverage, but does require universal insurance coverage at affordable prices for everyone except those with undocumented status. It eliminates pre-existing condition exclusions, eliminates life time caps, and sets minimum standards for benefit packages.

Specifically, the ACA takes aim at lowering the costs of the existing healthcare system by reducing unnecessary acute and emergency medical care by promoting more accessible community based care. This leads naturally to an emphasis on primary, as well as secondary and tertiary prevention efforts both on a systems, as well as individual level. This law has also produced significant resources research and innovation to the field of prevention science, such as the Patient Centered Outcomes Research Institute (PCORI), as well the Center for Medicaid & Medicare Innovation (CMMI). These initiatives not only open new research opportunities but they also incentivize the development of innovative care which will demand new skills within the healthcare workforce.

Quality matters in relation to cost and both are related to the availability of preventive community based health care. The extent to which individuals can receive continuity of care within a continuous healing relationship provided by a skilled multi-disciplinary team will determine quality improvements and cost outcomes. There are key facts that are important when one considers quality and cost. The United States outspends every other industrialized nation on health care, close to 16% of the country's gross domestic product (GDP), but ranks 25th in the area of quality healthcare outcomes. Additionally, Medicaid expenditures, the National insurance program for the poor and disabled , which is in part supported by State contributions, is growing so rapidly in most States that these costs are imposing a crushing burden on State's budgets. Further, existing evidence underscores the fact that people who are seriously mentally ill (SMI) live considerably shorter life spans than their non-disabled counterparts as a result of medical co-morbid conditions particularly substance abuse, diabetes, and cardio-vascular disorders that have been poorly managed. Over 50% of the people who have SMI also have at least one medical co-morbidity which increases the cost of care for them notwithstanding acute mental health related episodes they may experience. Finally, in NYS approximately 75% of Medicaid expenditures are spent on 20% of the Medicaid population most of whom have a primary disability and at least one medical co-morbid condition. Research has demonstrated that improving quality of care, especially to vulnerable populations with chronic co-morbid conditions by insuring continuity of care and coordination of specialty care will reduce costs and improve healthcare outcomes.

The ACA makes health insurance affordable and available in two ways. First, health insurance purchase subsidies are available through direct purchase options at the Federal and or State exchange sites. While initially mired in serious functional difficulties, the Federal website appears to be up and running. State based websites appear to also be functioning well. Second, States have the option to expand Medicaid coverage to people with low incomes by raising the federal poverty income level (FPL) which, in turn, sets Medicaid eligibility. However, based on a Supreme Court ruling, states are not required to do this and some States have opted not to expand Medicaid eligibility.

Actuarially, the ACA is dependent upon young, healthy individuals purchasing insurance through the exchanges in order to balance out what might become disproportionate risk pools. Many of the formally uninsured people probably did not receive continuous medical care in the past. They are signing up for health care insurance and bring with them pre-existing and perhaps, undiagnosed medical conditions. The likelihood that many new to the insurance rolls will have co-morbid conditions requiring complex collaborative care within newly formed networks is considerable.

In an effort to manage this expansion, the ACA has made new delivery system elements available to the community based system of care. Federally Qualified Health Center (FQHC) locations have been expanded, many of these intended to serve specialty underserved populations such as communities with a high proportion

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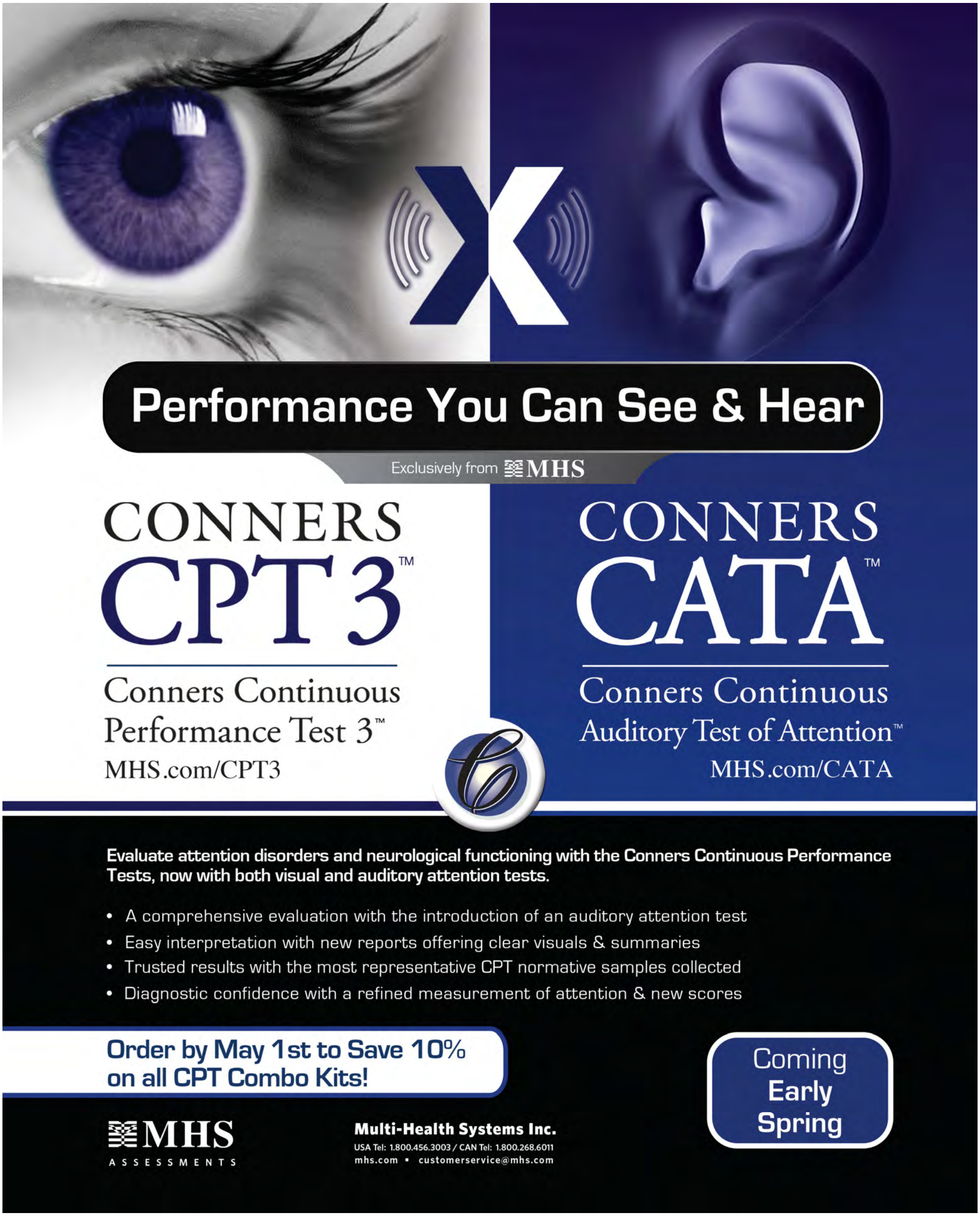
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The State of Children's Mental Health And Associated Costs of a Fragmented System

By David Woodlock
President & Chief Executive Officer
Institute for Community Living, Inc.

Past public policy has focused mostly on children's mental health issues—and with good reason. While 1 out of 10 children has a serious emotional disturbance, only 20% ever receive treatment. Children with mental health issues have the highest school dropout rate among all disability groups, and only 30% graduate with a standard high school diploma.***

Sadly, more children suffer from psychiatric illness than from leukemia, diabetes and AIDs combined.***

Progress has been made to address the needs of these troubled children more comprehensibly. Spurred by SAMSHA's "Systems of Care" initiative in the mid 1980s, states now recognize that emotionally troubled children often face a multiplicity of issues:

- Up to 75 % of children in juvenile justice settings have a mental illness. ***
- 50% of kids in the child welfare system have mental health problems*
- 21% of low-income children suffer mental health problems*

David Woodlock

Several government organizations have evolved to deal with these so-called "cross-system kids," including substance abuse, education, child welfare, child development and heath, and juvenile justice.

But the truth is *all* troubled children are cross-system kids, and the very systems created to address their multiple needs do so ineffectively. Departments operate in separate silos and rarely interact with each other, resulting in a fragmented approach that is both costly and inefficient. Efforts such as the Family Movement have exposed the overwhelming task that parents and caregivers face having to deal with so many organizations just to get minimal help.

Today, with the move to Medicaid Managed Care to contain costs, we should be concerned lest we take a giant step backward in our public policy thinking about troubled children and the funding to address their needs.

Yes, it is expensive to treat a cross-system child when you consider the breadth and the depth of fragmented and often duplicative services that don't necessarily communicate. Until substantive changes are made to address the lack of integration, we will continue to see a rise in the youth population transitioning into adults in need of services. Many continue to view the system as separate and distinct for the adult and children population, however, the same initiatives that work so well in the adult system—coordinated care among agencies to address multiple difficulties—should be applied to the whole children's system. Early behavioral interventions can improve healthcare *and* save money. When applied to children, the improvements are ten-fold.

Dealing effectively with a child's multiple issues while they are still young can go a long way to prevent future problems such as homelessness, substance abuse, unemployment, and crime. More than half of adults who were in foster care have an Axis I diagnosis, an employment status well below their peers, and a rate of PTSD twice that of combat veterans. *** Imagine what could have been done with effective early treatment.

Rather than looking solely at Medicaid expenditures, states should look more broadly with regard to children's mental health. Targeted behavioral health interventions can improve outcomes and reduce expenses for child welfare, education and special education, juvenile justice and more.

For example, Maryland, New Jersey, Oklahoma and Rhode Island have all employed a "wraparound" approach to customize services for troubled kids. These states have implemented changes in policy, services, financing, and training in order to expand their systems of care so that more children and their families can benefit. **

Footnotes

* Children's Mental Health: What Every Policymaker Should Know, National Center for Children in Poverty, 2010.

** Expanding Systems of Care: Improving the Lives of Children, Youth, and Families, National Technical Assistance Center for Children's Mental Health, 2012.

*** NYS Children's Plan 2007.

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Reframing treatment around recovery and resiliency offers new hope and a bright future for those who live with mental illness. While everyone must follow their own path to recovery, and every local community offers a unique set of supports, a few key principles can help ensure success:

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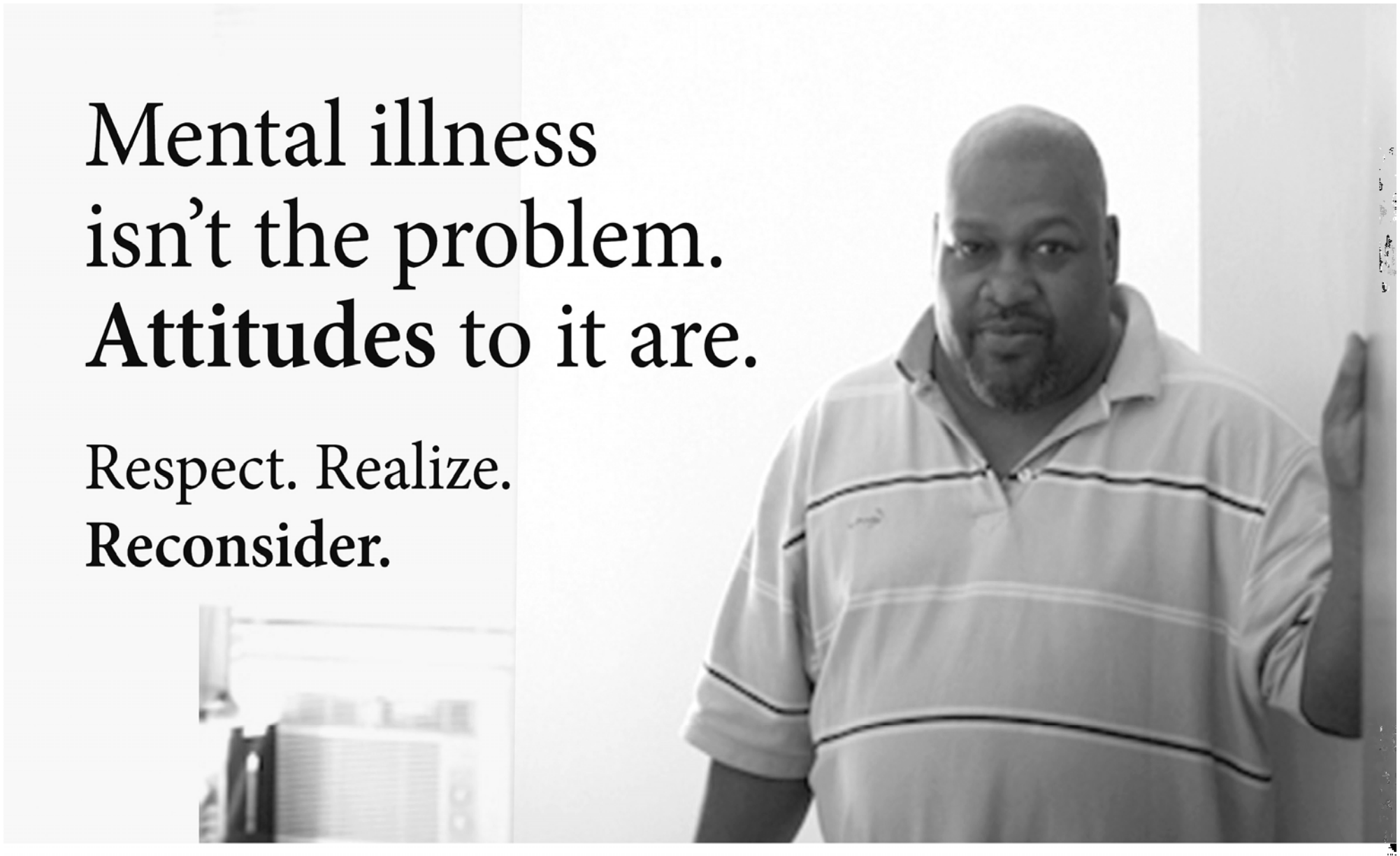

Ignorance is not bliss. 1 in 4 adults suffers from a diagnosable mental disorder each year.

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How Managed Care Influences Treatment Plans

By Mary Pender Greene, LCSW-R
MPG Consulting

Until about 20 years ago, mental health professionals set fees based on training and experience, and were reimbursed by health insurance companies a fair percentage of the bill. Mental health benefits are now part of managed care networks, meaning that patients are narrowly restricted to "in-network" providers. Providers who wish to be in-network must agree to accept significantly reduced fees – with per-session fees declining more than 40% since the late '80s.

Clinicians in private practice are prohibited from negotiating more reasonable fees, due to current anti-trust laws. Where as at one time mental health professionals could enjoy financial security, now they face crisis – a money crisis.

The concept of managed care was initiated to bring equity to health care and treat the underserved. Because they seek to reduce or eliminate waste, there is continual pressure to reduce reimbursement rates. The populations we treat are especially vulnerable, as emotional crisis is subjective and patients are not always assertive enough to demand treatment.

This is extremely frustrating and presents ethical challenges to clinicians who are committed to care of their patient. Often, the highest quality of care is limited to those who can pay out of pocket. This short fall is further escalated by poverty and race.

There is an overarching lack of proper care for People of Color (POC). Here are some statistics from a recent Surgeon General's report:

Disparities in Mental Health Care of POC Compared to Whites

- Less access to mental health services
- Less likely to receive needed mental health services
- Those in treatment often receive a poorer quality of care
- Are underrepresented in mental health research
- Disparities stem from historical and present struggles with racism and discrimination

Surgeon General's Findings

- POC disproportionately suffer a high disability burden due to unmet mental health needs
- There are disparities in diagnosis
- For POC, stigma is #1
- It is expected that over the next 50 years, the population of the US will become increasingly racially diverse
- White population decreasing
- More than half of the Population will be POC
- In NY this diversity is already reflected in the city and the patients we serve.
- Bilingual staff is hard to find and harder to keep
- Managed care companies often do not have clinicians who can provide culturally competent services
- POC need pre-treatment work, and there is often managed care issues related to time restrictions

Communication Barriers

- POC seek/advocate for health information differently than Whites
- POC have more personable expectations of their therapist than Whites
- Research shows that therapists are often less patient-centered with POC than with Whites
- Therapists often don't have time to address any of these issues, which leads to poor treatment and outcomes

Managed care is keeping psychotherapy costs artificially low, yet research estimates that more than a third of mental health disorders go untreated due to restricted access to care. Often patients simply cannot locate clinicians who will accept managed care fees. Publicly funded reimbursements, such as Medicare, have also been reduced. Reimbursements to clinicians have been cut near every year for almost a decade – and Medicaid payments are significantly lower than managed care rates. Clinicians in every sector are feeling the financial squeeze of managed care, from new graduates, to those in private practice, to those nearing retirement. Many who practice psychotherapy are finding other career niches.

There needs to be much more public education about mental health to educate consumers and eradicate stigma. Often parents of young children are encouraged to ignore emotional symptoms, with the notion they will "grow out of it." This coupled with lack of access to skilled providers causes misdiagnosis, delays or untreated mental health issues.

Every family in America has felt the impact of psychological problems, either directly or indirectly. The question becomes, how do we maintain a highly skilled and dedicated network of clinicians to meet the growing needs of our patients?

Education from page 6

of ethnic minority residents, and special populations with multiple medical comorbidities. FQHC's, by design, contain all the necessary specialty care elements to form multi-disciplinary systems of care with the capacity to engage in a "stepped care" and "treatment to target" methodology. Utilizing hi-tech electronic health records (EHR) many of these FQHC's, as well as group practices, have formed medical homes certified by the National Committee on Quality Assurance (NCQA). Additionally, networks of community based providers, including hospital systems, have formed Health Homes. HH's are provider networks with the capacity to meet the complex needs of people with co-morbid conditions tied together with technology that permits communication across providers, thus, forming the basis for patient-centered medical care coordination. Regional Health Information Organizations (RHIOs) have emerged with the intention of connecting provider groups with important patient specific information. These are cloud based information systems providing the ability of medical centers to connect with community provider organizations enhancing hospital to community continuity and facilitating smooth community care transitions for people who do require hospitalization.

Aligning Workforce Skills with System Transformation: Where the Rubber Meets the Road

There have been multiple articles written about workforce re-design rising up to meet the new demands of a transformed healthcare delivery systems since the signing of the ACA into law. Many of these focus upon workforce shortages in specialty and primary care in the face of the market expansion and expected increases in demand as the number of people with access to insurance grows.

The enactment of the ACA and the concomitant revamped healthcare system that emerges will undoubtedly have an impact on the health care workforce demanding new skills regardless of specialization.

The major specializations within the healthcare work force consist of nurses ,social workers, physicians, pharmacists, and psychologists. Most of these professionals have been trained within a solo practitioner model often using intervention strategies that were not empirically validated on specific categories of diagnostic groups or populations. Further, this initial training occurred within a system that created incentives for volume of care, rather than outcome as a measure of health improvement. This may be one of the reasons why healthcare has been so slow to adopt evidenced based treatment systems although the pace of innovation diffusion has picked up considerably pushed by new payment methodologies, the ever increasing use of managed care, and a prevention rather than medically necessary focus of care.

Additionally, the ACA has placed emphasis on the utilization of paraprofessional and peer supported interventions, such as family support, and care navigation. Some research points to the efficacy of peer support for people in recovery using evidence based treatments, such as motivational interviewing. This element of the workforce can greatly assist in lowering cost and improving quality, but will need training and supervision in new healthcare delivery strategies as well.

So, the existing health care workforce, as well as new graduates, find themselves entering a work environment with a host of challenges. New clinical skills are necessary to align with evidenced based models; group and multi-disciplinary skills that form the basis of collaborative case management need to be developed, and an understanding of new models of care must be assimilated, all against the backdrop of understanding new methods of health insurance accessibility, eligibility, and standard benefit packages.

The Role of Graduate Education and Certificate Training

The NYU Silver School of Social work has been very proactive in addressing the workforce needs in the new emerging healthcare system. This has been reflected in the Schools graduate program equipping its new MSW graduates to play an informed and competency based role within the new system. The School offers training in evidenced based treatment as well as integrated health. The School has also launched a special program that integrates advanced social policy in healthcare and behavioral healthcare to better equip students joining the new emerging healthcare system.

In September of 2011, the Dean of the Silver School commissioned a collaborative working group focused on integrated primary and behavioral healthcare. The committee consisted of prominent local experts to examine the possibility of developing an advanced certificate program in integrated health care as a continuing education program under the joint auspices of the McSilver Institute and the Office of Global & Life Long Learning. The Committee has been meeting on a quarterly basis and developed a recommendation to design a six module advanced certificate in healthcare reform program consisting of a total of approximately 100 continuing education units [hours] or CEU's. From among the menu of modules identified by the committee one was selected to fully develop and use as a beta test. This module, Leadership: Managing during Times of Change consisted of 22 contact hours. The curriculum focused on:

- Managing During Times of Change
- The Role of Leadership (Quality Improvement & Implementation Science)
- Collaborative Care Models
- Clinical Best Practices
- Technology/Hi Tech Coordination

see Education on page 12

Mary Pender Greene, LCSW-R, CGP

Mary Pender Greene, LCSW-R, CGP is a psychotherapist, clinical supervisor, career/executive coach, trainer, and consultant with 20+ years of experience and a private practice in Midtown Manhattan. She is a thought leader in the social services industry, recognized for her novel ideas on coaching and mentoring. Mary works with individuals, couples and organizations. She coaches and supervises therapists, and helps them to start and build their practices. She helps clinicians to enhance their psychosexual awareness and gain skill in addressing sexual expression in clinical practice.

Mary also works with organizations to enhance clinical capacity and improve leadership development. The MPG Consulting team brings to organizations a wide range of experience as clinicians, trainers, managers, and organizational consultants in mental health, child welfare, and other settings. The team enhances clinical capacity and performance by offering training and consultation on:

Evidence-Based Treatment Models • Building Mental Health Capacity in Child Welfare Programs
Individual/Group Coaching for Workers, Supervisors, Managers & Executives
Team Building • Clinical Team Conferencing • Recruitment of Culturally Competent Staff
Customized Training/Workshops/Supervision on Providing Culturally Sensitive Services to Males of Color

Mary's background includes executive management roles at The Jewish Board of Family Services in NYC. She gives inspiring keynotes and has been honored many times for her professional contributions. Mary has a popular blog on Tumblr and is frequently quoted in the press on mental health and business topics.

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If Only HOPSTOP Could Map Our Route to the Triple Aim

By Kristin M. Woodlock, RN, MPA
Chief Operating Officer, and
Jonas Waizer, PhD, Consultant, FEGS

Health care reform is driving consumer focused, outcome oriented change in New York and across the country. In the past decade we have come to look at health care differently and our technology -based tools have grown by leaps and bounds. Game changing opportunities are surfacing in supporting recovery and resiliency for people with the most serious mental illness or chemical dependencies, as well as new frontiers of collaborative care and viewing housing as healthcare. Behavioral health is on an incredible journey.

In an often used saying, when traveling one must know where you want to go. It is therefore critical that we select our final destination as the Triple Aim. The Triple Aim simply stated is a place where better care, better health at affordable costs is a reality. Striving toward the Triple Aim has meaning that connects with our non-profit roots and healthcare reform offers us new tools. The logical progression next takes us to the dreaded questions encountered on every family road trip "Are we there yet?" and "How do we get there?" This is where the journey to the Triple Aim becomes more challenging. Today when traveling around New York City we select our public transportation route using HOPSTOP. HOPSTOP is a savvy, decision-support tool offering multiple approaches to get to your destination. *If only HOPSTOP could map our route to the Triple Aim.*

Arriving at the Triple Aim is an inherently collaborative process. The mission of our agency, FEGS Health and Human Services, has remained constant for eight decades. To meet the needs of the Jewish and broader community through a diverse network of high quality, cost-efficient health and human services that help each person achieve greater independence at work, at home, at school and in the community, and meet the ever-changing needs of business and our society. The FEGS service delivery network includes: employment, career, and workforce development; help for individuals transitioning from welfare to work; behavioral health, developmental disabilities and rehabilitation programs; residential services; home care; services to individuals who are deaf or hard of hearing, older adults, refugees and immigrants, families in need, youth at risk, those with substance abuse problems, services for individuals facing life-limiting or end-of-life illness, and many others.

As we begin to chart our course towards the future, we can glean much from other States and healthcare arenas, even while the regulations are still being defined in negotiations between the State and Federal governments through task forces and committees. There are patterns of change that can guide behavioral health leaders, agencies and customers. The following are a sampling of key stops (HOPSTOPS) as we travel toward the Triple Aim.

1. *Value for the consumer.* All of health care will soon be oriented around the right service or support in the right amount at the right time. This will be achieved with focus on engagement and new outcomes of improved health, stable housing and employment. Peer services, which have always been part of our fabric of care coordination and direct services, gains new priority in engaging clients, coordinating services and assuring responsiveness and quality.

2. *Integrated Health and Behavioral Health.* In order to improve health we must reach true integration between primary health care and behavioral health. The Collaborative Care model is an evidence-based approach for integrating physical and behavioral health services that can be implemented within a primary care practice. Over the past 15 years, more than 70 randomized control studies have documented a strong evidence base for this model. These trials have also specifically addressed the effectiveness of the model in ethnic minority groups, where it can be employed to reduce health care disparities.

3. *Partnerships.* There is no "I" in success. Partners are essential to form care networks capable of achieving the Triple Aim. Formalized partnerships in many varieties set the stage for business arrangements that emphasize outcomes and can manage incentives for better performance. Partnerships mean more transparency and shared governance, including new roles for consumers. This is major change for providers.

4. *Technology.* Technology advancement will play an ever increasing role in behavioral health. The use of data analytics in decision-support is equally important to consumers and staff alike, especially for tailoring services and assuring performance quality. We are preparing for the creative use by consumers of iPads, direct access to personal health information, improved analytics and greater public accountability and transparency. In light of the transformative power of computer technology, FEGS established Center4, a venture in the creation of new technology solutions for health care.

5. *Workforce Development.* Learning Communities. One economical way to build energy, new skills and collaboration is to engage staff in collectives to learn from the experience of others. Learning communities meet to study the lessons of other States and healthcare systems, Managed Care Organizations (MCOs) and other providers that are a few steps ahead in transforming their systems for integrated behavioral and health care.

6. *Diversified Funding and Risk Sharing.* Redefining our operations to the new business models of the future will include both broadening our capacity to enter into risk and reward arrangements as well as joining networks serving those in Medicaid, Medicare, FIDA, Commercial, HARP, MLTC, etc.

7. *Innovation.* Innovation in our definition of outcomes for health care in the future should focus on education, employment and housing. In practice, innovation in service delivery combines evidence informed and based practice coupled with ongoing performance improvement at the consumer, family, service and system levels.

New York's non-profit's have strong roots and are well positioned to leverage the many opportunities offered by Governor Cuomo's Medicaid Redesign. Working together, we are on course to the Triple Aim and a bright future.

Education from page 10

- Sustaining Change: Supervision and Continuous Quality Improvement
- Performance Metrics: Outcome Evaluation

The committee focused on assessing the viability of the certificate program as well designing the optimal instructional model. These included:

- Ability to recruit a diverse group of middle to upper level managers who would attend early evening classes as measured by registration and attendance rates over a 20 week period
- Ability to successfully employ a mixed distanced learning (WebEx) and face to face instructional model as measured by engagement and satisfaction in each
- Ability to successfully pair field based health and behavioral experts with faculty to form a team teaching model that maintained a quality instructional environment and promoted by-in from provider groups as measured by participant satisfaction, and self- report of learning
- Ability to translate instructional material into field based changes as measured by final project design and implementation.

Results: Data Speaks Louder than Words

The leadership module consisted of a series of 13 class meetings intermixed between 2 hour face to face seminars and one hour WebEx presentations. The webinar series utilized power point presentations but also permitted viewers to view presenters and allowed for questions and answers through a chat box feature. There were a total of 20 hours of class presentations and a formal syllabus that contained readings geared to each topic area. Most topic area's had at least one web-ex presentation and one face to face presentation. WebEx technology, adapted from the Clinic Technical Assistance Collaborative (CTAC) was utilized to attempt to minimize the negative impact of traveling upon participants always associated with organized training activities. Marketing of the endeavor occurred through broad based out-reach to a diverse group including providers, managed care organizations (MCOs) and health homes (HHs).

Sixteen mid to upper level managers were recruited from twelve discrete organizations within NYC spanning a broad array of interest and experience. All were graduate trained with considerable field based experience. The cadre of team based faculty consisted of mostly graduate trained individuals who were professionals, peer educators and a doctoral student from the field. These were paired with University faculty members who were well known in the health and mental health fields and had years of both practice and teaching experience. The Dean of the Silver School taught the inaugural class session on the need for new skills to align with the transforming healthcare system. In addition, during the class, at

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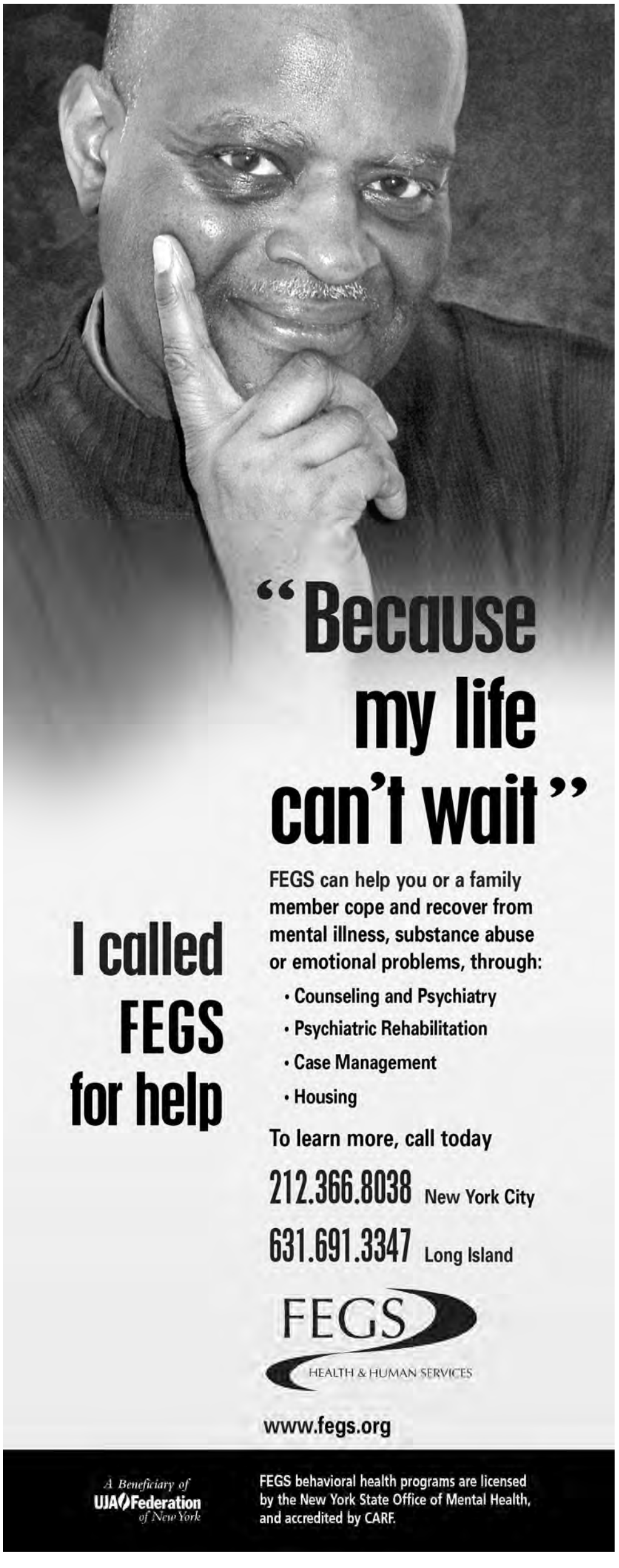


From Transition to Transformation

By Adam Karpati, MD, MPH
Executive Deputy Commissioner
New York City Department
of Health and Mental Hygiene

Adam Karpati, MD, MPH

The New York State behavioral health system's evolution toward greater care integration and accountability and a focus on recovery will include larger roles for managed care organizations in developing and managing systems of care, expanded care coordination and case management services, and new practice models. The principles and goals of this transformation, articulated in the Medicaid Redesign Team's Behavioral Health Workgroup report and recommendations (www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf) should continue to inform this process. A transformed system will work in an integrated and interconnected manner toward a holistic set of goals for each person, including physical health, behavioral health, and social well-being. Our challenges are in making the policy and design choices most likely to achieve these results.

Here are some of the areas that we at the New York City Department of Health and Mental Hygiene will be focused on as this transformative process continues:

Setting the right metrics of success. Clear, quantitative measures, to which plans and providers are held accountable, are perhaps the most essential elements of a transformed system and are the best ways to drive system change. Consequently, the metrics selected are critically important. They should address the following specific areas: increasing ongoing engagement in outpatient care; improving transitions from inpatient to outpatient care; reducing avoidable use of inpatient and emergency services; maintaining housing and employment and reducing incarceration; delivering best practices for particular behavioral health conditions and preventive clinical services for physical health issues; and maximizing consumer satisfaction with services. Obviously, accountability for social outcomes – for recovery – will be particularly challenging for plans and for the system as a whole, requiring new approaches and collaboration and coordination with government systems and services. In addition, a key aspect of using metrics to measure performance is to not examine only averages across entire populations, but to drill down and examine how groups within the population fare, in order to identify and address disparities in access, quality, or outcomes. This requires examining data by neighborhoods, by racial/ethnic groups, by condition, etc.

Balancing integration and specialization in managed care organizations. A distinctive component of the new Medicaid managed care system will be the development of "Health and Recovery Plans." These "lines of business" within existing managed care plans are being designed to achieve 2 important goals: (a) to create entities responsible for care that address all their enrollees' needs, including both physical health and behavioral health, while (b) maintaining a specialized expertise and focus on the unique needs of people with serious mental illnesses and substance use disorders. HARPs are due to begin operations in New York City in January 2015. We believe that HARPs will be models for how managed care plans can effectively organize and pay for services and can work with government to build a more robust, less fragmented system. A particular challenge for New York City around reducing fragmentation is managing the complexity of a system that serves such a large population. When there are multiple health plans and HARPs, interacting with several Health Homes, all interacting with large and overlapping networks of providers and a variety of government-run systems, the goal of seamlessness seems daunting. Health information systems and information exchange will be critical ingredients of an integrated, interconnected system. More broadly, we need to find ways at all levels of the system – care, care coordination, and care management organizations – to proactively and continuously engage consumers and leverage all the resources of our complex system.

Providing the most effective services to all who may benefit from them. An ongoing challenge in health care generally, and behavioral health in particular, is to provide the best, scientifically validated practices to all those who need them. This was a motivation behind adding the so-called "1915i" services, such as crisis respite, employment, peer services, and family support, to the Medicaid service package. We will be focused on how the emerging components of this transformed system will support and expand consumers' access to best practices. For example, the Patient Outcomes Research Team (PORT) recommendations for what works in helping consumers with schizophrenia manage their illness and work toward recovery include several components that go well beyond prescribing

see Transformation on page 30

Preparing for Managed Care:
Staff Credentialing, Evidence-Based Practices, and Fiscal Systems

By Gary Harmon, PhD
Vice President, Director of Research & Grants, and Peter Provet, PhD
President & CEO, Odyssey House

For decades, behavioral health (BH) professionals have fought for the right to have mental health (MH) and substance use disorders (SUD) regulated in a similar manner as medical/surgical conditions. First the Mental Health Parity and Addiction Equity Act of 2008 and more recently the 2012 Affordable Care Act (ACA) have begun to make parity a reality. However, with parity has come an entire new set of challenges that BH providers must traverse to ensure that the specialized treatment offered by MH and SUD providers does not become diluted in a managed care model.

Here in New York, Medicaid Redesign Team (MRT) initiatives have piggy-backed on parity laws to begin to reform the BH landscape. No longer will BH agencies exist in a world of "carve-outs" and specialty populations funded through large state contracts. Rather, they will have to navigate new relationships with Managed Care Organizations (MCOs), Behavioral Health Organizations (BHOs), and private insurers for reimbursement while being held to a higher standard of care.

Although all in the BH field will agree that improved outcomes for our clients is the ultimate goal, the process of getting there in a new system will be complex and require the following changes for both organizations and the clinicians they employ.

Credentialing/Licensure

While the MH treatment community has embraced licensed professionals for treatment of mental health conditions, the SUD community is often seen as employing "para-professionals" and clinicians that have little training and education beyond life experiences of SUD treatment and recovery. Whether or not this perception had any merit in the past, the SUD community has embraced education and training to ensure that clients (many of whom have co-occurring mental health conditions) are receiving optimal care. MCO/BHO contracting will be the final step in ending the old stigma of semi-professionals providing care, as they will require that anyone billing for BH services is properly credentialed and/or licensed. While most SUD providers will have no issues with this and have been hiring only credentialed and licensed staff for many years, some agencies will need to figure out how they can direct current staff to continue education and training. However, one major challenge will be the increased salary requirements that credentialed and licensed staff will demand, and how these costs can be absorbed or shared by MCOs/BHOs, without increasing costs for the already vulnerable clients we serve.

Evidence-Based Practices

The term "Evidence-Based Practice" (EBP)

Gary Harmon, PhD

Peter Provet, PhD

has been the buzz-word in the BH community for quite some time, and is often used anytime someone questions what type of treatment is being provided to BH clients. In the new managed care environment, simply saying that the treatment provided is "Evidence-Based" will not be sufficient. Providers will need to evaluate staff training and monitor fidelity to guarantee that interventions are being delivered in a manner where outcomes are optimized. The days of saying an organization practices "Motivational Interviewing – Type Services" for example, will be over, and the exact EBP will need to be manualized, delivered with consistency, with prescribed outcomes that can be directly attributed to the intervention. This will be a challenge for many organizations, as BH agencies often struggle with staff turn-over and issues related to the competency of staff to deliver complex EBPs.

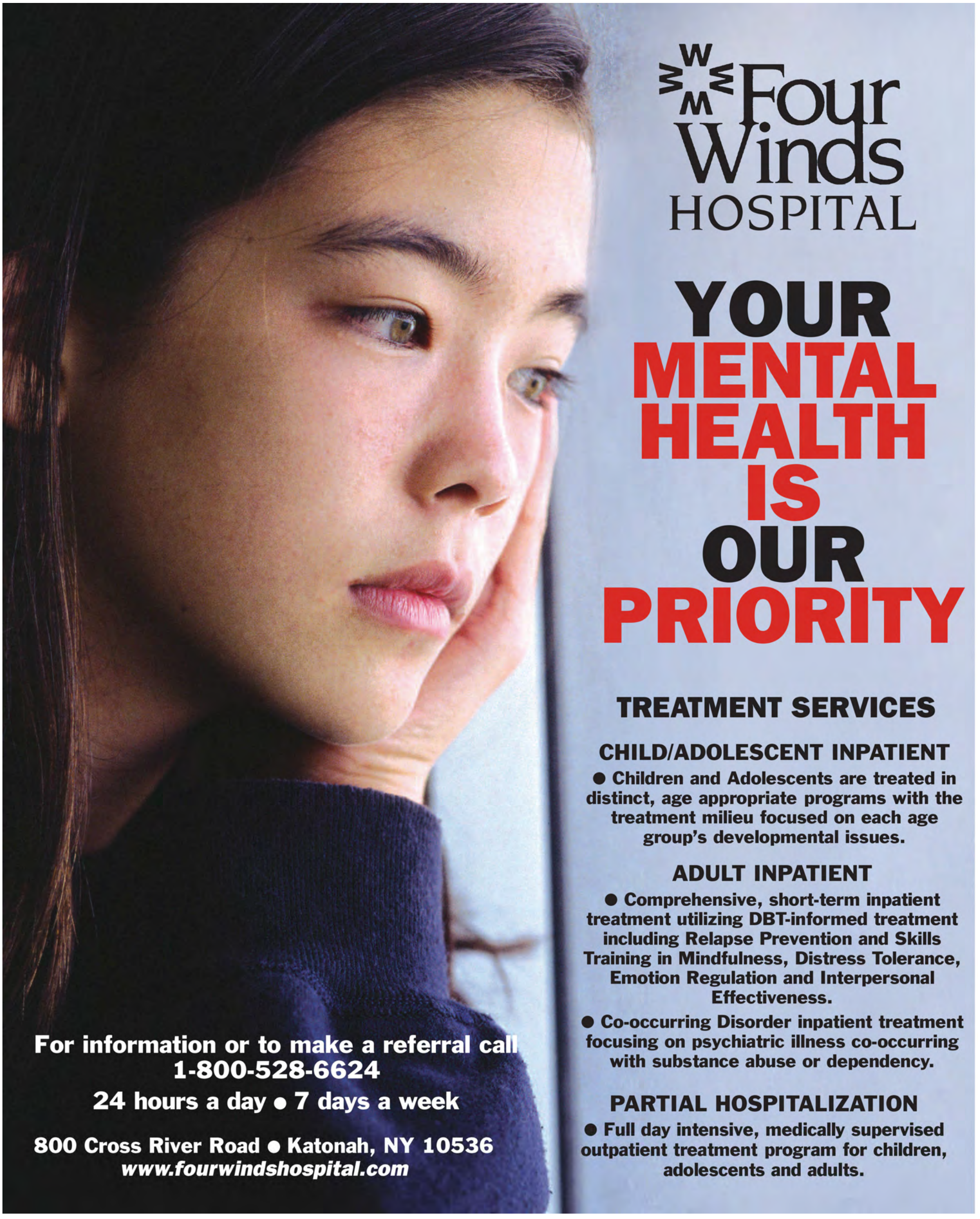
Fiscal Preparedness

Most not-for-profit BH agencies were begun as charities, often founded and operated by individuals who were champions of client rights and wanting to make a difference for individuals afflicted with SUD and/or MH conditions. Through the years, many of these agencies have evolved into corporate-like structures in an attempt to adapt to regulatory changes requiring agency and facility licensure and managing of state, federal, and city contracts. The managed care environment will require additional transformation, where fiscal preparedness and operations will be as key to agency survival as clinical services have been. For example, smaller agencies with little or no experience billing Medicaid or private insurers will undoubtedly struggle initially with the complex billing and justification requirements set forth through MCO/BHO contracts.

Additionally, many smaller agencies may not have the administrative/fiscal staff available to re-bill rejected claims, analyze and implement regulations, and adequately justify the reauthorization of treatment. Recent requirements by New York State related to the maximum percentage of costs that can be expended on administrative staff will further limit the number of staff that agencies can hire to navigate reimbursement, which will undoubtedly lead to mergers for a necessary "economy-of-scale."

These three challenges are only a few among the countless that will be encountered over the coming years. BH agencies will need to begin to work together through this process to maximize the success that can be achieved. As many large and established BH organizations are poised for success in this new landscape, they must work together will smaller agencies to help them survive and thrive. Recent data from SAMHSA showing that 18.9 million adults in the US had a past year SUD, and 41.4 million adults had mental illness in the past year underscores the need for more treatment options for clients (SAMHSA NSDUH 2011). The survival of all quality BH agencies, both big and small, is key to a strong BH system where help is available to those who need it.

Odyssey House is a not-for-profit, comprehensive, social services organization. Based in New York City, Odyssey House offers residential, outpatient, and family-based substance use disorder and mental health treatment, supported housing, medical, dental, vocational and educational services. For treatment referrals, admissions, and program services, please call: 212-987-5100, email: info@odysseyhouseinc.org, or visit us online at: www.odysseyhouseinc.org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Crucial Time for Change: NYS's Behavioral Health Care Transformation

By Kim Williams, LMSW
Vice President, The Center for Policy, Advocacy, and Education
MHA of New York City

New York State's behavioral health care transformation is the most significant shift in mental health policy since deinstitutionalization over a half a century ago. Despite improvements that emerged as a result of the shift from an institutional to community-based system of care, significant inadequacies continue to hamper the mental health system. The current behavioral health care reform efforts present a vital and timely opportunity to vastly improve the care delivery system for thousands of New Yorkers with unaddressed mental health needs.

However, there are numerous nearly simultaneous complex policy shifts that will impact different populations of individuals with varying levels of mental health needs across the health care sector. All require adequate attention and planning to ensure not only effective inclusion of mental health but sound, comprehensive reform. Some highlights of the broad system changes are:

Medicaid Redesign: NYS's Medicaid Redesign Team, which was formed to conduct a fundamental restructuring of the public health program, has approved an enormous system wide transformation. The changes include a vision of integrated care management for all Medicaid beneficiaries that will manage the complete needs of individuals' acute, long-term and behavioral care. This includes a major area of focus for the behavioral health community – the shifting of Medicaid-only beneficiaries with serious and persistent mental illness from fee-for-service to managed Medicaid in 2015.

Individuals will be enrolled in one of two behavioral health managed care models, mainstream Managed Care Organizations (MCOs) or Health and Recovery Plans (HARPs). To advance the vision of care management for all, New York State is taking advantage of incredible opportunities through the Affordable Care Act (ACA). Health homes, a financing and care delivery model option under the ACA, are already coordinating and managing care for NYS Medicaid eligible individuals with chronic physical and/or behavioral health conditions also referred to as "high cost, high need" individuals. Health homes will be a fundamental component of the managed Medicaid program.

Beginning in July 2014, dual eligibles (individuals enrolled in *both* Medicare and Medicaid) in the downstate region of NYS will be transitioned to the Fully Integrated Duals Advantage (FIDA) Program, an ACA demonstration opportunity, which will provide a comprehensive package of services and coordinate all care, including behavioral health services.

Affordable Care Act Implementation: Beyond the establishment of health

Kim Williams, LMSW

homes and the FIDA demonstration, NYS is implementing numerous other policy changes afforded to the state through the ACA. Among them is NYS's own health plan marketplace, a major feature of the ACA, which was launched in October 2013. NY's marketplace will help thousands of New Yorkers with mental health conditions but without health coverage shop for and enroll in health insurance, an essential benefit of which is coverage of mental health and substance use disorders.

Mental Health Parity: Our nation has long awaited mental health parity. In November 2013, the final Federal Parity Rules were issued to implement The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, which required health plans that offer mental health and substance use disorder benefits to cover them to the same extent that they cover medical and surgical benefits. Additionally, the ACA significantly extends the reach of MHPAEA, requiring that all small group and individual market plans comply with federal parity requirements and that plans offered through the marketplace include coverage of behavioral health and at parity. This final rule, along with the ACA's extension and the health plan marketplace, will give many more New Yorkers access to needed mental health services.

Community Transition: In addition to the above noted reform efforts, a few different policy shifts will transition individuals with psychiatric disabilities from institutional settings to community-based care. Over a three year time frame, NYS is planning to consolidate its inpatient psychiatric facilities, closing six of its 24 state hospitals, and converting designated areas into Regional Centers of Excellence (RCEs). RCEs will be state operated regionally-based networks of inpatient and community based services. Additionally, as a result of separate lawsuits, NYS must transition a select group of people with serious mental illness who are residents of adult and nursing homes into the community. Over a five year period, NYS will move more than 4,000 adult home residents with serious mental illness in NYC into community housing. Over a similar time period, the state must also transfer hundreds of out-of-state nursing home residents, some with serious mental illness who were transinstitutionalized, back into NYS. These significant policy transitions require careful planning to ensure that appropriate community-based resources are developed.

All of these sweeping changes have the great potential for achieving the aims of health reform, also known as the Triple Aim: Better coordinating care delivery, improving recovery, health and mental health outcomes, and decreasing the costs of care. But these policy shifts must be used to leverage a comprehensive, sustainable, coordinated behavioral health infrastructure that implements specific changes needed to substantially improve policy and practice for those with historic and future diverse, unmet mental health needs. The needs for this infrastructure are highlighted below:

- *Maintain and expand mental health as a major component of health policy reform* including maintenance of parity, enhanced integration of behavioral and physical health care, and workforce development

- *Build population-based mental health policy* for those whom mental health service expansion would be beneficial. Progressive expansion of the mental health system should focus particularly on underserved populations including (1) children and adolescents, (2) older adults, (3) minorities, (4) people with serious mental illnesses who do not use traditional services, (5) people with serious mental illnesses who are being deinstitutionalized, (6) people who are homeless, (7) people with co-occurring severe mental, substance use, and physical health conditions, and (8) military personnel, veterans, and their families.

- *Expand services for adults with serious mental illness* who are transitioning into the community and for those who are not adequately served by the current mental health system including those who are homeless, involved with the criminal justice system, living in adult homes or nursing homes, and those who are unwilling to use mental health services

- This effort should include expanding initiatives which emphasize recovery, enhance access to mainstream society, and improve quality of life. It should also include a mechanism for adults with serious mental illness who are enrolled in Medicaid behavioral health managed care plans, specifically Health and Recovery Plans (HARPs), to disenroll based on recovery benchmarks.

- Prepare for *predictable, major demographic shifts*, especially for older adults and cultural minorities and immigrants

  - *Access Issues*

    - *Ensure and monitor implementation of parity* between health and mental health insurance coverage

    - Expand the *use of technology* to engage people who are otherwise not willing, or able, to access care

    - *Assure that care is available to people who continue to lack insurance coverage* or with inadequate insurance coverage, including immigrants and undocumented aliens

  - *Quality Issues*

    - *Enhance integration of behavioral and physical health care*

    - Assure *widespread knowledge of state-of-the-art* treatment and rehabilitation

    - Develop adequate *monitoring and evaluation tools* and mechanisms that are population based

- *Retool the behavioral health workforce* and build it appropriately for the future demand for care, including:

  - Addressing the shortage of mental health professionals, especially for children, older adults, and minorities.

  - Addressing the need for enhanced clinical and cultural competence

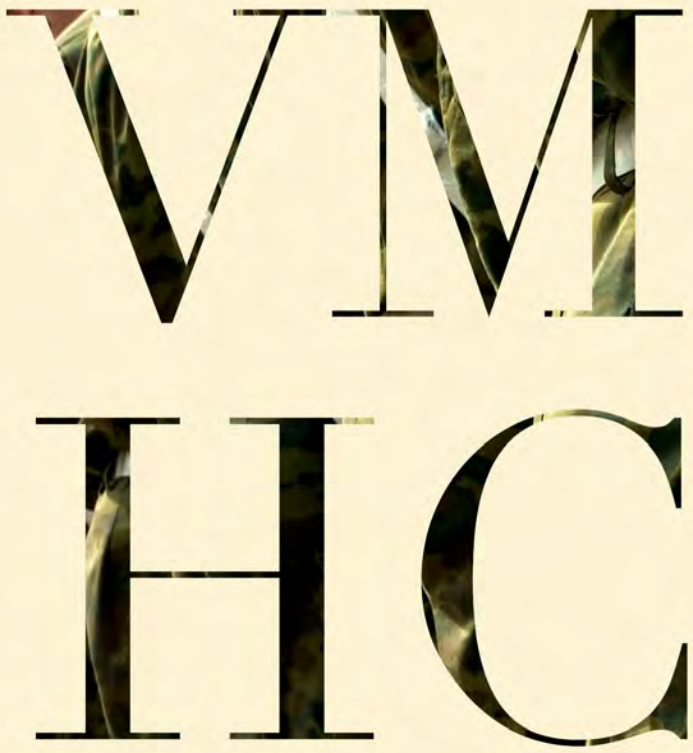
  - Expanding the use of peers, family members, and paraprofessionals

- *Provide family support* to assist families who are providing housing and other forms of care for people with mental illness

- Commit to *combat discrimination* against people with mental illness and educate the public about mental illness to foster better societal acceptance and integration

- *Overcome state and local financial and regulatory barriers* that prevent further progressive development of a comprehensive community-based system of care

Some of these recommendations are being embedded in the redesign of the behavioral health care system, while others have not been considered. As we continue to craft bold, far-reaching policy changes, we must use this extraordinary time to develop even bolder, more creative changes to achieve the promise of visionaries before us who imagined a society where *all* people with mental health needs are fully integrated in their communities with access to high quality, recovery-oriented mental health supports. This time is like no other, so we must use it wisely.



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— The NYSPA Report —
The Final Parity Rule – What NYS Should Do About It

By Barry B. Perlman, MD
Director, Department of Psychiatry,
Saint Joseph's Medical Center

On November 21, 2013, five years after the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the federal Departments of the Treasury, Labor and Health and Human Resources issued the final rule governing its implementation. Due to the fact that most health insurance plan years take effect on January 1st of a given year, this final rule will become broadly effective as of January 1, 2015. The final rule makes clear that the states will have the primary role in the enforcement of MHPAEA with the federal Department of Health and Human Service through its Centers for Medicare and Medicaid Services (CMS) having final authority over insurers in non compliant states. This time line gives interested stakeholder groups, such as the New York State Psychiatric Association and other professional organizations along with other organizations which advocate on behalf of persons with mental illness, 1 year to assure that a division devoted to Parity implementation is created within the Department of Financial Services (DFS), the successor agency which incorporates the charge of the previous Department of Insurance.

Only through the establishment of a dedicated bureau within the DFS will interested parties be assured that expertise is developed within the agency regarding the interpretation of this complex law and its regulations. The 13 page law and its accompanying final regulation of over 200 pages do not lend themselves to facile interpretation by persons who have not taken the necessary time to digest its nuances and complexities. For example, the regulations require that mental health/ addiction benefits offered by a plan which includes such benefits be no more restrictive in relation to the services offered on the dimensions of quantitative (QTL) and non-quantitative (NQTL) treatment limits than they are for the medical and surgical benefits offered. The 6 categories within which comparability of benefits are required include inpatient and outpatient services, both in and out of network if out of network benefits are offered for medical and surgical services, as well as for pharmacy benefits and emergency care.

The objective of having a bureau established within DFS can best be realized by gaining the support of the Governor and the Superintendent of DFS. Concerted action by a broad coalition of stakeholders will be required as was created in the effort to gain the passage of Timothy's Law, the New York mental health parity law, during the Pataki administration. As has been discussed in a previous NYSPA Report in Mental Health News (Summer, 2011, Vol13 # 3, p. 14), the nexus of the mandate in Timothy's Law and the parity requirements of MHPAEA, when mental health and substance abuse services are covered, create particularly powerful possibilities in NYS for those advocating on behalf of those with mental illness and will provide the fodder for consideration of plan violations to be considered in NYS by DFS. (It should be noted that the Final MHPAEA regulations do not apply to Medicaid Managed care plans as well as other specified and other federally sponsored health insurance plans which were addressed in a CMS Dear State Health Official and State Medicaid Director letter dated January 16, 2013.)

Given the mixed record of MPHAEA compliance by commercial insurers, a devoted bureau is self evidently needed. The final rule clarifies several areas of concern previously identified by advocates such as: 1) Intermediate behavioral services must be covered to the same extent that plans incorporate intermediate level of services for medical/ surgical conditions. 2) Residential treatment facilities for mental health and substance disorders must be covered as an inpatient benefit if the insurer covers either skilled nursing facilities or rehabilitation hospitals as an inpatient benefit. 3) Partial hospital or intensive outpatient mental health or substance use disorder services must be treated as a covered outpatient services if the plan covers home health care as an outpatient benefit. Passing judgment on the "comparability" of medical necessity reviews will be critical in preventing insurers from resorting to more stringent application of criteria in order to circumvent this law as will scrutinizing the bureaucratic processes to which they apply to the plans approval and utilization review processes. In each of the 6 categories, each incorporating a multiplicity of issues subject to a requirement of NQTL comparability, insurers may not apply more stringent processes to mental health/ substance use disorders than they do to medical / surgical benefits. Both advocates and the state share an interest in the vigorous enforcement of this law – for advocates it means assuring that their loved ones receive the treatment to which they are entitled through their health insurance policies and for the state it means assuring that insurers pay for the care for which their enrollees have contracted thus avoiding the shifting of costs to the public sector. Reaching the desired outcome from the robust application of the MHPAEA will require: 1) Forcing plans to disclose their medical necessity criteria, evidentiary standards, etc. and how they are applied to MH/ SA and medical/ surgical services. 2) Education of the interested public by advocacy and professional organizations about their rights under the law and about how to bring their complaints to the DFS, the NYS agency charged with protecting those rights under the law. That, therefore, is the reason we need to work towards the designation of a Parity enforcement bureau within NYS DFS.

Dr. Perlman is the Director of the Department of Psychiatry at Saint Joseph's Medical Center in Yonkers, New York and a past president, New York State Psychiatric Association.

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Practical Tips to Working With Managed Care

By Joe Ruggiero, PhD
Assistant Clinical Director
Addiction Institute of New York

With the changes to managed Medicaid, it is important for therapists to be ready to advocate for their clients and for the care they deserve. After over sixteen years of dealing with managed care, there are certain tips that might be helpful if you are new to the process of calling companies. Often this is a counselor's least favorite part of the job and making it easier can be useful.

1. When calling a managed care company, it is important to have an angle when asking for more visits. Calling managed care does help you define your goals concretely so that you can present them and also verbalize the progress the client has made. The therapist should be concrete and explicit about these goals (e.g., identifying certain triggers). If you speak in vague terms (e.g., client is struggling), the person you are speaking to may not have a sense of what you are working on with the client.

2. In general, the ideal scenario for getting more sessions is that the client is doing well and they are engaged in treatment but not well enough that they don't need further treatment at a certain level of care. This way the treatment is working but there is also a need for more contact and ongoing care.

3. Often clinicians are advocating for a certain level of care (e.g., intensive outpatient, outpatient rehab, etc). So it is important to understand why someone needs outpatient rehab as opposed to a twice a week recovery support group. Be clear why this is so and make a case for a certain amount of structure and support the person needs.

4. Involve the client. Clients should know what the implications are of their insurance company. For example insurance companies tend to be "unforgiving" of poor attendance and clients should know that this jeopardizes their treatment on multiple levels. There are times where clients may feel blindsided by the decisions of their managed care company. Therefore they should be informed of the process as it unfolds so that if treatment gets cut off, they will not be surprised or not prepared. If you feel a company is getting tighter about giving you more visits, it might be helpful for the client to know so that when they do need to end or transition to another level of care, they are ready. Companies may give you some time to terminate but at times it might just be a session.

5. Try to understand the criteria for levels of care. There are some companies that you learn will only give you a certain amount of IOP visits (20-30) for example and it's good to know that beforehand. If a company has a certain rigid criteria I have not found that challenging this has been helpful. For example I recently found that a company did not accept someone into inpatient rehab unless they had serious psychiatric or medical issues (though not serious enough to warrant inpatient psych or a medical unit). The former criteria of "failing IOP" which many companies use was not acceptable. When companies have very fixed timelines for more intensive outpatient treatment they usually don't go beyond the number of sessions allotted by the company.

6. Be prepared. If you aren't, it sounds bad. You should have access to very concrete information that you unfortunately may have to repeat over and over to different providers such as policy number, your facility tax ID, date of birth of client, etc. Clinically, a counselor may be asked to talk about how care will progress over time in the long term. While they often will not be held to this criteria they need to know what their discharge plan may be down the road.

7. So much has changed about inpatient substance abuse care. Many clients have a preconceived notion that they have to have inpatient to get better. However, it has gotten harder and harder for people to go inpatient. Clients can enter detox but only certain substances warrant this such as alcohol or benzodiazepines. With these substances, a medical professional needs to get vitals and the detox needs to be medically warranted. Often clients and family members feel they need it but should be prepared for a possible rejection.

8. Rehab stays are very difficult to get when using managed care. They are often time limited and do not go up to 28 days. A client does not tend to get approved for rehab if they have not tried outpatient first. There is some good reason for this because the client may stabilize with outpatient care. However once again clients and their families may be very disappointed by this.

9. Think long term. There are times where counselors may precert intensive outpatient treatment and exhaust benefits for ongoing care in the long term. While intensive care may help, clients may need to be in treatment over the course of a year and you want to make sure they can go to a recovery support group after intensive. A counselor needs to look at the long term trajectory for a client and recognize that their client will get better over time given the support.

10. Educate your client. Clients often will say, for example, I have 30 days inpatient benefits but they don't understand that these visits are granted if they are seen as medically necessary by the insurance company.

11. As clinicians and as supervisors we need to make our programs as flexible and realistic as possible to provide good care given the restrictions we are faced with. Clients for example may need to come part time for some of our day programs where there insurance is being tight. They may not be able to come as often but they will keep the continuity of working with their specific therapist.

12. There are times when managed care may ask for specific interventions such as involvement of family. It is important to make sure that this gets addressed because the next time a call gets made, there will be follow up.

Ensuring Humanity in Human Services Work

By Christine Schmidt, LCSW
Anti-Racist Alliance, New York City

As human services adopt more collaborative approaches through implementation of managed care, expansion of health homes, and other group treatment models, it is critical for mental health and human services professionals to understand racial oppression as an obstacle to mental and physical wellness. The structural and psychological impacts of racism affect us all—providers and clients. Yet the scourge of racism is often an invisible and silent "elephant" in the middle of the human services room.

Why Are We At a Critical Juncture Now?

With the advent of the Affordable Care Act and its requisite expansion of managed care and care coordination, accountability to provide quality and cost-effective services is the driving force for human services. Lost too often in the shuffle to control costs — an act for which agencies are accountable to governing bodies — is accountability to clients. Ensuring that our agencies are accountable to the clients must include bringing an antiracist approach to service.

What Does Racism in Human Services Look Like?

The most significant indicator of systemic racism is disproportionality—meaning that our services produce outcomes that disproportionately and negatively impact clients of color. Racial disproportionality shows up in all systems: foster care, criminal justice, special education, homeless shelters, and hospital emergency rooms—settings where people of color are over-represented as clients who need services that are not available to them through private providers. Often, we are too busy providing services to ask "Why?" and "Does it have to be this way?" Coming to understand the answers to these questions is complex, because it requires us to take a critical view of our society. It means coming to understand how structural racism is embedded in our history, in our current social services policies and in our psyches. As we examine our agencies' structures—their staffing, service practices, and institutional priorities—we can better understand how they produce biased results.

How Do We Apply an Anti-Racist Approach to Human Services?

Undoing racism begins by learning about racism, including learning the differences between racism, bigotry, diversity, and multiculturalism. Racism is the fusion of race-prejudiced attitudes with privileged access to power and resources. It has become embedded in our institutions, policies and laws.

We learn about colorblindness as the ideology that discourages us from confronting racism. Colorblindness is based on the idea that because racial discrimination is illegal, racism doesn't exist. We learn that in the United States we are all victims of internalized racial oppression. This means that our attitudes have been shaped over generations to reflect beliefs of racial superiority or racial inferiority.

Beginning to understand and discuss our internalized beliefs and attitudes is the first step towards personal transformation. Being able to understand how our beliefs and attitudes translate into expectations for ourselves, our clients and our agencies is another step towards dismantling racially unfair practices. We learn to organize strategically to change our agencies.

Making room for clients' voices to be heard about every policy and practice is the first step towards true accountability. For example, an agency with poor outcomes and a high level of end-of-month case closings could include clients in analysis of outcome data with the specific goal of improving services and reducing racial disparity. The agency might learn that decreased client response was triggered by clients' limited cell phone plans that lacked minutes at the end of the month. Case management could be adjusted to address clients' circumstances.

Understanding how to develop and maintain leadership—especially leadership among those previously marginalized—is crucial to creating more equitable practices. We learn how to recognize and confront micro-aggressions suffered daily by people of color. We learn to recognize when promotion and hiring practices are fair and when they result in racial bias. We learn when to take strategic risks to interrupt acts of racial discrimination. We

see Humanity on page 31

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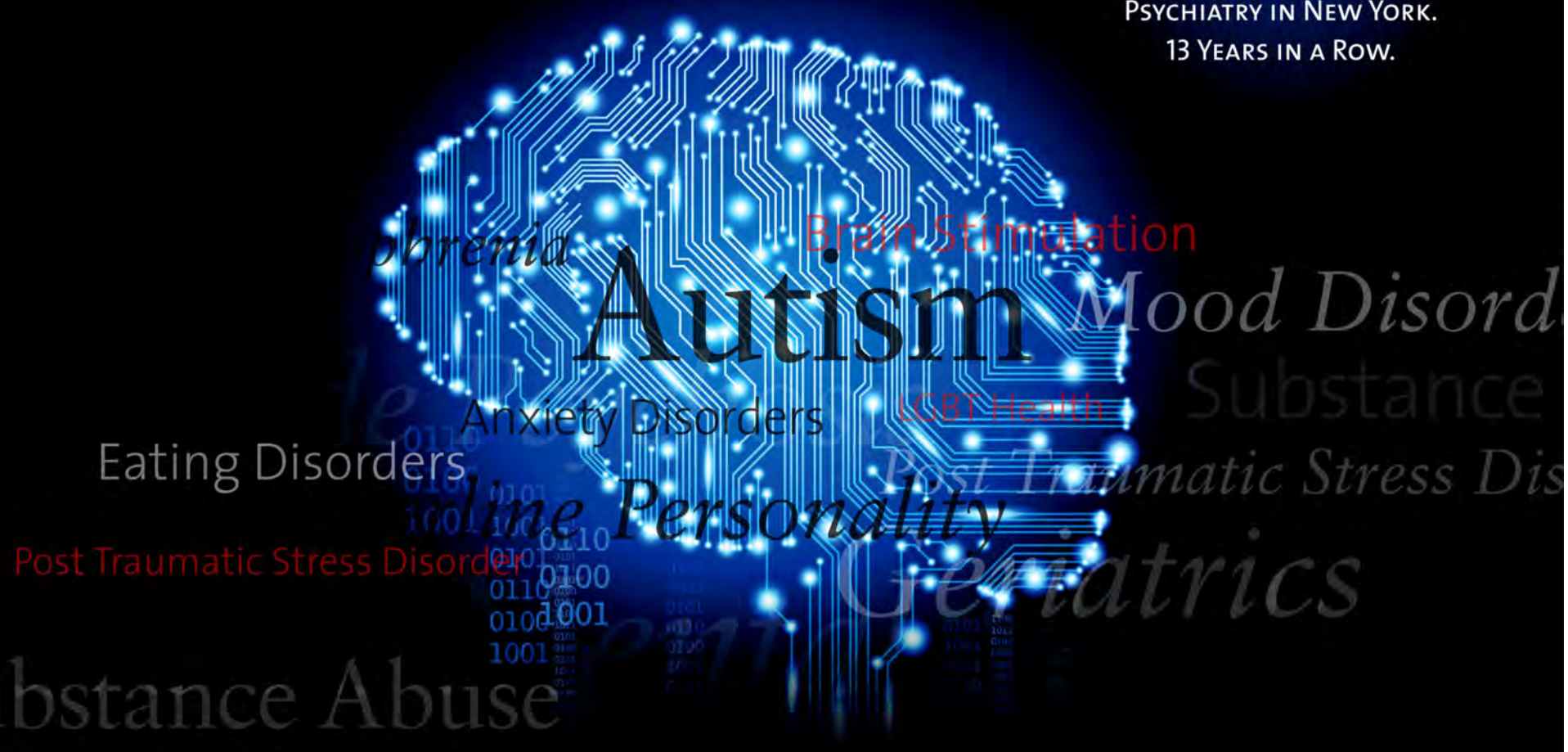

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Positioning for the New York State Managed Care Transition

By John Kastan, PhD, Senior Vice President, Strategy and Business Development, and Lauren Gasparine, Director of Human Resources, PSCH

Preparing your leadership and line staff for the "managed care transition," can seem daunting and perplexing. There is no simple formula that applies to providers in general, or certain types of providers, except in the broadest sense. Rather, it involves a critical assessment of strengths, challenges and opportunities in programmatic, administrative, financial and mission domains. Each of our organizations has a unique set of attributes, some of which likely help position us to move forward into uncharted territory and others which may themselves need to be "managed" in order not to become obstacles to progress.

It is very easy to get caught up in trying to map out every detail of the State's transition only to have the state change its timetable or the federal government decides to exclude certain services from the State's plan. Similarly, if you are not used to speaking with payer organizations such as health plans and BHO's, it is very easy to become confused about what reflects the industry in general and what's an idiosyncrasy of a particular payer.

Fortunately, while the pace of change seems rapid, the actual changes tend to be more incremental than you might imagine or fear. Complacency, however, is not an adequate response.

If you answer "yes" to one or both of the following questions, it may be a sign that you are not quite ready for the transition:

Do you look at all the changes that are occurring or being planned by government and payers, and say – I don't quite understand it but I'm sure government will make sure my organization survives? Can you articulate what distinguishes your organization from others that do the same thing you do?

So, get ready!

What follows are some selected activities that any provider organization can carry out to enhance its readiness and ability to embrace new opportunities.

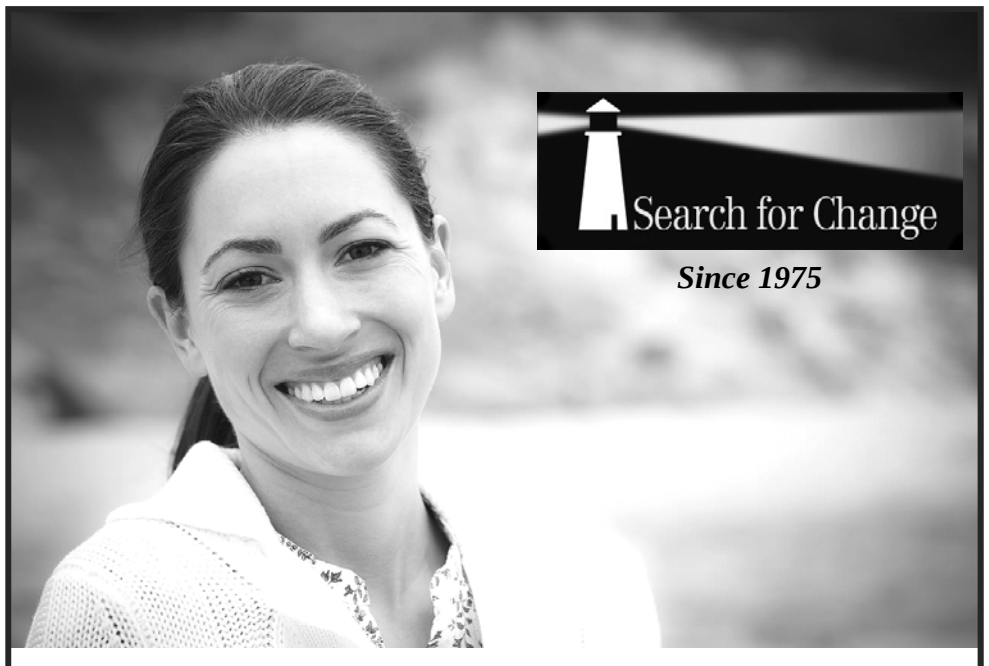
- Since financing models will change over time, it is important that your finance leadership becomes versed in the various payment models that exist. This includes the current fee for service systems involving CPT codes and APGs, as well as various partial risk approaches including case rates; gain-sharing; and the like. And, they should begin to school themselves on how to manage per member/per month payments.
- Your program leadership and your quality staff need to be concurrently thinking about the "value propositions" associated with managed care and population health, how that affects the way programs operate, and how you would "sell" them in an outcome oriented environment. For example, one of the major goals of the State plan (and managed care plans in general) is to reduce unnecessary emergency room and inpatient hospital use while helping clients function in the community as best as they can, with support, if needed. To the extent that your programs have been successful at this, document it, with solid data if possible.
- Develop approaches to providing "whole person" care to your clients and establish systems to measure and document these activities, including such simple things as improved access. Of particular importance is documenting efforts to integrate services with other healthcare organizations. Over time, there will be the expectation that you will implement models of services integration that require formerly autonomous organizations to work together. This will include identifying the practices and services you employ that support enhanced community tenure for consumers including pre-vocational and vocational services, social supports, housing related supports, and the like. In the NYS Plan, some of these will be included in Medicaid Managed Care in what are called 1915i-like services, referring to a Federal statute.

The more general point here is to look at what you are currently doing. Then, determine the extent to which it positions you to be effective in a care system that is less focused on producing visits, and more focused on measurable outcomes on a range of traditional clinical goals as well as day to day functioning and recovery. Further, your program development focus should be "how can we improve access to services so that they are available to clients when they need them."

In order to assess where things currently stand in your organization, here are a few things you can do right now:

- Walk through your agency as a consumer – does the environment and the procedures you have in place reflect your mission and create the kind of atmosphere that make you feel well-served as a consumer? Are there things you would change right now, regardless of how you get paid? Are there practices that seem counter to

see Positioning on page 28



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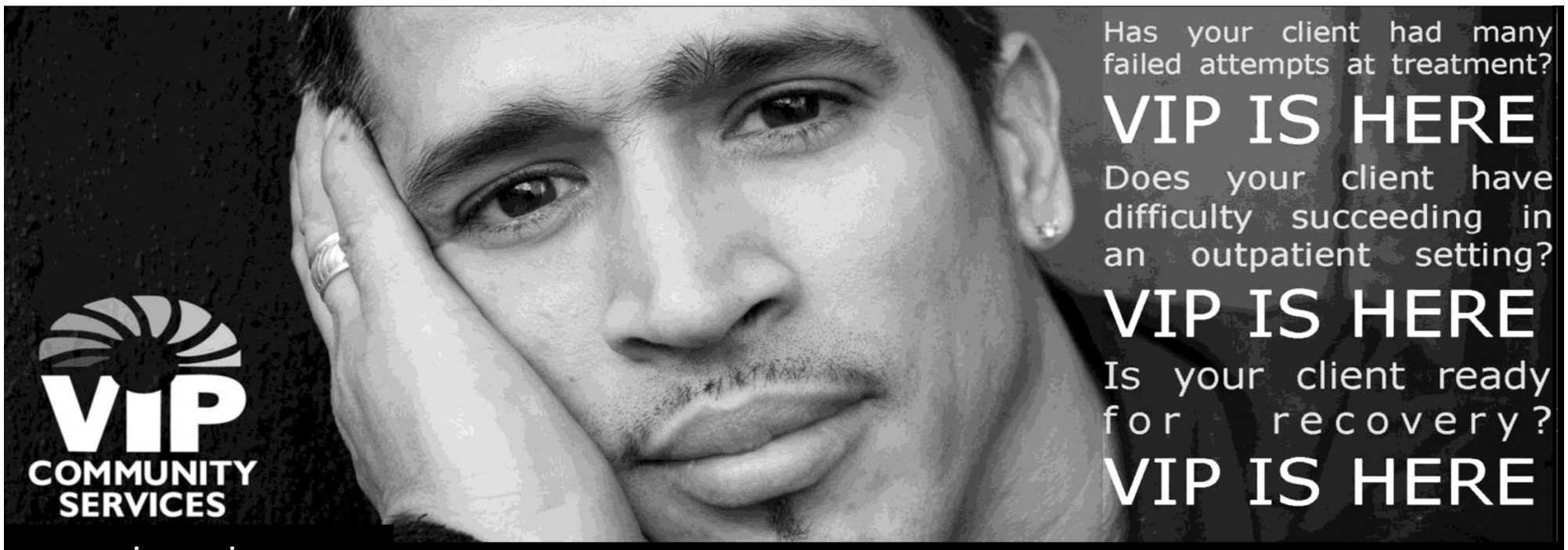

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Coordinated Behavioral Health Services, Inc. (CBHS) One Group's Pathway Toward Preparing for Managed Care

By Amy Anderson-Winchell, LCSW, CEO, Occupations Inc., Andrea Kocsis, LCSW, CEO, Human Development Services of Westchester (HDSW), Amy Kohn, DSW, CEO, Mental Health Association of Westchester County, Stephanie Madison, LMSW, CEO, Mental Health Association of Rockland, Alan Trager, LCSW, CEO Westchester Jewish Community Services (WJCS)

Coordinated Behavioral Health Services (CBHS), incorporated in 2012, is comprised of eight leading behavioral health and developmental disability nonprofit community-based agencies serving the Lower/ Mid-Hudson River Region of New York State, and providing services in Westchester, Putnam, Rockland, Orange, Sullivan, Dutchess, Ulster, Greene and Columbia Counties. CBHS has an invaluable partnership with New York Integrated Network (NYIN), a group of leading providers in the Developmental and Intellectual Disability field who are creating myriad innovative products and services. This article, however, will only focus on CBHS in the behavioral health space.

The five Behavioral Health agencies—Human Development Services of Westchester (HDSW), Mental Health Association of Rockland County, Mental Health Association of Westchester County, Occupations, Inc., and Westchester Jewish Community Services (WJCS)--are now forming an Independent Practice Association (IPA) to build a Multi-County Model to deliver the Triple Aim for people with behavioral health needs: improve patients' experience of care while improving their health and reducing the per capita cost of care.

The Context

Just a few years ago New York State announced it planned to move all Medicaid-funded services to managed care--which had potentially seismic implications for the people receiving services as well as for providers. Agencies needed to rapidly contemplate how to shift our focus and business model. For decades, these providers had developed valuable relationships and contracted with the "O's"—Office of Mental Health (OMH), Office of Alcohol and Substance Abuse Services (OASAS) and Office for People with Developmental Disabilities (OPWDD) – and we were now faced with the prospect of our primary business being delivered through contracts with managed care companies (MCO's). This move to managed care was a cost cutting/cost control effort. Many questions were raised for all providers: did the new rates established in the multi-year roll out of clinic transformation get marginalized; how do we market to the MCO's, and if we are successful, how would our agencies stay in business with even lower rates than under clinic restructuring; will this transition to managed care really give us more flexibility and allow us to be creative and more responsive to the people we serve, or will this simply boil down to needed cost-cutting; was this effort to reign in unsustainable Medicaid costs going to totally disrupt the delivery of services as we know it—and who among us would survive?

New York was also creating "Health Homes," a fundamental and important new service that would explicitly provide care management to all its customers… and potentially play an important role in what services were used (and what providers were utilized).

On the heels of the 2008 Great Recession, the government would likely have little if any funds available to facilitate this transition, and this transformation was occurring at a time when there was an expanded pool of people needing services.

On the federal level, The Affordable Care Act was now being implemented with its goals to improve access to quality care and to reform a stagnant system. The Institute for Healthcare Improvement called for health care systems to simultaneously address the "Triple Aim." *Noble goals that we should all embrace—but how to do it under a new and unfamiliar system!* At the same time, and not unrelated, there was increasing attention to improving the overall health care in the United States by paying for outcomes and not procedures. The concept of providers sharing risk – benefiting financially from achieving a defined set of quality outcomes but also being penalized for failing to achieve those goals—was a very new and challenging prospect for behavioral health providers.

Our Response

As providers, we had absorbed many challenges and changes over the past decades but this was different – radically and disruptively different. The usual tweaks and tools would no longer suffice. Each agency tackling the challenges in their habitual way would no longer work.

The five behavioral health agencies decided to meet and assess whether as a group we could address these challenges, changes and opportunities. Partly driven by concerns about self-preservation, we also wanted to address the opportunity to implement the federal strategy to identify the heavy users of more expensive inpatient and emergency department services and connect them proactively to those that are less expensive, and often more clinically appropriate, and create more person-centered services (perhaps less burdened by traditional regulations).

In 2012, the five organizations provided behavioral health services to an unduplicated 10,000 individuals. Services include a broad range of clinical, housing, supportive and recovery-oriented behavioral health services.

Although the group was convened based on some familiarity with each other and with our respective agencies, we did not all know each other well. We needed to confirm that we shared values, were mission-based and could trust each other. Two years into the process we continue to build trust and strengthen our partnership.

This group quickly became a robust learning collaborative: to identify the areas about which we needed to educate ourselves, to quickly develop expertise in those areas and to remain scrupulously on top of information.

With our increasing knowledge, we recognized that in the managed care world of "covered lives" and "depth and breadth of services" this group needed to become more than a learning collaborative. Guided by expert consultation, this informal group created a strategic alliance… and then formed a legal not-for-profit corporation in August 2012.

Organizations that were applying to be Health Homes approached our individual agencies to be providers in their Health Home. We responded as CBHS, underscoring our presence in the market.

As a consequence of our significant role in the local health homes, we tasked ourselves to become experts in care management. As CBHS providers, we will insure that our staff utilize best practices and adhere to the highest standards, regardless of "agency of origin."

With Health Homes 'launched' and our care management services active, we continued to do business in the current environment while preparing for the world-to-come. We are actively meeting with MCO's and health care providers to gain a better understanding of their needs and what CBHS and they can bring to the table

While remaining mission-centric and keeping our eyes on the needs of the people we serve, attention is required to implement leaner, more efficient work processes, establish a competitive advantage, and solidify reputations as go-to service providers of high quality efficient services. We created an extensive committee structure to dive deeper into metrics, care management, new products, financial models, and information technology.

In order to plan for negotiating with MCO's and other funders, we have created an IPA. As we write this article, we are in the midst of addressing the issues of clinical and financial integration. Integration as an IPA will allow us to negotiate as one organization—an organization that provides a broader array of services to more people than any one of us could offer individually. We have also developed a CBHS brand that compels us to maintain the highest standards, deliver quality care, and do it efficiently.

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The Process...and the Future

As a group of individual providers coming together we have had to address the issues of different corporate cultures, different management styles, different services and fidelity to one's own agency and doing things "that way"…not to mention 5 CEO's used to running their own shops finding a way to make this work.

As a collective, learning to manage risk, create new business models, and partner with folks "on the other side of the counter" brings its own challenges, including addressing the need to consider business partners that bring deep pockets—and different lenses—to better compete in the new world.

We have engaged with each other and consultants to learn about healthcare policy and finance, and the complexity of business models that are now shaping our industry. We are poised to partner with managed care organizations and other providers to implement our concepts to deliver the outcomes of the triple aim. There is risk in these initiatives for accomplishment and for failure. We have jumped in with perhaps equal doses of commitment, hubris, humility and fear. We recognize how much we do not know - but hold onto a steady, even renewed determination to play an active role in this transformation. We are certain that we will continue to learn from our experience and will utilize this learning to inform our practice of the future.

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Jorge R. Petit, MD Elected New MHNE Board Chairman
Dr. Peter Beitchman Hailed For His Many Years of Dedicated Service

Staff Writer
Behavioral Health News

This June Dr. Peter Beitchman will retire as Chairman of the Mental Health News Education, Inc. (MHNE) Board of Directors after seven years of dedicated service. MHNE is the nonprofit organization that publishes *Behavioral Health News* and *Autism Spectrum News.* Jorge R. Petit, MD, will succeed Dr. Beitchman as the new MHNE Board Chairman.

Dr. Beitchman joined the MHNE Board in June of 2006, serving as Treasurer for two years, then as Chairman since June of 2009. Dr. Beitchman is best known for his many years as Chief Executive Officer at The Bridge in New York City, an award-winning behavioral health organization which provides many vital services to the behavioral health community. Dr. Beitchman has worked and advocated within New York's mental health system for more than 45 years actively serving as a board member of a number of advocacy organizations as well as having held key public mental health policy positions. He has been an Adjunct Assistant Professor at Hunter College's Silberman School of Social Work and the Columbia University School of Social Work.

Jorge R. Petit, MD

Dr. Peter Beitchman

According to Ira Minot, Founder and Executive Director of MHNE and Publisher of Behavioral Health News, "Dr. Peter Beitchman has played an instrumental role in MHNE's success and development over the past eight years. Early on, he recognized the value of our newest publication, *Autism Spectrum News*, which premiered in 2008, and through his leadership helped to expand board membership to include members of the autism community. Dr. Beitchman was also instrumental in MHNE's recent transition from *Mental Health N*ews to *Behavioral Health News,* a process which was several years in the making. We are deeply grateful for his many years of dedicated service to MHNE."

Jorge R. Petit, MD joined the MHNE Board of Directors in the fall of 2008 and he was elected as incoming Chairman Elect in June of 2012. Dr. Petit came to MHNE with a vibrant background within the mental health system throughout New York State. Some of the many prominent positions he has held include: Former Associate Commissioner for the Division of Mental Hygiene (DMH) in the NYC Department of Health and Mental Hygiene (DOHMH); he Vice Chairman and Acting Chairman of the Department of Psychiatry at North General Hospital, an affiliate of Mount Sinai Medical Center and was the Director of the Psychiatry Emergency Services at Mount Sinai Medical Center. Dr. Petit is currently the President and Founder of Quality Healthcare Solutions Group (QHS), which provides training and consulting services for healthcare systems including community-based behavioral health agencies, hospital psychiatry/ behavioral health departments, and local and state regulatory entities. He has worked with the NYS Office of Mental Health (SOMH) in a complete restructuring of patient care services at Kingsboro Psychiatric Center in Brooklyn, New York; during 2011 he served as the Interim Director of Psychiatry at the Institute of

see New Chairman on page 28

Enhancing Behavioral Care Services Via Managed Care

By Stella V. Pappas, LCSW-R, ACSW and Sandy Forquer, PhD
Optum

The President's Freedom Commission on Mental Health, under President George Bush and lead by former New York State Office of Mental Health Commissioner Michael Hogan, has stated "the mental health system is broken." Great strides have been made in the decade since the Commission's report in 2003. The Affordable Care Act is now the law of the land, and it expands on the health care reform from the Mental Health Parity and Addiction Equity Act of 2008, which requires parity for behavioral health. This fundamental change in insurance coverage, along with some tragic current events such as Sandy Hook, has catapulted behavioral health care to the forefront of our national conversation. In our own state of New York, Governor Cuomo has empowered a Medicaid Redesign Team (MRT) to increase quality and efficiency in the New York Medicaid program within the rubric of the triple aim: 1) improving care, 2) improving health, and 3) reducing costs. New York State is moving toward "Care Management for All." Under this mandate, the vast majority of Medicaid-reimbursed services will be moved away from a fee-for-service model to a managed care model.

A Provider Perspective
By Stella Pappas, Executive Director, New York City Behavioral Health Organization (moved from provider field to managed care in 2013)

Before I go into the reasons for this change, I should first acknowledge that consumers, providers, and managed care companies are all apprehensive as they, together, wade these unchartered waters in New York Medicaid behavioral health. As a longstanding provider, I know that the predominant provider view has been that managed care is:

1. Exclusively bottom-line focused

2. Does not understand behavioral health

3. Develops "best practices" in isolation and then mandates them

4. A payer and not a partner

Having moved from the provider world to the managed care world in only the last few months, I have found much to my surprise, that quite the opposite is true on each of those points. Furthermore, I have been specifically surprised by:

1. The number of behavioral health professionals (aside from MDs) employed by Optum at all levels (sales, management, etc.) – MSWs, PhDs, PsyDs, etc.

2. The incredibly deep commitment to recovery and use of peer services as a means to improving both health and behavioral health outcomes.

3. The corporate values being much aligned with the consumer-based organization world from where I have come.

4. The use of an internal research team that reviews emerging best practices, as well as an internal clinical group that, with significant peer representation, develops clinical guidelines based on the literature. These are vetted with both our external policy advisory forum and our consumer advisory board which have representation from across many disciplines and geographic locations. For example, Optum has recently published an article in the December issue of Psychiatric Services that describes the first clinical level of care guidelines for peer services.

5. The strategic partnerships with providers across the country around pay-for-performance contracting and, more recently, episodic and bundled payments. Optum now has such contracts in place in 22 states.

So why is there a movement from fee-for-service to managed care? We are all aware of the research that demonstrated that persons with mental health and substance abuse disorders die 25 years earlier than those without those disorders. We know that many of these individuals lack basic primary health care.1 We know that their emergency room utilization, hospitalizations, and uncoordinated care for chronic health conditions and end of life are huge drivers of cost. The lack of integrated services and strategies, often due to lack of information and payment support, feed the lack of coordinated services. Managed care has developed strategies to help break the readmission cycle and will work closely with its network providers to address these cost drivers, while improving integration of care and recovery-based outcomes. The shift to managed care and its approved waiver will allow the Department of Health to move toward care integration and allow for payment of previously non-reimbursable services. Also, the role of the health homes will be well-facilitated through managed care.

A Managed Care Organization Perspective By Sandy Forquer, Senior Vice President, Government Programs, Optum (moved from government field to managed care in 1995)

Managed care functions have changed as the care models have changed. When I started in managed care in 1995 after serving as deputy commissioner for the New York State Office of Mental Health,

see Enhancing on page 31

Bullied By Addiction

By Lori Ashcraft, PhD, Executive Director, Recovery Innovations Recovery Opportunity Center

It's sort of embarrassing to have an eating disorder. It seems like such a silly problem to have. "Just stop it!" Well, unfortunately, it's not that easy. In fact it is not easy at all. Other addictions can be avoided, not easily, but one can live quite successfully without smoking or alcohol or drugs or gambling or even sex. But one has to eat to survive so there is no avoiding it. I hope my story will help others find ways of overcoming eating disorders and gain some freedom from the preoccupations that rob us of a full and meaningful life.

Like most addictions, an eating disorder serves to buffer us from tough times that come our way – first by comforting us, but then by preoccupying us with compulsions that are usually more painful and frustrating that the reality we hoped to cushion. Worst of all, we can't make it go away.

How did this happen to me? Well, that's a good question. In my case, I don't know what came first, the devastation of depression and the disabling effects of anxiety, or the eating disorder that has haunted me and bullied me for most of my life. I'm guessing the depression and anxiety came first and I began to use food as a way to comfort myself and remove me a step or two from painful situations.

Lori Ashcraft, PhD

As far as I can tell the preoccupation with food started when I was 10 years old. It was a tough year. My brother was born; I started my period, had my tonsils out and was sexually abused by someone close to me. Whew. This was also the year that I went from being a happy go lucky skinny little kid to a chubby prepubescent girl – moody and worried and sad.

When I was the skinny kid, mom always tried to get me to eat more- I was her only kid and since she had barely survived the great depression, food was a symbol of many things for her – love, health, wealth, and well being. If you ate what she fixed, that meant that you loved and respected her and that you accepted her gifts of food with gratitude. So I began to eat a lot to please her, and pleasing her became very important since my new baby brother (who I later came to love with all my heat) was soaking up all the attention. Also when I was sad and worried, mom's prescription was always, "Eat and you'll feel better." So I took her at her word.

Soon I was chubby and feeling self conscious and ashamed because I was fatter than the other kids. This is when I first felt the effects of the double edged sword: I could eat and feel the immediate comfort of being really full and make mom happy. Or not eat, make mom worried, but at least feel like I had some control over what was happening to my expanding body. Eating actually did make me feel better. I know now that it was because of the high doses of carbohydrates flooding my system that elevated my mood. But these temporary elevations soon dropped below the line when I felt fat and ashamed.

Yoyo dieting, diet pills, and a string of diet plans later, I became a fully fledged food addict. I was one of those people who do not meet the specific criteria for the two defined disorders, Anorexia Nervosa and Bulimia. When this happens people like me are given a diagnosis of an *Eating Disorder Not Otherwise Specified (EDNOS)*. Over one-half to two-thirds of people diagnosed with eating disorders fall into the category of EDNOS. More people are diagnosed with EDNOS than Anorexia Nervosa and Bulimia combined.

EDNOS is not less serious that the specific disorders. We have all the same negative psychological, social, and physical consequences as people who are diagnosed with Anorexia Nervosa or Bulimia. The only difference is we bounce around with a broad range of symptoms that may change in degree and duration. This unpredictability makes us jumpy and provides many opportunities for false hope of recovery.

So how does this affect my life? The affects are pervasive, but perhaps the most disabling aspect is the obsession with all things related to eating – what I ate, what I plan to eat, what I hope I don't eat, what I can't wait to eat, and how bad I feel after I eat due to weight gain. This takes up a lot of brain space and makes it hard to concentrate. I have had high level jobs most of my career, and many times I've sat in meetings where important decisions were being made. It's often been a struggle to participate from my most intelligent self because of the preoccupation with what I ate, what I hope I don't eat, what snacks are still left.

There are self help groups for people

see Bullied on page 30

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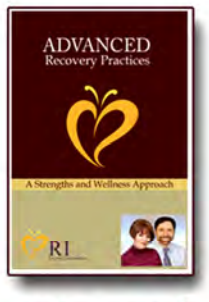

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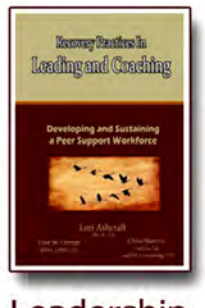

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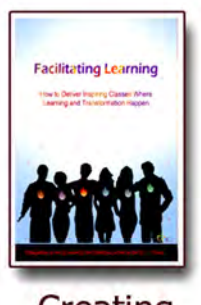

Creating Dynamic Classrooms

Keeping Recovery Skills Alive

Carmen Collado Elected Co-Chair of NYS Board for Social Work

Staff Writer
Behavioral Health News

Jewish Board of Family and Children's Services (JBFCS) recently announced that Carmen Collado, Assistant Executive Director, and Chief Government and Community Relations Officer, has been elected as Co-Chair of the New York State Board for Social Work. She was appointed to the Board by Governor Cuomo and elevated to Chair by her peers.

In 1891, medicine became the first profession licensed by the New York State Board of Regents. Since then, New York's unique system of professional regulation, recognized as a model for public protection, has grown to encompass 800,000 practitioners in 50 diverse professions.

Social workers are trained to provide a variety of services, ranging from psychotherapy to the administration of health and welfare programs. They work with human development and behavior, including the social, economic, and cultural systems in which people function. New York State offers two professional licenses to social workers: Licensed Master Social Worker (LMSW) and Licensed Clinical Social Worker (LCSW). The

Carmen Collado, LCSW

NYS Board for Social Work oversees licensing as well as disciplinary actions when necessary. As Co-Chair, Carmen will be integral in setting schedules and coordinating information from all Board members.

New Chairman from page 26

Family Health — a federally qualified health center with sites in Manhattan, Bronx and Mid-Hudson valley area; and currently is the Settlement Agreement Compliance Coordinator for Kings County Hospital Behavioral Health Services.

In addition, Dr. Petit is a member of the American Psychiatric Association (APA), American Association of Community Psychiatrist (AACP), American Association of Emergency Psychiatrists (AAEP) and is a past member of the NYC Mayor's 9/11 Medical Work Group and a prior advisor to the NYC Human Services Council on their Mental Health Disaster Preparedness Committee.

Dr. Petit earned his Medical School Diploma from the University of Buenos Aires, Argentina in 1991, completed his Internship and Adult Psychiatry Residency at Mount Sinai Medical Center's Department of Psychiatry, and his Public Psychiatry Fellowship at Columbia University/Psychiatric Institute—with field placement in Bellevue Hospital Center's Bilingual Treatment Program and Outpatient Commitment Program.

According to Dr. Peter Beitchman, "Jorge has a wealth of knowledge and experience with so many aspects of the behavioral health world. He is a noted author and educator who has been honored for his leadership as well as his work as a bilingual, bicultural leader in bridging the gap of disparities for Latinos in the United States. I know that I am passing the Chairman's torch to a leader who will be of enormous help in expanding the vital educational efforts of MHNE's two publications, *Behavioral Health News* and *Autism Spectrum News*.

David Minot, Associate Director of MHNE and publisher of *Autism Spectrum News* asked Dr. Petit about his vision for the future as MHNE's new Chairman. "What do you believe will be the biggest challenge in guiding MHNE ahead in the coming years?"

Dr. Petit stated, "The changing healthcare environment, at the federal and state levels, as well as the upcoming change in city government pose serious challenges, as well as opportunities, for the mental health, chemical dependency, and autism community we currently target. As the new chair of MHNE I feel we must strive to be at the forefront in communicating effectively and consistently about the impact these changes will have on our community of consumers, families and providers—as well as expand the reach of our vision to embrace overall health matters writ large. I envision MHNE as continuing to grow and be even more highly valued as the trusted source of clear, unbiased and serious content that promotes the advances of recovery and resiliency in our communities. In the coming months and years, we will make every effort to showcase best- and emerging-practices in mental health, autism, substance use prevention, treatment and advocacy. We will make additional efforts to expand our coverage and provide valuable education in the areas of general health and intellectual disabilities. The growth and future of MNHE must transition to a more holistic approach to health, including wellness

see New Chairman on page 31

Advancing the Goals from page 1

Medicaid. Despite its checkered history, they see managed care as a virtual panacea—as an instrument that can be used to improve care, improve health and mental health, and also contain costs—the "triple aim" as it is called.

For example, New York State created a Medicaid Redesign Team shortly after the election of Governor Andrew Cuomo, and it in turn created a Behavioral Health Workgroup. It "developed principles and recommendations for moving behavioral health services into managed care." Here are its "guiding principles:

- Coordinated care
- Integration of physical and behavioral health services
- Recovery oriented services
- Patient/consumer choice
- Protection of continuity of care
- Ensure adequate and comprehensive networks
- Tying payment to outcomes
- Track physical and behavioral health spending separately
- Reinvest savings to improve services for behavioral health populations
- Address the unique needs of children, families, and older adults."

"In an effort to ease the impact of transition, a two-phase transition was planned…." In phase 1, behavioral health organizations (BHOs) were put in place to manage access to inpatient treatment, to promote good discharge planning, and to shift away from a fee-for-service payment system. In phase 2, behavioral and physical health care will be managed by "risk bearing Qualified Mainstream Managed Care Plans and Health and Recovery Plans (HARPs)." (The quotes above are from NYS OMH's website, www.omh.ny.gov/omhweb/bho)

To me it is striking that the guiding principles of behavioral managed care in New York State do not include the primary goals for community mental health that I mentioned before. Instead it is a list of ways of doing things that presumably will have beneficial outcomes. Coordinated care, integration of services, recovery orientation, etc. are all supposed to make life better for people with psychiatric disabilities.

Will they? Maybe they will. But it is equally likely, it seems to me, that putting in place highly complex systems of behavioral managed care will leave the humane reasons for creating them behind as a myriad of unanticipated problems of implementation crop up.

For example, the call for coordinated care is not new. It goes back at least to the end of the 1960s; but judging from the unending repetition of calls for coordination, not much progress has been made in achieving it. Why? Because it depends on busy (often overburdened) people with diverse goals and objectives communicating with each other, learning to see things from each others' points of view, making the compromises necessary to work together, and maintaining working relationships over time despite turnover of personnel and the personal quirks that make some people congenial and others hostile. Before I retired, I kept a sign over my desk that said, "Collaboration is an unnatural act committed by non-consenting adults." Still true, I'm afraid. The new solution? "Meaningful use" of electronic case records. Maybe, but I'm skeptical.

So, here's my pie-in-the-sky suggestion. Medicaid managed care arrangements should be judged by answers to these four questions:

- Does this system result in more people with psychiatric disabilities having safe, stable housing?
- Does this system promote better health and increase life expectancy?
- Does this system result in more people developing lives that they find satisfying and meaningful?
- Does this system promote integration into mainstream society?

If Medicaid managed care can make life better for people with serious, long-term mental illness, great. But if not, let's dump it before it makes life worse.

Michael Friedman retired as Director of the Center for Mental Health Policy, Advocacy, and Education in 2010. He continues to write frequently on mental health policy issues. His writings are collected at www.michaelbfriedman.com. He can be reached at mbfriedman@aol.com.

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encouraging a wellness orientation among your clients?

- Follow a "charge" through the organization. Are you comfortable that your revenue cycle management is efficient and compliant?
- Meet with a few major referral sources and/or receivers and review protocols and how the changes such as Medicaid managed care expansion, health homes, etc. will affect the referral flow.
- Among your medical/clinical staff, is there a person-focused collaborative spirit that is collegial and responsive to client needs? Are clinical resources employed rationally, keeping in mind the scope of practice, cost and skills each type of clinician brings to work? Have you considered how peers and non-licensed staff can support service goals?

Because the velocity of change is increasing, planning and performance need to be embedded in day to day leadership, and the organization needs to be more nimble and more responsive to changing imperatives, while retaining a sense of purpose through shared sense of the mission and the values of the organization.

see Positioning on page 29

Education from page 12

the suggestion of one of the field based presenters, an opportunity arose to add an additional WebEx on "managed care in NYS" presented by a senior State regulator. The WebEx was added to the regular syllabus and was opened to a much broader audience. Over 200 individuals registered for this event which was coordinated between Albany and NYC. Class participants were exclusively accorded panelist status by permitting them to interact with the presenter through the chat box function.

Attendance at all sessions hovered at about an 85% average with 100% notification if personal circumstance did not permit attendance. All participants were asked to submit an anonymous semester-end survey to gain feedback. On quality measures most students rated the instructional quality as good to exceptional.

- 85% agreed that the sessions provided new and valuable information about the ACA
- Material presented was rated as significantly improving students work capacity
- Students indicated that they would recommend attendance to colleagues
- 60% of the class felt that WebEx presentations were as engaging as in class sessions

Interestingly, and perhaps mindful of the need for transformative change, strong endorsement of organizational change dynamics was seen.

Final projects were designed and implemented within the participating organizations Participants were encouraged to form working groups for the purpose of project design encouraging collaborative behavior and cross communication.. These projects included:

- Incorporating peer engagement support in ambulatory care settings
- Incorporating collaborative care focused on medical co-morbidity
- Developing an in-depth partnership with an FQHC to integrate behavioral and medical integration
- Developing a partnership between the MCO and HH to broaden the base of referrals across systems
- Developing medical access models for veterans not eligible for VA services due to discharge status

Clearly, these projects reflect the ACA goals toward integration and innovation of care. While it is premature to contemplate how sustainable these projects will be over time, it is likely that as new emerging payment models take hold forward transformative systems movement will "follow the money" and be seen as essential to survival.

Lessons Learned:
Future Directions

There is a growing understanding among agencies and seasoned professionals that the transformative process launched by the ACA will require new skills and an understanding of new technologies to be effectively implemented. A mixed instructional model utilizing team teaching consisting of faculty and field based professionals is effective, can be crafted to maintain instructional quality, and will promote buy-in. A final project model can be helpful in implementing actual change at the agency level resulting from educational processes.

The curriculum, as it responds to participant feedback, should incorporate presentations from medical professionals on integrative principals and sections on organizational change should be expanded. As a final note, during a meeting of MCO leaders hosted by the Silver School and the McSilver Institute, the MCO leadership noted two other important areas that they are focused upon as managed care takes the reins of Medicaid based healthcare. These are the need for more inclusive partnerships among providers to facilitate specialty care and support service to their members who have diverse and complicated needs, as well as the need for providers to develop medical literacy regarding medical co-morbidities among their staff at all levels.

Positioning from page 28

Regardless of the details of the managed care transition, the above actions can help you start your organization on the way.

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Collaborative Care from page 1

Many who are referred don't go. Others may receive an insufficient number of visits or ineffective forms of therapy, leaving big opportunities to close the gaps between what we know and what we do.

One way to help close these gaps is for psychiatrists to work more closely with our colleagues in primary care using a collaborative care approach. Originally developed and tested by Dr. Wayne Katon and colleagues at the University of Washington in the early 1990s, collaborative care has been examined in the treatment of depression and anxiety disorders in more than 80 randomized, controlled trials and has consistently been found to be more effective than care as usual. In such programs, psychiatrists work closely with primary care physicians and mental health care managers (usually a licensed clinical social worker, nurse, psychologist, or therapist). Each team has a designated psychiatric consultant who provides systematic treatment recommendations on patients who are not improving as expected.

Effective collaborative care programs follow the established principles of chronic illness care including measurement-based care, treatment-to-target, and stepped care. Each patient's progress is closely tracked using validated clinical rating scales (for example, PHQ-9 for depression), analogous to how patients with diabetes are monitored via regular HbA1c tests. Treatment is systematically adjusted if patients are not improving as expected. Such adjustments can often be made by the primary care treatment team, with input from the psychiatric consultant. This type of systematic treatment-to-target can overcome the clinical inertia that is often responsible for ineffective treatments of common mental disorders in primary care. The psychiatric consultant typically focuses in-person assessments on patients who present special diagnostic or therapeutic challenges. Patients who continue not to respond to treatment, who have an acute crisis, or who prefer to see a psychiatrist in traditional practice are referred to appropriate specialty mental health care.

In Washington State's Mental Health Integration Program (MHIP), for example, which was designed to help low-income or safety-net populations gain access to quality mental health care, psychiatric consultants typically support primary care–based care managers with active caseloads of about 50 to 100 patients. For patients who suffer from anxiety, depression, or bipolar disorder, most of the consultation is done directly with the care manager who then passes on psychotherapy and/or psychotropic recommendations to the primary care physician. Patients who are not improving or those with more serious forms of mental illness can be prioritized for a face-to-face or televideo consultation with the psychiatric consultant who then provides advice on an appropriate treatment plan. Using this collaborative care approach, MHIP has served over 35,000 patients in more than 148 primary care clinics statewide with the support of five FTE psychiatric consultants, a reach that would be impossible in a more traditional practice model, especially in rural areas.

Collaborating with our colleagues in primary care can substantially improve access to mental health care and create a more patient-centered care experience for patients who often have both mental health and acute or chronic medical problems. Closer collaboration may also help our patients with more severe mental illnesses such as bipolar disorder or schizophrenia. These patients often receive most of their care in community mental health centers and other specialty mental health programs where a psychiatrist is often the only physician they will see. Research from the United States and several European countries has demonstrated that patients with such chronic and persistent mental disorders die 10 to 25 years earlier than those without mental disorders, most often not from their mental illness but from health risk factors such as smoking and obesity and from inadequately treated hypertension and diabetes, sometimes worsened by the antipsychotic medications we prescribe. This is a situation where we need help from our primary care colleagues.

When behavioral health problems are effectively treated with collaborative care, patients experience improved quality of life, better self-care, better adherence to medical and mental health treatments, and better overall health outcomes. Evidence on collaborative care also suggests that these programs not only improve care at the individual and population-based levels, but also they can lower total health care costs. In the language of health care reform, this is called achieving the "Triple Aim." For psychiatrists who enjoy working in teams and working closely with their nonpsychiatric physician colleagues, collaborative care presents a wonderful opportunity to bring their expertise to help a larger population of patients.

Jürgen Unützer, MD, is Professor and Vice-Chair of Psychiatry and Behavioral Science at the University of Washington. Jeffrey Lieberman, MD, is Professor and Chair of Psychiatry at Columbia University and President of the American Psychiatric Association.

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Transformation from page 13

antipsychotic medications: assertive community treatment, substance use disorder treatment, cognitive-behavioral therapy, supported employment, skills training, family-based services, and weight management interventions. Studies have shown that most people with schizophrenia are not receiving all these potentially beneficial services. How will HARPs and other managed care plans and Health Home care coordinators and service providers assist all patients who need and want these evidence-based practices to receive them? How will the system expand specialized models that serve individuals early in the course of illness? Another example is medication-assisted treatment for opioid dependence. We in New York City are experiencing dramatic increases in the number of people using and becoming dependent on opioids – whether prescription painkillers or heroin. The most effective treatment for opioid dependence involves medications such as methadone and buprenorphine, coupled with counseling. We estimate that as many as half of those who may benefit from treatment are not receiving it. How will the new system expand capacity and access?

Improving how behavioral health is addressed in primary care. While much worthy attention is being placed on improving the system of care for those with the most serious behavioral health conditions, we must keep in mind that the MRT Workgroup rightly called for improvements in how our medical system identifies and helps manage mental health and substance use problems more broadly. Such conditions -- depression, anxiety disorders, alcohol and drug misuse -- are very common, and poorly addressed, in primary care. When we at the New York City Health Department examined the leading causes of poor health in our city, we found that depression and alcohol use were two of the top four. Primary care practice is undergoing its own transformation to better manage chronic conditions like diabetes and cardiovascular disease. This transformation into "patient-centered medical homes" entails increasing use of health information technology, standardized screening and management protocols, team-based care that includes counseling and support services for patients, and specialty consultation when needed. These are the necessary components for effective depression and substance use care as well. Expectations for behavioral health outcomes should be integrated into primary-care oriented managed care performance monitoring, and clinical providers should be supported in developing behavioral-health-specific capacity, such as collaborative care for depression, screening and brief intervention for alcohol use, and buprenorphine prescribing for opioid dependence.

The New York City Department of Health and Mental Hygiene has been, and will continue to be, an enthusiastic partner with our State colleagues in charting a course for our system's transformation. We will also be vigilant in monitoring progress toward our shared goals specifically for the people of New York City. The complexity of this task is immense, but so is the potential to benefit the people we serve.

Bullied from page 27

like me and the one that has helped me the most and has had lasting effects has been a 12 step program known as Food Addicts in Recovery. The things that make it work for me are the spiritual aspects, plus the camaraderie of people who understand and who are also recovering from this disorder. I've learned a lot about how to survive this disorder, but it has been a cruel teacher. Like most addictions it is too powerful to battle with willpower. Furthermore I've learned that I can't do it alone.

Overcoming any addiction is not for the faint of heart. It takes a lot of courage. I am not faint of heart. Over the course of my life I have experienced and risen above many difficult things often under adverse circumstances. I grew up in a logging camp and lived my childhood in poverty. I've learned to live with depression and anxiety. I have survived unhealthy marriages and unfair divorces. People close to me have died. I've earned a couple of Master's degrees and a PHP. I've managed large complicated behavioral health programs. So I'm no sissy. Yet, nearly every day, I am faced with the challenge of overcoming this addiction.

One of the most valuable lessons this pitiless teacher has taught me is that when I have the urge to indulge in compulsive eating, it is usually not because I am hungry. It is because I have lost connection with my spiritual anchor. This leaves a void that my brain wants to fill with food. However, there is never enough food to fill that void. So when I feel the pull to think about or indulge in compulsive eating that is a message I listen to with my third ear. It tells me to take a minute and reconnect to my true self and to re-anchor my spirit. This is not easy to explain, but it has to do with moving from my head to my heart, and then to connect with what's going on around me from that point. By "heart" I mean that place within me that is truly me.

What I just said in the paragraph above has sometimes been the basis of rooky diagnosticians labeling me with a borderline personality disorder. They are usually looking for evidence of this anyway since they think that eating disorders and personality disorders are close associates. Please don't discount my explanation of this struggle by labeling it. Just let it be. That is what I have had to do.

Another lesson that has been hard to learn is to stay away from highly addictive foods like flour and sugar. I have to remind myself that eating is about nurturing my body, not about having a party in my mouth.

I've alluded to this earlier, but just in case you missed it, I want to close with some advice I give myself every day. Don't fight it. When you fight it you give it power and it will win every time. Don't try to outsmart it. It knows your brain and will use it against you and you will lose every time. Don't deny it. It will continually produce evidence that it is ever present and you will be the only one fooled.

Surrender. Don't give up, but surrender the outcome to whatever higher power you can find. Make a food plan you like and follow it. There is freedom in this approach. Don't try to do this alone. Find kindred spirits who will understand your struggles and support you.

I wish you the best on your journey to wholeness and health.

To learn more about Lori and her work go to: www.recoveryopportunity.com.

Humanity from page 20

create collaborative efforts with clients, colleagues and administrators to implement practices that promote racial healing and racial equity. We organize to dismantle policies and practices that do not benefit our clients.

Bringing an anti-racism culture and mission to an agency is a slow process that involves a thorough examination of the agency's practices and history by all stakeholders. Undoing racism requires persistence.

Has It Been Done?

Yes. On a large scale, the Texas Department of Family Protective Services has been undertaking, from 2005 to the present, statewide re-organization aligned with anti-racism principles. This effort resulted from an in-state legislative study that found disproportionate reporting of African-American children to protective services and their placement in foster-care.

Stakeholder teams, including clients, were developed to address issues of staff recruitment, training, as well as services of investigation, placement, removal, placement and reunification. All managers completed Undoing Racism© training in order to understand that racial disproportionality is a manifestation of systemic/ institutional racism.

As a result of this massive undertaking, placement of African-American children has been reduced, families are stronger, workers feel more effective, and the state of Texas is saving significant sums of money.

Another example: The Human Services Council of New York City has sponsored Undoing Racism training for agency executives for ten years. As a result, many human services agencies include undoing racism in their core missions. In these agencies, leadership and staff recruitment, service delivery and accountability has changed to incorporate an anti-racist approach.

Who Is Doing This Work?

Fifteen years ago, 60 New York City-area social workers participated in a two and a half day Undoing Racism workshop conducted by the Peoples' Institute for Survival and Beyond. Realizing that their respective agencies were not incorporating anti-racist practices into client services, they formed the Anti-Racist Alliance to bring collectively a clear anti-racist vision to their work and to organize more human-services workers and agencies to participate in the Undoing Racism workshop.

Their goal was to equip a critical mass of human services professionals with an anti-racist lens, so that they could then begin to transform their agencies to reduce racial disproportionality and bring about more equitable outcomes. As part of the mission to educate and to organize, the Anti-Racist Alliance arranges Undoing Racism workshops by the Peoples' Institute for Survival and Beyond throughout the greater New York City area. To date, more than 8,000 people from hundreds of agencies and schools have been trained. Their antiracist organizing has expanded into many other cities.

How Can We Learn
More and Get Involved?

The Anti-Racist Alliance offers web-based resources and information at www.antiracistalliance.com. Upcoming Undoing Racism workshops are listed on the website, along with other events to support human services professionals in developing antiracist knowledge and skills. Visit the website and learn. Attend an Undoing Racism workshop and encourage your agency to participate in Undoing Racism training.

The Peoples' Institute for Survival and Beyond teaches that "Racism is the single most critical barrier to building effective coalitions for social change. Racism has been consciously and systematically erected, and it can be undone only if people understand what it is, how it functions, and why it is perpetuated."

Racism is an unsustainable drain on a faltering economy. In this era of accountability, it is critical that we become accountable to the most vulnerable people: our clients. Consciously working to dismantle the barriers of inequity means undoing racism, so as to ensure the humanity in human services work.

Enhancing from page 26

our functions were quite straightforward. We managed the utilization of services and therefore, managed financial risk. Managing services was a much simpler function at that time. In 1995, we only had five levels of service that included outpatient, day treatment, partial hospitalization, residential and inpatient services. That was it. We managed clinical services through the development of level of care guidelines and the use of utilization review. We would bring together respected clinicians from the community to help us identify inclusion and exclusion criteria. An appeals system was available to request a review of denials when the provider or family disagreed with the decision. As a result of so few levels of care, service options were very limited.

We also managed the provider network which consisted of credentialing tasks, renewals and recruitment where we had access deficits. Additionally we were responsible for ensuring quality measures were achieved and this required us to have a data system that was capable of collecting data from our providers and formatting it according to state specifications and then submitting it. We produced very simple data reports that shared penetration rates by geographic area, number of complaints, number of appeals, etc. We were accountable for contract deliverables but there were no financial penalties in those early days of managed care for missing objectives.

Today, managed care still performs these basic functions, but the scope and sophistication of work efforts have expanded. Our contracts now require us to monitor for complex medical conditions, coordinate and share information with primary care, provide wellness and technology solutions; use predictive modeling packages to identify high users of services and identify gaps in service, and reduce emergency room visits and hospitalizations. There is a new focus on reducing readmissions as well. We are also tasked with developing innovations to address all of these issues. There is a serious commitment to achieving the triple aim through enhancing the member's experience, improving outcomes and reducing cost trends. The use of peer support services in achieving all of these outcomes is a major investment and innovation for managed care today. At Optum, we invest in medical economics, the identification of existing and emergent evidence-based practices, and training our networks to become proficient in these practices.

Turning data and data analyses into useful information that can be shared with all stakeholders to reduce variation and improve outcomes is a major function of managed care today. The use of dashboard reporting on websites provides a new transparency that allows consumers to make better choices about where to receive services. These new and enhanced services give providers, families and consumers new information to meet both the physical and behavioral needs of our members. The speed of evolution of solutions is greatly enhanced today by advances in both peer support services and technological innovations.

Ensuring a Successful Transition

An assumption of positive intent of all stakeholders is a productive approach that will lead us all in the right direction. Consumers, providers, and managed care companies are truly much more aligned then we expect. All stakeholders are concerned about outcomes. Consumers want to feel better and lead enriched lives. That is also what providers and managed care companies want, for that achieves the triple aim of improved care, improved health, and reduced costs.

To get there, together, we must all shift our beliefs and our behavior. Together, we must protect the continuum of health care resources in New York City. While successfully deployed managed care programs will likely shift services, outright service disruption is completely unnecessary. The focus should be on "repurposing" services and resources to support an improved delivery system.

As a community we can continue to work together to identify existing gaps, consider solutions, make recommendations, and implement improvements. Optum believes that it is incumbent upon all of us to continue to transform the nation's crisis system into a community-based, recovery-oriented response system integrating peer supports and a no-force approach to care.

1. The National Association of State Mental Health Program Directors (2006). Morbidity and Mortality in People with Serious Mental Illnesses.

New Chairman from page 28

and recovery across the lifespan in all possible domains and be the 'must-read' for all matters related to behavioral health. Both *Behavioral Health News* and *Autism Spectrum News* are indispensable guides to the current state of affairs in our respective communities and provide important content to our readers while furthering best- and emerging-practices as well as promoting important advocacy initiatives to further improve the delivery of services for our consumers and families."

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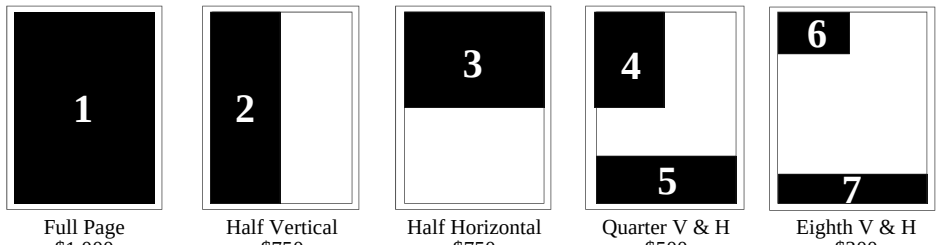

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